California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

SB1004 Technical Assistance Series: Topic 4: Gauging and Promoting Sustainability and Success

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Building blocks for implementing community-based palliative care

Estimating member/patient need

Estimating costs for delivering services

Assessing capacity for palliative care & launching svcs

Gauging and promoting sustainability and success

Lessons learned and adjusting programs

Webinar slides and a recording will be distributed at the end of the week

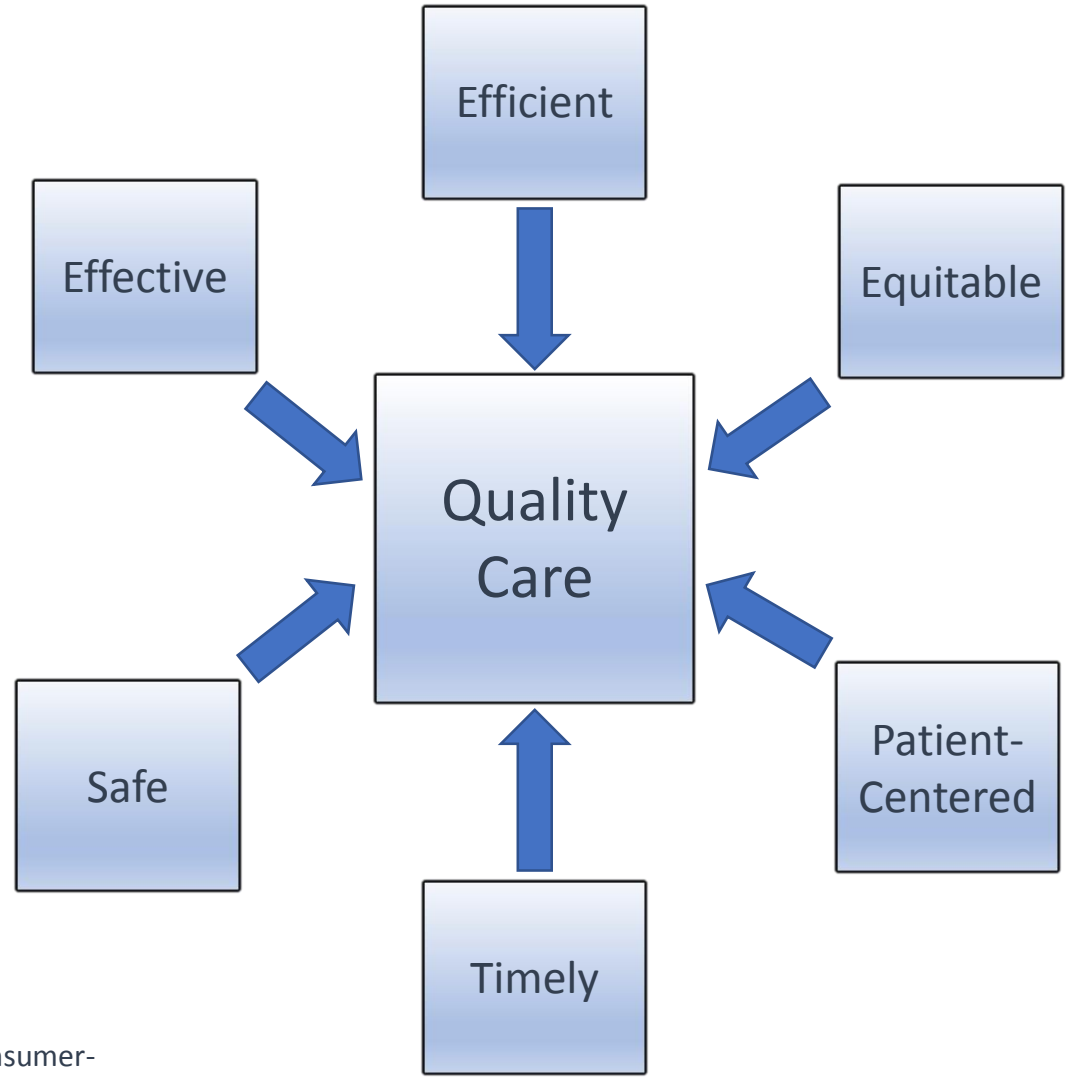
Objectives

- Review information from DHCS regarding initial program reporting requirements
- Describe resources available to measure palliative care quality
- Outline process steps to select quality metrics based on local needs, resources and challenges
- Create processes for routine program review and quality assessment
- Outline factors that promote sustainability and scaling of services

SB 1004 Reporting Requirements

- Final template released February 2018
- Quarterly reporting
- Reporting domains
  - ***Patient level***: name, diagnosis, approval date, disenrollment date, reason for disenrollment
  - ***Referrals***: number made, approved, accepted, declined, denied and if denied why
  - ***Network***: provider name, type (mix of disciplines and services), specialty, telehealth use

Components of quality



https://cahps.ahrq.gov/consumer-reporting/talkingquality/create/sixdomains.html

Much more you will want to know

Metrics that describe:

- What was done, by whom, how often
- Adherence to best practices
- Quality, from any number of perspectives

Where to find metrics?

- Case studies / peers
- QI collaboratives
- Endorsed by the field

Metrics used by CHCF Payer-Provider Partnerships Initiative participants

To learn more about the PPI project: https://www.chcf.org/project/payer-provider-partnerships-to-expand-community-based-palliative-care/

Operational

- # Patients referred, % with scheduled visits, % visited
- # Visits (average and range) per patient in enrollment period
- # Days (average and range) from referral to initial visit
- # Days (average and range) between visits
- % seen within 14 days of referral
- Referral source
- Referral reason
- Use of tele-visits

Metrics used by PPI teams

Screening and assessments

- % for which spiritual assessment is completed
- % for which functional assessment is completed
- Symptom Burden by ESAS (repeated)
- Patient distress by Distress Thermometer (repeated)
- % for which medication reconciliation is done with 72h of hospital discharge

Planning and preferences

- % with advance care planning discussed
- % with advance directive or POLST completed

Metrics used by PPI teams

Hospice and End of Life Care

- % remaining on service through end of life
- % death within one year of enrollment
- % enrolled in hospice at the time of death
- Average/median hospice length of service
- Location of death
- % dying in preferred location

Metrics used by PPI teams

Utilization and fiscal

- PMPM cost of care, enrolled patients vs comparison population
- Health care utilization/costs 6 months prior to enrollment compared to 6 months during/after:
  - # Acute care admissions
  - # (Total) hospital days
  - # ICU admissions
  - # ICU days
  - # ER visits
  - Cost per member (total)
  - Cost per member (inpatient)
  - Cost per member (outpatient)

Palliative Care Quality Network

National learning collaborative committed to improving the care of seriously ill patients and their families

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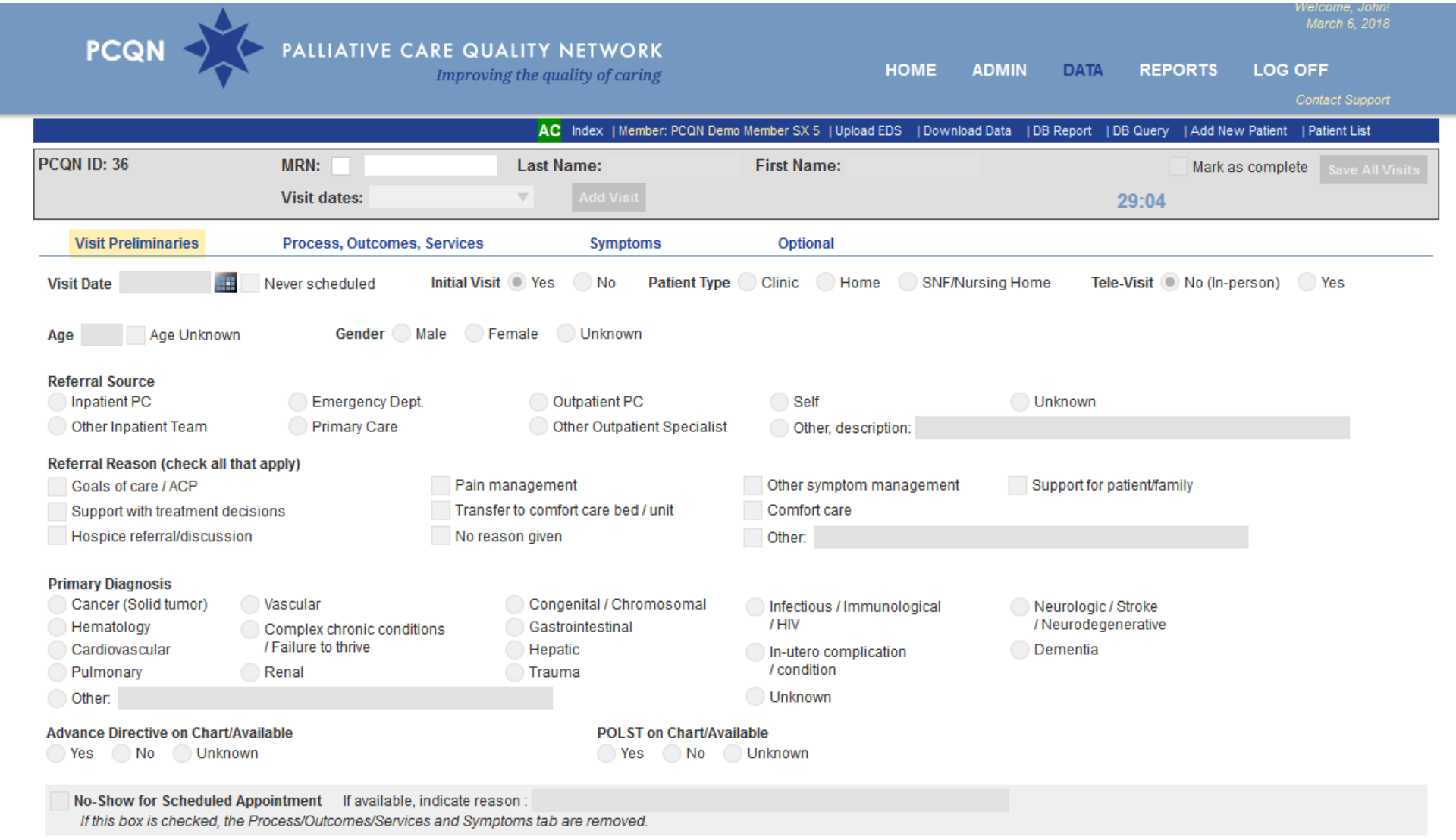
Patient- level data registry with real-time, easy to access reports that allow for benchmarking across member sites.

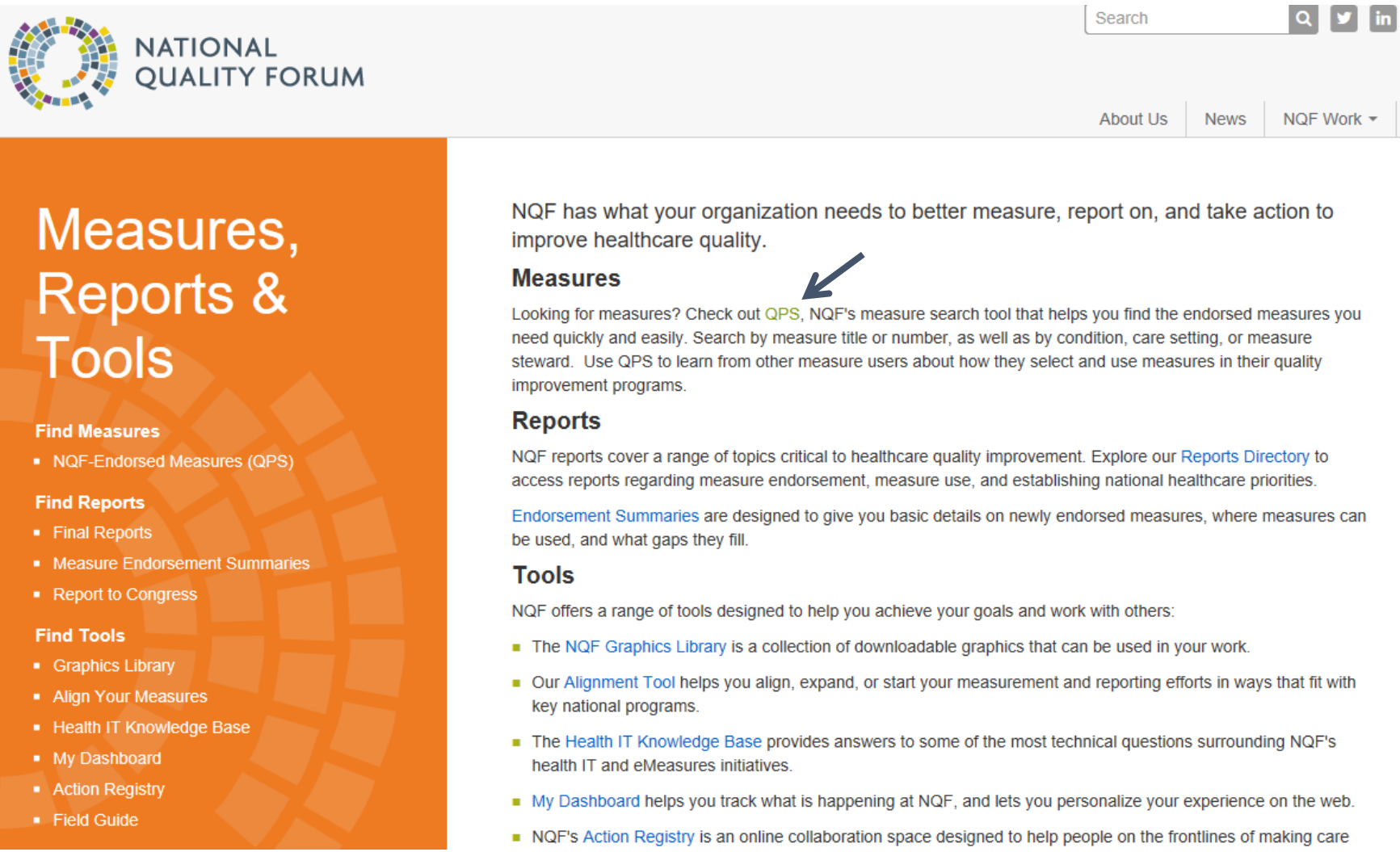
Quality improvement activities including mentored multi-site QI projects, QI education, and case reviews.

Education & community building opportunities including monthly educational webinars and in-person conferences.

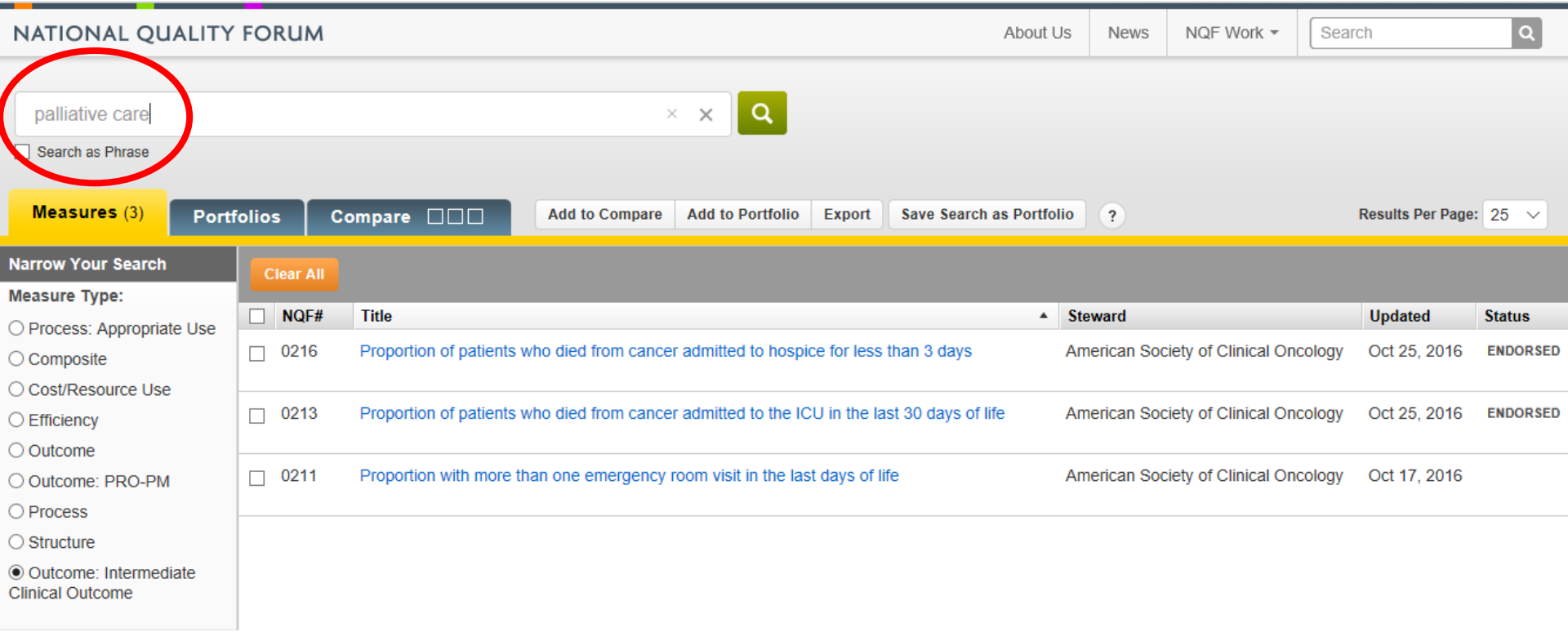
Learn More: https://pcqn.org ● Angela Marks angela.marks@ucsf.edu


PCQN
PALLIATIVE CARE QUALITY NETWORK
Improving the quality of caring
Welcome, John!
March 6, 2018
HOME ADMIN DATA REPORTS LOG OFF
Contact Support
AC Index | Member: PCQN Demo Member SX 5 | Upload EDS | Download Data | DB Report | DB Query | Add New Patient | Patient List
PCQN ID: 36
MRN:
Last Name:
First Name:
Mark as complete
Save All Visits
Visit dates:
Add Visit
29:04
Visit Preliminaries
Process, Outcomes, Services
Symptoms
Optional
Visit Date
Never scheduled
Initial Visit Yes No
Patient Type Clinic Home SNF/Nursing Home
Tele-Visit No (In-person) Yes
Age
Age Unknown
Gender Male Female Unknown
Referral Source
Inpatient PC
Emergency Dept.
Outpatient PC
Self
Unknown
Other Inpatient Team
Primary Care
Other Outpatient Specialist
Other, description:
Referral Reason (check all that apply)
Goals of care / ACP
Pain management
Other symptom management
Support for patient/family
Support with treatment decisions
Transfer to comfort care bed / unit
Comfort care
Hospice referral/discussion
No reason given
Other:
Primary Diagnosis
Cancer (Solid tumor)
Vascular
Congenital / Chromosomal
Infectious / Immunological / HIV
Neurologic / Stroke / Neurodegenerative
Hematology
Complex chronic conditions / Failure to thrive
Gastrointestinal
Cardiovascular
Hepatic
In-utero complication / condition
Dementia
Pulmonary
Renal
Trauma
Other:
Unknown
Advance Directive on Chart/Available
Yes No Unknown
POLST on Chart/Available
Yes No Unknown
No-Show for Scheduled Appointment
If available, indicate reason :
If this box is checked, the Process/Outcomes/Services and Symptoms tab are removed.

PC metrics endorsed by NQF



Use NQF's QPS to find endorsed metrics



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

MEMBERSHIP | EDUCATION & PRACTICE | ADVOCACY | CAREER DEVELOPMENT

Meetings
Annual Assembly
Board Review Course
Pediatrics Course
Webinars
Calendar

Publications
JPSM
PC-FACS
Quarterly
SmartBriefs

Self-Study
Board Prep Materials
Essentials
Primer
HPM PASS
HPM FAST
Hospice Products
Opioid REMS

Measuring What Matters

AAHPM & HPNA Measuring WHAT Matters

Measuring What Matters (MWM) is a consensus recommendation for a portfolio of performance measures for all hospice and palliative care programs to use for program improvement.

The Measuring What Matters team identified existing indicators that were then rated by mutiple panels to ultimately determine the **Top 10 Measures That Matter.** Read more about the findings and reccomendations of the consensus project in the Journal of Pain and Symptom Management.

Read the Actual Measures List or Measure Concepts List.

Access the New Frequently Asked Questions (FAQ) list about MWM
Access the Frequently Asked Questions (FAQ) list about MWM.
Access the Top Twelve Measures—Background Information, Evidence and Clinical User Panel (CUP) Comments

Project Overview

Read about the history of the project and the organizations involved.

AAHPM & HPNA Measuring WHAT Matters

TOP TEN MEASURES THAT MATTER

MEASURE 1: Hospice and Palliative Care—Comprehensive Assessment

Percentage of patients for whom a comprehensive assessment was completed

Source: PEACE Set[1,2] | http://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures

MEASURE 2: Screening for Physical Symptoms

Percentage of seriously ill patients receiving specialty palliative care in an acute hospital setting >1 day or patients enrolled in hospice >7 days who had a screening for physical symptoms (pain, dyspnea, nausea, and constipation)

Source: PEACE Set[1,2] | http://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures

MEASURE 3: Pain Treatment (ANY)

Seriously ill patients receiving specialty palliative care in an acute hospital setting >1 day or patients enrolled in hospice >7 days who screened positive for moderate to severe pain on admission, and the percent receiving medication or nonmedication treatment, within 24 hours of screening

Source: PEACE Set[1,2] | http://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures

Selecting Quality Metrics

Selecting Quality Metrics: Factors to Consider

- What matters to stakeholders
- Feasibility of data collection
- Balanced portfolio

Selecting Quality Metrics: Check in with Stakeholders

1. Who are your stakeholders?
   - Internal
     - Clinically-oriented
     - Financially-oriented
     - Regulatory
   - External
     - Payer/provider partner
     - Referring providers
     - Community partners
     - DHCS

Selecting Quality Metrics: Check in with Stakeholders

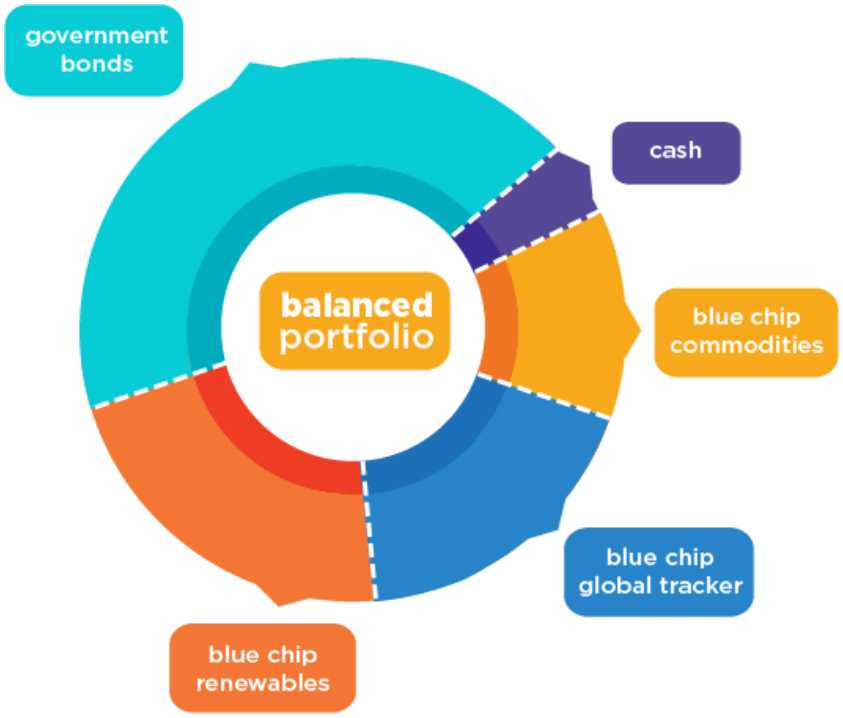
2. Questions to ask
   - What would a successful palliative care program look like?
   - What are you hoping the program will achieve?
   - If you only had one measurement of program quality, what would it be?
   - How might the palliative care program impact (or be impacted by) other programs?

Selecting Quality Metrics: Assess Availability and Feasibility

For each metric you're considering…

- Where would you get the data?
  - Available in EHR
  - Could be collected specifically for this purpose
    - How labor-intensive might that collection process be?
    - Who would need to be involved? How much bandwidth do those stakeholders have to take on new tasks?
- Would the data be consistently available?
- How reliable would the data be?
- Where/how would you house the data?
- What would the analysis process require?

Selecting Quality Metrics: Aim for a balanced portfolio



- Different types of metrics
  - Structure
  - Process
  - Outcome
- Different focus areas
- Effort required

Putting it all together

	Structure/ Process/ Outcome	Important to Plan	Important to Provider	Important to other(s)	Easy to collect?
Metric 1					
Metric 2					
Metric 3					

For each box, enter

- -- = not of interest/hard to collect
- 0 = neutral/some effort to collect, but doable
- + = important to stakeholder/easy to collect
- ++ = very important to stakeholder/very easy to collect

Don't select a metric without at least 2 +s

Example of metrics selection: Zuckerberg San Francisco General

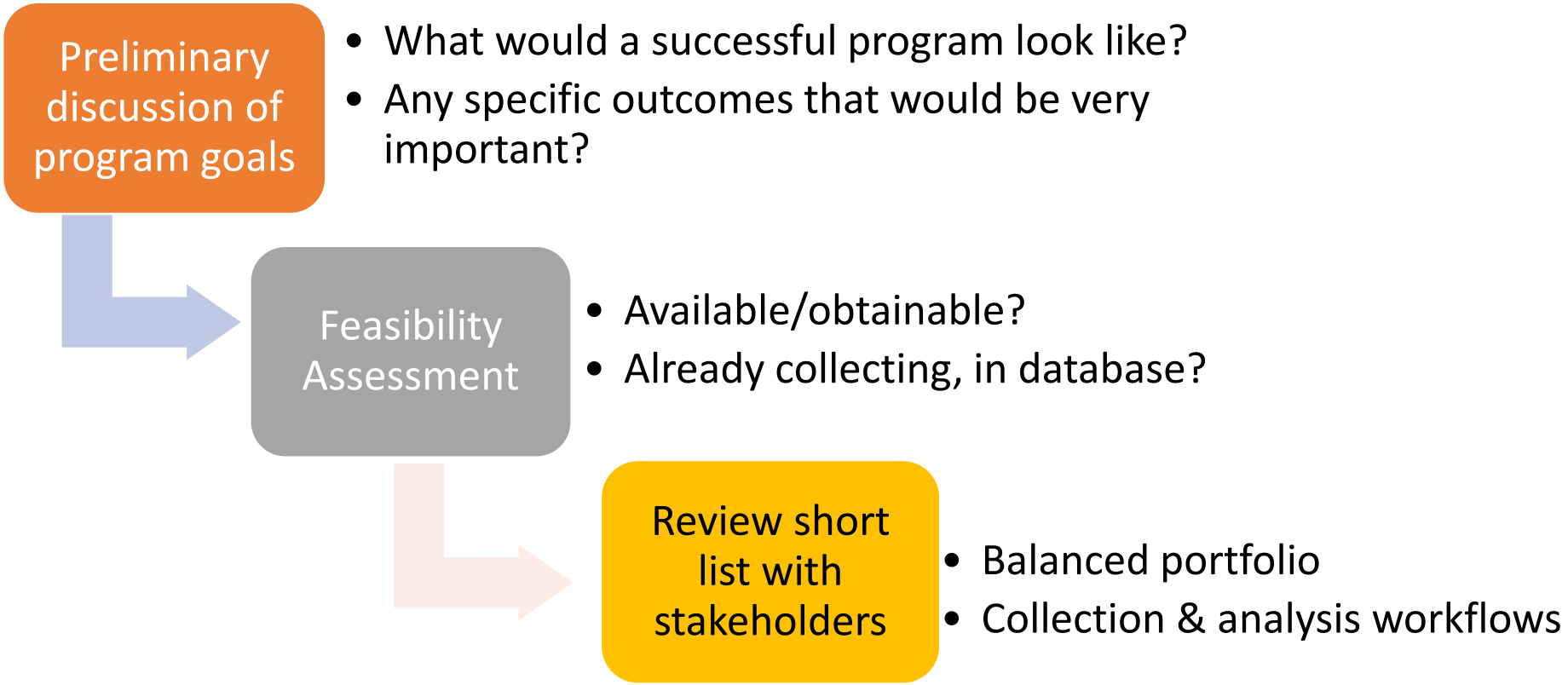
Context

- Inpatient & Outpatient programs
  - Patients seen by both, or just one
- Cannot pull data from EHR
- Limited administrative support

Stakeholders

- Internal
  - System leaders
  - Inpatient and outpatient teams
- External
  - SF Health Plan
  - Grant funders

Example of metrics selection: Zuckerberg San Francisco General



Example of metrics selection: Zuckerberg San Francisco General

	Structure/ Process/ Outcome	Important to Plan	Important to Provider	Important to other(s)	Easy to collect?
Interdisciplinary team, PC certified	Structure	++	++	++	++
% of patients screened for psychosocial distress	Process	0	++	++ Cancer Committee	0/+
Number of patients seen per year	Outcome	++	++	++	+
Average costs of patients in last yr. of life	Outcome	++	++		-/0

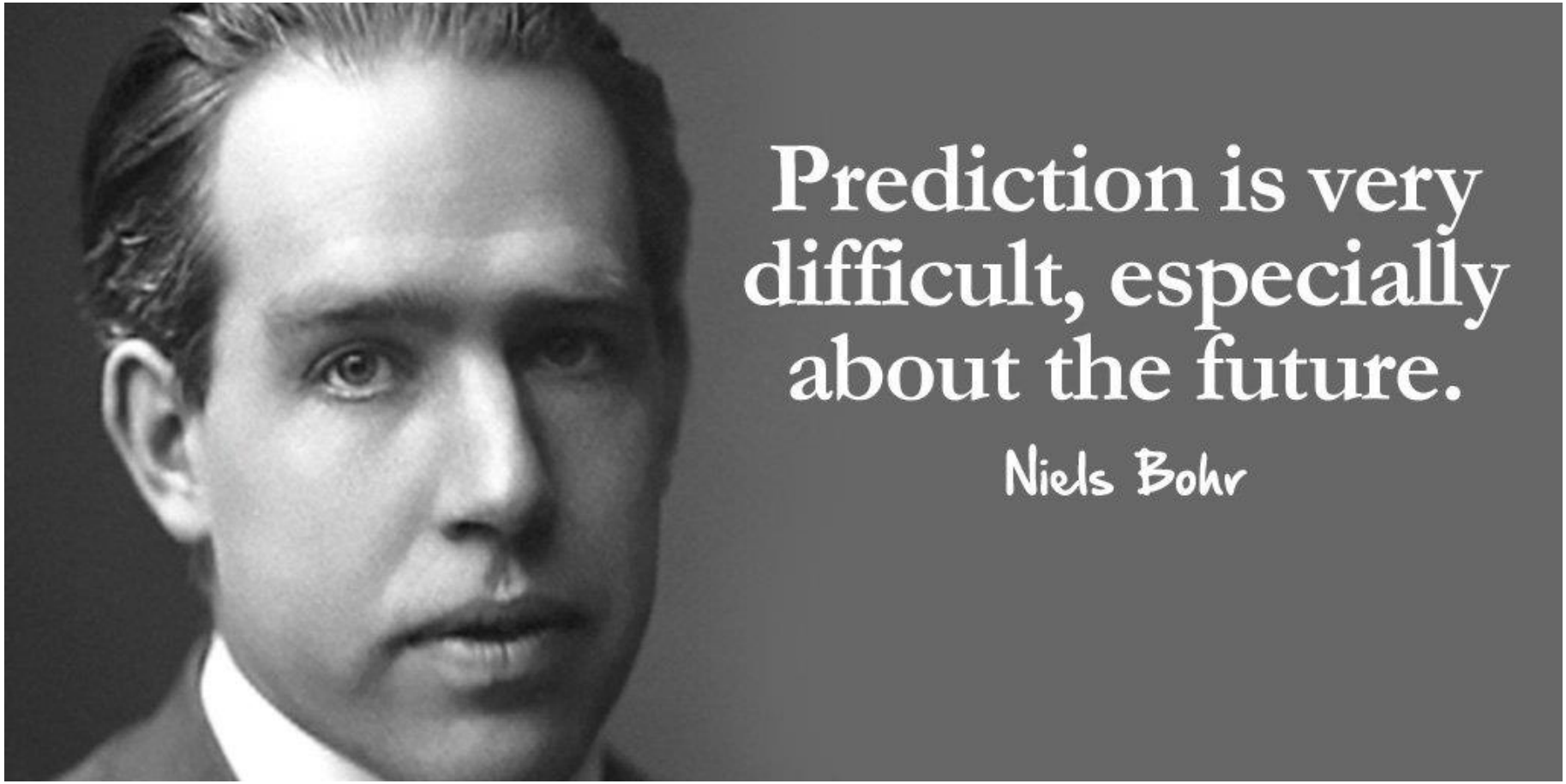
You've selected your metrics… Now What?

- Discuss with partner, stakeholders
  - Targets
    - What happens if target isn't achieved?
  - Interval for reporting
    - Internal
    - External
  - Format for reporting, communication preferences

Promoting Sustainability: Recommendations

- Pilot & Re-evaluate
- Routine communication
- Repeat the needs assessment
- Pay attention to relationship with payer/provider

A wise person once said…



Promoting Sustainability: Pilot & Re-evaluate

- Many things are hard to predict
  - Where referrals will come from, how much marketing and outreach will be required
  - Which patient populations will be largest
  - Roles/responsibilities of different team members
  - How workflows will need to change (with changes in venue, volume, staffing, etc.)
  - Projected vs. actual costs

Many successful payer-provider partnerships include routine re-evaluation of program goals, structures, workflows, outcomes

First choice … best choice?

INITIAL PLAN	CHALLENGES	POSSIBLE SOLUTIONS
(Pilot) contract mandated 2 RN home visits per patient per month	• Some patients did not make themselves available for visits at predictable intervals, which reduced revenues for provider • Some patients did not need both RN visits, but instead really needed weekly SW visits, at least in some months	• Create process to waive or adjust requirement for certain patients / certain circumstances • Suggest high-frequency initial phase followed by maintenance phase

Promoting Sustainability: Routine Communication

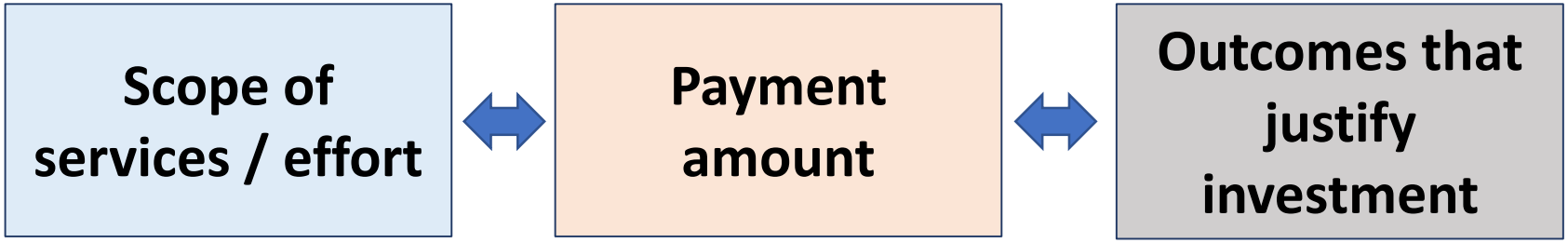
- Rationale
  - Changes in staffing/leadership happen
  - Your partner's goals/priorities will change
  - Identify gaps, unmet needs on both sides
  - Fix small issues before they grow
- Content to consider
  - Clinical
  - Operational/Programmatic
- What works best for communication?
  - Email/written
  - Remote
  - In-person

Promoting Sustainability: Repeat the Needs Assessment

You've done a thorough needs assessment at the outset of the program, now you're set, right?

- Because things change after the pilot phase, there may be key times when you should consider repeating a needs assessment
  - Change in partner(s) or key stakeholder(s)
  - Program expansion
  - Change in scope of work/responsibility

Balance is essential



Relationship issues

Even a great service can't thrive if the payer-provider relationship is bad: Partners need to be willing to communicate openly and frequently about all aspects of program planning and implementation. Partners need to build trust, understand why they each want to engage in this work, and show an appreciation for the pressures and priorities that impact the other organization.

- Listening, transparency, empathy and collaborative problem solving are valued highly; inflexibility may be a red flag
- Be aware that organizational culture influences relationships

“Most important” characteristic that you look for in a CBPC partner?

Provider:

“That they be collaborative and flexible, able to appreciate the perspective of a small partner”

Payer:

“Ideal partner characteristics would be an ability to take in information from many perspectives (vision and mission plus practical information about service delivery nuts and bolts, and the environment), including an ability to appreciate the perspective of a payer partner.”

Characteristics that might predict a poor fit?

Provider:

"As we brought issues to the forefront (big and small) the plan was always willing to engage in a conversation - to hear from our perspective how a contract requirement would impact care. Even if the plan didn't agree, it was important to us that they were willing to have that collaborative conversation. Not seeing this kind of openness would be a huge red flag; a payer that just says, 'This is the way we do it' would be a difficult partner."

Bridging differences between organizational cultures / perspectives

Payer:

"We were very successful in educating each other about our organizations, and in being transparent about priorities, risks and benefits. The foundation of these successes was a willingness to trust, a belief that, 'the person or group on the other side of the table is not going to take advantage of me.' This trust has to be earned, and then reflected in the contract. For example, the contract included language that allowed the provider to bill for services outside of the set PMPM rate in instances where a specific patient needed significantly more than the expected (usual) amount of support."

SUMMARY

- Supplement information reported to DHCS with process and outcome metrics that describe care quality
- When considering metrics look to what peers are using, those endorsed by professional organizations, QI collaboratives
- The right metrics are those that are feasible and that meet the information needs of both parties
- Just because you started doesn't mean you are done – ongoing monitoring and modifications will be needed
- Prioritize creating and sustaining good payer-provider relationships

Acknowledgements, and your questions

Thanks to colleagues who shared their knowledge, wisdom and experiences

- Topic 4 workshops
  - Northern California: April 23, 25
    - Oakland, CHCF offices
  - Southern California: April 27, 30
    - Los Angeles, the Garland Hotel
- SB 1004 Questions
  - http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx
  - SB1004@dhcs.ca.gov
- Technical Assistance Series: kmeyers@chcf.org

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