Measuring Outpatient Palliative Care

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IHHC Statewide Director of Palliative Care and Hospice

Objectives

• Outline the importance and necessity for consistent measurement for palliative care programs.

• Identify measures and methods developed by the Iowa Health Palliative Care Affinity Group to track palliative care data and outcomes.

• Discuss utilization of metrics to support palliative care program development.
Outpatient PC in Iowa

- Still in its infancy
- Many small, rural providers in Iowa
- Often a department of a CAH
- Often developed though a home care or hospice program

Who we are...

- We are Iowa Health Home Care – the state’s largest integrated home health provider with sites across the state (urban and rural)
- We are part of Iowa Health System
- IHHC OPPC Des Moines (ADC >50)
- Trinity *PC Fort Dodge (ADC <5)
- Trinity Pathways OPPC Quad Cities (ADC <20)
- Cass County OPPC (ADC <10)
- St. Luke’s OPPC Cedar Rapids (ADC 50)
OPPC Staffing Structure

- **Medical Director** – goal is to have access to certified physicians across the state
- **ARNP** – promoting hybrid positions (IPPC and OPPC)
- **RN** – assist ARNP with triage and case management
- **LISW** – psychotherapy & advanced directives
- **Chaplain** – spiritual support
- **Pharmacist** – clinical consultation

*Denotes core PC IDT members

The IHHC PC Affinity Group

- We have agreed on a PC definition
- We are developing our policies and processes based on the Clinical Standards (2nd Edition) from the National Consensus Project
- We are revising and standardizing our documentation tools
- We have agreed upon our initial metrics for measuring the effectiveness and impact of our programs
Model of Care

We provide both consultative and primary care:

- **Consultative:** through a Home Care episode
- **Primary Care:** for patients that do not qualify for home care services, including patients in their own home or in an ALF or LTCF (including skilled)

Systems-based Approach

- An organized, deliberate approach
- Identification, assessment, and management of a complex clinical problem
- Checklists (triggers)
- Treatment algorithms
- Provider education
- Quality improvement initiatives
- Changes in delivery and payment models
Collaborative

- Dual “ownership” of PC program between hospital and home care
  - Shared positions promote continuity of care thru transitions across care settings
  - Shared IDT meeting promotes collaboration and improved communication regarding patients’ goals of care
  - Improves medication reconciliation and ongoing medication management

Complex Patients

- Patients are triaged using an interdisciplinary approach with collaboration between the physician/ARNP, RN and LISW
- The Plan of Care is determined by assessment of the patient’s needs and goals of care
- Most often, an RN or LISW is coordinating the care with direction from the physician/ARNP
Extending PC Beyond Discharge

• Triggers should ensure fewer needs go unmet, prevent crises and hospitalizations for manageable problems, and improve quality of life

• PC patients often report a lack of supportive information upon hospital discharge

• Primary care physicians and specialists alike need to extend the reach of PC by working to ensure smooth transitions between care settings

  • (per Journal of Palliative Medicine editor-in-chief Charles F von Gunten)
Why do we measure?

The Purpose of Measurement

• Strategic Planning

• Quality Improvement

• Demonstration of program impact to healthcare administrators, private funders, and policymakers
The Dilemma Facing Palliative Care

- Current research does not yet provide a sufficient evidence base to support links between structure-process-outcomes for key palliative care domains:
  - Quality of life, family burden, spiritual well being, bereavement, continuity, pain and other symptoms

It’s all about QUALITY

- Quality measures are becoming the foundation for healthcare reform
  - Required by payers, regulatory bodies, certifying agencies
    - Pay for performance, Public reporting, CQI
  - Palliative care cannot afford to ignore quality!
Measuring Quality

- **Structure**
  - characteristics of the physician or health care institution (e.g., credentialing of palliative medicine professionals, presence of a palliative care program)

- **Process**
  - encounters between the patient and health care institution/provider (e.g., appropriate referral for palliative care, concurrent laxative treatment with opioid therapy)

- **Outcome**
  - the person's subsequent health status (e.g., reduction in symptom distress, improved quality of life)

The link between structure, process, and outcome

- Structure and process indices are most useful as quality indicators if changes in the attributes that they measure have been shown to improve patient outcomes.

- Outcome indices are most useful as quality indicators if they can be linked to specific process or structural measures that if altered, change the outcome.
What should we measure?

Metric Domains

- Operational
- Clinical
- Customer
- Financial

*Center to Advance Palliative Care Inpatient Unit
Operational Metrics: Consensus Recommendations
David E. Weissman, M.D. 1 and Diane E. Meier, M.D. 2
### Operational Metrics

- Patient ID number
- Patient age, gender, race/ethnicity
- Consultation diagnosis
- Referring service and/or referring MD
- Date of hospital admission
- Date of hospital discharge
- Date of consultation
- Disposition: inpatient death vs. discharge
- Hospice discharges

### Clinical Metrics

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<thead>
<tr>
<th>Data</th>
<th>Processes</th>
<th>Outcomes</th>
<th>Tools</th>
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<tr>
<td>Sx documented at initial visit</td>
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<td>MSAS, ESAS, POS, BCS</td>
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<tr>
<td>Management plan for all mod-sev sx</td>
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<td>Chart review</td>
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[Please note: The table format is not fully visible in this text representation.]
Clinical Metrics

<table>
<thead>
<tr>
<th>Data</th>
<th>Processes</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals of care/goals of treatment</td>
<td>Documented if indicated? missing elements</td>
<td>Fairview Family Conference Note</td>
</tr>
<tr>
<td>Support to patients and caregivers</td>
<td>Documented if indicated? missing elements</td>
<td>Central Baptist Pt Care Needs/ SW, Spiritual Care Assessments</td>
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<tr>
<td>Transition management</td>
<td>Documented if indicated? missing elements, f/u plan for palliative care across settings, AD follow patients across settings</td>
<td>CTM, POLST, MOLST</td>
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</tbody>
</table>

Customer Satisfaction

- Validated scales
  - FAMCARE scale
  - Family Assessment of Treatment at End-of-Life (FATE-S-VA)
- Other clinically useful instruments
  - Family Satisfaction Tool (Massachusetts General Hospital)
  - Family Satisfaction Survey (Mercy Health Partners, Supportive Care Coalition)
- Referral sources: track source and volume
Financial Metrics

• Cost avoidance: based on history of Ed/hospitalizations past 3-6 months prior to PC and post PC consult/admission
• Medicare Billable visits: physician, ARNP, LISW can bill. Estimate number of billable visits per day per discipline and audit for “quality” of billable visits (time and complexity)
• Track PC patients by payer
• Conversion to hospice (percentage)
• Hospice volume and ALOS/MLOS

How do we measure?

• The devil is in the details!
What makes a good measure?

- Uniform – no tweaking!
- Balance utility with data collection ease
- Based on best available evidence
  - Primarily structure and process measures
  - Select outcome measures
- Allows comparisons across institutions to guide program growth and development, ensure compliance with best practices, and explore quality

Getting started

- Start slow
  - Consider operational and financial first
- Identify:
  - Measure
  - Numerator and denominator
  - Definitions
  - Inclusions and exclusions
  - Additional clarification
  - Data elements
For example…

- **Measure**: OPPC Admissions
- **Numerator**: number of patients admitted to OPPC
- **Denominator**: not applicable
- **Definitions**: Initial admission and readmission
- **Inclusions and exclusions**: none
- **Additional Clarification**: Volume includes initial admissions and readmissions. Patients previously seen by IPPC but new to OPPC are initial admissions

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Data Elements

- What can be pulled from documentation?
  - OPPC Admission date/time
  - Source of IPPC discharge (IHS or non-IHS)
  - Location (FD, DSM, etc.)
  - Name
  - DOB
  - Address
  - Patient identifier
Storing Your Data

• Necessary
• “Database” options:
  o Spread sheets (Excel, Lotus, Quattro)
    ▪ Patients are rows
    ▪ Variables are columns
  o Statistical packages (SAS, Stata, SPSS)
  o Databases (MS Access)
    ▪ Simple forms that mimic your paper forms
    ▪ Data stored in corresponding tables

HIPPA

• Don’t forget to consider HIPPA regulations when determining your data base
  o Ownership
  o Access
  o Security
  o Confidentiality
Current OPPC Metrics

- Volume
- Discharge Distribution
- Hospital readmissions

Next steps

- Clinical metrics:
  - Standardized measurement
  - Pain and dyspnea
  - Advanced care planning
Telling the Story

• Metrics alone are not enough
• Provide compelling case studies to accompany your data – personalize the numbers
  o Bob with COPD
  o Art with Alzheimer’s dementia
  o Jenny with Trisomy 18

Celebrate Success!
References

- R. Sean Morrison, MD, Hermann Merkin Professor of Palliative Care, Mount Sinai School of Medicine, Director, National Palliative Care Research Center