NATIONAL QUALITY FORUM

Memo

September 27, 2019

To: Geriatrics and Palliative Care Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comments received and NQF member expression of support

Purpose of the Call

The Geriatrics and Palliative Care Standing Committee will meet via web meeting on October 3, 2019 from 2 pm to 4 pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period;
- Provide input on proposed responses to the post-evaluation comments;
- Review and discuss NQF members' expression of support of the measures under consideration;
- Determine whether reconsideration of any measures or other courses of action are warranted;
- Discuss measures that are related to the two measures recommended for endorsement during this evaluation cycle; and
- Identify gaps in measurement for geriatrics and palliative care.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table and additional documents included with the call materials).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar.

1. Direct your web browser to the following URL: https://core.callinfo.com/callme/?ap=8007682983&ac=5599510&role=p&mode=ad

2. Under “Join a Conference,” please enter your first and last name. The conference number will be **800-768-2983.** The access code is **5599510**. You may save the access code under “Geriatrics and Palliative Care.” Please click “save” if you have not already.
3. Please then enter your phone number under the “Call Me at” feature to complete registration. Please enter the appropriate designation under the “Save this number as” text box. Please click “save” if you have not already. This feature will allow CenturyLink to call you and add you to the conference.
4. Click the “Call Me & Join Web Meeting” button to enter the meeting.
5. Alternative dial-in: Please dial **800-768-2983** from your mobile phone, and then enter the access code **5599510**.

Background

In 2017, NQF expanded the scope of the Standing Committee charged with the oversight of NQF’s portfolio of palliative and end-of-life care measures by adding measures specifically relevant to the geriatric population. This renamed “Geriatrics and Palliative Care Standing Committee” has the requisite expertise to evaluate and assume oversight of measures that focus on key issues specific to older adults.

During its spring 2019 evaluation cycle, the 24-person Geriatrics and Palliative Care Standing Committee evaluated two new geriatrics measures. These process measures assess evaluation of functional status and cognitive function in home-based primary care and palliative care patients. The Standing Committee recommended both measures for endorsement.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits comments prior to the evaluation of the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from May 8, 2019 to June 1, 2019 for the measures under review. NQF did not receive any pre-evaluation comments prior to the measure evaluation meeting.

Post-evaluation Comments

Comments will be identified by staff and the Committee at the close of the comment period on September 6, 2019.

The draft report was posted on the project webpage for public and NQF member comment from August 8, 2019 to September 6, 2019. During this commenting period, NQF received a total of five comments from two member organizations and two members of the public. The stakeholder perspective of the NQF members who commented is shown in the table below.

Member Council	# of Member Organizations Who Commented
Consumer	2
Health Plan	0
Health Professional	0
Provider Organization	0
Public/Community Health Agency	0
Purchaser	0
QMRI	0
Supplier/Industry	0

We have included all comments that we received in the comment table (excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, and draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table before the meeting and consider the individual comments received and the proposed responses to each.

NQF received a total of five comments that applied to both measures. In order to facilitate discussion, the comments have been categorized into major topic areas or themes. Although all comments are subject to discussion, the intent is not to discuss each individual comment on the October 3 post-comment call. Instead, we will spend the majority of the time considering the three themes discussed below, and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

Comments and Their Disposition

Overall, commenters were supportive of the Committee's endorsement recommendations. Three main themes emerged from the comments, as described below.

Excluding Patient Encounters within the Last 90 Days of the Measurement Period

One commenter expressed concern with the denominator exception for those patients whose most recent patient encounter occurs within the last 90 days of the 12-month measurement period. The commenter suggested that this exception does not factor in the possibility of seasonal or geographic variation. The commenter also believes this exception creates a perverse incentive to neglect assessment of activities of daily living (ADL) and cognition for new patients in the last 90 days of the measurement period.

> **Measure Steward/Developer Response:**
> There are two measures under consideration—one examines the rate of functional assessment in the homebound population while the other focuses on cognitive assessment completed in the homebound population. Fall risk assessment is a worthy endeavor; however, functional assessment in this measure is focused on traditional basic activities of daily living and instrumental activities of daily living, which are supported by an extensive evidence base that has been developed over the past several

decades. There are a number of approaches for fall risk assessment, but this is distinct from assessment of basic and instrumental activities of daily living. While the ability to transfer and ambulate may be components of some fall risk assessment approaches, the focus of the functional assessment is not on fall risk, per se. While we do not disagree that seasonal or regional influences could affect fall rates, we do not expect that these influences would have an impact on rates of cognitive or functional status assessments in the homebound population, as defined in the measure.

Regarding the 90-day perverse incentive concern, the primary exceptions are for Newly-Enrolled (Submission Criteria 1) patients who enroll within the last 90 days of the measurement period. This allows for instances when the provider may require more than one visit/encounter to complete the assessment before the end of the measurement period. This was considered to be a reasonable exception by the experts who guided the development of the measure. Very few providers (~6) used this exception in the testing data. This exception is not applied in Established Patients (Submission Criteria 2).

Proposed Committee Response:

Thank you for your comment. The Committee agrees that the concern regarding seasonal or geographic variation could affect fall rates but should not affect ability of providers to conduct functional status or cognitive assessments in their homebound patients. The Committee agrees with the sentiment of the 90-day exception in providing time for assessments to be completed for new patients and also recognizes that few providers use this exception. However, the Committee encourages the developer to consider shortening the grace period as a way to minimize the potential perverse incentive of neglecting these assessments for their new patients. .

Broader Patient Populations

Another commenter encouraged the Committee to focus on measures that address the benefit of functional status and cognitive assessment measures for broader palliative care populations, including patients who may not require home visits. Additionally, the commenter encouraged the Committee and measure stewards to consider how these measures may be modified to address populations who are further upstream in their clinical progression (e.g., who may not yet require palliative care services), but who would nonetheless benefit from functional and cognitive status assessments.

Measure Steward/Developer Response:

Patients need not be exclusively enrolled in palliative care to be included in the measure. The measure aims to improve quality for patients receiving either primary care or palliative care in the home. The focus on the home derives from the lack of current functional assessment measures focused on homebound populations. Many patients receiving home-based primary care have palliative care needs, some of which may be addressed by home-based primary care providers. In other instances, palliative medicine provider input is needed. These measures are applicable to any upstream palliative care services provided to patients in the home.

Proposed Committee Response:

Thank you for your comment. The Committee agrees that similar measures that could be used for community-based palliative care are needed, as are similar measures targeted toward geriatric patients or those with serious illness more broadly..

Use Beyond the National Home-Based Primary Care & Palliative Care Registry

The same commenter also encouraged the measure steward to make these measures more broadly available for use beyond the National Home-Based Primary Care & Palliative Care Registry. The commenter noted that doing so could help integrate functional and cognitive status assessment into routine care for patients experiencing or at risk of serious illness and ensure timely access to palliative care services.

Measure Steward/Developer Response:

The measure developers agree that NQF endorsement is a critical first step for expanding the use of these measures beyond the National Home-Based Primary Care & Palliative Care Registry. These measures are currently also used in Quality Improvement activities approved by both the American Board of Internal Medicine and the National Home-Based Primary Care and Palliative Care Learning Collaborative. Now that the measure is endorsed by NQF, the measure developers will continue to advocate for the importance and use of this measure in other relevant programs as opportunities arise.

Proposed Committee Response:

Thank you for your comment. The Committee agrees that use of these measures should be expanded beyond the National Home-Based Primary Care & Palliative Care Registry. It also encourages the developers to track other uses of the measure and, potentially, seek to expand the specifications and testing of the measure beyond the registry data source.

Discussion of Related Measures

Evaluated Measure	Related Measures
3497 Evaluation of Functional Status (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients	• **2524e** Rheumatoid Arthritis: Patient-Reported Functional Status Assessment [*clinician-level measure used in outpatient setting; target population: adults with rheumatoid arthritis*] • **2624** Functional Outcome Assessment [*clinician-level measure (individual and group) used in outpatient setting; target population: adults with outpatient visit*] • **2631** Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function [*facility-level measure used in outpatient setting; target population: long-term care hospital patients*]

Evaluated Measure	Related Measures
3500 Evaluation of Cognitive Function for Home-Based Primary Care and Palliative Care Patients	• 2872e Dementia: Cognitive Assessment [clinician-level eCQM (group/practice and individual) used in hospital and outpatient settings; target population: patients diagnosed with dementia]

Discussion Questions

- Measures 2524e and 2624 allow use of several reliable and valid instruments/standardized tools. Should there be a similar requirement for 3497?
- Measure 2631 also includes assessment of a care plan that addresses function. Would a similar care plan component at some time in the future be a reasonable modification for 3497?

Measurement Gaps Discussion

In 2017, the NQF Palliative and End-of-Life Standing Committee pilot tested new prioritization criteria and an approach developed by NQF by applying them to measures in NQF's Palliative and End-of-Life Care portfolio. As part of this effort, the Committee identified priority gaps in measurement, as shown in the table below.

High-Impact Outcome	Driver Measures	Priority Measures	Improvement Measures
Health outcomes (function/well-being and survival)	• Preservation of functional status • Total pain (including spiritual pain) • Psychosocial health • Unmet need (e.g., through iPOS instrument)	• Quality of life (e.g., through single item self-report of quality of life as in McGill QOL Survey)	• Screening for depression, anxiety, etc. • Access to nutritional support
Patient experience	• Goal-concordance • Shared decision making • Comfort with decisions that are made (e.g., less decisional conflict) • Patient/family engagement	• Values conversation that elicits goals of care • Good communication (e.g., prognosis, health literacy, clarity of goals for all parties)	• Use of decisional conflict scale • Dying in preferred site of death

High-Impact Outcome	Driver Measures	Priority Measures	Improvement Measures
Preventable harm/ complications	• Unwanted care/care that is not goal-concordant • Symptomatology due to use of excess/poor value medications/ interventions • Unmet psychosocial and spiritual need	• Medication reconciliation (*potentially 0097, 2988, 0646*) • Safe medication use (*potentially 2993, 0022*) • Safe medication disposal • Feeding tube placement in dementia patients • Discussion about and potential discontinuation of available interventions in terminal patients (e.g., statin, aspirin, multivitamins, memory drugs, ICDs, CPR, chemo in last 2 weeks)	• Assessment of psychosocial and spiritual issues/needs • POLST form completion according to patient values
Prevention/ healthy behaviors	• Caregiver support • Caregiver stress • Good communication (early, open/shared)	• Basic caregiver skills training provided (e.g., how to lift patient without injury to caregiver's back, changing sheets when patient is bedridden, etc.)	• Assessing family/caregivers for risk (e.g., depression, complicated bereavement, etc.)
Total cost/low-value care	• None identified	• Potentially avoidable ED visits and hospitalizations • Proportion of elderly chronic kidney disease patients with multiple comorbidities who were started on dialysis • Proportion of dialysis patients admitted to ICU in last 30 days of life	• Percentage of elderly patients with chronic kidney disease and multiple comorbidities admitted to an "active medical management without dialysis" pathway of care
Access to needed care	• Geographic access to hospice and palliative care (both hospital and community) • Access to home and community-based services	• Time to palliative care consult OR Timeliness of palliative care consultation (>48 hours prior to death) • Access to specialty palliative care team • Nursing load or chaplain load	• Number of patients in a hospice or palliative care program who are getting chaplain visits
Equity of care	• Standard/minimum service offerings	• Materials offered at appropriate education levels/languages	• None identified

Discussion Questions

- To your knowledge, has there been any progress in filling these measurement gaps?

- Are there other priority gaps in measurement that you want to highlight for palliative care?
- Are there other priority gaps in measurement that you want to highlight for the geriatric population?