

Pediatric Palliative Care Quality Plan

PURPOSE

The purpose of this plan is to promote the delivery of quality palliative care to children with life limiting conditions and to their families in the military system. Ultimately it is the intent to support military parents of children with life limiting conditions and promote effective patient partnerships. Ultimately, quality care contributes to supporting military readiness under extreme personal and family situations.

GOALS¹

- 1) Address pain and symptom control, psychosocial distress, spiritual issues and practical needs with the child and family throughout the continuum of care
- 2) Promote advance care planning and the application of principles of palliative care by healthcare professional in all settings
- 3) Provide children and families with the information they need in an ongoing and understandable manner so that they can grasp their condition and treatment options. This includes eliciting their values and goals over time; regularly reassessing the benefits and burdens of treatment; and ensuring that the decision-making process about the care plan is sensitive to changes in the child's condition
- 4) Ensure genuine coordination and continuity of care across settings through regular, high-quality communication among healthcare professionals at times of transition or changing needs and through the provision of effective continuity of care that utilizes the techniques of case management
- 5) Prepare both the child and family for the dying process and for death, when it is anticipated; explore hospice option and ensure that opportunities for personal growth are enhanced and that bereavement support is available for the family; and continue bereavement support for the family beyond the patient's death.
- 6) Deliver palliative care through an organized structure that promotes a child/family centered model of interdisciplinary team care.

It is not necessary to include all 6 goals in your quality plan; an organization can pick those specific goals that reflect the intent of your program or add other goals that relate to your program type.

¹ National Quality Forum, A national Framework and Preferred Practices for Palliative and Hospice Care Quality, A Consensus Report, 2006, p. 4-5.

FRAMEWORK FOR QUALITY IN PEDIATRIC PALLIATIVE CARE

Principles which serve as a foundation for a pediatric model of palliative care are:²

- Children/ adolescents with a life limiting condition and members of their families have easy access to a comprehensive, coordinated, competent continuum of care in their community
- Care is family centered in its philosophy, values, practices and operation and seeks to support the child/ family culture, values, beliefs, priorities, circumstances, choices and structure
- Care and services are delivered in to child and family according to generally accepted ethical standards
- Management and operations are conducted as a comprehensive integrated continuum of services operating according to nationally recognized standards of care, evidence based treatments, and best practices and is accountable to all appropriate licensure, regulatory and accreditation bodies
- Care is delivered through an interdisciplinary approach
- Admission to palliative care services are barrier free and provide timely response to initial and presenting problems with access to on-call staff from the time of admission
- Comprehensive assessment processes and documentation are used to support the goals and plan of care and are identified as important to the child/ adolescent and family. The assessment process is ongoing to support changing and progressing needs
- A comprehensive written plan of care is used to delineate the needs, hopes and goals of each child/adolescent and family. The plan addresses the medical, nursing, psychological, spiritual and practical concerns and problems and identifies achievable outcomes and results. The plan integrates activity of the team implementing medical treatment services and the team implementing palliative services
- Care is delivered in an integrated and coordinated manner that promotes continuity across inpatient, outpatient, and community settings. This care delivery system includes a system for care management and a mechanism to include continuity across relationships important to the child/adolescent and family, such as school, religious affiliation, and community activities
- The range and intensity of symptoms which cause distress to a child/ adolescent and family are managed to achieve the most attainable quality of life
- Care includes access to a competent continuum of counseling and supportive services to assist with the physical, emotional and spiritual issues, interpersonal dynamics and psychosocial dimensions of their experience
- Family members or children/adolescents who die may continue to need supportive and/or professional services following the child's/adolescent's death for a period of time that varies among families and family members.

These principles have been developed by Children's Hospice International for the purpose of CHI PACC program development and were designed specifically for a pediatric population. Other principles of care can be included to meet the needs of the program type.

² Children's Hospice International, CHI PACC Implementation Manual, 2nd edition, 2003, P. 52-70, Principle of Care with Practice Guidelines

OVERSIGHT OF THE QUALITY PROGRAM

Level 1 (*This is the highest level of oversight and may be an Installation Commander of a MTF or other executive role in the organization. Replace this heading with the actual title of the role*)

This role provides the global oversight to the Quality Program and Plan with the assistance of the Level 2 (*insert title of level 2 role*). This role would be responsible for reviewing quarterly Quality reports and provides recommendations to the Quality Committee with input from Level 2 role described below.

Level 2 (*This level is typically leaders of various specialty divisions. They may represent clinical and administrative areas of a facility. Replace this heading with the actual title of the role*)

The Level 2 role is responsible for oversight of quality improvement activities and development of quality indicators within their respective Divisions and scope of responsibilities. This level will act as a resource and provide support to task forces or subcommittees chartered by a Quality Committee.

Quality Improvement Facilitator

The role of the Quality Improvement Facilitator is to monitor quality improvement activities and serve as a resource to the Level 2 role described above. The Quality Improvement Facilitator serves as the chairperson for the Quality Improvement Committee and is responsible for the following:

- Oversight relative to compliance with regulations, standards of care and installation policies.
- Identifies areas needing monitoring; with recommendations and input from other leaders within the organization.
- Assists with the gathering and analyzing of data.
- Assists with identifying patterns and trends.
- Assists with formulating and developing reports,
- Monitors follow up plans from Division and Program Leaders
- Acts as a consultant to issues of quality for subcommittees or other entities within the organization.

Identified patterns and trends may require a quality improvement initiative from the Quality Improvement Committee to the affected divisions. *An initiative, for example, may stem from the Satisfaction Survey. Families may indicate dissatisfaction with the referral/appointment process (i.e. a prolonged delay before seeing a pediatric specialist.). The Task Force assigned, may review the referral/appointment process and identify areas needing improvement.*

TEMPLATE

Quality Improvement Committee

The Quality Improvement Committee supports the Quality Program and Plan through participation, research and recommendations. The Committee will:

- Identify good practices or processes (i.e. - a patient's pain threshold will be kept at a minimum level of 3; on a scale of 1 to 10)
- Identify areas to be monitored (i.e. - pain thresholds of patients)
- Define benchmarks or standards that signal monitoring (i.e. - Focused monitoring will occur when 20% of the patients population experienced a pain level of 6 consistently)
- Identify desired outcomes. (i.e. - 95% of the patients with pain will be kept at a pain threshold of 3)
- Identify specific, measurable goals for a chartered Quality Work Group. (i.e. - Identify alternate treatment regimes for patients who do not respond to traditional pain medication.)
- Prioritize quality improvement activities/initiatives.
- Reviews monitoring reports and provide recommendations,
- Encourage collaboration among divisions and programs by chartering task force groups. (i.e. - The medical and nursing division work together to monitor, treat and decrease patients pain levels over 5
- Act as a catalyst to implement change in an effort to improve the quality of services

Please note that the examples used in this section relate to pain management, however any process can be applied within this structure.

The Quality Improvement Committee reviews reports following monitoring activities. The Committee may concur with the recommendations made by program leaders regarding any trends or patterns identified; or make further recommendations. If further information is needed a task force or subcommittee may be initiated. The Quality Improvement Committee will monitor follow up from any action plans generated from the subcommittee or task force.

The membership of the QI Committee includes: *(this is an example of how the committee could be structured)*

- Quality Improvement Facilitator
- Parent representative
- Deputy
- Medical Team member
- Surgical Team member
- Palliative Care Team member
- Social Services Team member
- Chaplain Services
- Information Technology representative (as needed)
- Administrative Support

TEMPLATE

The Quality Improvement Committee meets monthly. *Meeting frequency is determined by the committee but should be a regularly scheduled event.* Reports and minutes will be made available to the Level 2 and Level 1 roles by e-mail, report or presentation.

The Committee annually evaluates the Quality Improvement Plan and determines the priorities for the upcoming year. These priorities are developed with the assistance of the Division and Program Leaders.

A common component to delivering quality is the use of various committees to support decisions related to opportunities for improvement. For the purpose of palliative care, the committee could be an already existing one that addresses issues related to service delivery or quality or could be an advisory type committee composed of a subset of stakeholders. Often advisory committees include parents to ensure a balanced perspective for direction.

Palliative Care Committee

(This committee can also be composed of the champions of your palliative care effort. In some situations it may be just a few members who represent the individuals with expertise in your palliative care effort.)

The Palliative Care Committee addresses processes that affect the care of children and their family with life threatening and terminal illnesses.

The Committee will:

- Design, manage and monitor the palliative care delivery system.
- Develop and review policies and procedures.
- Define standards for palliative care.
- Develop tools and methods for measuring standards of palliative practice to improve family satisfaction.
- Addresses ethical issues related to palliative care.
- Collaborate with other involved entities

Subcommittees or Task Force Groups

Subcommittees or Task Force Groups are teams that are initiated by the Quality Improvement Committee. They are cross-functional, multidisciplinary, and formed when an issue is identified and a smaller group is needed to collect additional information or work on strategies to improve care practices, delivery systems, documentation, competencies of personnel etc.

Once the assignment has been completed, the Subcommittee or Task Force will report their findings and recommendations to the Quality Improvement Committee for review.

TEMPLATE

QUALITY IMPROVEMENT MONITORING PROCESS

The framework used for monitoring in this template is the Logic Model; however other models can be substituted as an alternate process for monitoring.

Framework for the Process Improvement and Outcome Analysis -

The **Program Logic Model**³ for Planning, Evaluation and Action, was created by the W.K Kellogg Foundation in 1998, with an update in 2003. The model provides the path to plan, design, implement, and analyze processes that can/will improve the quality of services. As defined by the W.K. Kellogg Foundation – “The program logic model is a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcome (both short and long term) with program activities/processes and the theoretical assumptions/principles of the program.” By reviewing and answering the questions in each phase the QI Committee or any Division, Program or Task Force can get a clearer picture of the issue and how to address it.

Logic Model Process –

The **first phase** of the logic model is the planning/identification phase.

- What is the problem or issue to solve?
- What are the needs of the patient/family, personnel or facility?
- What resources are available to help solve the problem or issue. (human resources, financial, technology etc).
- What things or people in the organization will influence change?
- What existing processes, tools, events, technology, or actions will help to solve the problem/issue?
- What activities does the organization believe/assume will solve the problem and why.

The **second phase** is to review what the organization intends to produce or change.

- What are the “now” deliverables or products produced by the activities
- What are the benefits/changes in individual behavior, knowledge, skills or functioning levels?
- What are the timeframes to achieve goals - 1-3 years (short term) or 4-6 years (long term)
- What will be the global changes in the organization, community or systems once the problem has been resolved. (This may be seen after several months or several years)

³ Logic Model Development Guide, Battle Creek, MI, W. K. Kellogg Foundation, 1998.

TEMPLATE

The **third phase** is to develop indicators or monitors that will measure the activities performed. Indicators are related to structures, processes or outcomes.

Structures are defined as resources (staff qualifications, office equipment, educational handout) that assist an organization achieve its mission and goals. (i.e. - All pediatric physicians who work with palliative care patients have background in terminal & life threatening illnesses.)

Processes are defined as procedures. (ie - The patient has an appointment with the pediatric medical specialist within 2 weeks of the referral.)

Outcomes are defined as what is expected from a change in a structure or process that has positive effect on personnel, patients/family members or healthcare providers. (ie - 95% of the pediatric patients with terminal or life threatening illnesses was seen by a qualified pediatrician and was initiated into the palliative care program within 2 weeks of the initial referral.)

When to Monitor -

Monitoring timeframes depends on the level of priority identified by the Division or Program or when there is an issue identified in:

- Division, Program or Personnel expectations
- Patient and family satisfaction
- Initiation of a new process or procedure
- High risk procedures
- Problem prone areas
- High cost processes
- Document completeness, accuracy or timely submission

Data can be Collected various areas which include, but not limited to:

- Division or Program reports
- Surveys or Questionnaires
- Complaints
- Patient medical files
- Billing reports

The **sampling size** will be determined by the significance of the study. Routine sampling will be 15 – 20% of the sample population. Critical sampling will be 100% for areas needing full compliance or consisting of a small population.

Sampling percentages can be determined by the entity implementing the Quality Plan.

TEMPLATE

The **fourth phase** is to evaluate the data and to determine if the goal was reached and the problem solved. If the problem/issues are not solved, than the logic model is repeated, with revised assumptions and strategies.

Quality Improvement Reports should follow a consistent format when presented to a committee. An example is provided

Format Elements

- Name of the Study
- Why the Study was Chosen
- Date of the Study
- Timeframe of the sample
- Standards and Thresholds (Benchmark)
- Where data was collected
- Sample Size
- Results
- Analysis/Patterns/Trends
- Recommendations
- Date and to whom report was given
- Action Plans
- Responsible Person to Facilitate Plan
- Due date

Example of Report Format

Pain Management of Children with malignancies.
There were numerous complaints from family members regarding their child suffering with consistent pain.
4/16/07
January to March 2007
90% of the population studied will have a maximum pain threshold of 4 consistently.
Patient medical record
40 children with malignancy (ICD 9 code) 100% of the population.
5 children (12%) had their pain level consistently at level 4 during their treatment.
35 of the 40 children did not receive adequate medication to relieve pain.
There were no trends related to one medical specialist.
Review treatment regimes.
Educate medical personnel on treatment regimes.
Review patient population 2 months after plan is in affect.
5/2/07 Report to QI Committee
Review treatment regimes.
Educate medical personnel on treatment regimes.
Medical Division Leader
August 2007

Reporting Pathway -

Reports are presented by the Palliative Care Program to the QI Committee for review and recommendations. Abbreviated reports are given to the Installation Commander from the Deputies. All recommendations provided to the Divisions and Programs will be reviewed for feasibility. Action plans will be executed per a designated timeframe. Results from these actions plans will reported by the Division Leaders to the Palliative Care Program and QI Committee. Outcomes are reported to the Deputies and the Installation Commander.



Plan of Action After Reporting -

Each Level 2 role, following the review of a report may recommend the following actions:

- Alert the affected Program to the concern.
- Revise policies/processes in that Program.
- In-service the affected Program personnel.
- Retrain affected medical or administrative personnel.
- Monitor the area of concern in more detail to gather additional data.

Annual Evaluation of the Palliative Program -

Yearly, each division, program and committee will report on goals achieved in the previous year, accomplishments, and areas still needing improvement with action plans and goals for the following year.

Confidentiality -

All activities set forth by the Quality Improvement Committee, including any information collected by any other associated committee, task force, divisions or program, in order to evaluate the quality of patient service, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure. Reports and data are safeguarded in the Information System by password entry. Hardcopy files are located in the office of the Division and Program leaders

QUALITY IMPROVEMENT EDUCATION

Personnel should receive education regarding quality improvement activities and monitoring annually through:

- Initial orientation
- Biannual Inservices
- Committees
- Quality Improvement Task Force Groups

REVIEW OF THE PROGRAM AND UPDATE OF THE PLAN

The Quality Program & Plan is reviewed and updated by the Quality Improvement Facilitator with the support of the Level 1 and Level 2 roles and the Quality Improvement Committee annually. Final approval of the plan is by the Level 1 or Level 2 roles.