Don’t Re-invent The Wheel... Benchmark With Existing Reliable Outcomes

2008 OCHC Fall Conference
Lynda Laff
Strategic Healthcare Programs
It’s Happening As We Speak!

Value Based Purchasing
Across The Continuum...
Deficit Reduction Act of 2005
- Value Based Purchasing plan
  - VBP Plan for hospital implementation in 2009
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
  - Post Acute Care (PAC) Reform
    - Care Tool
- Public reporting of hospital consumer satisfaction began in 2008

*Reporting Hospital Quality Data for Annual Payment Update*
Value Based Purchasing

It’s all about the data...

• Phase out current quality reporting system

• Payment contingent on performance NOT simply on reporting

• High performers = higher payments

• Hospitals report on 21 measures
  • No reporting = 2% reduction in APU
VBP Program Goals

• Improve Clinical Quality
• Address underuse, overuse, and misuse of services
• Encourage patient-centered care
• Reduce adverse events and improve patient safety
VBP Program Goals

• Transform Medicare from a passive payer to an active purchaser of high quality, efficient care

• Avoid unnecessary costs in care
  ▶ Current Medicare payment systems are based on resource consumption and quantity of care NOT proven quality or unnecessary costs avoided
VBP Program Goals

- Stimulate investments in effective information technology and the re-engineering of systems
- Make results transparent and useable
Currently HCAHPS is used by:
- Hospitals
- Hemodialysis Centers
- Medicare Advantage Plans
- Nursing Homes
But This Is About Hospice...

- Condition of Participation 418.58
  - Transparency
  - Encourage patient-centered care
  - Reduce adverse events and improve patient safety
  - To ensure that hospice resources are being used effectively and efficiently
  - Ability to Compare Provider Performance – Benchmark
  - Evidence of quality care...in other words – *Data Driven Quality and Performance!*
Condition of Participation  418.58

- **Collect and Use DATA to Improve Your Performance**
  - Develop, implement, and maintain an effective, continuous quality assessment and performance improvement program
  - Use proven and reliable tools and processes
  - Monitor and improve performance continually
  - Respond to the needs, desires, and satisfaction levels of the patients and families
  - Ensure effectiveness and efficiency
Condition of Participation § 418.58

Quality Assessment – Performance Improvement

• “We did not propose that hospices use any specific quality measures, data elements or benchmarks”

• “Currently no available, valid, reliable, widely applied set of clinical and/or administrative quality measures”

Federal Register, June 5, 2008 (page#32121)
Condition of Participation 418.58

Use Proven, Reliable QAPI Tools

CMS provides multiple resources

- PEACE Project - conducted by the North and South Carolina QIO – (medqic.org)

  List of Assessment Instruments for End of Life Care
  - Physical Symptoms
  - Multiple Domains
  - Psychological Symptoms
  - Continuity of Care
  - Social Aspects of Care
  - Spiritual Aspects of Care
  - Ethical/Legal Aspects of Care
  - Function
  - Cultural Aspects of Care
  - Prognosis

Federal Register, June 5, 2008 (pages 32118 – 32119)
Proven, Reliable QAPI Tools
Condition of Participation  418.58

• National Hospice and Palliative Care Organization (National Quality Initiative and Quality Collaborative)
• Brown University (Toolkit)
• National Quality Forum (NQF)
• Agency for Healthcare Quality and Research (AHRQ)
• National Association for Home Care and Hospice (NAHC)
  › Data collection tools
  › ESAS study
• Strategic Healthcare Programs (SHP)
  › Patient Satisfaction
  › Automated demographic and statistical data & benchmarking
  › Automated ESAS Hospice Symptom Management Tool

Federal Register, June 5, 2008 (pages 32118 – 32119)
Condition of Participation  418.58
Quality Assessment – Performance Improvement

• Surveyors will focus on;
  ▶ Scope of program...include **ALL** pertinent indicators
  ▶ How and why you chose specific quality measures
  ▶ How you ensure consistent data collection
  ▶ How you use data in patient care planning
  ▶ How you aggregate and analyze data
  ▶ How you use the data analysis to select PI projects
  ▶ How you implement PI projects
  ▶ How you use data to evaluate the effectiveness of those projects
Develop A QAPI Plan

- The PI Plan should include:
  - **Who** will be responsible for QAPI program
  - **What** services and processes are to be assessed
  - **What** data to be documented and aggregated
  - **When** high volume, problem prone care and services provided
  - **How** often data will be collected and analyzed and how will the findings be used
  - **How** you will implement action plan findings into ongoing care plan development
  - **What** method(s) will be used to evaluate improvement
  - **How** often you will report on performance
It’s All About The Data...

- Incorporate all PI activities into one program
  - Key Hospice demographic data collection and benchmarking
  - Patient and Family Satisfaction
  - Employee Satisfaction
  - Physician Satisfaction
  - Adverse Event Monitoring
  - Process Outcomes
  - Patient Outcomes
## SHP Hospice Demographic

### SHP for Patient Satisfaction™ Hospice V3.0
Average Scores and Percentiles - Patient Superior Outcomes Hospice
SHP Database
4/1/2008 - 6/30/2008

**Report Date: 7/28/2008**

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Surveys</th>
<th>Score</th>
<th>Percentile</th>
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<tbody>
<tr>
<td><strong>Q1</strong></td>
<td>Arrived for visits on time</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Scores required to achieve percentiles:</strong> 50th=4.68, 75th=4.83, 80th=4.89, 90th=5.00</td>
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<td></td>
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<tr>
<td>SHP Database</td>
<td>18.0</td>
<td>4.66</td>
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<tr>
<td>10082 Superior Outcomes Hospice</td>
<td>18</td>
<td>4.83</td>
<td>77.8 %</td>
<td></td>
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<tr>
<td><strong>Q2</strong></td>
<td>Taught how to give meds</td>
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<td></td>
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<tr>
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<td><strong>Scores required to achieve percentiles:</strong> 50th=4.82, 75th=4.89, 80th=4.93, 90th=5.00</td>
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<td>SHP Database</td>
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<td>4.80</td>
<td>NA</td>
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<td>10082 Superior Outcomes Hospice</td>
<td>18</td>
<td>4.89</td>
<td>66.7 %</td>
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<tr>
<td><strong>Q3</strong></td>
<td>Taught self-care</td>
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<td>4.89</td>
<td>55.6 %</td>
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<td><strong>Q4</strong></td>
<td>Staff was courteous and helpful</td>
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<td><strong>Scores required to achieve percentiles:</strong> 50th=4.91, 75th=5.00, 80th=5.00, 90th=5.00</td>
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</table>
Benchmark Important Statistics

• Average daily census
• Length of service
• Deaths – in place of preference
• Total patients discharged due to death
• Patients who died in less than 7 days
• Patients who died in greater than 180 days
# SHP Hospice Demographic

## Daily Census

<table>
<thead>
<tr>
<th>Daily Census</th>
<th>You</th>
<th>SHP Avg</th>
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</thead>
<tbody>
<tr>
<td>Average Daily Census</td>
<td>453.1</td>
<td>68.5</td>
</tr>
</tbody>
</table>

*All patient days for reporting period divided by the number of days in the reporting period.*

## Length of Service

<table>
<thead>
<tr>
<th>Length of Service</th>
<th>You</th>
<th>SHP Ref.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average length of service in days for patients discharged within period</td>
<td>64.3</td>
<td>59.2</td>
</tr>
<tr>
<td>Median length of service in days for patients discharged within period</td>
<td>18.0</td>
<td>20.0</td>
</tr>
</tbody>
</table>

*Half of the patients have an LOS longer than the median, and half have an LOS shorter.*

## Deaths by Period

<table>
<thead>
<tr>
<th>Deaths by Period</th>
<th>You</th>
<th>Your %</th>
<th>SHP Avg</th>
<th>SHP Avg %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients discharged due to death</td>
<td>377</td>
<td>83.6 %</td>
<td>54</td>
<td>76.2 %</td>
</tr>
<tr>
<td>Patients who died in &lt;= 7 days</td>
<td>147</td>
<td>32.6 %</td>
<td>19</td>
<td>26.7 %</td>
</tr>
<tr>
<td>Patients who died &gt;= 180 days</td>
<td>27</td>
<td>6.0 %</td>
<td>4</td>
<td>6.8 %</td>
</tr>
</tbody>
</table>
## SHP Hospice Program

### Comparative Outcomes Report

#### Your Hospice

<table>
<thead>
<tr>
<th>Diagnostic Categories</th>
<th>Admitted Patients</th>
<th>Active Patients</th>
<th>Percent Active Patients</th>
<th>SHP Reference %</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS</td>
<td>1</td>
<td>3</td>
<td>0.3 %</td>
<td>0.1 %</td>
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<tr>
<td>Cancer</td>
<td>125</td>
<td>199</td>
<td>21.4 %</td>
<td>11.3 %</td>
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<tr>
<td>Stroke/Coma</td>
<td>22</td>
<td>39</td>
<td>4.2 %</td>
<td>2.0 %</td>
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<tr>
<td>Dehility unspecified</td>
<td>40</td>
<td>102</td>
<td>11.0 %</td>
<td>5.6 %</td>
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<tr>
<td>Dementia</td>
<td>84</td>
<td>187</td>
<td>20.2 %</td>
<td>10.2 %</td>
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<tr>
<td>Diabetes</td>
<td>0</td>
<td>0</td>
<td>0.0 %</td>
<td>0.0 %</td>
</tr>
<tr>
<td>Heart</td>
<td>54</td>
<td>109</td>
<td>11.8 %</td>
<td>6.5 %</td>
</tr>
<tr>
<td>HIV</td>
<td>0</td>
<td>1</td>
<td>0.1 %</td>
<td>0.1 %</td>
</tr>
<tr>
<td>Kidney</td>
<td>17</td>
<td>25</td>
<td>2.7 %</td>
<td>1.1 %</td>
</tr>
<tr>
<td>Liver</td>
<td>1</td>
<td>4</td>
<td>0.4 %</td>
<td>0.5 %</td>
</tr>
<tr>
<td>Lung</td>
<td>30</td>
<td>59</td>
<td>6.4 %</td>
<td>3.8 %</td>
</tr>
<tr>
<td>Other motoneuron</td>
<td>8</td>
<td>27</td>
<td>2.9 %</td>
<td>0.8 %</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>43</td>
<td>4.6 %</td>
<td>5.1 %</td>
</tr>
<tr>
<td>Undocumented</td>
<td>100</td>
<td>130</td>
<td>14.0 %</td>
<td>52.9 %</td>
</tr>
</tbody>
</table>

#### Admitted Patients by Disease Category

- ALS
- Cancer
- Stroke/Coma
- Dehility unspecified
- Dementia
- Diabetes
- Heart
- HIV
- Kidney
- Liver
- Lung
- Other motoneuron
- Other
- Undocumented
SHP Hospice program

Percent of patients whose pain was brought to comfortable level within 48 hours

- Your %
- SHP Ref %
QAPI – It’s All About The Data

• Incorporate all PI activities into one program
  ▶ Processes within hospice (examples)
    • Timeliness of physician signature on certification of terminal illness
    • Timeliness of spiritual and bereavement assessment
    • Incorporation of IDT care plan updates to practice
  ▶ Patient symptom management
    • Not only at selected time points
    • Ongoing – incorporation into patient care planning
QAPI – It’s All About The Data

- Infection
  - Surveillance
  - Identification
  - Prevention,
  - Control and investigation of infections and communicable disease

- Customer Concerns

- Adverse Events
  - Falls – witnessed and un-witnessed
  - Unexpected death
  - Suicide
CMS - Adverse Events

- “Adverse patient events,” as used in the field, generally refer to occurrences that are harmful or contrary to the targeted patient outcomes.
Identify **Important Aspects** of Care

Examples of Important Clinical Functions

- Pain and Symptom management
- Administration of narcotics – titration of narcotics
- Use of standing orders
- Delivery and set up of medical equipment
- Management of Oxygen therapy in the home
- Transferring patients from bed to commode
- Administration of IV, IM and subque medications
Select Measurable Indicators

- Measurable Indicators
  - Relevant to YOUR hospice and YOUR patient population
- High volume and problem prone measures
- Potential areas of risk
- Processes and outcome measures common in your agency
  - Include all settings as appropriate
- Automate data collection whenever possible using established databases whenever possible
  - Demographics
  - Selected indicators
Select Measurable Indicators

MEASURABLE indicators
Patient & Family Outcomes

- Pain control to patient’s desired level of comfort within 4 hours
- Shortness of breath relieved to patient’s desired level of acceptance within 4 hours
- Patient remained in place of choice at time of death
- Family satisfaction with timeliness of response from hospice staff after hours
- Family satisfaction with quality and quantity of support provided by hospice staff
Select Measurable Indicators

MEASURABLE indicators

- Processes
  - Equipment delivery (timeliness, quality, patient education)
  - Timeliness of physician signature on certification of terminal illness
  - Timeliness of completion of interdisciplinary care plan
  - Timeliness of completion of initial assessment
  - Coordination of services for ECF patients
  - 24 hour availability of pharmacy – log calls
  - Accuracy and timeliness of communication among team members
  - On call response time
Incorporate All Levels of Care

- Routine home care
- Respite care
- General Inpatient Care
- Skilled Facility as Residence
- Continuous Care
  - Largest concentration of patients
  - Highest risk and / or problem prone
Tools...You Need Tools!

- Select or develop data gathering tools that allow for;
  - Easy capture of selected measures
  - Integration of results into practice
- Standardize documentation and data collection processes
- Document assessments at designated frequency
Use Proven Tools and Processes

• Incorporate data gathering into daily practice
  › Patient symptom management
    • Visit note – insert into clinical assessments
    • Communication note – telephone or telehealth contact
    • Create yes / no responses
    • Standardize assessments and responses
  • Collate data
    – Present ongoing findings at staff meetings
    – Use findings in IDG to update care plans
Tidewater Hospice

- Small privately owned hospice
  - Census of 25 patients
  - Performance Improvement plan initiated to include;
    - Infection control, surveillance and analysis
    - Employee occurrence monitoring
    - Patient adverse events
Performance Improvement Program

- Quarterly clinical record audits / Process measures
  - Documentation of Local Coverage Determinations (LCD) for each patient
  - Signed physician certification of terminal illness
  - Presence of orders for care and treatment
  - Timeliness of completion of interdisciplinary care plan
  - Timeliness of necessary assessments
  - Interventions implemented according to care plan
## Performance Improvement Calendar

<table>
<thead>
<tr>
<th></th>
<th>Monthly Data Gathering</th>
<th>Quarterly Reporting</th>
<th>Bi-Annual Data Gathering</th>
<th>Annual Reporting</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient Record Audit</strong></td>
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<td></td>
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<td></td>
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<tr>
<td><strong>Infection Control</strong></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Referral Source Staff</td>
<td></td>
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<tr>
<td><strong>Adverse Events</strong></td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Customer Concerns</strong></td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Process Measures</strong></td>
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<td></td>
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<tr>
<td><strong>Patient Outcomes</strong></td>
<td>X</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Safety Initiatives</strong></td>
<td>X</td>
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</tbody>
</table>
Patient Outcomes

Symptom Management

- Edmonton Symptom Assessment (ESAS)
- We chose 3 measures to begin
  - Pain score and SOB $\geq$ 4; intervention within 4 hours, assess at 24, 48 and 72 hours as indicated.
  - Constipation; no bowel movement $\geq$ 4 days; intervention within 4 hours; assess in 24, 48 and 72 hours as indicated.
Examples of ESAS Implementation

- Symptom assessment tool
  - Patient answers symptom related questions
  - Clinician may have patient answer question
- Pain and SOB are measured by a scale 1 – 10

1  2  3  4  5  6  7  8  9  10
Mild   Moderate   Severe   Worst   Possible
ESAS & SHP for Hospice™:
(Edmonton Survey Assessment System)

<table>
<thead>
<tr>
<th>ESAS Assesments</th>
<th>Pain</th>
<th>Fatigue</th>
<th>Nausea</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Drowsiness</th>
<th>Shortness of Breath</th>
<th>Appetite</th>
<th>Feeling of Well-Being</th>
<th>Constipation (Other)</th>
<th>TOTAL Distress Score</th>
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</thead>
<tbody>
<tr>
<td>Select 2/1/2008</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>18</td>
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<tr>
<td>Select 2/5/2008</td>
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<td>6</td>
<td>1</td>
<td>2</td>
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<td>1</td>
<td>1</td>
<td>3</td>
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<td>3</td>
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<td>3</td>
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<td>1</td>
<td>0</td>
<td>17</td>
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</tbody>
</table>

- 10 Symptoms
- Scale 0 – 10
- Pt Rating Symptoms
- Total Distress Score
- Tracking System
**Symptom Assessment Flow Sheet (with constipation)**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>ID#</th>
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</thead>
</table>

*Completed by: 1-Patient alone  2-Caregiver-Assisted  3-Health Professional-Assisted  4-Caregiver alone  5-Health Professional alone*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Completed by*</th>
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<table>
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<th>Shortness of breath</th>
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<th>Appetite</th>
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<thead>
<tr>
<th>Feeling of well-being</th>
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<th>Other:</th>
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<table>
<thead>
<tr>
<th># days since last BM</th>
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Quality Measures

- Percentage of patients with average time between regular symptom assessments (ESAS) = <8 days
- Percentage of new ratings of pain =>4 with treatment (or satisfied) w/in 4hrs
- Percentage of pain ratings =>4 with follow-up assessment w/in 24 hours
- Percentage of new ratings of pain =>4 with control (or satisfied) w/in 48hr
- Percentage of patients with last pain rating before death <4 (or satisfied)
- Percentage of new ratings of sob =>4 with treatment (or satisfied) w/in 4hrs
- Percentage of SOB ratings =>4 with follow-up assessment w/in 24 hours
Quality Measures

• Percentage of new ratings of sob =>4 with control (or satisfied) w/in 48hr
• Percentage of patients with last SOB rating before death <4 (or satisfied)
• Percentage of patients with bowel function assessment completed at least weekly
• Percentage of patients on opioids with bowel management regimen
• Percentage of reports of =>4 days since last BM with treatment w/in 4hrs
• Percentage of reports of =>4 days since last BM with bowel movement w/in 72hrs
Examples of ESAS Implementation

- Pain was also initially assessed using a Wong – Baker **FACES** scale (per caregiver)

![FACES Scale Diagram]

0 = no pain  
0 - 3 = (MILD)  
4 - 6 = (MODERATE)  
7 - 9 = (SEVERE)  
10 = worse pain ever
Examples of ESAS Implementation

• Constipation measured by date of last bowel movement & use of episodes with patient specific considerations;
  › If > than 4 days since last BM and patient’s satisfaction is BM in less than 4 days
  • Intervention(s) should occur within 4 hours
  • Assess patient again within 24 hours, 48 hours and 72 hours.
    – Visit or telephone contact
    – If no results – new intervention until results achieved
Integrate Data Collection Into Assessments – Pain ≥ 4

PAIN: □ No Problem □ Unchanged □ Deferred

Is patient experiencing pain? □ Yes □ No □ Unable to communicate

Non-verbals demonstrated: □ Diaphoresis □ Grimacing □ Moaning/ crying □ Anger
□ Irritability □ Guarding □ Tense □ Restlessness □ Change in VS □ Other

PAIN LOCATION: (specify site(s)): ____________________________________________________________________________________

COLLECTED USING:

Intensity:
□ NONE □ SEVERE □ 1-10 scale (subjective)

0 = no pain 0 - 3 4 - 6 7 - 9 10 = worse pain ever

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(MILD) (MODERATE) (SEVERE)

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□ Faces scale (per CGs)

Worse pain level past 24hrs: __________ Current pain level: _____________

Patient / caregiver current acceptable level of pain: _____________

If level of pain ≥ 4 over past 24 hrs, is Pt / CG satisfied w/ pain control regimen?
□ Yes □ No
Integrate Data Collection Into Assessments – Pain ≥ 4

- **Type:** □ Aching □ Nagging □ Dull □ Heavy □ Crushing □ Sharp □ Stabbing □ Throbbing □ Radiating □ Burning □ Tingling □ Cramping □ Pressure
- **Frequency:** □ Occasionally □ Continuous □ Intermittent □ Other: ____________________________
- **What makes pain worse:** □ Movement □ Ambulation □ Other: ____________________________
- **What makes pain better:** □ Heat / ice □ Massage □ Repositioning □ Rest / relaxation □ Medication □ Diversion □ Other: ____________________________
- **BREAKTHROUGH medication needed over past 24 hrs:** ____________________________
- **ROUTINE Pain medications taken over past 24 hrs:** ____________________________

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Integrate Data Collection Into Assessments – Pain ≥ 4

**Interventions:**
- Attending notified current pain regime not adequate; adjustment requested
- Medications ordered / re-ordered: ______________________________________
- [ ] New medication

**Instructed Patient/ CG:**
- How to assess patient’s pain level based on subjective or objective criteria
- Proper administration, use, desired effect, & potential side effects of medications used for symptom control
- Need for routine dosing of pain medication to prevent increasing pain levels
- Need for increasing frequency of dosing of pain medication to prevent frequent breakthrough pain
- Use of pain log to document breakthrough medication used for symptom mgmt.
- Pharmacological & non-pharmacological methods of alleviating pain & other sx.
- Call hospice nurse for any unrelieved symptoms
- Importance of maintaining pain & other medications in safe place to prevent diversion & accidental use.

Comments: __________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

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Integrate Data Collection Into Assessments - SOB

**RESPIRATORY:**
- No Problem
- Unchanged
- Deferred

**Lung sounds:**
- Clear
- Crackles/rales
- Rhonchi
- Absent
- Diminished

**Cough:**
- None
- Dry/Acute/Chronic
- Non-Productive
- Productive
- Amt: Small/ Med/ Lg

- Able / Unable to cough up secretions

**Respiratory Status:**
- Accessory muscles used
- Death rattle
- Cheyne Stokes
- Orthopnea
- Stridor/ retractions Used
- Dyspnea at rest
- With exertion/ activity
- O2 ______L/min
- Periods of apnea ______seconds
- Inhalation Therapy
- PRN
- Continuous

☐ **SOB** (Circle Degree) 1 2 3 4 5 6 7 8 9 10
  - Current:_______
  - Last 24 hrs._______

If level of dyspnea ≥ 4 over past 24 hrs is Pt / CG satisfied w/ dyspnea control?

☐ Yes
☐ No

Comments:__________________________________________________

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Integrate Data Collection Into Assessments - SOB

Interventions

☐ Oxygen ordered & Pt/ CG instructed safe use of O2 & equipment mgmt.
☐ Aerosol treatment equipment/ meds ordered & pt/CG instructed in use
☐ Increased medication dose________________________per standing orders.
☐ Contacted MD regarding need for medication change

Instructed patient/ CG:
☐ Respiratory disease process (disease progression/ measures to prevent exacerbation)
☐ Measures to control symptoms related to respiratory difficulties
☐ Notify hospice nurse of any unrelieved symptoms
☐ Changes in respiratory pattern of patient approaching death w/measures to control symptomology

Additional Interventions:____________________________________________
Integrate Data Collection Into Assessments - Constipation

**GASTROINTESTINAL:**
- □ Continent
- □ Incontinent
- □ Belching / indigestion
- □ Diarrhea
- □ Constipation/ impaction
- □ Nausea
- □ Vomiting

Current therapy for above symptoms: ___________________________

□ Effective sx. control?  Y  N

**OPIOID THERAPY:**  Y  N  (circle)

Current bowel / laxative therapy:

□ Ileostomy / Colostomy site: (describe surrounding skin)

**Abdomen:**  □ Tenderness  □ Pain  □ Distention  □ Hard/ Soft  □ Ascites

Bowel sounds:  □ Present  □ Absent  □ Hypoactive  □ Hyperactive

□ NG/ Enteral Tube  Tube feedings: __________________________

Rate: __________________________

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Integrate Data Collection Into Assessments - Constipation

Interventions:
☐ Check for impaction  ☐ Disimpacted  ☐ Fleet’s enema  ☐ SSE
☐ Bowel program initiated

Instructed Patient/ CG:
☐ GI disease process and progression & measures to control GI symptomology
☐ Potential for constipation R/T immobility and meds with measures to prevent
☐ Ileosotmy/ Colostomy care  ☐ NG/ enteral tube care and feeding technique
☐ Incontinent care
☐ Incontinent supplies left in home

Comments: ____________________________________________________________

___________________________________________________________

___________________________________________________________

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Follow Up Communication Note

Being completed for:  □ New rating PAIN ≥ 4  □ New rating DYSPNEA ≥ 4  □ No BM reported in ≥ 4 days

□ Telephone call  □ SNV (If treatment documented on visit note STOP HERE)

PROBLEM: Pain or Dyspnea Collected using: □ 0-10 scale
□ FACES scale

Date: __________

Worse symptom level past 24 hrs: __________
Acceptable level: __________
If level is ≥ 4, is Patient / CG satisfied with current level of symptom control? □ YES
Comments: __________

If YES STOP HERE. □

NO (If no, go to TREATMENT below)

PROBLEM: Constipation

Number of days since last BM: __________
If no BM in ≥ 4 days, is there a reason treatment for constipation is not being initiated at this time? □ Yes □ No (If yes, explain): __________

TREATMENT: For new rating pain or dyspnea ≥ 4 or no BM in ≥ 4 days, was treatment initiated within 4 hours? □ Yes □ No

□ Attending notified and requested adjustment in medications
□ Instructed patient / CG in medication changes: __________

□ Instructed patient / CG medication dosage adjustment: __________

□ Instructed patient / CG in non-pharmacological methods to relieve symptoms: __________

Comments: ____________________________________________________________________________

_____________________________________________________________________________________

Nurses Signature: ____________________________

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Integrate Findings Into Practice

- Concept of pain control
  - Patient’s level of acceptable pain
  - 24 hour pain control vs. at time of assessment
- Intervention requirement
  - Within 4 hours – response from MD
  - Is it acceptable for a patient to have a score of 9 on pain scale for more than 4 hours?
- Assessment
  - Telephone follow up
  - In home visit
- Documentation Clarity
  - Degree of ease / difficulty of audit process

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Integrate Findings Into Practice

- Each audit produces new data
- Findings initiate change in clinical practice
- Patient care has actually improved
- Clinicians are intervening in a timely manner
- Best practices are initiated for all hospice patients
  - Pain assessment is ongoing
  - Pain is managed to a level acceptable to the patient

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Pain

• Added assessment for present level of pain
• Changed wording; “worse pain in past 24 hours” instead of “worse pain gets”
• Implemented a faces scale to correspond with numerical 1 – 10 scale – mild-mod-severe
• Added patient/caregiver satisfied with current pain control regimen Y N
SOB

- Re-educated clinicians regarding use of 1 – 10 scale to measure SOB
- Determined that if SOB occurs ONLY with ambulation and the patient is satisfied with respiratory status = 0
  - Rate degree of SOB with ambulation for future monitoring
**Constipation**

- Re-educate clinicians regarding documentation of last bowel movement
- Re-educate clinicians regarding need to follow-up if intervention was to administer laxative
- If no result from intervention – continue to address problem
Performance Improvement Cycle

- Integrate Best Practices
  - Discuss patient findings at IDG
  - Identify specific interventions that have produced positive results
  - Update patient care plans with interventions as appropriate
  - Implement changes
  - Evaluate effectiveness of plan and interventions
  - Try again!
  - When it works...
    - Develop a best practice and implement organization-wide
References

Strategic Healthcare Programs (SHP)
Phone: (805) 963-9446

Lynda Laff, Principal
Laff Associates
117 Club Course Drive
Hilton Head Island, South Carolina
llaff@laffassociates.com

Susan Saxon, Administrator
Tidewater Hospice, Bluffton, South Carolina
SusanSaxon@TidewaterHospice.com

Federal Register, June 5, 2008 (pages 32118 – 32119)
Federal Register, June 5, 2008 (page#32121)
Benchmarking: In order to further the process of establishing widely-accepted, valid, benchmarked quality measures, CMS is actively pursuing additional research on selected quality measures. This research will help identify and refine measures that are valid, meaningful, and reliable for hospices. It will also help establish benchmarks for hospices to attain.