Adding the Secret Sauce: Expanding the Role of Social Work in Hospice and Palliative Care Quality Initiatives

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Questions

• How can we promote more social work leadership in hospice and palliative care quality initiatives?
• How can we make sure that social work is properly valued in alternative payment methods (APMs) and other quality payment schemes?
• How we can engage social workers in driving quality improvement that really matters?
Quality

• Value = Quality/Cost
• Three-part aim
  – Better health outcomes
  – Better experience of care
  – Lower per capita cost
  – With engaged, resilient clinicians
IOM 6 dimensions of quality

• Safe
• Effective
• Patient-centered
• Timely
• Efficient
• Equitable

*Crossing the Quality Chasm: A New Health System for the 21st Century* (2001)
### Why measure quality in hospice and palliative care?

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Example measures</th>
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<tbody>
<tr>
<td>Justify need for a palliative care program</td>
<td>Extended hospitalizations, intensive care unit stays near the end of life</td>
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<td>Demonstrate where improvements are needed</td>
<td>Pain scores</td>
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<td>Documentation of end-of-life discussions</td>
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<tr>
<td>Evaluate impact of new programs or quality improvement</td>
<td>Patient/family perceptions of care</td>
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<td>Monitor care for deficiencies, worsening care</td>
<td>Patient safety reporting on pain issues</td>
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<td>Scorecard including pain scores</td>
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<tr>
<td>Help patients, families, providers make informed choices</td>
<td>Hospice quality reporting, including patient/family perceptions of care</td>
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More reasons to measure quality

• Medicare and accreditation demand it
• We must show value to partners and payers
• Quality increasingly linked to payment
• Our patients and families deserve the best possible care and service—always connect back to what will make a difference for them!
What is a “quality measure”? 

**Instrument** – structured, specified tool to collect data about an individual **patient**

- Example: Caregiver Burden Inventory

**Quality measure** – a numeric summary of how often some care process or outcome (**numerator**) happens for a defined **population** (**denominator**)

- Example: Percentage of patients receiving palliative care with contact information for surrogate decision maker in the chart
What can we measure?

• Structure – actionable, indirect impact
  – Resources, staffing, credentialing, policies, procedures

• Processes – actionable, probable impact
  – Timing, frequency, quality of assessments and treatments

• Outcomes – what we really care about (but can providers control?)
  – Patient’s health status, comfort, quality of life, quality of the dying experience, family’s satisfaction
Patient-Reported Outcomes

Why is it so hard to implement Patient-Reported Outcomes in Hospice and Palliative Medicine?

Image by Joe Rotella. Used with permission.
Challenges with PROs in seriously ill

As patients progress toward death

- Function decreases
- Symptoms may increase
- May lose ability to report
- Surrogate reports may be unreliable
- Treatment goals shift
- Worsening outcomes may reflect progression of illness more than quality of care
How can we get the data?

• Administrative data (claims)
  – ICU days, cost per day, 30-day re-admission (PC)
  – GIP days, % patients with respite services (Hospice)

• Record reviews
  – Treatment preferences, pain assessment, screening for symptoms

• Surveys
  – Satisfaction with care, continuity of care, quality of life
Set priorities & goals
Develop & test measures
Endorse & harmonize measures
HIT specification & embed in EMR
Implementation strategies & Technical assistance
Data aggregation, benchmarks, registries
Public reporting
Public policy, including payment incentives
Improve quality & affordability
Continuously evaluate health & care

National Quality Framework

Adapted from the Consumer-Purchaser Disclosure Project: Idealized Framework for Quality and Cost Transparency for High-Value Care, QASC, January 2008
Frameworks for measuring quality in hospice and palliative care

• National Consensus Project (3rd Edition, 2013)
  – Guidelines and preferred practices in 8 domains

How do we know if practices match guidelines? ==> quality measures

• CMS funded the PEACE Project
  – 34 quality measures for hospice & palliative care
National Consensus Project

• Partnership of 6 leading hospice and palliative care organizations
• Clinical Guidelines for Quality Palliative Care
  - Domain 1: Structure and Processes of Care
  - Domain 2: Physical Aspects
  - Domain 3: Psychological and Psychiatric Aspects
  - Domain 4: Social Aspects
  - Domain 5: Spiritual, Religious, and Existential Aspects
  - Domain 6: Cultural Aspects
  - Domain 7: Care of the Patient at the End of Life
  - Domain 8: Ethical and Legal Aspects of Care

www.nationalconsensusproject.org
NCP Guidelines update (4\textsuperscript{th} Edition)

- Major update in process
- Goal to publish in Fall 2018
- More inclusive of emerging community-based palliative care program models
- Will include a systematic review of supporting evidence
NCP Guidelines—Recommendations of Stakeholder Summit

Emphasize—

• Comprehensive assessment described in all domains
• Caregiver assessment, support, and education
• Care coordination, especially during care transitions
• Culturally-inclusive care
• Communication within the palliative care team, with patients and families, with other clinicians, and with community resource providers
History of MWM Project

Measuring What Matters (MWM) is a consensus recommendation project begun in 2013 as a partnership between AAHPM and HPNA to develop a portfolio of quality performance measures for all hospice and palliative care programs to use for program improvement.

http://aahpm.org/quality/measuring-what-matters
Seized the opportunity

- Problem – Bewildering array of published measures (e.g. 15 measures about advance care planning and preferences)
- **Opportunity** – Focus providers on a few of the best, so they can begin to share and benchmark
- Problem – Few palliative care measures included in the national quality programs
- **Opportunity** – Set the agenda for what should be included
MWM indicator selection process

- Identify candidate measures
  - Identified 75 published measures

- Technical Advisory Panel Review
  - Narrowed to 34 technically strongest measures

- Clinical User Panel Review
  - Selected 12 best measures

- AAHPM & HPNA member ranking, public input
  - Prioritized top 10 measures
10 measures selected

Top 10 Measures that Matter

1. Comprehensive Assessment
2. Screening for Physical Symptoms
3. Pain Treatment
4. Dyspnea Screening and Management
5. Discussion of Emotional or Psychological Needs
6. Discussion of Spiritual/Religious Concerns
7. Documentation of Surrogate Decision-Maker
8. Treatment Preferences
9. Care Consistency with Documented Care Preferences
10. Global Measure of Patient/Caregiver Experience
Gaps identified

• 2 NCP domains have no recommended measures
  – NCP Domain 4: Social Aspects of Care
  – NCP Domain 6: Cultural Aspects of Care

• Few truly cross-cutting measures
  – Existing measures mostly specified for specific populations (e.g. cancer or hospice)
  – Need
Methodological research priorities

- Defining the denominator(s) for palliative care quality indicators
- Developing methods for measurement with different data sources
- Developing more patient/family-reported outcome indicators
The ongoing goal of Measuring What Matters (MWM) is to identify, promote, and refine measurable indicators of high-quality care for patients with serious illness.
Legacy of MWM Project

- AAHPM and HPNA have created two working groups to build on the MWM initiative:
  
  - The **Technical Specifications for electronic Clinical Quality Measures (eCQMs)** working group’s goal is partnering with EHR vendors and other stakeholders to develop eCQMs that matter for patients with serious illness and their families which can be meaningfully utilized by HPC providers.

  - The **Quality Improvement (QI) Education & Strategies** working group’s goals include development of QI Education tools, webinars and modules to improve patient care and meet new requirements for value-based reimbursement that also meet CME and MOC requirements.
Additional Quality Projects Underway

• **Measurement development**—AAHPM, in collaboration with AMGA, OptumLabs, and the NQF Measure Incubator, was awarded funding from AARP to develop and test new pain treatment and other outcome measures in a seriously ill population using a commercial clinical and claims database.

• **Registries collaborative project**—Supported by the Gordon and Betty Moore Foundation, AAHPM has partnered with organizations that currently offer HPM specialty registries to explore the creation of a merged registry to support Quality Improvement, Quality Reporting, and Research Initiatives.
Quality payment programs

- Hospice Quality Reporting Program
- MACRA and MIPS
- Alternative Payment Models (APMS)
<table>
<thead>
<tr>
<th>NQF NUMBER</th>
<th>NQF NAME</th>
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<tbody>
<tr>
<td>1641</td>
<td>Treatment Preferences</td>
</tr>
<tr>
<td>1647 (modified)</td>
<td>Beliefs/Values Addressed (if desired by patient)</td>
</tr>
<tr>
<td>1634</td>
<td>Pain Screening</td>
</tr>
<tr>
<td>1637</td>
<td>Pain Assessment</td>
</tr>
<tr>
<td>1639</td>
<td>Dyspnea Screening</td>
</tr>
<tr>
<td>1638</td>
<td>Dyspnea Treatment</td>
</tr>
<tr>
<td>1617</td>
<td>Patients Treated with Opioid Who Have Bowel Regimen</td>
</tr>
<tr>
<td></td>
<td>Hospice Visits When Death Is Imminent</td>
</tr>
<tr>
<td>3235</td>
<td>Composite Process Measure-Comprehensive Assessment</td>
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</tbody>
</table>
Hospice Quality: CAHPS Hospice Survey

• Composite Measures
  – Hospice team communication
  – Getting timely care
  – Treating family member with respect
  – Providing emotional support
  – Getting help for symptoms
  – Getting hospice care training

• Three single items
  – Providing support for religious and spiritual beliefs
  – Information continuity
  – Understanding the side effects of pain medication

• Global Measures
  – Overall rating of hospice care
  – Would you recommend hospice to family/friend?
Medicare Hospice Compare

- Search by name, address or zip code
- Compare to peers or national on 7 HIS measures
- 6 of 7 HIS measures are topped out
- Low scores may reflect difficulties with documentation and extraction from records
- Rife with errors
- Problem of small hospices (small sample size)
- Now includes Hospice CAHPS results
Future of Hospice Quality Reporting Program

• Hospice Evaluation and Reporting Tool (HEART) in development
• Five-star quality ratings
MACRA and MIPS

- Medicare Access and CHIP Reauthorization Act of 2015
- Links Part B physician payment to Merit-based Incentive Payment System (quality reporting, meaningful EHR use, resource use, clinical quality improvement)
- If not in alternative payment model, physicians report quality measures through Physician Quality Reporting System or a Qualified Clinical Data Registry
Introduction to MACRA

- Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act

“Quality Payment Program”

MIPS

Advanced APMs
Introduction to MIPS

• Merit-based Incentive Payment System (MIPS)

• Fee-for-Service (FFS) architecture

• Adjusts payment up or down based on quality and cost
MIPS Eligibility

Affected clinicians are called "MIPS eligible clinicians" and will participate in MIPS. The types of Medicare Part B eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals
Proposed Alternative Payment Models

• Two models have been proposed to CMS for improving care of people living with serious illness
  – AAHPM has proposed Patient and Caregiver Support for Serious Illness (PACSSI)
  – Center to Transform Advanced Care has proposed Advanced Care Model (ACM)
• The organizations are now working together to make joint recommendations to the Center for Medicare and Medicaid Innovation (CMMI)
• Social worker is key member of the team
How to do QI in your program
What to measure?

• Quality care outcomes or service satisfaction?
• Structure, process, or results?
• Externally validated or homemade?
• What matters most or what’s easiest to get?
• Broad or highly-specific?
• Do we need a track record or benchmark?
• What will leaders enthusiastically support?
• What would make most difference for patients and families?
QI resources

• PEACE measures
  http://www.med.unc.edu/picare/resources/PEACE-Quality-Measures

• IHI open school
  http://www.ihi.org/education/IHIOpenSchool/Pages/default.aspx

• BMJ Quality Learning Modules
  http://quality.bmj.com/
IHI uses the Model for Improvement* as the framework to guide improvement work

Not meant to replace change models already in place, but to accelerate improvement

Learn fundamentals of the model and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles

How to do a PI project (PDSA)

• Aim
  – What are we trying to accomplish?

• Measure
  – How will we know that change is an improvement?

• Changes
  – What changes can we make to achieve our aim?
Rallying the troops

• Build enthusiasm for change
• Use a patient story for why it matters
• Connect the dots—how does this quality improvement program add value to care and experience of those we serve
• Employ cross-functional work group including frontline staff
• Keep goals focused, simple and attainable
• Celebrate even the smallest early successes
Future of Quality Improvement in HPM

- Clinical data registries
- QI collaboratives
- Broader denominators that capture all people living with serious illness
- Electronic QMs that can be easily collected from EHRs
- Surveys of experience of care administered before death
- Further testing of Patient-Reported Outcomes
- Closer linkage to payment for value in APMs
Social Workers in the Quality Space

- Julie Bruno, LCSW, Chief Learning Officer, AAHPM
- Zachary S. Fried, LCSW, Advisory Panel for AAHPM’s Measure Development project to define serious illness
- Tracey Schroepfer, PhD, Professor, School of Social Work, U of Wisc-Madison, National Consensus Project (NCP) Writing Workgroup Co-Chair
- Stacie Sinclair, MPP, LBSW, Senior Policy Manager, CAPC, NCP Writing Workgroup Co-Chair
- Deborah Waldrop, PhD, LMSW, ACSW, National Quality Forum (NQF)’s Palliative and End-of-Life Care Standing Committee Co-Chair
Conclusion

• Quality initiatives in hospice and palliative care have come a long way in the last few years
• In future years, we need social workers to bring essential experience and expertise to the quality space
  – To guide development of measures in the spiritual and cultural domains
  – To promote prioritization of measures that matter to patients, families and caregivers
  – To lead QI efforts that make a difference
The secret of quality is love

Systems awareness and systems design are important for health professionals, but they are not enough. They are enabling mechanisms only. It is the ethical dimensions of individuals that are essential to a system’s success. Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system— Avedis Donabedian
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