PEACE

Prepare. Embrace. Attend. Communicate. Empower.

Specifications for Recommended Quality Measures*

Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
Structure and Process			
Use of standard questions to assess patient depression	Recommend that providers review and assess this aspect of care using an organizational readiness checklist (e.g.: the PEACE Organizational Readiness Screen)		
Percent of patients who have screening for physical and psychological symptoms during the admission visit	Patient level data collection	Pain Time=Pain screening date-date of admission Dyspnea Time= Dyspnea screening date-date of admission Nausea Time= Nausea screening date-date of admission Constipation Time= Constipation screening date-date of admission Depression Time= Depression screening date-date of admission Anxiety Time= Anxiety screening date-date of admission	Number of patients with all times=0 / total # of patients
Policy/procedure specifying the frequency with which pain/dyspnea should be addressed	Recommend that providers review and assess this aspect of care using an organizational readiness checklist (e.g.: the PEACE Organizational Readiness Screen)		

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Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
Percent of patients who have comprehensive assessment completed within 5 days of admission	Patient level data collection	Prognosis Time= Prognosis date-date of admission (Note: if Prognosis Time < 0, set = 0) Functional Status Time= Functional status screening date-date of admission Pain Time=Pain screening date-date of admission Dyspnea Time= Dyspnea screening date-date of admission Nausea Time= Nausea screening date-date of admission Constipation Time= Constipation screening date-date of admission Depression Time= Depression screening date-date of admission Anxiety Time= Anxiety screening date-date of admission Spiritual Time= Spiritual discussion date-date of admission Social Family Time= Family discussion date-date of admission	Number of patients with all times<=5 / total # of patients
Physical Aspects of Care			
Percent of patients screened for pain during the admission visit	Patient level data collection	Pain time = pain screening date – date of admission	Number of patients with pain time=0/ # of patients
For patients who screened positive for pain, the percent with clinical assessment within 1 day of screening	Patient level data collection	Clinical Pain Time = screening date – pain assessment date	Number of patients with (0<=Clinical Pain Time<=1)/patients with pain

Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
For patients who screened positive for pain, the percent with any treatment within 1 day of screening	Patient level data collection	Pain Treatment Time = date of treatment – pain assessment date	Number of patients with (0<=Pain Treatment Time<=1) and (pain treatment="Y") /patients with pain
For patients who screened positive for pain, the percent who have an order for regularly scheduled (not PRN) pain medication within 1 day of screening	Patient level data collection	Pain Treatment time = date of treatment – pain assessment date Treatment = 1 if type of treatment equals "Scheduled medication, opioid" or "Scheduled medication, non-opioid"	Number of patients with (0<=Pain Treatment Time<=1) and (Treatment=1) / Number of patients with pain
For patients who screened positive for pain, the percent with improvement within 1 day of screening	Patient level data collection	Improvement Time = Second Pain assessment date-Pain assessment date	Number of patients with (0<=Improvement Time<=1) and (Improvement=1) / Patients with pain
For patients who screened positive for pain, the percent whose pain was at a comfortable level within 2 days of screening (patient report of comfort or mild pain based on standard pain rating scale)	Patient level data collection	Improvement Time = Second Pain assessment date-Pain assessment date Comfort =1 if patient reports comfort or mild pain based on standard pain rating scale	Number of patients with (0<=Improvement Time<=2) and (Comfort =1) / Patients with pain

Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
Percent of patients with cognitive and language problems receiving pain assessment appropriate to communication needs	Patient level data collection		(Number of patients with dementia or confusion and pain assessment = observational) + (number of patients who are deaf or non-English speaking with pain assessment = translated materials) / Number of patients with dementia, confusion, deafness or non-English
Percent of patients who were screened for shortness of breath during the admission visit	Patient level data collection	Dyspnea time = dyspnea screening date –date of admission	Number of patients with dyspnea time=0/ # of patients
For patients who screened positive for dyspnea, the percent who received treatment within 1 day of screening	Patient level data collection	Dyspnea Treatment time = date of treatment – dyspnea assessment date	Number of patients with (0<=Dyspnea Treatment Time<=1 and dyspnea treatment="Y" / # patients with dyspnea
For patients who screened positive for dyspnea, the percent of patients who improved within 1 day of screening	Patient level data collection	Improvement Time = Second Dyspnea assessment date- Dyspnea assessment date	Number of patients with (0<=Improvement Time<=1 and Improvement=1) / # patients with dyspnea
For patients with moderate or severe shortness of breath, the percent with treatment or satisfied within 4 hours	Patient level data collection		Number of patients with moderate or severe shortness of breath with treatment or satisfied within 4 hours = "Y" / Total number patients with moderate or severe dyspnea

Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
For patients who screened positive for nausea, the percent who received treatment within 1 day of screening	Patient level data collection	Nausea Treatment time = date of treatment – nausea assessment date	Number of patients with (0<=Nausea Treatment Time<=1 and nausea treatment="Y") / Number of patients with nausea
Percent of patients with bowel function assessed at least weekly	Patient level data collection		Number of patients with bowel function assessed weekly = "Y" / Total # patients
For patients who screened positive for constipation, the percent who receive treatment within 1 day of screening	Patient level data collection	Constipation Treatment time = date of treatment – constipation assessment date	Number of patients with (0<=Constipation Time<=1 and constipation treatment="Y") /# patients with constipation
Percent of residents on opioids for whom a bowel regimen is established	Patient level data collection		Number of patients with opioids="Y" and bowel regimen="Y" / # patients on opioids
Percent of residents on opioids who have a bowel regimen within 1 day of opioid initiation	Patient level data collection	Time = bowel regimen date – pain treatment date	Number of patients with (0<=Time<=1 and opioids="Y" and bowel regimen="Y")/ # patients on opioids
Psychological Aspects of Care			
For patients who screened positive for depression, the percent who received further assessment, counseling or medication treatment	Patient level data collection		Number of patients with depression further assessment="Y" / # patients with depression screening=Yes
For patients diagnosed with depression, the percent who receive treatment within two weeks of diagnosis	Patient level data collection	Depression treatment time = date of treatment – depression diagnosis date	Number of patients with (0<=Depression Treatment Time<=14 days and depression treatment="Y") /# patients with depression diagnosis =Y

Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
For patients who screened positive for anxiety, the percent who receive treatment within two weeks of diagnosis	Patient level data collection	Anxiety treatment time = date of treatment – anxiety assessment date	Number of patients with (0<=Time<=14 days and anxiety treatment="Y") /# patients with anxiety screening=Y
Social Aspects of Care			
Percent of families reporting the hospice attended to family needs for information about medication, treatment and symptoms	Recommend that providers implement an after-death family survey with good conceptual framework and psychometric properties and use survey developer specifications for measuring this aspect of quality		
Percent of families reporting that hospice informed and communicated about patients	Recommend that providers implement an after-death family survey with good conceptual framework and psychometric properties and use survey developer specifications for measuring this aspect of quality		
Spiritual Aspects of Care			
Percent of patients with chart documentation of a discussion of spiritual concerns	Patient level data collection		Number of patients with spiritual discussion = "Y" / Total number of patients
Cultural Aspects of Care			
Availability of interpreter or translator for non-English-speaking or deaf patients	Recommend that providers review and assess this aspect of care using an organizational readiness checklist (e.g.: the PEACE Organizational Readiness Screen)		
Care for the Imminently Dying			
Percent of patients who had moderate to severe pain on a standard rating scale at any time in the last week of life	Patient level data collection		Number of patients with Pain in last week= "Moderate" or "Severe" / Number of patients who died

Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
Percent of families who reported they were informed of what to expect at the time of death	Recommend that providers implement an after-death family survey with good conceptual framework and psychometric properties and use survey developer specifications for measuring this aspect of quality		
Ethical and legal aspects of care			
Percent of patients with chart documentation of preferences for life sustaining treatments	Patient level data collection		Number of patients with documentation = "Y" / Number of Patients
Percent of patients with chart documentation of an advanced directive (living will or health care power of attorney) or discussion that there is no advanced directive	Patient level data collection		Number of patients with documentation of advanced directive ="Y" or Discussion of no advanced directive = "Y" / Number of Patients
Percent of patients with contact information for surrogate decision maker in the chart or documentation that there is no surrogate	Patient level data collection		Number of patients with surrogate contact info ="Y" or Discussion of no surrogate = "Y" / Number of Patients
Percent of patients with impaired decision making (dementia, coma or other impairment) that have documentation of surrogate decision maker in chart within 2 days of recognition of impaired decision making	Patient level data collection	Surrogate date = Date of documentation if chart has a surrogate decision maker, or date of documentation of no surrogate if chart contains contact info of surrogate or discussion of no surrogate is recorded Surrogate document time = surrogate date – admission date	Number of patients with (0<=Surrogate document time <=2days) and (Dementia="Y" or Confused-sedated-nonverbal="Y") / Number of patients with dementia="Y" or confused-sedated-nonverbal="Y"

Measure	Recommended data collection approach	Calculated Variables (if any)	Formula
Adverse Events			
Selected number of occurrences per 100 patient days (falls, medication errors, DME concerns, and patient or family complaints)	Occurrence report logs (e.g.: agency specific incident log)	Rates can be calculated separately for each individual type of occurrence Note: other adverse events can be monitored using this approach (e.g.: non-respite hospitalizations)	The total number of occurrences reported in the time period / total number of patient days in the time period

* Measures in black font can be calculated from data gathered using the PEACE data collection tool. All other measures (in gray font) require a different data collection approach.

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