# Palliative Care (PAL)

## Set Measures

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAL-01</td>
<td>Pain Screening</td>
</tr>
<tr>
<td>PAL-02</td>
<td>Pain Assessment</td>
</tr>
<tr>
<td>PAL-03</td>
<td>Dyspnea Screening</td>
</tr>
<tr>
<td>PAL-04</td>
<td>Treatment Preferences and Goals of Care</td>
</tr>
<tr>
<td>PAL-05</td>
<td>Treatment Preferences Discharge Document</td>
</tr>
</tbody>
</table>

## General Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>All Records,</td>
</tr>
<tr>
<td>Birthdate</td>
<td>All Records,</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>All Records,</td>
</tr>
<tr>
<td>ICD-10-CM Other Diagnosis Codes</td>
<td>All Records, Optional for HBIPS-2, HBIPS-3</td>
</tr>
<tr>
<td>ICD-10-CM Principal Diagnosis Code</td>
<td>All Records, Optional for HBIPS-2, HBIPS-3</td>
</tr>
<tr>
<td>ICD-10-PCS Other Procedure Codes</td>
<td>All Records, Optional for All HBIPS Records</td>
</tr>
<tr>
<td>ICD-10-PCS Principal Procedure Code</td>
<td>All Records, Optional for All HBIPS Records</td>
</tr>
<tr>
<td>Payment Source</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>Postal Code</td>
<td>All Records, CMS Only,</td>
</tr>
<tr>
<td>Race</td>
<td>All Records,</td>
</tr>
<tr>
<td>Sex</td>
<td>All Records,</td>
</tr>
</tbody>
</table>

## Measure Set Specific Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Disposition</td>
<td>PAL-05,</td>
</tr>
<tr>
<td>Dyspnea Severity</td>
<td>PAL-03,</td>
</tr>
<tr>
<td>Goals of Care</td>
<td>PAL-04,</td>
</tr>
</tbody>
</table>
Palliative Care (PAL) Initial Patient Population

The PAL Measure Set Population (common to all PAL measures) is defined as all patients who have received a consultation with any member of the palliative care service team. “Consultation” indicates that the patient received a face to face encounter visit with any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).

The population of the PAL measure set can be identified by using data elements that are common to all of the performance measures in the set:

- Discharge Date
- Initial Encounter

While not required for the identification of the initial patient population or the calculation of the measures, the following data elements are collected for purposes of case identification:

- Admission Date
- Birthdate
- Sex

Note – General Data Elements:

The following General Data Elements are optional for the PAL measure set. Collection of these data elements is not currently required for the identification of the initial patient population or the calculation of the measures for purposes of measure submission for certification.

Optional General Data Elements:

- Hispanic Ethnicity
- ICD-10-CM Other Diagnosis Codes
- ICD-10-CM Principal Diagnosis Code
- ICD-10-PCS Other Procedure Codes
- ICD-10-PCS Principal Procedure Code
- Payment Source
- Postal Code
- Race

Initial Patient Population Algorithm
Sampling / Sample Size Requirements

Sampling Methodology
Sampling is a process of selecting a representative part of a population to estimate the organization’s performance without collecting data for its entire population. Using a statistically valid sample, an organization can measure its performance in an effective and efficient manner. Sampling is a particularly useful technique for performance measures that require primary data collection from a source, such as the medical record. Sampling should not be used unless the organization has a large number of cases in the measure population, because a fairly large number of sample cases is needed to achieve a representative sample of the population of interest. To obtain statistically valid sample data, the sample size should be carefully determined, and the sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected. Only when the sample data truly represent the whole population can the sample-based performance measure data be meaningful and useful.

Sampling Approaches
Simple random sampling - selecting a sample size (n) from a population of size (N) in such a way that every case has the same chance of being selected. Systematic random sampling - selecting every kth record from a population of size N in such a way that a sample size of n is obtained, where k ≤ N/n. The first sample record (i.e., the starting point) must be randomly selected before taking every kth record. This is a two-step process: a) Randomly select the starting point by choosing a number between one and k using a table of random numbers or a computer-generated random number; and b) Then select every kth record thereafter until the selection of the sample size is completed. As an example, say the site has 33 cases for the month. These 33 cases would then be put on a list and numbered from 1 to 33. First we calculate the sampling interval k as 33/10 which rounds to 3. The site would then randomly choose a number between 1 and 3 to use as the starting point on the list, sample this case, and then from this point sample every 3rd case on the list until they come to the end of the list to create their sample.

<table>
<thead>
<tr>
<th>Monthly Patient Volume (number of discharges)</th>
<th>Monthly Sample Size (number of medical records)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 9</td>
<td>100%</td>
</tr>
<tr>
<td>10 - 49</td>
<td>10 cases</td>
</tr>
<tr>
<td>50 - 99</td>
<td>20%</td>
</tr>
<tr>
<td>=&gt; 100</td>
<td>20 cases</td>
</tr>
</tbody>
</table>
Measure Information Form

**Measure Set:** Palliative Care (PAL)

**Set Measure ID:** PAL-01

**Performance Measure Name:** Pain Screening

**Description:** Proportion of palliative care patients who were screened for pain during the palliative care initial encounter.

**Rationale:** As described from the University of Chapel Hill PEACE Measure Set project, pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Poor screening, assessment, and undertreatment of pain is more common for patients with serious illness who are also of minority race ethnicity. Use of the Pain Screening and Pain Assessment quality measures will increase reporting and efforts to improve awareness of the presence of pain (screening) and assessment of severity, etiology and effect on function (assessment) which are the essential first steps required for quality pain management and treatment. The prevalence of pain ranges from 40-80% in seriously ill patient populations. As detailed in a systematic review from AHRQ and the American Pain Society Quality of Care guidelines, pain screening and assessment are the essential steps required to ensure that pain is detected by clinicians and appropriate treatment implemented. (Wells et al., 2008; Gordon et al. 2005; as cited by PEACE) Failure to screen, assess, and treat pain results in functional limitations, physiologic stress, and psychological harms such as social withdrawal and depression. The current quality of pain screening, assessment, and treatment is poor, as documented in systematic pain prevalence and treatment studies from hospital, outpatient, cancer and nursing home settings. (Reynolds et al., 2002; Deandria et al., 2008; Mularski et al., 2006; Erdek et al., 2004; as cited by PEACE) In a systematic review of quality of pain care for diverse patient populations, Gordon reported high average pain severity (6.17-8.37 on 10 point scale) and moderate rates of pain severity screening or other assessment (47%-96%). These findings did not vary by underlying diagnosis. (Gordon et al., 2002) (PEACE, 2015)

The National Consensus Project for Quality Palliative Care (2013) guidelines recommend that the interdisciplinary team assesses and manages pain in a safe and timely manner to a level acceptable to the patient or surrogate and that symptom assessment, treatment, side effect and treatment outcome information should be recorded in the medical record.

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** Patients who are screened for the presence or absence of pain and its severity using a standardized quantitative tool during the initial encounter for palliative care.

**Included Populations:** Not applicable

**Excluded Populations:** None

**Data Elements:**

- Pain Severity

**Denominator Statement:** Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days

**Included Populations:**

**Excluded Populations:**

- Palliative care program length of stay less than 1 day
**Data Elements:**

- Initial Encounter
- Initial Encounter Date

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative/billing data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10CM/PCS diagnosis and procedure codes, which require retrospective data entry.

**Data Accuracy:** Variation may exist in the assignment of ICD-10CM/PCS codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None

** Sampling:** Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications Section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


**Original Performance Measure Source / Developer:**
American Academy of Hospice and Palliative Care (AAHPC) and Hospice and Palliative Nurses Association (HPNA)
Measuring What Matters Project Top Ten Measures That Matter List
CMS Hospice Item Set
PEACE Hospice and Palliative Care Quality Measures Set

**Measure Algorithm:**
**PAL-01: Pain Screening**

**Numerator:** Patients who are screened for the presence or absence of pain and its severity using a standardized quantitative tool during the initial encounter for palliative care.

**Denominator:** Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days.
Measure Information Form

Measure Set: Palliative Care (PAL)

Set Measure ID: PAL-02

Performance Measure Name: Pain Assessment

Description: Proportion of palliative care patients who screened positive for pain during the palliative care initial encounter and received a clinical assessment of pain, which included at least five of seven components, within one (1) day of screening.

Rationale: As described from the University of Chapel Hill PEACE Measure Set project, pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Poor screening, assessment, and undertreatment of pain is more common for patients with serious illness who are also of minority race ethnicity. Use of the Pain Screening and Pain Assessment quality measures will increase reporting and efforts to improve awareness of the presence of pain (screening) and assessment of severity, etiology and effect on function (assessment) which are the essential first steps required for quality pain management and treatment. The prevalence of pain ranges from 40-80% in seriously ill patient populations. As detailed in a systematic review from AHRQ and the American Pain Society Quality of Care guidelines, pain screening and assessment are the essential steps required to ensure that pain is detected by clinicians and appropriate treatment implemented. (Wells et al., 2008; Gordon et al. 2005; as cited by PEACE) Failure to screen, assess, and treat pain results in functional limitations, physiologic stress, and psychological harms such as social withdrawal and depression. The current quality of pain screening, assessment, and treatment is poor, as documented in systematic pain prevalence and treatment studies from hospital, outpatient, cancer and nursing home settings. (Reynolds et al., 2002; Deandria et al., 2008; Mularski et al., 2006; Erdek et al., 2004; as cited by PEACE) In a systematic review of quality of pain care for diverse patient populations, Gordon reported high average pain severity (6.17-8.37 on 10 point scale) and moderate rates of pain severity screening or other assessment (47%-96%). These findings did not vary by underlying diagnosis. (Gordon et al., 2002) (PEACE, 2015)

The National Consensus Project for Quality Palliative Care (2013) guidelines recommend that the interdisciplinary team assesses and manages pain in a safe and timely manner to a level acceptable to the patient or surrogate and that symptom assessment, treatment, side effect and treatment outcome information should be recorded in the medical record.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients who received a comprehensive clinical assessment, which included at least five of seven components, within one (1) day of screening positive for pain.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Pain Character
- Pain Duration
- Pain Effect
- Pain Factors
- Pain Frequency
- Pain Location
- Pain Severity

Denominator Statement: Patients receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the initial palliative care encounter.
**Included Populations:**

**Excluded Populations:**

- Palliative care program length of stay less than 1 day

**Data Elements:**

- Initial Encounter
- Initial Encounter Date
- Pain Severity

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative/billing data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10CM/PCS diagnosis and procedure codes, which require retrospective data entry.

**Data Accuracy:** Variation may exist in the assignment of ICD-10CM/PCS codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None

**Sampling:** Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications Section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


**Original Performance Measure Source / Developer:** Palliative Care Performance Measurement Implementation Guide
Discharges effective January 1, 2017
American Academy of Hospice and Palliative Care (AAHPM) and Hospice and Palliative Nurses Association (HPNA)
Measuring What Matters Project Top Ten Measures That Matter List
CMS Hospice Item Set
PEACE Hospice and Palliative Care Quality Measures Set

Measure Algorithm:
PAL-02: Pain Assessment

**Numerator:** Patients who received a comprehensive clinical assessment, which included at least five of seven components, within one (1) day of screening positive for pain.

**Denominator:** Patients receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the initial palliative care encounter.

![Flowchart for PAL-02: Pain Assessment](chart.png)

**Variable Key:**
- Pain Counter
Measure Information Form

Measure Set: Palliative Care (PAL)
Set Measure ID: PAL-03
Performance Measure Name: Dyspnea Screening

Description: Proportion of palliative care patients who were screened for dyspnea during the palliative care initial encounter.

Rationale: As described from the University of Chapel Hill PEACE Measure Set project, dyspnea is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Screening for dyspnea is necessary to determine its presence and severity, and forms the basis for treatment decision-making. Unlike pain, structured clinical assessment of the symptom is less well-defined, yet similar to pain, effective treatment is available to alleviate symptom distress. Prevalence of dyspnea in advanced cancer ranges from 50-70%. Among COPD patients with advanced illness enrolled in the SUPPORT Study, dyspnea which was moderate to severe at least half of the time was present for at least 65% of patients throughout the 6 months preceding death. Effective treatment for dyspnea is available, but not consistently administered. Evidence-based treatments include pharmacologic interventions such as opioids and inhaled bronchodilators, and non-pharmacologic interventions including oxygen for hypoxic patients, pulmonary rehabilitation and exercise in COPD, and drainage of pleural effusion. (PEACE, 2015)

National Consensus Project for Quality Palliative Care (2013) guidelines recommend that the interdisciplinary team assesses and manages pain in a safe and timely manner to a level acceptable to the patient or surrogate and that symptom assessment, treatment, side effect and treatment outcome information should be recorded in the medical record.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients who are screened for the presence or absence of Dyspnea and its severity during the initial encounter for palliative care.

Included Populations: Not applicable
Excluded Populations: None

Data Elements:

• Dyspnea Severity

Denominator Statement: Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days

Included Populations:
Excluded Populations:

• Palliative care program length of stay less than one (1) day

Data Elements:

• Initial Encounter
• Initial Encounter Date
**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10CM/PCS diagnosis and procedure codes, which require retrospective data entry.

**Data Accuracy:** Variation may exist in the assignment of ICD-10CM/PCS codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None

**Sampling:** Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications Section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


**Original Performance Measure Source / Developer:**
American Academy of Hospice and Palliative Care (AAHPM) and Hospice and Palliative Nurses Association (HPNA)
Measuring What Matters Project Top Ten Measures That Matter List
CMS Hospice Item Set
PEACE Hospice and Palliative Care Quality Measures Set

**Measure Algorithm:**
**PAL-03: Dyspnea Screening**

**Numerator:** Patients who are screened for the presence or absence of Dyspnea and its severity during the initial encounter for palliative care.

**Denominator:** Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days.
Measure Information Form

Measure Set: Palliative Care (PAL)
Set Measure ID: PAL-04
Performance Measure Name: Treatment Preferences and Goals of Care

Description: Proportion of palliative care patients with medical record documentation of treatment preferences and goals of care.

Rationale: Seriously ill and dying patients who are given the opportunity to express life-sustaining treatment preferences are more likely to receive care consistent with their values, and patient and family satisfaction outcomes improve. Patients and physicians alike hesitate to initiate discussions, while acknowledging their value and desirability. Use of the Treatment Preferences quality measure will improve attention to this important practice, in order to enhance patient autonomy, facilitate patient-centered decision-making, and communicate patient preferences via documentation to other treating providers. Poor communication about patient preferences has been identified as a major quality concern in palliative and end-of-life care since an early, comprehensive Institute of Medicine report. (Field et al., 1997; as cited by PEACE) The SUPPORT Study found marked discrepancies between patient report of treatment preferences and provider awareness of or use of these preferences to guide treatment. (1995; as cited by PEACE) Patients and families prioritize communication with providers and control over treatment choices when faced with serious or life-threatening illness. (Steinhauser et al., 2001; as cited by PEACE) However, physicians and other providers fail to open the door to these discussions at critical time points in illness progression. (Gysels et al., 2004; as cited by PEACE) A recent systematic review of communication research found a consistent discrepancy between the quality and content of communication providers believed they provided, and the quality and content of communication experienced by seriously ill patients and their families. (Hancock et al., 2007; as cited by PEACE)

The National Consensus Project for Quality Palliative Care (2013) guidelines recommend that patient or surrogate’s goals, preferences, and choices be respected and used as the basis for the plan of care within the limits of laws and standards of care. The palliative care interdisciplinary team discusses achievable goals with the patient and family using a patient-centered approach that includes the patient values and preferences and assists with advance care planning documents to communicate patient preferences across care settings.

Type of Measure: Process
Improvement Noted As: Increase in the rate

Numerator Statement: Patients with medical record documentation of treatment preferences and goals of care.

Included Populations: Not applicable
Excluded Populations: None

Data Elements:

- Goals of Care
- Treatment Preferences

Denominator Statement: Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days

Included Populations:
Excluded Populations:

- Palliative care program length of stay less than one (1) day
Data Elements:
- Initial Encounter
- Initial Encounter Date

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10CM/PCS diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-10CM/PCS codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

Original Performance Measure Source / Developer:
American Academy of Hospice and Palliative Care (AAHPM) and Hospice and Palliative Nurses Association (HPNA)
Measuring What Matters Project Top Ten Measures That Matter List
CMS Hospice Item Set
PEACE Hospice and Palliative Care Quality Measures Set

Measure Algorithm:
PAL-04: Treatment Preferences and Goals of Care

Numerator: Patients with medical record documentation of treatment preferences and goals of care.
Denominator: Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days.

[Flowchart diagram]

- START
  - Run cases that are included in the PAL Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
  - Treatment Preferences
    - $= 3$
    - $= 1, 2$
  - Goals of Care
    - $= N$
    - $= Y$
  - Cases will be rejected
  - In Numerator Population
  - In Measure Population
  - STOP
Measure Information Form

Measure Set: Palliative Care (PAL)
Set Measure ID: PAL-05

Performance Measure Name: Treatment Preferences Discharge Document

Description: Proportion of patients for whom a transition of care document containing information regarding goals of care and treatment preferences is completed and accompanies the patient to the next level of care at discharge.

Rationale: Seriously ill and dying patients who are given the opportunity to express life-sustaining treatment preferences are more likely to receive care consistent with their values, and patient and family satisfaction outcomes improve. Patients and physicians alike hesitate to initiate discussions, while acknowledging their value and desirability. According to the PEACE project the use of a Treatment Preferences quality measure will improve attention to this important practice, in order to enhance patient autonomy, facilitate patient-centered decision-making, and communicate patient preferences via documentation to other treating providers. Poor communication about patient preferences has been identified as a major quality concern in palliative and end-of-life care since an early, comprehensive Institute of Medicine report. (Field et al., 1997; as cited by PEACE) The SUPPORT Study found marked discrepancies between patient report of treatment preferences and provider awareness of or use of these preferences to guide treatment. (1995; as cited by PEACE) Patients and families prioritize communication with providers and control over treatment choices when faced with serious or life-threatening illness. (Steinhauser et al., 2001; as cited by PEACE) However, physicians and other providers fail to open the door to these discussions at critical time points in illness progression. (Gysels et al., 2004; as cited by PEACE) A recent systematic review of communication research found a consistent discrepancy between the quality and content of communication providers believed they provided, and the quality and content of communication experienced by seriously ill patients and their families. (Hancock et al., 2007; as cited by PEACE)

The National Consensus Project for Quality Palliative Care (2013) guidelines recommend that patient’s or surrogate’s goals, preferences, and choices be respected and used as the basis for the plan of care within the limits of laws and standards of care. The palliative care interdisciplinary team discusses achievable goals with the patient and family using a patient-centered approach that includes the patient values and preferences and assists with advance care planning documents to communicate patient preferences across care settings.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients for whom a transition of care document containing information regarding treatment preferences and goals of care is completed and accompanies the patient to the next level of care at discharge.

Included Populations: Not applicable
Excluded Populations: None

Data Elements:
- Treatment Preferences Document

Denominator Statement: Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days

Included Populations:
Excluded Populations:
- Patients with discharge disposition of expired or left against medical advice/AMA
Data Elements:

- Discharge Disposition
- Initial Encounter
- Initial Encounter Date

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10CM/PCS diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-10CM/PCS codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: Yes. Please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Original Performance Measure Source / Developer:
American Academy of Hospice and Palliative Care (AAHPM) and Hospice and Palliative Nurses Association (HPNA)
Measuring What Matters Project Top Ten Measures That Matter List
PEACE Hospice and Palliative Care Quality Measures Set

Measure Algorithm:
PAL-05: Treatment Preferences Discharge Document

**Numerator:** Patients for whom a transition of care document containing information regarding treatment preferences and goals of care is completed and accompanies the patient to next level of care at discharge.

**Denominator:** Patients receiving specialty palliative care in an acute hospital setting for one (1) or more days.
Data Elements
**Data Element Name:** Admission Date

**Collected For:** All Records

**Definition:** The month, day, and year of admission to acute inpatient care.

**Suggested Data Collection Question:** What is the date the patient was admitted to acute inpatient care?

**Format:**
- **Length:** 10
- **Type:** Date
- **Occurs:** 1

**Allowable Values:**
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)

**Notes for Abstraction:**
- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, the 'Statement Covers Period' is not synonymous with the 'Admission Date' and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period ("From" and "Through" dates) identifies the span of service dates included in a particular claim. The "From" Date is the earliest date of service on the claim.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.
- The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

**Suggested Data Sources:**
- ONLY ALLOWABLE SOURCES
  - Physician orders
  - Face sheet
  - UB-04
**Note:** The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

**Excluded Data Sources**
- UB-04, “From” and “Through” dates

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• Admit to observation</td>
</tr>
<tr>
<td></td>
<td>• Arrival date</td>
</tr>
</tbody>
</table>
Data Element Name: Birthdate
Collected For: All Records
Definition: The month, day, and year the patient was born.

Note:

- Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.
- For HBIPS discharge measures, i.e., HBIPS-1, 5, patient's age (in years) is calculated by Discharge Date minus Birthdate. For event measures, i.e., HBIPS-2, 3, patient's age at time of event (in years) is calculated by Event Date minus Birthdate. The algorithm to calculate age must use the month and day portion of birthdate, and discharge date or event, as appropriate to yield the most accurate age.

Suggested Data Collection Question: What is the patient's date of birth?
Format: Length: 10 MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (1880-Current Year)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form
- UB-04

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Discharge Date

Collected For: All Records, Not collected for HBIPS-2 and HBIPS-3

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format: Length: 10  MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values: MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

For HBIPS only, if the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Discharge Disposition

Collected For: ACHF, ASR-IP-3, CSTK-02, HBIPS-5, PAL-05, PC-04, PC-05, STK-10, STK-2, STK-3, STK-6, STK-8, THKR-IP-2, THKR-IP-3,

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 Home
2 Hospice - Home
3 Hospice - Health Care Facility
4 Acute Care Facility
5 Other Health Care Facility
6 Expired
7 Left Against Medical Advice/AMA
8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:
- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.
  
  Example:
  
  Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5" (Other Health Care Facility).

- The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.

- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.
  
  Examples:
  
  o Discharge summary dictated 2 days after discharge states patient went home. Physician note on day of discharge further clarifies that the patient will be going home with hospice. Select value "2" (Hospice - Home).
  
  o Discharge planner note from day before discharge states XYZ Nursing Home. Discharge order from day of discharge states Discharge home. Contradictory documentation, use latest. Select value "1" (Home).
  
  o Physician order on discharge states Discharge to ALF. Discharge instruction sheet completed after the physician order states patient discharged to SNF. Contradictory documentation, use latest. Select value "5" (Other Health Care Facility).

- If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
  
  o Acute Care Facility
  
  o Hospice - Health Care Facility
  
  o Hospice - Home
  
  o Other Health Care Facility
- **Home**
- Hospice (values "2" and "3") includes discharges with hospice referrals and evaluations.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value "4" (Acute Care Facility).
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows), and does not reflect the type of facility or level of care, select value "5" (Other Health Care Facility).
- If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select value "1" (Home).
- When determining whether to select value "7" (Left Against Medical Advice/AMA):
  - Explicit "left against medical advice" documentation is not required. E.g., Patient is refusing to stay for continued care - Select value "7".
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required, for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as contradictory. If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states Discharged home with belongings - Select “7”.

**Suggested Data Sources:**
- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Discharge planning notes
- Nursing discharge notes
- Social service notes
- Transfer record

**Excluded Data Sources**
- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home (Value 1):</strong></td>
<td>None</td>
</tr>
<tr>
<td>Assisted Living Facilities (ALFs) - Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities</td>
<td></td>
</tr>
<tr>
<td>Court/Law Enforcement - includes detention facilities, jails, and prison</td>
<td></td>
</tr>
<tr>
<td>Home - includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters</td>
<td></td>
</tr>
<tr>
<td>Home with Home Health Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization</td>
<td></td>
</tr>
</tbody>
</table>

**Hospice - Home (Value 2):**
- Hospice in the home (or other Home setting as above in Value 1)

**Hospice Health Care Facility (Value 3):**
- Hospice - General Inpatient and Respite
- Hospice - Residential and Skilled Facilities
- Hospice - Other Health Care Facilities

**Acute Care Facility (Value 4):**
- Acute Short Term General and Critical Access Hospitals
- Cancer and Childrens Hospitals
- Department of Defense and Veterans Administration Hospitals

**Other Health Care Facility (Value 5):**
- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veterans Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home
Data Element Name: Dyspnea Severity

Collected For: PAL-03,

Definition: Evaluation of the patient for the presence or absence of dyspnea (shortness of breath) and its severity at the time of the palliative care initial encounter.

Suggested Data Collection Question: What was the severity of dyspnea when the patient was first screened for dyspnea during the palliative care initial encounter?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
0    None
1    Mild
2    Moderate
3    Severe
4    Dyspnea severity not able to be rated
5    There is no documentation that the patient was screened for dyspnea, or unable to determine from medical record documentation.

Notes for Abstraction:

- Select “0” if documented in the medical record the patient’s dyspnea severity score was none. This would include a score of 0 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient reports no discomfort and is breathing shallowly but without signs of distress; no concerns about breathing from patient or family.”
- Select “1” if documented in the medical record the patient’s dyspnea severity score was mild. This would include a score of 1–3 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient unable to speak; observed during 20-minute evaluation; respiratory rate 28 with intermittent use of abdominal breathing; some wheezing on exam but good air movement.”
- Select “2” if documented in the medical record the patient’s dyspnea severity score was moderate. This would include a score of 4–6 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient reports he is currently not experiencing any shortness of breath. Patient reports that he does become short of breath when walking from the bed to the bathroom. Patient reports that when he is short of breath, shortness of breath is mild to moderate, depending on activity level.”
- Select “3” if documented in the medical record the patient’s dyspnea severity score was severe. This would include a score of 7–10 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient reports great difficulty with breathing when walking to the bathroom; breathing is eased after resting and better if using oxygen when active.”
- Select “4” if documented in the medical record the patient had dyspnea, but the patient’s dyspnea severity was not able to be evaluated by any manner. This would include documentation that staff was unable to rate severity by observation or patient was unable or declined to use a rating scale. Example: “patient intubated.”
- Select “5” if there is no documentation that the patient was screened for dyspnea, or unable to determine from medical record documentation. Example: “patient very drowsy; appears to be comfortable during visit.”
- If documentation indicates the patient had shortness of breath, but severity was not evaluated in any manner, select “5”.
- A screening for dyspnea must include evaluating the patient for presence or absence of
dyspnea (shortness of breath), and if dyspnea is present, rating of its severity. Structured clinical evaluation for dyspnea is not well defined, therefore documentation found in the medical record for screening of dyspnea may vary and may not include use of a standardized tool for rating severity.

- Examples of scales that may be used include, but are not limited to:
  - Modified Borg Scale (MBS) – Rating of Perceived Dyspnea (RPD)
  - Edmonton Symptom Assessment System (ESAS)
  - Memorial Symptom Assessment Scale
  - Visual Analogue Scale (VAS)
  - The Numeric Rating Scale (NRS)
  - Medical Research Council Dyspnea Scale
  - Baseline Dyspnea Index (BDI)
  - Respiratory Distress Observation Scale (RDOS)

- It is possible that at the time of the palliative care initial encounter there will have been multiple screenings for dyspnea that were documented in the clinical record. For purposes of this measure use the dyspnea screening based on the first dyspnea screening that appears during the palliative care initial encounter.

- If a range is provided, such as mild to moderate, select the highest level of severity recorded.

- The clinical record could include patient's self-report of distress or “trouble breathing” from shortness of breath or dyspnea; documentation of shortness of breath or dyspnea at rest, upon exertion, etc.; patient/family report of shortness of breath; observed clinical signs of distress from shortness of breath; and/or documentation that the symptom is distressing or limits patient function or quality of life.

- Evidence of a “positive” screen for shortness of breath should consider whether shortness of breath was an active problem for the patient at the time of the screening clinical encounter. In determining whether shortness of breath was an active problem for the patient, providers may need to consider historical report of patient’s shortness of breath, documentation of patient’s self-report of distress, and observed clinical signs of shortness of breath at the time of the encounter in which the screening was conducted. On the basis of reports of recent symptoms and current treatment, the assessing clinician may determine that dyspnea is an active problem, even if shortness of breath does not occur during the initial encounter.

- The initial screening documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).

Suggested Data Sources:
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

Additional Notes: Notes adapted from: Guidance Manual for Completion of the Hospice Item Set (HIS), Centers for Medicare and Medicaid Services, Hospice Quality Reporting Program, V 1.02 Effective June 28, 2015

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Goals of Care

Definition: There is documentation in medical record that the palliative care team discussed or attempted to discuss the patient's goals for care.

Suggested Data Collection Question: Is there documentation in medical record that the palliative care team discussed or attempted to discuss the patient's goals for care?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There is documentation in medical record that the palliative care team discussed or attempted to discuss the patient's goals for care.

N (No) There is no documentation in medical record that the palliative care team discussed or attempted to discuss the patient's goals for care or unable to determine from the medical record documentation.

Notes for Abstraction:

- Goals of care may be curative, rehabilitative, life-prolonging, or comfort focused.
- For the purpose of this patient-centered measure, the documentation should indicate that the patient, family or surrogate was involved in the discussion of goals of care and care planning (i.e. that it was not ordered solely by the clinician without input by the patient). Examples include (but not limited to) "discussed goals of care with patient, who chooses to..." "patient indicated desire to," or "patient verbalized agreement with plan to" may be illustrative of collaborative goals of care discussion.
- Goals of care should be derived based upon the patient's expressed preferences, values, needs, concerns and/or desires, through clinician-led discussion, professional guidance and support for patient and family decision making.
- Family is determined by the patient. Family may be defined as a person or persons who play a significant role in an individual's life. A family is a group of two or more persons united by blood or adoptive, marital, domestic partnership, or other legal ties. The family may also be a person or persons not legally related to the individual (such as a significant other, friend, or caregiver) whom the individual personally considers to be family. A family member may be the surrogate decision-maker if authorized to make care decisions for the individual should he or she lose decision-making capacity or choose to delegate decision making to another.
- A surrogate decision-maker is someone legally appointed to make decisions on behalf of another. This individual can be a family member or someone not related to the individual. A surrogate decision-maker makes decisions when the individual is without decision-making capacity or when the individual has given permission to the surrogate to make decisions. Such an individual is sometimes referred to as a legally responsible representative.
- If the patient or family declines to discuss the goals of care, and the documentation reflects this, select “Yes.” This would include statements such as, “I don’t want to talk about this” or “I’m only going to talk to my priest about this”.
- A discussion about goals of care can be initiated by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).

Suggested Data Sources:
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment
**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Hispanic Ethnicity

Collected For: All Records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values:
Y (Yes) Patient is of Hispanic ethnicity or Latino.
N (No) Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction: The data element, Race, is required in addition to this data element.

Suggested Data Sources:
- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
</table>
| A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term Spanish origin can be used in addition to Hispanic or Latino. Examples: Black-Hispanic
  Chicano
  H
  Hispanic
  Latin American
  Latino/Latina
  Mexican-American
  Spanish
  White-Hispanic                                                                  | None      |
Data Element Name: ICD-10-CM Other Diagnosis Codes

Collected For: All Records, Optional for HBIPS-2, HBIPS-3

Definition: The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization.

Suggested Data Collection Question: What were the ICD-10-CM other diagnosis codes selected for this medical record?

Format: Length: 3-7 (without decimal point or dot; upper or lower case)
Type: Character
Occurs: 24


Notes for Abstraction: None

Suggested Data Sources:
• Discharge summary
• Face sheet
• UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: **ICD-10-CM Principal Diagnosis Code**

**Collected For:** All Records, Optional for HBIPS-2, HBIPS-3

**Definition:** The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

**Suggested Data Collection Question:** What was the ICD-10-CM code selected as the principal diagnosis for this record?

**Format:**
- **Length:** 3-7 (without decimal point or dot; upper or lower case)
- **Type:** Character
- **Occurs:** 1


**Notes for Abstraction:** None

**Suggested Data Sources:**
- Discharge summary
- Face sheet
- UB-04

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name:  *ICD-10-PCS Other Procedure Codes*

Collected For:  All Records, Optional for All HBIPS Records

Definition:  The other or secondary (ICD-10-PCS) codes identifying all significant procedures other than the principal procedure.

**Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-10-PCS Other Procedure Date* exists, etc.) will apply.

Suggested Data Collection Question:  What were the ICD-10-PCS code(s) selected as other procedure(s) for this record?

Format:  
- **Length:** 3-7 (without decimal point or dot; upper or lower case)
- **Type:** Character
- **Occurs:** 24


Notes for Abstraction:  None

Suggested Data Sources:  
- Discharge summary
- Face sheet
- UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: **ICD-10-PCS Principal Procedure Code**

**Collected For:** All Records, Optional for All HBIPS Records

**Definition:** The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

**Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-10-PCS Principal Procedure Date* exists, etc.) will apply.

**Suggested Data Collection Question:** What was the ICD-10-PCS code selected as the principal procedure for this record?

**Format:**
- **Length:** 3-7 (without decimal point or dot; upper or lower case)
- **Type:** Character
- **Occurs:** 1

**Allowable Values:** Any valid procedure code as per the CMS ICD-10-PCS master code table (2017 PCS Long and Abbreviated Titles): https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-PCS-and-GEMs.html

**Notes for Abstraction:** None

**Suggested Data Sources:**
- Discharge summary
- Face sheet
- UB-04

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Initial Encounter
Collected For: PAL,
Definition: A patient who has received a consultation with any member of the palliative care service team.
Suggested Data Collection Question: Did the patient receive a palliative care service initial encounter at the organization?

Format:
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

Allowable Values:
- **Y** (Yes) There is documentation in the medical record that the patient received an initial encounter consultation with a member of the palliative care team.
- **N** (No) There is no documentation in medical record that the patient received an initial encounter consultation with a member of the palliative care team or unable to determine from the medical record documentation.

Notes for Abstraction:
- “Consultation” indicates that the patient received a face to face encounter visit with any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
- A formal order for a consultation does not need to be present in the medical record.
- Do not include attempted visits, use the first face to face visit.

Suggested Data Sources:
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
**Data Element Name:** Initial Encounter Date

**Collected For:** PAL,

**Definition:** The date that the patient was first seen in consultation by any member of the palliative care service.

**Suggested Data Collection Question:** What was the date the patient was first seen in consultation by any member of the palliative care service?

**Format:**
- **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1

**Allowable Values:**
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)
- UTD = Unable to Determine

**Notes for Abstraction:**
- “Consultation” indicates that the patient received a face to face encounter visit with any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
- A formal order for a consultation does not need to be present in the medical record.
- If multiple palliative care consultations took place, use the first face to face meeting date with any palliative care team member.
- Do not include attempted visits, use the first face to face visit.
- If the month and/or day contain only a single digit, enter a “0” in the first box of the month and/or day. For example, November 1, 20xx, would be entered as 11-01-20xx.
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the Discharge Date]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

**Example:**
Documentation indicates the palliative care initial encounter date was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the palliative care initial encounter date is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”

**Suggested Data Sources:**
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: *Pain Character*

Collected For: PAL-02,

Definition: Documentation of a comprehensive pain assessment that included pain character completed within one day of the pain screening.

Suggested Data Collection Question: Is there documentation of a comprehensive pain assessment including pain character completed within one day of the pain screening?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
- Y (Yes) There is documentation in the medical record that a comprehensive pain assessment including pain character was completed within one day of the pain screening.
- N (No) There is no documentation that a comprehensive pain assessment including pain character was completed within one day of the pain screening or unable to determine from the medical record.

Notes for Abstraction:
- A comprehensive pain assessment includes documentation of pain character. Examples for this component include but are not limited to:
  - Character – type of pain, quality or description, such as throbbing, aching, sharp, dull etc.
    - What does the pain feel like?
- Components of the comprehensive assessment must be documented in the medical record within one day of the pain screening to select "yes". The time frame for documentation is the day of and the day after the pain screening.
- The comprehensive assessment documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
- It is possible to include elements of the pain assessment for nonverbal patients. A family report may be used to complete one or more of the components of the comprehensive assessment. Clinical notes about assessment of nonverbal indicators of pain are also acceptable to select "1". Examples included but are not limited to:
  - Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.
- Documentation based on whether the clinician made an attempt to gather the information from the patient/family may be used. For example, if, for a nonverbal patient, the clinician asked the family about pain character and the family responded "I’m not sure" or "I don’t know."

Suggested Data Sources:
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Pain Duration
Collected For: PAL-02,
Definition: Documentation of a comprehensive pain assessment that included pain duration completed within one day of the pain screening.
Suggested Data Collection Question: Is there documentation of a comprehensive pain assessment including pain duration completed within one day of pain screening?
Format: Length: 1
Type: Alphanumeric
Occurs: 1
Allowable Values: Y (Yes) There is documentation in the medical record that a comprehensive pain assessment including pain duration was completed within one day of the pain screening.
N (No) There is no documentation that a comprehensive pain assessment including pain duration was completed within one day of the pain screening or unable to determine from the medical record.
Notes for Abstraction: • A comprehensive pain assessment includes documentation of pain duration. Examples for this component include but are not limited to:
  ○ Duration – pain onset, length of time
    ▪ When did pain start, how long does it last?
    • Components of the comprehensive assessment must be documented in the medical record within one day of the pain screening to select "yes". The time frame for documentation is the day of and the day after the pain screening.
    • The comprehensive assessment documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
    • It is possible to include elements of the pain assessment for nonverbal patients. A family report may be used to complete one or more of the components of the comprehensive assessment. Clinical notes about assessment of nonverbal indicators of pain are also acceptable to select “1”. Examples included but are not limited to:
      ○ Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.
      ○ An assessment that included pain duration for a nonverbal patient may include documentation about how long a patient exhibits any nonverbal cues of pain, such as “patient cradled right arm throughout entire visit.”
    • Documentation based on whether the clinician made an attempt to gather the information from the patient/family may be used. For example, if, for a nonverbal patient, the clinician asked the family about pain duration and the family responded “I'm not sure” or “I don't know.”
Suggested Data Sources:
• Palliative care consultation notes
• Palliative care team progress notes
• Palliative care initial encounter notes
• Palliative care admission assessment
Additional Notes:
Guidelines for Abstraction:
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Pain Effect

Collected For: PAL-02

Definition: Documentation of a comprehensive pain assessment that included pain effect completed within one day of the pain screening.

Suggested Data Collection Question: Is there documentation of a comprehensive pain assessment including pain effect completed within one day of pain screening?

Format: Length: 1
          Type: Alphanumeric
          Occurs: 1

Allowable Values:

Y (Yes) There is documentation in the medical record that a comprehensive pain assessment including pain effect was completed within one day of the pain screening.

N (No) There is no documentation that a comprehensive pain assessment including pain effect was completed within one day of the pain screening or unable to determine from the medical record.

Notes for Abstraction:

- A comprehensive pain assessment includes documentation of pain effect on function or quality of life. Examples for this component include but are not limited to:
  - Effect on function or quality of life – interference with activities, sleep, appetite, mood, relationships.
  - What impact does the pain have on your daily activities?
- Components of the comprehensive assessment must be documented in the medical record within one day of the pain screening to select "yes". The time frame for documentation is the day of and the day after the pain screening.
- The comprehensive assessment documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
- It is possible to include elements of the pain assessment for nonverbal patients. A family report may be used to complete one or more of the components of the comprehensive assessment. Clinical notes about assessment of nonverbal indicators of pain are also acceptable to select “1”. Examples included but are not limited to:
  - Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.
  - An assessment that included pain’s effect on function or quality of life for a nonverbal patient may include documentation about change in patient activity, such as “family caregiver reports that patient is no longer able to sit up in bed without moaning.”
- Documentation based on whether the clinician made an attempt to gather the information from the patient/family may be used. For example, if, for a nonverbal patient, the clinician asked the family about pain effect and the family responded “I’m not sure” or “I don’t know.”

Suggested Data Sources:

- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

Additional Notes:

Guidelines for Abstraction:
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name:  

Pain Factors

Collected For:

PAL-02,

Definition:

Documentation of a comprehensive pain assessment that included pain factors completed within one day of the pain screening.

Suggested Data Collection Question:

Is there documentation of a comprehensive pain assessment including pain factors completed within one day of the pain screening?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) There is documentation in the medical record that a comprehensive pain assessment including pain factors was completed within one day of the pain screening.

N (No) There is no documentation that a comprehensive pain assessment including pain factors was completed within one day of the pain screening or unable to determine from the medical record.

Notes for Abstraction:

● A comprehensive pain assessment includes documentation of factors that relieves or worsens pain. Examples for this component include but are not limited to:
  ○ Factors that relieve or worsen pain – aggravating or alleviating actions, activities, or positions
    ▪ What increases or decreases your pain?
  ○ Components of the comprehensive assessment must be documented in the medical record within one day of the pain screening to select "yes". The time frame for documentation is the day of and the day after the pain screening.
  ○ The comprehensive assessment documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
  ○ It is possible to include elements of the pain assessment for nonverbal patients. A family report may be used to complete one or more of the components of the comprehensive assessment. Clinical notes about assessment of nonverbal indicators of pain are also acceptable to select “1”. Examples included but are not limited to:
    ○ Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.
    ○ An assessment that included what relieves/worsens pain for a nonverbal patient may include documentation about actions, activities, or positions that relieve/worsens pain, such as "patient exhibits fewer nonverbal signs of pain when sitting up versus lying down."
  ○ Documentation based on whether the clinician made an attempt to gather the information from the patient/family may be used. For example, if, for a nonverbal patient, the clinician asked the family about factors that relieves or worsens pain and the family responded “I'm not sure” or “I don’t know.”

Suggested Data Sources:

● Palliative care consultation notes
● Palliative care team progress notes
● Palliative care initial encounter notes
● Palliative care admission assessment

Additional Notes:

Guidelines for Abstraction:
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: *Pain Frequency*

Collected For: PAL-02,

Definition: Documentation of a comprehensive pain assessment that included pain frequency completed within one day of the pain screening.

Suggested Data Collection Question: Is there documentation of a comprehensive pain assessment including pain frequency completed within one day of pain screening?

Format: 
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation in the medical record that a comprehensive pain assessment including pain frequency was completed within one day of the pain screening.
- N (No) There is no documentation that a comprehensive pain assessment including pain frequency was completed within one day of the pain screening or unable to determine from the medical record.

Notes for Abstraction: 
- A comprehensive pain assessment includes documentation of pain frequency. Examples for this component include but are not limited to:
  - Frequency – pain constant or intermittent, time of day
    - How often do you have pain? When is the pain present, daytime, nighttime?
  - Components of the comprehensive assessment must be documented in the medical record within one day of the pain screening to select “yes”. The time frame for documentation is the day of and the day after the pain screening.
  - The comprehensive assessment documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
  - It is possible to include elements of the pain assessment for nonverbal patients. A family report may be used to complete one or more of the components of the comprehensive assessment. Clinical notes about assessment of nonverbal indicators of pain are also acceptable to select “1”. Examples included but are not limited to:
    - Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.
    - An assessment that included pain frequency for a nonverbal patient may include documentation about how often a patient exhibits any nonverbal cues of pain, such as most of the time, only at night, intermittently.
  - Documentation based on whether the clinician made an attempt to gather the information from the patient/family may be used. For example, if, for a nonverbal patient, the clinician asked the family about pain frequency and the family responded “I’m not sure” or “I don’t know.”

Suggested Data Sources:
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

Additional Notes: 

Guidelines for Abstraction:
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Pain Location

Collected For: PAL-02,

Definition: Documentation of a comprehensive pain assessment that included pain location completed within one day of the pain screening.

Suggested Data Collection Question: Is there documentation of a comprehensive pain assessment including pain location completed within one day of pain screening?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation in the medical record that a comprehensive pain assessment including pain location was completed within one day of the pain screening.
- N (No) There is no documentation that a comprehensive pain assessment including pain location was completed within one day of the pain screening or unable to determine from the medical record.

Notes for Abstraction:
- A comprehensive pain assessment includes documentation of pain location. Examples for this component include but are not limited to:
  - Location – pain site(s), referral pattern, radiation
  - Where does it hurt? Does the pain radiate?
- Components of the comprehensive assessment must be documented in the medical record within one day of the pain screening to select "yes". The time frame for documentation is the day of and the day after the pain screening.
- The comprehensive assessment documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
- It is possible to include elements of the pain assessment for nonverbal patients. A family report may be used to complete one or more of the components of the comprehensive assessment. Clinical notes about assessment of nonverbal indicators of pain are also acceptable to select "1". Examples included but are not limited to:
  - Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.
  - An assessment that included pain location for a nonverbal patient may include documentation, such as "patient grimaced/shouted when clinician touched the right leg" or other documentation denoting patient exhibiting nonverbal cues of pain for a specific location on the body.
  - Documentation based on whether the clinician made an attempt to gather the information from the patient/family may be used. For example, if, for a nonverbal patient, the clinician asked the family about pain location and the family responded "I'm not sure" or "I don't know."

Suggested Data Sources:
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

Additional Notes:

Guidelines for Abstraction:
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Pain Severity

Collected For: PAL-01, PAL-02,

Definition: Evaluation of the patient for the presence or absence of pain, and its severity using a standardized tool at the time of the palliative care initial encounter.

Suggested Data Collection Question: What was severity of pain when the patient was first screened for pain during the palliative care initial encounter?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

0  None
1  Mild
2  Moderate
3  Severe
4  Pain severity not able to be rated
5  There is no documentation that the patient was screened for pain, or unable to determine from medical record documentation.

Notes for Abstraction:

- A comprehensive pain assessment includes documentation of pain character. Examples for this component include but are not limited to:
  - Severity – pain level or intensity rating
    - How severe is your pain now?
- The comprehensive assessment documentation may be completed by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
- It is possible to include elements of the pain assessment for nonverbal patients. A family report may be used to complete one or more of the components of the comprehensive assessment.
  - Clinical notes about assessment of nonverbal indicators of pain are also acceptable to select “1”. Examples included but are not limited to:
    - Nonverbal indicators of pain include nonverbal sounds such as crying, whining, and groaning; facial expressions, such as grimaces and clenched jaw; and protective body movements or postures such as bracing, guarding, rubbing, or clutching a body part.
    - An assessment that included pain severity for a nonverbal patient may include documentation about intensity of nonverbal expressions of pain (grimaces, winces, and clenched teeth/jaw) or protective body movements (bracing, guarding, rubbing, clutching, or holding of a certain body part/area). It could also include documentation of severity using a nonverbal standardized rating scale.
    - Documentation based on whether the clinician made an attempt to gather the information from the patient/family may be used. For example, if, for a nonverbal patient, the clinician asked the family about pain character and the family responded “I’m not sure” or “I don’t know.”
    - Select “0” if documented in the medical record the patient’s pain severity score was none. This would include a score of 0 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient very drowsy; appears to be comfortable during visit. No nonverbal signs of pain observed during the visit.”
    - Select “1” if documented in the medical record the patient’s pain severity score was mild. This would include a score of 1–3 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient reports 3/10 abdominal pain now; was 6/10 during past 24 hours.” Select “1 Mild” based on the patient’s pain severity rating at the time
of the initial encounter.

- Select “2” if documented in the medical record the patient’s pain severity score was moderate. This would include a score of 4–6 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient reports he has recently taken a dose of his pain medication, and throughout the visit his pain is reported as 4/10. Patient states he has a history of pain, at its worst pain is 9/10.” Select “2 Moderate” based on the patient’s pain status at the time of the screening.

- Select “3” if documented in the medical record the patient’s pain severity score was severe. This would include a score of 7–10 on a 10-point numeric scale or equivalent on verbal, visual, other numeric, or staff observation scale. Example: “patient unable to speak; observed during 20 minute evaluation; pain severity on nonverbal scale moderate to severe.” It is evident that the patient was in pain, and that the clinician evaluated the patient’s pain and noted pain severity. Although the clinical tool is not named, it is still evident that the clinician used a standardized approach or clinical protocol to screen the patient. Select “3 Severe” based on the highest severity of pain at the time of the screening.

- Select “4” if documented in the medical record the patient had pain, but the patient’s pain severity was not able to be evaluated by any manner. This would include documentation that staff was unable to rate severity by observation or patient was unable or declined to use a rating scale. Example: “patient intubated and sedated.”

- Select “5” if there is no documentation that the patient was screened for pain, or unable to determine from medical record documentation.

Pain screening includes evaluating the patient for presence of pain, and if pain is present, rating of its severity using a standardized tool. A standardized tool is one that (1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, non-institutionalized adults with disabilities, etc.), and (2) includes a standard response scale (for example, a scale where patients rate pain from 0-10). The standardized tool must be appropriately administered as indicated in the instructions and must be relevant for the patient’s ability.

- Examples of standardized numeric scales include, but are not limited to:
  - 10-point scale
  - Symptom Distress Scale (McCorkle)
  - Memorial Symptom Assessment Scale (MSAS)
  - Edmonton Symptom Assessment System (ESAS)

- Examples of standardized verbal descriptor scales include, but are not limited to:
  - Brief Pain Inventory
  - McGill pain questionnaire
  - 6-point Verbal Pain Scale

- Examples of standardized patient visual scales include, but are not limited to:
  - Wong-Baker FACES Pain Scale
  - Visual analog scale
  - Distress thermometer

- Examples of standardized staff observation scales include, but are not limited to:
  - Critical Care Pain Observation Tool (CPOT)
  - Checklist of Nonverbal Pain Indicators (CNPI)
  - Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)
  - Pain Assessment in Advanced Dementia (PAIN-AD)

- It is possible that at the time of the palliative care initial encounter there will have been multiple pain screenings documented in the clinical record. For purposes of this measure use the first pain screening that appears during the palliative care initial encounter.

- If a range is provided, such as mild to moderate, select the highest level of severity recorded during the initial encounter.

- If a non-numeric scale was used to screen the patient for pain, select the pain severity based on the standard established for that scale. If no standard has been established for that scale, the
organization must establish the standard to categorize severity.

- If documentation in the patient's medical record indicates the patient was assessed clinically and was found to have no pain, but no standardized pain tool was used to screen the patient, select “0, None”.

**Suggested Data Sources:**
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment

**Additional Notes:** Notes adapted from: Guidance Manual for Completion of the Hospice Item Set (HIS), Centers for Medicare and Medicaid Services, Hospice Quality Reporting Program, V 1.02 Effective June 28, 2015

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Payment Source
Collected For: All Records, Optional for HBIPS-2 and HBIPS-3
Definition: The source of payment for this episode of care.
Suggested Data Collection Question: What is the patient's source of payment for this episode of care?
Format: Length: 1
Type: Alphanumeric
Occurs: 1
Allowable Values: 1 Source of payment is Medicare.
2 Source of payment is NonMedicare.
Notes for Abstraction: • If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list or payers, select "1".
• If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select "2". If the patient has Medicaid and Medicare, select "1".
• If the patient is an Undocumented Alien or Illegal immigrant select "1". Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.
Suggested Data Sources: • Face sheet
• UB-04
Additional Notes: Guidelines for Abstraction:
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare includes, but is not limited to:</td>
<td></td>
</tr>
<tr>
<td>• Medicare Fee for Service (includes DRG or PPS)</td>
<td></td>
</tr>
<tr>
<td>• Black Lung</td>
<td></td>
</tr>
<tr>
<td>• End Stage Renal Disease (ESRD)</td>
<td></td>
</tr>
<tr>
<td>• Railroad Retirement Board (RRB)</td>
<td></td>
</tr>
<tr>
<td>• Medicare Secondary Payer</td>
<td></td>
</tr>
<tr>
<td>• Medicare HMO/Medicare Advantage</td>
<td>• None</td>
</tr>
</tbody>
</table>
**Data Element Name:** Postal Code

**Collected For:** All Records, CMS Only

**Definition:** The postal code of the patient's residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

**Suggested Data Collection Question:** What is the postal code of the patients residence?

**Format:**
- **Length:** 9
- **Type:** Character
- **Occurs:** 1

**Allowable Values:** Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "NON-US."

**Notes for Abstraction:** If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

**Suggested Data Sources:**
- Face sheet
- UB-04, Field Location: 09 (line 2d)

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• None</td>
</tr>
</tbody>
</table>
Data Element Name: Race
Collected For: All Records
Definition: Documentation of the patients race.
Suggested Data Collection Question: What is the patients race?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values: Select one:
1 White: Patients race is White or the patient has origins in Europe, the Middle East, or North Africa.
2 Black or African American: Patients race is Black or African American.
3 American Indian or Alaska Native: Patients race is American Indian/Alaska Native.
4 Asian: Patients race is Asian.
5 Native Hawaiian or Pacific Islander: Patients race is Native Hawaiian/Pacific Islander.
6 RETIRED VALUE (effective 07-01-05 discharges)
7 UTD: Unable to determine the patients race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Notes for Abstraction:
• The data element Hispanic Ethnicity is required in addition to this data element.
• If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
• Although the terms Hispanic and Latino are actually descriptions of the patients ethnicity, it is not uncommon to find them referenced as race. If the patients race is documented only as Hispanic/Latino, select White. If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic select Black). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

Suggested Data Sources:
• Emergency department record
• History and physical
• Face sheet
• Nursing admission assessment
• Progress notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African American</td>
<td>None</td>
</tr>
<tr>
<td>A person having origins in any of the black racial groups of Africa. Terms such as Haitian or Negro can be used in addition to Black or African American.</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
</tr>
<tr>
<td>A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment</td>
<td></td>
</tr>
</tbody>
</table>
(e.g., any recognized tribal entity in North and South America [including Central America, Native American.])

**Asian**
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**White**
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).

**Native Hawaiian or Pacific Islander**
A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
Data Element Name: Sex
Collected For: All Records
Definition: The patient's documented sex on arrival at the hospital.
Suggested Data Collection Question: What is the patient's sex on arrival?

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:
M = Male
F = Female
U = Unknown

Notes for Abstraction:
- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select Unknown if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:
- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- Nursing admission notes
- UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name:  Treatment Preferences
Collected For:  PAL-04,
Definition:  Medical record documentation includes the patient's preferences regarding life-sustaining treatments, or there is documentation of a discussion or attempted discussion regarding life-sustaining treatment preferences.

Documentation should include CPR preference as well as other life-sustaining treatments including, but not limited to:
- Blood transfusion
- Dialysis
- Hospitalization or transfer preference
- Intravenous [IV] fluids
- Mechanical ventilation
- Surrogate decision maker
- Tube feeding
- Use of antibiotics

Suggested Data Collection Question:  Does the medical record indicate the patients' preferences regarding or discussion of life-sustaining treatments?

Format:  Length:  1
Type:  Alphanumeric
Occurs:  1

Allowable Values:
1  Yes, there is documentation of the patients' preferences regarding life-sustaining treatments.
2  Yes, there is documentation of a discussion or attempted discussion about the patients' preferences regarding life-sustaining treatments.
3  No, there is no documentation of the patients' preferences or discussion of preferences or unable to determine from medical record documentation.

Notes for Abstraction:
- “Responsible party” refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the organization should use state law guidance to identify the appropriate surrogate decision-maker.
- In order to select “1” or “2” if a party other than the patient was asked about preferences regarding life-sustaining treatments, there must be evidence in the clinical record that the responsible party as defined above was asked about preferences.
- If there is no documentation that a discussion occurred or was attempted with the patient or responsible party, select value “3.”
- A discussion about preference for life-sustaining treatment can be initiated by any member of the palliative care core interdisciplinary team. The core interdisciplinary team is comprised of the following: Physician(s); Registered nurse(s) or advanced practice nurse(s); Chaplain(s) or, spiritual care professional(s); Social worker(s).
- Orders or short statements alone, such as “DNR/DNI” or “full code” without evidence of discussion or involvement from patient/responsible party, are not sufficient to select “1”. For example “discussed CPR status, patient wishes to remain full code” select value “1”.
- If there is no discussion regarding CPR preferences, select value “3”.
- There is no comprehensive list of life-sustaining treatments. Documentation in the clinical record indicating CPR preference and any life-sustaining treatments is sufficient to select “1” or “2”. Examples may include, as appropriate for the patient: ventilator support, tube feeding, dialysis, blood transfusion, antibiotics, and intravenous [IV] fluids.
- Documentation must include the specific life-sustaining treatments discussed, for example “discussed use of tube feeding, IV fluids, ventilator, and CPR, patients does not wish to have
any of these treatments” select value “1”.

- A newly completed Physician/Practitioner Orders for Life-Sustaining Treatment (POLST) form (or other state specific treatment preference form) that is signed by the organization clinician after the admission to organization is sufficient to select “1”, provided there is evidence of involvement from patient/responsible party, such as signature of the patient or responsible party on POLST forms, or clinical documentation, such as “treatment preference confirmed with responsible party.”

- If a patient is admitted to organization with a pre-existing POLST that was signed in a prior care setting, the organization should re-affirm the patient’s preferences that appear in the pre-existing POLST. This re-affirmation of preferences should be documented in the medical record. Documentation, such as “discussed life-sustaining treatment preferences during the admission visit with patient” select “1”. If the clinical record is ambiguous as to whether the organization attempted to re-affirm patient preferences present in a pre-existing POLST, select “3.”

- If there is documentation in the medical record that the organization attempted to have a conversation with the patient and responsible party, but both the patient and responsible party explicitly refused to discuss the topic with the organization, select value “2.” This would include statements such as, “I don’t want to talk about this” or “I’m only going to talk to my priest about this”.

- If the organization attempted to discuss the topic, but the patient was unable to discuss because of their clinical status and the responsible party explicitly refused to discuss, select value “2.”

- If there is documentation in the medical record that the organization brought up the topic of life-sustaining treatment, and there was a conversation with the patient and/or responsible party, but the conversation does not result in the patient stating a preference, select value “2”.

Suggested Data Sources:

- History and physical
- Progress notes
- Discharge summary
- Care transition record
- Consultation form
- Discharge planning form
- Palliative care consultation notes
- Palliative care team progress notes
- Palliative care initial encounter notes
- Palliative care admission assessment
- State specific treatment preference forms may include:
  - COLST (Clinician Orders for Life Sustaining Treatment)
  - MOLST (Medical Orders for Life-Sustaining Treatment)
  - MOST (Medical Orders for Scope of Treatment)
  - POLST (Physician/Practitioner Orders for Life-Sustaining Treatment)
  - POST (Physician Orders for Scope of Treatment)
  - TPOPP (Transportable Physician Orders for Patient Preferences)

Additional Notes: Notes adapted from: Guidance Manual for Completion of the Hospice Item Set (HIS), Centers for Medicare and Medicaid Services, Hospice Quality Reporting Program, V 1.02 Effective June 28, 2015

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Treatment Preferences Document

Collected For: PAL-05,

Definition: Patients preference regarding goals of care and treatment preferences are documented and accompany the patient to the next level of care at the time of discharge from the hospital.

Suggested Data Collection Question: Was a transition of care document detailing goals of care and treatment preferences developed and did it accompany the patient to the next level of care at the time of discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Yes, there is documentation in the medical record that a transition of care document detailing goals of care and treatment preferences was developed and sent with the patient at the time of discharge.

2 There is documentation in the medical record that the organization attempted either to have the discussion or complete the document but patient and/or responsible party declined.

3 No, a transition of care document detailing goals of care and treatment preferences was not developed and/or was not sent with the patient at the time of discharge, or unable to determine from medical record documentation.

4 Patient expired prior to discharge.

Notes for Abstraction:

- Documented treatment preferences, as appropriate to the patient's condition, may include, but are not limited to:
  - Blood transfusion
  - CPR preference
  - Dialysis
  - Hospitalization or transfer preference
  - Intravenous [IV] fluids
  - Mechanical ventilation
  - Surrogate decision maker
  - Tube feeding
  - Use of antibiotics
- Goals of care may be curative, rehabilitative, life-prolonging, or comfort focused.
- Any documentation in the medical record that the document was given to the patient and/or sent to the next care setting or provider may be used to select “1”. This documentation is NOT restricted to the palliative care team.
- If a document was previously completed prior to this admission there must be documentation of a conversation that the document continues to reflect the patients’ treatment preferences and care goals.
- If documentation is not clear that the treatment preferences document was sent with patient at discharge, select “3.”
- Documentation must include both the patient's preference regarding goals of care and treatment preferences in order to select “1.” For example: "patient's goal is to attend their daughter's wedding in 4 months, wishes to continue with all treatments and full code status"; "patient wants to be kept comfortable; DNR, no tube feedings, IVs or return to hospital."
- "Responsible party" refers to the legally responsible or authorized individual, such as the Health Care Power of Attorney or legal guardian. In cases where there is no legal guardian or power of attorney identified, the organization should use state law guidance to identify the appropriate surrogate decision-maker.
### Suggested Data Sources:
- Advanced directives
- Discharge summary
- Care transition record
- Discharge planning form
- State specific patient treatment preferences forms

### Additional Notes:

#### Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advance care plan</td>
<td>None</td>
</tr>
<tr>
<td>• Advance decision</td>
<td></td>
</tr>
<tr>
<td>• Advance directive</td>
<td></td>
</tr>
<tr>
<td>• Advance healthcare directive</td>
<td></td>
</tr>
<tr>
<td>• Goals of care</td>
<td></td>
</tr>
<tr>
<td>• Health care proxy</td>
<td></td>
</tr>
<tr>
<td>• Living will</td>
<td></td>
</tr>
<tr>
<td>• Personal directive</td>
<td></td>
</tr>
<tr>
<td>• Power of attorney for healthcare</td>
<td></td>
</tr>
<tr>
<td>• Treatment preferences</td>
<td></td>
</tr>
<tr>
<td>• State specific treatment preference forms may include:</td>
<td></td>
</tr>
<tr>
<td>◦ COLST (Clinician Orders for Life Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>◦ MOLST (Medical Orders for Life-Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>◦ MOST (Medical Orders for Scope of Treatment)</td>
<td></td>
</tr>
<tr>
<td>◦ POLST (Physician/Practitioner Orders for Life-Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>◦ POST (Physician Orders for Scope of Treatment)</td>
<td></td>
</tr>
<tr>
<td>◦ TPOPP (Transportable Physician Orders for Patient Preferences)</td>
<td></td>
</tr>
</tbody>
</table>