

Measuring Outpatient Palliative Care:

The Iowa Experience



Objectives

- Describe the structure of Iowa outpatient palliative care programs
- Discuss the importance and necessity for consistent measurement for palliative care programs
- Identify measures and methods developed by the Iowa Health PC Affinity Group to track PC data and outcomes



Outpatient PC in Iowa

- Still in its infancy
- Many small, rural providers in Iowa
- Often a department of a CAH
- Most often developed through 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
- For this project we are partnering with St. Luke’s in Cedar Rapids and Hospice of the Siouxland, two agencies affiliated with Iowa Health System but not part of Iowa Health Home Care



Who we are...

- IHHC OPPC Des Moines (ADC 100)
- Trinity PC Fort Dodge (ADC <5)
- Trinity Pathways OPPC Quad Cities (ADC <20)
- Cass County OPPC (ADC <10)
- St. Luke's OPPC Cedar Rapids
- PC of Siouxland



OPPC Structure

- **Medical Director** – goal is to have 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



The IHHC PC Affinity Group



Currently we are standardizing our programs:

- 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



The IHHC PC Model of Care



We provide both consultative and a 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)



IDT Meeting



Shared IDT meeting – IPPC and OPPC for patients in common

- Promotes smooth transitions between care settings
- Includes core members of IDT: physician, ARNP, RN, LISW, chaplain, pharmacist



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



Development of Metrics



- Preparation for ACO or bundled payment health care delivery system
- Collaboration between IPPC and OPPC to develop the metrics
- IHDM and St. Luke's in CR (IPPC) already had robust metrics



Considerations in Development of Metrics



- Complimentary metrics IPPC and OPPC
- Quality outcomes consistency across care continuum
- Start simple
- Ability to benchmark



Considerations in Development of Metrics



Aggregate vs. Patient Level Data

- Aggregate data is more vulnerable to integrity issues
- Patient level data can be sliced and diced in a variety of ways and is more reliable
- Patient level data requires a shared database which is complicated by HIPPA regulations



Considerations in Development of Metrics



- Regardless, need to develop clear definitions for metrics to ensure data integrity
- Consider four domains: operational, clinical, customer, financial per CAPC recommendations



Outpatient Palliative Care Metrics...



Measure #1: Consultation Volume Outpatient Palliative Care Admissions

Measures:

Outpatient Palliative Care Admissions Initial
Palliative Care Admissions & Readmitted Palliative
Care Admissions



Measure #1: Admissions



Additional Clarification:

Readmitted Palliative Care Admissions refer to patients who have previously received outpatient PC services

Ex: a patient who has received inpatient palliative care services, but never outpatient palliative care services, and then receives an outpatient palliative care consult would be considered an Initial Palliative Care Admission



Data Elements for Measure #1



- **OPPC Admission** date/time
- **Source of IPPC discharge (IHS or non-IHS)**
- Location (FD, DSM, etc.)
- Name
- DOB
- Address
- Patient identifier



Measure #2: Discharge



Measure #2: Discharge Distribution/Reason

Measure: Reason for Discharge from Outpatient Palliative Care services, including discharge distribution

Numerator: a. # OPPC patients discharged alive, categorized as one of the six sub-categories

b. # of OPPC patients discharged due to death

Denominator: # of patients discharged from outpatient palliative care services : Live discharge



Measure #2: Discharge



Definitions:

- Goals met
- Refusal of service
- Non-compliance or non-adherence
- Transition to Hospice
- Moved out of service area
- Elected another PC program
- Death



Measure #2: Discharge



Additional Clarification:

- Patients hospitalized while on OP care would remain, until true discharge per 1 of the 6 reasons
- Live discharge to be broken down and reported in all 6 categories
- Average Monthly Census, an average of a Daily Census, is also a data element to be captured



Data Elements for Measure #2



- **Discharge** date/time
- **Source of Discharge (IHS or non-IHS)**
- Discharge disposition
- Location (FD, DSM, etc.)
- Name
- DOB
- Address
- Patient identifier



Measure #3 : Readmissions to Inpatient Care



Measure #3 : Readmissions to Acute Inpatient Care (Referred from IPPC)

Purpose: Assesses the effectiveness of OPPC in reducing readmissions. Measure can be compared to those patients not receiving OPPC services

Measure: Readmissions to Acute Inpatient (Referred from IPPC)
 <30 days >=30 days & <=90 days >90 days



Measure #3 : Readmissions to Inpatient Care



Numerator: # patients readmitted to acute inpatient care from OPPC categorized into appropriate time category. Separately capture ED visits (if not admitted)

Denominator: # of patients discharged from IPPC and admitted to OPPC Services



Measure #3 : Readmissions to Inpatient Care



Definitions:

- Applies to patients who were hospitalized with inpatient palliative care services
- Day of discharge from IPPC = Day 1
- When patient is admitted to OPPC, we will need to know when the last hospitalization was
- Track # of days until return to ED or Hospital and stratify into appropriate category



Measure #3 : Readmissions to Inpatient Care



Additional Clarification:

Measure does not capture occurrences

- Ex: If a patient was admitted twice within 30 days, patient would be counted once in the <30 day bucket
- Ex: If patient was also admitted within 90 days, patient would be counted twice (once in the <30 day bucket, and once in the <=90 day bucket)



Measure #3 : Readmissions to Inpatient Care



Additional Clarification:

- CMS priorities include: Heart Failure, AMI, Pneumonia – if collect diagnosis and procedures for all patients, could group into the three CMS priority areas if need be
- For monthly reporting, a patient be included in the denominator based on date of DC from the hospital



Measure #3 : Readmissions to Inpatient Care



Additional Clarification:

- This metric considers only patients who had IPPC. The term “readmitted” in Numerator somewhat insinuated something other
- We must handle (and be able to separately report):
 - ✓ IPPC pts. discharged from non-IHS hospital
 - ✓ OPPC pts. admitted to non-IHS hospital



Measure #3 : Readmissions to Inpatient Care



Additional Clarification:

- This may require Horizon “Event Codes”
- ED visits important to capture as it signifies potential symptom control management issues
- How will we compare measure patients not receiving OPPC services?
- Dr. Archer suggested using average APR
- This is a reporting issue



Data Elements



- IPPC Discharge Date (Care Cast or Horizon Event Code)
- OPPC Admission date/time
- Acute Readmission date/time
 - ✓ Source (IHS or other) *
 - ✓ Denote as ED visit (if not a readmission)



Measure #4 : Readmissions to Inpatient Care (without IPPC)



Measure #4 : Readmissions to Acute Inpatient Care (for programs without IPPC)

Measure: Readmissions to Acute Inpatient (for programs without IPPC) <30 days >=30 days & <=90 days >90 days

Numerator: # patients readmitted to acute inpatient care from OPPC categorized into appropriate time category

Denominator: # of patients discharged from the hospital and admitted to OPPC Services



Measure #4 : Readmissions to Inpatient Care (without IPPC)



Definitions:

- Applies to patients who were hospitalized at a facility without IPPC services
- Day of discharge from Hospital = Day 1
- When patient is admitted to OPPC, we will need to know when the last hospitalization was
- Track # of days until return to ED or Hospital and stratify into appropriate category



Measure #4 : Readmissions to Inpatient Care (without IPPC)



Additional Clarification:

- Assesses the effectiveness of OPPC in reducing readmissions
- Compare to those without OPPC services



Measure #4 : Readmissions to Inpatient Care (without IPPC)



Additional Clarification:

- Measure does not capture occurrences
 - Ex: If a patient was admitted twice within 30 days, patient would be counted once in the <30 day bucket
 - Ex: If patient was also admitted within 90 days, patient would be counted twice (once in the <30 day bucket, and once in the <=90 day bucket)



Measure #4 : Readmissions to Inpatient Care (without IPPC)



Additional Clarification:

- CMS priorities include: Heart Failure, AMI, Pneumonia – if collect diagnosis and procedures for all patients, could group into the three CMS priority areas if need be
- How will we compare measure patients not receiving OPPC services? Dr. Archer suggested using average APR



Measure #4 : Readmissions to Inpatient Care (without IPPC)



Additional Clarification:

- Note: what about unrelated earlier hospitalization?
- For monthly reporting, will a patient be included in the denominator based on their date of admission to OPPC, or date of DC from the hospital?



Clinical Metrics*



#1: Symptom Assessment and Management

- Minimum list should include: pain, nausea, delirium, dyspnea, constipation, mood (anxiety/depression), appetite, fatigue
- Determine assessment tools to be used
- How will you obtain this data? What are the capabilities of your current documentation tools?

*CAPC Clinical Care and Customer Satisfaction Metrics Consensus Recommendations, Journal of Palliative Medicine, Volume 13, Number 2, 2010



Clinical Metrics*



#2: Patient-Centered Goals of Care

- Is there documentation of education of patient/family on diagnosis, prognosis and treatment options?
- Are patient goals identified and addressed?
- Is there evidence of Advanced Care Planning?

*CAPC Clinical Care and Customer Satisfaction Metrics Consensus Recommendations, Journal of Palliative Medicine, Volume 13, Number 2, 2010



Clinical Metrics*



#3: Support to Patient and Caregiver

- Has a PCG been identified?
- Is there evidence of identification of PCG's needs/concerns (including efforts to address and effectiveness of these efforts)?

*CAPC Clinical Care and Customer Satisfaction Metrics Consensus Recommendations, Journal of Palliative Medicine, Volume 13, Number 2, 2010



Clinical Metrics*

#4: Transition Management



- Determine standards for PC program including use of IDT, communication, and documentation expectations.
- Communication across care settings – how is this getting done and how do you show evidence of this? (e.g. patient goals and advanced directives follow patient across care settings)

*CAPC Clinical Care and Customer Satisfaction Metrics Consensus Recommendations, Journal of Palliative Medicine, Volume 13, Number 2, 2010



Clinical Metrics*

#4: Transition Management



- Consider Plan of Care development, initial and ongoing. Does this process include re-assessment expectations and regularly scheduled IDT meetings?

*CAPC Clinical Care and Customer Satisfaction Metrics Consensus Recommendations, Journal of Palliative Medicine, Volume 13, Number 2, 2010



Customer Metrics



- Satisfaction survey data from patient/family and referring clinician
- Could use referral numbers data per referral source as satisfaction indicator
- Drill down if referral numbers decrease



Customer Metrics



- FEPC survey available from NHPCO – draw back this survey is for family or PCG post patient death
- Consult CAPC website or article referenced for other satisfaction tools



Financial Metrics



- Review past 6 months of ED visits and hospitalizations per patient
- Track ED visits and hospitalizations during PC care and for 6 months post PC care



Financial Metrics



- Determine an average cost per ED visit and average cost per hospitalization
- This can be further broken down into disease categories (heart, lung, cancer, Alzheimer's/dementia, etc.)



Where we are today



- We have spent several months determining metrics
- Operational metrics are finalized and will begin pulling from electronic record April 1 for first quarter data
- We are in process of developing and standardizing our electronic documentation tool to include clinical metrics data elements extraction



Where we are today



- We have not addressed customer satisfaction metrics yet
- We have not finalized financial metrics extraction yet
- We have two IPPC partners that will have data available by end of March, including historical data from 2009



Where we are today



- We have developed a shared data warehouse that will be maintained by a neutral party (our IHS IT partner)
- Each participant will have access to their data and the data of patients they share with their PC partner (e.g. IHDM IPPC will have access to IHHC OPPC patients that have utilized IPPC)
- Data results will be reviewed in our monthly PC Affinity Group meetings



Where we are today



This project has already accomplished:

- Standardization of our PC programs (both IPPC and OPPC)
- Increased collaboration between health partners (hospitals, home care, hospice, physicians, and clinics)
- Identification of best practices and current barriers within our system



Great Expectations



We will use our metrics data to help us determine

- Opportunities for improvement
- Best practices (we can compare with ourselves and with state and national as available)
- Program effectiveness including quality outcomes, patient/family/referral satisfaction, cost avoidance for our hospital partners, and our worth as part of an ACO



Great Expectations



We will use our metrics data to help us determine

- Lobby efforts with state and national government and private insurance companies for reimbursement
- Assisting our state association (HPCAI) in development of PC standards through the HPCAI PC Advisory Group



It Takes a Village



The following are IDT participants on our PC Metrics Project:

- Stephanie Anderson, Dr. Jim Bell, Lori Bishop, Lori Crippen, Kathy Cunningham, RONALDA DICK, Susie Flood, Lois Glanz, Jennifer Gustafson, Marsha Haugen, Tiffani Heaberlin, Valerie Huntley, Dr. Tim Ihrig, Kathy Karpowicz, Maureen McEvoy, Mark Mitchell, Jessica Musil, Sandie Nichols, Faye Petersen, Monique Reese, Todd Richard, Mary Jo Romano, Kyla Routson, Callie Sandquist, Nadine Schlien, Brenda Schmit, Kimberly Shadur, Linda Todd, Todd Vorpahl and Jo Walters
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Contact Information



- Lori Bishop RN, CHPN
- Email: bishoplr@ihs.org
- Office phone: 515-727-1104
- Cell phone: 515-205-0823

