

# Palliative and End-of-Life Care 2015-2016

DRAFT REPORT FOR COMMENT

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# NATIONAL QUALITY FORUM

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# Palliative and End-of-Life Care

DRAFT REPORT

## Executive Summary

Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and alleviating suffering throughout the continuum of a person's illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. With its focus on improving quality of life, palliative care is distinct from care intended to cure an illness or condition, although it can be delivered concurrently with curative therapies. End-of-life care is comprehensive care that addresses medical, emotional, spiritual, and social needs during the last stages of a person's terminal illness. Much end-of-life care is palliative in nature, when life-prolonging interventions are no longer appropriate, effective, or desired.

Palliative care is holistic in nature, addressing the needs of the whole person. As such, palliative care requires an interdisciplinary, team-based approach that includes a variety of clinicians and other caregivers, including, but not limited to, physicians, nurses, social workers, chaplains, other mental health professionals, therapists, and pharmacists.

Improving both access to, and quality of, palliative and end-of-life care is becoming increasingly important due to the aging of the U.S. population, the projected increases in the number of Americans with chronic illnesses, disabilities, and functional limitations, and the growth in ethnic and cultural diversity, which has intensified the need for individualized, person-centered care.<sup>1</sup>

The National Quality Forum's (NQF) portfolio of measures for Palliative and End-of-Life Care includes measures addressing physical aspects of care, including the management of pain, dyspnea, and constipation. The portfolio also includes measures addressing several of the other domains of care including spiritual, psychological, cultural, and legal aspects of care and care of the patient at the end of life.

For this project, the Standing Committee evaluated 8 newly-submitted measures and 16 measures undergoing maintenance review against NQF's standard evaluation criteria. Nineteen measures were recommended for endorsement, and the Committee did not recommend/reach consensus on 5 measures. The 19 measures that were recommended by the Standing Committee are:

### ***Physical aspects of care (pain, dyspnea, constipation)***

- 1634: Hospice & Palliative Care: Pain Screening (UNC-Chapel Hill)
- 1637: Hospice & Palliative Care: Pain Assessment (UNC-Chapel Hill)
- 1628: Patients with advanced cancer screened for pain at outpatient visits (RAND Corporation)
- 1638: Hospice & Palliative Care: Dyspnea Treatment (UNC-Chapel Hill)
- 1617: Patients Treated with an Opioid who are Given a Bowel Regimen (RAND Corporation)

***Spiritual, religious, and existential aspects of care***

- 1647: Beliefs and Values Documentation (UNC-Chapel Hill)

***Ethical and legal aspects of care***

- 1641: Hospice & Palliative Care: Treatment Preferences (UNC-Chapel Hill)

***Care of the patient at the end of life***

- 0210: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life (American Society of Clinical Oncology)
- 0213: Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life (American Society of Clinical Oncology)
- 0215: Proportion of patients who died from cancer not admitted to hospice (American Society of Clinical Oncology)
- 0216: Proportion of patients who died from cancer admitted to hospice for less than 3 days (American Society of Clinical Oncology)
- 2651: CAHPS® Hospice Survey (experience with care) PRO-PMs (Centers for Medicare and Medicaid Services):
  - Hospice Team Communication;
  - Getting Timely Care;
  - Getting Emotional and Religious Support;
  - Getting Hospice Training;
  - Rating of the hospice care;
  - Willingness to recommend the hospice
  - Treating Family Member with Respect
  - Getting Help for Symptoms

The Committee did not reach consensus on the following measures:

- 1639: Hospice & Palliative Care: Dyspnea Screening (UNC-Chapel Hill) [***Physical aspects of care***]
- Treating Family Member with Respect (Hospice CAHPS PRO-PM included under #2651) [***Care of the patient at the end of life***]

The Committee did not recommend the following measures:

- 0209: Comfortable Dying: Pain Brought to a Comfortable Level within 48 hours of Initial Assessment (National Hospice and Palliative Care Organization) [***Physical aspects of care***]
- 1626: Patients admitted to the ICU who have care preferences documented (RAND Corporation) [***Ethical and legal aspects of care***]
- 0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life (American Society of Clinical Oncology) [***Care of the patient at the end of life***]

Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in [Appendix A](#).

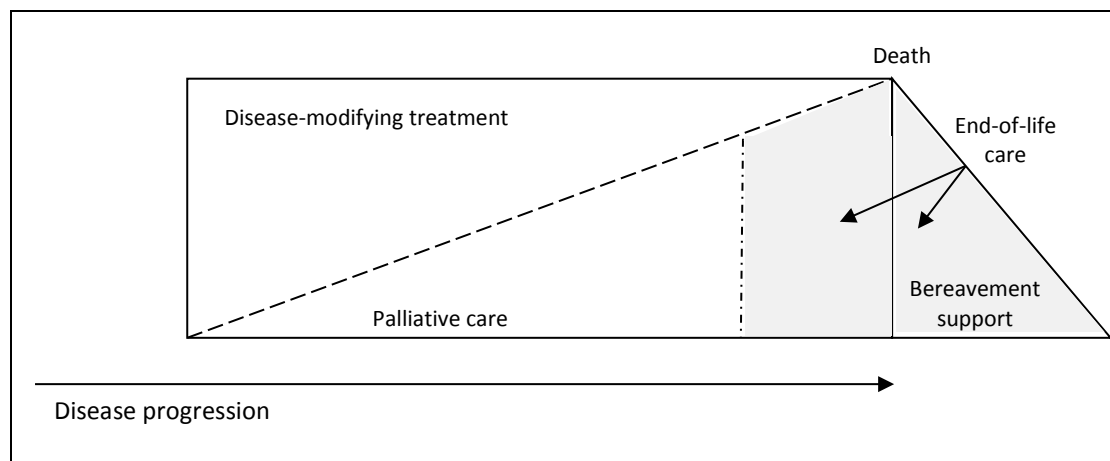
## Introduction

Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and alleviating suffering throughout the continuum of a person's illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.<sup>2</sup> With its focus on improving quality of life, palliative care is distinct from care intended to cure an illness or condition, although it can be delivered concurrently with curative therapies. End-of-life care is comprehensive care that addresses medical, emotional, spiritual, and social needs during the last stages of a person's terminal illness.<sup>3</sup> Much end-of-life care is palliative in nature, when life-prolonging interventions are no longer be appropriate, effective, or desired.<sup>4</sup>

As indicated in its definition, palliative care is holistic in nature, addressing the needs of the whole person. As such, palliative care requires an interdisciplinary, team-based approach that includes a variety of clinicians and other caregivers, including, but not limited to, physicians, nurses, social workers, chaplains, other mental health professionals, therapists, and pharmacists.

Palliative care can begin at any point in the disease progression (see Figure 1). In the earlier stages of illness, palliative care may play a relatively minor role in an individual's care, particularly when there an expectation that curative care will be effective. However, the role of palliative care often increases as the end of life draws near. An important facet of end-of-life care is bereavement support, which is provided to the family after the death of the patient (sometimes well beyond a year).

**Figure 1. Palliative and End-of-Life Care in the Overall Continuum of Care**



*Adapted from NQF, 2006*

Palliative care can be provided in any setting, including outpatient care settings and at home. In the current healthcare system, palliative care is provided primarily by specially trained teams of professionals in hospitals (often called “specialty palliative care”) or as end-of-life care through hospice. Hospice is both a philosophy of care and a service delivery system. As a philosophy of care, hospice is predicated on the concept that persons near the end of life should be able to make their own treatment decisions and have the opportunity to prepare for death,<sup>5</sup> which is consistent with the hospice goal to



enable living as “fully and as comfortably as possible.”<sup>6</sup> As a system of care, hospice relies on an interdisciplinary approach that emphasizes symptom management. The “unit of care” in hospice is the person who is dying and his or her family. While hospice care is covered through Medicaid and most private insurance plans, approximately 85% of enrollees receive hospice coverage through the Medicare hospice benefit.<sup>7</sup>

## Trends and Performance

Improving both access to, and quality of, palliative and end-of-life care is becoming increasingly important due to the aging of the U.S. population, the projected increases in the number of Americans with chronic illnesses, disabilities, and functional limitations, and the growth in ethnic and cultural diversity, which has intensified the need for individualized, person-centered care.<sup>8</sup>

While access to specialty palliative care in the U.S. hospitals has increased substantially in the last 10 years, it is still highly variable with hospital size and geography. For example, in 2015, only two-thirds of hospitals with ≥50 beds have palliative care teams (up from 53% in 2008), and only 17% of states have palliative care teams in at least 80% of their hospitals.<sup>9</sup> On average, only 3.4% of patients in hospitals that offer specialized palliative care services actually receive those services, and an estimated 7.5%-8.0% of all patients admitted to hospitals (between 1-1.8 million patients) could benefit but do not receive palliative care services.<sup>10</sup> The provision of specialty palliative care in the outpatient setting has been described recently as a “dominant” care delivery model for palliative care that is developing rapidly;<sup>11</sup> however, estimates of the number of such programs in the U.S. have yet to be published. In a recent study of organizational barriers to adoption of outpatient palliative care programs, participants identified a lack of performance measures as a potential barrier to implementation.<sup>12</sup> While several performance measures specific to inpatient and outpatient palliative care are used in quality improvement programs operated by the Center for Medicare & Medicaid Services (CMS), results currently are not publicly reported.

More than 1.6 million patients and their families receive hospice care each year,<sup>13</sup> accounting for an estimated 46% of U.S. decedents. The majority of hospice care, by statute, is delivered in the home, which includes private residences as well as institutional settings such as assisted living and nursing homes. Hospice care also is provided in hospitals and inpatient hospice facilities. While the average length of a hospice stay is 71.3 days, the median is only 17.4 days.<sup>14</sup> This difference in the average versus the median length of stay means that many dying persons enroll in hospice much too late to fully realize the benefits available through hospice. Although for many years patients with cancer made up the majority of hospice patients, this is no longer the case, as persons with other conditions such as dementia, heart disease, and lung disease account for more than 63% of hospice admissions.<sup>15</sup> Beginning in the second half of 2014, Medicare-certified hospices were required to report on seven quality measures as part of the Hospice Quality Reporting Program; those not reporting face a reduction in payments from Medicare. According to the Medicare Payment Advisory Commission, only seven percent of hospices did not report on these measures (non-reporters generally were small providers).<sup>16</sup> Performance rates for these measures are not yet publicly reported.

## NQF Portfolio of Performance Measures for Palliative and End-of-Life Care

The Palliative and End-of-Life Care Standing Committee (see [Appendix D](#)) oversees NQF's portfolio of 30 Palliative and End-of-Life Care measures (see [Appendix B](#)). The portfolio currently is organized according to the domains of care used in the clinical practice guidelines developed by the National Consensus Project for Quality Palliative Care.<sup>17</sup> The portfolio includes 1 structure measure, 18 process measures, and 11 outcome measures; currently there are no composite measures included in the portfolio (see table below).

**Table 1. NQF Palliative and End-of-Life Care Portfolio of Measures**

	Structure	Process	Outcome/ Resource Use
<b>Physical aspects of care</b>	0	10	4
<b>Psychological and psychiatric aspects of care</b>	0	1	1
<b>Cultural aspects of care</b>	1	0	1
<b>Spiritual, religious, and existential aspects of care</b>	0	1	0
<b>Ethical and legal aspects of care</b>	0	3	0
<b>Care of the patient at the end of life</b>	0	3	5
<b>Social aspects of care</b>	0	0	0
<b>Total</b>	<b>1</b>	<b>18</b>	<b>11</b>

Several of the measures included in the Palliative and End-of-Life Care portfolio have been or soon will be evaluated by other NQF Standing Committees in separate projects. These include experience of care measures and pain measures for the ambulatory, home health, and nursing facility settings, cultural communication and cultural competency measures, and health-related quality of life measures (Person- and Family-Centered Care and Renal Committees), pain measures for cancer patients (Cancer Committee), and an advance care planning measure (Care Coordination Committee).

### National Quality Strategy

NQF-endorsed measures for palliative and end-of-life care support the [National Quality Strategy \(NQS\)](#). NQS serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, State, and national) to improve the quality of healthcare in the U.S. The NQS establishes the "triple aim" of better care, affordable care, and healthy people/communities, focusing on six priorities to achieve those aims: *Safety, Person and Family Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care.*

Quality measures for palliative and end-of-life care align with three of the NQS priorities:

- Making care safer by reducing harm caused in the delivery of care.** Symptom management is a focus of palliative care, regardless of whether the symptoms result from the condition or illness or from treatment of illness. Moreover, treatment that is appropriate and effective in early stages of illness may become inappropriate near the end of life. Fourteen of the measures in the portfolio focus on management of pain, dyspnea, and constipation, while five measures assess utilization of care (i.e., ED, ICU, hospice, and chemotherapy) near the end-of-life care in

cancer patients, and one assesses deactivation of implantable cardioverter-defibrillators (ICDs) in individuals with a terminal illness.

- **Ensuring that each person and family is engaged as partners in their care.** Patient and family engagement is a hallmark of high quality palliative and end-of-life care. Engagement can be facilitated by soliciting goals of care and treatment preferences from both the patient and the family and incorporating these into the plan of care. Moreover, in order to effectively manage symptoms, providers must engage with both patients and families to understand the genesis and scope of symptoms both prior to and after initiation of treatment. Cultural sensitivity is another vital aspect of high-quality palliative and end-of-life care, particularly given the influence of culture in individuals' spiritual preferences, familial relationships, interactions with healthcare providers, and choices about treatment goals. In addition to the three measures that focus on advance care planning, care preferences, and treatment preferences, the current portfolio also includes two measures on cross-cultural communication and cultural competency and two measures that focus on quality of life.
- **Promoting effective communication and coordination of care.** Effective communication among patients, families, and providers ensures the needs and care preferences of the patient and family are known. Communication and coordination among providers is also important as palliative and end-of-life care is inherently multi-disciplinary, involving multiple providers across settings. Effective communication and coordination among these providers increases the likelihood of alignment between care preferences and care delivery. As already mentioned, the portfolio includes three measures that assess communication about preferences of care.

Additionally, all three of the NQS priorities listed above are encompassed in the new measures submitted for potential endorsement that are derived from the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

## Use of Measures in the Portfolio

Endorsement of measures by NQF is valued not only because the evaluation process itself is both rigorous and transparent, but also because evaluations are conducted by multi-stakeholder committees comprised of clinicians and other experts from the full range of healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, federal law requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

Several measures in NQF's Palliative and End-of-Life Care portfolio are used in at least one federal quality improvement programs (see [Appendix C](#)). These include the seven measures collected through the Hospice Item Set that are used in the CMS Hospice Quality Reporting Program (HQRP). During its 2016 review of measures under consideration, the Measure Applications Partnership (MAP), an NQF-convened public-private partnership that provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for use in Centers for Medicare and Medicaid Services (CMS) quality improvement programs, recommended the continued development of a composite measure that combines the seven measures from the HIS. At least one measure is used in

the Veteran’s Administration Hospice and Palliative Care Program. Several cancer-specific measures have been included in America’s Health Insurance Plans (AHIP)’s Medical Oncology Core Measure Set.

## Improving NQF’s Palliative and End-of-Life Care Portfolio

### *Measurement Framework*

In its foundational work on palliative and end-of-life care in 2006, NQF developed a framework to support future quality measure development and research for palliative and hospice care.<sup>18</sup> This comprehensive framework specified the scope of hospice and palliative care, structural and programmatic elements of care, and the domains of care.

A simplified version of this framework was drafted for the current project (see [Appendix B](#)). This draft framework places the patient and family at the center of care. The next ring of the framework includes the various domains of care (e.g., psychological aspects, physical aspects, etc.). The third ring recognizes the various settings of palliative and end-of-life care. Finally, the outside ring recognizes the overlapping nature of palliative, end-of-life, and bereavement care.

NQF’s portfolio of palliative and end-of-life care measures addresses many of the elements of the draft framework. Notable exceptions include a lack of measures addressing social aspects of care and bereavement, as well as measures applicable to the family or caregiver.

The Committee offered some initial suggestions for expanding the draft framework (e.g., specifically including concepts related to cost, decision-making, and safety), although additional discussion will be required before finalizing the framework.

### *Committee Input on Gaps in the Portfolio*

During their discussions the Committee identified numerous areas where additional measure development is needed, including:

- Measures that differentiate specialty palliative care from primary (sometimes called “basic”) palliative care
- Measures of palliative care for the pediatric and neonatal populations
- Measures specific to diseases other than cancer (e.g., chronic obstructive pulmonary disease, dementia)
- Measures that go beyond assessment of social, cultural, and spiritual needs to capture treatment or follow-up activities related to these aspects of care
- Measurement that assess how the environment in which the patient receives care is conducive to their social, cultural, and spiritual needs
- Workforce measures that track recruitment, training, retention, and other aspects of the workforce
- Measures specific to caregivers
- Measures of treatment burden, financial toxicity, and treatment-related harm
- Measures that capture the decision-making process (e.g., advance care planning and goals of care discussions) and the incorporation of those decisions into care processes

Additional gaps in palliative and end-of-life care measurement were highlighted in the [2016 report](#) from the MAP Post-Acute Care and Long-Term Care Workgroup. These gaps relate specifically to the Hospice Quality Reporting Program and include:

- Outcome measures that assess symptom management
- Measures of communication and care coordination, particularly the responsiveness of providers to the patient and family preferences for care
- Measures of patient and family engagement
- Patient safety measures, particularly timeliness and responsiveness of care to safety concerns

## Palliative and End-of-Life Care Measure Evaluation

On May 10-11, 2016 the Palliative and End-of-Life Care Standing Committee evaluated 8 new measures and 16 measures undergoing maintenance of endorsement review against [NQF's standard evaluation criteria](#). To facilitate the evaluation, the committee and candidate measures were divided into 4 workgroups for preliminary review of the measures against the evaluation sub-criteria prior to consideration by the entire Standing Committee.

### Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the [Quality Positioning System \(QPS\)](#). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. The pre-evaluation comment period was open from March 28-April 11, 2016 for all of the 24 measures under review. A total of 7 pre-evaluation comments were received (see [Appendix G](#)). Comments included questions about measure specifications; suggestions to strengthen measures by combining them or otherwise considering related or competing measures; recommendations to broaden assessment and screening measures beyond time of admission, make measures specific to palliative or hospice care (not both), expand palliative care measures to settings other than inpatient hospitals, and expand measure denominators (e.g., not limited to cancer patients only); and commentary regarding measurement challenges for the field.

All submitted comments were provided to the Committee prior to its initial deliberations during the workgroup calls.

### Refining the NQF Measure Evaluation Process

To streamline and improve the periodic evaluation of currently-endorsed measures, NQF has updated the evaluation of measures for maintenance of endorsement. This change took effect beginning October 1, 2015. NQF's endorsement criteria have not changed, and all measures continue to be evaluated using the same criteria. However, under the new approach, there is a shift in emphasis for evaluation of currently-endorsed measures:

- **Evidence:** If the developer attests that the evidence for a measure has not changed since its previous endorsement evaluation, there is a decreased emphasis on evidence, meaning that the Committee may accept the prior evaluation of this criterion without further discussion or need for a vote. This applies only to measures that previously passed the evidence criterion without

an exception. If a measure was granted an evidence exception, the evidence for that measure must be revisited.

- **Opportunity for Improvement (Gap):** For re-evaluation of endorsed measures, there is increased emphasis on current performance and opportunity for improvement. Endorsed measures that are “topped out” with little opportunity for further improvement are eligible for Inactive Endorsement with Reserve Status.
- **Reliability**
  - Specifications: There is no change in the evaluation of the current specifications.
  - Testing: If the developer has not presented additional testing information, the Committee may accept the prior evaluation of the testing results without further discussion or need for a vote.
- **Validity:** There is less emphasis on this criterion if the developer has not presented additional testing information, and the Committee may accept the prior evaluation of this subcriterion without further discussion and vote. However, the Committee still considers whether the specifications are consistent with the evidence. Also, for outcome measures, the Committee discusses questions required for the [SDS Trial](#) even if no change in testing is presented.
- **Feasibility:** The emphasis on this criterion is the same for both new and previously-endorsed measures, as feasibility issues might have arisen for endorsed measures that have been implemented.
- **Usability and Use:** For re-evaluation of endorsed measures, there is increased emphasis on the use of the measure, especially use for accountability purposes. There also is an increased emphasis on improvement in results over time and on unexpected findings, both positive and negative.

## Committee Evaluation

Of the 8 new measures and 16 measures undergoing maintenance of endorsement considered by the Committee at its May 10-11, 2016 meeting, 19 were recommended for endorsement. The Committee did not reach consensus on 2 measures and did not recommend 3 measures. Table 2 summarizes the results of the Committee’s evaluation.

**Table 2. Palliative and End-of-Life Care Measure Evaluation Summary**

	Maintenance	New	Total
Measures under consideration	16	8	24
Measures recommended for endorsement	12	7	19
Measures where consensus is not yet reached	1	1	2
Measures not recommended for endorsement	2	0	2
Measures withdrawn from consideration	1	0	1
Reasons for not recommending	Importance – 0 Scientific Acceptability – 2 Overall – 0 Competing Measure – 0	Importance – 0 Scientific Acceptability – 0 Overall – 0 Competing Measure – 0	

## Overarching Issues

During the Standing Committee's discussion of the measures, three overarching issues emerged and were factored into the Committee's ratings and recommendations for multiple measures; these issues are not repeated in detail for each individual measure.

### *Insufficient Evidence*

According to NQF measure evaluation criteria, both process measures and intermediate clinical outcome measures should be supported by a systematic review and grading of the body of empirical evidence demonstrating that the measured process or intermediate clinical outcome leads to a desired health outcome. Four of the measures in this project focused on screening and assessment and developers were unable to provide evidence of a link between the actual measure focus and a desired health outcome. Two other measures in the project (*#1647: Beliefs and Values Documentation*; *0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life*) were supported primarily by expert consensus. Systematic reviews presented by the developers to support these measures often were either tangential to the measure focus or not graded, and developers often did not summarize the quantity, quality, and consistency of the evidence. While developers frequently augmented systematic reviews with brief descriptions of additional studies, these did not always match the measure focus and it was not always clear whether the entire body of evidence was presented. For all six of the measures not supported by empirical evidence, the Committee invoked an exception to the evidence criterion.

### *Lack of Uptake of Measures and Unavailability of Data*

Several of the measures evaluated in this project are either not in use at all or are in use for only one of the specified care settings or levels of analysis. This hindered the measure developers' ability to provide current performance information and information concerning improvement over time—both of which receive increased emphasis in NQF's new process for evaluating previously-endorsed measures. Non-use also impeded the measure developers' ability to conduct additional reliability and validity testing of the measures. The Committee recommended all but one of these measures for continued endorsement, but strongly encouraged developers to advocate for use of the measures and to provide updated data to NQF when it becomes available.

## Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that were considered by the Committee. Details of the Committee's discussion and ratings of the criteria for each measure are included in [Appendix A](#).

### *Physical aspects of care (pain)*

#### **0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment (National Hospice and Palliative Care Organization): NOT RECOMMENDED**

**Description:** Percentage of patients who report being uncomfortable because of pain at the initial assessment who, at the follow up assessment, report pain was brought to a comfortable level within 48

hours.; **Measure Type:** PRO; **Level of Analysis:** Facility, Population : National; **Setting of Care:** Hospice; **Data Source:** Patient Reported Data/Survey

This patient-reported outcome based performance measure (PRO-PM) was first endorsed in 2009. It was initially included CMS Hospice Quality Reporting Program, but due to hospices' difficulties in implementing the measure—CMS removed it from the program. Committee members agreed that the developer identified at least one clinical action that could influence patient-reported pain levels and that hospice patients find questions regarding level of pain to be meaningful. Performance for hospice facilities that voluntarily submitted data to NHPCO between 2012 and 2015 were relatively stable, with averages near 65%. However, the number of reporting facilities has dropped precipitously over the years. Several members expressed concern about the lack of risk adjustment for this measure, which ultimately led to a decision not to recommend the measure for endorsement. Although the developer presented patient-level data that suggest there are no differences in scores by age, gender, or race, the Committee encouraged the developer to provide hospice-level results stratified by these factors, as well as for region, diagnosis, and co-morbidities during the upcoming post-comment webinar and, if indicated, to provide a plan for future risk-adjustment.

#### **1634 Hospice and Palliative Care -- Pain Screening (University of North Carolina-Chapel Hill): RECOMMENDED**

**Description:** Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.; **Measure Type:** Process; **Level of Analysis:** Facility, Clinician : Group/Practice; **Setting of Care:** Hospice, Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

This measure assesses whether an initial screening for pain was conducted (as opposed to an in-depth assessment of pain). Initially endorsed in 2012, this measure is specified for the facility level of analysis for the hospice setting and for the clinician group/practice level of analysis for the hospital palliative care setting. Currently, the measure is in use only for the hospice setting. It has been a part of the CMS Hospice Quality Reporting Program since 2014, with public reporting of the measure expected in 2017. The Committee acknowledged the lack of evidence directly linking pain screening to desired patient outcomes, but agreed to invoke an exception to the evidence criterion. Fiscal year 2015 data indicate an average performance rate of 93.5% for hospices and slight, yet statistically significant, disparities in care between genders and between socioeconomic subgroups. The Committee agreed the measure showed clear opportunity for improvement for the hospice setting of care. Committee members responded favorably to a change in the measure such that hospice patients with a length of stay <7 days are no longer excluded from the measure. The Committee acknowledged the limited scope of the reliability testing for the palliative care setting and strongly encouraged the developers to provide both performance data and updated reliability testing for the clinician-level measure in the palliative care setting when available.

#### **1637 Hospice and Palliative Care -- Pain Assessment (University of North Carolina-Chapel Hill): RECOMMENDED**

**Description:** Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.; **Measure Type:** Process; **Level of**



**Analysis:** Facility, Clinician : Group/Practice; **Setting of Care:** Hospice, Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

This measure assesses whether comprehensive clinical assessment for pain was conducted for patients who screened positive for pain. The pain assessment must include at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life. Initially endorsed in 2012, this measure is specified for the facility level of analysis for the hospice setting and for the clinician group/practice level of analysis for the hospital palliative care setting. Currently, the measure is in use only for the hospice setting. It has been a part of the CMS Hospice Quality Reporting Program since 2014, with public reporting of the measure expected in 2017. The Committee acknowledged the lack of evidence directly linking pain assessment to desired patient outcomes, but agreed to invoke an exception to the evidence criterion. Fiscal year 2015 data indicate an average performance rate of 65.7% for hospices and slight, yet statistically significant, disparities in care between rural versus urban localities. The Committee agreed the measure showed clear opportunity for improvement for the hospice setting of care. Committee members responded favorably to a change in the measure such that hospice patients with a length of stay <7 days are no longer excluded from the measure. The Committee acknowledged the limited scope of the reliability testing for the palliative care setting and strongly encouraged the developers to provide both performance data and updated reliability testing for the clinician-level measure in the palliative care setting when available.

#### **1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits (RAND Corporation): RECOMMENDED**

**Description:** Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit; **Measure Type:** Process; **Level of Analysis:** Facility, Health Plan, Integrated Delivery System; **Setting of Care:** Ambulatory Care : Clinician Office/Clinic; **Data Source:** Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Registry

Pain is a common symptom for individuals with advanced cancer. This measure, which was initially endorsed in 2012, assesses whether systematic screening for pain is done for these patients at each clinician visit. Although it has been considered for inclusion in a public reporting program in California, no other planned or ongoing uses of the measure were reported. Committee members encouraged the developer to continue to pursue opportunities for inclusion in accountability programs. The numerator for this measure requires screening with a standardized tool, although if pain is present, the severity of pain also should be noted (an activity that also may be considered as "assessment" for pain). However, some Committee members questioned whether the measure denominator, which is limited to persons with Stage IV cancer who survive at least 30 days post-diagnosis, is too narrow. The Committee agreed that although there is insufficient evidence to link pain screening with patient outcomes, the importance of pain screening is sufficient to justify an exception to the evidence criterion. The developers provided performance data from four individual studies, with measure results ranging from 37% to 79%. However, these results were based on data that are more than five years old, and no current data on performance were provided because the measure is not in use.

### *Physical aspects of care (dyspnea)*

#### **1639 Hospice and Palliative Care -- Dyspnea Screening (University of North Carolina-Chapel Hill): CONSENSUS NOT REACHED**

**Description:** Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.; **Measure Type:** Process; **Level of Analysis:** Facility, Clinician : Group/Practice; **Setting of Care:** Hospice, Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

This measure assesses whether an initial screening was conducted for dyspnea (shortness of breath), a common symptom for many seriously ill patients, including those near the end of life. Initially endorsed in 2012, this measure is specified for the facility level of analysis for the hospice setting and for the clinician group/practice level of analysis for the hospital palliative care setting. Currently, the measure is in use only for the hospice setting. It has been a part of the CMS Hospice Quality Reporting Program since 2014, with public reporting of the measure expected in 2017. The Committee acknowledged the lack of evidence directly linking screening for dyspnea to desired patient outcomes, but agreed to invoke an exception to the evidence criterion. Fiscal year 2015 data indicate an average performance rate of 97.3% for hospices, with only 6.7% of hospices reporting results lower than 90%. While there is some indication of disparities in care, it is unclear whether the differences are clinically meaningful, and the Committee did not reach consensus on whether there is opportunity for improvement. Committee members responded favorably to a change in the measure such that hospice patients with a length of stay <7 days are no longer excluded from the measure. The Committee acknowledged the limited scope of the reliability testing for the palliative care setting and strongly encouraged the developers to provide both performance data and updated reliability testing for the clinician-level measure in the palliative care setting when available.

#### **1638 Hospice and Palliative Care -- Dyspnea Treatment (University of North Carolina-Chapel Hill): RECOMMENDED**

**Description:** Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening; **Measure Type:** Process; **Level of Analysis:** Facility, Clinician : Group/Practice; **Setting of Care:** Hospice, Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

This measure assesses whether or not patients who screened positive for dyspnea receive treatment. Although dyspnea (shortness of breath) is a common symptom for many seriously ill patients, including those near the end of life, effective treatments are available. Initially endorsed in 2012, this measure is specified for the facility level of analysis for the hospice setting and for the clinician group/practice level of analysis for the hospital palliative care setting. Currently, the measure is in use only for the hospice setting. It has been a part of the CMS Hospice Quality Reporting Program since 2014, with public reporting of the measure expected in 2017. This measure is supported by several systematic reviews and one clinical practice guideline that recommend both pharmacological and non-pharmacological treatment options for dyspnea. Fiscal year 2015 data indicate an average performance rate of 93.3% for hospices and slight, yet statistically significant, disparities in care between for non-white and lower-income hospice patients. The Committee acknowledged the relatively high performance in most

hospices but agreed that there is still some opportunity for improvement for this setting of care, as well as in the broader palliative care community. Committee members responded favorably to a change in the measure such that hospice patients with a length of stay <7 days are no longer excluded from the measure. The Committee acknowledged the limited scope of the reliability testing for the palliative care setting and strongly encouraged the developers to provide both performance data and updated reliability testing for the clinician-level measure in the palliative care setting when available.

### *Physical aspects of care (constipation)*

#### **1617 Patients Treated with an Opioid who are Given a Bowel Regimen (RAND Corporation/UCLA): RECOMMENDED**

**Description:** Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed; **Measure Type:** Process; **Level of Analysis:** Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual; **Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility; **Data Source:** Paper Medical Records

Because constipation is a common side effect of opioids, patients on these medications should be using prophylaxis (e.g., laxatives, stool softeners, high-fiber supplements, high-fiber diet, etc.) to manage this symptom. Initially endorsed in 2012, this measure has been in use in the CMS Hospice Quality Reporting Program since 2014, with public reporting of the measure expected in 2017. The measure is aligned with two clinical practice guidelines from the American Geriatrics Society and the American Pain Society/American Academy of Pain Medicine that recommend initiation of a bowel regimen when beginning opioid therapy and treatment of opioid-associated adverse effects. While data from 2007 to 2010 indicated a range in performance from 44% to 71%, more current data were not provided because the developer did not have access to the data collected through the Hospice Item Set. Nonetheless, the Committee agreed that there is still opportunity for improvement for this measure. Some members of the Committee expressed concern that the measure denominator—vulnerable adults, defined as age 75 or older; score >2 on the Vulnerable Elder Survey-13, life expectancy <6 months, Stage IV cancer, or receiving hospice care—could be challenging to reliably extract from the medical record, but the developers clarified that patients meeting any one of these criteria would be included in the denominator. Other Committee members noted that important patient populations (e.g., persons with acute respiratory failure) may not be included in the denominator, and recommended broadening the denominator to include all palliative care and cancer patients.

### *Spiritual, religious, and existential aspects of care*

#### **1647 Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (University of North Carolina-Chapel Hill): RECOMMENDED**

**Description:** This measure reflects the 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.; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospice; **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

Spiritual care is a key domain of hospice and palliative care, and discussion of spiritual concerns is the starting point for assuring that spiritual care needs are met. This measure, unlike the other measures from UNC, is specified for the facility level of analysis in the hospice setting only. The measure was initially endorsed in 2012 and has been in use in the CMS Hospice Quality Reporting Program since 2014, with public reporting of the measure expected in 2017. The Committee acknowledged the lack of formal, published articles linking discussion of spiritual/religious concerns to improved patient outcomes, but noted that studies have suggested that patients and families welcome such discussions, which are supported by expert consensus. The Committee agreed that even though current performance is quite high (average=92.2%), there is still some opportunity for improvement, particularly as data from the Hospice Item Set suggest possible disparities in care for non-White, low socioeconomic, and urban patients.

### *Ethical and legal aspects of care*

#### **1626 Patients Admitted to ICU who Have Care Preferences Documented (RAND Corporation): NOT RECOMMENDED**

**Description:** Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.;

**Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data**

**Source:** Paper Medical Records

To receive care that is consistent with their values, seriously ill patients must be given the opportunity to discuss their care preferences. This measure, initially endorsed in 2012, focuses on vulnerable adults who have been admitted to an intensive care unit (ICU). The evidence underlying this measure links advance care planning and high-quality provider communication to positive patient outcomes and shows that patients want to communicate their care preferences to their physicians. Although studies provided for the previous endorsement evaluation reported results ranging from 9% to 63.7%, current data were not provided by the developer because the measure is not in use. The Committee could not reach consensus on the reliability of the measure, primarily due to concerns about the ability to consistently apply the numerator specifications. Specifically, there was confusion about what needed to be done and/or documented when there is an advance care planning document already in the medical record, particularly as such a document may or may not detail preferences for care. Although the developer cited three face validity assessments as indicators of the validity of the measure, several Committee members noted that one was specific to cancer patients only, that none were specific to ICU patients, and that this measure was not assessed specifically in the face validity assessments but was instead discussed more generally. The Committee agreed that this measure does not meet the validity subcriterion.

#### **1641 Hospice and Palliative Care – Treatment Preferences (University of North Carolina-Chapel Hill): RECOMMENDED**

**Description:** Percentage of patients with chart documentation of preferences for life sustaining treatments; **Measure Type:** Process; **Level of Analysis:** Facility, Clinician : Group/Practice; **Setting of Care:** Hospice, Hospital/Acute Care Facility; **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

To receive care that is consistent with their values, seriously ill patients must be given the opportunity to discuss their preferences regarding life-sustaining treatment. Initially endorsed in 2012, this measure is specified for the facility level of analysis for the hospice setting and for the clinician group/practice level of analysis for the hospital palliative care setting. Currently, the measure is in use only for the hospice setting. It has been a part of the CMS Hospice Quality Reporting Program since 2014, with public reporting of the measure expected in 2017. Several systematic reviews and other studies support the link between high-quality provider communication and reduction of family distress and the use of intensive treatments, per patient preferences. Fiscal year 2015 data indicate an average performance rate of 98% for hospices and slight, yet statistically significant, disparities in care for non-White, low socioeconomic, and urban subpopulations. The Committee agreed that the measure may be topped out for the hospice setting, but noted the possibility of disparities in care for this setting. Members also agreed that there may be room for improvement in the broader palliative care community. Committee members responded favorably to a change in the measure such that hospice patients with a length of stay <7 days are no longer excluded from the measure. The Committee acknowledged the limited scope of the reliability testing for the palliative care setting and strongly encouraged the developers to provide both performance data and updated reliability testing for the clinician-level measure in the palliative care setting when available. The Committee acknowledged this measure is related to measure #0326: Advance Care Plan, but in general agreed that treatment preferences and advance care plans are distinct care processes requiring individual measures to capture performance.

### *Care of the patient at the end of life*

#### **0210 Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life (American Society of Clinical Oncology): RECOMMENDED**

**Description:** Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice; **Setting of Care:** Ambulatory Care: Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data: Registry

The quality of life for both patients and their families is negatively impacted when patients receive unnecessary or ineffective treatment near the end of life. This appropriateness of care measure was initially endorsed in 2009. It is currently included in the American Society of Clinical Oncology's (ASCO's) Oncology Practice Initiative (QOPI®) registry and is used for internal quality improvement and benchmarking purposes and is also included in the CMS PQRS program, a pay-for-reporting quality improvement program. The measure also is included in AHIP's Medical Oncology Core Set, and payers involved in the AHIP collaboration have committed to using the measure for reporting as soon as feasible. Studies link receipt of chemotherapy near the end of life to toxicity and lower quality of life without any benefit convinced the Committee of the benefits of avoiding the chemotherapy in the last 14 days of life. Performance data from the QOPI® Registry indicated variation in performance for practices reporting to QOPI® (mean in 2015=13.16%; standard deviation=11.5%), suggesting there is opportunity for improvement. The Committee questioned the use of claims data for identifying cancer deaths, but the developer clarified that registry data are used for identifying cancer deaths, while claims or QOPI® data are used to identify chemotherapy administrations. The Committee questioned the

developer about inclusion of oral chemotherapy agents in the measure numerator, and the developer clarified all anti-cancer drugs except for hormonal therapies are included.

**0211 Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life (American Society of Clinical Oncology): WITHDRAWN FROM CONSIDERATION**

**Description:** Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life; **Measure Type:** Intermediate Clinical Outcome; **Level of Analysis:** Clinician : Group/Practice; **Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data : Registry

Many Emergency Department (ED) visits for cancer patients near the end of life are potentially avoidable. This appropriateness of care measure was initially endorsed in 2009. While not currently in use, it is included in AHIP's Medical Oncology Core Set, and payers involved in the AHIP collaboration have committed to using the measure for reporting as soon as feasible. The Committee agreed that patients would prefer to avoid ED visits near the end of life if possible. When invoking the exception to the evidence criterion, Committee members acknowledged that empirical evidence did not link ED visits to specific patient outcomes, but agreed that it is acceptable to hold providers accountable for this measure. There was substantial variation in performance within and between the two integrated health systems for which performance results were provided (ranging from 4% to 55%), suggesting opportunity for improvement. The Committee questioned the use of claims data for identifying cancer deaths, but the developer clarified that registry data are used to identify cancer deaths, while claims data are used to identify ED admissions. The Committee was concerned about the lack of risk-adjustment for the measure and stated that appropriateness of ED admission may vary by factors that include patient and family characteristics, geographic region, urban versus rural environment, and availability of homecare resources. In particular, Committee members highlighted a potential unintended consequence of limiting access to care for patients in rural areas, where admission to the ED may be the only care option during an urgent situation. Citing concerns related to the lack of risk-adjustment, the Committee agreed that the measure did not meet the validity subcriterion as currently constructed, and instead opted to defer their endorsement decision, pending additional analysis regarding risk-adjustment. Although initially agreeing with this stipulation, in subsequent communication with NQF, the developers withdrew this measure from consideration, stating that they would not be able to explore risk-adjustment of the measure at this time. Consequently, endorsement will be removed.

**0213 Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life (American Society of Clinical Oncology): RECOMMENDED**

**Description:** Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life; **Measure Type:** Intermediate Clinical Outcome; **Level of Analysis:** Clinician : Group/Practice; **Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data : Registry

Admission to the ICU—particularly if a patient dies in the ICU—often causes both physical and emotional distress for the patient and family and worsens the death experience. This appropriateness of care measure was initially endorsed in 2009. While not currently in use, it is included in AHIP's Medical Oncology Core Set, and payers involved in the AHIP a collaboration have committed to using the

measure for reporting as soon as feasible. Evidence links reduced ICU visits to desired outcomes, including adherence to patient and family preference to avoid the ICU. This evidence, along with other tangential evidence supporting the beneficial effect of palliative care on place of death and reduced symptom burden, convinced the Committee of the benefits of avoiding the ICU in the last month of life. There is substantial variation in performance within and between the two integrated health systems for which performance results were provided (ranging from 6.9% to 40.0%), suggesting opportunity for improvement. The Committee questioned the use of claims data for identifying cancer deaths, but the developer clarified that registry data are used for identifying cancer deaths, while claims data are used to identify ICU admissions. Members noted the high sensitivity and specificity of the ICU admission data element and agreed that registry data—particularly death registry data—generally are accepted as accurate.

#### **0215 Proportion of patients who died from cancer not admitted to hospice (American Society of Clinical Oncology): RECOMMENDED**

**Description:** Proportion of patients who died from cancer not admitted to hospice; **Measure Type:** Process; **Level of Analysis:** Clinician : Group/Practice; **Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data : Registry

Hospice care is considered high-quality care by both patients and their families. Initially endorsed in 2009, this appropriateness of care measure assesses whether persons who died of cancer were enrolled in hospice. The measure is currently included in ASCO's Oncology Practice Initiative (QOPI®) registry and is used for internal quality improvement and benchmarking purposes. The measure also is included in AHIP's Medical Oncology Core Set, and payers involved in the AHIP a collaboration have committed to using the measure for reporting as soon as feasible. Studies link hospice admission to higher family-reported quality of end-of-life care, alleviation of anxiety and depression, and death in the decedent's preferred location. Performance data from the QOPI® registry indicated variation in performance for practices reporting to QOPI® (mean in 2015=42.5%, standard deviation=20.9%), suggesting there is opportunity for improvement. The Committee questioned the use of claims data for identifying cancer deaths, but the developer clarified that registry data are used for identifying cancer deaths, while claims or QOPI® data are used to identify hospice admissions.

#### **0216 Proportion of patients who died from cancer admitted to hospice for less than 3 days (American Society of Clinical Oncology): RECOMMENDED**

**Description:** Proportion of patients who died from cancer, and admitted to hospice and spent less than 3 days there; **Measure Type:** Intermediate Clinical Outcome; **Level of Analysis:** Clinician : Group/Practice; **Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility; **Data Source:** Administrative claims, Electronic Clinical Data : Registry

Patients with very short hospice stays do not gain the maximum benefit from the services that are available through hospice. Initially endorsed in 2007, this appropriateness of care measure is currently included in ASCO's Oncology Practice Initiative (QOPI®) registry and is used for internal quality improvement and benchmarking purposes. The measure also is included in the AHIP's Medical Oncology Core Set, and payers involved in the AHIP a collaboration have committed to using the

measure for reporting as soon as feasible. Studies link hospice admission to higher family-reported quality of end-of-life care, alleviation of anxiety and depression, and death in the decedent's preferred location. The Committee agreed the performance data from the QOPI® registry (mean in 2015=17.9%, standard deviation=14.5%), indicated substantial room for improvement. The Committee questioned the use of claims data for identifying cancer deaths, but the developer clarified that registry data are used for identifying cancer deaths, while claims or QOPI® data are used to identify hospice admissions. Although the MAP requested the Standing Committee consider a longer timeframe (e.g., 7 days) for this measure, the Committee noted the substantial variation in performance for the measure and agreed that very short hospice stays remain a concern. The Standing Committee therefore did not recommend changing the timeframe for the measure at this time.

#### **1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated (RAND Corporation): RECOMMENDED**

**Description:** Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated;

**Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Hospital/Acute Care Facility; **Data**

**Source:** Paper Medical Records

An ICD is an implanted device that uses electrical pulses or shocks to help control irregular heartbeats that are life-threatening. The Committee agreed that continued operation of an ICD in terminally ill patients should be considered a "never event", given the suffering experienced by the patient and family due to repeated shocks during the terminal decline. Initially endorsed in 2012, this appropriateness of care measure is not currently in use. Several consensus statements, systematic reviews, and other studies support ICD deactivation in terminal patients. Because the measure is not in use, current performance data are limited. However, data from 2005-2006 indicates that only 25% of decedents with an ICD had it deactivated and Committee members noted that in their experience, there is still opportunity for improvement. Committee members strongly encouraged the developer to continue to pursue opportunities for inclusion in accountability programs, and to generally encourage wider use of the measure.

#### **2651 CAHPS® Hospice Survey (experience with care) (Centers for Medicare and Medicaid Services): 7 measures RECOMMENDED; 1 measure categorized as "CONSENSUS NOT REACHED"**

**Description:** survey is intended to measure the experiences of hospice patients and their primary caregivers. The measure proposed here includes the following six multi-item measures (1) Hospice team communication; (2) Getting timely care; (3) Treating family member with respect; (4) Getting emotional and religious support; (5) Getting help for symptoms; and (6) Getting hospice training. In addition, there are two other measures, also called, "global ratings": (1) Rating of the hospice care and (2) Willingness to recommend the hospice; **Measure Type:** PRO; **Level of Analysis:** Facility; **Setting of Care:** Hospice;

**Data Source:** Patient Reported Data/Survey

Stakeholders agree that assessment of patient and family experience with care should be a focus for measurement of person-centered care. The eight new PRO-PMs obtained through the Hospice CAHPS® survey assess patient and family caregiver experiences of hospice care in several domains, including



communication, respect, symptom management, emotional and religious support, and timeliness of care. These eight PRO-PMs are included in the Hospice Quality Reporting Program, with public reporting of the measures to begin in 2017. Hospice agencies with <50 decedents per year are not required to report the measures. Many processes and structures of care (e.g., timely visits, symptom assessment and treatment, provision of information and training) can affect the measured outcomes, and focus groups with both patients and caregivers indicate that both perceive the covered domains as important and meaningful facets of high-quality hospice care. Average scores for the measures for the second quarter of 2015 ranged from 72.7% for the hospice care training measure to 91.8% for the emotional and religious support measure, and the Committee agreed that there is opportunity for improvement for all eight PRO-PMs. The Committee found the reliability testing acceptable for seven of the eight measures. However, because the reliability estimate for the *“Treating family member with respect”* measure was somewhat lower than for most of the other measures, the Committee could not reach consensus regarding reliability for this measure. All eight of the PRO-PMs are adjusted for mode of administration and case-mix adjusted for nine factors including decedent and respondent age group, payer, primary diagnosis, respondent education, and respondent language. The Committee noted that smaller hospice agencies may not have the resources or infrastructure to support implementation of the survey but agreed that the measure is feasible for the majority of hospice agencies. Some Committee members were concerned that receipt of the survey upon which these measures are based might upset family members, an unintended consequence of the measure; however, the Committee agreed the benefits incurred by the use of these measures outweighs this potential risk, particularly if a hospice agency provides bereavement support to individuals who report being upset by the survey.

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## Appendix A: Details of Measure Evaluation

**Rating Scale:** H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

### Measures Recommended

#### *Physical aspects of care (pain)*

<b>1634 Hospice and Palliative Care -- Pain Screening</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.</p> <p><b>Numerator Statement:</b> Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.</p> <p><b>Denominator Statement:</b> Patients enrolled in hospice OR patients receiving specialty palliative care in an acute hospital setting.</p> <p><b>Exclusions:</b> Patients with length of stay &lt; 1 day in palliative care.</p> <p><b>Adjustment/Stratification:</b></p> <p><b>Level of Analysis:</b> Facility, Clinician : Group/Practice</p> <p><b>Setting of Care:</b> Hospice, Hospital/Acute Care Facility</p> <p><b>Type of Measure:</b> Process</p> <p><b>Data Source:</b> Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record</p> <p><b>Measure Steward:</b> University of North Carolina–Chapel Hill</p>
<p><b>STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]</b></p> <p><b>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u></b> (1a. Evidence, 1b. Performance Gap)</p> <p>1a. Evidence: <b>H-2; M-2; L-0; I-19;</b> 1b. Performance Gap: <b>H-1; M-19; L-2; I-1;</b></p> <p>Evidence Exception: <b>Y-23; N-0</b></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>For the 2012 endorsement evaluation, the developers cited individual studies, systematic reviews, and clinical practice guidelines to support the effectiveness of medical treatment for pain, the effectiveness of expert pain assessment and specialty care teams to improve pain, and the importance of screening, assessing, and treating pain in seriously and terminally ill patient populations. For the most part, this evidence was tangential to the measure focus. The exception was the American Pain Society (APS) guidelines recommendation that all patients should be routinely screened for pain, and when present, pain intensity should be recorded; however, this guideline was not graded and the evidence for screening was not provided.</li> <li>For the current evaluation, the developer updated the evidence by referencing a 2011 British Columbia Medical Services Commission guideline calling for the assessment of pain using the OPQRSTUV mnemonic (onset, provoking, quality, region, severity, treatment, understanding, values), and a 2013 Institute for Clinical Systems Improvement (ICSI) guideline on palliative care for adults recommending inclusion of physical aspects into the palliative care plan</li> <li>One Committee member referenced a study not provided by the developer that found as the severity of pain increased, based on the Edmonton Symptom Assessment Scale, pain-related actions such as referrals, treatments, or prescriptions also increased (Seow, et al., 2012). While other Committee members found this information compelling, they were reluctant to accept it at face value without an opportunity to review. Instead, the Committee noted that screening is required prior to treatment and agreed that empirical evidence is not needed to hold providers accountable for the measure.</li> </ul>

## 1634 Hospice and Palliative Care -- Pain Screening

Therefore, the Committee agreed to invoke the exception to the evidence subcriterion.

- Facility-level data presented by the developer from the FY15 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average hospice facility-level performance rate of 93.5%. Additional data presented by the developer indicate slight, yet statistically significant, disparities in care between genders and between socioeconomic subgroups.
- Developers did not provide clinician-level performance data for palliative care in the hospital setting. However, they noted that the measure is being used in a variety of palliative care settings through ongoing Center for Medicare & Medicaid Innovation (CMMI) and Palliative Care Research Cooperative projects, and indicated that clinician-level performance data will be available within the coming year.
- The Committee agreed that the measure showed clear opportunity for improvement in the hospice setting. Members also agreed that there may be room for improvement in the broader palliative care community.

### **2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-5; M-18; L-0; I-0** 2b. Validity: **H-1; M-22; L-0; I-0**

#### Rationale:

- When last endorsed, patients with a hospice stay of <7 days were excluded from the measure denominator. Developers have changed this specification and now no longer exclude any hospice patients because of length of stay (although patients with <1 day in hospital palliative care are excluded from the clinician-level measure).
- Reliability testing at the time of the 2012 endorsement evaluation was limited to an inter-rater reliability analysis based on data from 20 patients in one hospital ( $\kappa=1.0$ ). For the current evaluation, developers updated their reliability testing by providing score-level testing results for the hospice setting from two different analyses (a split-half analysis with an intra-class correlation coefficient of 0.86, and a signal-to-noise analysis with a signal-to-noise ratio of 0.97). The Committee agreed testing results showed the measure is reliable. As with the other measures submitted by this developer, the Committee strongly recommended that reliability testing for the clinician-level measure in the palliative care setting be updated and the results provided to NQF when available.
- Validity testing at the time of the 2012 endorsement evaluation included both a face validity assessment and a score-level construct validity analysis for the palliative care setting. Although face validity results from a group of nursing and physician stakeholders indicated broad endorsement of the measure, results from the construct validity analysis were inconclusive, as almost all patients were screened for pain regardless of receipt of specialty palliative care services.
- For the current evaluation, developers updated their validity testing by conducting a non-parametric Spearman rank correlation analysis between this measure and 5 other hospice quality measures. Although the magnitude of the correlations from this analysis was lower than expected, they were positive and statistically significant, confirming the developers' hypothesis that hospice agencies perform similarly on various assessment activities conducted at the time of hospice admission.
- Committee members did not express concern regarding the validity of the measure.

### **3. Feasibility: H-1; M-23; L-0; I-0**

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3d. Data collection strategy can be implemented)

#### Rationale:

- Because the issues regarding feasibility for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - The Committee noted that because data for this measure is part of the Hospice Item Set (HIS), the feasibility is high for the hospice setting. The HIS is a standardized, patient-level dataset used by CMS to collect data and calculate the seven performance measures included in the Medicare Hospice Quality Reporting Program. However, members noted that feasibility of the measure for

## 1634 Hospice and Palliative Care -- Pain Screening

other settings is unclear.

### 4. Usability and Use: H-2; M-22; L-0; I-0

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

#### Rationale:

- Because the issues regarding usability and use for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - This measure is included in the CMS Hospice Quality Reporting Program (HQRP), an accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY2015, 3,992 hospice organizations provided measure data for 1,218,786 patient stays.
  - The measure is not currently in use for clinical-level accountability in the palliative care setting.
  - Because reporting of this measure for the hospice setting began in FY2015, longitudinal data for this measure for this setting are not yet available and there is therefore no information regarding improvement.
  - The Committee did not report any unintended consequences associated with this measure.

### 5. Related and Competing Measures

- This measure competes with three measures:
  - 0383: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain [*a clinician-level process measure in ambulatory setting*]
  - 1628: Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit [*a facility-level, health plan, and integrated delivery system-level process measure in ambulatory setting*]
  - 1637: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening [*clinician-level & facility-level process measure in hospice and hospital setting*]
- This measure is related to (potentially competing with) three measures:
  - 0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment [*a facility-level PRO-PM in the hospice setting*]
  - 0384: Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified [*a clinician-level process measure in ambulatory setting*]
  - 0420: Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present [*a clinician-level process measure in ambulatory setting*]
- Because #0209 was not recommended for endorsement by this Committee during the in-person meeting, a best-in-class and harmonization discussion was not conducted.
- Due to differences in care settings for measures #0383, #0384, #0420, and #1628, the Committee was not asked to select a best-in-class measure.
- Patients identified as being in pain per this measure constitute the denominator for measure #1637. The measures are already harmonized.
- The Committee discussed the measures specified for the ambulatory care setting (#0383, #0384, #0420, 1628):
  - Members noted the narrow denominators for #1628 (stage IV cancer) and #0384 (cancer patients undergoing chemotherapy or radiation). They questioned whether a separate measure for screening and assessment is needed. They suggested that including a focus on the care plan

<b>1634 Hospice and Palliative Care -- Pain Screening</b>
is a stronger measure. They noted that #0420 is already included in the PQRS program and has a much broader denominator (i.e., not limited to cancer patients). Finally, they recommended that all of these measures be combined so as to incorporate screening, assessment, documentation, and follow-up for the broadest patient population possible, with these things occurring at each visit, not just once.
<b>Standing Committee Recommendation for Endorsement: Y-23; N-0</b>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

<b>1637 Hospice and Palliative Care -- Pain Assessment</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.</p> <p><b>Numerator Statement:</b> 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.</p> <p><b>Denominator Statement:</b> Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation / initial encounter.</p> <p><b>Exclusions:</b> Patients with length of stay &lt; 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.</p> <p><b>Adjustment/Stratification:</b></p> <p><b>Level of Analysis:</b> Facility, Clinician : Group/Practice</p> <p><b>Setting of Care:</b> Hospice, Hospital/Acute Care Facility</p> <p><b>Type of Measure:</b> Process</p> <p><b>Data Source:</b> Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record</p> <p><b>Measure Steward:</b> University of North Carolina-Chapel Hill</p>
<p><b>STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]</b></p> <p><b>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u></b> (1a. Evidence, 1b. Performance Gap)</p> <p>1a. Evidence: <b>H-0; M-0; L-0; I-23</b>; 1b. Performance Gap: <b>H-11; M-13; L-0; I-0</b>; Evidence Exception: <b>Y-24; N-0</b></p> <p><b>Rationale:</b></p> <ul style="list-style-type: none"> <li>For the 2012 endorsement evaluation, the developers cited individual studies, systematic reviews, and clinical practice guidelines to support the effectiveness of medical treatment for pain, the effectiveness of expert pain assessment and specialty care teams to improve pain, and the importance of screening, assessing, and treating pain in seriously and terminally ill patient populations. For the most part, this evidence was tangential to the measure focus. The exception was the American Pain Society (APS) guidelines recommending that all patients should be routinely screened for pain, and when present, pain intensity should be recorded; however, this guideline was not graded and the evidence for assessment was not provided.</li> <li>For the current evaluation, the developer updated the evidence by referencing a 2011 British Columbia Medical Services Commission guideline calling for the assessment of pain using the OPQRSTUV mnemonic</li> </ul>

## 1637 Hospice and Palliative Care -- Pain Assessment

(onset, provoking, quality, region, severity, treatment, understanding, values), and a 2013 Institute for Clinical Systems Improvement (ICSI) guideline on palliative care for adults recommending inclusion of physical aspects into the palliative care plan. The developer presented some additional information just prior to the in-person meeting. This included a brief summary of recommendations for pain assessment by the American College of Physicians and the Institute of Medicine, and a systematic review that some evidence that associates pain assessment with a shorter length of stay in the ICU, less time spent on mechanical ventilation, decreased pain intensity, fewer adverse events and complications, and reduced mortality. One member noted that this additional evidence was somewhat limited in terms of scope (e.g., cancer patients, critically ill patients).

- The additional evidence provided by the developer initially split the Committee's vote; after additional discussion, the Committee re-voted, unanimously agreeing that the evidence linking pain assessment to improved patient outcomes was insufficient. However, the Committee agreed that empirical evidence is not needed to hold providers accountable for the measure, and invoked the exception to the evidence subcriterion.
- Facility-level data presented by the developer from the FY15 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average hospice facility-level performance rate of 65.7%. Additional data presented by the developer indicate slight, yet statistically significant, disparities in care between geographic locations.
- Developers did not provide clinician-level performance data for palliative care in the hospital setting. However, they noted that the measure is being used in a variety of palliative care settings through ongoing Center for Medicare & Medicaid Innovation (CMMI) and Palliative Care Research Cooperative projects, and indicated that clinician-level performance data will be available within the coming year.
- The Committee agreed that the measure showed clear opportunity for improvement in the hospice setting. Members also agreed that there may be room for improvement in the broader palliative care community.

### **2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-3; M-20; L-0; I-1** 2b. Validity: **H-0; M-24; L-0; I-0**

#### Rationale:

- When last endorsed, patients with a hospice stay of <7 days were excluded from the measure denominator. Developers have changed this specification and now no longer exclude any hospice patients because of length of stay (although patients with <1 day in hospital palliative care are excluded from the clinician-level measure).
- Reliability testing at the time of the 2012 endorsement evaluation was limited to an inter-rater reliability analysis based on data from 20 patients in one hospital ( $\kappa=0.94$ ). For the current evaluation, developers updated their reliability testing by providing score-level testing results for the hospice setting from two different analyses (a split-half analysis with an intra-class correlation coefficient of 0.91, and a signal-to-noise analysis with a signal-to-noise ratio of 0.98). The Committee agreed testing results showed the measure is reliable. As with the other measures submitted by the developer of this measure, the Committee strongly recommended that reliability testing for the clinician-level measure in the palliative care setting be updated and the results provided to NQF when available.
- Validity testing at the time of the 2012 endorsement evaluation included both a face validity assessment and a score-level construct validity analysis for the palliative care setting. Results from the empirical analysis indicated that clinical assessments of pain were statistically significantly different for seriously ill patients seen in specialty interdisciplinary palliative care consultations (67%) compared to those who did not receive these services (42%). These results confirmed the developers' hypothesis that a formal palliative care intervention would result in more frequent treatment of pain.
- For the current evaluation, developers updated their validity testing by conducting a non-parametric Spearman rank correlation analysis between this measure and 5 other hospice quality measures. Although the magnitude of the correlations from this analysis was lower than expected, they were positive and statistically significant, confirming the developers' hypothesis that hospice agencies perform



## 1637 Hospice and Palliative Care -- Pain Assessment

similarly on various assessment activities conducted at the time of hospice admission.

- Committee members did not express concern regarding the validity of the measure.

### 3. Feasibility: H-1; M-23; L-0; I-0

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

#### Rationale:

- Because the issues regarding feasibility for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - The Committee noted that because data for this measure is part of the Hospice Item Set (HIS), the feasibility is high for the hospice setting. The HIS is a standardized, patient-level dataset used by CMS to collect data and calculate the seven performance measures included in the Medicare Hospice Quality Reporting Program. However, members noted that feasibility of the measure for other settings is unclear.

### 4. Usability and Use: H-2; M-22; L-0; I-0

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

#### Rationale:

- Because the issues regarding usability and use for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - This measure is included in the CMS Hospice Quality Reporting Program (HQRP), an accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY2015, 3,992 hospice organizations provided measure data for 1,218,786 patient stays.
  - The measure is not currently in use for clinical-level accountability in the palliative care setting.
  - Because reporting of this measure for the hospice setting began in FY2015, longitudinal data for this measure for this setting are not yet available and there is therefore no information regarding improvement.
  - The Committee did not report any unintended consequences associated with this measure.

### 5. Related and Competing Measures

- This measure competes with three measures:
  - 0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology. Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain [*a clinician-level process measure in ambulatory setting*]
  - 1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits. Description: Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit [*a facility-level, health plan, and integrated delivery system-level process measure in ambulatory setting*]
  - 1634: Hospice and Palliative Care -- Pain Screening. Description: Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter. [*clinician-level & facility-level process measure in hospice and hospital setting*]
- This measure is related to (potentially competing with) three measures:
  - 0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment [*a facility-level PRO-PM in the hospice setting*]
  - 0384: Oncology: Medical and Radiation - Pain Intensity Quantified. Description: Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified [*a clinician-level process measure in ambulatory setting*]

### 1637 Hospice and Palliative Care -- Pain Assessment

- 0420: Pain Assessment and Follow-Up. Description: Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present [*a clinician-level process measure in ambulatory setting*]
- Because #0209 was not recommended for endorsement by this Committee during the in-person meeting, a best-in-class and harmonization discussion was not conducted.
- Due to differences in care settings for measures #0383, #0384, #0420, and #1628, the Committee was not asked to select a best-in-class measure.
- Patients identified as being in pain per measure #1634 constitute the denominator for this measure #. The measures are already harmonized.
- The Committee discussed the measures specified for the ambulatory care setting (#0383, #0384, #0420, 1628):
  - Members noted the narrow denominators for #1628 (stage IV cancer) and #0384 (cancer patients undergoing chemotherapy or radiation). They questioned whether a separate measure for screening and assessment is needed. They suggested that including a focus on the care plan is a stronger measure. They noted that #0420 is already included in the PQRS program and has a much broader denominator (i.e., not limited to cancer patients). Finally, they recommended that all of these measures be combined so as to incorporate screening, assessment, documentation, and follow-up for the broadest patient population possible, with these things occurring at each visit, not just once.

**Standing Committee Recommendation for Endorsement: Y-24; N-0**

**6. Public and Member Comment**

**7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X**

**8. Board of Directors Vote: Y-X; N-X**

**9. Appeals**

### 1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits

[Submission](#) | [Specifications](#)

**Description:** Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit

**Numerator Statement:** Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool

**Denominator Statement:** Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit

**Exclusions:** None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)

**Adjustment/Stratification:**

**Level of Analysis:** Facility, Health Plan, Integrated Delivery System

**Setting of Care:** Ambulatory Care : Clinician Office/Clinic

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Registry

**Measure Steward:** RAND Corporation

**STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]**

**1. Importance to Measure and Report: The measure meets the Importance criteria**

## 1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-2; L-0; I-21**; 1b. Performance Gap: **H-0; M-15; L-2; I-7**

Evidence Exception: **Y-24; N-0**

### Rationale:

- For the 2012 endorsement evaluation, the developers cited non-graded systematic reviews pertaining to cancer pain management that underscored the importance of pain screening, although they did not link screening for pain to improved patient outcomes. The developer did not provide updated evidence for the current evaluation.
- As with the other pain screening and assessment measures (#1634 and #1637, respectively), the Committee agreed that there is no empirical evidence linking screening for pain to improved patient outcomes. Because the Committee acknowledged the importance of pain management in patients with cancer, members agreed that empirical evidence is not needed to hold providers accountable for the measure and therefore invoked the exception to the evidence subcriterion.
- The developers provided performance data from four individual studies, with measure results ranging from 37% to 79%. However, these results were based on data that are more than five years old, and no current data on performance were provided. One Committee member referenced a 2014 study from the Veteran's Administration (VA) that found a 98% performance on the measure, raising the possibility the measure may be topped out, at least in VA outpatient clinics.

## **2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2; M-19; L-2; I-1** 2b. Validity: **H-0; M-20; L-3; I-1**

### Rationale:

- The numerator for this measure requires screening with a standardized tool, although if pain is present, the severity of pain also should be noted (an activity that also may be thought of as "assessment" for pain).
- Some Committee members questioned whether the measure denominator, which is limited to persons with Stage IV cancer, is too narrow, particularly given that patients who do not survive at least 30 days post-diagnosis are excluded from the measure.
- Members noted that the developers did not provide information on how many patients were excluded from the measure (due to the 30-day survival requirement), so it isn't clear whether this exclusion is needed. However, the Committee did not think this exclusion threatens the validity of the measure.
- For the 2012 endorsement evaluation, the developers cited one reliability study that found a kappa value of 0.87 for the denominator and 0.86 for the numerator (the actual methodology was not described). The developers did not provide updated reliability testing. After considering these results, Committee members voiced no concerns regarding the reliability of the measure.
- For the 2012 endorsement evaluation, developers referenced two face validity assessment of the measure by the ASSIST and ACOVE expert panels. The modified Delphi method was used for these assessments. The developers did not conduct updated validity testing for the current evaluation.
- While the Committee recognized face validity as a weaker form of validity testing than empirical testing, members agreed that the testing meets NQF's requirements for validity testing.

## **3. Feasibility: H-2; M-22; L-0; I-0**

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)

### Rationale:

- The Committee did not note any concerns regarding feasibility, acknowledging that some data elements used to construct this measure are available in electronic sources.

## **4. Usability and Use: H-0; M-9; L-15; I-0**

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c.

## 1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits

*Benefits outweigh evidence of unintended consequences)*

### Rationale:

- This measure is not currently in use, even though it was conditionally supported by the MAP in 2014 for inclusion in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program.
- One Committee member suggested that because this measure is limited to those with stage IV cancer only, providers might not screen other cancer patients for pain, a potential unintended consequence.
- When questioned as to why this measure is not being used, the developers hypothesized that there is a perception that pain is being assessed in advanced cancer patients; they also noted an emphasis in the primary care setting in reducing opioid use. Committee members encouraged the developer to continue to pursue opportunities for use of this measure.

### **5. Related and Competing Measures**

- This measure competes with three measures:
  - 0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology. Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain [*a clinician-level process measure in ambulatory setting*]
  - 1634: Hospice and Palliative Care -- Pain Screening [*a clinician-level & facility-level process measure in hospice and hospital setting*]
  - 1637: Hospice and Palliative Care -- Pain Assessment. Description: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening [*clinician-level & facility-level process measure in hospice and hospital setting*]
- This measure is related to (potentially competing with) three measures:
  - 0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment [*a facility-level PRO-PM in the hospice setting*]
  - 0384: Oncology: Medical and Radiation - Pain Intensity Quantified. Description: Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified [*a clinician-level process measure in ambulatory setting*]
  - 0420: Pain Assessment and Follow-Up. Description: Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present [*a clinician-level process measure in ambulatory setting*]
- Because #0209 was not recommended for endorsement by this Committee during the in-person meeting, a best-in-class and harmonization discussion was not conducted.
- Due to differences in care settings for measures #0383, #0384, #0420, and #1628, the Committee was not asked to select a best-in-class measure.
- Patients identified as being in pain per this measure constitute the denominator for measure #1637. The measures are already harmonized.
- The Committee discussed the measures specified for the ambulatory care setting (#0383, #0384, #0420, 1628):
  - Members noted the narrow denominators for #1628 (stage IV cancer) and #0384 (cancer patients undergoing chemotherapy or radiation). They questioned whether a separate measure for screening and assessment is needed. They suggested that including a focus on the care plan is a stronger measure. They noted that #0420 is already included in the PQRS program and has a much broader denominator (i.e., not limited to cancer patients). Finally, they recommended that all of these measures be combined so as to incorporate screening, assessment, documentation, and follow-up for the broadest patient population possible, with each occurring at each visit, not just once.

<b>1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits</b>
<b>Standing Committee Recommendation for Endorsement: Y-24; N-0</b>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

*Physical aspects of care (dyspnea)*

<b>1638 Hospice and Palliative Care -- Dyspnea Treatment</b>
*Paired with #1639: Hospice and Palliative Care - Dyspnea Screening
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.</p> <p><b>Numerator Statement:</b> Patients who screened positive for dyspnea who received treatment within 24 hours of screening.</p> <p><b>Denominator Statement:</b> Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.</p> <p><b>Exclusions:</b> Patients with length of stay &lt; 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.</p> <p><b>Adjustment/Stratification:</b></p> <p><b>Level of Analysis:</b> Facility, Clinician : Group/Practice</p> <p><b>Setting of Care:</b> Hospice, Hospital/Acute Care Facility</p> <p><b>Type of Measure:</b> Process</p> <p><b>Data Source:</b> Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record</p> <p><b>Measure Steward:</b> University of North Carolina-Chapel Hill</p>
<b>STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]</b>
<b>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u></b>
(1a. Evidence, 1b. Performance Gap)
1a. Evidence: <b>Previous Evidence Evaluation Accepted</b> ; 1b. Performance Gap: <b>H-3; M-18; L-1; I-0</b>
<b>Rationale:</b>
<ul style="list-style-type: none"> <li>For the 2012 endorsement evaluation, the developers summarized systematic reviews of studies supporting the use of coping or relaxation interventions, as well as opioids (for breathlessness), beta agonists (for COPD patients), and oxygen (for hypoxic patients). For the current evaluation, the developer updated the evidence by referencing a 2011 British Columbia Medical Services Commission guideline for palliative care for patients with incurable cancer or advanced disease that recommends both pharmacological and non-pharmacological treatment options for dyspnea, and a 2013 Institute for Clinical Systems Improvement (ICSI) guideline on palliative care for adults that recommends addressing physical aspects of care.</li> <li>The Committee agreed that the updated evidence appears to be directionally the same since the last NQF endorsement evaluation. The Committee accepted the prior evaluation of this criterion without further discussion.</li> <li>Facility-level data presented by the developer from the FY15 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average hospice facility-level performance rate of 93.3%. Additional data presented by the developer indicate possible disparities in care for non-white and lower-income hospice patients.</li> </ul>

## 1638 Hospice and Palliative Care -- Dyspnea Treatment

\*Paired with #1639: Hospice and Palliative Care - Dyspnea Screening

- Developers did not provide clinician-level performance data for palliative care in the hospital setting. However, they noted that the measure is being used in a variety of palliative care settings through ongoing Center for Medicare & Medicaid Innovation (CMMI) and Palliative Care Research Cooperative projects, and indicated that clinician-level performance data will be available within the coming year.
- The Committee acknowledged the relatively high performance in most hospices but noted an opportunity for improvement for some. Members also agreed that there is likely still room for improvement in the broader palliative care community, even though clinician-level performance results are not yet available.

### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-20; L-2; I-0** 2b. Validity: **H-1; M-23; L-0; I-0**

#### Rationale:

- When last endorsed, patients with a hospice stay of <7 days were excluded from the measure denominator. Developers have changed this specification and now no longer exclude any hospice patients because of length of stay (although patients with <1 day in hospital palliative care are excluded from the clinician-level measure).
- Because implementation instructions for the HIS use the term "initiate" in reference to treatment, Committee members questioned whether continuation of treatment would meet the measure. The developer clarified that the measure specifies receipt of treatment, which would encompass both initiation and continuation or modification of treatment. Committee members recommended that the HIS instructions be clarified to match the specifications of the measure.
- One member questioned whether treatment should be initiated when the score on the dyspnea screening is very low. The developers acknowledged that there is not a clear threshold for initiation of dyspnea treatment and therefore constructed the measure to assess whether providers address any patient who screened as being short of breath. They also noted that treatment, as specified in the measure, does not have to include medication therapy. Committee members noted that some patients who report being short of breath prefer not to be treated.
- Reliability testing at the time of the 2012 endorsement evaluation was limited to an inter-rater reliability analysis based on data from 20 patients in one hospital ( $\kappa=0.89$ ). For the current evaluation, developers updated their reliability testing by providing score-level testing results for the hospice setting from two different analyses (a split-half analysis with an intra-class correlation coefficient of 0.86, and a signal-to-noise analysis with a signal-to-noise ratio of 0.96).
- The Committee voiced no concerns regarding reliability for the hospice setting. However, members acknowledged the limited scope of testing for the palliative care setting and noted uncertainty around the ability to consistently identify patients for the denominator. The Committee strongly recommended that the developer update reliability testing for the clinician-level measure in the palliative care setting and provide those results to NQF when available.
- Validity testing at the time of the 2012 endorsement evaluation included both a face validity assessment and a score-level construct validity analysis for the palliative care setting. Results from this analysis indicated that treatment for dyspnea was not statistically significantly different for seriously ill patients seen in specialty interdisciplinary palliative care consultations (96%) compared to those who did not receive these services (93%). These results only partially confirmed the developers' hypothesis that a formal palliative care intervention would result in more frequent treatment of dyspnea.
- For the current evaluation, developers updated their validity testing by conducting a non-parametric Spearman rank correlation analysis between this measure and 5 other hospice quality measures. Although the magnitude of the correlations from this analysis was lower than expected, they were positive and statistically significant, confirming the developers' hypothesis that hospice agencies perform similarly on various assessment activities conducted at the time of hospice admission. The Committee voiced no concerns regarding the validity testing results.
- Committee members questioned whether removal of the <7 day length of stay exclusion for the hospice setting might disadvantage agencies who tend to get referrals late in the day. The developers noted that

<b>1638 Hospice and Palliative Care -- Dyspnea Treatment</b>
*Paired with #1639: Hospice and Palliative Care - Dyspnea Screening
their exclusion analysis indicated that this likely would not be a problem, as most hospices are able to treat dyspnea within the 24-hour period required by the measure.
<p><b>3. Feasibility: H-1; M-23; L-0; I-0</b>  <i>(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3d. Data collection strategy can be implemented)</i></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>The Committee noted that because data for this measure is part of the Hospice Item Set (HIS), the feasibility is high for the hospice setting. The HIS is a standardized, patient-level dataset used by CMS to collect data and calculate the seven performance measures included in the Medicare Hospice Quality Reporting Program. However, members noted that feasibility of the measure for other settings is unclear.</li> </ul>
<p><b>4. Usability and Use: H-2; M-22; L-0; I-0</b>  <i>(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)</i></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>This measure is included in the CMS Hospice Quality Reporting Program (HQRP), an accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY2015, 3,992 hospice organizations provided measure data for 1,218,786 patient stays.</li> <li>The measure is not currently in use for clinical-level accountability in the palliative care setting.</li> <li>Because reporting of this measure for the hospice setting began in FY2015, longitudinal data for this measure for this setting are not yet available and there is therefore no information regarding improvement.</li> <li>The Committee did not report any unintended consequences associated with this measure.</li> </ul>
<p><b>5. Related and Competing Measures</b></p> <ul style="list-style-type: none"> <li>This measure is related to two measures: <ul style="list-style-type: none"> <li>0179: Improvement in dyspnea. Description: Percentage of home health episodes of care during which the patient became less short of breath or dyspneic</li> <li>1639: Hospice and Palliative Care – Dyspnea Screening. Description: Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter</li> </ul> </li> <li>Measure #0179 is an outcome measure used in the home health setting, and as such, there are no harmonization issues.</li> <li>Measure #1639 is paired with this measure. Patients identified as having shortness of breath in measure #1639 constitute the denominator for this measure (#1638).</li> </ul>
<b>Standing Committee Recommendation for Endorsement: Y-21; N-2</b>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

*Physical aspects of care (constipation)*

<b>1617 Patients Treated with an Opioid who are Given a Bowel Regimen</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<b>Description:</b> Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen

## 1617 Patients Treated with an Opioid who are Given a Bowel Regimen

or documentation of why this was not needed

**Numerator Statement:** Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed

**Denominator Statement:** Vulnerable adults who are given a prescription for an opioid

**Exclusions:** Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription

**Adjustment/Stratification:**

**Level of Analysis:** Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual

**Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility

**Type of Measure:** Process

**Data Source:** Paper Medical Records

**Measure Steward:** RAND Corporation/UCLA

### STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]

#### 1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-2; M-15; L-2; I-5**

Rationale:

- For the 2012 endorsement evaluation, the developers provided two clinical practice guideline recommendations for prescribing a bowel regimen (i.e., offer or prescription of a laxative, stool softener, or high-fiber supplement or diet within 24 hours of opioid prescription) when treating patients with an opioid; these recommendations were supported by moderate to strong evidence. A bowel regimen is needed because opioids cause constipation.
- The Committee agreed that there has been no new evidence and accepted the prior evaluation of this criterion without further discussion.
- For the current evaluation, the developers provided performance data from two individual studies using data from 2007-2010. Performance results from these studies ranged from 44% to 71% (Hanson, et al, 2012; Walling, et al, 2013). Although this measure is collected through the Hospice Item Set for the CMS Hospital Quality Reporting Program, the developer did not have access to these more current data.
- The Committee acknowledged that the performance data reported by the developer was somewhat old, but for the most part agreed that there is still an opportunity for improvement for this measure.

#### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-18; L-4; I-2** 2b. Validity: **H-0; M-17; L-3; I-4**

Rationale:

- Committee members expressed concerns that limiting the denominator of the measure to "vulnerable adults" as defined in the specifications (i.e., age 75 or older; score >2 on the Vulnerable Elder Survey-13, life expectancy <6 months, Stage IV cancer, receiving hospice care) would not capture important patient populations, such as those with acute respiratory failure. Committee members recommended broadening the denominator to include all palliative care and cancer patients.
- The developers clarified that non-hospice outpatients already taking an opioid at the time of measurement were excluded from the measure because they may not have needed a bowel regimen, having already been prescribed one.
- Some members expressed concern that those whose cancer had progressed to stage IV might inadvertently be excluded from the measure if they had not been formally re-staged. The developers clarified that the guidance for the measure does not rely on the term "stage IV" but instead uses various synonyms (e.g., metastatic) to identify patients with stage IV cancer.
- When questioned about the difficulty in abstracting the elements needed to define the denominator, the developers clarified that patients meeting any one of these criteria would be included in the



## 1617 Patients Treated with an Opioid who are Given a Bowel Regimen

denominator. They noted that in their testing of the measure, there is usually specific language in the medical record that identifies those with stage IV cancer or with a poor prognosis/terminal illness. They also stated that the Vulnerable Elder Survey-13 is used fairly widely, although they acknowledged that it is not available uniformly.

- For the 2012 endorsement evaluation, the developers provided inter-rate reliability statistics from three studies in which the kappa value for the denominator was 0.87 and the kappa value for the numerator was 0.64 to 0.86, indicating acceptable agreement. The developers did not provide updated reliability testing. Because there was concern among some members about consistently identifying the patients eligible for the denominator, the Committee wanted to vote on the measure rather than accept the prior Committee's evaluation of this criterion.
- For the 2012 endorsement evaluation, developers referenced four face validity assessments of the measure by expert panels. The modified Delphi method was used for these assessments. The developers did not conduct updated validity testing for the current evaluation.

### 3. Feasibility: H-0; M-24; L-0; I-0

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

#### Rationale:

- Although the measure is specified for paper medical records, the Committee suggested that the measure likely could be extracted from electronic medical records. The developers agreed, although they noted that identifying the exclusions in the EHR might be difficult as several of those data elements likely are not in structured data fields.

### 4. Usability and Use: H-3; M-20; L-1; I-0

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

#### Rationale:

- This measure is included in the CMS Hospice Quality Reporting Program (HQRP), an accountability program in which hospice providers are penalized financially if results are not reported to CMS.
- Longitudinal data for this measure are not yet available and there is therefore no information regarding improvement.
- Committee members did not report any awareness of unintended consequences of the measure.

### 5. Related and Competing Measures

- The definition of “vulnerable adults” is harmonized with measure #1626.

### Standing Committee Recommendation for Endorsement: Y-24; N-0

### 6. Public and Member Comment

### 7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

### 8. Board of Directors Vote: Y-X; N-X

### 9. Appeals

## *Spiritual, religious, and existential aspects of care*

### 1647 Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.

#### [Submission](#) | [Specifications](#)

**Description:** This measure reflects the 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.

**Numerator Statement:** Patients whose medical record includes documentation that the patient and/or caregiver

**1647 Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.**

was asked about spiritual/existential concerns within 5 days of the admission date.

**Denominator Statement:** Seriously ill patients 18 years of age or older enrolled in hospice.

**Exclusions:** Testing has only been done with the adult population; thus patients younger than 18 are excluded.

**Adjustment/Stratification:**

**Level of Analysis:** Facility

**Setting of Care:** Hospice

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

**Measure Steward:** University of North Carolina-Chapel Hill

**STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]**

**1. Importance to Measure and Report: The measure meets the Importance criteria**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-8; L-0; I-14**; 1b. Performance Gap: **H-0; M-23; L-0; I-0**

Evidence Exception: **Y-22; N-1**

Rationale:

- For the 2012 endorsement evaluation, the developers noted that no formal studies of this care process exist. However, the developer cited a National Consensus Project guideline and an NQF-endorsed Preferred Practice as evidence for the measure. A non-published study presented to the 2012 Steering Committee showed that patients whose records documented a conversation of their spiritual or religious concerns demonstrated improvement in overall spiritual distress, as opposed to those whose records did not document this conversation. For the current evaluation, the developer updated the evidence by referencing a 2013 Institute for Clinical Systems Improvement (ICSI) guideline on palliative care for adults that states that “A spiritual assessment should be an integral part of the palliative care plan.”
- The Committee agreed that based on expert opinion presented and other research, the care process measured is important, desired by patients and their family members, and may result in decreased spiritual distress, thereby warranting an exception to the evidence criteria.
- Facility-level data presented by the developer from the FY15 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average hospice facility-level performance rate of 92.2%. Additional data presented by the developer indicate statistically significant disparities in care between certain racial, socioeconomic, and geographic subgroups.
- The Committee agreed that the measure performance reflected a significant opportunity for improvement. One Committee member noted other settings of care for which this measure is not specified, such as acute care and outpatient settings, show a still greater opportunity for improvement.

**2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-12; M-11; L-0; I-0** 2b. Validity: **H-0; M-21; L-0; I-2**

Rationale:

- For the 2012 endorsement evaluation, developers conducted data element validity testing but no additional reliability testing for the facility level of analysis. For the current evaluation, developers updated their reliability testing by providing score-level testing results for the hospice setting from two different analyses (a split-half analysis with an intra-class correlation coefficient of 0.94, and a signal-to-noise analysis with a signal-to-noise ratio of 0.99). The Committee voiced no concerns regarding the reliability of the measure.
- Validity testing at the time of the 2012 endorsement evaluation compared agency-abstracted data to that abstracted by a research study abstractor (the gold standard), yielding a kappa value of 0.795 and indicating acceptable agreement.

**1647 Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.**

- For the current evaluation, developers updated their validity testing by conducting a non-parametric Spearman rank correlation analysis between this measure and 5 other hospice quality measures. The developer clarified that the “modification” of the measure for testing allows 5-day allowance for the initial comprehensive assessment, as implemented by CMS for the Hospice Item Set (HIS). The developers noted that this is consistent with the measure specifications that require discussion of spiritual/existential concerns within 5 days of the admission date. Although the magnitude of the correlations from this analysis was lower than expected, they were positive and statistically significant, confirming the developers' hypothesis that hospice agencies perform similarly on various assessment activities conducted at the time of hospice admission.
- Committee members did not express concern regarding the validity of the measure.

**3. Feasibility: H-1; M-23; L-0; I-0**

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3d. Data collection strategy can be implemented)*

Rationale:

- Because the issues regarding feasibility for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - The Committee noted that because data for this measure is part of the Hospice Item Set (HIS), the feasibility is high for the hospice setting. The HIS is a standardized, patient-level dataset used by CMS to collect data and calculate the seven performance measures included in the Medicare Hospice Quality Reporting Program.

**4. Usability and Use: H-2; M-22; L-0; I-0**

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

Rationale:

- Because the issues regarding usability and use for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - This measure is included in the CMS Hospice Quality Reporting Program (HQRP), an accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY2015, 3,992 hospice organizations provided measure data for 1,218,786 patient stays.
  - Because reporting of this measure for the hospice setting began in FY2015, longitudinal data for this measure for this setting are not yet available and there is therefore no information regarding improvement.
  - The Committee did not report awareness of unintended consequences associated with this measure.

**5. Related and Competing Measures**

- No related or competing measures noted.

**Standing Committee Recommendation for Endorsement: Y-22; N-1**

**6. Public and Member Comment**

**7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X**

**8. Board of Directors Vote: Y-X; N-X**

**9. Appeals**

<b>1641 Hospice and Palliative Care – Treatment Preferences</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> Percentage of patients with chart documentation of preferences for life sustaining treatments.</p> <p><b>Numerator Statement:</b> Patients whose medical record includes documentation of life sustaining preferences</p> <p><b>Denominator Statement:</b> Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.</p> <p><b>Exclusions:</b> Patients with length of stay &lt; 1 day in hospice or palliative care</p> <p><b>Adjustment/Stratification:</b></p> <p><b>Level of Analysis:</b> Facility, Clinician : Group/Practice</p> <p><b>Setting of Care:</b> Hospice, Hospital/Acute Care Facility</p> <p><b>Type of Measure:</b> Process</p> <p><b>Data Source:</b> Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record</p> <p><b>Measure Steward:</b> University of North Carolina-Chapel Hill</p>
<p><b>STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]</b></p> <p><b>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u></b> (1a. Evidence, 1b. Performance Gap)</p> <p>1a. <b>Previous Evidence Evaluation Accepted</b> 1b. Performance Gap: <b>H-2; M-18; L-2; I-0;</b></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>For the 2012 endorsement evaluation, the developers cited individual studies and systematic reviews that support the link between high-quality communication and reduced ICU utilization, family distress, and use of intensive treatments. However, the studies did not directly examine the link between <i>documentation</i> of care preferences and patient or family outcomes. For the current evaluation, the developer updated the evidence by referencing a 2014 Michigan Quality Improvement Consortium guideline calling for the incorporation of the patient’s treatment preferences and choices into the Treatment Preferences portion of the Advance Directive, and a 2013 Institute for Clinical Systems Improvement (ICSI) guideline on palliative care for adults that recommends facilitating advance care planning along with regular review as for all adult patients and their families, as well as engaging in shared decision-making.</li> <li>The Committee agreed that the updated evidence appears to be directionally the same since the last NQF endorsement evaluation. The Committee accepted the prior evaluation of this criterion without further discussion.</li> <li>Facility-level data presented by the developer from the FY15 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average hospice facility-level performance rate of 98.0%. Additional data presented by the developer indicate slight, yet statistically significant, disparities in care between certain racial, socioeconomic, and geographic subgroups.</li> <li>Developers did not provide clinician-level performance data for palliative care in the hospital setting. However, they noted that the measure is being used in a variety of palliative care settings through ongoing Center for Medicare &amp; Medicaid Innovation (CMMI) and Palliative Care Research Cooperative projects, and indicated that clinician-level performance data will be available within the coming year. The Committee agreed that there may be limited opportunity for further improvements in performance for the hospice setting, although members noted the possibility of disparities in care for this setting. Members also agreed that there may be room for improvement in the broader palliative care community.</li> </ul>
<p><b>2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u></b> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)</p> <p>2a. Reliability: <b>H-2; M-20; L-0; I-0</b> 2b. Validity: <b>H-0; M-22; L-0; I-0</b></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>When last endorsed, patients with a hospice stay of &lt;7 days were excluded from the measure</li> </ul>

## 1641 Hospice and Palliative Care – Treatment Preferences

denominator. Developers have changed this specification and now no longer exclude any hospice patients because of length of stay (although patients with <1 day in hospital palliative care are excluded from the clinician-level measure).

- When questioned by the Committee, the developers clarified that the measure requires evidence of a discussion with the patient (or with the surrogate decision-maker if the patient has lost decisional capacity) and that simply having the preferences included in the patient record (e.g., via a living will or a Do-Not-Resuscitate order) is not sufficient to meet the quality measure. One member noted that the numerator requirements are well-described in the Hospice Item Set manual. Reliability testing at the time of the 2012 endorsement evaluation was limited to an inter-rater reliability analysis based on data from 20 patients in one hospital ( $\kappa=1.0$ ). For the current evaluation, developers updated their reliability testing by providing score-level testing results for the hospice setting from two different analyses (a split-half analysis with an intra-class correlation coefficient of 0.91, and a signal-to-noise analysis with a signal-to-noise ratio of 0.98). The Committee voiced no concerns regarding reliability for the hospice setting. As with the other measures submitted by this developer, the Committee strongly recommended that reliability testing for the clinician-level measure in the palliative care setting be updated and the results provided to NQF when available.
- Validity testing at the time of the 2012 endorsement evaluation included both a face validity assessment and a score-level construct validity analysis for the palliative care setting. Results from this analysis indicated documenting treatment preferences was statistically significantly different for seriously ill patients seen in specialty interdisciplinary palliative care consultations (91%) compared to those who did not receive these services (59%).
- For the current evaluation, developers updated their validity testing by conducting a non-parametric Spearman rank correlation analysis between this measure and 5 other hospice quality measures. Although the magnitude of the correlations from this analysis was lower than expected, they were positive and statistically significant, confirming the developers' hypothesis that hospice agencies perform similarly on various assessment activities conducted at the time of hospice admission.
- Committee members did not express concern regarding the validity of the measure.

### 3. Feasibility: H-1; M-23; L-0; I-0

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

#### Rationale:

- Because the issues regarding feasibility for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - The Committee noted that because data for this measure is part of the Hospice Item Set (HIS), the feasibility is high for the hospice setting. The HIS is a standardized, patient-level dataset used by CMS to collect data and calculate the seven performance measures included in the Medicare Hospice Quality Reporting Program. However, members noted that feasibility of the measure for other settings is unclear.

### 4. Usability and Use: H-2; M-22; L-0; I-0

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

#### Rationale:

- Because the issues regarding usability and use for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - This measure is included in the CMS Hospice Quality Reporting Program (HQR), an accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY2015, 3,992 hospice organizations provided measure data for 1,218,786 patient stays.
  - The measure is not currently in use for clinical-level accountability in the palliative care setting.
  - Because reporting of this measure for the hospice setting began in FY2015, longitudinal data for

<b>1641 Hospice and Palliative Care – Treatment Preferences</b>
<p>this measure for this setting are not yet available and there is therefore no information regarding improvement.</p> <ul style="list-style-type: none"> <li>○ The Committee did not report awareness of any unintended consequences associated with this measure.</li> </ul>
<p><b>5. Related and Competing Measures</b></p> <ul style="list-style-type: none"> <li>• This measure competes with two measures: <ul style="list-style-type: none"> <li>○ 1626: Patients admitted to the ICU who have care preferences documented. Description: Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.</li> <li>○ 0326: Advance Care Plan. Description: The percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. Because #1626 was not recommended for endorsement, the Committee was not asked to select the superior measure.</li> </ul> </li> <li>• The Committee largely agreed that advance care planning—which can be done well in advance of a terminal illness may not be specific in regards to treatment preferences—and discussion of life-sustaining treatment preferences—which includes specific decisions such as use of feeding tubes, ventilators, hydration, etc. and is often done later in life or at a certain stage of a terminal illness—are sufficiently different to require two measures to appropriately capture healthcare provider performance. Several members also emphasized that preferences regarding treatment preferences often change over the course of a terminal illness. However, one Committee member suggested that advance care planning should be broadened to include specific treatment preferences, which could be revisited over time, and thus a consolidated measure could be constructed. Committee members noted that a strength of measure #0326 is its primary care setting and agreed that it should be broadened to include all patients 18 years and older.</li> </ul>
<b>Standing Committee Recommendation for Endorsement: Y-22; N-0</b>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

*Care of the patient at the end of life*

<b>0210 Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life  <b>Numerator Statement:</b> Patients who died from cancer and received chemotherapy in the last 14 days of life  <b>Denominator Statement:</b> Patients who died from cancer.  <b>Exclusions:</b> None  <b>Adjustment/Stratification:</b>  <b>Level of Analysis:</b> Clinician : Group/Practice  <b>Setting of Care:</b> Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility  <b>Type of Measure:</b> Process  <b>Data Source:</b> Administrative claims, Electronic Clinical Data : Registry  <b>Measure Steward:</b> American Society of Clinical Oncology</p>

## 0210 Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life

### STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]

#### 1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-19; L-1; I-1**; 1b. Performance Gap: **H-1; M-21; L-0; I-0**

#### Rationale:

- For the 2012 endorsement evaluation, the developers cited three individual studies indicating continuing chemotherapy near death does not prolong survival and often results in undesirable outcomes (e.g. toxicity, inconvenience, increased costs, and lower patient rating of quality of care). The developer also cited a 2003 expert consensus statement that identified a short interval between last chemotherapy dose and death as an indicator of poor quality of end-of-life cancer care.
- For the current evaluation, developers updated the evidence by referencing a 2013 Cochrane Collaborative systematic review that found that for patients with cancer, home-based palliative care services increases the chance of dying at home for patients with cancer and a 2012 provisional clinical opinion from the American Society of Clinical Oncology that recommends consideration of palliative care early in the course of illness for patients with metastatic cancer and/or high symptom burden
- In general, the Committee agreed that the evidence presented during the 2012 evaluation was sufficient to support the measure at the time. However, some members noted that this older evidence does not speak to the relationship between newer chemotherapies (e.g., oral agents that may be less toxic than older chemotherapy options) to patient outcomes. One member cited a recent longitudinal, multi-site study by Prigerson et al. (2015) that was not included in the evidence submitted by the developer. Although this study demonstrated the relationship between chemotherapy at the end of-life and poor quality of life, it also did not include newer chemotherapies. Committee members noted that the performance rate for this measure should not be zero, as in some cases, a continuation of chemotherapy is beneficial. Members also noted that when considering this measure, the possibility of both potential harm as well as failure to benefit should be considered. The Committee eventually reached consensus that the evidence cited provided was sufficient for the measure.
- The developer provided group/practice level performance data from the ASCO Quality Oncology Practice Initiative registry (QOPI) for 2013-2015. The median performance score was 9.88 in 2013, 11.45 in 2014, and 11.95 in 2015, an increasing trend that might be explained by higher participation in the QOPI® registry. The developer provided additional practice-level disparities data after the Committee's workgroup call. The Committee agreed these data indicated potential disparities in care by sex and race. The Committee agreed there is substantial room for improvement for this measure.

#### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted** 2b. Validity: **H-22; M-0; L-0; I-0**

#### Rationale:

- This measure is specified for both claims and registry data. When questioned about identifying cancer deaths from claims data, the developer clarified that the denominator is derived from registry data (e.g., a death registry or other cancer registry that includes information on cancer deaths) while the numerator is derived from claims data.
- The Committee questioned the developer about inclusion of oral and other new biologics in the measure numerator. The developer clarified that the specifications include all anti-neoplastic agents except for hormonal therapies.
- For the 2012 evaluation, the developer conducted data element validity testing for the QOPI® registry data by, comparing QOPI® registry data to data that were re-abstracted from medical records by QOPI nurse abstractors, which was considered the gold standard (kappa=0.818, indicating acceptable agreement).
- For the 2012 evaluation, the developer conducted data element validity testing for the measure numerator for claims data by comparing claims for 150 consecutive patients treated for advanced cancer at Boston's Dana-Farber Cancer Institute and Brigham and Women's Hospital to data from the full

## 0210 Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life

medical record (sensitivity=0.92; specificity=0.94). Although the developer did not conduct data element validity testing for the measure denominator, the Committee agreed that registry data (particularly death registry data), in general, are accurate and therefore additional testing is unnecessary.

- The developer did not provide any updated validity testing.
- The Committee again noted that the expected performance for this measure should not be zero, particularly for blood cancer. While members did not think this would be an argument for risk-adjustment at this point, the developers stated that they would consider this issue along with other risk-adjustment questions in the future
- The Committee agreed the previous validity testing demonstrated the scientific acceptability of the measure. Members accepted the prior evaluation of the reliability sub criterion without further discussion. Members did vote on validity because there was no empirical testing of the denominator (from claims or registry).

### 3. Feasibility: H-3; M-16; L-2; I-0

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

#### Rationale:

- The Committee did not note any concerns regarding feasibility, acknowledging that the data elements used to construct this measure are available in claims and the QOPI® Registry.

### 4. Usability and Use: H-3; M-19; L-0; I-0

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

#### Rationale:

- The measure is currently used in the Quality Oncology Practice Initiative (QOPI), a practice-based quality improvement and benchmarking program, operated by the American Society of Clinical Oncology. The measure also is included in the PQRS program and is also a part of America's Health Insurance Plans (AHIP) Medical Oncology Core Measure Set. The AHIP effort is a collaboration of both public and private stakeholders to identify measures that are meaningful to patients, consumers, and physicians and to reduce variability in measure selection, collection burden, and cost. Payers involved in the collaboration have committed to using for reporting as soon as feasible. By virtue of being included in the AHIP measure set, CMS will consider this measure for inclusion in other Medicare quality programs.
- Data from 2013-2015 indicate mean practice performance slightly worsened from 11.47% of patients receiving chemotherapy in last 14 days of life to 13.16%. These results are based on data from the QOPI® registry and reflect slightly greater use of the registry over time, from 180 practices in 2013 to 222 in 2015.
- Neither the Committee nor the developers reported awareness of unintended consequences associated with this measure.

### 5. Related and Competing Measures

- This measure is related to four measures:
  - 0213: Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life
  - 0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life
  - 0215: Proportion of patients who died from cancer not admitted to hospice
  - 0216: Proportion of patients who died from cancer admitted to hospice for less than 3 days
- These measures, all of which were developed by the American Society of Clinical Oncology, are harmonized to the extent possible.

**Standing Committee Recommendation for Endorsement: Y-22; N-0**

### 6. Public and Member Comment

**7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X**



**0210 Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life**

**8. Board of Directors Vote: Y-X; N-X**

**9. Appeals**

**0213 Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life**

[Submission](#) | [Specifications](#)

**Description:** Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life

**Numerator Statement:** Patients who died from cancer and were admitted to the ICU in the last 30 days of life

**Denominator Statement:** Patients who died from cancer

**Exclusions:** None

**Adjustment/Stratification:**

**Level of Analysis:** Clinician : Group/Practice

**Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility

**Type of Measure:** Intermediate Clinical Outcome

**Data Source:** Administrative claims, Electronic Clinical Data : Registry

**Measure Steward:** American Society of Clinical Oncology

**STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]**

**1. Importance to Measure and Report: The measure meets the Importance criteria**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-20; L-0; I-0**; 1b. Performance Gap: **H-3; M-18; L-1; I-0**;

**Rationale:**

- For the 2012 endorsement evaluation, the developers cited a 2011 study that examined trends in the aggressiveness of end-of-life (EOL) cancer care (including ICU admission within 30 days of death), and an expert consensus statement from 2003 that identified potential indicators of quality of end-of-life cancer care using administrative data.
- For the current evaluation, developers updated the evidence by referencing: a 2013 Cochrane Collaborative systematic review that evaluated the impact of home-based palliative care services on several patient and caregiver outcomes, which found that for patients with cancer, home-based palliative care services increases the chance of dying at home for patients with cancer; a 2012 provisional clinical opinion from the American Society of Clinical Oncology that recommends consideration of palliative care early in the course of illness for patients with metastatic cancer and/or high symptom burden; and two individual studies that support the relationship of reduced ICU visits to desired patient outcomes.
- The Committee also referenced an additional study of colorectal and lung cancer patients that found that ICU use in the last 30 days of life is did not align with patient preference and was associated with worse outcomes (Wright, et al., 2016). After considering this additional empirical evidence, the Committee agreed that there is a high certainty that benefits of avoiding the ICU in the last month of life outweighs undesirable effects.
- Although specified at the clinician group/practice level, the developers provided system-level performance data from two integrated health systems, one showing an increase from 20% in Fall 2011 to 37% in Spring 2013 and the other showing an average performance of 9.02% between June 2013 to May 2015.
- Given the variation in the results within and between the two systems, the Committee agreed that opportunity for improvement exists.

**2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-14; L-1; I-7** 2b. Validity: **H-0; M-20; L-1; I-1**

## 0213 Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life

### Rationale:

- This measure is specified for both claims and registry data. When questioned about identifying cancer deaths from claims data, the developer clarified that the denominator is derived from registry data (e.g., a death registry or other cancer registry that includes information on cancer deaths) while the numerator is derived from claims data.
- For the 2012 evaluation, the developer conducted data element validity testing for the measure numerator by comparing claims for 150 consecutive patients treated for advanced cancer at Boston's Dana-Farber Cancer Institute and Brigham and Women's Hospital to data from the full medical record (sensitivity=0.87; specificity=0.97). Although the developer did not conduct data element validity testing for the measure denominator, the Committee agreed that registry data (particularly death registry data), in general, are accurate and therefore additional testing is unnecessary.
- The developer did not provide any updated validity testing.
- The developers did not conduct reliability testing for either the numerator or the denominator. However, per NQF guidance, because data element validity testing was done for the measure numerator, additional data element reliability testing for the numerator is not required. As noted, the Committee agreed that the registry data used in the measure denominator are accurate, and therefore members agreed that additional data element reliability testing is not needed.
- The Committee agreed that because admission to the ICU is, for the most part, under the control of the provider, risk-adjustment is not needed for this measure.

### **3. Feasibility: H-4; M-18; L-0; I-0**

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

### Rationale:

- The Committee did not note any concerns regarding feasibility, acknowledging that the data elements used to construct this measure are available in electronic sources.

### **4. Usability and Use: H-6; M-16; L-0; I-0**

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

### Rationale:

- This measure is not currently in use. However, it is part of America's Health Insurance Plans (AHIP) Medical Oncology Core Measure Set. The AHIP effort is a collaboration of both public and private stakeholders to identify measures that are meaningful to patients, consumers, and physicians and to reduce variability in measure selection, collection burden, and cost. Payers involved in the collaboration have committed to using these measures for reporting as soon as feasible, and CMS has agreed to consider this measure for inclusion in Medicare quality programs.
- Because the developer provided limited longitudinal data, performance trends could not be inferred.
- Neither the Committee nor the developers reported awareness of unintended consequences associated with this measure.

### **5. Related and Competing Measures**

- This measure is related to four measures:
  - 0210: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life
  - 0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life
  - 0215: Proportion of patients who died from cancer not admitted to hospice
  - 0216: Proportion of patients who died from cancer admitted to hospice for less than 3 days
- These measures, all of which were developed by the American Society of Clinical Oncology, are harmonized to the extent possible.

<b>0213 Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life</b>
<b>Standing Committee Recommendation for Endorsement: Y-22; N-0</b>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

<b>0215 Proportion of patients who died from cancer not admitted to hospice</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> Proportion of patients who died from cancer not admitted to hospice</p> <p><b>Numerator Statement:</b> Proportion of patients not enrolled in hospice</p> <p><b>Denominator Statement:</b> Patients who died from cancer.</p> <p><b>Exclusions:</b> None</p> <p><b>Adjustment/Stratification:</b></p> <p><b>Level of Analysis:</b> Clinician : Group/Practice</p> <p><b>Setting of Care:</b> Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility</p> <p><b>Type of Measure:</b> Process</p> <p><b>Data Source:</b> Administrative claims, Electronic Clinical Data : Registry</p> <p><b>Measure Steward:</b> American Society of Clinical Oncology</p>
<p><b>STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]</b></p> <p><b>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u></b> (1a. Evidence, 1b. Performance Gap)</p> <p>1a. Evidence: <b>Previous Evidence Evaluation Accepted</b> 1b. Performance Gap: <b>H-20; M-2; L-0; I-0</b></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>For the 2012 endorsement evaluation, the developers cited two studies indicating hospice admission did not have detrimental effect on survival among elderly patients with lung cancer and was associated with bereaved family members reporting a) higher quality of end-of-life care, b) no unmet need for help with anxiety or depression, and c) death in the decedent’s died in preferred location. The developer also cited a 2003 expert consensus paper identifying hospice enrollment as an indicator of quality of end-of-life cancer care.</li> <li>For the current evaluation, developers updated the evidence by referencing: a 2013 Cochrane Collaborative systematic review that evaluated the impact of home-based palliative care services on several patient and caregiver outcomes, which found that for patients with cancer, home-based palliative care services increases the chance of dying at home for patients with cancer; a 2012 provisional clinical opinion from the American Society of Clinical Oncology that recommends consideration of palliative care early in the course of illness for patients with metastatic cancer and/or high symptom burden; and four individual studies that support the relationship of hospice admission to desired patient outcomes.</li> <li>The Committee agreed that the updated evidence appears to be directionally the same since the last NQF endorsement evaluation. The Committee accepted the prior evaluation of this criterion without further discussion.</li> <li>The developer provided group/practice level performance data from the ASCO Quality Oncology Practice Initiative registry (QOPI) for 2013-2015. The median performance score was 40.0 in 2013, 41.67 in 2014, and 41.42 in 2015. The developer provided additional practice-level disparities data after the Committee’s workgroup call. The Committee agreed these data indicated potential disparities in care men and racial/ethnic minorities. The Committee agreed that there is substantial room for improvement for this measure.</li> </ul>

## 0215 Proportion of patients who died from cancer not admitted to hospice

### 2. Scientific Acceptability of Measure Properties: **The measure meets the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Previous Reliability Evaluation Accepted** 2b. Validity: **Previous Validity Evaluation Accepted**

#### Rationale:

- This measure is specified for both claims and registry data. When questioned about identifying cancer deaths from claims data, the developer clarified that the denominator is derived from registry data (e.g., a death registry or other cancer registry that includes information on cancer deaths) while the numerator is derived from claims data or the ASCO Quality Oncology Practice Initiative (QOPI®) registry.
- For the 2012 evaluation, the developer conducted data element validity testing for the QOPI® registry data by, comparing QOPI® registry data to data that were re-abstracted from medical records by QOPI nurse abstractors, which was considered the gold standard (kappa=0.679, indicating acceptable agreement).
- For the 2012 evaluation, the developer conducted data element validity testing for the measure numerator for claims data by comparing claims for 150 consecutive patients treated for advanced cancer at Boston's Dana-Farber Cancer Institute and Brigham and Women's Hospital to data from the full medical record (sensitivity=0.24; specificity=0.96). Although the developer did not conduct data element validity testing for the measure denominator, the Committee agreed that registry data (particularly death registry data), in general, are accurate and therefore additional testing is unnecessary.
- The developer did not provide any updated reliability or validity testing.
- The Committee agreed the previous reliability and validity testing were demonstrated the scientific acceptability of the measure and accepted the prior evaluation of this criterion without further discussion.

### 3. Feasibility: **H-2; M-20; L-0; I-0**

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)

#### Rationale:

- The Committee did not note any concerns regarding feasibility, acknowledging that the data elements used to construct this measure are available in claims and the QOPI® Registry.

### 4. Usability and Use: **H-2; M-20; L-0; I-0**

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

#### Rationale:

- The measure is currently used in the QOPI® Registry, a practice-based quality improvement and benchmarking program, operated by the American Society of Clinical Oncology. It is also part of America's Health Insurance Plans (AHIP) Medical Oncology Core Measure Set. The AHIP effort is a collaboration of both public and private stakeholders to identify measures that are meaningful to patients, consumers, and physicians and to reduce variability in measure selection, collection burden, and cost. Payers involved in the collaboration have committed to using these measures for reporting as soon as feasible, and CMS has agreed to consider this measure for inclusion in Medicare quality programs.
- While the number of practices reporting to QOPI has increased between 2013 and 2015, the average performance has not changed.
- Neither the Committee nor the developers reported awareness of any unintended consequences associated with this measure.

### 5. Related and Competing Measures

- This measure is related to four measures:
  - 0210: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life
  - 0213: Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life

<b>0215 Proportion of patients who died from cancer not admitted to hospice</b>
<ul style="list-style-type: none"> <li>○ 0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life</li> <li>○ 0216: Proportion of patients who died from cancer admitted to hospice for less than 3 days</li> <li>● These measures, all of which were developed by the American Society of Clinical Oncology, are harmonized to the extent possible.</li> </ul>
<b>Standing Committee Recommendation for Endorsement: Y-22; N-0</b>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

<b>0216 Proportion of patients who died from cancer admitted to hospice for less than 3 days</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> Proportion of patients who died from cancer, and admitted to hospice and spent less than 3 days there</p> <p><b>Numerator Statement:</b> Patients who died from cancer and spent fewer than three days in hospice.</p> <p><b>Denominator Statement:</b> Patients who died from cancer who were admitted to hospice</p> <p><b>Exclusions:</b> None</p> <p><b>Adjustment/Stratification:</b></p> <p><b>Level of Analysis:</b> Clinician : Group/Practice</p> <p><b>Setting of Care:</b> Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility</p> <p><b>Type of Measure:</b> Intermediate Clinical Outcome</p> <p><b>Data Source:</b> Administrative claims, Electronic Clinical Data : Registry</p> <p><b>Measure Steward:</b> American Society of Clinical Oncology</p>
<b>STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]</b>
<p><b>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u></b></p> <p>(1a. Evidence, 1b. Performance Gap)</p> <p>1a. Evidence: <b>Previous Evidence Evaluation Accepted</b> 1b. Performance Gap: <b>H-14; M-7; L-0; I-0;</b></p> <p><b>Rationale:</b></p> <ul style="list-style-type: none"> <li>● For the 2012 endorsement evaluation, the developers cited two studies indicating hospice admission did not have detrimental effect on survival among elderly patients with lung cancer and was associated with bereaved family members reporting a) higher quality of end-of-life care, b) no unmet need for help with anxiety or depression, and c) death in the decedent’s died in preferred location. The developer also cited a 2003 expert consensus paper identifying short hospice enrollment as an indicator of quality of end-of-life cancer care.</li> <li>● For the current evaluation, developers updated the evidence by referencing: a 2013 Cochrane Collaborative systematic review that evaluated the impact of home-based palliative care services on several patient and caregiver outcomes, which found that for patients with cancer, home-based palliative care services increases the chance of dying at home for patients with cancer; a 2012 provisional clinical opinion from the American Society of Clinical Oncology that recommends consideration of palliative care early in the course of illness for patients with metastatic cancer and/or high symptom burden; and three individual studies that support the relationship of hospice admission to desired patient outcomes such as increased survival times and reductions in aggressive end-of-life care.</li> <li>● The Committee agreed that the updated evidence appears to be directionally the same since the last NQF</li> </ul>

## 0216 Proportion of patients who died from cancer admitted to hospice for less than 3 days

endorsement evaluation. The Committee accepted the prior evaluation of this criterion without further discussion.

- The developer provided group/practice level performance data from the ASCO Quality Oncology Practice Initiative registry (QOPI) for 2013-2015. The median performance score was 12.97 in 2013, 14.64 in 2014, and 15.38 in 2015, an increasing trend that might be explained by higher participation in the QOPI® registry. The developer provided additional practice-level disparities data after the Committee's workgroup call. The Committee agreed these data indicated potential disparities in care for racial/ethnic. The Committee agreed that there is substantial room for improvement for this measure.

### **2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-18; L-3; I-0** 2b. Validity: **H-0; M-19; L-2; I-0**

#### Rationale:

- This measure is specified for both claims and registry data. When questioned about identifying cancer deaths from claims data, the developer clarified that the denominator is derived from registry data (e.g., a death registry or other cancer registry that includes information on cancer deaths) while the numerator is derived from claims data or the ASCO Quality Oncology Practice Initiative (QOPI®) registry.
- The Committee questioned limiting the measure to Medicare patients only. The developers noted that only Medicare data were available for testing, thus the requirement for Medicare hospice enrollment. They are hopeful, however, that with the measure's inclusion in the AHIP oncology core set, enrollment data for other payers will be available for use. They also noted that the QOPI® registry is not limited to Medicare hospice enrollees.
- The Committee questioned the developer about the rationale for specifying 3-days as the threshold for appropriate timeframe for hospice enrollment. The developers noted that the QOPI® registry actually collects both 3-day and 7-day enrollment information and future versions of this measure may consider a longer timeframe. One Committee member noted that that enough variation currently exists in hospice enrollment that continued improvement is needed within the 3 day timeframe. While acknowledging that longer hospice enrollment is better, the Committee found this rationale for the 3-day threshold acceptable.
- For the 2012 evaluation, the developer conducted data element reliability testing for the QOPI® registry data by comparing QOPI® registry data to data that were re-abstracted from medical records by QOPI nurse abstractors, which was considered the gold standard (kappa=0.551, indicating acceptable agreement).
- For the 2012 evaluation, the developer conducted data element validity testing for the measure numerator from claims data by comparing claims for 150 consecutive patients treated for advanced cancer at Boston's Dana-Farber Cancer Institute and Brigham and Women's Hospital to data from the full medical record (sensitivity=0.97; specificity=1.00). Although the developer did not conduct data element validity testing for the measure denominator, the Committee agreed that registry data (particularly death registry data), in general, are accurate and therefore additional testing is unnecessary.
- The developer did not provide any updated reliability or validity testing.
- The Committee was not concerned with the lack of risk-adjustment for this measure.

### **3. Feasibility: H-3; M-16; L-2; I-0**

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)

#### Rationale:

- The Committee did not note any concerns regarding feasibility, acknowledging that the data elements used to construct this measure are available in claims and the QOPI® Registry.

### **4. Usability and Use: H-13; M-8; L-0; I-0**

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

## 0216 Proportion of patients who died from cancer admitted to hospice for less than 3 days

### Rationale:

- The measure is currently used in the QOPI® Registry, a practice-based quality improvement and benchmarking program, operated by the American Society of Clinical Oncology. It is also part of America's Health Insurance Plans (AHIP) Medical Oncology Core Measure Set. The AHIP effort is a collaboration of both public and private stakeholders to identify measures that are meaningful to patients, consumers, and physicians and to reduce variability in measure selection, collection burden, and cost. Payers involved in the collaboration have committed to using these measures for reporting as soon as feasible, and CMS has agreed to consider this measure for inclusion in Medicare quality programs.
- While the number of practices reporting to QOPI has increased between 2013 and 2015, the average performance has not changed.
- In its 2016 review, the MAP, supported by public comments, requested the Standing Committee consider a longer timeframe (e.g., 7 days) for this measure. However, the Committee agreed that very short hospice stays remain a concern and therefore did not recommend changing the timeframe for the measure at this time.
- The Committee acknowledged that the measure might create a disincentive to refer actively dying patients to hospice but agreed that the benefits of the measure outweigh the potential risk.

### 5. Related and Competing Measures

- This measure is related to four measures:
  - 0210: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life
  - 0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life
  - 0213: Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life
  - 0215: Proportion of patients who died from cancer not admitted to hospice
- These measures, all of which were developed by the American Society of Clinical Oncology, are harmonized to the extent possible.

**Standing Committee Recommendation for Endorsement: Y-21; N-0**

### 6. Public and Member Comment

**7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X**

**8. Board of Directors Vote: Y-X; N-X**

### 9. Appeals

## 1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated

[Submission](#) | [Specifications](#)

**Description:** Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated.

**Numerator Statement:** Patients from the denominator who have their ICDs deactivated prior to death or have documentation of why this was not done

**Denominator Statement:** Patients who died an expected death who have an ICD in place

**Exclusions:** None

**Adjustment/Stratification:**

**Level of Analysis:** Facility

**Setting of Care:** Hospital/Acute Care Facility

**Type of Measure:** Process

## 1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated

**Data Source:** Paper Medical Records

**Measure Steward:** RAND Corporation

### STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]

#### 1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-2; M-22; L-0; I-0**; 1b. Performance Gap: **H-1; M-23; L-0; I-0**

#### Rationale:

- For the 2012 endorsement evaluation, the developers provided a systematic review and a clinical practice guideline supporting care planning and communication for patients receiving an ICD. Although the developer did not provide additional evidence for the current evaluation, NQF Staff and Committee members identified two consensus statements from the U.S. and European Heart Rhythm Societies and several, as well as several systematic reviews and studies supporting ICD deactivation summarizing patient and provider attitudes on deactivation, and exploring barriers to deactivation. The Committee acknowledged the relatively small body of empirical evidence supporting ICD deactivation near the end of life, but particularly noted the expert consensus statements in favor of deactivation by both cardiologists and palliative care experts.
- Committee members discussed whether accountability for ICD deactivation very near time of death is appropriate, noting that expert consensus recommends a discussion about deactivation prior to implantation although typically such a discussion is not wanted by patients at that time. The Committee agreed that the optimal timing for this discussion is not yet known.
- For the current evaluation, the developers provided performance data from two individual studies using data from 2005-2006 and 2008. In one study, the one patient eligible did have the deactivation; in the other study, of the 12 patients eligible, only 25% had their ICDs deactivated prior to death.
- The Committee agreed that while the evidence presented on the performance gap was limited, clinical experience suggests that it is an area with opportunity for improvement. Members of the Committee agreed that, an expected death with an active ICD should be considered a "never event", given the suffering experienced by the patient and family due to repeated shocks during the terminal decline.

#### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-22; L-0; I-2** 2b. Validity: **H-0; M-23; L-0; I-1**

#### Rationale:

- When questioned by the Committee, the developers clarified that this measure includes those who died in a hospital.
- For the 2012 evaluation, the developers attempted to assess inter-rater reliability of the data elements by obtaining medical charts for 47 inpatient decedents (a 10% sample of 496 patients, 12 of whom had an ICD in place). However, none of the 12 patients with an ICD were included in the sample and therefore the inter-rater reliability analysis for the numerator was not possible.
- The Committee acknowledged that the relatively low prevalence of ICD implantation can affect the feasibility of empirical testing. However, Committee members strongly agreed that documentation of ICD deactivation in the medical record is clear and very easy to find. One member also noted that results of reliability testing from a large-scale study are forthcoming and promising.
- Validity testing at the time of the 2012 endorsement evaluation included face validity assessments by two expert panels using a modified Delphi method. Developers did not update validity testing for the current evaluation.

#### 3. Feasibility: **H-0; M-21; L-3; I-0**

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3d. Data collection strategy can be implemented)

#### Rationale:



<b>1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated</b>
<ul style="list-style-type: none"> <li>While the Committee noted the measure is specified for paper medical records and that the required data likely are not yet included in structured electronic data, members again agreed that the required data elements would be easy to find in the paper records.</li> </ul>
<p><b>4. Usability and Use: H-4; M-19; L-1; I-0</b>  <i>(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)</i></p> <p><u>Rationale:</u></p> <ul style="list-style-type: none"> <li>This measure is not currently in use, although it was supported by the MAP in 2013 for inclusion in the PQRS program (a clinician-level program).</li> <li>Longitudinal data for this measure are not yet available and there is therefore no information regarding improvement.</li> <li>Committee members did not suggest any potential unintended consequences for the measure.</li> <li>Committee members encouraged the developer to continue to pursue opportunities for inclusion in accountability programs.</li> </ul>
<p><b>5. Related and Competing Measures</b></p> <ul style="list-style-type: none"> <li>No related or competing measures noted.</li> </ul>
<b>Standing Committee Recommendation for Endorsement: Y-24; N-0</b>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

<b>2651 CAHPS® Hospice Survey (experience with care)</b>
<a href="#">Submission</a>   <a href="#">Specifications</a>
<p><b>Description:</b> The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. The survey is intended to measure the experiences of hospice patients and their primary caregivers. The measure proposed here includes the following six multi-item measures (1) Hospice team communication; (2) Getting timely care; (3) Treating family member with respect; (4) getting emotional and religious support; (5) Getting help for symptoms; and (6) Getting hospice training. In addition, there are two other measures, also called, “global ratings”: (1) Rating of the hospice care and (2) Willingness to recommend the hospice</p> <p><b>Numerator Statement:</b></p> <p><b>Denominator Statement:</b> The measure’s denominator is the number of survey respondents who answered the item. The target population for the survey is primary caregivers of hospice decedents. The survey uses screener questions to identify respondents eligible to respond to subsequent items. Therefore, denominators will vary by survey item (and corresponding multi-item measures, if applicable) according to the eligibility of respondents for each item.</p> <p><b>Exclusions:</b> Cases are excluded from the survey target population if:</p> <ul style="list-style-type: none"> <li>The hospice patient is still alive</li> <li>The decedent’s age at death was less than 18</li> <li>The decedent died within 48 hours of his/her last admission to hospice care</li> <li>The decedent had no caregiver of record</li> <li>The decedent had a caregiver of record, but the caregiver does not have a U.S. or U.S. Territory home address</li> <li>The decedent had no caregiver other than a nonfamilial legal guardian</li> </ul>

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- The decedent or caregiver requested that they not be contacted (i.e., by signing a no publicity request while under the care of hospice or otherwise directly requesting not to be contacted)
- The caregiver is institutionalized, has mental/physical incapacity, has a language barrier, or is deceased
- The caregiver reports on the survey that he or she “never” oversaw or took part in decedent’s hospice care

### Adjustment/Stratification:

**Level of Analysis:** Facility

**Setting of Care:** Hospice

**Type of Measure:** PRO

**Data Source:** Patient Reported Data/Survey

**Measure Steward:** Centers for Medicare and Medicaid Services

### STEERING COMMITTEE MEETING [05/11/2016]

#### 1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Pass-23; No Pass-0**; 1b. Performance Gap: **H-6; M-17; L-0; I-0**;

#### Rationale:

- As evidence for this measure, the developer provided a table linking multiple processes or structures of care to the outcomes captured in the 8 measures that are derived from the Hospice CAHPS survey. The developer also summarized results from focus groups and individual interviews with family members of hospice decedents who reviewed the Survey and supported its contents.
- The Committee agreed the evidence presented met NQF’s requirements for patient-reported outcome measures and passed all eight measures on the evidence criterion.
- The developer provided performance data from 2,512 hospice agencies serving at least 50 patients in second quarter of FY 2015. Mean measures scores ranged from 72.1 (Standard Deviation (SD) =12.8) for “Getting hospice care training” to 91.8 (SD=6.5) for “Getting emotional and religious support”.
- The developers presented data from the first half of 2015 showing variations in the PRO-PM results by race, suggesting potential disparities in care, and noted cited several studies that have also found disparities in hospice care.
- The Committee agreed that variation in agency scores for each measure indicates a performance gap exists. Members also noted that the disparities data were particularly compelling, given the direction of the identified disparities varies across the measures.

#### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: Two measures pulled out for separate voting:

- *Hospice team communication; getting timely care; Getting emotional and religious support; Getting hospice training; Rating of the hospice care; Willingness to recommend the hospice*-**H-1; M-20; L-2; I-0**
- *Treating family member with respect*-**H-0; M-10; L-10; I-2**
- *Getting help for symptoms*-**H-0; M-14; L-7; I-2**

2b. Validity: **H-6; M-14; L-3; I-0**

#### Rationale:

- One member voiced concern about use of the “top-box” scoring approach, suggesting that it is too stringent, as some people never respond with the most positive answer on a survey. This member suggested that with this scoring approach, the results may not accurately reflect the quality of care provided. The developers’ rationale for using top-box scoring was that (1) their testing showed that this scoring approach was the most easily understood and meaningful to consumers and (2) compared to a linear mean scoring approach, the ability to distinguish between providers is better when the top-box approach is used.
- Some Committee members expressed concern about combining emotional and religious items for the

## 2651 CAHPS® Hospice Survey (experience with care)

“Getting emotional and religious support” measure, seeing them as distinct concepts. The developer noted that in their testing of the survey instrument, including all three items into this domain improved the Cronbach’s alpha reliability result.

- The Committee asked why of hospice agencies that have fewer than 50 decedents per year are exempted from fielding the Hospice CAHPS survey. The developers stated that the cost of the survey may be prohibitive for very small agencies. They also noted that because the response rate is relatively low, very small agencies may not have enough respondents to achieve reliable results on the measures. The developers also clarified that there are no payment penalties for small hospice agencies that do not field the survey.
- Another Committee member asked about the exclusion due to language barriers. The developers noted that the Hospice CAHPS survey is available in English, Spanish, two versions of Chinese, Vietnamese, Portuguese, and Russian, and that additional languages would be added over time.
- Reliability testing of the Hospice CAHPS survey (i.e., data element testing) included examination of the internal consistency of the multi-item measures using Cronbach’s alpha and the item-total correlation using Pearson’s correlation for the multi-item and single-item measures. Cronbach’s alpha results ranged from 0.60 to 0.86.
- Measure score reliability was calculated using 1) intra-class correlations (ICCs) computed from the case mix-adjusted 0-100 top-box scores and 2) estimating reliability via the Spearman-Brown prophecy formula assuming 200 surveys were completed in each agency. ICC values ranged from 0.008 to 0.017, and the estimated reliability from the Spearman-Brown prophecy formula ranged from 0.61 to 0.78.
- Because the estimated reliability estimates were relatively lower for the “Treating family member with respect” and “Getting help for symptoms” measures, the Committee asked to vote on those separately. The Committee did not reach consensus on the reliability subcriterion for the “Treating family member with respect” measure; however, the remaining seven measures passed the reliability subcriterion.
- Validity testing of the measure score included examination of the relationship of agency-level results from the 6 multi-item measures to the agency-level results of the global rating and willingness to recommend measures via linear regression analysis and examination of the Pearson correlations between the agency-level multi-item measures to assess the magnitude of association. Results indicated all relationships were statistically significant and in the expected direction.
- All 8 of the PRO-PMs are case-mix adjusted for 9 factors: (1) response percentile; (2) decedent age group; (3) payer; (4) primary diagnosis; (5) length of final hospice episode; (6) respondent age group; (7) respondent education; (8) decedent’s relationship to respondent; and (9) a variable indicating survey language and respondent’s home language. One member noted that low literacy and low socio-economic status might also affect response rate.
- The Committee questioned the developer about potential threats to validity related non-response bias, the developers stated that response bias is difficult to assess directly, but surveys of varying lengths were used during field testing, but this had no effect on response rates. The developers also noted that the measure results are adjusted for mode of administration, because mode affects response rates. Specifically, the mail-only mode is the least expensive but has lower response rates. Higher response rates are possible with the mixed mode of administration (mail with telephone follow-up, but this is the most expensive option).
- One Committee member also asked if the developers can be sure that the performance results from caregivers of decedents who resided in a nursing home reflect the quality of care provided by the hospice rather than the quality of care provided by the nursing home. The developers stated that they ask specific questions on the survey to try to ascertain whether information provided by the hospice team differed from that given by nursing home staff and whether the hospice team and nursing home staff worked well together.

### **3. Feasibility: H-0; M-17; L-6; I-0**

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

Rationale:

## 2651 CAHPS® Hospice Survey (experience with care)

- The Committee questioned the developer as to whether feasibility of the measures varied by the mode administration (mail only, phone only, or mixed mode) or respondents' level of health literacy. The developer again noted that the responses are adjusted for mode of administration. With respect to health literacy, they developers stated that they were not certain as to the current reading level of survey, but believe it to be around at 10<sup>th</sup> grade reading level.
- The Committed voiced concern regarding the impact of cost on smaller hospice agencies' ability to participate in the survey. Committee members noted that agencies are required to contract with specific survey vendors and devote additional resources (e.g., staff time) to participate. The Committee asked the developer whether the Centers for Medicare and Medicaid considered provided monetary support to smaller agencies to enable their participation. The developers acknowledged the additional hospice agency resources required to conduct the survey, but stated they were not aware of any plans for offering monetary support to smaller hospice agencies.

### 4. Usability and Use: H-8; M-13; L-2; I-0

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

#### Rationale:

- The measures are currently included in the Hospice Quality Reporting Program (HQRP). The Committee discussed the exclusion of small hospice agencies (i.e., those with less than 50 decedents per year) from reporting to the HQRP and that this is a potential limitation to the measures' usability and use.
- The Committee discussed a potential unintended consequence of the measures in that receiving the survey may be upsetting to the decedent's caregiver. The Committee agreed this may happen, but the benefits of the measures outweigh this undesirable effect, particularly if a hospice agency provides bereavement support to individuals who report upset at the survey.

### 5. Related and Competing Measures

- These measures compete with two other patient-reported outcome measures:
  - 0208: Family Evaluation of Hospice Care.
    - The result of the Family Evaluation of Hospice Care (FEHC) measure (#0208) is a single score that indicates a hospice agency's overall performance on symptom management, communication, provision of information, emotional support, and care coordination. Note that only hospice agencies exempt from the Hospice CAHPS survey (i.e., <50 decedents per year) utilize the FEHC.
  - 1623: Bereaved Family Survey
    - The result of the Bereaved Family Survey measure (#1623) is a single score that indicates the family's perceptions of the quality of care that veterans received from the VA during the last month of life; aspects of care included in the measure are communication, emotional and spiritual support, pain management, and personal care needs.
- Although these measures are competing, they are targeted to different groups of hospice patients and their families (i.e., those served by small agencies and those in the VA). Also, as these two measures were recently evaluated by another Standing Committee, NQF staff did not ask the Committee to choose a superior measure or discuss potential areas of harmonization.

**Standing Committee Recommendation for Endorsement for:** (1) Hospice team communication; (2) Getting timely care; (3) getting emotional and religious support; (4) Getting help for symptoms; and (5) Getting hospice training (6) Rating of the hospice care and (7) Willingness to recommend the hospice **Y-22; N-1**

### 6. Public and Member Comment

### 7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

### 8. Board of Directors Vote: Y-X; N-X

### 9. Appeals

## Measures Where Consensus Is Not Yet Reached

### 1639 Hospice and Palliative Care -- Dyspnea Screening

\*Paired with #1638: Hospice and Palliative Care - Dyspnea Treatment

[Submission](#) | [Specifications](#)

**Description:** Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.

**Numerator Statement:** Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.

**Denominator Statement:** Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.

**Exclusions:** Patients with length of stay < 1 day in palliative care.

**Adjustment/Stratification:**

**Level of Analysis:** Facility, Clinician : Group/Practice

**Setting of Care:** Hospice, Hospital/Acute Care Facility

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

**Measure Steward:** University of North Carolina-Chapel Hill

#### STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]

##### 1. Importance to Measure and Report: **Consensus was not reached on the Importance criteria**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-3; L-1; I-19**; 1b. Performance Gap: **H-0; M-11; L-12; I-0**;

Evidence Exception: **Y-22; N-1**

##### Rationale:

- For the 2012 endorsement evaluation, the developers cited systematic reviews and clinical guidelines that support dyspnea treatment, and drew a causal link between screening and treatment. However, the studies did not directly examine the link between dyspnea screening and patient outcomes. For the current evaluation, the developer updated the evidence by referencing a 2011 British Columbia Medical Services Commission guideline calling for the assessment of dyspnea severity, and a 2013 Institute for Clinical Systems Improvement (ICSI) guideline on palliative care for adults that recommends frequent evaluation of the physical aspects of the patient's serious illness.
- One Committee member referenced a study not provided by the developer that found as the severity of dyspnea increased, based on the Edmonton Symptom Assessment Scale, symptom-related actions such as referrals, treatments, or prescriptions also increased (Seow, et al., 2012). ). While other Committee members found this information compelling, they were reluctant to accept it at face value without an opportunity to review. Instead, the Committee noted that screening is required prior to treatment and agreed that empirical evidence is not needed to hold providers accountable for the measure. Therefore, the Committee agreed to invoke the exception to the evidence subcriterion.
- Facility-level data presented by the developer from the FY15 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average hospice facility-level performance rate of 97.3%. Additional data presented by the developer indicate slight, yet statistically significant, disparities in care between certain racial, socioeconomic, and geographic subgroups in the hospice setting.
- Developers did not provide clinician-level performance data for palliative care in the hospital setting. However, they noted that the measure is being used in a variety of palliative care settings through ongoing Center for Medicare & Medicaid Innovation (CMMI) and Palliative Care Research Cooperative projects, and indicated that clinician-level performance data will be available within the coming year.
- The Committee did not reach consensus on whether the measure results demonstrate opportunity for improvement, noting the high performance rate for the hospice setting but indication of disparities in care in that setting, but lack of information about opportunity for improvement for the clinician level of

## 1639 Hospice and Palliative Care -- Dyspnea Screening

\*Paired with #1638: Hospice and Palliative Care - Dyspnea Treatment

analysis in the hospital setting.

### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-4; M-19; L-0; I-0** 2b. Validity: **H-2; M-21; L-0; I-0**

#### Rationale:

- When last endorsed, patients with a hospice stay of <7 days were excluded from the measure denominator. Developers have changed this specification and now no longer exclude any hospice patients because of length of stay (although patients with <1 day in hospital palliative care are excluded from the clinician-level measure).
- Reliability testing at the time of the 2012 endorsement evaluation was limited to an inter-rater reliability analysis based on data from 20 patients in one hospital ( $\kappa=.91$ ). For the current evaluation, developers updated their reliability testing by providing score-level testing results for the hospice setting from two different analyses (a split-half analysis with an intra-class correlation coefficient of 0.83, and a signal-to-noise analysis with a signal-to-noise ratio of 0.98). The Committee voiced no concerns regarding reliability for the hospice setting. As with the other measures submitted by the developer of this measure, the Committee strongly recommended that reliability testing for the clinician-level measure in the palliative care setting be updated and the results provided to NQF when available.
- Validity testing at the time of the 2012 endorsement evaluation included both a face validity assessment and a score-level construct validity analysis for the palliative care setting. Results from the empirical analysis indicated that screening for dyspnea was statistically significantly different for seriously ill patients seen in specialty interdisciplinary palliative care consultations (100%) compared to those who did not receive these services (95%). These results confirmed the developers' hypothesis that a formal palliative care intervention would result in more frequent screening for dyspnea.
- For the current evaluation, developers updated their validity testing by conducting a non-parametric Spearman rank correlation analysis between this measure and 5 other hospice quality measures. Although the magnitude of the correlations from this analysis was lower than expected, they were positive and statistically significant, confirming the developers' hypothesis that hospice agencies perform similarly on various assessment activities conducted at the time of hospice admission.
- Committee members did not express concern regarding the validity of the measure for either level of analysis.

### 3. Feasibility: **H-1; M-23; L-0; I-0**

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3d. Data collection strategy can be implemented)

#### Rationale:

- Because the issues regarding feasibility for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - The Committee noted that because data for this measure is part of the Hospice Item Set (HIS), the feasibility is high for the hospice setting. The HIS is a standardized, patient-level dataset used by CMS to collect data and calculate the seven performance measures included in the Medicare Hospice Quality Reporting Program. However, members noted that feasibility of the measure for other settings is unclear.

### 4. Usability and Use: **H-2; M-22; L-0; I-0**

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

#### Rationale:

- Because the issues regarding usability and use for this measure are the same as those for measure #1638, the Committee agreed to carry over both the discussion and votes, as follows:
  - This measure is included in the CMS Hospice Quality Reporting Program (HQR), an

## 1639 Hospice and Palliative Care -- Dyspnea Screening

\*Paired with #1638: Hospice and Palliative Care - Dyspnea Treatment

accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY2015, 3,992 hospice organizations provided measure data for 1,218,786 patient stays.

- The measure is not currently in use for clinical-level accountability in the palliative care setting.
- Because reporting of this measure for the hospice setting began in FY2015, longitudinal data for this measure for this setting are not yet available and there is therefore no information regarding improvement.
- The Committee did not report any unintended consequences associated with this measure.

### 5. Related and Competing Measures

- This measure is related to two measures:
  - 0179: Improvement in dyspnea. Description: Percentage of home health episodes of care during which the patient became less short of breath or dyspneic
  - 1638: Hospice and Palliative Care – Dyspnea Treatment. Description: Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening
- Measure #0179 is an outcome measure used in the home health setting, and as such, there are no harmonization issues.
- Measure #1638 is paired with this measure. Patients identified as having shortness of breath per this measure constitute the denominator for measure #1638.
- 

**Standing Committee Recommendation for Endorsement: Y-X; N-X Vote not taken.**

#### Rationale

- Because the Committee did not reach consensus on subcriterion 1b (Opportunity for Improvement), the Committee did not vote on a recommendation for endorsement. The Committee will vote on a recommendation for endorsement on the August 9, 2016 post-comment call.

### 6. Public and Member Comment

### 7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

### 8. Board of Directors Vote: Y-X; N-X

### 9. Appeals

## Measures Not Recommended

### *Physical aspects of care (pain)*

## 0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment

### Submission | Specifications

**Description:** Percentage of patients who report being uncomfortable because of pain at the initial assessment who, at the follow up assessment, report pain was brought to a comfortable level within 48 hours.

**Numerator Statement:** Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment.

**Denominator Statement:** Patients who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment.

**Exclusions:** Patients who do not report being uncomfortable because of pain at initial assessment (i.e., patients who reply "no" to the question "Are you uncomfortable because of pain?")

Patients under 18 years of age

Patients who cannot self report pain

## 0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment

Patients who are unable to understand the language of the person asking the initial and follow up questions

### Adjustment/Stratification:

**Level of Analysis:** Facility, Population : National

**Setting of Care:** Hospice

**Type of Measure:** PRO

**Data Source:** Patient Reported Data/Survey

**Measure Steward:** National Hospice and Palliative Care Organization

### STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]

#### 1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Y-21; N-1**; 1b. Performance Gap: **H-16; M-7; L-0; I-0**

#### Rationale:

- The rationale provided by the developer for this Patient-Reported Outcome-based Performance Measure (PRO-PM) notes that patients' beliefs about pain and pain management, along with cognitive factors such as the ability to follow instructions, affect adherence to pain interventions, suggesting that assessment of such factors is key to effective pain management. The developer described a pathway from self-reported pain to clinical and psychosocial assessment, then to intervention (e.g., pharmaceutical, non-pharmaceutical, counseling, and education), then to reassessment and additional intervention if needed, culminating in self-reported alleviation of pain.
- To demonstrate that the target population values the measured PRO and finds it meaningful, the developers cited a study (McMillan et al., 2002) that found a strong relationship between pain and distress among patients with cancer who were newly admitted to hospice.
- Committee members agreed that the developer identified at least one clinical action that could influence patient-reported pain levels and that hospice patients find questions regarding level of pain to be meaningful.
- Performance trends for hospice facilities that voluntarily submitted data to NHPCO between 2012 and 2015 were relatively stable, with a mean of 66.4 (SD=21.1) in 2012 across 143 reporting hospice facilities and a mean of 64.7 (SD=24.5) in 2015 across 46 reporting hospice facilities.
- Data presented by the developer suggest there are no disparities in care according to age group, sex, race, or condition (cancer vs. non-cancer).

#### 2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-3; M-18; L-2; I-0** 2b. Validity: **H-1; M-8; L-6; I-8**

#### Rationale:

- Committee members questioned excluding patients because of language barriers. The developer clarified that use of interpreters—including family interpreters—is allowable.
- Some Committee members voiced concern about the high number of patients who are excluded from the measure because they did not report being uncomfortable because of pain at initial assessment. The developer clarified that these patients are not actually excluded from the measure but instead are not eligible for the measure.
- Reliability testing at the time of the 2012 endorsement evaluation included score-level testing of agency-level between-versus-within variance using data from 58 hospice agencies and 38,000 patients (intra-class correlation coefficient= 0.71, 95% CI=0.63-0.77). For the current evaluation, developers updated their reliability testing by describing analyses that examined stability in performance over time; however, NQF does not consider analysis of data across time to be an appropriate method of testing the reliability.
- To demonstrate the validity of the measure for the 2012 endorsement evaluation, developers compared response rates obtained from 212 patients from 9 hospice agencies when using two different wordings for the measure (pain brought to a “comfortable” level versus an “acceptable” level). The developers



## 0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment

reported that that 96% of patients provided the same answer to the two wordings of the question ( $\kappa=0.91$ ). Updated testing was not conducted. Committee members agreed that this analysis and the results were sufficient to validate the measure.

- One member expressed concern that the measure might not be specific enough to reflect improvement in pain resulting from the terminal condition, noting that it may not be possible to alleviate more generalized pain (e.g., from arthritis) within the 48-hour timeframe for the measure. Another member noted that use of slower-acting medications (e.g., methadone) is increasing. The developer acknowledged that it may not be possible to manage all types of pain within 48 hours and noted that 100% performance on the measure is not expected.
- Another member questioned whether a clinically appropriate outcome measure for pain would be to assess the number of patients whose pain was reduced by a threshold amount over the 48 hours rather than to expect pain to be brought to a completely comfortable level. The developer acknowledged the “high bar” set by the measure, but reiterated the importance of allowing the patient to define what is comfortable. The developer also noted that different patients will require different rating scales (e.g., 0-10 scale, faces, etc.) and that assessing equivalent improvement across the different scales would be difficult.
- Several Committee members expressed concern about the lack of risk adjustment for this measure. While the developer presented patient-level data indicating no statistically significant effects of age (>65 years old vs  $\geq 65$ ; >75 years old vs  $\geq 75$ ), gender, or race (Caucasian vs non-Caucasian) on the measure score, facility-level data are needed to demonstrate that risk-adjustment is not needed to achieve fair comparisons across facilities. Members were particularly interested in potential differences in performance by region, diagnosis, and co-morbidities, and encouraged the developer to bring these data (or a plan for future risk-adjustment) to the post-comment call. The developers noted that they receive aggregate-level data from facilities and were not sure if they could bring back the requested analysis. They agreed to try to do so and to bring back a plan for risk-adjustment.

### 3. Feasibility: H-X; M-X; L-X; I-X

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

### 4. Usability and Use: H-X; M-X; L-X; I-X

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

### 5. Related and Competing Measures

- This measure is related to (potentially competing with) two measures:
  - 1634: Hospice and Palliative Care -- Pain Screening [*a clinician-level & facility-level process measure in hospice and hospital setting*]
  - 1637: Hospice and Palliative Care -- Pain Assessment. Description: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening [*clinician-level & facility-level process measure in hospice and hospital setting*]
- Because this measure was not recommended for endorsement by this Committee during the in-person meeting, a best-in-class and harmonization discussion was not conducted.

### Standing Committee Recommendation for Endorsement: Not recommended

#### Rationale:

- The Committee wants to see hospice-level analysis demonstrating that risk-adjustment is not needed, or, if analysis indicates risk-adjustment is needed, a plan for that risk-adjustment.

### 6. Public and Member Comment

### 7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

### 8. Board of Directors Vote: Y-X; N-X

## 1626 Patients Admitted to ICU who Have Care Preferences Documented

### 9. Appeals

#### *Ethical and legal aspects of care*

## 1626 Patients Admitted to ICU who Have Care Preferences Documented

### [Submission](#) | Specifications

**Description:** Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.

**Numerator Statement:** Patients in the denominator who had their care preferences documented within 48 hours of ICU admission or have documentation of why this was not done.

**Denominator Statement:** All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.

**Exclusions:** None

**Adjustment/Stratification:**

**Level of Analysis:** Facility

**Setting of Care:** Hospital/Acute Care Facility

**Type of Measure:** Process

**Data Source:** Paper Medical Records

**Measure Steward:** RAND Corporation

### STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]

#### 1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-24; L-0; I-0**; 1b. Performance Gap: **H-1; M-22; L-0; I-1**;

#### Rationale:

- For the 2012 endorsement evaluation, the developers cited two systematic reviews linking advance care planning to better patient outcomes and providing evidence that patients want to communicate their care preferences to their physicians. No updated evidence was submitted for the current evaluation. However, Committee members referenced additional guideline recommendations released since the 2012 evaluation and included in the submission for measure #1641; these recommendations support advance care planning and shared decision making.
- The Committee noted that the evidence presented does not pertain to the *documentation* of the care preferences themselves as much as to the importance of care preferences and the discussion around those.
- For the 2012 endorsement evaluation, the developers provided performance data from four individual studies with measure results ranging from 9% to 63.7%. However, these results were based on data that are more than five years old, and no updated performance data was presented for the current evaluation. However, using their own experience and judgement, Committee members agreed that there still is opportunity for improvement, and suggested there may be disparities in care for this measure.

#### 2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-13; L-8; I-3** 2b. Validity: **H-0; M-8; L-11; I-5**

#### Rationale:

- Committee members expressed concerns that limiting the denominator of the measure to 'vulnerable adults' as defined in the specifications (i.e., age 75 or older; score >2 on the Vulnerable Elder Survey-13, life expectancy <6 months, Stage IV cancer, receiving hospice care) would not capture important patient populations, including patients with acute respiratory failure.

## 1626 Patients Admitted to ICU who Have Care Preferences Documented

- The developer clarified that the timing of the admission to ICU “begins” when the admission orders are written.
- Committee members asked the developers to explain the numerator requirement of having “care preferences documented within 48 hours of ICU admission”, noting that the submission also indicates that “simply having an advance directive or other advance care planning document or POLST in the medical record does not satisfy this criterion”. The developers clarified that the measure assesses whether a discussion regarding care preferences with either the patient or the family occurred within 48 hours of ICU admission and that discussion could be with non-ICU providers and could occur during the hospitalization but prior to the ICU admission. The developers noted that care preference information may not always be included in an advance directive and further clarified that existence of an advance directive in the record is not sufficient.
- For the 2012 endorsement evaluation, the developers provided inter-rater reliability statistics from two studies in which the kappa value for the denominator was 0.87 to 0.95 and the kappa value for the numerator was 0.86 to 0.87 and 0.86, indication acceptable agreement. The developers did not provide updated reliability testing.
- The Committee did not reach consensus on reliability of the measure due to concerns about the ability to consistently apply the numerator specifications.
- Validity testing at the time of the 2012 endorsement evaluation included three face validity assessments by three expert panels using a modified Delphi method. Developers did not update validity testing for the current evaluation.
- This measure did not pass the validity subcriterion. Committee members noted that one of the face validity assessments was specific to cancer patients only, that none of the face validity assessments were specific to ICU patients, and that this measure was not assessed specifically but was instead discussed more generally.

### 3. Feasibility: H-X; M-X; L-X; I-X

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Data collection strategy can be implemented)*

### 4. Usability and Use: H-X; M-X; L-X; I-X

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

### 5. Related and Competing Measures

- This measure is related to one measure:
  - 1617: Patients Treated with an Opioid who are Given a Bowel Regimen
- The definition of “vulnerable adults” is harmonized between this measure and #1617.
- This measure directly competes with two measures:
  - 0326: Advance Care Plan. Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
  - 1641: Hospice and Palliative Care – Treatment Preferences. Description: Percentage of patients with chart documentation of preferences for life sustaining treatments
- Because this measure did not meet the Validity subcriterion, there was no need for a best-in-class discussion between this measure and the other competing measures.

**Standing Committee Recommendation for Endorsement: DID NOT PASS SCIENTIFIC ACCEPTABILITY**

<b>1626 Patients Admitted to ICU who Have Care Preferences Documented</b>
<b>Rationale</b>
<ul style="list-style-type: none"> <li>The Committee did not feel that the face validity assessments that were conducted for this measure were specific enough.</li> </ul>
<b>6. Public and Member Comment</b>
<b>7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X</b>
<b>8. Board of Directors Vote: Y-X; N-X</b>
<b>9. Appeals</b>

## Measures Withdrawn from Consideration

One measure previously endorsed by NQF has withdrawn during the endorsement evaluation process. Endorsement for this measure will be removed.

### *Care of the patient at the end of life*

Measure	Reason for withdrawal
<b>0211 Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life</b>	Other (unable to consider risk-adjustment at this time)

<b>0211 Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life</b>
<a href="#">Submission</a>   Specifications
<p><b>Description:</b> Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life</p> <p><b>Numerator Statement:</b> Patients who died from cancer and had at least one emergency department visit in the last 30 days of life</p> <p><b>Denominator Statement:</b> Patients who died from cancer</p> <p><b>Exclusions:</b> None</p> <p><b>Adjustment/Stratification:</b></p> <p><b>Level of Analysis:</b> Clinician : Group/Practice</p> <p><b>Setting of Care:</b> Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility</p> <p><b>Type of Measure:</b> Intermediate Clinical Outcome</p> <p><b>Data Source:</b> Administrative claims, Electronic Clinical Data : Registry</p> <p><b>Measure Steward:</b> American Society of Clinical Oncology</p>
<p><b>STANDING COMMITTEE MEETING [05/10/2016-05/11/2016]</b></p> <p><b>1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u></b> (1a. Evidence, 1b. Performance Gap)</p> <p>1a. Evidence: <b>H-1; M-4; L-1; I-16</b>; 1b. Performance Gap: <b>H-5; M-16; L-0; I-1</b></p> <p>Evidence Exception: <b>Y-21; N-1</b></p> <p><b>Rationale:</b></p> <ul style="list-style-type: none"> <li>For the 2012 endorsement evaluation, the developers cited a 2011 study (Ho, et al., 2011) that examined trends in the aggressiveness of end-of-life (EOL) cancer care (ED visits), and an expert consensus</li> </ul>

## 0211 Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life

statement (Earle, et al., 2003) that identified potential indicators of quality of end-of-life cancer care using administrative data.

- For the current evaluation, developers updated the evidence by referencing: a 2013 Cochrane Collaborative systematic review that evaluated the impact of home-based palliative care services on several patient and caregiver outcomes, which found that for patients with cancer, home-based palliative care services increases the chance of dying at home for patients with cancer; a 2012 provisional clinical opinion from the American Society of Clinical Oncology that recommends consideration of palliative care early in the course of illness for patients with metastatic cancer and/or high symptom burden; and three individual studies providing estimates of ED utilization for cancer patients near the end of life, although these studies did not link ED utilization to other patient outcomes.
- In their discussion of the evidence, the Committee agreed that the empirical evidence provided did not link fewer ED visits in the last month of life to patient or family outcomes. One Committee noted that a primary cause of ED visits among cancer patients is pain and the Committee agreed that at least some ED visits likely are avoidable. Therefore, the Committee deemed it acceptable to hold providers accountable for this measure and agreed to invoke the exception to the evidence subcriterion.
- Although specified at the clinician group/practice level, the developers provided system-level performance data from two integrated health systems, one showing an increase from 35% in Fall 2011 to 43.90% in Spring 2013, along with differences in performance according to sex and race/ethnicity, and the other showing an overall average performance of 5.38% for June 2013 to May 2015 along with differences in performance according to payer.
- Given the variation in the results within and between the two systems and between population groups, the Committee agreed that there is opportunity for improvement.

### **2. Scientific Acceptability of Measure Properties: The measure did not meet the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-10; L-2; I-10** 2b. Validity: **H-0; M-6; L-5; I-11**

#### Rationale:

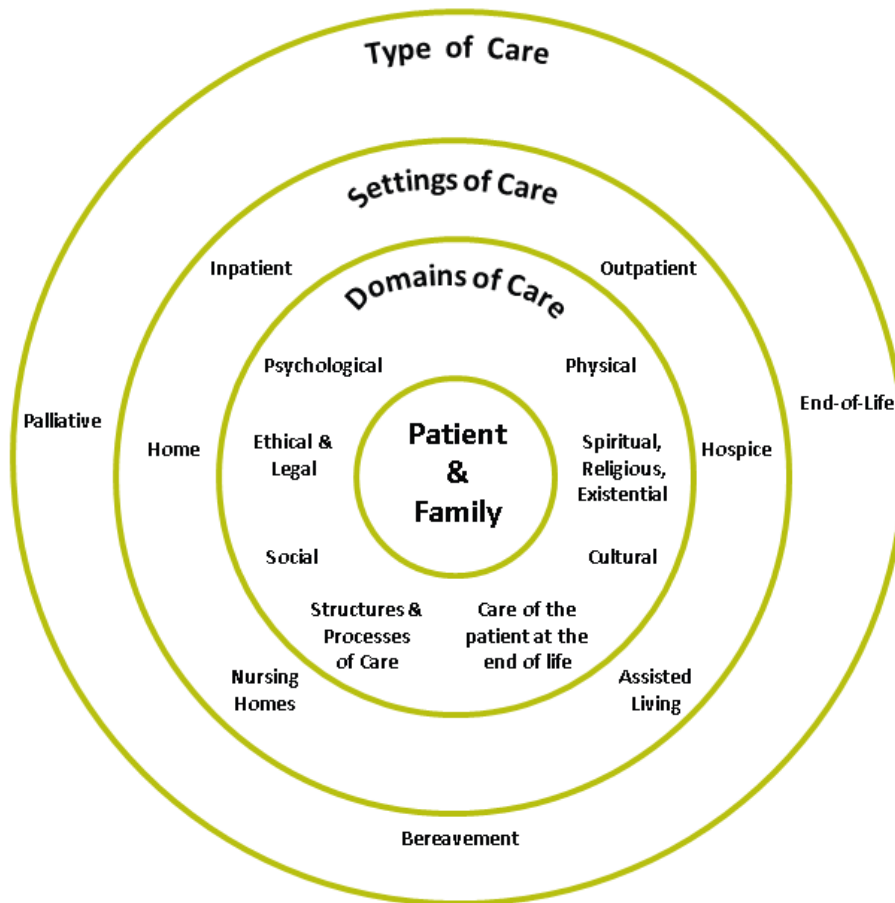
- This measure is specified for both claims and registry data. When questioned about identifying cancer deaths from claims data, the developer clarified that the denominator is derived from registry data (e.g., a death registry or other cancer registry that includes information on cancer deaths) while the numerator is derived from claims data.
- The developers did not conduct reliability testing for either the numerator or the denominator. However, per NQF guidance, because data element validity testing was done for the measure numerator, additional data element reliability testing for the numerator is not required.
- For the 2012 evaluation, the developer conducted data element validity testing for the measure numerator by comparing claims for 150 consecutive patients treated for advanced cancer at Boston's Dana-Farber Cancer Institute and Brigham and Women's Hospital to data from the full medical record. The developer reported the measure was 89% accurate (percent true positives + true negatives). Although the developer did not conduct data element validity testing for the measure denominator, several Committee members agreed that registry data (particularly death registry data), in general, are accurate and therefore additional testing is unnecessary.
- The developer did not provide any updated reliability or validity testing.
- The Committee did not reach consensus on reliability.
- The Committee questioned the developer on the lack of risk-adjustment for the measure. Members stated that appropriateness of ED admission may vary by patient characteristics such as age, morbidity status, and geographic location. In particular, Committee members highlighted a potential unintended consequence of limiting access to care for patients in rural areas where admission to the ED may be the only care option during an urgent situation. The developers agreed in principle with the need to risk-adjust the measure but did not have access to the appropriate resources to conduct those analyses before the Committee's meeting.
- As a result of the concerns related to the lack of risk-adjustment, the Committee did not pass the

**0211 Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life**

measure on the validity criterion but deferred their final endorsement decision, pending potential risk-adjustment of the measure. The Committee asked the measure developer to explore risk-adjustment of the measure over the next 12-month period. The developer agreed to consider the deferral option and respond to NQF with the formal decision within 14 business days of the in-person meeting. On May 27<sup>th</sup>, 2016, the measure developers communicated to NQF that they would not be pursuing the deferral option. Because as initially constructed the measure did not pass the validity subcriterion, the Committee's recommendation was changed from "Endorsement Decision Deferred" to "Not Endorsed".

## Appendix B: NQF Palliative and End-of-Life Care Portfolio and Related Measures

### Measurement Framework for Palliative and End-of-Life Care



### Measures in the portfolio

*\*Denotes measures that were not evaluated in the Palliative and End-of-Life Care project*

#### *Physical aspects of care*

0177: Improvement in pain interfering with activity\*

0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment

0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)\*

0384: Oncology: Medical and Radiation - Pain Intensity Quantified (paired with 0383)\*

0420: Pain Assessment and Follow-Up\*

0676: Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)\*

0677: Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)\*

1617: Patients Treated with an Opioid who are Given a Bowel Regimen

1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits

1634: Hospice and Palliative Care -- Pain Screening

1637: Hospice and Palliative Care -- Pain Assessment

1638: Hospice and Palliative Care -- Dyspnea Treatment

1639: Hospice and Palliative Care -- Dyspnea Screening

1822: External Beam Radiotherapy for Bone Metastases \*

### ***Psychological and psychiatric aspects of care***

0260: Assessment of Health-Related Quality of Life in Dialysis Patients\*

0700: Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation\*

### ***Spiritual, religious, and existential aspects of care***

1647: Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.

### ***Ethical and legal aspects of care***

0326: Advance Care Plan\*

1626: Patients Admitted to ICU who Have Care Preferences Documented

1641: Hospice and Palliative Care – Treatment Preferences

### ***Care of the imminently dying patient***

0208: Family Evaluation of Hospice Care\*

0210: Proportion receiving chemotherapy in the last 14 days of life

0211: Proportion with more than one emergency room visit in the last days of life

0213: Proportion admitted to the ICU in the last 30 days of life

0215: Proportion not admitted to hospice



0216: Proportion admitted to hospice for less than 3 days

1623: Bereaved Family Survey\*

1625: Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated

*Social aspects of care*

There are no NQF-endorsed measures for this domain.

## Appendix C: Palliative and End-of-Life Care Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized as of June 3, 2016
0177	Improvement in pain interfering with activity	Home Health Quality Reporting Program
0208	Family Evaluation of Hospice Care	
0209	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	
0210	Proportion receiving chemotherapy in the last 14 days of life	
0211	Proportion with more than one emergency room visit in the last days of life	
0213	Proportion admitted to the ICU in the last 30 days of life	
0215	Proportion not admitted to hospice	
0216	Proportion admitted to hospice for less than 3 days	
0260	Assessment of Health-related Quality of Life in Dialysis Patients	
0326	Advance Care Plan	Physician Quality Reporting System
0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Physician Quality Reporting System PPS-Exempt Cancer Hospital Quality Reporting Program
0384	Oncology: Medical and Radiation - Pain Intensity Quantified	Physician Quality Reporting System PPS-Exempt Cancer Hospital Quality Reporting Program
0420	Pain Assessment and Follow-Up	Physician Quality Reporting System End-Stage Renal Disease Quality Improvement Program
0676	Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)	Nursing Home Quality Initiative (MDS 3.0)
0677	Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)	Nursing Home Quality Initiative (MDS 3.0)
0700	Health-related Quality of Life in COPD patients before and after	

NQF #	Title	Federal Programs: Finalized as of June 3, 2016
	Pulmonary Rehabilitation	
1617	Patients Treated with an Opioid who are Given a Bowel Regimen	Hospice Quality Reporting Program
1623	Bereaved Family Survey	
1625	Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	
1626	Patients Admitted to ICU who Have Care Preferences Documented	
1628	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	
1634	Hospice and Palliative Care -- Pain Screening	Hospice Quality Reporting Program
1637	Hospice and Palliative Care -- Pain Assessment	Hospice Quality Reporting Program
1638	Hospice and Palliative Care -- Dyspnea Treatment	Hospice Quality Reporting Program
1639	Hospice and Palliative Care -- Dyspnea Screening	Hospice Quality Reporting Program
1641	Hospice and Palliative Care – Treatment Preferences	Hospice Quality Reporting Program
1647	Believes and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.	Hospice Quality Reporting Program
1822	External Beam Radiotherapy for Bone Metastases	PPS-Exempt Cancer Hospital Quality Reporting Program Hospital Outpatient Quality Reporting Program
1894	Cross-Cultural Communication Measure Derived from the Cross-Cultural Communication Domain of the C-CAT	
1919	Cultural Competency Implementation Measure	

## Appendix D: Project Standing Committee and NQF Staff

### STANDING COMMITTEE

#### **R. Sean Morrison, MD (Co-Chair)**

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Project Analyst

## Appendix E: Measure Specifications

	<b>0210 Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life</b>
Status	Submitted
Steward	American Society of Clinical Oncology
Description	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Registry ASCO Quality Oncology Practice Initiative (QOPI®) No data collection instrument provided Attachment Chemotherapy.xlsx
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and received chemotherapy in the last 14 days of life
Numerator Details	Claims: see attached chemotherapy code set. Registry: Date of death – date of last chemotherapy administration <= 14 days
Denominator Statement	Patients who died from cancer.
Denominator Details	Claims: Patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets. Registry: Deceased = Yes, patient is deceased as a consequence of his/her cancer or cancer treatment.
Exclusions	None
Exclusion details	None
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = lower score
Algorithm	Performance is calculated as: 1. Identify those patients that meet the denominator criteria defined in the measure. 2. Subtract those patients with a denominator exclusion from the denominator. Note: this measure does not have exclusions. 3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria. 4. Calculation: Numerator/Denominator-Denominator Exclusions No diagram provided
Copyright / Disclaimer	5.1 Identified measures:  5a.1 Are specs completely harmonized?  5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value:

	<b>0213 Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life</b>
Status	Submitted
Steward	American Society of Clinical Oncology
Description	Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life
Type	Intermediate Clinical Outcome
Data Source	Administrative claims, Electronic Clinical Data : Registry Not applicable No data collection instrument provided No data dictionary
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and were admitted to the ICU in the last 30 days of life
Numerator Details	MEDPAR only: did not include SNF claims did not include pediatric, psychiatric, burn or trauma ICUs (MEDPAR variable increind ne 3,4,7,8) <ul style="list-style-type: none"> <li>• variable in MEDPAR called incrdays, which is number of ICU days per visit</li> <li>• used hospital admission date variable (admitdate) and then checked if incrdays was &gt;0 for admissions occurring in the last 30 days before death</li> </ul>
Denominator Statement	Patients who died from cancer
Denominator Details	Claims:Patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion details	Not applicable
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = lower score
Algorithm	Performance is calculated as: <ol style="list-style-type: none"> <li>1. Identify those patients that meet the denominator criteria defined in the measure.</li> <li>2. Subtract those patients with a denominator exclusion from the denominator if applicable. Note: this measure does not have exclusions.</li> <li>3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria.</li> <li>4. Calculation: Numerator/Denominator-Denominator Exclusions No diagram provided</li> </ol>
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized?



	<b>0213 Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life</b>
	5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value:

	<b>0215 Proportion of patients who died from cancer not admitted to hospice</b>
Status	Submitted
Steward	American Society of Clinical Oncology
Description	Proportion of patients who died from cancer not admitted to hospice
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Registry ASCO Quality Oncology Practice Initiative (QOPI®) No data collection instrument provided No data dictionary
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility
Numerator Statement	Proportion of patients not enrolled in hospice
Numerator Details	Claims: Those without claims in Medicare HOSPICE file. No codes used. Registry: Hospice Enrollment = No
Denominator Statement	Patients who died from cancer.
Denominator Details	Claims: Patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets. Registry: Deceased = Yes, patient is deceased as a consequence of his/her cancer or cancer treatment
Exclusions	None
Exclusion details	Not applicable
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = lower score
Algorithm	Performance is calculated as: 1. Identify those patients that meet the denominator criteria defined in the measure. 2. Subtract those patients with a denominator exclusion from the denominator. Note: This measure does not have exclusions. 3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria. 4. Calculation: Numerator/Denominator-Denominator Exclusions No diagram provided
Copyright /	5.1 Identified measures:

	<b>0215 Proportion of patients who died from cancer not admitted to hospice</b>
Disclaimer	<p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value:</p>

	<b>0216 Proportion of patients who died from cancer admitted to hospice for less than 3 days</b>
Status	Steering Committee Review
Steward	American Society of Clinical Oncology
Description	Proportion of patients who died from cancer, and admitted to hospice and spent less than 3 days there
Type	Intermediate Clinical Outcome
Data Source	Administrative claims, Electronic Clinical Data : Registry ASCO Quality Oncology Practice Initiative (QOPI®) No data collection instrument provided No data dictionary
Level	Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and spent fewer than three days in hospice.
Numerator Details	<p>Claims: Medicare HOSPICE file only: Subtracted hospice admission date (admndate) from death date variable to get hospice length of stay.</p> <p>Registry: Date of Death – Hospice Enrollment Date &lt;= 3 days</p>
Denominator Statement	Patients who died from cancer who were admitted to hospice
Denominator Details	<p>Claims: Patients in the death registry with cancer as their cause of death who also appear in the Medicare hospice file. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.</p> <p>Registry: Deceased = Yes, patient is deceased as a consequence of his/her cancer or cancer treatment AND Hospice Enrollment = Yes</p>
Exclusions	None
Exclusion details	Not applicable
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>Not applicable</p>
Stratification	Not applicable

	<b>0216 Proportion of patients who died from cancer admitted to hospice for less than 3 days</b>
Type Score	Rate/proportion better quality = lower score
Algorithm	Performance is calculated as: 1. Identify those patients that meet the denominator criteria defined in the measure. 2. Subtract those patients with a denominator exclusion from the denominator. Note: this measure does not have any denominator exclusions 3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria. 4. Calculation: Numerator/Denominator-Denominator Exclusions No diagram provided
Copyright / Disclaimer	5.1 Identified measures:  5a.1 Are specs completely harmonized?  5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value:

	<b>1617 Patients Treated with an Opioid who are Given a Bowel Regimen</b>
Status	Submitted
Steward	RAND Corporation/UCLA
Description	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed
Type	Process
Data Source	Paper Medical Records Medical record abstraction tool No data collection instrument provided No data dictionary
Level	Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic, Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed
Numerator Details	Patients from the denominator given a bowel regimen (or one is already in place) defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR documentation of why such a bowel regimen is not needed.
Denominator Statement	Vulnerable adults who are given a prescription for an opioid
Denominator Details	All vulnerable adults >17 years old prescribed an opioid as: - An inpatient - A hospice patient (inpatient or outpatient) - A non-hospice outpatient in patients who are not already taking an opioid "Vulnerable" is defined as any of the following: - >74 years of age - Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001) - Poor prognosis/terminal illness defined as life expectancy of <6 months

	<b>1617 Patients Treated with an Opioid who are Given a Bowel Regimen</b>
	- Stage IV cancer - Patients receiving hospice care in any setting Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699
Exclusions	Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription
Exclusion details	Patients who are prescribed an opioid in the outpatient setting are excluded if they are NOT hospice patients AND at the time of the opioid prescription that occurred during the study period, they were already taking an opioid. This exclusion does NOT apply to inpatients or to hospice patients treated in any setting. Non-hospice outpatients who are prescribed an opioid who may have been on an opioid in the past, but are not taking an opioid at the time of the study period opioid prescription are NOT excluded.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Type Score	Rate/proportion better quality = higher score
Algorithm	Note that edits placed in brackets [] 1. Identify vulnerable adults with a prescription for an opioid. For inpatients, identify ALL patients with an order for [standing (not prn)] opioid treatment on admission or during the hospitalization. For hospice patients, identify ALL patients with an order for opioid treatment on admission or during the episode of hospice care. For outpatient non-hospice patients, identify patients with a "new" prescription for an opioid. "New" prescription for a non-hospice outpatient means that the patient is not already taking an opioid.  2. Include only patients who are vulnerable (age >74, VES-13 score >2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care). 3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed.
Copyright / Disclaimer	5.1 Identified measures:  5a.1 Are specs completely harmonized?  5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value: This measure was part of the National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided.

	<b>1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated</b>
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	<b>1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated</b>
Status	Submitted
Steward	RAND Corporation
Description	Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated
Type	Process
Data Source	Paper Medical Records Medical record abstraction tool No data collection instrument provided
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Patients from the denominator who have their ICDs deactivated prior to death or have documentation of why this was not done
Numerator Details	Documentation in the medical record that the ICD was deactivated or documentation of a discussion of deactivation of the ICD with the patient or documentation of why ICD deactivation was not done.
Denominator Statement	Patients who died an expected death who have an ICD in place
Denominator Details	Hospitalizations of adult patients of at least 3 days duration that ended in an expected death. Expected death is defined as physician documentation at least 3 days before death that the patient's illness was terminal or that the patient had a grave prognosis, was receiving comfort care, was receiving hospice care, had a life-threatening disease, or was expected to die.
Exclusions	None
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	None
Type Score	Rate/proportion better quality = higher score
Algorithm	<ol style="list-style-type: none"> <li>1. Identify adult hospitalizations of at least 3 days duration that ended in patient death</li> <li>2. Identify from the medical record patients who had an ICD in place</li> <li>3. Identify from physician documentation patients who were noted to have had an expected death at least 3 days prior to death</li> <li>4. Determine if the ICD was deactivated prior to death or documentation noted an attempt to discuss ICD deactivation with the patient or surrogate or other documentation addressing why the ICD was not deactivated.</li> </ol>
Copyright / Disclaimer	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure was part of the</p>

	<b>1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated</b>
	National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided.

	<b>1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits</b>
Status	Submitted
Steward	RAND Corporation
Description	Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit
Type	Process
Data Source	Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Registry Patients were identified via the testing organizations' cancer registries. At one institution, outpatient pain vital sign scores were extracted electronically from the patient EHR. At other institutions, quantitative pain scores were collected via medical record abstraction.
Level	Facility, Health Plan, Integrated Delivery System
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool
Numerator Details	Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.
Denominator Statement	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit
Denominator Details	Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion
Exclusions	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Identify patients at least 18 years of age with Stage IV cancer 2. Identify patients who have had at least 1 primary care or cancer-related visit. Exclude patients who are not alive 30 or more days after diagnosis. 3. For each applicable visit, determine if a screening for pain was performed using a quantitative standardized tool.

	<b>1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits</b>
	4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits
Copyright / Disclaimer	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized? Yes</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure was part of the National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided.</p> <p>Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure.</p> <p>It is unclear exactly what the scope of measure 0420 is, however it appears to be directed at ancillary, non-physician professionals. It is unclear what "initiation of therapy" is referring to. The measure's endorsement is time limited (endorsed July 31, 2008)</p> <p>Measure 0384 (paired with 0383) also has a time-limited endorsement (endorsed July 31, 2008). This measure targets only patients who are currently receiving chemotherapy or radiation therapy, and by definition, excludes some patients with advanced cancer who are not receiving this type of treatment. The proposed measure targets patients with Stage IV cancer and includes more venues of care than the existing measure where it would be applied (primary care and all cancer-related outpatient visits). This is in keeping with the reality that pain and pain control becomes a central focus for patients with late-stage cancer, and regular pain assessment should occur in multiple outpatient care settings. The developers propose that measure 0383 be limited to patients with Stage I-III cancer and endorse the proposed measure which targets Stage IV cancer patients.</p> <p>Proposed measure 1634: Hospice and Palliative Care - Pain Screening: Proposed measure 1634 targets patients with serious conditions who are entering hospice or hospital-based palliative care. The measure proposed here targets a sub-population (advanced cancer). However, the setting and timing of 1634 is hospice/palliative care admission and is a one-time screen. 1628 focuses on pain screening at all outpatient visits. Although the 2 measures focus on different venues of care (and 1 is a time measure and the other every visit), they are completely harmonized in content.</p>

	<b>1634 Hospice and Palliative Care -- Pain Screening</b>
Status	Submitted
Steward	University of North Carolina-Chapel Hill
Description	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool with separate collection of numerator and denominator data values.

	<b>1634 Hospice and Palliative Care -- Pain Screening</b>
	Available in attached appendix at A.1 No data dictionary
Level	Facility, Clinician : Group/Practice
Setting	Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.
Numerator Details	Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized tool during the admission evaluation for hospice / initial encounter for hospital-based palliative care. Screening may be completed using verbal, numeric, visual analog, rating scales designed for use the non-verbal patients, or other standardized tools.
Denominator Statement	Patients enrolled in hospice OR patients receiving specialty palliative care in an acute hospital setting.
Denominator Details	The Pain Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Pain Assessment quality measure (NQF #1637) to ensure that all patients who report significant pain are clinically assessed.]
Exclusions	Patients with length of stay < 1 day in palliative care.
Exclusion details	Calculation of length of stay: discharge date is identical to date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Screened for pain: a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting. b. Step 2- Exclude palliative care patients if length of stay is < 1 day. c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) using a standardized tool. Quality Measure = Numerator: Patients screened for pain in Step 3 / Denominator: Patients in Step 1-Patients excluded in Step 2 No diagram provided
Copyright / Disclaimer	5.1 Identified measures:  5a.1 Are specs completely harmonized? Yes  5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value: This measure was part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative



	<b>1634 Hospice and Palliative Care -- Pain Screening</b>
	Care Measures Bundle. This measure has been harmonized with ACOVE / ASSIST Measure 1628: Patients with advanced cancer screened for pain at outpatient visits. The two measures have the same focus, populations are different (although both include patients with advanced cancer), apply in different settings with different timing.

	<b>1637 Hospice and Palliative Care -- Pain Assessment</b>
Status	Submitted
Steward	University of North Carolina-Chapel Hill
Description	This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool with separate collection of numerator and denominator values. Available in attached appendix at A.1 No data dictionary
Level	Facility, Clinician : Group/Practice
Setting	Hospice, Hospital/Acute Care Facility
Numerator Statement	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.
Numerator Details	Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life.
Denominator Statement	Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation / initial encounter.
Denominator Details	The Pain Assessment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number >0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care. For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted in screening (response of moderate or severe on verbal scale, >4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator. [NOTE: This quality measure should be paired with the Pain Screening quality measure (NQF #1634) to ensure that all patients are screened and therefore given the opportunity to

	<b>1637 Hospice and Palliative Care -- Pain Assessment</b>
	report pain and enter the denominator population for Pain Assessment.]
Exclusions	Patients with length of stay < 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.
Exclusion details	Calculation of length of stay; discharge date is identical to date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Clinical assessment of Pain: a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting b.Step 2- Exclude palliative care patients if length of stay is < 1 day. c.Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) d.Step 4- Identify patients who screened positive for pain [any pain if hospice; moderate or severe pain if palliative care]. e.Step 5- Exclude patients who screened negative for pain f.Step 6- Identify patients who received a clinical assessment for pain within 24 hours of screening positive for pain Quality Measure= Numerator: Patients who received a clinical assessment for pain in Step 6 / Denominator: Patients in Step 4 No diagram provided
Copyright / Disclaimer	5.1 Identified measures:  5a.1 Are specs completely harmonized?  5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value: This measure was part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle.

	<b>1638 Hospice and Palliative Care -- Dyspnea Treatment</b>
Status	Submitted
Steward	University of North Carolina-Chapel Hill
Description	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data

	<b>1638 Hospice and Palliative Care -- Dyspnea Treatment</b>
	Available in attached appendix at A.1 No data dictionary
Level	Facility, Clinician : Group/Practice
Setting	Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.
Numerator Details	Treatment is administered if within 24 hours of the positive screen for dyspnea, medical treatment plan, orders or pharmacy records show inhaled medications, steroids, diuretics, or non-medication strategies such as oxygen and energy conservation. Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.
Denominator Statement	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.
Denominator Details	<p>The Dyspnea Treatment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.</p> <p>For patients enrolled in hospice or palliative care, a positive screen is indicated by any dyspnea noted as other than none on a verbal screen, any number &gt; 0 on a numeric scale or any observational or self-report of dyspnea.</p> <p>[NOTE: This quality measure should be paired with the Dyspnea Screening quality measure (NQF #1639) to ensure that all patients are screened and therefore given the opportunity to report dyspnea and enter the denominator population for Dyspnea Treatment.]</p>
Exclusions	Patients with length of stay < 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.
Exclusion details	Calculation of length of stay; discharge date is identical to date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Dyspnea treatment:</p> <ol style="list-style-type: none"> <li>Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care</li> <li>Step 2- Identify admission evaluation / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days</li> <li>Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) / initial encounter (palliative care)</li> <li>Step 4- Identify patients who screened positive for dyspnea</li> <li>Step 5- Identify patients who received treatment within 24 hours of screening positive for dyspnea</li> </ol> <p>Quality Measure= Numerator: Patients who received treatment for dyspnea in Step 5 / Denominator: Patients in Step 4 No diagram provided</p>
Copyright / Disclaimer	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p>

	<b>1638 Hospice and Palliative Care -- Dyspnea Treatment</b>
	<p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.</p>

	<b>1639 Hospice and Palliative Care -- Dyspnea Screening</b>
Status	Submitted
Steward	University of North Carolina-Chapel Hill
Description	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data Available in attached appendix at A.1 No data dictionary
Level	Facility, Clinician : Group/Practice
Setting	Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
Numerator Details	Patients who are screened for the presence or absence of dyspnea during the admission evaluation for hospice / initial encounter for hospital-based palliative care, and asked to rate its severity. Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients.
Denominator Statement	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.
Denominator Details	The Dyspnea Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Dyspnea Treatment quality measure (NQF #1639) to ensure that all patients who report dyspnea are clinically considered for treatment.]
Exclusions	Patients with length of stay < 1 day in palliative care.
Exclusion details	Calculation of length of stay; discharge date is identical to date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A

	<b>1639 Hospice and Palliative Care -- Dyspnea Screening</b>
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Screened for dyspnea:</p> <p>a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice care or who receive specialty palliative care in an acute hospital setting</p> <p>b.Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day.</p> <p>c.Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) OR during the initial encounter (palliative care)</p> <p>Quality measure = Numerator: Patients screened for dyspnea in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 No diagram provided</p>
Copyright / Disclaimer	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.</p>

	<b>1641 Hospice and Palliative Care – Treatment Preferences</b>
Status	Submitted
Steward	University of North Carolina-Chapel Hill
Description	Percentage of patients with chart documentation of preferences for life sustaining treatments.
Type	Process
Data Source	<p>Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.</p> <p>Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data</p> <p>Available in attached appendix at A.1 No data dictionary</p>
Level	Facility, Clinician : Group/Practice
Setting	Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients whose medical record includes documentation of life sustaining preferences
Numerator Details	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as “Full Code” or

	<b>1641 Hospice and Palliative Care – Treatment Preferences</b>
	“DNR/DNI” do 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.
Denominator Statement	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
Denominator Details	The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.
Exclusions	Patients with length of stay < 1 day in hospice or palliative care
Exclusion details	Calculation of length of stay; discharge date is identical to date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Chart documentation of life sustaining preferences: a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital b.Step 2- Exclude patients if length of stay is < 1 day. c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments.  Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 No diagram provided
Copyright / Disclaimer	5.1 Identified measures:  5a.1 Are specs completely harmonized?  5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.

	<b>1647 Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.</b>
Status	Submitted
Steward	University of North Carolina-Chapel Hill
Description	This measure reflects the percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the

	<b>1647 Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.</b>
	patient/caregiver/family did not want to discuss.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record The Hospice Item Set (HIS) is the data source used to calculate the quality measure. Available in attached appendix at A.1 Attachment QNAV CPD - Sample-634425372974245559.pdf
Level	Facility
Setting	Hospice
Numerator Statement	Patients whose medical record includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.
Numerator Details	<p>Examples of a discussion may include asking about patient’s need for spiritual or religious support, questions about the cause or meaning of illness or death. Other examples include discussion of God or a higher power related to illness, or offer of a spiritual resource including a chaplain. Discussion of spiritual or religious concerns may occur between patient and/or family and clergy or pastoral worker or patient and/or family and member of the interdisciplinary team.</p> <p>This item is meant to capture evidence of discussion and communication. Therefore, documentation of patient’s religious or spiritual affiliation by itself does not count for inclusion in numerator.</p> <p>Data are collected via chart review. Criteria are:</p> <ol style="list-style-type: none"> <li>1) evidence of a discussion about spiritual/religious concerns, or</li> <li>2) evidence that the patient, and/or family declined to engage in a conversation on this topic.</li> </ol> <p>Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments within 5 days of admission to hospice, visit notes documented by any member of the team, and/or the spiritual care assessment.</p>
Denominator Statement	Seriously ill patients 18 years of age or older enrolled in hospice.
Denominator Details	This quality measure is intended for patients with serious illness who are enrolled in hospice care. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.
Exclusions	Testing has only been done with the adult population; thus patients younger than 18 are excluded.
Exclusion details	N/A
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>Step 1- Identify all patients with serious, life-limiting illness who were discharged from hospice care during the designated reporting period.</p> <p>Step 2- Exclude patients who are less than 18 years of age.</p> <p>Step 3- Identify patients with documented discussion of spiritual/religious concerns or</p>

	<b>1647 Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.</b>
	documentation that the patient/family did not want to discuss spiritual/religious concerns. Quality measure = Numerator: Patients with documented discussion or who responded they did not want to discuss in Step 3 / Denominator: patients in Step 1 – Patients excluded in Step 2 No diagram provided
Copyright / Disclaimer	5.1 Identified measures:  5a.1 Are specs completely harmonized?  5a.2 If not completely harmonized, identify difference, rationale, impact:  5b.1 If competing, why superior or rationale for additive value: No known competing measures exist.

	<b>2651 CAHPS® Hospice Survey (experience with care)</b>
Status	Submitted
Steward	Centers for Medicare and Medicaid Services
Description	«Description»
Type	PRO
Data Source	Patient Reported Data/Survey CAHPS Hospice Survey Available at measure-specific web page URL identified in S.1 Attachment CAHPS_Hospice_Survey_Main_Submission_Form_Supplementary_Tables_2016_3_14-635936455961497856.xlsx
Level	Facility
Setting	Hospice
Numerator Statement	CMS calculates CAHPS Hospice Survey measures using top-box scoring. The top-box score refers to the percentage of caregiver respondents that give the most positive response. Details regarding the definition of most positive response are noted in Section
Numerator Details	For each survey item, the top box numerator is the number of respondents who selected the most positive response category(ies), as follows: For items using a “Never/Sometimes/Usually/Always” response scale, the top box numerator is the number of respondents who answer “Always.” For items using a “Yes, definitely/Yes, somewhat/No” response scale, the top box numerator is the number of respondents who answer “Yes, definitely.” For items using a “Too Little/Right Amount/Too Much” response scale, the top box numerator is the number of respondents who answer “Right Amount.” The top box numerator for the Rating of Hospice item is the number of respondents who answer 9 or 10 for the item (on a scale of 0 to 10, where 10 is the “Best Hospice Care Possible”). The top box numerator for the Willingness to Recommend item is the number of respondents who answer “Definitely Yes” (on a scale of “Definitely No/Probably No/Probably Yes/Definitely Yes”). Calculation of hospice-level multi-item measures



	<p><b>2651 CAHPS® Hospice Survey (experience with care)</b></p> <p>0. Score each item using top box method, possible values of 0 or 100</p> <p>1. Calculate mode adjusted scores for each item for each respondent</p> <p>2. Calculate case-mix adjusted scores for each item for each hospice</p> <p>3. Take the unweighted means of the mode- and case-mix-adjusted hospice-level items to form multi-item measures</p> <p>Example: hospice-level multi-item measure for ‘Getting Timely Care’:</p> <p>0. Score each item using top box method, possible values of 0 or 100</p> <p>Both items in “Getting Care Quickly” have four response options: Never, Sometimes, Usually, Always. Recode each item as 100 for “Always” and 0 for “Never”, “Sometimes”, or “Usually”.</p> <p>Item #1. While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?</p> <p>Item #2. How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?</p> <p>1. Calculate mode-adjusted scores for each item for each respondent</p> <p>2. Calculate case-mix adjusted scores for each item for each hospice</p> <p>Each item is case mix adjusted separately; this step produces case-mix adjusted item-level scores for each hospice.</p> <p>3. Take the unweighted means of the case-mix adjusted hospice-level items to form multi-item measures.</p> <p>If the case-mix adjusted scores for a hospice are 95 for item #1 and 90 for item #2, then the hospice-level ‘Getting Timely Care’ would be calculated as <math>(\text{Item1} + \text{Item2}) / 2 = (95 + 90) / 2 = 92.5</math>.</p>
Denominator Statement	<p>The measure’s denominator is the number of survey respondents who answered the item. The target population for the survey is primary caregivers of hospice decedents. The survey uses screener questions to identify respondents eligible to respond to subsequ</p>
Denominator Details	<p>For each item in a multi-item measure, as well as for the ratings measures, the top box denominator is the number of respondents per hospice who answered the item. For each multi-item measure score, the denominator is the number of respondents that answers at least one item within the multi-item measure. Multi-item measure scores are the average proportion of respondents that gave responses in the most positive category(ies) across the items in the multi-item measure (as discussed in S.6).</p> <p>Survey population: Primary caregivers of patients who died while receiving care from a given hospice in a given month.</p> <p>Denominator for Multi-Item Measures: The number of respondents who answer at least one item within the multi-item measure.</p> <p>Denominator for Rating Measures: The number of respondents who answered the item.</p>
Exclusions	<p>The exclusions noted in here are those who are ineligible to participate in the survey. The one exception is caregivers who report on the survey that they “never” oversaw or took part in the decedent’s care; these respondents</p> <p>#2651 CAHPS® Hospice Survey (experience with care), Last Updated: Jun 13, 2016</p> <p>NATIONAL QUALITY FORUM Form version 6.5 4</p> <p>are instructed to complete the “About You” and “About Your Family Member” sections of the survey only.</p> <p>Cases are excluded from the survey target population if:</p>

	<b>2651 CAHPS® Hospice Survey (experience with care)</b>
	<ul style="list-style-type: none"> <li>• The hospice patient is still alive</li> <li>• The decedent’s age at death was less than 18</li> <li>• The decedent died within 48 hours of his/her last admission to hospice care</li> <li>• The decedent had no caregiver of record</li> <li>• The decedent had a caregiver of record, but the caregiver does not have a U.S. or U.S. Territory home address</li> <li>• The decedent had no caregiver other than a nonfamilial legal guardian</li> <li>• The decedent or caregiver requested that they not be contacted (i.e., by signing a no publicity request while under the care of hospice or otherwise directly requesting not to be contacted)</li> <li>• The caregiver is institutionalized, has mental/physical incapacity, has a language barrier, or is deceased <ul style="list-style-type: none"> <li>• The caregiver reports on the survey that he or she “never” oversaw or took part in decedent’s hospice care</li> </ul> </li> </ul>
Exclusion details	Please see S.10.The CAHPS Hospice Survey Quality Assurance Guidelines (available at: ( <a href="http://www.hospicecahpsurvey.org/Content/QualityAssurance.aspx">http://www.hospicecahpsurvey.org/Content/QualityAssurance.aspx</a> ) contain detailed information regarding how to code decedent/caregiver cases, and how to code appropriately and inappropriately skipped items, as well as items with multiple responses.
Risk Adjustment	<p>Other Case Mix Adjustment</p> <p>Case-mix adjustment is conducted via linear regression. The following items are included in the case-mix adjustment model:</p> <p>Items from survey responses:</p> <p>What is your age?</p> <p>1=18 to 24 years</p> <p>2=25 to 34 years</p> <p>3=35 to 44 years</p> <p>4=45 to 54 years</p> <p>5=55 to 64 year</p> <p>Provided in response box S.15a</p>
Stratification	CAHPS Hospice Survey measure scores are used for reporting at the hospice-level (i.e., not stratified by region or other characteristics).
Type Score	Other (specify): 1. Top-box score 2. Case-mix adjusted score better quality = higher score
Algorithm	<p>Top Box Score Calculation:</p> <ol style="list-style-type: none"> <li>1) Identify target respondent population (i.e., primary caregivers of hospice patients who died while receiving hospice care from a given hospice in a given month)</li> <li>2) Identify any exclusions from the respondent population (as described above in S.10)</li> <li>3) Score each item using top box method, possible values of 0 or 100</li> <li>4) Calculate mode adjusted top box scores for each item.</li> <li>5) Calculate case-mix adjusted top box scores for each item for each hospice; case-mix adjustment is a linear regression based approach that adjusts for all variables listed in S.14. Specifically, a regression model predicting item scores is fit using the case-mix adjustor variables and fixed effects for hospices. Adjusted hospice means are then calculated (e.g., using LSMEANS in SAS).</li> <li>6) Top-box scores are averaged across the items within each multi-item measure, weighting each item equally. If data are missing for a respondent for an item(s) within a multi-item measure, the respondent’s answers to other items within the measure are still used in the</li> </ol>

	<b>2651 CAHPS® Hospice Survey (experience with care)</b>
	calculation of multi-item measure scores. (Please see S.22 below for more details). No diagram provided
Copyright / Disclaimer	<p>5.1 Identified measures: 0208 : Family Evaluation of Hospice Care 1623 : Bereaved Family Survey</p> <p>5a.1 Are specs completely harmonized? No</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact: 1623 Bereaved Family Survey's target population is families of veterans. The CAHPS Hospice Survey targets primary caregivers of patients who died under hospice care without regard to veteran status.</p> <p>5b.1 If competing, why superior or rationale for additive value: 0208 Family Evaluation of Hospice Care.</p> <p>The Family Evaluation of Hospice Care Survey (FEHC) is maintained by the NHPCO. NHPCO operated a voluntary repository that provided hospice programs with national benchmarks for FEHC measures. With the national implementation of the CAHPS Hospice Survey, NHPCO has shut down the voluntary repository, with the exception of those hospice programs that do not meet CMS's minimum threshold for participation in the CAHPS Hospice Survey. Once CMS publishes national benchmarks for the CAHPS Hospice Survey, NHPCO is no longer planning to support the FEHC or the voluntary repository.</p> <p>The FEHC was created nearly 20 years ago. The CAHPS Hospice Survey covers similar domains, but represents important methodological improvement in the response task, and is adjusted for case mix and mode. Additionally, more stringent survey administration guidelines are in place to permit public reporting of the survey results and valid comparison across hospice programs.</p>

## Appendix F: Related and Competing Measures

[Comparison of Measures 1641, 0326, 1626](#)

[Comparison of Measures 0179, 1639, 1638](#)

### Comparison of Measures 1641, 0326, and 1626

	Measure 1641: Hospice and Palliative Care – Treatment Preferences	Measure 0326: Advance Care Plan	Measure 1626: Patients Admitted to ICU who Have Care Preferences Documented
Steward	University of North Carolina-Chapel Hill	National Committee for Quality Assurance	RAND Corporation
Description	Percentage of patients with chart documentation of preferences for life sustaining treatments.	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.
Type	Process	Process	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record	Administrative claims, Electronic Clinical Data	Paper Medical Records
Level	Clinician : Group/Practice, Facility	Clinician : Group/Practice, Clinician : Individual	Facility
Setting	Hospice, Hospital/Acute Care Facility	Ambulatory Care : Clinician Office/Clinic, Home Health, Hospice, Hospital/Acute Care Facility, Post-Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Hospital/Acute Care Facility
Numerator Statement	Patients whose medical record includes documentation of life sustaining preferences	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Patients in the denominator who had their care preferences documented within 48 hours of ICU admission or have documentation of why this was not done.
Numerator	Documentation of life-sustaining treatment	Report the CPT Category II codes designated for	Edits indicated by [brackets]

	Measure 1641: Hospice and Palliative Care – Treatment Preferences	Measure 0326: Advance Care Plan	Measure 1626: Patients Admitted to ICU who Have Care Preferences Documented
Details	<p>preferences should reflect patient self-report; if not available due to patient loss of decisional capacity, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as “Full Code” or “DNR/DNI” do 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.</p>	<p>this numerator:</p> <ul style="list-style-type: none"> <li>- 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record</li> <li>- 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan</li> </ul> <p>Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship.</p>	<p>Patients whose medical record includes documentation of care preferences within 48 hours of admission to ICU. Care preferences may include any of the following:</p> <ul style="list-style-type: none"> <li>- Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR</li> <li>- Documentation that a care preference discussion was attempted and/or reason why it was not done</li> </ul> <p>[Simply having an advance directive or other advance care planning document or POLST in the medical record does not satisfy this criterion. However, a notation in the record during the allotted time period referring to preferences or decisions within such a document satisfies this requirement.]</p>
Denominator Statement	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.	All patients aged 65 years and older.	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.
Denominator Details	The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.	<p>Denominator Criteria (Eligible Cases):</p> <p>Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350,</p>	<p>All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.</p> <p>"Vulnerable" is defined as any of the following:</p> <ul style="list-style-type: none"> <li>- &gt;74 years of age</li> <li>- Vulnerable Elder Survey-13 (VES-13) score &gt;2 (Saliba 2001)</li> <li>- Poor prognosis/terminal illness defined as life expectancy of &lt;6 months</li> <li>- Stage IV cancer</li> </ul>

	Measure 1641: Hospice and Palliative Care – Treatment Preferences	Measure 0326: Advance Care Plan	Measure 1626: Patients Admitted to ICU who Have Care Preferences Documented
		G0402, G0438, G0439  *Clinicians indicating the place of service as the emergency department will not be included in this measure.	
Exclusions	Patients with length of stay < 1 day in hospice or palliative care	N/A	None
Exclusion Details	Calculation of length of stay; discharge date is identical to date of initial encounter.	N/A	
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	N/A	
Type Score	Rate/proportion	Rate/proportion	Rate/proportion
Algorithm	<p>a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital</p> <p>b.Step 2- Exclude patients if length of stay is &lt; 1 day.</p> <p>c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments.</p> <p>Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2</p>	<p>Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older.</p> <p>Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.</p> <p>Step 3: Determine the number of patients who meet the numerator criteria as specified in section 2a1.3 above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.</p> <p>Step 4: Calculate the rate by dividing the total</p>	<p>1. Identify all vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission</p> <p>2. Examine the medical record for evidence of a statement of patient care preferences OR attempt to elicit these or other reason why this was not done within 48 hours of ICU admission.</p>

	Measure 1641: Hospice and Palliative Care – Treatment Preferences	Measure 0326: Advance Care Plan	Measure 1626: Patients Admitted to ICU who Have Care Preferences Documented
		from Step 3 by the total from Step 2	
Submission items	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.</p>		<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.</p>

## Comparison of Measures 0179, 1638, 1639

	Measure 0179: Improvement in dyspnea	Measure 1638: Hospice and Palliative Care -- Dyspnea Treatment	Measure 1639: Hospice and Palliative Care -- Dyspnea Screening
Steward	Centers for Medicare and Medicaid Services	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill
Description	Percentage of home health episodes of care during which the patient became less short of breath or dyspneic.	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.
Type	Outcome	Process	Process
Data Source	Electronic Clinical Data	Administrative claims, Electronic Clinical Data	Paper Medical Records
Level	Facility	Clinician : Group/Practice, Clinician : Individual	Facility
Setting	Home Health	Ambulatory Care : Clinician Office/Clinic, Home Health, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Hospital/Acute Care Facility
Numerator Statement	Number of home health episodes of care where the patient has less dyspnea at discharge than at start (or resumption) of care.	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
Numerator Details	Number of home health episodes from the denominator in which the value recorded for the OASIS-C item M1400 ("Dyspnea") on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.	Treatment is administered if within 24 hours of the positive screen for dyspnea, medical treatment plan, orders or pharmacy records show inhaled medications, steroids, diuretics, or non-medication strategies such as oxygen and energy conservation. Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.	Patients who are screened for the presence or absence of dyspnea during the admission evaluation for hospice / initial encounter for hospital-based palliative care, and asked to rate its severity. Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients.
Denominator Statement	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.
Denominator Details	All home health episodes of care (except those defined in the denominator exclusions) in which the patient was eligible to improve in dyspnea(i.e., were not at the optimal level of health status according to the "Dyspnea" OASIS-C item M1400).	The Dyspnea Treatment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease,	The Dyspnea Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to:



	Measure 0179: Improvement in dyspnea	Measure 1638: Hospice and Palliative Care -- Dyspnea Treatment	Measure 1639: Hospice and Palliative Care -- Dyspnea Screening
		<p>dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.</p> <p>For patients enrolled in hospice or palliative care, a positive screen is indicated by any dyspnea noted as other than none on a verbal screen, any number &gt; 0 on a numeric scale or any observational or self-report of dyspnea.</p> <p>[NOTE: This quality measure should be paired with the Dyspnea Screening quality measure (NQF #1639) to ensure that all patients are screened and therefore given the opportunity to report dyspnea and enter the denominator population for Dyspnea Treatment.]</p>	<p>cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.</p> <p>[NOTE: This quality measure should be paired with the Dyspnea Treatment quality measure (NQF #1639) to ensure that all patients who report dyspnea are clinically considered for treatment.]</p>
Exclusions	All home health episodes where at the start (or resumption) of care assessment the patient had no impairment, or the episode of care ended in transfer to inpatient facility or death at home, or was covered by the generic exclusions.	Patients with length of stay < 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.	Patients with length of stay < 1 day in palliative care.
Exclusion Details	<p>Measure-specific exclusions:</p> <p>All home health episodes where: (1) the value recorded for the OASIS-C item M1400 ("Dyspnea") on the start (or resumption) of care assessment is zero, indicating minimal or no impairment. These patients are excluded because it would be impossible for them to show measurable improvement; OR (2) the patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home; OR (3) all episodes covered by the generic exclusions.</p> <p>Generic Exclusions:</p> <ol style="list-style-type: none"> <li>Pediatric home health patients - less than 18 years of age.</li> <li>Home health patients receiving maternity care only.</li> <li>Home health clients receiving non-skilled care only.</li> </ol>	Calculation of length of stay; discharge date is identical to date of initial encounter.	Calculation of length of stay; discharge date is identical to date of initial encounter.

	Measure 0179: Improvement in dyspnea	Measure 1638: Hospice and Palliative Care -- Dyspnea Treatment	Measure 1639: Hospice and Palliative Care -- Dyspnea Screening
	<p>d. Home health patients for which neither Medicare or Medicaid is a payment source.</p> <p>e. The episode of care does not end during the reporting period.</p> <p>f. Small and new agencies and rare conditions - the publicly-reported data on CMS' Home Health Compare web site also repress cells with fewer than 20 observations, and reports for home health agencies in operation less than six months.</p>		
Risk Adjustment	Statistical risk model	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Not stratified	N/A	N/A
Type Score	Rate/proportion	Rate/proportion	Rate/proportion
Algorithm	<p><a href="https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQI-Revision1TechnicalDocumentationofMeasures.zip">https://www.cms.gov/HomeHealthQualityInits/Downloads/HHQI-Revision1TechnicalDocumentationofMeasures.zip</a></p>	<p>Dyspnea treatment:</p> <p>a. Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care</p> <p>b. Step 2- Identify admission evaluation / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days</p> <p>c. Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) / initial encounter (palliative care)</p> <p>d. Step 4- Identify patients who screened positive for dyspnea</p>	<p>Screened for dyspnea:</p> <p>a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice care or who receive specialty palliative care in an acute hospital setting</p> <p>b.Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day.</p> <p>c.Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) OR during the initial encounter (palliative care)</p> <p>Quality measure = Numerator: Patients screened for dyspnea in Step 3 / Denominator: Patients in Step 1 – Patients</p>

	Measure 0179: Improvement in dyspnea	Measure 1638: Hospice and Palliative Care -- Dyspnea Treatment	Measure 1639: Hospice and Palliative Care -- Dyspnea Screening
		<p>e. Step 5- Identify patients who received treatment within 24 hours of screening positive for dyspnea</p> <p>Quality Measure= Numerator: Patients who received treatment for dyspnea in Step 5 / Denominator: Patients in Step 4</p>	excluded in Step 2
Submission items		<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.</p>	<p>5.1 Identified measures:</p> <p>5a.1 Are specs completely harmonized?</p> <p>5a.2 If not completely harmonized, identify difference, rationale, impact:</p> <p>5b.1 If competing, why superior or rationale for additive value: This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.</p>

## Appendix G: Pre-Evaluation Comments

Comments received as of April 11, 2016.

Topic	Commenter	Comment
1641: Hospice and Palliative Care – Treatment Preferences	Submitted by Michele Galioto, RN, MSN	<p>Palliative care should be initiated with diagnosis and treatment. Measure specifications seem to focus on the benefits of early communication of treatment preferences, therefore recommending that the measure focus on communication of this within a time frame following diagnosis and less about timing related to enrollment in hospice</p> <p>Without these changes, recommend making the measure specific to hospice care, not palliative care or both in the same measure. Palliative care is not restricted to inpatient treatment.</p>
1639: Hospice and Palliative Care -- Dyspnea Screening	Submitted by Michele Galioto, RN, MSN	<p>Recommend making the measure specific to palliative or hospice care, not both in the same measure. Palliative care is not restricted to inpatient treatment.</p>
1638: Hospice and Palliative Care -- Dyspnea Treatment	Submitted by Michele Galioto, RN, MSN	<p>Recommend making the measure specific to palliative or hospice care, not both in the same measure. Palliative care is not restricted to inpatient treatment.</p>
1637: Hospice and Palliative Care -- Pain Assessment	Submitted by Michele Galioto, RN, MSN	<p>Recommend making the measure specific to palliative or hospice care, not both in the same measure. Palliative care is not restricted to inpatient treatment.</p> <p>Consider reworking measures 1634 &amp; 1637 to be a singular, stronger measure related to screening for pain.</p> <p>Consider reviewing measure 209 along with measures 1634 &amp; 1637 to strengthen measures for pain assessment and intervention.</p> <p>Consider incorporating recommended intervals for screening as the current measure indicates one assessment but one screening is not sufficient in this setting. Perhaps "at each patient encounter" is more appropriate?</p>
1634: Hospice and Palliative Care -- Pain Screening	Submitted by Michele Galioto, RN, MSN	<p>Recommend making the measure specific to palliative or hospice care, not both in the same measure. Palliative care is not restricted to inpatient treatment.</p> <p>Consider reworking measures 1634 &amp; 1637 to be a singular, stronger measure related to screening for pain.</p>

Topic	Commenter	Comment
		<p>Consider reviewing measure 209 along with measures 1634 &amp; 1637 to strengthen measures for pain assessment and intervention.</p> <p>Consider incorporating recommended intervals for screening as the current measure indicates one assessment but one screening is not sufficient in this setting. Perhaps "at each patient encounter" is more appropriate?</p>
1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Submitted by Michele Galioto, RN, MSN	Recommend suggesting assessment tools
1626: Patients Admitted to ICU who Have Care Preferences Documented	Submitted by Michele Galioto, RN, MSN	There could be patients who survive to meet this criteria but who are unable to communicate their preferences and/or do not have preferences documented.
1617: Patients Treated with an Opioid who are Given a Bowel Regimen	Submitted by Michele Galioto, RN, MSN	<p>Is the term "vulnerable adult" the best descriptor?</p> <p>Excluding non-hospice patients already taking an opioid at the time of study would likely exclude the majority of people with cancer; would be in favor of removing this exclusion.</p>
0216: Proportion of patients who died from cancer admitted to hospice for less than 3 days	Submitted by Michele Galioto, RN, MSN	<p>Should the measure include immunotherapy? Does "chemotherapy" include hormonal and biotherapy? It may be more inclusive to refer to all as "antineoplastic therapy."</p> <p>Should the measure include radiation therapy as well?</p> <p>Does "death from cancer" include all death within 14 days? Death may be the result of infection, accident (e.g., fall), bleeding, etc. which could be tied to cancer or cancer treatment. Death attributed to side effects of therapy may be indistinguishable from cancer deaths. Is the intent that death occurs within a timeframe of receiving chemotherapy?</p> <p>Please clarify enrollment in hospice vs. hospice/palliative care services with hospice enrollment as the specific for the measure (specifications may confuse data extraction).</p>
0215: Proportion of patients who died from cancer	Submitted by Michele Galioto, RN, MSN	Please clarify enrollment in hospice vs. hospice/palliative care services with hospice enrollment as the specific for the measure (specifications may confuse data extraction).

Topic	Commenter	Comment
not admitted to hospice		The intent of the measure is not clear - is it that all should be enrolled in hospice at the end of life?
0213: Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life	Submitted by Michele Galioto, RN, MSN	<p>Should the measure include immunotherapy? Does “chemotherapy” include hormonal and biotherapy? It may be more inclusive to refer to all as "antineoplastic therapy."</p> <p>Should the measure include radiation therapy as well?</p> <p>Does “death from cancer” include all death within 14 days? Death may be the result of infection, accident (e.g., fall), bleeding, etc. which could be tied to cancer or cancer treatment. Death attributed to side effects of therapy may be indistinguishable from cancer deaths. Is the intent that death occurs within a timeframe of receiving chemotherapy?</p>
0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life	Submitted by Michele Galioto, RN, MSN	<p>Should the measure include immunotherapy? Does “chemotherapy” include hormonal and biotherapy? It may be more inclusive to refer to all as "antineoplastic therapy."</p> <p>Should the measure include radiation therapy as well?</p> <p>Does “death from cancer” include all death within 14 days? Death may be the result of infection, accident (e.g., fall), bleeding, etc. which could be tied to cancer or cancer treatment. Death attributed to side effects of therapy may be indistinguishable from cancer deaths. Is the intent that death occurs within a timeframe of receiving chemotherapy?</p> <p>Does “emergency room” apply to other urgent care facilities?</p> <p>How is this data captured if they are seen out of network?</p>
0210: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life	Submitted by Michele Galioto, RN, MSN	<p>Should the measure include immunotherapy? Does “chemotherapy” include hormonal and biotherapy? It may be more inclusive to refer to all as "antineoplastic therapy."</p> <p>Should the measure include radiation therapy as well?</p> <p>Does “death from cancer” include all death within 14 days? Death may be the result of infection, accident (e.g., fall), bleeding, etc. which could be tied to cancer or cancer</p>

Topic	Commenter	Comment
		treatment. Death attributed to side effects of therapy may be indistinguishable from cancer deaths. Is the intent that death occurs within a timeframe of receiving chemotherapy?
0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Submitted by Michele Galioto, RN, MSN	Is 48-hour a standard benchmark? Might be important to reduce timeframe.
General Draft	Submitted by Michele Galioto, RN, MSN	<p>Overall, ONS recommends differentiating between palliative and end of life care in introductory information. ONS does not define palliative care as equal to end of life care. Hospice care is a form of palliative care but not inclusive of all palliative care. Palliative care should begin at the point of diagnosis or awareness of symptoms and continue throughout the trajectory of treatment through end of life care. See ONS position statement on palliative care for further detail.</p> <p>ONS is also in favor of including recommendations for intervals of assessment as the current measures imply that one screening is sufficient. Screening at each patient encounter may be more appropriate.</p>
General Draft	Submitted by Katherine Act, MSW, LCSW	<p>On behalf of the palliative care community, we thank the National Quality Forum for convening its Palliative and End-of-Life Care 2015-2016 Project and for the opportunity to provide preliminary feedback on the palliative and end-of-life care measures that will soon be evaluated by the project's Standing Committee. The American Academy of Hospice and Palliative Medicine (AAHPM) is the professional organization for physicians specializing in hospice and palliative medicine, and our membership also includes nurses and other health and spiritual care providers committed to improving quality of life for seriously ill patients and their families. We support the pursuit of interdisciplinary, team-based palliative care and its emphasis on care coordination, pain and symptom management, shared decision making, and patient-centered goal-setting. The provision of palliative care has been shown to improve patient experience and satisfaction, reduce caregiver burden, and increase survival; it has also been shown to reduce needless hospital admissions and readmissions through effective care coordination and symptom management; and through these gains in quality, it reduces costs.</p>

Topic	Commenter	Comment
		<p>While we do not, at this time, view any of the measures under consideration as particularly controversial, their limited scope reflects the critical ongoing gaps related to palliative and end-of-life care measurement and highlights the unique challenges that have contributed to those gaps. For example, the current set of measures under consideration is largely limited to cancer or hospice settings. These measures employ a narrow denominator (e.g., hospice patients rather than dying patients). This is certainly a good start, but measuring only hospice patients in order to improve the quality of end-of-life care is like searching for a lost dollar bill only where the light is good. It will not move the needle to the extent that we need it to. The National Hospice and Palliative Care Organization (NHPCO) reports in its 2011 Facts and Figures that only 42% of those who died in 2010 were enrolled in hospice. How do we measure the quality of end-of-life care for the majority of patients who die in hospitals, skilled nursing facilities, and homes without the benefit of hospice care? These are questions we have not yet been able to answer. The fact that the current set of measures under consideration by the NQF only includes one new measure (i.e., the Hospice CAHPS) also illustrates that the standard default pathways for measure development, testing, and endorsement are not working for the patients, providers and researchers in our field. Patient and family preferences and experience of care are critical elements of quality palliative care, and ongoing funding, data analysis and personnel are required to develop these kinds of measures and keep them endorsed and in use. For example, the current NQF requirement for measure developers to test survey instrument data elements in addition to the measures themselves (double testing) poses a barrier to advancing the field. While the process of submitting the PEACE measures from the University of North Carolina has gone well because of RTI's support and the national data coming from the Hospice Item Set (HIS), the process that the NQF requires to submit measures is not feasible for the majority of the palliative care field. The absence of a national sample or 100 testing sites should not stand in the way of progress.</p> <p>Another challenge our field continues to face is the perpetuation of silos in our healthcare delivery system. Since hospitals are designed to treat acute, potentially-reversible problems, they report post-discharge, patient-rated satisfaction surveys that completely miss the</p>



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		<p>experience of the many patients who die during their stay. Likewise, skilled nursing facilities are viewed as places for rehabilitation, so federal reporting mandates focus only on restoration of function, even though many patients languish and die there. Since hospice is the place for dying, that is where the federal government mandates reporting of end-of-life quality measures, but again, that is not going to improve the quality of dying where most of it happens. We have worked together with other organizations and independently to wade through numerous existing quality measures. Throughout these efforts, we have been struck by how difficult it is to design really good measures that capture the quality of palliative and end-of-life care. We are dismayed by the tendency to pursue and require “measures of convenience” in national reporting programs instead of focusing on fewer measures that really matter to patients. We continue to emphasize that more funding is needed for measure development in our field, as well as assistance from organizations like the NQF to shine a spotlight on measure gaps and encourage collaboration from various stakeholders, such as what’s occurring in the NQF’s measure incubator project. We encourage the NQF to help advocate for CMS to use the \$75 million allocated by MACRA to invest in activities to fill critical measure gaps in our field and to collaborate with organizations such as ours that can provide appropriate clinical expertise to guide such work.</p> <p>In late 2013, AAHPM and the Hospice and Palliative Nurses Association (HPNA) – in consultation with the Center to Advance Palliative Care (CAPC), NHPCO, The Joint Commission, the U.S. Department of Veterans Affairs and numerous other stakeholders – initiated the Measuring What Matters (MWM) project, which set forth to produce a consensus recommendation for a portfolio of performance measures that all hospice and palliative care programs could use for program improvement. The goal of MWM was to sort through all relevant published measures and select a concise set that would matter most for patients with palliative care needs across all settings. The belief is that voluntary adoption of these measures broadly in hospice and palliative care could lay the groundwork for benchmarking and meaningful comparison. We are now sorting through and prioritizing what will constitute Phase 2 of the project, which we hope will include more complex tasks, such as creating e-specifications and patient-reported outcome measures, field-testing altered,</p>

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		<p>expanded and untested measures, and developing a common palliative care denominator.</p> <p>Given the value of palliative care and our nation’s rapidly aging population, there is an urgent need to focus attention on the quality and availability of palliative care services – both for acutely ill patients and older adults with life-limiting diseases. AAHPM continues to highlight the need for a common denominator that comprehensively captures the patient population appropriate for palliative care. No measure currently used under federal quality reporting programs, or recommended for future years, focuses on this population exclusively. For example, there are currently no measures in the PQRS program that specifically address the broad category of palliative care for patients of any age, without being disease-specific. This puts palliative care providers (or really any provider who cares for seriously ill patients across settings) in the difficult position of either having to report on measures that are not clinically relevant, or being subject to CMS review and possible negative payment adjustments despite the high quality of care they provide.</p> <p>For many years, experts have tried to develop a common denominator that will enable the field to target patients who are most likely to benefit from palliative care. Doing so involves striking the right balance between number and/or type of chronic conditions, extent of functional and cognitive impairments, and overarching quality of life. AAHPM is committed to the goal of transitioning from basic to more meaningful measures that focus on this broader population, important outcomes, care coordination, and patient experience. We have worked with relevant stakeholders to identify a priority list of measures and broader measure concepts that are either not quite ready for accountability purposes or are not necessarily as robust as NQF and CMS request (e.g. process vs. outcomes measures or not grounded in Grade A evidence). However, with some guidance, collaboration, and funded technical assistance, we believe these could evolve into more meaningful and useful measures and help to close the gap in measures that target the palliative care patient population specifically. We know that NQF is increasingly emphasizing that measures developed from electronic data sources such as electronic health records (EHRs) and Qualified Clinical Data Registries (QCDRs) draw from a rich set of clinical 18 data and can reduce data collection and reporting burden while supporting more timely</p>

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		<p>performance feedback to physicians and other clinicians than is possible through traditional claims- or paper-based measures. While AAHPM agrees with this observation, our specialty has faced challenges in regards to electronic data collection and measure specifications. The Institute of Medicine’s (IOM) 2014 report titled Dying in America, recognized that in order to better understand and improve the care received by those at the end-of-life, we need better information about dying and about those with serious illness—not just about the demographic characteristics and health conditions of those who die, but also about their quality of life as they cope with declining health, the quality of the health care provided to them during this time, and the quality of their death. The ability to better capture this data would serve many other specialties, beyond Hospice and Palliative Medicine, and could drive patient-centered and family-oriented quality care. However, most EHRs still do not capture much of what is needed to measure palliative care quality. Processes and programs to develop standardized data elements and corresponding quality measures in partnership with large electronic medical record vendors (EPIC, Cerner) and other government agencies would spur this development. We understand that it is not the responsibility of the NQF to solve these broader policy challenges. However, the NQF does have substantial influence over the type and scope of measures ultimately selected for both public and private payer reporting programs and seems to be playing an increasingly larger role in measure “incubation.” We hope that as it continues down those paths that it keep in mind the critical need to accelerate the development and testing of new palliative care and end-of-life care measures that align with the goals of our organizations. We are also working with the National Coalition for Hospice and Palliative Care (NCHPC) and other organizations in our field on issues and challenges related to measure development. Both the Hospice and Palliative Nurses Association (HPNA) and the Center to Advance Palliative Care (CAPC) endorse these comments at this time. Thank you again for the opportunity to submit these comments. Please do not hesitate to contact Katherine Ast, AAHPM’s Director of Quality and Research (kast@aahpm.org), if we can provide any additional detail or assistance.</p>



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