HealthCatalyst
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# Quality Improvement in Healthcare: An ACO Palliative Care Case Study

OSF HEALTHCARE

## HEALTHCARE ORGANIZATION

Accountable Care Organization

## TOP RESULTS

- Developed and deployed a community-wide palliative care program
- Completed advance care planning with more than 16,000 patients
- Engaged more than 980 physicians and community facilitators
- Leveraged their EDW platform in a heterogeneous EHR environment

## PRODUCTS

- Late-Binding™ Data Warehouse Platform
- Instant Data Entry Application (IDEA)

## SERVICES

- Installation Services

Quality improvement is essential for healthcare organizations as they transition to value-based care. Including palliative care in the planning and implementation of value-based care initiatives is more important than ever—especially for accountable care organizations (ACOs). Ensuring better health, better care and lowering healthcare costs across a community requires understanding and translating patients' values into their medical decisions.

A recent study conducted by the Institute of Medicine (IOM) sheds light on the quality and cost of end-of-life care. The study highlights the fact that increased spending is not associated with higher-quality care, as measured by longevity, quality of life and patient satisfaction. In addition, the study shows that the cost of caring for individuals in their last year of life represents 13 percent of total annual health care spending. High-cost hospital-based treatment is often inconsistent with patient preferences and may contribute to patient suffering.

OSF HealthCare—one of the first Pioneer ACOs—has a strong history of supporting end-of-life and palliative care. In fact, OSF received the new 2014 Tim Philipp Award for Excellence in Palliative and End-of-Life Care, an IHA Quality Excellence Achievement Award for outstanding quality improvement in healthcare initiatives in hospitals and health systems in Illinois.

A key component of this Catholic health organization's faith-based mission and palliative care program is to assist patients with advance care planning. OSF had spent almost a decade developing supportive care programs, but as a Pioneer ACO, they knew the need for advance care planning extended beyond the patients within their healthcare system. This ACO launched a community-wide supportive care initiative—enabled by technology—that has successfully spread advance care planning throughout their population.

> I didn't expect to need palliative care so soon. But this summer I underwent cancer surgery. It was a huge relief to know my advance care planning was already done—and that my desires were understood by my family members. I've told everyone about the palliative care services OSF provides and how grateful I am for them.
>
> Oncology patient

## THE IMPORTANCE OF A PATIENT-CENTERED PALLIATIVE CARE EXPERIENCE

For OSF, advance care planning involves much more than producing a documented plan. Rather, it involves understanding the patient's value system and aligning his or her healthcare goals with these values. The service is available for free to all community members—including OSF patients, OSF employees and OSF employee family members—and involves a trained facilitator leading the patient through a series of questions to help discern personal values, beliefs and preferences for care at the end of life or in the event the patient is no longer able to speak for him or herself. It helps not only the patient but also the patient's medical power of attorney understand what decisions the patient would want in a variety of circumstances.

Studies show that the vast majority of people at the end of their life are not able to express their wishes, nor are they able to give consent. Hence, it is wise for a person to engage in advance care planning, as the name implies, in advance of a crisis. According to Robert Sawicki, MD, Senior Vice President of Supportive Care, OSF Healthcare System, "It is widely understood that making advance healthcare plans for a future medical scenario, when a person cannot make decisions for themselves, is a critical step toward ensuring the patient gets the medical care they would want."

Not only does going through the process of documenting an advance care plan prevent unwanted care; it can also be empowering for a patient. When patients know their care goals are documented—and they have shared their desires with their physicians and their family—they are more confident the care they receive will be aligned with their wishes.

However, advance care planning is not top of mind for many, especially those who are in good health or who do not feel that death is near. As a result, it is all too common for an advance care planning discussion to take place when a patient is already in crisis.

## THE CHALLENGE: IMPLEMENTING COMMUNITY-WIDE ADVANCE CARE PLANNING

OSF's supportive care team—which spearheaded the initiative—wanted to maximize the number of patients who had completed advance care planning. This meant that more advance care planning discussions and documentation of those discussions needed to occur. To achieve this goal, the team knew they need to engage physicians, nurses, care providers, facilitators, employees and patients. Most importantly, this effort needed to span the entire community covered by the ACO, not just OSF facilities.

> Ongoing studies show that just having a legal document in place has ZERO impact on healthcare. For advance care planning to be effective, it is critical to have not only the legal document but also documentation about the patient's goals and value system and how those translate to medical decision-making.
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> Dr. Robert Sawicki
> Senior Vice President of
> Supportive Care, OSF HealthCare

An audience that OSF particularly needed to target was ambulatory care providers. Because care delivery is evolving into a continuum-of-care model, these providers—who already have many demands on their schedule—would be one of the linchpins in ensuring that advance care planning took place. OSF knew they would have to provide the training and tools to engage these providers and help them be successful.

Although OSF offers free advance care planning to all of its patients, the organization felt the process was particularly important for high-risk patients. As a Pioneer ACO, OSF had data from the Centers for Medicare and Medicaid Services, which contained information necessary to help identify the high-risk patients. They also had other payer claims data. In order to identify high-risk patients and focus their palliative care initiative, they needed to aggregate and analyze this data.

OSF also needed an effective method for documenting both advance care planning discussions and the advance care plans themselves. They needed a solution that:

- Could be implemented quickly—in days rather than weeks or months. This requirement eliminated their electronic health record (EHR) as a possible solution.
- Was compatible with the community's heterogeneous EHR environment. Since providers throughout the ACO community use disparate EHRs, OSF couldn't rely on its own EHR as the solution.
- Was easy for facilitators to access and enter data with minimal training.
- Consisted of one common database to enable community-wide, customized reporting.
- Could integrate the advance care planning information into OSF EHR patient records.

## THE SOLUTION: AN ENTERPRISE DATA WAREHOUSE PLATFORM AND COMMUNITY ENGAGEMENT

To drive quality improvement and to resolve these challenges, OSF's supportive care team adopted a two-pronged approach. This approach involved establishing both the technological infrastructure and the community engagement programs in place to implement a successful advance care planning initiative.

> Patients who have completed advance care planning are comforted knowing their decisions are known by their family and physicians. We've also found that patients who complete advance care planning spend less on their end-of-life care because the care they receive is only the care they want. Most importantly, the advance care planning conversation helps us as caregivers meet not just the patient's medical needs, but their spiritual and emotional needs as well.
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> Dr. Robert Sawicki
> Senior Vice President of
> Supportive Care, OSF HealthCare

## Technology-enabled solution to drive community engagement

OSF had already implemented a healthcare enterprise data warehouse (EDW) from Health Catalyst® to drive performance improvement initiatives. This EDW aggregates clinical, claims, financial and other data to create a consistent view of the ACO's data—a single source of truth to inform decisions. On top of the EDW, OSF implemented Health Catalyst's Instant Data Entry Application (IDEA). Together the EDW and IDEA enabled data aggregation, risk stratification, documentation and reporting across the ACO's heterogeneous EHR environment.

## Engaged and educated community resources

The supportive care team placed considerable focus on training physicians, nurses, care providers, facilitators and other employees to talk with patients about advance care planning. They delivered education on how to understand the patients' values, how to translate those values into medical decision-making and how to document stated preferences for care.

A particularly important target for the team was care managers. A care management program had previously been established in OSF ambulatory practices. Since this group of care managers was already reaching out to high-risk patients, the team leveraged that opportunity and encouraged them to conduct advance care planning discussions with those patients.

In addition to education, OSF adopted several strategies to encourage care teams to meet advance care planning targets. One such strategy was healthy competition. Monthly leadership reports generated from the EDW clearly indicated how different entities (such as hospitals and clinics) were performing against each other and against targets.

The supportive care team also worked diligently to sign up OSF employees for advance care planning. The reasoning behind this strategy was straightforward. Not only did the team believe that advance care planning is important for everyone, but they also viewed OSF employees as important advocates of the process. If a patient were to ask a care provider whether they had completed advance care planning, the team wanted the answer to be "yes" as often as possible to give the concept more validity.

Finally, OSF hosted community events. In one region, where OSF is the smallest of three hospital systems, OSF facilitators engaged physicians and nurses from two other systems to jointly lead an awareness effort that involved co-sponsoring the screening of a film called "Considering the Conversation" to the public. Producers of

> Because so many stakeholders were involved, our greatest achievement has been spreading the vision of advance care planning across the community and establishing an accountability structure. And technology played a critical role in helping us engage these stakeholders effectively. The EDW allowed us to bring all the data together and then distribute information to drive adoption of our targeted best practice.
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> Roopa Foulger, Executive Director Data Delivery, OSF HealthCare

the film, along with the CEOs from each of the three hospitals, were united on one stage. The event was very well attended, and advance care planning rates increased across the community as a result.

## RESULTS

### Developed and deployed a community-wide palliative care program—completing advance care planning with more than 16,000 patients and engaging more than 980 physicians and community facilitators

OSF's initiative has been embraced by the entire community, including the OSF healthcare system and other systems and providers. In fact, OSF exceeded its targets. Here are highlights of the team's achievements:

- They established a target of completing advance care planning with 1,200 high-risk patients within the year. In just nine months, they completed the process for 1,243 patients.
- Previously, OSF had a total of 1,952 high-risk patients who had completed advance care planning. They have increased this figure now by 64 percent.
- For patients who were not high risk, the team documented over 4,300 (annualized) advance care plans in 2014, bringing the total number of patients completing advance care plans to 16,000.
- To date, 980 physicians and community facilitators have been trained to help guide patients through the process and document their advance care plan.

### Leveraged their EDW platform in a heterogeneous EHR environment

The EDW enabled multiple sources of claims data to be aggregated. Then, using this rich, community-wide view of data, OSF was able to stratify its patients to target those at high risk.

In addition, all community resources were trained on and given access to Health Catalyst's easy-to-use IDEA application, which enabled them to document advance care planning and to access patient information. Users are able to collect such information as type of visit, region, advance care planning completion date and facilitator name. The EDW platform also captures information about when facilitators reached out to the patient to talk about advance care planning, ensuring patients don't receive multiple outreach calls.

> We work with excellent care managers. But getting these care managers to add advance care planning to conversations they were already having with high-risk patients wasn't as easy as it might sound. The fact is that, in the transition to value-based care, these care managers are being asked to do so many new things, and adding one more request can be overwhelming. Helping them embrace this new practice and understand its importance was a matter of continuing change management, education and encouragement.
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> Linda Fehr, RN, Division Director of Supportive Care, OSF HealthCare

For patients within the OSF healthcare system, the EDW integrates advance care planning information directly into the patient's clinical record in the EHR. The EDW updates the advance care planning data in near real-time, requiring no manual effort to transcribe information from paper to the EHR or other systems. This automation improves data integrity.

### Data exposure at all levels: Reporting and visualizations

The solution automatically generates customized reports and delivers them to facilitators, medical group offices, CEOs and other executives. Reports include the following:

- Medical group staff receive a report on a daily basis showing them who the high-risk patients are so that facilitators can reach out to them. They also can see how many patients in each location have completed advance care plans to date.
- The supportive care team receives a weekly report of patients who have completed advance care planning.
- On a monthly basis, the executive leadership team receives a dashboard report to show trends and progress against the target.

## WHAT'S NEXT

OSF is continuing to expand the initiative throughout the community by on-going engagement with physicians, care providers, facilitators, patients and families—including employees and their family members. As the initiative progresses, OSF plans to measure how well the care that was delivered to a patient aligned with that patient's stated goals. They also plan to perform further analyses; for example:

- Correlating how well the patients' care goals were met and the timing of the advance care planning discussion. So far, OSF's experience has shown that the sooner patients have the discussion, the more likely the patients' goals will be met and the more likely effective, high-quality care will be delivered.
- Comparing readmissions rates for patients with advance care planning versus those without. The team hypothesizes that readmissions will be lower because patients generally specify the desire to be cared for in the comfort of their home.
- The number of hospice referrals for patients with advance care plans. Hospice is associated with higher-quality, effective care and high levels of family member satisfaction.

## ABOUT HEALTH CATALYST

Health Catalyst is a mission-driven data warehousing and analytics company that helps healthcare organizations of all sizes perform the clinical, financial, and operational reporting and analysis needed for population health and accountable care. Our proven enterprise data warehouse (EDW) and analytics platform helps improve quality, add efficiency and lower costs in support of more than 30 million patients for organizations ranging from the largest US health system to forward-thinking physician practices. Faster and more agile than data warehouses from other industries, the Health Catalyst Late-Binding™ EDW has been heralded by KLAS as a "newer and more effective way to approach EDW."

For more information, visit, www.healthcatalyst.com, and follow us on Twitter, LinkedIn, and Facebook.