Specifications Manual for National Hospital Inpatient Quality Measures

Discharges 01-01-15 (1Q15) through 09-30-15 (3Q15)

Version 4.4a

Data Element Name: *Comfort Measures Only*

Collected For: CMS/The Joint Commission: STK-1, STK-6, STK-8, VTE-1, VTE-2, VTE-3, VTE-6; **The Joint Commission Only:** STK-2, STK-3, STK-5, STK-10, All SUB Measures, All TOB Measures; **CMS Voluntary Only:** AMI-1, AMI-3, AMI-5, HF-2, PN-6, STK-2, STK-3, STK-5, STK-10, VTE-4; **CMS Informational Only:** All SUB Measures, All TOB Measures

Definition: Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as “comfort care” by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of comfort measures only?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 **Day 0 or 1:** The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).

2 **Day 2 or after:** The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).

3 **Timing unclear:** There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.

4 **Not Documented/UTD:** There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction:

- **Only accept terms identified in the list of inclusions. No other terminology will be accepted.**
- Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:
  - Comfort measures only recommendation

- Order for consultation or evaluation by a hospice care service
- Patient or family request for comfort measures only
- Plan for comfort measures only
- Referral to hospice care service
- Discussion of comfort measures

- Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value "1," "2," or "3" accordingly.
  Example:
  "Discussed comfort care with family on arrival" noted in day 2 progress note – Select "2."
- **State-authorized portable orders (SAPOs):**
  - SAPOs are specialized forms or identifiers authorized by state law that translate a patient's preferences about specific end-of-life treatment decisions into portable medical orders.
    Examples:
    - DNR-Comfort Care form
    - MOLST (Medical Orders for Life-Sustaining Treatment)
    - POLST (Physician Orders for Life-Sustaining Treatment)
    - Out-of-Hospital DNR (OOH DNR)
  - If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select value "1."
  - If a SAPO lists different options for CMO and any CMO option is checked, select value "1," "2," or "3" as applicable.
  - If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
  - For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.
    Example:
    Patient has a POLST dated prior to arrival in his chart and ED physician states in current record "Patient is refusing comfort measures, wants to receive full treatment and be a full code."
- Documentation of an inclusion term in the following situations should be **disregarded**. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the **ONLY** documentation found is an inclusion term in the following situations, select value "4."
  - Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.
    Examples:
    - Comfort measures only order in previous hospitalization record.
    - "Pt. on hospice at home" in MD ED note.
  - Inclusion term clearly described as negative or conditional.
    Examples: