Top 10 Pearls in Palliative Care Quality

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PCQC

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Disclosure

No relevant disclosures.

Learning Outcomes

Upon Completing this session, participants will be able to:

1. Identify recent trends in healthcare quality improvement
2. Use the foundational language for quality improvement
3. Understand common pitfalls in conducting effective QI

Historical Perspective

→1974 Hospice, Inc., New Haven

→1975 Palliative Care Service, Montreal, Canada

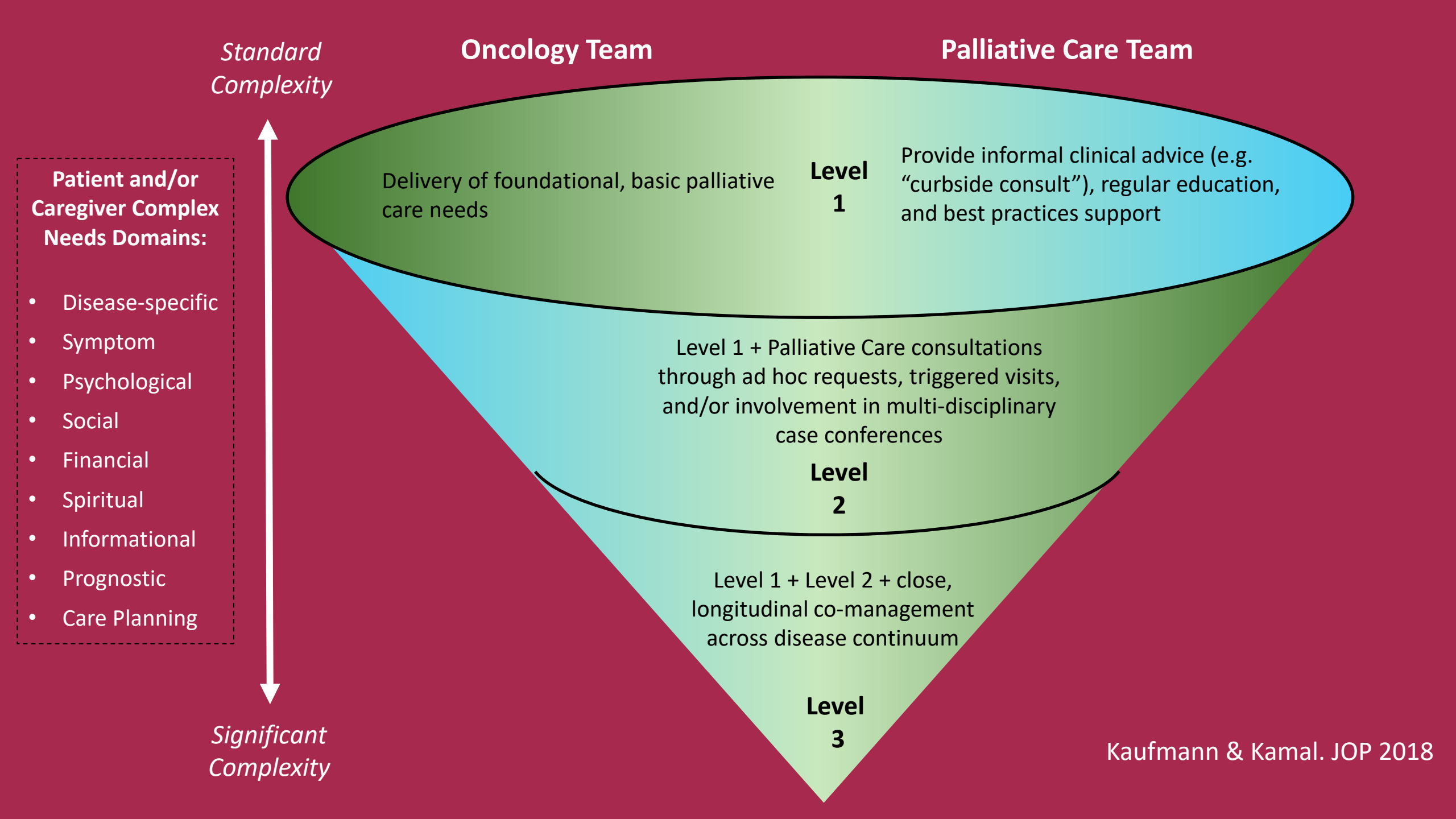
→1983 Medicare Hospice Benefit

→1997 Approaching Death: Improving Care at the End of Life, IOM

→2008 Hospice and Palliative Medicine, Subspecialty

→2014 Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life, IOM

→2018 4th Edition Clinical Practice Guidelines for Quality Palliative Care, National Consensus Project



Kaufmann & Kamal. JOP 2018

Evidence-Based Medicine	Quality Improvement
Term coined in 1992	Introduced formally to medicine in 1966
Based on conceptual knowledge - "knowing what"	Based on working knowledge – "knowing how"
"Doing the right thing"	"Doing things right"
Actions are informed by the best available evidence	Assuring intended actions done thoroughly, efficiently, reliably
Context-independent	Highly context-dependent
Efficacy	→ Effectiveness

Glasziou, BMJ Quality & Safety 20:i13-i17, 2011

“We’re all in the service industry, we just happen to be delivering health care”

“the great enemy of the truth is not the lie – deliberate, contrived, and dishonest – but the myth – persistent, persuasive, and unrealistic”

“If I had an hour to solve a problem, I’d spend 55 minutes thinking about the problem, and 5 minutes thinking about solutions.”

GAPS IN QUALITY ARE SYSTEMS ISSUES

– Avoid identifying people, organizations, events, settings

- Quality improvement is not about finding “bad apples”

-Save specific entities for the driver diagram (e.g. Fishbone) discussed later

~~“It’s because Dr. X is always so far behind during his clinic day that patient’s just get up and leave. They don’t want to wait for him. “~~

Blaming people

HAVE A PROBLEM STATEMENT

– one or two sentences describing specifically the Who, What, When, Where, and Harm of the problem (but not How or Why)

"In our outpatient clinic, 40% of lung cancer patients referred for outpatient palliative care did not show in the last 12 months, reducing opportunities for timely symptom management"

~~"So we're here to talk about growing our clinic"~~

Not defining the problem

REVIEW THE PROBLEM STATEMENT DURING EACH MEETING

– review the Who, What, When, Where, and Harm of the problem (but not How or Why)

"In our outpatient clinic, 40% of ~~lung cancer~~ all patients referred for outpatient palliative care did not show in the last 12 months, reducing opportunities for timely symptom management"

"~~And thus….we need…..to do….~~"

Not defining the problem again

HAVE AN AIM STATEMENT

- What is the goal of your quality improvement project?

- Include the Who, What, When, Where (but not Why or How)

- “We will reduce the no-show rate among all patients in the outpatient palliative care clinic by 20% over the next 6 months ~~by calling patients the night before to remind them to come~~”

Not knowing where you’re going

PROVE THE PROBLEM

– Develop a plan to prove the problem

A. Exists
B. Is Important
C. Is Affected by Stakeholders Involved

Divide comments/suggestions during early meeting into “problem proving” or “potential solutions”

Too many solutions, too early

EXPLORE THE PROBLEM

– What are the drivers of the problem?

Can you brainstorm, organize, and quantify those drivers (e.g. Fishbone/Ishikawa, Process Map, Pareto Chart)?

Did you ask all stakeholders (e.g. patient survey)?

“We believe the leading reasons patients do not show for clinic are lack of transportation and long wait times”

Developing a solution not fit to the problem

RIGHT PROBLEM, RIGHT TEAM

Are all stakeholders represented on the team (think frontline staff, patients, environmental services)?

Do you have a guarantor? Is he/she aware?

Is your team agile enough to discuss and make decisions in-person?

Not having the right people on the team

RIGHT PROBLEM, WRONG SOLUTION

“Our patients are missing their appointments due to transportation issues, we will give our clinicians a PowerPoint presentation during the next faculty meeting about being more efficient during clinic visits and not getting behind”

“Our patients are missing their appointments due to transportation issues, we will give them taxi vouchers after they arrive.”

Not aligning the drivers of problem to solution

FAIL EARLY, TRY OFTEN

Interventions of change should be tried for short periods (typically weeks to few months)

Interventions of change should not be complex

Bad interventions should be abandoned

Emotional/historical attachments to interventions should be checked at door

Testing for too long

FAIL EARLY, FAIL OFTEN

MOST quality improvement interventions do not work

You are not testing a hypothesis

Cultural, political, environmental, timing factors affect success

Solutions that work may be too expensive, resource-laden, difficult, or not sustainable long-term

Fearing failure

1. Blaming people
2. Not defining the problem
3. Not defining the problem – again
4. Not knowing where you're going
5. Too many solutions – too early
6. Developing a solution not fit to the problem
7. Not having the right people on the team
8. Not aligning drivers of solution to problem
9. Testing for too long
10. Fearing failure

Questions?

Discussion?

Thank You!

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