Quality and Fiscal Metrics: What Proves Success?

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Defining measurement success

Success: being able to describe your service, what it does, for whom, and its impact on outcomes of interest
But measuring is hard

- Measuring takes time and effort
- Different stakeholders care about different outcomes
- It's hard to know what to measure
- Data needed for some metrics are difficult to access

Process and framework for selecting metrics

- Reflect on best practices
- Reflect on stakeholder priorities
- Consider structure, process, outcome metrics
- Reflect on burden and feasibility
- Pick your portfolio
- Set performance goals
Why start with best practices?

_Outcomes flow from structures and processes_

Given what you do/plan to do …

... what can you expect to influence?

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>Requisite structure/process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce ED visits</td>
<td>24/7 availability</td>
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<tr>
<td>Improve pain</td>
<td>Clinical expertise</td>
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<tr>
<td>Improved family satisfaction with communication, information sharing</td>
<td>Expert communication skills; processes for engaging the family</td>
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</table>
NCP Clinical Practice Guidelines

National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care (NCP guidelines), 3rd edition (March 2013)

- Developed by multidisciplinary expert panel, firmly anchored in evidence
- Endorsed by diverse group of 54 organizations (Aetna, American Cancer Society, Institute for Healthcare Improvement, National Business Group on Health, American College of Surgeons)
- Describe best practices across 8 domains:
  1. Structures and processes of care
  2. Physical aspects of care
  3. Psychological and psychiatric aspects of care
  4. Social aspects of care
  5. Spiritual, religious and existential aspects of care
  6. Cultural aspects of care
  7. Care for the patient at the end of life
  8. Ethical and legal aspects of care
- 27 Guidelines, 140 criteria

DOMAIN 1: STRUCTURE AND PROCESSES OF CARE

Guideline 1.1 A comprehensive and timely interdisciplinary assessment of the patient and family forms the basis of the plan of care.

<table>
<thead>
<tr>
<th>Title</th>
<th>How will this be addressed by your service?</th>
<th>Policy or metric needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial comprehensive assessment and subsequent reevaluation</td>
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<tr>
<td>The interdisciplinary team (IDT) completes an initial comprehensive assessment and subsequent reevaluation through patient and family interviews, review of medical and other available records, discussion with other providers, physical examination and assessment, along with relevant laboratory and/or diagnostic tests or procedures.</td>
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<tr>
<td>An initial evaluation includes:</td>
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<tr>
<td>Assessment includes documentation of disease status, diagnosis and prognosis, current medical and psychiatric condition, physical and psychological status, functional status, social, cultural, and spiritual strengths, values, needs, concerns, and goals to identify care planning, treatment, preferences, and decision making.</td>
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<tr>
<td>All four domains must be addressed with consideration of age and stage of neurocognitive development.</td>
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</tr>
</tbody>
</table>

Guidelines and criteria from National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care, Third Edition (2013). Available at: [National Consensus Project](http://nationalconsensusproject.org/LinkClick.aspx)
Core Components of Quality EOL Care (IOM)

- Frequent assessment of the patient’s physical emotional social and spiritual well-being
- Management of emotional distress
- Offer referral to hospice if the patient has a prognosis of 6 months or less
- Round the clock access to coordinated care and services
- Management of pain and other symptoms
- Counseling of patient and family
- Attention to the patient’s social and cultural context and social needs
- Attention to the patient’s spiritual and religious needs
- Regular personalized revision of the care plan and access to services based on the changing needs of the patient and family

https://www.capc.org/payers/palliative-care-payer-provider-toolkit/

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### Essential skills and structures (PPP toolkit)

**Essential clinical skills**
- Pain and symptom management
- Goal setting
- Family caregiver support
- Practical and social support

**Essential structures**
- Interdisciplinary team-based care
- 24/7 meaningful response
- Integrated medical and social supports
- Concurrent care
### Consider stakeholder priorities

Consider what is important, to whom

- Patients and families
- Payers
- Organizational leadership
- Important donors
- Referring providers
- Your team

### Measure shopping

Look for measures that:

- Speak to your goals
- Are appropriate for your patients
- Demonstrate adherence to best practices
- Capture the impact your intervention has on outcomes you hope to achieve

<table>
<thead>
<tr>
<th>Structures</th>
<th>Processes</th>
<th>Outcomes</th>
</tr>
</thead>
</table>

15

16
Structures

What you have in place to serve patients and families; team composition, training, availability

**Sample Structure Metrics**

1. Program staffing
2. Services offered
3. Locations / settings / availability
4. Adherence to consensus statements

Processes

- **Who** – which patients were seen? What are their characteristics? What proportion of the potential population was seen?
- **What** – what did the palliative care team do? Pain management, other symptom management, goals of care, changes / recommendations in intensity of care, discharge planning, bereavement services?
- **Where** – where were services provided?
- **When** – when were services provided, in relation to patients’ admission date, discharge date, or disease trajectory (e.g., relative to time of diagnosis or time of death)?
- **Why** – what were the reasons that palliative care was asked to help? Were these appropriate?
Process metrics

Sample Process Metrics

1. Volume and characteristics of those approached or seen
2. Percent agreeing / refusing
3. Those seen as percent of target or appropriate population
4. What was addressed
5. Where did this take place
6. How many contacts per patient
7. Duration of engagement
8. Timing of first contact relative to diagnosis and/or death
9. Adherence to consensus statements

Outcomes

Describe the impact of clinical contacts

- On patients: for example, the impact of palliative care on pain scores and other symptom scores
- On families and care teams: for example, how satisfied were families with the services provided?
- On institutions: for example, the impact of palliative care have on hospital use. Are costs reduced? Are there fewer in-hospital deaths?
### Outcome metrics

#### A. Sample clinical and patient-reported outcomes

| A1. symptom control (physical) |
| A2. Improve / stabilize performance or functional status |
| A3. Improve quality of life |
| A4. Decrease depression, anxiety, distress |
| A5. Patient satisfaction with healthcare |
| A6. Concordance between patient preferences and actual care |

#### B. Sample social outcomes

| B1. Family satisfaction with healthcare |
| B2. Decrease depression, anxiety, distress |
| B3. Avoid super-bad bereavement |

#### C. Sample cost, quality (utilization) measures

| C1. >=2 ED visits last 30 days of life |
| C2. ICU use in last 30 days of life |
| C3. Chemo in last 14 days of life |
| C4. No hospice at all |
| C5. <=2 days of hospice |
| C6. Death in hospital |
| C7. Burdensome transitions at EOL |
| C8. Provider / payer / patient costs at EOL |
| C9. Death within 30 days of hospital admit |
| C10. Re-admissions |
Finding potential metrics

- Endorsed by professional organizations
- The literature
- Case studies

National Quality Forum Endorsed Measures

- Nonprofit, nonpartisan, public service organization that reviews, endorses, and recommends use of standardized healthcare performance measures
- Expert committees made up of varied stakeholders use rigorous process for evaluating evidence-base and utility of proposed measures
- The federal government and many private sector entities use NQF-endorsed measures in payment and public reporting programs; broad national use
- Currently there are 20 measures that address cancer EOL care and palliative care generally
http://www.qualityforum.org/QPS/QPSTool.aspx

http://aahpm.org/quality/measuring-what-matters
The “Measuring What Matters” initiative recommendations

- Consensus project sponsored by the American Academy of Hospice and Palliative Medicine Quality and Practice Standards Task Force and the Hospice and Palliative Nurses Association Research Advisory Group
  - Goal: identify a portfolio of cross-cutting performance measures for all hospice and palliative care programs; applicable across settings and patient populations
  - Likely output = a core set of “basic” measures, an additional set of “advanced” measures, and a set of “aspirational” measures, with the intent of selecting at least one measure for each of the 8 NCP domains
  - Portfolio intended to yield a big picture assessment of a palliative care program or health system’s palliative care performance; NOT expected to be the only measures used
  - Measure selection by Technical Advisory Panel (focusing on reliability, validity) and a Clinical User Panel (focusing on feasibility, importance, usefulness)
  - TAP started with 75 possible measures, narrowed to 34 (2 domains, Social and Cultural aspects of care, with zero measures); CUP review narrowed to top 12

Mine the literature


326 indicators addressing the 8 core PC domains

Appendix 3: List of Quality indicators for palliative care stratified by domain

<table>
<thead>
<tr>
<th>Domain 1.1: Structure of care (33 indicators)</th>
<th>Numerator/Denominator/Exclusion/Performance standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reference/year</strong></td>
<td><strong>Description/type of indicator</strong></td>
</tr>
<tr>
<td>1</td>
<td>Documentation of a policy that allows for unrestricted violation by family members and friends.</td>
</tr>
<tr>
<td>2</td>
<td>Family meeting room: dedicated space for meetings between clinicians and ICU families.</td>
</tr>
<tr>
<td>3</td>
<td>Families and carers can access designated quiet spaces, and are able to view the deceased in appropriate surroundings.</td>
</tr>
</tbody>
</table>
Case Studies: AHRQ Innovations Exchange

System-Integrated Program Coordinates Care for People With Advanced Illness, Leading to Greater Use of Hospice Services, Lower Utilization and Costs, and High Satisfaction

https://innovations.ahrq.gov/

Case study results: Sutter AIM Program

“Lower inpatient and ambulatory utilization: Preliminary, unpublished data from November 2009 through September 2010 indicate that 413 AIM patients who lived at least 90 days following enrollment experienced 54 percent fewer hospitalizations over those 90 days (compared with the 90-day period before enrollment). Over the same period, intensive care unit days were reduced by 80 percent and length of stay on subsequent admissions was reduced by 26 percent. A 52-percent reduction in physician visits was also seen, although telephone encounters between doctors and their patients increased by 10 percent.”
### Building a measure set

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Source / Supporting Guideline</th>
<th>Type of Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Structures and Processes of Care</td>
<td>Nurses, social workers and chaplains serving on the PC team are certified in palliative care</td>
<td>NCP Guidelines</td>
<td>Structure</td>
</tr>
<tr>
<td>Physical Aspects of Care</td>
<td>Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present</td>
<td>NQF (0420; PQRS)</td>
<td>Process</td>
</tr>
<tr>
<td>Psychological and psychiatric aspects of care</td>
<td>Results of the Family Evaluation of Palliative Care, proportion of patients who experienced anxiety or sadness while receiving PC who received too much or too little help</td>
<td>NHCPO</td>
<td>Outcome</td>
</tr>
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### Who bears the burden?

<table>
<thead>
<tr>
<th>Measure</th>
<th>Type of Measure</th>
<th>Data Source</th>
<th>Who bears the burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses, social workers and chaplains serving on the PC team are certified in palliative care</td>
<td>Structure</td>
<td>Program description / policy</td>
<td>• Administrative leaders</td>
</tr>
<tr>
<td>Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present</td>
<td>Process</td>
<td>Medical record</td>
<td>• Clinical team</td>
</tr>
<tr>
<td>Results of the Family Evaluation of Palliative Care, proportion of patients who experienced anxiety or sadness while receiving PC who received too much or too little help</td>
<td>Outcome</td>
<td>Survey</td>
<td>• Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Administrative staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Analytic staff</td>
</tr>
</tbody>
</table>
(Feasible) Minimal Measuring

<table>
<thead>
<tr>
<th>Domain</th>
<th>Structure</th>
<th>Process</th>
<th>Outcome (patient/social)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Structures and Processes of Care</td>
<td></td>
<td>One structure or process metric for each Domain, including at least 2 process measures</td>
<td>Two patient or social outcomes, addressing any of the 8 domains</td>
</tr>
<tr>
<td>Physical Aspects of Care</td>
<td></td>
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<tr>
<td>Ethical &amp; Legal Aspects of Care</td>
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</table>

Plus 2-4 utilization or cost outcomes

Minimal measuring = 12-14 items

Performance standards – what to aim for

- National statistics
  - NHPCO 2014 Facts and Figures*
  - 35.4% patients have hospice LOS ≤ 7 days
  - Median hospice LOS 18.5 days
- Literature
  - 41% older patients > 1 ED visit last 6 months of life**
  - 51% ED visit last month of life**
- Case studies
- Local trending, historical comparisons

*NHPCO’s Facts and Figures Hospice Care in America 2014 Edition
**Smith AK, et al. Half of older Americans seen in emergency department in last month of life; Most admitted to hospital, and many die there. Health Affairs 2012; 31(6): 1277-1285.
### Top 5 five things not to do

1. Measure nothing  
2. Gather lots of data ... and never use it  
3. Measure only utilization/cost outcomes  
4. Measure beyond your resources  
5. Measure things no one cares about

### Top 5 five things to do

1. Understand the core components of PC  
2. Understand what you are trying to accomplish, and for whom  
3. Understand what your stakeholders care about  
4. Use structure, process and outcome metrics that map to your program’s priorities and resources  
5. Use national standards, literature, and internal data when deciding on performance goals
## Acknowledgements

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- The Coalition for Compassionate Care of California  
- The CSU Institute for Palliative Care

## Audience poll- rate your evaluation program

For those of you with active PC services, please select the option that best describes your current evaluation program:

- [ ] Robust program – an area of strength for us  
- [ ] More than adequate  
- [ ] OK, but room for improvement  
- [ ] We’re not measuring anything  
- [ ] Random array of metrics that no one cares about, which are derived from data that are exhausting to gather
Questions and Discussion

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