

NATIONAL QUALITY FORUM

1 TO: NQF Members and Public

2

3 FR: NQF Staff

4

5 RE: Pre-voting review for *National Voluntary Consensus Standards: Palliative Care and End-of-Life*
6 *Care: A Consensus Report*

7

8 DA: October 17, 2011

9

10 The number of palliative care and EOL care programs has increased rapidly in recent years. Nonetheless,
11 palliative care and EOL care services remain underused, and more than one million people in the United
12 States die each year of chronic and debilitating illnesses without receiving hospice services. Measuring
13 quality of care across the many and varied locations in which palliative care and end-of-life care takes
14 place is important to ensure safe, cost-effective care consistent with the current evidence base. The
15 recommended measures include measures endorsed before 2009 that have undergone maintenance. The
16 majority of measures considered focus on pain management, dyspnea management, care preference, and
17 quality of care at the end of life.

18

19 A 21-member Steering Committee representing a range of stakeholder perspectives was appointed to
20 review a total of 15 candidate and endorsement maintenance standards for quality performance in
21 palliative care and end-of-life care. The Steering Committee is recommending 14 measures.

22

23 The draft document, *National Voluntary Consensus Standards: Palliative Care and End-of-Life Care: A*
24 *Consensus Report*, is posted on the NQF website along with the following additional information:

25

- 26 • [Measure submission forms](#)
- 27 • [Meeting and call summaries](#) from the Steering Committee's discussions.

28

29 Pursuant to section II.A of the Consensus Development Process v. 1.9, this draft document, along with the
30 accompanying material, is being provided to you at this time for purposes of review and comment only
31 and is not intended to be used for voting purposes. You may post your comments and view the comments
32 of others on the [NQF website](#).

33

34 **NQF Member comments must be submitted no later than 6:00 pm ET, November 15, 2011. Public**
35 **comments must be submitted no later than 6:00 pm ET, November 8, 2011.**

36

37 Thank you for your interest in NQF's work. We look forward to your review and comments.

38

39

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

**NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011,
6:00 PM ET**

NATIONAL QUALITY FORUM

40 NATIONAL VOLUNTARY CONSENSUS STANDARDS: PALLIATIVE CARE AND
41 END-OF-LIFE CARE—A CONSENSUS REPORT

42

43

44

45

46

47

DRAFT REPORT FOR COMMENTING

48

NATIONAL QUALITY FORUM

49 **NATIONAL VOLUNTARY CONSENSUS STANDARDS: PALLIATIVE CARE AND**
50 **END-OF-LIFE CARE: A CONSENSUS REPORT**

51

52

TABLE OF CONTENTS

53

54

55	BACKGROUND	4
56	NATIONAL PRIORITIES PARTNERSHIP	6
57	RELATED NQF WORK	6
58	NQF'S CONSENSUS DEVELOPMENT PROCESS.....	7
59	<i>Overarching Measure Evaluation Issues</i>	8
60	RECOMMENDATIONS FOR ENDORSEMENT	11
61	<i>Candidate Consensus Standards Recommended for Endorsement</i>	11
62	<i>Candidate Consensus Standards Not Recommended for Endorsement</i>	12
63	PAIN MANAGEMENT MEASURES	12
64	DYSPNEA MANAGEMENT MEASURES	17
65	CARE PREFERENCE MEASURES	20
66	QUALITY OF CARE AT THE END OF LIFE MEASURES.....	24
67	APPENDIX A: NQF PALLIATIVE CARE AND END-OF-LIFE CARE MEASURE	
68	SPECIFICATIONS.....	33
69	APPENDIX B: PROJECT STEERING COMMITTEE AND NQF STAFF	54
70	APPENDIX C: MEASURE GAPS.....	56
71	APPENDIX D: NQF PALLIATIVE CARE AND END-OF-LIFE CARE RELATED OR	
72	COMPETING MEASURES	57

73

74

NATIONAL QUALITY FORUM

NATIONAL VOLUNTARY CONSENSUS STANDARDS: PALLIATIVE CARE AND END-OF-LIFE CARE: A CONSENSUS REPORT

EXECUTIVE SUMMARY

Assessing the quality of palliative care and end-of-life care programs by using measures that reflect the current evidence base is crucial to ensure safe, cost-effective care. Palliative care programs in US hospitals have grown by 125 percent in the last decade; by 2030, there will be 72.1 million older persons in the United States, more than twice the number as 2000.^{1,2} The need for high-quality and safe palliative care and end-of-life care services will only continue to grow as the population ages.

Attention recently has been focused on increasing the quality and availability of palliative care and end-of-life care services, both for acutely ill patients and those with life-limiting illnesses. Studies have found that palliative care programs across the trajectory of a patient's illness, including end-of-life care, can result in improved quality of care, including higher patient satisfaction; improved communication; fewer admissions to intensive care units, emergency departments, and acute care hospitals; more referrals to hospice; and overall reduced costs.

This report presents the results of the evaluation of 22 measures considered under the National Quality Forum's Consensus Development Process (CDP) version 1.9, 9 of which were undergoing endorsement maintenance. Fourteen measures are recommended for endorsement as voluntary consensus standards suitable for accountability and quality improvement, and one measure is not recommended for endorsement. In addition, seven measures that were undergoing endorsement maintenance were withdrawn by the developer during the review process. These measures are not discussed in the report.

NOTES

¹ Center to Advance Palliative Care (CAPC), *Palliative Care Programs Continue Rapid Growth in U.S. Hospitals*, New York, NY:CAPC;2010. Available at www.capc.org/news-and-events/releases/04-05-10. Last accessed October 2011.

² Department of Health and Human Services (HHS), Administration on Aging (AOA), *Aging Statistics*, Washington, DC:AOA;2011. Available at www.aoa.gov/aoaroot/aging_statistics/index.aspx. Last accessed October 2011.

NATIONAL QUALITY FORUM

106 BACKGROUND

107
108 Palliative care generally refers to patient- and family-centered care that optimizes quality of life
109 by anticipating, preventing, and alleviating suffering across the continuum of a patient's illness.
110 Historically, palliative care referred to treatment available to patients at home and enrolled in
111 hospice. More recently, palliative care has become available to acutely ill patients, and its
112 meaning has evolved to encompass comprehensive care that may be provided along with
113 disease-specific, life-prolonging treatment. End-of-life (EOL) care refers to comprehensive care
114 for a life-limiting illness that meets the patient's medical, physical, psychological, spiritual, and
115 social needs. Hospice care is a service delivery system that emphasizes symptom management
116 without life-prolonging treatment and is intended to enhance the quality of life for both patients
117 with a limited life expectancy and their families.

118
119 The number of palliative care and EOL care programs has increased rapidly in recent years.
120 Nonetheless, palliative care and EOL care services remain underused, and more than one million
121 people in the United States die each year of chronic and debilitating illnesses without receiving
122 hospice services. A comprehensive set of performance metrics is needed to gauge our progress in
123 these clinical areas.

124
125 The current project sought to endorse performance measures focusing on:

- 126
- 127 • assessment and management of relief of symptoms at EOL and for acutely ill patients
128 (e.g., pain, dyspnea, weight loss, weakness, nausea, serious bowel problems, delirium,
129 and depression);
 - 130 • patient- and family-centered palliative and hospice care that address psychosocial needs
131 and care transitions; and
 - 132 • patient, caregiver, and family experiences of care.
- 133

134 The recommended measures add to the 38 National Quality Forum (NQF)-endorsed[®] preferred
135 practices, which were endorsed in 2006 for implementation by palliative care and hospice
136 programs and provide a foundation for quality measurement and reporting systems in these areas.

NATIONAL QUALITY FORUM

137

138 **STRATEGIC DIRECTIONS FOR NQF**

139 NQF’s mission includes three parts: 1) setting national priorities and goals for performance
140 improvement, 2) endorsing national consensus standards for measuring and publicly reporting on
141 performance, and 3) promoting the attainment of national goals through education and outreach
142 programs. As greater numbers of quality measures are developed and brought to NQF for
143 consideration of endorsement, NQF must assist stakeholders in measuring “what makes a
144 difference” and addressing what is important to achieve the best outcomes for patients and
145 populations.

146

147 Several strategic issues have been identified to guide consideration of candidate consensus
148 standards:

149

150 **DRIVE TOWARD HIGH PERFORMANCE.** Over time, the bar of performance expectations
151 should be raised to encourage achievement of higher levels of system performance.

152

153 **EMPHASIZE COMPOSITES.** Composite measures provide much-needed summary
154 information pertaining to multiple dimensions of performance and are more comprehensible to
155 patients and consumers.

156

157 **MOVE TOWARD OUTCOME MEASUREMENT.** Outcome measures provide information
158 of keen interest to consumers and purchasers, and when coupled with healthcare process
159 measures, they provide useful and actionable information to providers. Outcome measures also
160 focus attention on much-needed system-level improvements because achieving the best patient
161 outcomes often requires carefully designed care process, teamwork, and coordinated action on
162 the part of many providers.

163

164 **CONSIDER DISPARITIES IN ALL WE DO.** Some of the greatest performance gaps relate to
165 care of minority populations. Particular attention should be focused in identifying disparities-

NATIONAL QUALITY FORUM

166 sensitive performance measures and on identifying the most relevant
167 race/ethnicity/language/socioeconomic strata for reporting purposes.

168

169 NATIONAL PRIORITIES PARTNERSHIP

170 The [National Priorities Partnership](#), a multi-stakeholder collaborative of 48 organizations
171 convened by NQF, plays a key role in identifying strategies for achieving national goals for
172 quality healthcare and facilitating coordinated, multi-stakeholder action. The Department of
173 Health and Human Services has asked the Partnership for its collective, multi-stakeholder input
174 on the [National Quality Strategy](#) (NQS) framework, which includes three inextricably linked
175 domains—better care, affordable care, and healthy people/healthy communities—around which
176 priorities, goals, measures, and strategic opportunities for improvement are to be identified and
177 refined.

178

179 The NQS, released in March 2011, identified six national priorities, two of which are closely
180 aligned with objectives of the Palliative Care and End-of-Life Care project. These two priorities,
181 “ensuring person- and family-centered care” and “promoting effective communication and
182 coordination of care” emphasize goals to improve patient family and caregiver experience of
183 care, encourage shared decision-making, and improve quality of life for patients with chronic
184 illness and disability with care plans that address pain, symptom management, and psychosocial
185 needs. Many of the measures considered for endorsement in this project address these goals and
186 their related measure concepts and could be used to track performance and monitor improvement
187 of both palliative care and end-of-life care. Such measures include those documenting treatment
188 preferences and spiritual care, family experience of care, and pain and other symptom
189 management. Additionally, NPP identified inappropriate/unwanted non-palliative services at
190 EOL as one of the areas under the overuse goal in the affordability priority area.

191 RELATED NQF WORK

192 In 2006, NQF endorsed 38 preferred practices for palliative and hospice care, under the [National
193 Framework and Preferred Practices for Hospice and Palliative Care](#) project, as part of an effort
194 that created a foundation for which a quality measurement and reporting system could be
195 built. The preferred practices were derived from the eight domains of quality palliative and

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

**NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011,
6:00 PM ET**

NATIONAL QUALITY FORUM

196 hospice care as established by the National Consensus Project for Quality Palliative Care:
197 structures and processes of care; physical aspects of care; psychological and psychiatric aspects
198 of care; social aspects of care; spiritual, religious, and existential aspects of care; cultural aspects
199 of care; care of the imminently dying patient; and ethical and legal aspects of care.

200

201 Before 2008, NQF endorsed nine national voluntary consensus standards for addressing
202 symptom management and EOL care for cancer patients within the [National Voluntary](#)
203 [Consensus Standards for the Quality of Cancer Care](#) project. These endorsed measures included:
204 the National Hospice and Palliative Care Organization survey instrument, components of the
205 Family Evaluation of Hospice Care, and measures addressing healthcare utilization at the EOL.

206

207 **NQF'S CONSENSUS DEVELOPMENT PROCESS**

208 NQF's National Voluntary Consensus Standards for Palliative Care and End-of-Life Care seeks
209 to endorse additional measures for quality improvement and accountability. Candidate consensus
210 standards were solicited through a Call for Measures that closed on May 18, 2011. Additionally,
211 relevant measures endorsed previously through previous projects were brought into the Palliative
212 Care and End-of-Life Care project as part of NQF's endorsement maintenance process. Twenty-
213 two measures were submitted in response to this project's Call for Measures. Fifteen measures
214 were evaluated for suitability as voluntary consensus standards for quality improvement and
215 accountability using NQF's standard evaluation criteria. Seven measures were withdrawn from
216 consideration by the measure developer as a result of Steering Committee discussions
217 questioning the utility of the measures for public reporting. Steering Committee subgroups rated
218 each measure's strengths and weaknesses using the criteria and subcriteria to assist the
219 Committee in making recommendations. The 21-member, multi-stakeholder Committee
220 provided final evaluations of the four main criteria—importance to measure and report, scientific
221 acceptability of the measure properties, usability, and feasibility – and made endorsement
222 recommendations. Most measure developers were available during Committee discussions to
223 respond to questions and clarify any issues or concerns.

224

NATIONAL QUALITY FORUM

225 **Overarching Measure Evaluation Issues**

226 The Steering Committee encountered several overarching issues during its discussions and
227 evaluations of the measures. These issues were factored into the Committee's ratings and
228 recommendations for measures and are described below, as well as for each individual measure
229 in the evaluation summary table.

230

231 *Use of Expert Judgment or Additional Evidence in Reviews*

232 While reviewing the evidence provided to support several of the measures, the Steering
233 Committee noted that the evidence provided in the forms did not directly address the measure's
234 focus. In those instances, the Steering Committee members discussed their role regarding using
235 their expert judgment or applying additional evidence based on their own knowledge or expertise
236 during the evaluation process. It was determined that committee members could use their own
237 expert knowledge in their decisions and ratings of the subcriteria but that additional research on
238 the evidence would not be conducted.

239

240 Measure #1625: *Hospitalized patients who die an Expected Death with an ICD that has been*
241 *deactivated* serves as an example of how the Committee applied additional evidence based on its
242 knowledge and expertise. This measure had limited documentation on the underlying evidence.
243 However, Steering Committee members were able to cite evidence to support the measure based
244 on their individual expertise and clinical knowledge, which has not yet been incorporated into
245 clinical guidelines.

246

247 In other instances when the evidence presented for a particular measure did not meet the NQF
248 subcriteria of the quantity, quality, and consistency of the evidence, it was determined that the
249 Committee's collective judgment was acceptable for those measures whose benefits far outweigh
250 any potential risks associated with it. Measure #1647: *Percentage of hospice patients with*
251 *documentation in the clinical record of a discussion of spiritual/religious concerns or*
252 *documentation that the patient/caregiver did not want to discuss* serves as a good example of
253 applying expert judgment. The Committee was presented with data from a retrospective study
254 showing that patients whose records documented a conversation of their spiritual or religious
255 concerns demonstrated improvement in overall spiritual distress as opposed to those whose

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

**NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011,
6:00 PM ET**

NATIONAL QUALITY FORUM

256 records did not document this conversation. In this discussion, the Steering Committee raised
257 concerns that the evidence presented, though compelling given the topic area addressed by the
258 measure, does not meet the NQF criteria for the quantity, quality, and consistency of evidence.
259 However, the Steering Committee's expert consensus of the measure's importance related to the
260 quality of care provided to a patient and the potential benefits patients will experience based on
261 this assessment was deemed acceptable.

262

263 *Process-Outcome Links*

264 The Committee discussed the link between the process of care and desired health outcome in
265 selected measures. Several measures presented to the Committee did not have a clear process-
266 outcome link, and data on how these measures lead to better outcomes were presented. For
267 example, the Committee discussed to what degree assessments for pain led to better outcomes
268 (Measure #1637: *Hospice and Palliative Care - Pain Assessment*); but given the performance
269 gap in this area, with only 60 percent of hospice patients and 67 percent of palliative patients
270 having a pain assessment, the Committee supported the measure's importance to measure and
271 report. Regarding measure #1647: *Percentage of hospice patients with documentation in the*
272 *clinical record of a discussion of spiritual/religious concerns or documentation that the*
273 *patient/caregiver did not want to discuss*, the Steering Committee noted that effective
274 interventions to address the issues faced by patients reporting spiritual distress might not exist.
275 However, the Committee was presented with data to show that having this conversation resulted
276 in 63 percent of patients reporting improvement in their spiritual distress scores.

277

278 *Unintended Consequences of Measures*

279 The Committee discussed potential unintended consequences following the use of a measure. In
280 particular, the Steering Committee questioned whether emphasizing screening for a condition or
281 symptom might result in overtreatment. The Steering Committee suggested that an unintended
282 consequence of Measure #1638: *Hospice and Palliative Care - Dyspnea Treatment* is the
283 potential for overtreating dyspnea. The developer suggested that at this time the more pressing
284 concern the measure addresses is undertreatment rather than overtreatment of dyspnea.

285 *Related and Competing Measures*

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

**NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011,
6:00 PM ET**

NATIONAL QUALITY FORUM

286 For those measures that are determined to be competing or related, additional guidance was
287 provided to the Committee requesting them to see if harmonization should be sought for related
288 measures or if one measure could be recommended if more than one competing measure were
289 identified. Competing measures are those that essentially address the same concepts for the target
290 process, condition, and event outcome, as well as the same target patient population. Related
291 measures are those that have the same concepts either for measure focus or target population, but
292 not both. Each measure must meet the measure evaluation criteria before this additional
293 discussion. No measures were determined to be competing, but several measures were
294 determined to be related, and opportunities for harmonization were considered. For example,
295 measure #1641: *Hospice and Palliative Care – Treatment Preferences* and the previously
296 endorsed measure #326: *Advanced Care Plan* were reviewed to determine if they were
297 competing measures. The measures address populations that were overlapping but differed in
298 focus and intent. Measure #1641 captures documentation of life-sustaining preferences when the
299 end of life is imminent (hospice/specialty palliative care setting) and addresses a different set of
300 questions. Measure #326 captures legal documentation via an advance care plan or through a
301 designated surrogate decision maker. The patient population is over age 65, but the measure is
302 not intended to capture a population of patients who are approaching the immediate end of life.
303 Rather, the measure is intended to encourage a discussion in advance. For these reasons, the
304 Steering Committee did not recommend further action toward harmonization but did make
305 recommendations to improve both measures further.

306

307 In addition, the Steering Committee requested that the measure developers harmonize the
308 numerators of two measures: #1634: *Hospice and Palliative Care – Pain Screening* and #1628:
309 *Patients with advanced cancer assessed for pain at outpatient visits*. These measures both
310 specify pain screening, but for different populations, thus making them related and not competing
311 measures. However, the measures specified different screening tools within the numerators. At
312 the Committee's request, developers harmonized the numerators of these measures so both
313 specify screening for presence or absence of pain, rating pain if available and using a
314 standardized quantitative tool (with examples of pain screening tools provided).

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

**NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011,
6:00 PM ET**

NATIONAL QUALITY FORUM

315 **RECOMMENDATIONS FOR ENDORSEMENT**

316 This report presents the results of the evaluation of 15 measures considered under the NQF
317 Consensus Development Process (CDP).

318

319 **Candidate Consensus Standards Recommended for Endorsement**

320 Fourteen measures are recommended for endorsement as voluntary consensus standards
321 suitable for public reporting and accountability. Evaluation summary tables follow the list of
322 measures and summarize the results of the Steering Committee’s recommendation for
323 endorsement and subsequent public and NQF member comments. Hyperlinks are provided:

- 324 • from each listed measure to the evaluation summary table;
- 325 • from each summary table to the detailed measure specifications;
- 326 • from each summary table to the web page where all materials submitted by the
327 developer or steward are posted; and
- 328 • from each summary table to the web page where the meeting and call summaries,
329 transcripts, and recordings can be assessed.

330 The Steering Committee recommended the following candidate consensus standards for
331 endorsement:

332 ***Pain Management Measures***

333 1634: Hospice and Palliative Care- Pain Screening (UNC)

334 1637: Hospice and Palliative Care – Pain Assessment (UNC)

335 1617: Patients treated with an Opioid who are given a bowel regimen (RAND)

336 1628: Patients with advanced cancer assessed for pain at outpatient visits (RAND)

337

338 ***Dyspnea Management Measures***

339 1638: Hospice and Palliative Care- Dyspnea Treatment (UNC)

340 1639: Hospice and Palliative Care – Dyspnea Screening (UNC)

341

342 ***Care Preference Measures***

343 1626: Patients admitted to the ICU who have care preferences documented (RAND)

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

**NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011,
6:00 PM ET**

NATIONAL QUALITY FORUM

- 344 1641: Hospice and Palliative Care- Treatment Preferences (UNC)
345 1647: Percentage of hospice patients with documentation in the clinical record of a discussion of
346 spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss
347 (Deyta)
348 0209: Comfortable dying (NHPCO) (maintenance)
349 1625: Hospitalized patients who die an expected death with an ICD that has been deactivated
350 (RAND)

351

352 **Quality of Care at the End of Life Measures**

- 353 0208: Family Evaluation of Hospice Care (NHPCO) (maintenance)
354 1632: CARE- Consumer Assessments and Reports of End of Life (Center for Gerontology and
355 Health Care Research)
356 1623: Bereaved Family Survey (PROMISE Center)

357

358 **Candidate Consensus Standards Not Recommended for Endorsement**

359 The Steering Committee recommended that the following candidate consensus standard not be
360 endorsed:

- 361 1630: Hospitalized patients who die an expected death who have dyspnea addressed (RAND)
362

363 **PAIN MANAGEMENT MEASURES**

364

365 **LEGEND: Y = Yes; N = No; C = Completely; P = Partially; M = Minimally; N = Not at all**

366

<p>1634: Hospice and Palliative Care- Pain Screening (measure specifications) (developer materials and meeting summaries)</p> <p>Description: Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter</p> <p>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 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.</p> <p>Denominator Statement: Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.</p> <p>Exclusions: Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.</p> <p>Adjustment/Stratification: None</p> <p>Level of Analysis: Clinician : Group/Practice, Facility</p> <p>Type of Measure: Process</p>
--

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

1634: Hospice and Palliative Care- Pain Screening (measure specifications) (developer materials and meeting summaries)
Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Measure Steward: University of North Carolina- Chapel Hill 725 Martin Luther King Jr Blvd, CB 7590 Chapel Hill North Carolina 27599-7590
Steering Committee Recommendation for Endorsement: <u>Y-20, N-0, A-0</u> Rationale:
If Applicable, Conditions/Questions for Developer: <ol style="list-style-type: none"> 1) Steering Committee members requested harmonization of the numerator of this measure with that of measure 1628 2) Please explain the rationale for the denominator being limited to 1 day for palliative care and 7 days for hospice care Developer Response: <ol style="list-style-type: none"> 1) The developer harmonized the numerator with measure 1628: Patients with advanced cancer assessed for pain at outpatient visits (RAND), and it met the Committee's approval. 2) These two time intervals were selected after consulting with hospice and palliative care providers about the timeframes for evaluation. The aim was to allow for the timeframes be generalizable and realistic (in duration) for the scope of the initial evaluation. The measure, as tested, did not specify a definition of the initial evaluation.
1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-12, M-7, L-1, I-0; 1c. Evidence Quantity H-14, M-6, L-0, I-0; Evidence Quality H-16, M-4, L-0, I-0; Evidence Consistency H-17, M-2, L-1; I-0)</i>
Rationale: <ul style="list-style-type: none"> • The Steering Committee stated that the measure is important, particularly because it prompts treatment when pain screening is positive; however, it was noted that the supplied evidence is more directly related to a gap in pain assessment rather than screening. • This assessment, therefore, is triggered by the screening; a factor the Committee considered as additional evidence when making its decision.
2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-16, M-4, L-0, I-0; 2b. Validity Testing H-17, M-3, L-0, I-0; 2c. Disparities: H-11, M-7, L-2, I-0)</i>
Rationale: <ul style="list-style-type: none"> • The Steering Committee noted that the specifications requiring that patients be enrolled in palliative care for 7 or more days OR hospice care for 1 or more days will exclude a significant percentage of patients. Steering Committee members would prefer to see the measure without these constraints. Ultimately, the Steering Committee recommended the measure as there is no testing or evidence for the measure with any other specifications.
3. Usability: <u>H-16, M-3, L-1, I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i>
Rationale: <ul style="list-style-type: none"> • Measure is important and prevalent. • From its use in the University of North Carolina's PEACE project, an effort that aimed to develop quality measures for hospice and palliative care. In this project, it was found to be useful for those seeking care and quality improvement.
4. Feasibility: <u>H-19, M-1, L-0, I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i>
Rationale: <ul style="list-style-type: none"> • The measure is easily implemented electronically. • If electronic data are not available, Steering Committee members noted that substantial data collection effort may be required, as data must be extracted from the patient chart.

367

1637: Hospice and Palliative Care- Pain Assessment (measure specifications) (developer materials and meeting summaries)
Description: This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1637: Hospice and Palliative Care- Pain Assessment (measure specifications) (developer materials and meeting summaries)</p>
<p>who received a clinical assessment of pain within 24 hours of screening. Numerator Statement: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain. Denominator Statement: Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter. Exclusions: Patients with length of stay < 1 day in palliative care or < 7 days in hospice, patients who were not screened for pain. Adjustment/Stratification: No risk adjustment or stratification necessary. Level of Analysis: Clinician : Group/Practice, Facility Type of Measure: Process Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Measure Steward: University of North Carolina- Chapel Hill 725 Martin Luther King Jr Blvd, CB 7590 Chapel Hill North Carolina 27599-7590</p>
<p>Steering Committee Recommendation for Endorsement: <u>Y-16, N-4, A-0</u> Rationale:</p>
<p>If Applicable, Conditions/Questions for Developer:</p> <ul style="list-style-type: none"> • Within the denominator details, the measure has a positive screen for hospice patient of “if greater than 0,” hospice patient is “greater than 4”? <p>Developer Response:</p> <ul style="list-style-type: none"> • Screening scores were based on clinicians’ input
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-14, M-5, L-0, I-1; 1c. Outcome or Evidence: Evidence Quantity H-11, M-6, L-2, I-1; Evidence Quality H-10, M-8, L-2, I-0; Evidence Consistency H-10, M-6, L-1, I-3)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The Steering Committee noted that there is uncertainty as to what degree these components are associated with better outcomes if you measure them; however, given the demonstrated performance gap in assessment, the Steering Committee voted that this measure met the criteria for importance. • Steering Committee members noted that consistent follow-up assessments may have more therapeutic value than an initial assessment alone, but this may be difficult to capture through measurement currently.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-7, M-11, L-2, I-0; 2b. Validity Testing H-6, M-11, L-2, I-1; 2c. Disparities: H-5, M-9, L-3, I-3)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The Steering Committee noted that the reliability testing was conducted with appropriate method and scope. • The measure has good face validity and the endorsement of both an expert panel and several consensus statements.
<p>3. Usability: <u>H-7, M-7, L-6, I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The measure seems to be easily understandable to the public. • The measure will allow hospices and palliative care units to lay the foundation for the next steps to reduce and manage pain. • From its use in the University of North Carolina’s PEACE project, an effort that aimed to develop quality measures for hospice and palliative care. In this project, it was found to be useful for those seeking care and quality improvement.
<p>4. Feasibility: <u>H-3, M-12, L-5, I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The measure is easily captured electronically. • If electronic data are not available, Steering Committee members noted that substantial data collection effort may be required,

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

368

1637: Hospice and Palliative Care- Pain Assessment ([measure specifications](#)) ([developer materials and meeting summaries](#))
as data must be extracted from the patient chart.

<p>1617: Patients Treated with an Opioid who are given a bowel regimen (measure specifications) (developer materials and meeting summaries)</p> <p>Description: Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed Numerator Statement: Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed Denominator Statement: Vulnerable adults who are given a new prescription for an opioid Exclusions: None Adjustment/Stratification: No risk adjustment or stratification necessary Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan Type of Measure: Process Data Source: Electronic Clinical Data : Electronic Health Record, Paper Records, Patient Reported Data/Survey Measure Steward: RAND Corporation 1776 Main Street Santa Monica California 90407</p>
<p>Steering Committee Recommendation for Endorsement: <u>Y-19, N-1, A-0</u> Rationale:</p>
<p>If Applicable, Conditions/Questions for Developer:</p> <ol style="list-style-type: none"> 1) Why is a bulk agent being considered as a bowel regimen? 2) Why is this particular population being considered? And could it (has there been testing) be considered more broadly as a measure for all elders, not just vulnerable elders? <p>Developer Response:</p> <ol style="list-style-type: none"> 1) The developer provided information that bulk agents are used in treating constipation. 2) Population being considered is not just vulnerable elders but has been expanded to vulnerable adults. Measure has been tested but does not have reliability testing (only prevalence).
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-16, M-3, L-1, I-0; 1c. Outcome or Evidence: Evidence Quantity: H-10, M-10, L-0, I-0; Evidence Quality: H-16, M-4, L-0, I-0; Evidence Consistency: H-17, M-3, L-0, I-0)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Measure demonstrates a high impact—this is an important treatment issue. • Evidence is provided through literature studies. • Impact on healthcare cost and patient distress is significant. • The measure is easily implemented and can have significant impact.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-15, M-5, L-0, I-0; 2b. Validity Testing: H-13, M-6, L-1, I-0; 2c. Disparities: H-8, M-6, L-3, I-3)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Reliability testing was measured against current acceptable statistical assessments. • Validity testing was conducted empirically.
<p>3. Usability: <u>H-10, M-9, L-1, I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The measure is easily understood by the public.
<p>4. Feasibility: <u>H-13, M-7, L-0, I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p>

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

1617: Patients Treated with an Opioid who are given a bowel regimen ([measure specifications](#)) ([developer materials and meeting summaries](#))

Rationale:

- Data are easily collected.

369

1628: Patients with advanced cancer assessed for pain at outpatient visits ([measure specifications](#)) ([developer materials and meeting summaries](#))

Description: Adult patients with advanced cancer who have an assessment of pain with a standardized quantitative tool at each outpatient visit

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 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.

Denominator Statement: Adult patients with advanced cancer who have at least 1 primary care or cancer-related outpatient visit

Exclusions: None

Adjustment/Stratification: No risk adjustment or stratification

Level of Analysis: Facility, Integrated Delivery System

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Registry, Paper Records

Measure Steward: RAND Corporation | 1776 Main Street | Santa Monica | California | 90407

Steering Committee Recommendation for Endorsement: Y-20, N-0, A-0

Rationale:

If Applicable, Conditions/Questions for Developer:

- 1) Steering Committee members requested harmonization of the numerator of this measure with that of measure 1634.

Developer Response:

- 1) The developer harmonized the numerator with measure 1634: Hospice and Palliative Care- Pain Screening (UNC), and it met the Committee's approval.

Recommendations:

- Codes for the two lowest level office visits should not be included, as they are typically not long enough for a discussion of pain and may or may not include time with a physician.
- Unlikely to be any unintended consequences from removing these codes from the measure specifications.

1. Importance to Measure and Report: Overall, the criteria for importance were met.

(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-16, M-4, L-0, I-0; 1c. Outcome or Evidence: Evidence Quantity: H-8, M-8, L-4, I-0; Evidence Quality: H-10, M-10, L-0, I-0; Evidence Consistency: H-10, M-10, L-0, I-0)

Rationale:

- Pain assessment is standard of care and well documented. The Steering Committee noted that inadequate management as an outpatient is more likely to lead to increased healthcare costs than poor management as an inpatient.
- There is a demonstrated performance gap in pain assessment.
- Steering Committee members noted that this measure is limited by the study population.

2. Scientific Acceptability of Measure Properties: Overall, the criteria for scientific acceptability were met.

(2a. Reliability Testing: H-10, M-8, L-0, I-2; 2b. Validity Testing: H-9, M-11, L-0, I-0; 2c. Disparities: H-5, M-5, L-3, I-7)

Rationale:

- Reliability testing was well documented.
- Validity testing was accomplished through an expert panel using a modified Delphi.
- The Steering Committee noted that it is unclear why this would be limited to only Stage 4 cancer patients; however, given that there is no testing in other populations and the Steering Committee acknowledged the importance of this assessment, the measure was voted as meeting the criteria for scientific acceptability.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1628: Patients with advanced cancer assessed for pain at outpatient visits (measure specifications) (developer materials and meeting summaries)</p> <ul style="list-style-type: none"> Steering Committee members noted the relationship of this measure to measure 1634 and asked the measure developers to harmonize the numerators.
<p>3. Usability: H-9, M-10, L-1, I-0 (<i>Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement</i>)</p> <p>Rationale:</p> <ul style="list-style-type: none"> This measure is important for public reporting and will be easily understood.
<p>4. Feasibility: H-12, M-7, L-1, I-0 (<i>4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented</i>)</p> <p>Rationale:</p> <ul style="list-style-type: none"> As data capture in oncology practice increasingly uses EMRs, this measure will become more feasible.

370

371 **DYSPNEA MANAGEMENT MEASURES**

372 **LEGEND: Y = Yes; N = No; C = Completely; P = Partially; M = Minimally; N = Not at all**

<p>1639: Hospice and Palliative Care- Dyspnea Screening (measure specifications) (developer materials and meeting summaries)</p> <p>Description: Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter. Numerator Statement: Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care. Denominator Statement: Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days. Exclusions: Patients with length of stay < 7 days in hospice, or < 1 day in palliative care. Adjustment/Stratification: No risk adjustment Level of Analysis: Clinician: Group/Practice, Facility Type of Measure: Process Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Measure Steward: University of North Carolina- Chapel Hill 725 Martin Luther King Jr Blvd, CB 7590 Chapel Hill North Carolina 27599-7590</p>
<p>Steering Committee Recommendation for Endorsement: Y-20, N-0, A-0</p> <p>Rationale:</p>
<p>If Applicable, Conditions/Questions for Developer:</p> <p>1) Are there disparities data for this measure?</p> <p>Developer Response:</p> <p>1) No data currently available</p>
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> (<i>1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-20, M-0, L-0, I-0; 1c. Outcome or Evidence: Evidence Quantity: H-11, M-9, L-0, I-0; Evidence Quality: H-14, M-6, L-0, I-0; Evidence Consistency: H-18, M-2, L-0, I-0</i>)</p> <p>Rationale:</p> <ul style="list-style-type: none"> This is a prevalent problem. There is not demonstrated evidence that solely screening for dyspnea leads to better outcomes, but it is a necessary step leading to treatment. For this reason, the Steering Committee believes it meets importance criteria given the vulnerable population addressed by this measure. There is an opportunity for improvement.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> (<i>2a. Reliability Testing: H-18, M-2, L-0, I-0; 2b. Validity Testing: H-17, M-3, L-0, I-0; 2c. Disparities: H-7, M-7, L-2, I-4</i>)</p>

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

1639: Hospice and Palliative Care- Dyspnea Screening (measure specifications) (developer materials and meeting summaries)
<p>Rationale:</p> <ul style="list-style-type: none"> • Initially, Steering Committee members raised concerns that the numerator data may not be consistently documented. • The testing results signified that the measure is clearly specified. • The reliability testing used appropriate data elements and demonstrated high reliability. • Validity evidence for the measure is within acceptable statistical norms.
<p>3. Usability: <u>H-18, M-2, L-0, I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The measure is very clear and straightforward; quality improvement action may be taken to improve opportunities for treatment of patients with dyspnea. • Steering Committee members raised concerns that the numerator data may not be consistently documented.
<p>4. Feasibility: <u>H-16, M-4, L-0, I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy can be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The data are available electronically and can be extracted. • If electronic data are not available, Steering Committee members noted that substantial data collection effort may be required, as data must be extracted from the patient chart.

373

374

1638: Hospice and Palliative Care- Dyspnea Treatment (measure specifications) (developer materials and meeting summaries)
<p>Description: Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening. Numerator Statement: Patients who screened positive for dyspnea who received treatment within 24 hours of screening. Denominator Statement: Patients enrolled in hospice for 7 or more days OR patients receiving palliative care who report dyspnea when dyspnea screening is done on the admission evaluation / initial encounter. Exclusions: Palliative care patients with length of stay < 1 day or hospice patients with length of stay < 7 days, patients who were not screened for dyspnea, and/or patients with a negative screening. Adjustment/Stratification: No risk adjustment Level of Analysis: Clinician : Group/Practice, Facility Type of Measure: Process Data Source: Electronic Clinical Data Measure Steward: University of North Carolina- Chapel Hill 725 Martin Luther King Jr Blvd, CB 7590 Chapel Hill North Carolina 27599-7590</p>
Steering Committee Recommendation for Endorsement: <u>Y-17, N-3, A-0</u> Rationale:
<p>If Applicable, Conditions/Questions for Developer</p> <ol style="list-style-type: none"> 1) Is what constitutes treatment too broad to be clear to raters of the measure? 2) Did chart abstracters rely on narrative data to catch non-pharmacological interventions? 3) Is there an expectation that anyone, with any level of dyspnea, would get treatment? 4) How was 24 hours chosen for screening? <p>Developer Response:</p> <ol style="list-style-type: none"> 1) There are separate reliability and validity data for this measure and measure 1639, which was not submitted, as these are paired measures. There was very good ability for independent raters to identify presence of treatment—kappa of 0.89. 2) Abstracters relied on physicians, nursing notes, MARs. 3) That is correct. The measure developer could not find good, well-validated instruments for consistent measurement of dyspnea. Unlike pain, there is not a broad array of well-accepted severity standards

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1638: Hospice and Palliative Care- Dyspnea Treatment (measure specifications) (developer materials and meeting summaries)</p> <p>4) Comparable to other measures in set—given different settings—the consensus for the response time was 24 hours.</p> <p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-15, M-4, L-1, I-0; 1c. Outcome or Evidence: Evidence Quantity: H-12, M-7, L-1, I-0; Evidence Quality: H-8, M-11, L-1, I-0; Evidence Consistency: H-7, M-12, L-1, I-0)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> As with screening, treatment of dyspnea remains problematic for a large number of patients. The Steering Committee stated that this measure would likely benefit these patients. <p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met</u> <i>(2a. Reliability Testing: H-7, M-11, L-2, I-0; 2b. Validity Testing: H-10, M-9, L-1, I-0; 2c. Disparities: H-5, M-6, L-4, I-5)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> Reliability and validity data are strong. Steering Committee members noted that the range of what constitutes treatment is large, from opioids to non-pharmacological interventions. <p>3. Usability: <u>H-8, M-11, L-1, I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> Information produced for dyspnea treatment is meaningful and understandable such that quality improvement action may be taken to improve opportunities for treatment and improved patient outcomes of dyspnea. <p>4. Feasibility: <u>H-2, M-11, L-6, I-1</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The measure is easily implemented electronically. If electronic data are not available, Steering Committee members noted that substantial data collection effort may be required, as data must be extracted from the patient chart.

375

376

<p>1630: Hospitalized patients who die an expected death who have dyspnea addressed (measure specifications) (developer materials and meeting summaries)</p> <p>Description: 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</p> <p>Numerator Statement: Percentage of patients with dyspnea from the denominator who on any day(s) during the denominator time window had:</p> <p>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</p> <p>b) a reassessment of their dyspnea (response to treatment or reassessment in untreated dyspnea) within 24 hours</p> <p>Denominator Statement: Hospitalized patients who died an expected death and who had dyspnea in the 7 days prior to death</p> <p>Exclusions: None</p> <p>Adjustment/Stratification: No risk adjustment or stratification</p> <p>Level of Analysis: Facility</p> <p>Type of Measure: Process</p> <p>Data Source: Electronic Clinical Data : Electronic Health Record, Paper Records</p> <p>Measure Steward: RAND Corporation 1776 Main Street Santa Monica California 90407</p> <p>Steering Committee Recommendation for Endorsement: <u>No vote taken—measure did not pass importance criterion</u></p> <p>Rationale:</p> <p>If Applicable, Conditions/Questions for Developer:</p>
--

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1630: Hospitalized patients who die an expected death who have dyspnea addressed (measure specifications) (developer materials and meeting summaries)</p>
<p>1) Could this measure be expanded to other settings of care? 2) Unexpected death and “addressing dyspnea” are unclear. 3) Feasibility concerns regarding collection of data and identification of dyspnea. 4) How was 24 hours selected as a timeframe for addressing/intervention for dyspnea?</p> <p>Developer Response:</p> <p>1) The measure has not been tested in other settings of care. 2) These terms are defined in the measure specifications. 3) Identifying dyspnea is not as easy as pain, but it is identifiable and can be reliably abstracted, although it does take time. 4) This timeframe simplifies data abstraction.</p>
<p>1. Importance to Measure and Report: <u>The measure did not pass the importance criterion.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-4, M-10, L-5, I-1; 1c. Outcome or Evidence: Evidence Quantity: H-1, M-5, L-12, I-2; Evidence Quality: H-0, M-7, L-11, I-2; Evidence Consistency: H-1, M-5, L-7, I-7)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Lack of a strong evidence base cited by multiple committee members. • Significant gaps in information. • Would favor one major dyspnea measure and not a smaller subset like this.
<p>2. Scientific Acceptability of Measure Properties: <u>No vote taken—measure did not pass importance criterion</u> <i>(2a. Reliability Testing; 2b. Validity Testing; 2c. Disparities)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Definition of unexpected death is unclear
<p>3. Usability: <u>No vote taken—measure did not pass importance criterion</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p>
<p>4. Feasibility: <u>No vote taken—measure did not pass importance criterion</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Hard to see how this can be implemented with paper medical records.

377 **CARE PREFERENCE MEASURES**

378

379 **LEGEND: Y = Yes; N = No; C = Completely; P = Partially; M = Minimally; N = Not at all**

380

<p>1626: Patients Admitted to ICU who have care preferences documented (measure specifications) (developer materials and meeting summaries)</p>
<p>Description: Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done. Numerator Statement: Patients in the denominator who had their care preferences documents within 48 hours of ICU admission or have documentation of why this was not done. Denominator Statement: All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission Exclusions: None Adjustment/Stratification: No risk adjustment or stratification. Level of Analysis: Facility, Health Plan, Integrated Delivery System Type of Measure: Process</p>

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

1626: Patients Admitted to ICU who have care preferences documented (measure specifications) (developer materials and meeting summaries)
Data Source: Electronic Clinical Data: Electronic Health Record, Paper Records Measure Steward: RAND Corporation, 1776 Main Street, Santa Monica, California 90407
Steering Committee Recommendation for Endorsement: <u>Y-20; N-0; A-0</u> Rationale: <ul style="list-style-type: none"> • The measure impacts many patients. • Determination of patient wishes at the end of life is crucial to patient care for both the patients and their families/caregivers.
If Applicable, Conditions/Questions for Developer:
1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-19; M-1; L-0; I-0; 1c. Evidence Quantity: H-11; M-9; L-0; I-0; Evidence Quality H-12; M-8; L-0; I-0; Evidence Consistency: H-15; M-5; L-0; I-0)</i>
Rationale: <ul style="list-style-type: none"> • Performance gap is well documented. • The measure is important for all ICU patients, including, but not limited to, vulnerable adults. • The Steering Committee noted that ensuring documentation of care preferences is linked to improved quality of life and experience of care. • The evidence is solid, though there are no clinical trials cited.
2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-10; M-9; L-1; I-0; 2b. Validity Testing: H-7; M-12; L-1; I-0; 2c. Disparities: H-9; M-7; L-0; I-4)</i>
Rationale: <ul style="list-style-type: none"> • Steering Committee members acknowledged that it is difficult to measure whether there was a failure to attempt to meet patient preferences. • Concern that chart data may not always be present and that definitions are too broad for implementation. • Concern that many patients may not be communicative in the first 48 hours in the ICU; as such, this measure may not be usable. • Concern that this measure is an ICU documentation issue rather than one that captures the intended process. • However, Steering Committee members noted that there is strong inter-rater reliability with the measure. • Steering Committee stated that face validity was acceptable.
3. Usability: <u>H-10; M-8; L-1; I-1</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i>
Rationale: <ul style="list-style-type: none"> • The Steering Committee stated that this measure provides important information for those seeking care.
4. Feasibility: <u>H-7; M-8; L-4; I-1</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i>
Rationale: <ul style="list-style-type: none"> • Clinical measures are routinely generated during daily patient care. Data are easily obtainable through EMRs or medical record chart documentation.

381

382

1641: Hospice and Palliative Care-Treatment Preferences (measure specifications) (developer materials and meeting summaries)
Description: Percentage of patients with chart documentation of preferences for life sustaining treatments.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1641: Hospice and Palliative Care-Treatment Preferences (measure specifications) (developer materials and meeting summaries)</p>
<p>Numerator Statement: Patients whose medical record includes documentation of life sustaining preferences. Denominator Statement: Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting. Exclusions: Patients with length of stay < 1 day in palliative care or < 7 days in hospice Adjustment/Stratification: No risk adjustment or stratification. Level of Analysis: Clinician: Group/Practice, Facility Type of Measure: Process Data Source: Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record Measure Steward: University of North Carolina-Chapel Hill, 725 Martin Luther King Jr Blvd, CB 7590, Chapel Hill, North Carolina 27599-7590</p>
<p>Steering Committee Recommendation for Endorsement: <u>Y-19; N-1; A-0</u> Rationale:</p> <ul style="list-style-type: none"> • The measure affects many patients. • Use of this measure will improve attention to the important practice of documenting preferences for life-sustaining treatments.
<p>If Applicable, Conditions/Questions for Developer:</p> <p>Recommendations While the Committee did not recommend harmonization of this measure with NQF-endorsed measure 0326: <i>Advance Care Plan (NCQA/PCPI)</i>, it did encourage the developer to improve it by including the completion of a Physicians Order for Life Sustaining Treatment (POLST) form as a way to document care preferences in the numerator.</p>
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-16; M-3; L-1; I-0; 1c. Evidence Quantity: H-16; M-4; L-0; I-0; Evidence Quality H-13; M-7; L-0; I-0; Evidence Consistency: H-19; M-1; L-0; I-0)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Performance gap is well documented. • There is a large number of both palliative care and end-of-life care patients who are affected. • There is evidence demonstrating a need for a discussion of life-sustaining treatment preferences with the patient, and poor communication about patient preferences has been identified as a major quality concern in palliative and end-of-life care. • The numerator captures a discussion with the patient, not simply prescribed orders. This is important because it captures the patient's preferences.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-12; M-8; L-0; I-0; 2b. Validity Testing: H-12; M-7; L-1; I-0; 2c. Disparities: H-8; M-6; L-1; I-5)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Inter-rater reliability is very strong. • Validity testing for this measure focuses on the target population consistent with research; construct validity is demonstrated.
<p>3. Usability: <u>H-13; M-5; L-1; I-1</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Data submitted shows that the measure results are meaningful, understandable, and very usable to affect quality outcomes for palliative and hospice patient populations.
<p>4. Feasibility: <u>H-8; M-10; L-2; I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • All data elements are available electronically.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

1641: Hospice and Palliative Care-Treatment Preferences (measure specifications) (developer materials and meeting summaries)

- If electronic data are not available, Steering Committee members noted that substantial data collection effort may be required, as data must be extracted from the patient chart.
- Concern that the documentation may not be standardized, making it somewhat challenging to extract reliably.

383

384

1647: Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss (measure specifications) (developer materials and meeting summaries)

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

Numerator Statement: Number of patient with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss

Denominator Statement: Total number of patient's discharged from hospice care during the designated reporting period.

Exclusions: Testing has only been done with the adult population, but there is no reason to believe that this wouldn't be applicable to all hospice patients.

Adjustment/Stratification: No risk adjustment or stratification.

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

Measure Steward: Deyta, LLC, 7400 New LaGrange Road, Suite 200, Louisville, Kentucky 40222

Steering Committee Recommendation for Endorsement: Yes-13; No-5

Rationale:

- The measure will affect a significant number of patients.
- The benefits of assessing spiritual distress and attempting to intervene far outweigh any harms.

If Applicable, Conditions/Questions for Developer:

- 1) Steering Committee members have requested data on reliability testing be provided.
- 2) The Steering Committee has requested that the measure developer address the lack of a use of a standardized instrument to measure spiritual distress or religious concerns.
- 3) The Committee considered whether the measure addresses and fully meets the NQF criteria for the quantity, quality, and consistency of evidence.

Developer Response:

- 1) The data provided were sufficient for the Steering Committee members.
- 2) Further specification of the numerator details was sufficient for Steering Committee members.
- 3) The Steering Committee noted that its own expert opinion on the importance of the measure to report is sufficient for the measure to pass the NQF importance criteria even though the measure may not meet the guidelines for quantity, quality, and consistency of evidence.

1. Importance to Measure and Report: Overall, the criteria for importance were met.

(1a. High Impact: H-9; M-7; L-1; I-1; 1b. Performance Gap: H-4; M-8; L-5; I-0; 1c. Evidence Quantity:H-0; M-4; L-10; I-2; Evidence Quality H-0; M-6; L-10; I-1; Evidence Consistency: H-1; M-6; L-5; I-4)

Rationale:

- Consumers are interested in this measure.
- There has been variation demonstrated in performance across hospices using the measure.
- Spiritual care has been shown to be a critical element of quality of life at the end of life and is of significance to the 1.5 million patients who receive services from approximately 5,000 hospices throughout the United States.
- Steering Committee members noted that there may not be effective interventions to address the issues faced by patients reporting spiritual distress. It is difficult to link this process to outcomes, but it is still important to the quality of life for these individuals.
- Steering Committee members noted that though the body of evidence for this measure does not yet exist, the benefits to this measure far outweigh any potential risks associated with it. Consensus from the Steering Committee was that though the

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1647: Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss (measure specifications) (developer materials and meeting summaries)</p> <p>evidence does not meet the importance criteria, the measure should pass on importance based on the Committee's collective expertise.</p>
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-3; M-10; L-3; I-2; 2b. Validity Testing: H-2; M-9; L-4; I-3; 2c. Disparities: H-1; M-5; L-2; I-9)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The Steering Committee noted that the reliability testing the measure developer provided was sufficient by common standards. The Steering Committee stated that face validity was sufficient for this measure.
<p>3. Usability: <u>H-9; M-6; L-3; I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The Steering Committee stated that the measure will be useful for encouraging assessments of spiritual distress, the first step in ensuring that patients are treated for spiritual distress.
<p>4. Feasibility: <u>H-9; M-7; L-2; I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> Steering Committee members noted that measure information is easily abstracted through chart data.

385

386 **QUALITY OF CARE AT THE END OF LIFE MEASURES**

387 **LEGEND: Y = Yes; N = No; C = Completely; P = Partially; M = Minimally; N = Not at all**

<p>0209: Comfortable Dying (measure specifications) (developer materials and meeting summaries)</p> <p>Description: Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.</p> <p>Numerator Statement: Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment (after admission to hospice services).</p> <p>Denominator Statement: Patients who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment (after admission to hospice services).</p> <p>Exclusions: Inclusions: Patients are eligible if they: Report they are uncomfortable because of pain at the initial assessment (after admission to hospice services); Are able to communicate and understand the language of the person asking the question; Are able to self-report; and, Are at least 18 years of age or older.</p> <p>Adjustment/Stratification: No risk adjustment or stratification.</p> <p>Level of Analysis: Facility, Population: National</p> <p>Type of Measure: Outcome</p> <p>Data Source: Patient Reported Data/Survey</p> <p>Measure Steward: National Hospice and Palliative Care Organization, 1731 King Street, Suite 100, Alexandria, Virginia 22314</p> <p>Steering Committee Recommendation for Endorsement: <u>Y-20; N-0; A-0</u></p> <p>Rationale:</p> <ol style="list-style-type: none"> The measure affects many patients. Use of this measure will improve attention to the important practice of documenting preferences for life-sustaining treatments. <p>If Applicable, Conditions/Questions for Developer:</p>
--

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>0209: Comfortable Dying (measure specifications) (developer materials and meeting summaries)</p>
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-17; M-3; L-0; I-0; 1c. Evidence: This measure is an outcome measure; as such, evidence criteria were not individually voted on)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Management of pain is a key priority identified by NPP.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2b. Reliability Testing: H-12; M-8; L-0; I-0; 2c. Validity Testing: H-13; M-7; L-0; I-0; 2d. Exclusions Justified; 2e. Risk Adjustment/Stratification; 2f. Meaningful Differences; 2g. Comparability; 2h. Disparities: H-9; M-8; L-1; I-2)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The measure was presented with strong data on scientific acceptability. • Some information on disparities was presented indicating no difference in the ethnic distribution of patients whose pain was not brought to a comfortable level to those whose pain was relieved.
<p>3. Usability: <u>H-18; M-2; L-0; I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The measure captures whether pain was controlled or not based on the patient's own perception, acknowledging that pain scales are not reliable across patients. It is usable for that purpose currently. However, the measure does not capture pain relief for patients who are in obvious pain yet unable to answer questions related to their pain, or patients who are unconscious.
<p>4. Feasibility: <u>H-14; M-6; L-0; I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Data elements are easily accessible through patient self-report.

388

<p>1625: Hospitalized Patients who Die an Expected Death with an ICD that has been deactivated (measure specifications) (developer materials and meeting summaries)</p>
<p>Description: Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated</p> <p>Numerator Statement: Patients from the denominator who have their ICDs deactivated prior to death or have documentation of why this was not done</p> <p>Denominator Statement: Patients who die an expected death who have an ICD in place</p> <p>Exclusions: None</p> <p>Adjustment/Stratification: No risk adjustment or stratification.</p> <p>Level of Analysis: Facility</p> <p>Type of Measure: Process</p> <p>Data Source: Paper Records</p> <p>Measure Steward: RAND Corporation, 1776 Main Street, Santa Monica, California 90407</p>
<p>Steering Committee Recommendation for Endorsement: <u>Y-13; N-7; A-0</u></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The measure affects many patients, and ICD use is becoming much more prevalent. This measure will become more useful as ICD use continues to grow. • There is emerging literature about ICS use near death.
<p>If Applicable, Conditions/Questions for Developer:</p>

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1625: Hospitalized Patients who Die an Expected Death with an ICD that has been deactivated (measure specifications) (developer materials and meeting summaries)</p>
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-20; M-0; L-0; I-0; 1b. Performance Gap: H-10; M-10; L-0; I-0; 1c. Evidence Quantity: H-3; M-6; L-9; I-2; Evidence Quality H-5; M-9; L-3; I-3; Evidence Consistency: H-10; M-7; L-0; I-3)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> Steering Committee noted that processes and the evidence base have not caught up with information coming from research and clinical trials dealing with the issue of ICDs left in place at the time of death. This is a painful and serious event when it occurs, and use of ICDs in patients is increasing.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-5; M-9; L-3; I-3; 2b. Validity Testing: H-5; M-7; L-6; I-2; 2c. Disparities: H-7; M-4; L-1; I-8)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> Charts used in reliability testing were for patients who did not have an ICD in place at the time of death. Strong inter-rater reliability of the presence on an ICD was demonstrated. Face validity and expert panel review were accepted for scientific acceptability criteria.
<p>3. Usability: <u>H-11; M-8; L-1; I-0</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The Steering Committee noted that there is no accepted standard of performance for this measure, as there are not yet enough data to establish a benchmark or standard. The measure is not yet used for public reporting.
<p>4. Feasibility: <u>H-7; M-8; L-5; I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> Data elements are accessible through paper records. The measure developer is working to implement this measure in EHRs, which will make it more feasible to use.

389

<p>0208: Family Evaluation of Hospice Care (measure specifications) (developer materials and meeting summaries)</p>
<p>Description: Composite Score: Derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 to 100. Global Score: Percentage of best possible response (Excellent) to the overall rating question on the FEHC survey. Target Population: The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. Timeframe: The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service.</p> <p>Numerator Statement: Composite Score: Numerator is the hospice’s composite score, which is the weighted incidence of problem scores derived from responses from 17 items on the FEHC survey. The 17 questions focus on the following aspects of hospice care: symptom management, communication, provision of information, emotional support, and care coordination.</p> <p>Global Score: Numerator is the number of best possible responses (excellent) to the overall rating question on the FEHC survey.</p> <p>Denominator Statement: Composite Score: 100 (100 is the best possible composite score which indicates 0% incidence of problem scores).</p> <p>Global Score: Total number of responses to the overall rating of care quality on the FEHC survey, question G1.</p> <p>Exclusions: Composite Score: If a survey respondent did not enter a response to more than 14 of the 17 FEHC survey questions included in calculation of the composite score then a composite score will not be calculated for that survey and the survey will not be included in the calculation of a composite score for the hospice.</p> <p>Global Score: If survey respondent has not entered a response to overall rating question (G1), the question is not included in the</p>

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>0208: Family Evaluation of Hospice Care (measure specifications) (developer materials and meeting summaries)</p> <p>denominator.</p> <p>Adjustment/Stratification: No risk adjustment or stratification.</p> <p>Level of Analysis: Facility, Population: National</p> <p>Type of Measure: Process</p> <p>Data Source: Patient Reported Data/Survey</p> <p>Measure Steward: National Hospice and Palliative Care Organization, 1731 King Street, Alexandria, Virginia 22314</p>
<p>Steering Committee Recommendation for Endorsement: <u>Y-19; N-0; A-0</u></p> <p>Rationale:</p> <ul style="list-style-type: none"> This measure is straightforward and highly usable. Its focus, by and large, will likely demonstrate important differences in the quality of care offered by different hospices. The FEHC has considerable experience to support its use, and its voluntary adoption by more than 1000 hospices offers good evidence of its feasibility and utility.
<p>If Applicable, Conditions/Questions for Developer:</p> <p>1) The Steering Committee would like more information on disparities and issues related to stratification of the measure.</p> <p>Response:</p> <p>1) The developer provided the Committee with additional information on the numerator specifications and updated evidence. The updates also included the composite score and information on importance. Additional information was provided on reliability and validity, along with added data on disparities that was unintentionally left out of the original submission. The Committee raised no concerns with this information being presented.</p>
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u></p> <p><i>(1a. High Impact: H-19; M-0; L-0; I-0; 1b. Performance Gap: H-17; M-1; L-1; I-0; 1c. Evidence Quantity: H-12; M-6; L-0; I-1; Evidence Quality H-13; M-6; L-0; I-0; Evidence Consistency: H-14; M-4; L-1; I-0)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> A significant variance in performance was demonstrated. The body of evidence is based on studies, focus groups, and professional guidelines demonstrating that the measured aspects of care are those valued by patients and for which the patients (or in this case, the bereaved family members surveyed) are the best and only source of information.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u></p> <p><i>(2a. Reliability Testing: H-15; M-4; L-0; I-0; 2b. Validity Testing: H-15; M-3; L-1; I-0; 2c. Disparities: H-11; M-6; L-1; I-1)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The FEHC survey is well defined and precisely specified so it can be implemented consistently within and across hospice organizations and allow for comparability. The measure developer did not adequately address disparities and issues related to stratification. The developer presented evidence that the items of the composite score have good face validity and should be easily understood by the public.
<p>3. Usability: <u>H-10; M-9; L-0; I-0</u></p> <p><i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> This measure is already in extensive use.
<p>4. Feasibility: <u>H-12; M-6; L-1; I-0</u></p> <p><i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The data elements would not be in an electronic record, but they would be available electronically when using a vendor. This survey process is not a part of normal hospital or office routine, and it requires additional resources to obtain responses.

NATIONAL QUALITY FORUM

391

1632: CARE- Consumer Assessments and Reports of End of Life (measure specifications) (developer materials and meeting summaries)

Description: The CARE survey is mortality follow back survey that is administered to the bereaved family members of adult persons (age 18 and older) who died of a chronic progressive illness receiving services for at least 48 hours from a home health agency, nursing homes, hospice, or acute care hospital. The survey measures perceptions of the quality of care either in terms of unmet needs, family reports of concerns with the quality of care, and overall rating of the quality of care. The time frame is the last 2 days of life up to last week of life spent in a hospice, home health agency, hospital, or nursing home.

The survey is based on structured literature review,(1) cognitive testing,(2) pre-test,(2) and national survey of the quality of end of life care.(3) The conceptual model is patient focused, family centered care(1) that posits that high quality care at the end of life is obtained when health care institutions: 1) provide the desired level of symptom palliation and emotional support; 2) treat the patient with respect; 3) promote shared decision making; 4) attend to the needs of caregivers for information and skills in providing care for the patient; 5) provide emotional support to the family before and after the patient's death; and 6) coordinates care across settings of care and health care providers.

This is the "parent" survey of the Family Evaluation of Hospice Care Survey (4-7) that my colleagues and I have collaborated with the National Hospice and Palliative Care Organization to create a self-administered survey that is used widely by hospices in the USA and other nations. With the proposed development of accountable care organizations and other potential innovations in health care financing, we recognized the need for an instrument that would allow the comparisons across place of care when there is one entity coordinating and/or financing the care for population of decedents. We have decided to submit the telephone based survey for NQF consideration based on the void of validated measures to capture consumer perceptions (i.e, bereaved family members) of the quality of care at the end of life across place of care. This submission is not meant to be competitive with the existing NQF endorsed Family Evaluation of Hospice Care survey.

This new proposed measure for NQF consideration consists of the survey which has six domains and the new creation of 0-100 composite score that is composed of 14 of 17 core items.

1. Teno JM, Casey VA, Welch L, Edgman-Levitan S. Patient-Focused, Family-Centered End-of-Life Medical Care: Views of the Guidelines and Bereaved Family Members. *J Pain Symptom Manage-Special Section on Measuring Quality of Care at Life's End II*. 2001 Sep 2001;22(3):738-751.

2. Teno JM, Clarridge B, Casey V, Edgman-Levitan S, Fowler J. Validation of Toolkit After-Death Bereaved Family Member Interview. *J Pain Symptom Manage*. 2001 Sep 2001;22(3):752-758.

3. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004 Jan 7 2004;291(1):88-93.

4. Rhodes RL, Mitchell SL, Miller SC, Connor SR, Teno JM. Bereaved family members' evaluation of hospice care: what factors influence overall satisfaction with services? *J Pain Symptom Manage*. 2008 Apr 2008;35(4):365-371.

5. Mitchell SL, Kiely DK, Miller SC, Connor SR, Spence C, Teno JM. Hospice care for patients with dementia. *J Pain Symptom Manage*. 2007 Jul 2007;34(1):7-16.

6. Rhodes RL, Teno JM, Connor SR. African American bereaved family members' perceptions of the quality of hospice care: lessened disparities, but opportunities to improve remain. *J Pain Symptom Manage*. 2007 Nov 2007;34(5):472-479.

7. Connor SR, Teno J, Spence C, Smith N. Family Evaluation of Hospice Care: Results from Voluntary Submission of Data Via Website. *J Pain Symptom Manage*. 2005 Jul 2005;30(1):9-17.

Numerator Statement: Respondent reports of concerns with the quality of care, their self-efficacy in basic tasks of caregiving, or unmet needs that indicate an opportunity to improved end of life care provided by either a nursing home, hospital, hospice, or home health agency.

Denominator Statement: Non-traumatic deaths and deaths from chronic progressive illnesses based on ICD 9/10 codes are included. A list will be provided as technical appendix to the proposed survey. Note the survey is for only persons that died with the following services or location of care: nursing home, hospital, hospice, or home health agency

Exclusions: We excluded deaths due to accidents, trauma, during surgery, lethal injection, acute overwhelming infections, and from complications of pregnancy.

Adjustment/Stratification: No risk adjustment or stratification.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1632: CARE- Consumer Assessments and Reports of End of Life (measure specifications) (developer materials and meeting summaries)</p>
<p>Level of Analysis: Facility, Population: Community, Population: National, Population: Regional Type of Measure: Patient Engagement/Experience Data Source: Other Measure Steward: Center for Gerontology and Health Care Research, 121 South Main Street, Providence, Rhode Island 02912</p>
<p>Steering Committee Recommendation for Endorsement: <u>Y-19; N-0; A-0</u> Rationale:</p> <ul style="list-style-type: none"> This mortality follow-back survey measure fills a need to obtain feedback from family members or others closest to the patient during the last days of life and can be an invaluable source for public reporting as well as quality improvement. This measure assesses aspects of end-of-life care considered crucial to patients, families, practitioners, and payers. Its suitability for use in most of the possible end-of-life settings has the potential to inform practice, educate consumers, demonstrate the importance of end-of-life care, and lead to the development of care structures and incentives to support patients and families better at end of life.
<p>If Applicable, Conditions/Questions for Developer:</p> <ul style="list-style-type: none"> The measure developer provided the Committee with additional detail on the numerator specifications and updated evidence. The Committee raised no concerns with the information presented.
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-19; M-0; L-0; I-0; 1b. Performance Gap: H-14; M-5; L-0; I-0; 1c. Evidence Quantity: H-9; M-9; L-1; I-0; Evidence Quality H-8; M-10; L-0; I-0; Evidence Consistency: H-10; M-9; L-0; I-0)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> Compelling evidence was presented both for being high impact and demonstrating a performance gap. The measure is based upon a credible structure-process-outcome relationship with great consensus.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-11; M-8; L-0; I-0; 2b. Validity Testing: H-9; M-10; L-0; I-0; 2c. Disparities: H-10; M-9; L-0; I-0)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The measure elements, although complicated, are unambiguous with reliable data elements and measure score.
<p>3. Usability: <u>H-9; M-9; L-0; I-1</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The Steering Committee noted that the FEHC is a good proxy for the CARE instrument; as such, the developer has presented relatively strong evidence of the usability of the measure.
<p>4. Feasibility: <u>H-7; M-10; L-2; I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended Consequences Identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> The data are not routinely generated as part of care and would require a follow-back survey. As this is a survey, electronic data collection is not possible. The ease of surveying should be similar to the "offspring" survey and thus is feasible.

392

393

<p>1623: Bereaved Family Survey (measure specifications) (developer materials and meeting summaries)</p>
<p>Description: The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer</p>

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

1623: Bereaved Family Survey ([measure specifications](#)) ([developer materials and meeting summaries](#))

survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.

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

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

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

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

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

Denominator Statement: The denominator consists of all inpatient deaths for which a survey was completed (at least 12 of 17 structured items completed), excluding: 1) deaths within 24 hours of admission (unless the Veteran had a previous hospitalization in the last month of life); 2) deaths that occur in the Emergency Department; 3) deaths that occur in the operating room; and 4) deaths due to suicide or accidents. Additional exclusion criteria include: 1) Veterans for whom a family member knowledgeable about their care cannot be identified (determined by the family member's report); or contacted (no current contacts listed or no valid addresses on file); 2) absence of a working telephone available to the family member.

Exclusions: - Veterans for whom a family member knowledgeable about their care cannot be identified (determined by family member's report)

- Absence of a current address and/or working telephone number for a family member or emergency contact.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

<p>1623: Bereaved Family Survey (measure specifications) (developer materials and meeting summaries)</p> <ul style="list-style-type: none"> - Deaths within in 24 hours of admission without a prior hospitalization of last least 24 hours in the last 31 days of life. - Deaths that occur in the operating room during an outpatient procedure. - Deaths due to a suicide or accident - Surveys in which less than 12 items were answered. <p>Adjustment/Stratification: No risk adjustment or stratification. Level of Analysis: Facility, Population: National, Population: Regional Type of Measure: Outcome Data Source: Other Measure Steward: PROMISE Center, 3800 Woodland Avenue, Building 4100, Philadelphia, Pennsylvania 19104</p>
<p>Steering Committee Recommendation for Endorsement: <u>Y-19; N-0; A-0</u></p> <p>Rationale:</p> <ul style="list-style-type: none"> • This is a straightforward measure with clear and feasible implementation, based upon evidence, that will be useful as it was intended. • This measure captures a unique population in the VA system, which differs from traditional healthcare settings and is not captured in the other surveys under consideration.
<p>If Applicable, Conditions/Questions for Developer:</p>
<p>1. Importance to Measure and Report: <u>Overall, the criteria for importance were met.</u> <i>(1a. High Impact: H-19; M-0; L-0; I-0; 1b. Performance Gap: H-15; M-4; L-0; I-0; 1c. Evidence Quantity: H-8; M-10; L-1; I-0; Evidence Quality H-6; M-12; L-1; I-0; Evidence Consistency: H-7; M-11; L-1; I-0)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • Demographic characteristics in a VA population are atypical of the larger US population, and the survey relies on family perceptions of care. However, this survey offers a way to assess the quality of care that is provided to the family before, during, and after a patient's death.
<p>2. Scientific Acceptability of Measure Properties: <u>Overall, the criteria for scientific acceptability were met.</u> <i>(2a. Reliability Testing: H-7; M-10; L-2; I-0; 2b. Validity Testing: H-7; M-11; L-1; I-0; 2c. Disparities: H-8; M-9; L-0; I-2)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • This is a straightforward, easily accessible survey tool that is well defined and specified with sufficient reliability statistics for administration and scoring. • It is worth noting that the measure fails to address the quality of the care that veterans without family at end of life are receiving.
<p>3. Usability: <u>H-12; M-6; L-0; I-1</u> <i>(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)</i></p> <p>Rationale:</p> <ul style="list-style-type: none"> • The BFS is currently an optional performance measure as part of the VA's nationwide Comprehensive End of Life Care Initiative. The BFS assesses the initiative's impact on the care that VA facilities provide to veterans and their families. As noted earlier, it is limited in its usability for a broad population, as only a smaller percentage of veterans receive their end-of-life care in VA facilities. • The Steering Committee believes that the BFS measure results will be meaningful and understandable to the public.
<p>4. Feasibility: <u>H-8; M-11; L-0; I-0</u> <i>(4a. Clinical Data Generated During Care Delivery; 4b. Electronic Sources; 4c. Susceptibility to Inaccuracies/Unintended consequences identified; 4d. Data Collection Strategy Can Be Implemented)</i></p> <p>Rationale:</p>

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

1623: Bereaved Family Survey ([measure specifications](#)) ([developer materials and meeting summaries](#))

- The data are not routinely generated as part of care and would require a follow-back survey.
- As this is a survey, electronic data collection is not possible. This survey process is not a part of normal hospital or office routine, and it requires additional resources to make three attempts to contact next of kin by phone, with a follow-up written survey sent when not reached.

394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433

NATIONAL QUALITY FORUM

434
435
436

APPENDIX A: NQF PALLIATIVE CARE AND END-OF-LIFE CARE MEASURE SPECIFICATIONS

	Measure 0208: Family Evaluation of Hospice Care (National Hospice and Palliative Care Organization)
Description	<p>Composite Score: Derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 to 100.</p> <p>Global Score: Percentage of best possible response (Excellent) to the overall rating question on the FEHC survey.</p> <p>Target Population: The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. Timeframe: The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service.</p>
Numerator	<p>Composite Score: Numerator is the hospice's composite score, which is the weighted incidence of problem scores derived from responses from 17 items on the FEHC survey. The 17 questions focus on the following aspects of hospice care: symptom management, communication, provision of information, emotional support, and care coordination.</p> <p>Global Score: Numerator is the number of best possible responses (excellent) to the overall rating question on the FEHC survey.</p>
Numerator Details	<p>Composite Score: Responses to the following questions on the FEHC survey:</p> <p>B2 (How much medicine did the patient receive for his/her pain?)</p> <p>B4 (Did you want more information than you got about the medicines used to manage the patient's pain?)</p> <p>B6 (How much help in dealing with his/her breathing did the patient receive while under the care of hospice?)</p> <p>B8 (Did you want more information than you got about what was being done for the patient's trouble with breathing?)</p> <p>B10 (How much help in dealing with these feelings did the patient receive?)(refers to feelings of anxiety and sadness)</p> <p>D3 (How confident did you feel about doing what you needed to do in taking care of the patient?)</p> <p>D4 (How confident were you that you knew as much as you needed to about the medicines being used to manage the patient's pain, shortness of breath, or other symptoms?)</p> <p>D5 (How often did the hospice team keep you or other family members informed about the patient's condition?)</p> <p>D7 (Would you have wanted more information about what to expect while the patient was dying?)</p> <p>D8 (How confident were you that you knew what to expect while the patient was dying?)</p> <p>D9 (How confident were you that you knew what to do at the time of death?)</p> <p>E2 (Did you have as much contact of that kind as you wanted?) (refers to spiritual care)</p> <p>E3 (How much emotional support did the hospice team provide to you prior to the patient's death?)</p> <p>E4 (How much emotional support did the hospice team provide to you after the patient's death?)</p> <p>F1 (How often did someone from the hospice team give confusing or contradictory information about the patient's medical treatment?)</p> <p>F2 (While under the care of hospice, was there always one nurse who was identified as being in charge of the patient's overall care?)</p> <p>F3 (Was there any problem with hospice doctors or nurses not knowing enough about the patient's medical history to provide the best possible care?)</p> <p>Global Score: Number of responses of "Excellent" to the overall rating of care quality on the FEHC survey,</p>

NATIONAL QUALITY FORUM

	question G1 (Overall, how would you rate the care the patient received while under the care of hospice?)
Denominator	<p>Composite Score: 100 (100 is the best possible composite score which indicates 0% incidence of problem scores).</p> <p>Global Score: Total number of responses to the overall rating of care quality on the FEHC survey, question G1.</p>
Denominator Details	<p>Composite Score: 100 (100 is the best possible composite score which indicates 0% incidence of problem scores).</p> <p>Global Score: All responses to overall rating of care question on the FEHC survey (G1) are included. If survey respondent has not entered a response, the question is not included in the denominator.</p>
Exclusions	<p>Composite Score: If a survey respondent did not enter a response to more than 14 of the 17 FEHC survey questions included in calculation of the composite score then a composite score will not be calculated for that survey and the survey will not be included in the calculation of a composite score for the hospice.</p> <p>Global Score: If survey respondent has not entered a response to overall rating question (G1), the question is not included in the denominator.</p>
Exclusion details	<p>Composite Score: If a survey respondent did not enter a response to more than 3 of the 17 FEHC survey questions included in calculation of the composite score then a composite score will not be calculated for that survey and the survey will not be included in the calculation of a composite score for the hospice.</p> <p>Global Score: If survey respondent has not entered a response to overall rating question (G1), the question is not included in the denominator.</p>
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	Time period eligible for inclusion is the entire length of service the patient was enrolled in hospice.
Type	Composite
Type of Score	Weighted score/composite/scale
Data Source	Patient Reported Data/Survey
Level	Facility, Population : National
Setting	Hospice

NATIONAL QUALITY FORUM

Measure 0209: Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment (National Hospice and Palliative Care Organization)	
Description	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.
Numerator	Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment (after admission to hospice services).
Numerator Details	Number of patients who replied "yes" when asked if their pain was brought to a comfortable level within 48 hours of initial assessment (after admission to hospice services).
Denominator	Patients who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment (after admission to hospice services).
Denominator Details	Adult patients who are able to self report pain information and replied "yes" when asked if they were uncomfortable because of pain at the initial assessment (after admission to hospice services).
Exclusions	Inclusions: Patients are eligible if they: Report they are uncomfortable because of pain at the initial assessment (after admission to hospice services); Are able to communicate and understand the language of the person asking the question; Are able to self-report; and Are at least 18 years of age or older.
Exclusion details	Exclusion: Patients are excluded if they are: Are less than 18 years of age; Cannot understand language of hospice nurse performing the assessment; Cannot self report pain information; Deny being uncomfortable because of pain
Risk Adjustment	No risk adjustment or risk stratification
Stratification	None
Numerator Time window	Up to 48 hours after initial assessment (after admission to hospice services).
Type	Outcome
Type of Score	Rate/proportion
Data Source	Patient Reported Data/Survey
Level	Facility, Population : National
Setting	Hospice

NATIONAL QUALITY FORUM

Measure 1617: Patients Treated with an Opioid who are Given a Bowel Regimen (RAND Corporation)	
Description	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed
Numerator	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed
Numerator Details	Patients from the denominator given a bowel regimen defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR documentation of why such a bowel regimen is not needed.
Denominator	Vulnerable adults who are given a new prescription for an opioid
Denominator Details	<p>All vulnerable adults >18 years old prescribed an opioid as an inpatient OR as an outpatient in those patients who are not already taking this type of medication</p> <p>"Vulnerable" is defined as any of the following:</p> <ul style="list-style-type: none"> - >74 years of age - Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001) - Poor prognosis/terminal illness defined as life expectancy of <6 months - Stage IV cancer <p>Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699</p>
Exclusions	None
Exclusion details	None
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Numerator Time window	Within 24 hours of new opioid prescription.
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data : Electronic Health Record, Paper Records, Patient Reported Data/Survey
Level	Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan
Setting	Ambulatory Care : Clinician Office, Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

Measure 1623: Bereaved Family Survey (PROMISE Center)	
Description	<p>The purpose of this measure is to assess families' perceptions of the quality of care that Veterans received from the VA in the last month of life. The BFS consists of 19 items (17 structured and 2 open-ended). The BFS items were selected from a longer survey that was developed and validated with the support of a VA HSR&D Merit Award and have been approved for use by the Office of Management and Budget.</p> <p>Seventeen items in the survey have predefined response options and ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support. Two additional items are open-ended and give family members the opportunity to provide comments regarding the care the patient received.</p> <p>A growing body of research has underscored the degree to which end-of-life care in the United States needs to be improved. The challenges of end-of-life care are particularly significant in the U.S. Department of Veterans Affairs Health Care system because the VA provides care for an increasingly older population with multiple comorbid conditions. In FY2000, approximately 104,000 enrolled Veterans died in the U.S., and approximately 27,200 Veterans died in VA facilities. At least 30% of the Veterans are over age 65 now, and 46% will be over 65 by 2030. Therefore, it is clear that the number of deaths in VA facilities will increase substantially as the World War II and Korean War Veterans age. These demographic trends mean that, like other healthcare systems, the VA will face substantial challenges of providing care to Veterans near the end-of-life.</p> <p>The VA has addressed this challenge aggressively in the last 5 years, however the VA has not yet developed and implemented measures of the quality of end-of-life care it provides to Veterans. There are at least 3 reasons why adoption of a quality measurement tool is essential. First, it would make it possible to define and compare the quality of end-of-life care at each VA facility and to identify opportunities for improvement. Second, facilities and VISNs (geographic service divisions within the VA system) would be able to monitor the effectiveness of efforts to improve care locally and nationally, and would enable monitoring of the impact of the Comprehensive End of Life Care Initiative, ensuring that expenditures are producing improvements in care. Third, it will help the VA to recognize those facilities that provide outstanding end-of-life care, so that successful processes and structures of care can be identified and disseminated throughout the VA.</p> <p>The BFS's 17 close-ended items ask family members to rate aspects of the care that the Veteran received from the VA in the last month of life. These items cover areas of care such as communication, emotional and spiritual support, pain management and personal care needs. Two additional items (not used in scoring) are open-ended and give family members the opportunity to provide comments regarding the care the patient received. The BFS has undergone extensive development and has been pilot-tested for all inpatient deaths in Q4FY2008 in seven VISNs (1,2,4,5,8,11, and 22). As of October 1, 2009, Q1FY2010, all inpatient deaths in all VISNs were included in the project.</p>
Numerator	The numerator is comprised of completed surveys (at least 12 of 17 structured items completed), where the global item question has an optimal response. The global item question asks "Overall, how would you rate the care that [Veteran] received in the last month of life" and the possible answer choices are: Excellent, Very good, Good, Fair, or Poor. The optimal response is Excellent.
Numerator Details	Included are those patients included in the denominator with completed surveys (at least 12 of 17 structured items completed) that receive an optimal response on the global item question.
Denominator	The denominator consists of all inpatient deaths for which a survey was completed (at least 12 of 17 structured items completed), excluding: 1) deaths within 24 hours of admission (unless the Veteran had a previous hospitalization in the last month of life); 2) deaths that occur in the Emergency Department; 3) deaths that occur in the operating room; and 4) deaths due to suicide or accidents. Additional exclusion criteria include: 1) Veterans for whom a family member knowledgeable about their care cannot be identified (determined by the family member's report); or 2) not contacted (no current contacts listed or no valid addresses on

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

	file); 2) absence of a working telephone available to the family member.
Denominator Details	The indicator denominator is comprised of the number of Veterans who die in an inpatient VA facility (intensive care, acute care, hospice unit, nursing home care or community living center) for whom a survey is completed. Completed surveys are defined as those with at least 12 of the 17 structured items completed.
Exclusions	<ul style="list-style-type: none"> - Veterans for whom a family member knowledgeable about their care cannot be identified (determined by family member's report) - Absence of a current address and/or working telephone number for a family member or emergency contact. - Deaths within in 24 hours of admission without a prior hospitalization of last least 24 hours in the last 31 days of life. - Deaths that occur in the operating room during an outpatient procedure. - Deaths due to a suicide or accident - Surveys in which less than 12 items were answered. -
Exclusion details	Name, address, and phone number of patient's family member or emergency contact are required for determining exclusion. In addition, information regarding the patient's admission(s) during the last 31 days of life, including length of stay and circumstances of death are also required to determine exclusion.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Variables necessary to stratify the measure are VISN, facility, quarter, year, outcome. VISN refers to "Veterans Integrated Service Network" and is a geographic area of the country where a facility is located. Facility is the actual VA medical center or affiliated community living center where the Veteran died. Quarter is the 3 month time period in which the patient died. Year is the VA fiscal year (runs from Oct 1 to Sept 30). Outcome refers to whether or not a survey was completed.
Numerator Time window	Does not apply to this measure
Type	Outcome
Type of Score	Rate/proportion
Data Source	Other
Level	Facility, Population : National, Population : Regional
Setting	Hospice, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

NATIONAL QUALITY FORUM

Measure 1625: Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated (RAND Corporation)	
Description	Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated
Numerator	Patients from the denominator who have their ICDs deactivated prior to death or have documentation of why this was not done
Numerator Details	Documentation in the medical record that the ICD was deactivated or documentation of a discussion of deactivation of the ICD with the patient or documentation of why ICD deactivation was not done.
Denominator	Patients who died an expected death who have an ICD in place
Denominator Details	Hospitalizations of adult patients of at least 3 days duration that ended in an expected death. 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 disease, or was expected to die.
Exclusions	None
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	None
Numerator Time window	During hospitalization ending in an expected death
Type	Process
Type of Score	Rate/proportion
Data Source	Paper Records
Level	Facility
Setting	Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

Measure 1626: Patients Admitted to ICU who Have Care Preferences Documented (RAND Corporation)	
Description	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.
Numerator	Patients in the denominator who had their care preferences documented within 48 hours of ICU admission or have documentation of why this was not done.
Numerator Details	Patients whose medical record includes documentation of care preferences within 48 hours of admission to ICU. Care preferences may include any of the following: <ul style="list-style-type: none"> - Code status, preferences for general aggressiveness of care, mechanical ventilation, hemodialysis, transfusion, or permanent feeding tube, OR - Documentation that a care preference discussion was attempted and/or reason why it was not done
Denominator	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.
Denominator Details	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission. "Vulnerable" is defined as any of the following: <ul style="list-style-type: none"> - >74 years of age - Poor prognosis/terminal illness defined as life expectancy of <6 months - Stage IV cancer
Exclusions	None
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Numerator Time window	48 hours starting from time of ICU admission
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Facility, Health Plan, Integrated Delivery System
Setting	Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

Measure 1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits (RAND Corporation)	
Description	Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit
Numerator	Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool
Numerator Details	Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.
Denominator	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit
Denominator Details	Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion
Exclusions	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Numerator Time window	At the time of outpatient visit(s)
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data, Electronic Clinical Data : Registry, Paper Records
Level	Facility, Health Plan, Integrated Delivery System
Setting	Ambulatory Care : Clinician Office

NATIONAL QUALITY FORUM

	Measure 1630: Hospitalized Patients Who Die an Expected Death Who Have Dyspnea Addressed (RAND Corporation)
Description	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
Numerator	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
Numerator Details	Dyspnea treatment = Any of the following: <ul style="list-style-type: none"> - 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
Denominator	Hospitalized patients who died an expected death and who had dyspnea in the 7 days prior to death
Denominator Details	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.
Exclusions	None
Exclusion details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	
Numerator Time window	Within 24 hours of noting the presence of dyspnea
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data : Electronic Health Record, Paper Records

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

Level	Facility
Setting	Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

	Measure 1632: CARE - Consumer Assessments and Reports of End of Life (Center for Gerontology and Health Care Research)
Description	<p>The CARE survey is mortality follow back survey that is administered to the bereaved family members of adult persons (age 18 and older) who died of a chronic progressive illness receiving services for at least 48 hours from a home health agency, nursing homes, hospice, or acute care hospital. The survey measures perceptions of the quality of care either in terms of unmet needs, family reports of concerns with the quality of care, and overall rating of the quality of care. The time frame is the last 2 days of life up to last week of life spent in a hospice, home health agency, hospital, or nursing home.</p> <p style="text-align: center;">The survey is based on structured literature review,(1) cognitive testing,(2) pre-test,(2) and national survey of the quality of end of life care.(3) The conceptual model is patient focused, family centered care(1) that posits that high quality care at the end of life is obtained when health care institutions: 1) provide the desired level of symptom palliation and emotional support; 2) treat the patient with respect; 3) promote shared decision making; 4) attend to the needs of caregivers for information and skills in providing care for the patient; 5) provide emotional support to the family before and after the patient's death; and 6) coordinates care across settings of care and health care providers.</p> <p style="text-align: center;">This is the "parent" survey of the Family Evaluation of Hospice Care Survey (4-7) that my colleagues and I have collaborated with the National Hospice and Palliative Care Organization to create a self-administered survey that is used widely by hospices in the USA and other nations. With the proposed development of accountable care organizations and other potential innovations in health care financing, we recognized the need for an instrument that would allow the comparisons across place of care when there is one entity coordinating and/or financing the care for population of decedents. We have decided to submit the telephone based survey for NQF consideration based on the void of validated measures to capture consumer perceptions (i.e, bereaved family members) of the quality of care at the end of life across place of care. This submission is not meant to be competitive with the existing NQF endorsed Family Evaluation of Hospice Care survey.</p> <p style="text-align: center;">This new proposed measure for NQF consideration consists of the survey which has six domains and the new creation of 0-100 composite score that is composed of 14 of 17 core items.</p> <ol style="list-style-type: none"> 1. Teno JM, Casey VA, Welch L, Edgman-Levitan S. Patient-Focused, Family-Centered End-of-Life Medical Care: Views of the Guidelines and Bereaved Family Members. J Pain Symptom Manage-Special Section on Measuring Quality of Care at Life's End II. 2001 Sep 2001;22(3):738-751. 2. Teno JM, Clarridge B, Casey V, Edgman-Levitan S, Fowler J. Validation of Toolkit After-Death Bereaved Family Member Interview. J Pain Symptom Manage. 2001 Sep 2001;22(3):752-758. 3. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. JAMA. 2004 Jan 7 2004;291(1):88-93. 4. Rhodes RL, Mitchell SL, Miller SC, Connor SR, Teno JM. Bereaved family members' evaluation of hospice care: what factors influence overall satisfaction with services? J Pain Symptom Manage. 2008 Apr 2008;35(4):365-371. 5. Mitchell SL, Kiely DK, Miller SC, Connor SR, Spence C, Teno JM. Hospice care for patients with dementia. J Pain Symptom Manage. 2007 Jul 2007;34(1):7-16. 6. Rhodes RL, Teno JM, Connor SR. African American bereaved family members' perceptions of the quality of hospice care: lessened disparities, but opportunities to improve remain. J Pain Symptom Manage. 2007 Nov 2007;34(5):472-479.

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE
NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

	7. Connor SR, Teno J, Spence C, Smith N. Family Evaluation of Hospice Care: Results from Voluntary Submission of Data Via Website. J Pain Symptom Manage. 2005 Jul 2005;30(1):9-17.
Numerator	Respondent reports of concerns with the quality of care, their self-efficacy in basic tasks of caregiving, or unmet needs that indicate an opportunity to improved end of life care provided by either a nursing home, hospital, hospice, or home health agency.
Numerator Details	Detailed information is provided below.
Denominator	Non-traumatic deaths and deaths from chronic progressive illnesses based on ICD 9/10 codes are included. A list will be provided as technical appendix to the proposed survey. Note the survey is for only persons that died with the following services or location of care: nursing home, hospital, hospice, or home health agency
Denominator Details	<p>1. Denominator for Mortality Follow Back Survey</p> <p>Decedents age 18 and older with chronic progressive illness who receive care from an home health agency, hospice, hospital, or nursing home.</p> <p>Respondents are the person who stated they know best about the decedent and would have or were involved in medical decision making.</p> <p>It is easiest to define the chronic progressive illness by listing what diseases are excluded.</p> <p>Accidents or trauma listed as cause of death - V01---V99, W00—W99, X00-X99, Y00—Y89.9 Acute overwhelming infections A00—A99, B03—B81.8, J00—J06 Death from complications of pregnancy 024.9—099.8 Please note a list of these codes are at http://www.chcr.brown.edu/dying/SAMPLE_FOR_MFB_FOR_WWW_SITE_JAMA_FINAL.PDF</p> <p>The denominators for the domains will be explained separately in the specification of the denominator for each of those domains.</p>
Exclusions	We excluded deaths due to accidents, trauma, during surgery, lethal injection, acute overwhelming infections, and from complications of pregnancy.
Exclusion details	See answer to 2a1.7
Risk Adjustment	No risk adjustment or risk stratification
Stratification	There is no proposed stratification variable
Numerator Time window	Respondent perceptions are reported for the last place of care for the care received up to and inclusive of the last week of life. The decedent must have spent at least 48 hours in that location of care.
Type	Patient Engagement/Experience
Type of Score	Non-weighted score/composite/scale
Data Source	Other
Level	Facility, Population : Community, Population : National, Population : Regional
Setting	Home Health, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

	Home/Skilled Nursing Facility
--	-------------------------------

NATIONAL QUALITY FORUM

Measure 1634: Hospice and Palliative Care -- Pain Screening (University of North Carolina-Chapel Hill)	
Description	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.
Numerator	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.
Numerator Details	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.
Denominator	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.
Denominator Details	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.]
Exclusions	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.
Exclusion details	Calculation of length of stay; discharge date - date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	Hospice admission evaluation / initial clinical encounter for palliative care
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record
Level	Clinician : Group/Practice, Facility
Setting	Hospice, Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

Measure 1637: Hospice and Palliative Care -- Pain Assessment (University of North Carolina- Chapel Hill)	
Description	This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
Numerator	Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
Numerator Details	Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life.
Denominator	Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.
Denominator Details	<p>The Pain Assessment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.</p> <p>For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number >0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care.</p> <p>For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted in screening (response of moderate or severe on verbal scale, >4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator.</p> <p>[NOTE: This quality measure should be paired with the Pain Screening quality measure to ensure that all patients are screened and therefore given the opportunity to report pain and enter the denominator population for Pain Assessment.]</p>
Exclusions	Patients with length of stay < 1 day in palliative care or < 7 days in hospice, patients who were not screened for pain.
Exclusion details	Calculation of length of stay; discharge date - date of initial encounter
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	24 hours
Type	Process
Type of Score	Rate/proportion

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE
NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record
Level	Clinician : Group/Practice, Facility
Setting	Hospice, Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

	Measure 1638: Hospice and Palliative Care -- Dyspnea Treatment (University of North Carolina- Chapel Hill)
Description	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.
Numerator	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.
Numerator Details	Treatment is administered if within 24 hours of the positive screen for dyspnea, medical treatment plan, orders or pharmacy records show inhaled medications, steroids, diuretics, or non-medication strategies such as oxygen and energy conservation. Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.
Denominator	Patients enrolled in hospice for 7 or more days OR patients receiving palliative care who report dyspnea when dyspnea screening is done on the admission evaluation / initial encounter.
Denominator Details	<p>The Dyspnea Treatment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.</p> <p>For patients enrolled in hospice or palliative care, a positive screen is indicated by any dyspnea noted as other than none on a verbal screen, any number > 0 on a numeric scale or any observational or self-report of dyspnea.</p> <p>[NOTE: This quality measure should be paired with the Dyspnea Screening quality measure to ensure that all patients are screened and therefore given the opportunity to report dyspnea and enter the denominator population for Dyspnea Treatment.]</p>
Exclusions	Palliative care patients with length of stay < 1 day or hospice patients with length of stay < 7 days, patients who were not screened for dyspnea, and/or patients with a negative screening.
Exclusion details	Discharge date – admission date = 1 or hospice patients with discharge date – admission date = 7.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	24 hours
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data
Level	Clinician : Group/Practice, Facility
Setting	Hospice, Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

Measure 1639: Hospice and Palliative Care -- Dyspnea Screening (University of North Carolina- Chapel Hill)	
Description	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.
Numerator	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
Numerator Details	Patients who are screened for the presence or absence of dyspnea during the admission evaluation for hospice / initial encounter for hospital-based palliative care, and asked to rate its severity. Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients.
Denominator	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.
Denominator Details	The Dyspnea Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Dyspnea Treatment quality measure to ensure that all patients who report dyspnea are clinically considered for treatment.]
Exclusions	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care.
Exclusion details	Calculation of length of stay; discharge date - date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	Hospice admission evaluation / initial clinical encounter for palliative care
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record
Level	Clinician : Group/Practice, Facility
Setting	Hospice, Hospital/Acute Care Facility

NATIONAL QUALITY FORUM

	Measure 1641: Hospice and Palliative Care – Treatment Preferences (University of North Carolina-Chapel Hill)
Description	Percentage of patients with chart documentation of preferences for life sustaining treatments.
Numerator	Patients whose medical record includes documentation of life sustaining preferences
Numerator Details	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of life-sustaining treatments. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as "Full Code" or "DNR/DNI" do not count in the numerator.
Denominator	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
Denominator Details	The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.
Exclusions	Patients with length of stay < 1 day in palliative care or < 7 days in hospice
Exclusion details	Calculation of length of stay; discharge date - date of initial encounter.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Numerator Time window	N/A
Type	Process
Type of Score	Rate/proportion
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record
Level	Clinician : Group/Practice, Facility
Setting	Hospice, Hospital/Acute Care Facility
	Measure 1647: Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (Deyta, LLC)

NATIONAL QUALITY FORUM

Description	This measure reflects the percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver/family did not want to discuss.
Numerator	Number of patient with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss.
Numerator Details	<p>Examples of a discussion may include asking about patient's need for spiritual or religious support, questions about the cause or meaning of illness or death. Other examples include discussion of God or a higher power related to illness, or offer of a spiritual resource including a chaplain. Discussion of spiritual or religious concerns may occur between patient and/or family and clergy or pastoral worker or patient and/or family and member of the interdisciplinary team.</p> <p>Documentation of only patient's religious or spiritual affiliation does not count for inclusion in numerator.</p> <p>Data are collected via chart review. Criteria are:</p> <ol style="list-style-type: none"> 1) evidence of a discussion about spiritual/religious concerns, or 2) evidence that the patient, and/or family declined to engage in a conversation on this topic. <p>Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments across the entire period of care, visit notes documented by any member of the team, and/or the spiritual care assessment. Note that these examples and not a complete list.</p>
Denominator	Total number of patient's discharged from hospice care during the designated reporting period.
Denominator Details	Total number of patient's discharged from hospice care during the designated reporting period.
Exclusions	Testing has only been done with the adult population, but there is no reason to believe that this wouldn't be applicable to all hospice patients.
Exclusion details	N/A
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A – The measure does not require stratification.
Numerator Time window	Cases are eligible for inclusion upon admission to a hospice program. The numerator criteria must be met during the time the patient is enrolled in the hospice program and can be met anytime during that period. The numerator data is collected within 1 to 12 months following discharge from hospice services.
Type	Process
Type of Score	Non-weighted score/composite/scale
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records
Level	Facility
Setting	Hospice

437

438

NATIONAL QUALITY FORUM

APPENDIX B: PROJECT STEERING COMMITTEE AND NQF STAFF

439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482

June Lunney, PhD, RN, Co-Chair

Hospice and Palliative Nurses Association, Kennett Square, PA

Sean Morrison, MD, Co-Chair

Mount Sinai School of Medicine, New York, NY

Russell Acevedo, MD

Crouse Hospital, Syracuse, NY

Eduardo Bruera, MD, FAAHPM

The University of Texas MD Anderson Cancer Center, Houston, TX

David Casarett, MD, MA

University of Pennsylvania School of Medicine, Philadelphia, PA

Robert Fine, MD, FACP

Baylor Health Care System, Dallas, TX

Richard Goldstein, MD, FAAP

Dana Farber Cancer Institute, Boston, MA

Sarah Hill, MA

Ascension Health, Maryland Heights, MO

Pamela Kalen

National Business Group on Health, Washington, DC

Naomi Karp, JD

AARP Public Policy Institute, Washington, DC

Mark Leenay, MD

Optum Health, Princeton, MN

Michael Lepore, PhD

PlaneTree, Derby, CT

Solomon Liao, MD

University of California-Irvine, Irvine, CA

Stephen Lutz, MD

Blanchard Valley Regional Cancer Center, Findlay, OH

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

- 483 **Helene Martel, MA**
484 Kaiser Permanente, Oakland, CA
485
- 486 **Naomi Naierman, MPA**
487 American Hospice Foundation, Washington, DC
488
- 489 **Douglas Nee, PharmD, MS**
490 OptiMed, Inc., San Diego, CA
491
- 492 **Kathleen O'Malley**
493 California HealthCare Foundation, Oakland, CA
494
- 495 **Tina Picchi, MA, BCC**
496 Supportive Care Coalition, Hillsboro, OR
497
- 498 **Tracy Schroeffer, PhD**
499 University of Wisconsin-Madison, School of Social Work, Madison, WI
500
- 501 **Douglas White, MD, MAS**
502 University of Pittsburgh; Department of Critical Care Medicine, Pittsburgh, PA
503
504
505
- 506 **NQF STAFF**
507
- 508 **Helen Burstin MD, MPH**
509 Senior Vice President, Performance Measures
510
- 511 **Heidi Bossley, MSN, MBA**
512 Vice President, Performance Measures
513
- 514 **Caren Ginsberg, PhD**
515 Senior Director, Performance Measures
516
- 517 **Lindsey Tighe, MS**
518 Project Manager, Performance Measures
519
- 520 **Eric Colchamiro, MPA**
521 Project Analyst, Performance Measures
522

NATIONAL QUALITY FORUM

523

APPENDIX C: MEASURE GAPS

524 The Committee identified gaps in performance measurement of palliative care and end-of-life care. The
525 following summarizes these identified measure gap areas:

526 Patient Preferences

- 527 • Measures that focus on discussions with patients in an acute care setting and over the course of their
528 illness about patient preferences, within 48 hours and then weekly within the ICU.
- 529 • Measures that focus on advance care planning and documentation, particularly measures that span the
530 duration of illness and across care settings.
- 531 • Measures that address patient decisions to avail themselves of hospice care.
- 532 • Measures incorporating the use of Physicians Orders for Life-Sustaining Treatment (POLST) in
533 hospitals; across transitions of care and in reference to care coordination.

534

535 Quality of Life

- 536 • Measures that assess quality of life for all patients, and not just those seen by palliative care or hospice
537 teams.
- 538 • Measures that look at quality of life across the continuum of care, including the outpatient setting or
539 nursing homes.
- 540 • Outcome measures on end-of-life care that allow for benchmarking.
- 541 • Measures that incorporate the use of post-mortem surveys.
- 542 • Process measures related to communication of critically ill patients; for example, ICU family meetings.
- 543 • Measures addressing children or young adults, for example, minors with decision making capacity; the
544 presence or availability of hospices with expertise to care for children; the availability of functional
545 services such as occupational therapy (OT), physical therapy (PT), and child life educational support
546 services in the community for critically ill children and families.
- 547 • Measures of cultural and linguistic competence in delivering palliative and end-of-life care.
- 548 • Measures addressing psychosocial and spiritual end-of-life care.

549 Family/Caregiver Experience of Care

- 550 • Measures of after-death care regarding treatment of the body and treatment of the patient's family.
- 551 • Measures reflecting education of the patient's family on the signs and symptoms of imminent death.
- 552 • Measures about education and support of caregivers, particularly regarding the dying episode.

553 Process Measures in Palliative and End of Life Care

- 554 • Measures of resource use and efficiency in hospice care.
- 555 • Measures of artificial hydration and nutrition.
- 556 • Communication measures reflecting clarity of prognosis.
- 557 • Measures reflecting the interdisciplinary nature and training of the palliative care team, including
558 spiritual and psychosocial care needs.
- 559 • Measures of palliative care for chronically ill patients who are not at the end of life.

560

NATIONAL QUALITY FORUM

561
562

APPENDIX D: NQF PALLIATIVE CARE AND END-OF-LIFE CARE RELATED OR COMPETING MEASURES

	0326: Advance Care Plan	1641: Hospice and Palliative Care – Treatment Preferences
Steward	NCQA/AMA-PCPI	UNC
Description	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	Percentage of patients with chart documentation of preferences for life sustaining treatments.
Type	Process	Process
Data Source	Administrative claims data; Other: PQRS Registry	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record
Level	Clinician: Individual; Clinician: Group Practice	Clinician: Group/Practice, Facility
Setting	Ambulatory Care: Clinician Office, Ambulatory Care: Ambulatory Surgery Center (ASC), Ambulatory Care: Clinic/Urgent Care; Ambulatory Care: Clinician; Home Health; Hospital/Acute Care Facility; Post Acute/Long Term	Hospice, Hospital/Acute Care Facility
Numerator Statement	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	Patients whose medical record includes documentation of life sustaining preferences
Numerator Details	Numerator Instructions: If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report 1124F.	Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of life-sustaining

NQF REVIEW DRAFT—DO NOT CITE OR QUOTE

NQF MEMBER comments due November 15, 2011, 6:00 PM ET; PUBLIC comments due November 8, 2011, 6:00 PM ET

NATIONAL QUALITY FORUM

	0326: Advance Care Plan	1641: Hospice and Palliative Care – Treatment Preferences
	<p>Definition:</p> <p>Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan – May also include, as appropriate, the following:</p> <ul style="list-style-type: none"> • That the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship. <p>Numerator Quality-Data Coding Options for Reporting Satisfactorily: Advance Care Planning Discussed and Documented</p> <p>CPT II 1123F: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record</p> <p>OR</p> <p>CPT II 1124F: Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan</p>	<p>treatments. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as “Full Code” or “DNR/DNI” do not count in the numerator.</p>

NATIONAL QUALITY FORUM

	0326: Advance Care Plan	1641: Hospice and Palliative Care – Treatment Preferences
	<p>OR</p> <p>Advance Care Planning not Documented, Reason not Specified</p> <p>Append a reporting modifier (8P) to CPT Category II code 1123F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.</p> <p>1123F with 8P: Advance care planning not documented, reason not otherwise specified</p>	
Denominator Statement	All patients aged 65 years and older	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.
Denom Categories	Female; Male Aged 65 years and older	Adult/Elderly Care

NATIONAL QUALITY FORUM

	0326: Advance Care Plan	1641: Hospice and Palliative Care – Treatment Preferences
Denominator Details	<p>Denominator Criteria (Eligible Cases):</p> <p>Patients aged ≥ 65 years on date of encounter</p> <p>Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404</p> <p>*Clinicians indicating the place of service as the emergency department will not be included in this measure.</p>	<p>The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.</p>
Exclusions	N/A	Patients with length of stay < 1 day in palliative care or <7 days in hospice
Exclusion Details	N/A	Calculation of length of stay; discharge date – date of initial encounter
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	No risk stratification	No risk stratification
Type Score	Better score = better quality	Better quality = higher score

NATIONAL QUALITY FORUM

	0326: Advance Care Plan	1641: Hospice and Palliative Care – Treatment Preferences
Algorithm	See attached for calculation algorithm.	Chart documentation of life sustaining preferences: <ul style="list-style-type: none"> a. Step 1 – Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital b. B. Step 2 – Exclude palliative care patients if length of stay is < 1 day. Exclude hospice patients if length of stay is < 7 days c. Step 3 – Identify patients with documented discussion of preference for life sustaining treatments Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2

563

564