

Quality and Fiscal Metrics:
What Proves Success?

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I have no relevant financial disclosures

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
- Its hard to know what to measure
- Data needed for some metrics are difficult to access

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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

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Why start with best practices?

Outcomes flow from structures and processes

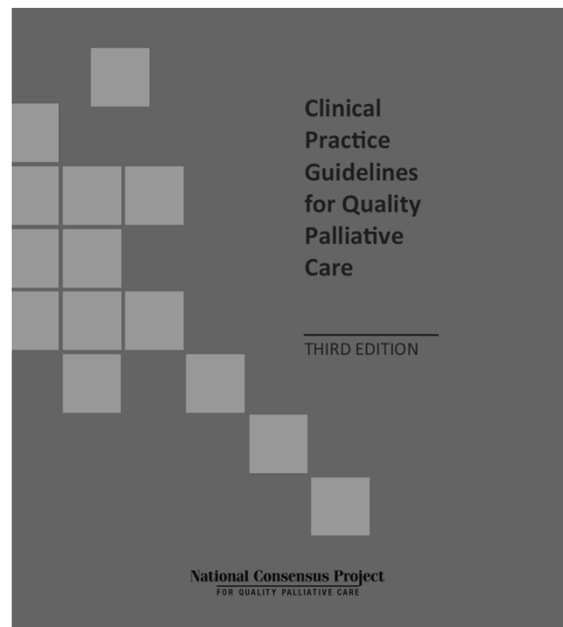
Given what you do/plan to do ...

... what can you expect to influence?

Desired outcome	Requisite structure/process
Reduce ED visits	24/7 availability
Improve pain	Clinical expertise
Improved family satisfaction with communication, information sharing	Expert communication skills; processes for engaging the family

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Reflecting on best practices



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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.

Criteria	How will this be addressed by your service?	Policy or metric needed?
Palliative assessment and documentation are interdisciplinary and coordinated.		
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.		
An initial evaluation includes: the patient's current medical status; adequacy of diagnosis and treatment consistent with review of past history; diagnosis and treatment; and responses to past treatments.		
Assessment includes documentation of disease status; diagnoses and prognosis; comorbid medical and psychiatric disorders; physical and psychological symptoms; functional status; social, cultural, and spiritual strengths, values, practices, concerns, and goals; advance care planning concerns, preferences, and documents; and appropriateness of hospice referral		
Assessment of neonates, children, and adolescents must be conducted with consideration of age and stage of neurocognitive development.		
The IDT documents assessment of the patient and family perception and understanding of the serious or life limiting illness including: patient and family expectations of treatment, goals for care, quality of life, as well as preferences for the type and site of care.		

Guidelines and criteria from National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines for Quality Palliative Care*, Third Edition (2013). Available at: http://nationalconsensusproject.org/Guidelines_Download2.aspx

DYING IN AMERICA
Improving Quality and Honoring Individual Preferences Near the End of Life

Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life

www.iom.edu/endoflife

TABLE ■ SEPTEMBER 2014

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Dying in America

IOM Committee's Proposed Core Components of Quality End-of-Life Care

COMPONENT	RATIONALE
Frequent assessment of the patient's physical, emotional, social, and spiritual well-being	Interventions and assistance must be based on accurately identified needs.
Management of emotional distress	All clinicians should be able to identify distress and direct its initial and basic management. This is part of the definition of palliative care, a basic component of hospice, and clearly of fundamental importance.
Offer referral to expert-level palliative care	People with palliative needs beyond those that can be provided by non-specialist-level clinicians deserve access to appropriate expert-level care.
Offer referral to hospice if the patient has a prognosis of 6 months or less	People who meet the hospice eligibility criteria deserve access to services designed to meet their end-of-life needs.
Management of care and direct contact with patient and family for complex situations by a specialist-level palliative care physician	Care of people with serious illness may require specialist-level palliative care physician management, and effective physician management requires direct examination, contact, and communication.
Round-the-clock access to coordinated care and services	Patients in advanced stages of serious illness often require assistance, such as with activities of daily living, medication management, wound care, physical comfort, and psychosocial needs. Round-the-clock access to a consistent point of contact that can coordinate care obviates the need for multiple and often overlapping medical services.

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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

IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press.

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<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

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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

Structures	Processes	Outcomes
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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 |

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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?

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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

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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?

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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

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Outcome metrics (continued)	
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

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Finding potential metrics

- Endorsed by professional organizations
- The literature
- Case studies

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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**

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NATIONAL QUALITY FORUM

palliative and end of life care

Search as Phrase

Measures (Result List) Portfolios Compare Add to Compare Add to Portfolio Export

0216 VIEW THE NEW SPEC - There is a new version under consideration.

Proportion admitted to hospice for less than 3 days
STEWARD: American Society of Clinical Oncology

Measure Description:
Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there

Numerator Statement:
Patients who died from cancer and spent fewer than three days in hospice.

Denominator Statement:
Patients who died from cancer who were admitted to hospice

Exclusions:
None

Risk Adjustment:
No

Classification:
National Quality Strategy Priorities:
Effective Communication and Care Coordination
Use in Federal Program:
Actual/Planned Use:
Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

Measure Steward Contact Information:
For additional measure specification information, please contact the Measure Steward.
Organization Name:
American Society of Clinical Oncology
Email Address:

<http://www.qualityforum.org/QPS/QPSTool.aspx>

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aaahpm AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE

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Measuring What Matters

AAHPM & HPNA
Measuring What Matters

AAHPM and the Hospice and Palliative Nurses Association (HPNA) have partnered on Measuring What Matters (MWM), a consensus project aimed at identifying a recommended portfolio of cross-cutting performance measures for all hospice and palliative care programs.

Access the [Frequently Asked Questions \(FAQ\)](#) list about MWM.

Access the [Top Twelve Measures—Background Information, Evidence and CUP Comments](#)

Steps in the MWM process so far include

1. The Technical Advisory Panel (TAP) rated published measures on their scientific soundness and referred a set of measures (n=34) for review by the Clinical User Panel (CUP).
2. The CUP rated those measures based on three dimensions of meaningfulness:
 - a. How MEANINGFUL is this for patients/families?
 - b. How ACTIONABLE is this for providers/organizations?
 - c. How large is the POTENTIAL IMPACT?
3. The CUP achieved consensus on their top 12 initial published measures.
4. The draft was posted on AAHPM's website in an effort to elicit feedback from AAHPM and HPNA members and their interdisciplinary teams, and ask them to reduce the list of 12 measures down to 10 (or less) of the best measures.
5. Next step: elicit feedback from selected organizations and patient advocacy groups.

Discussion highlights of the project so far include
Many measures do not apply in all settings; however, for now, we are working with what we have today. We've asked ourselves "Is this measure among the best we have today?" Some

<http://aaahpm.org/quality/measuring-what-matters>

produce measures worthy of accountability programs. As a field, we do not yet have a global

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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

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Mine the literature

De Roo ML et al. Quality indicators for palliative care: update of a systematic review. J Pain Symptom Manage. 2013 Oct;46(4):556-72.
326 indicators addressing the 8 core PC domains

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

Domain 1.1: Structure of care (33 indicators)			
	Reference/ year	Description/type of indicator	Numerator/Denominator/Exclusion/Performance standard
1	Mularski, 2006	Documentation of a policy that allows for unrestricted visitation by family members and friends. Structure	Numerator: Presence of a policy in the ICU that allows for family and friends to spend time in the patient’s room regardless of the time of the day. Policy may include restrictions on the number of visitors at one time or restrictions based on disturbance of other patients or family members or disturbance of the functioning of the ICU. Policies may also include provisions for asking family members or friends to wait in the waiting room during procedures Denominator: ICU Exclusion: - Performance standard: -
2	Nelson, 2006	Family meeting room: dedicated space for meetings between clinicians and ICU families. Structure	Periodic point measurement: presence or absence of room designated for family meetings. Numerator: - Denominator: - Exclusion: - Performance standard: -
3	NEW ELCQuA, 2011	Families and carers can access designated quiet spaces, and are able to view the deceased in appropriate surroundings. Structure	Numerator: Number of wards with designated quiet area per organisation Denominator: Total number of wards per organisation Exclusion: - Performance standard: 100%

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Case Studies: AHRQ Innovations Exchange

The screenshot shows the AHRQ Innovations Exchange website. At the top, it features the U.S. Department of Health & Human Services logo and the AHRQ logo (Agency for Healthcare Research and Quality). Below this is a navigation bar with links for Home, What's New, Browse By Subject, Downloadable Database, Videos, Scale Up & Spread, Articles & Guides, and Events. The main content area displays a 'Service Delivery Innovation Profile' for a program titled 'System-Integrated Program Coordinates Care for People With Advanced Illness, Leading to Greater Use of Hospice Services, Lower Utilization and Costs, and High Satisfaction'. A 'Snapshot' section includes a 'Summary' that describes Sutter Health's Advanced Illness Management program. A sidebar on the right offers a 'Contact the Innovator' button and a 'Look for Similar Items by Subject' section with categories like Medicare, Terminally ill, Palliative care, pain management, Transitions between settings, End-of-life care, and Home hospice care. A URL <https://innovations.ahrq.gov/> is visible in the bottom left, and the page number '29' is in the bottom right.

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			
Domain	Measure	Source / Supporting Guideline	Type of Measure
General Structures and Processes of Care	Nurses, social workers and chaplains serving on the PC team are certified in palliative care	NCP Guidelines	Structure
Physical Aspects of Care	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	NQF (0420; PQRS)	Process
Psychological and psychiatric aspects of care	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	NHCPO	Outcome

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Who bears the burden?			
Measure	Type of Measure	Data Source	Who bears the burden
Nurses, social workers and chaplains serving on the PC team are certified in palliative care	Structure	Program description / policy	<ul style="list-style-type: none"> Administrative leaders
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	Process	Medical record	<ul style="list-style-type: none"> Clinical team IT staff (electronic extract) Administrative staff if manual chart review (gasp)
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	Outcome	Survey	<ul style="list-style-type: none"> Family Administrative staff Analytic staff

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(Feasible) Minimal Measuring

Domain	Structure	Process	Outcome (patient/social)
General Structures and Processes of Care	One structure or process metric for each Domain, including at least 2 process measures		Two patient or social outcomes, addressing any of the 8 domains
Physical Aspects of Care			
Psychological and psychiatric aspects of care			
Social aspects of care			
Spiritual, religious & existential aspects of care			
Cultural aspects of care			
Care for the patient at the end of life			
Ethical & Legal Aspects of Care			

Plus 2-4 utilization or cost outcomes

Minimal measuring = 12-14 items

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Performance standards – what to aim for

- National statistics
 - NHCPO 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

*NHCPO'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.

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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

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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

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

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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

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Questions and Discussion

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