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Judy: Hello, and welcome to our webinar today. Thank you for joining us. I'm Judy Thomas, CEO of the Coalition for Compassionate Care. We are excited to be able to share with you today our experience with making community-based palliative care a more routine part of healthcare, through the development and evaluation of consensus standards.

We believe the information we will be sharing today will be a value to a wide audience, including policymakers and advocates, both at the state and national level. Health plans, both that currently provide community-based palliative care as a benefit and those that do not. And providers of palliative care, both those who already have value-based contracts with payers, and those who would like to establish such contracts, as well as researchers.

We believe the information we'll be sharing with you through this webinar series is unique. To our knowledge, this is the first effort of its time to standardize community-based palliative care on a statewide basis, across all payer lines. And to evaluate community-based palliative care across all payer lines, including Medicaid, Medicare, and commercial populations. Next slide. Can you move to the next slide? We are excited to welcome our 220 attendees from 33 states to today's webinar. I just want to do a check with my team here, oh, there it is. Thank you.

Just a few housekeeping items as we get started here. First, this webinar is being recorded, and you will receive an email in the next few days with a link to both the recording and the slides. Second, we will be using the chat box for questions. So, please feel free to post questions in the chat box throughout the webinar. We will pause during the webinar to answer questions. Next slide. Today's webinar is the first of a three part series. Today we'll be –

So, for those of you who are not familiar with the Coalition for Compassionate Care of California, we are a nonprofit dedicated to creating a future where people live their best lives possible during serious illness, by making conversations about serious illness a part of everyday life and palliative care a part of everyday healthcare, wherever people receive care. We know that this change is bigger than any one of us can do on our own, and that's why we work

collaboratively across stakeholders to change the system for everyone. Next slide.

I'd like to take a moment to thank our sponsors. First and foremost, I would like to thank the California Health Care Foundation, whose generous financial support funded the demonstration project that tested and evaluated the impact of the consensus standards and is the focus of this webinar series. I'd also like to thank John A. Hartford Foundation and Atlantic Philanthropies, whose financial support through the Practice Change Leaders Program made development of the consensus standards possible. And lastly, I'd like to thank our national partners that sponsored this webinar series, including NHPCO, C-TAC, and HCCI. Next slide.

Today's webinar is the first of a three part series. Today we'll be talking about the rationale and impact of consensus standards, including why consistency matters, what types of variation were diminished when health plan contracts were met or exceeded the standards, and what types of variation persisted even with the standards.

The second webinar, which will be held one week from today, we'll examine the financial outcomes and explore whether those outcomes were sufficient to make community-based palliative care sustainable. The third webinar, which will be held two weeks from today, we'll delve more deeply into lessons learned and how to build on these learnings to drive increased consistency and quality in community-based palliative care.

Please note that you must register for each webinar individually, that you wish to attend. Each webinar has a separate registration and Zoom link. Next slide. It is my distinct pleasure to introduce our presenters for this webinar series. First, Dr. Brian Castle is a PhD researcher in palliative care, as well as associate professor at Virginia Commonwealth University School of Medicine, where he is leader of the cross disciplinary Palliative Care Research Interest Group. Dr. Castle's research focuses on outcomes of specialty palliative care, especially economic outcomes. While Dr. Castle will not be presenting today, he is on the webinar and will be helping to moderate questions in the chat box and at the end.

Kathleen Kerr, who you will hear from today, is a healthcare consultant in palliative care, quality assessment, and program evaluation. Currently, 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 under resourced and rural areas. Again, I'm Judy Thomas, CEO of the Coalition for Compassionate Care of California, and I've been leading the Coalition for 20 years and my background is in healthcare law and policy. Next slide.

So, for today's agenda, first we're going to review the background of the consensus standards. And then, we'll provide an overview of the standards themselves, as well as a deeper dive into the impact of the standards on community-based care variation and the experiences of the payers and providers that participated in the demonstration project. Along with a time for reflection and discussion. Next slide. We have a wide audience today.

So, just as a little level setting, as many of you know, palliative care is specialized medical care for people with serious illness that relieves the symptoms, pain, and stress of a serious illness, improves quality of life for both the patient and the family, is provided by a team of doctors, nurses, and others who serve as an extra layer of support, and is appropriate at any age and any stage in a serious illness, along with curative treatment. For purposes of our discussion today, community-based palliative care is palliative care provided in a home, wherever, and in whatever setting the individual calls home.

So, what inspired the creation of these standards? Well, in 2016, research showing the positive impact of palliative care was growing. National guidelines for the clinical practice of palliative care were well developed, and a lot of progress had been made in making hospital-based palliative care a standard part of acute care. But when it came to the delivery of palliative care outside of a hospital setting, the path forward was unclear. In California, with the support of the California Health Care Foundation, opportunities for moving community-based palliative care forward had been examined and studied.

Payers and providers who were early champions for palliative care have received support to establish community-based palliative care benefits and programs. But this work did not lead to a scalable model that supported statewide spread. Also around this time, legislation had been passed in California to require our Medicaid program, Medi-Cal, to make community-based palliative care available to Medi-Cal beneficiaries.

And our state was deep in trying to figure out what that meant and how to operationalize that mandate. At the same time, there was a

growing concern that some organizations were marketing themselves as providing community-based palliative care, but weren't providing services consistent with national, clinical guidance.

So, the coalition identified a need for broader consensus on how palliative care should be developed, delivered in the home setting. We found a kindred spirit in the chief mental health officer at a prominent health plan in California, Blue Shield. In collaboration with Blue Shield, we convened a workgroup of key and diverse stakeholders, which we call the California Advanced Illness Collaborative, or CAIC. And it's that group that produced the consensus standards. Next slide.

So, why is standardization important? Well, if you have a situation where payers have different definitions, expectations, and/or requirements as to what constitutes community-based palliative care, it creates a very chaotic business environment and a barrier to scale and sustainability of community-based palliative care, which is the exact opposite of what we all want to see.

For palliative care providers who serve a community with more than one health plan or patient populations, they can end up with contracts that impose different requirements for all the basic aspects of delivering care, including how they staff their service, how frequently they visit patients, how they're reimbursed, and how they measure the impact and quality of the service and more.

For health plans, they're left to create their benefit and expectations from scratch. Establishing their network of providers and the contracting process can become cumbersome and time confusing. For referring providers, who are key to getting enough palliative care patients to make sure the service is viable, they end up being confused and unsure about what services their patient would receive on palliative care, and when it's appropriate to refer their patient. For the state of California, they didn't want to be out of the broader healthcare practices, in defining community-based palliative care. Next slide.

So, that's why we came together to develop the California standards for community-based palliative care. So, what do these standards do? The standards put forth a minimum set of services that are to be delivered to a defined patient population. Our goal was to identify a floor, based on best practices, which would be acceptable to any payer or provider. And to the extent possible the

standards are aligned with the requirements for Medi-Cal palliative care.

The standards address patient population, including general criteria and disease specific criteria, essential services, composition of the palliative care team, disenrollment criteria, when does somebody go off of palliative care, whether they graduate or they transition to hospice or they pass away, payment models, measurement, and reporting. And from the beginning, we expected that the payers might broaden the set of services, the team of providers, or expand the patient populations, or build on this. Again, this was intended to be a floor. So, now, I'm going to pass it over to Kathleen.

Kathleen:

All right, hello. Thanks, Judy. Once the standards were completed and released, the idea arose that it would be useful to evaluate them. And so, with the support of the California Health Care Foundation, we launched a demonstration project. And the goal was really to determine if the standards make it easier for the payers and the providers to develop and implement contracts that increase access to quality, sustainable, community-based palliative care services. In terms of the features of the demonstration project, there are multiple payers and multiple providers delivering community-based palliative care in Sacramento and/or Los Angeles.

All of the contract requirements met or exceeded the consensus standards, or the requirements put forth in the Medi-Cal Palliative Care All Plan letter, the requirements for Medi-Cal palliative care. And that's appropriate per business line, so Medi-Cal would be expected to comply with **SB1004**, but all other business lines would be compliant with the standards. Many, but not all of the participating providers had contracts with multiple participating payers, and we encourage that to truly get a sense of what it was like to work from minimum standards.

The project was led by The Coalition, it was funded by CHCF and it was supported by an evaluation team and an advisory group. And it's been a long project. The participants were finally assembled in 2018. The analysis period for looking at the claims data to assess fiscal impacts, that was from January 2019 through March of 2020. And we were doing qualitative data collection and group activities, like webinars, in-person meetings, developing tools together, all the way through December of 2021.

In terms of the payer participants, we had four health plans, three

of them were operating in both Sacramento and Los Angeles. Two only offered Medi-Cal services, so they only offered Medi-Cal palliative care. Two offered community-based palliative care across multiple business lines. The payers had anywhere from 5 to 27 community-based palliative care partners across the two regions. And there was a range of experience with offering community-based palliative care to their members. Two began offering the service upon implementation of SB1004, so pretty new to it. Two others were in the midst of multi-year efforts to develop their benefits and create statewide networks.

Provider participants, there was a total of 11, we lost two along the way and another one joined, so usually had 10. This was a subset of the contracted providers who participated in our evaluation activities and group meetings and so on. The provider participants had a range of one to three payer partners that were participating in the project. But many of them had other payer partners who were not, be they health plans or medical groups or NCOs, etc., who had engaged with them to deliver palliative care services.

None of the providers were delivering services in both Los Angeles and Sacramento. So, we had planned partners that had a presence in both regions. None of the provider partners had a presence in both regions. These groups had a range of anywhere from fewer than 10 to greater than 400 palliative care patients that they saw annually, and those numbers did go up across the project period. And there was a range of one to 10 years of experience in delivering community-based palliative care. So, if you're looking for a varied pool of testers, of standards, we really had it both in terms of the payers and the providers.

In terms of the evaluation, it was a quantitative component and qualitative components. And the questions that we were looking to answer were, do the standards facilitate provision of community-based palliative care services? Is it easier to provide better care if you're working from the minimums that were expressed in the standards? Are the financial outcomes sufficient to make community-based palliative care services sustainable for both the payers and the providers? And do patients and families value the services that they received?

In terms of the data sources that we had, the plans provided demographic data, information about palliative care enrollment, and then claims data, so that we could evaluate impact on important cost and utilization outcomes. The providers shared their

tools and their data that they were using to assess patient experience of care. And the plans and providers shared oral and written information regarding their policies, their practices, and their experiences delivering community-based palliative care. And it's a lot of that information that we'll be going through today.

So, before we move on to talking about sort of specific aspects of the standards and how those worked, and how they were received, any important questions about the standards and the structure of the pilot, that seems like we should address now?

Brian: No burning questions in the chat so far, Kathleen, we've addressed some along the way.

Kathleen: Okay, great. Thank you, sir.

Brian: Yep.

Kathleen: And that was Brian Castle, our chat moderator for today. Okay, let's take a look at some of the specific elements of the standards. So, as Judy mentioned, these five areas are among the six that are included in the standards. Eligibility, so what population would you be serving? Services, what specifically are you doing for these people? Staffing and providers, who's delivering the services? Payment model, and measurement and reporting. And I want to note that payment model and measurement and reporting are not addressed in the guidance put forward to the Medi-Cal managed care plans around the SB1004 palliative care requirement.

Nonetheless, those are certainly issues that need to be addressed in any contract between the Medi-Cal managed care plan and the palliative care provider partner. And just as a reminder, those standards are really intended to set a minimum, and the folks are invited to do more. So, there's expected variation, do at least this, you're welcome to do more. So, as plans do more or as providers do more, you will see variation in what is required and what is offered. The standards also specify the what, but not the how, so you need to offer a specific set of services.

But the standards don't go into a lot of detail about the processes or specifics of how those services are delivered. And you would expect to see variation from that as well. I think it's also useful, at this point, as we're thinking about assessing, determining if the standards work, what was their impact? Is really thinking about what are the hope for effects of setting minimum standards? Well, you're looking to promote some things and prevent some other

things.

And thinking on that variation, that sort of chaotic picture that Judy described in the period in 2016/2017, when the standards were being developed, you would want to define eligibility criteria in the hopes of promoting, getting these services to an appropriate population, and you'd want to prevent being overly restrictive or too loose, giving the services to folks who wouldn't need them. You would want to define services to make sure that there's a comprehensive intervention that's aligned with national consensus guidelines. You would want to prevent too narrow or an incomplete scope. So, we'll come and look at your symptoms, but we're not gonna talk about advanced care planning, for example.

We'd wanna define staffing and providers because you really want to promote use of a trained interdisciplinary team that includes the disciplines that are referenced in our national guidelines. You wanna prevent no team, so you don't want to have single discipline interventions. You don't want to have the wrong team, so the wrong disciplines on it. And you also want to make sure that people don't have zero training in palliative care, which does happen in the absence of standards or requirements.

For measurement and recording, you want to make sure that folks are looking at meaningful and feasible items, and the items that are being looked at are acceptable to both the plans and the providers. And what you want to prevent is no monitoring or excessive or burdensome monitoring.

For payment, you want to make sure that you're covering the entire team in the cost of all the core services, and that there's aligned incentives, and that it's an arrangement that's acceptable to both the plan and the provider. What you're trying to prevent, what you often saw in fee-for-service, is unreimbursable effort from core team members or unreimbursable services that are deemed to be central to palliative care. And also, misaligned incentives. So, incentives to provide a lot of volume versus value-based care.

So, if you're trying to achieve these things with minimum standards, and there's certainly other things that you can be trying to achieve, but this is one perspective on what you're trying to – These are the effects that you're hoping for. If you're not achieving those effects, that lack of success could be a result of a failure to adhere to the standards as written, flaws in the standards, maybe they're recommending the wrong things, or they're too vague, or

there's some issue with the standards itself. Or it could be from implementation issues that are not addressed in the standards, all of those hows that are needed to support the whats that are specified in the standards.

So, keep that in mind. What we're looking for is, did we achieve those hope for effects? Another thing to keep in mind as we sort of position ourselves to talk about assessment is really thinking about variation. And there's several possible causes of variation. You could have expected variation if people enhance the standards, if they're more inclusive in the population they care for, or they specify that they want more services or more disciplines, etc. There could be implementation issues that are not addressed in the standards, and that's certainly happened, and it's not unexpected because there were no specifics in the standards about how to do things.

You could also have variation because there was failure to adhere to the standards. Or variation because of flaws in the standards, there was confusing recommendations or some such. Regardless of the cause of the variation, we'll sort of think of it in two big buckets. So, there's manageable variation and problematic variation. For manageable variation, a good example of that would be one plan, but not another, working from the minimums that are expressed in the standards.

They expanded eligibility criteria. So, there were more appropriate patients who were enrolled, with a wider range of illness, that would be different from plan A, from plan B, perhaps, but it's not problematic. It's variation, but that's okay. It's actually an improvement. Problematic variation would be when there's differences that are difficult for either the plan or the provider to accommodate. So, for example, one plan has extensive reporting requirements that require double data entry, or extra data collection effort by clinical staff. Another plan maybe is asking for different measurement items. That creates a huge burden on the provider, it makes assessments more difficult. That's problematic variation.

So, as we look for variation in the post-implementation period for the standards, we want to consider, one, did we achieve the hope for effects? And two, what were the possible causes and the significance of the variation that our plan and provider participants noted? All right, so let's look at some specifics. So, eligibility criteria. There's a general criteria and qualifications in all of these areas that I'm gonna talk through, you're invited to go to the

consensus standards, or go to the link on the Department of Health Care Services website to review the documents that have the complete requirements and criteria.

I'll just present a brief summary here; there's general criteria and qualifications. Late stage of illness, using the hospital to manage their illness, the patient is not enrolled in hospice and so on. There's four specific diseases that are referenced, both in the SB1004 standards and in the consensus standards, cancer, COPD, heart failure, and liver disease. So, you've got to deliver services to at least those folks.

There's detailed clinical criteria for each of those diseases. That's really there to verify advanced illness in the consensus standards, but not the SB1004 standards, have another diagnosis category. So, folks with other serious progressive illnesses, where you wouldn't be surprised if they had a 12 month or less life expectancy. So, in terms of the operational variation, what differences did we see in the actual contracts, the actual care delivery requirements across plans and providers? Well, there was variation in determining who was eligible. Some plans added eligible diagnoses, others eliminated specific clinical criteria needed to document advanced illness, just to make processing referrals and increasing access.

There's also differences in the ways that plans verify the eligibility. There was one set of practices, which was the palliative care provider completes an assessment. And then, it's assumed that if the patient has these diagnoses, that they're eligible and its automatic authorization. In other processes, review the information about the patient, and then there's a formal authorization process by the planning staff.

Then we asked the plans and the providers about their experiences across all of these five elements of the standards, and so, starting here with eligibility, we asked the plans, "Do the eligibility criteria in your contracts effectively identify the members who would benefit from palliative care?" And while the plans agreed that some important diagnoses were missing, they did feel that they usually accept seriously ill members with other conditions. Interestingly, they noted that the criteria might be too inclusive.

So, there were some issues with the criteria as written, catching patients with chronic illness, maybe pain management, but not really palliative care. And some enrollees were kind of more advanced illness, not really ready for the intensive interdisciplinary

home-based palliative care intervention, in the view of the plan. As evidence of this, the answer to the surprise question is yes, they would be surprised if the patient died in the next year.

And there were also challenges with implementation. One plan report that the clinical requirements for enrollment were not monitored closely, and that resulted in enrolling numerous members that were not really part of their target population. From the provider perspective, we asked them the same question. And a minority felt that they were effective and inclusive, that you're hitting on the right patients. But most of the providers felt that they were missing patients, so that they were too restrictive.

When we see in our end stage renal disease patients, who would really benefit. And we have bed bound patients who, somehow, don't meet criteria. So, a lot more concern on the provider side, about restrictiveness of the criteria. In terms of sort of reflecting on the variation, and what we heard from the plans and the providers, did we achieve our hope for effect? So, did we promote having an appropriate population receiving services? And did we prevent being overly restrictive or overly loose?

So, there was agreement that there was a missing of important diagnoses, but disagreement between the plans and the providers if that was really limiting access. There was a suggestion about adding a PPS score to the criteria, to better target patients with the specific diseases, who really needed palliative care at that time. And then, there were implementation issues that resulted in too loose access. In terms of the presence and the significance of variation, there was expected manageable variation, from enhancing access by adding diagnoses or relaxing criteria. There was problematic variation, too loose access, resulting from an implementation issue for one plan.

All right, moving on to required services. There's three categories here, services related to assessment, services that are clinical services, and then also care coordination and communication activities. The items that are in red are not included in the SB1004 Medi-Cal palliative care guidance, but they are in the consensus standards. And these services map pretty closely, I would imagine, to your vision of what comprehensive palliative care, comprehensive guideline, concordant palliative care would look like.

In terms of the variation that we saw and once these were

implemented, there was very little variation, in terms of the specific services that were being offered. Folks weren't adding a ton of new services. There was a lot of variation in implementation, and that related to visit frequency by discipline specified. So, you're providing these services, but we're telling you how frequently those services need to be delivered. So, two RN visits per month, or the palliative care team, where the prescribing clinician has to visit once every three months.

And also, there was some variation in specifying the mode of required contact. So, for example, four contacts per month, one of which must be in person. In terms of plan experiences with the services, in general, they were pleased. They think they matched well with what the patients and families need. The folks that were offering Medi-Cal palliative care, who were not required to do so, all added spiritual support and 24/7 access as a as a service that they wanted to see their members get. So, that was a variation, but it was universally adopted.

And there was some feeling that members and families could benefit from more caregiver services. From the provider perspective, there was agreement that the services that were delivered were aligned with patients and family needs, but there was a lot of tension around how that was implemented. So, implementation variation leading to problematic variation. We're being asked to provide more visits and contacts than patients and families may want, and those requirements about type of support and visit frequency is guiding our care versus being guided by the needs of the patient. And the providers really felt that that was problematic.

So, just reflecting on the services, did we achieve the hope for effects? We did get to a point where the plans or the providers felt that the services matched the patient and the family needs, and they were comprehensive and guideline concordant. There was good alignment with national consensus guidelines, none of this very narrow, incomplete scope that was out in the market, for care that was being delivered that was not concordant with the standards. In terms of presence and significance of variation, really, revolving around implementation choices versus anything that was in the standard. So, issues not described in the standards, related to frequency and mode of contact.

All right, next focus area is staffing and providers. So, the standards say that you need to have an interdisciplinary team, they

need to have demonstrated competency, so training in palliative care. And at minimum that team needs to include physician, nurse, social worker, spiritual care professionals. These are very similar to the requirements for Medi-Cal palliative care, with the exception of, there is no requirement for spiritual care professional, it's recommended, but not required.

In terms of operational variation seen with the staffing and providers, there was variation in the requirements that plan had to then, also, the practices of the providers related to use of different disciplines. So, some providers use community health workers and home health aides, some plans required home health aide visits. And there was also variation in whether a physician was in a program oversight role or a direct clinical care role.

There was also a variation, in terms of which plans required that the provider be certified in palliative care or not, the organization, not the individual. In terms of plan experiences with staffing, in general, they were satisfied. They did recognize some training deficits, and I think this had to do with the fact that many of the providers were accustomed to delivering hospice care as opposed to palliative care. And there was a need recognized for perhaps a little more training in the differences there, the scope of palliative care, and being able to differentiate from hospice.

And also, training related to how to communicate with a primary care provider and share information, to effectively do care coordination. In terms of the provider experiences, they were mostly satisfied. When staffing works for us, we utilize a chaplain routinely, it's a great benefit of our patients. We have an experienced team and we're working towards certification. There was some concern expressed by some providers about the effort required to attend meetings and learn new things. And they felt that the time commitment might be interfering or competing with providing patient care.

So, reflecting on staffing, did we achieve the hope for effects? Well, definitely got delivering team-based care. And there's partial requirements from a subset of the plans around certification in palliative care, so that's moving in the right direction of appropriately trained disciplines, and having practices that are aligned with quality. And there were no strong feelings expressed by the plans or providers that it was the wrong team.

There was variation, that was manageable, from implementation

choices related to the disciplines on the team. Do you have community health workers? Do you have home health aides? What is the specific role of the physician? And that was noted, but it didn't appear to be problematic. And then, there was manageable variation, in terms of certification requirements. Nobody seemed to mind being asked to be certified if the plan required that, but nobody expressed concern that they weren't being asked for that. And no plans were like, "Gosh, I should really start doing this."

Okay. So, that's three of the five areas, gone through a ton of material. And so, I want to pause here before getting to measurement and recording and payment. And Brian, are there any questions, that it feels important for us to address now?

Brian: Well, it's funny you should ask, Kathleen. There's a couple of questions to clarify the eligibility criteria in the consensus standards and in the Medicaid SB1004 all plan letter. You had mentioned late stage disease, is that meant to be limited to people with a certain prognosis like six months or 12 months or 18 months? Or is that more of a general guideline and it's open to interpretation between the provider and the payer?

Kathleen: Yeah. For Medi-Cal palliative care, if you look at the framework that the Department of Health Care Service has posted, and the specifics that are in their guidance, they really do view palliative care as being appropriate for individuals who are about in the last year of life. With an expectation that other supports would be delivered by other providers, advanced care planning, and so on. Earlier than that, you get palliative care in that period from 12 month prognosis forward, and then some individuals will transition to hospice, others will stay on palliative care.

So, it is intended to be largely a final year of life intervention for Medi-Cal, per the minimum standards. Some plans that I know of have expanded that, to where it's really intended for folks in the last couple years of life. But that's the minimum. For the consensus standards, you'll see here in the description of the other diagnoses, 12 month life expectancy if the disease follows its natural course. So, that's aligned with roughly the same period. And so, again, these are minimum standards, and folks are welcome to expand upon them. But the goal was, what would any payer or provider find acceptable in a minimum set of eligibility criteria for home-based palliative care?

Brian: Right. So, setting a floor and taking some of the guesswork out.

And then, there was another question about the staffing. What do the standards mean by community healthcare worker? Is there a standard idea of what that is?

Kathleen: Yeah, the standards don't require use of a community health worker. But that is one of the disciplines that was added in by some provider partners. And so, that's typically a person who – an unlicensed individual, who job title, I know the one they use at CareOregon is care and outreach specialist.

So, an individual who assists with navigation and helping to connect folks to services. And oftentimes, is taking some of the workload off, say, a social worker, to help get people connected to the services that they're eligible for and need. And also, just sort of create another connection point, a relationship point for the certifications. So, no community health workers in the standards, but yes, some of the variation we saw is that some providers use them.

Brian: Great. We have one more question on staffing, and then I think it'd be appropriate to move on to the rest of the slide content. The question is, as part of the project, the demonstration project, did we or did you all collect information on staffing, and what exactly people were doing with staffing?

Kathleen: Yeah, we know the disciplines, we don't know average contact by discipline, by a patient, not at that level. But we certainly know the core care model, and the core care model that folks are using.

Brian: Great. Thank you for taking those and we'll pose some more after the next section.

Kathleen: All right. Okay, buckle your seatbelt because we're moving into the most problematic area, measurement and reporting. There are process measures and outcome measures that are referenced in the consensus standards. The Medi-Cal guidance is silent on what the providers need to provide to the plans, or what the plans have to monitor. There wasn't really oversight about enrollment numbers and how many people were eligible and so on. That was discontinued after 18 months. And from the perspective of, really, ongoing monitoring, the Medi-Cal guidance doesn't go there.

In terms of what's in the consensus standards, there's process measures and outcome measures. And folks are doing pretty well with most of the process measures. The plans and providers have a

handle on how many patients they're serving, and duration of enrollment, and transition to hospice and so on. They're looking at advanced care planning activities, but not getting to the level of detail that's documented in the standards.

So, on this page, you'll see a number of items are highlighted in yellow, there were adherence issues with those, meaning, that they weren't being done. There were also implementation issues with those, of where folks maybe wanted to, but they simply couldn't do it effectively. And this had to do with some of the finer nuances of documenting goals and preferences, [inaudible] [00:40:25] decision maker and so on, enormous issues with monitoring patient and family satisfaction. And it was not my conclusion that any of the plans were routinely assessing this final outcome measure of total days at home in the last six months of life.

So, adherence issues, implementation issues, really, this is the biggest, messiest, most problematic area in the standards. In terms of operational variation, getting into a little more detail, the tools and the practices for assessing patient and family experience of care across the provider partners. And also, amongst – at least one plan was doing a member experience survey. The tools had tremendous variation in the number of items, the timing and frequency of administering them, variation in the focus of the questions, some questions that perhaps could have been phrased in a way that would make them easier to respond to.

Many sites had very small numbers of returned surveys, and some had zero responses to report for entire quarters. In terms of other activities related to measurement and reporting and variation that was noted, there was tremendous variation in the amount and nature of data that was delivered from the providers to the plans. And the range went to everything from no data at all shared with the plan, beyond your claims, versus weekly reporting required on some specific items that summarize encounters in their care plan. So, lots and lots of reporting to no reporting at all.

There was also a lot of variation, in terms of audits of services and processes, and everything from routine audits of quality indicators, and looking at notes to look for specific elements, to no plan assessment of process measures at all. They're just kind of looking at a handful of outcomes. In terms of experiences with measurement and reporting from the plan perspective, some felt that their practices were acceptable. So, even if they weren't really following what was in the standards, or really following what was

in the standards, they thought that what they were doing was appropriate for their palliative care providers.

They want to know about discharge disposition, and hospital utilization, and care planning documentation. A few process measures, that's just fine by me, but not really interested in all those items. And there were some deficits that – So, some happy, but there were also some deficits that were identified. Some really wanted patient and number satisfaction data, and as I described, that wasn't really readily available.

One plan felt that what was being asked of the providers was just too burdensome. And one provider just thought that the data was just completely inadequate. It wasn't really getting at the picture of quality and contributions, or the overall – the contributions of the provider or the quality of the program.

In terms of the provider experiences, a minority felt it was feasible and acceptable. It varies from plan to plan, but for the most part, data collection is reasonable and necessary. The much louder voices were concerns about burden and pertinence and sustainability. So, feelings that the administrative requirements were really burdensome, that there was little consistency in what they were being asked to deliver to multiple plan partners. It didn't feel like it was really getting at any pertinent quality issues.

And that given how much time it takes to document the number of visits and calls and consoles and **IVT** meetings and so on, it's not gonna be sustainable, as this provider was looking to grow and do this over time. It was just too much. So, reflecting on measurement and reporting, do we get to those hope for effects? Did we promote use of a meaningful and feasible approach for plans and providers? And are we avoiding no monitoring at all?

Well, there was definitely incomplete adherence. There were mixed perceptions around meaningful, whether the data that was being collected and the outcomes that were being assessed, the measures that were being used, if they were meaningful and feasible. And there were a lot of concerns about burden from the provider partners. In terms of presence and significance of variation, you name it, it was there.

There was problematic variation resulting from enhancements, so what people built on to what was in the standards. There was variation resulting from adherence, if you did it or not. There was

variations coming from implementation practices. And also, variation coming from the specifics and the standards, but it seemed to be asking for items that people just didn't have the capacity to deliver.

All right, final section that we're gonna consider, payment models. The standards specify that the Medi-Cal guidance is silent on preferred models for paying for palliative care, recommended that it emphasize value-based reimbursement, and that folks consider aligning the needs and acuity of the patient with the services that are covered. So, perhaps having tier payments, recommend a per enrolled member per month case rate, and then think about payment incentives for quality and utilization management.

In terms of operational variation, some plans had tiers of service with different payments amount versus others had a single rate that – with an expectation that acuity and need would be sort of evened out over a population. So, you pay one rate and it'll all even out at the end. There was also variation, in terms of whether supplemental payments were made on top of a per enrolled member per month payment for high utilizers. So, even with the case rate, you're not covering all the services that you're delivering for some folks who just really have intensive needs. Some plans did that, some plans did not.

In terms of plan experiences with the payment model, their perceptions of it, case rate was universally endorsed and universally used. So, monthly case rates work. We have occasional exceptions for which we pay extra fee-for-service, or for extraordinary intensity of services for their super high utilizer members. And it was less clear, there was a little less of a ringing endorsement around whether or not there was alignment between the cost of paying for these services and the resulting impact. What was the ROI?

There was some concern about alignment. So, I wouldn't say that we're actually getting quality and impact that justifies our costs. And this was from a plan that had some implementation issues, and perhaps, over enrolled members who maybe really didn't need the service. So, this is clouded by, who did you serve and what were the results from that population? And one plan I felt like they just didn't have enough experience yet with delivering community-based palliative care, to know if there was adequate alignment between the cost of delivering services and the impact on cost of care.

I should say that these perceptions were shared before Brian has completed the final assessments of fiscal outcomes. So, some of these perceptions might change. Excuse me. In terms of the provider experiences, there's a pretty consistent message that they prefer case rates, but a lot of concerns about adequacy and sustainability. The reimbursement needs to be more to have a profitable program.

Case rate is better, case rate varies though, and in some instances, it's difficult to provide excellent palliative care with a lower case rate. Most contracts require care delivery models that exceed reimbursement sustainability. So, yes, pay as a case rate, but it needs to be enough to cover these services. A lot of the providers didn't think it met that mark.

So, payment model reflections, did we achieve the hope for effects? Well, case rates were universally used and endorsed, so that's definitely something that we wanted to promote. Providers have concerns about the adequacy of the payment amount, and the plans have mixed and evolving perceptions about the ROI. In terms of the presence and significance of variation, there was manageable variation from implementation choices related to payment for high utilizers and tiers of service. Nobody minded that some plans had tiers and others did not.

There was problematic variation, something that needs to be ironed out, related to the payment amount, which is not addressed in the standards and reflects in implementation choices. So, a couple conclusions and reflections before we open it up to questions. One, it's possible to develop and implement minimum standards for community-based palliative care, that are applicable across lines of business. Nobody was saying this works for commercial, but not for Medicare Advantage. This actually worked, who knew. You could have these standards and they could work across business lines.

The standards were largely effective in achieving hope for effects, and in reducing problematic variation. Plans and providers have differing perspectives on the strengths and limitations of different aspects of the standards. So, even if you have standards and you implement them, you need to talk, you need to dialogue about how they are implemented. Because plan and provider preferences and practices, the how, are just as important as the specifics and the standards, the what.

Implementation issues that are not addressed in the standards created a good bit of problematic variation. And finally, measurement and reporting is the area with the most persistent problematic variation, in our standards that we studied. So, if you're developing your own standards, really pay attention to that, get a lot of feedback and think about what's meaningful and what's feasible. And really, any parameters around variation, to try to make it less competing demands on the provider population.

So, before we move to questions, just want to acknowledge the contributions of the health plans, of the palliative care providers that participated in the demonstration project. These folks shared their data, their policies, their tools, they did webinars for each other talking about their quality programs, they shared their perceptions and recommendations. And really, helped to make this a really, really interesting project, which I hope is gonna generate some information that's useful to a whole bunch of other folks.

And also, a reminder that next up in the series and in February, be sure to register for the webinar that Brian will be leading, that focuses on affordability and sustainability across business lines. And with that, I'm happy to open it up to questions and discussion.

Brian: Terrific. We'll start off with an easy one, Kathleen.

Kathleen: Okay.

Brian: There was one question about, given all this work that has been done, is there a place on a coalition website or somewhere else, where it's easy to find community-based palliative care programs that are available in California?

Kathleen: Ooo, I'll defer to Judy for that.

Judy: Well, Kathleen, you're the one that has done the mapping project in California and know how that could be a moving target. So, we would love to be able to provide that. It is a pretty intensive service to provide, so do you have thoughts about that?

Kathleen: Yeah. I think it's a dynamic area, where there's folks who offer this, folks who don't, people who maybe started with one model and moved to another model. I think if you're a health plan, and you're looking to find provider organizations that might be able to meet your needs, one place that you might start is asking your

friends. Who are other health plans in the region contracting with? That might be one way that you could find partners. In terms of developing a directory and posting it on the coalition site, that is something that requires a bit of effort. And so, we'd need to find some funding for that.

Brian: Great. There was a couple of questions around advanced care planning, and we're gonna pick out of that conversation. A couple of those have been responded to. But you had noted, in the measurement and reporting section, that adherence around documentation of the conversations or documents is one of those areas where it's difficult. Is there any further work being done on guidance for people, for providers to have these conversations, or to document them in a way that's not overly burdensome to the providers?

Kathleen: Yeah. That wasn't part of the charge with the pilot, focusing on those – or on the demonstration project, focusing on those specific areas. So, I don't have anything from this project to report. I would say that a lot of folks who weren't involved in this project, seemed to do this fairly well. I think that for the Medi-Cal population in particular, it's super important to note the conversation because there may be reluctance in some populations to complete a document or sort of go through a formal process.

If they still have preferences around a surrogate or whether one exists or not. I think there's a bunch of organizations that do a ton of great work around supporting effective advanced care planning practices. I think one of them is the Coalition for Compassionate Care of California. And so, Judy, do you have anything to share about this?

Judy: Well, I think, yeah, this is a great observation and kind of a learning from the demonstration project, that there's still a lot more work for us to do. And we need to be doing more public education around advanced care planning, and framing it in a way that makes it consistent, culturally congruent with the diverse populations in our state. And I think part of the challenge is that, right now, as we think about advanced care planning, it's pretty much a white, upper middle class kind of concept. So, I think there is a lot of work to be done in that area, and that's something that we're working on definitely outside of this project.

Kathleen: I do want to clarify that, in terms of practices related to documenting the surrogate, or in absence of a surrogate, or documentation of conversations, I was not saying that folks aren't

doing it, I'm saying that they had not developed the measurement and reporting processes that allowed them to monitor this in a way that was recommended in the consensus standards. So, sort of two different things, doing the work and then documenting the work, so that you can demonstrate your value.

Brian: That's more about the visibility of that process, whether the process is actually being done.

Kathleen: Exactly.

Brian: Terrific. We had another question and I'll tell you how badly I answer it, and you can correct me publicly for this, one person asked, this is not in her words, but, "Well, what if I have a staffing model that does not include a physician? Am I left out of the playing field with this?" And what I said was, "The standards really emphasize the need for a full multidisciplinary team." So, any comments that you or Judy want to make on the necessity of these roles on the team?

Kathleen: Yeah, I can just tell you from a implementation perspective, the physician role could include direct clinical care or program oversight. So, you don't necessarily have to hire a physician, who's doing direct clinical care, to adhere to these standards. You can just have a medical director, who's helping to oversee the program, maybe just painting IBTs, that sort of thing. So, the group who developed the standards felt that this was a necessary minimum element for assuring quality care.

But there are different roles that require different level of engagement from a qualified physician. So, even if you feel a little left out right now, I think it's a lower bar than hiring someone who sees a patient monthly. Judy, you were there for all of those 7:00 a.m. meetings, when the standards were developed. Do you have anything to add to that?

Judy: Well, we did get a number of comments about the role of nurse practitioners, that nurse practitioners are often really qualified and well suited to have a significant role in the team. And we just felt that, at this point in time, it was a minimum, again, to have the physician involved in that oversight role. We definitely encourage the engagement of nurse practitioners and other physician extenders. But as far as the minimum, this is what we meant, what the group felt was really the minimum floor.

Kathleen: Yeah. Thank you.

Brian: There were other questions, but I think we should stop there and allow you to wrap up.

Kathleen: Judy, I'll hand it over to you.

Judy: Great. Well, thank you all for being with us today. And we do have the questions that are posted and if we haven't had a chance to follow-up with you, we will do our best to do that after the webinar today. But a couple of additional things The Coalition has going on, we wanna make sure that you're aware of. We have our annual conference coming up in May, we will be back in-person. So, barring any new variants that change things. So, we're looking forward to actually seeing you all in-person and celebrating that we've survived through all of this so far. Hope you'll be able to join us, next slide.

We also have a webinar coming up, that I think is a good complement to community-based palliative care, that's focusing on the role of caregivers, which are really important when you're providing care in the home. So, I haven't seen that slide come up, but you can watch for an email about that. We're excited about our speakers, [Theresa Vaughn and Carolyn Acklin](#). And with that, I think we will conclude our webinar for today. We hope to see you next week for the second in this webinar series. Have a great day.

[End of Audio]

Duration: 60 minutes