Department of Health Care Services
Stakeholder Responses to 'Draft Potential Palliative Care Quality, Structure, Process Measures'
July 13, 2015

At the June 5, 2015 stakeholder meeting on Palliative Care and SB 1004 (Hernandez), the Department of Health Care Services (DHCS) requested input on the document titled, "Draft Potential Palliative Care Quality, Structure, Process Measures". This document contained 65 potential measures from a variety of sources, including the National Quality Forum (NQF), Coalition for Compassionate Care of California (CCCC) and Let's Get Healthy California (LGHC). Additionally, there was a companion document that was also discussed – "DHCS Proposed Criteria and Desirable Characteristics for Evaluation of Palliative Care Performance Measures." This document provided stakeholders with the criteria used for the development of the measures that were discussed at the June 5 meeting. Below are the three responses that were received as feedback on the proposed measures; additional comments were provided as letters that are posted on the Palliative Care/SB 1004 website.

No.	Measure Name	Stakeholder Input 1	Stakeholder Input 2	Stakeholder Input 3
1	Hospice and Palliative Care – Comprehensive Assessment	1. Clarification is needed on who does the comprehensive assessment (Any hospice and palliative care team member? A physician/NP?). As well as whether or not the comprehensive assessment includes direct patient contact (face-to-face interaction), especially if the assessment is performed by a physician or whether it is done via chart review or based on the info from a team meeting etc. 2. What about patients who start getting hospice services in an acute care setting or at a SNF? Comprehensive assessment needs to be done sooner in those settings. 3. Why is the outpatient palliative care not included?	Hospice is already a benefit with criteria. Anthem uses MCG. a. In general for inpatients metrics… 1. Who is the reporting party? 2. Who is capturing the data? 3. What is the data source, medical record, standardized form? b. Why are the time windows for PC more stringent than Hospice, especially as Hospice is closer to end of life? c. Need to have codes for consultation vs comprehensive assessment with attributes to differentiate level of service, especially with such tight turn-around times.	No Comment
2	Screening for Physical Symptoms	1. Why are symptoms only limited to pain, dyspnea, nausea and constipation? Screening for physical symptoms of ANY kind is an integral part of any hospice and palliative assessment (what about delirium, diarrhea, aesthenia, anorexia, cough, prurirus, etc.).	What is seriously ill? Define denominator, tie to claims. May need logic statements, e.g. COPD and > 1 hospitalization within 6 months and home oxygen.	Similar to the HIS Quality Measures by CMS. This would be duplication and not be a benefit.
3	Pain Treatment (Any)	1. Some patients refuse treatment for pain (both pharmacological and nonpharmacological). In addition, it is a question of which level of pain is the patient's goal (which level of pain control is acceptable to the patient). So if a given patient is comfortable with having 7/10 pain, using	What is seriously ill? Define denominator, tie to claims. Labor intensive to pull all the data from charts, MARs.	Similar to the HIS Quality Measures by CMS. This would be duplication and not be a benefit.

		% receiving treatment after assessment as a measure of quality of care may be a flawed measure because of a substantial proportion of patients. 2. For all patients on opiates, pain and side effect assessment and determination of dose adjustment should be done at least once every 24 hours until pain is at an acceptable level to the patient.		
4	Dyspnea Screening and Management	No Comment	Can be adapted to community PC, can be important.	Similar to the HIS Quality Measures by CMS. This would be duplication and not be a benefit.
5	Discussion of Emotional or Psychological Needs	1. For many patients who have severe physical symptoms (not uncommon on hospice admission or at the time of inpatient palliative consult) it is often inappropriate to have this discussion until the physical symptoms are more or less under control. 2. Many patients are lethargic, unresponsive, or confused at the time of admission/consult, and this discussion cannot be held.	What is seriously ill? Define denominator, tie to claims. May be unrealistic expectation in acute setting, often the individual may be very compromised in ability to communicate and the focus is on the decision-makers.	Similar to the HIS Quality Measures by CMS. This would be duplication and not be a benefit.
6	Discussion of Spiritual/Religious Concerns	1. See comment on #5.	Maybe, this could also be part of CM work and in community. Think should be an element of any plan of care.	Similar to the HIS Quality Measures by CMS. This would be duplication and not be a benefit.
7	Documentation of Surrogate	1. Sometimes it takes days to get that information, and not due to lack of effort. Add a clause regarding "daily documentation in the chart of specific efforts made to obtain contact information of the surrogate decision maker if that information was not initially available."	Very important, this is a must have.	What value does this add to patient care?
8	Treatment Preferences	1. Some patients (not a small percent) refuse to make those decisions. A clause should be added regarding "documentation in the chart in case the patient/surrogate refuses to discuss or decide on the life-sustaining treatment." 2. Goals of care discussion are a dynamic one, as the patient's condition changes often and so do the goals. It may be better to use the wording of "goals of care" as opposed to limiting it to "life sustaining treatment."	Adapt for outpt POLST. Challenge to capture input again from a chart or standardized form? Also wonder if 1 day turn around on determining wishes is fair or realistic, this kind of decision-making is an iterative process usually involves several people.	Similar to the HIS Quality Measures by CMS. This would be duplication and not be a benefit.

9	Care Consistency with Documented Care Preferences	This should be applied to any patient, not just vulnerable elders.	Would like this measure to work but many challenges to accurately capture. Would need to standardize definitions and parameters. a. Need criteria to define most recent POLST? b. How long is a POLST in effect? c. What are the criteria that require updating/re-review of POLST?	No Comment
10	Global Measure	No Comment	Challenge identifying who should be surveyed, how will the health plan know about a non-hospitalized death?	This is being captured through the CAHPS survey being directed by CMS and will be publicly reported. Again unnecessary duplication of effort with no added value.
11	Terminal hospital stays that include intensive care unit days	Consider adding another measure "percent of patients who die in an acute hospital setting that were offered hospice and/or palliative services >7 days before death."	How to define "terminal stay", "died during the hospitalization" - will it include 2 /5/7/10/or 30 days post discharge? This was specific to a cancer diagnosis. Would need to define "seriously ill." Is this for all terminal individuals or those utilizing the PC benefit? Would have to develop criteria of how defined as enrolled in PC benefit. How do you know it was not an acute event, trauma vs chronic that became fatal? What if the POLST showed the person wanted everything done? This metric may be biased as to the preferred outcome.	No Comment
12	Percent of California hospitals providing inpatient palliative care	No Comment	CA Foundation has done this, do not see how this is a health plan metric.	No Comment
13	Hospice Enrollment Rates	No Comment	Cannot be done without death data.	No Comment
14	Hospice and Palliative Care - Pain Screening (UNC) (paired with measure 1637)	No Comment	Yes and adapt to community setting. But how will this be captured, what is the data source, and who is reporting?	Similar to the HIS Quality Measures by CMS. This would be duplication and not be an added benefit.

15	Patients treated with an Opioid who are given a bowel regimen	No Comment	Like this one, would need more work, e.g., > 3 fills of narcotic scripts and no bowel regimen. However, since many bowel preps are OTC how will this information be captured?	Similar to the HIS Quality Measures by CMS. This would be duplication and not be an added benefit.
16	Patients with advanced cancer assessed for pain at outpatient visits	No Comment	Define advanced cancer… can EMR's be audited? Should be limited to oncologist? Potentially like this one.	No Comment
17	Hospice and Palliative Care – Dyspnea Treatment (UNC) (paired with measure 1638)	No Comment	See #4.	Similar to the HIS Quality Measures by CMS. This would be duplication and not be an added benefit.
18	Comfortable Dying (maintenance)	1. Consider changing that to 72 hours (many patients have complex pain, including severe neuropathic pain or mixed physical/emotional/spiritual pain that may be very difficult to manage). 2. Another consideration could be adding "pain improvement within 24 hours of assessment." So any improvement even if it's not down to a comfortable level.	May be standard part of hospice.	Discontinued over a year ago as it shown to be ineffective to demonstrate anything. A flawed study.
19	Hospitalized patients who die an expected death with an ICD that has been deactivated	No Comment	Very controversial, may not want to go there (misunderstood by the public).	No Comment
20	Family Evaluation of Hospice Care (NHPCO) (maintenance)	No Comment	Need very clear definition of involved family member and caregivers. Who should be surveyed? Hospices can do this already. Hard to do without death data.	FEHC survey is no longer required for hospice. Now using the CAHPS. To use the FEHC along with the CAHPS would add burden to the families with no added value.

21	CARE – Consumer Assessments and Reports of End of Life	No Comment	Need very clear definition of involved family member and caregivers. Who should be surveyed? Hospices can do this already. Hard to do without death data.	Too many surveys with no added value.
22	Bereaved Family Survey	No Comment	Need very clear definition of involved family member and caregivers. Who should be surveyed? Hospices can do this already. Hard to do without death data, how would health plan know about out of hospital death? May be something that hospice providers already do.	No Comment

Metrics that Address Reach and Use of Palliative Services				
23	Number of individuals receiving specialist PC services	No Comment	23-26 are dashboard metrics. a. Define advanced disease. b. Is there an assumption that PC for advanced disease is out of scope for the PCP? c. What is the time frame for this metric?	No Comment
24	Types of Services	No Comment	Dashboard metrics. 24 Doable	No Comment
25	Number of contacts	No Comment	These are dashboard metrics. Is there an assumption that PC is out of scope for the PCP? How to capture if part of routine visit?	No Comment
26	Timing of initial offering	No Comment	These are dashboard metrics. Not without death data.	No Comment
Structure Metrics				
27	Providers with advanced training	No Comment	Health Plans can report on # of PC specialists in their networks. What constitutes advanced training? Is this self-report or required documentation? These are survey items that CA Foundation captures, not sure redundancy is necessary.	No Comment
28	Accessibility of specialist services	No Comment	These are survey items that CA Foundation captures, not sure redundancy is necessary. Challenge to define if within scope of PCP.	No Comment
29	Specialist Team	No Comment	Are survey items that CCC is capturing, not sure the Health Plans need to report on these. Understand important to assess accessibility but not sure these are relevant to HP performance.	No Comment
30	Settings	No Comment	Doable once services and codes are available, not sure what the quality metric is though.	No Comment
31	Educational Materials Access	No Comment	No Comment	No Comment

Process Metrics				
32	Assessment Timeliness	No Comment	This is a fine one, and speaks to accessibility within the scope of HP responsibilities.	No Comment
33	Surrogate Decision-Maker Identified	No Comment	Reconcile with measure #7.	No Comment
34	Treatment for Pain	No Comment	In theory good metric, but need: a. standardize pain scales b. need clear definitions of acceptable treatment c. does not include whether pain managed Challenge getting info in inpt setting, labor intensive.	No Comment
Outcome Metrics				
35	Concordance	No Comment	Also previously mentioned and again need to reconcile time factors.	No Comment
36	Reduction in Symptoms	No Comment	Many tools, scales, data capture and reporting challenges here.	No Comment
37	Family Satisfaction	No Comment	Define family. When administered? a. May not know when death occurred.	No Comment
38	Use of ED and Hospital	No Comment	Good one and should be able to capture from claims data.	No Comment
39	Total Cost of Care	No Comment	Good one if measured from initial PC contact. CANNOT do otherwise without death data.	No Comment
Utilization/Cost Metrics				
44	Hospice Referral Timeliness	No Comment	Great to have but need death data.	No Comment
45	ICU Use	No Comment	Great to have but need death data.	No Comment
46	ED Use	No Comment	Great to have but need death data.	No Comment
47	Chemotherapy	No Comment	No Comment	No Comment
48	Place of Death	No Comment	Great to have but need death data.	No Comment
49	In-Hospital Death	No Comment	What are you comparing to, if do not have the other death data?	No Comment

51	Hospital Admission in last 30 days of life	No Comment	Great to have but need death data.	No Comment
52	Died within 3 days of discharge from hospital	No Comment	Great to have but need death data.	No Comment
53	Number of days enrolled in hospice	No Comment	YES, important one would also include Days enrolled in PC.	No Comment
54	Admits per patient in last 6-12 months of life	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
55	ICU Days per patient in last 6-12 months of life	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
56	ED visits per patient in last 6-12 months of life	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
57	Expenditures in last 6-12 months of life	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
58	Number of 30 day re-admits in last six months of life	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
60	Number of hospital admissions	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment

61	Length of Stay	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	LOS for which LOC?
62	Number of 30 day readmissions	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
63	ED visits	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
64	ICU Days	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment
65	Total Expenditures	No Comment	Great to have but need death data. Would change to "since enrolled in PC in which at least 3 distinct PC services had been rendered in the same time period of study" (need codes!).	No Comment