NATIONAL QUALITY FORUM

Measuring and Integrating Personal Preferences in Advanced Illness Care

National Quality Partners' Advanced Illness Care Action Team

@NatQualityForum #advancedillness

March 15, 2017

Virtual Forum Objectives

- Discuss how measures can serve as a practical tool to improve person-centered care delivery across various healthcare settings.
- Share experiences with the implementation of person-centered advanced illness care measures, preferences, and goals.

NQP Advanced Illness Care Action Team: Past, Present, Future?

David Longnecker, MD
Chief Clinical Innovations Officer,
The Coalition to Transform Advanced Care
(C-TAC)

What is NQP and Its Role?

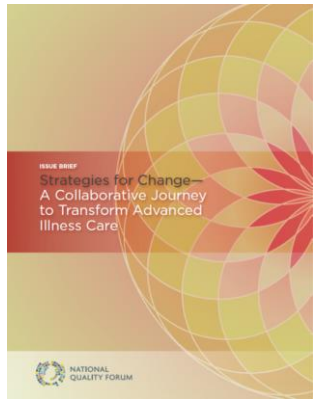
- Forum of NQF-member leaders convened to drive quality measurement and improvement
- Builds on NQF's role as a trusted neutral convener
- Engages NQF's membership of 430+ organizations
- Supports NQF's strategic plan to drive measures that matters

Mission Statement

Collectively works to impact health and healthcare quality through collaboration and partnership that catalyzes action and accelerates improvement.

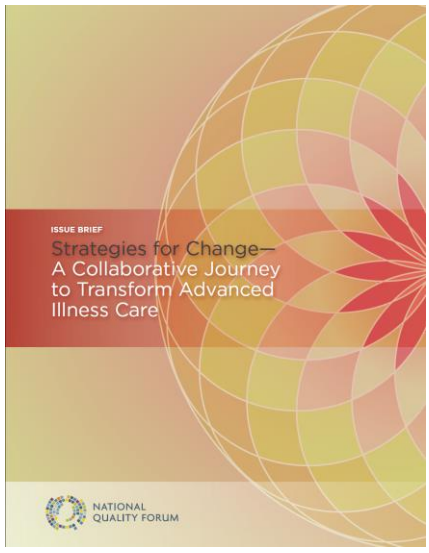
National Quality Partners—Advanced Illness Care Action Team

- Support a national movement to transform person-centered advanced illness care in the U.S.
- Galvanize stakeholders around six key preferences to guide person-centered advanced illness care featured in NQP's new Issue Brief
- Explore opportunities for measurement around incorporating the values, needs, and goals of individuals with advanced illness into treatment and care



Advanced Illness Care Action Team

- Coalition to Transform Advanced Care
- Planetree
- AARP
- Aetna
- AMDA – The Society for Post-Acute and Long Term Care Medicine
- American Case Management Association
- American Health Care Association
- American Society of Clinical Oncology
- Anthem
- Carolinas Healthcare System
- Community Health Accreditation Partner
- Compassion & Choices
- Compassus
- Connecticut Center for Patient Safety
- HealthCare Chaplaincy Network
- Healthwise/Informed Medical Decisions Foundation
- Hospice and Palliative Nurses Association
- Johns Hopkins Medicine
- MD Anderson Cancer Center
- National Coalition for Cancer Survivorship
- National Coalition for Hospice and Palliative Care
- National Committee for Quality Assurance
- National Partnership for Hospice Innovation
- Patient & Family Centered Care Partners
- Providence Institute for Human Caring
- University of Pennsylvania Health System

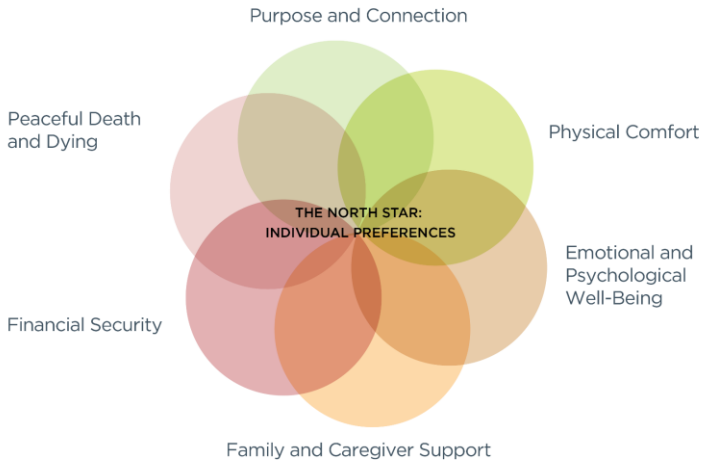


Issue Brief Link: http://www.qualityforum.org/Publications/2016/11/Strategies_for_Change_-_A_Collaborative_Journey_to_Transform_Advanced_Illness_Care.aspx

Advanced Illness & Advanced Illness Care

- **Advanced illness** may result in impairment of daily activities, reduced mental and physical capabilities, frequent medical treatments and visits, and a higher risk of death—all of which can cause an overall decline in health and quality of life.
- **Advanced illness** care encompasses a broad range of services that bridges families and caregivers, communities, and the healthcare system across different settings of care, including home, community, hospital, hospice, nursing home, and other long-term care facilities.

Person-centered Preferences to Guide Advanced Illness Care



Advanced Illness Care Action Team: Call to Action

NQP's Advanced Illness Care Action Team issued a national call to action for all stakeholders to ensure that individuals with advanced illness, their families, and caregivers are at the center of care decisions.

The Action Team urges healthcare systems, communities, and policymakers to engage individuals, families, and their caregivers as true partners in care planning.

Advanced Illness Care Action Team: Future?

- C-TAC Campaign
- NQP Playbook on Advance Care Planning
  - *Implementation examples*
  - *Barriers and solutions*
  - *Tools and resources*

Integrating Personal Preferences across the Continuum of Care—Approaches to Measurement and Implementation

Susan Frampton, PhD
President, Planetree International

Hazel's Journey Across the Healthcare Continuum

Panel Discussion

- Lisa Freeman, Connecticut Center for Patient Safety @CTPatientSafety @PA4CT
- John Barkley, Post-Acute Care Services, Carolinas HealthCare System @Carolinas
- Ron Walters, The University of Texas MD Anderson Cancer Center @MDAndersonNews
- Anna Fisher, Hillcrest Health Services (Representing the American Health Care Association) @HillcrestHealth @ahcancal
- Traci Padgett, Community Health Accreditation Partner @CHAP_Inc
- Theresa Schmidt, National Partnership for Hospice Innovation @QualityHospice

Background: Hazel

- 63-year old woman recently diagnosed with advanced lung cancer
- History of COPD, diabetes, depression, and anxiety
- Lives in a suburban community
- Supports care of her daughter Judy, a 44-year-old with multiple chronic conditions
- Worries she will have to use retirement savings to help cover medical expenses
- Hopes to continue to earn an income and care for Judy
- Receives care from multiple providers across care several care sites

Primary/Specialty Care

Personal Goals	Hazel would like to feel less depressed and fatigued, miss fewer days of work, and be able to take Judy to her son's basketball games on weekends.
NQF-Endorsed Performance Measures	• 0326 Advance Care Plan* • 0701 Functional Capacity in COPD Patients Before and After Rehabilitation • 0712 Depression Utilization of the PHQ-9 Tool* • 0711 Depression Remission at Six Months* **Measure included in the Center for Medicare & Medicaid Services (CMS) Physician Feedback Program/Value-Based Payment Modifier and Quality and Resource Use Reports*
Action Plan	Together, Hazel and her physician discuss the importance of creating an advance care plan with her treatment preferences. Her physician suggests that she use an advance care planning tool such as Five Wishes® with Judy between now and her next visit and that she consider how her preferences might affect Judy in both the short- and long- term. He administers the Patient Health Questionnaire (PHQ-9) to gain a baseline understanding of her depression. At Hazel's request, he offers options for treating her depression and fatigue without medication and plans to re-check her PHQ-9 scores in six months.

Inpatient Acute Care

Personal Goals	Hazel takes several medications due to her many conditions. She expresses concerns about the cost and potential side effects of adding to her already complex medication regimen. She also notes a decline in stamina while in the hospital and feels that she will not be able to manage well if discharged home. She is concerned about how Judy will manage without her support, but recognizes that she is not strong enough to take care of herself.
NQF-Endorsed Performance Measures	• 0166 HCAHPS* (review items related to communication, explanation of medications) • 0228 3-Item Care Transition Measure* • 0419 Documentation of Current Medications in the Medical Record • 0553 Care of Older Adults (COA)—Medication Review **Measure included in the CMS Hospital Compare, Hospital Inpatient Quality Reporting, and Hospital Value-Based Purchasing programs*
Action Plan	While Hazel is hospitalized, her care team initiates a palliative care consultation given the complexities of her medical and social situation. The consultation covers Hazel's unmanaged symptoms, care needs, and the possible benefits of hospice and palliative care now and in the future. Upon discharge, she receives a social work referral from an inpatient physician and consults with a pharmacist to minimize medication changes and obtain assistance with medication management. The physician recommends a short-term subacute rehabilitation stay at a nursing home close to her house. The discharge staff coordinates closely with the post-acute care facility to exchange important information about Hazel's inpatient stay, including her depression and potential cognitive issues.

Post-Acute/Skilled Nursing Home Facility Care

Personal Goals	Hazel has a strong desire to regain her independence and to go back home. She continues to worry about Judy and her ability to return to work..
NQF-Endorsed Performance Measures	• 0326 Advance Care Plan • 0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up • 0676 Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) • 2612 CARE: Improvement in Mobility • 2613 CARE: Improvement in Self Care • 2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities • 2769 Functional Change: Change in Self Care Score for Skilled Nursing Facilities • 2858 Discharge to Community
Action Plan	As a result of Hazel's complicated medical history and home situation, it is critical that she has an advance care plan. The staff work with her on completing one before discharge. The post-acute care facility coordinates Hazel's return home and recommends a short course of home health care. The discharge staff communicates directly with the home health agency. Prior to discharge, the staff perform a final medication review to make decisions about which medicines to continue at home.

Home Health Care

Personal Goals	Hazel is most concerned about how her ongoing illness is affecting her daughter Judy, and wants to avoid another hospitalization or rehabilitation stay. She wants to be able to take care of herself without relying on Judy. Hazel is having trouble coping with her pain and is worried about whether she will be able to return to work even on a limited basis.
NQF-Endorsed Performance Measures	• 0167 Improvement in Ambulation* • 0171 Acute Care Hospitalization During the First 60 Days of Home Health • 0177 Improvement in Pain Interfering with Activity* • 0326 Advance Care Plan • 0518 Depression Assessment Conducted* **Measure included in the CMS Home Health Quality Reporting program*
Action Plan	The home health care team continues to work on helping Hazel regain function so that she can be independent at home. The team continues to monitor her for signs of depression and pain that may adversely impact her quality of life. The agency staff emphasize the importance of knowing about her advance care plan and communicating it to the next care provider, if applicable.

Hospice Care

Personal Goals	Hazel recognizes that she is approaching end of life and wishes to remain in her home with Judy. She hopes for spiritual support since she can no longer attend church, and she is concerned about worsening pain and shortness of breath, which cause significant anxiety. She would like to be comfortable and spend as much of her time as possible with her Judy and her grandson.
NQF-Endorsed Performance Measures	• 0208 Family Evaluation of Hospice Care • 0209 Comfortable Dying • 0211 Proportion with more than one emergency room visit in the last days of life • 1638 Hospice and Palliative Care—Dyspnea Treatment • 1637 Hospice and Palliative Care—Pain Assessment* • 1641 Hospice and Palliative Care—Treatment Preferences* • 1647 Beliefs and Values—Discussions of Spiritual/Religious Concerns* • 2651 CAHPS® Hospice Survey • 1623 Bereaved Family Survey **Measure included in the CMS Center for Medicare Hospice Quality Reporting program*
Action Plan	The hospice staff work closely with Hazel and her family to ensure that her care preferences are clearly documented, communicated, and integrated into all aspects of her care during this difficult time. The staff monitor and adjust Hazel's medication regime to keep her comfortable yet alert so that she can interact with her family. The team offers her specific advice and guidance on what would constitute an appropriate reason to return to the emergency room and whom to contact in the event of a change in her clinical condition. The team makes modifications in her home, including the use of medical equipment, to provide a safe and comfortable environment. The chaplain helps Hazel find comfort through her spiritual beliefs, and the hospice staff have begun working with Judy and Hazel's grandson to address their anticipatory grief. After Hazel passes, the hospice agency offers bereavement counseling and support to Judy and other family members.

Open Q&A

Please type your question into the chat box anytime
OR
Dial: 844-476-2063

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