

Dr. Lynn McPherson:

This is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast series brought to you by the online master of science, PhD and graduate certificate program in palliative care at the University of Maryland. I am delighted to welcome you to our podcast series, titled Founders, Leaders, and Futurists in Palliative Care, a series I have recorded with Connie Dahlin to support coursework in the PhD in palliative care offered by the University of Maryland, Baltimore.

Connie Dahlin:

Welcome, everyone, to our podcast series. What Comes Next? The Future of Palliative Care. Today, we are going to talk with an expert in the field, Kathleen Kerr. Kathleen is a health care consultant in private practice in Northern California. Her work is focused on scaling sustainable models of community-based palliative care, with a particular emphasis on payer provider partnerships and supporting programs that operate in underserved and rural areas. Ms. Kerr has worked in several statewide initiatives sponsored by the California Health Care Foundation, including multiple efforts aimed at facilitating implementation of their California State law that mandates access to palliative care for the seriously ill Medicaid beneficiaries. She's a long-time member of the selection committee of the American Hospital Association Circle of Life Award, which recognizes excellence and innovation in the delivery of hospice and palliative care across the continuum. And she serves on the national hospice and palliative care organization, Palliative Care Council. So welcome Kathleen. Indeed, welcome.

Kathleen Kerr:

Hi. Thanks for having me.

Connie Dahlin:

I would love you to introduce yourself and talk about what is the most entertaining thing about you that we don't know from your introduction?

Kathleen Kerr:

Well, as you said, Kathleen Kerr, healthcare consultant. I'd like to think that most people don't know most things about me, entertaining or otherwise, but something that stands out, for a couple years up until just about 2021, our little 1,690 square foot house was multi-generational. And we had our census maxed at 13 mammals, 7 humans, and 6 other mammals. And at that point, my wife and I put down a moratorium and nothing else at the heartbeat was allowed to move in until something else moved out. And we've since settled into a much more manageable census of six mammals.

Dr. Lynn McPherson:

There you go.

Connie Dahlin:

Wow. Okay. Well, that's palliative care, it's best. Thinking about the population and thinking about serious illness and all of that care.

Kathleen Kerr:

We had a population, definitely.

Connie Dahlin:

So tell us a little more about what you do in palliative care. And what do you love about it?

Kathleen Kerr:

Yeah, well, I do lots of things. When I saw this was coming up and saw that was a question, I actually looked and I have 10 clients and 15 projects right now. So I do a lot of different things. I do technical assistance. So it's just offering frank advice and providing support for programs. I do some teaching work. I do typical consulting work where I offer advice on strategy, or program design, or how would I evaluate something? I work on actual evaluations. So foundation X has invested X amount of dollars over Y number of years into palliative care. And they want to know, "Well, what was the impact of all that?" And I can go and help them figure that out. I do analytics. So looking at data sets to try to gain some insights from that work. And I help with tool development, tool design.

I do some of that work with some close colleagues I worked with for a long time, trying to develop tools, often spreadsheet or narrative or database based that help people put in information and do some scenario modeling or understand what is happening or what is needed to increase the probability that they'll be able to offer quality, sustainable palliative care to a particular population.

Connie Dahlin:

And I think you've said several things that are so important at this time of thinking about equity and sustainability. Because I think with your focus on metrics, we've moved beyond the heart of only doing it because we want to do it, but making sure that it's compatible with reimbursement and quality that makes it sustainable.

Kathleen Kerr:

Yeah, absolutely. When I think of quality, I think it's really useful for people to go back to the basics, to the heart of what that means. And I like the who definition where you think of quality as being efficacy. So does it work? Does it do what you intend it to do? Efficiency? Efficient, so is it helping to steward resources or prevent waste of resources. Safety? So is it safe and is it not introducing new risks or harms? Timeliness? So are you able to deliver it at the time when people need it? Equity? So is it available to all, is there justice there? Or is it only available to a few and then really what that heart of palliative care is it's patient centered. And so I think it's still part of quality and it's still something that can be measured, but it's measured as part of a portfolio of domains that point to quality health care.

Dr. Lynn McPherson:

So interesting. If I could just ask one question, Connie, I think hospice was in for such a shock when they realized that it's not all kumbaya, that this really is a business. So for you to talk about strategy and quality and metrics and measures, I think that was a hard-learned lesson. Do you agree?

Kathleen Kerr:

Yeah. And I think it's maybe the pendulum has swung a little bit in some facets of the field of hospice and there's some lessons there that palliative care can learn from. I think that hospice had that rich history of being anchored in volunteerism and compassion and caring for the dying and involving the community, and what Connie called that the heart of end of life care. I think that with the introduction of the demonstration project and the benefit, which didn't happen till many years after hospice was first established in the United States, I think it was still dominated by folks who were very interested in that

part of it. I think that to survive, even nonprofit entities, had to learn to operate within the confines of the available revenue. But I think as the model has been scaled and it's available now in most communities, and as some of those entities have developed other lines of business, or perhaps have been consolidated into organizations that have a for-profit tax status, that at times it's been too much of a business.

And so I think there was a shock and a correction, and then maybe a little bit of an overcorrection in some places. And it's perhaps a moving target, but it's also possible to err on either side. You can try to offer too much of everything that very vulnerable folks and families that are in very difficult situations need, so they'll blow up the scope and elevate patient centeredness, but then they're going to lose sight of all those other issues related to quality, such as efficiency and efficacy and timeliness and all of those things, which you can't maintain for a population unless you have an enormous staff and unlimited resources. So it's really a balancing act. One of my favorite things in recent years has been involved in projects where there's both providers and payers in the same project, often in the same room, working on the same problems to try to figure out what you need to develop care models and contracts with expectations around revenues and reporting, and also hitting benchmarks and metrics. How do you approach those things in a way that's going to work for everybody?

And I, typically, talk about how it's a balancing act where it has to be level, where the scope of service and the cost of delivering care and the amount of payment that you received to do that care is aligned with the outcomes that justify the fiscal output on the part of the payer, the health plan or the ACO or whomever. And if any one of those three bits gets out of line, your service is not going to be sustainable or it's not going to be effective. And if you keep the balance in mind, you don't have to do away with the heart or do away with the business. They just have to be all sitting there together in a way where everybody's getting enough of what they need.

Dr. Lynn McPherson:

I love that.

Kathleen Kerr:

Does that answer your question?

Dr. Lynn McPherson:

Absolutely. Absolutely.

Connie Dahlin:

That was great. When you think though about this quality and metrics, you spoke a little bit to it, I think, of the being out of balance. But when you think about where we are and where we're going, what are your biggest concerns or what do you think the biggest challenge is?

Kathleen Kerr:

Yeah, there's so many challenges. My biggest global concern is an absence of standardization and regulation, which means a ton of variation. And the variation exists across multiple domains. There's variation in eligibility criteria for palliative care, who it's being delivered to. There's variation in the care model, so who is doing the care delivery and which combination of people, or even if it's a single person. And there's also variation in scope, what they're intending to do for that population. And then there's variation in quality that comes from the team that's assembled and the amount of time they have and

the money they're being paid that dictates the time, [inaudible 00:11:02] absence of training. So all of that variation, it's a very dangerous mix in particular because many people, including all non-palliative care providers, just about, most patients and families and many payers, including health plans, they don't really know what palliative care is.

They could not define it, or if they defined it, it would be a little bit unfortunate in the way that they do. Most folks don't know. And when you combine lack of familiarity with tremendous variation and the variation leads to variation in quality, it sets things up where the first experience that a referring provider or a patient's family or a health plan has, those early experiences, cement in their mind what palliative care is and what the expected impact is. And it could be a great experience, but it could also be a really bad and unsatisfying experience. And I would include in that also an experience that appeared to have no appreciable benefit. Didn't provide enough service to actually change a symptom profile, or didn't provide the right service to change the way that a patient would use healthcare resources. So no impact on costs.

And so that even though palliative care has been around a while, we're at such an important point in time in terms of trying to scale, that this variation and the confusion it causes for referring providers and patients and families and payers, and also the variation in experience they have with the service can really slow scale, because you can have a health plan that says, "Oh, we tried that. It didn't work." It is going to be a long time before they try it again. It's the exact same thing that we saw when folks are trying to scale inpatient palliative care services. If they had a bad experience early on, it would take years for them to try again. And so that really, really worries me. The absence of standardization. Absence standardization also creates an opportunity where profit motive, whether it's done by a nonprofit entity or for-profit entity, can be inappropriately elevated.

And if all you're looking to do is spend the least amount of money possible to check the box and hope that you're going to control costs, you can wind up offering really non-optimal care. And I think there's some lessons in other healthcare sectors there, and I'm hoping that palliative care can learn from them. And I do think one way to reduce the variation, ensure a minimum level of quality. And then you can talk about the metrics that are right to look at. A lot of that can flow from standards. In hospice, there's conditions of participation and there's minimum requirements. And you know there's at least a certain amount that you're supposed to get. And if you don't get that, then the money can be clawed back and there's penalties to pay. There's no such situation like that in palliative care right now. So you are free to call just about anything palliative care, and there's nobody who can tell you to do otherwise. And I think that is a big risks to quality and it's a huge impediment to measuring quality.

Dr. Lynn McPherson:

Connie, can I build on that?

Connie Dahlin:

Sure.

Dr. Lynn McPherson:

It seems to me listening to you speak that this lack of standardization also could be contributing to what I perceive as a lot of room to grow in our continuum of care, from community-based palliative care, to inpatient palliative care, to home-based, long-term care based, and hospice finally. Just seems like we're the only funky in the world that has parsed it out in this fashion. Do you agree with that? Or how can we fix that do you think?

Kathleen Kerr:

Yeah, I do agree with that. I think there's a lot of smart and really well-meaning people that are trying to shoehorn the services that we know benefit seriously ill individuals and their families into the very oddly structured boxes, which are the things that our healthcare system currently pays for. And I think there's a lot of potential for that to be corrected through health plans and MA plans, Medicaid, managed care plans, commercial plans to re-envision services outside of the narrow confines of what we think of as particular clinical services or benefits and think more longitudinally about what is it that we know this person and their family, when they reach a certain stage of heart failure, or a certain type of cancer, or certain level of compromise because of COPD or dementia, we know what helps. And how can you define a benefit that allows for titration of the right amount of care in whatever setting they happen to be in?

And I think there is a struggle with too hot and too cold. There can be folks who are enrolled in hospice for two years, because that's the only service that provides an interdisciplinary home-based support, when they could be served maybe even better with a different construct of services offered through a home-based palliative care team. And so you're spending more money on not the exact right intervention. So it can be too hot or too cold, not enough care or too much care. So I think getting over this concept of clinical services as they're defined in payment benefits and helping those that are responsible for the financiers and purchasers of healthcare, to realize that there's a better way and to allow for payment models that are aligned with that better way. That's the promise of the future. And you could say that VBID is getting there a little bit, or there's more MA plans that are interested in home-based medical services.

There's certainly entities that have been offering a continuum of services, which they may or may not be entirely sustainable, given the payment models. Connie and I have seen some of those should the Circle of Life Award committee meetings. There's folks that are doing it. It's that alignment that we talked about. You have to have the payment mechanism and the payment amount and the cost of care delivery all lined up. And it's not impossible to do. A lot of it has to do with what we're accustomed to. There's no law of physics that prevents us from creating a payment mechanism that offers that flexible continuum of care that we can envision.

Dr. Lynn McPherson:

That would be lovely.

Connie Dahlin:

Kathleen, so here's a question for you though that I'm curious about. So as you know I'm pretty invested in the NCP guidelines, since I edited several additions, was there from the beginning. And the whole goal of that was to try to have the standardization of palliative care without the blocking in that the hospice conditions of participation did. A very good benefit, but a lot of people would feel like, in fact, that closed things in. And that was to have standardization. Do you see any ability for us to be using those in a more systematic way for quality and in a metrics form that's your expertise?

Kathleen Kerr:

Yeah. I am a huge fan of the NCP guidelines, in particular, the last version, which talked about delivery of palliative care in different settings and primary palliative care versus a specialty. I think it's an amazing document that has a lot of terrific guidance. I think, I mean this from a position of tremendous respect, it's too long and too guideliney to serve as the basis for standards that you can't handle the NCP

guidelines to awesomehospice.com and say, "Okay, you're going to be offering palliative care now. Read this and do what's in there." That's just an unworkable structure. If you're trying to educate a local health plan about palliative care and what it could do for their members, you can't say, "And here's this amazing 90-page document. I need you to read through. And when you're done with that, we can get together and talk about the specifics of the contract."

Now, there are certain parameters that need to be built into a benefit that are more concrete and also a little more practical than what's in the NCP guidelines. So I think anybody who's delivering palliative care should read NCP guidelines. I think if you're offering a health plan benefit in palliative care, it would be awesome if the medical director read the NCP guidelines. But if you're sitting down with the folks who do contracting or network development, or are looking over time to see if this organization delivering the type of care that we want our members to have, the NCP guidelines are just too exhausted to fill that role.

Connie Dahlin:

So what would you suggest instead?

Kathleen Kerr:

I think you can get at minimum standards. So it's certainly the experiment that was run in California with the Medicaid managed care mandate, they set out minimum scrimmage. You at least have to offer palliative care for these people, for these types of members. You at least have to offer this set of services. You at least have to engage with these types of providers to deliver it. And it was an absolute floor. And the same thing can be said of the California Advanced Illness Collaborative standards for community-based palliative care, which were developed almost at the same time that the SB 1004, the Medicaid palliative care, benefit came out in California. So there's a set of standards that were developed by the Coalition for Compassionate Care of California in partnership, co-sponsored by Blue Shield of California. And there was a group of health plan representatives and palliative care provider representatives, and a little bit of policy work in there as well.

These poor people who met in a conference room in Sacramento for a couple hours early in the morning, over the course of a couple of years, to try to iron out what are the minimum standards that we think should be there. And it's really, really hard to do, to reach agreement across those different stakeholders, but they came up with a set of minimum standards and it's exactly the same as the SB 1004 standards, but they're close to the Medicaid palliative care standards. And it's like, "Look, you can do a ton more than this, but at least do that." And I think that if you at least set those minimums, you get rid of some of the worst types of variation. So having just a checkbox on a home health nurses orders that says, well, you're going to be doing palliative care with this person you're about to visit.

And that nurse may have no training, no other tools, no other team to work with, but then that gets called palliative care. Or maybe you have a physician consultation service where that one individual is offering palliative care, but they don't have the nurse, and the social worker, and the chaplain and the community health worker or anybody else to help with the things that they didn't do such a hot job of teaching in medical school. And that could be called palliative care, but neither of those models would fit the minimum requirements as put forward in SB 1004 or the CAIC's standards. So I think you can get rid of some variation and help have something that's practical, but not limiting, if you set minimum standards. I think that also encourages people to, in the absence of a mandate, which is hard to get, having minimum standards, encourages folks to dip a toe in like, "We're only going to do the minimum that's required in these standards."

And they had to do that in California with Medicaid, because it was a mandate and some plans were all over it and had pilots running for years before the benefit took effect. Others, you could see the skid marks on the floor. They came kicking and screaming into delivering palliative care to their members and they just had to do the bare minimum. And that was fine. Just do the bare minimum. And then they could sit back and watch and see those had more robust programs and where they had put more effort into it, better enrollment, better impact for their members. And really just a better experience in interfacing with the palliative care providers in their community and the other members of their clinical care network that referred to palliative care. So if you just create a very doable minimum, I think that gives people something to build off of. And it still allows for differentiation for those that are doing it super well and to be recognized for that, and then perhaps pick up more of the market.

Connie Dahlin:

So when you think about quality moving forward, what do you think we need to focus on?

Kathleen Kerr:

Well, I think correcting the absence of standards and regulations is probably one of the most important things. And I think the step that's available now is encouraging organizations to be accredited or certified and encouraging individuals to get certification, whether that's board certification for a physician. But I think the much more doable mid-career certification that's available to all levels of nurses and social workers and chaplains. I think there's ways for community health workers to get education in palliative care, plan case managers. So I think that training on the individual level and certification and accreditation on the provider organization level will do a lot to help. It's assuring some minimum sets of structures and processes, which, if you talk to some folks, is really the way to go given the changing nature of what's preferred and possible amongst the seriously ill.

So you can have situations where a symptom scores may not be the best measure of what that person wanted. Or care concordance is really hard to measure, unless you measure it serially, because people's preferences change over time. But what you can measure is do you have an organization that has people that are appropriately trained in palliative care? Are you doing a comprehensive assessment for everybody within a certain period of time? Are you documenting? Do you have a goals-of-care conversation within a certain period of time and that it's repeated? Are you available 24/7 in some meaningful fashion so that you can help with crises? Are you asking the people that you serve, "Do who to call if there's a crisis? Was I treated with respect? Would I recommend this to family or friends?" You can measure those things, even if you don't know the perfect benchmark to aim for, in terms of pain score modification or proportion referred to hospice, or whether what's the right number of folks to have to have an advanced directive.

So many things about the population we serve, make universal measures of outcomes difficult, but universal measures of process much more doable and probably almost more meaningful.

Dr. Lynn McPherson:

For obvious reasons, I'm very pleased to hear you talk about the training opportunities. I hear the University of Maryland's got a pretty cool program and a master's degree and a PhD in palliative care. Right, Connie?

Connie Dahlin:

Yes.

Dr. Lynn McPherson:

Even if we could just get a learning unit on primary palliative care skills in every professional school, that would be huge. Don't you think?

Connie Dahlin:

Yeah. Yes.

Kathleen Kerr:

Yeah, I do. There's this amazing project which will be coming to a close in September that the California healthcare foundation sponsored, includes nine of the county safety net hospitals in California. and it includes the leads of their palliative care service and then a partner service line. So trauma surgery, or the heart failure clinic, or radiation oncology, or the oncology clinic, or primary care practices. And the entire goal of the project was to introduce an improvement in primary palliative care in the partner service line. And they were able to select a target population. So who do you want to be doing this? And what's the specific behavior. So very, very focused. We want people to document goals of care discussions. We want people to measure pain with a peg score. We want people to develop a meaningful plan of pain for the folks seen in radiation oncology.

And these projects are incredibly successful. They've done really wise things with leveraging the capabilities within the EHR to identify populations and offer prompts to remind people to do the behavior. And then also easy ways for them to document that they did it, so that they can monitor their impact over time. They're very low cost. They're very high yield. They're very satisfying for these folks. I can't tell you how many people I've heard everywhere from nephrologists to the nurse practitioner and the heart failure clinic through this project say, "We knew that our patients needed this, but we didn't know how to do it." So it's just a matter of connecting with a palliative care provider, giving them vial training or some CAPSI courses or whatever it was that was appropriate to their goal. These people experience distress, even if it's a little bit varied, of knowing they should do it, but not knowing how.

And then once they know how they become amazing ambassadors for the learning with all of their peers. So we're in the process of seeing the end of these projects, but then doing write ups of them that are detailed enough, so that you could almost do a toolkit sort of thing. Well, I already did heart failure clinic here. Let's try with that nephrology line. Or we have a trauma surgery team that's interested, let's do that. And so the hope is by scaling that way, you can create very feasible, integrate it into the work plan appropriate for the amount of time that these folks have to spend on palliative care, helping them to help their patients on a scale that you could never achieve with specialty service. So the thing that blew me away with this project is the scale.

And once you get into primary care and we're going to do this for everybody over the age of 60, it's like, "Wow, how big of a palliative care team would you need to take care of all those people?" Are all those people coming to the ED. So, I agree with you, primary palliative care is super important and super simple measures there, like documentation of a goals-of-care discussion, or documentation of a surrogate. Just get the process going and get it on the radar screen of the department, acknowledge it as something that's important. And that's plenty. You don't need six-part evaluation plans that take a 0.5 FTE of analyst. Use your EHR, be smart about it. Pick the thing that tells you was the behavior done and a little bit about did it achieve the effect that you needed, and you got two measures and away you go.

Connie Dahlin:

Wonderful. Great. Well, last question, Kathleen is you are very excited about what you do. It's clearly you're passionate and who would have thought that 50 years ago, we'd be talking about quality metrics and whatever. So if you think about people going into the field, one, or people who are thinking about going into quality, what advice would you give them at this point?

Kathleen Kerr:

Yeah, I think so many things. One rule of thumb that I hope that your program enrollees would take to heart, is I think it was back in 1999 that Don Berwick published an essay called Escape fire. And there was a great movie, a documentary made, but the essay itself, which you can grab off the Commonwealth Fund website, it's a very interesting discourse about his family's experiences and what's wrong with the healthcare system, and what does it take for new innovations to take hold? And my colleague, Brian Castle, and I we're very, very taken with this. We actually used it in an introduction to a paper we wrote for JPSM on the business case for palliative care. And in Escape fire, Don Berwick identified four domains slash groups that all have to be on board if you want some new intervention or innovation to take place.

So that new thing needs to make sense from the perspective of science, of evidence and professionalism. It has to be something that actually works and that there's proof that it does good. It has to make sense from the perspective of patients and families that are getting the care. So they have to understand what this will do for them and why they should accept it. It has to make sense from the business and finance perspective of healthcare. So it has to be sustainable. It has to make business sense. And, finally, it has to make sense to what Berwick called the good kind people that do the caring work. So providers. Whether they're palliative care providers, or the oncologists, and nephrologists, and others who we want to refer their patients to palliative care. And I've seen that dynamic play out in the palliative care programs that have been started and failed or started and thrived in the real world, that it does need to work across all four of those domains.

And the thing that I would offer as a good touchstone for people who are getting into this field is to remember those four areas and to respect all four of them. And I think it's very natural for the providers, the nurses, and physicians, and pharmacists and social workers that are doing this work. Of course, we are going to approach patients and families with humility and respect and curiosity to find out what's important to them and to try make our actions be guided by what's important to them, to account for their preferences. And I would suggest that as a field, we would do a whole lot better if that same respect and curiosity and humility was extended to all four of those areas that need to be on board, if we're going to scale and optimize this model.

So take a deep breath and approach health plan representatives with respect and humility and curiosity, and find out what their priorities and pressures are and what's important to them use that same approach when you're talking to the oncologist, who never refers their patients who are suffering, because they don't do so. Find out why, and try to understand their needs. And you're still allowed to not meet those needs. And you can use I wish statements. "I wish I could. I wish I could offer all of these services for \$300 a month. It's just not possible." Use your training and your skills, but be mindful of, and respectful of, and curious about all four of those areas and bring that into your research or your teaching or your practice or the organizations that you're starting. And if you do that, everything has a much greater chance of being optimized, scaled and sustained.

Dr. Lynn McPherson:

Wow.

Connie Dahlin:

Wow, Kathleen. Well, that's really impressive. We'll have to make sure that we have that article available for people to look at, because we know that everybody has their different articles. So we're so appreciative of you spending time and offering your thoughts and perspectives. I think this will really be helpful for our students to be thinking about all these different places. And so thank you very much. Lynn, do you have anything else to add?

Dr. Lynn McPherson:

No. And our podcast listeners, as a whole, I think this was eye opening and I've been in this field a long, long time, and I learned a lot in this half an hour. So thank you so much.

Kathleen Kerr:

Well, thank you. It was my pleasure. You guys take care, and good luck with your podcast, and good luck with your PhD program. I can't wait to see it in action.

Dr. Lynn McPherson:

Thank you so much.

Connie Dahlin:

Thank you. All right.

Kathleen Kerr:

Bye-bye.

Dr. Lynn McPherson:

I'd like to thank our guest today, and Connie Dahlin, for the continuing journey in our podcast series, titled Founders, Leaders, and Futurists in Palliative Care. I'd also like to thank you for listening to the Palliative Care Chat podcast. This is Dr. Lynn McPherson and this presentation is copyright 2021, University of Maryland. For more information on our completely online master of science, PhD, and graduate certificate program in palliative care, or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.