

LTC Pain



THE INSTITUTE FOR
PALLIATIVE MEDICINE
at San Diego Hospice

To prevent and
relieve suffering,
and promote quality of life
at every stage of life

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at San Diego Hospice

**Breathing Life into
Palliative Care
Standards &
Outcome Measures**

Frank D. Ferris, MD

Institute for Palliative Medicine
at San Diego Hospice

University of California San Diego
University of Toronto

Standards / Outcome Measures

1. What is quality palliative care ?
2. Model of Patient / Family Care
3. Organizational Standards / Outcomes
4. Regional / National Standards / Outcomes

Standards / Outcome Measures

1. What is quality palliative care ?
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Imagine . . .

**What quality
of palliative care
would you like ?**

Role-play...

Perspectives

- Patient / family
- Staff
- Administrators
- Policy-makers, regulators
- Funders
- Accreditors

Standards / Outcome Measures

1. What is quality palliative care ?
2. **Model of Patient / Family Care**
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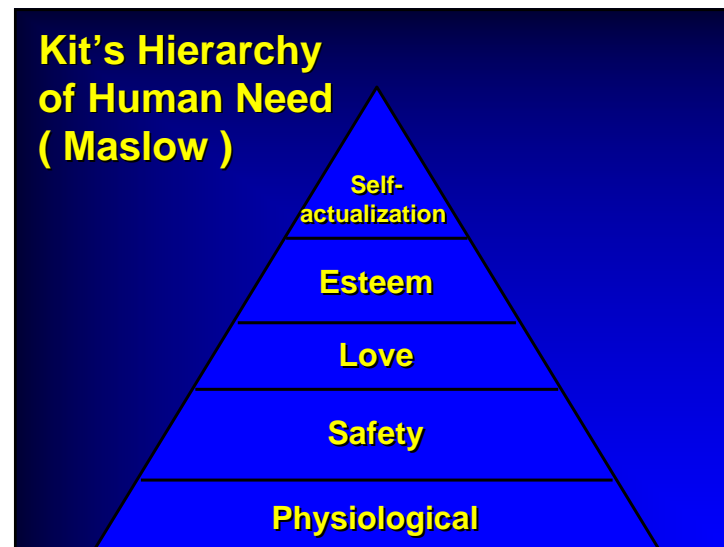
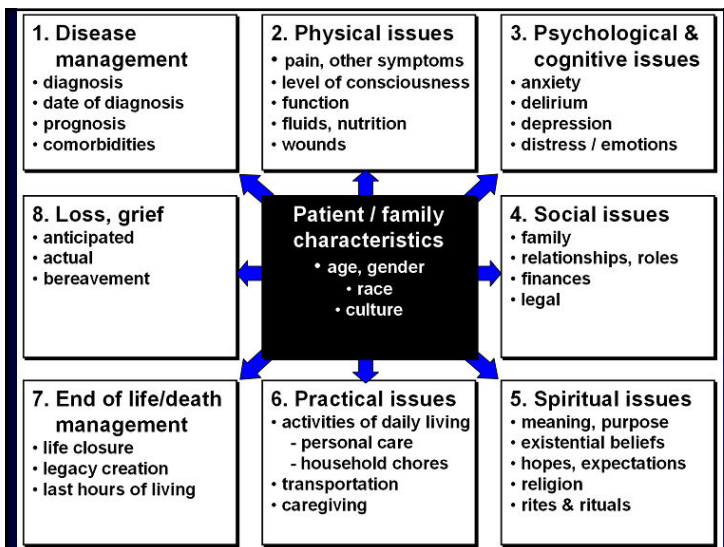
Kit
58 yo Health Care Executive

- Peripheral lung mass
- Resected – Adenocarcinoma
- No primary or other metastases



Kit:
days post OR

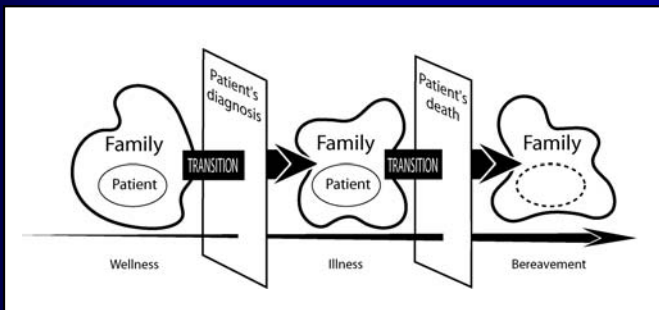
- Post thoracotomy pain syndrome
- Opioids and adjuvants controlled

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Who is Affected



Why does Kit come to the Healthcare system ?

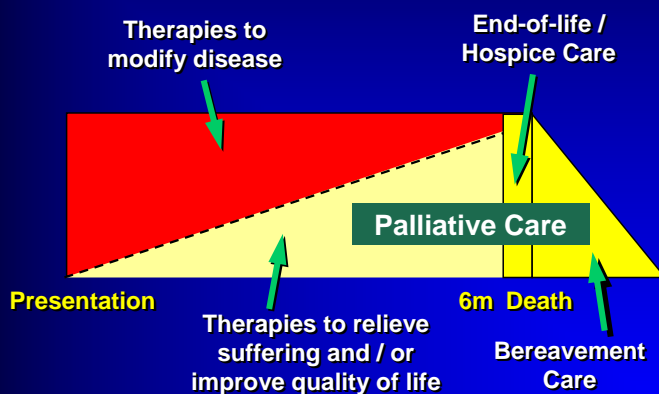
Normal path of life with an anticipated future



Illness path with an uncertain future

Help me fix my broken story (Brody)

Palliative Care



Therapeutic process

- | | | |
|-----------------------------|----------------|--|
| | Situation | |
| | Before Care | |
| | Initial: | |
| Patient / Family Experience | • Disease | |
| | • Issues | |
| | • Distress | |
| | • Needs | |
| | • Expectations | |
| | • Hopes | |
| | • Satisfaction | |

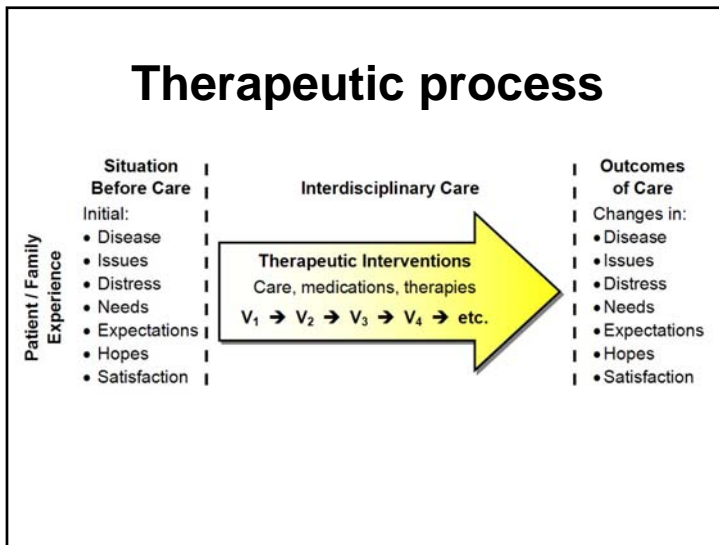
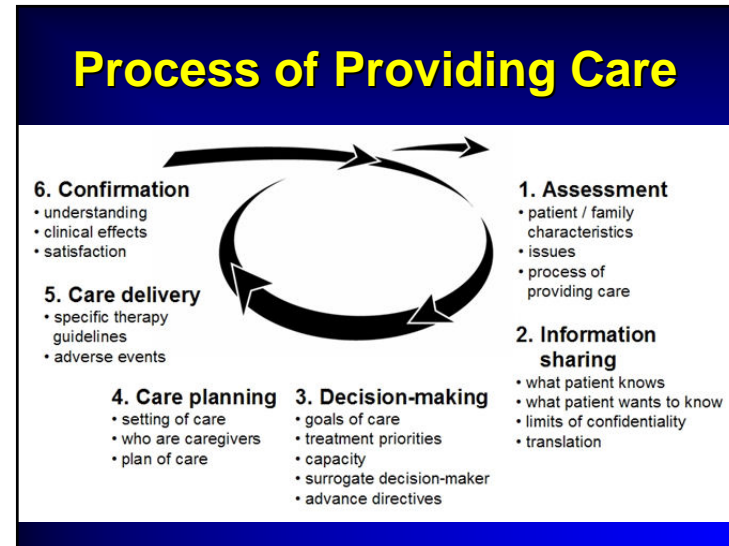
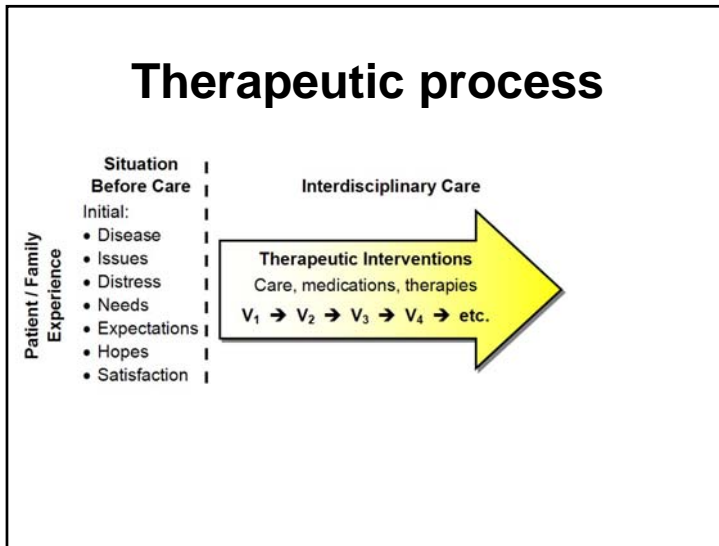
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Square of Care

		Process of Providing Care (Skills)					
		1. Assessment	2. Information Sharing	3. Decision-making	4. Care Planning	5. Care Delivery	6. Confirmation
Issues Patients & Families Experience (Knowledge)	A. Disease Management						
	B. Physical						
	C. Psychological						
	D. Social						
	E. Spiritual						
	F. Practical						
	G. End-of-life / Death Management						
	H. Loss, Grief, Bereavement						
Healthcare System							
Ethics / Laws							
Common Language							
Culture (Individuals, Healthcare System)							

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Standards / Outcome Measures

1. What is quality palliative care ?
2. Model of Patient / Family Care
3. Organizational Standards / Outcomes
4. Regional / National Standards / Outcomes

Organizational Standards / Outcome Measures

- 01: Define process
- 02: Adopt a model of patient / family care
- 03: Create shared strategic plan
- 04: Develop a shared approach to patient / family care
- 05: Develop a quality improvement strategy

Organizational Standards / Outcome Measures

- 01: Define process
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Pre-negotiate process

- Committee to lead
- Inclusive consensus-building process
 - Delphi technique
 - Group forming, storming, norming, performing
- Values, principles guiding discussions
- Process to collect staff opinions

Guiding principles

- Engage everyone – staff & volunteers likes to contribute
 - Needs to own and implement
- “ People who help build a plan, don’t battle the plan;
People who don’t participate, often throw stones “

Ground rules

1. Agree that quality process is important
2. Honest, open, share opinions
3. Listen
4. Consensus = 75 % agreement
5. Agree to work with the results
 - Even if they don’t agree with the results

Organizational Standards / Outcome Measures

- O1: Define process
- O2: Adopt a model of patient / family care
- O3: Create shared strategic plan
- O4: Develop a shared approach to patient / family care
- O5: Develop a quality improvement strategy

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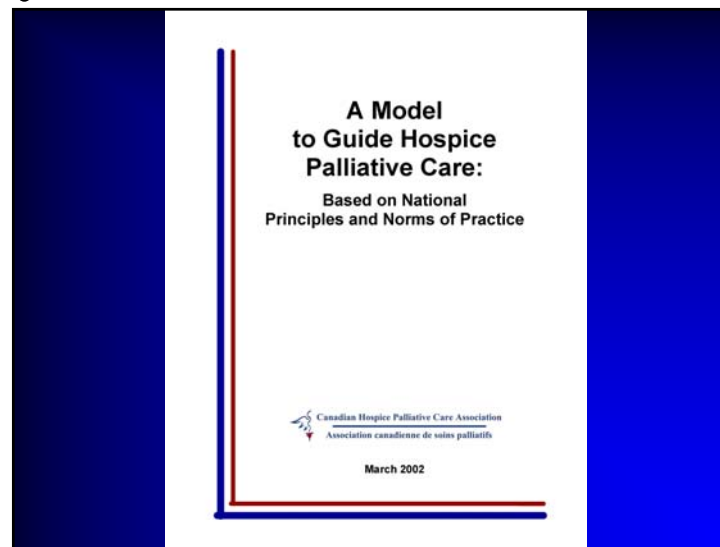
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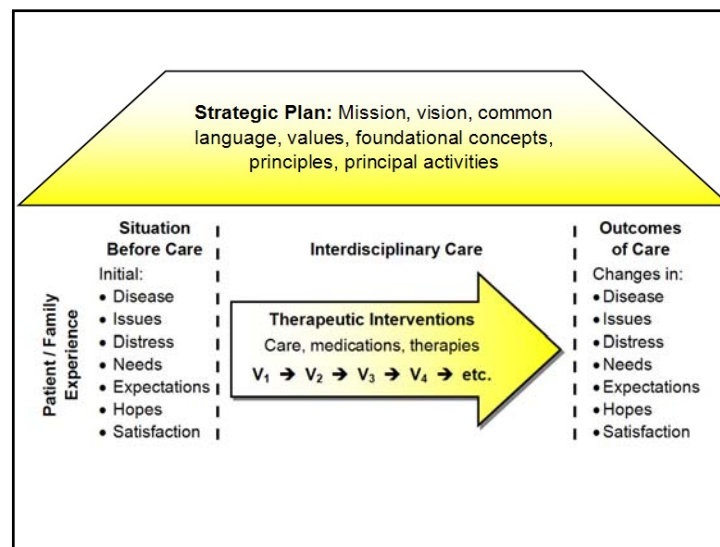
Adopt / Customize an Existing Model

- Dutch National Model
- Australia
- Canadian Hospice Palliative Care Association
- UK Nice
- US National Consensus Guidelines
- US National Quality Forum



Organizational Standards / Outcome Measures

- O1:** Define process
- O2:** Adopt a model of patient / family care
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Who knows their strategic plan ?



SAN DIEGO HOSPICE
and The Institute for Palliative Medicine

Our Mission

To prevent and relieve suffering,
and promote quality of life
at every stage of life
through patient and family care,
education, research and advocacy

Common language

Let's Talk About



SAN DIEGO HOSPICE
and The Institute for Palliative Medicine

We believe
no one
should die
feeling
alone.



Children
deserve
to have
their grief
honored
and their
lives
celebrated.



We believe
no one
should live
in pain.



Beliefs

Everyone
deserves the
right to be
a partner in
his/her care,
not just
a patient.



No one
should live
in fear.



We are
changing
the way
people face
living, dying
and death...
...for the
better.



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Values in Action

- Respect
- Integrity
- Honesty
- Trust
- Accountability


Organizational Standards / Outcome Measures

- O1: Define process
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Guidelines

- Practice
 - Pain assessment & management
 - Advance care planning
- Treatment
 - Morphine use
 - Massage

Education Strategy - Dixon 6

1. Awareness / Attitudes
 2. Knowledge
 3. Skills
 4. Behavior
 - Change Experience
 5. Patient / Family
 6. Organization / Society
- 

Dixon J. Evaluation and the Health Professions, 1978.

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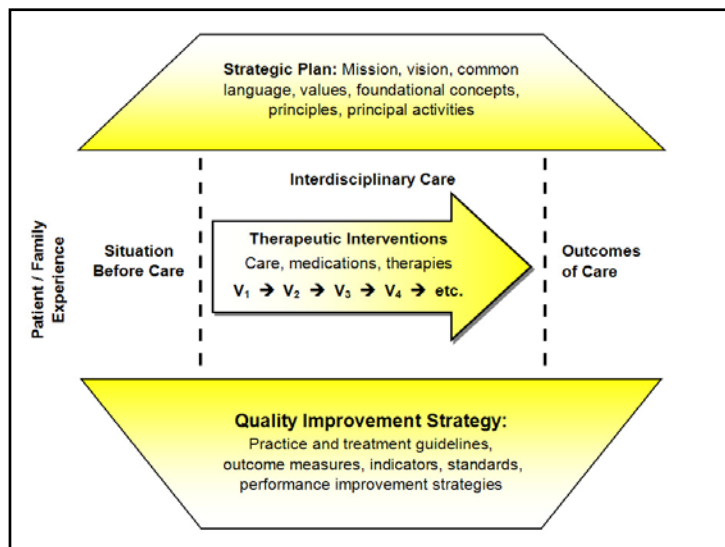
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Pain Management

- Consensus tools
 - Assessment – 5 fields
 - Location
 - Type
 - Change over time
 - Severity
 - Effect of medications + / -
 - Titration – catch-up technique
 - Equianalgesic dosing
- Mandatory education
 - All clinical staff (500)
 - 4 @ 2 hour modules
 - 2.5 years to complete

Organizational Standards / Outcome Measures

- O1: Define process
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Quality Improvement

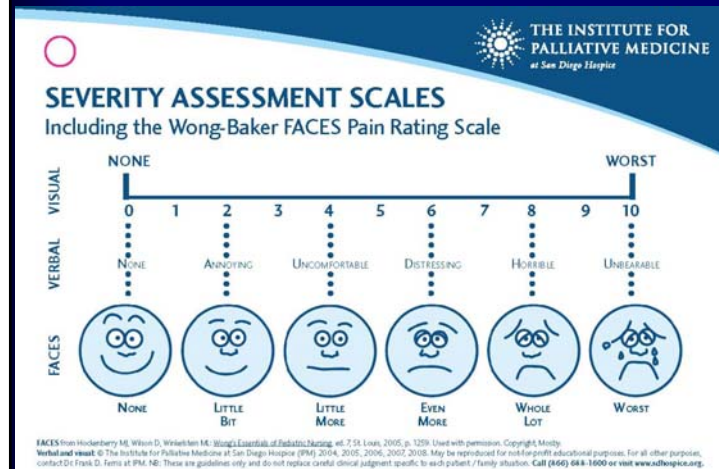
- Standards (targets)
- Outcome measures
 - Simple, eg, pain severity
- Indicators
 - Complex
- Performance improvement strategy

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Pain Standards

- > 90 % of care plans follow the network's policies and procedures
- The incidence of medication interactions and adverse events is < 1 %
- > 90 % of patients and families express their acceptance of the therapies offered to manage their pain
- 50 % pts have pain < 5 / 10 within 48 hr admission

Pain Outcome Measure



Pain indicator 2005-6

% Pts Whose Pain Brought To A Comfortable Level Within 48hrs of Admisson to SDHPC As Reported by Patient or PCG*

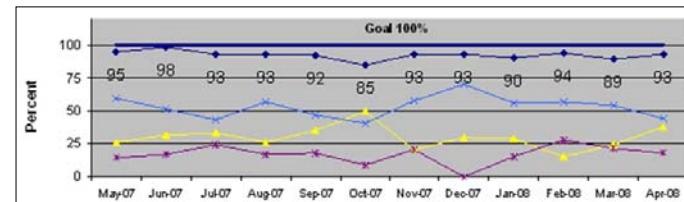


Pain Indicator 2007-8

% Pts Whose Pain Brought To A Comfortable Level Within 48hrs of Admisson to SDHPC As Reported by Patient or PCG*



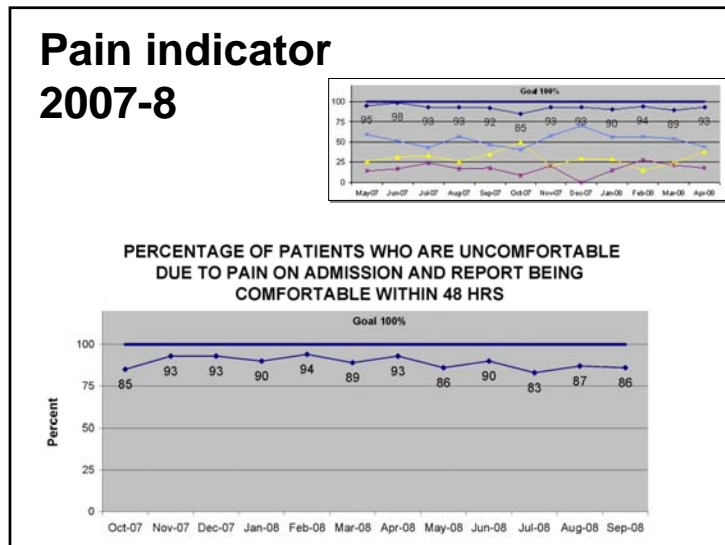
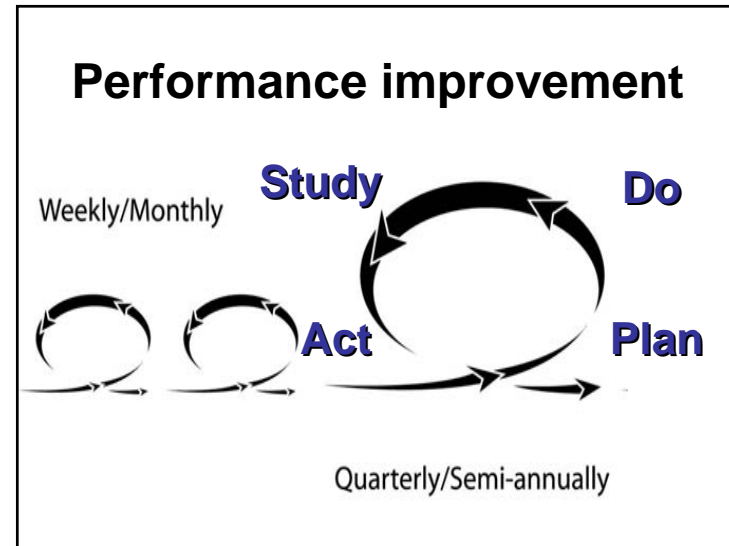
% Patients Whose Pain Brought to a Comfortable Level within 48 Hours of Admission



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Square of Care

		Practice and Treatment Guidelines (Essential Steps in the Process of Providing Care)						Outcome Measures	Standards – Process, Outcomes
		1. Assess	2. Share information	3. Make decisions	4. Plan Care	5. Deliver Care	6. Confirm		
Patient / Family Issues	Disease management								
	Pain	✗	✗	✗	✗	✗	✗	✗	✗
	Psychological								
	Social								
	Spiritual								
	Practical								
	End-of-life Care / Death management								
Loss, grief									



Same process nationally . . .

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National Standards / Outcome Measures

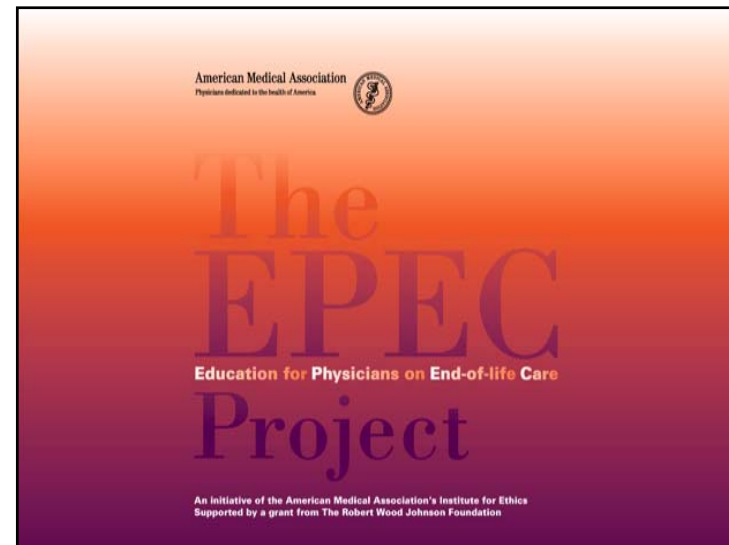
- N1:** Define process
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National Standards / Outcome Measures

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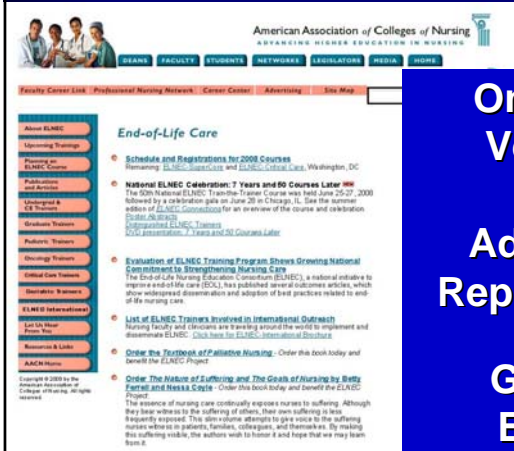
Palliative Care Education

- 1. All health care workers**
Basic knowledge / skills



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ELNEC – Nursing Curricula



Oncology
Version:
Open
Adaptable
Reproducible

Google:
ELNEC

Palliative Care Education

1. All health care workers
Basic knowledge / skills
2. Clinicians seeing a lot, eg, AIDS, geriatrics, oncology
Advanced knowledge / skills



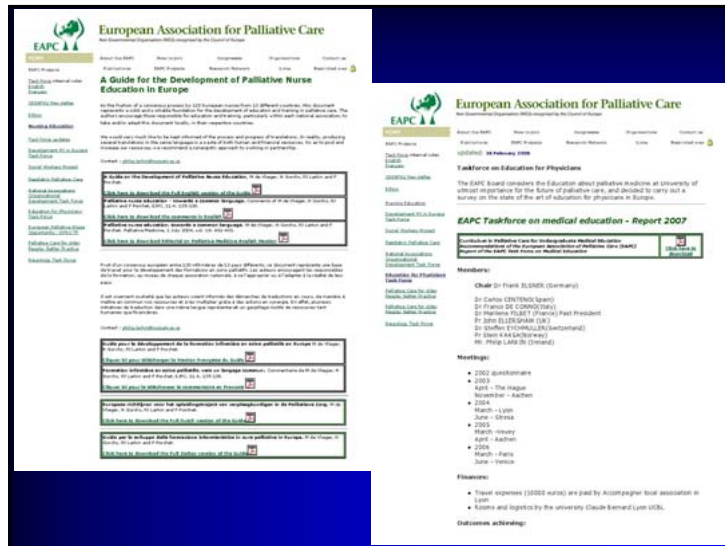
Open
Adaptable
Reproducible
Free CD / DVD

Google:
EPEC-O

Palliative Care Education

1. All health care workers
Basic knowledge / skills
2. Clinicians seeing a lot, eg, AIDS, geriatrics, oncology
Advanced knowledge / skills
3. Palliative care experts
Expert skills
Fellowship training / exams
Advanced degrees

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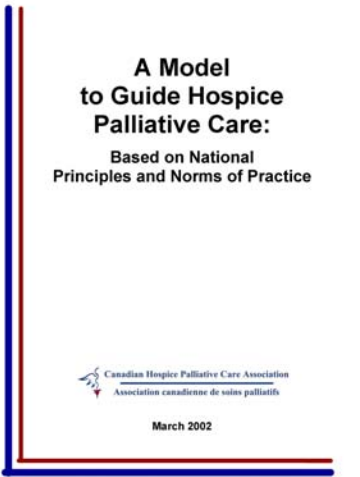


Kwaliteitskader voor het opleiden van verpleegkundigen in de palliatieve zorg in Nederland, 2008



National Standards / Outcome Measures

- N1:** Define process
- N2:** Adopt a model of patient / family care
- N3:** Create shared strategic plan
- N4:** Develop a shared approach to patient / family care
- N5:** Develop a national quality improvement strategy



- National consensus-building process
- 1993-95 – Committee / First working document
- 1997 – National workshops / consensus ?
- 2001 – Proposed Norms of Practice / consensus ?
- 2002 – National Model

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National Outcomes / Indicators

- Bench-marking
- SECPAL
- Accreditation
- National Quality Forum
- JCAHO / JCI
- Report cards



Special Article

Implementing Quality Palliative Care

Frank D. Ferris, MD, Xavier Gómez-Batiste, MD, PhD, Carl Johan Fürst, MD, and Stephen Connor, PhD
San Diego Hospice & Palliative Care (E.D.F.), San Diego, California, USA; Institut Català d'Oncologia (X.G.-B.), Barcelona, Spain; Stockholms Sjukhem Foundation (C.J.F.), Stockholm, Sweden; and National Hospice and Palliative Care Organization (S.C.), Alexandria, Virginia, USA

Abstract

Quality palliative care is of interest to everyone who is receiving or providing care. The quality of the care that is provided depends on everyone's understanding of the underlying model that is guiding patient/family care; the organization's mission and vision; and the consistency of the language, practice and treatment guidelines, outcome assessment and performance improvement strategies that everyone is using from day-to-day. Implementation of quality palliative care within an organization starts with careful strategic planning

National viewpoint

How to ensure good quality palliative care: a Spanish model

In the first of a two-part series, Xavier Gómez-Batiste, Frank Ferris, Josep Maria Plana, Miquel Pal, Jose Espinosa, Josep Puria Sales and Jaume Espinosa describe a model for the evaluation and improvement of the quality of care for patients with terminal illness

Advances in palliative care research – in the evaluation, testing and research – in the evaluation and improvement of the quality of care. This is not to be confused with the usual, reactive objectives and actions for the short, medium and long term.

Several criteria were used to evaluate and improve the quality of palliative care services and, specifically, of specialist palliative care services or other services that had a high number of patients with advanced terminal illness. Evaluation was through quantitative and qualitative aspects, in a combination of levels. This article presents a pragmatic approach based on a comprehensive model of care that includes all the areas of need of patients and their families. We present a preliminary evaluation and the care that can be used by the palliative team. It includes quantitative and



The number of the image 2008 in Barcelona, Spain, at which the authors report to evaluate quality of care has been low

Key points

- This article describes a system for evaluating and improving the quality of specialist and conventional healthcare services for patients with advanced terminal illness and their families.
- The system is based on something known as the 'Square of Care' model composed with an adapted version of a model used for organizational management systems.
- The model has been used for four years at the Catalan Institute of Oncology (ICO) in Barcelona, Spain, but is suitable for any healthcare service that deals with patients with advanced terminal illness and their families.
- Its use could result in a systematic plan of improvement, including a set of quality measures for change relating to the clinical and organizational aspects of the service.

National viewpoint

Ensure quality public health programmes: a Spanish model

In the second of a two-part series, Xavier Gómez-Batiste, Frank Ferris, Miquel Pal, Jose Espinosa, Josep Puria Sales, Jan Sjöerqvist and Jaume Espinosa look at a pragmatic approach to improving the quality of palliative care public health programmes

Palliative care public health programmes were proposed by the WHO in the 1980s, and have since been developed, in order that palliative care is a key element of any public healthcare system. Several programmes have shown good results in terms of coverage, effectiveness, efficiency and satisfaction with the service.¹⁻³

When considering how to evaluate and improve the quality of a PCHP, several approaches can be used, either quantitative or qualitative or both. This article reviews the state of PCHPs, the indicators involved in evaluation and suggested areas for improvement.

The authors propose a model based on a comprehensive quantitative and qualitative aspects of care. This model involves selecting key objectives of a palliative care service and using a pragmatic but systematic approach. This approach is based on concrete quantitative indicators as well as on an adaptation of the ECOM model of evaluation and improvement of quality. The ECOM model is a framework for

organizational management systems proposed by the European Foundation for Quality Management – see the first article on this subject in this previous issue of this journal.⁴ The model proposed here has been used to evaluate a 12-year project of Catalonia (Spain), the WHO Demonstration Project.⁵ It could be of interest to planners, health departments, decision-makers and service managers.

The need for a systematic approach

Access to palliative care is now seen as a basic human right and, therefore, the provision of such care should be one of the core elements of any healthcare system. Palliative care has been defined as the trade between care and suffering.^{6,7}

Since 1995, several regional and national governments have developed models of palliative care, one of them being the WHO Demonstration Project.⁸ More recently, the WHO principles for public health programmes have been disseminated and accepted.⁹ Similarly, today, many regions and countries follow these principles to implement their programmes using a systematic approach.¹⁰⁻¹²

There is a growing need for systematic approaches such as the WHO PCHPs, given the quality of the service they provide and the need to improve their practices and establish standards to enable comparison between services.

Definitions and aspects of care

A PCHP can be defined as one that covers a specific population within the principles and methodology of public health care and is led by a public health administration, in collaboration with healthcare professionals, service providers and volunteers.

It may be a local, district-wide, regional or national. It is publicly financed and its main aim is to improve systematic, quality palliative care that is accessible and equitable.¹³

Key points

- Palliative care public health programmes (PCHPs) were proposed by the WHO in the 1980s, and have since been developed, in order that palliative care is a key element of any public health system.
- There is a growing need for systematic assessment tools to evaluate PCHPs, assess the quality of the service they provide, describe ways of improving their practices and establish standards to enable comparison between services.
- The authors propose a model – quantitative and qualitative – based on a comprehensive quantitative and qualitative aspects of care. This model involves selecting key objectives of a palliative care service and using a pragmatic but systematic approach. This approach is based on concrete quantitative indicators as well as on an adaptation of the ECOM model of evaluation and improvement of quality. The ECOM model is a framework for

Is it worth the effort ?

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Kit: 6 Months

- Recurrence in axillary lymph nodes
- Chemo: partial response
 - XRT: partial response
- Chemo: stable disease
 - Resection?
 - Progression



Kit: 21 months

- Hospice care 3 months
- Oncologist attending
 - Resolution
 - Gifts
 - Surprises



5-year Impact Canadian Model

- | | |
|---|--|
| <ul style="list-style-type: none"> • Endorsements • Patient / family care <ul style="list-style-type: none"> Part of 2004 National Health Accord All provinces now have palliative care formularies • Accreditation – CCHSA | <ul style="list-style-type: none"> • Education <ul style="list-style-type: none"> EFPPEC – 17 medical schools • Research – CIHR • Companion documents <ul style="list-style-type: none"> Nursing, volunteer, residential hospices, pediatrics |
|---|--|

**What Experience . . .
your patients & families,
your loved ones, and
ultimately yourselves?**



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**“ The standards of practice we create
and the people we train
will look after you
when it’s your turn to receive care. . .**

**Will the Netherlands be ready
in time for you ? ”**



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