

Metrics and Assessing Impact

The right way is the way that works for both parties. There is no universally accepted or feasible set of metrics that is required for or used by all community-based palliative care (CBPC) programs. The right metrics are the ones that are feasible to implement and that meet the information and decisionmaking needs of both the plan and the provider organization.

1 Expect variation in reporting requirements and metrics across contracts.

- ▶ The data-reporting requirements and metrics used by the six California Health Care Foundation payer-provider partnership teams varied significantly. Some plans required no data reporting at all, others had extensive requirements, and some providers routinely collected additional information beyond required elements to support internal quality-assessment activities.
- ▶ Most partnerships monitored the amount of service delivered, where it was delivered, and by whom; key care processes; patient, family, and caregiver experiences; and use of health care services and fiscal outcomes, with wide variation in specific metrics used across contracts.

Sample Metrics Used by Payer-Provider Partnership Teams

Operational

- ▶ Number of patients referred, percentage with scheduled visits, percentage visited
- ▶ Average number (and range) of:
 - ▶ Visits per patient in enrollment period
 - ▶ Days from referral to initial visit
- ▶ Average number (and range) of days between visits
- ▶ Percentage of patients seen within 14 days of referral
- ▶ Referral sources
- ▶ Referral reasons
- ▶ Use of telehealth/video visits

Screening and Assessments

- ▶ Percentage for which:
 - ▶ Spiritual assessment is completed
 - ▶ Functional assessment is completed
- ▶ Symptom burden measured by standardized instrument, at initial visit and at follow-ups
- ▶ Patient distress measured by standardized instrument, at initial visit and at follow-ups
- ▶ Percentage for which medication reconciliation is done with 72 hours of hospital discharge

Planning and Preferences

- ▶ Proportion of patients with advance care planning discussed
- ▶ Percentage of patients with advance directive or POLST (Physician Orders for Life-Sustaining Treatment) completed

Hospice and End-of-Life Care

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

Service Use and Fiscal Outcome

- ▶ Per member, per month cost of care, enrolled patients versus comparison population
- ▶ Health care use/costs 6 to 12 months prior to enrollment compared to 6 to 12 months during/after enrollment:
 - ▶ Number of acute care admissions
 - ▶ Number of (total) hospital days
 - ▶ Number of intensive care unit (ICU) admissions
 - ▶ Number of ICU days
 - ▶ Number of emergency room visits
 - ▶ Total cost per member/patient

2 Consider feasibility — data access and data collection burden.

- ▶ Assessing process and outcome metrics is essential for plans to demonstrate return on investment, and for providers to demonstrate the value of their services and identify quality gaps. However, data collection and reporting can require significant resource investment. In general, a shorter list of items that can be assessed well is better than a very long list of items that may be cumbersome to implement or may be hard to collect with accuracy. Partners should avoid situations where clinical staff must choose between dedicating time to patient care or dedicating time to mandatory data collection. Partners should set reasonable benchmarks, knowing that optimal care delivery and outcomes will vary across the patient population. For example, a metric describing the proportion of individuals who die at home would need to account for the fact that dying at home is not a viable or preferred option for all patients.
- ▶ Plans and providers should approach metrics selection thoughtfully and be prepared to negotiate on the items to be collected, the reporting format, and the reporting frequency. Each party should be clear on what data they are able to collect and their capacity to monitor specific quality metrics, and contracts should specify which party carries responsibility for each selected metric (who gathers the data, who analyzes the data, who reports the data, which data/outcomes are shared between the parties, with what frequency).

- ▶ Some plans have extensive measurement and reporting requirements that can be onerous for smaller provider organizations to execute. This results in time-consuming manual data collection and tracking, which is difficult to sustain over the long term.
- ▶ Providers with multiple contracts find that variation in required metrics threatens sustainable data collection and outcomes measurement. For such organizations, a starting point in developing an evaluation plan for a new contract should be the metrics they already collect and report for other contracts.

3 Share the burden and prepare for the long haul.

- ▶ Both parties can expect to contribute some data and carry some of the burden of data collection, aggregation, and analysis.
- ▶ While some metrics used early in a payer-provider partnership may be discontinued over time, many requirements are likely to be maintained, especially those used to assess impact on fiscal and health care service use outcomes. Partners should expect to revisit evaluation plans and reporting requirements intermittently but should not be surprised if only minimal adjustments are made.
- ▶ Plans requiring extensive data reporting can soften the burden on provider partners by using plan staff to aggregate and analyze the raw data that providers collect, by offering incentive payments for submitting data, or by adjusting case rate payments to reflect the added effort required to collect data

that is beyond what is needed to provide clinical care. Some plans have supported data collection and a focus on quality by covering membership fees for contracted providers wishing to join quality and benchmarking organizations, such as the Palliative Care Quality Network (PCQN) or the Global Palliative Care Quality Alliance.

- ▶ Membership in palliative care quality/benchmarking organizations can also help both partners interpret their own outcomes. This is especially useful if the population being served is somewhat different than the populations most commonly studied in published reports (e.g., care is being delivered to a Medicaid population, which is notably younger and more complex than the populations featured in the palliative care literature.)

TOOLS AND RESOURCES

Programs or partnerships that are developing a metrics plan might consider items included in [Measuring What Matters](#), a set of performance measures recommended by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

A broader set of possible metrics is included in the [Palliative Care Measure Menu](#), which allows users to select palliative care metrics based on focus area, required data, and other criteria.

Programs looking for benchmarking opportunities might consider the [PCQN](#), a continuous learning collaborative that features a patient-level registry and a common set of metrics for both inpatient and community-based palliative care services.

This paper is part of a series on payer-provider partnerships in palliative care. To read the rest of the lessons, visit www.chcf.org/payer-provider-lessons.