NATIONAL QUALITY FORUM

Memo

TO: Consensus Standards Approval Committee (CSAC)

FR: Karen Johnson & Jean-Luc Tilly

RE: Palliative and End-of-Life Care Off-Cycle Review

DA: July 11, 2017

CSAC ACTION REQUIRED: The CSAC will review recommendations from the Palliative and End-of-Life Care Off-Cycle Review project at its July 11-12, 2017 meeting and vote whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, recommended measures, and a brief summary of the public and member comments and associated responses.

NQF Member voting on these recommended measures closed on June 23, 2017.

Accompanying this memo are the following documents:

1. **Palliative and End-of-Life Care Draft Report.** The draft report has been updated to reflect the changes made following Standing Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. **Comment Table.** Staff has identified themes within the comments received. This table lists three comments received during the post meeting comment period and the NQF/Standing Committee responses.

BACKGROUND

The off-cycle activities of the Palliative and End-of-Life Care Standing Committee in the spring of 2017 have focused on the evaluation of one measure, further refinement of a measurement framework for palliative and end-of-life care, and piloting NQF's new prioritization criteria for measures and gaps.

DRAFT REPORT

The Palliative and End-of-Life Care Draft Report presents the results of the evaluation of one measure considered under the Consensus Development Process (CDP). The measure was recommended for endorsement.

The measure was evaluated against the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	0	1	1
Measures recommended for endorsement	0	1	1

CSAC ACTION REQUIRED

Pursuant to the CDP, the CSAC is asked to consider endorsement of one candidate consensus measure.

Palliative and End-of-Life Care Off-Cycle Review Measures Recommended for Endorsement:

- 3235: Hospice and Palliative Care Composite Process Measure - Comprehensive Assessment at Admission

Overall Suitability for Endorsement: Y-22; N-0

COMMENTS AND THEIR DISPOSITION

NQF received three comments from three organizations (all member organizations) pertaining to the general draft report and to the measure under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Palliative and End-of-Life Care Off-Cycle Review project page under the Public and Member Comment section.

Comment and Committee Responses

Comments about specific measure specifications and rationale were forwarded to the developers, who were invited to respond.

The Standing Committee reviewed all of the submitted comments (general and measure specific) and developer responses.

General Comments

One commenter recommended a revision to the measurement framework proposed in the draft report. While the commenter supported most changes made to the framework, the commenter indicated concern over the addition of the term “care-a-tive” to the “Types of Palliative Care” circle. The commenter described the term as potentially confusing, and unfamiliar to those in care delivery. The commenter also advanced several suggestions for additional off-cycle activities.

Committee Response: Thank you for your comments regarding the framework. We agree that the term "care-a-tive" is new and therefore unfamiliar to the field. We have therefore changed the label from “care-a-tive” to “chronic”.

NQF Response: Thank you for your suggestions for potential topics for future off-cycle activities. During the May 30, 2017 post-comment call, we asked the Standing Committee to

prioritize existing measures and gaps for palliative and end-of-life care, using the prioritization criteria recently developed as part of NQF's strategic plan to "drive measurement that matters". NQF will consider how we might implement your other suggestions in future Committee deliberations.

Measure Specific Comments

3235: Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Description: NQF received 2 post-evaluation comments on this measure. One comment supported the measure. The second commenter suggested that performance on the measure was disproportionately driven by the Pain Assessment component and noted that several of the components of the measure are not proximal to desired patient outcomes.

Developer Response (summarized): The developer noted that experts in the field, hospice providers, and caregivers agree that the processes of care included in the measure are important in promoting a person-centered approach to care and achieving the patient comfort throughout the delivery of hospice and palliative care. The developer also noted that focus groups and interviews with stakeholders supported the all-or-none construction of the composite measure. The developer also summarized analyses (submitted in response to subcrition 2d) that demonstrate that each component in the composite contributes to the overall composite performance score.

Committee Response: The Committee agreed that that performance on the pain assessment component will drive a substantial amount of variation in performance for this composite. However, members also agreed that each of the components contribute to the overall composite and that the all-or-none construction of the composite will help to incent hospice providers to complete all of the care processes included in this measure. The Committee also agreed that additional measures should be developed to assess provision of treatment and outcomes of treatment.

NQF MEMBER VOTING RESULTS

The recommended measure was approved with 100% approval or higher. Representatives of three member organizations voted; no votes were received from the Health Plan, Health Professional, Public/Community Health Agency, Purchaser, QMRI, Supplier/Industry Councils. Results for each measure are provided in Appendix B.

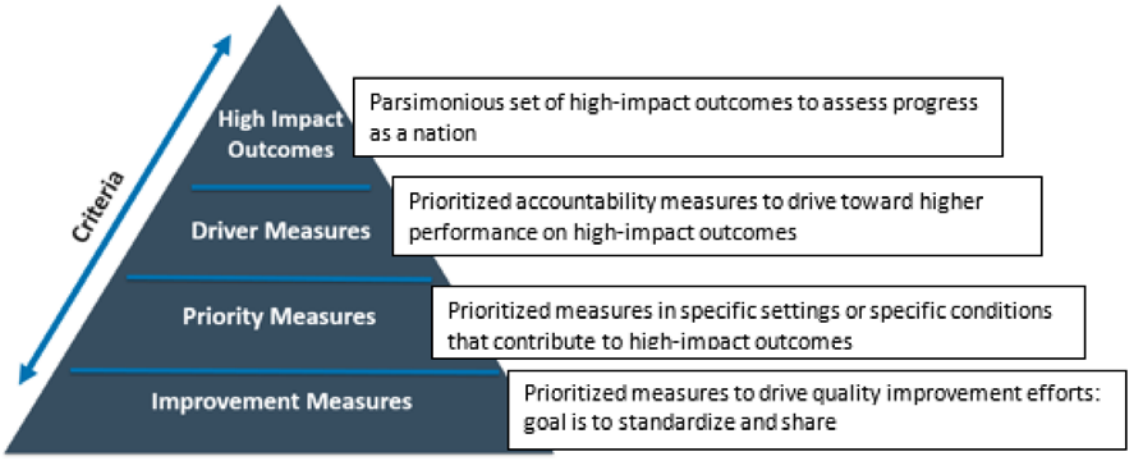
PRIORITIZING MEASURES AND GAPS

One of the key tasks of NQF's 2016-2019 Strategic Plan is to identify the most important measures to improve U.S. healthcare. To accomplish this task, NQF staff identified four criteria for prioritizing measures and gaps in measurement:

- ***Outcome-focused***: Preference for outcome measures and measures with strong link to improved outcomes and costs
- ***Improvable and actionable***: Preference for actionable measures with demonstrated need for improvement and evidence-based strategies for doing so

- ***Meaningful to patients and caregivers***: Preference for person-centered measures with meaningful and understandable results for patients and caregivers
- ***Support systemic and integrated view of care***: Preference for measures that reflect care that spans settings, providers, and time to ensure that care is improving within and across systems of care

To aid in prioritizing those measures that will effect the strongest change, NQF has proposed a pyramid-shaped organizing framework that includes high-impact outcomes at the apex, supported by driver measures, priority measures, and improvement measures (see figure below).



The Palliative and End-of-Life Care Standing Committee piloted the prioritization criteria, applying them to measures in NQF's Palliative and End-of-Life Care portfolio. Not surprisingly, given the relatively few measures for this topic area, the Standing Committee identified more gaps than existing priority or driver measures.

The Committee was unable to complete the prioritization exercise during its May 30, 2017 post-comment call but will continue the work over the next two months. Initial results of the pilot exercise are included in the table below.

High-impact outcome[a]	Driver measures	Priority measures	Improvement measures
Patient experience	• Goal-concordance • Shared decision-making • Comfort with decisions that are made (less decisional conflict) • Patient/family engagement	• #0326: Advance care plan • #1626: Patients admitted to ICU who have care preferences documented • #1623: Bereaved Family Survey • Values conversation that elicits goals of care • Good communication (e.g., prognosis, health literacy, clarity of goals for all parties) • POLST form completion according to patient values	• Completion of decisional conflict scale before and after • Patient dying in preferred site of death
Preventable harm/ complications	• Unwanted care/care that is not goal-concordant • Potentially #2888: Hospital admissions for those with multiple chronic conditions (NOTE: Committee discussed readmissions, not admissions) • Symptomatology due to use of excess/poor value medications/interventions • Unaddressed psychosocial and spiritual issues	• #0101: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future • Medication reconciliation; possibilities include: o #0097: Medication Reconciliation Post-Discharge o #2988: Medication Reconciliation for Patients Receiving Care at Dialysis Facilities o #0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) • Safe medication use: o #2993: Potentially Harmful Drug-Disease Interactions in the Elderly o #0022: Use of High-Risk Medications in the Elderly • Safe medication disposal • Feeding tube placement in dementia patients • Discontinuation of available interventions in terminal patients (e.g., statin, aspirin, multivitamins, memory drugs, ICDs, CPR, chemo in last 2 weeks) [or at least having a conversation about it]	• Assessing patient for psychosocial and spiritual issues/needs
Prevention/ healthy behaviors	• Caregiver support • Good communication (early, open/shared)	• Assessing family/caregivers for risk (e.g., depression, complicated bereavement, etc.) • Basic caregiver skills training provided (e.g. how to lift patient without injury to caregiver's back, changing sheets when patient bedridden, etc.)	

Total cost/low-value care	• None identified	• #0213: Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life • #0210: Proportion receiving chemotherapy in the last 14 days of life • Potentially avoidable ED visits and hospitalizations • Proportion of elderly chronic kidney disease patients with multiple comorbidities who were started on dialysis • Dialysis patients admitted to ICU in last 30 days of life	• None identified
Access to needed care	• Geographic access to hospice and palliative care (both hospital and community) • Access to home and community-based services	• Time to palliative care consult OR Timeliness of palliative care consultation (>48 hours prior to death) • Access to specialty palliative care team • Nursing load or chaplain load	• None identified
Equity of care	• Standard/minimum service offerings	• Materials offered at appropriate education levels/languages	• None identified
Functional status/well-being	• Preservation of functional status • Free of pain (to extent desired) • Psychosocial health	• Patient single item self-report of quality of life as in McGill QOL Survey	• Administra-tion of the iPOS 5 • #1634: Hospice and Palliative Care Pain Screening • Screening for depression, anxiety, etc.

[a]These were defined by NQF as part of the organizing framework

Appendix A – NQF Member Voting Results

NQF MEMBER VOTING RESULTS

The recommended measure was approved with 100% approval or higher. Representatives of three member organizations voted; no votes were received from the Health Plan, Health Professional, Public/Community Health Agency, Purchaser, QMRI, Supplier/Industry Councils. Results for each measure are provided below.

NQF Member Council	Voting Organizations	Eligible to Vote	Rate
Consumer	2	38	5%
Health Plan		21	0%
Health Professional		104	0%
Provider Organizations	1	110	1%
Public/Community Health Agency		15	0%
Purchaser		22	0%
QMRI		74	0%
Supplier/Industry		35	0%
All Councils	**3**	**419**	**1%**

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	2			2	100%
Health Plan				0	
Health Professional				0	
Provider Organizations	1			1	100%
Public/Community Health Agency				0	
Purchaser				0	
QMRI				0	
Supplier/Industry				0	
All Councils	3	0	0	3	100%
Percentage of councils approving (>60%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Voting Comments

Coalition to Transform Advanced Care (C-TAC): This is an important, indeed essential, component of proper assessment that drives high-quality, person-centered care.

Appendix B – Measure Evaluation Summary Tables

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

Submission | Specifications

Description: The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.

Numerator Statement: The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive assessment measure numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.

Denominator Statement: The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.

Exclusions: Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Hospice

Type of Measure: Composite

Data Source: Other

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING 3/8/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

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

1a. Evidence: **H-0**; **M-3**; **L-0**; **I-19**; 1b. Performance Gap: **H-18**; **M-4**; **L-0**; **I-0; ;** Evidence Exception: **Y-22; N-0**

Rationale:

- The developer cited the 2013 Institute for Clinical Systems Improvement (ICSI) Palliative Care for Adults guidelines to support the components in the composite. All of the recommendation statements from the ICSI guideline refer to inclusion of the measured components in the palliative care plan.
- The Committee concluded that the evidence presented is tangential to the foci of the measure, which assesses actual screening, assessment, discussions, or treatment not simply inclusion of these processes in the palliative care plan. The Committee recognized the evidence base linking dyspnea treatment, bowel regimens, and communication regarding treatment preferences to improved patient outcomes. However, members acknowledged that similar evidence for the other components of the measure (pain screening, pain assessment, dyspnea screening, and addressing spiritual and religious concerns) does not exist and likely would not be forthcoming. The Committee agreed that empirical evidence is not needed to hold providers accountable for those components of the measure, and agreed to invoke the exception to the evidence subcriterion.

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

- Data presented by the developer from the FY2015-2016 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average performance rate for the composite of 71.8% in 2015 and 76.2% in 2016.
- The developers described this all-or-none measure as designed "to reflect the overall quality of comprehensive assessment at hospice admission for each patient stay." They noted that the seven components included in the measure "address high-priority aspects of quality hospice care as identified by the National Consensus Project, are required by the Medicare Hospice Conditions of Participation, and are supported by hospice stakeholders." Finally, the developers supported the composite itself and its all-or-none aggregation and weighting approach by suggesting it will help to incentivize hospices to complete all of the critical care processes included in the measure, set a higher bar for performance compared to the individual measures, and provide summary results that can be more easily understood by consumers and providers.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-20**; **M-2**; **L-0**; **I-0** 2b. Validity: **H-20**; **M-2**; **L-0**; **I-0**

<u>Rationale</u>:

- The Committee questioned how the measure is calculated when a patient screens negative for pain or for dyspnea (as only those who screen positive would then receive a pain assessment or dyspnea treatment, respectively). The developer clarified that all patients are included in the measure and that those whose screens are negative for pain or dyspnea are "given credit" for receiving the pain assessment and dyspnea treatment, respectively. Similarly, patients who are not receiving opioid treatment are "given credit" for receiving a bowel regimen.
- Reliability testing of the measure score was conducted on FY2015 HQRP data using a split-half analysis and a signal-to-noise analysis. The split-half analysis yielded an intra-class correlation coefficient of 0.94, while the signal-to-noise ratio was 0.99.
- The developer tested the validity of the measure score with a non-parametric Spearman rank correlation analysis between the composite measure and the seven individual NQF-endorsed measures that correspond to the components of the composite. Correlations ranged from .43 to .64, and were statistically significant.
- The developers provided the results of three analyses to support the construction of the composite as all-or-none measure with seven components. First, they noted the moderate correlations between the composite measure and the individual measures, which were high enough to infer consistency with the quality construct yet not so high as to indicate that the composite is redundant to the individual measures. Next, they noted how the average performance of the combined seven components differed from the average performance seen when each of the seven components were excluded one at a time. They also noted that removal of each of the components identified a different, although overlapping, group of outliers than that identified when using all seven components.
- Committee members also noted that a caregiver focus group convened by the developer supported the construction of a composite measure, believing it would alleviate confusion they had in interpreting the results from the individual measures.

3. Feasibility: H-21; M-1; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee noted that because data for this measure are part of the Hospice Item Set (HIS), a standardized patient-level dataset used by CMS to collect data for the individual measures, feasibility is high.

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

4. Usability and Use: H-20; M-2; L-0; I-0

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

Rationale:

- The measure is included in the Hospice Quality Reporting Program (HQRP), an accountability program in which hospice providers are penalized financially if results are not reported to CMS. In FY 2015, 3,992 hospices reported data on 1,215,247 patient stays.
- The Committee again noted the focus group results regarding the ease of interpretability of the composite measure.
- The Committee did not note any potential unintended consequences to patients from using the measure.

5. Related and Competing Measures

- This measure is related to its seven component measures, all endorsed by NQF:
    - Hospice and Palliative Care – Pain Screening (NQF #1634),
    - Hospice and Palliative Care – Pain Assessment (NQF #1637),
    - Hospice and Palliative Care – Dyspnea Screening (NQF #1639),
    - Hospice and Palliative Care – Dyspnea Treatment (NQF #1638),
    - Patients Treated with an Opioid Who Are Given a Bowel Regimen (NQF #1617),
    - Hospice and Palliative Care – Treatment Preferences (NQF #1641), and
    - Beliefs and Values - 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 (NQF #1647).
- Measures are harmonized to the extent possible.
- The Committee agreed that the individual measures should retain endorsement, particularly since most of the individual measures also assess care at the clinician group level in the hospital setting.

Standing Committee Recommendation for Endorsement: **Y-22**; **N-0**

6. Public and Member Comment

Comments received:

NQF received 2 post-evaluation comments on this measure. One comment supported the measure. The second commenter suggested that performance on the measure was disproportionately driven the Pain Assessment component and noted that several of the components of the measure are not proximal to desired patient outcomes.

Developer response (summarized):

- The developer noted that experts in the field, hospice providers, and caregivers agree that the processes of care included in the measure are important in promoting a person-centered approach to care and achieving the patient comfort throughout the delivery of hospice and palliative care. The developer also noted that focus groups and interviews with stakeholders supported the all-or-none construction of the composite measure.
- The developer also summarized analyses (submitted in response to subcrition 2d) that demonstrate that each component in the composite contributes to the overall composite performance score.

Committee response:

- The Committee agreed that that performance on the pain assessment component will drive a substantial amount of variation in performance for this composite. However, members also agreed that each of the components contribute to the overall composite and that the all-or-none construction of the composite will help to incent hospice providers to complete all of the care processes included in

3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission
this measure. The Committee also agreed that additional measures should be developed to assess provision of treatment and outcomes of treatment.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

Palliative and End-of-Life Care Off-Cycle Review

Consensus Standards Approval Committee Review and Recommendations

July 11-12, 2017

R. Sean Morrison
Deborah Waldrop
Karen Johnson
Jean-Luc Tilly

NATIONAL QUALITY FORUM

Palliative and End-of-Life Care Off-Cycle Review

- One measure evaluated:
  - 3235: Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission
  - Description:
    - » Assesses the percentage of hospice stays in which patients received a comprehensive patient assessment at hospice admission.
    - » Seven NQF-endorsed components:
      - *Pain screening and assessment*
      - *Dyspnea screening and treatment*
      - *Bowel regimen administered with opioids*
      - *Documentation of life-sustaining preferences*
      - *Documentation of spiritual and existential concerns*

Palliative and End-of-Life Care Off-Cycle Review

- 3235: Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission
  - **Recommended** by the Standing Committee for Endorsement
  - Vote Tally: Y-22, N-0

Comments Received

Comments Received:

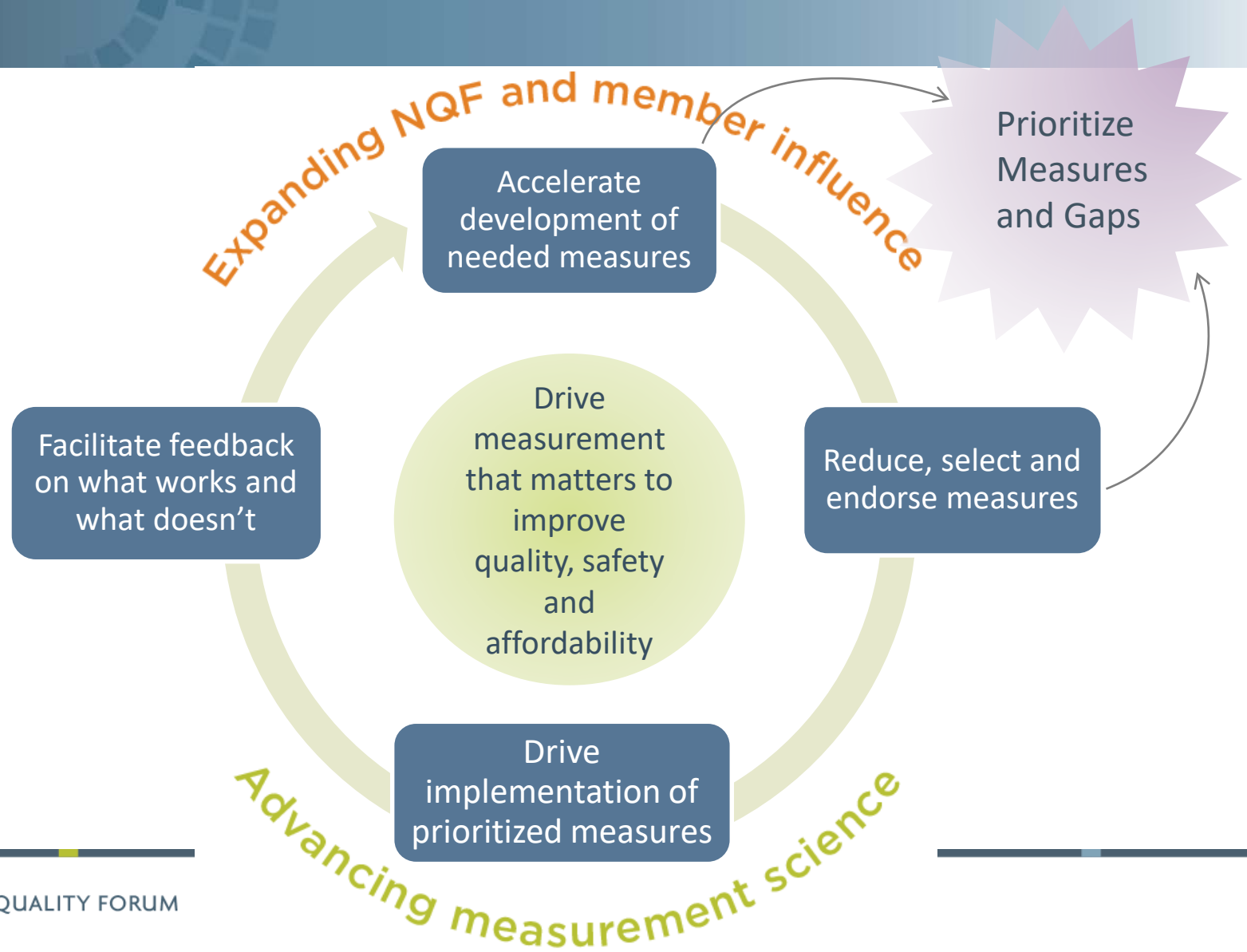
- 3 Comments from 3 Member Organizations
  - General Comment:
    - Reconsider using “Care-a-tive” in Measurement Framework
    - Proposes off-cycle activities
  - Measure-Specific Comment:
    - One commenter supported the measure.
    - The second commenter noted two concerns:
      - *Performance on the measure disproportionately by driven the Pain Assessment component*
      - *Several of the components of the measure are not proximal to desired patient outcomes*

Committee Recommendation Following Public and Member Comment

- The Committee upheld its recommendation to endorse 3235: Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

Prioritization of Measures and Gaps – Approach

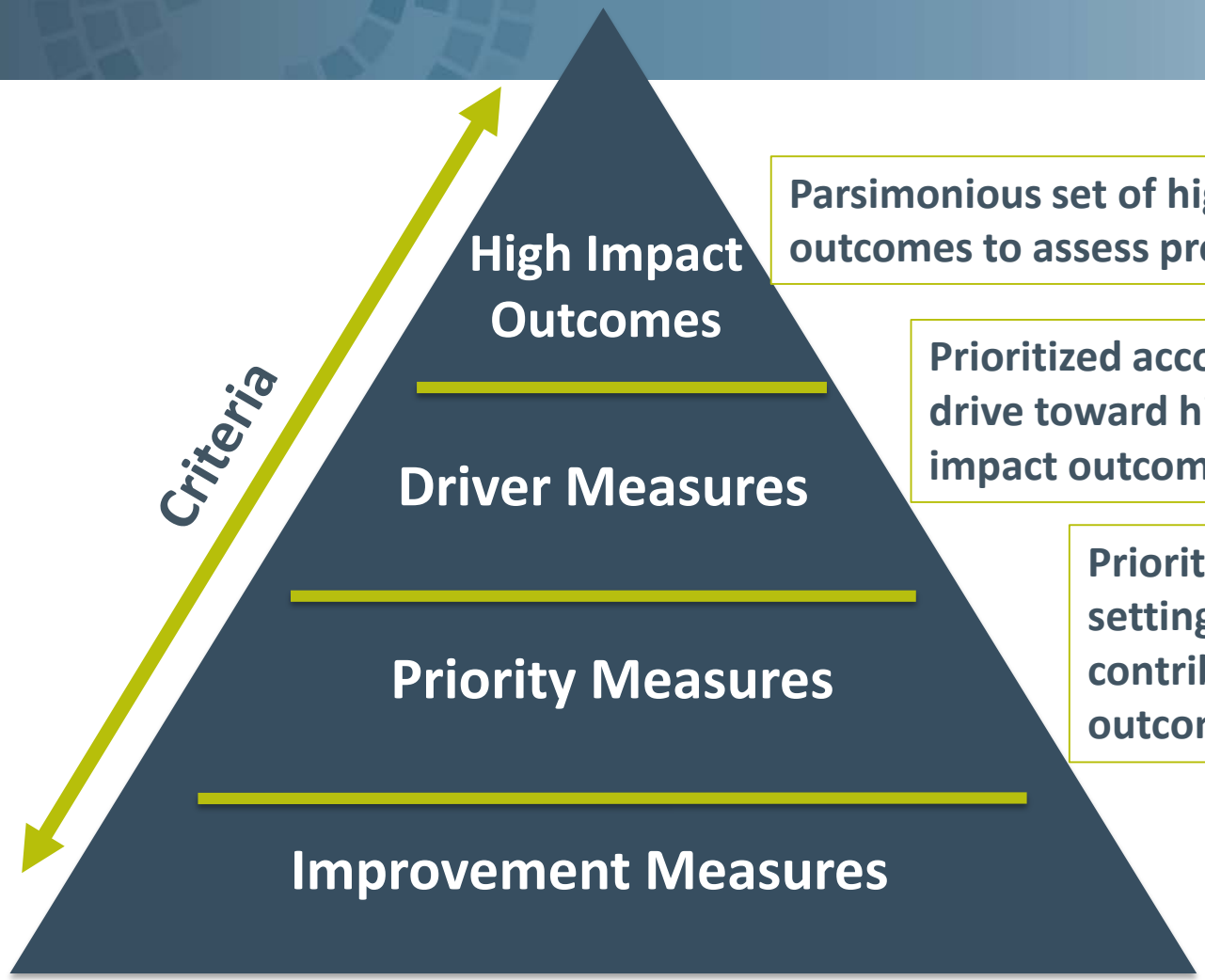
NQF: Lead. Prioritize. Collaborate.



NQF Prioritization Criteria

Criterion	Description
Outcome-focused	Preference for outcome measures and measures with strong link to improved outcomes and costs
Improvable and actionable	Preference for actionable measures with demonstrated need for improvement and evidence-based strategies for doing so
Meaningful to patients and caregivers	Preference for person-centered measures with meaningful and understandable results for patients and caregivers
Support systemic and integrated view of care	Preference for measures that reflect care that spans settings, providers, and time to ensure that care is improving within and across systems of care

Hierarchical Framework



Parsimonious set of high-impact outcomes to assess progress as a nation.

Prioritized accountability measures to drive toward higher performance on high-impact outcomes.

Priority measures in specific settings and conditions that contribute to high-impact outcomes.

Prioritized measures to drive improvement: standardize & share

High-Impact Outcomes

High Impact Outcomes	High Impact Outcomes: Person-Centered Translation
Functional status/well-being	*Are you getting better?*
Patient experience (including care coordination, shared decision-making)	*How was your care?*
Preventable harm/complications	*Did you suffer adverse events from your care?*
Prevention/healthy behaviors	*Do you need more help staying healthy?*
Total cost/low-value care	*Did you receive the care you needed and no more?*
Access to needed care	*Can you get the care you need when and where you need it?*
Equity of care	*Are you getting high quality care regardless of who you are or where you live?*

Initial Results: Prevention/Healthy behaviors

Driver measures	Priority measures	Improvement measures
• Caregiver support • Good communication (early, open/shared)	• Assessing family/caregivers for risk (e.g., depression, complicated bereavement, etc.) • Basic caregiver skills training provided (e.g. how to lift patient without injury to caregiver's back, changing sheets when patient bedridden, etc.)	• None identified

Initial Results: Preventable Harm/Complications

Driver measures	Priority measures	Improvement measures
• Unwanted care/care that is not goal-concordant • Potentially #2888: Hospital admissions for those with multiple chronic conditions (NOTE: Committee discussed readmissions, not admissions) • Symptomatology due to use of excess/poor value medications/interventions • Unaddressed psychosocial and spiritual issues	• #0101: Falls: Screening, Risk-Assessment, and PoC • #2993: Potentially Harmful Drug-Disease Interactions in the Elderly • #0022: Use of High-Risk Medications in the Elderly • Medication reconciliation (e.g., #0097, #2988, #0646) • Safe medication disposal • Feeding tube placement in dementia patients • Discontinuation of available interventions in terminal patients	• Assessing patient for psychosocial and spiritual issues/needs

Piloting NQF's New Prioritization Criteria

- PC/EoL Standing Committee first to use NQF's new prioritization criteria
- "Findings": More gaps than identified measures; practically no driver measures currently available
- Lessons learned: Needed more context setting and more pre-work; need more clarity about how this fits with already existing frameworks; need more clarity on definitions (e.g., driver vs priority; gaps); provides consistency, but still need flexibility

Project Timeline and Next Steps

Process Step	Timeline
Appeals Period	July 17-August 14
Adjudication of Appeals	August-September
Final Report	September 15

Questions?

NATIONAL QUALITY FORUM