California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

SB1004 Technical Assistance Series: Topic 4: Gauging and Promoting Sustainability and Success

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Building blocks for implementing community-based palliative care

Estimating member/patient need

Estimating costs for delivering services

Assessing capacity for palliative care & launching svcs

Gauging and promoting sustainability and success

Lessons learned and adjusting programs

Objectives

- Review information from DHCS regarding initial program reporting requirements
- Describe resources available to measure palliative care quality
- Outline process steps to select quality metrics based on local needs, resources and challenges
- Create processes for routine program review and quality assessment
- Outline factors that promote sustainability and scaling of services

Outline

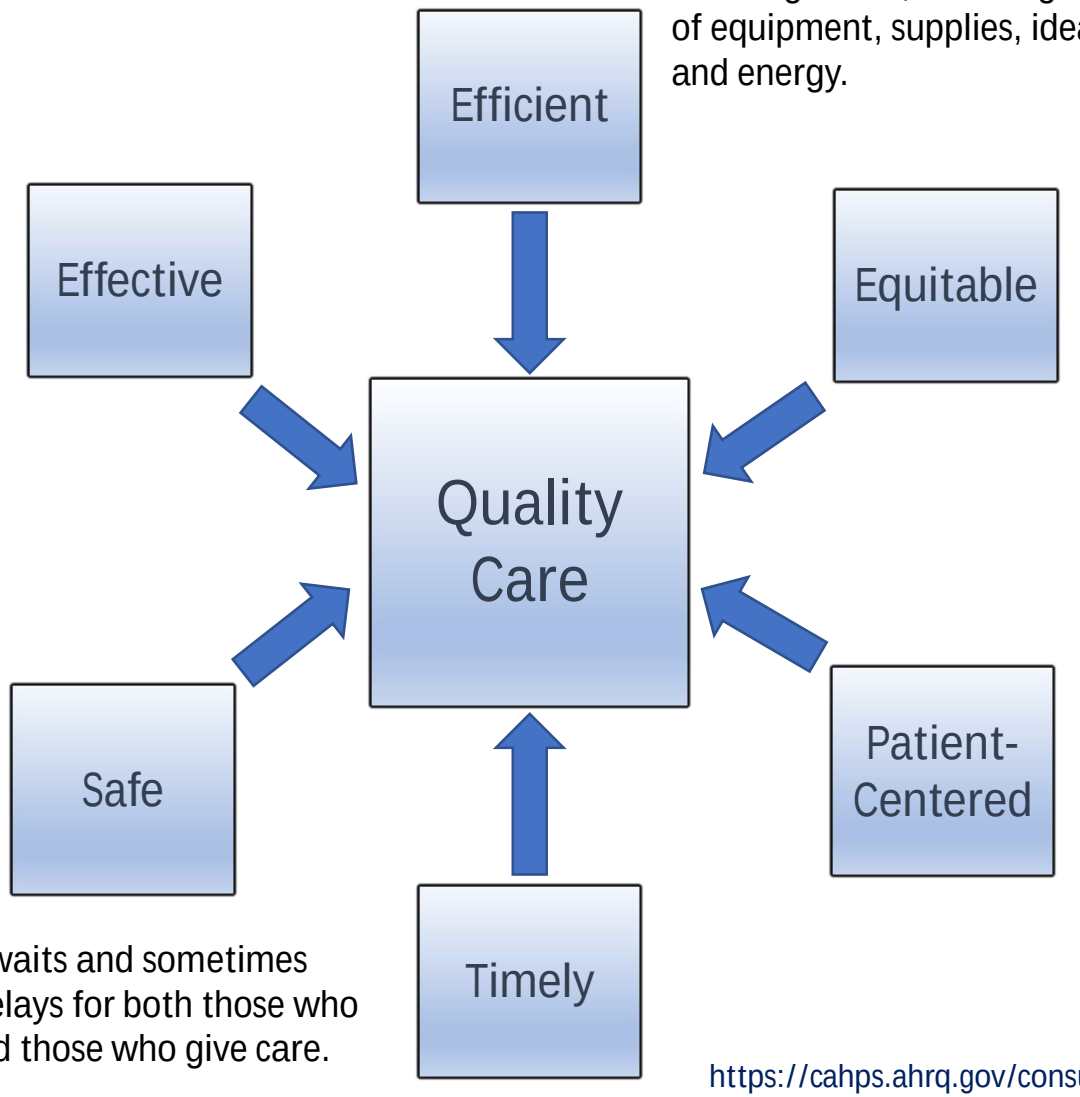
- Review SB 1004 reporting requirements
- Measuring quality in palliative care
- Selecting metrics for your program
- Recommendations for promoting program sustainability
- Review

SB 1004 Reporting Requirements

- Final template released February 2018
- Quarterly reporting
- Reporting domains
  - Patient level: name, diagnosis, approval date, disenrollment date, reason for disenrollment
  - Referrals: number made, approved, accepted, declined, denied and if denied why
  - Network: provider name, type (mix of disciplines and services), specialty, telehealth use

Focus: Who was referred, who was served, why/why not served, how long served, by whom

Components of quality



Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit

Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

Avoiding harm to patients from the care that is intended to help them.

Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Reducing waits and sometimes harmful delays for both those who receive and those who give care.

https://cahps.ahrq.gov/consumer-reporting/talkingquality/create/sixdomains.html

Much more you will want to know

Metrics that describe:

- What was done, by whom, how often
- Adherence to best practices
- How things turned out

Where to find metrics?

- Case studies / peers
- QI collaboratives
- Endorsed by the field

CHCF Payer-Provider Partnerships Initiative

- 6 teams of payer and provider organizations
- Providers: large academic medical centers, hospices, and a specialty palliative care practice
- Payers: national insurers, regional insurers, a Medicaid managed care plan
- 6 month planning process, resulting in operational and financial plans for delivering CBPC
- 24 month implementation phase, where contracts were executed and clinical services were delivered

To learn more about the PPI project: https://www.chcf.org/project/payer-provider-partnerships-to-expand-community-based-palliative-care/

(Selected) Metrics used by PPI participants

Operational

- # Patients referred, % with scheduled visits, % visited
- # Visits (average and range) per patient in enrollment period
- # Days (average and range) from referral to initial visit
- # Days (average and range) between visits
- % seen within 14 days of referral
- Referral source
- Referral reason
- Use of tele-visits

Metrics used by PPI teams

Screening and assessments

- % for which spiritual assessment is completed
- % for which functional assessment is completed
- Symptom Burden by ESAS (repeated)
- Patient distress by Distress Thermometer (repeated)
- % for which medication reconciliation is done with 72h of hospital discharge

Planning and preferences

- % with advance care planning discussed
- % with advance directive or POLST completed

Metrics used by PPI teams

Hospice and End of Life Care

- % remaining on service through end of life
- % death within one year of enrollment
- % enrolled in hospice at the time of death
- Average/median hospice length of service
- Location of death
- % dying in preferred location

Metrics used by PPI teams

Utilization and fiscal

- PMPM cost of care, enrolled patients vs comparison population
- Health care utilization/costs 6 months prior to enrollment compared to 6 months during/after:
  - # Acute care admissions
  - # (Total) hospital days
  - # ICU admissions
  - # ICU days
  - # ER visits
  - Cost per member (total)
  - Cost per member (inpatient)
  - Cost per member (outpatient)

Palliative Care Quality Network

National learning collaborative committed to improving the care of seriously ill patients and their families

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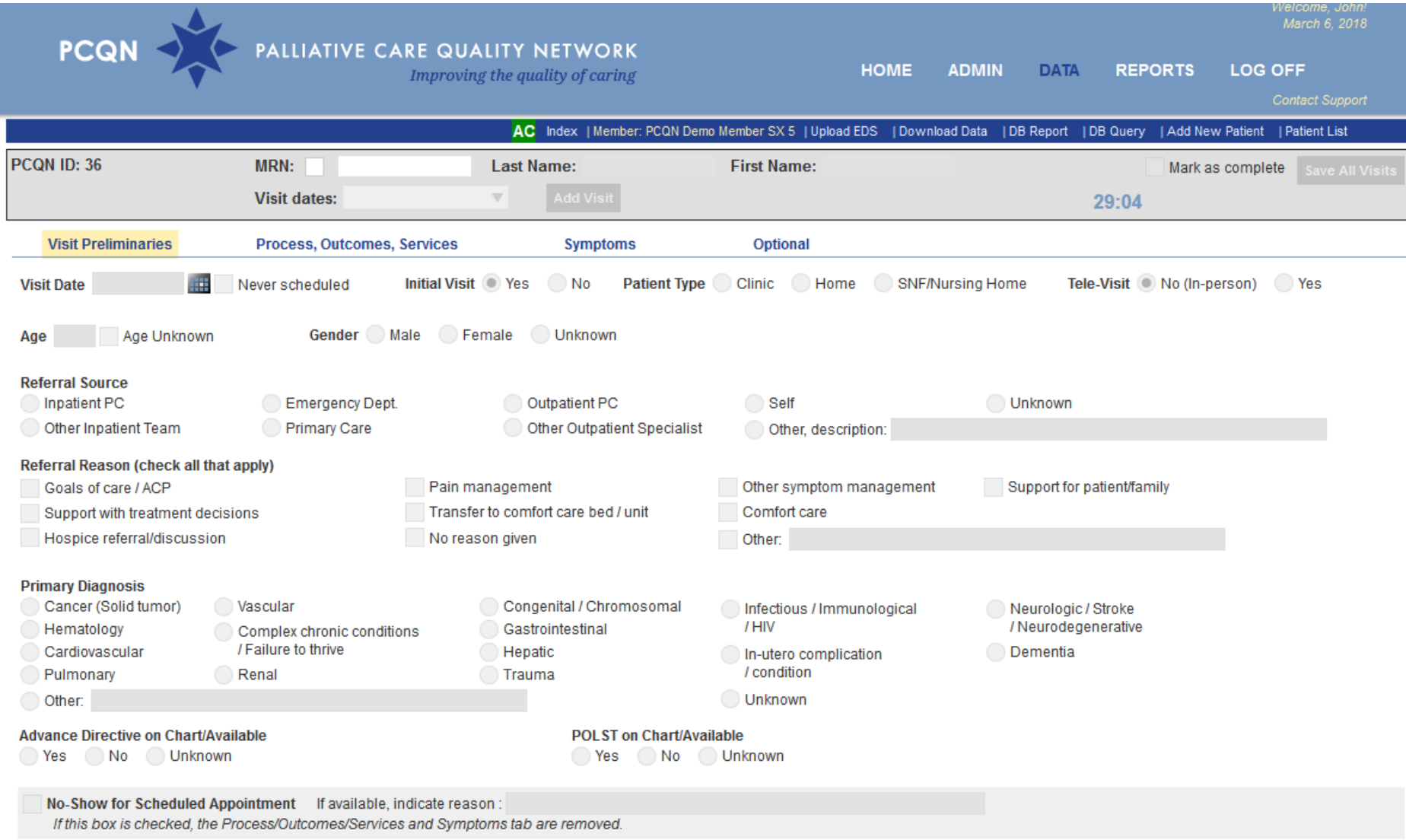
Patient- level data registry with real-time, easy to access reports that allow for benchmarking across member sites.

Quality improvement activities including mentored multi-site QI projects, QI education, and case reviews.

Education & community building opportunities including monthly educational webinars and in-person conferences.

Learn More: https://pcqn.org ● Angela Marks angela.marks@ucsf.edu

Encounter level data collection



Metrics for assessment and benchmarking

PCQN PALLIATIVE CARE QUALITY NETWORK

Core Metrics – Adult Community-Based Palliative Care

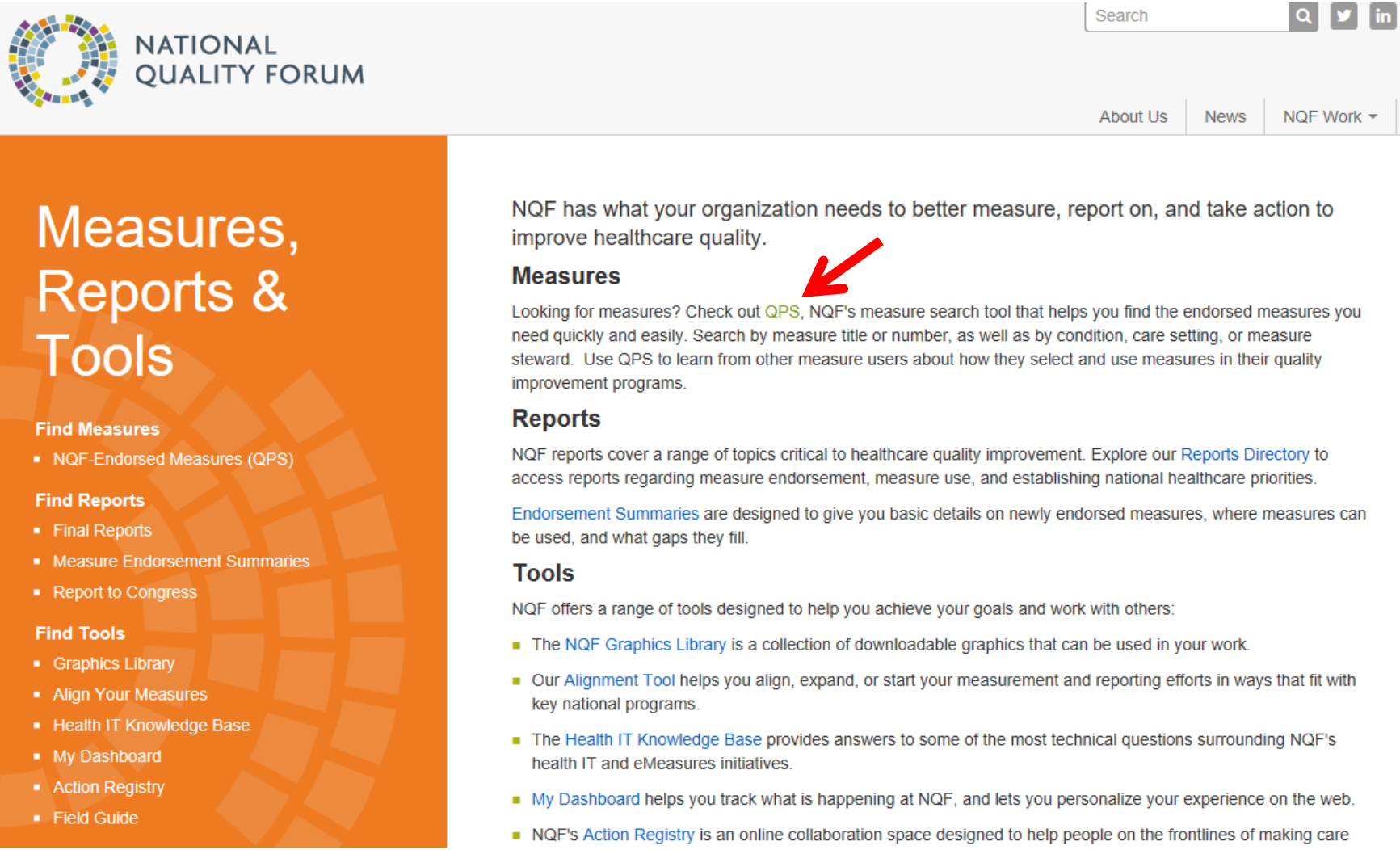
Data Element	Current metrics available for benchmarking
Patient Characteristics / Info at time of PC request	

Age	• Mean age
	• Percent of patients in the following age bands:
	  ○ 20 or under
	  ○ 21-40
	  ○ 41-60
	  ○ 61-80
	  ○ Over 80

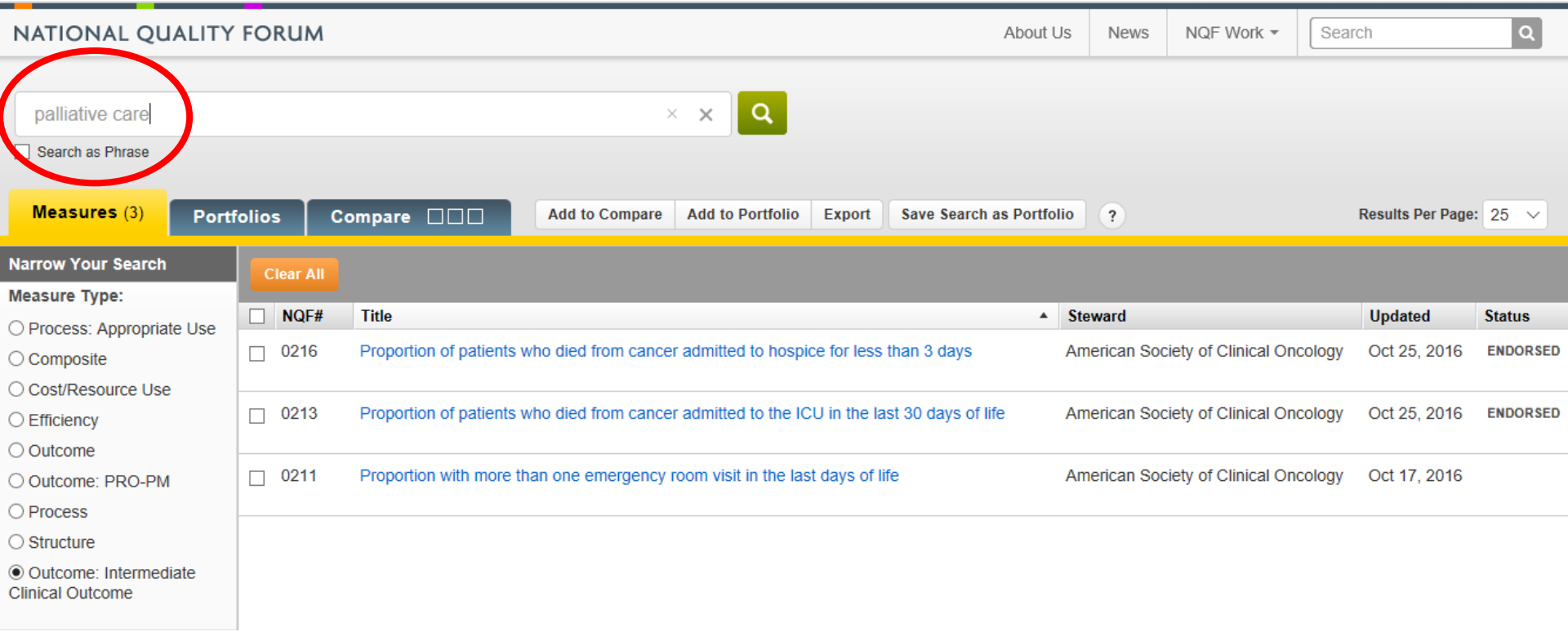
Gender	• M/F (%)
Referral source	Percent of patients referred from the following: • Inpatient PC • Other Inpatient Team • Emergency Dept. • Primary Care • Outpatient PC • Other Outpatient Specialist • Self • Unknown • Other

SEE HANDOUT

PC metrics endorsed by NQF



Use NQF's QPS to find endorsed metrics



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HPM PASS
HPM FAST
Hospice Products
Opioid REMS

Measuring What Matters

AAHPM & HPNA Measuring WHAT Matters

Measuring What Matters (MWM) is a consensus recommendation for a portfolio of performance measures for all hospice and palliative care programs to use for program improvement.

The Measuring What Matters team identified existing indicators that were then rated by mutiple panels to ultimately determine the **Top 10 Measures That Matter.** Read more about the findings and reccomendations of the consensus project in the Journal of Pain and Symptom Management.

Read the Actual Measures List or Measure Concepts List.

Access the New Frequently Asked Questions (FAQ) list about MWM
Access the Frequently Asked Questions (FAQ) list about MWM.
Access the Top Twelve Measures—Background Information, Evidence and Clinical User Panel (CUP) Comments

Project Overview

Read about the history of the project and the organizations involved.

AAHPM & HPNA Measuring WHAT Matters

TOP TEN MEASURES THAT MATTER

MEASURE 1: Hospice and Palliative Care—Comprehensive Assessment

Percentage of patients for whom a comprehensive assessment was completed

Source: PEACE Set[1,2] | http://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures

MEASURE 2: Screening for Physical Symptoms

Percentage of seriously ill patients receiving specialty palliative care in an acute hospital setting >1 day or patients enrolled in hospice >7 days who had a screening for physical symptoms (pain, dyspnea, nausea, and constipation)

Source: PEACE Set[1,2] | http://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures

MEASURE 3: Pain Treatment (ANY)

Seriously ill patients receiving specialty palliative care in an acute hospital setting >1 day or patients enrolled in hospice >7 days who screened positive for moderate to severe pain on admission, and the percent receiving medication or nonmedication treatment, within 24 hours of screening

Source: PEACE Set[1,2] | http://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures

PUBLICATION

Palliative Care Measure Menu

FEBRUARY 5, 2016

By Kathleen Kerr, Brian Cassel, Lewis Broome

Measuring quality in palliative care (PC) is important, but can be challenging. Because PC has a broad and far-reaching scope, there are literally hundreds of metrics that might be used to assess quality. Some metrics require data that are difficult or impossible for a given program or organization to obtain. Not all metrics are appropriate for every type of service or every patient population.

Designed for palliative care leaders, quality professionals, and administrators, the Palliative Care Measure Menu simplifies the task of reviewing possible measures, enabling users to quickly and efficiently select a feasible, balanced portfolio of measures that mirror the scope and focus of a given PC program.

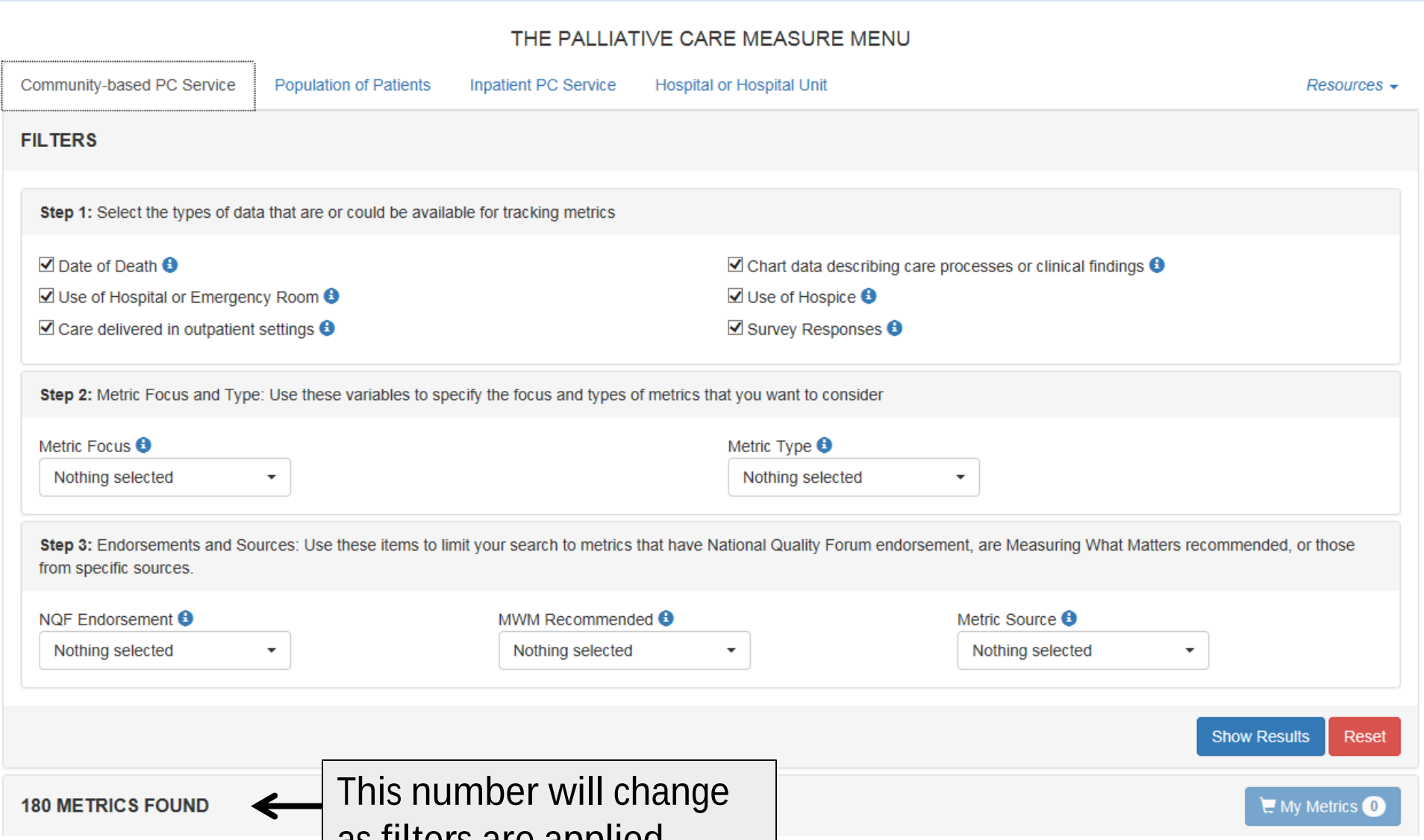
To begin, download and review the Brief Tutorial and the Instructions documents.

What‘s inside

- 299 metrics from 19 sources
- Information about each metric:
  - Required data
  - Metric type (structure, process, outcome)
  - National Consensus Project (NCP) guideline it addresses
  - Who developed it
  - Settings used/tested in
  - Important endorsements

You can use the tool to select for the types of metrics that are appropriate for your setting and service, and to exclude from consideration metrics that are unimportant (to you) or not feasible.

Filter view



This number will change as filters are applied

Results view

Community-based PC Service | Population of Patients | Inpatient PC Service | Hospital or Hospital Unit | *Resources*

FILTERS — Show Filters

32 METRICS FOUND — My Metrics 0

Learn more about the NCP guideline reference for a metric by going to the NCP Guidelines section of the Resources tab

Metrics that meet the criteria specified in the Filters section.

Domain	Metric Type	Source	Original Population	NCP Ref		Add
Social	Process	NQF PP	PC patients	NCP 4.2	Proportion of patients/families who were invited to participate in a care conference with the interdisciplinary team	Add
Social	Process	NQF PP	PC patients	NCP 4.2	Proportion of patients for whom a comprehensive social care plan is developed (comprehensive social care plan addressed relationships, communication, existing social and cultural networks, decision-making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress and access to medicines and equipment.)	Add
Spiritual	Structure	NQF PP	PC patients	NCP 5.1	Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.	Add
Spiritual	Structure	NQF PP	PC patients	NCP 5.2	Presence of a policy or procedure requiring assessment of religious, spiritual and existential concerns using a structured instrument	Add
Spiritual	Structure	NCP	PC patients	NCP 5.3	Palliative care programs create procedures to facilitate patients' access to clergy, religious, spiritual and culturally-based leaders, and/or healers in their own religious, spiritual, or cultural traditions.	Add
Spiritual	Structure	NCP	PC patients	NCP 5.3	Non-chaplain palliative care providers obtain training in basic spiritual screening and spiritual care skills	Add
Spiritual	Structure	NQF PP	PC patients	NCP 5.3	Spiritual care is available through organizational spiritual counseling or through the patient's own clergy relationships	Add

Results view

Community-based PC Service | Population of Patients | Inpatient PC Service | Hospital or Hospital Unit | *Resources*

FILTERS — Show Filters

32 METRICS FOUND — My Metrics 0

Use the "Add" buttons to save metrics to your My Metrics cart

Metrics that meet the criteria specified in the Filters section.

Domain	Metric Type	Source	Original Population	NCP Ref	Metric or Quality Indicator	Add
Social	Process	NQF PP	PC patients	NCP 4.2	Proportion of patients/families who were invited to participate in a care conference with the interdisciplinary team	Add
Social	Process	NQF PP	PC patients	NCP 4.2	Proportion of patients for whom a comprehensive social care plan is developed (comprehensive social care plan addressed relationships, communication, existing social and cultural networks, decision-making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress and access to medicines and equipment.)	Add
Spiritual	Structure	NQF PP	PC patients	NCP 5.1	Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.	Add
Spiritual	Structure	NQF PP	PC patients	NCP 5.2	Presence of a policy or procedure requiring assessment of religious, spiritual and existential concerns using a structured instrument	Add
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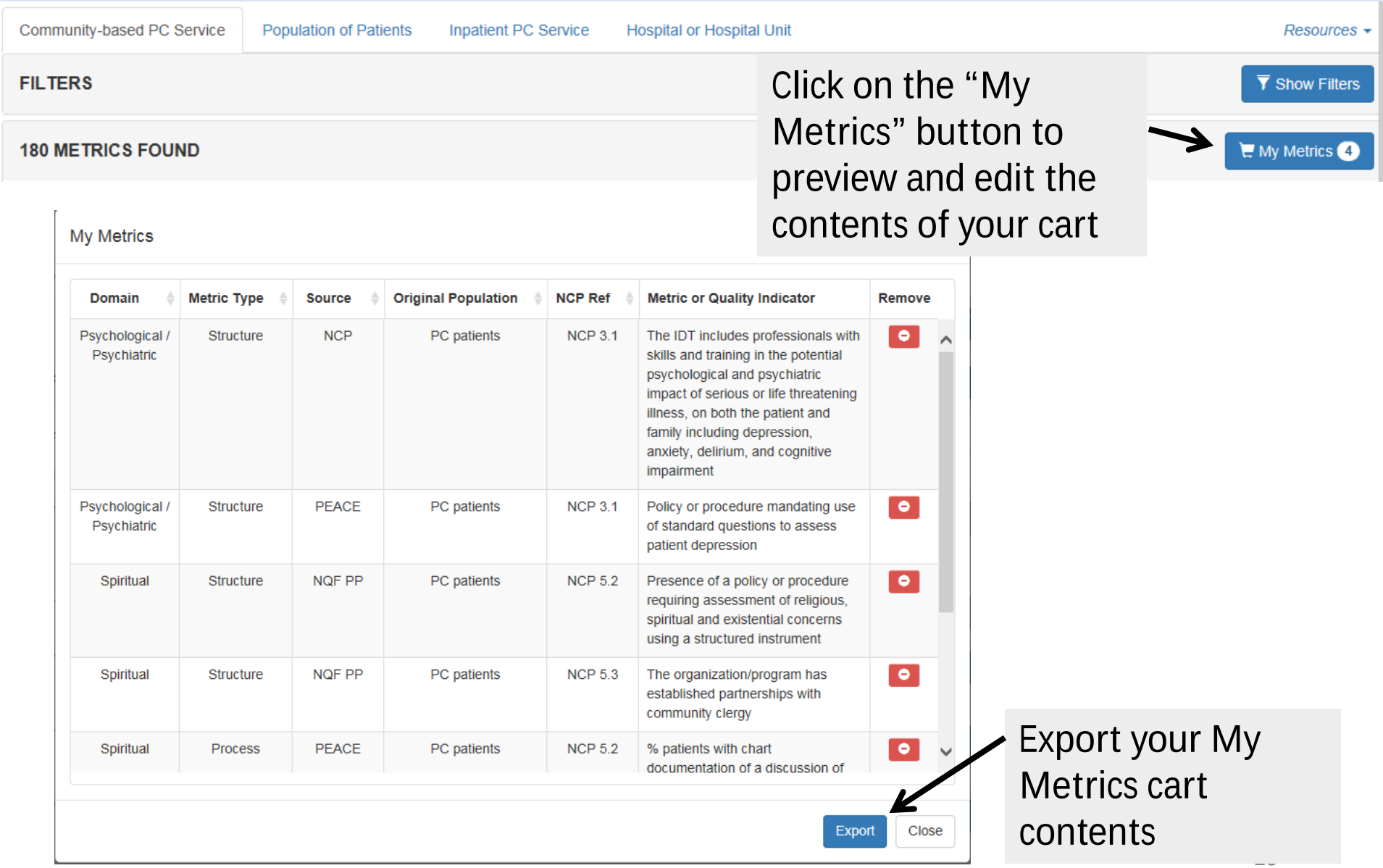
My Metrics


Community-based PC Service
Population of Patients
Inpatient PC Service
Hospital or Hospital Unit
Resources
FILTERS
Show Filters
180 METRICS FOUND
My Metrics 4
Click on the "My Metrics" button to preview and edit the contents of your cart
My Metrics
Domain
Metric Type
Source
Original Population
NCP Ref
Metric or Quality Indicator
Remove
Psychological / Psychiatric
Structure
NCP
PC patients
NCP 3.1
The IDT includes professionals with skills and training in the potential psychological and psychiatric impact of serious or life threatening illness, on both the patient and family including depression, anxiety, delirium, and cognitive impairment
Psychological / Psychiatric
Structure
PEACE
PC patients
NCP 3.1
Policy or procedure mandating use of standard questions to assess patient depression
Spiritual
Structure
NQF PP
PC patients
NCP 5.2
Presence of a policy or procedure requiring assessment of religious, spiritual and existential concerns using a structured instrument
Spiritual
Structure
NQF PP
PC patients
NCP 5.3
The organization/program has established partnerships with community clergy
Spiritual
Process
PEACE
PC patients
NCP 5.2
% patients with chart documentation of a discussion of
Export
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Export a Spreadsheet File

A	B	C	D	E	F	G
Metric ID	**Domain**	**Metric Type**	**Metric or Quality Indicator**	**Source**	**Original Population**	**NQF Deta**
173	Psychological / Psychiatric	Structure	The IDT includes professionals with skills and training in the potential psychological and psychiatric impact of serious or life threatening illness, on both the patient and family including depression, anxiety, delirium, and cognitive impairment	NCP	PC patients	
255	Psychological / Psychiatric	Structure	Policy or procedure mandating use of standard questions to assess patient depression	PEACE	PC patients	
218	Spiritual	Structure	Presence of a policy or procedure requiring assessment of religious, spiritual and existential concerns using a structured instrument	NQF PP	PC patients	
221	Spiritual	Structure	The organization/program has established partnerships with community clergy	NQF PP	PC patients	
260	Spiritual	Process	% patients with chart documentation of a discussion of spiritual or religious concerns	PEACE	PC patients	1647 (adapted
166	Ethical/Legal	Process	% heart failure patients who have documentation in the medical record that an advance directive was executed.	Joint Commission	Individuals with heart failure	
262	Ethical/Legal	Process	% patients with chart documentation of an advanced directive or discussion that there is no advanced directive	PEACE	PC patients	

Outline

- Review draft SB 1004 reporting requirements
- Measuring quality in palliative care
- Selecting metrics for your program
- Recommendations for promoting program sustainability
- Review

Selecting Quality Metrics: Factors to Consider

- Whenever possible, start with metrics recognized by external entities and/or used by other programs

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From that long list, make selections by considering:

- What matters to stakeholders
- Feasibility of data collection & analysis
- Balanced portfolio

Selecting Quality Metrics: What Matters to Stakeholders

1. Who are your stakeholders?
   - Whose support is needed for success, sustainability, scaling?
   - Whose initiatives/programs might be impacted (or threatened)?
   - Who might have expectations about what the program will deliver?

Selecting Quality Metrics: What Matters to Stakeholders

1. Who are your stakeholders?
   - Internal
     - Organizational leadership
     - Clinically-oriented
     - Financially-oriented
     - Regulatory
   - External
     - Payer/provider partner
     - Referring providers
     - Community partners
     - DHCS

Selecting Quality Metrics: What Matters to Stakeholders

2. Initial questions to ask
   - What would a successful palliative care program look like?
   - What are you hoping the program will achieve?
   - If you only had one measurement of program quality, what would it be?
   - How might the palliative care program impact (or be impacted by) other programs?

Selecting Quality Metrics: Assess Availability and Feasibility

For each metric you're considering...

- Is it already being collected, reported?
- Where would you get the data?
  - Available in EHR
    - What would it take to generate routine reports?
  - Could be collected specifically for this purpose
    - How labor-intensive might that collection process be?
    - Who would need to be involved? How much bandwidth do those stakeholders have to take on new tasks?

Selecting Quality Metrics: Assess Availability and Feasibility

For each metric you're considering...

- Would the data be consistently available?
- How reliable would the data be?
- Where/how would you record the data?
- What would the analysis process require?

Preparing for Metrics Selection

With stakeholders from your organization and/or partner organization, complete:

Metrics Preparation Worksheet

Selecting Quality Metrics: Factors to Consider

✓Recognition of metric by external entities, use by other programs

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✓What matters to stakeholders

✓Feasibility of data collection & analysis

- Balanced portfolio

Selecting Quality Metrics: Aim for a balanced portfolio

Aim for a diverse portfolio of palliative care program metrics, with balance across:

- Different types of metrics
  - Structure
  - Process
  - Outcome
- Different focus areas
- Effort required

Selecting Quality Metrics: Aim for a Balanced Portfolio

Different types of metrics

Structure

- Describe the program
- Ex. Available 24/7

Process

- Describe how care is delivered
- Ex. Screenings done at specific points in time

Outcome

- Describe the impact of the program
- Ex. Change in pain scores

Selecting Quality Metrics: Aim for a Balanced Portfolio

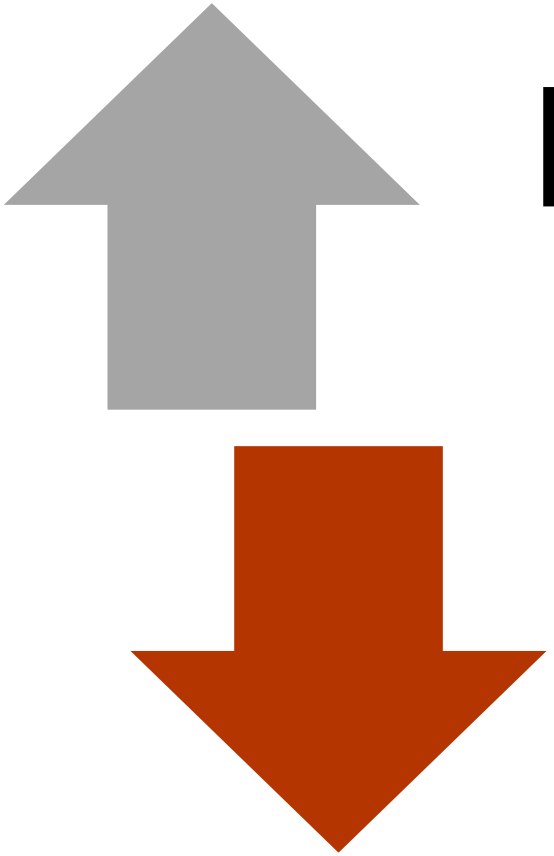
Different focus areas

- Operational
- Screening & Assessments
- Planning & Preferences
- Hospice & End-of-Life Care
- Utilization & Fiscal

See Metrics Balance Check Worksheet for examples of metrics in each category

Selecting Quality Metrics: Aim for a Balanced Portfolio

Consider total effort required for collection, analysis



Easy

Hard

Key point:
Make sure that you don't have all high-effort metrics… but consider adding a small number of these if the information would be particularly valuable to you or your partner organization

Example of metrics selection: Zuckerberg San Francisco General

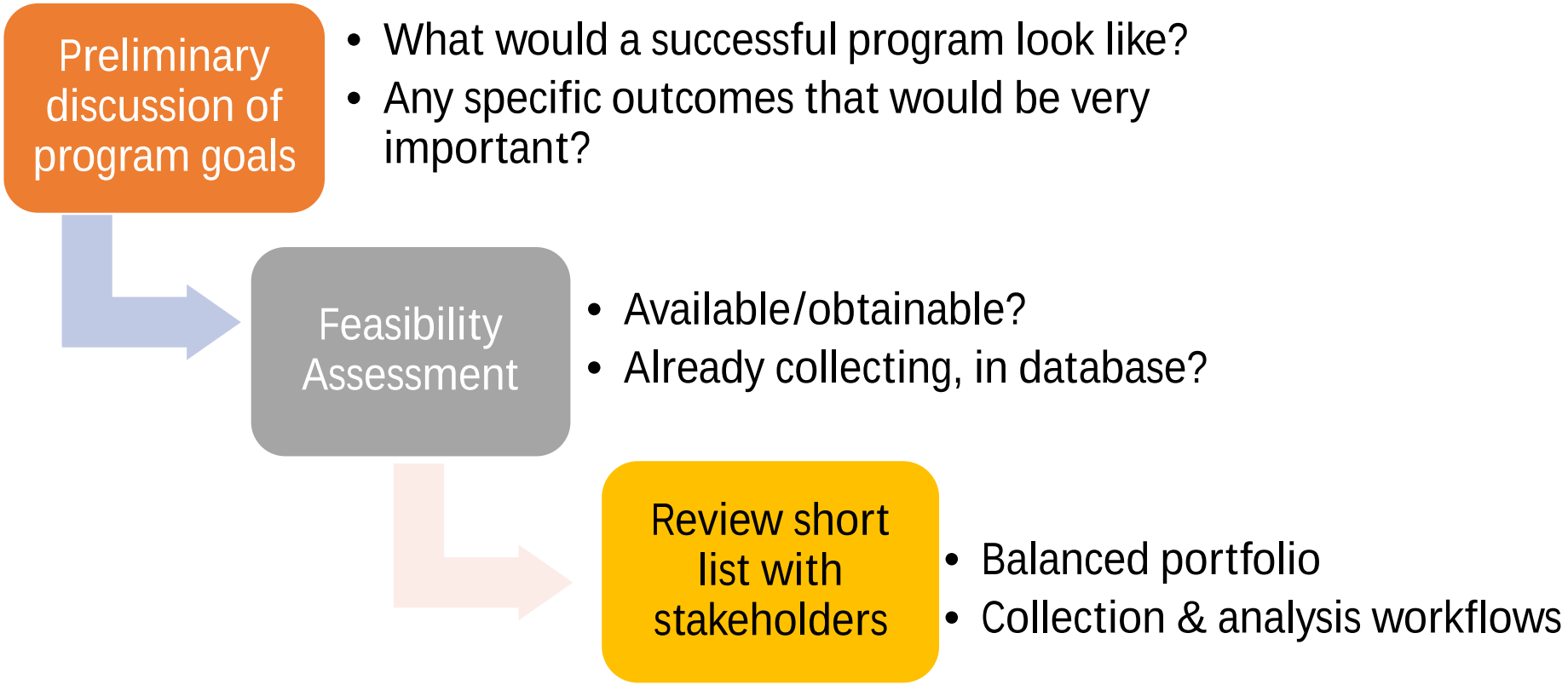
Context

- Inpatient & Outpatient programs
  - Patients seen by both, or just one
- Cannot pull data from EHR
- Limited administrative support

Stakeholders

- Internal
  - System leaders
  - Inpatient and outpatient teams
- External
  - SF Health Plan
  - Grant funders

Example of metrics selection: Zuckerberg San Francisco General



Example of metrics selection: Zuckerberg San Francisco General

	Structure/ Process/ Outcome	Quality Focus area	Important to Plan	Important to Provider	Important to other(s)	Easy to collect, analyze
Interdisciplinary team, PC certified	Structure	Operational	++	++	++ Joint Commission	++
% of patients screened for psychosocial distress	Process	Screening & Assessments	0	++	++ Cancer Committee	0/+
Number of patients seen per year	Outcome	Operational	++	++	++ System leadership	+
Average costs of patients in last yr. of life	Outcome	Utilization & Fiscal	++	++	++ PC field	-/0

Putting it all together

	Structure/ Process/ Outcome	Quality Focus area	Important to Plan	Important to Provider	Important to other(s)	Easy to collect, analyze
Metric 1						
Metric 2						
Metric 3						

With others from your organization and your partner organization, complete the Metrics Balance Check Worksheet

You've selected your metrics… Now What?

- Discuss with partner, stakeholders
  - Targets
    - Who defines the target?
    - What happens if target isn't achieved?
  - Interval for reporting
    - Internal
    - External
  - Format for reporting, communication preferences

Outline

- Review draft SB 1004 reporting requirements
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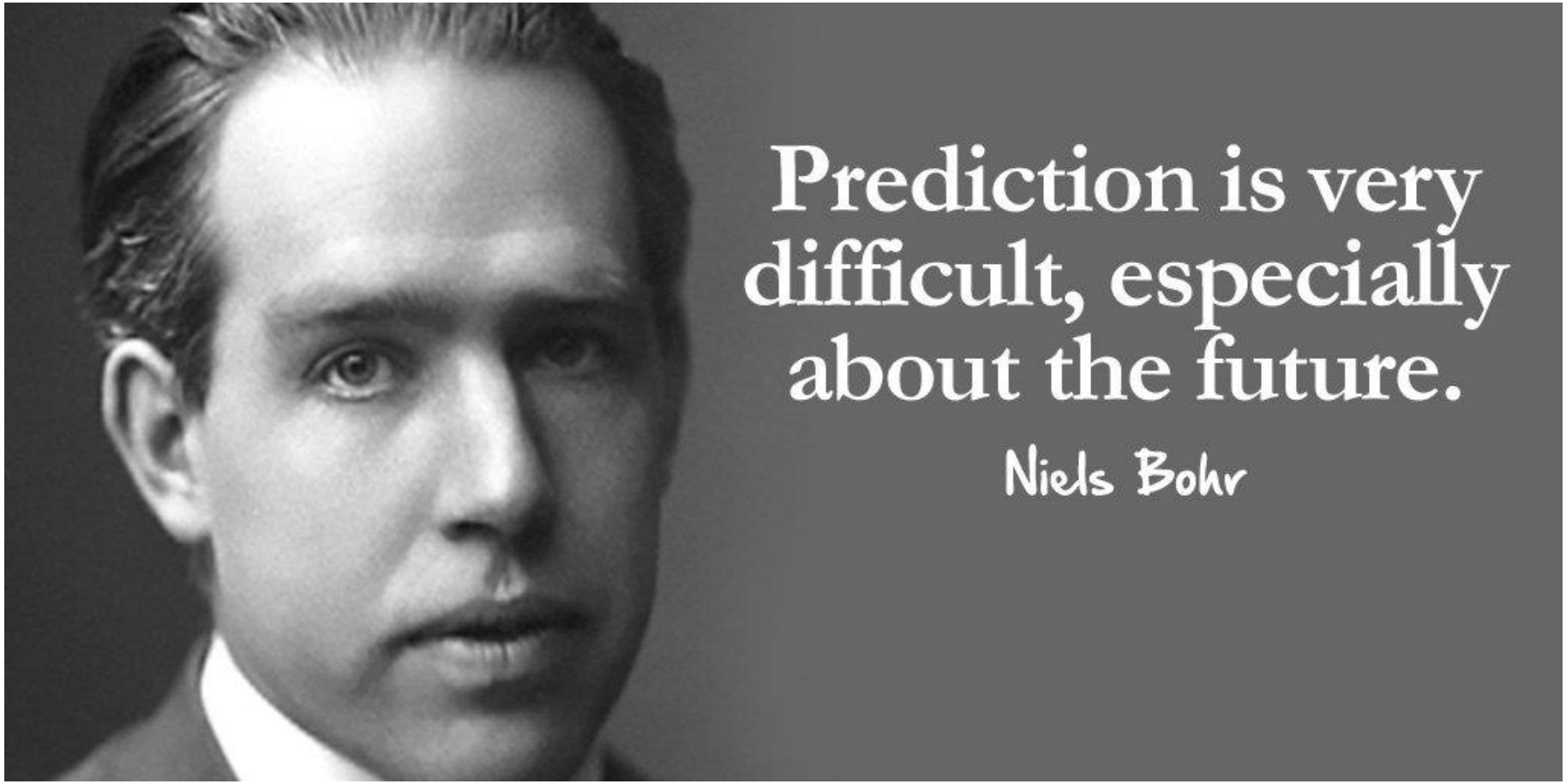
Promoting Sustainability: Recommendations

- Pilot & Re-evaluate
- Routine communication
- Repeat the needs assessment
- Pay attention to relationship with payer/provider

A wise person once said…



Promoting Sustainability:

Issue #1:

Predicting the future is impossible

Promoting Sustainability: Pilot & Re-evaluate

Many things are hard to predict

- Where referrals will come from, how much marketing and outreach will be required
- Which patient populations will be largest
- Roles/responsibilities of different team members
- How workflows will need to change (with changes in venue, volume, staffing, etc.)
- Projected vs. actual costs

First choice … best choice?

INITIAL PLAN	CHALLENGES
(Pilot) contract mandated 2 RN home visits per patient per month	• Some patients did not make themselves available for visits at predictable intervals, which reduced revenues for provider • Some patients did not need both RN visits, but instead really needed weekly SW visits, at least in some months

Promoting Sustainability: Pilot & Re-evaluate

- Initial efforts should be framed as pilot
- Start with expectation that things will need to be adjusted
- Define parameters
  - Interval for reassessment
  - Evaluation metrics

First choice … best choice?

INITIAL PLAN	CHALLENGES	POSSIBLE SOLUTIONS
(Pilot) contract mandated 2 RN home visits per patient per month	• Some patients did not make themselves available for visits at predictable intervals, which reduced revenues for provider • Some patients did not need both RN visits, but instead really needed weekly SW visits, at least in some months	• Create process to waive or adjust requirement for certain patients / certain circumstances • Suggest high-frequency initial phase followed by maintenance phase

Promoting Sustainability: Pilot & Re-evaluate

Issue #1:

Predicting the future is impossible

Lesson #1:

Many successful payer-provider partnerships include routine re-evaluation of program goals, structures, workflows, outcomes

Promoting Sustainability:

Issue #2:

Different organizations have different cultures and different ways they prefer to communicate

Promoting Sustainability: Routine Communication

- Develop plan for communicating regularly, particularly at the beginning of the partnership, and after any major changes in the program
- Rationale
  - Changes in staffing/leadership happen
  - Your partner's goals/priorities will change
  - Identify gaps, unmet needs on both sides
  - Fix small issues before they grow

Promoting Sustainability: Routine Communication

Content to consider

- Clinical
  - Troubleshooting difficult cases
  - Foster communication between plan-based providers and palliative care providers
- Operational/Programmatic
  - How many patients/members are being enrolled? How does this compare with predictions?
  - Which clinics/provider groups are (or aren't) referring?
  - Are there barriers or inefficiencies in the referral process?
  - How long are patients/members remaining enrolled?
  - What resources are lacking, for patient/caregiver support?

Promoting Sustainability: Routine Communication

- What works best for communication?
  - Email/written
  - Remote
  - In-person
- How often are meetings needed?
- Who should be involved in different meetings?

Promoting Sustainability: Routine Communication

Issue #2:

Different organizations have different cultures and different ways they prefer to communicate

Lesson #2:

Be explicit in developing routine communication strategies with your plan/provider partner(s) that will work for both organizations.

Promoting Sustainability:

Issue #3:

Changes in personnel, leadership, and program scope can dramatically affect payer-provider partnerships.

Promoting Sustainability: Repeat the Needs Assessment

You've done a thorough needs assessment at the outset of the program, now you're set, right?

- Because things change, there may be key times when you should consider repeating a needs assessment
  - Change in partner(s) or key stakeholder(s)
  - Program expansion
  - Change in scope of work/responsibility
  - Changes in support and/or funding

Promoting Sustainability: Repeat the Needs Assessment

Change in partner or key stakeholder

- Leadership
- Key clinician
- Referring partner
- Community partner

Program expansion

- New location
- New setting of care
- New patient population

Promoting Sustainability: Repeat the Needs Assessment

Change in scope or responsibility

- New task assigned
- Partner takes over task
- Incentive/penalty proposed

Change in support or funding

- Grant start/finish
- In-kind donation changes
- Community program changes

Promoting Sustainability: Repeat the Needs Assessment

Resources for needs assessments

- SB 1004 Technical Assistance Series (chcf.org/sb1004)
  - Topic 1: Estimating Volume
  - Topic 2: Estimating Costs
  - Topic 3: Gauging Capacity
- Center to Advance Palliative Care
- CSU Institute for Palliative Care

Promoting Sustainability: Repeat the Needs Assessment

Issue #3:

Changes in personnel, leadership, and program scope can dramatically affect payer-provider partnerships.

Lesson #3:

Repeat a needs assessment after significant changes occur on either side.

Promoting Sustainability:

Issue #4:

Relationships are really important, but hard.

Relationship issues

Even a great service can't thrive if the payer-provider relationship is bad

- Partners need to be willing to communicate openly and frequently about all aspects of program planning and implementation.

- Partners need to build trust, understand why they each want to engage in this work, and show an appreciation for the pressures and priorities that impact the other organization.

“Most important” characteristic that you look for in a CBPC partner?

Provider:

“That they be collaborative and flexible, able to appreciate the perspective of a small partner”

Payer:

“Ideal partner characteristics would be an ability to take in information from many perspectives (vision and mission plus practical information about service delivery nuts and bolts, and the environment), including an ability to appreciate the perspective of a payer partner.”

Characteristics that might predict a poor fit?

Provider:

"As we brought issues to the forefront (big and small) the plan was always willing to engage in a conversation - to hear from our perspective how a contract requirement would impact care. Even if the plan didn't agree, it was important to us that they were willing to have that collaborative conversation. Not seeing this kind of openness would be a huge red flag; a payer that just says, 'This is the way we do it' would be a difficult partner."

Payer:

"I try to get a sense during early meetings whether they are comfortable taking risks, if they have demonstrated an ability to think differently, and if they have a record of implementing innovations. An absence of such characteristics/history, or a rigid attachment to their own model of care delivery would indicate a poor fit."

Promoting Sustainability: Pay Attention to Relationships

Issue #4:

Relationships are important, but hard.

Lesson #4:

Flexible good. Rigid bad.
Listening, transparency, empathy and collaborative problem solving are valued highly; inflexibility is not

Outline

- Review draft SB 1004 reporting requirements
- Measuring quality in palliative care
- Selecting metrics for your program
- Recommendations for promoting program sustainability
- Review

Objectives Review

Review information from DHCS regarding initial program reporting requirements

Describe resources available to measure palliative care quality

- Supplement information reported to DHCS with process and outcome metrics that describe care quality
- When considering metrics look to what peers and QI collaboratives are using, and those endorsed by professional organizations

Objectives Review

Outline process steps to select quality metrics based on local needs, resources and challenges

- Think about how success is defined by key stakeholders, and focus on the subset of metrics that speak to those areas
- Assess feasibility of both data collection and analysis
- Aim for a balance of metrics – in terms of metric type, focus area, and effort required to obtain the data

Objectives Review

Create processes for routine program review and quality assessment

- Establish schedule for program reporting, communication
- Repeat needs assessments at key junctures (e.g. change in personnel, leadership, or patient population)

Objectives Review

Outline factors that promote sustainability and scaling of services

- Just because you started doesn't mean you are done – ongoing monitoring and modifications will be needed
- Culture and communication differences can have a big impact on partnerships – identify issues up-front and work toward solutions that work for both organizations
- Prioritize creating and sustaining good payer-provider relationships

Acknowledgements and Resources

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- SB 1004 Questions
  - http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx
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