Palliative and End-of-Life Care 2015-2016

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

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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.[1] 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.[2] Much end-of-life care is palliative, when life-prolonging interventions are no longer appropriate, effective, or desired.[3]

Palliative care is holistic, 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, 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.[4]

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 eight newly submitted measures and 16 measures undergoing maintenance review against NQF's standard evaluation criteria. Twenty-three measures were recommended for endorsement, and one measure (#0211) was withdrawn from consideration by the developer. The 23 measures that were endorsed during this project include:

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    - Getting Help for Symptoms

Brief summaries of the measures evaluated in this project are included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

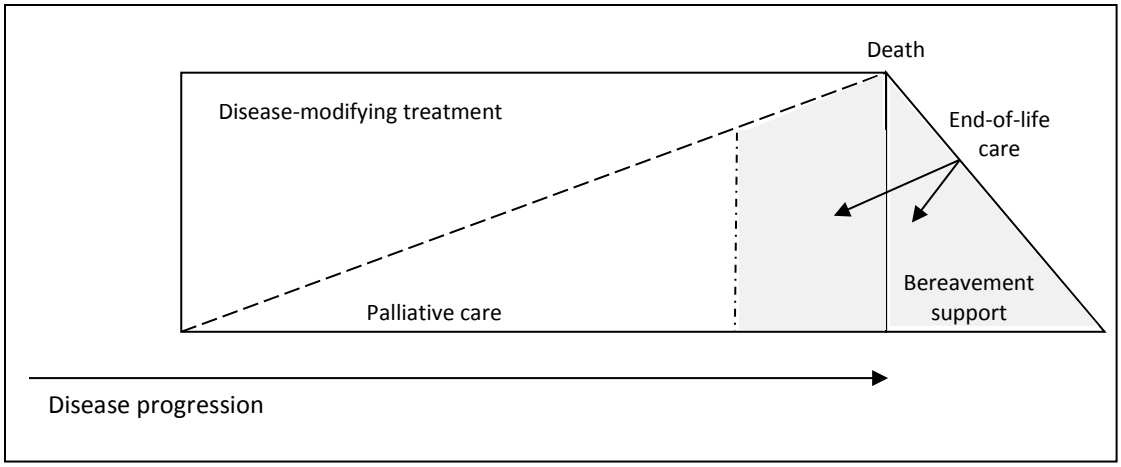
Introduction

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.[5] 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.[6] Much end-of-life care is palliative, when life-prolonging interventions are no longer appropriate, effective, or desired.[7]

As indicated in its definition, palliative care is holistic, 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, 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 is 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 the 2006 NQF report, A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report

Palliative care can be provided in any setting, including outpatient care settings and at home. In the current U.S. 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,[8] which is consistent with the hospice goal to enable living as "fully and as comfortably as possible."[9] 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 percent of hospice enrollees receive coverage through the Medicare hospice benefit.[10]

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.[11]

While access to specialty palliative care in U.S hospitals has increased substantially in the last 10 years, it is still highly variable according to hospital size and geography. For example, in 2015, only two-thirds of hospitals with ≥50 beds had palliative care teams (up from 53 percent in 2008), and only 17 percent of states had palliative care teams in at least 80 percent of their hospitals.[12] On average, only 3.4 percent of patients in hospitals that offer specialized palliative care services actually receive those services, while an estimated 7.5 to 8.0 percent of hospitalized patients (between 1 million and 1.8 million individuals) could benefit from, but do not receive, palliative care services.[13]

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, although estimates of the number of such programs in the U.S. have not yet been published[14] and a lack of performance measures has been identified as a potential organizational barrier to implementation of outpatient palliative care.[15] While several performance measures specific to inpatient and outpatient palliative care are used in quality improvement programs operated by the Centers 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,[16] accounting for an estimated 46 percent 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.[17] This difference in the average versus the median length of stay means that many dying persons enroll in hospice 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 now account for more than 63 percent of hospice admissions.[18] 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 7 percent of hospices did not report on these measures (non-reporters generally were small providers).[19] 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 36 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.[20] The portfolio includes one structure measure, 17 process measures, and 18 outcome measures; currently no composite measures are included in the portfolio (see table below).

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

	Structure	Process	Outcome/ Resource Use
Physical aspects of care	0	10	4
Psychological and psychiatric aspects of care	0	0	1
Cultural aspects of care	1	0	1
Spiritual, religious, and existential aspects of care	0	1	0
Ethical and legal aspects of care	0	3	0
Care of the patient at the end of life	0	3	12
Social aspects of care	0	0	0
Total	**1**	**17**	**18**

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.*

NQF-endorsed 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 four measures assess

utilization of care (i.e., ICU, hospice, and chemotherapy) near the end of life 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 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. To manage symptoms effectively, 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 on 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 that 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 multidisciplinary, 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 newly endorsed measures derived from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice 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 multistakeholder 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 many 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 program (see Appendix C). These include the seven measures collected through the Hospice Item Set (HIS) 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 & Medicaid Services (CMS) quality improvement programs—recommended the continued development of a composite measure that combines the seven measures from the HIS. In addition, at least one measure is used in the Hospice and Palliative Care Program of the U.S. Department of Veterans Affairs, and several cancer-specific measures are included in the Medical Oncology Core Measure Set of America's Health Insurance Plans (AHIP).

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.[21] This comprehensive framework specified the scope of hospice and palliative care, structural and programmatic elements of care, and 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 models 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.

Although the Committee offered initial suggestions for expanding the draft framework (e.g., specifically including concepts related to cost, decision making, and safety), members indicated a desire to further refine the framework, perhaps as part of off-cycle work in 2017.

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, end-stage heart 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
- Measures 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
- Measures addressing legacy support (e.g., evidence-based dignity therapy)
- Measures focusing on creativity (e.g., art or music therapy)
- Measures that address the NQS priorities of Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care
- Measures that consider hospice stays of less than 30 days
- Measures that consider social determinants of care (e.g., socioeconomic, educational, spiritual, cultural, etc.), particularly as related to advance care planning
- Measures related to bereavement care
- Measures for patients with chronic or life-limiting conditions (i.e., the patient population appropriate for palliative care), including those in settings other than hospice and hospital-based palliative care (e.g., home, nursing homes, ambulatory care, etc.)
- Measures of outcomes, particularly patient-reported outcomes
- Measures of alignment between care that is provided and patients' preferences, goals, values, and wishes
- Measures related to advance care planning
- Measures that assess care longitudinally and across care settings

A 2016 report from the MAP Post-Acute Care and Long-Term Care Workgroup highlighted additional gaps in palliative and end-of-life care measurement. These gaps specifically relate 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 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 eight new measures and 16 measures undergoing maintenance of endorsement review against NQF's standard evaluation criteria. To facilitate the evaluation, NQF staff divided the Committee into four workgroups. Each workgroup conducted a preliminary review of a subset of measures against the evaluation 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 to April 11, 2016, for all of the 24 measures under review. A total of 16 pre-evaluation comments were received; these are included in the Comment and Responses excel file, which is posted on the project page on the NQF website. Comments included questions about measure specifications, suggestions to strengthen measures by combining them or otherwise considering related or competing measures, and discussion of measurement challenges for the field. Commenters also recommended:

- broadening assessment and screening measures beyond time of admission;
- making measures specific to palliative or hospice care (not both);
- expanding palliative care measures to settings other than inpatient hospitals; and
- expanding measure denominators (e.g., beyond cancer patients only).

The Committee received all submitted comments 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 its process for 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 a 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, a 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 a committee may accept the prior evaluation of this subcriterion without further discussion and vote. However, a committee still considers whether the

specifications are consistent with the evidence. Also, for outcome measures, a 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 eight new measures and 16 measures undergoing maintenance of endorsement that were considered by the Committee at its May 10-11, 2016 meeting, 19 were recommended for endorsement. During this meeting, the Committee did not reach consensus on two measures and did not recommend two measures. One of the previously endorsed measures was subsequently withdrawn from consideration by the developer; endorsement was removed from this measure.

After review and discussion of comments received and additional materials provided by the developers during the August 3 post-comment call, the Committee reversed its two do-not recommend decisions and reached consensus on the remaining two measures, ultimately recommending all four of them for endorsement. Table 2 summarizes the final 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	15	8	23
Measures not recommended for endorsement	0	0	0
Measures withdrawn from consideration	1	0	1

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 they become available.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. 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 (NHPCO)): Endorsed

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 in the 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 was relatively stable, with averages near 65 percent. 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 an initial decision by the Committee 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, for the post-comment

webinar, hospice-level results stratified by these factors, as well as for region, diagnosis, and co-morbidities and, if indicated, to provide a plan for future risk adjustment.

NQF received six post-evaluation comments regarding this measure. Four of the commenters supported the decision of the Committee not to endorse the measure, with two of these agreeing that additional analyses are needed. Two commenters did not support the Committee's decision not to endorse the measure. Both emphasized the importance of outcome measures for pain—particularly patient-reported outcome measures—in NQF's portfolio of palliative and end-of-life care measures. During the post-comment webinar, the developers reiterated their position that risk adjustment is not necessary, maintaining that hospice providers are equally responsible for optimizing pain management for all patients who state that they are uncomfortable on the initial pain screening. Also, per the Committee's request, the developer submitted results from additional analyses of facility-level data; these results supported the developer's decision not to risk-adjust the measure. After review of this additional information, the Committee agreed that the rationale and analysis addressed their initial concerns with the lack of risk adjustment and ultimately recommended the measure for continued endorsement.

1634 Hospice and Palliative Care — Pain Screening (University of North Carolina-Chapel Hill): Endorsed

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 on admission (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 percent for hospices and slight, yet statistically significant, disparities in care between genders and between socioeconomic subgroups. The Committee agreed that 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): Endorsed

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 on admission. The pain assessment must include at least five of the following seven 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 percent for hospices and slight, yet statistically significant, disparities in care between rural verus 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): Endorsed

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 percent to 79 percent. 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): Endorsed

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 percent for hospices, with only 6.7 percent of hospices reporting results lower than 90 percent. While there is some indication of disparities in care, it is unclear whether the differences are clinically meaningful, and the Committee did not initially 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.

NQF received five post-evaluation comments on the measure, four of which were supportive of continued endorsement. To address the Committee's lack of consensus on the opportunity for improvement criterion, the developer submitted preliminary performance data for the measure in the hospital-based palliative care setting. These results indicated that 81.8 percent of patients were screened for dyspnea. Upon revote, the Committee agreed that there is opportunity for improvement for dyspnea screening in the hospital-based palliative care setting.

1638 Hospice and Palliative Care — Dyspnea Treatment (University of North Carolina-Chapel Hill): Endorsed

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 on admission received 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 nonpharmacological treatment options for dyspnea. Fiscal year 2015 data indicate an average performance rate of 93.3 percent 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): Endorsed

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 percent to 71 percent, 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): Endorsed

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 percent), 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): Endorsed

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 evalution reported results ranging from 9 percent to 63.7 percent, current data were not provided by the developer because the measure is not in use. The Committee initially could not reach consensus on the reliability of the measure, primarily due to concerns about the ability to apply the numerator specifications consistently. 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 face validity was not assessed specifically for this measure. Thus, the Committee initially agreed that this measure does not meet the validity subcriterion.

NQF received five post-evaluation comments on this measure, one of which supported the Committee's decision not to recommend the measure for continued endorsement, two that did not support the Committee's decision, one that requested that the Committee reconsider the measure after obtaining additional information and clarification regarding the measure specification, and one that noted the importance of emergency, critical, and advance care plans and provided specific suggestions on ensuring these are available to healthcare providers. In addition, the measure developer submitted the final comment, formally requesting a reconsideration of the measure. During the post-comment call, the developer clarified the numerator specifications so that the Committee could understand how the measure can be met. It also clarified the face validity evaluations of the measure by three expert panels, noting that the same procedures were used for this measure as for those described for measures #1617, #1624, and #1628. The Committee agreed to re-vote on the reliability and validity subcriteria, and ultimately recommended the measure for continued endorsement.

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

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 reduction in the use of intensive treatments, per patient preferences. Fiscal year 2015 data indicate an average performance rate of 98 percent 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 that 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): Endorsed

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 affected 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) Quality 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 linking 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 percent; standard deviation=11.5 percent), 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 that all anticancer 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 percent to 55 percent), 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 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 was 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): Endorsed

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 percent to 40.0 percent), 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): Endorsed

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 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 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 percent, standard deviation=20.9 percent), 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): Endorsed

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 currently is 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 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 percent, standard deviation=14.5 percent), 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 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): Endorsed

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 percent 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): Eight PRO-PMs Endorsed

Description: The CAHPS® Hospice 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 slated 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 percent for the hospice care training measure to 91.8 percent 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 initially 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 that the benefits incurred by the use of these measures outweigh this

potential risk, particularly if a hospice agency provides bereavement support to individuals who report being upset by the survey.

NQF received three post-evaluation comments regarding the eight PRO-PMs under NQF #2651, each supporting endorsement of these measures. NQF also sought feedback on the measure from the Person- and Family-Centered Care Standing Committee, as this Committee has extensive experience in evaluating PRO-PMs from CAHPS surveys and other PRO-PM/instrument-based measures. One of the PFCC Committee members expressed concern with the low Intraclass Correlation Coefficient (ICC) values for the measures. During the public comment period, the developer updated the reliability estimates for all eight PRO-PMs based on data from April-September, 2015. The addition of an extra three months of data increased the reliability estimates for seven of the eight PRO-PMs (for the "Treating family member with respect" measure, the estimate increased from 0.61 to 0.68). The developer also provided further interpretation of the ICC values. Upon revote, the Committee agreed that the developer had demonstrated adequate reliability for the "Treating Family Member with Respect" measure, based on April-September, 2015 data.

Comments Received After Committee Evaluation

The 30-day post-evaluation public and member commenting period was open from June 20, 2016 to July 19, 2016. During this period, NQF received a total of 89 comments from six member organizations and five members of the public (both organizations and individuals). Comments included support for the measures recommended by the Committee, as well as comments highlighting the importance of patient choice in measurement, comments identifying additional measure gaps, and comments addressing the measures for which the Committee did not reach consensus and those that the Committee did not initially recommend. Measure-specific comments are included in the Appendix A measure discussions.

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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 Endorsed

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

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

Adjustment/Stratification: No risk adjustment or risk 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

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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 by age group, sex, race, or condition (cancer vs. non-cancer).

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2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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 (i.e., only those who report having pain at initial assessment are included in this measure that assesses pain relief to a comfortable level within 48 hours).
- 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 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 ≥65; >75 years old vs ≥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.

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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)

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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)

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5. Related and Competing Measures

- This measure is related to (potentially competing with) two measures:
    - 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*].
    - 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.

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6. Public and Member Comment: June 20 - July 19, 2016; Post-comment call August 3, 2016

Comments received:

- Four commenters supported the initial decision of the Committee not to endorse the measure, with two of these agreeing that additional analyses are needed.
- Two commenters did not support the Committee's initial decision not to endorse the measure. Both emphasized the importance of outcome measures for pain—particularly patient-reported outcome measures—in NQF's portfolio of palliative and end-of-life care.

Developer response to Committee's request for additional data analysis:

- The developers reiterated their position that risk adjustment is not necessary, maintaining that hospice providers are equally responsible for optimizing pain management for all patients who state they are uncomfortable on the initial pain screening.
- Per the Committee's request, the developer submitted results additional analyses of facility-level data. They examined several potential risk factors, including geographic location, service area, ownership, race and ethnicity, patient age, patient gender, patient principle diagnosis, and referral source. None of the factors examined were statistically significantly associated with the measure scores.

Committee response:

- After review of the additional information provided by the developer, the Committee agreed to re-vote on the Validity subcriterion. Upon re-vote, the Committee agreed that the rationale and analysis addressed their initial concerns with lack of risk-adjustment.
- Because the measure passed the Validity subcriterion upon re-vote, the Committee then discussed and voted on the Feasibility and Usability and Use criteria.
- Feasibility
    - Hospices provide aggregate data to NHPCO through an on-line system. NHPCO provides a Data Submission Worksheet for hospice agency use, so that they can compile and aggregate their data. NHPCO also offers guidance for calculating the measure, without requiring licensing or fees. Required data elements are not necessarily kept electronically – some providers may use paper record system to track responses.
    - Although some hospices had difficulty implementing the measure when it was required in the first year of reporting as part of the Hospice Quality Reporting Program (HQRP), the Committee did not voice concerns about the feasibility of the measure.
- Usability and Use
    - Although specified at the facility level of analysis, this measure is in use in the PQRS program (a clinician program). NHPCO provides data collection and comparative reporting (i.e., benchmarking) for those hospices that voluntarily submit data to NHPCO. The developers note that in 2014, 156 hospices provided measure data for 20,548 patients. Although initially included in the HQRP, it was removed by CMS because of patient ineligibility for the measure and patients' denying pain at the initial assessment, which resulted in a small denominator and created validity concerns.
    - Committee members expressed concern that the measure is not publicly reported and that relatively few hospice agencies report on the measure.

    - Committee members also noted that no performance improvement over time had been observed.
    - The Committee did not report any unintended consequences from using the measure.
- Related/Competing discussion, comparing this measure to measures #1634 and #1637 (NOTE: Due to differences in care setting, level of analysis, and measure type, NQF did not ask the Committee to select a best-in-class measure or discuss harmonization, but instead asked members to consider the need for the process measures for pain in the hospice setting, given that an outcome measure is available).
    - Committee members agreed that for now, both the process and outcome measures are needed, but noted that this may change in the future.

Vote Following Consideration of Public and Member Comments:

Validity: **H-2**; **M-17**; **L-0**; **I-0**

Feasibility: **H-0; M-14; L-4; I-0**

Usability and Use: **H-0; M-5; L-13; I-0**

Standing Committee Overall Recommendation for Endorsement: **Y-18**; **N-0**

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

1634 Hospice and Palliative Care — Pain Screening

*Paired with #1637: Hospice and Palliative Care – Pain Assessment

Submission | Specifications

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

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.

Denominator Statement: Patients enrolled in hospice OR patients receiving specialty palliative care in an acute hospital setting.

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

Adjustment/Stratification: No risk adjustment or risk 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: The measure meets the Importance criteria

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

1a. Evidence: **H-2**; **M-2**; **L-0**; **I-19**; 1b. Performance Gap: **H-1**; **M-19**; **L-2**; **I-1;**

Evidence Exception: **Y-23; N-0**

Rationale:

- 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.
- 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.
- 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. 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 on-going 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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.

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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)

<u>Rationale</u>:

- 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 are 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.

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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 in 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.

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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 [*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 [*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 [*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 [*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 [*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 these measures be combined 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-23**; **N-0**

6. Public and Member Comment: June 20 - July 19, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, all of which were supportive of the measure.
- One commenter expressed concern about inclusion of short-stay patients, recommending stratification of results for patients with length of stay <7 days and an exclusion for those patients who are imminently dying.
    - ***Developer response*****:** Results various statistical analyses show that applying or removing the inclusion of short-stay patients did not affect the measures scores. Moreover, a large portion of care processes, including pain screening, were performed on the first day of admission to hospice.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

1637 Hospice and Palliative Care — Pain Assessment

*Paired with #1634: Hospice and Palliative Care – Pain Screening

Submission | Specifications

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.

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.

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.

Exclusions: Patients with length of stay < 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.

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: The measure meets the Importance criteria

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

1a. Evidence: **H-0**; **M-0**; **L-0**; **I-23**; 1b. Performance Gap: **H-11**; **M-13**; **L-0**; **I-0;**

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

Rationale:

- 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.
- 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. The developer presented some additional information just prior to the in-person meeting. This included a 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 on-going 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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 similarly on various assessment activities conducted at the time of hospice admission.
- Committee members did not express concern regarding the validity of the measure.

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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 are 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.

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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 in 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.

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5. Related and Competing Measures

- This measure competes with three measures:

    - 0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology. 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 [*clinician-level process measure in ambulatory setting*]
    - 1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits. Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit [*facility-level, health plan, and integrated delivery system-level process measure in ambulatory setting*]
    - 1634: Hospice and Palliative Care — Pain Screening. 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. 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 [*clinician-level process measure in ambulatory setting*]
    - 0420: Pain Assessment and Follow-Up. 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 [*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 these measures be combined 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: June 20 - July 19, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, all of which were supportive of the measure.
- One commenter expressed concern about inclusion of short-stay patients, recommending stratification of results for patients with length of stay <7 days and an exclusion for those patients who are imminently dying.
    - ***Developer response*:** Results various statistical analyses show that applying or removing the inclusion of short-stay patients did not affect the measures scores. Moreover, a large portion of care processes, including pain screening, were performed on the first day of admission to hospice.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

9. Appeals

No Appeals received.

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: No risk adjustment or risk 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

(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.

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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.

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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. 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 and thus measurement is not needed; 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.

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5. Related and Competing Measures

- This measure competes with three measures:
    - 0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology. 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 [*clinician-level process measure in ambulatory setting*]
    - 1634: Hospice and Palliative Care — Pain Screening. 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*]
    - 1637: Hospice and Palliative Care — Pain Assessment. 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 [*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 [*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 [*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 these measures be combined to incorporate screening, assessment, documentation, and follow-up for the broadest patient population possible, with each occurring at each visit, not just once.

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

6. Public and Member Comment: June 20 - July 19, 2016

Comments received:

- NQF received 3 post-evaluation comments on this measure, all of which were supportive of the measure.
- One commenter expressed concern about the denominator, suggesting both patients with less advanced cancers and those who die within a month of diagnosis would also benefit from outpatient screening.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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: No risk adjustment or risk 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 on-going 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 analysis in the hospital setting.

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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.

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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 are 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.

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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 in 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.

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5. Related and Competing Measures

- This measure is related to two measures:
    - 0179: Improvement in dyspnea. 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. 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: **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 3, 2016 post-comment call.

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6. Public and Member Comment: June 20 - July 19, 2016; Post-Comment Call: August 3, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, 4 of which were supportive of the measure.
- One commenter expressed concern about inclusion of short-stay patients, recommending stratification of results for patients with length of stay <7 days and an exclusion for those patients who are imminently dying.
    - ***Developer response*:** Results various statistical analyses show that applying or removing the inclusion of short-stay patients did not affect the measures scores. Moreover, a large portion of care processes, including pain screening, were performed on the first day of admission to hospice.

Developer response regarding performance gap (opportunity for improvement):

- To address the Committee's lack of consensus on opportunity for improvement, the developer submitted preliminary performance data for the measure in the hospital-based palliative care setting. These results, which were based on data from 895 patients admitted to an acute care hospital for at least 1 day from January 2014 to June 2015, indicated that 81.8% of patients were screened for dyspnea.

Committee response:

- After discussion, the Committee re-voted on the Performance Gap subcriterion. Upon revote, the Committee agreed that there is opportunity for improvement for dyspnea screening in the hospital-based palliative care setting.

Vote Following Consideration of Public and Member Comments:

Performance Gap: **H-0**; **M-18**; **L-0**; **I-0**

Standing Committee Overall Recommendation for Endorsement: **Y-18**; **N-0**

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

1638 Hospice and Palliative Care — Dyspnea Treatment

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

Submission | Specifications

Description: Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.

Numerator Statement: Patients who screened positive for dyspnea who received treatment within 24 hours of screening.

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, patients who were not screened for dyspnea, and/or patients with a negative screening.

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: The measure meets the Importance criteria

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

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: **H-3**; **M-18**; **L-1**; **I-0**

Rationale:

- 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.
- 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.
- 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.

- 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 on-going 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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 <u>receipt</u> 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 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.

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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:

- The Committee noted that because data for this measure are 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.

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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:

- 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 in 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.

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5. Related and Competing Measures

- This measure is related to two measures:
    - 0179: Improvement in dyspnea. Percentage of home health episodes of care during which the patient became less short of breath or dyspneic

- 1639: Hospice and Palliative Care – Dyspnea Screening. Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter

- Measure #0179 is an outcome measure used in the home health setting, and as such, there are no harmonization issues.
- Measure #1639 is paired with this measure. Patients identified as having shortness of breath in measure #1639 constitute the denominator for this measure (#1638).

Standing Committee Recommendation for Endorsement: **Y-21**; **N-2**

6. Public and Member Comment: June 20 - July 19, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, all of which were supportive of the measure.
- One commenter expressed concern about inclusion of short-stay patients, recommending stratification of results for patients with length of stay <7 days and an exclusion for those patients who are imminently dying.
  - ***Developer response*:** Results various statistical analyses show that applying or removing the inclusion of short-stay patients did not affect the measures scores. Moreover, a large portion of care processes, including pain screening, were performed on the first day of admission to hospice.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

Physical Aspects of Care (Constipation)

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

Submission | Specifications

Description: Percentage of vulnerable adults treated with an opioid that are offered/prescribed 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: No risk adjustment or risk 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 are somewhat old, but for the most part agreed that there is still an opportunity for improvement for this measure.

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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 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-rater 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 voted on the measure rather than accepting 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.

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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.

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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, for the most part, harmonized with measure #1626. For this measure, patients receiving hospice care are included in the definition of "vulnerable" adults. However, for measure #1626 (which assesses care preferences for patients admitted to the ICU); hospice patients are not included in the definition of "vulnerable" adults. The developer explained this difference in definitions by noting that would be unusual for hospice patients to be admitted to ICU.

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

6. Public and Member Comment: June 20 - July 19, 2016

Comments received:

- NQF received 3 post-evaluation comments on this measure, all of which were supportive of the measure.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

9. Appeals

No Appeals received.

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 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: No risk adjustment or risk 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 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 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.

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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.
- 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.

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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 are 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.

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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 in 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: June 20 - July 19, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, all of which were supportive of the measure.
- One commenter expressed concern about inclusion of short-stay patients, recommending stratification of results for patients with length of stay <7 days and an exclusion for those patients who are imminently dying.
    - ***Developer response*:** Results various statistical analyses show that applying or removing the inclusion of short-stay patients did not affect the measures scores. Moreover, a large portion of care processes, including pain screening, were performed on the first day of admission to hospice.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

9. Appeals

No Appeals received.

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: No risk adjustment or risk 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, based on 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.

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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.
- 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, indicating 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.

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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)

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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)

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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. 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 [*individual and clinician group/practice-level measure in various settings including hospital and hospice*]
    - 1641: Hospice and Palliative Care – Treatment Preferences. Percentage of patients with chart documentation of preferences for life sustaining treatments [*clinician group/practice- and facility-level measure in hospitals and hospice*]
- 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**

Rationale

- The Committee did not feel that the face validity assessments that were conducted for this measure were specific enough.

6. Public and Member Comment: June 20 - July 19, 2016; Post-comment call: August 3, 2016

Comments received:

- One commenter supported the Committee's decision not to recommend the measure for continued endorsement.
- Two commenters did not support the Committee's decision.
- One commenter requested that the Committee reconsider the measure after obtaining additional information and clarification regarding the measure specifications.
- One commenter noted the importance of emergency, critical, and advance care plans and provided specific suggestions on ensuring these are available to healthcare providers.
- The developer of the measure formally requested a reconsideration of the measure due to inappropriate application of the evaluation criteria:
    - We are requesting that the Committee reconsider the measure that was considered for maintenance. First, regarding the concerns about face validity, while it is true that one of the panels was cancer only, each measure was reviewed individually at each expert panel for face validity and only those that met the criteria as explained in provided documents were considered to be valid. This measure was considered to have face validity by these expert panels. I think the panel may have been confused by a paragraph in the measure testing document that talks about a higher level of evidence for validity (the process-outcome link). For this higher level of validity, there is only data in aggregate. Second, regarding the reliability of the measure we provided kappa statistics in the reliability section that showed high inter-rater reliability showing that we were able to reliably collect this data using the proposed specifications.

Committee response:

- To address its concerns regarding the reliability of the measure, the Committee asked the developer to clarify the numerator specifications so that members could understand how the measure can be met. The developer noted that simply having an advance directive in the record does not meet the measure numerator's inclusion criteria. However, annotation of a conversation with the patient or family (within the proper timeframe) regarding treatment preferences would satisfy the inclusion criteria, with the assumption that if an advance directive is available in the patient record it would inform treatment choices and/or be reviewed with the patient or family. The developer also noted that documentation of a reason why the conversation did not occur would also meet the measure (e.g., surrogate decision maker is unavailable). Based on these clarifications regarding the measure numerator, the Committee agreed to re-vote on the reliability subcriterion.
- Based on the developer's clarification that the face validity of the measure was explicitly evaluated by three expert panels (using the same procedures as those described for measures #1617, #1624, and #1628) and on NQF staff clarification that updated validity testing is not required, the Committee agreed to re-vote on the validity subcriterion. One member, however,

expressed concern regarding the validity of the measure because the measure can be met if there is documentation of a reason why a preferences conversation was not held.

- Because the measure passed the Reliability and Validity subcriteria upon re-vote, the Committee then discussed and voted on the Feasibility and Usability and Use criteria.
- Feasibility
    - The Committee questioned the developer about the feasibility of data collection for this measure by small hospitals. The developers responded that the feasibility of the measure should not vary by hospital size (if that hospital has an ICU).
    - The Committee asked the developer whether it was feasible to collect data for the measure from electronic health records (EHRs), even though the measure currently is specified for paper records only. The developers noted a study conducted by one of the developers where the measure was abstracted from the EHR system used within the Veterans Health Administration, stating that the process of abstraction was very similar to, and perhaps somewhat easier than, the process for paper records; feasibility issues were not identified with for those abstracting data from an EHR.
- Usability and Use
    - 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).
    - Longitudinal data for this measure are not available and there is therefore no information regarding improvement.
    - The developer noted that the measure is referenced in the VA´s draft handbook for planned Life Sustaining Treatment policy, but knew of no other plans for use. The developer did note, however, that they are pursuing avenues to "convert" the measure to an eMeasure, potentially through use of natural language processing. The Committee encouraged the developer to seek out opportunities to implement this measure.
- Related/Competing discussion, comparing this measure to measures #0326 and #1641
    - Committee members noted the additional care settings for the measures, and justified the need for this measure as one that emphasizes the importance of advance care planning—and particularly the review of previously-recorded advance care plans—on admission to the ICU, which itself indicates a substantial change in treatment plan or clinical condition.

Vote Following Consideration of Public and Member Comments:

Reliability: **H-0**; **M-12**; **L-5**; **I-0**

Validity: **H-0**; **M-15**; **L-4**; **I-0**

Feasibility: **H-0; M-16; L-1; I-0**

Usability and Use: **H-0; M-11; L-7; I-0**

Standing Committee Overall Recommendation for Endorsement: **Y-18**; **N-0**

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

9. Appeals

No Appeals received.

1641 Hospice and Palliative Care – Treatment Preferences

Submission | Specifications

Description: Percentage of patients with chart documentation of preferences for life sustaining treatments.

Numerator Statement: Patients whose medical record includes documentation of life sustaining preferences

Denominator Statement: Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.

Exclusions: Patients with length of stay < 1 day in hospice or palliative care

Adjustment/Stratification: No risk adjustment or risk 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: The measure meets the Importance criteria

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

1a. **Previous Evidence Evaluation Accepted** 1b. Performance Gap: **H-2**; **M-18**; **L-2**; **I-0;**

Rationale:

- 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 *documentation* 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.
- 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.
- 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.

- 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 on-going 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 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-2**; **M-20**; **L-0**; **I-0** 2b. Validity: **H-0**; **M-22**; **L-0**; **I-0**

<u>Rationale</u>:

- 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).
- When questioned by the Committee, the developers clarified that the measure requires evidence of a <u>discussion</u> 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.

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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 are 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.

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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 in this setting are not yet available and there is therefore no information regarding improvement.
    - The Committee did not report awareness of any unintended consequences associated with this measure.

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5. Related and Competing Measures

- This measure competes with two measures:
    - 1626: Patients admitted to the ICU who have care preferences documented. 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.
    - 0326: Advance Care Plan. 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.

- The Committee largely agreed that advance care planning—which can be done well in advance of a terminal illness and 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 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.

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

6. Public and Member Comment: June 20 - July 19, 2016

Comments received:

- NQF received 7 post-evaluation comments on this measure, all of which were supportive of the measure.
- One commenter expressed concern about inclusion of short-stay patients, recommending stratification of results for patients with length of stay <7 days and an exclusion for those patients who are imminently dying.
    - ***Developer response*:** Results various statistical analyses show that applying or removing the inclusion of short-stay patients did not affect the measures scores. Moreover, a large portion of care processes, including pain screening, were performed on the first day of admission to hospice.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

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

Submission | Specifications

Description: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life

Numerator Statement: Patients who died from cancer and received chemotherapy in the last 14 days of life

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice

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

Type of Measure: Process

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-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 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 increase the chance of dying at home, and a 2012 provisional clinical opinion from the American Society of Clinical Oncology 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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 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 subcriterion without further discussion. Members voted 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 currently is 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: June 20 - July 19, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, all of which were supportive of the measure.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

9. Appeals

No Appeals received.

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: No risk adjustment or risk 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; 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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.

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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.

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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 were aware of unintended consequences associated with this measure.

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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.

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

6. Public and Member Comment: June 20 - July 19, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, all of which were supportive of the measure.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

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

Submission | Specifications

Description: Proportion of patients who died from cancer not admitted to hospice

Numerator Statement: Proportion of patients not enrolled in hospice

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice

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

Type of Measure: Process

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: **Previous Evidence Evaluation Accepted** 1b. Performance Gap: **H-20**; **M-2**; **L-0**; **I-0**

Rationale:

- 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 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.

- 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.
- 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.
- 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

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

<u>Rationale</u>:

- 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
    - 0211: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life
    - 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: June 20 - July 19, 2016

Comments received:

- NQF received 5 post-evaluation comments on this measure, all of which were supportive of the measure.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

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

Submission | Specifications

Description: Proportion of patients who died from cancer, and admitted to hospice and spent less than 3 days there

Numerator Statement: Patients who died from cancer and spent fewer than three days in hospice.

Denominator Statement: Patients who died from cancer who were admitted to hospice

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk 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: **Previous Evidence Evaluation Accepted** 1b. Performance Gap: **H-14**; **M-7**; **L-0**; **I-0;**

Rationale:

- 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 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.

- 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; 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.
- 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.
- 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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 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.

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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.

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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)

Rationale:

- The measure currently is 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.

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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: June 20 - July 19, 2016

Comments received:

- NQF received 4 post-evaluation comments on this measure, all of which were supportive of the measure.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

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9. Appeals

No Appeals received.

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: No risk adjustment or risk 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-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, 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.

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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.

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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:

- 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.

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4. Usability and Use: H-4; M-19; 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 not currently in use, although it was supported by the MAP in 2013 for inclusion in the PQRS program (a clinician-level program).
- Longitudinal data for this measure are not yet available and there is therefore no information regarding improvement.
- Committee members did not suggest any potential unintended consequences for the measure.
- Committee members encouraged the developer to continue to pursue opportunities for inclusion in accountability programs.

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5. Related and Competing Measures

- No related or competing measures noted.

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

6. Public and Member Comment: June 20 - July 19, 2016

Comments received:

- NQF received 2 post-evaluation comments on this measure, both of which were supportive of the measure.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for continued endorsement

8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for continued endorsement

9. Appeals

No Appeals received.

2651 CAHPS® Hospice Survey (experience with care) [8 PRO-PMs]

Submission | Specifications

Description: 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

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.

Denominator Statement: 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, denomniators will vary by survey item (and corresponding multi-item measures, if applicable) according to the eligibility of respondents for each item.

Exclusions: Cases are excluded from the survey target population if:

- The hospice patient is still alive
- The decedent's age at death was less than 18
- The decedent died within 48 hours of his/her last admission to hospice care
- The decedent had no caregiver of record
- The decedent had a caregiver of record, but the caregiver does not have a U.S. or U.S. Territory home address
- The decedent had no caregiver other than a nonfamilial legal guardian
- 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: Case-mix adjustment is conducted via linear regression.

From hospice administrative data:

- Decedent age at death

- Payer
- Primary diagnosis
- Length of final episode of hospice care
- Language of survey administration

The case-mix adjustment uses a regression methodology, also called covariance adjustment. If data are missing for an adjuster variable, the missing value should be imputed using the hospice-specific mean for that variable.

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 measures meet the Importance criteria

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

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

Rationale:

- As evidence for these measures, 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 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.

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2. Scientific Acceptability of Measure Properties: 7 of the 8 measures meet 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 (Consensus not reached)**
- *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 because 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 "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 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 voted on those measures 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 to non-response bias. The developers stated that response bias is difficult to assess directly, but surveys of varying lengths were used during field testing, with 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.

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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:

- 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 the survey, but believe it to be around at 10th 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 CMS considered providing 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.

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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 thought 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.

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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**

Because the Committee did not reach consensus on the reliability subcriterion for the "*Treating family member with respect*" measure, the Committee did not vote on an overall recommendation for endorsement for that measure. For this measure, the Committee will re-vote on the reliability subcriterion and vote on a recommendation for endorsement on the August 3, 2016 post-comment call.

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6. Public and Member Comment: June 20 - July 19, 2016; Post-comment call: August 3, 2016

Comments received:

- NQF received 3 post-evaluation comments the 8 PRO-PMs under NQF #2651, all of which were supportive of the measures.
- NQF also sought feedback on the measure from the Person- and Family-Centered Care Standing Committee, as this Committee has extensive experience in evaluating PRO-PMs from CAHPS surveys and other PRO-PM/instrument-based measures. One of the PFCC Committee members expressed concern with the low ICC values for all of the measures.

Developer response regarding the *Treating Family Member with Respect* measure:

- To address the Committee's lack of consensus on reliability, the developer updated the reliability estimates for all 8 PRO-PMs based on data from April-September, 2015. The addition of an extra three months of data resulted in increased reliability estimates for 7 or the 8 PRO-PMs. For the "*Treating family member with respect"* measure*,* the reliability estimate increased from 0.61 to 0.68.
- To address the concern regarding the low ICC values, the developer cited Lyratzopoulos et al. (2011), who suggested benchmarks such that ICCs less than 0.01 are labeled "Low" and ICCs greater than 0.10 are labeled "High." Lyratzopoulos, et al. also states that the ICC can be interpreted as the reliability of the quality measure with a sample size = 1 respondent per hospice. The developers therefore applied the Spearman-Brown prophecy formula to estimate the reliability assuming 200 respondents per hospice (with estimates for the 8 measures ranging from 0.66 to 0.81, based on the April-September, 2015 data).

Committee response:

- After discussion, the Committee re-voted on the reliability subcritierion. Upon revote, the Committee agreed that the developer had demonstrated adequate reliability for the *Treating Family Member with Respect* measure, based on April-September, 2015 data.

Vote Following Consideration of Public and Member Comments:

Reliability: **H-0**; **M-17**; **L-1**; **I-0**

Standing Committee Overall Recommendation for Endorsement: **Y-18**; **N-0**

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-16; N-0

Decision: Approved for endorsement

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8. Board of Directors Executive Committee Vote: Yes (October 25, 2016)

Decision: Ratified for endorsement

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9. Appeals

No Appeals received.

Measures Withdrawn from Consideration

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

Care of the Patient at the End of Life

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

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

Submission

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

Numerator Statement: Patients who died from cancer and had at least one emergency department visit 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-1**; **M-4**; **L-1**; **I-16**; 1b. Performance Gap: **H-5**; **M-16**; **L-0**; **I-1**

Evidence Exception: **Y-21; N-1**

Rationale:

- 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 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; 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 by 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 by 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.

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2. Scientific Acceptability of Measure Properties: <u>The measure did not meet the Scientific Acceptability criteria</u>

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

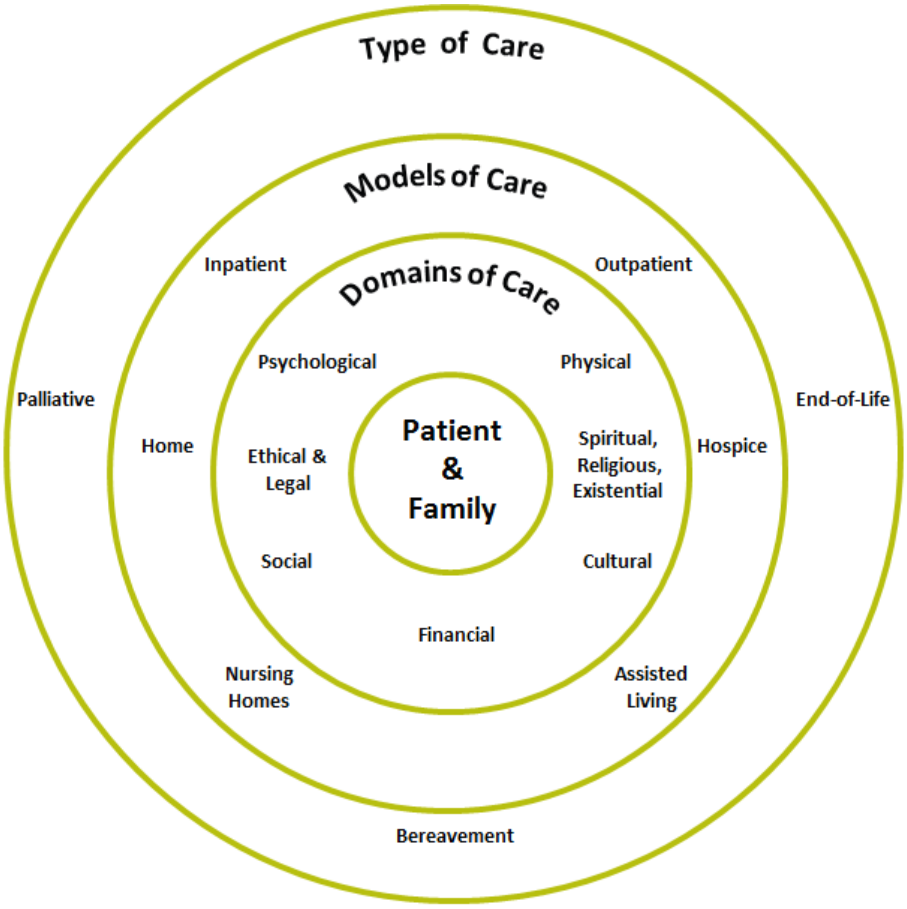
2a. Reliability: **H-0**; **M-10**; **L-2**; **I-10** 2b. Validity: **H-0**; **M-6**; **L-5**; **I-11**

<u>Rationale</u>:

- 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 in-person evaluation meeting.
- As a result of the concerns related to the lack of risk-adjustment, the Committee did not pass the 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 27th, 2016, the measure developers communicated to NQF that they would not be pursuing the deferral option.

Appendix B: NQF Palliative and End-of-Life Care Framework and Portfolio of 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

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

Cultural Aspects of Care

1894: Cross-Cultural Communication Measure Derived from the Cross-Cultural Communication Domain of the C-CAT

1919: Cultural Competency Implementation Measure

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 Patient at the End of Life

0208: Family Evaluation of Hospice Care*

0210: Proportion receiving chemotherapy in the last 14 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

2651: CAHPS Hospice Survey (Experience with Care): 8 PRO-PMs: (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)

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 November 28, 2016
0177	Improvement in pain interfering with activity	Home Health Quality Reporting Program (HH QRP), Home Health Value-Based Purchasing(HH VBP)
0326	Advance Care Plan	Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier (VBM), Physician Feedback/Quality and Resource Use Reports (QRUR),* Home Health Value-Based Purchasing Program
0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier (VBM), Physician Feedback/Quality and Resource Use Reports (QRUR),* PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
0384	Oncology: Medical and Radiation - Pain Intensity Quantified	Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier (VBM), Physician Feedback/Quality and Resource Use Reports (QRUR),* PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
0420	Pain Assessment and Follow-Up	Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier (VBM), Physician Feedback/Quality and Resource Use Reports (QRUR)*
1617	Patients Treated with an Opioid who are Given a Bowel Regimen	Hospice Quality Reporting Program (HQRP)
1634	Hospice and Palliative Care — Pain Screening	Hospice Quality Reporting Program (HQRP)
1637	Hospice and Palliative Care — Pain Assessment	Hospice Quality Reporting Program (HQRP)
1638	Hospice and Palliative Care — Dyspnea Treatment	Hospice Quality Reporting Program (HQRP)
1639	Hospice and Palliative Care — Dyspnea Screening	Hospice Quality Reporting Program (HQRP)
1641	Hospice and Palliative Care – Treatment Preferences	Hospice Quality Reporting Program (HQRP)

* Beginning in 2017, the PQRS and VBM programs will be consolidated into the Merit-Based Incentive Payment System (MIPS) program.

NQF #	Title	Federal Programs: Finalized as of November 28, 2016
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 (HQRP)
1822	External Beam Radiotherapy for Bone Metastases	PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR) Hospital Outpatient Quality Reporting Program (HOQR)

Appendix D: Project Standing Committee and NQF Staff

STANDING COMMITTEE

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Linda Schwimmer, Attorney, Vice President, NJ Health Care Quality Institute
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Appendix E: Measure Specifications

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

STATUS

Public and Member Commenting

STEWARD

National Hospice and Palliative Care Organization

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.

TYPE

PRO

DATA SOURCE

Patient Reported Data/Survey Data specific to measure (initial question on admission and follow-up question asked between 48 and 72 hours of admission) recorded by hospice. Data can be part of patient record or recorded and tracked separately.

Data are aggregated and submitted quarterly by hospices to NHPCO which maintains a national data repository. NHPCO analyzes the data and produces a quarterly national level report for hospices as a source of comparative data for use in performance improvement initiatives.

Available at measure-specific web page URL identified in S.1 No data dictionary

LEVEL

Facility, Population : National

SETTING

Hospice

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

Number of patients who replied "yes" when asked if their pain was brought to a comfortable level 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.

DENOMINATOR DETAILS

Patients who are able to self report pain information and 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

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

EXCLUSION DETAILS

Patients who replied 'No" to initial question: "Are you uncomfortable because of pain?"

Patients under 18 years of age

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

Patients who cannot self report pain

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

None

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Calculation of measure score:

1. Identify number of patients admitted to hospice services during the timeframe of interest (e.g., CY quarter).

2. Identify number of admitted patients who were able to respond to the question "Are you uncomfortable because of pain?" during the initial assessment and were not excluded because they met the exclusion criteria.

3. Identify the number of patients who responded "yes" to the question "Are you uncomfortable because of pain?" during the initial assessment.

4. Identify the number of patients who were contacted between 48 and 72 hours of the initial assessment and responded "yes" to the question: "Was your pain brought to a comfortable level within 48 hours of the start of hospice services?" This number is the numerator.

4. Divide the number of patients whose pain was brought to a comfortable level within 48 hours after initial assessment by the number of patients who reported they were uncomfortable because of pain at the initial assessment.

2. Multiply this number by 100 to get the hospice's score as a percent. This is the proportion of patients who reported being uncomfortable because of pain at initial assessment whose pain was brought to a comfortable level within 48 hours of the start of hospice services.

NOTE: A Problem Score may also calculated as a complement to the measure score The Problem Score is calculated by dividing the number of patients whose pain was NOT brought to a comfortable level within 48 hours after the initial assessment by the number of patients who were uncomfortable on admission. Multiply this number by 100 to get the hospice's score as a percent. A lower score/percentile = better performance. The Problem Score is useful for assessing the proportion of patients for whom comfort was not achieved and subsequent root cause analysis for quality improvement purposes. Available at measure-specific web page URL identified in S.1

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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: N/A

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

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

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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:

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

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)

• variable in MEDPAR called incrdays, which is number of ICU days per visit

• used hospital admission date variable (admitdate) and then checked if incrdays was >0 for admissions occurring in the last

30 days before death

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:

1. Identify those patients that meet the denominator criteria defined in the measure.

2. Subtract those patients with a denominator exclusion from the denominator if applicable. 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

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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:

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

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

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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:

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

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

Claims: Medicare HOSPICE file only:

Subtracted hospice admission date (admndate) from death date variable to get hospice length of stay.

Registry:

Date of Death – Hospice Enrollment Date </= 3 days

DENOMINATOR STATEMENT

Patients who died from cancer who were admitted to hospice

DENOMINATOR DETAILS

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.

Registry:

Deceased = Yes, patient is deceased as a consequence of his/her cancer or cancer treatment

AND

Hospice Enrollment = Yes

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 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

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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:

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

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

- 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

None

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.

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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.

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

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

None

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

None

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

1. Identify adult hospitalizations of at least 3 days duration that ended in patient death

2. Identify from the medical record patients who had an ICD in place

3. Identify from physician documentation patients who were noted to have had an expected death at least 3 days prior to death

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.

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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.

1626 Patients Admitted to ICU who Have Care Preferences Documented

STATUS

Public and Member Commenting

STEWARD

RAND Corporation

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.

TYPE

Process

DATA SOURCE

Paper Medical Records Medical record abstraction tool

No data collection instrument provided No data dictionary

LEVEL

Facility

SETTING

Hospital/Acute Care Facility

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.

NUMERATOR DETAILS

Edits indicated by [brackets]

Patients whose medical record includes documentation of care preferences within 48 hours of admission to ICU. Care preferences may include any of the following:

- Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR

- Documentation that a care preference discussion was attempted and/or reason why it was not done

[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.]

DENOMINATOR STATEMENT

All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.

DENOMINATOR DETAILS

All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.

"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
- Stage IV cancer

EXCLUSIONS

None

EXCLUSION DETAILS

None

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

None

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

1. Identify all vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission

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.
No diagram provided

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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 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.

1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits

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

None

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

None

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.

4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits

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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 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.

Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure.

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)

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.

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.

1634 Hospice and Palliative Care — Pain Screening

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.

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

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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 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.

1637 Hospice and Palliative Care — Pain Assessment

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 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

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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.

1638 Hospice and Palliative Care — Dyspnea Treatment

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

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

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.

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 > 0 on a numeric scale or any observational or self-report of dyspnea.

[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.]

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

Dyspnea treatment:

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

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

c. Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) / initial encounter (palliative care)

d. Step 4- Identify patients who screened positive for dyspnea

e. Step 5- Identify patients who received treatment within 24 hours of screening positive for dyspnea

Quality Measure= Numerator: Patients who received treatment for dyspnea in Step 5 / Denominator: Patients in Step 4 No diagram provided

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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.

1639 Hospice and Palliative Care — Dyspnea Screening

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

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Screened for dyspnea:

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

b.Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day.

c.Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) OR during the initial encounter (palliative care)

Quality measure = Numerator: Patients screened for dyspnea in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 No diagram provided

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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.

1641 Hospice and Palliative Care – Treatment Preferences

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

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 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 “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

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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.

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.

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 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

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.

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.

Data are collected via chart review. Criteria are:

1) evidence of a discussion about spiritual/religious concerns, or

2) evidence that the patient, and/or family declined to engage in a conversation on this topic.

Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments within 5 days of admission to hospice, visit notes documented by any member of the team, and/or the spiritual care assessment.

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

Step 1- Identify all patients with serious, life-limiting illness who were discharged from hospice care during the designated reporting period.

Step 2- Exclude patients who are less than 18 years of age.

Step 3- Identify patients with documented discussion of spiritual/religious concerns or 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

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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.

2651 CAHPS® Hospice Survey (experience with care)

STATUS

Submitted

STEWARD

Centers for Medicare and Medicaid Services

DESCRIPTION

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 measures proposed here include the following six multi-item measures.

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms
- Getting Hospice Training

In addition, there are two other measures, also called "global ratings."

- Rating of the hospice care
- Willingness to recommend the hospice

Below we list each multi-item measure and its constituent items, along with the two ratings questions. Then we briefly provide some general background information about CAHPS surveys.

List of CAHPS Hospice Survey Measures

Multi-Item Measures

Hospice Team Communication (Composed of 6 items)

+ While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member?

+ While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?

+ How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?

+ While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?

+ While your family member was in hospice care, how often did the hospice team listen carefully to you?

+ While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care?

Getting Timely Care (Composed of 2 items)

+ 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?

+ How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?

Treating Family Member with Respect (Composed of 2 items)

+ While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?

+ While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?

Providing Emotional Support (Composed of 3 items)

+ While your family member was in hospice care, how much emotional support did you get from the hospice team?

+ In the weeks after your family member died, how much emotional support did you get from the hospice team?

+ Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?

Getting Help for Symptoms (Composed of 4 items)

+ Did your family member get as much help with pain as he or she needed?

+ How often did your family member get the help he or she needed for trouble breathing?

+ How often did your family member get the help he or she needed for trouble with constipation?

+ How often did your family member receive the help he or she needed from the hospice team for feelings of anxiety or sadness?

Getting Hospice Care Training (Composed of 5 items)

+ Did the hospice team give you enough training about what side effects to watch for from pain medicine?

+ Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?

+ Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?

+ Did the hospice team give you the training you needed about what to do if your family member became restless or agitated?

+ Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with your or your family member?

Rating Measures:

In addition to the multi-item measures, there are two “global” ratings measures. These single-item measures indicate on the one hand the need for quality improvement and on the other hand provide families and patients looking for care with evaluations of the care provided by the hospice. The items are rating of hospice care and willingness to recommend the hospice.

+ Rating of Hospice Care: Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member’s hospice care?

+ Willingness to Recommend Hospice: Would you recommend this hospice to your friends and family?

The CAHPS Hospice Survey is a standardized survey instrument designed to collect reports and ratings of experiences with hospice care. The survey is completed by the primary caregiver of

the patient who died while receiving hospice care (hereafter, “decedent”). The primary caregiver is intended to be the family member or friend most knowledgeable about the decedent’s hospice care, and is identified through hospice administrative records. Data collection for sampled decedents/caregivers is initiated two months following the month of the decedent’s death.

The CAHPS Hospice Survey is part of the CAHPS family of experience of care surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/hospice/index.html. CMS initiated national implementation of the CAHPS Hospice Survey in 2015. Hospices meeting CMS eligibility criteria were required to administer the survey for a “dry run” for at least one month of sample from the first quarter of 2015. Beginning with the second quarter of 2015, hospices are required to participate on an ongoing monthly basis in order to receive their full Annual Payment Update from CMS. Information regarding survey content and national implementation requirements, including the latest versions of the survey instrument and standardized protocols for data collection and submission, are available at: http://www.hospicecahpssurvey.org/.

A list of the CAHPS Hospice Survey measures, including the components of the multi-item measures can be found in Appendix A.

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

0. Score each item using top box method, possible values of 0 or 100

1. Calculate mode adjusted scores for each item for each respondent

2. Calculate case-mix adjusted scores for each item for each hospice

3. Take the unweighted means of the mode- and case-mix-adjusted hospice-level items to form multi-item measures

Example: hospice-level multi-item measure for ‘Getting Timely Care’:

0. Score each item using top box method, possible values of 0 or 100

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”.

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?

Item #2. How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?

1. Calculate mode-adjusted scores for each item for each respondent

2. Calculate case-mix adjusted scores for each item for each hospice

Each item is case mix adjusted separately; this step produces case-mix adjusted item-level scores for each hospice.

3. Take the unweighted means of the case-mix adjusted hospice-level items to form multi-item measures.

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 (Item1 + Item2) / 2 = (95 + 90) / 2 = 92.5.

DENOMINATOR STATEMENT

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

DENOMINATOR DETAILS

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).

Survey population: Primary caregivers of patients who died while receiving care from a given hospice in a given month.

Denominator for Multi-Item Measures: The number of respondents who answer at least one item within the multi-item measure.

Denominator for Rating Measures: The number of respondents who answered the item.

EXCLUSIONS

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

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are instructed to complete the "About You" and "About Your Family Member" sections of the survey only.

Cases are excluded from the survey target population if:

• The hospice patient is still alive

• The decedent's age at death was less than 18

• The decedent died within 48 hours of his/her last admission to hospice care

• The decedent had no caregiver of record

• The decedent had a caregiver of record, but the caregiver does not have a U.S. or U.S. Territory home address

• The decedent had no caregiver other than a nonfamilial legal guardian

• 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

EXCLUSION DETAILS

Please see S.10.The CAHPS Hospice Survey Quality Assurance Guidelines (available at: (http://www.hospicecahpssurvey.org/Content/QualityAssurance.aspx) 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

Other Case Mix Adjustment

Case-mix adjustment is conducted via linear regression. The following items are included in the case-mix adjustment model:

Items from survey responses:

What is your age?

1=18 to 24 years

2=25 to 34 years

3=35 to 44 years

4=45 to 54 years

5=55 to 64 year

Provided in response box S.15a

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

Top Box Score Calculation:

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)

2) Identify any exclusions from the respondent population (as described above in S.10)

3) Score each item using top box method, possible values of 0 or 100

4) Calculate mode adjusted top box scores for each item.

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).

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 calculation of multi-item measure scores. (Please see S.22 below for more details). No diagram provided

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5.1 Identified measures: 0208 : Family Evaluation of Hospice Care

1623 : Bereaved Family Survey

5a.1 Are specs completely harmonized? No

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.

5b.1 If competing, why superior or rationale for additive value: 0208 Family Evaluation of Hospice Care.

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.

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.

Appendix F1: Related and Competing Measures (tabular format)

Comparison of Measures 1641, 0326, 1626

Comparison of Measures 0209, 0383, 0384, 0420, 1628, 1634, 1637

Comparison of Measures 0383, 0384, 0420, 1628

Comparison of Measures 1641, 0326, and 1626

	1641: Hospice and Palliative Care – Treatment Preferences	0326: Advance Care Plan	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	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.

	1641: Hospice and Palliative Care – Treatment Preferences	0326: Advance Care Plan	1626: Patients Admitted to ICU who Have Care Preferences Documented
		a surrogate decision maker or provide an advance care plan.	
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 "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.	Report the CPT Category II codes designated for this numerator: - 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record - 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 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.	Edits indicated by [brackets] Patients whose medical record includes documentation of care preferences within 48 hours of admission to ICU. Care preferences may include any of the following: - Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR - Documentation that a care preference discussion was attempted and/or reason why it was not done [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.]
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	Denominator Criteria (Eligible Cases): 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,	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission. "Vulnerable" is defined as any of the following: - >74 years of age - Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001)

	1641: Hospice and Palliative Care – Treatment Preferences	0326: Advance Care Plan	1626: Patients Admitted to ICU who Have Care Preferences Documented
	neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.	99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439 *Clinicians indicating the place of service as the emergency department will not be included in this measure.	- Poor prognosis/terminal illness defined as life expectancy of <6 months - Stage IV cancer
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	None
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	None
Type Score	Rate/proportion	Rate/proportion	Rate/proportion
Algorithm	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	Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older. Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above. 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.	1. Identify all vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission 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.

	1641: Hospice and Palliative Care – Treatment Preferences	0326: Advance Care Plan	1626: Patients Admitted to ICU who Have Care Preferences Documented
		Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2	
Submission items	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.		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.

Comparison of Measures 0209, 1634, 1637

	0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	1634: Hospice and Palliative Care — Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
Steward	National Hospice and Palliative Care Organization	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill
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.	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.	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	PRO	Process	Process
Data Source	Patient Reported Data/Survey Data specific to measure (initial question on admission and follow-up question asked between 48 and 72 hours of admission) recorded by hospice. Data can be part of patient record or recorded and tracked separately. Data are aggregated and submitted quarterly by hospices to NHPCO which maintains a national data repository. NHPCO analyzes the data and produces a quarterly national level report for hospices as a source of comparative data for use in performance improvement initiatives. Available at measure-specific web page URL identified in S.1 No data dictionary	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. Available in attached appendix at A.1 No data dictionary	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, Population : National	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice
Setting	Hospice	Hospice, Hospital/Acute Care Facility	Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment.	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.	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.

	0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	1634: Hospice and Palliative Care — Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
Numerator Details	Number of patients who replied "yes" when asked if their pain was brought to a comfortable level within 48 hours of initial assessment.	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.	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 who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment.	Patients enrolled in hospice OR patients receiving specialty palliative care in an acute hospital setting.	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	Patients who are able to self report pain information and replied "yes" when asked if they were uncomfortable because of pain at the initial assessment.	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.]	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-

	0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	1634: Hospice and Palliative Care — Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
			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 report pain and enter the denominator population for Pain 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 Patients who are unable to understand the language of the person asking the initial and follow up questions	Patients with length of stay < 1 day in palliative care.	Patients with length of stay < 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.
Exclusion Details	Patients who replied 'No" to initial question: "Are you uncomfortable because of pain?" Patients under 18 years of age Patients who are unable to understand the language of the person asking the initial and follow up questions Patients who cannot self report pain	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.
Risk Adjustment	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A	No risk adjustment or risk stratification N/A

	0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	1634: Hospice and Palliative Care — Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
Stratification	None	N/A	N/A
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Calculation of measure score: 1. Identify number of patients admitted to hospice services during the timeframe of interest (e.g., CY quarter). 2. Identify number of admitted patients who were able to respond to the question "Are you uncomfortable because of pain?" during the initial assessment and were not excluded because they met the exclusion criteria. 3. Identify the number of patients who responded "yes" to the question "Are you uncomfortable because of pain?" during the initial assessment. 4. Identify the number of patients who were contacted between 48 and 72 hours of the initial assessment and responded "yes" to the question: "Was your pain brought to a comfortable level within 48 hours of the start of hospice services?" This number is the numerator. 4. Divide the number of patients whose pain was brought to a comfortable level within 48 hours after initial assessment by the number of patients who reported they were uncomfortable because of pain at the initial assessment. 2. Multiply this number by 100 to get the hospice's score as a percent. This is the proportion of patients who reported being uncomfortable because of pain at initial	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	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

	0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	1634: Hospice and Palliative Care — Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	assessment whose pain was brought to a comfortable level within 48 hours of the start of hospice services. NOTE: A Problem Score may also calculated as a complement to the measure score The Problem Score is calculated by dividing the number of patients whose pain was NOT brought to a comfortable level within 48 hours after the initial assessment by the number of patients who were uncomfortable on admission. Multiply this number by 100 to get the hospice's score as a percent. A lower score/percentile = better performance. The Problem Score is useful for assessing the proportion of patients for whom comfort was not achieved and subsequent root cause analysis for quality improvement purposes. Available at measure-specific web page URL identified in S.1		
Submission items	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: N/A	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 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	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.

	0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	1634: Hospice and Palliative Care — Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
		patients with advanced cancer), apply in different settings with different timing.	

Comparison of Measures 0383, 0384, 0420, 1628

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
Steward	American Society of Clinical Oncology	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Centers for Medicare & Medicaid Services	RAND Corporation
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	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	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit
Type	Process	Process	Process	Process
Data Source	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry No data dictionary	Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry Not Applicable Attachment EP_eCQM_ValueSet_CMS157v4_NQF0384_AMA-PCPI.xlsx	Claims (Only), Paper Records The data source is the patient medical record. Medicare Part B claims data and registry data is provided for test purposes. No data collection instrument provided Attachment Data_Dictionary_033016.xlsx	Electronic Health Record (Only), Paper Records, 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	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual	Facility, Health Plan, Integrated Delivery System
Setting	Clinician Office/Clinic, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic	Clinician Office/Clinic, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic	Clinician Office/Clinic, Behavioral Health : Outpatient, Outpatient Rehabilitation	Clinician Office/Clinic

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
Numerator Statement	Patient visits that included a documented plan of care* to address pain	Patient visits in which pain intensity is quantified	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	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	Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval. For EHR: eSpecification currently under development For Claims/Administrative Data: To submit the numerator option for patient visits that included a documented plan of care to address pain, report the following CPT Category II code: 0521F – Plan of care to address pain documented	Definitions: Pain intensity should be quantified using a standard instrument, such as a 0-10 numeric rating scale, visual analog scale, a categorical scale, or the pictorial scale. For Claims/Registry: To submit the numerator option for number of patient visits in which pain intensity was quantified, report one of the following CPT Category II codes: 1125F: Pain severity quantified; pain present OR 1126F: Pain severity quantified; no pain present For EHR: HQMF eMeasure developed and is included in this submission.	Definitions: Pain Assessment – Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration. Standardized Tool – An assessment tool that has been appropriately normed and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal	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.

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS) and Visual Analog Scale (VAS). Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions. Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented: • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status NUMERATOR NOTE: The standardized tool used to assess	

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			the patient's pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity). G-codes are defined as Quality Data Codes (QDCs), which are subset of HCPCs II codes. QDCs are non-billable codes that providers will use to delineate their clinical quality actions, which are submitted with Medicare Part B Claims. There are 6 G-code options for this measure. Numerator Quality-Data Coding Options for Reporting Satisfactorily: Pain Assessment Documented as Positive AND Follow-Up Plan Documented (One quality-data code [G8730 or G8731] is required on the claim form to submit this numerator option) Performance Met: G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented OR Pain Assessment Documented as Negative, No Follow-Up Plan Required	

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			Performance Met: G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required OR Pain Assessment not Documented Patient not Eligible (One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option) Other Performance Exclusion: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool OR Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible Other Performance Exclusion: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible OR Pain Assessment not Documented, Reason not Given (One quality-data code [G8732 or G8509] is required on the claim	

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			form to submit this numerator option) Performance Not Met: G8732: No documentation of pain assessment, reason not given OR Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given Performance Not Met: G8509: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not.	
Denominator Statement	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain	All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	All visits for patients aged 18 years and older	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit
Denominator Details	For EHR: eSpecification currently under development For Claims/Administrative Data: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain Eligible patients for this measure are identified by: ICD-9-CM diagnosis codes: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1,	For For Claims/Registry: Eligible patients for this measure are identified by: Diagnosis for cancer (ICD-9-CM) [reportable through 9/30/2015]: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5,	Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 96151, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439 Lists of individual codes with descriptors for the measure	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

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1,	146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51,	specifications are provided in an Excel file at S.2b	

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8,	173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01,		

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	196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41,	200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72,		

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	201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02,	201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20,		

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	203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3,	205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9 ICD-10-CM diagnosis codes: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C26.0, C26.1,	239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9 Diagnosis for cancer (ICD-10-CM) [reportable beginning 10/1/2015]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500,	C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82,C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C44.30, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212,	C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C44.30, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422,		

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	C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30,	C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1,	C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54,	C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60,	C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0,	C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10,	C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8 D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1,		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09 AND Report CPT Category II code: 1125F: Pain severity quantified; pain present AND either option 1 or 2: 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215, AND o CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration)	D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09 AND either Option 1 or 2 Option 1: Chemotherapy CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 AND CPT Procedure Codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration) OR Option 2: Radiation therapy CPT Codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470 For EHR: HQMF eMeasure developed and is included in this submission.		

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	OR 2. Radiation therapy • CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470			
Exclusions	None	None	Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented: Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)
Exclusion Details	There are no exceptions for this measure.	Not applicable	Pain Assessment not Documented Patient not Eligible (One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option) Other Performance Exclusion: G8442: Pain assessment NOT documented as being performed, documentation the patient is not	None

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			eligible for a pain assessment using a standardized tool OR Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible Other Performance Exclusion: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible	
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification n/a	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.	All eligible patients are subject to the same numerator criteria	None
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates:	To calculate performance rates:	Satisfactory reporting criteria are met by valid submission of one of	1. Identify patients at least 18 years of age with Stage IV cancer

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator	1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure.	six G codes on claims that meet denominator criteria. A rate of quality performance is calculated by dividing the number of records with G codes indicating that the quality actions were performed or that the patient was not eligible by total number of valid G code submissions. THIS SECTION PROVIDES DEFINITIONS & FORMULAS FOR THE NUMERATOR (A), TOTAL DENOMINATOR POPULATION (TDP), DENOMINATOR EXCLUSIONS (B) CALCUATION & PERFORMANCE DENOMINATOR (PD) CALCULATION. NUMERATOR (A): HCPCS Clinical Quality Codes G8730, G8731 TOTAL DENOMINATOR POPULATION (TDP): Patient aged 18 years and older on the date of the encounter of the 12-month reporting period, with denominator defined encounter codes & Medicare Part B Claims reported HCPCS Clinical Quality Codes G8730, G8731, G8442, G8939, G8732, G8509 DENONINATOR EXCLUSION (B): HCPCS Clinical Quality Code G8442, G8939 DENOMINATOR EXCLUSION CALCULATION: Denominator	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. 4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits

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	for performance calculation. – Although exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.		Exclusion (B): # of patients with valid exclusions # G8442+G8939 / # TDP PERFORMANCE DENOMINATOR CALCULATION: Performance Denominator (B): Patients meeting criteria for performance denominator calculation # A / (# TDP - # B) (Refer to section V. Measure Logic Flow Diagram for Performance Rate Calculation in attached "NQF Endorsement Measurement Submission Summary Materials" Document) Available in attached appendix at A.1	
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0524 focuses on steps to monitor and mitigate pain were implemented. Our measure is similar in concept seeking a plan of care to address pain. A plan of care is further defined as include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.	5.1 Identified measures: 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: There are a number of NQF-endorsed measure focusing on the assessment of pain in a variety of unique settings and circumstances. Several of these measures (0523 and 0420) refer to conducting the assessment using a standardized tool. Similarly, our measure suggests that pain should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical	5.1 Identified measures: 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) 0383 : Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384) 1628 : Patients with Advanced Cancer Screened for Pain at Outpatient Visits 1634 : Hospice and Palliative Care — Pain Screening	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 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

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
	5b.1 If competing, why superior or rationale for additive value: No competing measure.	scale, or the pictorial scale. Two of the measures are specific to the pediatric intensive care unit and do not require use of a standardized instrument. 5b.1 If competing, why superior or rationale for additive value: No competing measure.	1637 : Hospice and Palliative Care — Pain Assessment 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Six related measures were identified that are not harmonized with NQF# 0420. The differences between these related measures and the submitted measure NQF# 0420 are listed below: 0383 - Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384 which is unrelated to and non-competing with 0420) - target population is specific to patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain; 0383 does not include the use of a standardized pain assessment tool. Both measures are process measures. Both measures have outpatient care setting. 0676 - Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) – target population is specific to short - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure,	Key Palliative Measures Bundle was provided. Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure. 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) 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

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			it is an eligible provider report; 0676 does not include the use of a standardized pain assessment tool; 0676 does not include documentation of a follow-up plan if pain is present; 0676 is an outcome measure whereas 0420 is a process measure. Care setting for 0676 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 0677 - Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay) – target population is specific to long - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure, it is an eligible provider report; 0677 does not include the use of a standardized pain assessment tool; 0677 does not include documentation of a follow-up plan if pain is present; 0677 is an outcome measure whereas 0420 is a process measure. Care setting for 0677 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 1628 - Patients with Advanced Cancer Screened for Pain at Outpatient Visits - target	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. 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.

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			population is specific to patients with a diagnosis of advanced cancer; 1628 does not include a follow-up plan if pain is present; Both 1628 and 0420 are process measures; Both measures have outpatient care setting. 1634 - Hospice and Palliative Care -- Pain Screening: target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1634 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1634 does not include documentation of a follow-up plan if pain is present; Both 1634 and 0420 are process measures; Care setting for 1634 is restricted to Hospice/Hospital/Acute Care Facility, whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 1637 – Hospice and Palliative Care—Pain Assessment- target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1637 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1637 measure focus is clinical assessment within 24hrs of positive screening for pain; 0420 measure focus is performing a	

	0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384: Oncology: Medical and Radiation - Pain Intensity Quantified	0420: Pain Assessment and Follow-Up	1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits
			screening and a documented follow-up plan not just limited to a clinical assessment; Both are process measures; Care setting for 1637 is restricted to Hospice/Hospital/Acute Care Facility; whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures.	

Appendix F2: Related and Competing Measures (narrative format)

Comparison of Measures 1641, 0326, and 1626

1641: Hospice and Palliative Care – Treatment Preferences
0326: Advance Care Plan
1626: Patients Admitted to ICU who Have Care Preferences Documented

Steward

1641: Hospice and Palliative Care – Treatment Preferences

University of North Carolina-Chapel Hill

0326: Advance Care Plan

National Committee for Quality Assurance

1626: Patients Admitted to ICU who Have Care Preferences Documented

RAND Corporation

Description

1641: Hospice and Palliative Care – Treatment Preferences

Percentage of patients with chart documentation of preferences for life sustaining treatments.

0326: Advance Care Plan

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.

1626: Patients Admitted to ICU who Have Care Preferences Documented

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

1641: Hospice and Palliative Care – Treatment Preferences

Process

0326: Advance Care Plan

Process

1626: Patients Admitted to ICU who Have Care Preferences Documented

Process

Data Source

1641: Hospice and Palliative Care – Treatment Preferences

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

0326: Advance Care Plan

Administrative claims, Electronic Clinical Data

1626: Patients Admitted to ICU who Have Care Preferences Documented

Paper Medical Records

Level

1641: Hospice and Palliative Care – Treatment Preferences

Clinician : Group/Practice, Facility

0326: Advance Care Plan

Clinician : Group/Practice, Clinician : Individual

1626: Patients Admitted to ICU who Have Care Preferences Documented

Facility

Setting

1641: Hospice and Palliative Care – Treatment Preferences

Hospice, Hospital/Acute Care Facility

0326: Advance Care Plan

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

1626: Patients Admitted to ICU who Have Care Preferences Documented

Hospital/Acute Care Facility

Numerator Statement

1641: Hospice and Palliative Care – Treatment Preferences

Patients whose medical record includes documentation of life sustaining preferences

0326: Advance Care Plan

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.

1626: Patients Admitted to ICU who Have Care Preferences Documented

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 Details

1641: Hospice and Palliative Care – Treatment Preferences

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 "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.

0326: Advance Care Plan

Report the CPT Category II codes designated for this numerator:

- 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record

- 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

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.

1626: Patients Admitted to ICU who Have Care Preferences Documented

Edits indicated by [brackets]

Patients whose medical record includes documentation of care preferences within 48 hours of admission to ICU. Care preferences may include any of the following:

- Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR

- Documentation that a care preference discussion was attempted and/or reason why it was not done

[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.]

Denominator Statement

1641: Hospice and Palliative Care – Treatment Preferences

Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.

0326: Advance Care Plan

All patients aged 65 years and older.

1626: Patients Admitted to ICU who Have Care Preferences Documented

All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.

Denominator Details

1641: Hospice and Palliative Care – Treatment Preferences

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.

0326: Advance Care Plan

Denominator Criteria (Eligible Cases):

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, G0402, G0438, G0439

*Clinicians indicating the place of service as the emergency department will not be included in this measure.

1626: Patients Admitted to ICU who Have Care Preferences Documented

All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.

"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
- Stage IV cancer

Exclusions

1641: Hospice and Palliative Care – Treatment Preferences

Patients with length of stay < 1 day in hospice or palliative care

0326: Advance Care Plan

N/A

1626: Patients Admitted to ICU who Have Care Preferences Documented

None

Exclusion Details

1641: Hospice and Palliative Care – Treatment Preferences

Calculation of length of stay; discharge date is identical to date of initial encounter.

0326: Advance Care Plan

N/A

1626: Patients Admitted to ICU who Have Care Preferences Documented

Risk Adjustment

1641: Hospice and Palliative Care – Treatment Preferences

No risk adjustment or risk stratification

0326: Advance Care Plan

No risk adjustment or risk stratification

1626: Patients Admitted to ICU who Have Care Preferences Documented

No risk adjustment or risk stratification

Stratification

1641: Hospice and Palliative Care – Treatment Preferences

N/A

0326: Advance Care Plan

N/A

1626: Patients Admitted to ICU who Have Care Preferences Documented

Type Score

1641: Hospice and Palliative Care – Treatment Preferences

Rate/proportion

0326: Advance Care Plan

Rate/proportion

1626: Patients Admitted to ICU who Have Care Preferences Documented

Rate/proportion

Algorithm

1641: Hospice and Palliative Care – Treatment 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

0326: Advance Care Plan

Step 1: Determine the eligible population. The eligible population is all the patients aged 65 years and older.

Step 2: Determine number of patients meeting the denominator criteria as specified in Section 2a1.7 above.

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.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2

1626: Patients Admitted to ICU who Have Care Preferences Documented

1. Identify all vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission

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.

Submission items

1641: Hospice and Palliative Care – Treatment Preferences

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.

0326: Advance Care Plan

1626: Patients Admitted to ICU who Have Care Preferences Documented

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.

Comparison of Measures 0209, 1634, 1637

0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment
1634: Hospice and Palliative Care — Pain Screening
1637: Hospice and Palliative Care — Pain Assessment

Steward

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

National Hospice and Palliative Care Organization

1634: Hospice and Palliative Care — Pain Screening

University of North Carolina-Chapel Hill

1637: Hospice and Palliative Care — Pain Assessment

University of North Carolina-Chapel Hill

Description

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

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.

1634: Hospice and Palliative Care — Pain Screening

Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.

1637: Hospice and Palliative Care — Pain Assessment

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

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

PRO

1634: Hospice and Palliative Care — Pain Screening

Process

1637: Hospice and Palliative Care — Pain Assessment

Process

Data Source

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

Patient Reported Data/Survey Data specific to measure (initial question on admission and follow-up question asked between 48 and 72 hours of admission) recorded by hospice. Data can be part of patient record or recorded and tracked separately.

Data are aggregated and submitted quarterly by hospices to NHPCO which maintains a national data repository. NHPCO analyzes the data and produces a quarterly national level report for hospices as a source of comparative data for use in performance improvement initiatives.

Available at measure-specific web page URL identified in S.1 No data dictionary

1634: Hospice and Palliative Care — Pain Screening

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.

Available in attached appendix at A.1 No data dictionary

1637: Hospice and Palliative Care — Pain Assessment

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

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

Facility, Population : National

1634: Hospice and Palliative Care — Pain Screening

Facility, Clinician : Group/Practice

1637: Hospice and Palliative Care — Pain Assessment

Facility, Clinician : Group/Practice

Setting

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

Hospice

1634: Hospice and Palliative Care — Pain Screening

Hospice, Hospital/Acute Care Facility

1637: Hospice and Palliative Care — Pain Assessment

Hospice, Hospital/Acute Care Facility

Numerator Statement

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

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

1634: Hospice and Palliative Care — Pain Screening

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.

1637: Hospice and Palliative Care — Pain Assessment

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

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

Number of patients who replied "yes" when asked if their pain was brought to a comfortable level within 48 hours of initial assessment.

1634: Hospice and Palliative Care — Pain Screening

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.

1637: Hospice and Palliative Care — Pain Assessment

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

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

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

1634: Hospice and Palliative Care — Pain Screening

Patients enrolled in hospice OR patients receiving specialty palliative care in an acute hospital setting.

1637: Hospice and Palliative Care — Pain Assessment

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

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

Patients who are able to self report pain information and replied "yes" when asked if they were uncomfortable because of pain at the initial assessment.

1634: Hospice and Palliative Care — Pain Screening

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.]

1637: Hospice and Palliative Care — Pain Assessment

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 report pain and enter the denominator population for Pain Assessment.]

Exclusions

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

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

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

1634: Hospice and Palliative Care — Pain Screening

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

1637: Hospice and Palliative Care — Pain Assessment

Patients with length of stay < 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.

Exclusion Details

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

Patients who replied 'No" to initial question: "Are you uncomfortable because of pain?"

Patients under 18 years of age

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

Patients who cannot self report pain

1634: Hospice and Palliative Care — Pain Screening

Calculation of length of stay: discharge date is identical to date of initial encounter.

1637: Hospice and Palliative Care — Pain Assessment

Calculation of length of stay; discharge date is identical to date of initial encounter.

Risk Adjustment

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

No risk adjustment or risk stratification

N/A

1634: Hospice and Palliative Care — Pain Screening

No risk adjustment or risk stratification

N/A

1637: Hospice and Palliative Care — Pain Assessment

No risk adjustment or risk stratification

N/A

Stratification

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

None

1634: Hospice and Palliative Care — Pain Screening

N/A

1637: Hospice and Palliative Care — Pain Assessment

N/A

Type Score

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

Rate/proportion better quality = higher score

1634: Hospice and Palliative Care — Pain Screening

Rate/proportion better quality = higher score

1637: Hospice and Palliative Care — Pain Assessment

Rate/proportion better quality = higher score

Algorithm

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

Calculation of measure score:

1. Identify number of patients admitted to hospice services during the timeframe of interest (e.g., CY quarter).

2. Identify number of admitted patients who were able to respond to the question "Are you uncomfortable because of pain?" during the initial assessment and were not excluded because they met the exclusion criteria.

3. Identify the number of patients who responded "yes" to the question "Are you uncomfortable because of pain?" during the initial assessment.

4. Identify the number of patients who were contacted between 48 and 72 hours of the initial assessment and responded "yes" to the question: "Was your pain brought to a comfortable level within 48 hours of the start of hospice services?" This number is the numerator.

4. Divide the number of patients whose pain was brought to a comfortable level within 48 hours after initial assessment by the number of patients who reported they were uncomfortable because of pain at the initial assessment.

2. Multiply this number by 100 to get the hospice's score as a percent. This is the proportion of patients who reported being uncomfortable because of pain at initial assessment whose pain was brought to a comfortable level within 48 hours of the start of hospice services.

NOTE: A Problem Score may also calculated as a complement to the measure score The Problem Score is calculated by dividing the number of patients whose pain was NOT brought to a comfortable level within 48 hours after the initial assessment by the number of patients who were uncomfortable on admission. Multiply this number by 100 to get the hospice's score as a percent. A lower score/percentile = better performance. The Problem Score is useful for assessing the proportion of patients for whom comfort was not achieved and subsequent root cause analysis for quality improvement purposes. Available at measure-specific web page URL identified in S.1

1634: Hospice and Palliative Care — Pain Screening

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

1637: Hospice and Palliative Care — Pain Assessment

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

Submission items

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

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: N/A

1634: Hospice and Palliative Care — Pain Screening

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 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.

1637: Hospice and Palliative Care — Pain Assessment

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.

Comparison of Measures 0383, 0384, 0420, 1628

0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
0384: Oncology: Medical and Radiation - Pain Intensity Quantified
0420: Pain Assessment and Follow-Up
1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits

Steward

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

American Society of Clinical Oncology

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

0420: Pain Assessment and Follow-Up

Centers for Medicare & Medicaid Services

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

RAND Corporation

Description

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

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

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

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

0420: Pain Assessment and Follow-Up

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

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

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

Type

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

Process

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Process

0420: Pain Assessment and Follow-Up

Process

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

Process

Data Source

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

Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry

No data dictionary

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Claims (Only), Electronic Health Record (Only), Other, Paper Records, Registry Not Applicable

Attachment EP_eCQM_ValueSet_CMS157v4_NQF0384_AMA-PCPI.xlsx

0420: Pain Assessment and Follow-Up

Claims (Only), Paper Records The data source is the patient medical record. Medicare Part B claims data and registry data is provided for test purposes.

No data collection instrument provided Attachment Data_Dictionary_033016.xlsx

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

Electronic Health Record (Only), Paper Records, 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

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

Clinician : Group/Practice, Clinician : Individual

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Clinician : Group/Practice, Clinician : Individual

0420: Pain Assessment and Follow-Up

Clinician : Group/Practice, Clinician : Individual

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

Facility, Health Plan, Integrated Delivery System

Setting

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

Clinician Office/Clinic, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Clinician Office/Clinic, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic

0420: Pain Assessment and Follow-Up

Clinician Office/Clinic, Behavioral Health : Outpatient, Outpatient Rehabilitation

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

Clinician Office/Clinic

Numerator Statement

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

Patient visits that included a documented plan of care* to address pain

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Patient visits in which pain intensity is quantified

0420: Pain Assessment and Follow-Up

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.

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

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

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

Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

For EHR:

eSpecification currently under development

For Claims/Administrative Data:

To submit the numerator option for patient visits that included a documented plan of care to address pain, report the following CPT Category II code:

0521F – Plan of care to address pain documented

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Definitions:

Pain intensity should be quantified using a standard instrument, such as a 0-10 numeric rating scale, visual analog scale, a categorical scale, or the pictorial scale.

For Claims/Registry:

To submit the numerator option for number of patient visits in which pain intensity was quantified, report one of the following CPT Category II codes:

1125F: Pain severity quantified; pain present

OR

1126F: Pain severity quantified; no pain present

For EHR:

HQMF eMeasure developed and is included in this submission.

0420: Pain Assessment and Follow-Up

Definitions:

Pain Assessment – Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normed and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS) and Visual Analog Scale (VAS).

Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

• Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools

• Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The standardized tool used to assess the patient's pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity).

G-codes are defined as Quality Data Codes (QDCs), which are subset of HCPCs II codes. QDCs are non-billable codes that providers will use to delineate their clinical quality actions, which are submitted with Medicare Part B Claims. There are 6 G-code options for this measure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pain Assessment Documented as Positive AND Follow-Up Plan Documented

(One quality-data code [G8730 or G8731] is required on the claim form to submit this numerator option)

Performance Met: G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented

OR

Pain Assessment Documented as Negative, No Follow-Up Plan Required

Performance Met: G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required

OR

Pain Assessment not Documented Patient not Eligible

(One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option)

Other Performance Exclusion: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible

Other Performance Exclusion: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

OR

Pain Assessment not Documented, Reason not Given

(One quality-data code [G8732 or G8509] is required on the claim form to submit this numerator option)

Performance Not Met: G8732: No documentation of pain assessment, reason not given

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given

Performance Not Met: G8509: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not.

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

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

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

All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

0420: Pain Assessment and Follow-Up

All visits for patients aged 18 years and older

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

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

Denominator Details

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

For EHR:

eSpecification currently under development

For Claims/Administrative Data:

All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

Eligible patients for this measure are identified by:

ICD-9-CM diagnosis codes:

140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6,

194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

ICD-10-CM diagnosis codes:

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C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND

Report CPT Category II code: 1125F: Pain severity quantified; pain present

AND either option 1 or 2:

1. Chemotherapy

- CPT codes:

o 99201, 99202, 99203, 99204, 99205,

o 99212, 99213, 99214, 99215,

AND

o CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration)

OR

2. Radiation therapy

- CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

For For Claims/Registry:

Eligible patients for this measure are identified by:

Diagnosis for cancer (ICD-9-CM) [reportable through 9/30/2015]:

140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9,

165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17,

209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

Diagnosis for cancer (ICD-10-CM) [reportable beginning 10/1/2015]:

C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C44.30, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922,

C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3,

C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8 D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND either Option 1 or 2

Option 1: Chemotherapy

CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

AND

CPT Procedure Codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration)

OR

Option 2: Radiation therapy

CPT Codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470

For EHR:

HQMF eMeasure developed and is included in this submission.

0420: Pain Assessment and Follow-Up

Denominator Criteria (Eligible Cases): Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 96151, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201,

99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439

Lists of individual codes with descriptors for the measure specifications are provided in an Excel file at S.2b

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

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

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

None

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

None

0420: Pain Assessment and Follow-Up

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools

Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

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

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

Exclusion Details

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

There are no exceptions for this measure.

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Not applicable

0420: Pain Assessment and Follow-Up

Pain Assessment not Documented Patient not Eligible

(One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option)

Other Performance Exclusion: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible

Other Performance Exclusion: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

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

Risk Adjustment

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

No risk adjustment or risk stratification

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

No risk adjustment or risk stratification

0420: Pain Assessment and Follow-Up

No risk adjustment or risk stratification

n/a

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

No risk adjustment or risk stratification

Stratification

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

We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

0420: Pain Assessment and Follow-Up

All eligible patients are subject to the same numerator criteria

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

None

Type Score

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

Rate/proportion better quality = higher score

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

Rate/proportion better quality = higher score

0420: Pain Assessment and Follow-Up

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

Algorithm

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

To calculate performance rates:

1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).

2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.

3) From the patients within the denominator, find the patients who qualify for the numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. –Although exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

0420: Pain Assessment and Follow-Up

Satisfactory reporting criteria are met by valid submission of one of six G codes on claims that meet denominator criteria.

A rate of quality performance is calculated by dividing the number of records with G codes indicating that the quality actions were performed or that the patient was not eligible by total number of valid G code submissions.

THIS SECTION PROVIDES DEFINITIONS & FORMULAS FOR THE NUMERATOR (A), TOTAL DENOMINATOR POPULATION (TDP), DENOMINATOR EXCLUSIONS (B) CALCUATION & PERFORMANCE DENOMINATOR (PD) CALCULATION.

NUMERATOR (A): HCPCS Clinical Quality Codes G8730, G8731

TOTAL DENOMINATOR POPULATION (TDP): Patient aged 18 years and older on the date of the encounter of the 12-month reporting period, with denominator defined encounter codes & Medicare Part B Claims reported HCPCS Clinical Quality Codes G8730, G8731, G8442, G8939, G8732, G8509

DENONINATOR EXCLUSION (B): HCPCS Clinical Quality Code G8442, G8939

DENOMINATOR EXCLUSION CALCULATION: Denominator Exclusion (B): # of patients with valid exclusions # G8442+G8939 / # TDP

PERFORMANCE DENOMINATOR CALCULATION: Performance Denominator (B): Patients meeting criteria for performance denominator calculation # A / (# TDP - # B)

(Refer to section V. Measure Logic Flow Diagram for Performance Rate Calculation in attached "NQF Endorsement Measurement Submission Summary Materials" Document) Available in attached appendix at A.1

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

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.

4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits

Submission items

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

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 0524 focuses on steps to monitor and mitigate pain were implemented. Our measure is similar in concept seeking a plan of care to address pain. A plan of care is further defined as include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

5b.1 If competing, why superior or rationale for additive value: No competing measure.

0384: Oncology: Medical and Radiation - Pain Intensity Quantified

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: There are a number of NQF-endorsed measure focusing on the assessment of pain in a variety of unique settings and circumstances. Several of these measures (0523 and 0420) refer to conducting the assessment using a standardized tool. Similarly, our measure suggests that pain should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale. Two of the measures are specific to the pediatric intensive care unit and do not require use of a standardized instrument.

5b.1 If competing, why superior or rationale for additive value: No competing measure.

0420: Pain Assessment and Follow-Up

5.1 Identified measures: 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)

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

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

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Six related measures were identified that are not harmonized with NQF# 0420. The differences between these related measures and the submitted measure NQF# 0420 are listed below:

0383 - Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384 which is unrelated to and non-competing with 0420) - target population is specific to patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain; 0383 does not include the use of a standardized pain assessment tool. Both measures are process measures. Both measures have outpatient care setting.

0676 - Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) – target population is specific to short - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure, it is an eligible provider report; 0676 does not include the use of a standardized pain assessment tool; 0676 does not include documentation of a follow-up plan if pain is present; 0676 is an outcome measure whereas 0420 is a process measure. Care setting for 0676 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

0677 - Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay) – target population is specific to long - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure, it is an eligible provider report; 0677 does not include the use of a standardized pain assessment tool; 0677 does not include documentation of a follow-up plan if pain is present; 0677 is an outcome measure whereas 0420 is a process measure. Care setting for 0677 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

1628 - Patients with Advanced Cancer Screened for Pain at Outpatient Visits - target population is specific to patients with a diagnosis of advanced cancer; 1628 does not include a follow-up plan if pain is present; Both 1628 and 0420 are process measures; Both measures have outpatient care setting.

1634 - Hospice and Palliative Care -- Pain Screening: target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1634 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1634 does not include documentation of a follow-up plan if pain is present; Both 1634 and 0420 are process measures; Care setting for 1634 is restricted to Hospice/Hospital/Acute Care Facility, whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

1637 – Hospice and Palliative Care—Pain Assessment- target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1637 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1637 measure focus is clinical assessment within 24hrs of positive screening for pain; 0420 measure focus is performing a screening and a documented follow-up plan not just limited to a clinical assessment; Both are process measures; Care setting for 1637 is restricted to Hospice/Hospital/Acute Care Facility; whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures.

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

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 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.

Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure.

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)

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.

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.

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