

NCCCP Cancer Palliative Care Matrix Assessment Tool

Purpose: The Palliative Care Matrix is designed for community cancer programs to use as a self-assessment tool in evaluating and improving their palliative care services. Palliative care programs in some health care settings may utilize “supportive care” or “symptom management” in their titles.

CATEGORY	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Patient Symptom Assessment at Each Physician/Care Provider Encounter: - Pain - Fatigue - Mobility / Independence - Constipation - Diarrhea - Nausea / Vomiting - Lack of Appetite - Shortness of Breath - Sexual Dysfunction - Distress- (See psychosocial matrix) (Additional symptoms as appropriate for disease site)	None documented	Inconsistent documentation of symptoms	Consistent documentation, variable measurement tools	Consistent documentation with consistent tools	4 plus sequential comparisons available

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Palliative Care/Supportive Care (PC/SC) services are provided across the continuum of patient care settings	None available	Consultative inpatient PC/SC program (physician, APN or NP-led)	Level 2 plus 24/7 Availability of Consultative PC/SC outpatient multi-disciplinary team	Level 3 and Outpatient PC/SC continuity clinic care services available	Palliative Care/Supportive Care services regardless of patient location
Patient Identification/Case Finding for Palliative Care Services	Only end-of-life patients are referred	Patients with advanced stage cancer with severe symptoms	Patients at any stage cancer with severe symptoms	Patients referred at any stage, regardless of symptoms	Referral for any diagnosis stage as well as survivors with concerns/symptoms
Patient Identification/Case Finding for Hospice Care Services	Hospice option presented when death is imminent		Hospice option presented to all patients with stage IV disease		Hospice presented as an option to all patients and families when death within a year would not be surprising and is reintroduced as an option as the patient declines
Patient Access/Referral	Single practice or specialty refers		Multiple physician referral sources		Referrals from patient, family or non-MD staff permitted

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Assessment of Potential Barriers to Palliative Care	No specific assessment utilized		Cultural, socioeconomic, geographic assessment for each patient		Resources available to overcome patient disadvantages and barriers
Quality and Impact Measurements Measures are defined, routinely monitored and improvements documented. Includes monitoring data for the following categories: ² - Pain and symptom control - Program operational measures (e.g. number and type of referrals, number of advanced directives, hospice referrals, etc.) - Patient, family, and healthcare provider satisfaction - Financial impact and resource utilization (e.g. hospital and/or ICU length of stay, pharmacy costs before and after consultation, etc.)	None	Pain and symptom control outcome data measured and monitored	Level two plus one additional quality/impact outcome measure category	Level three plus one additional quality/impact outcome measure category	Monitoring all 4 quality outcome/impact measure categories
Palliative Care Program Leadership Hospice care and specialized palliative care professionals should be appropriately trained, credentialed and/or certified in their area of expertise ¹	None	Leader has documented annual attendance at Hospice and Palliative Care CME/CEU programs	EPEC / ELNEC curriculum trained physician or nurse clinical leader	Physician leader is board eligible for American Board of Hospice and Palliative Medicine (ABHPM)	Physician leader is ABHPM certified.

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<p>Staff Competencies Education/Training/Awareness Provide adequate training and clinical support to assure that professional staff are confident in their ability to provide palliative care for patients.¹</p>	None	Education program offered annually	Annual education and PC/SC training provided during new staff orientation for IP and OP oncology settings	Level 3 and Annual staff competency evaluations for IP and OP oncology settings	Ongoing education, training, and assessment for all levels of staff for IP and OP oncology settings.
<p>Patient Education and Self-Management Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.¹</p>	No educational materials or resources provided		Print or web-site resources are provided specific to disease site		Customized and individualized resources are provided
<p>Advanced Care Planning Formulate, utilize and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.¹</p>	Not addressed	Advanced Directives requested and copy in patient chart. Conduct community education programs on advanced care planning	Care plan discussion with patient occurs at hospital admission or initial visit	Conduct and document goal of care conferences with patient and family and entire health care team	Care plan is reviewed and discussed with patient and family when patient condition changes or at regular intervals (at least annually) All patients have advanced directives

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Advanced Care Plan Dissemination Make advance directives and surrogacy designations available across care settings while protecting patient privacy and adherence to HIPAA regulations, e.g., by Internet-based registries or electronic personal health records. ¹	No specific mechanism		Advance directives and surrogacy designations are shared across hospital settings	Advance directives and surrogacy designations are shared across hospital settings and physician offices	Advance directives and surrogacy designations are readily available and follow the patient across all health settings
Rehabilitation Services	None available	PT/OT/Speech services	2 and inpatient rehabilitation care available	3 and outpatient rehabilitation physician consultation available	4 and cancer program-associated rehabilitation physician
Psychosocial Interventions Assess and manage psychological reactions of patients and families to address emotional and functional impairment and loss, including stress, anticipatory grief and coping, in a regular ongoing fashion. ¹	None provided		Available to inpatients		Readily available to both inpatients and outpatients
Spiritual Care Program	No specific assessment or resources	Chaplain service available for all patients and families	Spiritual assessment for all patients		Spiritual resources available as patient needs and requests around the clock

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Palliative Care Staff Support Examples include formal debriefing and/or case conferences for difficult cases, Schwartz Center Rounds, team support group sessions, and educational needs-assessment-driven programs ¹	None	Bi-annual	Annual	Quarterly	Monthly

1. Policies and Tools for Hospital Palliative Care Programs: A Crosswalk of National Quality Forum Preferred Practices. Center to Advance Palliative Care. http://www.capc.org/support-from-capc/capc_publications/ngf-crosswalk.pdf
2. Center to Advance Palliative Care. http://www.capc.org/building-a-hospital-based-palliative-care-program/measuring-quality-and-impact/index_html#2.

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SCORING

Patient Assessment: _____

Services Provided _____

Patient Identification _____

Patient Identification for Hospice _____

Access/Referral _____

Barrier Assessment _____

Quality Outcomes _____

Physician Leadership _____

Staff Competency _____

Patient Education _____

Advanced Care Planning _____

Care Plan Dissemination _____

Rehabilitation _____

Psychosocial _____

Spiritual Care _____

Palliative Care Staff Support _____

Total Score: _____ out of 80

Organization Name: _____

Date Completed: _____