Advanced Palliative Care Certification
New Standardized Performance Measures
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Advanced Palliative Care Certification - New Standardized Performance Measures

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November 9, 2016
Disclosure Statement

The following staff and speakers have disclosed that neither they nor spouses/partners have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity:

- Susan Yendro
Objectives

- Review standardized measures for Palliative Care Certification required as of 1/1/2017
- Review measure specifications and algorithms
- Provide opportunity for questions and answers
Certification in Palliative Care

Advanced Certification Program for Palliative Care

- Recognizes hospital inpatient programs that demonstrate exceptional patient and family-centered care and optimize the quality of life for adult and pediatric patients with serious illness.

New Community-Based Palliative Care Certification Option for Home Health & Hospice

- Launched 7/1/2016
- Recognizes home health and hospice organizations that provide top caliber, community-based palliative care to patients and families in their home
Palliative Care Performance Measure Expectations

Current state: Non-standardized
- Palliative Care Program must identify, analyze and collect data on four performance measures.
- Two of the four should be clinical measures related to or identified in clinical practice guidelines for palliative care.

Future state: Standardized
- Palliative Care programs participating in certification will collect, analyze and submit data for standardized performance measures identified by The Joint Commission.
Advanced Certification for Palliative Care

New Performance Measure Requirements Coming 1/1/2017

- All hospitals certified in the Advanced Palliative Care program will be required to implement data collection for five standardized measures effective with discharges on and after January 1, 2017

- Hospitals are required to collect monthly data points (numerator and denominator values) and report data quarterly to The Joint Commission via the extranet Certification Measure Information Process (CMIP)

- Submission of non-standardized measures will not be required after 12/31/2016
Palliative Care Measure Development

The Joint Commission engaged with AAHPM and HPNA Measuring What Matters project.

With the assistance of a Technical Advisory Panel, a subset of the measures were selected for testing.

Pilot testing conducted to assess

- 1) measures and specifications enhancement
- 2) reliability of measures and data elements to ensure comparability
- 3) feasibility of collecting data elements through an electronic health record or registry system
Pilot Testing Key Steps

1. Volunteer hospitals collected all measures and provided feedback
2. Joint Commission staff conducted reliability visits, re-abstracted records, received feedback
3. Analyzed pilot site and reliability data
4. Presented findings and discussed recommendations with Technical Advisory Panel
5. Finalized measure specifications and posted the Implementation Guide
6. Launch standardized measure set Jan 1, 2017
Palliative Care (PAL) Measures

- PAL-01: Pain Screening
- PAL-02: Pain Assessment
- PAL-03: Dyspnea Screening
- PAL-04: Treatment Preferences and Goals of Care
- PAL-05: Treatment Preferences Discharge Document
PAL – Initial Patient Population

- 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.
Required General Data Elements

- The initial population is identified by:
  - Discharge Date
  - Initial Encounter

- The following data elements are collected for purposes of case identification:
  - Admission Date
  - Birthdate
  - Sex
Optional General Data Elements

Collection is not required for PAL and are not submitted in CMIP:

- 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
Sampling

- Is allowed using a valid sampling methodology

<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>
**Definition:** A patient who has received a consultation with any member of the palliative care service team.

- “Consultation” = patient received a face to face visit with any member of the palliative care core interdisciplinary team, 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 not required
- Do not include attempted visits, use the first visit.
Initial Encounter Allowable Values

Did the patient receive a palliative care service initial encounter at the organization?

- Y (Yes) There is documentation that the patient received an initial encounter consultation with a member of the palliative care team.

- N (No) There is no documentation that the patient received an initial encounter consultation with a member of the palliative care team or unable to determine.
Initial Encounter Date

**Definition:** The date that the patient was first seen in consultation by any member of the palliative care service.
- If multiple palliative care consultations took place, use the first face to face meeting date with any palliative care team member.

Palliative Care Length of Stay (in days) = Discharge Date – Initial Encounter Date
- If less than 1 day this case is not in the PAL Initial Population
PAL-01 Pain Screening

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

- NQF # 1634: Hospice and Palliative Care - Pain Screening
PAL-01 Pain Screening

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

**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.
Measure Specific Data Elements

- **Denominator**
  - Initial Encounter
  - Initial Encounter Date

- **Numerator**
  - Pain Severity
Pain Severity

**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.

- Palliative care team only, any member of the palliative care core interdisciplinary team may document
- Any validated patient reported or observational tool may be used
- Crosswalk any tool to the allowable values
Pain Severity Allowable Values

What was severity of pain when the patient was first screened for pain during the palliative care initial encounter?

- 0 None
- 1 Mild (1–3 on a 10-point scale)
- 2 Moderate (4–6 on a 10-point scale)
- 3 Severe (7–10 on a 10-point scale)
- 4 Pain severity not able to be rated
- 5 no documentation patient was screened for pain, or unable to determine
Algorithm

Run cases that are included in the ICD-10 Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

START

Pain Severity

Missing

= 0, 1, 2, 3, 4

= 5

In Measure Population

D goes to Denominator

E goes to Numerator

CASE will be rejected

STOP
PAL-02 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.

- NQF # 1637: Hospice and Palliative Care - Pain Assessment
PAL-02 Pain Assessment

**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.

**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.
Measure Specific Data Elements

- Denominator
  - Initial Encounter
  - Initial Encounter Date
  - Pain Severity

- Numerator
  - Pain Character
  - Pain Duration
  - Pain Effect
  - Pain Factors
  - Pain Frequency
  - Pain Location
  - Pain Severity
Notes for Abstraction

- Components must be documented within one day of the pain screening, includes the day of and the day after the pain screening.
- May be completed by any member of the palliative care core interdisciplinary team.
- Include elements of the pain assessment for nonverbal patients. A family report may be used.
- Clinician attempt to gather the information from the patient/family may be used.
Pain Assessment Allowable Values

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

- Y (Yes) There is documentation that a comprehensive pain assessment including XXX was completed within one day of the pain screening.

- N (No) There is no documentation that a comprehensive pain assessment including XXX was completed within one day of the pain screening or unable to determine.
Pain Character

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

- Type of pain, quality or description, such as throbbing, aching, sharp, dull etc.
- What does the pain feel like?
- Nonverbal indicators of pain are also acceptable, such as crying, whining, and groaning; grimaces and clenched jaw; and bracing, guarding, rubbing, or clutching a body part.
Pain Duration

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

- Pain onset, length of time
- When did pain start, how long does it last?
- Nonverbal patient’s may include: how long a patient exhibits any nonverbal cues of pain, such as “patient cradled right arm throughout entire visit.”
Pain Effect

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

- Effect on function or quality of life – interference with activities, sleep, appetite, mood, relationships.
- What impact does the pain have on your daily activities?
- Nonverbal patient’s may include: change in patient activity, such as “family caregiver reports that patient is no longer able to sit up in bed without moaning.”
**Pain Factors**

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

- Factors that relieve or worsen pain – aggravating or alleviating actions, activities, or positions
- What increases or decreases your pain?
- Nonverbal patient’s may include: documentation about actions, activities, or positions that relieve/worsen pain, such as “patient exhibits fewer nonverbal signs of pain when sitting up versus lying down.”
Pain Frequency

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

- Pain constant or intermittent, time of day
- How often do you have pain? When is the pain present, daytime, nighttime?
- Nonverbal patient’s may include: how often a patient exhibits any nonverbal cues of pain, such as most of the time, only at night, intermittently.
Pain Location

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

- Pain site(s), referral pattern, radiation
- Where does it hurt? Does the pain radiate?
- Nonverbal patient’s may include: “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.
Algorithm

B is Not in Population
Algorithm (Cont.)

D goes to Denominator

E goes to Numerator
PAL-03 Dyspnea Screening

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

- NQF # 1639: Hospice and Palliative Care - Dyspnea Screening
PAL-03 Dyspnea Screening

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

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

- **Denominator**
  - Initial Encounter
  - Initial Encounter Date

- **Numerator**
  - Dyspnea Severity
Dyspnea Severity

**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.

- Palliative care team only, any member may document
- Reports of recent symptoms/ current treatment, determine an active problem, even if it does not occur during the visit
- If a range is provided, select the highest severity recorded
Dyspnea Severity Allowable Values

What was the severity of dyspnea when the patient was first screened for dyspnea during the palliative care initial encounter?

- 0 None
- 1 Mild (1–3 on a 10-point scale)
- 2 Moderate (4–6 on a 10-point scale)
- 3 Severe (7–10 on a 10-point scale)
- 4 Dyspnea severity not able to be rated
- 5 no documentation patient was screened for dyspnea, or unable to determine
Algorithm

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.

Dyspnea Severity

= 5

= 0, 1, 2, 3, 4

Case will be rejected

E goes to Numerator

E in Numerator Population

D in Measure Population

D goes to Denominator

STOP

END
PAL-04 Treatment Preferences and Goals of Care

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

- NQF # 1641: Hospice and Palliative Care - Treatment Preferences
- Note Goals of Care was added
PAL-04 Treatment Preferences and Goals of Care

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

**Numerator:** Patients with medical record documentation of treatment preferences and goals of care.
Measure Specific Data Elements

- **Denominator**
  - Initial Encounter
  - Initial Encounter Date

- **Numerator**
  - Goals of Care
  - Treatment Preferences
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.

- May be curative, rehabilitative, life-prolonging, or comfort focused.
- The patient, family or surrogate was involved in discussion and care planning.
- Based upon the patient’s preferences, values, needs, concerns and/or desires, through clinician-led discussion, professional guidance and support for patient and family decision making.
Goals of Care Notes

- Family is determined by the patient, may not be legally related.

- A surrogate decision-maker is someone legally appointed to make decisions on behalf of another.

- Includes attempted discussion, if the patient or family declines to discuss the goals of care, and this is documented.

- A discussion about goals of care can be initiated by any member of the palliative care core interdisciplinary team.
Goals of Care Allowable Values

Is there documentation in medical record that the palliative care team discussed or attempted to discuss the patient’s goals for care?

- Y (Yes) There is documentation that the palliative care team discussed or attempted to discuss the patient’s goals for care.

- N (No) There is no documentation that the palliative care team discussed or attempted to discuss the patient’s goals for care or unable to determine.
Treatment Preferences

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.

- A discussion about preference for life-sustaining treatment can be initiated by any member of the palliative care core interdisciplinary team.
- Orders or short statements alone, without evidence of discussion with patient, are not sufficient.
Treatment Preferences Notes

- Documentation should include CPR preference AND other life-sustaining treatments as appropriate for the patient:
  - Blood transfusion
  - Dialysis
  - Hospitalization or transfer preference
  - Intravenous [IV] fluids
  - Mechanical ventilation
  - Surrogate decision maker
  - Tube feeding
  - Use of antibiotics
Treatment Preferences (Cont.)

- A newly completed state treatment preference form signed by the organization with evidence of involvement from patient is sufficient to select “1”.

- Pre-existing forms signed in a prior care setting, that the organization re-affirms and documents in the medical record is sufficient to select “1”.

- If there is documentation that the organization attempted to have a conversation with the patient and responsible party, but they refused to discuss the topic, were unable to discuss or did not result in preferences stated, select value “2.”
Treatment Preferences
Allowable Values

Does the medical record indicate the patients’ preferences regarding or discussion of life-sustaining treatments?

- 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.
Algorithm

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

Goals of Care

E goes to Numerator

D goes to Denominator
PAL-05 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 next level of care at discharge.

– NQF #: Not Applicable
PAL-05 Treatment Preferences Discharge Document

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

**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.
Measure Specific Data Elements

- **Denominator**
  - *Discharge Disposition*
  - *Initial Encounter*
  - *Initial Encounter Date*

- **Numerator**
  - *Treatment Preferences Document*
**Treatment Preferences Document**

**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.

- Any documentation that the document was given to the patient/sent to the next setting/provider may be used. It is NOT restricted to the palliative care team.
- Documentation must include both the patient’s preference regarding goals of care and treatment preferences.
Treatment Preferences Document

Allowable Values

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?

– **1 Yes**, there is documentation that a was developed and sent at the time of discharge.

– **2** There is documentation that the org attempted to discuss or complete the document but patient **declined**.

– **3 No**, a document was not developed or was not sent with the patient at discharge, or unable to determine.

– **4** Patient **expired** prior to discharge.
Discharge Disposition

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

- 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)
Algorithm

- **E goes to Numerator**
- **D goes to Denominator**
- **B is Not in Population**

Diagram:
- Start
- Discharge Disposition
- Treatment Preferences Document
- In Numerator Population
- STOP
Data Collection Tips

Create a collection tool
- Include all required data elements and
- Include all required allowable values
- Use the Implementation Guide

Aggregate numerator and denominator monthly
- Total number of category E = Numerator
- Total number of category D+E = Denominator

Figure out your rate:
Numerator/Denominator x 100 = % Rate
# Data Collection Tool Example

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Allowable Value</th>
<th>Case #1</th>
<th>Case #2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>MM-DD-YYYY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthdate</td>
<td>MM-DD-YYYY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Date</td>
<td>MM-DD-YYYY</td>
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</tr>
<tr>
<td>Sex</td>
<td>M = Male</td>
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<td></td>
<td>F = Female</td>
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<td></td>
<td>U = Unknown</td>
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<tr>
<td>Initial Encounter</td>
<td>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.</td>
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</tr>
<tr>
<td>Initial Patient Population - answer from Initial Encounter</td>
<td>Yes = in the population</td>
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<tr>
<td></td>
<td>No = not in the population; stop abstracting</td>
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<td>Initial Encounter Date</td>
<td>MM-DD-YYYY</td>
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<td></td>
<td>If same as discharge date - stop abstracting</td>
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<tr>
<td>Pain Severity</td>
<td>0 None</td>
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<tr>
<td></td>
<td>1 Mild</td>
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<td>2 Moderate</td>
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<td>3 Severe</td>
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<td></td>
<td>4 Pain severity not able to be rated</td>
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<td></td>
<td>5 There is no documentation that the patient was screened for pain, or unable to determine from medical record documentation.</td>
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<tr>
<td>PAL-01 Measure Category</td>
<td>0,1,2,3,4 = E</td>
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<tr>
<td>Assignment</td>
<td>5 = D</td>
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<tr>
<td>If Pain Severity 1,2 or 3</td>
<td>add 1 to counter; continue with PC-02</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>If Pain Severity 0, 4 or 5</td>
<td>go to PAL-03</td>
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<td></td>
</tr>
<tr>
<td>Data Element</td>
<td>Allowable Value</td>
<td>Case #1</td>
<td>Case #2</td>
<td>Total</td>
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<tr>
<td>Pain Character</td>
<td>Y (Yes) There is documentation in the medical record that a comprehensive pain</td>
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<td>assessment including pain character was completed within one day of the pain</td>
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<td>determine from the medical record.</td>
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<td>Y (Yes) There is documentation in the medical record that a comprehensive pain</td>
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<td>determine from the medical record.</td>
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<td>Y (Yes) There is documentation in the medical record that a comprehensive pain</td>
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<td>assessment including pain effect was completed within one day of the pain</td>
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<td>determine from the medical record.</td>
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<td>Pain Factors</td>
<td>Y (Yes) There is documentation in the medical record that a comprehensive pain</td>
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<td>assessment including pain factors was completed within one day of the pain</td>
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<td>Pain Frequency</td>
<td>Y (Yes) There is documentation in the medical record that a comprehensive pain</td>
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<td>screening.</td>
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<td>N (No) There is no documentation that a comprehensive pain assessment including</td>
<td></td>
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<td></td>
<td>pain frequency was completed within one day of the pain screening or unable to</td>
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<tr>
<td></td>
<td>determine from the medical record.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Pain Location</td>
<td>Y (Yes) There is documentation in the medical record that a comprehensive pain</td>
<td></td>
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<tr>
<td></td>
<td>assessment including pain location was completed within one day of the pain</td>
<td></td>
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<tr>
<td></td>
<td>screening.</td>
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<tr>
<td></td>
<td>N (No) There is no documentation that a comprehensive pain assessment including</td>
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<tr>
<td></td>
<td>pain location was completed within one day of the pain screening or unable to</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>determine from the medical record.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAL-02 Measure Category</td>
<td>equal or greater than 5 = E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assignment</td>
<td>less than 5 = D</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Data Collection Tool Example

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Allowable Value</th>
<th>Case #1</th>
<th>Case #2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyspnea Severity</td>
<td>0 None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Mild</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Moderate</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>3 Severe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Dyspnea severity not able to be rated</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>5 There is no documentation that the patient was screened for dyspnea, or unable to determine from medical record documentation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAL-03 Measure Category Assignment</td>
<td>0,1,2,3,4 = E 5 = D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Preferences</td>
<td>1 Yes, there is documentation of the patients’ preferences regarding life-sustaining treatments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Yes, there is documentation of a discussion or attempted discussion about the patients’ preferences regarding life-sustaining treatments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 No, there is no documentation of the patients’ preferences or discussion of preferences or unable to determine from medical record documentation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals of Care</td>
<td>Y (Yes) There is documentation in medical record that the palliative care team discussed or attempted to discuss the patient’s goals for care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAL-04 Measure Category Assignment</td>
<td>Treatment Preferences 1,2 AND Goals of Care Y = E Treatment Preferences 3 OR Goals of Care N = D</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Disposition</td>
<td>1 Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Hospice - Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Hospice - Health Care Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Acute Care Facility</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>5 Other Health Care Facility</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>6 Expired</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>7 Left Against Medical Advice/AMA</td>
<td></td>
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<tr>
<td></td>
<td>8 Not Documented or Unable to Determine (UTD)</td>
<td></td>
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</tr>
<tr>
<td>Treatment Preferences Document</td>
<td>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.</td>
<td></td>
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<tr>
<td></td>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Patient expired prior to discharge.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PAL-05 Measure Category Assignment</td>
<td>Discharge Disposition 6 or 7 = B 1, 2 = E 3 = D 4 = B</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Data Submission

- Hospitals are required to collect monthly data points
  - Numerator value
  - Denominator value
- Report data quarterly to The Joint Commission
- Submit data via the extranet Certification Measure Information Process (CMIP)
More Information


- Direct Measure questions to: http://manual.jointcommission.org

- Certification questions: certification@jointcommission.org
Contact

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Q&A

Submit your questions into our attendee control panel. We will answer as many questions as we can.
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