Today's Agenda

Now – 1:15pm	**Showcase Panel - State-of-the-Art Methods for Electronic Clinical Quality Measures for Palliative Care**
1:25pm – 2:15pm	**Learning from PCQC's Clinical Quality Data in Telehealth**
2:15pm - 2:30pm	**Break**
2:30pm - 3:20pm	**Clinician Wellness and Palliative Care**
3:25pm - 4:15pm	**Quality and Research: Better Together**
4:15pm - 4:30pm	**Conference Closing**

QMC Quality Matters Conference
December 14-15, 2023

PCQC

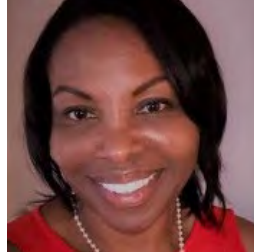# THANK YOU TO OUR SPONSORS!

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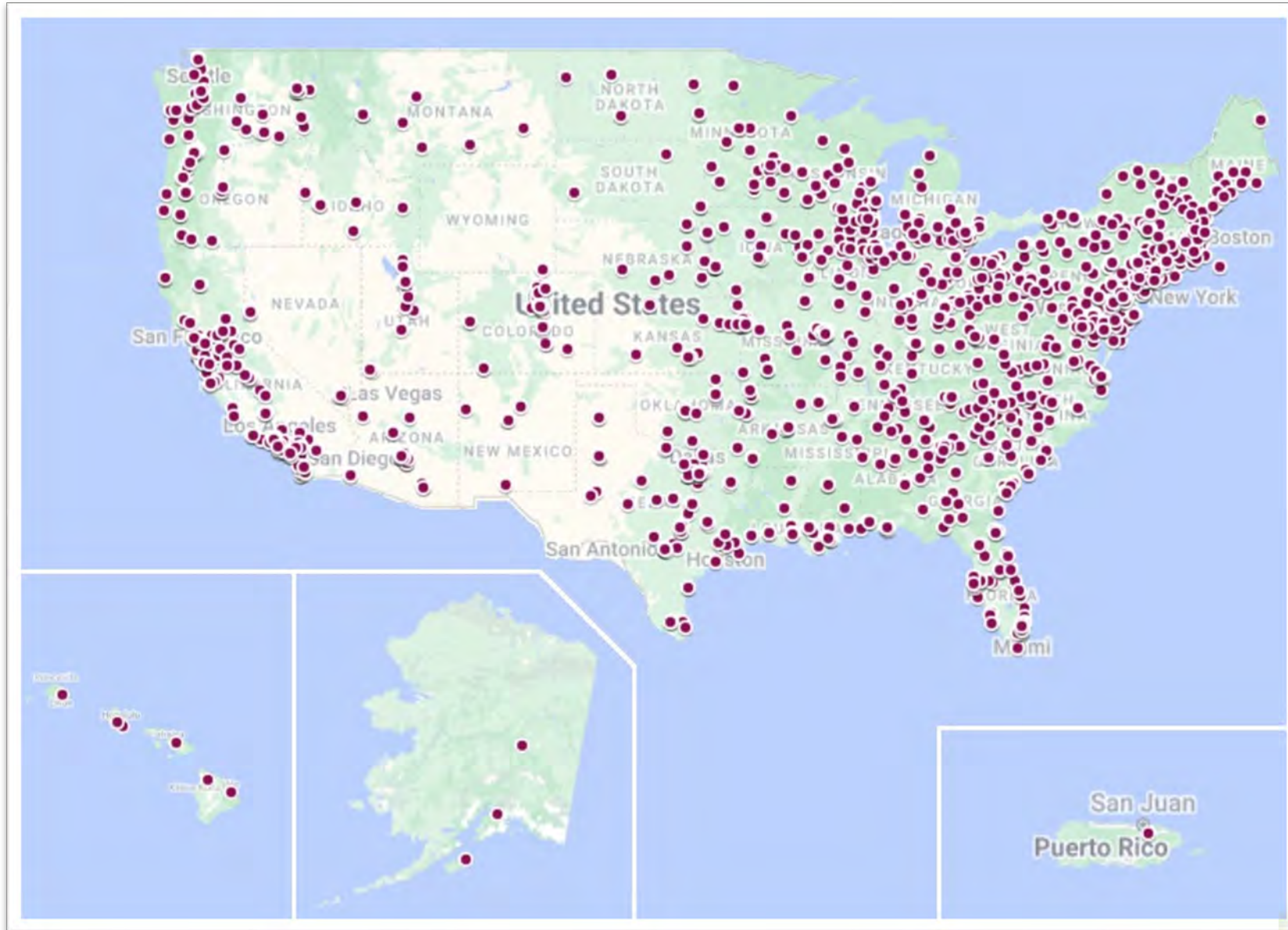Director

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Thank You PCQC Members!

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LinkedIn X **#QMC2023**

Sessions will last 50-60 minutes with 5-10 minutes for Q&A .

Participants are muted and cannot use cameras.

Ask your questions in the Q&A Box.

Share your thoughts in the chat throughout the presentation and conversation.

We are recording the conference. You will be notified when the recordings are available.

Eligible for up to 7.5 hours of continuing education.

QMC Quality Matters Conference
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State of the Art Methods for Electronic Quality Metrics for Palliative Care

Panelist
Charlotta Lindvall, MD, PhD
Anne Walling, MD, PhD
Prasanna Ananth, MD, MPH

Moderator
Angelo Volandes, MD, MPH

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Disclosure

Declare any relevant financial relationship(s) with ineligible companies:

With disclosures:

- Angelo Volandes, moderator for this educational event, is Co-Founder of ACP Decisions Nonprofit Foundation.

- All of the relevant financial relationships listed for these individuals have been mitigated.

Learning Outcomes

Upon Completing this session, participants will be able to:

1. Understand approaches to reliably and accurately identify a population of interest (i.e., denominator) for palliative care quality measurement from the EHR

2. Understand when NLP may be an important tool for palliative care quality measurement

3. Understand steps needed to apply methods within a health system

Overview

Brief presentations

- Introduce electronic quality measures
- Discuss novel methods in natural language processing
- Practical example
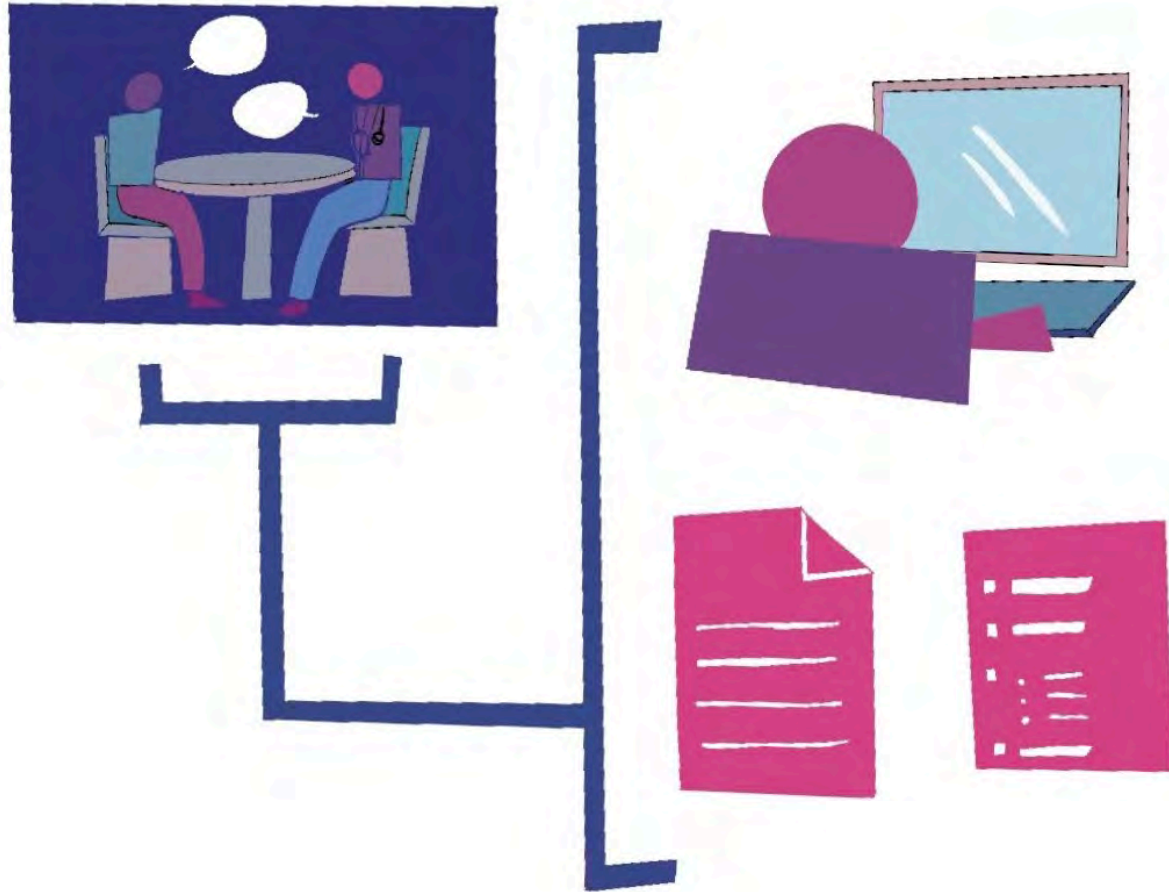
Panel discussion with Q&A

Seriously ill patients face important decisions
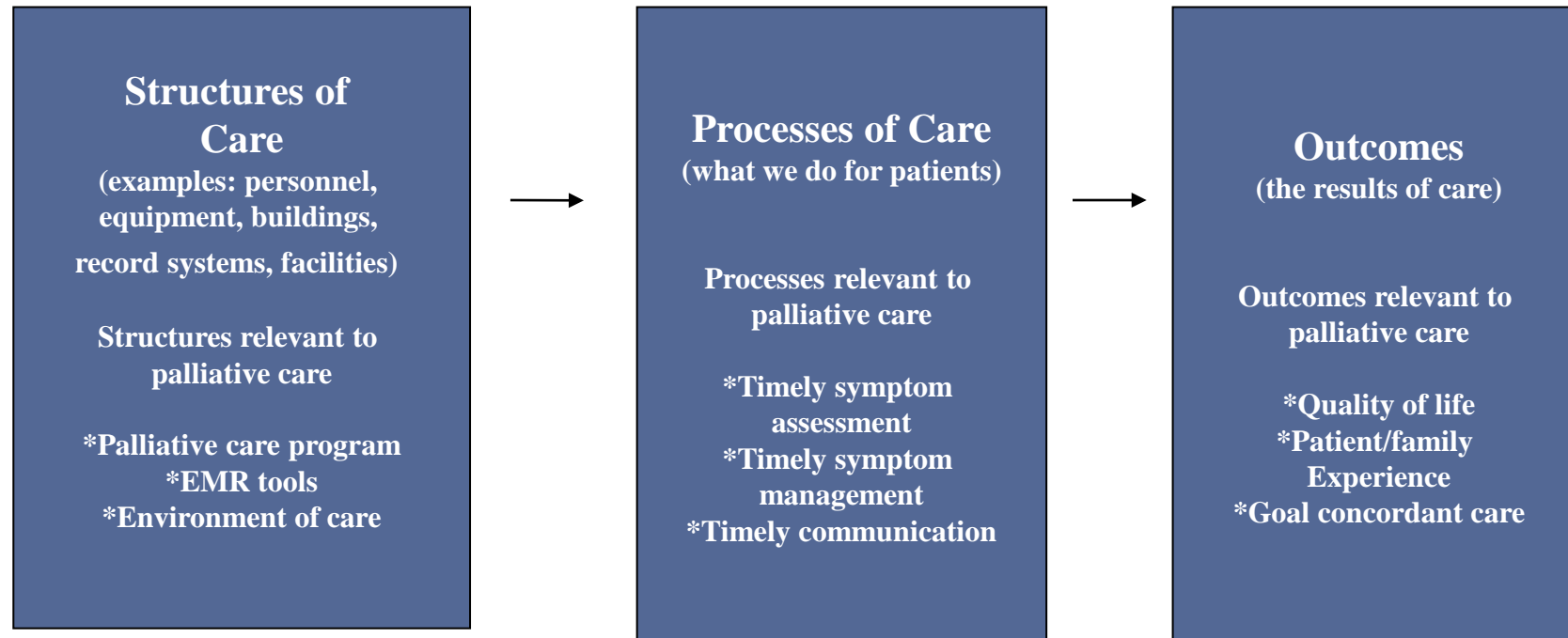
HOURS LATER

Measurement Challenges

- Identify target population
- Data: unstructured, structured
- Manually abstracting this information is costly and time-intensive
- Structured data may provide an incomplete proxy measure

Donabedian Model for Palliative Care

Structures of Care
(examples: personnel, equipment, buildings, record systems, facilities)

Structures relevant to palliative care

*Palliative care program
*EMR tools
*Environment of care

→

Processes of Care
(what we do for patients)

Processes relevant to palliative care

*Timely symptom assessment
*Timely symptom management
*Timely communication

→

Outcomes
(the results of care)

Outcomes relevant to palliative care

*Quality of life
*Patient/family Experience
*Goal concordant care

UCLA Health

Anatomy of a Quality Measure

Denominator: The given population to which a measure applies

Numerator: Measure focus or what is being measured about the denominator

UCLA Health

Electronic Clinical Quality Measures

What are eCQMs?

"Electronic clinical quality measures (eCQMs) are measures specified in a standard electronic format that use data electronically extracted from electronic health records (EHR) and/or health information technology (IT) systems to measure the quality of health care provided. The Centers for Medicare & Medicaid Services (CMS) uses eCQMs in a variety of quality reporting and value-based purchasing programs."

From: Electronic Clinical Quality Measure Basics (CMS.gov)

UCLA Health

What are EHR Phenotypes?

"A clinical condition or characteristic that can be ascertained via a computerized query into an EHR system or clinical data repository using a defined set of data elements and logical expressions. These queries can identify patients with a particular condition, such as diabetes mellitus, obesity, or heart failure, and can be used to support a variety of purposes and data needs for observational and interventional research."

From: Rethinking Clinical Trials: A Living textbook for pragmatic clinical trials https://sites.duke.edu/rethinkingclinicaltrials/ehr-phenotyping/ (NIH Collaboratory)

UCLA Health

Denominators and EHR phenotypes

- **Denominator ~EHR Phenotype**

  - Event based
    - Examples, patients admitted to ICU, patients discharged from the hospital, patients prescribed a medication

  - Population based
    - For example, primary or specialty care populations, patients with a disease or condition, patients with advanced disease, patients at risk for a disease

  - Combination of both

UCLA Health

# Where to start? Measurement as central to QI and Research

- Establishing reliable and valid quality measures are key to almost any QI or research project

- What is the quality problem that you want to solve and for which patients?

    - Denominator: Event measure vs. Population measure vs. Both?

- Do you have a specific intervention in mind and what outcome will it improve? Is the outcome measurable with currently available EHR data?

- Are there quality measures and specifically electronic quality measures that already exist for your purpose?

    - Can you get this as a PCQC measure

    - Review quality literature and EHR phenotyping resources

    - If not, consider which data elements you would need to specify the denominator and numerator

UCLA Health

Natural Language Processing (NLP) enhances language comprehension in computers
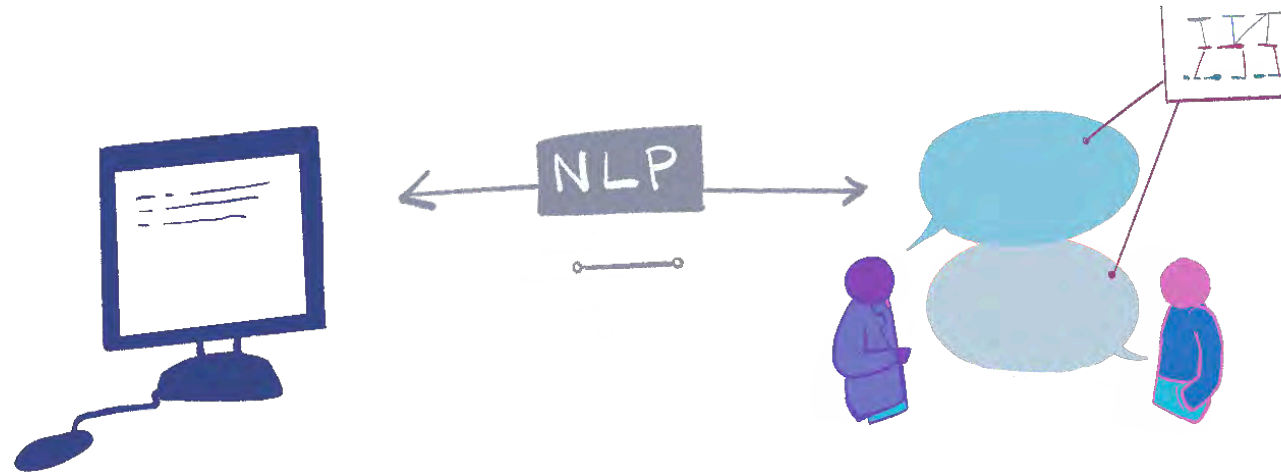
NLP enables the capture of text-based data

https://lindvalllab.github.io/clinical-regex/
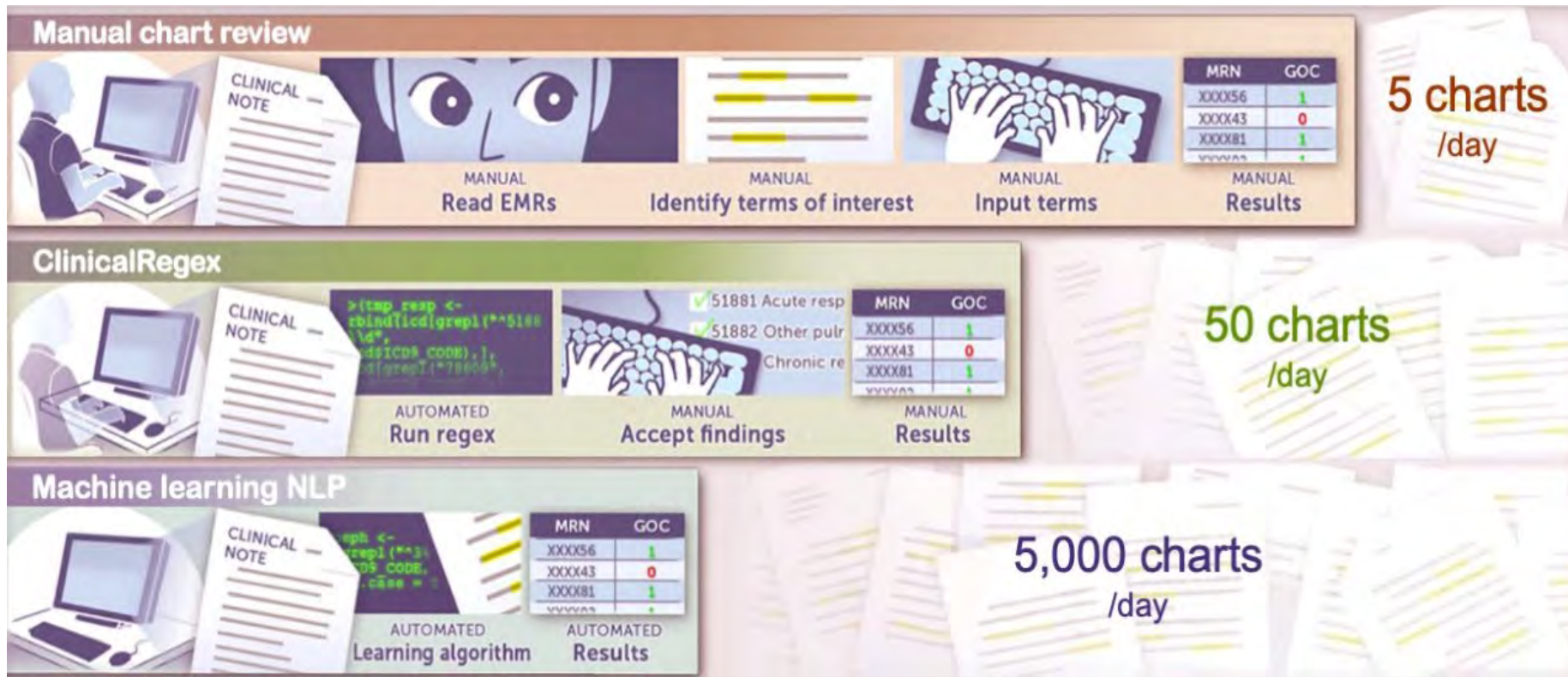
Collapse All   Expand All   ☐ Hide

68 words not shown   Less   More

... confirmed is her healthcare `proxy`. Patient is eating OK, and able to get around home, though is requiring more ...

46 words not shown   Less   More

... Patient expressed gratitude towards our clinical team and towards family.

We discussed the patient⬦s `prognosis` and her `goals of care`. During this discussion, the patient expressed understanding that her life expectancy was limited, and ...

5 words not shown   Less   More

... free and being at home.

The patient agreed with her daughter to enroll in `hospice`. The `palliative care` team consulted with the patient shortly after, with the `goals of care` focused on ensuring the ...

26 words not shown   Less   More

☐ Time Limited Trial of Dialysis

| 0 | ▲ |
| | ▼ |

🟩 Goals of Care

| 1 | ▲ |
| | ▼ |

🟪 Palliative Care

| 1 | ▲ |
| | ▼ |

🟧 Hospice

| 1 | ▲ |
| | ▼ |

☐ Code Status Limitations

| 0 | ▲ |
| | ▼ |

🟦 Surrogate Decision Maker

| 1 | ▲ |
| | ▼ |

Submit and continue ➡

Submit

Association of an Advance Care Planning Video and Communication Intervention With Documentation of Advance Care Planning Among Older Adults
A Nonrandomized Controlled Trial

- Participants: 42,019 patients followed in 22 clinics

- Primary outcome: documentation of goals of care conversation in the electronic health record

Dana-Farber Cancer Institute

A Natural Language Processing Study to Assess Quality of End-of-Life Care for Children with Cancer

Prasanna Ananth, MD, MPH

December 15, 2023

Photo used with parent permission

YALE SCHOOL OF MEDICINE

COPPER — CANCER OUTCOMES, PUBLIC POLICY AND EFFECTIVENESS RESEARCH CENTER
Yale School of Medicine • Yale Cancer Center
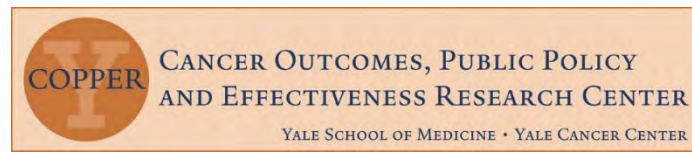
Yale CANCER CENTER
A Comprehensive Cancer Center Designated by the National Cancer Institute

Natural Language Processing Study: Sample

Participants

Childhood cancer decedents 0-25 years old (N = 101)
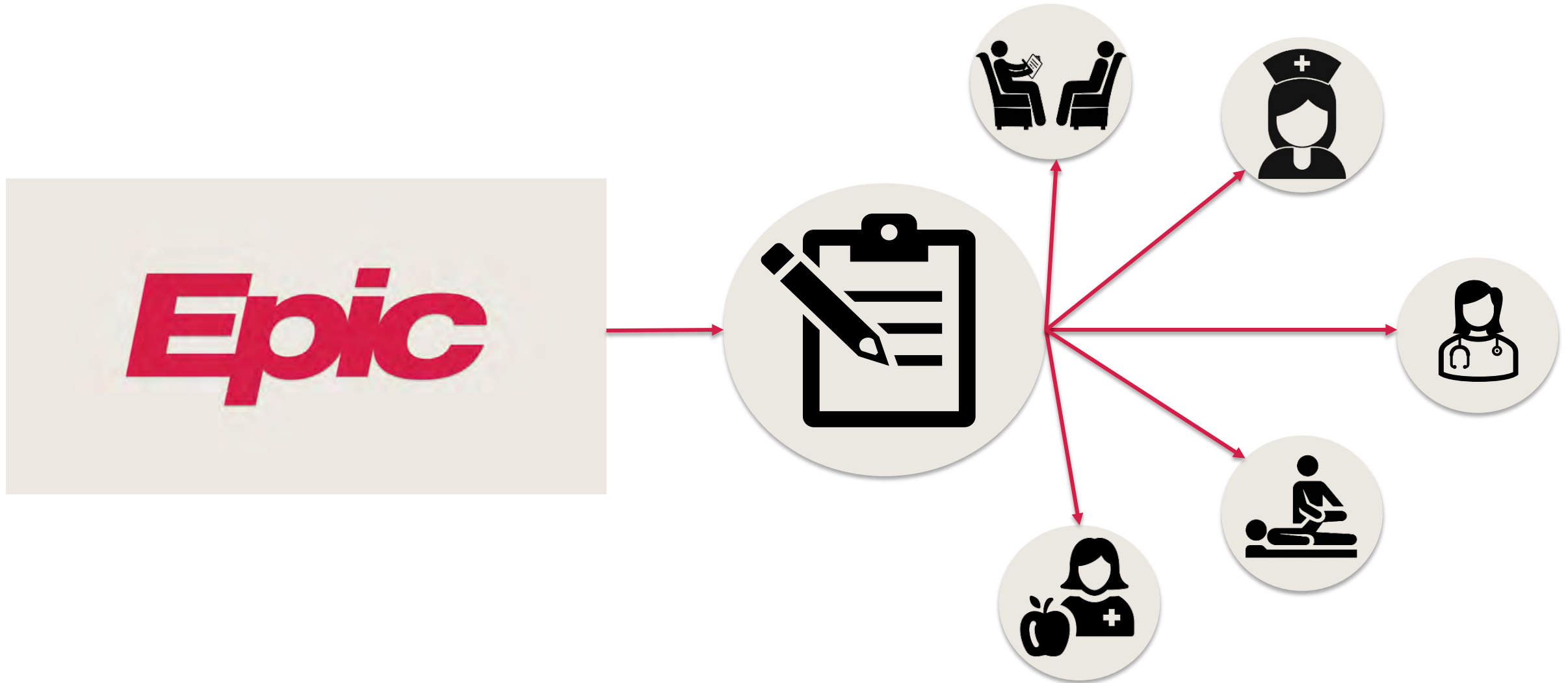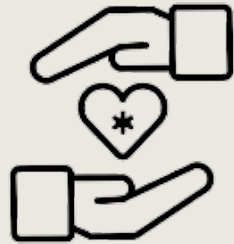
End-of-Life Care Quality Measures
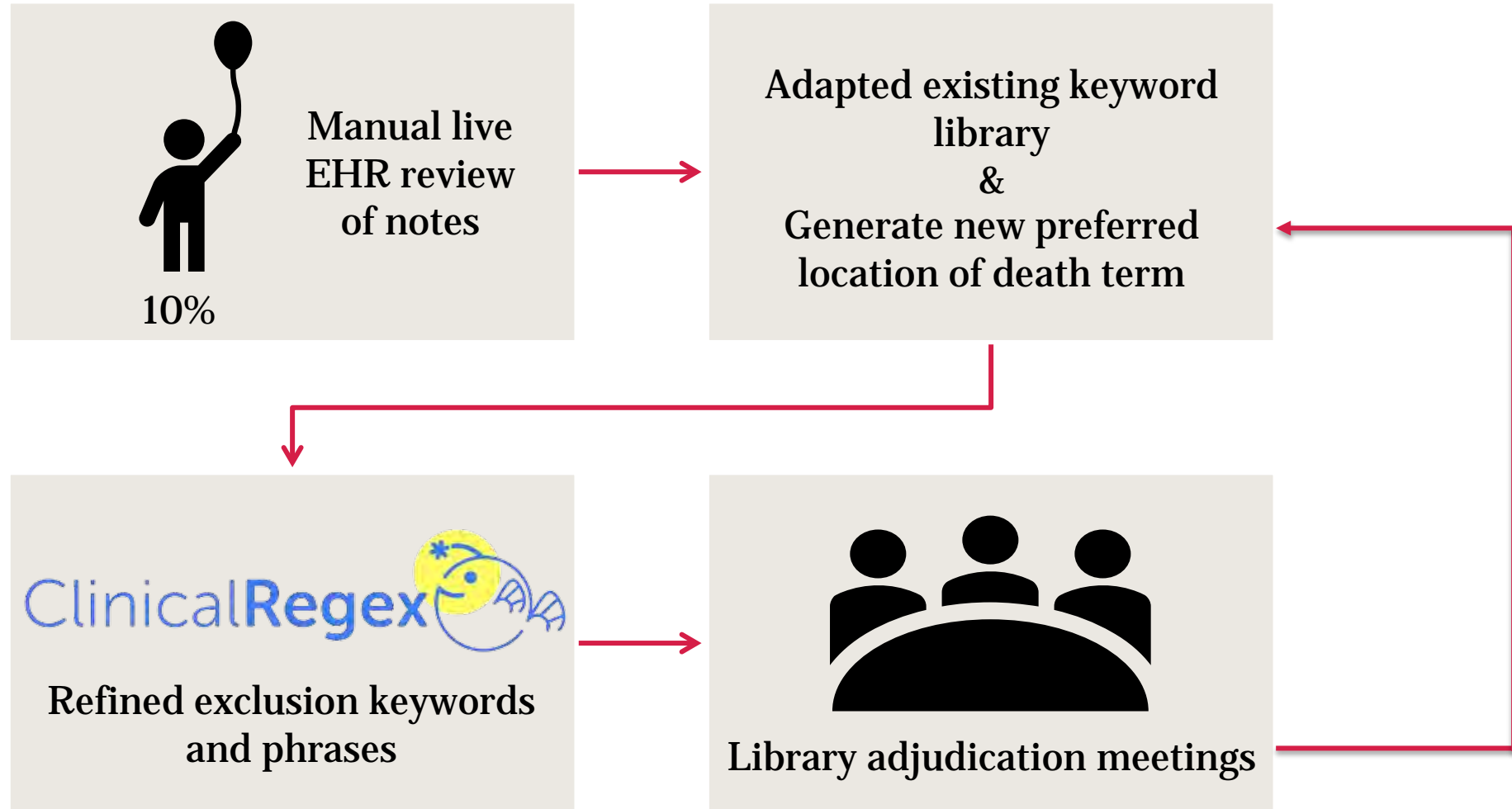

Goals of Care

Code Status Limitations

Hospice

Palliative Care Consultation

Preferred Location of Death

Keyword Library Development

Manual live EHR review of notes

10%

Adapted existing keyword library
&
Generate new preferred location of death term

ClinicalRegex

Refined exclusion keywords and phrases

Library adjudication meetings

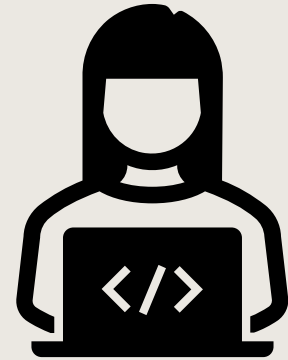# Natural Language Processing Study: Keyword Library Validation

10%

Annotated manually in EHR & ClinicalRegex
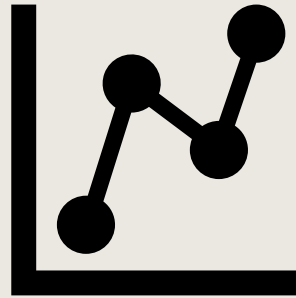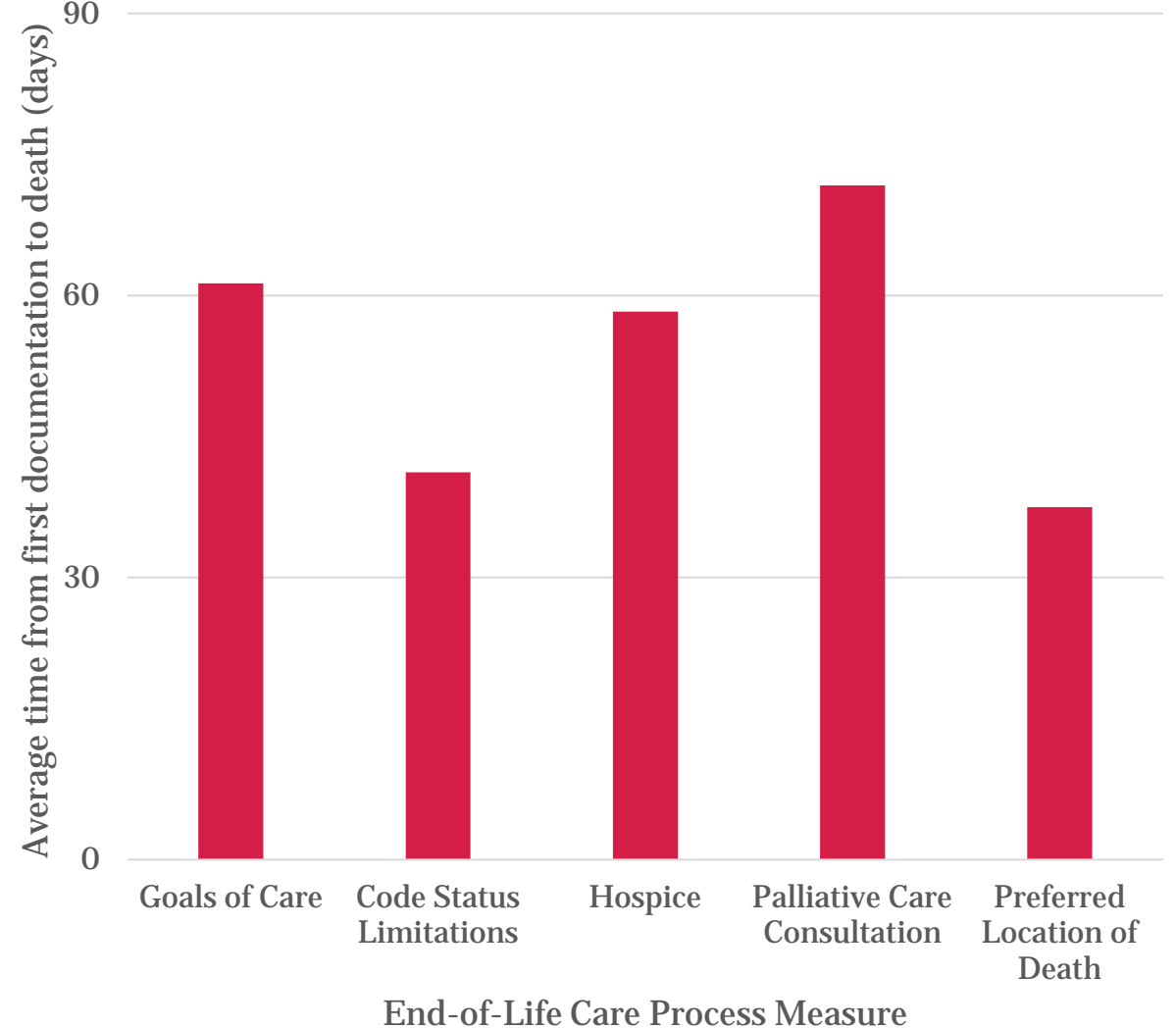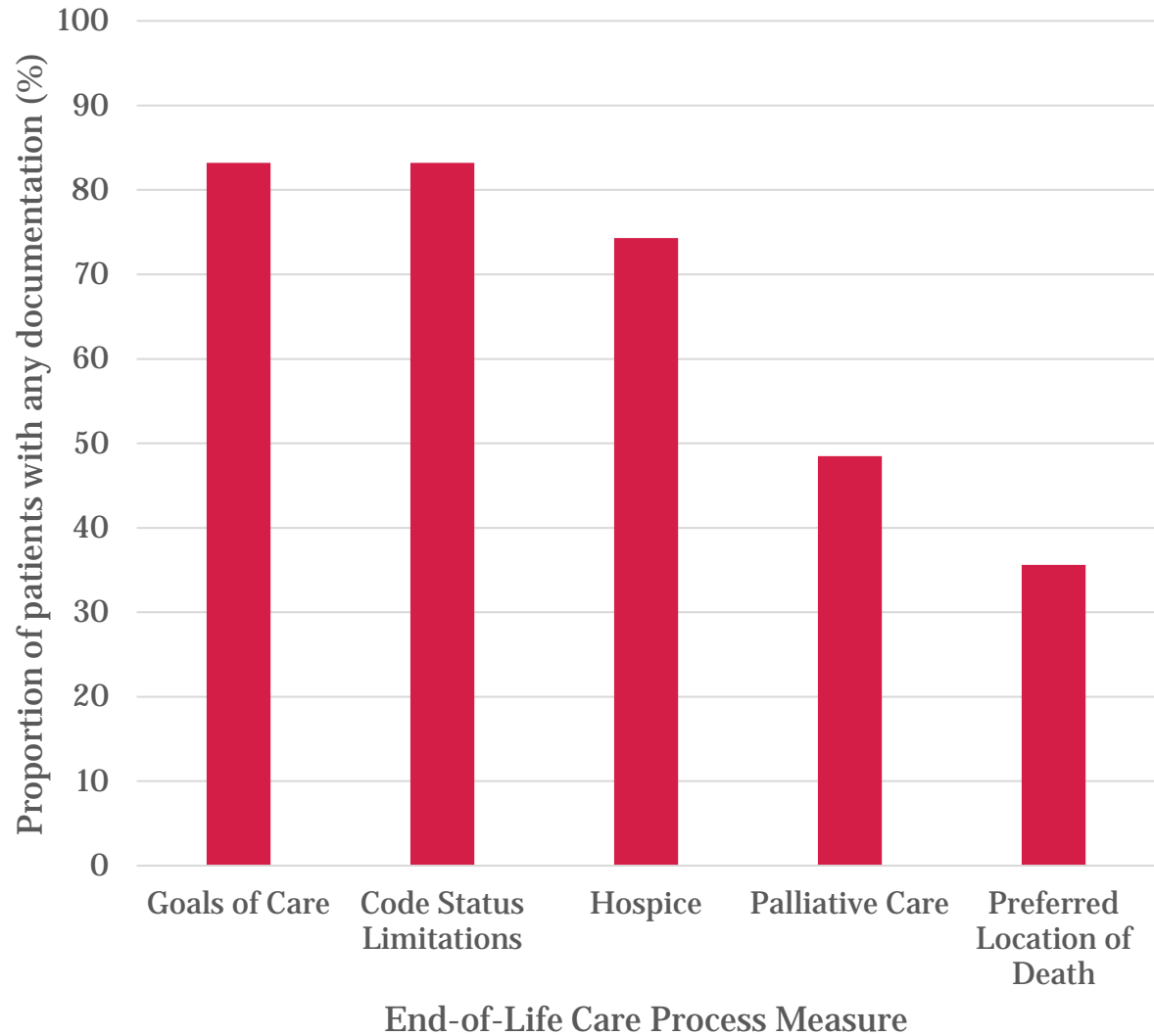
Computed performance statistics

Iterative revisions of keyword library

Conducted study analyses in full sample

Natural Language Processing Study: Main Results
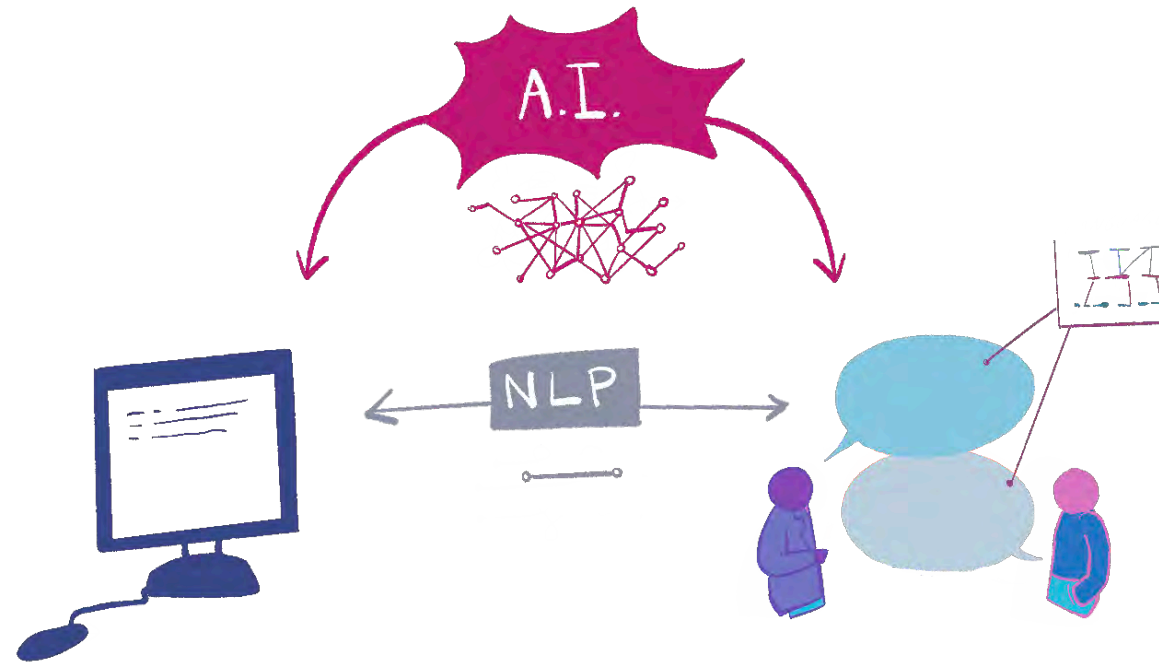
Envision the possibility…

Rapid development in NLP methods including AI

AI show promise in their ability to capture symptoms directly from conversations

- Gold standard identified symptoms in 400 of 578 conversations

- Using GPT-4, our prompt identified 442 symptoms with

  0.98 sensitivity and 0.71 specificity

- GPT-4 had improved performance over GPT-3.5 (p<0.01)

Example excerpt

P: The cough has stayed the same.

D: OK, are you bringing up any phlegm or sputum with the cough?

P: Um, it's not really phlegm, but sometimes I cough up, like bits of like. You know little bits that look like blood or something.

D: OK, so you're seeing some like red when when you're coughing up?

P: Mmmm

D: OK, and how much of this are you seeing like, is it like a teaspoon amount or or more?

P: Oh, it's it's very little. It's like maybe a little bit bigger than like the tip of a pencil.

D: Oh OK, are you, OK, are you seeing this on like kind of tissues afterwards sort of thing?

P: Yeah.

D: OK, um and any triggers for the cough you can think of?

Output following detailed prompt

Please generate a table of **only the symptoms cough, pain, shortness of breath** discussed in the following transcript. For each symptom, please indicate whether it was confirmed by the patient, denied, or of unknown status. For each symptom, please include context from the transcript to show where the symptom was discussed.

Symptom	Status	Context from Transcript
Cough	Confirmed	P: The cough has stayed the same.
Pain	Unknown	Not discussed in the transcript.
Shortness of breath	Unknown	Not discussed in the transcript.

Recommendations for quality measurement in serious illness care

Infrastructure to:

- Disseminate free or low-cost NLP tools

- Support secure computing platforms

- Share methodology and lessons learned

"Ultimately, the secret of quality is **love**. …. If you have love, you can then work backward to monitor and improve the system."

Avedis Donabedian

References

1. Establishing a Denominator for Palliative Care Quality Metrics for Patients with Advanced Cancer. J Palliat Med. 2020 Sep;23(9):1239-1242. doi: 10.1089/jpm.2019.0346.
2. Rethinking Clinical Trials: A Living textbook for pragmatic clinical trials https://sites.duke.edu/rethinkingclinicaltrials/ehr-phenotyping/ (NIH Collaboratory)
3. Natural Language Processing to Identify Advance Care Planning Documentation in a Multisite Pragmatic Clinical Trial. J Pain Symptom Manage. 2021 Jul 13:S0885-3924(21)00428-0. doi: 10.1016/j.jpainsymman.2021.06.025.
4. Association of an Advance Care Planning Video and Communication Intervention With Documentation of Advance Care Planning Among Older Adults: A Nonrandomized Controlled Trial JAMA Netw Open. 2022 Feb 1;5(2):e220354. doi: 10.1001/jamanetworkopen.2022.0354.
5. Mitigating bias in AI at the point of care. Science. 2023 Jul 14;381(6654):150-152. doi: 10.1126/science.adh2713.

Thank You!

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PCQC Clinical Data Review: Learning from PCQC's Clinical Quality Data

During this session, we will provide you with an overview of telehealth in outpatient palliative care. Participants will be guided through a comprehensive review of PCQC's clinical quality data, shedding light on the landscape and significance of telehealth while addressing disparities in access and utilization. We will review how we have gained valuable insights into how PCQC clinical quality data can be harnessed to examine clinical outcomes and disparities associated with telehealth.

Sarah Nouri
MD, MPH
Assistant Professor and Associate Chief
for Diversity, Equity, and Inclusion,
Division of Palliative Medicine,
University of California San Francisco

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December 14-15, 2023

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UCSF

Learning from PCQC's Clinical Quality Data: a review of PCQC data examining telehealth outcomes

Sarah Nouri, MD, MPH

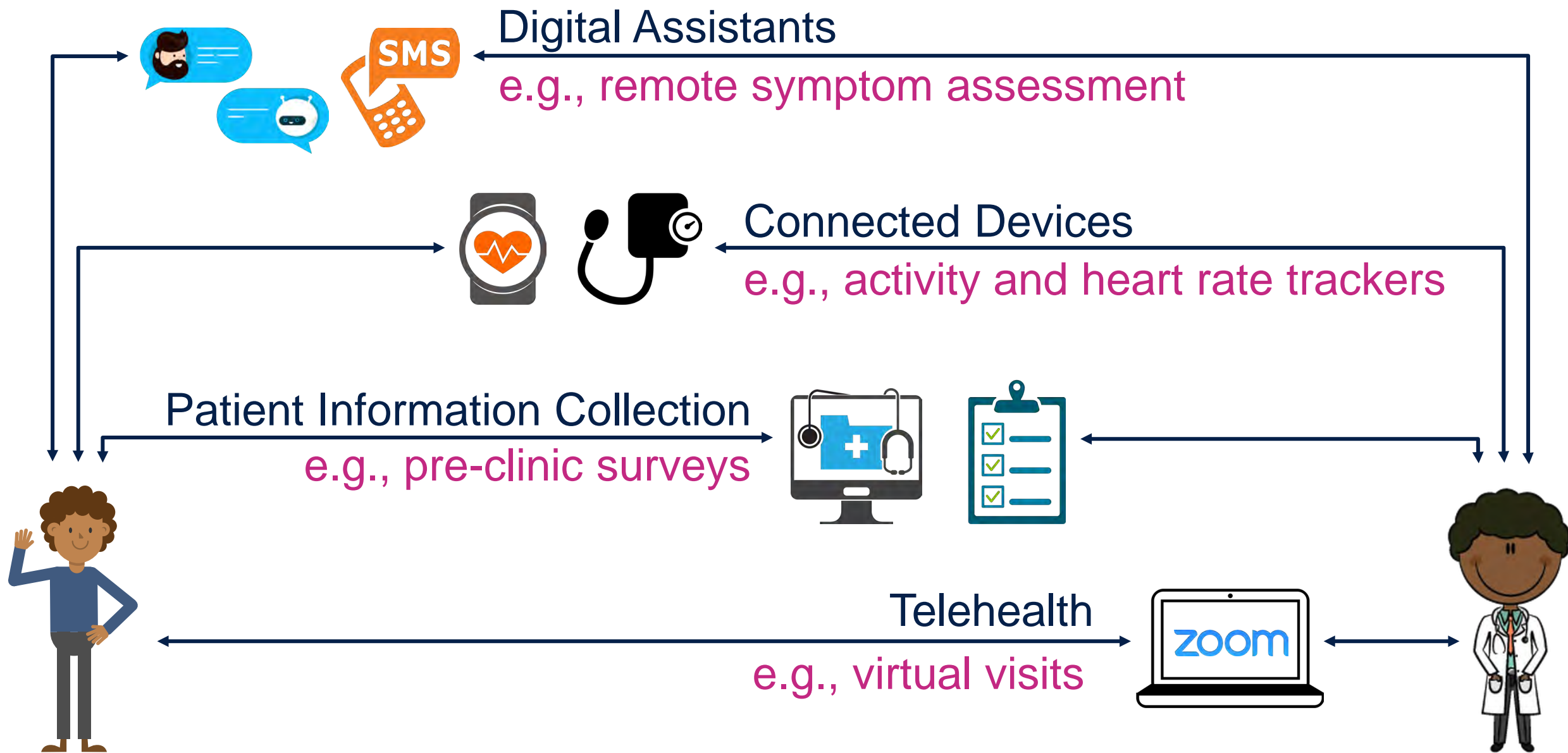PCQC Quality Matters Conference – 12/15/2023

What is telehealth?

m-Health digital assistants

telehealth public health artificial

chatbot wearable devices surveillance telemedicine intelligence video visits

electronic activity trackers

self tracking surveys remote monitoring connected devices

What is telehealth?

the use of digital technologies for health

Telehealth is rapidly growing

- Nearly 90% of Americans use at least one telehealth tool

- Significant growth during COVID-19

- Private sector investing billions ($6.1 billion in first half of 2023)

- Growth ranges from EHR to patient-facing apps and includes novel methods (e.g., artificial intelligence, machine learning)

Bottom line: It's here to stay.

PCQC

Digital Assistants
e.g., remote symptom assessment

Connected Devices
e.g., activity and heart rate trackers

Patient Information Collection
e.g., pre-clinic surveys

Telehealth
e.g., virtual visits

Digital health can improve serious illness care

- Identifying patients who would benefit from palliative care
- Estimating prognosis & mortality
- Education re: palliative care, hospice
- Increasing engagement in advance care planning
- Improving home symptom management

Nicolla et al. *Am J Manag Care. 2020;26(4 Spec No.):SP124-SP126.*

The Good, the Bad, & the Ugly

- Digital health in palliative care is feasible and acceptable by patients and their loved ones

- Not everyone can benefit

- Can widen existing disparities

Calton et al. *J Palliat Med* 2019;22(8):981-985. Kidd et al. *J Telemed Telecare* 2010;16(7):394-402.
Nouri et al. *NEJM Catalyst* 2020. Frydman et al. *J Pain Symptom Manage* 2022(63(3):423-429.
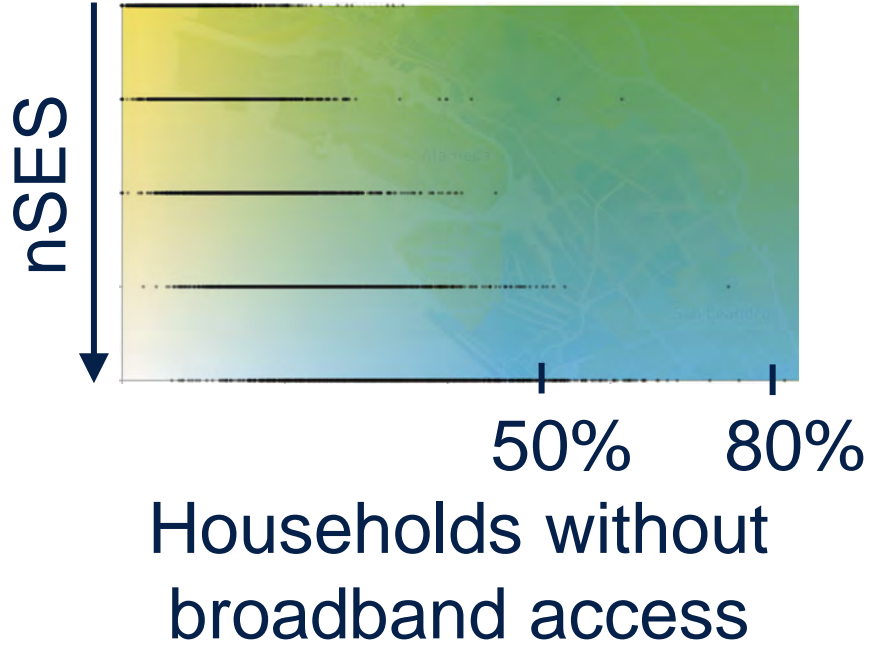
The Digital Divide

Video visit "unreadiness"

- Access → Not owning Internet-enabled devices

- Digital literacy → Not knowing how to use devices, or no texting or Internet use in past month

- Usability → Difficulty hearing, speaking, seeing; cognitive impairment
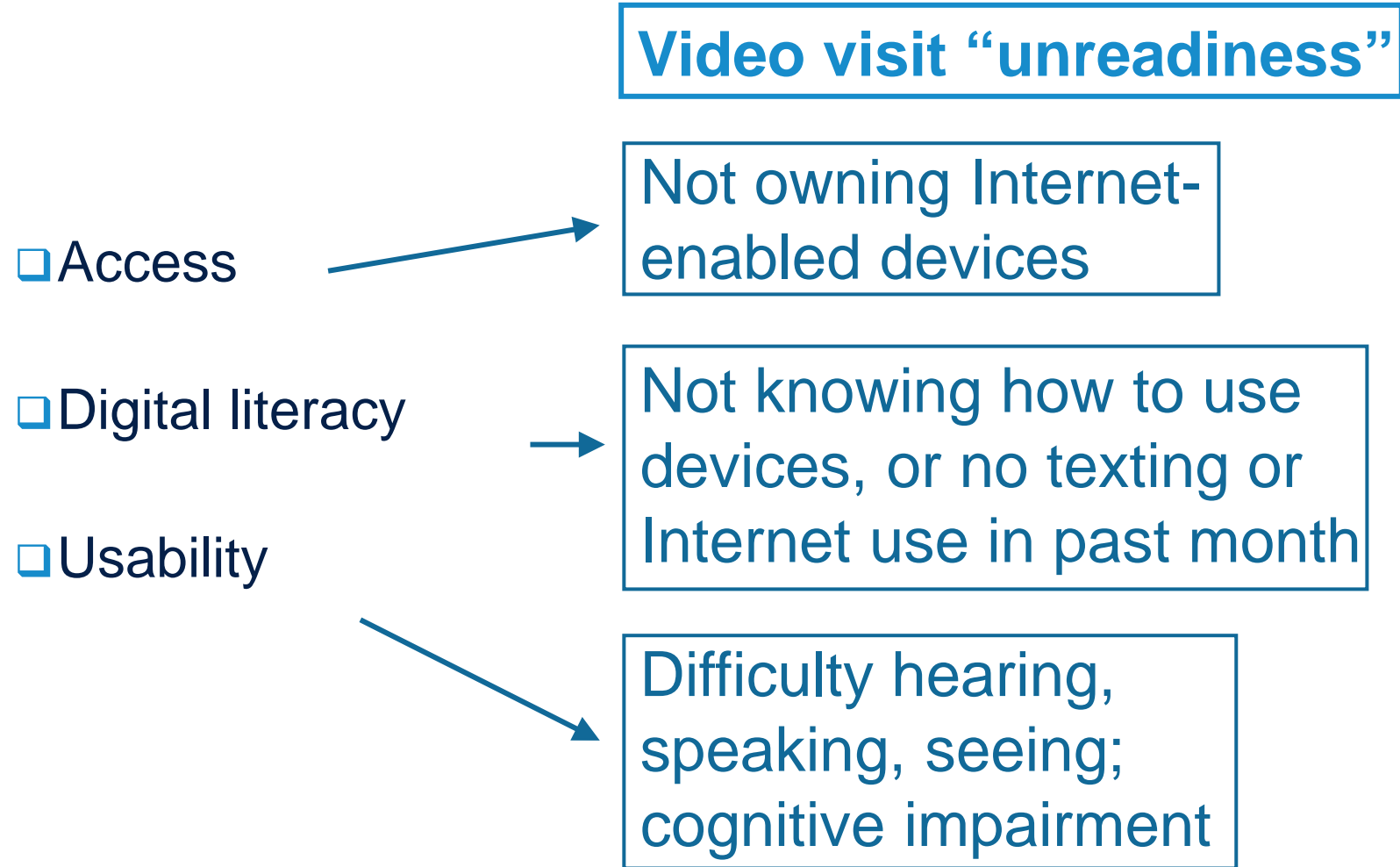
38% of older adults are not ready for video visits

Hispanic: 70%
Black: 60%
<high school: 74%
Low SES: 67%
Poor health: 77%

Lam et al. JAMA Intern Med. 2020;180(10):1389-1391.

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Broadband access is a social determinant of health

nSES

50%   80%

Households without
broadband access

QMC Quality Matters
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Overlap with other disparities in palliative care

- Lower access to, utilization of, and quality of palliative care

- The digital divide risks widening these existing disparities by further limiting access and quality of care

Virtual visit outcomes are unknown

- Limited data on the association between virtual visits and palliative care outcomes

- Especially among historically marginalized populations

Calton et al. *J Palliat Med* 2019;22(8):981-985. Kidd et al. *J Telemed Telecare* 2010;16(7):394-402. Lally et al. *JCO Oncol Pract*. 20201;17(1):e62-e67. Watanabe et al. *Support Care Cancer* 2013;21(4):1201-1207. Hoek. *BMC Med* 2017;15(1):119.

Research questions

- Evaluate differences in outpatient palliative care *process* and *clinical* outcomes by visit type (in-person vs virtual)

- Assess disparities in outcomes by race-ethnicity and preferred language
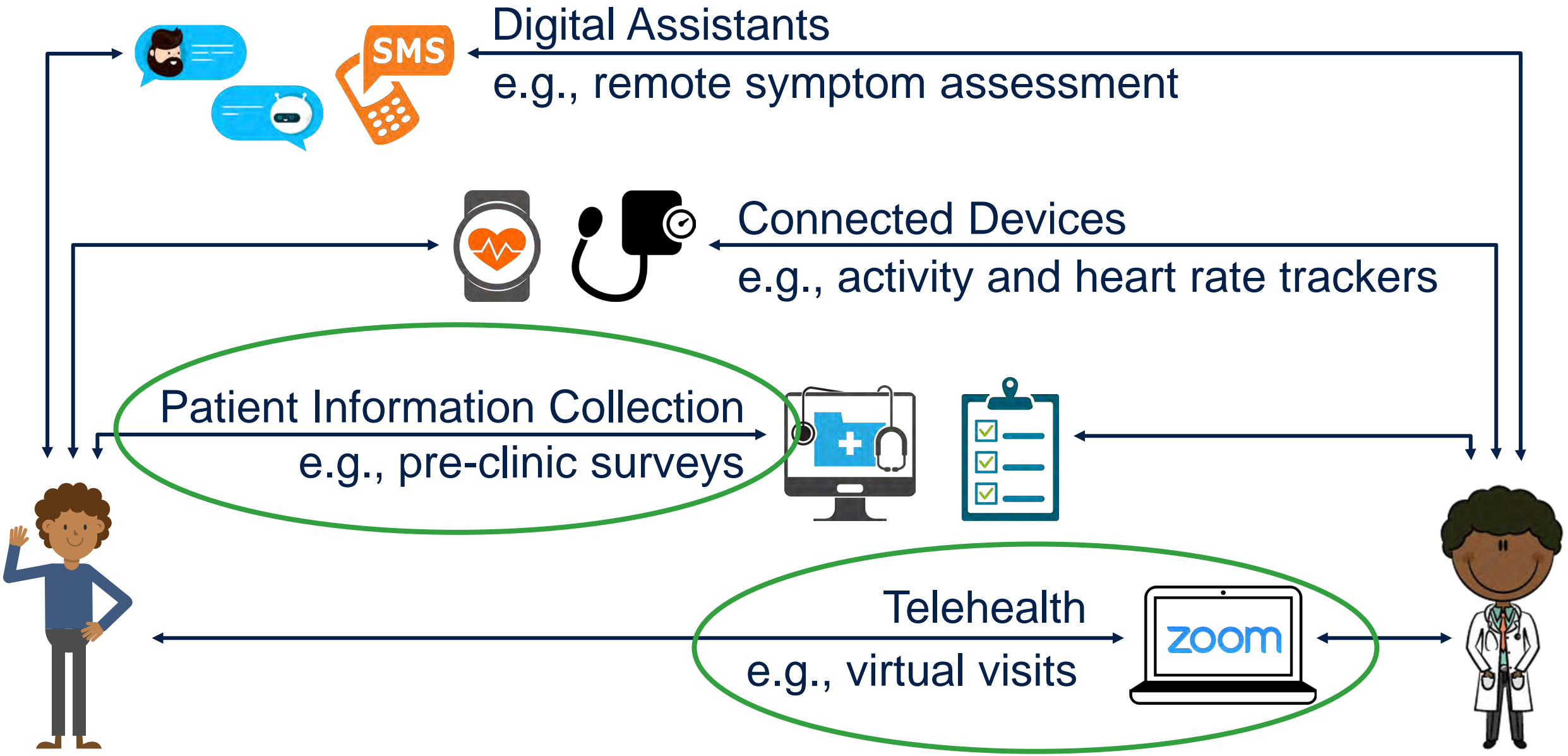
Data & Participants

- Palliative Care Quality Network (now PCQC) data from 2017-2021

- Standardized data are collected *as part of usual patient care*

- 58 outpatient palliative care teams participate
  - Restricted to sites that consistently (<10% missing) recorded race, ethnicity, and preferred language (N=6 sites)

- Included all adults (18+) with ≥1 outpatient visit

Six sites were included

- 3 public safety-net systems
- 2 academic health systems
- 1 non-profit community health system

- 5 in California
- 1 in Hawai'i

Outcome measures

Process Outcomes
Screening for psychosocial needs
Screening for spiritual needs
Screening for goals of care needs

Outcome measures

Process Outcomes	Clinical Outcome
Screening for psychosocial needs	ESAS score (0-100) over time
Screening for spiritual needs	
Screening for goals of care needs	

Independent variables

Primary Predictor
Visit type (virtual vs in-person)

Independent variables

Primary Predictor	Covariables
Visit type (virtual vs in-person)	Preferred language (English vs. other)
	Visit number
	Race-ethnicity
	Age
	Sex
	Primary diagnosis (cancer vs. other)
	Reason for referral (symptoms vs. other)

Process outcomes analysis

- Multivariable logistic regression clustered by site

- Interaction visit type*preferred language for effect modification

- No correlation or collinearity between covariables

Characteristic	Overall (N=2684)	In-Person (N=1904)	Virtual (N=780)
Age, %			
45-64	40	43	32
65+	49	46	**58**

Characteristic	Overall (N=2684)	In-Person (N=1904)	Virtual (N=780)
Age, %			
45-64	40	43	32
65+	49	46	**58**
Reason for referral, %			
Pain	52	**58**	39
Other symptoms	50	45	61
GOC/ACP	48	47	52
Support for patient/family	38	36	41

Characteristic	Overall (N=2815)	In-Person (N=1960)	Virtual (N=855)
Cancer, %	58	**69**	33

Characteristic	Overall (N=2815)	In-Person (N=1960)	Virtual (N=855)
Cancer, %	58	**69**	33
Race/ethnicity, %			
White	46	42	**54**
Hispanic/Latinx	17	18	14
Black/African American	9	10	6
Asian	16	18	12
NH/PI	5	7	1
AI/AN	0.3	0.2	0.6
Other	3	2	5

Characteristic	Overall (N=2815)	In-Person (N=1960)	Virtual (N=855)
Cancer, %	58	**69**	33
Race/ethnicity, %			
White	46	42	**54**
Hispanic/Latinx	17	18	14
Black/African American	9	10	6
Asian	16	18	12
NH/PI	5	7	1
AI/AN	0.3	0.2	0.6
Other	3	2	5
Non-English language, %	23	**25**	17

N=2474	Screening for psychosocial needs aOR (95% CI)	Screening for spiritual needs aOR (95% CI)	Screening for goals of care needs aOR (95% CI)
Virtual visit (n=780)	0.87 (0.60, 1.25)	0.81 (0.57, 1.15)	1.05 (0.85, 1.31)

Interaction term visit type*language was negative for each model.
Models were also adjusted for age, sex, and primary diagnosis.

N=2474	Screening for psychosocial needs aOR (95% CI)	Screening for spiritual needs aOR (95% CI)	Screening for goals of care needs aOR (95% CI)
Virtual visit (n=780)	0.87 (0.60, 1.25)	0.81 (0.57, 1.15)	1.05 (0.85, 1.31)
Non-English (n=617)	**0.47 (0.38, 0.58)**	**0.54 (0.47, 0.62)**	**0.48 (0.39, 0.59)**

Interaction term visit type*language was negative for each model.
Models were also adjusted for age, sex, and primary diagnosis.

N=2474	Screening for psychosocial needs aOR (95% CI)	Screening for spiritual needs aOR (95% CI)	Screening for goals of care needs aOR (95% CI)
Virtual visit (n=780)	0.87 (0.60, 1.25)	0.81 (0.57, 1.15)	1.05 (0.85, 1.31)
Non-English (n=617)	**0.47 (0.38, 0.58)**	**0.54 (0.47, 0.62)**	**0.48 (0.39, 0.59)**
Black (n=236)	**0.38 (0.29, 0.51)**	**0.51 (0.38, 0.69)**	**0.41 (0.34, 0.49)**
Hispanic (n=451)	0.89 (0.66, 1.20)	1.00 (0.74, 1.36)	0.95 (0.71, 1.28)
Asian (n=435)	1.43 (0.98, 2.09)	1.33 (0.98, 1.80)	**1.53 (1.06, 2.23)**
Other R-E (n=225)	1.29 (0.86, 1.94)	1.38 (0.96, 1.99)	1.39 (0.82, 2.38)

Interaction term visit type*language was negative for each model.
Models were also adjusted for age, sex, and primary diagnosis.

Clinical Outcomes

- Longitudinal analysis of ESAS scores over time

- Restricted cohort to adults with ≥2 visits (N=897)
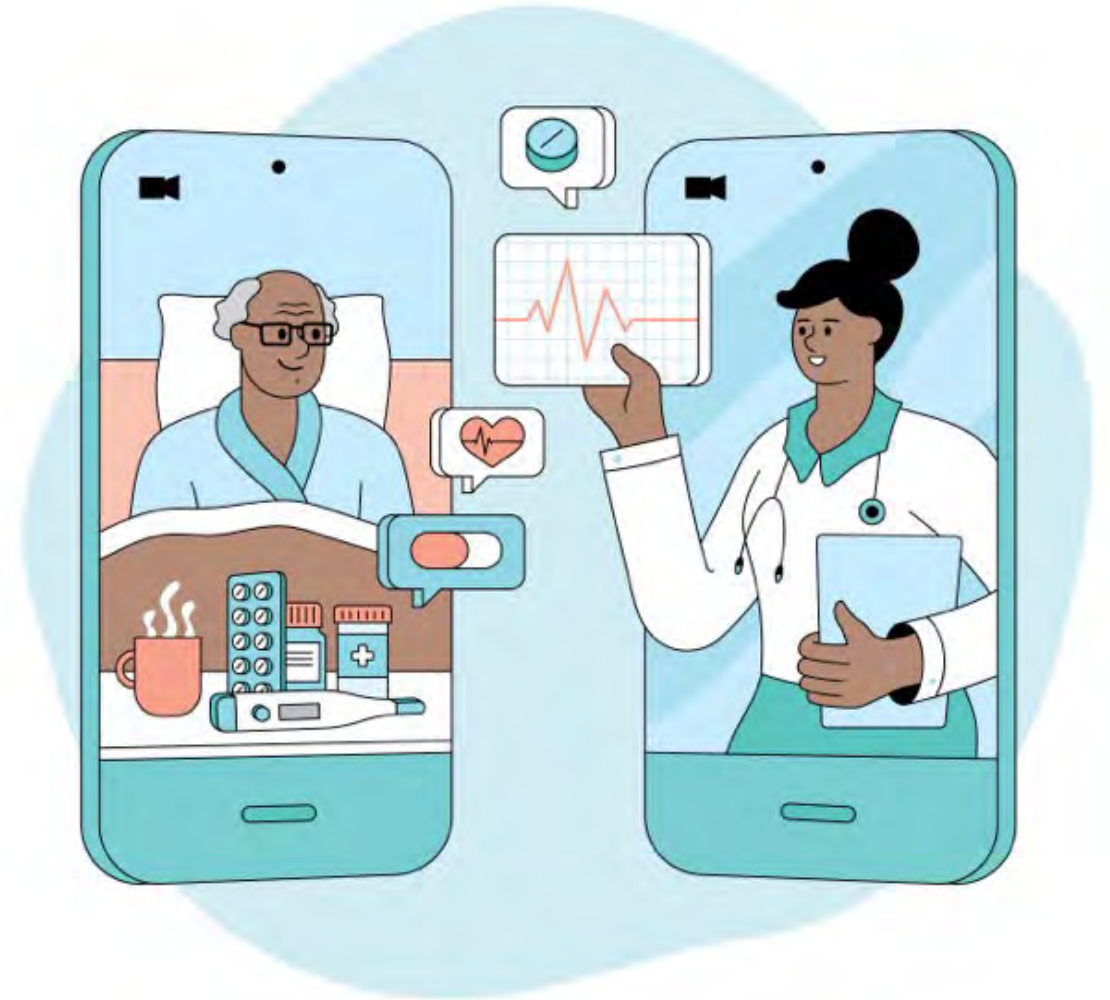
Clinical outcomes analysis

- Mixed effects generalized linear regression model with random effect for patient, fixed effect for time*visit type

- Generated adjusted mean estimates

- Difference in linear trend by visit type
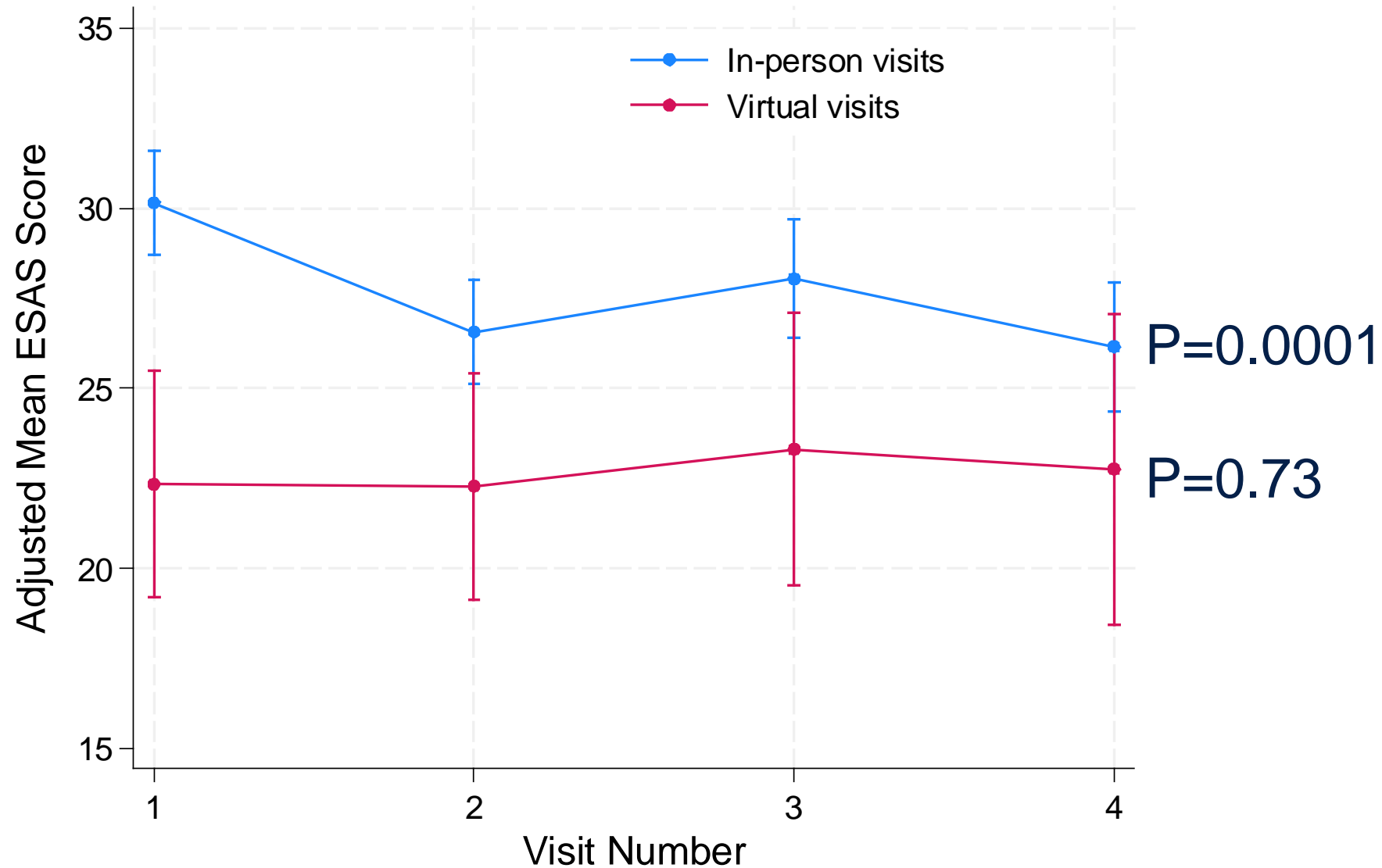
Key points

- Overall, there are no differences in process or clinical outcomes by visit type in outpatient palliative care

- People with non-English preferred languages and those who identify as Black or African American are significantly less likely to be screened for psychosocial, spiritual, and goals of care needs

Key points

- PCQC provided us with multi-site, real-world data collected during usual, routine visits

- We were able to incorporate several aspects of telehealth into analyses (e.g., virtual visits, ESAS scores collected through patient portal surveys, etc.)

Next steps

Further analysis of clinical outcomes with interactions by race-ethnicity and language

- Qualitative interviews with Spanish- and Cantonese-speaking patients/caregivers and patients identifying as Black or African-American at UCSF

Interpreter, staff interviews underway

Conclusions

- Across several academic, community, and safety-net health systems in the Western US, there are significant disparities in outpatient palliative care outcomes by race-ethnicity and language, regardless of whether visits are conducted in-person or virtually. Research to identify causes and develop interventions to address disparities is needed.

- PCQC has expanded opportunities for multi-site analyses. New improvements in race-ethnicity and language data collection will improve data quality and completeness.

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Clinician Wellness and Palliative Care

Rachel Thienprayoon
MD, MSCS
Chief Clinical Wellness Officer and an
Associate Professor of Anesthesia and
Pediatrics, Cincinnati Children's Hospital

Join us for an insightful session where we delve into the critical intersection of healthcare, palliative care, and the well-being of those who provide these essential services. This session will equip participants with a comprehensive understanding of workplace wellness and the unique challenges faced by clinicians in palliative care. Through a focus on national models, we will explore practical strategies for addressing burnout and fostering organizational compassion for palliative care clinicians.

QMC Quality Matters Conference
December 14-15, 2023

PCQC

Disclosures

Rachel Thienprayoon, faculty for this educational event, is a board member of the PCQC Board of Directors.

Research has been funded by the Cambia Health Foundation and the Ho Chiang Foundation

I have no other relevant conflicts of interest to disclose.

All of the relevant financial relationships listed for these individuals have been mitigated.

Learning Outcomes

Upon completing this session, participants will be able to:

- Define the concept of workplace wellness and describe features of wellness based on national models
- Articulate challenges to wellness in healthcare/ palliative care and cite sources of burnout for clinicians
- Describe individual, team and organizational strategies to care for palliative care clinicians

What is Wellness or Well-being?

"Well-being encompasses **quality of life** and the ability of people and societies to contribute to the world with a sense of **meaning and purpose**.
Focusing on well-being supports the tracking of the **equitable** distribution of resources, overall **thriving** and **sustainability**.
A society's well-being can be determined by the extent to which it is **resilient**, builds capacity for action, and is prepared to transcend challenges

--The World Health Organization

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What is Burnout?

- A psychological syndrome associated with the workplace
- Thought to be due to prolonged job-related stressors
- Three domains
  - Low professional accommplishment
  - High cynicism or depersonalization
  - High emotional exhaustion

The opposite of wellness isn't burnout

Engagement is thought to be the antithesis of burnout

- High energy
- Strong involvement
- High efficacy

"The limits of my language mean the limits of my world."

- Ludwig Wittgenstein, adapted from "Atlas of the Heart" by Brene' Brown

Compassion is *noticing* that another person is suffering, making an *emotional connection* with their suffering, and *acting* to mitigate or relieve the suffering.

Compassion is *noticing* that another person is suffering, making an *emotional connection* with their suffering, and *acting* to mitigate or relieve the suffering.

Organizational compassion in healthcare:
The proactive, continuous, and systematic identification, prevention and alleviation of suffering in the workplace.

Compassion is *noticing* that another person is suffering, making an *emotional connection* with their suffering, and *acting* to mitigate or relieve the suffering.

Organizational compassion in healthcare:
The proactive, continuous, and systematic identification, prevention and alleviation of suffering in the workplace.

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Organizational compassion in healthcare:
The proactive, continuous, and systematic identification, prevention and alleviation of suffering in the workplace.

Thienprayoon, et al J Wellness 2022

What is suffering?

"Distress caused by a threat to the intactness of the whole person."

- Eric J. Cassel, MD
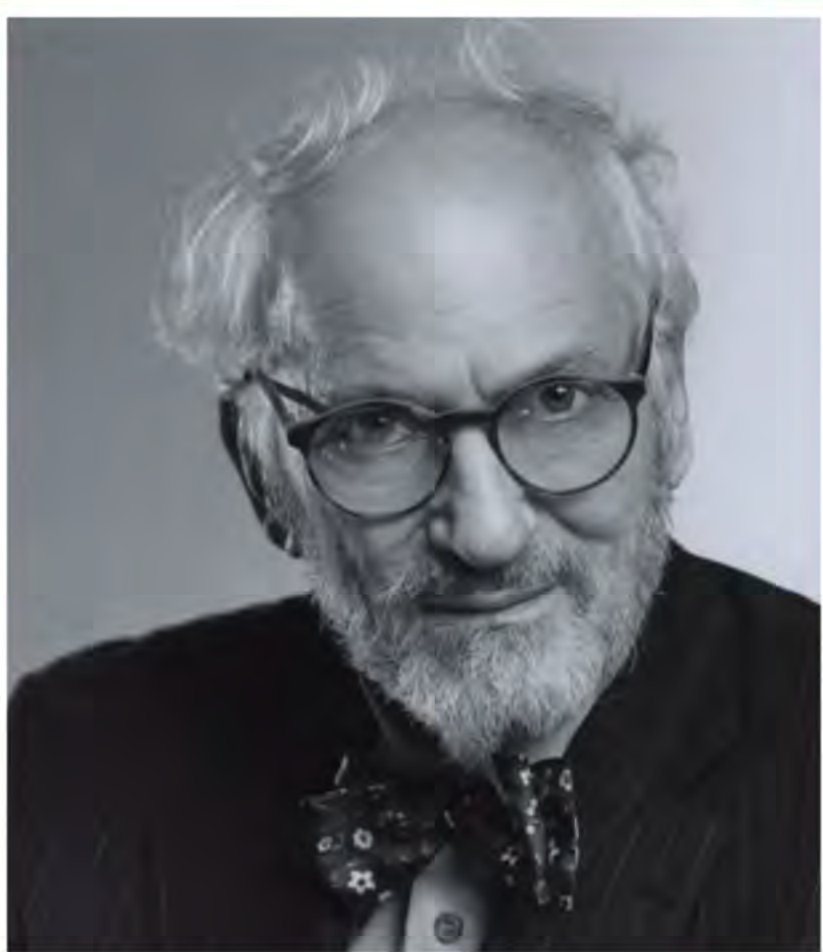
The medical ethicist Dr. Eric Cassell in 2013. He was at the forefront of efforts to emphasize palliative care in treating patients. HIRO

"*The intellectual father of palliative care.*"

\- Susan Block, MD

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Clinicians are suffering

- Moral distress
- Dehumanizing training
- Physical and verbal abuse
- Anti-medicine, anti-science
- Trauma
- Staffing shortages
- US Healthcare system
  - For profit healthcare
  - Less autonomy

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According to the Surgeon General

Our Nation's Current Workplace Landscape

Recent surveys suggest...

76%

of U.S. workers reported at least one symptom of a mental health condition.

Source:
Mind Share Partners' 2021 Mental Health at Work Report ☒

84%

of respondents said their workplace conditions had contributed to at least one mental health challenge.

Source:
Mind Share Partners' 2021 Mental Health at Work Report ☒

81%

of workers reported that they will be looking for workplaces that support mental health in the future.

Source:
APA's 2022 Work and Well-being Survey results ☒
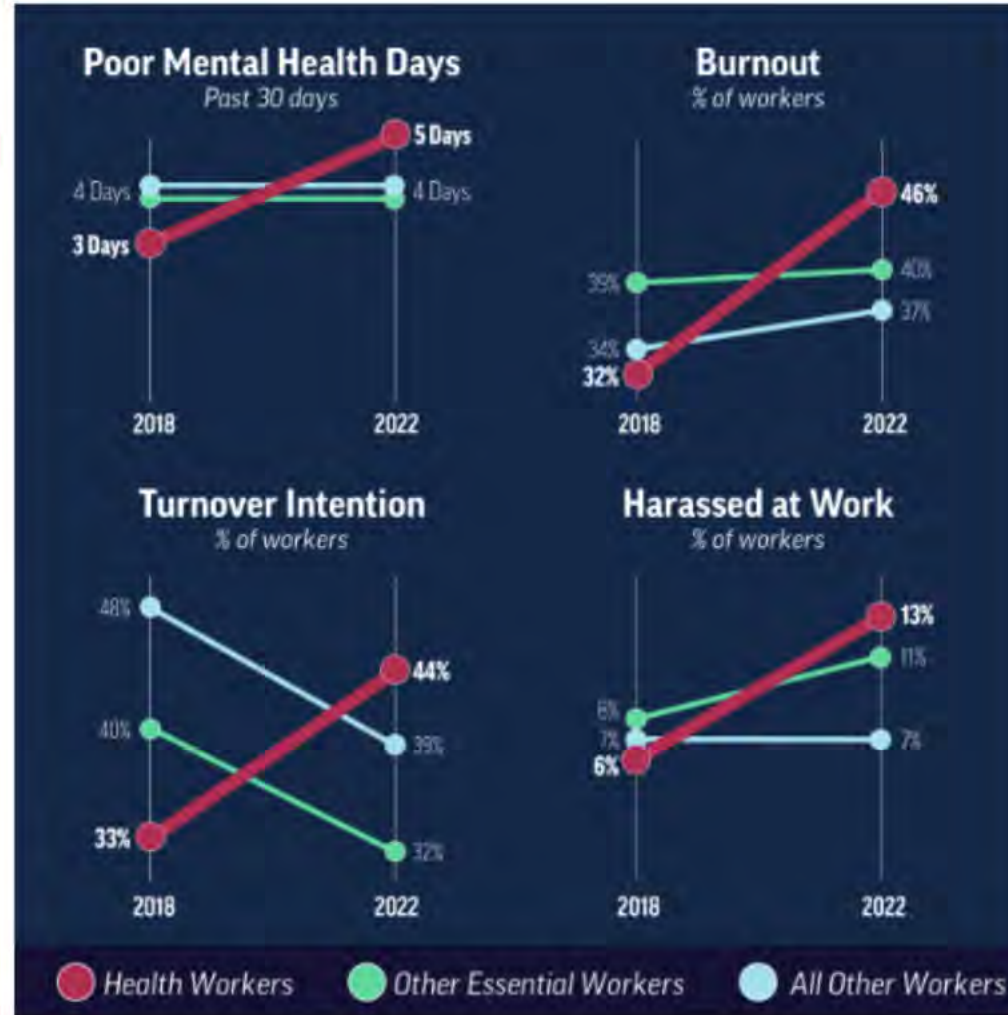
Data Specific to Palliative Care

- Most recent data published in 2020
- Surveyed AAHPM list serve in 2019
- Overall burnout rate 38.7 %
- Either high emotional exhaustion or high depersonalization
- 42% felt work left them enough time for personal life

- 32.3% were non-physicians and had higher odds of burnout
- No pediatrics-specific data

Kamal, et al 2020

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Challenges in Pediatric Palliative Care

"Even though I didn't say anything my presence felt, threatening. Because I was advocating for something that was different than what their plan was."

"I've had a doctor say like I want this kid to live so I don't want you to meet them. And I'm like me too. I also like we don't we don't try to kill our children."

""I think the biggest source of distress is other medical providers. So, I think, not understanding what our team does and how we can be helpful and not collaborating with us."
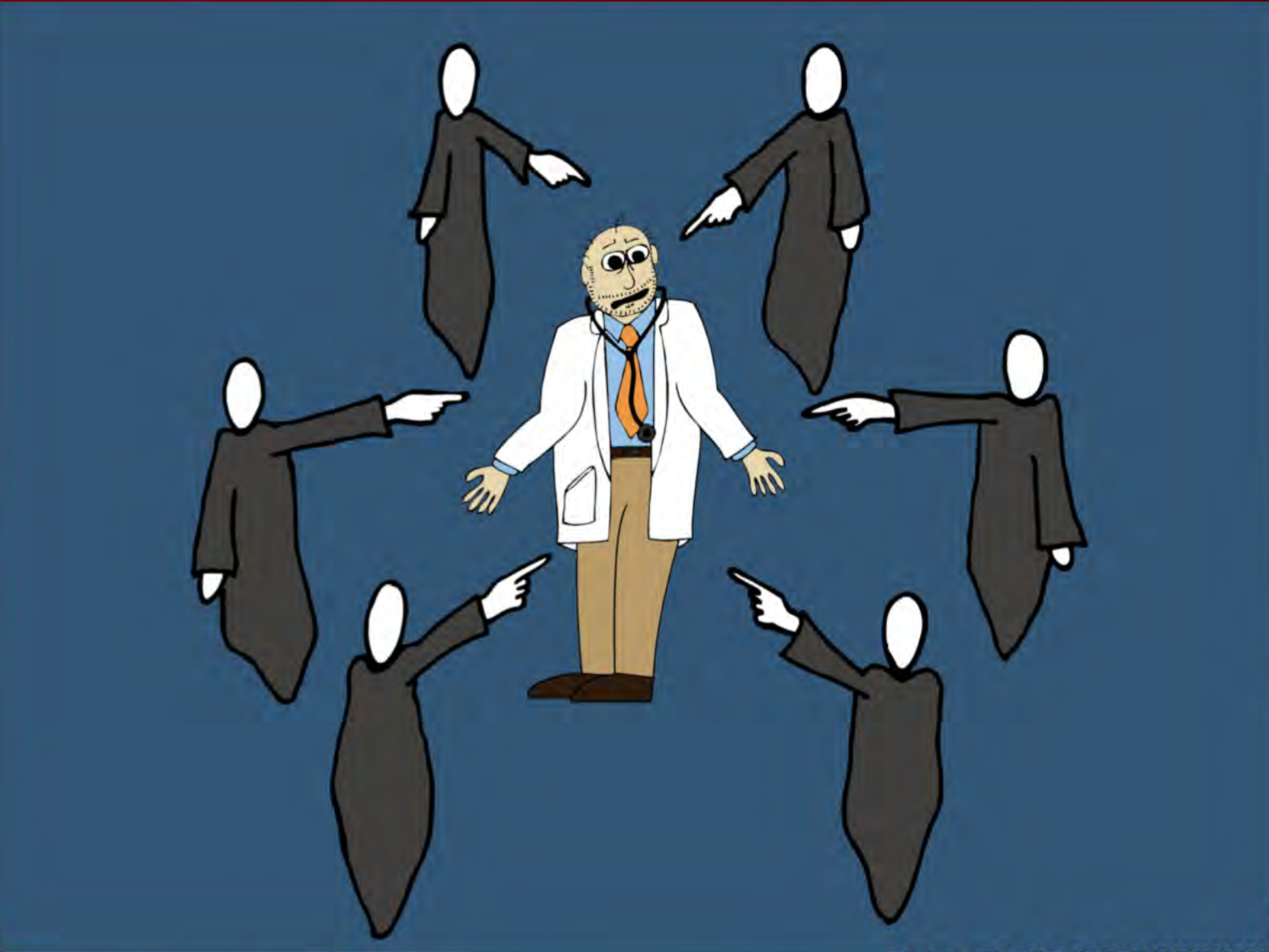
Artist credit: Joe Rotella

Spectrum of Clinician Mental Health

Spectrum of Clinician Mental Health

Spectrum of Clinician Mental Health

Thriving

Spectrum of Clinician Mental Health

Thriving

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Spectrum of Clinician Mental Health
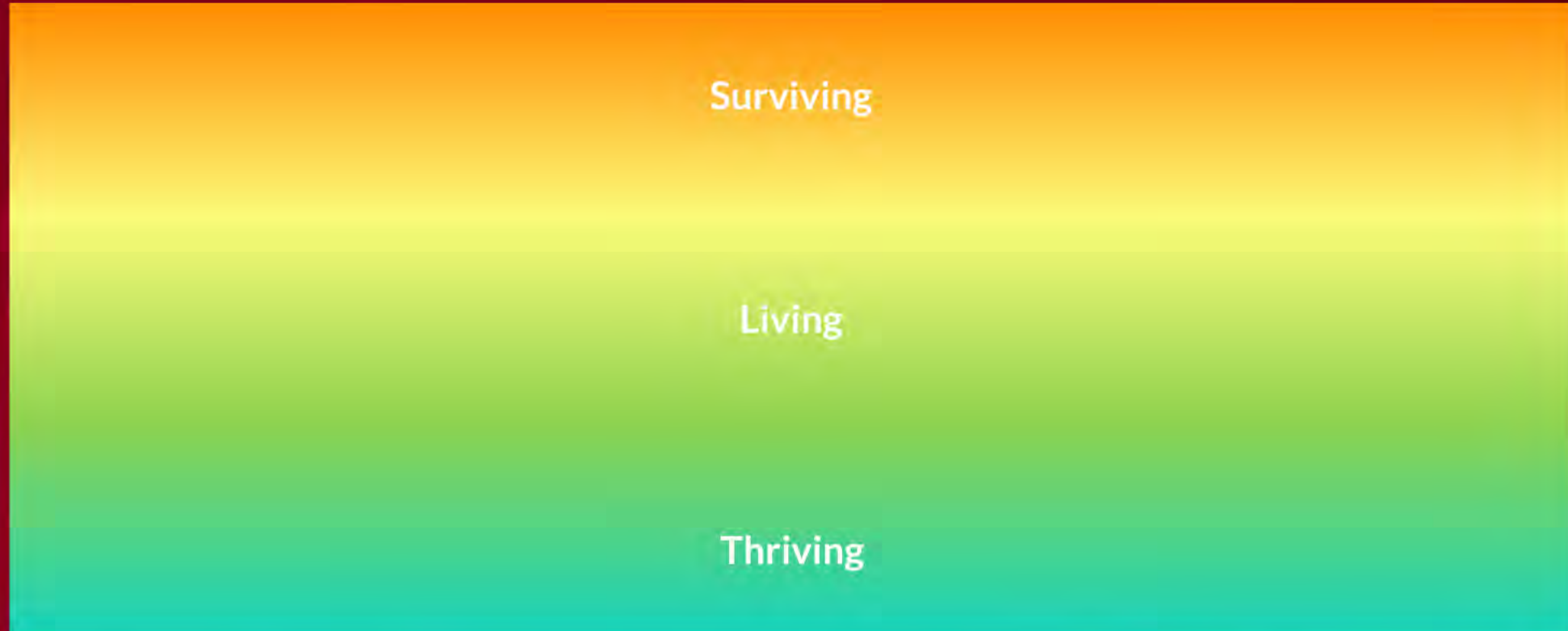
Spectrum of Clinician Mental Health

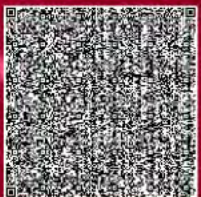# Spectrum of Clinician Mental Health

Suicide and Healthcare Workforce
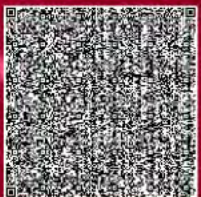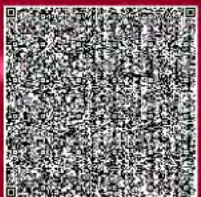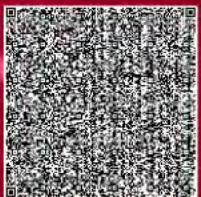
Annual standardized suicide rate per 100,000 persons

Olfson, et al 2023
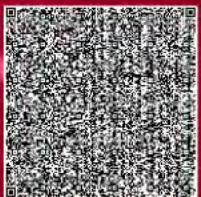
Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

12.6
lay public

Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

12.6
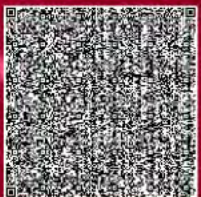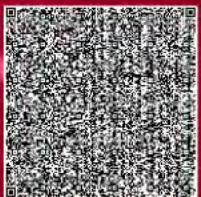lay public

Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

12.6
lay public

21.4
healthcare
support workers

Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

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                    |                          |              |
────────────────────┼──────────────────────────┼──────────────┼──────────
                   12.6                                      21.4
                 lay public                                healthcare
                                                         support workers
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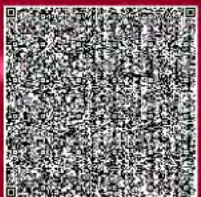
Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

12.6
lay public

16.0
RNs

21.4
healthcare
support workers

Olfson, et al 2023

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Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

12.6	15.6	16.0	21.4
lay public	health technicians	RNs	healthcare support workers

Olfson, et al 2023

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Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

| 12.6 | 15.6 | 16.0 | 21.4 |
| lay public | health technicians | RNs | healthcare support workers |

Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

| 12.6 | 13.1 | 15.6 | 16.0 | 21.4 |
| lay public | MD/DOs | health technicians | RNs | healthcare support workers |

Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

12.6	13.1		15.6	16.0	21.4
lay public	MD/DOs		health technicians	RNs	healthcare support workers

Olfson, et al 2023

Suicide and Healthcare Workforce

Annual standardized suicide rate per 100,000 persons

10.1	12.6	13.1	15.6	16.0	21.4
social/behavioral health workers	lay public	MD/DOs	health technicians	RNs	healthcare support workers

Olfson, et al 2023

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Other Physician-Specific Data

- 2019 systematic review and meta-analysis
- Standardized mortality rate for suicide in physicians was 1.44
- Women were at higher risk with SMR 1.9
- Suicide in physicians has been declining over time worldwide
- 1% death by suicide and 17% suicidal ideation

Dutheil, et al 2019

Drivers of suicide in healthcare

3 DRIVERS OF SUICIDE IN THE HEALTH CARE WORKFORCE

Stigma

The stigma associated with behavioral health disorders and the fear of losing their medical license often impacts health professionals' willingness to seek help and can increase the risk of suicide.

Access

Health care workers are most likely to seek out behavioral health and well-being services when there are multiple options that are accessible (via both on- and off-site care options), affordable, convenient and anonymous.

Job Stressors

Health care workers can experience situations on the job that are stressful, emotionally draining and uncertain. This can contribute to feelings of psychological distress that, when not addressed, can be detrimental to their mental well-being.

AHA Suicide Prevention Toolkit

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Strategies to Improve Wellness at the Individual, Team and Organizational Level
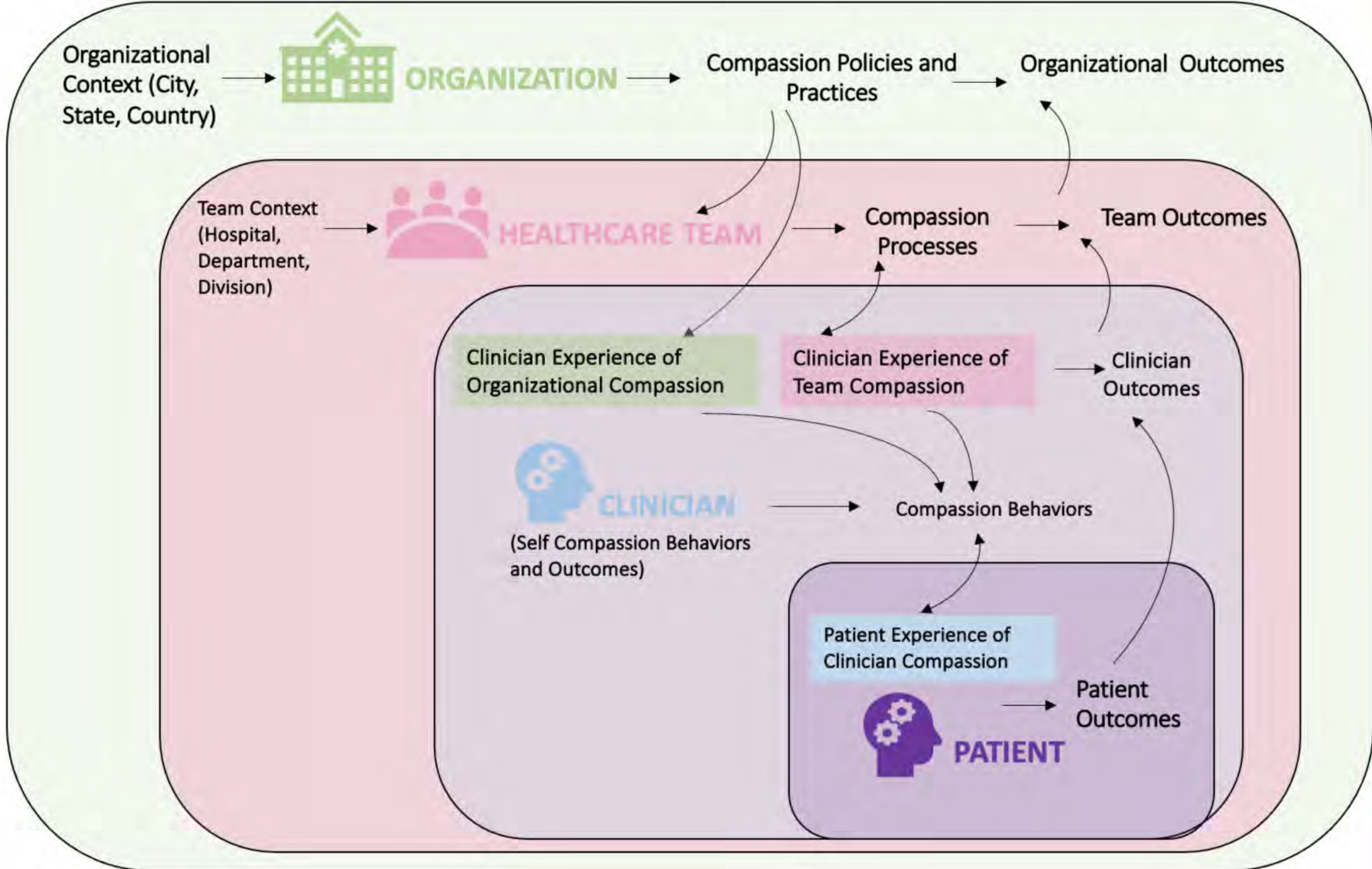
Surgeon General's Model of Workplace Well-being

Necessary but insufficient conditions

- Physical Safety

- Psychological Safety

- Justice (accountability)

- Adequate staffing (capacity)

How do you operationalize this- individual level?

- Self Compassion

- Self Care

- Boundaries

- Creating a culture that incentivizes and rewards these behaviors

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How do you operationalize this- Team?

THE STRESS CONTINUUM MODEL

READY	REACTIVE	INJURED	ILL

• Description:
  • Optimal functioning
  • Adaptive growth
 	
• Causes:
  • Health & wellbeing
  • Positive social environment
  • Resources
 	
• Features:
  • At one's best
  • Well-trained and prepared
  • In control
  • Physically, mentally and spiritually fit
  • Mission-focused
  • Motivated
  • Calm and steady
  • Having fun
  • Behaving ethically
	• Description:
	  • Mild transient distress/impairment
	  • Low risk, resolves
	
	• Causes:
	  • Any personal or professional stressor
	
	• Features:
	  • Irritability
	  • Feeling anxious or down
	  • Loss of motivation
	  • Loss of focus
	  • Difficulty sleeping
	  • Muscle tension or other physical changes and somatic symptoms
	  • Not having fun
		• Description:
		  • More severe, distress or impairment
		  • Leaves a scar
		  • Higher risk
		
		• Causes:
		  • Traumatic injury
		  • Grief injury
		  • Moral injury
		  • Fatigue injury
		  • Loss of control
		
		• Features:
		  • Panic, rage, intense anxiety or depression
		  • No longer feeling like normal self
		  • Excessive guilt, shame or blame
		  • Substance use
		  • Misconduct
			• Description:
			  • Clinical mental disorder
			  • Unhealed stress injury
			  • Persistent impairment
			
			• Causes:
			  • PTSD
			  • Depression
			  • Anxiety
			
			• Features:
			  • Symptoms persist and worsen over time
			  • Severe distress
			  • Social and occupational impairment

Schwartz Center for Compassion in Healthcare

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How do you operationalize this- Team?

STRESS FIRST AID MODEL

Seven Cs of Stress First Aid

1. CHECK
Assess: observe and listen

2. COORDINATE
Get help, refer as needed

3. COVER
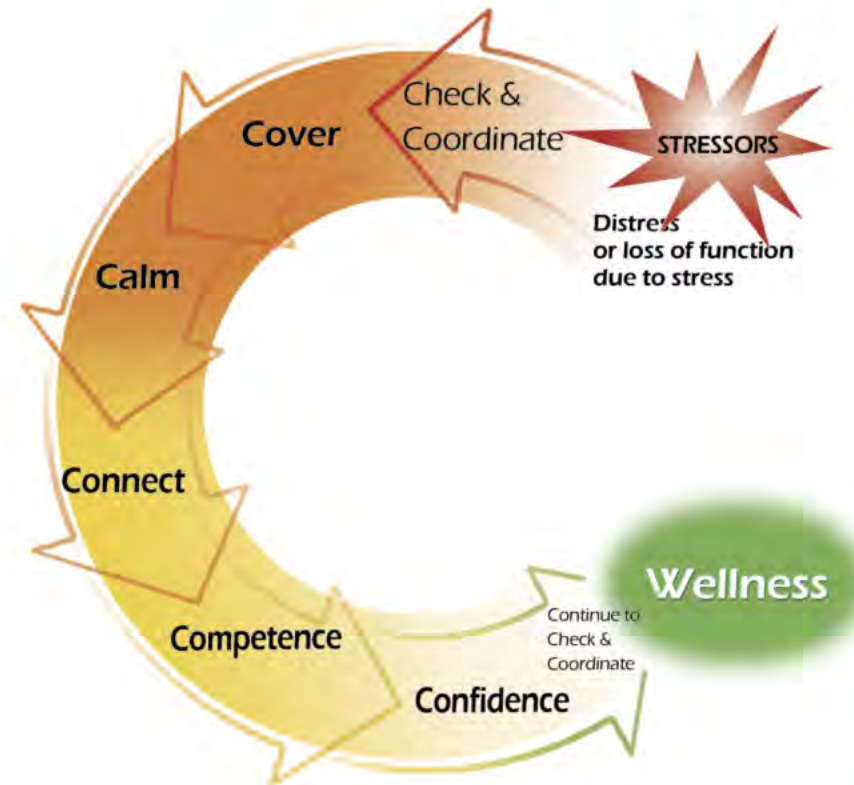Get to safety ASAP

4. CALM
Relax, slow down, refocus

5. CONNECT
Get support from others

6. COMPETENCE
Restore effectiveness

7. CONFIDENCE
Restore self-esteem and hope

Cover · Check & Coordinate · STRESSORS · Distress or loss of function due to stress · Calm · Connect · Wellness · Continue to Check & Coordinate · Competence · Confidence

How do you operationalize this- Team?

- Check on each other
- Share the workload
- Regular debriefing sessions
- Normalizing self care (flexibility for therapy)

Leadership

- Accountability for toxicity and bullying
- Let people know you value them
- Advocate for resources

How do you operationalize this organizationally?

- Healing Healthcare Initiative

- Congruency of organizational values and leadership behaviors
- Perception that leaders genuinely care
- Understanding needs of frontline staff
- Effective resources for self care (EAP)
- Willingness to change for the better
- Remove stigmatizing language from credentialing

- Justice, psychological safety, physical safety

My Approach

Quality Excellence

- Standardized measurement
- Drive improvement through sites of care
- Drive improvement through departments and divisions for faculty

Operational

- Supportive programs
  - Peer to Peer, Schwartz Center Program, Suicide Prevention, Stress First Aid, Joy In Work
- Robust, comprehensive, reliable crisis response
- Improving experience of our EAP
- Organizational grief

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LinkedIn

Quality and Research: Better Together

Christine Seel Ritchie
MD, MSPH
Kenneth L. Minaker, MD Endowed Chair in Geriatric Medicine
Research Director, Division of Palliative Care and Geriatric Medicine
Director, Center for Aging and Serious Illness, Mongan Institute at Massachusetts General Hospital
Professor of Medicine, Harvard Medical School

Understanding the evolving landscape is paramount for palliative care professionals. During this session, participants will learn to describe the need for quality and research in palliative care. Additionally, we'll explore the intersection of quality and research in clinical care and discovery. Participants will be engaged in a discussion that explores the opportunities to leverage quality efforts and optimize collaboration moving forward between the PCQC Registry, the Collaborative, and research networks in order to conduct evidence-based care.

Quality and Research: Better Together

Christine S. Ritchie, MD, MSPH

Professor of Medicine

Massachusetts General Hospital and Harvard Medical School

# Disclosure

I have no conflicts of interest to report.

Learning Outcomes

Upon Completing this session, participants will be able to:

1. Describe the need for quality and research in palliative care

2. Define quality and research and their intersection in clinical care and discovery

3. Discuss opportunities to leverage quality efforts and optimize collaboration between the PCQC Registry, Collaborative and research going forward

Quality vs Research

- **Research/Building Evidence**: the design, development, and evaluation of complex interventions to produce generalizable new knowledge

- **Quality** (Measurement and) **Improvement**: systematic, data-guided activities designed to bring about immediate, positive changes in the delivery of health care in particular settings

- **Quality**: the degree to which health services for persons and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge
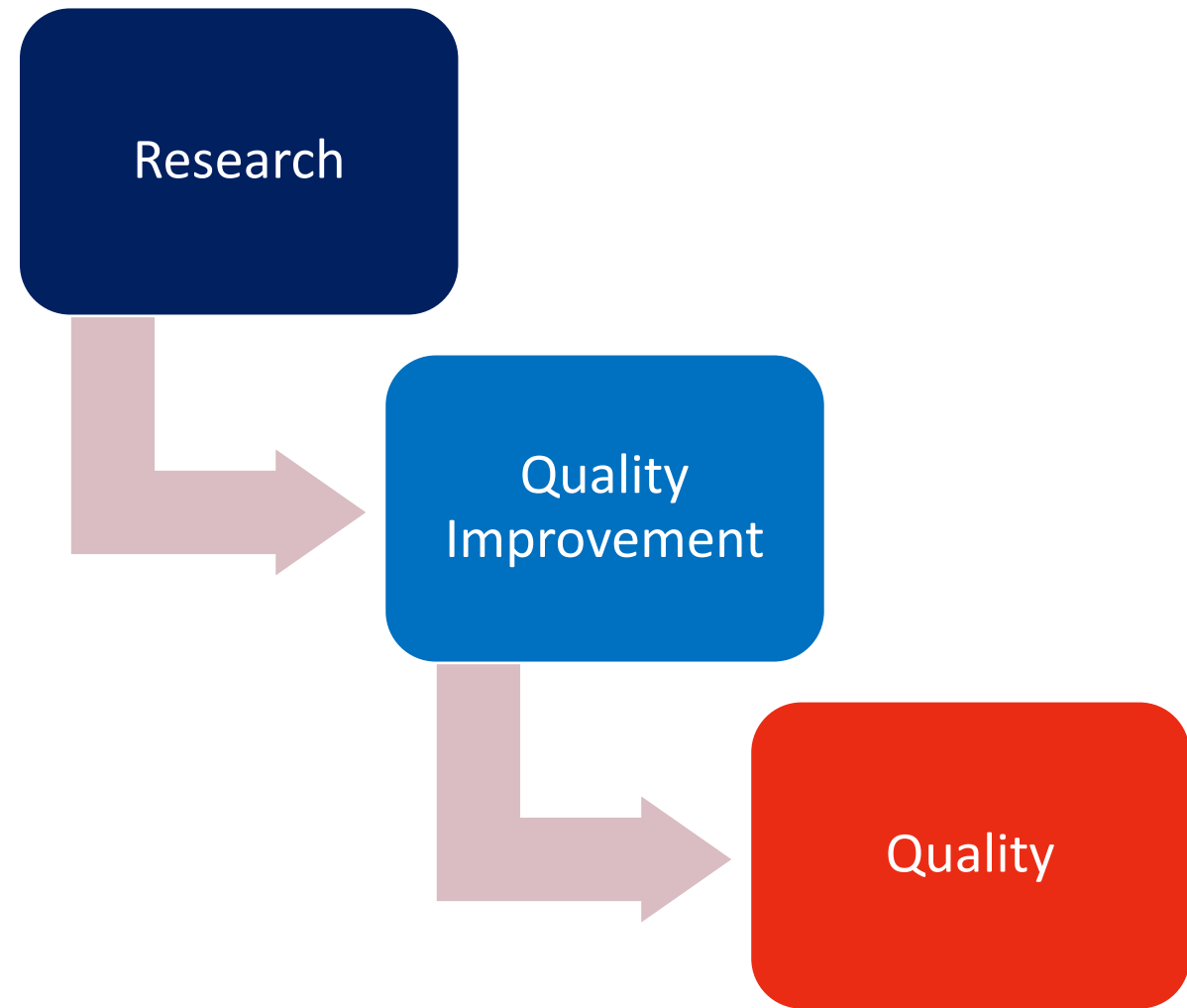
The Need for Palliative Care Evidence and Quality

The Field:

> Bright spots of evidence and quality
>
> BUT Not consistent across diagnoses

Components of Palliative Care Need More Evidence and Quality

> Symptom management
>
> Coping and adjusting to serious illness
>
> Communication/Treatment decisions/Advance care planning

What do you see as Bright Spots in our Palliative Care Evidence Base?

Bright Spots of Evidence

→ Greatest evidence for palliative care in oncology
- We know core components
- We see positive outcomes for palliative care multi-component interventions
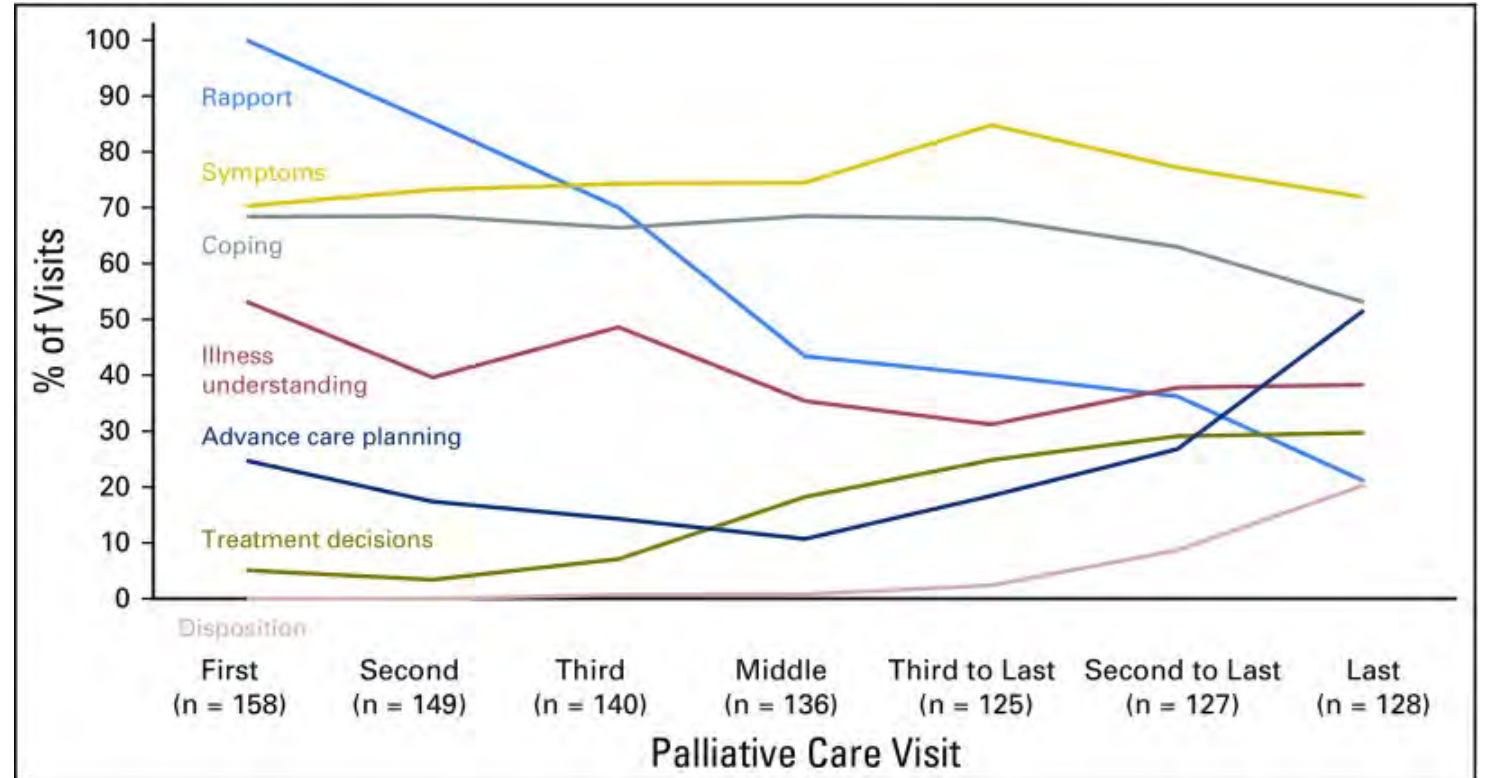
What do you see as Bright Spots in Palliative Care Quality?

Bright Spots of Quality

→ Quality of care in the ICU for hospitals engaged in PCQC

→ States with A grades

→ Interprofessional care in California hospitals

Utilization and Delivery of Specialty Palliative Care in the ICU: Insights from the Palliative Care Quality Network

Allyson Cook Chapman, MD, FACS,

Joseph A. Lin, MD,

Julien Cobert, MD,

Angela Marks, MSE,

Jessica Lin, MPH,

David L. O'Riordan, PhD,

Steven Z. Pantilat, MD

Division of Palliative Medicine, Department of Medicine (A.C.C., J.A.L., J.L., D.L.O.R., S.Z.P.), University of California San Francisco, San Francisco, California; Department of Surgery (A.C.C., J.A.L.), University of California San Francisco, San Francisco, California; Anesthesia Service (J.C.), San Francisco VA Health Care System, San Francisco, California; Critical Care Medicine, Department of Anesthesia (A.C.C., J.C.), University of California San Francisco, San Francisco, California; Department of Medicine (A.M.), University of California San Francisco, San Francisco, California

What do you see as evidence gaps?
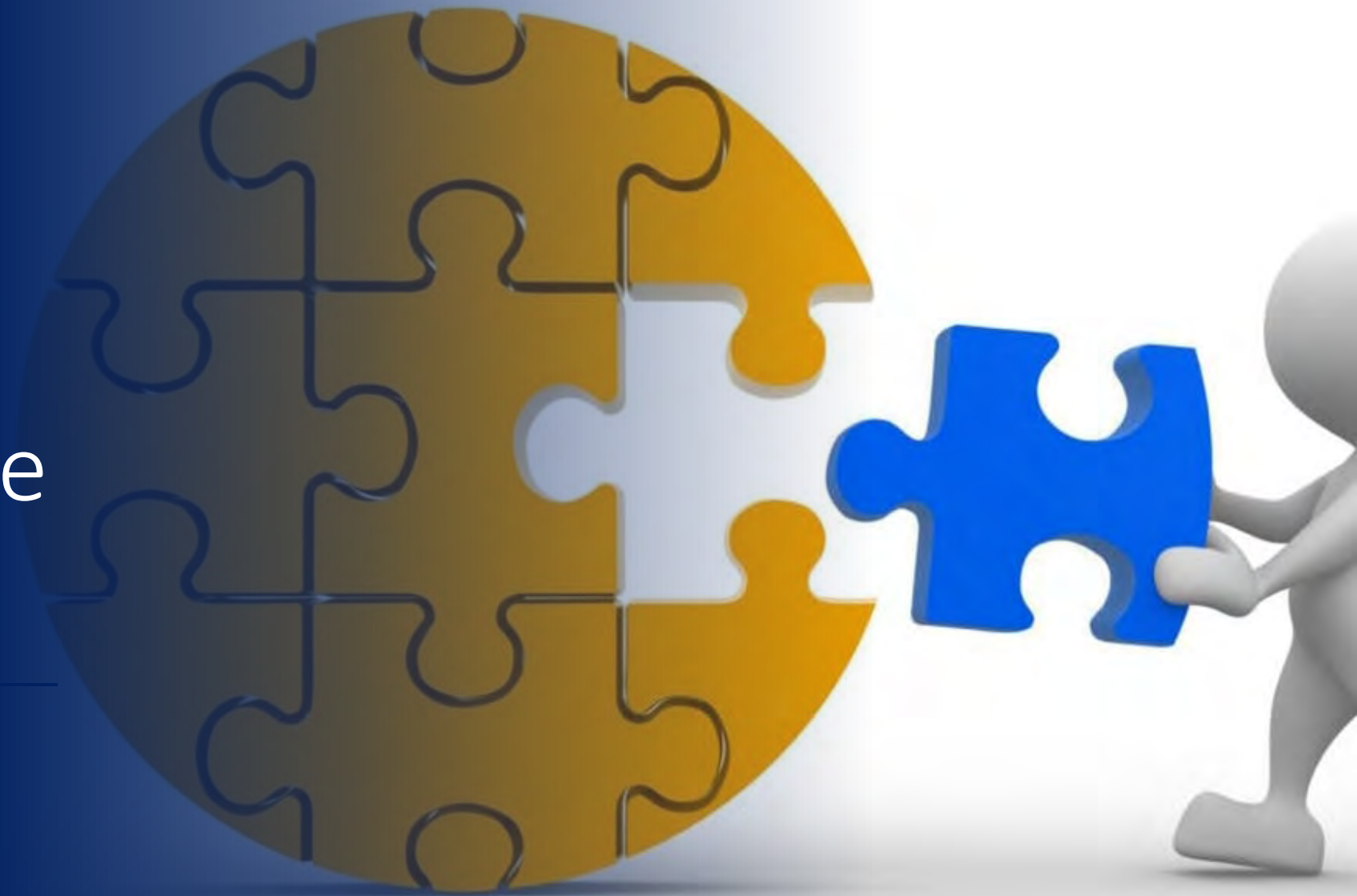
Evidence Gap

→ Least amount of evidence in pediatric non-oncological serious illness, multimorbidity, and dementia

→ Modest data on any of palliative care core components
- Symptoms
- Prognostication
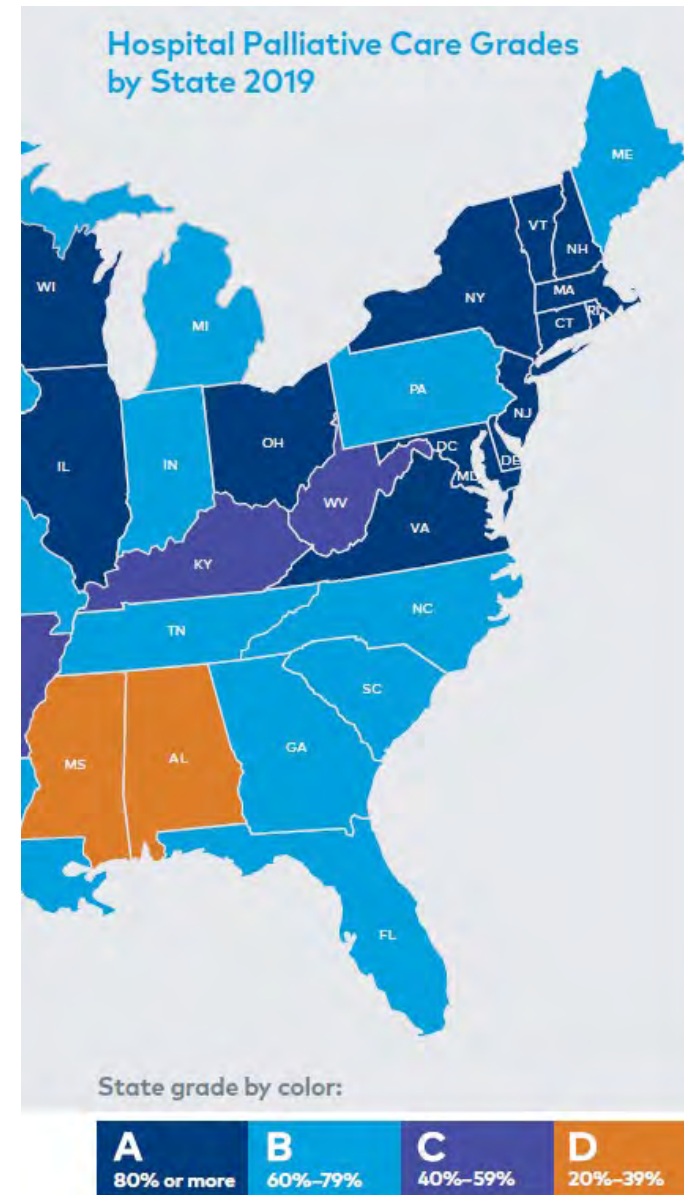- Shared decision making
- Cultural adaptation
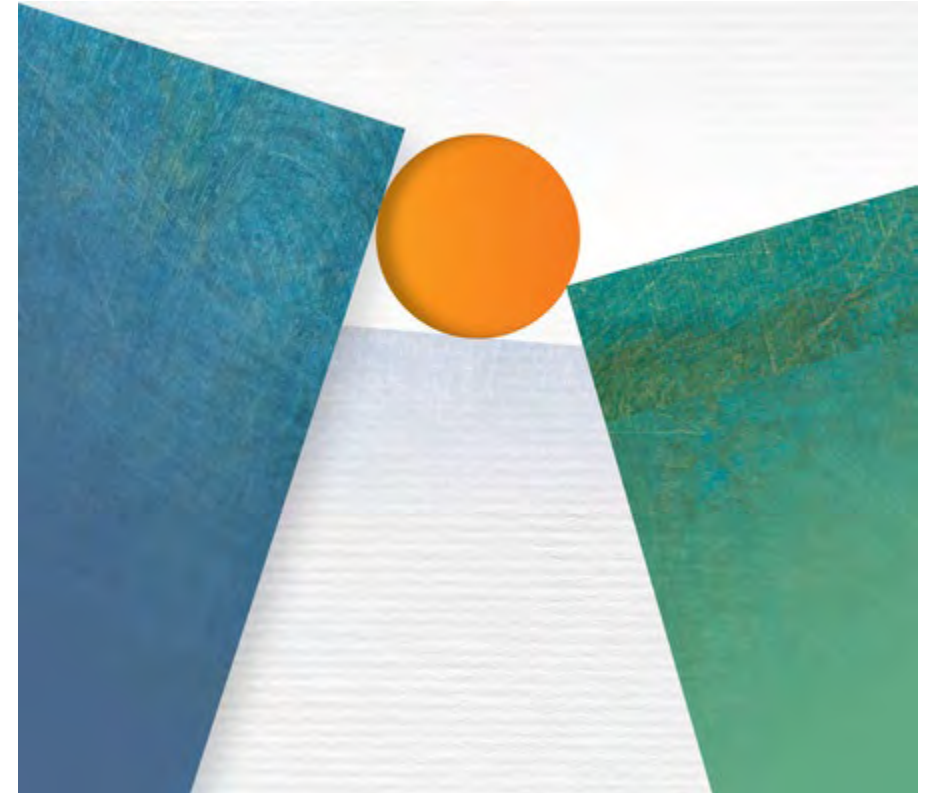
What do you see as quality gaps?

Quality Gap

→ Access to services

→ Quality of services

→ Integration of behavioral health

→ Consistent provision of interprofessional care

→ Proactive screening

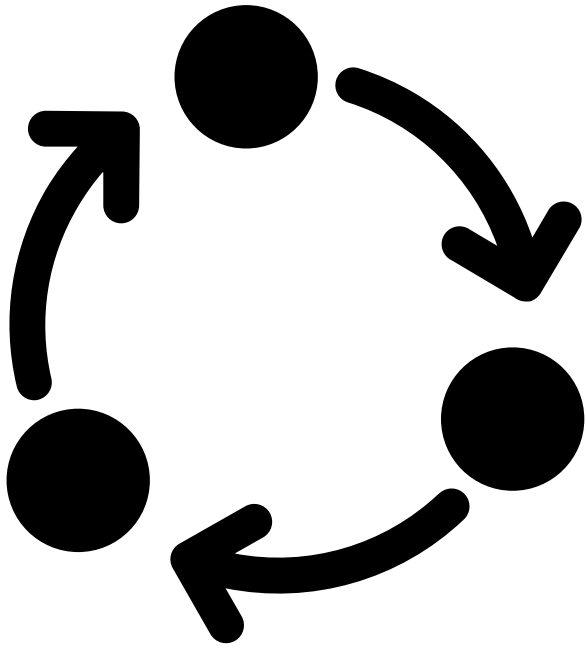→ Adaptation to specific cultural and language elements

Hospital Palliative Care Grades by State 2019

State grade by color:

| A 80% or more | B 60%–79% | C 40%–59% | D 20%–39% |

Quality Variability

Fig. 1 Hospital variability in pattern of care of brain tumor patients in the last 30 days of life
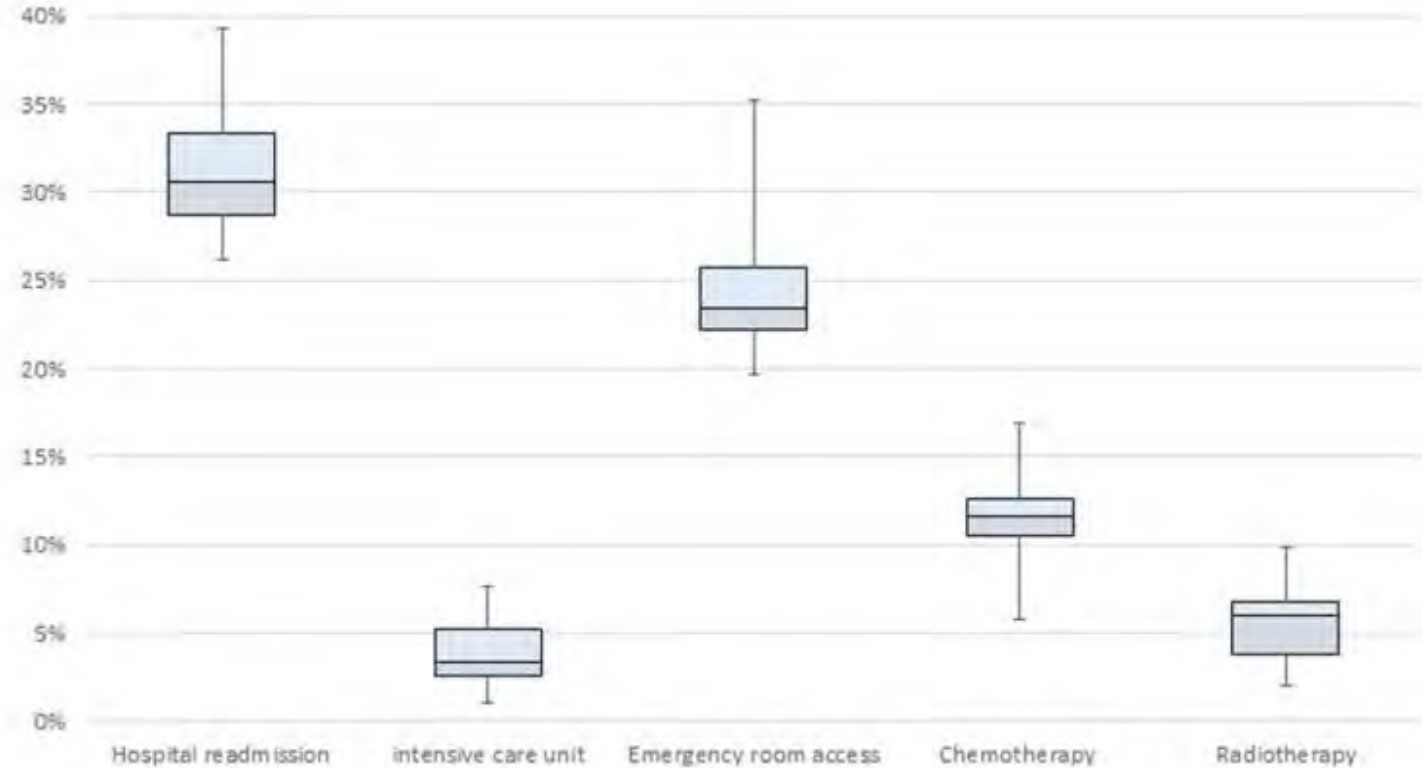
Evidence and Quality
Measurement:
a Positive Reinforcing Cycle

Your Ideas for the interface between Quality Measurement, Quality Improvement and Research?

PCQC and Research Opportunities

→ Based on the evidence, establish quality gaps

- Pain management in persons with SUDS
- Behavioral health in persons with serious illness and SMI
- Palliative care in rehabilitation settings

→ Create interventions to address gaps and test the interventions

- Use the PCQC to identify sites for multi-site studies
- Conduct natural experiments
- Work with the U54 Consortium to support early career investigators and pilot awardees

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- Quinn KL, Shurrab M, Gitau K, Kavalieratos D, Isenberg SR, Stall NM, Stukel TA, Goldman R, Horn D, Cram P, Detsky AS, Bell CM. Association of Receipt of Palliative Care Interventions With Health Care Use, Quality of Life, and Symptom Burden Among Adults With Chronic Noncancer Illness: A Systematic Review and Meta-analysis. JAMA. 2020 Oct 13;324(14):1439-1450. doi: 10.1001/jama.2020.14205. PMID: 33048152; PMCID: PMC8094426.

Thank You!

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- https://www.mghagingandseriousillness.org