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Geriatrics and Palliative Care, Fall 2020 Cycle: CDP Report

TECHNICAL REPORT
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Contents

Executive Summary

Factors including the aging United States (U.S.) population; the projected increases in the number of Americans with chronic illnesses, disabilities, and functional limitations; and increases in ethnic and cultural diversity have intensified the importance of improving the quality of palliative, end-of-life, and geriatric care, with an emphasis on the need for individualized, person-centered care. To date, the National Quality Forum (NQF) has endorsed more than 30 measures that address geriatric, palliative, and end-of-life care. These measures address physical, spiritual, and legal aspects of care, as well as the care of patients nearing the end of life.

For this project, the Standing Committee evaluated four measures undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended three measures for endorsement but did not recommend the remaining measure for endorsement. The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendation to endorse two measures and not endorse one measure. The CSAC did not uphold the Standing Committee's recommendation to endorse one measure and is sending the measure back to the Standing Committee for reconsideration in a future cycle. Endorsement of this measure will be retained until its review is complete.

The endorsed measures are listed below:

- NQF #3235 Hospice and Palliative Care Composite Process Measure (Centers for Medicare & Medicaid Services [CMS])
- NQF #0326 Advance Care Plan (National Committee for Quality Assurance [NCQA])

The following measure was not endorsed:

- NQF #0209 Comfortable Dying Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment (National Hospice and Palliative Care Organization)

The following measure will be sent back to the Standing Committee for reconsideration in a future cycle, and endorsement will be retained until its review is complete:

- NQF #1623 Bereaved Family Survey (U.S. Department of Veterans Affairs)

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

Introduction

Improving the quality of both palliative and end-of-life care, and geriatric care more generally, is becoming increasingly important due to factors that have intensified the need for individualized, person-centered care. Some of these factors include the aging U.S. population; the projected increases in the number of Americans with chronic illnesses, disabilities, and functional limitations; and increases in ethnic and cultural diversity.[1] In 2018, the 65-and-older population numbered 50.9 million individuals (15.6 percent of the U.S. population), and this figure is expected to increase to 94.7 million by 2060.[2] As many as 35 percent of older Americans have some type of disability (e.g., vision, hearing, ambulation, and cognition), while 46 percent of those 75 years of age and older report limitations in physical functioning.[2] Additionally, data indicate that 46 percent of the noninstitutionalized U.S. population 65 years of age or older have two or three chronic conditions, and 15 percent have four or more.[3]

Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and alleviating suffering throughout the continuum of a person's illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.[4] Palliative care is holistic; therefore, it requires an interdisciplinary, team-based approach to care. With its focus on improving quality of life, palliative care is distinct from care intended to cure an illness or condition, although it can be delivered concurrently with curative therapies and can begin at any point in the disease progression. It can be provided in any setting, including outpatient care settings and at home.

Although palliative care is still provided primarily by specially trained teams of professionals in hospitals and through hospice, there is increased focus on provision of palliative care in the community,[5] often by clinicians who are not palliative care specialists. The provision of palliative care has been shown to increase patient and family satisfaction with care[6]; reduce emergency department (ED) visits, hospital admissions, and hospital readmissions[7]; and decrease costs to the healthcare system.[8,9] However, access to hospital-based specialty palliative care continues to vary by hospital size and location, and even when programs are available, not all patients who could benefit actually receive those services.[10]

Palliative care is appropriate for those who are expected to recover, as well as for those who have chronic, progressive, and/or terminal illness. For those with a terminal illness, high quality, end-of-life care is comprehensive care that addresses medical, emotional, spiritual, and social needs during the last stages of illness.[1] Much end-of-life care is palliative, when life-prolonging interventions are no longer appropriate, effective, or desired.[4] Thus, for patients nearing the end of life, there will often be a greater emphasis on palliative care rather than curative treatment. In many instances, this care is provided in the form of hospice.

Hospice is a service delivery system that relies on an interdisciplinary approach that emphasizes symptom management for patients near the end of life. While hospice care is covered through Medicaid and most private insurance plans, most hospice enrollees receive coverage through the Medicare hospice benefit.[11] Approximately 1.55 million Medicare beneficiaries received hospice care in 2018.[11] For these individuals, the average length of stay was 89.6 days; however, the median length of stay was only 18 days, meaning that many enrolled in hospice too late to fully realize the benefits of the program.[11] Beginning in 2014, Medicare-certified hospices were required to report performance on quality measures as part of the Hospice Quality Reporting

Program (HQRP); those who do not report face a reduction in payments from Medicare. Performance rates for these measures are publicly reported on the CMS Care Compare website.[12]

Since 2006, when it first developed a measurement framework for palliative and end-of-life care and endorsed 38 evidence-based preferred practices for high quality palliative care programs,[4] NQF has endorsed more than 30 measures in this topic area, many of which are currently used in federal quality improvement and public reporting programs.

In 2017, NQF expanded the scope of the Standing Committee charged with the oversight of the Palliative and End-of-Life Care measures portfolio by adding measures specifically relevant to older adults (i.e., the geriatric population). Several previously seated and new members of this renamed "Geriatrics and Palliative Care Standing Committee" are geriatric healthcare professionals. Thus, the Standing Committee has the requisite expertise to assume oversight of measures that focus on key issues specific to older adults, such as multimorbidity and frailty. At present, measures specifically relevant to the geriatric population remain aspirational. Therefore, for the time being, the Geriatrics measures evaluated by this Standing Committee include setting-specific measures that primarily affect older individuals. Examples of such measures include those that assess care provided by home health agencies or other home-based care providers.

NQF Portfolio of Performance Measures for Geriatrics and Palliative Care Conditions

The Geriatrics and Palliative Care Standing Committee (Appendix C) oversees NQF's portfolio of Geriatrics and Palliative Care measures (Appendix B). This portfolio contains 35 measures: 18 process measures, 16 outcome measures, and one composite measure (see table below).

Table 1. NQF Geriatrics and Palliative Care Portfolio of Measures

Measure Type	Process	Outcome	Composite
Palliative/End-of-Life Care Physical Aspects of Care	9	0	0
Palliative/End-of-Life Care Psychological and Psychiatric Aspects of Care	0	0	0
Palliative/End-of-Life Care Social Aspects of Care	0	0	0
Palliative/End-of-Life Care Spiritual, Religious, and Existential Aspects of Care	1	0	0
Palliative/End-of-Life Care Cultural Aspects of Care	0	0	0
Palliative/End-of-Life Care Care of the Patient Nearing the End of Life	3	11	1

Measure Type	Process	Outcome	Composite
Palliative/End-of-Life Care Ethical and Legal Aspects of Care	3	0	0
Geriatrics	2	5	0
Total	18	16	1

Some of the measures in the Geriatrics and Palliative Care portfolio will be evaluated by other NQF Standing Committees. These include a cultural communication measure (Patient Experience and Function Standing Committee) and pain measures for cancer patients (Cancer Standing Committee).

Geriatrics and Palliative Care Measure Evaluation

On February 17 and 18, 2021, the Geriatrics and Palliative Care Standing Committee evaluated four measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Geriatrics and Palliative Care Measure Evaluation Summary

Measure Status	Maintenance	New	Total
Measures endorsed	2	0	2
Measures not endorsed	1	0	1
Measure sent back to the Standing Committee for reconsideration	1	0	1
Reasons for not endorsing and/or sending back to the Standing Committee for reconsideration	Importance – 1 Scientific Acceptability – 0 Use – 1 Overall Suitability – 0 Competing Measure – 0	Importance – 0 Scientific Acceptability – 0 Overall Suitability – 0 Competing Measure – 0	2

Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on December 11, 2020, and closed on April 30, 2021. As of January 26, 2021, one comment was submitted and shared with the Standing Committee prior to the measure evaluation meetings (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on April 30, 2021. Following the Standing Committee's evaluation of the measures under review, NQF received five comments on

two measures from two member organizations and one member of the public. The comments expressed support of the measures that were recommended for endorsement, addressed the measure specifications for NQF #0326, and acknowledged the lack of data available to support performance gap for NQF #0209. All comments received have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure to inform the Standing Committee's recommendations during the commenting period. This expression of support (or not) during the commenting period replaces the NQF member voting opportunity that was previously held subsequent to the Standing Committee's deliberations. No NQF members provided their expression of support or non-support for the measures.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

NQF #1623 Bereaved Family Survey (Department of Veterans Affairs): Sent back to the Standing Committee for reconsideration

Description: This measure calculates the proportion of Veteran decedent's family members who rate overall satisfaction with the Veteran decedent's end-of-life care in an inpatient setting as "Excellent" versus "Very good", "good", "fair", or "poor". **Measure Type**: Outcome: PRO-PM; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital, Post-Acute Care; **Data Source**: Instrument-Based Data

Research has emphasized the extent to which end-of-life care in the U.S. needs to be improved.

Originally endorsed in 2016, this measure was recently reviewed for maintenance of endorsement in two different cycles. The first maintenance review occurred during the fall 2019 cycle, and the second maintenance review occurred during the fall 2020 cycle. During the fall 2019 review cycle, the Standing Committee recommended the *Bereaved Family Survey* (BFS) measure for continued endorsement. However, due to concerns with how the validity and use criteria were applied, the CSAC sent the measure back to the Standing Committee for reconsideration. During the CSAC review for the fall 2019 cycle, CSAC members were not comfortable with the measure meeting the validity subcriterion due to the wide variation presented in the beta-binomials. The CSAC also raised concern with the Standing Committee's decision to overturn the Scientific Methods Panel's (SMP) low rating on validity; however, the developer noted that the data evaluated by the SMP were not current. Regarding the use criterion, the CSAC raised concerns that the measure is only reported in Veterans Affairs (VA) sites, and if it is endorsed, it would be available for other populations that have not been previously evaluated for this measure. The developer responded by stating that public reporting of this measure is dependent on the approval of VA senior leadership; nonetheless, they are pursuing reporting for private facilities and nursing homes. The CSAC voted to overturn the Standing Committee's recommendation for continued endorsement and returned the measure to the Standing Committee for reconsideration.

For the current review in the fall 2020 cycle, the SMP reviewed this measure (with updated data) and passed it on both the reliability and validity subcriteria without discussion. Because the measure passed the SMP's review without issue, the Standing Committee was instructed to focus their discussion on reconsideration of the use criterion for which a vote would be taken. As per NQF's process for the CSAC sending measures back to the Standing Committee for reconsideration, discussion and voting on the remaining criteria were not needed for this measure.

The developer was provided with an opportunity to introduce the measure, with a specific focus on the use criterion. The developer stated that performance on the BFS is reported within VA, as each facility/Veterans Integrated Service Networks/VA leadership all have access to all results (available via the Hospice and Palliative Care Data Dashboard link as well as housed in the VA's internal databases) in addition to the public reporting that occurs regularly in academic journals. In addition, the BFS is used by VA staff when educating consumers about the choice of venue for hospice care as well for accountability and quality improvement purposes. The developer also shared that the BFS has been adopted at Stanford, Duke, University of California Los Angeles, and Kaiser Medical Centers.

The Standing Committee raised a question about the performance dashboard mentioned by the developer, specifically whether it is a program related to any sort of reimbursement or other kind of incentives. The developer responded by stating that the BFS is uploaded to the Data Dashboard every quarter and is considered a VA performance measure, which means incentives are attached to it. Facilities are incentivized for meeting the minimum of their performance measure or scoring beyond the national mean on that performance measure.

The Standing Committee acknowledged that some progress has been made in meeting the use criterion since the last measure submission in terms of sharing the information within the VA and with external academic institutions. However, concerns remained with the lack of public-facing, facility-level data to date. The Standing Committee had much discussion on the public's ability to understand whether they are choosing a facility they would want to go to and whether the VA itself can really use the data for quality improvement at a facility level. The developer clarified that clinical staff and leadership in individual facilities can access the data for quality improvement purposes. In addition, the VA has biannual calls with every single facility in the nation to review their data from the BFS. With an emphasis on quality improvement, the VA tracks scores over time nationally, regionally, and at the facility level. The developer stated that they are still working towards public reporting of this measure, which is dependent on the approval of VA senior leadership, with all the associated nuances of being a federal healthcare system.

Following a robust discussion about the use criterion, the Standing Committee voted to pass the measure on use and recommended the measure for continued endorsement. No comments were received on this measure during the post-evaluation commenting period.

The CSAC voted to not uphold the Standing Committee's recommendation to endorse NQF #1623 and sent it back to the Standing Committee for a second reconsideration. The CSAC was concerned that the information provided about the measure's use is not very different from the last time the CSAC reviewed the measure and expressed concerns with both the use criterion and overall suitability for endorsement. CSAC members shared

concerns with how the use criterion was applied for this measure and noted that as a must-pass criterion, the CSAC has increased its efforts to be consistent in the application of the use criterion. The CSAC, NQF staff, and other stakeholders will soon review guidance for the use criterion to assess whether greater specificity on public reporting can be included to help guide developers, Consensus Development Process (CDP) Committees, and the CSAC. As a maintenance measure, NQF #1623 will retain endorsement but will be reconsidered by the Standing Committee during the next review cycle.

NQF #0326 Advance Care Plan (National Committee for Quality Assurance): Endorsed

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice; **Setting of Care**: Outpatient Services; **Data Source**: Claims

Originally endorsed in 2016, this clinician-level measure addresses advance care planning as one facet of high quality care for older adults. Publicly reported in the Centers for Medicare & Medicaid Services' (CMS) Merit-Based Incentive Payment System (MIPS), the intent is to promote advance care planning discussions between older adults and their providers and documentation of that discussion in the patient's record.

During the pre-evaluation commenting period, the developer submitted a comment outlining updated evidence for this measure. The Standing Committee questioned whether the evidence supports improved perceptions of care and quality of care at the end of life, as the evidence submitted supports more cost and efficiency improvement and avoidance of unwanted care. Although Standing Committee members acknowledged that limited evidence existed for this measure despite it being in use for a long time, they generally agreed that sufficient evidence is available to support the measure's focus.

When discussing disparities as part of the performance gap subcriterion, the Standing Committee noted that the developer did not provide any disparities data. However, the developer summarized the literature addressing disparities and the advance care planning studies that identified racial and ethnic minorities, as well as individuals and lower socioeconomic groups, as being less likely to have an advance care plan. Despite concerns regarding the lack of data to address disparities, the Standing Committee agreed that a performance gap exists that warrants a national performance measure.

Standing Committee members had concerns that the second part of the numerator could be considered subjective for providers, leading them to avoid conversations on an advance care plan. The Standing Committee asked for clarification from the developer. The developer stated that the numerator component in question is designated by Current Procedural Terminology (CPT) II code 1124F, which states "Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan." The Standing Committee was satisfied with the developer's response. During the discussion on validity, the Standing Committee asked for clarification about whether the testing assessed whether this measure reflected that a healthcare proxy or treatment directive was present in the medical record or that a conversation on the goals of care had been documented in the medical record. The developer described the method of testing in that a measure of similar construct was selected to demonstrate

validity. NQF staff confirmed that construct validity at the measure score level is an acceptable method of testing. The Standing Committee agreed that the measure met the validity subcriterion.

The Standing Committee had no concerns regarding the feasibility or use and usability for this measure and agreed that the measure meets each criterion without much discussion. The Standing Committee recommended this measure for continued endorsement.

Two comments were received on this measure during the post-evaluation commenting period. One commenter raised concerns about whether the "surrogate" has the legal authority to make decisions about the person's care. The commenter suggested that the developer clarify that the healthcare proxy, surrogate, legal representative, or agent (whichever term, or using examples of terms) has the authority to be a decision maker. The developer responded by stating that “NCQA appreciates this request for clarification of the language used in the measure description referring to surrogate decision maker. This language reflects the code’s descriptions used to identify numerator compliance. We do not envision a formal process that would be outlined in the measure description to designate legal authority.” Another commenter raised a concern that this measure may encourage "check-box" advance care planning. The commenter suggested that the measure would ideally want to encourage a deeper, longitudinal elicitation of values/surrogates. The developer responded to the check-box comment by stating that the availability of CPT codes limits the ability of the measure to be more outcome based. Additionally, the commenter encouraged stratifying by race/ethnicity, as research suggests disparities are present in ACP completion. The developer responded by stating “we are constrained by the reporting requirements of the CMS Quality Payment Program (QPP)/MIPS reporting program in the matter of stratification of results by race and ethnicity. NCQA looks forward to working with CMS and its vendors to support reporting all measure results (where appropriate) by race and ethnicity and relevant social factors.” Overall, the Standing Committee was satisfied with the developer’s responses but supported stratifying by race/ethnicity. The CSAC upheld the Standing Committee’s recommendation and maintained endorsement of the measure.

NQF #3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (Abt Associates): Endorsed

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 measures 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**: Other; **Data Source**: Other

This measure is a comprehensive assessment of admission in several categories: whether or not the patient was treated with an opioid or given a bowel regimen, pain screening, pain assessment, dysthymia treatment and screening, treatment preferences, and whether beliefs and values were addressed if desired by the patient on admission. It is the only measure in the current measure set for the HQRP that includes the entire Medicare

hospice population. According to the developer, the rationale for this measure is not so much about the completion of each of the seven individual components; rather, it reflects the totality of all the processes being completed and captured in a way that is meaningful to consumers.

The developer attested that no change had occurred in the evidence since its last endorsement. The Standing Committee agreed to accept the evidence rating from the previous review, which was a passing rating. When discussing performance gap, Standing Committee members noted that the disparities data submitted by the developer demonstrate the rate of completion of the seven care processes within this composite across racial identities as statistically significant. The Standing Committee agreed that a sufficient performance gap existed to warrant measurement. In agreement that the quality construct and a rationale for the composite are both logical and the method for aggregation and weighting of the components is explicitly stated, the Standing Committee voted to pass the measure on the performance gap and the quality construct subcriteria.

The Standing Committee noted that the SMP reviewed the measure. The SMP commented that the reliability testing methodology and results were appropriate and passed the measure on reliability. The Standing Committee agreed with this assessment and voted to accept the SMP's rating on reliability. During the discussion of the validity subcriterion, the Standing Committee noted a few concerns raised by SMP members. First, there was a question about the measure's ability to truly identify meaningful differences in performance, as the distribution is fairly compressed to the top. Second, concerns were raised about the approach to validity, which was demonstrated by correlating the composite with its individual NQF-endorsed component measures. The developer clarified that the submission was updated with more current data since the previous submission and that correlation between the composite and components was the only approach initially taken. The Standing Committee also raised the issue of the measure's exclusion of pediatric hospice patients. The developer clarified that the pediatric exclusion is consistent with the composite's seven NQF-endorsed component measures that also exclude patients under 18 years of age. After the robust discussion concluded, the Standing Committee voted to accept the SMP's passing rating on validity. The Standing Committee also voted to accept the SMP's passing rating on the composite construction subcriterion.

The Standing Committee had no concerns about the feasibility of this measure, and without much discussion, the Standing Committee agreed that the measure met the requirements of the use and usability criteria. The Standing Committee recommended the measure for continued endorsement. No comments were received on this measure during the post-evaluation commenting period. The CSAC upheld the Standing Committee's recommendation and maintained endorsement of the measure.

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

Description: Percentage of patients who report being uncomfortable because of pain at the initial assessment who, at the follow-up assessment, report pain was brought to a comfortable level within 48 hours. **Measure Type**: Outcome: PRO-PM; **Level of Analysis**: Facility, Other; **Setting of Care**: Home Care; **Data Source**: Instrument-Based Data

As a patient-reported outcome (PRO), this measure captures and reflects patient goals for pain management. According to the developer, the use of a dichotomous rating, which incorporates the patient's perception of

their own degree of comfort, provides a means of assessing provider performance of initial pain management. Consequently, this measure provides a comprehensive picture of pain management.

The Standing Committee noted that the developer did not present new evidence since the prior review in 2016 and asked NQF staff for clarification on whether that is acceptable. NQF staff clarified that it is acceptable at the time of maintenance of endorsement review if the developer attests that the underlying evidence for the measure has not changed. However, the Standing Committee must decide to agree that the evidence base to support the measure focus has not changed since the prior review. The Standing Committee agreed and voted unanimously to pass the measure on the evidence criterion.

When discussing performance gap, the Standing Committee noted that the developer has not collected data on this measure since 2015. This measure (in a modified form) is included in CMS' MIPS, but data are not available on the utilization of the measure. Performance data for facility scores were provided for years 2012-2015 for those hospice facilities that voluntarily submitted data. However, for NQF maintenance of endorsement, measure stewards/developers are expected to provide current performance data. NQF staff clarified the implications of an insufficient vote on performance gap, meaning the measure would not move forward as recommended for endorsement. NQF informed the Standing Committee that the developers would have an opportunity to submit current performance data during the upcoming public commenting period. The Standing Committee could then have an opportunity to discuss and reconsider the measure during the post-comment call in June. The measure did not pass on the must-pass criterion of performance gap and will be released for public comment as not recommended for endorsement.

During the post-evaluation commenting period, the developer submitted a comment acknowledging a lack of data tracking and analysis available during this evaluation period to inform NQF #0209 and noted several registries that promote the use of this measure (through MIPS registries). The developer also stated that "throughout treatment, patient reported outcome measures (PROMs) can assist with evaluation of effectiveness of treatment and lead to revisions to the plan of care. PROMs also are an indicator of patient satisfaction with the experience of care" and provided references to support the importance of PROMs for acute and chronic pain. The Standing Committee agreed with the importance of a PRO to capture and reflect patient goals for pain management; they also encouraged the measure developer to continue working to acquire the needed data and potentially resubmit the measure for endorsement consideration in the future. The Standing Committee acknowledged that this measure is critically important to the Geriatrics and Palliative Care measure portfolio and is one of the few outcome measures available. However, the Standing Committee understands that the measure developer does not have access to the data needed to demonstrate an opportunity for improvement, which is required for maintenance of endorsement. The Standing Committee did not re-vote on this measure. The CSAC upheld the Standing Committee's recommendation to not maintain endorsement of the measure.

Measure Withdrawn From Consideration

One measure previously endorsed by NQF was not resubmitted for maintenance of endorsement during the endorsement evaluation process. Endorsement for this measure will be removed.

Table 3. Measure Withdrawn From Consideration

Measure	Reason for withdrawal
#0420 Pain Assessment and Follow-Up	Retired by the developer

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12. Centers for Medicare & Medicaid Services (CMS). Care Compare. https://www.medicare.gov/care-compare/?providerType=Hospice&redirect=true. Last accessed March 2021.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present for that vote as the denominator. Quorum (16 Standing Committee members) was met and maintained for the entirety of the meeting, although some Standing Committee members were unable to attend the entire meeting due to early departures and late arrivals. The vote totals reflect members present and eligible to vote at the time of the vote.

Measures Endorsed

NQF #0326 Advance Care Plan

Measure Worksheet | Specifications

Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Numerator Statement: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Denominator Statement: All patients aged 65 years and older.

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician: Group/Practice

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: National Committee for Quality Assurance (NCQA)

STANDING COMMITTEE MEETING: 02/17/2021 and 02/18/2021

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

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

1a. Evidence: **Total Votes: 20; H-2; M-16; L-1; I-1**; 1b. Performance Gap: **Total Votes: 20; H-0; M-14; L-5; I-1**

Rationale:

- For the 2016 review, the developer referenced a 2014 systematic review that evaluated the effect of advance care planning (ACP) on hospitalization and length of stays. Evidence from the 21 studies showed that use of an ACP is linked to a decreased rate of hospitalizations.
- In the current submission, the developer provided two additional studies to support the systematic review provided in the previous review. The developer stated that the new studies provide additional support for the measure.
- The Standing Committee voiced concerns regarding the limited evidence for this measure despite the length of time this measure has been in use; nonetheless, they felt sufficient evidence was provided to support the measure's focus.

- The developer did not provide disparities data and indicated that MIPS data do not include disparities results. The developer summarized literature addressing disparities and advance care plans. One study found that beneficiaries who are African American are less likely to have formal documentation of their end-of-life wishes, while another study found that African American beneficiaries along with those who are Latino, less educated, or had lower income were less likely to have an advance care plan.
- The developer provided an additional study that found that while racial and ethnic minorities were aware of advance care plans, they were less likely to have completed one.
- The Standing Committee agreed that a clear performance gap exists that warrants a national performance measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **Total Votes: 19; H-7; M-11; L-1; I-0**; 2b. Validity: **Total Votes: 20; H-4; M-13; L-3; I-0**

Rationale:

- The developer presented measure score level reliability testing results. Using 2017 MIPS data from 1,031 group/practices, the developer used a beta-binominal model to assess the signal-to-noise ratio. Using this method, the overall mean reliability score was 0.999. The developer concluded that the scores indicated good reliability.
- The Standing Committee raised concerns that due to the second part of the numerator, which states "or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan," providers may avoid conversations on advance care plans. The developer clarified that providers should be informed about guidance regarding the corresponding CPT II code 1124F that providers must submit for this measure. The Standing Committee was satisfied with the developer's response and agreed that the measure meets the reliability subcriterion.
- Validity testing was performed at the measure score level through construct validity testing and face validity. The developer conducted a Pearson correlation for construct validity against NCQA's *Documentation of Current Medications in the Medical Record* measure and found a positive correlation (Correlation coefficient = 0.63, $p < 0.001$).
- In the submission, the developer concluded that there is a moderate correlation between the *Documentation of Current Medications in the Medical Record* measure and the *Advance Care Plan* measure.
- The Standing Committee asked for clarification about whether the testing assessed whether this claims-based measure reflected that a healthcare proxy or treatment directive was present in the medical record or that a conversation on goals of care had been documented in the medical record. The developer described the method of testing in that a measure of similar construct was selected to demonstrate validity, which NQF considers an appropriate method.
- The developer also referred to the 2016 face validity results in which the 33-member panel and public found the measure to be valid.
- The Standing Committee asked the developer for clarification on whether the measure testing addressed the surrogate decision maker, to which the developer responded by stating that a similar measure was chosen for testing measure score. The developer also explained that the mechanism for addressing the issue of surrogates largely depends on the electronic health record (EHR) that the

provider uses. Having no other comments, the Standing Committee voted to pass the measure on the validity subcriterion.

3. Feasibility: Total Votes: 20; H-1; M-19; 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)

Rationale:

- Data elements for this measure are coded by someone other than the person obtaining original information on claims.
- All data elements are in defined fields in a combination of electronic sources. Some components of this measure draw on structured fields, while others are available in narrative notes or other nonstructured fields.
- The Standing Committee did not have any concerns regarding the feasibility of this measure.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 20; Pass-19; No Pass-1** 4b. Usability*:* **Total Votes: 22; H-6; M-14; L-2; I-0**

Rationale:

- The measure is currently used in CMS' MIPS. Data are reported publicly via Care Compare.
- In 2017, the developer found that for 1,031 practices and 13,849 physicians, the mean performance was 74%; in 2018, the developer found that for 1,754 practices and 14,287 physicians, the mean performance was 72.1%.
- The developer stated that no unexpected findings or unintended consequences were identified for this measure.
- The Standing Committee did not voice any concerns regarding the use and usability of this measure.

5. Related and Competing Measures

- No related or competing measures were noted.

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

7. Public and Member Comment

- Two public comments were received. One commenter raised concerns about whether the "surrogate" has the legal authority to make decisions about the person's care. The other comment expressed concern that this measure may encourage "check-box" advance care planning and encouraged the developer to stratify the measure by race/ethnicity.
- The measure developer provided the following responses to the comments received:
    - Regarding the "surrogate" comment, "NCQA appreciates this request for clarification of the language used in the measure description referring to surrogate decision maker. This language reflects the code's descriptions used to identify numerator compliance. We do not envision a formal process that would be outlined in the measure description to designate legal authority."
    - Regarding the race/ethnicity stratification comment, "we are constrained by the reporting requirements of the CMS QPP/MIPs reporting program in the matter of stratification of results by race and ethnicity. NCQA looks forward to working with CMS and its vendors to support

reporting all measure results (where appropriate) by race and ethnicity and relevant social factors." The Standing Committee was satisfied with the developer's response but also supports stratifying by race/ethnicity.

- The Standing Committee discussed the concerns raised and agreed that the comments did not provide additional concerns or information that would require a revote on the evaluation criteria.

8. **Consensus Standards Approval Committee (CSAC) Vote: (June 29, 2021) Y-11; N-0**
   - **CSAC Decision: Approved for continued endorsement**
9. **Appeals:** No appeals were received.

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

Measure Worksheet | 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 measures 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 measures (QMs) 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: Other

Type of Measure: Composite

Data Source: Other

Measure Steward: Centers for Medicare & Medicaid Services (CMS)

STANDING COMMITTEE MEETING: 02/18/2021

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

(1a. Evidence, 1b. Performance Gap; 1c. Composite – Quality Construct and Rationale)

1a. Evidence: **The Standing Committee agreed to apply the vote from the previous review cycle**; 1b. Performance Gap: **Total Votes: 21; H-5; M-14; L-2; I-0**; 1c. Composite – Quality Construct and Rationale: **Total Votes: 21; H-6; M-14; L-1; I-0**

Rationale:

- During the prior review in 2017, the developer provided a rationale for the relationship between a comprehensive assessment of physical and psychosocial well-being and positive treatment outcomes, including improved quality of life; treatment that is consistent with preferences; improved management of symptoms, including constipation, pain, and dyspnea; and meeting spiritual care needs.
- The Standing Committee noted that new evidence was not submitted. The Standing Committee discussed and agreed that no change occurred in the evidence from the previous endorsement. The Standing Committee agreed not to vote and to accept both the decision and vote from the previous review cycle, in which the measure passed on the evidence criterion.
- The developer provided disparities data and indicated that the rate of completion for the seven categories was statistically significant. Data provided from the HQRP represented four calendar years from 2016-2019. Over time, the hospice-level mean score increased from 77.8% for patient stays admitted in 2016 to 89.6% in 2019, the median increased from 82.3% to 94.1%, the interquartile range (IQR) decreased from 22.9% to 12.0%, and the standard deviation (SD) decreased from 18.2% to 12.7%. For patient stays admitted between January 1, 2016, and December 31, 2016, only 2.2% of hospices (81 of 3,745 hospices) had perfect scores, and 34.6% of hospices scored lower than 75% on this QM. In 2019, 8.4% percent of hospices (344 of 4,080 hospices) had perfect scores, and 11.0% of hospices scored lower than 75%.
- The developer stated that the aggregation of the seven measure components will incentivize hospices to conduct all critical care processes for each patient; set a higher standard of care for hospices, which will reveal a larger performance gap and thus room for improvement; and provide consumers and providers with a single measure representing the overall quality and completeness of assessment of patient needs at hospice admission, which can be easily used to compare quality processes across providers. As for the aggregation method, the developer stated that this measure calculates the percentage of patients who received all seven HQRP care processes at admission. All seven components are equally weighed. The score indicates the percentage of patients who received all seven care processes.
- The Standing Committee agreed with the developer that the quality construct and rationale for the composite were logical and clearly stated. The method for the aggregation and weighting of the components was also explicitly stated.
- With minimal discussion from the Standing Committee, the Standing Committee voted to pass the measure on the performance gap and the quality construct subcriteria.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity
2a. Reliability: **Total Votes: 21; Yes-21; No-0**; 2b. Validity: **Total Votes: 21; Yes-21; No-0**; 2c. Composite Construction: **Total Votes: 21; Yes-21; No-0**

Rationale:

- SMP subgroup members reviewed this measure and found it to be both reliable and valid. SMP members also passed the measure on the composite construction subcriterion.
- The SMP's ratings for reliability: **H-5; M-3; L-0; I-0** (Pass).
- The SMP's ratings for validity: **H-2; M-5; L-1; I-0** (Pass).
- The SMP's ratings for composite construction: **H-2; M-6; L-0; I-0** (Pass).

- The Standing Committee agreed with the SMP's assessment that the reliability testing methodology and results were appropriate and voted to accept the SMP's rating for this subcriterion.
- During the discussion of the validity subcriterion, the Standing Committee noted a few comments from SMP members. First, a question was raised about the measure's ability to truly identify meaningful differences in performance, as the distribution is fairly compressed to the top. Second, concerns were raised about the approach to validity, which was demonstrated by correlating the composite with its individual NQF-endorsed component measures. The developer clarified that updates were provided since the previous (original) submission with more current data, and the correlation between the composite and components was the initial approach taken. At time of the original endorsement submission, the individual components were the only other quality measures available for validation in the HQRP. Since then, the program has added measures calculated from CAHPS survey (NQF #2651). The updated testing as part of this submission included additional evidence of validity by estimating correlations between the composite measure and hospice-level *CAHPS Hospice Survey*, which are widely accepted to be valuable measures of hospice quality of care. Correlations between the comprehensive assessment measure and the CAHPS measures were positive for all seven CAPHS measures and significant.
- The Standing Committee also raised the issue of the measure's exclusion of pediatric hospice patients. The developer clarified that the pediatric exclusion is consistent with the composite's seven NQF-endorsed component measures that also exclude patients under 18 years of age. The developer also explained that the clinical guidelines used to support these processes were explicitly noted as "appropriate for adult patients… [but would] not assist providers in the identification or care for pediatric patients with life-threatening or chronic progressive illness."
- After the robust discussion concluded, the Standing Committee voted to accept the SMP's rating on validity.
- The Standing Committee voted to accept the SMP's rating on composite construction without concerns.

3. **Feasibility: Total Votes: 20; H-17; M-3; 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)

Rationale:

- This measure's data elements are generated or collected by and used by healthcare personnel during the provision of care, and all data elements are in defined fields in electronic clinical data.
- The Standing Committee did not have any concerns regarding the feasibility criteria of this measure.

4. **Use and Usability**

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 20; Pass-20; No Pass-0** *4b. Usability:* **Total Votes: 21; H-15; M-6; L-0; I-0**

Rationale:

- This measure is currently publicly reported by CMS on the Care Compare website and is currently included in the HQRP.
- The Standing Committee noted that performance results on this measure indicated that hospices have made significant improvements in completing a comprehensive assessment at hospice admission. The

developer suggested that the results indicate that this measure encourages hospices to conduct all critical care processes for each patient and sets a higher standard of care for hospices.
- The Standing Committee did not have any concerns regarding the use and usability criteria of this measure.

5. **Related and Competing Measures**

- The measure is related to the following measures:
    - NQF ##1634 Hospice and Palliative Care – Pain Screening
    - NQF ##1637 Hospice and Palliative Care – Pain Assessment
    - NQF ##1639 Hospice and Palliative Care – Dyspnea Screening
    - NQF ##1638 Hospice and Palliative Care – Dyspnea Treatment
    - NQF #1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen
    - NQF ##1641 Hospice and Palliative Care – Treatment Preferences
    - NQF ##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.
- The measures are harmonized to the extent possible. During the post-comment call, NQF will ask the Standing Committee to discuss the utility of continued endorsement of the individual measures.

6. **Standing Committee Recommendation for Endorsement**: **Y-21**; **N-0**
7. **Public and Member Comment**
    - No member or public comments were received.
8. **Consensus Standards Approval Committee (CSAC) (July 29, 2021) Vote: Y-11; N-0**
    - **CSAC Decision: Approved for continued endorsement**
9. **Appeals:** No appeals were received.

Measure Not Endorsed

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

Measure Worksheet | Specifications

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

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

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

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

Patients under 18 years of age

Patients who cannot self-report pain

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

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Other

Setting of Care: Home Care

Type of Measure: Outcome: PRO-PM
Data Source: Instrument-Based Data
Measure Steward: National Hospice and Palliative Care Organization (NHPCO)

STANDING COMMITTEE MEETING: 02/18/2021

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

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

1a. Evidence: **Total Votes: 20; Pass-20; No Pass-0** 1b. Performance Gap: **Total Votes: 22 H-1**; **M-4**; **L-4**; **I-13**

Rationale:

- During the prior review in 2016, the developer provided a rationale and diagram illustrating the pain assessment process and how it relates to the outcome of pain being brought to a comfortable level. The developer also addressed a new submission question regarding demonstration that the target population values the measured PRO and finds it meaningful. The developer stated "The negative effect of pain on quality of life and the need for timely and effective pain management is universally accepted. Consequently, minimal investigation has been done related to the importance of pain management at end of life. One study investigating symptom distress and quality of life in patients with cancer newly admitted to hospice home care did find a strong relationship between pain and distress."
- The 2016 Standing Committee agreed that the developer's rationale from self-reported pain to clinical and psychosocial assessment to intervention is an effective way of reporting alleviation of pain. The Standing Committee also agreed with the clinical action that could influence patient-reported pain levels and that hospice patients find questions regarding level of pain to be meaningful.
- For the current review, the Standing Committee noted that the developer did not present new evidence and asked NQF staff for clarification on whether that is acceptable. NQF staff clarified that it is acceptable at the time of maintenance of endorsement review if the developer attests that the underlying evidence for the measure has not changed. However, the Standing Committee must decide to agree that no changes have been made since the prior review. The Standing Committee voted unanimously to pass the measure on the evidence criterion.
- According to the developer, NHPCO has not collected data on this measure since 2015. A similar version of this measure is included in CMS' MIPS; however, data are not available on the utilization of the measure. Performance data for facility scores were provided for years 2012–2015 for those hospice facilities that voluntarily submitted data. The mean and standard deviation were 66.4 (SD=21.1) in 2012 across 143 reporting hospice facilities and 64.7 (SD=24.5) in 2015 across 46 reporting hospice facilities.
- When discussing performance gap, the Standing Committee noted that the developer has not collected data on this measure since 2015. The Standing Committee acknowledged that this measure (in a modified form) is included in CMS' MIPS; however, data are not available on the utilization of the measure. For NQF maintenance of endorsement, measure stewards/developers are expected to provide current performance data, which are lacking as part of the current measure submission.
- NQF staff clarified the implications of an insufficient vote on performance gap, meaning the measure would not move forward as recommended for endorsement. NQF informed the Standing Committee that the developers would have an opportunity to submit current performance data during the upcoming public commenting period. The Standing Committee could then have an opportunity to discuss and reconsider the measure during the post-comment call in June. The Standing Committee

encouraged the developer to do so and because they were not present during the meeting, NQF staff will follow-up with the developer offline.
- The Standing Committee did not pass the measure on the must-pass criterion of performance gap, and it will be released for public comment as not recommended for endorsement.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. Composite construction)
2a. Reliability: **H-X**; **M-X**; **L-X**; **I-X** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**
Rationale: N/A

3. Feasibility: H-X; M-X; L-X; I-X
(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)
Rationale: N/A

4. Use and Usability
(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)
4a. Use: **Pass-X; No Pass-X** *4b. Usability:* **H-X; M-X; L-X; I-X**
Rationale: N/A

5. Related and Competing Measures

6. Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**
Rationale: N/A

7. Public and Member Comment
- The measure developer submitted a comment during the public commenting period acknowledging the lack of available data tracking and analysis during this evaluation period to inform NQF #0209 and noted several registries that promote the use of this measure through MIPS registries. The developer also underlined the importance of this measure.
- The Standing Committee replied to the comment and agreed with the importance of a PRO to capture and reflect patient goals for pain management. The Standing Committee encouraged the measure developer to continue working with potential co-stewards to acquire the needed data and potentially resubmit the measure for endorsement consideration in the future. The Standing Committee acknowledged that this measure is critically important to the Geriatrics and Palliative Care measure portfolio, as it is one of the few outcome measures available. However, the Standing Committee understands that the measure developer does not have access to the data needed to demonstrate an opportunity for improvement, which is required for maintenance of endorsement.

8. Consensus Standards Approval Committee (CSAC) (July 29, 2021) Vote: Y-9; N-2
- **CSAC Decision: Not approved for continued endorsement**

Measure Sent Back to the Standing Committee for Reconsideration

NQF #1623 Bereaved Family Survey
Measure Worksheet | Specifications

Description: This measure calculates the proportion of Veteran decedent's family members who rate overall satisfaction with the Veteran decedent's end-of-life care in an inpatient setting as "Excellent" versus "Very Good", "Good", "Fair", or "Poor".

Numerator Statement: The numerator is composed of completed surveys (at least 12 of 17 structured items completed), in which the global item question has an optimal response. The global item question asks "Overall, how would you rate the care that [Veteran] received in the last month of life" and the possible answer choices are “Excellent”, “Very Good”, “Good”, “Fair”, or “Poor”. The optimal response is Excellent.

Denominator Statement: The denominator consists of all inpatient deaths for which a survey was completed (at least 12 of 17 structured items completed), excluding (1) deaths within 24 hours of admission (unless the Veteran had a previous hospitalization in the last month of life) and (2) deaths that occur in the ED (unless the Veteran had a prior hospitalization of at least 24 hours in the last 31 days of life). Additional exclusion criteria include the following: (1) Veterans for whom a family member knowledgeable about their care cannot be identified (determined by the family member's report) or contacted (no current contacts listed or no valid addresses on file) and (2) absence of a working telephone available and valid mailing address to the family member.

Exclusions:

- Veterans for whom a family member knowledgeable about their care cannot be identified (determined by family member’s report)
- Absence of a current address and/or working telephone number for a family member or emergency contact
- Deaths within 24 hours of admission without a prior hospitalization of last least 24 hours in the last 31 days of life
- Deaths that occur in the operating room during an outpatient procedure
- Deaths due to a suicide or accident
- Surveys in which less than 12 items were answered

Adjustment/Stratification: Statistical risk model

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital, Post-Acute Care

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: Department of Veterans Affairs (VA) / Hospice and Palliative Care

STANDING COMMITTEE MEETING 02/17/2021

The Standing Committee recommended this measure for endorsement during the fall 2019 review cycle. However, the CSAC requested that the Standing Committee reconsider the use criterion and overall suitability for endorsement during the subsequent fall 2020 review cycle. The Standing Committee did not revisit the Importance to Measure and Report criterion during the fall 2020 cycle. The summary information included in this section is abstracted from the Fall 2019 Review Cycle Technical Report.

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

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

1a. Evidence: **Rating accepted from previous review cycle (Pass)**; 1b. Performance Gap: **Total Votes: 16; H-7**; **M-9**; **L-0**; **I-0**

Rationale:

- During the prior review in 2015, the developer provided a logic model, stating that receiving a palliative care consult or dying in a hospice unit results in a greater likelihood of families rating end-of-life inpatient care as excellent. The developer included a recommendation from the 2009 version of the

Clinical Practice Guidelines for Quality Palliative Care. In addition to the guideline recommendation, the developer stated that physical symptoms, such as pain, nausea, constipation, and dyspnea, are common at end of life, and clinicians do not always recognize these symptoms or manage them appropriately. The developer stated that studies have found that providers do not communicate with patients about their healthcare preferences and that providers' treatment decisions may not be consistent with patients' preferences.

- The Standing Committee agreed that no change occurred in the evidence from the previous endorsement and agreed to accept both the decision and vote from the previous review cycle, in which the measure passed on the evidence criterion.
- The developer provided results from 2017 (n=146 VA facilities) demonstrating a 65% mean overall score, (a score ranges from 13%-100%) and an IQR of 85 and 72. The Standing Committee felt that a clear performance gap exists that warrants a national performance measure.

The Standing Committee recommended this measure for endorsement during the fall 2019 review cycle. However, the CSAC requested that the Standing Committee reconsider the use criterion and overall suitability for endorsement during the subsequent fall 2020 review cycle. Although the SMP reviewed updated testing information, the Standing Committee did not revisit the Scientific Acceptability criterion during the fall 2020 cycle. The summary information included in this section is abstracted from the Fall 2019 Review Cycle Technical Report with the exception of the fall 2020 SMP evaluation summary.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity
2a. Reliability: **Total Votes: 16; Yes -16; No -0**; 2b. Validity: **Total Votes: 16; H-2**; **M-11**; **L-2**; **I-1**
Rationale:

- The SMP reviewed and discussed this measure.
- The SMP's ratings for reliability: **H-3; M-2; L-0; I-1**
- The SMP's ratings for validity: **H-0; M-1; L-4; I-0**
- Because the SMP rated this measure low on validity, the Standing Committee deliberations began with a discussion of the SMP's rating, the rationale for that rating, and a vote on whether the Standing Committee should choose to accept that rating. Accepting the rating would have removed endorsement and ended discussion of the measure. The SMP raised two main concerns: (1) the risk adjustment model did not include sociodemographic status (SDS), particularly race/ethnicity; and (2) the beta-binomial values presented as part of the construct validity were too low. Per NQF process, the SMP may recommend discussion points to the Standing Committee regarding the use of SDS in risk adjustment models but may not fail a measure solely for this reason.
- In discussion with the Standing Committee, the developer shared that they have updated testing results demonstrating stronger beta-binomial values and strong odds ratios, and they would be happy to share this information formally during the post-meeting public comment period. The Standing Committee felt this was sufficient rationale to overturn the SMP's rating and continue discussion of the measure.
- The Standing Committee voted to overturn the SMP's validity rating and continue discussion on this subcriterion: Accept-2; Overturn-14
- The Standing Committee asked for some clarifications on the measure specifications, including the use of male pronouns in the survey, the exact scope and inclusions of the survey, and the grade level of some of the survey questions. The developer clarified that separate surveys exist for male and female

patients, each with corresponding pronouns. The developer further clarified that the measure encompasses all deaths in a VA facility (and only in a VA facility), regardless of setting of care (hospice versus intensive care). The developer noted that they offer an "unsure" option if caregivers are unsure of how to answer a question but agreed that appropriate, grade-level content is a worthy goal. The developer hopes to include more survey questions in future endorsement submissions and will review the readability.

- The Standing Committee asked the developer to elaborate on the rationale for the measure's risk adjustment model. The developer clarified that this measure is developed for use by the VA and that VA's strong preference is to not apply risk adjustment to measures. There is concern about obscuring the source of variation in measure performance. The developer noted that they felt some risk adjustment was necessary, and they had developed their model to be closely aligned with the model for NQF #2651. The Standing Committee noted that NQF #2651 does not include race/ethnicity in its risk adjustment model, yet this was not raised as a significant concern by either the SMP or the Standing Committee. The Standing Committee was satisfied with the explanation and rationale behind risk adjustment, and the discussion turned to the construct validity concern. The developer reported that they have updated testing results that show beta-binomial values of 0.13–1.57 at the facility level and odds ratios of 1.44–19.16 at the national level between the measure under review and other accepted process measures. The developer stated they will be sharing these results through the commenting process. The Standing Committee was satisfied that the measure meets the validity criterion.
- The Standing Committee noted that the SMP rated the measure high on reliability.
- The Standing Committee did not have any concerns with the measure meeting this criterion and voted unanimously to accept the SMP's rating.

[UPDATED Fall 2020 Evaluation Cycle] Scientific Methods Panel Evaluation Summary

- In 2019, CSAC members were not comfortable with the measure meeting the validity subcriterion due to the wide variation presented in the beta-binomials. The CSAC also raised concerns with the Standing Committee's decision to overturn the SMP's low rating on validity; however, the developer noted that the data evaluated by the SMP were not current. To address these issues, the SMP reviewed the measure with updated testing information provided by the developer in fall 2020. The proceeding bullets summarize the fall 2020 SMP review; the Standing Committee was not asked to reconsider and vote on reliability or validity.
- SMP members commented that reliability at the data-element level is marginal, and reliability at the measure score level is acceptable; however, the reported intraclass correlation (ICC) value of 0.04 is low. Due to the stronger findings from the measure score-level testing, SMP members passed the measure on reliability.
- The SMP's ratings for reliability: H-1; M-6; L-1; I-0 (Pass).
- To demonstrate validity of the survey item used in this measure, the developers analyzed 5 percent (randomly selected) of written responses to the following question: "Is there anything else that you would like to share about the Veteran's care during the last month of life?" These comments were categorized as positive, neutral, or negative. These categorizations were correlated with the responses from the overall rating of the care item (i.e., the item from the survey used in this measure). The Spearman correlation coefficient was 0.51; $p<0.001$.

- Using patient-level data (N=84,616) and facility-level data (N=146), the developer ran nine separate logistic/linear regressions adjusted for nonresponse bias and patient case-mix. The independent variables were the process measures, the outcome variable was the individual BFS item, and facility and patient level BFS percent rated "excellent." The developer hypothesized that receipt of each of the "best-practices" processes should result in a statistically significant higher BFS score, and the results of these analyses support the developer's hypotheses. Logistic regression analyses demonstrate statistically significant, positive associations between receipt of quality indicators and patient-level BFS performance measure scores.
- In the analysis of exclusions/missing data, a total of 16 percent of eligible decedent veterans were excluded from the measure. A total of 4 percent were excluded because they died within 24 hours of admission. The remaining excluded cases were included in a nonresponse bias analysis.
- Prior to the reporting of facility-level scores, the *BFS-Performance Measure* is adjusted for patient case-mix and survey nonresponse and is stratified by facility complexity level. The measure is risk-adjusted using five factors: (1) veteran's age at the time of death, (2) number of medical comorbidities present at the time of death, (3) veteran's primary diagnosis on last admission, (4) relationship of veteran's next-of-kin (i.e., spouse), and (5) model of administration mode (i.e., mail).
- The SMP's ratings for validity: H-0; M-7; L-0; I-1 (Pass).

The Standing Committee recommended this measure for endorsement during the fall 2019 review cycle. However, the CSAC requested that the Standing Committee reconsider the use criterion and overall suitability for endorsement during the subsequent fall 2020 review cycle. The Standing Committee did not revisit the feasibility criterion during the fall 2020 cycle. The summary information included in this section is abstracted from the Fall 2019 Review Cycle Technical Report.

3. Feasibility: Total Votes: 17; H-2; M-15; 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)

Rationale:

- Standing Committee members noted that while some of the data elements are available in the EHR, the key responses must be gathered via mail or telephone surveys. The developer stated they have been refining both procedures for gathering electronic data and survey contact procedures for more efficient survey administration.
- The Standing Committee acknowledged that the measure developer is also the measure's main user and that this should result in a very feasible measure.

The Standing Committee Recommended this measure for endorsement during the fall 2019 review cycle. However, the CSAC requested that the Standing Committee reconsider the use criterion and overall suitability for endorsement during the subsequent fall 2020 review cycle. The summary information included in this section is abstracted from the Fall 2019 Review Cycle Technical Report, followed by a summary of the fall 2020 Standing Committee reconsideration of the use criterion.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes: 16; Pass-16; No Pass-0** 4b. Usability*:* **Total Votes: 17; H-4; M-12; L-0; I-1**

Rationale:

- The Standing Committee asked NQF staff about the use criterion and asked the developer about the current use of the measure. NQF clarified that use is currently a must-pass criterion for maintenance measures such as this measure, and NQF defined *use* as publicly reported within six years of initial endorsement and use within an accountability program within three years.
- The developer reported that the measure is used for accountability across all VA facilities. They have been working to establish a plan for public reporting. For VA patients, facility choice is based almost entirely on location. Publicly reporting the survey results would not assist in choosing care.
- The developer has been working to expand use of the measure in private facilities and health systems. They are also working to report results for nursing homes where patient choice may be more available, especially since the enactment of the VA MISSION Act of 2018. This reporting would require authorization from the U.S. Secretary of VA. A Standing Committee member pointed out that veterans with Medicare coverage also have additional facility choices, and this could be a potential focus area for reporting.
- The Standing Committee was willing to accept the developer's plan for public reporting but strongly encouraged the measure to be publicly reported. The Standing Committee expects to see the measure reported when it returns for its next maintenance endorsement. The Standing Committee had no concerns about the usability of the measure.

[UPDATED Fall 2020 Evaluation Cycle] Standing Committee Reconsideration of Use

4a. Use: **Total Votes: 19; Pass-17; No Pass-2**

Rationale:

- During the fall 2019 review cycle, the CSAC raised concerns that the measure is only reported in VA sites, and if it is endorsed, it would be available for other populations that have not been previously evaluated for this measure. The developer responded by stating that public reporting of this measure is dependent on VA leadership approval; nonetheless, they are pursuing reporting for private facilities and nursing homes. The CSAC voted to overturn the Standing Committee's recommendation for continued endorsement and returned the measure to the Standing Committee for reconsideration.
- For the current review, the developer stated that performance on the measure is reported within VA as each facility/Veterans Integrated Service Networks (VISN)/VA leadership has access to all results (available via the Hospice and Palliative Care Data Dashboard link as well as housed in the VA's internal databases) in addition to the public reporting that occurs regularly in academic journals. In addition, the measure is used by VA staff when educating consumers about choice of venue for hospice care as well for accountability and quality improvement purposes. The developer also shared that the measure has been adopted at Stanford, Duke, University of California Los Angeles, and Kaiser Medical Centers.
- The Standing Committee raised a question about the performance Data Dashboard mentioned by the developer and whether it is a program related to any sort of reimbursement or other kinds of incentives. The developer responded by stating that the BFS is uploaded to the Data Dashboard every quarter and is considered a VA performance measure, which means incentives are attached to it. Facilities are incentivized for meeting the minimum of their performance measure or scoring beyond the national mean on that performance measure.

- The Standing Committee acknowledged that some progress has been made in meeting the use criterion since the last measure submission in terms of sharing the information within VA and with external academic institutions. However, concerns remained with the lack of public-facing, facility-level data to date. The Standing Committee had much discussion about the public's ability to understand whether they are choosing a facility that they would want to go to and whether the VA itself can really use the data for quality improvement at a facility level. The developer clarified that individual facilities and clinical staff and leadership in each of those facilities can access the data for quality improvement purposes. In addition, the VA has biannual calls with every single facility in the nation to review their data from the BFS. With an emphasis on quality improvement, the VA tracks scores over time nationally, regionally, and at the facility level.
- The developer is still working towards public reporting of this measure, which is dependent on the approval of VA senior leadership, with all the associated nuances of being a federal healthcare system.
- Following a robust discussion about use, the Standing Committee voted to pass the measure on this criterion.

The Standing Committee Recommended this measure for endorsement during the fall 2019 review cycle. However, the CSAC requested that the Standing Committee reconsider the use criterion and overall suitability for endorsement during the subsequent fall 2020 review cycle. The summary information included in this section is abstracted from the Fall 2019 Review Cycle Technical Report. There were no additional or related and competing measures identified during the fall 2020 review cycle.

5. **Related and Competing Measures**
   - This measure is related to NQF #2651 *CAHPS Hospice Survey.*
     - The developer stated that the populations are different for these two measures, as NQF #1623 is focused on deaths in a VA inpatient setting.

   - The Standing Committee engaged in a brief discussion of NQF #1623 and NQF #2651 as related measures. The Standing Committee felt a clear difference existed between the two measures and stated that they are different measures with different populations. The Standing Committee also felt that the differences between VA and other health systems justified different measures. Standing Committee members did identify areas such as questions about supports in which the content of the questions could be more aligned, stating that strong evidence exists regarding best practices in these areas.
6. **Standing Committee Recommendation for Endorsement**: **Y-18**; **N-1**
7. **Public and Member Comment**
   - No member or public comments were received.
8. **Consensus Standards Approval Committee (CSAC) (July 29, 2021) Vote: Y-7; N-5**
   - The CSAC co-chair expressed concern that the information provided about the measure's use is not very different from the CSAC's previous review of the measure; they also expressed concerns with the use criterion and overall suitability for endorsement. Another CSAC member shared concerns with the application of the use criterion for this measure and noted that the CSAC has increased its efforts to be consistent in the use criterion's application because it is a must-pass criterion.
   - The CSAC voted to not uphold the Standing Committee's recommendation to endorse NQF #1623 and returned it to the Standing Committee for a second reconsideration (Vote: Y-6; N-5).
   - Following the CSAC's vote, the Standing Committee co-chair noted that the measure has been a key quality metric within the health system, and the Standing Committee followed NQF's process very carefully considering the CSAC's earlier concerns when reconsidering the measure. Furthermore,

returning the measure to the Standing Committee for a second time without clear direction was believed to be counterproductive, and removing the only measure that assesses end-of-life experience from NQF's portfolio would be a consequential decision.

- Other CSAC members shared that they appreciate the intent of the measure as well as having access to the information, and public reporting from a patient's perspective is very important. Another CSAC member questioned how public reporting of important data improves care particularly related to this measure when there is no current ability to conduct a comparative analysis with the patient experience of veterans.
- Due to the additional discussion from the CSAC and the Standing Committee co-chair after the initial vote, the CSAC voted on NQF #1623 a second time and did not uphold the Standing Committee's recommendation (Vote: Y-7; N-5) and returned the measure to the Standing Committee in a future cycle for reconsideration of public reporting within the use criterion. As a maintenance measure, NQF #1623 will retain endorsement until the reconsideration is complete.

Appendix B: Geriatrics and Palliative Care Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized or Implemented as of February 8, 2021
0167	Improvement in Ambulation and Locomotion	None
0174	Improvement in Bathing	None
0175	Improvement in Bed Transferring	None
0176	Improvement in Management of Oral Medications	Home Health Quality Reporting (Implemented)
0177	Improvement in Pain Interfering With Activity	Home Health Quality Reporting (Implemented)
0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with #0384)	Prospective Payment System-Exempt Cancer Hospital Quality Reporting (Implemented) Merit-Based Incentive Payment System (MIPS) Program (Implemented)
0384	Oncology: Medical and Radiation – Pain Intensity Quantified (paired with #0383)	Merit-Based Incentive Payment System (MIPS) Program (Implemented)
0420	Pain Assessment and Follow-Up	None
1617	Patients Treated With an Opioid Who Are Given a Bowel Regimen	Hospice Quality Reporting (Implemented)
1628	Patients With Advanced Cancer Screened for Pain at Outpatient Visits	None
1634	Hospice and Palliative Care — Pain Screening	Hospice Quality Reporting (Implemented)
1637	Hospice and Palliative Care — Pain Assessment	Hospice Quality Reporting (Implemented)
1638	Hospice and Palliative Care — Dyspnea Treatment	Hospice Quality Reporting (Implemented)
1639	Hospice and Palliative Care — Dyspnea Screening	Hospice Quality Reporting (Implemented)
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	Hospice Quality Reporting (Implemented)
1626	Patients Admitted to ICU Who Have Care Preferences Documented	None

NQF #	Title	Federal Programs: Finalized or Implemented as of February 8, 2021
1641	Hospice and Palliative Care – Treatment Preferences	Hospice Quality Reporting (Implemented)
0210	Proportion Receiving Chemotherapy in the Last 14 Days of Life	Merit-Based Incentive Payment System (MIPS) Program (Implemented) Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Implemented)
0213	Proportion Admitted to the ICU in the Last 30 Days of Life	Merit-Based Incentive Payment System (MIPS) Program (Implemented) Care Compare (Finalized) Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Implemented)
0215	Proportion Not Admitted to Hospice	Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Implemented)
0216	Proportion Admitted to Hospice for Less Than Three Days	Merit-Based Incentive Payment System (MIPS) Program (Implemented) Prospective Payment System – Exempt Cancer Hospital Quality Reporting: (Implemented)
1623	Bereaved Family Survey	None
1625	Hospitalized Patients Who Die an Expected Death With an ICD That Has Been Deactivated	None
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)	Hospice Quality Reporting (Implemented)
3235	Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	Hospice Quality Reporting (Implemented)

Appendix C: Geriatrics and Palliative Care Standing Committee and NQF Staff

STANDING COMMITTEE

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Appendix D: Measure Specifications

NQF #0326 Advance Care Plan

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

TYPE

Process

DATA SOURCE

Claims None

LEVEL

Clinician : Group/Practice

SETTING

Outpatient Services

NUMERATOR STATEMENT

Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

NUMERATOR DETAILS

Report the CPT Category II codes designated for this numerator:

- 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record
- 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
- Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient´s beliefs and thus harmful to the physician-patient relationship.
- NUMERATOR NOTE: The CPT Category II codes used for this measure indicate: Advance Care Planning was discussed and documented. The act of using the Category II codes on a claim indicates the provider confirmed that the Advance Care Plan was in the medical record (that is, at the point in time the code was assigned, the Advance Care Plan in the medical record was valid) or that advance

care planning was discussed. The codes are required annually to ensure that the provider either confirms annually that the plan in the medical record is still appropriate or starts a new discussion.

- The provider does not need to review the Advance Care Plan annually with the patient to meet the numerator criteria, documentation of a previously developed advanced care plan that is still valid in the medical record meets numerator criteria.
- Services typically provided under CPT codes 99497 and 99498 satisfy the requirement of Advance Care Planning discussed and documented minutes. If a patient received these types of services, submit CPT II 1123F or 1124F.

DENOMINATOR STATEMENT

All patients aged 65 years and older.

DENOMINATOR DETAILS

Denominator Criteria (Eligible Cases):

Patients aged > 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

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

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

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

Step 2: Determine number of patients meeting the in Question S.7. above.

Step 3: Determine the number of patients who meet the numerator criteria as specified in Question S.5. above. The numerator includes all patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan

was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2. 123834| 140881| 135810

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NQF #1623 Bereaved Family Survey

STEWARD

Department of Veterans Affairs / Hospice and Palliative Care

DESCRIPTION

This measure calculates the proportion of Veteran decedent's family members who rate overall satisfaction with the Veteran decedent's end-of-life care in an inpatient setting as "Excellent" versus "Very good", "good", "fair", or "poor".

TYPE

Outcome: PRO-PM

DATA SOURCE

Instrument-Based Data For 2a1.25 - Family reported data/survey.

For 2a1.26 - Bereaved Family Survey

LEVEL

Facility, Other

SETTING

Inpatient/Hospital, Post-Acute Care

NUMERATOR STATEMENT

The numerator is comprised of completed surveys (at least 12 of 17 structured items completed), where the global item question has an optimal response. The global item question asks "Overall, how would your rate the care that [Veteran] received in the last month of life" and the possible answer choices are: Excellent, Very good, Good, Fair, or Poor. The optimal response is Excellent.

NUMERATOR DETAILS

Included are those patients included in the denominator with completed surveys (at least 12 of 17 structured items completed) that receive an optimal response on the global item quesstion.

DENOMINATOR STATEMENT

The denominator consists of all inpatient deaths for which a survey was completed (at least 12 of 17 structured items completed), excluding: 1) deaths within 24 hours of admission (unless the Veteran had a previous hospitalization in the last month of life); 2) deaths that occur in the Emergency Department (unless the Veteran had a prior hospitalization of at least 24 hours in the last 31 days of life); Additional exclusion criteria include: 1) Veterans for whom a family member knowledgeable about their care cannot be identified (determined by the family member's report); or contacted (no current contacts listed or no valid addresses on file); 2) absence of a working telephone available and valid mailing address to the family member.

DENOMINATOR DETAILS

The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-ended and give family members the opportunity to provide comments regarding the care the patient received.

A growing body of research has underscored the degree to which end-of-life care in the United States needs to be improved. The challenges of end-of-life care are particularly significant in the U.S. Department of Veterans Affairs Health Care system because he VA provides care for an increasingly older population with multiple comorbid conditions. In FY2000, approximately 104,000 enrolled Veterans died in the U.S., and approximately 27,200 Veterans died in VA facilities. At least 30% of the Veterans are over age 65 now, and 46% will be over 65 by 2030. Therefore, it is clear that the number of deaths in VA facilities will increase substantially as the World War II and Korean War Veterans age. These demographic trends mean that, like other healthcare systems, the VA will face substantial challenges of providing care to Veterans near the end-of-life.

The VA has addressed this challenge aggressively in the last 5 year, however the VA has not yet developed and implemented measures of the quality of end-of-life care it provides to Veterans. There are at least 3 reasons why adoption of a quality measurement tool is essential. First, it would make it possible to define and compare the quality of end-of-life care at each VA facility and to identify opportunities for improvement. Second, facilities and VISNs (geographic service divisions within the VA system) would be able to monitor the effectiveness of efforts to improve care locally and nationally, and would enable monitoring of the impact of the Comprehensive End of Life Care Initiative, ensuring that expenditures are producing improvements in care. Third, it will help the VA to recognize those facilities that provide outstanding end-of-life care, so that successful processes and structures of care can be identified and disseminated throughout the VA.

The BFS's 17 close-ended items ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support, pain management and personal care needs. Two addditional items (not used in scoring) are open-ended and give family members the opportunity to provide comments regarding the care the patient received. The BFS has undergone extensive development and has been

pilot-tested for all inpatient deaths in Q4FY2008 in seven VISNs (1,2,4,5,8,11, and 22). As of October 1, 2009, Q1FY2010, all inpatient deaths in all VISNs were included in the project.

The indicator denominator is comprised of the number of Veterans who die in an inpatient VA facility (intensive care, acute care, hospice unit, nusing home care or community living center) for whom a survey is completed. Completed surveys are defined as those with at least 12 of the 17 structured items completed.

EXCLUSIONS

- Veterans for whom a family member knowledgeable about their care cannot be identified (determined by family member's report)
- Absence of a current address and/or working telephone number for a family member or emergency contact.
- Deaths within 24 hours of admission without a prior hospitalization of last least 24 hours in the last 31 days of life.
- Deaths that occur in the operating room during an outpatient procedure.
- Deaths due to a suicide or accident
- Surveys in which less than 12 items were answered.

EXCLUSION DETAILS

Name, address, and phone number of patient's family member or emergency contact are required for determining exclusion. In addition, information regarding the patient's admission(s) during the last 31 days of life, and including length of stay are also required to determine exclusion.

RISK ADJUSTMENT

Statistical risk model

STRATIFICATION

Variables necessary to stratify the measure are VISN, facility, quarter, year, outcome. VISN refers to "Veterans Integrated Service Network" and is a geographic area of the country where a facility is located. Facility is the actual VA medical center or affiliated community living center where the Veteran died. Quarter is the 3 month time period in which the patient died. Year is the VA fiscal year (runs from Oct 1 to Sept 30). Outcome refers to whether or not a survey was completed.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-

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The VA has addressed this challenge aggressively in the last 5 year, however the VA has not yet developed and implemented measures of the quality of end-of-life care it provides to Veterans. There are at least 3 reasons why adoption of a quality measurement tool is essential. First, it would make it possible to define and compare the quality of end-of-life care at each VA facility and to identify opportunities for improvement. Second, facilities and VISNs (geographic service divisions within the VA system) would be able to monitor the effectiveness of efforts to improve care locally and nationally, and would enable monitoring of the impact of the Comprehensive End of Life Care Initiative, ensuring that expenditures are producing improvements in care. Third, it will help the VA to recognize those facilities that provide outstanding end-of-life care, so that successful processes and structures of care can be identified and disseminated throughout the VA.

The BFS's 17 close-ended items ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support, pain management and personal care needs. Two addditional items (not used in scoring) are open-ended and give family members the opportunity to provide comments regarding the care the patient received. The BFS has undergone extensive development and has been pilot-tested for all inpatient deaths in Q4FY2008 in seven VISNs (1,2,4,5,8,11, and 22). As of October 1, 2009, Q1FY2010, all inpatient deaths in all VISNs were included in the project.

The 17 structured items of the Bereaved Family Survey are scored as either "1" (optimal response) or "0" (all other answer choices). A score of "1" indicates that the family member perceived that the care they and/or the Veteran received was the best possible care (Excellent). A score of "0" reflects all other possible responses (Very good, Good, Fair, Poor). Items are coded as missing if respondents cannot or refuse to answer the item. Thus, the score for each item can be expressed as a fraction corresponding to the number of families who reported that the Veteran received optimal care (numerator), divided by the number of valid, non-missing responses for that item (denominator). Similarly, the score for the 17-item survey is calculated based on the global question item (Overall, how would you rate the care received in the last month of life? - Excellent, Very Good, Good, Fair, Poor). The global item is scored as the # of optimal responses/# of valid, non missing responses for all completed surveys (12 of 17 structured items answered). This scoring system produces a facility- or VISN-level score that reflects the proportion of Veterans who received the best possible care overall (BFS score) and in specific areas corresponding to BFS items (e.g. pain management, communication, personal care, etc).

We then add nonresponse and patient case mix weights to the model. All adjusted scores are reported.
122841| 146971| 135548| 118571

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

STEWARD

Centers for Medicare & 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.

LEVEL

Facility

SETTING

Other 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
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 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

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 of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100. 144877| 141015| 147894| 147981| 140646| 151025| 152468| 152554| 152665| 150289| 151817| 137428

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Appendix E: Related and Competing Measures

Comparison of NQF #3235, #1634, #1637, #1639, #1638, #1617, #1641 and #1647

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

#1634 Hospice and Palliative Care – Pain Screening

#1637 Hospice and Palliative Care – Pain Assessment

#1639 Hospice and Palliative Care – Dyspnea Screening

#1638 Hospice and Palliative Care – Dyspnea Treatment

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

#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

#3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission
Centers for Medicare & Medicaid Services

#1634 Hospice and Palliative Care – Pain Screening
University of North Carolina-Chapel Hill

#1637 Hospice and Palliative Care – Pain Assessment
University of North Carolina-Chapel Hill

#1639 Hospice and Palliative Care – Dyspnea Screening
University of North Carolina-Chapel Hill

#1638 Hospice and Palliative Care – Dyspnea Treatment
University of North Carolina-Chapel Hill

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen
RAND Corporation/UCLA

#1641 Hospice and Palliative Care – Treatment Preferences
University of North Carolina-Chapel Hill

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

Description

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

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.

#1634 Hospice and Palliative Care – Pain Screening

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

#1637 Hospice and Palliative Care – Pain Assessment

This quality measure is defined as:

Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

#1639 Hospice and Palliative Care – Dyspnea Screening

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

#1638 Hospice and Palliative Care – Dyspnea Treatment

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

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed

#1641 Hospice and Palliative Care – Treatment Preferences

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

#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

This measure reflects the percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver/family did not want to discuss.

Type

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

Composite

#1634 Hospice and Palliative Care – Pain Screening

Process

#1637 Hospice and Palliative Care – Pain Assessment

Process

#1639 Hospice and Palliative Care – Dyspnea Screening

Process

#1638 Hospice and Palliative Care – Dyspnea Treatment

Process

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Process

#1641 Hospice and Palliative Care – Treatment Preferences

Process

#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

Process

Data Source

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

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.

#1634 Hospice and Palliative Care – Pain Screening

Electronic Health Records, 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.

#1637 Hospice and Palliative Care – Pain Assessment

Electronic Health Records, 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.

#1639 Hospice and Palliative Care – Dyspnea Screening

Electronic Health Records, 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 denominator and numerator data

#1638 Hospice and Palliative Care – Dyspnea Treatment

Electronic Health Records, 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 denominator and numerator data

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Electronic Health Records, Paper Medical Records Medical record abstraction tool

#1641 Hospice and Palliative Care – Treatment Preferences

Electronic Health Records, 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 denominator and numerator data

#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

Electronic Health Records, Other The Hospice Item Set (HIS) is the data source used to calculate the quality measure.

Level

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

Facility

#1634 Hospice and Palliative Care – Pain Screening

Facility, Clinician : Group/Practice

#1637 Hospice and Palliative Care – Pain Assessment

Facility, Clinician : Group/Practice

#1639 Hospice and Palliative Care – Dyspnea Screening

Facility, Clinician : Group/Practice

#1638 Hospice and Palliative Care – Dyspnea Treatment

Facility, Clinician : Group/Practice

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual

#1641 Hospice and Palliative Care – Treatment Preferences

Facility, Clinician : Group/Practice

#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

Facility

Setting

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

Other Hospice

#1634 Hospice and Palliative Care – Pain Screening

Home Care, Inpatient/Hospital

#1637 Hospice and Palliative Care – Pain Assessment

Home Care, Inpatient/Hospital

#1639 Hospice and Palliative Care – Dyspnea Screening

Home Care, Inpatient/Hospital

#1638 Hospice and Palliative Care – Dyspnea Treatment

Home Care, Inpatient/Hospital

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Home Care, Inpatient/Hospital, Outpatient Services

#1641 Hospice and Palliative Care – Treatment Preferences

Home Care, Inpatient/Hospital

#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

Home Care

Numerator Statement

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

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.

#1634 Hospice and Palliative Care – Pain Screening

Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.

#1637 Hospice and Palliative Care – Pain Assessment

Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.

#1639 Hospice and Palliative Care – Dyspnea 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.

#1638 Hospice and Palliative Care – Dyspnea Treatment

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

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

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

#1641 Hospice and Palliative Care – Treatment Preferences

Patients whose medical record includes documentation of life sustaining 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

Patients whose medical record includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.

Numerator Details

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

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
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 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.

#1634 Hospice and Palliative Care – Pain Screening

Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized tool during the admission evaluation for hospice / initial encounter for hospital-based palliative care. Screening may be completed using verbal, numeric, visual analog, rating scales designed for use the non-verbal patients, or other standardized tools.

#1637 Hospice and Palliative Care – Pain Assessment

Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life.

#1639 Hospice and Palliative Care – Dyspnea Screening

Patients who are screened for the presence or absence of dyspnea during the admission evaluation for hospice / initial encounter for hospital-based palliative care, and asked to rate its severity. Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients.

#1638 Hospice and Palliative Care – Dyspnea Treatment

Treatment is administered if within 24 hours of the positive screen for dyspnea, medical treatment plan, orders or pharmacy records show inhaled medications, steroids, diuretics, or non-medication strategies such as oxygen and energy conservation. Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

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.

#1641 Hospice and Palliative Care – Treatment Preferences

Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or

hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as "Full Code" or "DNR/DNI" do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.

#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

Examples of a discussion may include asking about patient's need for spiritual or religious support, questions about the cause or meaning of illness or death. Other examples include discussion of God or a higher power related to illness, or offer of a spiritual resource including a chaplain. Discussion of spiritual or religious concerns may occur between patient and/or family and clergy or pastoral worker or patient and/or family and member of the interdisciplinary team.

This item is meant to capture evidence of discussion and communication. Therefore, documentation of patient's religious or spiritual affiliation by itself does not count for inclusion in numerator.

Data are collected via chart review. Criteria are:

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

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

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

Denominator Statement

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

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

#1634 Hospice and Palliative Care – Pain Screening

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

#1637 Hospice and Palliative Care – Pain Assessment

Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation / initial encounter.

#1639 Hospice and Palliative Care – Dyspnea Screening

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

#1638 Hospice and Palliative Care – Dyspnea Treatment

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

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Vulnerable adults who are given a prescription for an opioid

#1641 Hospice and Palliative Care – Treatment Preferences

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

#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

Seriously ill patients 18 years of age or older enrolled in hospice.

Denominator Details

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

The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.

#1634 Hospice and Palliative Care – Pain Screening

The Pain Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

[NOTE: This quality measure should be paired with the Pain Assessment quality measure (NQF ##1637) to ensure that all patients who report significant pain are clinically assessed.]

#1637 Hospice and Palliative Care – Pain Assessment

The Pain Assessment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number >0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care.

For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted in screening (response of moderate or severe on verbal scale, >4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator.

[NOTE: This quality measure should be paired with the Pain Screening quality measure (NQF ##1634) to ensure that all patients are screened and therefore given the opportunity to report pain and enter the denominator population for Pain Assessment.]

#1639 Hospice and Palliative Care – Dyspnea Screening

The Dyspnea Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

[NOTE: This quality measure should be paired with the Dyspnea Treatment quality measure (NQF ##1639) to ensure that all patients who report dyspnea are clinically considered for treatment.]

#1638 Hospice and Palliative Care – Dyspnea Treatment

The Dyspnea Treatment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

For patients enrolled in hospice or palliative care, a positive screen is indicated by any dyspnea noted as other than none on a verbal screen, any number > 0 on a numeric scale or any observational or self-report of dyspnea.

[NOTE: This quality measure should be paired with the Dyspnea Screening quality measure (NQF ##1639) to ensure that all patients are screened and therefore given the opportunity to report dyspnea and enter the denominator population for Dyspnea Treatment.]

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

All vulnerable adults >17 years old prescribed an opioid as:

- An inpatient
- A hospice patient (inpatient or outpatient)
- A non-hospice outpatient in patients who are not already taking an opioid
- "Vulnerable" is defined as any of the following:
- >74 years of age
- Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001)
- Poor prognosis/terminal illness defined as life expectancy of <6 months
- Stage IV cancer
- Patients receiving hospice care in any setting
- Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699

#1641 Hospice and Palliative Care – Treatment Preferences

The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary

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

#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

This quality measure is intended for patients with serious illness who are enrolled in hospice care. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

Exclusions

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

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).

#1634 Hospice and Palliative Care – Pain Screening

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

#1637 Hospice and Palliative Care – Pain Assessment

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

#1639 Hospice and Palliative Care – Dyspnea Screening

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

#1638 Hospice and Palliative Care – Dyspnea Treatment

Patients with length of stay < 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

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

#1641 Hospice and Palliative Care – Treatment Preferences

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

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

Exclusion Details

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

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)

#1634 Hospice and Palliative Care – Pain Screening

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

#1637 Hospice and Palliative Care – Pain Assessment

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

#1639 Hospice and Palliative Care – Dyspnea Screening

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

#1638 Hospice and Palliative Care – Dyspnea Treatment

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

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Patients who are prescribed an opioid in the outpatient setting are excluded if they are NOT hospice patients AND at the time of the opioid prescription that occurred during the study period, they were already taking an opioid. This exclusion does NOT apply to inpatients or to hospice patients treated in any setting. Non-hospice outpatients who are prescribed an opioid who may have been on an opioid in the past, but are not taking an opioid at the time of the study period opioid prescription are NOT excluded.

#1641 Hospice and Palliative Care – Treatment Preferences

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

#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

N/A

Risk Adjustment

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

No risk adjustment or risk stratification

#1634 Hospice and Palliative Care – Pain Screening

No risk adjustment or risk stratification

#1637 Hospice and Palliative Care – Pain Assessment

No risk adjustment or risk stratification

#1639 Hospice and Palliative Care – Dyspnea Screening

No risk adjustment or risk stratification

#1638 Hospice and Palliative Care – Dyspnea Treatment

No risk adjustment or risk stratification

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

No risk adjustment or risk stratification

#1641 Hospice and Palliative Care – Treatment Preferences

No risk adjustment or risk stratification

#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

No risk adjustment or risk stratification

Stratification

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

N/A

#1634 Hospice and Palliative Care – Pain Screening

N/A

#1637 Hospice and Palliative Care – Pain Assessment

N/A

#1639 Hospice and Palliative Care – Dyspnea Screening

N/A

#1638 Hospice and Palliative Care – Dyspnea Treatment

N/A

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

N/A

#1641 Hospice and Palliative Care – Treatment Preferences

N/A

#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

N/A

Type Score

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

Rate/proportion better quality = higher score

#1634 Hospice and Palliative Care – Pain Screening

Rate/proportion better quality = higher score

#1637 Hospice and Palliative Care – Pain Assessment

Rate/proportion better quality = higher score

#1639 Hospice and Palliative Care – Dyspnea Screening

Rate/proportion better quality = higher score

#1638 Hospice and Palliative Care – Dyspnea Treatment

Rate/proportion better quality = higher score

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Rate/proportion better quality = higher score

#1641 Hospice and Palliative Care – Treatment Preferences

Rate/proportion better quality = higher score

#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

Rate/proportion better quality = higher score

Algorithm

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

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. 144877| 141015| 147894| 147981| 140646| 151025| 152468| 152554| 152665| 150289| 151817| 137428

#1634 Hospice and Palliative Care – Pain Screening

Screened for pain:

a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting.

b. Step 2- Exclude palliative care patients if length of stay is < 1 day.

c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) using a standardized tool.

Quality Measure =

Numerator: Patients screened for pain in Step 3 / Denominator: Patients in Step 1-Patients excluded in Step 2 123213| 129544| 137428

#1637 Hospice and Palliative Care – Pain Assessment

Clinical assessment of Pain:

a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting

b. Step 2- Exclude palliative care patients if length of stay is < 1 day.

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

d. Step 4- Identify patients who screened positive for pain [any pain if hospice; moderate or severe pain if palliative care].

e. Step 5- Exclude patients who screened negative for pain

f. Step 6- Identify patients who received a clinical assessment for pain within 24 hours of screening positive for pain

Quality Measure= Numerator: Patients who received a clinical assessment for pain in Step 6 / Denominator: Patients in Step 4 123213| 129544| 137428

#1639 Hospice and Palliative Care – Dyspnea Screening

Screened for dyspnea:

a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice care or who receive specialty palliative care in an acute hospital setting

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

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

Quality measure = Numerator: Patients screened for dyspnea in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 123213| 129544| 137428

#1638 Hospice and Palliative Care – Dyspnea Treatment

Dyspnea treatment:

a. Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care

b. Step 2- Identify admission evaluation / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days

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

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

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

Quality Measure= Numerator: Patients who received treatment for dyspnea in Step 5 / Denominator: Patients in Step 4 123213| 129544| 137428

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

Note that edits placed in brackets []

1. Identify vulnerable adults with a prescription for an opioid. For inpatients, identify ALL patients with an order for [standing (not prn)] opioid treatment on admission or during the hospitalization. For hospice patients, identify ALL patients with an order for opioid treatment on admission or during the episode of hospice care. For outpatient non-hospice patients, identify patients with a "new" prescription for an opioid. "New" prescription for a non-hospice outpatient means that the patient is not already taking an opioid.
2. Include only patients who are vulnerable (age >74, VES-13 score >2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care).
3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 113885| 136569| 110832| 141057| 137428| 151025| 152468

#1641 Hospice and Palliative Care – Treatment Preferences

Chart documentation of life sustaining preferences:

a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital
b. Step 2- Exclude patients if length of stay is < 1 day.
c. Step 3- Identify patients with documented discussion of preference for life sustaining treatments.

Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 123213| 129544| 137428

#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

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| 137428

Submission Items

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

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

N/A

#1634 Hospice and Palliative Care – Pain Screening

5.1 Identified measures: No

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

This measure was part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle.

This measure has been harmonized with ACOVE / ASSIST Measure 1628: Patients with advanced cancer screened for pain at outpatient visits. The two measures have the same focus, populations are different (although both include patients with advanced cancer), apply in different settings with different timing.

#1637 Hospice and Palliative Care – Pain Assessment

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

This measure was part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle.

#1639 Hospice and Palliative Care – Dyspnea Screening

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

This measure was part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle.

#1638 Hospice and Palliative Care – Dyspnea Treatment

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

This measure was part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle.

#1617 Patients Treated With an Opioid Who Are Given a Bowel Regimen

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

This measure was part of the National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover

letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided.

#1641 Hospice and Palliative Care – Treatment Preferences

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

This measure was part of the NPCRC Key Palliative Care Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Care Measures Bundle.

#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

5.1 Identified measures: No

5a.1 Are specs completely harmonized? N/A

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value:

No known competing measures exist.

Comparison of NQF #1623 and NQF #2651

#1623 Bereaved Family Survey

#2651 CAHPS® Hospice Survey (Experience With Care)

Steward

#1623 Bereaved Family Survey

Department of Veterans Affairs / Hospice and Palliative Care

#2651 CAHPS® Hospice Survey (Experience With Care)

Centers for Medicare and Medicaid Services

Description

#1623 Bereaved Family Survey

This measure calculates the proportion of Veteran decedent's family members who rate overall satisfaction with the Veteran decedent's end-of-life care in an inpatient setting as "Excellent" versus "Very good", "good", "fair", or "poor".

#2651 CAHPS® Hospice Survey (Experience With Care)

The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. The survey is intended to measure the care experiences of hospice patients and their primary caregivers. Respondents to the survey are the primary informal caregivers of patients who died under hospice care. These are typically family members but can be friends. The hospice identifies the primary informal caregiver from their administrative records. Data collection for

sampled decedents/caregivers is initiated two months following the month of the decedent's death.

The publicly reported measures described here include the following six multi-item measures.

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms
- Getting Hospice Training
- In addition, there are two global rating items that are publicly-reported measures.
- Rating of the hospice care
- Willingness to recommend the hospice

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

List of CAHPS Hospice Survey Measures

Multi-Item Measures

Hospice Team Communication (Composed of 6 items)

- While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member?
- While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?
- How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?
- While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?
- While your family member was in hospice care, how often did the hospice team listen carefully to you?
- While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care?

Getting Timely Care (Composed of 2 items)

- While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?
- How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?
- Treating Family Member with Respect (Composed of 2 items)
- While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?

- While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?
- Providing Emotional Support (Composed of 3 items)
- While your family member was in hospice care, how much emotional support did you get from the hospice team?
- In the weeks after your family member died, how much emotional support did you get from the hospice team?
- Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?

Getting Help for Symptoms (Composed of 4 items)

- Did your family member get as much help with pain as he or she needed?
- How often did your family member get the help he or she needed for trouble breathing?
- How often did your family member get the help he or she needed for trouble with constipation?
- How often did your family member receive the help he or she needed from the hospice team for feelings of anxiety or sadness?

Getting Hospice Care Training (Composed of 5 items)

- Did the hospice team give you enough training about what side effects to watch for from pain medicine?
- Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?
- Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?
- Did the hospice team give you the training you needed about what to do if your family member became restless or agitated?
- Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with your or your family member?

Global Rating Measures:

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

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

The CAHPS Hospice Survey is part of the CAHPS family of experience of care surveys. English and other translations of the survey are available here. CMS initiated national implementation of the CAHPS Hospice Survey in 2015. Hospices meeting CMS eligibility criteria were required to administer the survey for a "dry run" for at least one month of sample from the first quarter of 2015. Beginning with the second quarter of 2015, hospices are required to participate on an ongoing monthly basis in order to receive their full Annual Payment Update from CMS. Information regarding survey content and national implementation requirements, including the latest versions of the survey instrument and standardized protocols for data collection and submission, are available here. Public reporting of the survey-based measures on Hospice Compare started in February 2018 (www.medicare.gov Choose find hospice care)

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

Type

#1623 Bereaved Family Survey

Outcome: PRO-PM

#2651 CAHPS® Hospice Survey (Experience With Care)

Outcome: PRO-PM

Data Source

#1623 Bereaved Family Survey

Instrument-Based Data For 2a1.25 - Family reported data/survey.

For 2a1.26 - Bereaved Family Survey

Available in attached appendix at A.1 No data dictionary

#2651 CAHPS® Hospice Survey (Experience With Care)

Instrument-Based Data CAHPS Hospice Survey; please see S.16 for information regarding modes of data collection. The survey instrument is available in English, Spanish, Chinese, Russian, Portuguese, Vietnamese, Polish and Korean.

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

Level

#1623 Bereaved Family Survey

Facility, Other

#2651 CAHPS® Hospice Survey (Experience With Care)

Facility

Setting

#1623 Bereaved Family Survey

Inpatient/Hospital, Post-Acute Care

#2651 CAHPS® Hospice Survey (Experience With Care)

Other

Numerator Statement

#1623 Bereaved Family Survey

The numerator is comprised of completed surveys (at least 12 of 17 structured items completed), where the global item question has an optimal response. The global item question asks "Overall, how would your rate the care that [Veteran] received in the last month of life" and the possible answer choices are: Excellent, Very good, Good, Fair, or Poor. The optimal response is Excellent.

#2651 CAHPS® Hospice Survey (Experience With Care)

CMS calculates CAHPS Hospice Survey measure scores using top-, middle- and bottom- box scoring. The top-box score refers to the percentage of caregiver respondents that give the most positive response(s). The bottom box score refers to the percentage of caregiver respondents that give the least positive response(s). The middle box is the proportion remaining after the top and bottom boxes have been calculated; see below for details. Details regarding the definition of most and least positive response(s) are noted in Section S.5 below.

Numerator Details

#1623 Bereaved Family Survey

Included are those patients included in the denominator with completed surveys (at least 12 of 17 structured items completed) that receive an optimal response on the global item quesstion.

#2651 CAHPS® Hospice Survey (Experience With Care)

- For each survey item, the top and bottom box numerators are the number of respondents who selected the most and least positive response category(ies), respectively, as follows:
- For items using a “Never/Sometimes/Usually/Always” response scale, the top box numerator is the number of respondents who answer “Always” and the bottom box numerator is the number of respondents who answer “Never” or “Sometimes.” The one exception to this guidance is for the Q10 “While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member’s condition or care?” For this item, the top box numerator is the number of respondents who answer “Never” and the bottom box numerator is the number of respondents who answer “Always” or “Usually.”
- For items using a “Yes, definitely/Yes, somewhat/No” response scale, the top box numerator is the number of respondents who answer “Yes, definitely” and the bottom box numerator is the number of respondents who answer “No.”
- For items using a “Too Little/Right Amount/Too Much” response scale, the top box numerator is the number of respondents who answer “Right Amount” and the bottom box numerator is the number of respondents who answer “Too little” or “Too much.” (There is no middle box for items using this response scale.)
- The top box numerator for the Rating of Hospice item is the number of respondents who answer 9 or 10 for the item (on a scale of 0 to 10, where 10 is the “Best Hospice Care Possible”); the bottom box numerator is the number of respondents who answer 0 to 6.

- The top box numerator for the Willingness to Recommend item is the number of respondents who answer “Definitely Yes” (on a scale of “Definitely No/Probably No/Probably Yes/Definitely Yes”); the bottom box numerator is the number of respondents who answer “Probably No” or “Definitely No.”
- Calculation of hospice-level multi-item measures
- Score each item using top- box method, possible values of 0 or 100
- Calculate mode- adjusted scores for each item for each respondent
- Calculate case-mix adjusted scores for each item for each hospice
- Take the unweighted means of the mode- and case-mix-adjusted hospice-level items to form multi-item measures
- Here is an example of calculations for the measure “Getting Timely Care.”
- Score each item using top box method, possible values of 0 or 100
- Both items in “Getting Care Quickly” have four response options: Never, Sometimes, Usually, Always. Recode each item as 100 for “Always” and 0 for “Never”, “Sometimes”, or “Usually”.
- Item #1. While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?
- Item #2. How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?
- Calculate mode-adjusted scores for each item for each respondent
- Calculate case-mix adjusted scores for each item for each hospice
- Each item is case mix adjusted separately; this step produces case-mix adjusted item-level scores for each hospice.
- Take the unweighted means of the case-mix adjusted hospice-level items to form multi-item measures.
- If the case-mix adjusted scores for a hospice are 95 for item #1 and 90 for item #2, then the hospice-level ‘Getting Timely Care’ would be calculated as (Item1 + Item2) / 2 = (95 + 90) / 2 = 92.5.

Denominator Statement

#1623 Bereaved Family Survey

- The denominator consists of all inpatient deaths for which a survey was completed (at least 12 of 17 structured items completed), excluding:
- deaths within 24 hours of admission (unless the Veteran had a previous hospitalization in the last month of life);
- deaths that occur in the Emergency Department (unless the Veteran had a prior hospitalization of at least 24 hours in the last 31 days of life); Additional exclusion criteria include:
- Veterans for whom a family member knowledgeable about their care cannot be identified (determined by the family member's report); or contacted (no current contacts listed or no valid addresses on file);
- absence of a working telephone available to the family member.

#2651 CAHPS® Hospice Survey (Experience With Care)

- CAHPS® Hospice Survey measure scores are calculated only for hospices that had at least 30 completed questionnaires over the most recent eight quarters of data collection.
- The target population for the survey are the adult primary caregivers of hospice decedents. Respondent eligibility and exclusions are defined in detail in the sections that follow. A survey is defined as completed when at least 50 percent of the questions applicable to all decedents/caregivers are answered (Questions 1 – 4, 6 – 13, 15, 17, 21, 24, 26, 28, 30 – 32, and 35 47). The survey uses screener questions to identify respondents eligible to respond to subsequent items. Therefore, denominators vary by survey item (and corresponding multi-item measures, if applicable) according to the eligibility of respondents for each item. In addition, for the Getting Hospice Care Training measure, scores are calculated only among those respondents who indicate that their family member received hospice care at home or in an assisted living facility.

Denominator Details

#1623 Bereaved Family Survey

- The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.
- Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-ended and give family members the opportunity to provide comments regarding the care the patient received.
- A growing body of research has underscored the degree to which end-of-life care in the United States needs to be improved. The challenges of end-of-life care are particularly significant in the U.S. Department of Veterans Affairs Health Care system because he VA provides care for an increasingly older population with multiple comorbid conditions. In FY2000, approximately 104,000 enrolled Veterans died in the U.S., and approximately 27,200 Veterans died in VA facilities. At least 30% of the Veterans are over age 65 now, and 46% will be over 65 by 2030. Therefore, it is clear that the number of deaths in VA facilities will increase substantially as the World War II and Korean War Veterans age. These demographic trends mean that, like other healthcare systems, the VA will face substantial challenges of providing care to Veterans near the end-of-life.
- The VA has addressed this challenge aggressively in the last 5 year, however the VA has not yet developed and implemented measures of the quality of end-of-life care it provides to Veterans. There are at least 3 reasons why adoption of a quality measurement tool is essential. First, it would make it possible to define and compare the quality of end-of-life care at each VA facility and to identify opportunities for improvement. Second, facilities and VISNs (geographic service divisions within the VA system) would be able to monitor the effectiveness of efforts to improve care locally and nationally, and would enable monitoring

of the impact of the Comprehensive End of Life Care Initiative, ensuring that expenditures are producing improvements in care. Third, it will help the VA to recognize those facilities that provide outstanding end-of-life care, so that successful processes and structures of care can be identified and disseminated throughout the VA.

- The BFS's 17 close-ended items ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support, pain management and personal care needs. Two addditional items (not used in scoring) are open-ended and give family members the opportunity to provide comments regarding the care the patient received. The BFS has undergone extensive development and has been pilot-tested for all inpatient deaths in Q4FY2008 in seven VISNs (1,2,4,5,8,11, and 22). As of October 1, 2009, Q1FY2010, all inpatient deaths in all VISNs were included in the project.
- The indicator denominator is comprised of the number of Veterans who die in an inpatient VA facility (intensive care, acute care, hospice unit, nusing home care or community living center) for whom a survey is completed. Completed surveys are defined as those with at least 12 of the 17 structured items completed.

#2651 CAHPS® Hospice Survey (Experience With Care)

- For each item in a multi-item measure, as well as for the ratings measures, the top box denominator is the number of respondents per hospice who answered the item. For each multi-item measure score, the denominator is the number of respondents who answer at least one item within the multi-item measure. Multi-item measure scores are the average proportion of respondents that gave responses in the most positive category across the items in the multi-item measure (as discussed in S.6).
- Survey population: Primary caregivers of patients who died while receiving care from a given hospice in a given month.
- Denominator for Multi-Item Measures: The number of respondents who answer at least one item within the multi-item measure.
- Denominator for Rating Measures: The number of respondents who answered the item.

Exclusions

#1623 Bereaved Family Survey

- Veterans for whom a family member knowledgeable about their care cannot be identified (determined by family member's report)
- Absence of a current address and/or working telephone number for a family member or emergency contact.
- Deaths within 24 hours of admission without a prior hospitalization of last least 24 hours in the last 31 days of life.
- Deaths that occur in the operating room during an outpatient procedure.
- Deaths due to a suicide or accident
- Surveys in which less than 12 items were answered.

#2651 CAHPS® Hospice Survey (Experience With Care)

- The eight measures included here are calculated only for hospices that have at least 30 completed surveys over eight quarters of data collection.
- The exclusions noted in here are those who are ineligible to participate in the survey. The one exception is caregivers who report on the survey that they "never" oversaw or took part in the decedent's care; these respondents are instructed to complete the "About You" and "About Your Family Member" sections of the survey only.
- Cases are excluded from the survey target population if:
- The hospice patient is still alive
- The decedent's age at death was less than 18
- The decedent died within 48 hours of his/her last admission to hospice care
- The decedent had no caregiver of record
- The decedent had a caregiver of record, but the caregiver does not have a U.S. or U.S. Territory home address
- The decedent had no caregiver other than a nonfamilial legal guardian
- The decedent or caregiver requested that they not be contacted (i.e., by signing a no publicity request while under the care of hospice or otherwise directly requesting not to be contacted)
- The caregiver is institutionalized, has mental/physical incapacity, has a language barrier, or is deceased
- The caregiver reports on the survey that he or she "never" oversaw or took part in decedent's hospice care

Exclusion Details

#1623 Bereaved Family Survey

Name, address, and phone number of patient's family member or emergency contact are required for determining exclusion. In addition, information regarding the patient's admission(s) during the last 31 days of life, and including length of stay are also required to determine exclusion.

#2651 CAHPS® Hospice Survey (Experience With Care)

Please see S.10.The CAHPS Hospice Survey Quality Assurance Guidelines contain detailed information regarding how to code decedent/caregiver cases, and how to code appropriately and inappropriately skipped items, as well as items with multiple responses.

Risk Adjustment

#1623 Bereaved Family Survey

Statistical risk model

#2651 CAHPS® Hospice Survey (Experience With Care)

Statistical risk model

Stratification

#1623 Bereaved Family Survey

Variables necessary to stratify the measure are VISN, facility, quarter, year, outcome. VISN refers to "Veterans Integrated Service Network" and is a geographic area of the country where a facility is located. Facility is the actual VA medical center or affiliated community living center where the Veteran died. Quarter is the 3 month time period in which the patient died. Year is the VA fiscal year (runs from Oct 1 to Sept 30). Outcome refers to whether or not a survey was completed.

#2651 CAHPS® Hospice Survey (Experience With Care)

CAHPS Hospice Survey measure scores are used for reporting at the hospice-level (i.e., not stratified by region or other characteristics).

Type Score

#1623 Bereaved Family Survey

Rate/proportion better quality = higher score

#2651 CAHPS® Hospice Survey (Experience With Care)

Rate/proportion better quality = higher score

Algorithm

#1623 Bereaved Family Survey

The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-ended and give family members the opportunity to provide comments regarding the care the patient received.

A growing body of research has underscored the degree to which end-of-life care in the United States needs to be improved. The challenges of end-of-life care are particularly significant in the U.S. Department of Veterans Affairs Health Care system because he VA provides care for an increasingly older population with multiple comorbid conditions. In FY2000, approximately 104,000 enrolled Veterans died in the U.S., and approximately 27,200 Veterans died in VA facilities. At least 30% of the Veterans are over age 65 now, and 46% will be over 65 by 2030. Therefore, it is clear that the number of deaths in VA facilities will increase substantially as the World War II and Korean War Veterans age. These demographic trends mean that, like other healthcare systems, the VA will face substantial challenges of providing care to Veterans near the end-of-life.

The VA has addressed this challenge aggressively in the last 5 year, however the VA has not yet developed and implemented measures of the quality of end-of-life care it provides to Veterans. There are at least 3 reasons why adoption of a quality measurement tool is essential. First, it would make it possible to define and compare the quality of end-of-life care at each VA facility and to identify opportunities for improvement. Second, facilities

and VISNs (geographic service divisions within the VA system) would be able to monitor the effectiveness of efforts to improve care locally and nationally, and would enable monitoring of the impact of the Comprehensive End of Life Care Initiative, ensuring that expenditures are producing improvements in care. Third, it will help the VA to recognize those facilities that provide outstanding end-of-life care, so that successful processes and structures of care can be identified and disseminated throughout the VA.

The BFS's 17 close-ended items ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support, pain management and personal care needs. Two addditional items (not used in scoring) are open-ended and give family members the opportunity to provide comments regarding the care the patient received. The BFS has undergone extensive development and has been pilot-tested for all inpatient deaths in Q4FY2008 in seven VISNs (1,2,4,5,8,11, and 22). As of October 1, 2009, Q1FY2010, all inpatient deaths in all VISNs were included in the project.

The 17 structured items of the Bereaved Family Survey are scored as either "1" (optimal response) or "0" (all other answer choices). A score of "1" indicates that the family member perceived that the care they and/or the Veteran received was the best possible care (Excellent). A score of "0" reflects all other possible responses (Very good, Good, Fair, Poor). Items are coded as missing if respondents cannot or refuse to answer the item. Thus, the score for each item can be expressed as a fraction corresponding to the number of families who reported that the Veteran received optimal care (numerator), divided by the number of valid, non-missing responses for that item (denominator). Similarly, the score for the 17-item survey is calculated based on the global question item (Overall, how would you rate the care received in the last month of life? - Excellent, Very Good, Good, Fair, Poor). The global item is scored as the # of optimal responses/# of valid, non missing responses for all completed surveys (12 of 17 structured items answered). This scoring system produces a facility- or VISN-level score that reflects the proportion of Veterans who received the best possible care overall (BFS score) and in specific areas corresponding to BFS items (e.g. pain management, communication, personal care, etc).

We then add nonresponse and patient case mix weights to the model. All adjusted scores are reported. The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-ended and give family members the opportunity to provide comments regarding the care the patient received.

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facilities will increase substantially as the World War II and Korean War Veterans age. These demographic trends mean that, like other healthcare systems, the VA will face substantial challenges of providing care to Veterans near the end-of-life.

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The 17 structured items of the Bereaved Family Survey are scored as either "1" (optimal response) or "0" (all other answer choices). A score of "1" indicates that the family member perceived that the care they and/or the Veteran received was the best possible care (Excellent). A score of "0" reflects all other possible responses (Very good, Good, Fair, Poor). Items are coded as missing if respondents cannot or refuse to answer the item. Thus, the score for each item can be expressed as a fraction corresponding to the number of families who reported that the Veteran received optimal care (numerator), divided by the number of valid, non-missing responses for that item (denominator). Similarly, the score for the 17-item survey is calculated based on the global question item (Overall, how would you rate the care received in the last month of life? - Excellent, Very Good, Good, Fair, Poor). The global item is scored as the # of optimal responses/# of valid, non missing responses for all completed surveys (12 of 17 structured items answered). This scoring system produces a facility- or VISN-level score that reflects the proportion of Veterans who received the best possible care overall (BFS score) and in specific areas corresponding to BFS items (e.g. pain management, communication, personal care, etc).

We then add nonresponse and patient case mix weights to the model. All adjusted scores are reported.

#2651 CAHPS® Hospice Survey (Experience With Care)

Top Box Score Calculation:

1) Identify target respondent population (i.e., primary caregivers of hospice patients who died while receiving hospice care from a given hospice in a given month)
2) Identify any exclusions from the respondent population (as described above in S.10)
3) Score each item using top box method, possible values of 0 or 100
4) Calculate mode adjusted top box scores for each item.

5) Calculate case-mix adjusted top box scores for each item for each hospice; case-mix adjustment is a linear regression based approach that adjusts for all variables listed in S.14. Specifically, a regression model predicting item scores is fit using the case-mix adjustor variables and fixed effects for hospices. Adjusted hospice means are then calculated (e.g., using LSMEANS in SAS).

6) Top-box scores are averaged across the items within each multi-item measure, weighting each item equally. If data are missing for a respondent for an item(s) within a multi-item measure, the respondent's answers to other items within the measure are still used in the calculation of multi-item measure scores. (Please see S.22 below for more details). Top Box Score Calculation:

   1) Identify target respondent population (i.e., primary caregivers of hospice patients who died while receiving hospice care from a given hospice in a given month)
   2) Identify any exclusions from the respondent population (as described above in S.10)
   3) Score each item using top box method, possible values of 0 or 100
   4) Calculate mode adjusted top box scores for each item.
   5) Calculate case-mix adjusted top box scores for each item for each hospice; case-mix adjustment is a linear regression based approach that adjusts for all variables listed in S.14. Specifically, a regression model predicting item scores is fit using the case-mix adjustor variables and fixed effects for hospices. Adjusted hospice means are then calculated (e.g., using LSMEANS in SAS).
   6) Top-box scores are averaged across the items within each multi-item measure, weighting each item equally. If data are missing for a respondent for an item(s) within a multi-item measure, the respondent's answers to other items within the measure are still used in the calculation of multi-item measure scores. (Please see S.22 below for more details).

Submission Items

#1623 Bereaved Family Survey

5.1 Identified measures: 2651 : CAHPS® Hospice Survey (experience with care)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Survey items different as well as coding of items, Target group is also different, We are specifically looking at inpatient Veteran deaths, regardless of hospice use. Currently, the BFS is the only tool assessing end of life care in a VA inpatient setting. We believe that assessing all deaths, not just hospice deaths, is critical to the VA mission of improving care for all Veterans regardless of choice of level of care at death. We do see any negative impact to interpretability or burden of data collection.

5b.1 If competing, why superior or rationale for additive value: NQF 2651 CAHPS Hospice Survey

Although the Bereaved Family Survey is in many ways similar to the CAHPS Hospice Survey, it provides information on a specific population (Veterans) and measures the quality of care provided a single health care system. Unlike the CAHPS-Hospice, the BFS provides a coherent measurement strategy that allows comparisons across systems of care and sites of death in a single health care system. This measure assesses the quality of care of the largest unified health care system in the United States and cares for more than 5 million patients annually. Because it is a unified health system, the VA is uniquely situated to make

use of the quality data that can be easily and quickly disseminated. The BFS also measures satisfaction of care that are unique to a Veteran population (i.e, survivor and funeral benefits, PTSD). The popoulation of Veterans and families that the VA serves is unique in several key respects: 1) Veterans and their families may face different challenges at the end of life than non-Veterans do. The costs of hospitalization are less likely to be relevant to non-VA populations.

#2651 CAHPS® Hospice Survey (Experience With Care)

5.1 Identified measures: 0208 : Family Evaluation of Hospice Care

1623 : Bereaved Family Survey

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

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

The Family Evaluation of Hospice Care Survey (FEHC), developed more than 20 years ago, assesses hospice care experiences from the perspective of bereaved family members. The CAHPS Hospice Survey covers similar domains, but includes important methodological improvements in the response task, and is adjusted for case mix and mode. Additionally, more stringent survey administration guidelines are in place to permit public reporting of the survey results and valid comparison across hospice programs. FEHC measures were maintained by the National Hospice and Palliative Care Organization (NHPCO), which operated a voluntary repository that provided hospice programs with national benchmarks for FEHC measures. With the national implementation of the CAHPS Hospice Survey, NHPCO shut down the voluntary repository. NQF endorsement of FEHC measures was removed in January 2018.

1623 Bereaved Family Survey.

The Department of Veterans Affairs Bereaved Family Survey assesses experiences of veterans' health care in the last month of life from the perspective of bereaved family members. Importantly, the Bereaved Family Survey assesses care for those who die in inpatient settings, regardless of whether they have received hospice care; this is distinct from respondents to the CAHPS Hospice Survey, who include informal caregivers of decedents who received hospice care across a range of care settings (including both inpatient and other settings).

#1623 Bereaved Family Survey

#1623 Bereaved Family Survey

#2651 CAHPS® Hospice Survey (Experience With Care)

#2651 CAHPS® Hospice Survey (Experience With Care)

Steward

#1623 Bereaved Family Survey

Department of Veterans Affairs / Hospice and Palliative Care

#2651 CAHPS® Hospice Survey (Experience With Care)

Centers for Medicare and Medicaid Services

Description

#1623 Bereaved Family Survey

This measure calculates the proportion of Veteran decedent's family members who rate overall satisfaction with the Veteran decedent's end-of-life care in an inpatient setting as "Excellent" versus "Very good", "good", "fair", or "poor".

#2651 CAHPS® Hospice Survey (Experience With Care)

The measures submitted here are derived from the CAHPS® Hospice Survey, which is a 47-item standardized questionnaire and data collection methodology. The survey is intended to measure the care experiences of hospice patients and their primary caregivers. Respondents to the survey are the primary informal caregivers of patients who died under hospice care. These are typically family members but can be friends. The hospice identifies the primary informal caregiver from their administrative records. Data collection for sampled decedents/caregivers is initiated two months following the month of the decedent's death.

The publicly reported measures described here include the following six multi-item measures.

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms
- Getting Hospice Training
- In addition, there are two global rating items that are publicly-reported measures.
- Rating of the hospice care
- Willingness to recommend the hospice

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

List of CAHPS Hospice Survey Measures

Multi-Item Measures

Hospice Team Communication (Composed of 6 items)

- While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member?
- While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?
- How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?
- While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?
- While your family member was in hospice care, how often did the hospice team listen carefully to you?

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

Getting Timely Care (Composed of 2 items)

- While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?
- How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?

Treating Family Member with Respect (Composed of 2 items)

- While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?
- While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?

Providing Emotional Support (Composed of 3 items)

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

Getting Help for Symptoms (Composed of 4 items)

- Did your family member get as much help with pain as he or she needed?
- How often did your family member get the help he or she needed for trouble breathing?
- How often did your family member get the help he or she needed for trouble with constipation?
- How often did your family member receive the help he or she needed from the hospice team for feelings of anxiety or sadness?

Getting Hospice Care Training (Composed of 5 items)

- Did the hospice team give you enough training about what side effects to watch for from pain medicine?
- Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?
- Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?

- Did the hospice team give you the training you needed about what to do if your family member became restless or agitated?
- Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with your or your family member?

Global Rating Measures:

In addition to the multi-item measures, there are two "global" ratings measures. These single-item measures provide families and patients looking for care with overall evaluations of the care provided by the hospice. The items are rating of hospice care and willingness to recommend the hospice.

- Rating of Hospice Care: Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?
- Willingness to Recommend Hospice: Would you recommend this hospice to your friends and family?

The CAHPS Hospice Survey is part of the CAHPS family of experience of care surveys. English and other translations of the survey are available here. CMS initiated national implementation of the CAHPS Hospice Survey in 2015. Hospices meeting CMS eligibility criteria were required to administer the survey for a "dry run" for at least one month of sample from the first quarter of 2015. Beginning with the second quarter of 2015, hospices are required to participate on an ongoing monthly basis in order to receive their full Annual Payment Update from CMS. Information regarding survey content and national implementation requirements, including the latest versions of the survey instrument and standardized protocols for data collection and submission, are available here. Public reporting of the survey-based measures on Hospice Compare started in February 2018 (www.medicare.gov Choose find hospice care)

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

Type

#1623 Bereaved Family Survey

Outcome: PRO-PM

#2651 CAHPS® Hospice Survey (Experience With Care)

Outcome: PRO-PM

Data Source

#1623 Bereaved Family Survey

Instrument-Based Data For 2a1.25 - Family reported data/survey.

For 2a1.26 - Bereaved Family Survey

Available in attached appendix at A.1 No data dictionary

#2651 CAHPS® Hospice Survey (Experience With Care)

Instrument-Based Data CAHPS Hospice Survey; please see S.16 for information regarding modes of data collection. The survey instrument is available in English, Spanish, Chinese, Russian, Portuguese, Vietnamese, Polish and Korean.

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

Level

#1623 Bereaved Family Survey

Facility, Other

#2651 CAHPS® Hospice Survey (Experience With Care)

Facility

Setting

#1623 Bereaved Family Survey

Inpatient/Hospital, Post-Acute Care

#2651 CAHPS® Hospice Survey (Experience With Care)

Other

Numerator Statement

#1623 Bereaved Family Survey

The numerator is comprised of completed surveys (at least 12 of 17 structured items completed), where the global item question has an optimal response. The global item question asks "Overall, how would your rate the care that [Veteran] received in the last month of life" and the possible answer choices are: Excellent, Very good, Good, Fair, or Poor. The optimal response is Excellent.

#2651 CAHPS® Hospice Survey (Experience With Care)

CMS calculates CAHPS Hospice Survey measure scores using top-, middle- and bottom- box scoring. The top-box score refers to the percentage of caregiver respondents that give the most positive response(s). The bottom box score refers to the percentage of caregiver respondents that give the least positive response(s). The middle box is the proportion remaining after the top and bottom boxes have been calculated; see below for details. Details regarding the definition of most and least positive response(s) are noted in Section S.5 below.

Numerator Details

#1623 Bereaved Family Survey

Included are those patients included in the denominator with completed surveys (at least 12 of 17 structured items completed) that receive an optimal response on the global item quesstion.

#2651 CAHPS® Hospice Survey (Experience With Care)

For each survey item, the top and bottom box numerators are the number of respondents who selected the most and least positive response category(ies), respectively, as follows:

For items using a “Never/Sometimes/Usually/Always” response scale, the top box numerator is the number of respondents who answer “Always” and the bottom box numerator is the number of respondents who answer “Never” or “Sometimes.” The one exception to this guidance is for the Q10 “While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member’s condition or care?” For this item, the top box

numerator is the number of respondents who answer “Never” and the bottom box numerator is the number of respondents who answer “Always” or “Usually.”

For items using a “Yes, definitely/Yes, somewhat/No” response scale, the top box numerator is the number of respondents who answer “Yes, definitely” and the bottom box numerator is the number of respondents who answer “No.”

For items using a “Too Little/Right Amount/Too Much” response scale, the top box numerator is the number of respondents who answer “Right Amount” and the bottom box numerator is the number of respondents who answer “Too little” or “Too much.” (There is no middle box for items using this response scale.)

The top box numerator for the Rating of Hospice item is the number of respondents who answer 9 or 10 for the item (on a scale of 0 to 10, where 10 is the “Best Hospice Care Possible”); the bottom box numerator is the number of respondents who answer 0 to 6.

The top box numerator for the Willingness to Recommend item is the number of respondents who answer “Definitely Yes” (on a scale of “Definitely No/Probably No/Probably Yes/Definitely Yes”); the bottom box numerator is the number of respondents who answer “Probably No” or “Definitely No.”

Calculation of hospice-level multi-item measures

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

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

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

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

Here is an example of calculations for the measure “Getting Timely Care.”

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

Both items in “Getting Care Quickly” have four response options: Never, Sometimes, Usually, Always. Recode each item as 100 for “Always” and 0 for “Never”, “Sometimes”, or “Usually”.

Item #1. While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?

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

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

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

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

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

If the case-mix adjusted scores for a hospice are 95 for item #1 and 90 for item #2, then the hospice-level ‘Getting Timely Care’ would be calculated as (Item1 + Item2) / 2 = (95 + 90) / 2 = 92.5.

Denominator Statement

#1623 Bereaved Family Survey

The denominator consists of all inpatient deaths for which a survey was completed (at least 12 of 17 structured items completed), excluding:

1) deaths within 24 hours of admission (unless the Veteran had a previous hospitalization in the last month of life);

2) deaths that occur in the Emergency Department (unless the Veteran had a prior hospitalization of at least 24 hours in the last 31 days of life); Additional exclusion criteria include:

1) Veterans for whom a family member knowledgeable about their care cannot be identified (determined by the family member's report); or contacted (no current contacts listed or no valid addresses on file);

2) absence of a working telephone available to the family member.

#2651 CAHPS® Hospice Survey (Experience With Care)

CAHPS® Hospice Survey measure scores are calculated only for hospices that had at least 30 completed questionnaires over the most recent eight quarters of data collection.

The target population for the survey are the adult primary caregivers of hospice decedents. Respondent eligibility and exclusions are defined in detail in the sections that follow. A survey is defined as completed when at least 50 percent of the questions applicable to all decedents/caregivers are answered (Questions 1 – 4, 6 – 13, 15, 17, 21, 24, 26, 28, 30 – 32, and 35 – 47). The survey uses screener questions to identify respondents eligible to respond to subsequent items. Therefore, denominators vary by survey item (and corresponding multi-item measures, if applicable) according to the eligibility of respondents for each item. In addition, for the Getting Hospice Care Training measure, scores are calculated only among those respondents who indicate that their family member received hospice care at home or in an assisted living facility.

Denominator Details

#1623 Bereaved Family Survey

The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-ended and give family members the opportunity to provide comments regarding the care the patient received.

A growing body of research has underscored the degree to which end-of-life care in the United States needs to be improved. The challenges of end-of-life care are particularly significant in the U.S. Department of Veterans Affairs Health Care system because he VA provides care for an increasingly older population with multiple comorbid conditions. In FY2000, approximately 104,000 enrolled Veterans died in the U.S., and approximately 27,200 Veterans died in VA facilities. At least 30% of the Veterans are over age 65 now,

and 46% will be over 65 by 2030. Therefore, it is clear that the number of deaths in VA facilities will increase substantially as the World War II and Korean War Veterans age. These demographic trends mean that, like other healthcare systems, the VA will face substantial challenges of providing care to Veterans near the end-of-life.

The VA has addressed this challenge aggressively in the last 5 year, however the VA has not yet developed and implemented measures of the quality of end-of-life care it provides to Veterans. There are at least 3 reasons why adoption of a quality measurement tool is essential. First, it would make it possible to define and compare the quality of end-of-life care at each VA facility and to identify opportunities for improvement. Second, facilities and VISNs (geographic service divisions within the VA system) would be able to monitor the effectiveness of efforts to improve care locally and nationally, and would enable monitoring of the impact of the Comprehensive End of Life Care Initiative, ensuring that expenditures are producing improvements in care. Third, it will help the VA to recognize those facilities that provide outstanding end-of-life care, so that successful processes and structures of care can be identified and disseminated throughout the VA.

The BFS's 17 close-ended items ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support, pain management and personal care needs. Two addditional items (not used in scoring) are open-ended and give family members the opportunity to provide comments regarding the care the patient received. The BFS has undergone extensive development and has been pilot-tested for all inpatient deaths in Q4FY2008 in seven VISNs (1,2,4,5,8,11, and 22). As of October 1, 2009, Q1FY2010, all inpatient deaths in all VISNs were included in the project.

The indicator denominator is comprised of the number of Veterans who die in an inpatient VA facility (intensive care, acute care, hospice unit, nusing home care or community living center) for whom a survey is completed. Completed surveys are defined as those with at least 12 of the 17 structured items completed.

#2651 CAHPS® Hospice Survey (Experience With Care)

For each item in a multi-item measure, as well as for the ratings measures, the top box denominator is the number of respondents per hospice who answered the item. For each multi-item measure score, the denominator is the number of respondents who answer at least one item within the multi-item measure. Multi-item measure scores are the average proportion of respondents that gave responses in the most positive category across the items in the multi-item measure (as discussed in S.6).

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

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

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

Exclusions

#1623 Bereaved Family Survey

- Veterans for whom a family member knowledgeable about their care cannot be identified (determined by family member's report)
- Absence of a current address and/or working telephone number for a family member or emergency contact.

- Deaths within 24 hours of admission without a prior hospitalization of last least 24 hours in the last 31 days of life.
- Deaths that occur in the operating room during an outpatient procedure.
- Deaths due to a suicide or accident
- Surveys in which less than 12 items were answered.

#2651 CAHPS® Hospice Survey (Experience With Care)

The eight measures included here are calculated only for hospices that have at least 30 completed surveys over eight quarters of data collection.

The exclusions noted in here are those who are ineligible to participate in the survey. The one exception is caregivers who report on the survey that they "never" oversaw or took part in the decedent's care; these respondents are instructed to complete the "About You" and "About Your Family Member" sections of the survey only.

Cases are excluded from the survey target population if:

- The hospice patient is still alive
- The decedent's age at death was less than 18
- The decedent died within 48 hours of his/her last admission to hospice care
- The decedent had no caregiver of record
- The decedent had a caregiver of record, but the caregiver does not have a U.S. or U.S. Territory home address
- The decedent had no caregiver other than a nonfamilial legal guardian
- The decedent or caregiver requested that they not be contacted (i.e., by signing a no publicity request while under the care of hospice or otherwise directly requesting not to be contacted)
- The caregiver is institutionalized, has mental/physical incapacity, has a language barrier, or is deceased
- The caregiver reports on the survey that he or she "never" oversaw or took part in decedent's hospice care

Exclusion Details

#1623 Bereaved Family Survey

Name, address, and phone number of patient's family member or emergency contact are required for determining exclusion. In addition, information regarding the patient's admission(s) during the last 31 days of life, and including length of stay are also required to determine exclusion.

#2651 CAHPS® Hospice Survey (Experience With Care)

Please see S.10.The CAHPS Hospice Survey Quality Assurance Guidelines contain detailed information regarding how to code decedent/caregiver cases, and how to code appropriately and inappropriately skipped items, as well as items with multiple responses.

Risk Adjustment

#1623 Bereaved Family Survey

Statistical risk model

#2651 CAHPS® Hospice Survey (Experience With Care)

Statistical risk model

Stratification

#1623 Bereaved Family Survey

Variables necessary to stratify the measure are VISN, facility, quarter, year, outcome. VISN refers to "Veterans Integrated Service Network" and is a geographic area of the country where a facility is located. Facility is the actual VA medical center or affiliated community living center where the Veteran died. Quarter is the 3 month time period in which the patient died. Year is the VA fiscal year (runs from Oct 1 to Sept 30). Outcome refers to whether or not a survey was completed.

#2651 CAHPS® Hospice Survey (Experience With Care)

CAHPS Hospice Survey measure scores are used for reporting at the hospice-level (i.e., not stratified by region or other characteristics).

Type Score

#1623 Bereaved Family Survey

Rate/proportion better quality = higher score

#2651 CAHPS® Hospice Survey (Experience With Care)

Rate/proportion better quality = higher score

Algorithm

#1623 Bereaved Family Survey

The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-ended and give family members the opportunity to provide comments regarding the care the patient received.

A growing body of research has underscored the degree to which end-of-life care in the United States needs to be improved. The challenges of end-of-life care are particularly significant in the U.S. Department of Veterans Affairs Health Care system because he VA provides care for an increasingly older population with multiple comorbid conditions. In FY2000, approximately 104,000 enrolled Veterans died in the U.S., and approximately 27,200 Veterans died in VA facilities. At least 30% of the Veterans are over age 65 now, and 46% will be over 65 by 2030. Therefore, it is clear that the number of deaths in VA facilities will increase substantially as the World War II and Korean War Veterans age.

These demographic trends mean that, like other healthcare systems, the VA will face substantial challenges of providing care to Veterans near the end-of-life.

The VA has addressed this challenge aggressively in the last 5 year, however the VA has not yet developed and implemented measures of the quality of end-of-life care it provides to Veterans. There are at least 3 reasons why adoption of a quality measurement tool is essential. First, it would make it possible to define and compare the quality of end-of-life care at each VA facility and to identify opportunities for improvement. Second, facilities and VISNs (geographic service divisions within the VA system) would be able to monitor the effectiveness of efforts to improve care locally and nationally, and would enable monitoring of the impact of the Comprehensive End of Life Care Initiative, ensuring that expenditures are producing improvements in care. Third, it will help the VA to recognize those facilities that provide outstanding end-of-life care, so that successful processes and structures of care can be identified and disseminated throughout the VA.

The BFS's 17 close-ended items ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support, pain management and personal care needs. Two addditional items (not used in scoring) are open-ended and give family members the opportunity to provide comments regarding the care the patient received. The BFS has undergone extensive development and has been pilot-tested for all inpatient deaths in Q4FY2008 in seven VISNs (1,2,4,5,8,11, and 22). As of October 1, 2009, Q1FY2010, all inpatient deaths in all VISNs were included in the project.

The 17 structured items of the Bereaved Family Survey are scored as either "1" (optimal response) or "0" (all other answer choices). A score of "1" indicates that the family member perceived that the care they and/or the Veteran received was the best possible care (Excellent). A score of "0" reflects all other possible responses (Very good, Good, Fair, Poor). Items are coded as missing if respondents cannot or refuse to answer the item. Thus, the score for each item can be expressed as a fraction corresponding to the number of families who reported that the Veteran received optimal care (numerator), divided by the number of valid, non-missing responses for that item (denominator). Similarly, the score for the 17-item survey is calculated based on the global question item (Overall, how would you rate the care received in the last month of life? - Excellent, Very Good, Good, Fair, Poor). The global item is scored as the # of optimal responses/# of valid, non missing responses for all completed surveys (12 of 17 structured items answered). This scoring system produces a facility- or VISN-level score that reflects the proportion of Veterans who received the best possible care overall (BFS score) and in specific areas corresponding to BFS items (e.g. pain management, communication, personal care, etc).

We then add nonresponse and patient case mix weights to the model. All adjusted scores are reported. The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

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We then add nonresponse and patient case mix weights to the model. All adjusted scores are reported.

#2651 CAHPS® Hospice Survey (Experience With Care)

Top Box Score Calculation:

1) Identify target respondent population (i.e., primary caregivers of hospice patients who died while receiving hospice care from a given hospice in a given month)
2) Identify any exclusions from the respondent population (as described above in S.10)
3) Score each item using top box method, possible values of 0 or 100
4) Calculate mode adjusted top box scores for each item.
5) Calculate case-mix adjusted top box scores for each item for each hospice; case-mix adjustment is a linear regression based approach that adjusts for all variables listed in S.14. Specifically, a regression model predicting item scores is fit using the case-mix adjustor variables and fixed effects for hospices. Adjusted hospice means are then calculated (e.g., using LSMEANS in SAS).
6) Top-box scores are averaged across the items within each multi-item measure, weighting each item equally. If data are missing for a respondent for an item(s) within a multi-item measure, the respondent's answers to other items within the measure are still used in the calculation of multi-item measure scores. (Please see S.22 below for more details). Top Box Score Calculation:
    1) Identify target respondent population (i.e., primary caregivers of hospice patients who died while receiving hospice care from a given hospice in a given month)
    2) Identify any exclusions from the respondent population (as described above in S.10)
    3) Score each item using top box method, possible values of 0 or 100
    4) Calculate mode adjusted top box scores for each item.
    5) Calculate case-mix adjusted top box scores for each item for each hospice; case-mix adjustment is a linear regression based approach that adjusts for all variables listed in S.14. Specifically, a regression model predicting item scores is fit using the case-mix adjustor variables and fixed effects for hospices. Adjusted hospice means are then calculated (e.g., using LSMEANS in SAS).
    6) Top-box scores are averaged across the items within each multi-item measure, weighting each item equally. If data are missing for a respondent for an item(s) within a multi-item measure, the respondent's answers to other items within the measure are still used in the calculation of multi-item measure scores. (Please see S.22 below for more details).

Submission Items

#1623 Bereaved Family Survey

5.1 Identified measures: 2651 : CAHPS® Hospice Survey (experience with care)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Survey items different as well as coding of items, Target group is also different, We are specifically looking at inpatient Veteran deaths, regardless of hospice use. Currently, the BFS is the only tool assessing enf of life care in a VA inpatient setting. We believe that assessing alldeaths, not just hospice deaths, is critical to the VA mission of improving care for all Veterans regardless of choice of level of care at death. We do see any negative impact to interpretability or burden of data collection.

5b.1 If competing, why superior or rationale for additive value: NQF 2651 CAHPS Hospice Survey

Although the Bereaved Family Survey is in many ways similar to the CAHPS Hospice Survey, it provides information on a specific population (Veterans) and measures the quality of care provided a single health care system. Unlike the CAHPS-Hospice, the BFS provides a coherent measurement strategy that allows comparisons across systems of care and sites of death in a single health care system. This measure assesses the quality of care of the largest unified health care system in the United States and cares for more than 5 million patients annually. Because it is a unified health system, the VA is uniquely situated to make use of the quality data that can be easily and quickly disseminated. The BFS also measures satisfaction of care that are unique to a Veteran population (i.e, survivor and funeral benefits, PTSD). The popoulation of Veterans and families that the VA serves is unique in several key respects: 1) Veterans and their families may face different challenges at the end of life than non-Veterans do. The costs of hospitalization are less likely to be relevant to non-VA populations.

#2651 CAHPS® Hospice Survey (Experience With Care)

5.1 Identified measures: 0208 : Family Evaluation of Hospice Care

1623 : Bereaved Family Survey

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

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

The Family Evaluation of Hospice Care Survey (FEHC), developed more than 20 years ago, assesses hospice care experiences from the perspective of bereaved family members. The CAHPS Hospice Survey covers similar domains, but includes important methodological improvements in the response task, and is adjusted for case mix and mode. Additionally, more stringent survey administration guidelines are in place to permit public reporting of the survey results and valid comparison across hospice programs. FEHC measures were maintained by the National Hospice and Palliative Care Organization (NHPCO), which operated a voluntary repository that provided hospice programs with national benchmarks for FEHC measures. With the national implementation of the CAHPS Hospice Survey, NHPCO shut down the voluntary repository. NQF endorsement of FEHC measures was removed in January 2018.

1623 Bereaved Family Survey.

The Department of Veterans Affairs Bereaved Family Survey assesses experiences of veterans' health care in the last month of life from the perspective of bereaved family members. Importantly, the Bereaved Family Survey assesses care for those who die in inpatient settings, regardless of whether they have received hospice care; this is distinct from respondents to the CAHPS Hospice Survey, who include informal caregivers of decedents who received hospice care across a range of care settings (including both inpatient and other settings).

Appendix F: Pre-Evaluation Comments

Comments received during the pre-evaluation commenting period.

Topic: NQF #0326 Advance Care Plan (National Committee for Quality Assurance [NCQA])
Commenter: NCQA
Comment: This comment addresses the Fall 2020 cycle measure #0326 *Advance Care Plan.*

NCQA would like to add the following data to the 4b. Usability (4a1. Improvement; 4a2. Benefits of measure) section of the submission:
PQRS (Data Source: Centers for Medicare & Medicaid Services (CMS), 2016 PQRS Experience Report Appendix Tables)
EPs Who Reported Continuously [During] 2013–2016: 3,220
Average Performance Rate in 2013: 69.6 percent
Average Performance Rate in 2014: 72.9 percent
Average Performance Rate in 2015: 75.3 percent
Average Performance Rate in 2016: 76.6 percent
Improvement Rate: 3.3 percent

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