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 #: 1634   **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: Hospice and Palliative Care -- Pain Screening
Co.1.1 Measure Steward: University of North Carolina-Chapel Hill
De.2 Brief Description of Measure: Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.
2a1.1 Numerator Statement: Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.
2a1.4 Denominator Statement: Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.
2a1.8 Denominator Exclusions: Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.
1.1 Measure Type: Process **2a1. 25-26 Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record **2a1.33 Level of Analysis:** Clinician : Group/Practice, 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*): Part of the PEACE Measures Set Paired with Hospice and Palliative Care - Pain Assessment (percentage of hospice or palliative care patients who screen positive for pain and who received a clinical assessment of pain within 24 hours of screening.

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, OPPORTUNITY, 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*):
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, Severity of illness

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

1a.3 Summary of Evidence of High Impact (*Provide epidemiologic or resource use data*):
The Hospice and Palliative Care - Pain Screening measure addresses pain for patients with high severity of illness and risk of death, including seriously and incurably ill patients enrolled in hospice or hospital-based palliative care. Research on care of patients with serious incurable illness and those nearing the end of life shows they experience high rates of pain (40-70% prevalence) and other physical, emotional, and spiritual causes of distress. (1,2) The National Priorities Partnership has identified palliative and end-of-life care as one of its national priorities. A goal of this priority is to ensure that all patients with life-limiting illness have access to effective treatment for symptoms such as pain and shortness of breath.(3) The affected populations are large; in 2009, 1.56 million people with life-limiting illness received hospice care.(4) In 2008, 58.5% of US hospitals with 50 or more beds had some form of palliative care service, and national trends show steady expansion of these services.(5) Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses. (6) The consequences of inadequate screening, assessment and treatment for pain include physical suffering, functional limitation, and development of apathy and depression. (7)

1a.4 Citations for Evidence of High Impact cited in 1a.3: 1. The Writing Group for the SUPPORT Investigators. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognosis and preferences for outcomes and risks of treatments (SUPPORT). JAMA. 1995;274:1591-1598.

2. Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med. 2008;11(2):180–190.

3. http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?id=608

4. NHPCO Facts and figures: hospice care in America 2010 edition
http://www.nhpco.org/files/public/Statistics_Research/Hospice_Facts_Figures_Oct-2010.pdf

5. Center to Advance Palliative Care http://www.capc.org/news-and-events/releases/04-05-10

6. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients´ perspective. JAMA 1999; 281: 163-168.

7. Gordon DB, Dahl JL, Miaskowski C et al. American Pain Society recommendations for improving the quality of acute and cancer pain management. Arch Intern Med 2005; 165:1574-1580.

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:
Pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Poor screening, assessment and undertreatment of pain is more common for patients with serious illness who are also of minority race ethnicity. Use of the Pain Screening and Pain Assessment quality measures will increase reporting and efforts to improve awareness of the presence of pain (screening) and assessment of severity, etiology and effect on function (assessment) which are the two essential first steps required for quality pain management and 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.*]

Pain is prevalent, underdiagnosed and undertreated in cancer and other life-limiting or serious illnesses. The prevalence of pain ranges from 40-80% in seriously ill patient populations. As detailed in a systematic review from AHRQ and the American Pain Society Quality of Care guidelines, pain screening and assessment are the essential steps required to ensure that pain is detected by clinicians and appropriate treatment implemented.(1,2) Failure to screen, assess, and treat pain results in functional limitations, physiologic stress, and psychological harms such as social withdrawal and depression.

The current quality of pain screening, assessment, and treatment is poor, as documented in systematic pain prevalence and treatment studies from hospital, outpatient, cancer and nursing home settings. (3,4,5,6) In a systematic review of quality of pain care for diverse patient populations, Gordon reported high average pain severity (6.17-8.37 on 10 point scale) and moderate rates of pain severity screening or other assessment (47%-96%). These findings did not vary by underlying diagnosis. (7)

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*]

1. Wells N, Pasero C, McCaffery M. Improving the Quality of Care through Pain Assessment and Management. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 17.

2. Gordon DB, Dahl JL, Miaskowski C et al. American Pain Society recommendations for improving the quality of acute and cancer pain management. Arch Intern Med 2005; 165:1574-1580.

3. Reynolds K, Henderson M, Schulman A, Hanson LC. Needs of the dying in nursing homes. J Pall Med 2002; 5:895-901.

4. Deandria S, Montanri M, Moja L et al. Prevalence of undertreatment of cancer pain: a review of published literature. Ann Oncol 2008; 19:1985-91.

5. Mularski R, White-Chu F, Overbay D et al. Measuring pain as the 5th vital sign does not improve quality of pain management. J Gen Intern Med 2006; 6:607-612.

6. Erdek MA, Pronovost PA. Improving assessment and treatment of pain in the critically ill. Int J Qual Health Care 2004; 16:59-64.

7. Gordon DB, Pelliano TA, Miaskowski C et al. A 10-year review of quality improvement monitoring in pain management: recommendations for standardized outcome measures. Pain Manage Nurs 2002; 4:116-130.

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

Extensive evidence documents disparities in cancer pain treatment and control.(1,2) Nursing home residents with advanced cancer receive less effective pain treatment if they are African American.(3,4) The Eastern Cooperative Oncology Group Minority Outpatient Pain Study enrolled 1308 patients with advanced cancer. After clinic visits, physicians underestimated pain severity for 64% of Hispanic and 74% of African American patients.(5) Among patients with pain, 65% of Hispanic and African American patients received inadequate treatment relative to practice guidelines, as did 50% of white patients.(6,7)

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*]

1.Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioids prescribing by race for patients seeking care in US emergency departments. JAMA 2008; 299:70-78.

2.Green CR, Montague L, Hart-Johnson TA. Consistent and breakthrough pain in diverse advanced cancer patients: a longitudinal examination. J Pain Sympt Manage 2009; 37:831-847.

3.Bernabei R, Gambassi G, Lapane K, Landi F, Gatsonis C, Dunlop R, Lipsitz L, Steel K, Mor V. Management of pain in elderly patients with cancer. SAGE Study Group. JAMA 1998; 279:1877-82.

4.Engle VF, Fox-Hill E, Graney MJ. The experience of living-dying in a nursing home: self-reports of black and white older adults. JAGS 1998; 46:1091-96.

5.Anderson KO, Mendoza TR, Valero V, Richman SP, Russell C, Hurley J, DeLeon C, Washington P, Palos G, Payne R, Cleeland CS. Minority cancer patients and their providers: pain management attitudes and practices. Cancer 2000; 88: 1929-38.

6.Cleeland CS, Gonin R, Baez L et al. Pain and treatment of pain in minority patients with cancer. The ECOG Minority Outpatient Pain Study. Ann Intern Med 1997; 127:813-16.

7.Cleeland CS, Gonin R, Hatfield AD et al. Pain and its treatment in outpatients with metastatic cancer. N Engl J Med 1994; 330:592-96.

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)*:
Pain is under-recognized by clinicians and undertreated, resulting in excess suffering for patients with serious illness. Pain screening and assessment are necessary processes in order to improve the patient-centered outcome of pain, and its effects on global outcomes of function and quality of life. Pain, like other symptoms, can only be understood through patient self-report and patient observation. Screening and assessment for pain are essential steps in pain management. Without initial screening to identify patients in pain, and clinical assessment to determine the severity, etiology, and effect on function of this symptom, effective treatment cannot be administered. Additional guidelines from American College of Physicians and the American Pain Society recommend systematic pain screening and assessment. Additional evidence includes numerous systematic reviews and individual studies.

1c.2-3 Type of Evidence *(Check all that apply)*:
Clinical Practice Guideline, Selected individual studies (rather than entire body of evidence), 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)*:
Pain is a highly prevalent, distressing, and functionally limiting symptom common to many serious illness conditions, and its relief is an important priority for patients and families.
a)Strong evidence supports the effectiveness of medical treatment for pain in cancer and in other serious illnesses to improve pain outcomes (randomized controlled trials, systematic reviews)
b)Moderate quality evidence supports the effectiveness of expert pain assessment and structural innovations such as specialty palliative care teams to improve pain outcomes. Published after the most recent systematic reviews, 3 new randomized trials and 1 controlled observational study report interventions enhancing the structure and process of palliative care delivery. Two report improved pain and quality of life outcomes (Casarett, Temel), one reports improved quality of life but no change in symptom scores (Bakitas), and one reports no change in symptom scores (Gade) (randomized and non-randomized trials, systematic reviews, individual studies)
c)Three comprehensive practice guidelines support the importance of screening, assessing, and treating pain for seriously ill and terminally ill patient populations with a wide range of diagnoses.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: 1. Systematic review of varied strategies in palliative care (Lorenz, 2004, 2008): reported results for pain management of 9 systematic reviews, 24 individual studies of interventions
2. Systematic review of RCTs of specialty palliative care services(Zimmerman, 2008): systematic review of 22 randomized trials of specialty palliative care effects on various outcomes, including symptom distress.
3. 2 additional guidelines from American College of Physicians, American Pain Society recommend systematic pain screening and assessment
4. 3 additional RCTs and 1 controlled observational study of palliative care interventions (Gade, Casarett, Bakitas, Temel)

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)*: a) Multiple high quality randomized trials of pain treatment, and high quality systematic reviews address interventions to improve pain management and outcomes.
b) Studies of pain treatment include expert screening and assessment in the protocols, but do not define the effect of these processes alone on pain outcomes. Studies of complex structural and process interventions to improve specialty palliative care show varied effects on pain outcomes; however, these interventions are complex and heterogeneous in design, and provide less direct evidence for targeted interventions to improve pain as a primary outcome.
c) Included studies range in size, but many of the highest quality randomized trials have adequate power for hypothesis testing.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* Evidence from studies explicitly targeting pain outcomes with more discrete interventions is very consistent, and provides strong evidence for improved outcomes. Evidence from studies of complex palliative care interventions shows less consistent effect on pain outcomes, and pain is used as a secondary rather than a primary outcome measure.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:
Net benefit for pain screening and assessment is strong, and clearly outweighs potential harms. Benefit is high due to the high numbers of patients affected and the marked suffering experienced as a result of current under-reporting and undertreatment, a problem more marked among patients of minority race or ethnicity. Potential harms from quality measures focused on pain management include over-treatment with medication toxicities and inattention to other symptoms. These harms are reduced in the context of hospice and specialty palliative care, delivered by professional teams with appropriate expertise and training.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? Yes

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: (Lorenz, 2008) Strong evidence for treatment of cancer pain. Weak evidence supports complex interventions such as multidisciplinary teams.

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

1c.12 If other, identify and describe the grading scale with definitions:

1c.13 Grade Assigned to the Body of Evidence: See 1c.10.

1c.14 Summary of Controversy/Contradictory Evidence: N/A

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:
OTHER GUIDELINES:
1. Qaseem A, Snow V, Shekelle P et al. Evidence-based interventions to improve the palliative care of pain, dyspnea and depression at the end of life: a clinical practice guideline from the American College of Physicians. Ann Intern Med 2008; 148:141-146.
2. Gordon DB, Dahl JL, Miaskowski C et al. American Pain Society recommendations for improving the quality of acute and cancer pain management. Arch Intern Med 2005; 165:1574-1580.

SYSTEMATIC REVIEWS:

3. Lorenz KA, Lynn J, Dy SM et al. Evidence for improving palliative care at the end of life: a systematic review. Ann Intern Med 2008; 148:147-159.

4. Lorenz KA, Lynn J et al. End-of-life care and outcomes. AHRQ Publication No. 05-E004-2, December 2004.

5. Zimmerman C, Riechelmann R, Krzyzanowska M et al. Effectiveness of specialized palliative care: a systematic review. JAMA 2008; 299:1698-1709.

ADDITIONAL INDIVIDUAL STUDIES

6. Bakitas M, Lyons KD, Hegel MT et al. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. JAMA 2009; 302:741-749.

7. Casarett D, Pickard A, Bailey FA et al. Do palliative consultations improve patient outcomes? J Am Geriatr Soc 2008; 56:593-599.

8. Temel JS, Greer JA, Muzikansky A et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 2010; 363:733-742.

9. Gade G, Venohr I, Conner D et al. Impact of an inpatient palliative care team: a randomized controlled trial. J Palliat Med 2008; 11:180-190.

1c.16 Quote verbatim, <u>the specific guideline recommendation</u> *(Including guideline # and/or page #)*:
Guideline 2.1 Pain, other symptoms, and side effects are managed based upon the best available evidence, with attention to disease-specific pain and symptoms, which is skillfully and systematically applied.

• Regular, ongoing assessment of pain, non-pain symptoms (including but not limited to shortness of breath, nausea, fatigue and weakness, anorexia, insomnia, anxiety, depression, confusion, and constipation), treatment side effects, and functional capacities are documented through a systematic process. Validated instruments, where available, should be utilized. Symptom assessment in children and cognitively impaired patients should be performed by appropriately trained professionals with appropriate tools.

1c.17 Clinical Practice Guideline Citation: National Quality Forum: A National Framework and Preferred Practices for Palliative and Hospice Care Quality. Washington, D.C.: National Quality Forum 2006. (Review and endorsement of National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care 2004.)

1c.18 National Guideline Clearinghouse or other URL: Citation: National Guideline Clearinghouse
http://www.guideline.gov/content.aspx?id=14423

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: Not Graded

1c.23 Grade Assigned to the Recommendation:

1c.24 Rationale for Using this Guideline Over Others: The National Consensus Project for Quality Palliative Care was the first United States national guidelines development project for palliative care quality, inclusive of hospice care. This set of guidelines, along with 38 preferred practices, has been rigorously reviewed and endorsed by the National Quality Forum. Although specific investigative groups and specialty organizations have published other guidelines in pain management or hospice or palliative care practice for specific settings, practices or populations, none have been as comprehensive or comprehensively debated, peer reviewed, or NQF endorsed.

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

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, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (<u>evaluation criteria</u>)
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 <u>guidance on measure testing</u>.

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 <u>this</u> measure can be obtained? Yes

S.2 If yes, provide web page URL: PEACE Project http://www.thecarolnascenter.org/default.aspx?pageid=24

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

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
Hospice admission evaluation / initial clinical encounter for palliative care

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

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.

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)*:
Hospice admission evaluation / palliative care initial encounter

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

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

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.

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)*:
Calculation of length of stay; discharge date - date of initial encounter.

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)*:
N/A

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.)*:
N/A

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.)*:
Screened for pain :
a. Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care
b. Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days
c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) using a standardized tool.

Quality Measure =
Numerator: Patients screened for pain in Step 3 / Denominator: Patients in Step 1-Patients excluded in Step 2

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):
Hospice and palliative care: consecutive sample of equal numbers of admissions + decedent records beginning with a randomly selected date; minimum sample size 100.

Data collection using a structured chart abstraction tool and operational definition

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

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.*): Structured medical record abstraction tool with separate collection of numerator and denominator data values.

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: URL
PEACE Project Data Dictionary http://www.thecarolinascenter.org/default.aspx?pageid=46

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
URL
PEACE Project Data Dictionary http://www.thecarolinascenter.org/default.aspx?pageid=46

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

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

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)*:
Two research nurse abstractors independently recorded quality measures data on a random subset of 20 seriously ill patients. Abstractors used the pre-defined operational definitions and a structured chart abstraction tool to record numerator and denominator data separately. Patients were a subsample of 460 seriously ill patients without specialty palliative care admitted to an acute care hospital for at least 1 day to 4 inpatent services. Records eligible for sampling included all seriously ill adult patients admitted to medical and surgical intensive care, medically complex patients aged 65 and older admitted to an Acute Care of the Elderly Unit, and medical oncology patients with Stage IV carcinoma.

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)*:
Inter-rater reliability between the two abstractors was assessed using kappa statistics.

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
The nurse abstractors achieved excellent inter-rater reliability for this measure with 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:**
The measure focus is Pain Screening, designed to pair with Pain Assessment to ensure quality care processes for pain. The target populations are hospice patients, and seriously ill hospitalized patients with diverse underlying diagnoses who are at high risk for palliative care clinical needs, including pain.

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)*:
Hospice: The total patient sample size was 126. Fourteen hospices, located in seven different states, representing both free-standing and hospital based providers were recruited to participate. We asked each hospice to contribute data from nine patient records to the study. Nine hospices were asked to collect data on their most recent nine discharges; five hospices were asked to

collect data on their most recent nine admissions.

Palliative Care: The total patient sample size was 562. Chart abstractions were completed for 102 consecutive seriously ill patients with specialty palliative care consultation, and a random sample of 460 seriously ill patients without specialty palliative care admitted to an acute care hospital for at least 1 day to four inpatient services with high proportions of seriously ill patients. Records eligible for sampling included all patients admitted to medical and surgical intensive care, medically complex patients aged 65 and older admitted to a Geriatric Evaluation Unit, and medical oncology patients with Stage IV carcinoma. Because palliative care domains become even more relevant closer to death, patients dying in hospital were over-sampled to ensure a final ratio of 1 decedent to 1 live discharge. Consistent with oversampling of decedent records, 55% of these patients died in hospital.
The age of the patients ranged from 16 to 99 years, with the mean age 61. Patients were predominantly Caucasian (65%), with smaller subgroups who were African American (24%) and Hispanic / Latino (4%) The most common life-limiting diagnoses were infections (37%), cancer (34%), pulmonary (29%), and neurologic diseases (21%).

2b2.2 **Analytic Method** *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
Hospice sample: Face validity was tested using formal expert panel review. The PEACE project team convened a 14-member Technical Expert Panel (TEP) of nationally recognized experts with extensive experience in the following areas: medical or nursing expertise in hospice and palliative care, methods and instrumentation, and quality improvement. Using criteria provided by the CCME study team, TEP members rated each potential quality measure from 1 (low) to 5 (high) on four criteria: importance, scientific soundness, feasibility and usability. The rating criteria mirrored those used by the National Quality Forum and the CMS Measures Management System. To identify the measures with the most favorable ratings, we created a summary measure.   For each quality measure, we calculated the average TEP rating for each criterion and then tabulated an overall Average Measure Rating (AMR), weighting each the criteria equally.

Palliative Care sample: Face validity of PEACE quality measures for hospital-based specialty palliative care was addressed using stakeholder review and feedback. Investigators prepared data reports in a summary format with detailed operational definitions, and led a 1-hour discussion with nursing and physician leaders from each service group – MICU, SICU, Acute Care for the Elderly (Geriatrics), Oncology, and Palliative Care. The discussion included feedback of quality measure data, response to questions and critiques, and eliciting stakeholder feedback about the validity and actionability of this data for the care of their patients. Stakeholders were specifically asked to comment on the accuracy of the data as a reflection of current care practices, and their highest priority area for future quality improvement.
Construct validity was tested by comparing the PEACE quality measures for patients seen by specialty interdisciplinary palliative care consultants to those not receiving specialty palliative care services.

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)*:
Hospice sample: Completed ratings were received from 13 of the 14 TEP members. The 75th percentile cut-point translated into an AMR =3.73 (on a scale of 1 to 5 where 5 is highest). This process resulted in the identification of 23 measures with the highest TEP ratings for importance, scientific soundness, feasibility and usability. Clinical assessment of pain had an overall rating of 4.15 while screening for pain was added as an antecedent measure.
Pilot testing in the hospice sample revealed that only 78% of 126 hospice patients were screened for pain, and 60% of those who screened positive were given a comprehensive clinical assessment of their pain.

Palliative Care sample: Face Validity: Stakeholder discussions provided broad endorsement of face validity, with some considerations for specific patient populations. Intensive care and geriatrics clinicians endorsed the primary importance of pain screening and assessment, but expressed doubts about the validity of numerical pain severity ratings when used for nonverbal or confused patients. Medical oncologists endorsed the face validity of these quality measures, but favored quality measures endorsed by oncology professional organizations.

Construct Validity: Screening for pain with a numerical pain scale was nearly universal for all seriously ill patients (99.5%), regardless of use of specialty palliative care, and half had moderate or severe pain. Patients with moderate or severe pain were more likely to have a clinical assessment of pain if seen by specialty palliative care (67% vs 42%, p=0.002).

CITATION: Schenck AP, Rokoske FS, Durham DD et al. The PEACE Project: identification of quality measures for hospice and palliative care. J Palliat Med 2010; 13:1451-1459.

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)*:
N/A

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

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

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)*:
N/A

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

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)*:
N/A

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

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)*:
Hospice: The total patient sample size was 126. Fourteen hospices, located in seven different states, representing both free-standing and hospital based providers were recruited to participate. We asked each hospice to contribute data from nine patient records to the study. Nine hospices were asked to collect data on their most recent nine discharges; five hospices were asked to collect data on their most recent nine admissions.
A common structured data collection tool was developed for use by all hospices, regardless of whether the patient record was an admission or discharge record.   Instructions embedded in the tool indicated the data items appropriate to each type of record. Hospices were instructed not to institute new data collection procedures for the data collection pilot. If a data item could not be found, they were told to mark the item as "unable to determine."
A data dictionary containing item-specific instructions and notes related to the patient data collection tool was distributed to each hospice center. Technical assistance was provided by email and phone to staff during the data collection period. Questions, and responses, that arose during data collection were immediately distributed to all hospices participating in the data pilot.

Palliative Care: The total patient sample size was 562. Chart abstractions were completed for 102 consecutive seriously ill patients with specialty palliative care consultation, and a random sample of 460 seriously ill patients without specialty palliative care admitted to an acute care hospital for at least 1 day to four inpatient services with high proportions of seriously ill patients. Records eligible for sampling included all patients admitted to medical and surgical intensive care, medically complex patients aged 65 and

older admitted to a Geriatric Evaluation Unit, and medical oncology patients with Stage IV carcinoma. Because palliative care domains become even more relevant closer to death, patients dying in hospital were over-sampled to ensure a final ratio of 1 decedent to 1 live discharge. Consistent with oversampling of decedent records, 55% of these patients died in hospital.
The age of the patients ranged from 16 to 99 years, with the mean age 61. Patients were predominantly Caucasian (65%), with smaller subgroups who were African American (24%) and Hispanic / Latino (4%) The most common life-limiting diagnoses were infections (37%), cancer (34%), pulmonary (29%), and neurologic diseases (21%).

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:
Construct validity was tested by comparing the PEACE quality measures for patients seen by specialty interdisciplinary palliative care consultants to those not receiving specialty palliative care services.   Percentage of patients with and without specialty palliative care for whom the quality measure was met was compared for difference using the chi-square statistic.

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)*:
 Hospice and Palliative Care – Pain Screening:
　 Hospice sample*: 78% met quality measure
　 Seriously ill patients with palliative care sample: 99% met quality measure
　 Seriously ill patients without palliative care: 100% met quality measure (p=NS)
*Note additional data under 3.b1 Use in QI

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)*:
N/A

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)*:
N/A

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:
Future research with larger sample sizes can be used to test for differential performance by race/ethnicity, gender, cognitive status, age or other characteristics.

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.*]
Use of the Hospice and Palliative Care - Pain Screening and Hospice and Palliative Care - Pain Assessment quality measures for public reporting requires rigorous peer review, NQF endorsement and subsequent policy change to facilitate data access for public use. The proposed quality measures are similar to pain measures derived from the Minimum Dataset and publicly reported for nursing home care.

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: The Hospice and Palliative Care – Pain Screening quality measure is meaningful and understandable for quality measurement and public reporting. The quality measure is simply calculated -- few denominator exclusions, no risk adjustment, and no complex calculations -- permitting easy interpretation of results. The quality measure separates simple screening for pain – asking if it is present or absent – from clinical assessment which is necessary in order to discern etiology, severity, and effect on the patient in order to plan appropriate pain treatment. The definition of a clinical pain assessment – capturing five of seven key elements – is clinically feasible and readily understood in terms of the pain experience in serious illness. Further, the operational definition has been endorsed by a national TEP (Hospice sample) and a diverse group of physicians and nurses caring for seriously ill patients in hospital (Palliative Care sample).

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): N/A

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*].
The Hospice and Palliative Care-Pain Screening and Pain Assessment quality measures has been used in an NHPCO Quality Partners Collaborative. Data from 367 patient records in 38 agencies showed that, in the context of a QI collaborative, 94% met Pain Screening and 94% met Pain Assessment measures.

Measures are currently being used in an internal quality improvement project in a single academic tertiary hospital.

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:
Similar, but not identical quality measures have been effective in nursing home quality improvement for pain screening, assessment and management.

CITATIONS:
1. Horner JK, Hanson LC, Wood D, Silver AG, Reynolds KS. Using quality improvement to address pain management practices in

nursing homes. J Pain Symptom Manage 2005; 30:271-277.
2. Hanson LC, Reynolds KS, Henderson M, Pickard CG. A quality improvement intervention to increase palliative care in nursing homes. J Palliat Med, 2005 8:576-584.
3. Baier RR, Gifford DR, Patry D, et al. Ameliorating pain in nursing homes: a collaborative quality improvement project. J Am Geriatr Soc 2004; 52:1988-1995.

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:
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition,
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)*: ALL data elements are in a combination of 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:

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:
In any quality measure reliant on medical record documentation, actual care may have differed from documented care. Unintended consequences could include purposeful documentation of care processes not performed; audit methodology would include patient survey to report the patient's experience of pain screening and pain assessment.

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)*:
For each chart abstraction, data collection for the Hospice and Palliative Care Pain Screening and Pain Assessment quality measures together requires 1 minute to complete. There was no missing data for the elements needed to calculate this subset of pain measures for either the Hospice or the Palliative Care samples. Record abstraction does not require collection of unique patient identifiers and thus protects confidentiality. Timing of data collection can be concurrent with admission / initial encounter care, or can be retrospective based on medical record sampling.

Costs have not been formally estimated; medical record abstraction or electronic capture of the elements of a pain assessment will have more modest costs compared to survey data.

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:**
0384 : Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383
0420 : Pain Assessment Prior to Initiation of Patient Therapy
0523 : Pain Assessment Conducted

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?** Yes

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

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

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): University of North Carolina-Chapel Hill, 725 Martin Luther King Jr Blvd, CB 7590, Chapel Hill, North Carolina, 27599-7590

Co.2 Point of Contact: Laura, Hanson, MD, MPH, lhanson@med.unc.edu, 919-843-4096-

Co.3 Measure Developer if different from Measure Steward: University of North Carolina-Chapel Hill, 725 Martin Luther King Jr Blvd, CB 7590, Chapel Hill, North Carolina, 27599-7590

Co.4 Point of Contact: Laura, Hanson, MD, MPH, lhanson@med.unc.edu, 919-843-4096-

Co.5 Submitter: Laura, Hanson, MD, MPH, lhanson@med.unc.edu, 919-843-4096-, University of North Carolina-Chapel Hill

Co.6 Additional organizations that sponsored/participated in measure development:
Carolinas Center for Medical Excellence, Cary, North Carolina

Co.7 Public Contact: Laura, Hanson, MD, MPH, lhanson@med.unc.edu, 919-843-4096-, University of North Carolina-Chapel Hill

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.
The Carolinas Center for Medical Excellence PEACE Project Technical Expert Panel

The PEACE project team convened a 14-member Technical Expert Panel (TEP) of nationally recognized experts with extensive experience in the following areas: medical or nursing expertise in hospice and palliative care, methods and instrumentation, and quality improvement. Using criteria provided by the CCME study team, TEP members rated each potential quality measure on four criteria: importance, scientific soundness, feasibility and usability.

Mary Ersek, PhD, RN, Research Associate Professor, Swedish Medical Center- Pain Research Department, Seattle, WA
Betty R. Ferrell, PhD, FAAN, Research Scientist, City of Hope National Medical Center, Duarte, CA
Sean Morrison, MD, Mount Sinai Medical Center, NY, NY
Richard Payne, MD, Director, Duke Institute on Care at the End of Life, Duke Divinity School, Durham, NC
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Karen Steinhauser, PhD, Research Health Scientists, Center for Health Services Research in Primary Care, Durham VA Medical Center and Duke University, Durham, NC
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David Casarett, MA, MD, Assistant Professor, Division of Geriatrics, Institute on Aging and Center for Bioethics, University of Pennsylvania School of Medicine and NHPCO Board of Directors
Judi Lund-Person, Vice President, Division of Quality, National Hospice and Palliative Care Organization, Washington, DC
Jean Kutner, MD, MSPH, Associate Professor, University of Colorado Health Sciences Center, Denver, CO
Lin Simon, Analyst, National Hospice and Palliative Care Organization, Washington, DC
Karen Pace, NAHC

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: 2010
Ad.4 Month and Year of most recent revision:
Ad.5 What is your frequency for review/update of this measure? 3 years or as required
Ad.6 When is the next scheduled review/update for this measure?

Ad.7 Copyright statement:

Ad.8 Disclaimers:

Ad.9 Additional Information/Comments: 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.

Date of Submission (*MM/DD/YY*): 05/25/2011