Palliative and End-of-Life Care Off-Cycle: Measure Review 2017

DRAFT REPORT FOR ~~COMMENT~~ VOTING

~~April 10~~June 8, 2017

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I Task Order HHSM-500-T0000

Contents

Palliative and End-of-Life Care Off-Cycle Measure Review

DRAFT REPORT

Executive Summary

The NQF Palliative and End-of-Life Standing Committee is responsible for overseeing NQF's palliative and end-of-life care measure portfolio. This oversight function includes evaluating both newly submitted and previously endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing input on how the portfolio should evolve, and serving on any ad hoc, off-cycle, or expedited projects in the palliative and end-of-life care topic area. When not involved in the more traditional endorsement project activities, which usually include evaluation of 20-25 measures over a 7-month timeframe, the Committee is available for "off-cycle" activities. These can include any of the actions noted above, but are accomplished through an abbreviated format (e.g., evaluation of 1-2 measures over a shorter timeframe, quarterly web-based meetings to discuss various measurement issues).

This report summarizes the two tasks of the Committee's spring 2017 off-cycle activities: evaluation of one new measure against NQF's standard evaluation criteria and refinement of the measurement framework for palliative and end-of-life care. As part of these activities, the Committee recommended the following measure for endorsement:

- 3235: Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission

A brief summary of the measure evaluated in this off-cycle review is included in the body of the report; a detailed summary of the Standing Committee's discussion and ratings of the criteria for the measure is included in Appendix A.

Introduction

Consensus Development Process Off-Cycle Activities

Volunteer, multi-stakeholder committees are a key component of NQF's Consensus Development Process (CDP), and thus the success of the process is due in large part to the participation of its committee members. In 2013, NQF began transitioning to the use of standing committees for CDPs. These standing committees oversee NQF's various measure portfolios. This oversight function includes evaluating both newly submitted and previously endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing feedback on how the portfolio should evolve, and serving on any ad hoc or expedited projects in their designated topic areas.

When not involved in the more traditional endorsement project activities, which usually include evaluation of 20-25 measures over a 7-month timeframe, the Committee is available for "off-cycle" activities. These can include any of the actions noted above, as well as other activities such as serving as clinical or technical experts for other standing bodies (e.g., Measure Applications Partnership or cross cutting measurement areas), collaborating with measure developers on gap filling, and participating in thoughtful discussion and activities on prospecting for new measures and addressing strategic measurement issues in the topic area. Typically, these off-cycle activities will be conducted via quarterly, two-hour web meetings or conference calls for each standing committee, as needed.

The off-cycle activities of the Palliative and End-of-Life Care Standing Committee in the spring of 2017 have focused on the evaluation of one measure and further refinement of a measurement framework for palliative and end-of-life care.

Refining the NQF Measure Evaluation Process

The New Endorsement and Appeals Process

In August 2016, NQF implemented changes to its ratification and appeals process that was initiated and approved by its Board of Directors. Following public comment and voting by the NQF membership, the Consensus Standards Approval Committee (CSAC) will make the final measure endorsement decision, without ratification by another body. Additionally, the Board requested NQF to establish a five-member Appeals Board that will be responsible for adjudicating all submitted appeals regarding measure endorsement decisions. These changes apply to NQF measure endorsement projects with initial evaluation meetings scheduled after August 2016.

The newly constituted Appeals Board, composed of NQF Board members and former CSAC and/or committee members, will adjudicate appeals to measure endorsement decisions without a review by the CSAC. The decision of the Appeals Board will be final.

All submitted appeals will be published on the NQF website. Staff will compile the appeals for review by the Appeals Board, which will evaluate the concern(s) raised and determine if the appeal should warrant overturning the endorsement decision. Decisions on an appeal of endorsement will be publicly available on NQF's website.

Throughout the process, project staff will serve as liaisons between the CSAC, the Appeals Board, the committee, developers/stewards, and the appellant(s) to ensure the communication, cooperation, and appropriate coordination to complete the project efficiently.

Refining NQF's Measurement Framework for Palliative and End-of-Life Care

As part of its work in the 2015-2016 project, the Standing Committee drafted a simplified version of the NQF measurement framework that was developed in 2006. The revised framework is a series of concentric circles that 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). 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.

As part of its 2017 off-cycle work, the Committee revisited the framework and made the following changes (see Appendix B):

- Further described palliative care by differentiating two "types" of palliative care ("curative" and "~~care-a-tive~~chronic") in the outer ring of the framework. "Curative-palliative care" is care that is provided alongside curative care, and includes care to help manage the disease or condition until it is cured and helps to manage side effects of curative treatment. "~~Care-a-tive~~Chronic palliative care" is care provided to those with non-curable conditions who are not near the end of life.
- Switched the label from "Models of Care" back to "Settings of Care" and combined hospice, nursing facility, and assisted living under an "institutional facility" entry. The Committee had previous chosen the "models" label primarily because of the inclusion of "hospice," which is both a setting of care as well as a system of care. However, the Committee agreed that it would be difficult to include a comprehensive listing of the various models of care and was not convinced that various models of care would require different measures.
- Added two new domains: a *Safety* domain and the *Structure and Processes of Care* domain from the National Consensus Project. The Committee initially omitted the latter domain from the framework because it seemed somewhat redundant with other elements in the framework. However, on further consideration, the Committee agreed that the domain is necessary because it reflects the need for a well-trained and supported interdisciplinary team that develops and executes a plan of care in concert with the stated preferences, values, and goals and of the patient and family.
- Emphasized the need for measurement focused on the caregiver by adding the word *caregiver* to the middle ring of the framework.

The Committee also recognized that many important avenues for measurement may not be explicitly depicted in the current framework. For example, the concept of shared decision-making is crucial, yet is subsumed in the existing domains, particularly the ethical/legal and structure and processes of care domains. Likewise, the Committee agreed that the concept of "cost" is included in the "Financial" domain, yet members also noted the need to consider measurement of cost from various perspectives, including the "individual" perspective of the patient and family as well as for the healthcare system as a

whole. The Committee also agreed that concepts such as communication, transitions of care, and care coordination are important for measurement, as is the ability to measure longitudinally, although these are not explicitly included in the framework.

Palliative and End-of-Life Care Measure Evaluation

On March 8, the Palliative and End-of-Life Care Standing Committee evaluated one new measure against NQF's standard evaluation criteria.

Table 2. Palliative and End-of-Life Care 2017 Off-Cycle Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	0	1	1
Measures recommended for endorsement	0	1	1

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 February 21 to March 27, 2017. NQF did not receive any pre-evaluation comments.

Summary of Measure Evaluation

The following brief summary of the measure evaluation highlights the major issues that were considered by the Committee. Details of the Committee's discussion and ratings of the criteria for the measure are in included in Appendix A.

3235 Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission (Centers for Medicare and Medicaid Services): Recommended

Description: The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels; **Measure Type**: Composite; **Level of Analysis**: Facility; **Setting of Care**: Hospice; **Data Source**: Other

Because symptom management is the focus of care for patients enrolled in hospice, the assessment and treatment of physical, emotional, spiritual, and social needs must be both comprehensive and timely. This all-or-none composite measure assesses whether hospices perform all of the seven critical care

processes on admission (i.e., pain screening and assessment, dyspnea screening and treatment, ensuring receipt of a bowel regimen for patients on opioids, discussing spiritual or religious concerns, and discussing preferences for life-sustaining treatments). While the Committee recognized the empirical evidence base linking dyspnea treatment, bowel regimens, and communication regarding treatment preferences to improved patient outcomes, members acknowledged the lack of similar evidence for the other components of the measure and therefore agreed to invoke the exception to the evidence subcriterion. With almost one-quarter of hospices unable to meet the measure in 2016, the Committee agreed that there is an opportunity for improvement. The Committee agreed with the rationale behind the construct of the measure as an all-or-none composite and accepted the empirical analyses that supported its construction. The Committee agreed the measure was reliable and valid. The Committee noted the high feasibility of the measure and caregiver focus group results suggesting higher interpretability of the composite measure score. Because the seven components of the composite also are individual NQF-endorsed measures, staff asked the Committee to consider whether endorsement of the individual measures is still needed if the composite is also endorsed. The Committee agreed that the individual measures hold considerable value as indicators of quality care on their own, and should retain endorsement.

NQF received 2 comments on this measure. One commenter supported the measure. The second commenter suggested that performance on the measure was disproportionately driven the Pain Assessment component measure and noted that several of the components of the measure are not proximal to desired patient outcomes. The Committee agreed that that performance on the pain assessment component will drive a substantial amount of variation in performance for this composite. However, members also agreed that each of the components contribute to the overall composite and that the all-or-none construction of the composite will help to incent hospice providers to complete all of the care processes included in this measure.

Comments Received After Committee Evaluation

The 30-day post-evaluation Public and Member Commenting period was open from April 10, 2017 to May 10, 2017. During this period, NQF received a total of three comments from three member organizations. Comments included support for the measure recommended by the Committee, concern about the utility of the measure to drive improvement, and suggestions for amending the measurement framework.

Prioritizing Measures and Gaps

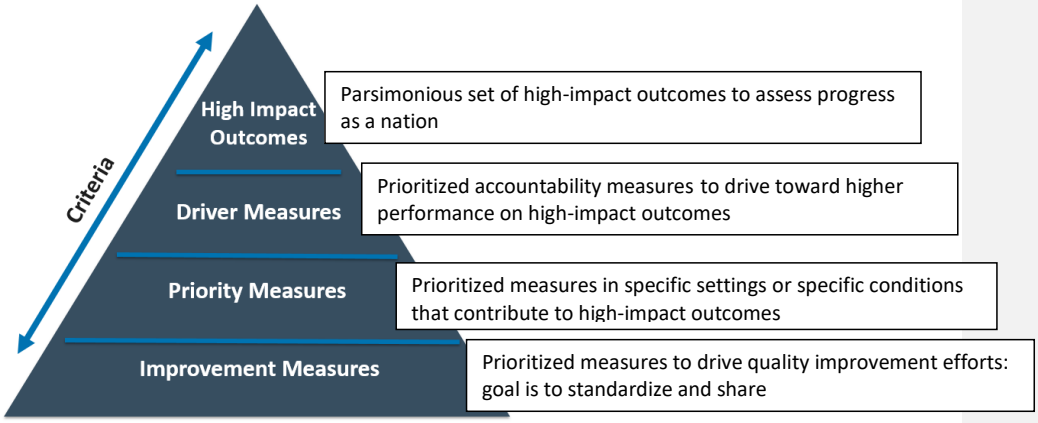
NQF's 2016-2019 Strategic Plan urges NQF to lead, prioritize, and collaborate to drive measurement that can result in better, safer, and more affordable healthcare for patients, providers, and payers. The plan also aims to reduce the redundancy and cost of measurement.

One of the key tasks of Strategic Plan is to identify the most important measures to improve U.S. healthcare. By identifying priority measures for the nation as a whole as well as for specific settings or populations, NQF can focus the quality community on specific metrics needed to improve the quality, safety, and affordability of care. This prioritization work holds promise to yield fewer, more meaningful measures overall.

To accomplish this task, NQF staff identified four criteria for prioritizing measures and gaps in measurement:

- ***Outcome-focused***: Preference for outcome measures and measures with strong link to improved outcomes and costs
- ***Improvable and actionable***: Preference for actionable measures with demonstrated need for improvement and evidence-based strategies for doing so
- ***Meaningful to patients and caregivers***: Preference for person-centered measures with meaningful and understandable results for patients and caregivers
- ***Support systemic and integrated view of care***: Preference for measures that reflect care that spans settings, providers, and time to ensure that care is improving within and across systems of care

These criteria can be applied using a hierarchical framework that is meant to help prioritize those measures that will effect the strongest change, while de-emphasizing those measures that are not priorities. The framework connects measures of national, high-impact outcomes to accountability measures that will help drive performance improvement, as well as more micro-targeted quality improvement measures that should be standardized across settings.



NQF has identified 7 high-impact outcomes for the framework:

- Functional status/well-being
- Patient experience (including care coordination, shared decision-making)
- Preventable harm/complications
- Prevention/healthy behaviors
- Total cost/low-value care
- Access to needed care
- Equity of care

The Palliative and End-of-Life Care Standing Committee piloted the prioritization framework and criteria, applying them to measures in NQF's Palliative and End-of-Life Care portfolio. Not surprisingly, given the relatively few measures for this topic area, the Standing Committee identified more gaps than priority or driver measures.

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The Committee was unable to complete the prioritization exercise during its May 30, 2017 post-comment call but will continue the work over the next two months. Some of the Committee's initial recommendations for the high-impact outcomes of patient experience, preventable harm, and prevent/healthy behaviors include the following:

- **Patient experience**
  - No existing measures were identified as driver measures; instead, goal-concordance, shared decision-making, patient and family engagement, and comfort with decisions were identified as gaps.
  - Committee identified two endorsed measures of care planning and documentation (NQF#0326 and #1626) as priority measures, and also identified two priority measure gaps areas related to having conversations that elicit goals of care and adequacy of communication.
- **Preventable harm/complication**
  - An existing measure of hospital readmissions for those with multiple chronic conditions was identified as a driver measure, with unwanted/discordant care identified as a gap area.
  - Two exiting priority measures were identified (fall risk assessment, medication reconciliation), with measures around safe medication use and disposal and feeding tube placement in dementia patients identified as gaps.
- **Prevention/healthy behaviors**
  - No existing measures were identified as driver measures; instead, measures of caregiver support and preservation of functional status were identified as gap areas.

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A priority measure gap that was identified including discontinuing preventative medications in terminal patients.

Complete results of the prioritization exercise will be included in the final report for this off-cycle project.

Appendix A: Details of Measure Evaluation

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

Measures Recommended

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

Submission | Specifications

Description: The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.

Numerator Statement: The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive assessment measure numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.

Denominator Statement: The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.

Exclusions: Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Hospice

Type of Measure: Composite

Data Source: Other

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING 3/8/2017

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

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

1a. Evidence: **H-0**; **M-3**; **L-0**; **I-19**; 1b. Performance Gap: **H-18**; **M-4**; **L-0**; **I-0; ;** Evidence Exception: **Y-22; N-0**

Rationale:

- The developer cited the 2013 Institute for Clinical Systems Improvement (ICSI) Palliative Care for Adults guidelines to support the components in the composite. All of the recommendation statements from the ICSI guideline refer to inclusion of the measured components in the palliative care plan.
- The Committee concluded that the evidence presented is tangential to the foci of the measure, which assesses actual screening, assessment, discussions, or treatment not simply inclusion of these processes in the palliative care plan. The Committee recognized the evidence base linking dyspnea treatment, bowel regimens, and communication regarding treatment preferences to improved patient outcomes. However, members acknowledged that similar evidence for the other components of the measure (pain screening, pain assessment, dyspnea screening, and addressing spiritual and religious concerns) does not exist and likely would not be forthcoming. The Committee agreed that empirical

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission
evidence is not needed to hold providers accountable for those components of the measure, and agreed to invoke the exception to the evidence subcriterion. • Data presented by the developer from the FY2015-2016 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 performance rate for the composite of 71.8% in 2015 and 76.2% in 2016. • The developers described this all-or-none measure as designed "to reflect the overall quality of comprehensive assessment at hospice admission for each patient stay." They noted that the seven components included in the measure "address high-priority aspects of quality hospice care as identified by the National Consensus Project, are required by the Medicare Hospice Conditions of Participation, and are supported by hospice stakeholders." Finally, the developers supported the composite itself and its all-or-none aggregation and weighting approach by suggesting it will help to incentivize hospices to complete all of the critical care processes included in the measure, set a higher bar for performance compared to the individual measures, and provide summary results that can be more easily understood by consumers and providers.
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-20**; **M-2**; **L-0**; **I-0** 2b. Validity: **H-20**; **M-2**; **L-0**; **I-0** <u>Rationale</u>: • The Committee questioned how the measure is calculated when a patient screens negative for pain or for dyspnea (as only those who screen positive would then receive a pain assessment or dyspnea treatment, respectively). The developer clarified that all patients are included in the measure and that those whose screens are negative for pain or dyspnea are "given credit" for receiving the pain assessment and dyspnea treatment, respectively. Similarly, patients who are not receiving opioid treatment are "given credit" for receiving a bowel regimen. • Reliability testing of the measure score was conducted on FY2015 HQRP data using a split-half analysis and a signal-to-noise analysis. The split-half analysis yielded an intra-class correlation coefficient of 0.94, while the signal-to-noise ratio was 0.99. • The developer tested the validity of the measure score with a non-parametric Spearman rank correlation analysis between the composite measure and the seven individual NQF-endorsed measures that correspond to the components of the composite. Correlations ranged from .43 to .64, and were statistically significant. • The developers provided the results of three analyses to support the construction of the composite as all-or-none measure with seven components. First, they noted the moderate correlations between the composite measure and the individual measures, which were high enough to infer consistency with the quality construct yet not so high as to indicate that the composite is redundant to the individual measures. Next, they noted how the average performance of the combined seven components differed from the average performance seen when each of the seven components were excluded one at a time. They also noted that removal of each of the components identified a different, although overlapping, group of outliers than that identified when using all seven components. • Committee members also noted that a caregiver focus group convened by the developer supported the construction of a composite measure, believing it would alleviate confusion they had in interpreting the results from the individual measures.
3. Feasibility: H-21; M-1; L-0; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* <u>Rationale</u>: • The Committee noted that because data for this measure are part of the Hospice Item Set (HIS), a standardized patient-level dataset used by CMS to collect data for the individual measures, feasibility is high.

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

4. Usability and Use: H-20; M-2; 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 included in the Hospice Quality Reporting Program (HQRP), an accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY 2015, 3,992 hospices reported data on 1,215,247 patient stays.
- The Committee again noted the focus group results regarding the ease of interpretability of the composite measure.
- The Committee did not note any potential unintended consequences to patients from using the measure.

5. Related and Competing Measures

- This measure is related to its seven component measures, all endorsed by NQF:
  - Hospice and Palliative Care – Pain Screening (NQF #1634),
  - Hospice and Palliative Care – Pain Assessment (NQF #1637),
  - Hospice and Palliative Care – Dyspnea Screening (NQF #1639),
  - Hospice and Palliative Care – Dyspnea Treatment (NQF #1638),
  - Patients Treated with an Opioid Who Are Given a Bowel Regimen (NQF #1617),
  - Hospice and Palliative Care – Treatment Preferences (NQF #1641), and
  - 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 (NQF #1647).
- Measures are harmonized to the extent possible.
- The Committee agreed that the individual measures should retain endorsement, particularly since most of the individual measures also assess care at the clinician group level in the hospital setting.

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

6. Public and Member Comment

Comments received:

NQF received 2 post-evaluation comments on this measure. One comment supported the measure. The second commenter suggested that performance on the measure was disproportionately driven the Pain Assessment component and noted that several of the components of the measure are not proximal to desired patient outcomes.

Developer response (summarized):

- The developer noted that experts in the field, hospice providers, and caregivers agree that the processes of care included in the measure are important in promoting a person-centered approach to care and achieving the patient comfort throughout the delivery of hospice and palliative care. The developer also noted that focus groups and interviews with stakeholders supported the all-or-none construction of the composite measure.
- The developer also summarized analyses (submitted in response to subcrition 2d) that demonstrate that each component in the composite contributes to the overall composite performance score.

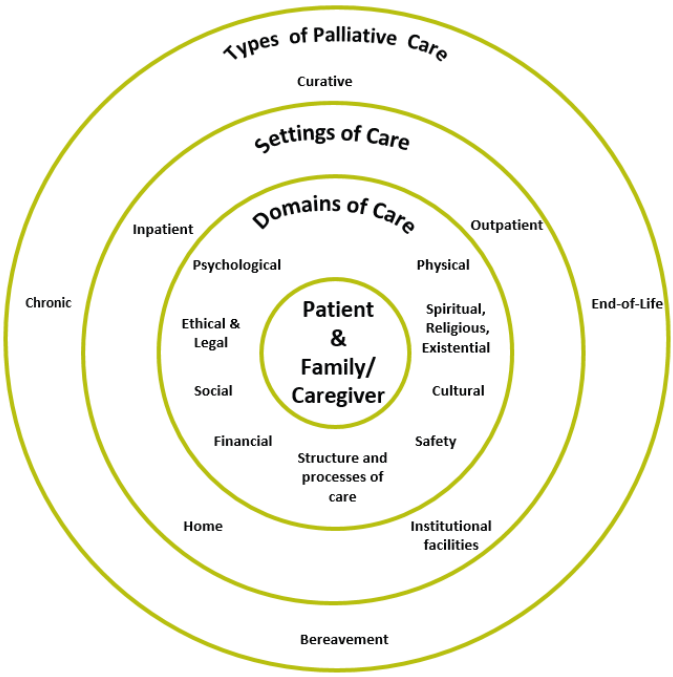
Committee response:

- The Committee agreed that that performance on the pain assessment component will drive a substantial amount of variation in performance for this composite. However, members also agreed that each of the components contribute to the overall composite and that the all-or-none construction of the composite will help to incent hospice providers to complete all of the care processes included in

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission
this measure. The Committee also agreed that additional measures should be developed to assess provision of treatment and outcomes of treatment.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

Appendix B: NQF [Topic Area] Portfolio and Related Measures

Measurement Framework for Palliative and End-of-Life Care



Measures in the Portfolio

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

Physical Aspects of Care

0177: Improvement in pain interfering with activity*

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

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

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

0420: Pain Assessment and Follow-Up*

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

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

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

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

1634: Hospice and Palliative Care — Pain Screening

1637: Hospice and Palliative Care — Pain Assessment

1638: Hospice and Palliative Care — Dyspnea Treatment

1639: Hospice and Palliative Care — Dyspnea Screening

1822: External Beam Radiotherapy for Bone Metastases *

Psychological and Psychiatric Aspects of Care

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 March 29, 2017
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	Merit-based Incentive Payment System (MIPS), Home Health Value-Based Purchasing Program
0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Merit-based Incentive Payment System (MIPS), PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
0384	Oncology: Medical and Radiation - Pain Intensity Quantified	Merit-based Incentive Payment System (MIPS), PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
0420	Pain Assessment and Follow-Up	Merit-based Incentive Payment System (MIPS)
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)
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	Hospice Quality Reporting Program (HQRP)

NQF #	Title	Federal Programs: Finalized as of March 29, 2017
	patient/caregiver did not want to discuss.	
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

R. Sean Morrison, MD (Co-Chair)
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Appendix E: Measure Specifications

	3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission
Steward	Centers for Medicare and Medicaid Services
Description	The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.
Type	Composite
Data Source	Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014. Available in attached appendix at A.1 No data dictionary
Level	Facility
Setting	Hospice
Numerator Statement	The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive assessment measure numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.
Numerator Details	The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQRP quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are: 1. NQF 1634: Patient stays that include a screening 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. 2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain. 3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care. 4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening. 5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed

	3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission
	6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences 7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date. Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria: 1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^]) AND 2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^]) AND 3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient's pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4])) AND* 4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^]) AND 5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^]) AND* 6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^]) AND* 7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^]) NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment

	3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission
	measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be 'given credit' for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.
Denominator Statement	The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.
Denominator Details	The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.
Exclusions	Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).
Exclusion details	The exclusion criteria are: 1. Patients under 18 years of age as indicated by the birth date (A0900) and admission date (A0220) 2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Type Score	Continuous variable, e.g. average better quality = higher score
Algorithm	Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria. Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs. Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100. Please see Appendix A.1 for a flow chart of the measure logic.
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Appendix F: Related and Competing Measures

Comparison of NQF 3235 and NQF 1617, 1634, 1637

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
Steward	Centers for Medicare and Medicaid Services	RAND Corporation/UCLA	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill
Description	The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	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.

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	spiritual and existential concerns, and management of pain, dyspnea, and bowels.			
Type	Composite	Process	Process	Process
Data Source	Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014. Available in attached appendix at A.1 No data dictionary	Paper Records Medical record abstraction tool No data collection instrument provided No data dictionary	Electronic Health Record (Only), Other 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 Health Record (Only), Other 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	Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice
Setting	Hospice	Clinician Office/Clinic, Hospice, Hospital	Hospice, Hospital	Hospice, Hospital
Numerator Statement	The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed	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.

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	assessment measure numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.			
Numerator Details	The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQRP quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are: 1. NQF 1634: Patient stays that include a screening for the presence or absence of pain	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.	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.

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	(and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care. 2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain. 3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care. 4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening. 5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed 6. NQF 1641: Patient stays with a medical record that			

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	includes documentation of life sustaining preferences 7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date. Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria: 1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 =			

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	F2000B – A0220 = 5 and F2000B ? [-,^]) AND 2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^]) AND 3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient's pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4])) AND* 4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened			

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^]) AND 5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^]) AND* 6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^]) AND*			

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^]) NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be 'given credit' for completing the comprehensive			

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.			
Denominator Statement	The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.	Vulnerable adults who are given a prescription for an opioid	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	The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.	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)	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	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

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
		- 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	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.]	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.

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
				[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	Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).	Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription	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	The exclusion criteria are: 1. Patients under 18 years of age as indicated by the birth date (A0900) and admission date (A0220) 2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)	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	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.

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
		opioid prescription are NOT excluded.		
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A		N/A	N/A
Type Score	Continuous variable, e.g. average better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria. Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs. Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result	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	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 123213| 129544	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

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1617: Patients Treated with an Opioid who are Given a Bowel Regimen	1634: Hospice and Palliative Care -- Pain Screening	1637: Hospice and Palliative Care -- Pain Assessment
	of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100. Please see Appendix A.1 for a flow chart of the measure logic. 144877| 141015	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. 113885| 136569| 110832| 141057		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 123213| 129544

Comparison of NQF 3235 and NQF 1638, 1639, 1641, 1647

	3235: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	1638: Hospice and Palliative Care -- Dyspnea Treatment	1639: Hospice and Palliative Care -- Dyspnea Screening	1641: Hospice and Palliative Care – Treatment Preferences	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.
Steward	Centers for Medicare and Medicaid Services	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill
Description	The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647.	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.	Percentage of patients with chart documentation of preferences for life sustaining treatments.	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.

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	These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.				
Type	Composite	Process	Process	Process	Process
Data Source	Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281).	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.	Electronic Health Record (Only), Other 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

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	Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014. Available in attached appendix at A.1 No data dictionary	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	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	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	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice	Facility
Setting	Hospice	Hospice, Hospital	Hospice, Hospital	Hospice, Hospital	Hospice
Numerator Statement	The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive assessment measure numerator, a patient	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.	Patients whose medical record includes documentation of life sustaining preferences	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.

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	must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.				
Numerator Details	The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQRP quality measures. This includes patients who received all 7 care process which	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.	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	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	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

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	are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are: 1. NQF 1634: Patient stays that include a screening 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. 2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.	Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.	scales designed for use with non-verbal patients.	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	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.

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	3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care. 4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening. 5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed 6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences			patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.	

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	7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date. Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria: 1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A =				

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	[1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^]) AND 2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^]) AND 3. The patient was screened for pain within 2 days of the				

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	admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient's pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4])) AND* 4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of				

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	the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^]) AND 5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^]) AND* 6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1				

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	day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^]) AND* 7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^]) NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the				

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	calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be 'given credit' for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen.				

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	While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.				
Denominator Statement	The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.	Seriously ill patients 18 years of age or older enrolled in hospice.
Denominator Details	The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.	The Dyspnea Treatment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease,	The Dyspnea Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease,	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,	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.

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		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	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.]	dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.	

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		population for Dyspnea Treatment.]			
Exclusions	Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).	Patients with length of stay < 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.	Patients with length of stay < 1 day in palliative care.	Patients with length of stay < 1 day in hospice or palliative care	Testing has only been done with the adult population; thus patients younger than 18 are excluded.
Exclusion Details	The exclusion criteria are: 1. Patients under 18 years of age as indicated by the birth date (A0900) and admission date (A0220) 2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)	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.	Calculation of length of stay; discharge date is identical to date of initial encounter.	N/A
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	N/A	N/A	N/A	N/A

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Type Score	Continuous variable, e.g. average better quality = higher 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	Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria. Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs.	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)	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	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	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 123241| 127411| 123213| 129544

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	Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100. Please see Appendix A.1 for a flow chart of the measure logic. 144877| 141015	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 123213| 129544	screened for dyspnea in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 123213| 129544	excluded in Step 2 123213| 129544	

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