Special Article

The Quality Imperative for Palliative Care

Arif H. Kamal, MD, Laura C. Hanson, MD, David J. Casarett, MD,
Sydney M. Dy, MD, Steven Z. Pantilat, MD, Dale Lupu, PhD, and
Amy P. Abernethy, MD, PhD

Duke Cancer Institute (A.H.K., A.P.A.), Duke University Medical Center; Center for Learning Health Care (A.H.K., A.P.A.), Duke Clinical Research Institute, Durham, North Carolina; Division of Geriatric Medicine (L.C.H.), University of North Carolina, Chapel Hill, North Carolina; Department of Medicine (D.J.C.), University of Pennsylvania Perelman School of Medicine, Philadelphia, Pennsylvania; Department of Health Policy and Management (S.M.D.), Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; Palliative Care Program (S.Z.P.), Division of Hospital Medicine, University of California, San Francisco, California; and Center for Aging, Health and Humanities (D.L.), George Washington University, Washington, DC, USA

Abstract

Palliative medicine must prioritize the routine assessment of the quality of clinical care we provide. This includes regular assessment, analysis, and reporting of data on quality. Assessment of quality informs opportunities for improvement and demonstrates to our peers and ourselves the value of our efforts. In fact, continuous messaging of the value of palliative care services is needed to sustain our discipline; this requires regularly evaluating the quality of our care. As the reimbursement mechanisms for health care in the U.S. shift from fee-for-service to fee-for-value models, palliative care will be expected to report robust data on quality of care. We must move beyond demonstrating to our constituents (including patients and referrers), "here is what we do," and increase the focus on "this is how well we do it" and "let us see how we can do it better." It is incumbent on palliative care professionals to lead these efforts. This involves developing standardized methods to collect data without adding additional burden, comparing and sharing our experiences to promote discipline-wide quality assessment and improvement initiatives, and demonstrating our intentions for quality improvement on the clinical frontline. J Pain Symptom Manage 2015;49:243–253. *© 2015 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Quality, palliative care

Introduction

The specialty of palliative care has undergone remarkable growth over the past decade.[1] The reasons for this growth are many, most notably, the simultaneous uptake of palliative philosophy into mainstream medical care coupled with the demonstration of the value in improving patients and health systems outcomes.[2,3] There has been a conscious, discipline-wide effort to develop

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Address correspondence to: Arif H. Kamal, MD, Duke Cancer Institute, Duke University Medical Center and Center for Learning Health Care, Box 3436, Durham, NC 27710, USA. E-mail: arif.kamal@duke.edu

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and communicate a growing evidence base, ultimately conveying a compelling data-driven story that argues for the need for palliative care, characteristics of best practice, and demonstrated benefit.[4]

Just as there is the need to develop and disseminate research-informed evidence on best palliative care, there is the need to ensure that the care provided at the clinical frontline aligns with expectations of best practice. This alignment meets the expectations on the horizon, demanding dramatic shifts in the way care is delivered, evaluated, and reimbursed across all medical disciplines. Similarly to other fields, palliative care across all aspects of the serious illness trajectory must be prepared to meet an evolving imperative for quality assessment, reporting, and monitoring. This requires greater participation by all members of the palliative care community in demonstrating high-quality care that respects the art and science of our practice. Herein, we review several critical areas related to quality in palliative care to understand where we are, outline the roadmap for where we need to go, and explore some approaches for getting there.

Improving the Quality of Care Is Intrinsic to Palliative Care

Routine quality assessment as a method to improve patient-centered care is an intrinsic component of the spirit of palliative care. Ensuring that all palliative care patients receive excellent care has been a priority for the hospice and palliative care movement since its early years. When reflecting on the varying quality of care for seriously ill and dying British patients in the 1970s, Dame Cicely Saunders was quoted as saying to a colleague, “We can only send our patients to (a named institution) when they are becoming unconscious and we can reassure the families that they will not realize where they are going.”[5] Even during the formative years of the palliative care movement, Dame Saunders identified differences across institutions in quality of care provided. Parallel to the establishment of a clinical service came the recognition that not all services would be equal; quality would have to be monitored. Dame Saunders first identified this issue in hospice care; naturally, this attention extends to all other palliative care service models as well.

Sadly, poor processes of end-of-life care also have touched those who have been influential in the field of quality improvement in health care. Avedis Donabedian, who most people identify as the father of the modern health care quality movement, lamented on his own personal experience with end-of-life care in an interview with Fitzhugh Mullan.[6] Dying of advanced prostate cancer, Dr. Donabedian noted several instances of lack of care coordination, delays and inefficiencies in care delivery, and a certain detachment between his care providers and understanding his personal story. He also remarked about the seemingly poor understanding of suffering in those with serious illness, and the continued misperceptions regarding the role of opioids, double effect, and providing comfort without hastening death. His experience was representative of standard practice at the time and led many health care quality experts to conclude that the quality of palliative care in the U.S. must continue to evolve.

The Evolving Landscape of Quality and Value Within Health Care Reform

The way health care is delivered, evaluated, and reimbursed is rapidly changing. In the face of shrinking reimbursement and financially unsustainable practices, new models for evaluating value of care and matching that value to reimbursement are being developed. These have a common theme: transitioning from reimbursement systems that are highly dependent on fee-for-service and undefined accountability, to value-based purchasing and accountable care organizations that stress physician and medical group responsibility for quality of care and outcomes.

Emerging quality and performance metrics for palliative and supportive care herald evolving expectations for routine collection of quality monitoring data (e.g., the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care,[7] National Quality Forum,[8] Center for Medicare and Medicaid Services [CMS] Conditions of Participation for hospice organizations, and