Project Option 2.10.1 Use of Palliative Care Programs: MS3 Integrating Palliative Care into Critical Care

Unique RHP Project Identification Number: 111810101.2.9
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.10 Use of Palliative Care Programs (Option 2.10.1)

The project will entail identifying patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization. Patients will be screened based on meeting one or more of the following criteria: severe life-threatening acute illness, progressive terminal illness, significant exacerbation of chronic debilitating illness, or declining quality of life and independent functioning in the past 6 months. In collaboration with the primary clinical team, these patients will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility. Patient/family experience surveys regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care will also be implemented.

UTHealth will recruit additional physicians trained in palliative care and other team staff to expand the existing palliative care program. The current partnership of UTHealth and Memorial Hermann Hospital-TMC has been a successful program, which is seeing increased demand and needs further expansion. Since the start of the program in 2004, over 1,000 patients have received palliative care related to cancer, heart failure, and various other illnesses, including infants in the NICU. In 2010, palliative care was provided to 84 cancer patients, 467 non-cancer patients, and 25 patients for whom the illness is unknown. In 2011, 203 patients with heart failure (DRGS 291,292, 293) received palliative care. (Data from the UTHealth Medical School, Geriatric & Palliative Medicine Division, Palliative Fact Sheet August 2012.) Finally, quality improvement processes will be put in place to assess project impacts and opportunities for continuous improvement.

Goal and Relationship to Regional Goals:

Patients receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

One of the goals of the region is "to develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction". The palliative care project when successfully implemented will make the health system bettr suited to attend to patients' needs at the end-of-life thereby invcreasing satisfaction

Challenges:

Need: 1) Education and information about the dying process and the various options for care. 2) Support and navigation in acting upon their preferences for care.

Implementation: 1) Staff recruitment and retention. 2) Willingness of patients, or their families, to embrace palliative care. The project will mitigate the challenges patientts and their families face due to lack of access to information to enable informed end-of-life decisions that are satisfactory. Gradually as the program gets establishe, the learning process will enable development of best practices in palliative care and increased likelihood of patients to embrace care options

5-Year Expected Outcome for Provider and Patients:

Increased uptake of palliative care services, greater involvement of patients and/or their families in end-of-life decisions, and increased satisfaction with end-of-life care.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

While end-of-life care was once associated almost exclusively with terminal cancer, today we are providing end-of-life care for a number of other conditions, such as congestive heart failure and infants and their families in the NICU. Our experience has shown that that palliative and hospice care could be more widely embraced for many dying patients. The goal of palliative medicine is to improve or maintain quality of life in patients with life-limiting or life-threatening diseases. Palliative medicine is a recognized medical subspecialty of both the American Board of Medical Specialties and American Osteopathic Association. Palliative medicine involves the control of symptoms associated with chronic disease such as nausea, pain and shortness of breath for example, as well as management of the symptoms that are part of the dying process. Along with symptom control, palliative medicine teams provide comfort, social and spiritual interventions for patients & their families. Palliative care, unlike hospice, is provided simultaneously with all other appropriate disease-directed treatments (Morrison RS, Meier DE. Clinical practice: palliative care. N Engl J Med. 2004;350(25): 2582-2590). Palliative medicine programs markedly reduce lengths of stay in hospitals on both wards and ICU settings. Data from the 2009 American Hospital Association Annual Survey showed that between 2000 and 2008, the number of hospitals with palliative medicine programs grew by 125.8% from 658 to 1486 (Center for the Advancement of Palliative Care. http://www.capc.org/news-and-events/releases/04-05-10 accessed April 15, 2010). U.S. News and World Report has included palliative medicine as a criterion in its rankings of America's Best Hospitals since 2003 (Center for the Advancement of Palliative Care. http://www.capc.org/support-from-capc/capc_publications/JCAHO-crosswalk-new.pdf accessed January 21, 2008). In 2007, the National Quality Forum released a national framework and preferred practices for quality palliative and hospice care and in 2008 identified palliative care as one of seven priorities for rapid action (National Quality Forum. http://www.qualityforum.org/Projects/n-r/Palliative_and_Hospice_CareFramework/Palliative_Hospice_Care_Framework_and _Practices.aspx accessed April 15, 2010).

In addition to providing improved care and comfort for dying patients and their families, palliative care programs have been shown to provide considerable cost savings. According to a study of 5,354 subjects conducted by Morrison, et al. (Archives of Internal Medicine, 2008), palliative care teams saved $1,696 in direct costs per admission (P = .004) for patients discharged alive and $4,908 in direct costs per admission (P=.003) for patients who died. For a 400-bed hospital seeing 500 patients a year, this translates into a net savings of $1.3 million per year after adding physician revenues and subtracting personnel costs (Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with United States hospital palliative care consultation programs. Arch Intern Med. 2008;168(16): 1783-1790). The palliative medicine service provided by UTHealth at Memorial Hermann Hospital-TMC has seen consistent growth in consult numbers since the program's inception in 2004. For the 532 patients receiving care in 2008, we saw a median per person per day savings of $5,292 after the palliative care consult (with a reduction in the average length of stay from 9.5 to 2.3 days) and for the 698 patients receiving palliative care consults in 2009, we realized a median per person per day savings of $4,727 (with a reduction in the average length of stay from 8.5 to 2.5 days). (Data from white paper: CBDyer, MD, GVaras, DO, N Walter. Palliative Medicine: A Critical Component of Modern Health Care. April, 2010.)

Project Components:

Through the Integrating Palliative Care into Critical Care Program, we propose to meet all required project components listed below.

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program

b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility

c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time

d) Conduct quality improvement for project using methods such as rapid cycle improvement.

Milestones and Metrics:

For the Integrating Palliative Care into Critical Care Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1.]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
Metric 1 [P-1.1.]: Business case
Milestone 2 [P-5.]: Implement a palliative care program
Metric 1 [P-5.1.]: Implement comprehensive palliative care program

Improvement Milestones and Metrics:

Milestone 3 [P-6.]: Increase the number of palliative care consults
Metric 1 [P-6.1.]: Palliative care consults meet targets established by the program
Milestone 4 [I-11.]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care
Metric 1 [I-11.1.]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.
Milestone 5 [I-12.]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
Metric 1 [I-12.1.]: Survey developed and implemented; scores increased over time
Milestone 6 [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services.
Metric 1 [I-9.1.]: Transitions accomplished

Unique community need identification numbers the project addresses:

This project addresses community needs CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs) and CN.23 (Lack of patient navigation, patient and family education and information programs).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

This project represents an expansion of a currently existing program. This project proposes to expand palliative care services to patients beyond cancer, congestive heart failure, and infants and their families in the NICU, to any patients and their families admitted to any adult ICU.

Related Category 3 Outcome Measure(s):

OD-13 Palliative Care
IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

OD-13 Palliative Care
IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)
Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.
Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

OD-13 Palliative Care
IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st
Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns
or documentation that the patient/family did not want to discuss during the reporting period.

Relationship to other Projects:

1.9 (C4) - The disease management registry will serve as a useful resource to every provider, including palliative care providers, involved in caring for the enrolled patients.
2.11 (C10) - The medication management program will serve as a useful resource to palliative care providers, as they work to help the patient and their family achieve their care goals.

Relationship to Other Performing Providers' Projects in the RHP:

To be described by RHP Anchor.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be rated on a 10-point scale each project. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds available for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of available funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with a couple of exceptions. First, we did not use two of the criteria and second, we began with a 5-point scale for each criteria rated, then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 2 X 2 = **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. If a significant proportion of the target population is uninsured/Medicaid, add 1 additional point.

   This project's score for this criteria: 1 X 2 = **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

   This project's score for this criteria: 1 X 2 = **2**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

   This project's score for this criteria: 5 X 2 = **10**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth plans to partner with Harris Health to perform many similar projects, so the rating would have been the same for all

projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another, so giving the projects the same, or very similar ratings on this criteria would have again had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3.1**

111810101.2.9	***OPTION 2.10.1***		***MS3 INTEGRATING PALLIATIVE CARE INTO CRITICAL CARE***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.20* *111810101.3.21* *111810101.3.22*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment (NQF-1637) (Non-standalone measure)* *Treatment Preferences (NQF 1641) (Non-standalone measure)* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1.]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program Metric 1 [P-1.1.]: Business case Baseline/Goal: TBD Data Source: Business case write-up; documentation of planning activities Milestone 1 Estimated incentive payment: $ 1,460,146	Milestone 2 [P-5.]: Implement a palliative care program Metric 1 [P-5.1.]: Implement comprehensive palliative care program Baseline/Goal: TBD Data Source: Palliative care program Milestone 2 Estimated incentive payment: $ 1,603,421	Milestone 3 [P-6.]: Increase the number of palliative care consults Metric 1 [P-6.1.]: Palliative care consults meet targets established by the program Goal: TBD Data Source: EHR, palliative care database Milestone 3 Estimated incentive payment: $ 857,643 Milestone 4 [I-11.]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care Metric 1 [I-11.1.]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation/ palliative care	Milestone 5 [I-12.]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time Metric 1 [I-12.1.]: Survey developed and implemented; scores increased over time Goal: TBD Data Source: Patient/family experience survey Milestone 5 Estimated incentive payment: $ 828,641 Milestone 6 [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services.

111810101.2.9	***OPTION 2.10.1***		***MS3 INTEGRATING PALLIATIVE CARE INTO CRITICAL CARE***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.20* *111810101.3.21* *111810101.3.22*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment (NQF-1637) (Non-standalone measure)* *Treatment Preferences (NQF 1641) (Non-standalone measure)* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		initial encounter. Goal: TBD Data Source: EHR, palliative care database Milestone 4 Estimated incentive payment: $ 857,644	Metric 1 [I-9.1.]: Transitions accomplished Goal: TBD Data Source: EHR, data warehouse, palliative care database Milestone 6 Estimated incentive payment: $ 828,641
Year 2 Estimated Milestone Bundle Amount: $1,460,146	Year 3 Estimated Milestone Bundle Amount: $1,603,421	Year 4 Estimated Milestone Bundle Amount: $1,715,287	Year 5 Estimated Milestone Bundle Amount: $1,657,282
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $6,436,136			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.20

Outcome Measure Description:

IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

Process Milestones:

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:
IT-13.1 Increase by 3% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.
DY5:
IT-13.1 Increase by 5% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

Rationale:

Reasearch shows that the prevalence of pain among patients with incurable illness and at the end of life is as high as 40 – 70% (Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med. 2008;11(2):180–190), and pain is under-recognized by clinicians and undertreated, resulting in excess suffering among these patients. Pain screening and assessments will thus be a good measure of the quality of palliative care services provided to patients.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.20	*3.IT-13.1*	*Pain assessment (NQF-1637) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.9*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 25,617	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 29,693 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 29,693	Outcome Improvement Target 1 [IT-13.1]: Increase by 3% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 63,530	Outcome Improvement Target 2 [IT-13.1]: Increase by 5% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 138,106
Year 2 Estimated Outcome Amount: $ 25,617	Year 3 Estimated Outcome Amount: $ 59,386	Year 4 Estimated Outcome Amount: $ 63,530	Year 5 Estimated Outcome Amount: $ 138,106
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 286,639			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.21

Outcome Measure Description:

IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)
Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.
Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

Process Milestones:

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:
Increase by 3% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.
Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.
DY5:
Increase by 5% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.
Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

Rationale:

In the absence of a clear guideline for end-of-life care, care decisions are often taken by the physician/care team and this tends to be in favor of life sustaining treatments. As a result of these aggressive treatments, lots of expensive interventions are given to patients in the last few months of life with poor and questionable outcomes. Site of death accounts for significant variation in end-of-life costs; for example costs for Medicare beneficiaries who died in a hospital inpatient setting have been found to be twice those for beneficiaries who died in other settings such as their homes (Carol Raphael, Joann Ahrens, & Nicole Fowler. Financing end-of-life care in the USA. J R Soc Med. 2001 September; 94(9): 458–461). Palliative care aims to address these imbalances and it is necessary to measure the success of the project by assessing how much patient preferences are being respected.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.21	*3.IT-13.2*	*Treatment Preferences (NQF 1641) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.9*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 25,617	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 29,693 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 29,693	Outcome Improvement Target 1 [IT-13.2]: Increase by 3% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 63,530	Outcome Improvement Target 2 [IT-13.2]: Increase by 5% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 138,106
Year 2 Estimated Outcome Amount: $ 25,617	Year 3 Estimated Outcome Amount: $ 59,386	Year 4 Estimated Outcome Amount: $ 63,530	Year 5 Estimated Outcome Amount: $ 138,106
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 286,639			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.22

Outcome Measure Description:

IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st
Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns
or documentation that the patient/family did not want to discuss during the reporting period.

Process Milestones:

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:
Increase by 3% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns
or documentation that the patient/family did not want to discuss during the reporting period.
DY5:
Increase by 5% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns
or documentation that the patient/family did not want to discuss during the reporting period.

Rationale:

A comprehensive interdisciplinary approach is one of the hallmarks of pallaitive care, and this entails caring for the physical, psychosocial, and spiritual needs of patients and their families. An essential step to providing for the needs of patients is initiating discussions about their spiritual concerns. This measure will thus be an important indicator of the quality of palliative care provided throught this project.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.22	*3.IT-13.5*	*Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.9*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 25,617	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 29,693 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 29,693	Outcome Improvement Target 1 [IT-13.5]: Increase by 3% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 63,530	Outcome Improvement Target 2 [IT-13.5]: Increase by 5% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 138,106
Year 2 Estimated Outcome Amount: $ 25,617	Year 3 Estimated Outcome Amount: $ 59,386	Year 4 Estimated Outcome Amount: $ 63,530	Year 5 Estimated Outcome Amount: $ 138,106
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 286,639			