NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 1630 NQF Project: Palliative Care and End-of-Life Care
(for Endorsement Maintenance Review) Original Endorsement Date: Most Recent Endorsement Date:
BRIEF MEASURE INFORMATION
De.1 Measure Title: Hospitalized Patients Who Die an Expected Death Who Have Dyspnea Addressed
Co.1 Measure Steward: RAND Corporation | 1776 Main Street | Santa Monica | California | 90407
De.2 Brief Description of Measure: Percentage of hospitalized patients who died an expected death who had dyspnea in the last 7 days of life and who had documentation that they received dyspnea care and follow up
2a1.1 Numerator Statement: Percentage of patients with dyspnea from the denominator who on any day(s) during the denominator time window had: a) their dyspnea treated within 24 hours OR had documentation that the dyspnea had improved OR reason why it was not/could not be treated b) a reassessment of their dyspnea (response to treatment or reassessment in untreated dyspnea) within 24 hours
2a1.4 Denominator Statement: Hospitalized patients who died an expected death and who had dyspnea in the 7 days prior to death
2a1.8 Denominator Exclusions: None
1.1 Measure Type: Process 2a1. 25-26 Data Source: Electronic Clinical Data : Electronic Health Record, Paper Records 2a1.33 Level of Analysis: Facility 1.2-1.4 Is this measure paired with another measure? No De.3 If included in a composite, please identify the composite measure (*title and NQF number if endorsed*):

STAFF NOTES (*issues or questions regarding any criteria*)
Comments on Conditions for Consideration:
Is the measure untested? Yes☐ No☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*): 5. Similar/related endorsed or submitted measures (*check 5.1*): Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria)

1a. High Impact: H☐ M☐ L☐ I ☐
(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 Subject/Topic Areas *(Check all the areas that apply)*: Cancer
De.5 Cross Cutting Areas (*Check all the areas that apply)*: Palliative Care and End of Life Care

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers; Patient/societal consequences of poor quality

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact *(Provide epidemiologic or resource use data)*:
More than half of cancer patients, and up to 90% of patients at the end of life, experience dyspnea, with increased prevalence in patients with lung cancer and metastases to the lung. (Lorenz 2006; Claessens 2000) Dyspnea can be very distressing to patients and families, and can impact quality of life and provoke anxiety. (Kvale 2003) Limited studies evaluating performance on palliative quality indicators suggest undertreatment of dyspnea (Twaddle 2007), and dyspnea is an important component of palliative care guidelines. (NCCN, NCP) In one study that looked at 194,017 emergency room visits by 76,759 cancer patients made in the last 6 months of life found that dyspnea was the reason for the visit in over 3% of visits in the final 6 months of life and was the reason in 5% during the final 2 weeks of life. (Barbera 2010)

1a.4 Citations for Evidence of High Impact cited in 1a.3:
Barbera L, Taylor C, Dudgeon D. Why do patients with cancer visit the emergency department near the end of life? Can Med Assoc J 2010;182(6):563-568
Claessens MT, Lynn J, Zhong Z et al. Dying with lung cancer or chronic obstructive pulmonary disease: insights from SUPPORT. Study to understand prognoses and preferences for outcomes and risks of treatments. J Am Geriatr Soc 2000;123(1 Suppl):S146-S153
Kvale PA, Simoff M, Prakash UB. Lung cancer. Palliative care. Chest 2003;123(1 Suppl):284S-311S
Lorenz KA, Lynn J, Dy SM, et al. Quality measures for symptoms and advance care planning in cancer: a systematic review. J Clin Oncol 2006;24(30):4933-4938
National Comprehensive Cancer Network (NCCN): Palliative care.
http://www.nccn.org/professionals/physician_gls/PDF/palliative.pdf Accessed December 4, 2006
National Consensus Project (NCP): Clinical practice guideline for quality palliative care.
hhttp://www.nationalconsensusproject.org/guideline.pdf Accessed December 4, 2006
Twaddle ML, Maxwell TL, Cassel JB et al. Palliative care benchmarks from academic medical centers. J Palliat Med 2007;10(1):86-98

1b. Opportunity for Improvement: H☐ M☐ L☐ I ☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
This measure aims to ensure that dyspnea is an end-of-life symptom that is addressed and effectively managed with the potential for resulting in increased patient comfort and avoidance of emergent and/or more aggressive treatment.

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers)*:
[*For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
N, % performance
Assessing Care of Vulnerable Elders (ACOVE3) (Walling 2010), hospitalized decedents, N=38, dyspnea treatment=87%; Follow up=70%

1b.3 Citations for Data on Performance Gap: [*For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]
Walling AM, Asch SM, Lorenz KA, et al. The quality of care provided to hospitalized patients at the end of life. Arch Intern Med 1020;170(12):1057-63.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐ If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I☐ Quality: H☐ M☐ L☐ I☐ Consistency: H☐ M☐ L☐ I☐

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes☐
L	M-H	M	Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms; otherwise No☐
M-H	L	M-H	Yes☐ IF potential benefits to patients clearly outweigh potential harms; otherwise No☐
L-M-H	L-M-H	L	No ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? Yes☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)*:
This measure focuses on providing dyspnea care and reassessment for patients identified with dyspnea in the last days before an expected death

1c.2-3 Type of Evidence *(Check all that apply)*: Clinical Practice Guideline; Systematic review of body of evidence (other than within guideline development)

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)*:
There is no direct evidence that reassessment of dyspnea results in improved outcomes, however it is a necessary step in identifying continued clinical need and dyspnea is an important symptom in dying patients. Also see 1a3.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: See 1a3

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*):

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):*

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? No

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:

1c.11 System Used for Grading the Body of Evidence: Other

1c.12 If other, identify and describe the grading scale with definitions: RCTs, non-RCTs, cohort or case analysis or multiple

time series, textbooks, opinions, descriptive studies

1c.13 Grade Assigned to the Body of Evidence:

1c.14 Summary of Controversy/Contradictory Evidence:

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:
See also 1a4
Lorenz KA, Rosenfeld K, Wenger N. Quality indicators for palliative and end-of-life care in vulnerable elders. J Amer Geriatr Soc 2001;55:S318-S326

1c.16 Quote verbatim, the specific guideline recommendation *(Including guideline # and/or page #)*:

1c.17 Clinical Practice Guideline Citation: See 1a4

1c.18 National Guideline Clearinghouse or other URL:

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? No

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: Was not graded

1c.23 Grade Assigned to the Recommendation:

1c.24 Rationale for Using this Guideline Over Others:

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: Moderate 1c.26 Quality: Moderate 1c.27 Consistency: Moderate

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? No

S.2 If yes, provide web page URL:

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I ☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)*:
Percentage of patients with dyspnea from the denominator who on any day(s) during the denominator time window had:
a) their dyspnea treated within 24 hours OR had documentation that the dyspnea had improved OR reason why it was not/could not be treated
b) a reassessment of their dyspnea (response to treatment or reassessment in untreated dyspnea) within 24 hours

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
Within 24 hours of noting the presence of dyspnea

2a1.3 Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses*:
Dyspnea treatment = Any of the following:
- administration of supplemental oxygen or increase in rate of flow if already on supplemental oxygen,
- respiratory therapy
- nonpharmacologic intervention targeted at easing dyspnea (e.g., position change, pillow support, etc.)
- pharmacologic intervention targeted at easing dyspnea (e.g., opiate, benzodiazipine, etc.)
Dyspnea follow up = Any assessment of the patient´s response to treatment or reassessment of untreated dyspnea

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
Hospitalized patients who died an expected death and who had dyspnea in the 7 days prior to death

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*: Adult/Elderly Care

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
Up to 7 days prior to an expected death

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
Adult hospitalized patients who had dyspnea in the 7 days prior to an expected death during a hospitalization of at least 3 days duration. Expected death is defined as physician documentation at least 3 days before death that the patient´s illness was terminal or that the patient had a grave prognosis, was receiving comfort care, was receiving hospice care, had a life-threatening illness, or was expected to die.
Although the original indicator was targeted at vulnerable elders, it was applied to all hospitalized adults in the sample who died an expected death because these patients are also vulnerable and would be expected to benefit from the identified processes of care.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
None

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)*:

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification 2a1.12 If "Other," please describe:

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with

descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*: better quality = higher score

2a1.20 Calculation Algorithm/Measure Logic*(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*:
1. Identify hospitalized patients who died during a hospitalization of at least 3 days
2. identify from provide documentation those patients whose death was noted to be expected at least 3 days prior to death
3. Looking at each day between the notation of expected death and the day of death (up to 7), identify patients who were noted to have dyspnea.
4. For each day with dyspnea, note if the patient had a treatment for the dyspnea within 24 hours.
5. For each day with dyspnea, note if the patient had an assessment of response to treatment or reassessment of untreated dyspnea within 24 hours
6. Calculate the performance for treatment (days with dyspnea treatment/total days with dyspnea) and follow up (days with dyspnea follow up/total days with dyspnea)

2a1.21 – 23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe:
Electronic Clinical Data : Electronic Health Record, Paper Records

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): Medical record abstraction tool

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)*: Facility

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)*: Hospital/Acute Care Facility 113885

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability*.)

2a2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
See 2a2.3

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)*:
See 2a2.3

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
ACOVE3 (Walling 2010) N=47 re-abstraction reliability records (n=4 eligible patients): Treatment eligibility kappa=0.46, specified care=100% agreement (no kappa); Follow-up eligibility 100% agreement; Follow-up specified care kappa=1.0

2b. VALIDITY. Validity, Testing, <u>including all Threats to Validity</u>: H☐ M☐ L☐ I ☐

2b1.1 Describe how the measure specifications *(measure focus, target population, and exclusions)* are consistent with the evidence cited in support of the measure focus (*criterion 1c)* and identify any differences from the evidence:
S

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

2b2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
See 2b2.2

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
Validity of the process-outcome link was explicitly evaluated by the ACOVE and ACOVE-3 expert panels that reviewed the relevant literature and used a modified Delphi panel of voting on the validity of the measure. (Shekelle 2001; Lorenz 2007)
Lorenz KA, Rosenfeld K, Wenger N. Quality indicators for palliative and end-of-life care in vulnerable elders. J Am Geriatr Soc 2007;55:S318-26.
Shekelle PG, MacLean CH, Morton SC, et al. Assessing care of vulnerable elders: Methods for developing quality indicators. Ann Intern Med 2001;135:647-52.

2b2.3 Testing Results *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment)*:

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
None

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)*:

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
None

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)*:

2b4.3 Testing Results *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)*:

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment:

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:

Has not yet been tested in multiple samples

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
N/A

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)*:

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)*:

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts)*:

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)

C.1 Intended Purpose/ Use *(Check all the purposes and/or uses for which the measure is intended)*: Public Reporting, Quality Improvement (Internal to the specific organization)

3.1 Current Use *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [*For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.*]

3a.2.Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public

reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results:

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s):

3b. Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[*For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement*].
Clinical care process that is needed can be readily identified and subjected to quality improvement.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are: Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

4b. Electronic Sources: H☐ M☐ L☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)*: No data elements are in electronic sources

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources: The nature of the data elements associated with end-of-life care (similar to other aspects of geriatric-focused care) are not generally amenable to electronic data capture (MacLean 2006)
MacLean CH, Louie R, Shekelle PG, et al. Comparison of administrative data and medical records to measure quality of medical care provided to vulnerable older patients. Med Care 2001;44(2):141-148

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H☐ M☐ L☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I ☐

A.2 Please check if either of the following apply (*regarding proprietary measures*):
4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues *(e.g., fees for use of proprietary measures)*:

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐

Rationale:
If the Committee votes No, STOP. If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

5.1 If there are related measures *(either same measure focus or target population)* or competing measures *(both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures *(e.g., a more valid or efficient way to measure quality);* OR provide a rationale for the additive value of endorsing an additional measure. *(Provide analyses when possible)*:
This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): RAND Corporation | 1776 Main Street | Santa Monica | California | 90407

Co.2 Point of Contact: Carol | Roth, RN, MPH | roth@rand.org | 310-393-0411-6425

Co.3 Measure Developer if different from Measure Steward: RAND Corporation | 1776 Main Street | Santa Monica | California, 90407

Co.4 Point of Contact: Neil | Wenger, MD, MPH | nwenger@mednet.ucla.edu | 310-794-2288-

Co. 5 Submitter: Carol | Roth, RN, MPH | roth@rand.org | 310-393-0411-6425 | RAND Corporation

Co.6 Additional organizations that sponsored/participated in measure development:

Co.7 Public Contact: Carol | Roth, RN, MPH | roth@rand.org | 310-393-0411-6425 | RAND Corporation

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
ACOVE-3 project expert panel members and ACOVE-3 Clinical Committee members as listed below.
ACOVE-3 project (Panel 2) expert panel members:
Helena Chang, MD
UCLA School of Medicine, Los Angeles, CA
Nick Fitterman, MD

Northshore Medical Group, Huntington, NY
Jean S. Kutner, MD, MSPH
University of Colorado Health Sciences Center, Aurora, CO
Patrick J. Loehrer, Sr., MD
Indiana University School of Medicine, Indianapolis, IN
Thomas Mattimore, MD
University of California at Los Angeles, Los Angeles, CA
Hyman B. Muss, MD
Vermont Cancer Center at University of Vermont, Burlington, VT
James L. Naughton, MD
Alliance Medical Group, Pinole, CA
Cheryl Phillips, MD
Sutter Medical Group, Sacramento, CA
Doron Schneider, MD
Muller Center for Senior Health, Abington Memorial Hospital, Abington, PA
Michael Stamos, MD
University of California, Irvine, CA
Ronald D. Stock, MD
Center for Senior Health, Eugene, OR
May Lin Tao, MD, MSPH
John Wayne Cancer Institute, Saint John´s Health Center, Santa Monica, CA and Valley Radiotherapy Associates Medical Group, El Segundo, CA
Role of ACOVE Expert Panel: Expanded and updated the Assessing Care of Vulnerable Elders (ACOVE) quality indicators via literature review, face-to-face discussion, and 2 rounds of anonymous ratings to evaluate whether the QIs were valid measures of quality of care using a process that is an explicit combination of scientific evidence and professional consensus.
ACOVE-3 CLINICAL COMMITTEE MEMBERS:
Alpesh N. Amin, MD - Hospitalist
University of California, Irvine Medical Center, Irvine, CA
Richard W. Besdine, MD - Geriatrician and Clinical Committee Chair
Brown University Center for Gerontology and Health Care Research, Providence, RI
Dan G. Blazer, MD - Geriatric Psychiatrist
Duke University Medical Center, Durham, NC
Harvey J. Cohen, MD - Geriatric Oncologist
Duke University Medical Center, Durham, NC
Terry Fulmer, PhD, RN, FAAN - Nurse
New York University, New York, NY
Patricia A. Ganz, MD - Oncologist
UCLA Schools of Medicine & Public Health, Jonsson Comprehensive Cancer Center, Los Angeles, CA
Mark A. Grunwald, MD - Family Practitioner
Gunderson Lutheran Clinic, Prairie du Chien, WI
William J. Hall, MD, MACP - Geriatrician
Highland Hospital, Rochester, NY
Ira R. Katz, MD, PhD - Psychiatrist
University of Pennsylvania, Philadelphia, PA
Paul R. Katz, MD - Geriatrician
Monroe Community Hospital, Rochester, NY
Dalane W. Kitzman, MD - Geriatric Cardiologist
Wake Forest University School of Medicine, Winston-Salem, NC
Rosanne M. Leipzig, MD, PhD - Geriatrician
Mount Sinai School of Medicine, New York, NY
Ronnie A. Rosenthal, MD - Surgeon
Yale University School of Medicine, New Haven, CT
Role of ACOVE-3 Clinical Committee: Evaluated the coherence of the complete set of QIs that the experts rated as valid as well as determined exclusions for advanced dementia and poor prognosis.

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:
Measure Developer/Steward Updates and Ongoing Maintenance Ad.3 Year the measure was first released: 2007 Ad.4 Month and Year of most recent revision: 07/2010 Ad.5 What is your frequency for review/update of this measure? Every 3 years Ad.6 When is the next scheduled review/update for this measure?
Ad.7 Copyright statement/disclaimers:
Ad.8 Additional Information/Comments:
Date of Submission (*MM/DD/YY*): May 16, 2011