

Case Study

From Measurement to Management: A Case Study in Hospice QAPI

JoAnne Reifsnyder, PhD, APRN, BC-PCM

The Challenge of Measurement in Hospice Quality Assessment and Performance Improvement (QAPI)

Measurement of the quality of hospice care is challenging given the severity of illness of hospice patients; the rapid decline in their functional status and ability to report symptoms; the fact that they are receiving care in their homes, which generally means that a clinician is present only episodically to record symptoms or other outcomes of interest; and the fact that most hospices are relatively small, with correspondingly limited operating budgets. Lack of automation leads to laborious manual recording and aggregation of data for quality assurance purposes.

Capturing Self-report

It is well documented in the medical literature that symptom distress and quality of life (QOL) are entirely subjective experiences. Although clinicians frequently “measure” patients’ symptoms or elicit measures from caregivers, it is also well documented that proxy ratings rarely coincide with patient self-report. Therefore, patient self-report is considered the “gold standard” for symptom and QOL measurement. While many scales can be applied to symptom and QOL ratings, in recent years, patients have become accustomed to rating symptoms using a zero to 10 (0-10) numeric rating scale (NRS), where zero is conceptualized as the absence of the symptom or problem and 10

is the “worst” imaginable rating. Single-item subjective measures can be used effectively to monitor response to treatment, quality of life, and quality of care in the hospice setting.

Development of a QAPI Measurement Tool

As a large, national medication therapy management company specializing in palliative pharmacotherapy, we routinely collect patient symptom and quality-of-life outcome data as an integral component of our medication care planning process with hospice partners. In an effort to improve the reliability of data collected and develop patient and organizational level symptom/QOL reports that would be useful to our hospice partners, we developed and began a series of trials of an 8-item patient self-report instrument called PROM (Patient Reported Outcomes Measure). The 8 items are scaled on a 0-10 NRS, where zero is “none” or “best” and 10 is “worst.” The 6 symptom items are pain, nausea, dyspnea (short-

It is well documented that proxy ratings rarely coincide with patient self-report. Therefore, patient self-report is considered the “gold standard” for symptom and QOL measurement.

ness of breath), constipation, sleep, and emotional problems (eg, anxiety or depression). The 2 QOL items 1) the degree to which symptoms interfere with relationships with family and friends, and 2) global QOL.

Pilot Testing by Telephone

The instrument was pilot tested for feasibility and utility with a large hospice program in the mid-Atlantic United States. We were

fortunate to partner with an extraordinarily flexible and optimistic hospice champion within the partnering agency who had a sunny disposition and a “can do” attitude. We trained 2 pharmacy technicians within our organization to collect the self-report data via outbound telephone calls from our

Surprisingly, the patients told us details about their symptoms that they had not told their hospice caregivers. For reasons that are not entirely clear, patients will frequently reveal different clinical information to a “stranger.”

call center in Philadelphia. During training, we role-played various scenarios using a script, including what to do if we called and the patient had just died. For each patient call, the technicians log the data, patient/family comments, and their own impressions of the conversations into spreadsheets we designed for this purpose.

Very Sick Patients Take Part

What we found surprised us—a sure sign that we entered this project with an array of assumptions. The conventional wisdom is that hospice patients are too sick to take part in research projects and that such projects are simply too burdensome. Bottom line—hospice clinicians often believe that patients are neither able nor willing to do so. What we found was exactly the opposite. We approached 79 patients and their families to participate in the project. Of those, 77 consented (a 97% participation rate). Further, we found that while the patients were, in fact, very ill (all were cancer patients in this particular project), 50% of the patients could self-report. Surprisingly, the patients told us details about their symptoms that they had

not told their hospice caregivers. This finding has been replicated in subsequent trials in different hospice programs. For reasons that are not entirely clear, patients will frequently reveal additional or different clinical information to a “stranger.” The pharmacy technicians who participated as the data collectors rapidly developed a rapport with the patients and their families, not unlike hospice caregivers themselves. This phenomenon of telephone-elicited, “new” information needs further exploration.

An Opportunity to Manage

Data were collected daily for 3 days, and then every 3 days thereafter. Scores were logged and reported to the hospice program if they exceeded 6 (ie, “severe” range) or if there was a change of greater than 3 scale steps. In the second week of the project, we noted that dyspnea scores appeared to be higher than other symptom scores. We reported the variance to the hospice for the individual patients who were affected and monitored the trend. Eventually, it became apparent that there was an actual trend related to dyspnea. One of our team members then reviewed the medication profiles for several of the patients with high dyspnea scores and noted that the standard treatment for dyspnea in cancer patients was missing, and a less effective treatment was in place. The finding prompted an educational intervention with the hospice nurses and demonstrated the value of measuring outcomes at a population level. This finding was subtle, yet it was critically important, to those patients who were affected with dyspnea, and the practice pattern might have gone undetected indefinitely.

This project produced numerous insights, that have led to refinement of the tool, the methodology for collecting the data, and the reports. MPM

JoAnne Reifsnyder, PhD, APRN, BC-PCM is Senior Vice President of Research & Innovation at ex-celleRx, Inc., a division of Omnicare Inc., located in Philadelphia, PA.

Dr. Reifsnyder wishes to acknowledge the project team from Hospice Pharmacia: Terri Maxwell, PhD (c), APRN, BC-PCM; David Kupperman, PharmD; Missy Clardy, CphT; and Lawrence Pysher, CphT.