Palliative Care Quality Network

“If you want to go fast go alone, if you want to go far go together”

Spring Meeting
April 20-21, 2017
PCQN Mission

To transform healthcare by defining and promoting quality palliative care
PCQN

![Bar Chart] PCQN Data
- Core dataset: inpt, community, peds
- Web-based database
- Reports

![People] Education & Community Building
- In-person conferences
- Monthly webinars

![Circle] Quality Improvement
- Strategy Exchange
- QI Collaborative

![Currency] CaseMaker PCS
- Financial outcomes
- Tool for talking to leadership
The Palliative Care Quality Network: Improving the Quality of Caring

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Abstract

Objective: Describe the establishment of the palliative care quality network (PCQN) with guidance on how teams can develop similar collaborations.

Background: In the current healthcare environment, palliative care (PC) teams must be able to demonstrate value and provide efficient care while supporting the clinicians who provide that care.

Description: The PCQN is a national quality improvement (QI) collaborative comprised of specialty PC teams from a diverse range of hospitals across the United States.

Results: PCQN members identified five core activities to support PC teams. 1) Collection of standardized data: 23 core items and 22 optional data elements document patient demographics, consultation characteristics, processes of care, and clinical outcomes. 2) Data analyses with benchmarking including reports generated in real time providing summary, trend, member comparison, and cross-tab analyses. 3) QI collaborative; QI initiatives have addressed pain management, surrogate decision-making, spiritual screening, and anxiety assessment. 4) Education and personal development provided through monthly conference calls, a listserv, PCQN website, and twice-yearly conferences. 5) Financial analysis; a software program enables PC teams to calculate the financial impact of the care provided.

Conclusions: The central tenet of the PCQN is to improve quality of care for patients with serious illness and their families, increase the efficient use of healthcare resources, and support growth and sustainability of PC programs. Building and tending to this community takes time to ensure engagement of all members and remain responsive to evolving needs of patients, families, PC teams, and stakeholders.
Inspired

Motivated

Connected

Excited

Relaxed

Energized

Restored

Hopeful

Thought-Provoking

Moved

Family

Grateful

Palliative Care Quality Network

PCQN

5/9/2017
If you want to go fast, go alone.
If you want to go far, go together.
PCQN Forum

What’s up
Who we are
What we do
What’s new
What’s coming
PCQN and The Joint Commission
Advanced Certification in Palliative Care

Members certified: 6
Some are already recertified/ying
Members actively pursuing certification: 4
The Joint Commission Advanced Certification in Palliative Care

Collect data monthly
Report quarterly
Chart review
The Joint Commission Advanced Certification in Palliative Care

“Use of the Pain Screening and Pain Assessment quality measures will increase reporting and efforts to improve awareness of the presence of pain (screening) and assessment of severity, etiology and effect on function (assessment) which are the essential first steps required for quality pain management and treatment.”
The Joint Commission Advanced Certification in Palliative Care

Pain Screening

all patients are screened during initial visit

Pain Assessment

if screen +, number with assessment of 5 of 7 components within one day of screen

character, duration, effect, factors, frequency, location, severity
The Joint Commission Advanced Certification in Palliative Care

Dyspnea Screening
- screen for dyspnea on initial encounter

Treatment Preferences and Goals of Care
- documentation of treatment preferences and goals of care

Treatment Preferences Discharge Document
- discharge document with treatment preferences and goals of care accompanies patient to next site of care
The Joint Commission Advanced Certification in Palliative Care

Dyspnea Screening
screen for dyspnea on initial encounter

Treatment Preferences and Goals of Care
documentation of treatment preferences and goals of care

Treatment Preferences Discharge Document
discharge document with treatment preferences and goals of care accompanies patient to next site of care
Registry Collaborative

PCQN, GPCQA, CAPC, AAHPM

Future of registries in specialty palliative care

One front door
All programs participate
Multiple uses

Program sustainability
Benchmarking/best practices
QI
Payment
Evidence generation
Palliative Care

Hospital
Acute Illness
Palliative Care teams

Clinic/Outpatient

Home

SNF/LTC

End of Life
Hospice

PCQN
PALLIATIVE CARE QUALITY NETWORK
Design Challenge

Design an effective system to provide comprehensive and coordinated palliative care to people with serious
Vision for PC

To provide integrated, high quality, person-centered palliative care across the continuum
Population Health

• Proactive
• Case finding
• Targeted
  – Colonoscopy screening
  – Mammograms
  – Flu shots
  – Blood pressure checks
  – Palliative care
Population Health Approach to Addressing Palliative Care Needs

- Advance care planning
- Primary Palliative Care
- PC as primary focus of care
- Consultative PC
- Primary Palliative Care

Intensity of PC needs vs. time

PCQN
Palliative Care Quality Network
PCQN
87,341 inpatient encounters

Discharges

Community encounters: 1346 visits; 564 patients; 2.4 visits/patient
## Patient Demographics

<table>
<thead>
<tr>
<th></th>
<th>Inpatient</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>71 yrs</td>
<td>62 yrs</td>
</tr>
<tr>
<td>Cancer</td>
<td>30%</td>
<td>68%</td>
</tr>
<tr>
<td>PPS</td>
<td>35%</td>
<td>67%</td>
</tr>
<tr>
<td>DNR</td>
<td>38%</td>
<td>32%</td>
</tr>
</tbody>
</table>
# Reason for Referral

<table>
<thead>
<tr>
<th>Reason</th>
<th>Inpatient</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOC/ACP</td>
<td>72%</td>
<td>38%</td>
</tr>
<tr>
<td>Pain</td>
<td>19%</td>
<td>74%</td>
</tr>
<tr>
<td>Symptom management</td>
<td>15%</td>
<td>51%</td>
</tr>
<tr>
<td>Hospice</td>
<td>18%</td>
<td>4%</td>
</tr>
<tr>
<td>Support pt/family</td>
<td>21%</td>
<td>33%</td>
</tr>
<tr>
<td>Support tx decision</td>
<td>-</td>
<td>25%</td>
</tr>
</tbody>
</table>
# Pain

## First Assessment (n=34117)

<table>
<thead>
<tr>
<th>Pain</th>
<th>Mean (excl. 7 and 9)</th>
<th>Score</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1</td>
<td>0</td>
<td>9923</td>
<td>29.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>4735</td>
<td>13.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>4831</td>
<td>14.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>3786</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>1782</td>
<td>5.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9</td>
<td>9014</td>
<td>26.4%</td>
</tr>
</tbody>
</table>

## Second Assessment (n=34117)

<table>
<thead>
<tr>
<th>Pain</th>
<th>Mean (excl. 7 and 9)</th>
<th>Score</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.8</td>
<td>0</td>
<td>11685</td>
<td>34.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>6145</td>
<td>18.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>3629</td>
<td>10.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>1523</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>2048</td>
<td>6.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9</td>
<td>9054</td>
<td>26.5%</td>
</tr>
</tbody>
</table>
Pain Member Comparison

First to Second Assessment Pain Improvement - Moderate to Severe Symptoms Only
01/01/2013 - 12/31/2016

Report Data Last Updated on Apr 19, 2017 at 21:05 Excludes patients with non-applicable status for chosen variable. Excludes members with N < 5
# Pain improvement by diagnosis

Earliest discharge date in range for PCQN Network: 01/03/2013; Latest discharge date in range for PCQN Network: 12/31/2016

PCQN Network - Date Range = 01/01/2013 to 12/31/2016

Excludes patients with pending or non-applicable status for chosen variables and patients who were not seen

Only includes patients with moderate to severe symptoms at first assessment

<table>
<thead>
<tr>
<th>Primary Diagnosis Leading to PC Consult</th>
<th>Cancer</th>
<th>All Dx Not Selected</th>
<th>Cardiovascular</th>
<th>Pulmonary</th>
<th>Neurologic/Stroke</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>First to Second Assessment Pain Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2,949</td>
<td>68.6%</td>
<td>1,062</td>
<td>65.1%</td>
<td>244</td>
<td>72.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>189</td>
<td>72.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>118</td>
<td>68.6%</td>
</tr>
<tr>
<td></td>
<td>4,562</td>
<td>68.1%</td>
<td>1,062</td>
<td>65.1%</td>
<td>244</td>
<td>72.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>189</td>
<td>72.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>118</td>
<td>68.6%</td>
</tr>
<tr>
<td>No</td>
<td>1,349</td>
<td>31.4%</td>
<td>570</td>
<td>34.9%</td>
<td>94</td>
<td>27.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>72</td>
<td>27.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>54</td>
<td>31.4%</td>
</tr>
<tr>
<td></td>
<td>2,139</td>
<td>31.9%</td>
<td>570</td>
<td>34.9%</td>
<td>94</td>
<td>27.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>72</td>
<td>27.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>54</td>
<td>31.4%</td>
</tr>
<tr>
<td>Total</td>
<td>4,288</td>
<td>100.0%</td>
<td>1,632</td>
<td>100.0%</td>
<td>338</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>261</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>172</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 12.1 \quad p-value = 0.0156 \]

5/9/2017
## Disposition

### Alive: 76%

<table>
<thead>
<tr>
<th>Disposition Location</th>
<th>Total</th>
<th>Home Health</th>
<th>Palliative Care Clinic Based</th>
<th>Palliative Care Home Based</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Home</td>
<td>28,767</td>
<td>34.5%</td>
<td>7,708</td>
<td>11.7%</td>
<td>1,934</td>
</tr>
<tr>
<td>LTAC</td>
<td>1,817</td>
<td>2.2%</td>
<td>9</td>
<td>0.0%</td>
<td>24</td>
</tr>
<tr>
<td>ECF</td>
<td>13,551</td>
<td>16.2%</td>
<td>153</td>
<td>0.2%</td>
<td>296</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>8,023</td>
<td>9.6%</td>
<td>87</td>
<td>0.1%</td>
<td>113</td>
</tr>
<tr>
<td>Non-Hosp Inpatient</td>
<td>3,379</td>
<td>4.0%</td>
<td>10</td>
<td>0.0%</td>
<td>5</td>
</tr>
<tr>
<td>Res Care/Assist Live</td>
<td>2,792</td>
<td>3.3%</td>
<td>315</td>
<td>0.5%</td>
<td>32</td>
</tr>
<tr>
<td>Respite/Shelter/SRO</td>
<td>94</td>
<td>0.1%</td>
<td>12</td>
<td>0.0%</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2,451</td>
<td>2.9%</td>
<td>39</td>
<td>0.1%</td>
<td>53</td>
</tr>
<tr>
<td>Unknown</td>
<td>2,778</td>
<td>3.3%</td>
<td>6</td>
<td>0.0%</td>
<td>4</td>
</tr>
<tr>
<td>Pending</td>
<td>2,316</td>
<td>2.8%</td>
<td>18</td>
<td>0.0%</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>65,968</td>
<td>78.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(% of Patients Seen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>8,357</td>
<td>12.6%</td>
<td>2,468</td>
<td>3.6%</td>
<td></td>
</tr>
<tr>
<td>(% of Alive at Disposition)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5/9/2017

PCQN
Palliative Care Quality Network
Disposition: Alive

Patient Status at Discharge - Alive
01/01/2013 - 12/31/2016

Report Data Last Updated on Apr 19, 2017 at 21:05 Excludes patients with non-applicable status for chosen variable. Excludes members with N < 5
# Disposition by Diagnosis

**UC San Francisco - Date Range = 01/01/2013 to 12/31/2016**

Excludes patients with pending or non-applicable status for chosen variables and patients who were not seen

<table>
<thead>
<tr>
<th>Patient Status at Discharge</th>
<th>Cancer</th>
<th>All Dx Not Selected</th>
<th>Cardiovascular</th>
<th>Neurologic/Stroke</th>
<th>Pulmonary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alive</td>
<td>1,224</td>
<td>61.2%</td>
<td>319 (74.4%)</td>
<td>99 (46.0%)</td>
<td>84 (54.2%)</td>
<td>2,012 (69.9%)</td>
</tr>
<tr>
<td>Dead</td>
<td>387</td>
<td>38.8%</td>
<td>110 (25.6%)</td>
<td>116 (54.0%)</td>
<td>71 (45.8%)</td>
<td>865 (30.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>1,611</td>
<td></td>
<td>429 (100.0%)</td>
<td>215 (100.0%)</td>
<td>155 (100.0%)</td>
<td>2,877 (100.0%)</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 125.4 \quad \text{p-value} = 0.0000 \]
Length of Stay

<table>
<thead>
<tr>
<th>Total Patients Seen: 83496</th>
<th>Patient Days</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS (Days) Prior to Consult</td>
<td>480,086</td>
<td>5.8</td>
<td>3</td>
<td>1 - 972</td>
</tr>
<tr>
<td>LOS (Days) During Consult</td>
<td>570,585</td>
<td>6.9</td>
<td>4</td>
<td>1 - 1106</td>
</tr>
<tr>
<td>Number of Contacts</td>
<td>168,205</td>
<td>2</td>
<td>2</td>
<td>1 - 56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patients With Assessments Within One Day of Admission</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21063</td>
<td>25.2%</td>
</tr>
</tbody>
</table>
Length of Stay During Consult

Length of Stay - Days During Consult
01/01/2013 - 04/19/2017

PCQN Mean: 6.7

Report Data Last Updated on Apr 19, 2017 at 23:05 Excludes patients with non-applicable status for chosen variable. Excludes members with N < 5
Length of Stay During Consult: Academic Medical Center Teams
Length of Stay During Consult:
Not-for-profit community hospital teams

PCQN Mean: 6.7
PCQN Structure Survey

David O’Riordan
Importance of the Structure Survey

• Compare members according to PC team and organizational characteristics

• Link team structure & processes to patient outcomes

• Support sustainability of growth of PCS
## Palliative Care Service Characteristics

<table>
<thead>
<tr>
<th>Length of Stay (LOS)</th>
<th>n</th>
<th>%</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveys completed</td>
<td>41</td>
<td>48*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital size</td>
<td></td>
<td></td>
<td>342 beds</td>
<td>50 – 900 beds</td>
</tr>
<tr>
<td>50 – 149 beds</td>
<td>5</td>
<td>13.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>150 – 299 beds</td>
<td>10</td>
<td>27.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300 – 499 beds</td>
<td>14</td>
<td>38.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500+ Beds</td>
<td>7</td>
<td>19.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not-for-profit</td>
<td>21</td>
<td>58.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For-profit</td>
<td>1</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching</td>
<td>8</td>
<td>22.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>5</td>
<td>14.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part of a system</td>
<td></td>
<td></td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>

*of the 86 PCQN members in 2016
Palliative Care Service Availability

<table>
<thead>
<tr>
<th>Availability</th>
<th>Onsite</th>
<th>Able to return</th>
<th>Telephone only</th>
<th>No coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekday 9am - 5pm</td>
<td>98</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Weekend 9am - 5pm</td>
<td>25</td>
<td>22</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Weekday nights</td>
<td>3</td>
<td>32</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Weekend nights</td>
<td>3</td>
<td>22</td>
<td>36</td>
<td>39</td>
</tr>
</tbody>
</table>
Frequency of PCS Meetings

- Daily: 64
- Several times a week: 15
- Weekly: 13
- Monthly or less: 5
- No meetings: 3

PCQN - Palliative Care Quality Network
## Staffing

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Number of staff</th>
<th>FTE</th>
<th>Credentialed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>2.3</td>
<td>1.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Nurse</td>
<td>2.0</td>
<td>1.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1.0</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Chaplain</td>
<td>0.7</td>
<td>0.3</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Mean FTE       Median FTE       FTE Range
Nurse, MD, SW, Chap. 3.9            3.1          0.1 – 10.3
Nurse, MD          2.9            2.5          0.1 – 8.4

Mean     Median     Range
Staff/100 beds*  2.6            2.0          0.7 – 5.7

*Chaplain, Social Worker, Nurse, Physician
## Hospital Size and Staffing* & FTE per 100 beds

<table>
<thead>
<tr>
<th>Hospital Size</th>
<th>n</th>
<th>Mean (95%CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital size</td>
<td></td>
<td>Staff/100 beds</td>
<td>0.008</td>
</tr>
<tr>
<td>50 – 149 beds</td>
<td>5</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>150 – 299 beds</td>
<td>10</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>300 – 499 beds</td>
<td>14</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>500+ Beds</td>
<td>7</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

| Hospital size          |   | FTE/100 beds       | 0.3  |
| 50 – 149 beds         | 5 | 1.5                |     |
| 150 – 299 beds        | 10| 1.4                |     |
| 300 – 499 beds        | 14| 1.2                |     |
| 500+ Beds             | 7 | 0.8                |     |

*Chaplain, Social Worker, Nurse, Physician
## Association between hospital size and length of stay

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Length of Stay Mean Days (95%CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOS Prior to Consult Request</strong></td>
<td></td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>50 – 149 beds</td>
<td>1,628</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>150 – 299 beds</td>
<td>3,284</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>300 – 499 beds</td>
<td>5,413</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>500+ Beds</td>
<td>553</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td><strong>LOS on Palliative Care Service</strong></td>
<td></td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>50 – 149 beds</td>
<td>1,628</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>150 – 299 beds</td>
<td>3,284</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>300 – 499 beds</td>
<td>5,413</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>500+ Beds</td>
<td>553</td>
<td>7.2</td>
<td></td>
</tr>
</tbody>
</table>
Overall Length of Stay & Hospital Size

Number of Days vs. Hospital size (Beds)

- 50 - 149: 9
- 150 - 299: 9
- 300 - 499: 11
- 500+: 15

p< 0.0001

PCQN
PALLIATIVE CARE QUALITY NETWORK
## Association between LOS and FTE

<table>
<thead>
<tr>
<th>Length of Stay (LOS)</th>
<th>n</th>
<th>Mean (95%CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOS prior to consult request</strong></td>
<td></td>
<td>Total* FTE/100 beds</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>0 – 1 Days</td>
<td>4,875</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>2 – 4 Days</td>
<td>3,010</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>5+ Days</td>
<td>2,993</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td><strong>Time seen by PCS</strong></td>
<td></td>
<td>Total* FTE/100 beds</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>0 - 2 days</td>
<td>4,789</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>3 – 5 days</td>
<td>3,117</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>6+ days</td>
<td>3,057</td>
<td>1.5</td>
<td></td>
</tr>
</tbody>
</table>

*Chaplain, Social Worker, Nurse, Physician
Length of Stay Prior to PC Consult for Hospitals (201 – 400 beds)

[Graph showing length of stay with data for UC San Francisco highlighted. The graph includes a bar chart with bars for PCQI members sorted by mean. The highlighted bar for UC San Francisco shows a mean of 10.7 with a confidence interval of 8.8 to 12.5.]

Report Data Last Updated on Apr 18, 2017 at 09:05 Excludes patients with non-applicable status for chosen variable. Excludes members with N < 5.
Next Steps

- Examine the relationship between team composition and patient outcomes
- Establish benchmarks to identify clinically meaningful findings
- Track changes in individual PCS over time
- Use data to identify staffing needs
- Complete survey to improve representativeness of findings
- Develop similar survey for community-based/outpatient programs
PCQN QI Collaborative:
A brief summary of what we’ve been up to

Kara Bischoff
The QI Collaborative

Interactive didactic sessions to teach QI methods

Monthly calls to review data, learn from best performers, discuss stumbling blocks

Ongoing support
Pain
POLST
Surrogate Decision Maker
Spiritual Screening

Anxiety Screening & Improvement
QI Framework: PDSA Cycle

- Examine baseline data
- Set a SMART goal
- Brainstorm barriers & opportunities
- Detail your 1st test of change (who, what, when)
- Amend your plan(s)
- Just do it!
- Report back to the group
- Keep track of your progress
- Act
- Plan
- Study
- Do

PCQN
PALLIATIVE CARE QUALITY NETWORK
Initial Improvement Plan

Tools:
• HADS
• GAD-7
• PHQ-4
• NCCN Distress Thermometer

Suggested Screening Questions:
• Are you feeling anxious?
• ... nervous?
• ... worried?
• ... on edge?
• ... fearful?
% of Patients Screened for Anxiety at First PC Assessment

- PCQN
- Anxiety Collaborative

December | January | February | March
---|---|---|---
60% | 70% | 70% | 80%
% of Patients Screened for Anxiety at Least Once during PC Consult

<table>
<thead>
<tr>
<th>Month</th>
<th>PCQN</th>
<th>Anxiety Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>December</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PCQN PALLIATIVE CARE QUALITY NETWORK
Mindfulness-Based Interventions

Selected Resources:

Mindfulness-Based Stress Reduction, Center for Mindfulness, U Mass Medical School http://www.umassmed.edu/cfm/

Compassion Cultivation Training, Stanford Medical School http://ccare.stanford.edu/education/about-compassion-cultivation-training-cct/

UCSD Health’s Center for Mindfulness https://health.ucsd.edu/specialties/mindfulness/Pages/default.aspx includes: Mindfulness-Based Emotional Balance


UCLA Mindful Awareness Research Center http://marc.ucla.edu/
Quality Improvement Pearls

• **Choose** a goal you care about, **align** with institutional priorities
• Identify engaged and dedicated **champion(s)**
• Engage the **entire PC team** in improvement work
• **Track data** regularly, make it visible
• Make the **system** work for you – e.g. modify note templates or team lists
• **Garner support** from other clinicians/services who share your goals
Next Steps

MONTHLY CALLS
Anxiety Screening and Improvement

QUARTERLY CALLS
Pain, POLST, SDM, Spiritual Screening
PCQN DATABASE UPDATES:
Community Based & Pediatrics Databases & Activities
• 22 existing hospital members
• 5 new community based organizations
• 13 sites entered data
• 539 patients; 1,265 visits
Patient Type

- 52% clinic
- 34% home
- 2% SNF/Nursing home

Average Age: 62 yrs

Primary Diagnosis: 67% cancer

Referral Reason: 74% pain management

Referral Location: 52% other OP specialist
CB Reports

Phase 1:
Summary Report

Trend & Member
Comparison

LIVE

Phase 2:
Summary Report+

Cross-tabs

APRIL

Cross-location

MAY

JUNE

FALL
Key Differences:

- Age
- Item choices
- No PPS
- Added symptoms

Reporting → Summer

- 4 existing hospital members; 23 patient encounters
Patient Identifiers & Symptom Improvement: Coming Soon!
How can we better integrate outpatient/community-based & pediatric programs into PCQN?

- Educational webinars
- Quality improvement collaborative
- Inpatient conferences
- Committee involvement
IT Integration and Security

Giovanni Elia, MD
Data Submission

Manual Entry

• Direct real-time data entry
• Data entry after discharge

Secure/Automated or Manual transfer

• Report → csv file
• sFTP server or PDARP.org upload
Data Transfer

Flowsheet

Note template

REPORT (specs)
REPORT
(s specs)

Automated/Manual

PDARP.ORG

Manual

sFTP Server
UCSF

PCQN DATABASE
Data Security Review

• “Wall of Shame” DHHS Office of Civil Rights
  – Breaches of ≥500 health records

• General Principles
  – Always log-off
  – Never tell anybody your password
  – Never open attachments or hyperlinks from unknown (or even known) sources
Data Security Review

• PASSWORD
  – Never same password across sites
  – More than 8 characters
  – At least ONE CAPITAL, 1 number & #@
  – Never words from vocabulary
  – Never info from public record (i.e. wife’s or child’s name or street where you live)
  – The more sensitive the data the more complex the password
Data Security Review

PASSPHRASE
Questions and Discussion