Palliative Care Quality Network: Improving the Quality of Caring

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Palliative Care Patients

- Sickest
- Costliest
- Most resource intensive

Hospitals and healthcare systems need to understand how best to care for these patients in order to provide the highest quality and most efficient and effective care.
To Improve Care, We Must...

- **Measure** how well we are performing
- **Examine** the care we provide and **benchmark** to others
- **Learn** from gaps in our care and from better performers
- **Develop** and implement an improvement plan
- **Continue to measure** outcomes
- **Reassess and fine tune** care to achieve more improvements

Key to this process is the collection of standardized data with the ability to compare to and learn from others
Challenges for PCS Teams

- Intense clinical demands
  - Growing census outstrips resources
  - Increasing recognition of need for PC
- Work in isolation
  - Within institution
  - Within field
- Focus on value
  - Demonstrate quality
  - Justify investment
PCQN: PC Team Needs

- Data collection and analysis: standardized, feasible
- Benchmark and compare outcomes
- Best practices: efficiency, effectiveness
- QI, and how to do it
- Financial outcome analysis
- Expert level education
- Team dynamics, self care, leadership
- Sustainability and growth
PCQN

- PCQN is a continuous learning collaborative committed to improving the care of seriously ill patients and their families
- Established in 2009 with grant funding
- 33 members and growing
  - Diverse group of hospitals including academic, community, system, public
  - 19 submitting data
PCQN

Patient centered, multi-level approach
PCQN Components: Responding to PC Team Needs

- Core Dataset and optional data elements
- Database and Reports with comparisons
- Quality Improvement Collaborative
- Community: conference calls, in-person conferences, networking, best practices, education, support, self care, team work
- CaseMaker PCS
- PCQN Website
Development of PCQN Dataset

- Feasible, clinically meaningful, simple, comparable, concise, prospective
- Guided by national guidelines
- Consensus process based on input from PCQN members
PCQN Dataset

- PCQN core dataset: 23 data elements
  - Demographics: 8
  - Operations: 5
  - Processes: 3
  - Clinical outcomes: 7
- Data dictionary
  - Definitions, categories, measures
- Optional data elements: 22
PCQN Data

- PCQN members collect a core dataset for each patient that includes clinical outcomes
- Data collection supports standardized assessment
- Data are entered into the PCQN database
  - Direct data entry into database
  - Data collection on paper form
  - Upload of data downloaded from EHR
PCQN Database

- Secure, web-based database
- Each site owns its data
  - Can download data at any time
  - Only a site can see its data
- 13,000+ patient encounters to date
  - Benchmark processes and outcomes
  - Identify and disseminate best practices
  - Drive collaborative QI projects
### PCQN Database

**Provider ID: DEMO**

**Patient Encounter ID: 15**

**Data Year: 2014**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRN:</td>
<td></td>
</tr>
<tr>
<td>Encounter #:</td>
<td></td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>PC consult request date:</td>
<td></td>
</tr>
<tr>
<td>Hospital admission date:</td>
<td></td>
</tr>
<tr>
<td>Patient never admitted:</td>
<td></td>
</tr>
<tr>
<td>Age on date of PC request:</td>
<td></td>
</tr>
<tr>
<td>Unknown:</td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnicity:</td>
<td></td>
</tr>
<tr>
<td>Primary Language:</td>
<td></td>
</tr>
<tr>
<td>Surrogate Decision Maker:</td>
<td></td>
</tr>
<tr>
<td>Location at time of PC request:</td>
<td></td>
</tr>
<tr>
<td>If other, enter description:</td>
<td></td>
</tr>
<tr>
<td>Reasons given by referring provider for initial PC consult</td>
<td></td>
</tr>
<tr>
<td>- Goals of care discussion/Advance care planning</td>
<td></td>
</tr>
<tr>
<td>- Withdrawal of interventions</td>
<td></td>
</tr>
<tr>
<td>- Hospice referral/discussion</td>
<td></td>
</tr>
<tr>
<td>- Pain management</td>
<td></td>
</tr>
<tr>
<td>- Transfer to comfort care bed/unit</td>
<td></td>
</tr>
<tr>
<td>- Other symptom management</td>
<td></td>
</tr>
<tr>
<td>- Comfort care</td>
<td></td>
</tr>
<tr>
<td>- No reason given</td>
<td></td>
</tr>
<tr>
<td>Primary diagnosis leading to PC consult:</td>
<td></td>
</tr>
<tr>
<td>If other, enter description:</td>
<td></td>
</tr>
<tr>
<td>Code status at time of PC request:</td>
<td></td>
</tr>
<tr>
<td>Advance Directive document on chart at time PC request?</td>
<td></td>
</tr>
<tr>
<td>POLST at time of PC request?</td>
<td></td>
</tr>
</tbody>
</table>

**PCQN**

**PALLIATIVE CARE QUALITY NETWORK**

*Improving the quality of caring*
PCQN Reports

- Reports in real time with click of mouse
- Include comparisons to all PCQN sites
- Data available in reports as soon as data submitted
- Summary, trend, and hospital comparison reports
PCQN Members
PCQN Community

- Conference calls
  - Expert-level education by members
- Twice yearly conferences
  - Team building, clinical education, peer learning, guidance and support

“The PCQN has truly improved my team's function, understanding of our multiple missions, and has helped us feel not "siloe-ed" but networked”
CaseMaker PCS

- Automated, web-based financial analysis tool
- Integrated with PCQN database
- Provide cost savings, net margin, saved bed days
- Editable report
- Value
PCQN Lessons Learned

- Balance democracy and autocracy
- Participation is important to some
- Decisions need to be made
PCQN Lessons Learned

- Balance democracy and autocracy
- Building infrastructure takes time and is key to success
  - Spinning plates
  - Do what you promise
PCQN Lessons Learned

- Balance democracy and autocracy
- Building infrastructure takes time and is key to success
- Focus
  - Identify, prioritize and complete the key tasks
PCQN Lessons Learned

- Balance democracy and autocracy
- Building infrastructure takes time and is key to success
- Focus
- Be aware of context and environment
PCQN Lessons Learned: Data

- Data collection is hard
  - Teams are busy
  - Greatest barrier to participation
  - Fantasy about the EHR
  - It’s not research
  - Can be done!
Census per month: UCSF
# Referral Location: UCSF/PCQN

<table>
<thead>
<tr>
<th>Referral Location</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>Percent</td>
</tr>
<tr>
<td>Medical / Surgical</td>
<td>807</td>
</tr>
<tr>
<td>Critical Care</td>
<td>498</td>
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<tr>
<td>Emergency Department</td>
<td>76</td>
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<tr>
<td>Labor &amp; Delivery</td>
<td>0</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>0</td>
</tr>
<tr>
<td>Telemetry / Step Down</td>
<td>311</td>
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<tr>
<td>Ambulatory / Outpatient clinic</td>
<td>1</td>
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<tr>
<td>Pediatrics</td>
<td>0</td>
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<tr>
<td>Acute Rehab</td>
<td>0</td>
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<tr>
<td>Other</td>
<td>6</td>
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<tr>
<td>Unknown</td>
<td>46</td>
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<tr>
<td>Pending</td>
<td>8</td>
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Primary Dx: UCSF/PCQN

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Member N</th>
<th>Member Percent</th>
<th>PCQN N</th>
<th>PCQN Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>973</td>
<td>55.5%</td>
<td>4,709</td>
<td>36.6%</td>
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<tr>
<td>Cardiovascular</td>
<td>229</td>
<td>13.1%</td>
<td>1,520</td>
<td>11.8%</td>
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<tr>
<td>Pulmonary</td>
<td>98</td>
<td>5.6%</td>
<td>1,435</td>
<td>11.2%</td>
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<tr>
<td>Vascular</td>
<td>17</td>
<td>1.0%</td>
<td>92</td>
<td>0.7%</td>
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<tr>
<td>Complex chronic/failure to thrive</td>
<td>47</td>
<td>2.7%</td>
<td>676</td>
<td>5.3%</td>
</tr>
<tr>
<td>Renal</td>
<td>19</td>
<td>1.1%</td>
<td>466</td>
<td>3.6%</td>
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<tr>
<td>Trauma</td>
<td>3</td>
<td>0.2%</td>
<td>229</td>
<td>1.8%</td>
</tr>
<tr>
<td>Congenital / Chromosomal</td>
<td>2</td>
<td>0.1%</td>
<td>17</td>
<td>0.1%</td>
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<tr>
<td>Gastrointestinal</td>
<td>18</td>
<td>1.0%</td>
<td>342</td>
<td>2.7%</td>
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<tr>
<td>Hepatic</td>
<td>103</td>
<td>5.9%</td>
<td>473</td>
<td>3.7%</td>
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<tr>
<td>Infectious / immunological/HIV</td>
<td>26</td>
<td>1.5%</td>
<td>531</td>
<td>4.1%</td>
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<tr>
<td>In-utero</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>0.0%</td>
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<tr>
<td>Neuro / Stroke</td>
<td>149</td>
<td>8.5%</td>
<td>1,251</td>
<td>9.7%</td>
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<tr>
<td>Dementia</td>
<td>19</td>
<td>1.1%</td>
<td>518</td>
<td>4.0%</td>
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<tr>
<td>Hematology</td>
<td>0</td>
<td>0.0%</td>
<td>76</td>
<td>0.6%</td>
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<tr>
<td>Other</td>
<td>13</td>
<td>0.7%</td>
<td>152</td>
<td>1.2%</td>
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<tr>
<td>Unknown</td>
<td>32</td>
<td>1.8%</td>
<td>285</td>
<td>2.2%</td>
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<tr>
<td>Pending</td>
<td>5</td>
<td>0.3%</td>
<td>81</td>
<td>0.6%</td>
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</table>

1/1/13 to 4/12/15
PCQN Lessons Learned: Data

- Data collection is hard
- Standardized data collection standardizes patient assessment
  - Symptoms
  - Advance care planning
  - Psychosocial and spiritual issues
  - PPS
PPS: Site Comparison

Mean Palliative Performance Scale (PPS) Score
01/01/2014 - 02/28/2015

PCQN Members Sorted by Mean. UC San Francisco in Red

PCQN Mean: 34.3
PCQN Lessons Learned: Data

- Data collection is hard
- Standardized data collection standardizes patient assessment
- Data reports and benchmarking are powerful
  - We’re not in Lake Wobegon
  - Humbling and motivating
  - Gets people to pay attention
Pain Improvement: Site Comparison

First to Second Assessment Pain Improvement - Moderate to Severe Symptoms Only
01/01/2014 - 02/28/2015

% of Patients with Moderate to Severe Symptoms at First Assessment

PCQN Percent: 67.3

PCQN Members Sorted by Percentage. UC San Francisco in Red
PCQN Lessons Learned: Data

- Data collection is hard
- Standardized data collection standardizes patient assessment
- Data reports and benchmarking are powerful
- Wide variation in all aspects
Referral Location: Critical Care

Site Comparison

Referral Location - Critical Care
01/01/2014 - 02/28/2015

Percent of Total Consults

PCQN Members Sorted by Percentage. UC San Francisco in Red

PCQN Percent: 21.9
ED Referrals: Site Comparison

Referral Location - Emergency Department
01/01/2014 - 02/28/2015

Percent of Total Consults

PCQN Members Sorted by Percentage. UC San Francisco in Red

PCQN Percent: 5.3
Cardiology Patients: Site Comparison

Primary Diagnosis - Cardiovascular
01/01/2014 - 02/28/2015

Percent of Total Consults

PCQN Members Sorted by Percentage. UC San Francisco in Red

PCQN Percent: 11.4
PCQN QI Collaboratives

- QI committee chooses projects
- QI education
- Coordinated, mentored QI project
  - Monthly conference calls
  - Sharing strategies
  - Providing peer support
- Reports and run charts
PCQN Quality Improvement

- Strategy Exchange: Share effective, practical solutions to common challenges
  
  How do you triage high volume?

- QI: Identify gaps in care and close them
  
  What % of patients with moderate/severe pain should have improved pain between 1st and 2nd assessments?
Pain Scores: Initial Assessment

<table>
<thead>
<tr>
<th>Score</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>161</td>
<td>24.4%</td>
</tr>
<tr>
<td>1</td>
<td>120</td>
<td>18.2%</td>
</tr>
<tr>
<td>2</td>
<td>94</td>
<td>14.2%</td>
</tr>
<tr>
<td>3</td>
<td>80</td>
<td>12.1%</td>
</tr>
<tr>
<td>7</td>
<td>16</td>
<td>2.4%</td>
</tr>
<tr>
<td>9</td>
<td>189</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Mean Score: 1.2

Day 1 (N = 660)

Sx scoring
0: none
1: mild
2: moderate
3: severe
7: pt seen but sx not assessed
9: pt seen, pt unable to report
PCQN QI: Pain Management

- Review processes of care
  - See patients in pain first
  - Communicate with nurse and team right after
  - Afternoon check in
- Examine those who don’t improve
  - Non-opioid responsive pain
  - Anxiety
  - Chronic, neuropathic pain
- Monitor process, progress and report to team
Pain Improvement: Trend

First to Second Assessment Pain Improvement - Moderate & Severe Symptoms Only

Year/Quarter

PCQN
PALLIATIVE CARE QUALITY NETWORK
Improving the quality of caring
PCQN Lessons Learned: QI

- QI is a skill
- Most clinicians did not learn it
PCQN Lessons Learned: QI

- QI is a skill
- QI is hard
  - Change is difficult
  - Progress can be slow
  - Need lots of buy in
  - Success builds on itself
PCQN Lessons Learned: QI

- QI is a skill
- QI is hard
- Choose the projects carefully
  - Believe in it
  - Room for improvement
PCQN Lessons Learned: QI

- QI is a skill
- QI is hard
- Choose the projects carefully
- Community and collaboration are key
  - In it together
  - Learning from each other
  - Support
PCQN Next Steps

- Expand membership, reports and QI
- Linking outcomes with structure and processes
- Comparisons and benchmarking with like hospitals
- Outpatient & home-based PC data collection
- Collaboration with other organizations
  - Measuring What Matters
  - qdact, PCRC, TJC, CAPC, UHC, MHA
  - UW PCCE
PCQN: A Magic Trip

If you want to go fast, go alone.
If you want to go far, go together.

African proverb
Acknowledgement

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- PCQN members
PCQN Leadership Team

- Ashley Bragg: Deputy Director
- David O’Riordan, PhD: Statistician
- Shayna McElveny: Analyst
- Kara Bischoff, MD: Director, QI
- Niraj Seghal, MD: Director, Education
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