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My comments should be received in light of my role as a measure developer of the ACOVE and ASSIST measures.

I do not believe the metrics should emphasize inpatient palliative care – a structural metric might be its ‘availability’ but specialist palliative delivery should be a specialist narrow band approach to improving end of life care instead of the main emphasis.

Measures that target population denominators instead of services are most needed. Those can focus on ‘vulnerable elders’ (ACOVE end of life measures) or cancer (ASSIST and others) Both of these measure sets focus on the population, not the service and are most appropriate. If other examples of such broadband approaches exist they are most appropriate for the needs. I do not seem them represented on the tables. All of the ACOVE and ASSIST measures meet full NQF requirements although they have not been submitted due to lack of resources to do so.

The VA uses the Bereaved Family Survey. An experience metric is crucial and a terrible omission. Given the lack of a validated broad measure, the focus should be on development or alternative ways of involving patients and families in program oversight. This should be a state policy priority to fund someone to develop these measures for integrated payment and delivery models.

Healthcare use measures are entirely appropriate. Patients and families should have a voice, more than nominally, in selecting, operationalizing, and specifying aggregated measures of efficiency as well as overall quality. How is there voice represented in this process?