



“We believe in the power
of love and goodness.”

MEMORANDUM

To: Julia Logan, MD
California Department of Health Care Services

From: Craig Dresang, Executive Director
Gwendolyn Kaltoft, RN, EdD, Director of Quality and Compliance
Nancy Johnston, MSW, LCSW, Manager of Social Work and Spiritual Care Services
Leah C. Morris, RN, MPH, Nurse Practitioner

Date: June 19, 2015

Re: Feedback on Potential Palliative Care Quality, Structure and Process Measures

Yolo Hospice is pleased to provide feedback regarding performance measures tied to outpatient, community based palliative care. We understand the desire for feedback to be provided directly on the Attachment 2 materials distributed at the June 5, 2015 Stakeholder meeting. However, in the interest of time and ability to gather our team together, we ended up brainstorming the concepts of measurements as opposed to editing the specific measures on the spreadsheet. We hope this summary is of some use, and are happy to discuss any questions you may have for us.

Priority areas for Palliative Care measurement:

1. Assessment and **management of symptoms**. While palliative patients are under active care with their disease by their attending/managing physician, the palliative team must be involved in and measured for their ability to manage symptoms such as pain, dyspnea, agitation, insomnia, anxiety and depression, etc.
2. Setting, understanding and adhering to **goals of care**, including completion of appropriate documentation. Patients and caregivers or families need to be involved in and educated on topics such as Advance Directives, setting and understanding Goals of Care and having confidence in adhering to such goals. This area included completion of appropriate documentation such as the selection of a delegated decision maker, completion of Advance Directives, POLST forms, etc.)
3. Assessing program **satisfaction** and success at enriching or maintaining **Quality of Life**. This includes assessing the patient’s satisfaction with the program’s effectiveness, family or caregiver satisfaction and community health care and social service providers. Patients and caregivers need to be asked about their experiences with palliative programs, and their perceptions of program contributions to their Quality of Life. Community medical providers and other partners

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need to be assessed for their experiences as well, to understand the success of any such programs.

4. Assessing use of resources. While this idea gets at measuring costs or savings, it also ties to supporting the effectiveness of an interdisciplinary team. Team based care is critical in palliative care, and it would be valuable to assess the participation and contribution of the various team members according to discipline or specialty. Often, non-medical team members (Social Workers, Chaplains or community volunteers) can be the key to addressing patient concerns ranging from emotional distress or simply needing transportation to an appointment. More traditional measures of cost (or cost avoided) would include, for example: hospitalizations in the last 30 days of life, use of emergency department services, consumption of services such as surgery/chemotherapy/radiation/transfusions or other intense services within the last 30 days of life and place of death.
5. Measuring timely referral and earlier access to hospice. When the time is appropriate, often earlier in the patient’s trajectory of illness, referral to hospice has proven to improve quality of life and, for some, extend life. We believe outpatient, community based palliative care must be partnered with hospice services (when the time is right) to support patients and families when end-of-life care is most needed. Per Medicare Guidelines, patients are entitled to six months of hospice care. With many hospice admissions averaging days to weeks, patients are often short-changed of their options for care.

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