NATIONAL QUALITY FORUM

Memo

TO: NQF Members

FR: NQF Staff

RE: Voting Draft Report: *NQF-Endorsed Measures for Palliative and End-of-Life Care*

DA: June 9, 2017

Background

When not involved in the more traditional endorsement project activities, which usually include evaluation of 20-25 measures over a 7-month timeframe, the Palliative and End-of-Life Care Standing Committee is available for "off-cycle" activities. As part of its spring 2017 off-cycle activities, the Palliative and End-of-Life Care Standing Committee evaluated one measure against NQF's standard evaluation criteria and recommended the measure for endorsement. The committee also continued to refine the measurement framework for palliative and end-of-life care and offered additional input on gaps in measurement.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from February 21 through February 27 for the measure under review. No pre-evaluation comments were received.

Post-evaluation comments

The Draft Report went out for Public and Member comment from April 10 to May 10, 2017. During this commenting period, NQF received three comments from three member organizations:

Consumers – 0	Professional – 0
Purchasers – 0	Health Plans – 0
Providers – 1	QMRI – 2
Supplier and Industry – 0	Public & Community Health - 0

A complete table of comments, along with the responses to each comment and the actions taken by the Standing Committee, is posted to the project page on the NQF website, along with the measure submission forms.

The Committee responded to all post-evaluation comments. Revisions to the draft report and the accompanying measure specifications are identified as red-lined changes. (Note: Typographical errors and grammatical changes have not been red-lined, to assist in reading.)

Comments and their Disposition

Two of the commenters supported the measure, while the third commenter questioned the utility of the composite measure to drive improvement, particularly given the use of the components as individual measures. One commenter also asked the Committee to consider an alternative label to the word "care-a-tive" in the measurement framework.

Comment 1: Support for the measure

The Johns Hopkins Armstrong Institute supports the endorsement of this measure.

Committee Response: Thank you for your comment.

Action Item: None.

Comment 2: Concern regarding ability of the measure to drive improvement

The Federation of American Hospitals ("FAH") appreciates the opportunity to comment on measure #3235: Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment on Admission. The FAH believes that effective and timely assessment of the critical care processes included in this composite are vital, and we support the intent of the measure. However, the FAH is concerned that many of the measures included in the composite are not proximal to patient outcomes. Specifically, the measure currently assesses screening and assessment for pain but neglects to examine whether treatment is provided. The FAH also notes that all but one of the measures achieved 90 percent or higher in performance. While the data demonstrates that variations in care delivery remain, it appears that most of those composite score variations are driven by the performance of measure #1637: Hospice and Palliative Care – Pain Assessment. Based on the report, it appears that the Standing Committee discussed the general gap in care of the total composite score but did not specifically evaluate whether the performance of one measure should drive the use of this composite. The FAH respectfully requests that the Standing Committee reconsider the overall value of the composite measure in light of the performance data of the individual measure. Specifically, the FAH calls for the Committee to ask: "Will this composite measure drive additional care improvement; or is there a different set of measures that will help to improve end-of-life care?" The FAH is not convinced the composite, as currently constructed, will drive care improvement without further assessment of the above question.

Developer Response: We thank the Federation of American Hospitals for their support of NQF #3235: Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment on Admission. We acknowledge their concerns regarding the proximity of the seven component measures to patient outcomes. While the evidence base linking pain screening, pain assessment, dyspnea screening, and addressing spiritual beliefs and values to improved

patient outcomes exists, it is less robust than is desirable. In lieu of robust evidence, experts in the field, hospice providers, and caregivers all reported that these processes of care are important to promote a person-centered approach to care and to achieve the outcome of patient comfort throughout the delivery of hospice and palliative care. The Standing Committee also agreed that the evidence clearly linking these process measures to patient outcomes was tangential; however, they agreed that empirical evidence was not needed to hold providers accountable for completing all care processes.

The measure developer's focus groups and interviews with experts, providers, and caregivers also supported the current construction of the Hospice Comprehensive Assessment Measure. The Technical Expert Panel supported the all-or-none scoring approach since, by using this approach, the measure sets a clear quality expectation that all care processes captured by the seven QM components are expected to be performed, and missing any one of these measures could be recognized as an indicator of suboptimal care. Caregivers believed that a composite process measure assessing whether patients received a comprehensive assessment upon hospice admission would help alleviate some of the difficulties disentangling quality information from seven individual measures. Furthermore, caregivers felt that a single measure using the all-or-none approach would provide consumers with an easy way to compare quality processes across providers. Finally, hospice providers reported that a single composite measure would be important in incentivizing hospices to conduct all critical care processes for each patient and setting a higher standard of care for hospices, which will reveal a larger performance gap and thus room for improvement. Therefore, providers believed that a single measure for all seven care processes would be more actionable than seven individual measures.

We agree that measuring quality of symptom management beyond pain screening and assessment is important. There are challenges associated with accurately assessing pain treatment in accordance with patient preference. The CAHPS measures address symptom management aspect of care by surveying hospice caregivers and considering their perception of patient preference. Patient-reported outcome measures, remain a gap and priority development area in in the Hospice Quality Reporting Program.

To address concerns about the impact of individual measures on the composite score, we completed two analyses. We first assessed the contribution and impact of each individual component measure on the comprehensive assessment QM score. We constructed seven 'alternative' composite measures by building alternative QMs using only 6 out of the 7 component QMs, each time changing the component QM that was omitted. The results of these analyses showed that the mean QM score calculated differed amongst all the alternative composite measures. The mean QM scores ranged from a score of 72.22% when QM 1639 Dyspnea Treatment was removed to a score of 80.97% when the QM 1637 Pain Assessment was removed. The mean QM score produced by each of the alternative construction approaches was higher than the mean score of the complete comprehensive assessment measure. Scores

differed by 0.22% when QM 1634 Pain Screening was removed to 4.23% when QM 1647 Beliefs/Values was removed.

We also examined whether each of the alternative constructions could identify the same poor-quality outliers as the complete comprehensive assessment measure, based on the analysis of 200 hospices with the lowest score identified through each approach. The results of these analyses showed that each of the alternative measures identified a different but overlapping group of poor quality outliers, compared to those identified by the original composite measure. A smaller overlap between the outlier groups indicates more quality information contributed by the component measure that is missing from the alternative measure. Only 6.5% of the same outliers were identified when QM 1617 Bowel Regimen was removed. The greatest overlap was seen when QM 1647 Beliefs/Values was removed, capturing 48.5% of the same outliers which is still below half. However, the majority of alternative approaches were only able to = 23% of the outliers identified by the complete comprehensive assessment measure.

Our findings from these two analyses suggest that each QM meaningfully contributes to the comprehensive assessment measure, and that the variation in the composite measure, particularly at the lower score end, is not driven by any single component measure. Therefore, the Hospice Comprehensive Assessment Measure provides the overall quality of assessment of patient needs at hospice admission, quality information that cannot be determined from any single measure alone. Thus, the composite measure is expected to provide a larger incentive for quality improvement than any of the component measures alone.

Committee Response: Thank you for your comment. We agree that performance on the pain assessment component will drive a substantial amount of variation in performance for this composite. However, we specifically considered the contribution of each of the components when evaluating subcriterion 2d (empirical analysis to support composite construction). We believe the analyses submitted by the developer to address this subcriterion demonstrate that each of the components contribute to the overall composite. Although performance is high for several of the components, we agree 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. We also agree that additional measures should be developed that assess provision of treatment and outcomes of treatment.

Comment 3: Revision to the Palliative and End-of-Life Care Measurement Framework

The National Coalition for Hospice and Palliative Care (NCHPC) wants to thank the NQF Palliative and End of Life Care Standing Committee for its leadership in ensuring that there are sufficient quality measures to protect seriously ill patients as they navigate the health care system. The NCHPC also appreciates the opportunity to provide feedback on the Off-Cycle draft report. Our comments are as follows:

REFINING NQF'S MEASUREMENT FRAMEWORK FOR PALLIATIVE AND END-OF-LIFE CARE.

The Coalition generally supports the changes made to the measurement framework. For instance, we support the Standing Committee's decision to change "models of care" to "settings of care," particularly as we agree with the assertion that different models do not necessarily require different measures. We also strongly support any efforts to increase harmonization between the NQF Framework and the National Consensus Project's (NCP) Clinical Practice Guidelines for Quality Palliative Care. This will be increasingly important as the NCP revises its clinical practice guidelines next year for use in the community. We encourage the Committee to remain apprised of this and other ongoing quality measurement initiatives, and strive for alignment where appropriate. Finally, we agree with the Committee's decision to add "Caregiver" to the center of the ring, as the person caring for the seriously ill individual may not always be a family member.

The only change in the framework that is of concern is the addition of "care-a-tive" to the "Types of Palliative Care" ring. While we emphatically agree that there should be a distinction between quality measures for long-term patients who are expected to be cured vs. those who are not expected to regain function, the phrase "care-a-tive" is confusing and an unfamiliar term from a care delivery perspective. We therefore request that the Committee consider alternate names for this term.

SUGGESTIONS FOR ADDITIONAL OFF-CYCLE ACTIVITIES.

This Standing Committee is comprised of many of today's foremost experts in palliative care and hospice quality measurement, and the Coalition continues to be excited about its potential to drive the field forward. Therefore, we wanted to provide a few additional suggestions for future off-cycle activities:

- *Prioritizing the measures gaps identified on pp. 10-11 of the Palliative and End-of-Life Care 2015-2016 Final Report (released December 23, 2016)*
- *Engaging with palliative care and hospice measure developers around the best way(s) to address the highest priority gaps*
- *Discussing the possibility of creating a Palliative Care Measures Group for the Merit-based Incentive Payment System*

Thank you again for your excellent work. Please do not hesitate to contact the Coalition at amym@nationalcoalitionhpc.org if you have questions or would like to discuss any of these comments.

Committee Response: Thank you for your comments regarding the framework. We agree that the term "care-a-tive" is new and therefore unfamiliar to the field. We have therefore changed the label from "care-a-tive" to "chronic".

NQF response: Thank you for your suggestions for potential topics for future off-cycle activities. During the May 30, 2017 post-comment call, we asked the Standing Committee to prioritize existing measures and gaps for palliative and end-of-life care, using the prioritization criteria recently developed as part of NQF's strategic plan to "drive measurement that matters". NQF will consider how we might implement your other suggestions in future Committee deliberations.

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. To accomplish this task, NQF staff identified a set of four prioritization criteria to be used in conjunction with a hierarchical measurement framework that includes and seven national, high-impact outcomes. 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. The Committee also began using this approach to prioritize gaps in the portfolio.