Improving the Quality of Palliative Care: Lessons from Collaborative QI

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Palliative Care Program
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Palliative Care is Good for Patients & Families

• Could it be better?

• Could it be more effective?

• Could it be more efficient?
Pair Share

In what ways could the palliative care your team provides be better, more effective or more efficient?
Session Objectives

1. Describe the importance of engaging in quality measurement and reporting to improve care and meet payment reform imperatives

2. Describe a framework for palliative care QI and how to use data to drive QI

3. Describe strategies for improving care gleaned from a national palliative care QI collaborative
Why Collect Data & Measure Outcomes?

- Monitor service operations
- Demonstrate value locally
- Support standardized assessment
- Interpret data, find quality gaps
- Conduct collaborative QI
- Identify best practices
- Advance the field
- Ensure payment

Can use any data

Need standardized data
Measurement for Payment: MACRA

- Medicare Access and CHIP Reauthorization Act of 2015
- Holds physicians accountable for quality and cost of care
- Quality Payment Program: QPP
  - Alternative Payment Models (APM)
  - Merit-based Incentive Payment System (MIPS)
Alternative Payment Models

- Accountable care organization
- Patient-centered medical home
- Bundled payments
Merit-based Incentive Payment System (MIPS)

- Quality of care: 50%
- Meaningful use of the EHR: 25%
- Clinical practice improvement activities: 15%
- Resource use: 10%
MIPS – Quality Reporting

Beginning in 2018:

• Report at least 6 measures
• Must include 1 clinical outcome or high-priority measure
• Select from individual MIPS measures, a MIPS specialty measure set, or a specialty measure set approved for a Qualified Clinical Data Registry (QCDR)
Merit-based Incentive Payment System (MIPS)

- High score: bonus
- Low score: penalty
- Performance year: 2017
  - Payment year 2019: ±4%
- By 2022: ±9%
Why Collect Data & Measure Outcomes?

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Palliative Care Quality Network

To transform healthcare by defining and promoting quality palliative care

1. Data Collection & Reporting System
2. Education & Community Building
3. Financial Analysis
4. QI Collaborative
Components of PCQN QI Collaborative

- Interactive didactic sessions to teach QI methods
- Monthly calls to review data, discuss stumbling blocks, learn from best performers
- Ongoing support
Advance Care Planning
QI Collaborative

POLST Completion
&
Documentation of Surrogate Decision Maker

Start: July 1, 2015
Using a QI Framework to Improve Care

1. **Set the vision for improvement**
2. Understand the problem(s)
3. Identify areas for improvement
4. Prioritize small tests of change
5. Devise a measurement strategy
6. Monitor your progress
7. Assess & adjust
8. Sustain the change
Choose an Area of Focus

- Examined baseline PCQN data
- Chose an area that appealed to all teams

Among patients discharged, not full code
Set an Improvement Goal

• Each team chose a SMART goal:
  ➢ **S**pecific
  ➢ **M**easurable
  ➢ **A**chievable
  ➢ **R**elevant
  ➢ **T**ime-Bound

*Ex: “Among patients who are discharged with a code status other than FULL, increase the % of pts who are discharged with a completed POLST to 50% during at least 9 of 12 months of the year.”*
Using a QI Framework to Improve Care

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Pair Share

Where are our quality gaps?

Why aren’t POLSTs completed consistently?
Fishbone Diagram

- Education
- Process
- Communication

- Materials
- Culture
- Leadership

The Problem
Fishbone Diagram

**Education**
- Lack of provider knowledge re POLST
- Low comfort w/ conversations
- Pts aren’t familiar

**Process**
- No ? at admit
- POLST not scanned & sent home with pt
- No system to get to PMD

**Communication**
- No standard way to document ACP convos
- We don’t know how to explain POLST to pts
- No registry

**Materials**
- POLSTs not available
- Hard to find in EMR
- EMR can’t modify POLSTs

**Culture**
- "PC’s job"
- Cultural differences about forms
- We don’t think of POLSTs

**Leadership**
- No CM motivation
- No accountability
- Attgs don’t emphasize/prioritize/teach

**Inconsistent POLST completion**

UCSF Palliative Care Program
PCQN Palliative Care Quality Network
Using a QI Framework to Improve Care

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A 75yo M with metastatic pancreatic cancer is being discharged from the hospital with home hospice services. He recently expressed a preference to be DNR/DNI.
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Where to Begin?

Low Impact

Low Effort

High Effort

High Impact

Thankless tasks

Educate every patient/family about POLST from time of admission

Display POLST status next to code status on team list

Easy Wins

Educate every patient/family about POLST from time of admission

Display POLST status next to code status on team list
Get Specific

Describe your test of change

<table>
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<tr>
<th>Action items</th>
<th>Person responsible</th>
<th>Deadline</th>
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Decide What to Measure

Outcomes (patient level results)

Processes (our actions)

Structure (attributes of a system)
Using a QI Framework to Improve Care

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Monitoring Progress

- Frequent, granular data feedback to teams
- Benchmark to others
- Consider public recognition
POLST Completion:
Pts who are not full code at discharge

Percent Completed

- 7/15: N=129
- 8/15: N=177
- 9/15: N=181
- 10/15: N=199
- 11/15: N=186
- 12/15: N=184
- 1/16: N=218
- 2/16: N=176
- 3/16: N=241
- 4/16: N=166
- 5/16: N=156
POLST Completion by PCQN Site

(Patients who are not full-code at discharge)
POLST Completion by PCQN Site

(Patients who are not full-code at discharge)
POLST Completion by PCQN Site
(Patients who are not full-code at discharge)
POLST Completion by PCQN Site
(Patients who are not full-code at discharge)
POLST Completion by Site:
Patients who are not full code at discharge

* Numbers on top of columns represent # of POLSTs completed

PCQN Average = 49.7%
Using a QI Framework to Improve Care

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Recommended Strategies

• Make IT work for you: POLST status on “list”
• Process improvement: Daily IDT review of POLST status, registration process to include inquiry about ACP documents and upload
• Champion: SW dedicated to following up
• Use your allies: Education to case managers, hospice team assists with POLST completion
• Coordination: Align with incentive programs
Screening for Spiritual Care Needs

July 1, 2016
Why Spiritual Screening?

- Increasing evidence for the benefits of spiritual care
- Alignment with MWM / national QI trends
- Interest among PCQN members
- Wide range of clinical practice
- Data shows room for improvement
## Potential Contributions of Psychosocial-Spiritual Providers

<table>
<thead>
<tr>
<th>Contribution</th>
<th>Connection to MACRA</th>
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<tr>
<td>Increasing Patient &amp; Family Satisfaction</td>
<td>Quality (CAHPS), CPIA</td>
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<tr>
<td>Reducing Aggressive Care at EOL Through Meeting Spiritual &amp; Emotional Needs</td>
<td>Resource Use, Quality</td>
</tr>
<tr>
<td>Improving Physician-Patient Communication &amp; Compliance Through Reducing Emotional &amp; Spiritual Distress</td>
<td>Quality, CPIA</td>
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<tr>
<td>Reducing Symptoms Including Pain and Dyspnea Through Use of Complimentary Therapies Such as Relaxation and Prayer</td>
<td>Quality, CPIA, Resource Use (indirect)</td>
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<td>Facilitating Culturally/Ethnically/Religiously Appropriate Communication and Decision Making</td>
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Why Spiritual Screening?

• Increasing evidence for the benefits of spiritual care
• Alignment with MWM / national QI trends
• Interest among PCQN members
• Wide range of clinical practice
• Data shows room for improvement
Percent of Patients with Spiritual Needs

- 2013: 60%
- 2014: 50%
- 2015: 30%
- 2016: 20%
QI Framework

Act  Plan  
Study  Do
QI Framework

- **Examine baseline data**
- **Set a SMART goal**
- **Brainstorm barriers & opportunities**
- **Detail your 1st test of change (who, what, when)**

**Act**
- Amend your plan(s)

**Plan**
- Keep track of your progress
- Report back to the group

**Study**
- How did it go?

**Do**
- Detail your 1st test of change (who, what, when)
PDSA Worksheet

Quality Improvement Collaborative PDSA Worksheet

DATE:
HOSPITAL NAME:

Baseline data: % of pts who screen positive for spiritual needs during baseline time period

SMART goal: Specific, Measurable, Achievable, Relevant & Time-bound

Current barriers and/or opportunities for improvement

Describe first test of change: Initial process change.

<table>
<thead>
<tr>
<th>Tasks needed to execute this test of change</th>
<th>Person responsible</th>
<th>When to be done</th>
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Do

What are you currently doing to execute the plan? Describe what happened when you carried out the test of change. Observations, issues encountered.

Study

Provide up-to-date data for your site.

Act

How is this plan working for you? Changes to your plan? Next steps? Additional tests of change?
Goals

Primary:
• Increase % of patients screened for spiritual needs by any member of the palliative care team

Secondary:
• Identify & implement best practices for screening pts and families for spiritual needs
Pair Share

What are the barriers to screening for spiritual needs in your patients?
Barriers & Opportunities for Improvement

- Clinicians don’t feel responsible
- MDs don’t feel confident about how to screen
- Inconsistent definition of spiritual screen
- Not a priority
- Spiritual screen isn’t documented
- Concern that screen could reveal thorny issues
Initial Improvement Plans

• Standardized screening questions:
  – Where do you draw your strength?
  – What are the most important issues that have been raised for you by your illness?
  – In the past, what has helped you cope during the challenging moments of your life?
  – Are there particular beliefs or faith practices that give meaning to your life?

• Set the stage:
  – “We want to support you in as many ways as we can…” “hope they can help us understand you...”
## Crosswalk between Instruments

<table>
<thead>
<tr>
<th>Coping/Strength/Values</th>
<th>HOSP</th>
<th>PICA</th>
<th>SPIRIT</th>
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<th>HCAP</th>
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<tr>
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<td>Do you consider yourself part of an organized religion? How important is that to you? What aspect of your religion or spirituality is helpful and not helpful to you?</td>
<td>Do you have spiritual beliefs that help you cope with stress?</td>
<td>In difficult times, what brings you meaning or hope? How have you felt connected to that during this illness or hospitalization?</td>
<td>Where do you draw your strength?</td>
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<td>Are you part of a religious or spiritual community? Does it help you? How?</td>
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<td>Describe the beliefs and practices of your religion that you personally accept. Do you have a formal religious affiliation? Can you describe this?</td>
<td>Do you have a faith tradition or spiritual belief system? How is it helping or not helping you?</td>
<td>Are you part of a spiritual or religious community? Is this of support to you and how?</td>
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**UCSF Palliative Care Program**

**PCQN (Palliative Care Quality Network)**
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Improvement Plans

• Standardized spiritual screening questions
  • Delineate “positive” answers to questions
• Vet questions with Literacy Review and Interpretive Services Department
• Incorporate questions into note templates
• Develop spiritual screening pocket cards & posters for awareness campaign
• Regular data feedback to team
Monthly Trends

Graph showing the trend of screened spiritual needs over the months from 2016/05 to 2016/12. The trend starts at 23% in 2016/05, rises to 53% in 2016/09, peaks at 59% in 2016/10, and then decreases to 53% in 2016/12.
Percent Screened for Spiritual Needs: Monthly Trends

July August September October November December

PCQN

Spiritual Screen Collaborative
Member Comparison

Screened - Spiritual Needs
07/01/2016 - 12/31/2016

PCQN Percent: 51.3

Coaching for Success

- Talk about why this is important
- Identify early wins
- Recognize & celebrate your successes
- This is a marathon – small wins to a big goal
Appeal to Both Sides of our Brains

Left Brain*
Logical
Sequential
Rational
Analytical
Objective
Looks at parts

Right Brain
Random
Intuitive
Holistic
Synthesizing
Subjective
Looks at wholes
Find your Story
5 Stages of QI – Kübler-Ross Style

- **Denial** – That can’t be our data
- **Anger** – The measurement strategy must be flawed
- **Bargaining** – OK, but our patients are sicker
- **Depression** – This is hopeless – we will never do better
- **Acceptance** – Let’s make this better
Quality Measurement and Improvement in Practice

- Data reports and benchmarking are powerful
  - Turn data into knowledge
  - Humbling and motivating
  - Gets people to pay attention
  - Reports alone do not improve care

- Structured process for QI is essential
  - Choose outcomes you really care about
  - Stepwise approach guides activities
  - Support of colleagues/network/collaboration is key
Quality Improvement Pearls

- **Align** improvement efforts with institutional & team priorities
- **Garner support** from other clinicians/services who share your goals
- Identify engaged and dedicated champion(s)
- **Track data** regularly, make it visible
- Engage the **entire PC team** in improvement work
- Make the **system** work for you – modify patient list, leverage EHR
“Ultimately, the secret of quality is love. If you have love, you can then work backward to monitor and improve the system.”

Avedis Donabedian
Questions?

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