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OCTOBER 24TH, 2019
2-3 PM ET

Utilizing Quality Measures to Build an Effective Palliative Care System
Logistics

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Agenda

- Introduction
- Presentation: Palliative Care Measures Used for the New York State Medicaid Population
- Presentation: NCQA, Measuring the Quality of Serious Illness Care
- Questions
- Wrap up and Evaluation
Today’s Speakers

Kitty Purington
Senior Program Director, NASHP

Amy Berman
Senior Program Officer, The John A. Hartford Foundation

Melissa Lurie
Research Scientist, New York State Department of Health
Office of Quality and Patient Safety, Bureau of Quality Measurement and Evaluation

Jessica Briefer-French
Assistant Vice President, Research
National Committee for Quality Assurance (NCQA)
Amy Berman, RN, LHD, FAAN
Senior Program Officer
Who We Are
Improving the Care of Older Adults

$585,000,000 amount invested in aging and health since 1982

$13,880,000 + in Palliative Care & EOL
Palliative Care

- Focuses on improving the quality of life for people facing serious illness:
  - Pain & symptom management
  - Communication & coordinated care
  - Appropriate from time of diagnosis
  - Can be provided w/ curative treatment

Resource: Center to Advance Palliative Care [www.CAPC.org](http://www.CAPC.org)
NASHP: Supporting the Continuum of Palliative Care

Goal of Grant
Improve access to and the quality of hospital and community-based palliative care services

Approach
- Review palliative care activity & policies in states
- Convene State Leadership Council on Palliative Care
- Develop briefs for State Health Policymakers
- Provide technical support to states
- Disseminate findings and resources

www.johnahartford.org  www.nashp.org
Palliative Care Measures Used for the New York State Medicaid Population

Melissa Lurie, MPH
NYS Department of Health
Office of Quality and Patient Safety

October 2019
New York State DSRIP Program
At A Glance: New York State’s Delivery System Reform Incentive Payment (DSRIP) Program

What Is it?
A $7.3 billion Medicaid-funded program designed to reduce avoidable hospital admissions and ED visits by 25% in five years by changing the way health care is paid for and delivered.

How will that goal be met?
The state hopes that within five years programs will make at least 80% of Medicaid managed care payments to health care providers based on the value of care rather than the number or type of services delivered.

Will the changes be sustainable?
Across the state, Medicaid providers and community-based organizations have formed integrated delivery networks of Performing Provider Systems (PPS). Twenty-five of these networks are launching projects to improve health outcomes for their patient populations, enhance disease management programs for chronic conditions, and reform the way providers are paid. After baseline established, assessments should be conducted at least every six months.
25 DSRIP Performing Provider Systems (PPS)
Each PPS was able to select between 5 and 11 projects across 3 domains*

**Domain 2: System Transformation Projects**
- **Create Integrated Delivery Systems** focused on Evidence-Based Medicine and Population Health Management
- Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

**Domain 3: Clinical Improvement Projects**
- Integration of primary care and behavioral health services
- Evidence-based strategies for disease management in high risk/affected populations

**Domain 4: Population-Wide Projects**
- Strengthen Mental Health and Substance Use Disorder Infrastructure across Systems
- Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health

*Applicants chose Minimum 2, Maximum 4 Projects

Applicants chose Minimum 2, Maximum 4 Projects

Applicants chose Minimum 1, Maximum 2 Projects

*Project 2.d.i is described as “Implementation of patient and community activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care,” which PPSs could select as their 11th project.*
Palliative Care Projects

Project 3.g.i: Integration of Palliative Care into the PCMH Model
Project 3.g.ii: Integration of Palliative Care into Nursing Homes
11 PPS Chose a Palliative Care Project

Integration of Palliative Care into the PCMH Model (3.g.i)
- Alliance for Better Health Care
- Central New York Care Collaborative
- Leatherstocking Collaborative Health Partners
- Adirondack Health Institute
- OneCity Health
- Community Care of Brooklyn
- The New York and Presbyterian Hospital
- Care Compass Network
- Community Partners of Western New York

Integration of Palliative Care into Nursing Homes (3.g.ii)
- Staten Island PPS
- The New York and Presbyterian Hospital/Queens
Palliative Care Projects’ Aim & Measure

• Projects aim to further integrate palliative care into patient-centered medical home (PCMH) practices and nursing home settings.

• A tool was selected to measure access to palliative care services for patients most in need, not to evaluate the outcomes associated with palliative care interventions.

• Both projects use the Integrated Palliative Care Outcome Scale (IPOS), a standardized screening tool to identify which patients are most in need of palliative care interventions.
Quality Metrics & Data Collection
Palliative Care Measures Used for DSRIP

The percentage of patients who were offered or provided an intervention for a “symptom”.

- pain
- other physical symptoms
- advanced directive
- feeling at peace
- depression
Survey Tool: Integrated Palliative Care Outcome Scale (IPOS)

✓ A 10-item questionnaire to assess patient’s physical symptoms, psychological, emotional, and spiritual needs.

✓ Widely used in palliative care projects across the US and internationally.

✓ Greater focus on symptom identification & less emphasis on look-back period.

Palliative Care Outcome Scale: https://pos-pal.org/maix/
IPOS Implementation

Versions
• the patient version (self-administered or administered by a family member/caregiver)
• the staff version

Frequency of administration
• After baseline established, assessments should be conducted at least every six months
• Assessments should be additionally administered when a patient:
  • Enters a palliative care treatment regimen (or as soon as possible if already participating)
  • Experiences a significant change in patient status (defined as changes to the patient’s care plan, such as hospitalization, changes in home care needs, independent living status)
Pain & Physical Symptoms Question

Q2. Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick one box that best describes how it has affected you over the past week.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Severely</th>
<th>Overwhelmingly</th>
<th>STAFF COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Weakness or lack of energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Nausea (feeling like you are going)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Vomiting (being sick)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Constipation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>Sore or dry mouth</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Poor mobility</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
</tbody>
</table>
## Depression & Feeling at Peace Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
<th>Intervention offered or provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3. Have you been feeling anxious or worried about your illness or treatment?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Q4. Have any of your family or friends been anxious or worried about you?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Q5. Have you been feeling depressed?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Q6. Have you felt at peace?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Q7. Have you been able to share how you are feeling with your family or friends as much as you wanted?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Q8. Have you had as much information as you wanted?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>No</td>
</tr>
</tbody>
</table>
**Advanced Directive Question**

<table>
<thead>
<tr>
<th>Health Care Proxy</th>
<th>Living Will</th>
<th>Organ Donation</th>
<th>Documentation of Oral Advance Directive</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q10: Check all advance directives known to have been completed:

- 0
- 1
- 2
- 3
- 4

- No
- Yes

STAFF COMPLETED

Intervention offered or provided?
Measure Calculation

Calculation for the pain, depression and feeling at peace measure:

\[
\text{Numerator} = \text{Number of patients offered or provided an intervention for the question} \\
\text{Denominator} = \text{Number of patients with responses 2, 3, or 4 for the question}
\]

Calculation for the physical symptoms measure:

\[
\text{Numerator} = \text{Number of symptoms indicating that an intervention was offered or provided} \\
\text{Denominator} = \text{Number of symptoms with responses 2, 3, or 4 for the question}
\]

Calculation for the advanced directive measure:

\[
\text{Numerator} = \text{Number of patients offered or provided an intervention for the question} \\
\text{Denominator} = \text{Number of patients with response of 4 (None)}
\]
### Assessing Project Progress

<table>
<thead>
<tr>
<th>Performance</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q2.</strong> Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick one box that best describes how it has affected you over the past week:</td>
<td></td>
</tr>
<tr>
<td><strong>Q5.</strong> Have you been feeling depressed?</td>
<td></td>
</tr>
<tr>
<td><strong>Q6.</strong> Have you felt at peace?</td>
<td></td>
</tr>
</tbody>
</table>

#### Assessment Method & Achievement Points

- Five measures: Pain (Q2), Physical symptoms (Q2), Depression (Q5), Peacefulness (Q6), and completion of advance directives (Q10) align with an IPOS question.
- Numerator is # of patients offered or provided an intervention for the “symptom”.
- Denominator is # of patients whose response to the assessment indicated the need for such intervention.
- Achievement Value is earned if ratio of current measurement year result to baseline year is greater than 1.
Measure Results
Total Number of IPOS Surveys Administered by PPS, MY3 and MY4

<table>
<thead>
<tr>
<th>PPS</th>
<th>MY3</th>
<th>MY4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPS A</td>
<td>249</td>
<td>1867</td>
</tr>
<tr>
<td>PPS B</td>
<td>1200</td>
<td>1277</td>
</tr>
<tr>
<td>PPS C</td>
<td>439</td>
<td>538</td>
</tr>
<tr>
<td>PPS D</td>
<td>283</td>
<td>454</td>
</tr>
<tr>
<td>PPS E</td>
<td>0</td>
<td>407</td>
</tr>
<tr>
<td>PPS F</td>
<td>59</td>
<td>237</td>
</tr>
<tr>
<td>PPS G</td>
<td>93</td>
<td>177</td>
</tr>
<tr>
<td>PPS H</td>
<td>76</td>
<td>147</td>
</tr>
<tr>
<td>PPS I</td>
<td>14</td>
<td>122</td>
</tr>
<tr>
<td>PPS J</td>
<td>74</td>
<td>108</td>
</tr>
<tr>
<td>PPS K</td>
<td>24</td>
<td>47</td>
</tr>
</tbody>
</table>

*Target Population: patients receiving palliative care services who are also either enrolled in a PCMH or currently residing in a nursing home*
Number of Patients Eligible for Being Offered or Provided an Intervention, July 2017- June 2018

- Pain: 1539
- Advanced Directive: 1512
- Depression: 884
- At Peace: 843
Percentage of Patients who were Offered or Provided an Intervention by “Symptom”

- Pain: MY3 79.53, MY4 70.63
- Physical Symptoms: MY3 74.6, MY4 75.17
- At Peace: MY3 53.87, MY4 62.28
- Depression: MY3 68.58, MY4 72.62
- Advanced Directive: MY3 41.01, MY4 56.35
Percentage of patients who were offered or provided an intervention for pain symptoms experienced during the past week in MY3 and MY4.
Percentage of patients who were offered or provided an intervention for physical symptoms (other than pain) experienced during the past week in MY3 and MY4.
Percentage of patients who were offered or provided an intervention for depressive feelings experienced during the past week in MY3 and MY4.
Percentage of patients who were offered or provided an intervention for not feeling at peace during the past week in MY3 and MY4.
Percentage of patients who were offered or provided an intervention when there was no advance directive in place

Improving

Not Improving

NEW YORK STATE Department of Health
Key Takeaways

• The IPOS is a useful tool to measure access to palliative care services for patients most in need.

• The IPOS allowed for a mechanism through which standardized data could be collected, quality metrics could be calculated, and applied to quality improvement projects.

• Improvement was demonstrated from year 3 to year 4 for the majority of palliative care quality measures on average and among the integrated delivery networks (Performing Provider Systems) in New York for the DSRIP Program.
Melissa Lurie, MPH

- Research Scientist
- Division of Quality Measurement and Evaluation

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- Phone: 518.486.9012
- melissa.lurie@health.ny.gov
Measuring the Quality of Serious Illness Care
Overlapping Delivery Systems for Frail Older Adults Without Aligned Quality Framework

- Dual Eligible 10 million
- Medicare
- Medicaid
- Medicare Advantage
- Managed LTSS (MLTSS)
- IMPACT Measures for Post-Acute Care
- CMMI Demonstrations focused on frail elderly (Independence at Home, etc)
- Integrated SNP
- Dual-SNP
- Medicaid-Medicare Plans (MMP)
- PACE
- Other Measures:
  - Nursing Home Compare
  - Home Health Compare

CMMI Demonstrations focused on frail elderly (Independence at Home, etc)
Quality Framework for Serious Illness Care

Standards paired with performance measures

Assessment
Serious Illness Conversation
Person Centered Care Plan
Care Coordination
Utilization, Cost and Experience of Care
Health and Quality of Life Outcomes

Processes

Outcomes

Structures that need to be in place for high quality care
-
Staff qualifications
-
Critical incident management
-
Ongoing measurement and quality improvement
Quality Framework for Frail Elderly Population

Standards paired with performance measures

- MMP Requirement
- MLTSS/HEDIS Measures
- SNP Requirements
- HEDIS Care for Older Adults
- HEDIS Transitions of Care

How can CMS, States and NCQA align and streamline these measures addressing the same population?

- HEDIS Risk-Adjusted Utilization
- CAHPS
- Person Reported Outcome Measures

How can CMS, States and NCQA continue to build capacity for outcome measures?
Quality Measurement: One Size Does Not Fit All
What Matters Most?

Health and Quality of Life Goals
- Manage symptoms
- Stop falling as much
- Stay sharp
- Take fewer medications
- Avoid dialysis
- Get my doctors to talk to each other
- Be heard by my doctors
- Stay out of the hospital
- Choose who helps me dress and bathe
- Increase mobility and stamina
- Lose weight
- Play with my grandchildren
- Have privacy
- Choose who cares for me in my home
- Not be a burden to my family
- Stay in my home
- Help my caregiver be less stressed

Care Preferences
- Stay out of the hospital
- Be heard by my doctors
- Stay in my home
- Have privacy
- Choose who cares for me in my home
- Not be a burden to my family
- Stay in my home
- Help my caregiver be less stressed

Values
- Stay out of the hospital
- Be heard by my doctors
- Stay in my home
- Have privacy
- Choose who cares for me in my home
- Not be a burden to my family
- Stay in my home
- Help my caregiver be less stressed
Sample of Specific Goals

To eat without worry
To get off oxygen and breath with room air only
Go to the pool one time with daughter.
Avoid hospitalizations or ED visits over the next 6 months
Identify a home provider (agency) who can stay at home with pt when caregiver needs to attend to his own medical appts within the next 2 months.
To attend 1 lunch + 1 activity at her new senior living residence within 1 month.
Walk 5 blocks 3x/wk in 6 months
I want to get out of the house more for things other than medical appointments
Feel good about herself in spite of her pain
Practice her faith
Measures we use for Medicare Advantage plans

Examples

- **Patient Safety**: Drugs to Avoid in the Elderly, Potentially Dangerous Drug-Disease Interactions to avoid, Risk of Continued Opioid Use
- **Care Coordination**: Medication reconciliation, Transitions of care, Follow up after Emergency room use for patients with Multiple Chronic Conditions
- **Chronic Care**: Controlling High Blood Pressure, Care for Older Adults, Pharmacotherapy of COPD, Antidepressant Medication Management
- **Prevention**: Body Mass Index, Breast Cancer Screening, Colorectal cancer screening, Adult Immunization Composite
- **Utilization**: Acute Hospital Utilization, Emergency Room Utilization, All Cause Readmission, Hospitalization for Potential Preventable Conditions, Hospitalization Following Discharge from SNF
Our Vision: Person-Driven Outcomes

Person-Driven Outcomes
Outcomes identified by the individual (or caregiver) as important that can be used for care planning and quality measurement
Person-Driven Outcome Approach and Quality Measures

Measuring what individuals say matters most to them

- % individuals with person-driven outcome and action step documented
- % individuals with assessment of progress on person-driven outcome
- % individuals who show improvement (or maintain) in a person-driven outcome
Goal Attainment Scaling

- Clinicians and individuals (and/or caregiver) jointly set a SMART goal and define a set of possible outcomes along a 5-point scale.
  - A numerical weight from +2 to -2 is assigned to each possible outcome.
  - At follow up the patient and clinician discuss the patient’s progress and decide together which outcome most closely matches what the patient achieved.

<table>
<thead>
<tr>
<th>Much Less than Expected (-2)</th>
<th>Somewhat less than Expected (-1)</th>
<th>Expected level (0)</th>
<th>Somewhat better than Expected (+1)</th>
<th>Much better than Expected (+2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not leaving the house at all</td>
<td>Only leaving the house for appointments</td>
<td>Attending appts and taking a walk around the block once a week</td>
<td>Attending appts and taking a walk around the block twice per  week</td>
<td>Attending appts and taking a walk twice plus meeting a friend for lunch once a week</td>
</tr>
</tbody>
</table>
Calculating quality from person-driven outcomes

*Results from eight pilot sites testing person-driven outcomes*

<table>
<thead>
<tr>
<th></th>
<th>Goal Attainment Scaling (N=184)</th>
<th>PROM (N=49)</th>
<th>Total (N=232)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up on goal</td>
<td>80%</td>
<td>67%</td>
<td>78%</td>
</tr>
<tr>
<td>Goal Met</td>
<td>74%</td>
<td>70%</td>
<td>73%</td>
</tr>
</tbody>
</table>

“'You know, you can tell somebody what to do, but *I think you convey better things when you give people options* to do, find out what they like.” – 69 year old female patient
Essential questions about serious illness care

Who is seriously ill and how do we find them?

What entities should be accountable for care?

What should they be accountable for?
Measurement Challenges
Necessary characteristics for a denominator

- Seriously ill patients are easy to find
- Adequate numbers for performance measurement
- Sensitivity/specificity balance

ICD codes
EHR
Pharmacy claims
DME

Reliability
Validity

Chart Review
Logic Model  
**Person Driven Care for People with Serious Illness**

Person Driven, Goal Aligned Serious Illness Care

- **Evaluate Prognosis and Care Options**
- **Conduct Comprehensive Assessment**
- **Conduct Serious-Illness Conversation and Set Goals (Shared Decision-Making)**
- **Create a Comprehensive Care Plan**
- **Provide Goal-Aligned Care**
- **Track Progress, Reassess, Update Goals and Plan**
- **Follow-up on Goal**
- **Attainment of Person-Driven Outcome**

**Process Measures**:
- Comprehensive Assessment
- Patient Goal Setting
- Comprehensive Care Plan

**Outcome**:
- Follow-up on Goal Attainment of Person-Driven Outcome
What can states and CMS do to help move this agenda forward

Examine overlapping measurement requirements and aim for alignment across programs that cross Medicare Advantage, Medicare FFS, and Medicaid space.

Adopt and promote standard data elements for documenting assessment and care plan components electronically along with medical data.

Promote and facilitate real-time sharing of information between health plans, facilities and clinicians and merging Medicare with Medicaid data.

Require care that is based on what matters most to people with serious illness, and make sure measures don’t incentivize care that is misaligned with goals.
To ask a question, please use the ‘raise your hand’ feature or type it into the ‘chat’ box.
Thank You!

Thank you for joining this Utilizing Quality Measures to Build an Effective Palliative Care System Webinar!

Please complete the evaluation form following this presentation.