HOMECARE & HOSPICE
National Association for Home Care & Hospice

HQRP Reference Table:
Data Details — NQF Measures Proposed by CMS to Comprise Initial Hospice Information Set (HIS) (5/13/2013)

NQF MEASURE	DESCRIPTION	NUMERATOR	DENOMINATOR	POPULATION	MEASURE DETAILS
1617 Patients Treated With An Opioid Who Are Given A Bowel Regimen	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed TIMEFRAME: Within 24 hours of new prescription	Vulnerable adults who are given a new prescription for an opioid	>18 YO Not already taking an opioid	Key words are vulnerable, adults and new New prescription: any new prescription – means the patient was not already taking an opioid Bowel regimen: offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR documentation of why one of these not needed
1634 Pain Screening	Percentage Of Patients Who Were Screened For Pain During The Hospice Admission Evaluation	Patients who are screened for presence or absence of pain (if present, rating of its severity) using a standardized quantitative tool during the admission evaluation	Patients enrolled in hospice for 7 or more days		Paired with NQF 1637 – Pain Assessment Screening may be completed using verbal, numeric, visual analog, rating scales designed for use in non-verbal patients or other standardized tools.
1637 Pain Assessment	Percentage Of Patients Who Screened Positive For Pain and Who Received a Clinical Assessment of Pain Within 24 Hours of Screening	Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain	Patients enrolled in hospice who report pain when pain screening is done on the admission evaluation/initial encounter	LOS >7 days Exclude: Patients not screened for pain Patients who screened negative for pain	Positive Screen • Any response other than none on verbal scale • Any number >0 on numerical scale • Any observation • Any self-report of pain Clinical assessment of pain must include at least 5 of the following characteristics of pain: *Location, Frequency, Severity, Character, Duration, What relieves or worsens the pain, Effect on function or quality of life*
1638 Dyspnea Treatment	Percentage of Patients Who Screened Positive for Dyspnea Who Received Treatment Within 24 Hours of Screening	Patients who screened positive for dyspnea who received treatment within 24 hours of screening	Patients who screened positive for dyspnea when screening is done on the admission evaluation/initial encounter	LOS >7 days	This includes dyspnea screening at the admission evaluation/initial assessment only. Positive Screen • Any response other than none on verbal screen • Any number >0 on numerical scale • Any observation • Any self-report of dyspnea Treatment – within 24 hours of positive screen - medical treatment plan, orders or pharmacy records show • Inhaled medications • Steroids • Diuretics • Non-medication strategies (O2, energy conservation) • Benzodiazepine or opioid (IF clearly prescribed for dyspnea)

NQF MEASURE	DESCRIPTION	NUMERATOR	DENOMINATOR	POPULATION	MEASURE DETAILS
1639 Dyspnea Screening	Percentage of Patients Who Were Screened for Dyspnea During the Admission Evaluation	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation	Patients enrolled in hospice for 7 or more days	LOS >7 days	Paired with 1638 Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients
1641 Patient Preferences	Percentage of patients with chart documentation of preferences for life sustaining treatments.	Patients whose medical record includes documentation of life sustaining preferences	Seriously ill patients enrolled in hospice	LOS >7 days	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. Must be evidence of discussion/communication. Documentation of short statements such as "Full Code" or "DNR/DNI" does not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.
1647 Beliefs/values addressed (if the patient desires)	Percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/ caregiver/family did not want to discuss.	Number of patients with clinical record documentation of spiritual/ religious concerns or documentation that the patient/family did not want to discuss.	Total number of patients discharged from hospice care during the designated reporting period.		Cases are eligible for inclusion upon admission to a hospice program. The numerator criteria must be met during the time the patient is enrolled in the hospice program and can be met anytime during that period. The numerator data is collected within 1 to 12 months following discharge from hospice services. Discussion of spiritual/religious concerns can occur with any member of the IDT. Documentation of only patient's religious or spiritual affiliation does not count for inclusion in numerator. Data are collected via chart review. Criteria are: 1) evidence of a discussion about spiritual/religious concerns, or 2) evidence that the patient, and/or family declined to engage in a conversation on this topic. Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments across the entire period of care, visit notes documented by any member of the team, and/or the spiritual care assessment. *Note that these are examples and not a complete list.*