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Geriatrics and Palliative Care, Spring 2022 Cycle: CDP Report

TECHNICAL REPORT
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Contents

Executive Summary

Palliative care focuses on improving the quality of life for people living with a serious illness. Palliative care is beneficial to patients and the family, as it provides mental and physical comfort while allowing the continuation of curative measures and prolonging survival. While the percentage of hospitals (50 or more beds) implementing palliative care services has tripled over the past 16 years, millions of Americans with severe illnesses lack access to palliative care.[1]

Through the Consensus Development Process (CDP), NQF's Geriatrics and Palliative Care (GPC) Standing Committee strives toward this mission by vetting and endorsing performance measures across various conditions and settings. Measures in the GPC portfolio encompass topic areas relating to physical, spiritual, religious, ethical, and legal aspects of palliative and end-of-life (EOL) care; general care of the patient nearing the EOL; and measures relating to geriatrics.

Measures reviewed during this cycle focused on several clinical areas, including timely enrollment in palliative and hospice services, reduction of aggressive EOL interventions, and documentation of patient treatment preferences.

For this cycle, the Standing Committee evaluated four measures undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended three measures for endorsement. The Standing Committee also voted on different levels of analysis for one measure; it did not recommend that measure for endorsement at the clinician-group level but did recommend the measure for endorsement at the facility level. The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendations.

The Standing Committee recommended the following measures for endorsement:

- NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life (American Society of Clinical Oncology [ASCO])
- NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (ASCO)
- NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days (ASCO)
- NQF #1641 Hospice and Palliative Care – Treatment Preferences (University of North Carolina-Chapel Hill) *Note: This measure was endorsed at the facility level only.

Brief summaries of the measures and their evaluations 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

Palliative care focuses on easing pain and discomfort and relieving the stress and symptoms associated with a severe medical illness.[2,3] It aims to improve the quality of life for the patient and those who care for the patient.[3] Palliative care is beneficial to patients because it provides mental and physical comfort while allowing the continuation of curative measures and prolonging survival.[4,5] The need for palliative care is further highlighted by the increasing population of individuals ages 65 and older in the United States (U.S.). In 2019, more than 1 in every 7 Americans were over the age of 65, which totaled approximately 54.1 million older American adults (16 percent of the total U.S. population).[6] Trends show that the senior population is expected to grow significantly in the future. With close to 95 million older Americans projected in 2060, the need for palliative care is further underscored as millions of Americans still lack access to these services.[6] Additionally, the provision of palliative care lowers healthcare expenditures, thereby increasing cost savings with an average of $3,237 per hospital stay per patient.[7–9] Four measures were reviewed during the Geriatric and Palliative Care (GPC) Standing Committee's spring 2022 measure evaluation cycle, focusing on EOL care and treatment preferences.

EOL Cancer Care

Integrating palliative care into a cancer patient's routine oncology treatment soon after a diagnosis of advanced cancer has clinical benefits. It can improve the patient's quality of life and mood and may even prolong survival. Evidence suggests that early palliative care improves EOL outcomes among cancer patients by decreasing the need for aggressive EOL care.[5] Palliative care is beneficial to both cancer patients and insurers. It has a synergistic effect on cancer patient survival and improves overall outcomes, as some studies have found up to a one-year difference in survival upon receipt of palliative care.[11,12] Furthermore, the economic impact of prompt palliative care is more significant in cancer patients when compared to non-cancer patients.[13] The cost savings of palliative care is estimated to be $4,251 per hospital stay per cancer patient compared to $2,105 for non-cancer patients.[9] The Standing Committee evaluated three measures this cycle that assessed the provision of palliative care among cancer patients and addressed topics such as chemotherapy during the last 14 days of life (NQF #0210), admission to an intensive care unit (ICU) within the last 30 days of life (NQF #0213), and admission to hospice services within the last three days of life (NQF #0216).

Treatment Preferences

Conversations surrounding treatment preferences for patients with severe medical conditions are valued and desired by both patients and providers but are often not initiated. Patient wishes surrounding life-sustaining treatments should be determined and honored to ensure that they are followed by all medical personnel, irrespective of the care setting.[14] Patients with the opportunity to express their treatment preferences are more likely to receive care that is consistent with their values and beliefs, leading to increased patient and family satisfaction outcomes. Documentation of treatment preferences is necessary to enhance patient autonomy, facilitate patient-centered decision making, and communicate patient preferences to other treating providers. However, documentation of treatment preferences is suboptimal, leading to providers often being unaware of patients' treatment preferences.[15] The Standing Committee evaluated a measure this cycle that assessed the percentage of patients who have had discussions regarding their preferences for life-sustaining treatment documented within the medical record (NQF #1641).

NQF Portfolio of Performance Measures for Geriatrics and Palliative Care Conditions

The GPC Standing Committee (Appendix C) oversees NQF's portfolio of GPC measures (Appendix B), which includes measures relating to physical, spiritual, religious, ethical, and legal aspects of palliative/EOL care; general care of the patient nearing the EOL; and measures relating to geriatrics. This portfolio contains 18 measures: 10 process measures, seven outcome measures (including two patient reported outcome performance measures [PRO-PM]), and one composite measure.

Additional measures have been assigned to other portfolios. These include a cultural communication measure (Patient Experience and Function [PEF]) and pain measures for cancer patients (Cancer).

Geriatrics and Palliative Care Measure Evaluation

On June 30, 2022, the GPC Standing Committee evaluated four measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 1. Geriatrics and Palliative Care Measure Evaluation Summary

Measure	Maintenance	New	Total
Measures under review for endorsement	4	0	0
Measures endorsed	4	0	4

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 period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 16, 2022, and pre-meeting commenting closed on June 15, 2022. Prior to June 15, 2022, seven comments were submitted and shared with the Standing Committee prior to the measure evaluation meeting (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous public commenting period with NQF member support closed on September 13, 2022. Following the Standing Committee's evaluation of the measures under review, NQF did not receive any comments from organizations or individuals pertaining to the draft report and the measures under review.

NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations during the commenting period. One NQF member expressed "support" for NQF #0210, NQF #0213, and NQF #0216. Conversely, another NQF member expressed "do not support" for NQF #1641.

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.

EOL Cancer Patients

NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life (American Society of Clinical Oncology [ASCO]): Endorsed

Description: Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life; **Measure Type**: Process; **Level of Analysis**: Clinician: Individual, Clinician: Group/Practice; **Setting of Care**: Outpatient Services, Ambulatory Care; **Data Source**: Registry Data

This clinician-level and clinician group-level measure was originally endorsed in 2009 and retained endorsement in 2016. It is publicly reported in the Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Measures and the Centers for Medicare & Medicaid Services' (CMS) Merit-Based Incentive Payment System (MIPS) reporting program.

While the Standing Committee did express concern that the evidence appeared tangential, it agreed that the quantity of evidence was abundant and that the measure evaluated an important aspect of healthcare. The Standing Committee also agreed that substantial gaps and disparities exist, particularly among racial and ethnic groups. The Standing Committee passed the measure on evidence and performance gap.

The Standing Committee applauded the developer for including immunotherapy infusion in the measure specifications and acknowledged that the developer conducted robust reliability testing. With respect to validity, one Standing Committee member noted that the measure does not differentiate between hematologic malignancies versus solid tumors. Furthermore, this Standing Committee member highlighted that the measure performance may be worse in patients with hematologic malignancies, as life prolongation is directly related to the continued use of infusion therapy, and generally experiences a shorter duration between treatment cessation and death. The Standing Committee recommended that the developer consider excluding hematologic malignancies within the denominator or stratify between those two populations in future iterations of the measure. The Standing Committee decided the measure was both reliable and valid.

The Standing Committee agreed that the data elements required for the measure are readily available and could be captured without undue burden. The Standing Committee also acknowledged that the measure is publicly reported and used within several accountability programs and implemented within the Core Quality Measures Collaborative's (CQMC) 2020 Medical Oncology Core Set. Additionally, the Standing Committee acknowledged that there were no unintended consequences related to usability and passed the measure on feasibility, use, usability, and overall suitability for endorsement.

The Standing Committee recommended the measure for continued endorsement. The Standing Committee also reviewed two related measures and agreed that both measures are harmonized to the extent possible. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received. No NQF member and public comments were received.

NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (ASCO): Endorsed

Description: Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life; **Measure Type**: Process; **Level of Analysis**: Clinician: Individual, Clinician: Group/Practice; **Setting of Care**: Outpatient Services, Ambulatory Care; **Data Source**: Registry Data

This clinician-level and clinician group-level measure was originally endorsed in 2009 and retained endorsement in 2016. It is publicly reported in the PCHQR Program Measures and CMS' MIPS reporting program.

The Standing Committee noted that the evidence supported actions that an accountable entity can take regarding timely enrollment in palliative or hospice care and reduction in aggressive interventions at the EOL. The Standing Committee also acknowledged that a performance gap exists across different racial and ethnic groups, specifically Black and Hispanic patients and those patients covered by Medicaid. The Standing Committee passed the measure on evidence and performance gap.

The Standing Committee noted that the developer selected both individual and clinician group-level analyses, but it was not clear that the data source could distinguish between the two levels of analyses. The developer explained that while only individual clinician National Provider Identifiers (NPIs) are eligible for the MIPS program, those NPIs could be grouped to acquire a clinician-group level of analysis. Additionally, the developer expressed that the reliability at the individual level was indicative of the reliability at the clinician-group level. The Standing Committee accepted the developer's explanation for the level of analysis specified in the measure and agreed that the reliability was sufficient. During the discussion of validity, the Standing Committee noted that this measure is not risk-adjusted or risk-stratified and recommended the developer consider risk-adjusting the measure by demographic groups to account for the differences in ICU admissions across different demographic groups. The developer expressed concern with the potential unintended consequence of risk-adjusting or stratifying across racial and ethnic groups, as doing so could result in further disparities in care. The Standing Committee expressed appreciation for the developer's response; it further emphasized that health equity is an important issue and that a better understanding of disparities in care is critical. The Standing Committee passed the measure on reliability and validity.

The Standing Committee agreed that the measure is feasible and that the data elements required for the measure are readily available and can be captured without undue burden. The Standing Committee acknowledged that the measure is reported publicly and that its results could be used for accountability and performance improvement. However, the Standing Committee raised concern about the unintended consequence of labeling clinicians as low performers when patients and families might prefer ICU care as EOL care. The developer reiterated that the goal is not to have a zero-percent performance score, and patient and family preferences for EOL treatment are considered in the measure. The Standing Committee recommended that the developer continue to monitor for unintended consequences and passed the measure on feasibility, use, usability, and overall suitability for endorsement.

The Standing Committee recommended the measure for continued endorsement. The Standing Committee also reviewed three related measures and agreed that the measures are harmonized to the extent possible. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received.

NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days (ASCO): Endorsed

Description: Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice; **Setting of Care**: Ambulatory Care, Outpatient Services; **Data Source**: Registry Data

This clinician group-level measure was originally endorsed in 2007 and retained endorsement in 2016. It is publicly reported in the PCHQR Program Measures and CMS' MIPS reporting program.

The Standing Committee noted that the evidence supported actions that an accountable entity can take regarding timely enrollment in palliative or hospice care and reduction in aggressive interventions at the EOL. The Standing Committee acknowledged that a performance gap exists and passed the measure on evidence and performance gap.

During the discussion of reliability, the Standing Committee requested clarification from the developer on whether a patient diagnosed with cancer whose cause of death was related to a medical reason other than cancer would be excluded from the denominator (i.e., discontinuing dialysis for a patient with kidney disease). The developer responded and confirmed that the patient would not be included in the denominator. The Standing Committee also highlighted that some patients might have justified shorter than three-day hospice periods, as federal policy requires that treatments be discontinued before enrollment in hospice care services and the discontinuation of certain treatments can cause a rapid decline in patients. Recognizing this was out of the developer's control, the Standing Committee recommended broader policies be changed to allow a patient diagnosed with cancer to receive concurrent therapy and hospice services. The Standing Committee had no further concerns and passed the measure on reliability and validity.

The Standing Committee agreed on the following: (1) The data elements are routinely generated and available in electronic form; (2) The measure is utilized in several accountability programs; and (3) There were no unintended consequences other than what was previously discussed during the scientific acceptability discussion. The Standing Committee passed the measure on feasibility, use, usability, and overall suitability for endorsement.

The Standing Committee recommended the measure for continued endorsement. It reviewed three related measures and agreed that the measures are harmonized to the extent possible. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received.

Treatment Preferences

NQF #1641 Hospice and Palliative Care – Treatment Preferences (University of North Carolina-Chapel Hill): Endorsed at the Facility Level

Description: Percentage of patients with chart documentation of preferences for life sustaining treatments; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Facility; **Setting of Care**: Home Care, Inpatient/Hospital; **Data Source**: Other, Assessment Data, Electronic Health Records

This clinician group-level and facility-level measure was initially endorsed in 2012 and retained endorsement in 2016. It was implemented in the Hospice and Palliative Nurses Association (HPNA) and the American Academy of Hospice and Palliative Medicine (AAHPM) Measuring What Matters (MWM) project, the Palliative Care Quality Collaborative (PCQC) national data registry, and the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) pay-for-performance program.

The Standing Committee acknowledged that the new evidence the developer provided is similar to the evidence previously reviewed by the Standing Committee during the initial endorsement review and the most recent measure evaluation in 2016. The Standing Committee agreed that the evidence tangentially supports the measure and passed it on the evidence criterion. However, the Standing Committee raised concern with the measure being topped out at the hospice and palliative care facility level and noted that the developer did not provide data specific to the clinician group level of analysis. The developer reported that they intend to retire the stand-alone measure and have it function as a component of a hospice composite measure. The developer further explained that the clinician-group level was included in the measure specifications due to the diversity of practice and organizational structures that provide hospice and palliative care services. The Standing Committee also noted that no clear distinction exists between hospice and acute specialty palliative care data in the submission. During the measure evaluation meeting, the developer provided the acute specialty palliative care data derived from the PRIME program from 52 California hospitals (a mean of 82.9 percent, a median of 89.4 percent, and a range of 0-100 percent). The Standing Committee did not have any further concerns or questions and agreed to vote on the performance gap separately at the facility and clinician-group levels. The Standing Committee did not pass the measure at the clinician-group level due to insufficient data and did not reach consensus at the facility level for the performance gap. The remaining criteria were evaluated at the facility level.

The Standing Committee reviewed the reliability testing provided by the developer and requested an update on the recommendations made during the prior maintenance of endorsement review in 2016. The Standing Committee questioned whether the numerator details were updated to clarify whether a treatment discussion with the patient was required. The developer stated that the numerator is meant to capture direct communication and that documentation should reflect patient self-report; if unavailable, a conversation with a surrogate decision maker and a purposeful review of any advance directive are acceptable. The Standing Committee also previously requested updated reliability testing for acute specialty palliative care during the previous maintenance review due to insufficient data for palliative care. The developer expressed that they do not have access to the palliative care data; however, they do not expect significant differences in reliability data between hospice and palliative care populations. The Standing Committee then reviewed the validity testing that the developer provided and had no concerns. The Standing Committee passed the measure on reliability and validity.

The Standing Committee agreed that facilities could easily extract hospice data elements from the electronic medical record; however, it expressed concern about data extraction for palliative care. The developer explained that multiple centers are working toward a future state in which facilities can extract numerator data directly from the electronic medical record in various care settings, including palliative care. The Standing Committee accepted the developer's response and passed the measure on feasibility.

The Standing Committee expressed concern that the measure is not publicly reported, which is required within six years of initial NQF endorsement. The developer clarified that the measure is publicly reported as part of the PCQC accountability program for hospice. The Standing Committee had no further concerns related to use and passed the measure on this criterion. The Standing Committee also noted that the developer did not provide year-over-year performance data. The developer explained that more recent performance data are available; however, they did not have access to the data at the time and could not provide updated performance results to demonstrate improvement. The Standing Committee did not reach a consensus on usability; however, usability is not a must-pass criterion. Therefore, the Standing Committee could move forward without reaching consensus. Since the Standing Committee did not reach a consensus on performance gap, a must-pass criterion, it did not vote on overall suitability for endorsement during the measure evaluation meeting.

During the post-comment meeting on October 18, 2023, the Standing Committee discussed performance gap at the facility level again. No public comments following the Standing Committee's initial evaluation were submitted. During the post-comment discussion, the Standing Committee reiterated its concern with the lack of palliative care data and asked whether there were other performance gap data that could be considered. The developer explained that data from the National Palliative Care Registry will not be available until next year. The developer further highlighted the 98 percent achievement in hospice within nationally collected data and the 82.9 percent achievement from hospital-based palliative care in California derived from PRIME program data. The Standing Committee discussed whether the data from California were representative of a generalizable performance gap, agreeing that the California data set was large and included a diverse data set of public hospitals.

A Standing Committee member asked for clarification on the preliminary data at the facility level for outpatient palliative care. The developer responded by stating that there are no preliminary data and highlighted that the measure is in the Palliative Care Quality Collaborative (PCQC) registry, which can draw data from multiple sites and settings within palliative care.

The Standing Committee acknowledged the concern regarding data availability and inquired about the implications should the measure not pass on performance gap at the facility level. NQF staff explained that endorsement would be removed but the developer could resubmit the measure in a future cycle, if desired.

The Standing Committee agreed that a performance gap was demonstrated at the palliative care setting. Upon revote, the Standing Committee passed the measure on performance gap at the facility level and recommended the measure for endorsement at the facility level. The CSAC upheld the Standing Committee's recommendation and endorsed the measure. No appeals were received.

Measures Withdrawn From Consideration

Two measures previously endorsed by NQF either have not been resubmitted for maintenance of endorsement or were withdrawn during the endorsement evaluation process. Endorsement for these measures has been removed.

Table 2. Measures Withdrawn From Consideration

Measure	Reason for Withdrawal
NQF #0215 Proportion of Patients Who Died From Cancer Not Admitted to Hospice	Measure is no longer in use.
NQF #1628 Patients With Advanced Cancer Screened for Pain at Outpatient Visits	Retired by the developer.

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Appendix A: Details of Measure Evaluation

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

NQF ensures that quorum is maintained for all live voting. Quorum is 66 percent of active Standing Committee members minus any recused Standing Committee members. Due to the exclusion of recused Standing Committee members from the quorum calculation, the required quorum for live voting may vary among measures. Quorum (14 out of 21 Standing Committee members for all measures) was reached and maintained throughout the full measure evaluation meeting on June 30, 2022. For the post-comment call on October 18, 2022, quorum was not reached and vote totals were collected via an online voting tool. Vote totals may differ between measure criteria and between measures because Standing Committee members may have joined the meeting late, stepped away for a portion of the meeting, or had to leave the meeting before voting was complete. The vote totals listed below reflect Standing Committee members present and eligible to vote at the time of the vote. Voting results are provided below.

A measure is recommended for endorsement by the Standing Committee when greater than 60 percent of voting members select a passing vote option (i.e., Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40 percent of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement.

Measures Endorsed

NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life

Measure Worksheet | Specifications

Description: Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
Numerator Statement: Patients who received chemotherapy in the last 14 days of life
Denominator Statement: Patients who died from cancer
Exclusions: None
Adjustment/Stratification: No risk adjustment or stratification
Level of Analysis: Clinician: Individual, Clinician: Group/Practice
Setting of Care: Outpatient Services, Ambulatory Care
Type of Measure: Process
Data Source: Registry Data
Measure Steward: American Society of Clinical Oncology (ASCO)

STANDING COMMITTEE MEETING June 30, 2022

1. Importance to Measure and Report:
(1a. Evidence, 1b. Performance Gap)
1a. Evidence: **Total votes-16**; **H-0**; **M-15**; **L-1**; **I-0**; 1b. Performance Gap: **Total votes- 16; H-1**; **M-14**; **L-1**; **I-0**
Rationale:

- The Standing Committee agreed that the evidence continues to support actions the accountable entities can take in terms of timely enrollment in palliative care services, as well as a reduction in aggressive interventions at the EOL (not directly contributing to patient comfort) to improve the quality of life, patient and caregiver/family satisfaction at EOL, and lower resource utilization costs.
- The Standing Committee reviewed the three clinical practice guidelines that the developer provided as updated evidence for this measure. Although the Standing Committee did express concern that the

evidence appeared tangential, it agreed that the quantity of evidence was abundant and that the measure evaluated an important aspect of healthcare.

- The Standing Committee acknowledged a gap and an opportunity for improvement as demonstrated by the ASCO QOPI performance data, the Centers for Medicare & Medicaid Services' (CMS) MIPS program benchmarks, and empirical literature.
- The Standing Committee also agreed that substantial gaps and disparities exist across Black and Hispanic groups and people with Medicaid status.
- The Standing Committee agreed that an opportunity for improvement remains and passed the measure on performance gap.

2. Scientific Acceptability of Measure Properties:

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

2a. Reliability: **Total votes-16**; **H-0**; **M-16**; **L-0**; **I-0**; 2b. Validity: **Total votes-15**; **H-0**; **M-15**; **L-0**; **I-0**

Rationale:

- The SMP did not review this measure.
- The Standing Committee noted that the developer conducted inter-rater reliability testing at the patient/encounter level during the previous evaluation and reported a kappa value of 0.818.
- The Standing Committee noted that the developer provided updated reliability testing at the accountable-entity level and reported a signal-to-noise (SNR) analysis of 0.8128 (range: 0.3007 to 1; interquartile range [IQR]: 0.3732).
- While the Standing Committee did applaud the developer for incorporating immunotherapy in the measure specifications, one Standing Committee member recommended an amendment to the measure title to include both targeted therapies (i.e., immunotherapies) and chemotherapy.
- The Standing Committee noted that the developer provided updated validity testing at the accountable-entity level by performing concurrent bivariate correlation analysis using two correlated measures (#0216 and #0210) reporting a Pearson correlation coefficient of 0.9158.
- One Standing Committee member noted that the measure does not differentiate between hematologic malignancies and solid tumors.
- Furthermore, this Standing Committee member highlighted that measure performance might be worse in patients with hematologic malignancies, considering life prolongation is directly related to the continued use of infusion therapy and generally experiences a shorter duration between treatment cessation and death.
- The Standing Committee recommended that the developer consider excluding hematologic malignancies within the denominator or stratify between those two populations in future iterations of the measure.
- The Standing Committee agreed that the reliability and validity testing were robust and passed the measure on reliability and validity.

3. Feasibility: Total votes-15; **H-2; M-13; 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:

- The Standing Committee agreed that the data elements required for the measure are readily available and could be captured without undue burden and passed the measure on feasibility.

4. Usability and Use:

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

4a. Use**: Total votes-15**; **Pass-15; No Pass-0**; 4b. Usability: **Total votes-16**; **H-4; M-12; L-0; I-0**

Rationale:

- The Standing Committee acknowledged that the measure is publicly reported, used within several accountability programs, and implemented within the CQMC's 2020 Medical Oncology Core Set.

- The Standing Committee agreed that measure performance has improved over the years as indicated by the ASCO QOPI and MIPS performance data.
- The Standing Committee passed the measure on use and usability.

5. Related and Competing Measures

- This measure is related to the following measures:
    - NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life
    - NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days
- The Standing Committee reviewed the two related measures and agreed that both are harmonized to the extent possible.

6. Standing Committee Recommendation for Endorsement: **Total votes- 16**; **Yes-16**; **No-0**

7. Public and Member Comment

- One NQF member pre-evaluation comment in favor of the measure was submitted.
- During the pre-evaluation commenting period, the developer submitted a public comment clarifying aspects of the measure specification (i.e., level of analysis).
- No NQF member or public comments were received after the measure evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes – 15; Yes – 15; No – 0; [December 9, 2022: Endorsed]

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

- No appeals were received.

NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the ICU in the Last 30 Days of Life

Measure Worksheet | Specifications

Description: Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

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

Denominator Statement: Patients who died from cancer

Exclusions: None

Adjustment/Stratification: No risk adjustment or stratification

Level of Analysis: Clinical: Individual, Clinician: Group/Practice

Setting of Care: Outpatient Services, Ambulatory Care

Type of Measure: Process

Data Source: Registry Data

Measure Steward: ASCO

STANDING COMMITTEE MEETING June 30, 2022

1. Importance to Measure and Report:

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

1a. Evidence: **Total votes-15**; **H-0**; **M-15**; **L-0**; **I-0**; 1b. Performance Gap: **Total votes- 15; H-0**; **M-15**; **L-0**; **I-0**

Rationale:

- The Standing Committee agreed that the evidence continues to support actions the accountable entities can take in terms of timely enrollment in palliative care services, as well as a reduction in aggressive interventions at the EOL (not directly contributing to patient comfort) to improve the quality of life, patient and caregiver/family satisfaction at EOL, and lower resource utilization costs.

- The Standing Committee noted seven additional sources of evidence that the developer provided. It also agreed that the quantity of evidence was abundant and that the measure evaluated an important aspect of healthcare.
- The Standing Committee acknowledged a gap and an opportunity for improvement as demonstrated by the ASCO QOPI performance data, CMS' MIPS program benchmarks, and empirical literature.
- The Standing Committee acknowledged that a performance gap exists across different racial and ethnic groups, specifically Black and Hispanic patients and those patients covered by Medicaid.
- The Standing Committee agreed that an opportunity for improvement remains and passed the measure on evidence and performance gap.

2. Scientific Acceptability of Measure Properties:

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

2a. Reliability: **Total votes-15**; **H-0**; **M-15**; **L-0**; **I-0**; 2b. Validity: **Total votes-15**; **H-0**; **M-14**; **L-1**; **I-0**

Rationale:

- The SMP did not review this measure.
- The Standing Committee noted that the developer provided updated reliability testing at the accountable-entity level and reported an SNR analysis of 0.9465 (range: 0.7213 to 1; IQR: 0.046).
- The Standing Committee noted that the developer selected both individual and clinician group-level analyses, but it was not clear that the data source could distinguish between the two levels of analysis.
- The developer explained that while only individual-clinician NPIs are eligible for the MIPS program, those NPIs could be grouped to acquire a clinician-group level of analysis. Additionally, the developer expressed that the reliability at the individual level was indicative of the reliability at the clinician-group level.
- The Standing Committee accepted the developer's explanation for the level of analysis specified in the measure and agreed that the reliability was sufficient.
- The Standing Committee noted that the developer provided updated validity testing at the accountable-entity level by performing concurrent bivariate correlation analysis for NQF #0213, NQF #0210, and NQF #0215 using two subsets of providers and reported Pearson correlation coefficients of 0.9166 and 0.9945.
- The Standing Committee agreed that the updated validity results demonstrate a strong positive relationship between NQF #0120 and NQF #0216, which indicate that patients should stop receiving chemotherapy and be placed in hospice to provide the highest possible quality of life in their final days.
- During the discussion of validity, the Standing Committee noted that this measure is not risk-adjusted or risk-stratified and recommended the developer consider risk-adjusting the measure by demographic groups to account for the differences in ICU admissions across different demographic groups.
- In response, the developer expressed concern that risk adjustment or stratification across racial and ethnic groups might unintentionally result in increasing disparities. The Standing Committee agreed that the validity testing was robust and passed the measure on validity.

3. Feasibility: Total votes-15; H-1; M-14; 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:

- The Standing Committee agreed that the data elements required for the measure are readily available and could be captured without undue burden and passed the measure on feasibility.

4. Usability and Use:

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

4a. Use**: Total votes-15**; **Pass-15; No Pass-0**; 4b. Usability: **Total votes-15**; **H-1; M-13; L-1; I-0**

Rationale:

- The Standing Committee acknowledged that the measure is publicly reported, used within several accountability programs, and implemented within the CQMC's 2020 Medical Oncology Core Set.

- The Standing Committee raised concern about the unintended consequence of labeling clinicians as low performers when patients and families might prefer ICU care as EOL care. The developer reiterated that the goal is not to have a zero-percent performance score, and patient and family preferences for EOL treatment are considered in the measure.
- The Standing Committee recommended that the developer continue to monitor for unintended consequences and passed the measure on use and usability.

5. Related and Competing Measures

- This measure is related to the following measures:
    - NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life
    - NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days
    - NQF #1626 Patients Admitted to ICU Who Have Care Preferences Documented
- The Standing Committee reviewed the three related measures and agreed that the measures are harmonized to the extent possible.

6. Standing Committee Recommendation for Endorsement: **Total votes- 15**; **Yes-15**; **No-0**

7. Public and Member Comment

- One NQF member pre-evaluation comment in favor of the measure was submitted.
- During the pre-evaluation commenting period, the developer submitted a public comment clarifying aspects of the measure specification (i.e., level of analysis).
- No NQF member and public comments were received after the measure evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes – 15; Yes – 15; No – 0; [December 9, 2022: Endorsed]

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

- No appeals were received.

NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days

Measure Worksheet | Specifications

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

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

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

Exclusions: None

Adjustment/Stratification: No risk adjustment or stratification

Level of Analysis: Clinician: Group/Practice

Setting of Care: Outpatient Services, Ambulatory Care

Type of Measure: Outcome: Intermediate Clinical Outcome

Data Source: Registry Data

Measure Steward: American Society of Clinical Oncology

STANDING COMMITTEE MEETING June 30, 2022

1. Importance to Measure and Report:

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

1a. Evidence: **Total votes-15**; **H-0**; **M-15**; **L-0**; **I-0**; 1b. Performance Gap: **Total votes- 17; H-2**; **M-15**; **L-0**; **I-0**

Rationale:

- The Standing Committee agreed that the evidence continues to support actions the accountable entities can take in terms of timely enrollment in palliative care services, as well as a reduction in aggressive interventions at the EOL (not directly contributing to patient comfort) to improve the quality of life, patient and caregiver/family satisfaction at EOL, and lower resource utilization costs.
- The Standing Committee reviewed the three additional clinical practice guidelines and one systematic review that the developer provided as updated evidence for this measure. It agreed that the quantity of evidence was abundant and that the measure evaluated an important aspect of healthcare.
- The Standing Committee acknowledged a gap and an opportunity for improvement as demonstrated by the ASCO QOPI performance data, CMS' MIPS program benchmarks, and empirical literature.
- The Standing Committee also agreed that substantial gaps and disparities exist across Black and Hispanic groups and people with Medicaid status.
- The Standing Committee agreed that an opportunity for improvement remains and passed the measure on evidence and performance gap.

2. Scientific Acceptability of Measure Properties:

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

2a. Reliability: **Total votes-17**; **H-0**; **M-17**; **L-0**; **I-0**; 2b. Validity: **Total votes-17**; **H-2**; **M-15**; **L-0**; **I-0**

Rationale:

- The SMP did not review this measure.
- The Standing Committee noted that the developer conducted inter-rater reliability testing at the patient/encounter level during the previous evaluation and reported a kappa value of 55.13 percent.
- The Standing Committee noted that the developer provided updated reliability testing at the accountable-entity level and reported an SNR analysis of 0.7921 (range: 0.1099 to 1; IQR: 0.4698).
- The Standing Committee noted that the developer provided updated validity testing at the accountable-entity level by performing concurrent bivariate correlation analysis using two correlated measures (NQF #0216 and NQF #0210) reporting a Pearson correlation coefficient of 0.9158.
- The Standing Committee requested clarification from the developer on whether a patient diagnosed with cancer whose cause of death was related to a medical reason other than cancer would be excluded from the denominator (i.e., discontinuing dialysis for a patient with kidney disease), to which the developer responded and confirmed that the patient would not be included in the denominator.
- The Standing Committee highlighted that some patients might have justified shorter than three-day hospice periods, considering federal policy requires that treatments be discontinued before enrollment in hospice care services and the discontinuation of certain treatments can cause a rapid decline in patients.
- Recognizing this was out of the developer's control, the Standing Committee recommended broader policies be changed to allow a patient diagnosed with cancer to receive concurrent therapy and hospice services.
- The Standing Committee agreed that the reliability and validity testing were robust and passed the measure on both criteria.

3. Feasibility: Total votes-17; **H-3; M-14; 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:

- The Standing Committee agreed that the data elements required for the measure are readily available and could be captured without undue burden and passed the measure on feasibility.

4. Usability and Use:

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

4a. Use**: Total votes-17**; **Pass-17; No Pass-0**; 4b. Usability: **Total votes-16**; **H-1; M-15; L-0; I-0**

Rationale:

- The Standing Committee acknowledged that the measure is publicly reported, used within several accountability programs, and implemented within the CQMC's 2020 Medical Oncology Core Set.
- The Standing Committee agreed that the measure's performance has improved over the years as indicated by the ASCO QOPI and MIPS performance data.
- The Standing Committee passed the measure on use and usability.

5. Related and Competing Measures

- This measure is related to the following measures:
    - NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life
    - NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life
    - NQF #2651 CAHPS Hospice Survey (Experience With Care)
    - NQF #3235 Hospice and Palliative Care Composite Process Measure Comprehensive Assessment at Admission
- The Standing Committee reviewed the four related measures and agreed that they are harmonized to the extent possible.

6. Standing Committee Recommendation for Endorsement: **Total votes- 17**; **Yes-17**; **No-0**

7. Public and Member Comment

- One NQF member comment in favor of the measure was submitted. While generally supportive of the measure, one NQF member expressed concern about the unintended consequences, as practices may be disincentivized to refer patients to hospice to evade the patient spending less than three days in hospice, thereby reducing the percentage of referrals. Additionally, the NQF member questioned whether patients who died from cancer but were never admitted to hospice were accounted for in the measure's development.
- During the pre-evaluation commenting period, the developer submitted a public comment clarifying aspects of the measure specification (i.e., level of analysis).
- No NQF member or public comments were received after the measure evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes – 15; Yes – 15; No – 0; [December 9, 2022: Endorsed]

The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

- No appeals were received.

NQF #1641 Hospice and Palliative Care – Treatment Preferences

Measure Worksheet | Specifications

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

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

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

Exclusions: There are no denominator exclusions for this measure.

Adjustment/Stratification: No risk adjustment or stratification

Level of Analysis: Facility, Clinician: Group/Practice

Setting of Care: Inpatient/Hospital, Home Care

Type of Measure: Process

Data Source: Assessment Data, Other, Electronic Health Records

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

Measure Steward: University of North Carolina-Chapel Hill

STANDING COMMITTEE MEETING June 30, 2022

1. Importance to Measure and Report:

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

1a. Evidence: **Total votes-17**; **H-1**; **M-14**; **L-2**; **I-0**; 1b. Performance Gap (Facility Level): **Total votes- 17; H-1**; **M-9**; **L-7**; **I-0;** Post-Comment Performance Gap (Facility Level): **Total votes- 14; H-1; M-8; L-3; I-2;** Performance Gap (Clinician Group/Practice Level): **Total votes- 17; H-0; M-4; L-3; I-10**

Rationale:

- The Standing Committee acknowledged that the new evidence (i.e., the 2020 Institute for Clinical Systems Improvement [ICSI] guidelines) the developer provided is similar to the evidence previously reviewed by the Standing Committee during the initial endorsement review and the most recent measure evaluation from 2016.
- The Standing Committee agreed that the evidence tangentially supports the measure and passed the measure on evidence.
- The Standing Committee noted that the mean performance score at the facility level was 98 percent with a range from 0 to 100 (median: 100, IQR: 1.5) and raised concern with the measure being topped out.
- The Standing Committee noted that the developer did not provide data specific to the clinician-group level of analysis. The developer further explained that the clinician-group level was included in the measure specifications due to the diversity of practice and organizational structures that provide hospice and palliative care services.
- The Standing Committee also noted that no clear distinction exists between hospice and acute specialty palliative care data in the submission. During the web meeting, the developer provided the acute specialty palliative care data derived from the PRIME program from 52 California hospitals (mean: 82.9 percent, median: 89.4 percent, and range: 0–100 percent).
- The Standing Committee acknowledged that the developer conducted disparity analyses across different racial, gender, socioeconomic groups, and facilities in rural/urban locations.
- During the discussion on the performance gap, one Standing Committee member noted that this measure is also included in a hospice composite measure. The developer confirmed that the intent is to retire the stand-alone measure and have it function as a component of a hospice composite measure.
- The Standing Committee decided to vote on performance gap separately at the facility- and clinician-group levels.
- The Standing Committee did not pass the measure on the performance gap criterion at the clinician-group level. Therefore, the Standing Committee did not evaluate the remaining criteria for the clinician-group level of analysis and did not recommend the measure at the clinician-group level.
- The Standing Committee did not reach consensus on performance gap (a must-pass criterion) at the facility level and discussed and re-voted on the performance gap criterion at the facility level during the post-comment meeting on October 18, 2022.
- At the post-comment meeting, the Standing Committee reiterated its concern with the lack of palliative care data available and asked whether there were other performance gap data that could be considered. The developer explained that data from the National Palliative Care Registry will not be available until next year. The developer further highlighted the 98 percent achievement in hospice within nationally collected data and the 82.9 percent achievement from hospital-based palliative care in California derived from PRIME program data.
- The Standing Committee discussed whether the data from California were representative of a generalizable performance gap, agreeing that the California data set was large and included a diverse data set of public hospitals.
- The Standing Committee asked NQF staff whether a specific number was associated with being topped out. However, NQF staff did not give a specific number. Given the experience in California, which is the publicly reported data for public hospitals, the Standing Committee agreed that the measure is not topped out.
- A Standing Committee member asked for clarification on preliminary data at the facility level for outpatient palliative care. The developer responded by stating that there are no preliminary data and highlighted that the measure is in the PCQC registry, which can draw data from multiple sites and settings within palliative care.

- The Standing Committee agreed that a performance gap was demonstrated at the palliative care setting.
- Upon revote during the post-comment meeting, the Standing Committee passed the measure on performance gap at the facility level.

2. Scientific Acceptability of Measure Properties:

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

2a. Reliability: **Total votes-17**; **H-0**; **M-14**; **L-3**; **I-0**; 2b. Validity: **Total votes-17**; **H-0**; **M-17**; **L-0**; **I-0**

Rationale:

- The SMP did not review this measure.
- The Standing Committee reviewed the specifications that the developer provided and requested an update from the developer on a few Standing Committee recommendations made during the measure's 2016 maintenance review. Specifically, the Standing Committee questioned whether the developer clarified the numerator criteria because during the previous evaluation, ambiguity surrounded whether a treatment discussion with the patient was required to meet the criteria.
- The developer stated that the numerator is meant to capture direct communication and that documentation should reflect patient self-report; if unavailable, a conversation with a surrogate decision maker and purposeful review of any advance directive will be accepted.
- The Standing Committee noted that the reliability testing has not changed since the previous measure evaluation in 2016.
- The Standing Committee noted that the developer conducted inter-rater reliability testing at the patient/encounter level and reported a kappa statistic of 1.0.
- The Standing Committee noted that the developer also conducted split-half and SNR reliability analyses at the accountable-entity level, which had an intraclass correlation coefficient (ICC) of 0.91 and an SNR ratio of 0.98 and agreed that the reliability testing was robust.
- The Standing Committee questioned whether the developer had reliability data for palliative care at the clinician-group level. The developer stated that they do not have access to the palliative care data; however, they do not expect significant differences in reliability data between hospice and palliative care populations.
- The Standing Committee noted that the validity testing has not changed since the previous measure evaluation in 2016.
- The Standing Committee noted that the developer initially conducted face and construct validity in 2012 and a nonparametric Spearman rank correlation analysis in 2016.
- The Standing Committee agreed that the testing is sufficient and passed the measure on reliability and validity.

3. Feasibility: Total votes-17; **H-0; M-17; 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:

- The Standing Committee agreed that facilities could easily extract hospice data elements from the electronic medical record; however, the Standing Committee expressed concern about data extraction for palliative care data facilities.
- The developer explained that multiple centers are working toward a future state in which facilities can extract numerator data directly from the electronic medical record in various care settings, including palliative care.
- The Standing Committee accepted the developer's response and passed the measure on feasibility.

4. Usability and Use:

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

4a. Use**: Total votes-17**; **Pass-16; No Pass-1**; 4b. Usability: **Total votes-17**; **H-0; M-8; L-7; I-2**

Rationale:

- This measure was implemented in the AAHPM/HPNA MWM project, the PCQC national data registry, and the PRIME pay-for-performance program.
- The Standing Committee expressed concern that the measure is not publicly reported, which is a must-pass criterion, within six years of initial NQF endorsement.
- The developer clarified that the measure is publicly reported as part of the PCQC accountability program for hospice and may not have made that clear in their submission.
- The Standing Committee noted that the developer did not provide year-over-year performance data. The developer explained that more recent performance data are available; however, they did not have access to them and could not provide updated performance results to demonstrate improvement.
- The Standing Committee passed the measure on the use criterion but did not reach consensus on the usability criterion.

5. Related and Competing Measures

- This measure is related to the following measure:
    - NQF #0326 Advance Care Plan
- The Standing Committee was unable to discuss related and competing measures during the measure evaluation meeting but had the opportunity to do so during the post-comment call in the fall of 2022.
- At the post-comment meeting, the Standing Committee agreed that the measures were harmonized to the extent possible

6. Standing Committee Recommendation for Endorsement: **Total Votes–14; Yes–11; No–3**

7. Public and Member Comment

- One NQF member pre-evaluation comment was submitted. The NQF member expressed concern about the level of analysis (i.e., facility level, clinician-group/practice level) to which the measure is specified and tested.
- The developer submitted a public comment clarifying aspects of the measure specification (i.e., level of analysis).
- No NQF member or public comments were received after the measure evaluation meeting.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes- 15; Yes-15; No-0 [December 9, 2022: Endorsed]

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement at the facility level.

9. Appeals

- No appeals were received.

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

NQF#	Title	Federal Programs (Finalized or Implemented)
0167	Improvement in Ambulation and Locomotion	None
0174	Improvement in Bathing	Care Compare Home Health Quality Reporting
0175	Improvement in Bed Transferring	Care Compare Home Health Quality Reporting
0176	Improvement in Management of Oral Medications	Care Compare Home Health Quality Reporting
0177	Improvement in Pain Interfering With Activity	None
0210	Proportion Receiving Chemotherapy in the Last 14 Days of Life	MIPS Prospective Payment System – Exempt Cancer Hospital Quality Reporting
0213	Proportion Admitted to the ICU in the Last 30 Days of Life	MIPS Prospective Payment System – Exempt Cancer Hospital Quality Reporting
0216	Proportion Admitted to Hospice for Less Than Three Days	MIPS Prospective Payment System – Exempt Cancer Hospital Quality Reporting
0326	Advanced Care Plan	HEDIS Quality Measure Rating System
1617	Patients Treated With an Opioid Who Are Given a Bowel Regimen	None
1623	Bereaved Family Survey	None
1625	Hospitalized Patients Who Die an Expected Death With an ICD That Has Been Deactivated	None

NQF#	Title	Federal Programs (Finalized or Implemented)
1626	Patients Admitted to ICU Who Have Care Preferences Documented	None
1641	Hospice and Palliative Care – Treatment Preferences	Care Compare
2651	CAHPS Hospice Survey (Experience With Care)	Care Compare Hospice Quality Reporting
3235	Hospice and Palliative Care Composite Process Measure — Comprehensive Assessment at Admission	Care Compare
3497	Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	None
3500	Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	None

*Adapted from the CMS Measures Inventory Tool. Last Accessed on July 19, 2022.

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

STANDING COMMITTEE

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Appendix D: Measure Specifications

NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life

STEWARD

American Society of Clinical Oncology

DESCRIPTION

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

TYPE

Process

DATA SOURCE

Registry Data
Not applicable

LEVEL

Clinician: Individual, Clinician: Group/Practice

SETTING

Outpatient Services, Ambulatory Care

NUMERATOR STATEMENT

Patients who received chemotherapy in the last 14 days of life

NUMERATOR DETAILS

Individuals in the denominator who received chemotherapy in the last 14 days of life will be counted in the numerator. This measure is to be submitted a minimum of once per performance period for patients who died of cancer during the measurement year (January 1-December 31). Numerator Instructions: INVERSE MEASURE – A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.Numerator Options: Performance Met: Patient received chemotherapy in the last 14 days of life (G9847)OR Performance Not Met: Patient did not receive chemotherapy in the last 14 days of life (G9848)

DENOMINATOR STATEMENT

Patients who died from cancer.

DENOMINATOR DETAILS

This measure is to be submitted a minimum of once per performance period for patients who died of cancer during the measurement year (January 1- December 31). It is anticipated that eligible clinicians who provide services for patients with the diagnosis of cancer will submit this measure. Denominator Criteria (Eligible Cases): Diagnosis for cancer (ICD-10-CM): Refer to attached data dictionary (Excel file).AND At least two patient encounters during the performance period (CPT): 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02AND Patients who died from cancer: G9846

EXCLUSIONS

None

EXCLUSION DETAILS

None

RISK ADJUSTMENT

No additional risk adjustment analysis included

No risk adjustment or stratification

STRATIFICATION

Not applicable

TYPE SCORE

Rate/proportion

Better quality = Lower score

ALGORITHM

Performance is calculated as:

1. Identify those patients that meet the denominator criteria defined in the measure.
2. Subtract those patients with a denominator exclusion from the denominator. Note: this measure does not have exclusions.
3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria.
4. Calculation: Numerator/Denominator-Denominator Exclusions

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NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life

STEWARD

American Society of Clinical Oncology

DESCRIPTION

Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

TYPE

Process

DATA SOURCE

Registry Data

Not applicable

LEVEL

Clinician: Individual, Clinician: Group/Practice

SETTING

Outpatient Services, Ambulatory Care

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

Individuals in the denominator who died from cancer and were admitted to the ICU in last 30 days of life will be counted in the numerator. This measure is to be submitted a minimum of once per performance period for patients who died of cancer during the measurement year (January 1-December 31). Numerator Instructions: INVERSE MEASURE- A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.Numerator Options: Performance Met: Patient admitted to the ICU in the last 30 days of life (G9853)OR Performance Not Met: Patient was not admitted to the ICU in the last 30 days of life (G9854)

DENOMINATOR STATEMENT

Patients who died from cancer

DENOMINATOR DETAILS

This measure is to be submitted a minimum of once per performance period for patients who died of cancer during the measurement year (January 1- December 31). It is anticipated that eligible clinicians who provide services for patients with the diagnosis of cancer will submit this measure.Denominator Criteria (Eligible Cases): Diagnosis for cancer (ICD-10-CM): Refer to attached data dictionary (Excel file).AND At least two patient encounters during the performance period (CPT): 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215WITHOUTTelehealth Modifier: GQ, GT, 95, POS 02AND Patients who died from cancer: G9852

EXCLUSIONS

None

EXCLUSION DETAILS

Not applicable

RISK ADJUSTMENT

No additional risk adjustment analysis included

No risk adjustment or stratification

STRATIFICATION

Not applicable

TYPE SCORE

Rate/proportion

Better quality = Lower score

ALGORITHM

Performance is calculated as:

1. Identify those patients that meet the denominator criteria defined in the measure.
2. Subtract those patients with a denominator exclusion from the denominator if applicable. Note: this measure does not have exclusions.
3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria.
4. Calculation: Numerator/Denominator-Denominator Exclusions

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NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days

STEWARD

American Society of Clinical Oncology

DESCRIPTION

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

TYPE

Outcome: Intermediate Clinical Outcome

DATA SOURCE

Registry Data
Not applicable

LEVEL

Clinician: Group/Practice

SETTING

Outpatient Services, Ambulatory Care

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

Individuals in the denominator who died from cancer and spent fewer than 3 days in hospice will be counted in the numerator. This measure is to be submitted a minimum of once per performance period for patients who died of cancer during the measurement year (January 1-December 31). Numerator Instructions: INVERSE MEASURE- A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control. Numerator Options: Performance Met: Patient spent less than three days in hospice care Performance Not Met: Patient spent greater than or equal to three days in hospice care

DENOMINATOR STATEMENT

Patients who died from cancer who were admitted to hospice

DENOMINATOR DETAILS

This measure is to be submitted a minimum of once per performance period for patients who died of cancer who were admitted to hospice during the measurement year (January 1- December 31). It is anticipated that eligible clinicians who provide services for patients with the diagnosis of cancer will submit this measure. Denominator Criteria (Eligible Cases):Diagnosis for cancer (ICD-10-CM): Refer to attached data dictionary (Excel file). AND At least two patient encounters during performance period (CPT): 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215WITHOUTTelehealth Modifier: GQ, GT, 95, POS 02AND Patients enrolled in hospice: G9858AND Patients who died from cancer: G9852

EXCLUSIONS

None

EXCLUSION DETAILS

Not applicable

RISK ADJUSTMENT

No additional risk adjustment analysis included

No risk adjustment or stratification

STRATIFICATION

Not applicable

TYPE SCORE

Rate/proportion

Better quality = Lower score

ALGORITHM

Performance is calculated as:

1. Identify those patients that meet the denominator criteria defined in the measure.
2. Subtract those patients with a denominator exclusion from the denominator. Note: this measure does not have any denominator exclusions
3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria.
4. Calculation: Numerator/Denominator-Denominator Exclusions

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These clinical indicators and quality measures are not intended to and should never supplant independent physician judgment with respect to particular patients or clinical situations. Patient care is always subject to the independent physician judgment with respect to particular patients or clinical situations. Patient care is always subject to the independent professional judgment of the treating physician.

Accordingly, QOPI participants' adherence to quality measures contained in this research report is strictly voluntary and discretionary, with the ultimate determination regarding their application to be made by the treating physician in his or her professional judgment and in light of each patient's individual circumstances. ASCO does not endorse the QOPI® measures as guidelines for standards of practice or 'best practices.'

NQF #1641 Hospice and Palliative Care – Treatment Preferences

STEWARD

University of North Carolina-Chapel Hill

DESCRIPTION

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

TYPE

Process

DATA SOURCE

Assessment Data, Other, Electronic Health Records

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

LEVEL

Facility, Clinician: Group/Practice

SETTING

Inpatient/Hospital, Home Care

NUMERATOR STATEMENT

Patients whose medical record includes documentation of life sustaining preferences

NUMERATOR DETAILS

Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as “Full Code” or “DNR/DNI” do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.

DENOMINATOR STATEMENT

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

DENOMINATOR DETAILS

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

EXCLUSIONS

There are no denominator exclusions for this measure.

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No additional risk adjustment analysis included

No risk adjustment or stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion

Better quality = Higher score

ALGORITHM

Chart documentation of life sustaining preferences:

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

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

c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments.

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

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N/A

Appendix E: Related and Competing Measures

Comparison of NQF #0210 and NQF #0213

Steward/Developer

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

American Society of Clinical Oncology

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

American Society of Clinical Oncology

Description

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

Numerator

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who received chemotherapy in the last 14 days of life

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

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

Denominator

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who died from cancer.

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Patients who died from cancer

Measure Type

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Process

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Process

Data Source

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Registry Data

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Registry Data

Target Population

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Adults (Age >= 18), Elderly (Age >= 65)

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Elderly (Age >= 65), Adults (Age >= 18)

Care Setting

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Outpatient Services, Ambulatory Care

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Outpatient Services, Ambulatory Care

Level of Analysis

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

Comparison of NQF #0210 and NQF #0216

Steward/Developer

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

American Society of Clinical Oncology

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

American Society of Clinical Oncology

Description

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

Numerator

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who received chemotherapy in the last 14 days of life

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

Denominator

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who died from cancer.

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Patients who died from cancer who were admitted to hospice

Measure Type

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Process

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outcome: Intermediate Clinical Outcome

Data Source

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Registry Data

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Registry Data

Target Population

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Adults (Age >= 18), Elderly (Age >= 65)

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Elderly (Age >= 65), Adults (Age >= 18)

Care Setting

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Outpatient Services, Ambulatory Care

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outpatient Services, Ambulatory Care

Level of Analysis

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Clinician: Group/Practice

Comparison of NQF #0213 and NQF #0210

Steward/Developer

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

American Society of Clinical Oncology

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

American Society of Clinical Oncology

Description

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

Numerator

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

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

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who received chemotherapy in the last 14 days of life

Denominator

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Patients who died from cancer

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who died from cancer.

Measure Type

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Process

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Process

Data Source

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Registry Data

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Registry Data

Target Population

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Elderly (Age >= 65), Adults (Age >= 18)

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Adults (Age >= 18), Elderly (Age >= 65)

Care Setting

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Outpatient Services, Ambulatory Care

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Outpatient Services, Ambulatory Care

Level of Analysis

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

Comparison of NQF #0213 and NQF #0216

Steward/Developer

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

American Society of Clinical Oncology

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

American Society of Clinical Oncology

Description

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

Numerator

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

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

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

Denominator

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Patients who died from cancer

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Patients who died from cancer who were admitted to hospice

Measure Type

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Process

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outcome: Intermediate Clinical Outcome

Data Source

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Registry Data

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Registry Data

Target Population

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Elderly (Age >= 65), Adults (Age >= 18)

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Elderly (Age >= 65), Adults (Age >= 18)

Care Setting

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Outpatient Services, Ambulatory Care

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outpatient Services, Ambulatory Care

Level of Analysis

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Clinician: Group/Practice

Comparison of NQF #0213 and NQF #1626

Steward/Developer

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

American Society of Clinical Oncology

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

RAND Corporation

Description

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

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

Numerator

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

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

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

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

Denominator

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Patients who died from cancer

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

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

Measure Type

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Process

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

Process

Data Source

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Registry Data

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

Paper Medical Records

Target Population

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Elderly (Age >= 65), Adults (Age >= 18)

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

Individuals with multiple chronic conditions, Elderly

Care Setting

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Outpatient Services, Ambulatory Care

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

Inpatient/Hospital

Level of Analysis

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

NQF #1626 PATIENTS ADMITTED TO ICU WHO HAVE CARE PREFERENCES DOCUMENTED

Facility

Comparison of NQF #0216 and NQF #0210

Steward/Developer

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

American Society of Clinical Oncology

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

American Society of Clinical Oncology

Description

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

Numerator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who received chemotherapy in the last 14 days of life

Denominator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Patients who died from cancer who were admitted to hospice

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Patients who died from cancer.

Measure Type

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outcome: Intermediate Clinical Outcome

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Process

Data Source

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Registry Data

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Registry Data

Target Population

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Elderly (Age >= 65), Adults (Age >= 18)

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Adults (Age >= 18), Elderly (Age >= 65)

Care Setting

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outpatient Services, Ambulatory Care

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Outpatient Services, Ambulatory Care

Level of Analysis

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Clinician: Group/Practice

NQF #0210 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER RECEIVING CHEMOTHERAPY IN THE LAST 14 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

Comparison of NQF #0216 and NQF #0213

Steward/Developer

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

American Society of Clinical Oncology

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

American Society of Clinical Oncology

Description

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Percentage of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

Numerator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

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

Denominator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Patients who died from cancer who were admitted to hospice

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Patients who died from cancer

Measure Type

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outcome: Intermediate Clinical Outcome

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Process

Data Source

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Registry Data

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Registry Data

Target Population

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Elderly (Age >= 65), Adults (Age >= 18)

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Elderly (Age >= 65), Adults (Age >= 18)

Care Setting

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outpatient Services, Ambulatory Care

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Outpatient Services, Ambulatory Care

Level of Analysis

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Clinician: Group/Practice

NQF #0213 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO THE INTENSIVE CARE UNIT (ICU) IN THE LAST 30 DAYS OF LIFE

Clinician: Individual, Clinician: Group/Practice

Comparison of NQF #0216 and NQF #2651

Steward/Developer

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

American Society of Clinical Oncology

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

Centers for Medicare & Medicaid Services

Description

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #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 experiences of hospice patients and their primary caregivers.

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

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms
- Getting Hospice Training
- In addition, there are two other measures, also called "global ratings."
- Rating of the hospice care
- Willingness to recommend the hospice

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

List of CAHPS Hospice Survey Measures

Multi-Item Measures

Hospice Team Communication (Composed of 6 items)

1. 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?
2. While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?
3. How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?
4. While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?
5. While your family member was in hospice care, how often did the hospice team listen carefully to you?
6. 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)

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?
2. 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)

1. While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?
2. 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)

1. While your family member was in hospice care, how much emotional support did you get from the hospice team?
2. In the weeks after your family member died, how much emotional support did you get from the hospice team?
3. 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)

1. Did your family member get as much help with pain as he or she needed?
2. How often did your family member get the help he or she needed for trouble breathing?
3. How often did your family member get the help he or she needed for trouble with constipation?
4. 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)

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

Rating Measures:

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

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

The CAHPS Hospice Survey is a standardized survey instrument designed to collect reports and ratings of experiences with hospice care. The survey is completed by the primary caregiver of the patient who died while receiving hospice care (hereafter, "decedent"). The primary caregiver is intended to be the family member or friend most knowledgeable about the decedent's hospice care, and is identified through hospice administrative records. Data collection for sampled decedents/caregivers is initiated two months following the month of the decedent's death.

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

Numerator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

CMS calculates CAHPS Hospice Survey measures using top-box scoring. The top-box score refers to the percentage of caregiver respondents that give the most positive response. Details regarding the definition of most positive response are noted in Section S.6 below.

Denominator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Patients who died from cancer who were admitted to hospice

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

The measure's denominator is the number of survey respondents who answered the item. The target population for the survey is primary caregivers of hospice decedents. The survey uses screener questions to identify respondents eligible to respond to subsequent items. Therefore, denominators will vary by survey item (and corresponding multi-item measures, if applicable) according to the eligibility of respondents for each item.

Measure Type

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outcome: Intermediate Clinical Outcome

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

Outcome: PRO-PM

Data Source

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Registry Data

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

Instrument-Based Data

Target Population

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Elderly (Age >= 65), Adults (Age >= 18)

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

Elderly (Age >= 65); Women

Care Setting

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outpatient Services, Ambulatory Care

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

Home Care

Level of Analysis

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Clinician: Group/Practice

NQF #2651 CAHPS® HOSPICE SURVEY (EXPERIENCE WITH CARE)

Facility

Comparison of NQF #0216 and NQF #3235

Steward/Developer

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

American Society of Clinical Oncology

NQF #3235 HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT AT ADMISSION

Centers for Medicare & Medicaid Services

Description

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #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.

Numerator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

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

NQF #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.

Denominator

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Patients who died from cancer who were admitted to hospice

NQF #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.

Measure Type

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outcome: Intermediate Clinical Outcome

NQF #3235 HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT AT ADMISSION

Composite

Data Source

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Registry Data

NQF #3235 HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT AT ADMISSION

Other

Target Population

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Elderly (Age >= 65), Adults (Age >= 18)

NQF #3235 HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT AT ADMISSION

Hospice patients, Adults (Age >= 18)

Care Setting

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Outpatient Services, Ambulatory Care

NQF #3235 HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT AT ADMISSION

Other

Level of Analysis

NQF #0216 PERCENTAGE OF PATIENTS WHO DIED FROM CANCER ADMITTED TO HOSPICE FOR LESS THAN 3 DAYS

Clinician: Group/Practice

NQF #3235 HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT AT ADMISSION

Facility

Comparison of NQF #1641 and NQF #0326

Steward/Developer

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

University of North Carolina-Chapel Hill

NQF #0326 ADVANCE CARE PLAN

National Committee for Quality Assurance

Description

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

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

NQF #0326 ADVANCE CARE PLAN

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

Numerator

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

Patients whose medical record includes documentation of life sustaining preferences

NQF #0326 ADVANCE CARE PLAN

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

Denominator

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

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

NQF #0326 ADVANCE CARE PLAN

All patients aged 65 years and older.

Measure Type

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

Process

NQF #0326 ADVANCE CARE PLAN

Process

Data Source

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

Electronic Health Records, Other, Assessment Data

NQF #0326 ADVANCE CARE PLAN

Claims

Target Population

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

Populations at Risk, Elderly (Age >= 65), Individuals with multiple chronic conditions

NQF #0326 ADVANCE CARE PLAN

Dual eligible beneficiaries, Elderly

Care Setting

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

Inpatient/Hospital, Home Care

NQF #0326 ADVANCE CARE PLAN

Outpatient Services

Level of Analysis

NQF #1641 HOSPICE AND PALLIATIVE CARE – TREATMENT PREFERENCES

Facility, Clinician: Group/Practice

NQF #0326 ADVANCE CARE PLAN

Clinician: Group/Practice

Appendix F: Pre-Evaluation Comments

Comments received as of June 15, 2022.

NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life

Commenter

Lela Durakovic, on behalf of American Society of Clinical Oncology

Comment

Measures #0210, #0213, and #0216 were tested using a 2017 PQRS/MIPS registry dataset, and the signal-to-noise analysis was performed at the provider NPI level. Since CMS de-identified all practice and provider ID's in the registry dataset, we were initially unable to determine whether these NPIs belong to individual clinicians or provider organizations. Therefore, the initial level of analysis was set as Clinician-Group as ASCO could not confidently state that the dataset contained only individual clinician NPIs. However, after the initial signal-to-noise analysis, ASCO received feedback from CMS that only individual clinician NPIs are eligible for the MIPS program. Hence, we can now confidently state that the 2017 PQRS/MIPS registry dataset contains only individual clinician NPIs and that the analysis meets the specificity requirements for the Clinician-Individual level. Additionally, since the signal-to-noise reliability results at the NPI level were high for all three measures, ASCO feels confident in recommending that the NPI level analysis be used to prove reliability at the Clinician-Group level. Calculating group-level reliability by combining patient scores under individual NPIs into larger groupings according to organizations' TINs will increase the sample sizes of patient scores and produce more reliable results with greater precision and power. Therefore, performing a group-level analysis will introduce no potential threats to the measures' reliability. The reliability of measure scores at group-level analysis can only increase.

NQF #0210 Percentage of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life

Commenter

Anna Kim, on behalf of American Geriatrics Society

Comment

The American Geriatrics Society believes this is an important measure.

NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life

Commenter

Anne Kim, on behalf of American Geriatrics Society

Comment

The American Geriatrics Society believes this is an important measure.

NQF #0213 Percentage of Patients Who Died From Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life

Commenter

Lela Durakovic, on behalf of American Society of Clinical Oncology

Comment

Measures #0210, #0213, and #0216 were tested using a 2017 PQRS/MIPS registry dataset, and the signal-to-noise analysis was performed at the provider NPI level. Since CMS de-identified all practice and provider ID's in the registry dataset, we were initially unable to determine whether these NPIs belong to individual clinicians or provider organizations. Therefore, the initial level of analysis was set as Clinician-Group as ASCO could not confidently state that the dataset contained only individual clinician NPIs. However, after the initial signal-to-noise analysis, ASCO received feedback from CMS that only individual clinician NPIs are eligible for the MIPS program. Hence, we can now confidently state that the 2017 PQRS/MIPS registry dataset contains only individual clinician NPIs and that the analysis meets the specificity requirements for the Clinician-Individual level. Additionally, since the signal-to-noise reliability results at the NPI level were high for all three measures, ASCO feels confident in recommending that the NPI level analysis be used to prove reliability at the Clinician-Group level. Calculating group-level reliability by combining patient scores under individual NPIs into larger groupings according to organizations' TINs will increase the sample sizes of patient scores and produce more reliable results with greater precision and power. Therefore, performing a group-level analysis will introduce no potential threats to the measures' reliability. The reliability of measure scores at group-level analysis can only increase.

NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than 3 Days

Commenter

Anne Kim, on behalf of American Geriatrics Society

Comment

While the American Geriatrics Society (AGS) is generally supportive of the measure, we are concerned that practices may be disincentivized to refer patients to hospice in order to evade the patient spending less than three days in hospice and reduce the percentage of referrals. We believe that a later referral to hospice would be more helpful than none at all, particularly as caregivers may benefit from bereavement support and patients may die at home more peacefully. Further, it was not clear from the materials provided whether patients who died from cancer but were never admitted to hospice were accounted for in the measure development. The AGS recommends further consideration of the concerns raised and how they can be addressed.

NQF #0216 Percentage of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days

Commenter

Lela Durakovic, on behalf of American Society of Clinical Oncology

Comment

Measures #0210, #0213, and #0216 were tested using a 2017 PQRS/MIPS registry dataset, and the signal-to-noise analysis was performed at the provider NPI level. Since CMS de-identified all practice and provider ID's in the registry dataset, we were initially unable to determine whether these NPIs belong to individual clinicians or provider organizations. Therefore, the initial level of analysis was set as Clinician-Group as ASCO could not confidently state that the dataset contained only individual clinician NPIs. However, after the initial signal-to-noise analysis, ASCO received feedback from CMS that only individual clinician NPIs are eligible for the MIPS program. Hence, we can now confidently state that the 2017 PQRS/MIPS registry dataset contains only individual clinician NPIs and that the analysis meets the specificity requirements for the Clinician-Individual level. Additionally, since the signal-to-noise reliability results at the NPI level were high for all three measures, ASCO feels confident in recommending that the NPI level analysis be used to prove reliability at the Clinician-Group level. Calculating group-level reliability by combining patient scores under individual NPIs into larger groupings according to organizations' TINs will increase the sample sizes of patient scores and produce more reliable results with greater precision and power. Therefore, performing a group-level analysis will introduce no potential threats to the measures' reliability. The reliability of measure scores at group-level analysis can only increase.

NQF #1641 Hospice and Palliative Care – Treatment Preferences

Commenter

Koryn Rubin, on behalf of American Medical Association

Comment

The American Medical Association (AMA) requests clarification on whether this measure is truly intended to be used at the group/practice level. On review of the measure testing and its current and planned future uses, we believe that the measure has only been tested and implemented for use at the facility level. We ask that the Committee consider this inconsistency and ensure that the measure is only endorsed at the appropriate level(s) of analysis.

Appendix G: Post-Evaluation Comments

No comments have been received as of September 13, 2022.

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