MARCH 5, 2018

Community Care Collaborative

A Central Health and Seton partnership

DSRIP Measure Specifications For Palliative Care Provider Selected by CCC

Table of Contents

Bundle G1 Palliative Care Introduction

Measure Bundle Objectives
Provide palliative care services to patients and their families and/or caregivers to improve patient outcomes and quality of life with a focus on relief from symptoms, stress, and pain related to serious, debilitating or terminal illness.
Target Population
Individuals enrolled in palliative or hospice care program during the measurement year or the year prior to the measurement year per measure specifications
Related System Components
Hospice Program or Palliative Care Program including home based and community based programs *NOTE: System components are included for planning purposes only and are not intended to further narrow the measure bundle target population or measure denominator specifications*

Measure Outpatient Services	NA	**Measures Hospital Based Services**	NA

G1-276: Hospice and Palliative Care – Pain Assessment

Measure Description:
Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

G1-276: Hospice and Palliative Care – Pain Assessment			
DY7/DY8 Program ID	G1-276		
Measure Details	**Steward:** University of North Carolina-Chapel Hill **NQF #:** 1637 **Source:** https://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures		
Data Source	E.H.R.		
Required Status	Required		
Measure Classification	**Type:** Process	**Measure Parts:** 1	
Achievement Calculations	**Category:** P4P	**Goal Calculation:** IOS **HPL:** NA **MPL:** NA NA	**Directionality:** Positive
Unit of Measurement for Payer Type	**Unit:** Individuals Measure will be reported for all-payer, medicaid, and uninsured unless an exception is requested and approved through the RHP Plan Update.		
Baseline Details	Shortened baseline measurement period is allowed with justification submitted in the RHP Plan Update. Measure is not eligible for a baseline of 0.		

Denominator Description

Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation / initial encounter.

Denominator Inclusions

The Pain Assessment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic
failure.

For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number >0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care.

For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted in screening (response of moderate or severe on verbal scale, >4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator.

G1-276: Hospice and Palliative Care – Pain Assessment

[NOTE: This quality measure should be paired with the Pain Screening quality measure to ensure that all patients are screened and therefore given the opportunity to report pain and enter the denominator population for Pain Assessment.]

Denominator Exclusions

Patients with length of stay < 1 day in palliative care or < 7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

Calculation of length of stay:
discharge date - date of initial encounter

Numerator Description

Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.

Numerator Inclusions (Performance Met)

Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain:

1. location
2. severity
3. character
4. duration
5. frequency
6. what relieves or worsens the pain
7. the effect on function or quality of life.

Numerator Exclusions (Performance Not Met)

None

DSRIP Specific Modifications

Providers may exclude from the denominator patients who are non-verbal for whom no clinically appropriate pain assessment is available

Additional Information

Clinical assessment of Pain:
a.Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care
b.Step 2- Identify admission evaluation / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days
c.Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care)
d.Step 4- Identify patients who screened positive for pain [any pain if hospice; moderate or severe pain if palliative care].
e.Step 5- Exclude patients who screened negative for pain
f.Step 6- Identify patients who received a clinical assessment for pain within 24 hours of screening positive for pain

G1-276: Hospice and Palliative Care – Pain Assessment
Numerator:Patients who received a clinical assessment for pain in Step 6 Denominator: Patients in Step 4 Sampling Methodology: Hospice and palliative care: consecutive sample of equal numbers of admissions + decedents beginning with a randomly selected date; minimum sample size 100. Data collection using a Structured medical record abstraction tool with separate collection of numerator and denominator values.

G1-277: Hospice and Palliative Care – Treatment Preferences

Measure Description:
Percentage of patients with chart documentation of preferences for life sustaining treatments.

G1-277: Hospice and Palliative Care – Treatment Preferences			
DY7/DY8 Program ID	G1-277		
Measure Details	**Steward:** University of North Carolina-Chapel Hill **NQF #:** 1641 **Source:** https://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures		
Data Source	E.H.R.		
Required Status	Required		
Measure Classification	**Type:** Process	**Measure Parts:** 1	
Achievement Calculations	**Category:** P4P	**Goal Calculation:** IOS **HPL:** NA **MPL:** NA NA	**Directionality:** Positive
Unit of Measurement for Payer Type	**Unit:** Individuals Measure will be reported for all-payer, medicaid, and uninsured unless an exception is requested and approved through the RHP Plan Update.		
Baseline Details	Shortened baseline measurement period is allowed with justification submitted in the RHP Plan Update. Measure is not eligible for a baseline of 0.		
Denominator Description			
Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.			
Denominator Inclusions			
The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.			
Denominator Exclusions			
Patients with length of stay < 1 day in palliative care or < 7 days in hospice Calculation of length of stay; discharge date - date of initial encounter			
Numerator Description			
Patients whose medical record includes documentation of life sustaining preferences			
Numerator Inclusions (Performance Met)			

G1-277: Hospice and Palliative Care – Treatment Preferences
Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of life-sustaining treatments. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about lifesustaining treatment, such as "Full Code" or "DNR/DNI" do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.
Numerator Exclusions (Performance Not Met)
NA
DSRIP Specific Modifications
None
Additional Information
Chart documentation of life sustaining preferences: a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital b.Step 2- Exclude palliative care patients if length of stay is < 1 day. Exclude hospice patients if length of stay is < 7 days c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments Numerator: Patients with documented discussion in Step 3 Denominator: Patients in Step 1 – Patients excluded in Step 2 Sampling Methodology: Hospice and palliative care: consecutive sample of equal numbers of admissions + decedents beginning with a randomly selected date. Data collection using a structured medical record abstraction tool, with separate collection of denominator and numerator data

G1-278: Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss

Measure Description:

Percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver/family did not want to discuss.

G1-278: Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss			
DY7/DY8 Program ID	G1-278		
Measure Details	**Steward:** University of North Carolina-Chapel Hill **NQF #:** 1647 **Source:** https://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures		
Data Source	E.H.R.		
Required Status	Required		
Measure Classification	**Type:** Process	**Measure Parts:** 1	
Achievement Calculations	**Category:** P4P	**Goal Calculation:** IOS **HPL:** NA **MPL:** NA NA	**Directionality:** Positive
Unit of Measurement for Payer Type	**Unit:** Individuals Measure will be reported for all-payer, medicaid, and uninsured unless an exception is requested and approved through the RHP Plan Update.		
Baseline Details	Shortened baseline measurement period is allowed with justification submitted in the RHP Plan Update. Measure is not eligible for a baseline of 0.		
Denominator Description			
Seriously ill patients 18 years of age or older enrolled in hospice.			
Denominator Inclusions			
This quality measure is intended for patients with serious illness who are enrolled in hospice care. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure			
Denominator Exclusions			
Testing has only been done with the adult population; thus patients younger than 18 are excluded.			
Numerator Description			
Patients whose medical record includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.			

G1-278: Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss

Numerator Inclusions (Performance Met)

Examples of a discussion may include asking about patient's need for spiritual or religious support, questions about the cause or meaning of illness or death. Other examples include discussion of God or a higher power related to illness, or offer of a spiritual resource including a chaplain. Discussion of spiritual or religious concerns may occur between patient and/or family and clergy or pastoral worker or patient and/or family and member of the interdisciplinary team.
This item is meant to capture evidence of discussion and communication. Therefore, documentation of patient's religious or spiritual affiliation by itself does not count for inclusion in numerator.

Data are collected via chart review. Criteria are:
1) evidence of a discussion about spiritual/religious concerns, or
2) evidence that the patient, and/or family declined to engage in a conversation on this topic.
Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments within 5 days of admission to hospice, visit notes documented by any member of the team, and/or the spiritual care assessment.

Cases are eligible for inclusion upon admission to a hospice program. The numerator criteria must be met during the time the patient is enrolled in the hospice program and can be met anytime during that period. The denominator/numerator data is collected within 1 to 12 months following discharge from hospice services.

Numerator Exclusions (Performance Not Met)

NA

DSRIP Specific Modifications

None

Additional Information

Step 1- Identify all patients with serious, life-limiting illness who were discharged from hospice care during the designated reporting period.
Step 2- Exclude patients who are less than 18 years of age.
Step 3- Identify patients with documented discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss spiritual/religious concerns.

Numerator: Patients with documented discussion or who responded they did not want to discuss in Step 3
Denominator: patients in Step 1 – Patients excluded in Step 2

G1-361: Patients Treated with an Opioid who are Given a Bowel Regimen

Measure Description:
Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed

G1-361: Patients Treated with an Opioid who are Given a Bowel Regimen			
DY7/DY8 Program ID	G1-361		
Measure Details	**Steward:** 0 **NQF #:** 1617 **Source:** HQRP: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html		
Data Source	Any		
Required Status	Required		
Measure Classification	**Type:** Process	**Measure Parts:** 1	
Achievement Calculations	**Category:** P4P	**Goal Calculation:** IOS **HPL:** NA **MPL:** NA NA	**Directionality:** Positive
Unit of Measurement for Payer Type	**Unit:** Encounters Measure will be reported for all-payer, medicaid, and uninsured unless an exception is requested and approved through the RHP Plan Update.		
Baseline Details	Shortened baseline measurement period is allowed with justification submitted in the RHP Plan Update. Measure is not eligible for a baseline of 0.		
Denominator Description			
Type 1 patient stays, except for those with exclusions, in which scheduled opioid was initiated or continued			
Denominator Inclusions			
None listed by measure steward.			
Denominator Exclusions			
1. Under 18 years of age as indicated by the birth date (A0900) and admission date (A0220) OR 2. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)			
Numerator Description			
The numerator for the measure includes all patient stays from the denominator in which the patients are given a bowel regimen or have a documented reason for why a bowel regimen was not initiated or continued.			
Numerator Inclusions (Performance Met)			
The numerator for the measure includes all patient stays from the denominator in which the patient meets the following criteria:			

G1-361: Patients Treated with an Opioid who are Given a Bowel Regimen

1. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1])
OR
2. A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B ≤ [1] and N0520B and N0500B ≠ [-,^])

All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

Numerator Exclusions (Performance Not Met)

NA

DSRIP Specific Modifications

None

Additional Information

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of NQF #1617, Patients Treated with an Opioid who are Given a Bowel Regimen, is as follows:

1. Calculate the denominator count:
   • Calculate the total number of patient stays that do not meet the exclusion criteria and a scheduled opioid was initiated or continued.
2. Calculate the numerator count:
   • Calculate the total number of Type 1 patient stays that indicates a documentation of why a bowel regimen was not initiated or continued or a bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued.

DEFINITIONS
(The below definitions are specific to the Hospital Quality Reporting Program, and may be useful in generating DSRIP rates for this measure):
Stay:
The period of time between a patient's admission to a hospice and either (a) a discharge, or (b) the end of the target period, whichever comes first. A patient can have multiple stays assigned to a target period.

• A patient stay starts with an admission record. The stay start date is the admission date on the HIS-Admission record.
– When the admission record that starts a stay is missing (i.e., when a discharge record has no matching admission record for the same patient with the same admission date and in the same hospice), the stay start date is the admission date on the discharge record.
• A patient stay ends with either (a) a HIS-Discharge record, or (b) the end of the target period, whichever comes first.
– When a patient stay ends with a discharge record, the stay end date is the discharge date (A0270) on the discharge record.
▪ The stay end date must be the same as or later than the stay start date.
▪ Both the admission and the discharge records associated with the patient stay must have identical admission dates.
– When a patient stay ends with the end of the target period (this typically indicates that the patient is still enrolled with the hospice at the end of the target period), the stay end date is the end of the target period.
▪ The stay end date must be the same as or later than the stay start date.

G1-361: Patients Treated with an Opioid who are Given a Bowel Regimen
The admission and discharge records that define the start and the end of patient stays are paired by matching the patient identifier (State Code and Resident Internal ID), hospice identifier (Provider Internal Number) and admission date. If multiple admission records (or multiple discharge records) share the same information in these matching criteria, the last chronological submission is kept and used. The submission time is first determined by submission date and then, if multiple records are submitted on the same day, by the Hospice Assessment ID. • The definitions above generate three types of stays for a target period: - Type 1: stays with both the admission and the discharge records (i.e., discharged stays) - Type 2: stays with the discharge record but no admission record (i.e., discharged stays but missing the admission records) - Type 3: stays with the admission record but no discharge record (i.e., active stays as of the end of the target period)

G1-362: Hospice and Palliative Care - Dyspnea Treatment

Measure Description:
Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.

G1-362: Hospice and Palliative Care - Dyspnea Treatment			
DY7/DY8 Program ID	G1-362		
Measure Details	**Steward:** University of North Carolina-Chapel Hill **NQF #:** 1638 **Source:** https://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures		
Data Source	E.H.R.		
Required Status	Required		
Measure Classification	**Type:** Process	**Measure Parts:** 1	
Achievement Calculations	**Category:** P4P	**Goal Calculation:** IOS **HPL:** NA **MPL:** NA NA	**Directionality:** Positive
Unit of Measurement for Payer Type	**Unit:** Individuals Measure will be reported for all-payer, medicaid, and uninsured unless an exception is requested and approved through the RHP Plan Update.		
Baseline Details	Shortened baseline measurement period is allowed with justification submitted in the RHP Plan Update. Measure is not eligible for a baseline of 0.		

Denominator Description

Patients enrolled in hospice for 7 or more days OR patients receiving palliative care who report dyspnea when dyspnea screening is done on the admission evaluation / initial encounter.

Denominator Inclusions

The Dyspnea Treatment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases , stroke, HIV/AIDS, and advanced renal or hepatic failure.

For patients enrolled in hospice or palliative care, a positive screen is indicated by any dyspnea noted as other than none on a verbal screen, any number > 0 on a numeric scale or any observational or self-report of dyspnea.

[NOTE: This quality measure should be paired with the Dyspnea Screening quality measure to ensure that all patients are screened and therefore given the opportunity to report dyspnea and enter the denominator population for Dyspnea Treatment.]

Denominator Exclusions

Palliative care patients with length of stay < 1 day or hospice patients with length of stay < 7 days, patients who were not screened for dyspnea, and/or patients with a negative screening.
Discharge date – admission date = 1 or hospice patients with discharge date – admission date = 7.

G1-362: Hospice and Palliative Care - Dyspnea Treatment
Numerator Description
Patients who screened positive for dyspnea who received treatment within 24 hours of screening.
Numerator Inclusions (Performance Met)
Treatment is administered if within 24 hours of the positive screen for dyspnea, medical treatment plan, orders or pharmacy records show inhaled medications, steroids, diuretics, or non-medication strategies such as oxygen and energy conservation. Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.
Numerator Exclusions (Performance Not Met)
NA
DSRIP Specific Modifications
None
Additional Information
Dyspnea treatment: a.Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care b.Step 2- Identify admission evaluation / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days c.Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) / initial encounter (palliative care) d.Step 4- Identify patients who screened positive for dyspnea e.Step 5- Identify patients who received treatment within 24 hours of screening positive for dyspnea Numerator: Patients who received treatment for dyspnea in Step 5 Denominator: Patients in Step 4 Sampling Methodology: Hospice and palliative care: consecutive sample of equal numbers of admissions + decedents beginning with randomly selected date; minimum sample size 100. Data collection using a structured medical record abstraction tool, with separate collection of denominator and numerator data

G1-363: Hospice and Palliative Care - Dyspnea Screening

Measure Description:
Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.

G1-363: Hospice and Palliative Care - Dyspnea Screening			
DY7/DY8 Program ID	G1-363		
Measure Details	**Steward:** University of North Carolina-Chapel Hill **NQF #:** 1639 **Source:** https://www.med.unc.edu/pcare/resources/PEACE-Quality-Measures		
Data Source	E.H.R.		
Required Status	Required		
Measure Classification	**Type:** Process	**Measure Parts:** 1	
Achievement Calculations	**Category:** P4P	**Goal Calculation:** IOS **HPL:** NA **MPL:** NA NA	**Directionality:** Positive
Unit of Measurement for Payer Type	**Unit:** Individuals Measure will be reported for all-payer, medicaid, and uninsured unless an exception is requested and approved through the RHP Plan Update.		
Baseline Details	Shortened baseline measurement period is allowed with justification submitted in the RHP Plan Update. Measure is not eligible for a baseline of 0.		
Denominator Description			
Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.			
Denominator Inclusions			
The Dyspnea Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Dyspnea Treatment quality measure to ensure that all patients who report dyspnea are clinically considered for treatment.]		
Denominator Exclusions			
Patients with length of stay < 7 days in hospice, or < 1 day in palliative care. Calculation of length of stay; discharge date - date of initial encounter			
Numerator Description			
Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.			

G1-363: Hospice and Palliative Care - Dyspnea Screening
Numerator Inclusions (Performance Met)
Patients who are screened for the presence or absence of dyspnea during the admission evaluation for hospice / initial encounter for hospital-based palliative care, and asked to rate its severity. Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients.
Numerator Exclusions (Performance Not Met)
NA
DSRIP Specific Modifications
None
Additional Information
Screened for dyspnea: a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice care or who receive specialty palliative care in an acute hospital setting b.Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days c.Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) OR during the initial encounter (palliative care) Numerator: Patients screened for dyspnea in Step 3 Denominator: Patients in Step 1 – Patients excluded in Step 2 Sampling Methodology: Hospice and palliative care: consecutive sample of equal numbers of admissions + discharges beginning with a randomly selected date. Data collection using a structured medical record abstraction tool, with separate collection of denominator and numerator data