Marking a New Era for Quality End-of-Life Care: NHPCO's Quality Partners Initiative

At September’s Management and Leadership Conference in New York City, NHPCO will unveil its new national quality initiative, “Quality Partners.” Two years in the making, this campaign encompasses 10 key components of quality that our provider members will be asked to affirm. In this new monthly column, we aim to familiarize our members with the initiative as well as explain its key concepts and put them in a helpful context for hospice and palliative care professionals. We will try to anticipate and answer your questions about the initiative and the implications it holds for all hospices — starting with the most basic and obvious question.

What Do We Mean By Quality?

The actual quality of the care given by America’s hospice and palliative care providers was a major theme and focus of NHPCO’s recent Clinical Team Conference, held April 25-28 in San Diego, CA. In her plenary address, NHPCO board member Dr. Diane Meier, director of the Center to Advance Palliative Care at Mount Sinai School of Medicine in New York City, reviewed the major national initiatives now promoting quality in this area, including the National Quality Forum and NHPCO’s spectrum of quality tools and measures. She also summarized evidence for how our industry is doing overall on six primary domains of quality health care identified by the Institute of Medicine in 2001.1

Other conference sessions addressed the state of end-of-life quality measurement and looming requirements contained in Medicare’s new Conditions of Participation for hospices. In addition, NHPCO members attending MLC can expect to hear a lot more about this initiative, which is a cornerstone of the organization’s current strategic plan.

Some readers of this newsletter may wonder what all the fuss is about. Others may wonder how these national quality initiatives relate to individual hospice and palliative care professionals and their natural impulse to do the best they can in caring every day for vulnerable, seriously ill patients and their families. It is the challenge of NHPCO’s board, staff and leadership to make that connection clear — and more than that, to get hospice and palliative care professionals excited about using the tools and frameworks developed under the new quality initiative to continually improve the care they provide at the patient’s bedside.

Dr. Meier, in her plenary address, acknowledged the challenge of defining quality, beyond the most basic level of “I know it when I see it.” If patients and families are to rely upon consistent, reliable high-quality care from their hospice and palliative

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care providers, there has to be a way to clearly define quality, assess it, measure it, compare it and improve it, she explained. Providers need a way to quantify quality. That requires measures that are simple, inexpensive, easy to use, and connected to actual quality of care — not just paper exercises to satisfy external regulators.

What, then, is quality? It can be understood as desired health outcomes, as defined by the recipients of health care. Obviously, we know quality when we see it, even if we don’t always agree on its hallmarks. Hospice professionals receive verbal expressions of gratitude while standing at the grocery checkout line and thank-you letters from bereaved families to indicate that they provided a valued service. But is that enough? Most quality experts say no — because it does not document actual outcomes of service or offer a basis for comparison between providers.

The thing that’s missing in this rule-of-thumb view of quality is consistency — providing the same high level of care to every patient and family, says NHPCO president Donald Schumacher. “Quality is a buzz word in healthcare today — but how do people mean it? Not just clinical care, but in terms of all aspects such as the quality of your business ethics, compliance with laws and regulations, and how you treat your own staff and volunteers,” he says.

“Some hospice people don’t yet understand that payment eventually will be attached to quality measurement. That will be a tremendous motivator, beyond the desire to satisfy yourself and prove to yourself that your contributions to the lives of patients and families are the best they can be and continually getting better,” Schumacher explains. “The real excitement of a commitment to quality is in your relationship with your patients and families and your community. Demonstrating your commitment to quality will also go a long way toward lifting employee morale and job satisfaction.”

**Finally Understanding Quality**

Evidence for these high hopes comes from Susan Fuglie, CEO of Hospice of the Red River Valley, a well-regarded rural hospice based in Fargo, ND, and a member of NHPCO’s Quality Advisory Council. “Our agency had just been doing the minimum required for accreditation and certification,” Fuglie reports. “We never changed anything we did based on what we monitored for quality improvement. Our staff understood QA and QI as necessary evils for compliance but not anything meaningful or relevant to their jobs. We didn’t know what quality really was, and we didn’t know that we didn’t know.”

A discussion with the agency’s board of directors about future Medicare quality requirements for hospices led to an offer by board member Linda O’Halloran to teach the agency about how quality is understood in the rest of the healthcare system. “Linda came and taught our Quality Committee, spending hours showing them how to peel back the layers and dig into what the quality data can tell us and what to do with them. She helped
us implement our first true quality initiative, based on what we all agreed was an area in need of improvement,” Fuglie says.

“Suddenly, there was a huge, collective ‘aha’ in the organization. Quality isn’t just a nuisance but an opportunity for improvement — and everyone can benefit from improved outcomes. That may seem terribly obvious, but when your hands are full with all of the other things you have to do in this job, it can get overlooked. What we discovered is that this is a remarkable opportunity, not just to improve the quality of care for our patients, but to improve the lives of our clinicians.”

The topic for the first quality improvement cycle was how to meet the needs of patients and families for home health aide services when there aren’t enough aide hours to go around. The Quality Committee, under O’Halloran’s tutelage, met to review the problem. “Staff had been frustrated with this issue for years. As we started peeling back the layers, we ran into glitches in our policy and practices right from the start. As people began to identify the barriers, they saw that the problems were fixable,” Fuglie relates.

“I’ve never seen our staff so enthusiastic. They are starting to see that things are going to work, and that’s where the real buy-in comes. They already have a long list of things that need improving.”

— Larry Beresford

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