MAP Post-Acute/Long-Term Care Workgroup In-Person Meeting #4

NATIONAL
QUALITY FORUM

Tuesday, February 14, 2012
9:00 am – 5:00 pm EST

National Quality Forum
9th Floor Conference Center
1030 15th Street, NW
Washington, DC 20005

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NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

PAC/LTC Workgroup
In-Person Meeting #4

National Quality Forum Conference Center
1030 15th Street NW, 9th Floor, Washington, DC 20005

Public Dial-In: 888-298-3457
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AGENDA: FEBRUARY 14, 2012

Meeting Objectives:

- *Determine measurement priorities for hospice and end-of-life care across settings*
- *Identify available measures and prioritize gaps*
- *Identify a pathway for improving hospice and end-of-life care quality measurement*

8:30 am **Breakfast**

9:00 am **Welcome, Review of Meeting Objectives**
Carol Raphael, Workgroup Chair
Aisha Pittman, Senior Program Director, Strategic Partnerships, NQF
- Review workgroup charge and report outline

9:15 am **Defining the Scope of the Hospice Care Report**
Carol Raphael
Shari Ling, Deputy Chief Medical Officer, Office of Clinical Standards and Quality, CMS
Robin Dowell, Nurse Consultant, Office of Clinical Standards and Quality, CMS
Carol Spence, VP, Research and Quality, NHPCO
- Review key definitions including Medicare hospice benefit, end-of-life care, and palliative care
- Discuss the scope of the hospice report

9:45 am **Quality Issues for Hospice Care**
Carol Raphael
Sean Morrison, Director, National Palliative Care Research Center, Mt. Sinai Hospital
Gerri Lamb, Associate Professor, Arizona State University, College of Nursing and Health Innovation

Bruce Leff, Professor of Medicine, Division of Geriatric Medicine, Johns Hopkins University School of Medicine
- Review and discuss the quality issues for hospice care within each National Quality Strategy priority

11:15 am **Break**

11:30 am **Measurement Priorities for Hospice Care**
Carol Raphael
- Review and finalize measurement priorities
- Rank measurement priorities

12:15 pm **Lunch**

12:50 pm **Measurement Priorities for Hospice Care continued**
Carol Raphael
- Review results of prioritization exercise

1:15 pm **Opportunity for Public Comment**

1:30 pm **Current Landscape of Hospice Care Measurement**
Carol Raphael
Rachel Weissburg, Project Manager, Strategic Partnerships, NQF
- Review current measures, including measures in the NQF portfolio, measures finalized or proposed for use in federal programs, and measures in the pipeline

2:30 pm **Breakout: Identification of Measures for Application and Gaps**
Small Group Activity
- Identify measures that should be applied to the Medicare hospice program
- Identify measures that should be applied across all federal programs
- Identify measure gaps

3:45 pm **Report Out from Small Groups**
Carol Raphael and Workgroup members

4:30 pm **Opportunity for Public Comment**

4:45 pm **Summary of Day**
Carol Raphael and Aisha Pittman

5:00 pm **Adjourn for the Day**

Measure Applications Partnership
Post-Acute Care/Long-Term Care Workgroup
In-Person Meeting #4

February 14, 2011

NATIONAL QUALITY FORUM

Welcome and
Review of Meeting Objectives

Workgroup Charge

The charge of the MAP Post-Acute Care/Long-Term Care Workgroup is to advise on quality reporting for post-acute care and long-term care settings. The Workgroup will:

- Develop a coordination strategy for quality reporting that is aligned across post-acute care and long-term care settings by:
  - Identifying a core set of available measures, including clinical quality measures and patient-centered cross cutting measures
  - Identifying critical measure development and endorsement gaps
- ➢ **Identify measures for quality reporting for hospice programs and facilities**
- Provide input on measures to be implemented through the Federal rulemaking process that are applicable to post-acute settings

Meeting Objectives

- Determine measurement priorities for hospice and end-of-life care across settings;
- Identify available measures and prioritize gaps;
- Identify a pathway for improving hospice and end-of-life care quality measurement

Agenda

- Defining the Scope of the Hospice Care Report
- Quality Issues for Hospice Care
- Measurement Priorities for Hospice Care
- Current Landscape of Hospice Care Measurement
- Identification of Measures for Application and Gaps

Report Outline

**Overall theme: Hospice care as an opportunity to emphasize two National Priorities:*
Person- and Family- Centered Care** and **Effective Communication and Care Coordination*

- Executive Summary
- MAP Background
- Intro to Report
- Strategy for Hospice Care Assessment
- Pathway for Improving Measure Application for Hospice Care

Defining the Scope of the Hospice Care Report

Defining the Scope of the Hospice Care Report

The Medicare Hospice Benefit:

According to Title 18, Section 1861 of the Social Security Act, the term "hospice care" means the following items and services provided to a terminally ill individual by [or others under arrangements made by], a hospice program under a written plan . . . established and periodically reviewed by the individual's attending physician and by the medical director (and interdisciplinary group) of the program[including]:

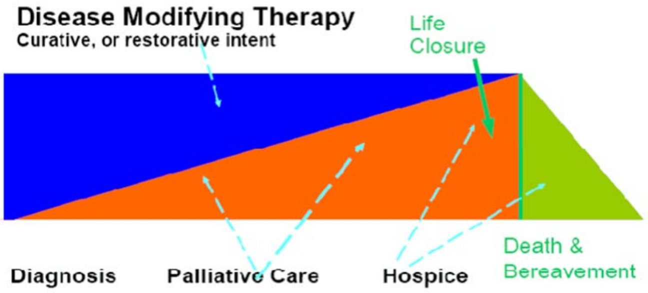
- Nursing care
- Physical, occupational, or speech-language pathology therapy services
- Medical social services
- Services of a home health aide
- Homemaker services
- Medical supplies (including drugs, biological, and the use of medical appliances)
- Physicians' services
- Short-term inpatient care (no longer than 5 days)
- Counseling

Defining the Scope of the Hospice Care Report

Definitions

- **Hospice care**: a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition. It also supports family members coping with the complex consequences of illness, disability, and aging as death nears; and addresses the bereavement needs of the family following the death of the patient.
- **Palliative care:** patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.
- **End-of-life (EOL) care:** comprehensive care for a life-limiting illness that meets the patient's medical, physical, psychological, spiritual, and social needs.

Defining the Scope of the Hospice Care Report



Quality Issues for Hospice Care

Quality Issues for Hospice Care

National Quality Strategy Priorities:

- Making care safer by reducing harm caused in the delivery of care
- Ensuring that each person and family are engaged as partners in their care
- Promoting effective communication and coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

Quality Issues for Hospice Care

Within each NQS priority:

- What are the unique opportunities in hospice care to achieve each NQS priority?
- Are there members of the hospice care team (e.g. social worker, spiritual care counselor, pharmacist, etc.) who demonstrate effective practices for achieving each priority?
- How does care vary for sub-populations of hospice patients (i.e., children, elderly, advanced illness) across each of the priorities?
- What are immediate opportunities to improve care within each of the priorities?

Measurement Priorities for Hospice Care

Measurement Areas

NQS Priority	Measurement Area
Better health in communities	• Access to palliative or hospice care • Provider education • Spiritual, religious, and existential aspects of care—assessment of concerns, availability of spiritual care services • Other?
Prevention / treatment - leading causes of mortality	• Physical aspects of care—pain, dyspnea, constipation, and other symptoms using standardized scale • Psychological and psychiatric aspects of care—manage anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms • Care of the imminently dying patient • *Functional and cognitive status and assessment* • *Mental health assessment* • Other?

Measurement Areas

NQS Priority	Measurement Area
Person- and family-centered care	• Grief and bereavement care planning • Patient education and support to families • Social care planning- social, practical, and legal needs of patient and caregivers • Ethical and legal aspects of care—advance directives, surrogate decision makers • *Establishment of patient/family/caregiver goals, care planning* • *Advanced care planning and treatment* • *Experience of care* • *Shared decision-making* • Other?

Measurement Areas

NQS Priority	Measurement Area
Safer care	- *Falls* - *Pressure ulcers* - *Adverse drug events* - Other?
Care Coordination	- Timely communication of patients goals, preferences upon transfer - *Transition planning* - Other?
Affordable Care	- *Inappropriate medicine use* - *Infection rates* - *Avoidable readmissions* - Other?

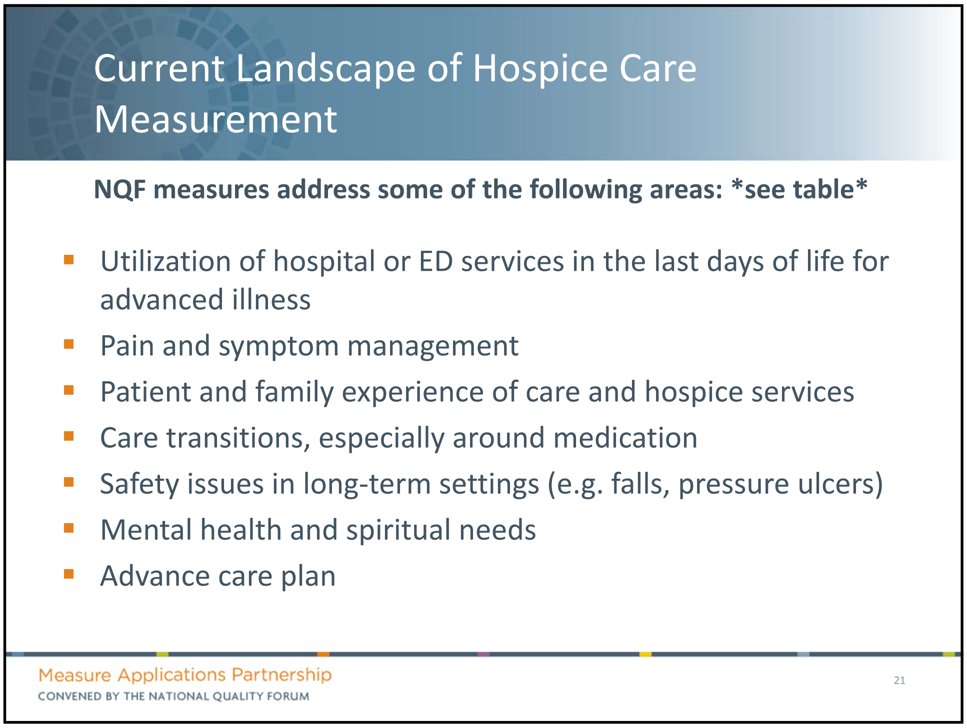
Measurement Priorities for Hospice Care

Prioritization exercise

- Each member has 6 dots
- Place dots on the measurement areas you believe are of the highest priority
  - You may only assign one dot to each measurement area
  - You may assign dots to multiple measurement areas within one NQS priority (e.g., you may assign a dot to both falls and adverse drug events under the Safety priority)
- Once the voting has finished we will review and discuss the results of the prioritization

Opportunity for Public Comment

Current Landscape of Hospice Care Measurement



Current Landscape of Hospice Care Measurement

NQF measures address some of the following areas: *see table*

- Utilization of hospital or ED services in the last days of life for advanced illness
- Pain and symptom management
- Patient and family experience of care and hospice services
- Care transitions, especially around medication
- Safety issues in long-term settings (e.g. falls, pressure ulcers)
- Mental health and spiritual needs
- Advance care plan

Small Group Session

Identification of Measures for Application and Gaps

Breakout Session Instructions:

- Use the following materials to assist you:
  - *Table of available NQF-endorsed measures*
  - *Measure gaps – Appendix C of 2011 NQF Consensus Report*
  - *The ranked measurement priorities from the 11:30 am agenda item*
  - *Measure worksheet*

Current Landscape of Hospice Care Measurement

- Please use your worksheet to indicate if each measure should be explored for application to performance measurement programs:
  - Medicare Hospice Program
  - Broad application (e.g. other federal programs, private sector)
- Please identify any additional measurement gaps

Report Out from Small Groups

Report Out from Small Groups

Measures that should be applied to the Medicare hospice program:

- Real-time capture

Report Out from Small Groups

Measures that should be applied broadly across federal and private sector programs:

- Real-time capture

Report Out from Small Groups

Measure gaps:

- Real-time capture

Opportunity for Public Comment

Summary of the Day

Adjourn

Next Meeting:

TBD- Web Meeting if Needed

Hospice Care Quality Measurement –Definitions

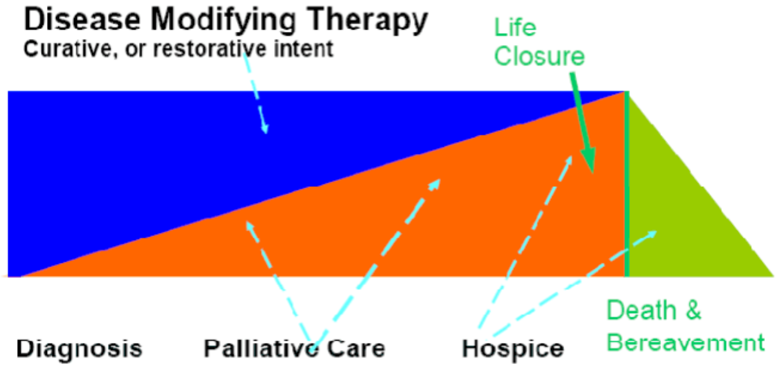
The Medicare Hospice Benefit:

According to Title 18, Section 1861 of the Social Security Act, the term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan . . . established and periodically reviewed by the individual's attending physician and by the medical director (and interdisciplinary group . . .) of the program . . [including]:

- **Nursing care** provided by or under the supervision of a registered professional nurse
- **Physical, occupational, or speech-language pathology therapy services**
- **Medical social services** under the direction of a physician
- **Services of a home health aide** who has successfully completed a training program approved by the Secretary
- **Homemaker services**
- **Medical supplies** (including drugs, biological, and the use of medical appliances)
- Physicians' services
- **Short-term inpatient care** (no longer than 5 days); such respite may only be intermittent and nonroutine
- **Counseling** (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death

Nursing care and the services of a home health aide may be provided on a 24 hour, continuous basis **only** during periods of crisis (criteria established by the Secretary) and **only** as necessary to maintain the terminally ill individual at home.[1][2]

The following definitions and visual model were gathered from previous work done in the field of hospice and palliative care, including NQF's 2006 *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*, the 2011 Consensus Report, *National Voluntary Consensus Standards: Palliative Care and End-of-Life Care*, and the National Priorities Partnership's 2010 *Palliative Care and End-of-Life Care Convening Meeting Synthesis Report*.



Hospice care is a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition. It also supports family members coping with the complex consequences of illness, disability, and aging as death nears. Hospice care further addresses the bereavement needs of the family following the death of the patient.

Palliative care refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

End-of-life (EOL) care refers to comprehensive care for a life-limiting illness that meets the patient's medical, physical, psychological, spiritual, and social needs.

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[1] https://www.cms.gov/Hospice/20_Medicare_Hospice_Data.asp

[2] https://www.cms.gov/Hospice/01_overview.asp#TopOfPage

Hospice Care – Measurement Areas

This table maps proposed measurement areas for hospice care to the six National Quality Strategy (NQS) priorities. The workgroup will have an opportunity to revise and then prioritize the measurement areas to guide identification of high-leverage measures for hospice programs.

The measurement areas are derived from the 38 NQF-endorsed preferred practices established by the National Consensus Project for Quality Palliative Care. In addition, the MAP Post-Acute Care/Long-Term Care Core Measure Concepts are included *in italics.*

NQS Priority	**Measurement Area**
Better health in communities	• Access to palliative or hospice care • Provider education • Spiritual, religious, and existential aspects of care—assessment of concerns, availability of spiritual care services • Other
Prevention / treatment - leading causes of mortality	• Physical aspects of care—pain, dyspnea, constipation, and other symptoms using standardized scale • Psychological and psychiatric aspects of care—manage anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms • Care of the imminently dying patient • *Functional and cognitive status and assessment* • *Mental health assessment* • Other?
Person- and family- centered care	• Grief and bereavement care planning • Patient education and support to families • Social care planning- social, practical, and legal needs of patient and caregivers • Ethical and legal aspects of care—advance directives, surrogate decision makers • *Establishment of patient/family/caregiver goals, care planning* • *Advanced care planning and treatment* • *Experience of care* • *Shared decision-making* • Other?
Safer care	• *Falls* • *Pressure ulcers* • *Adverse drug events* • Other?
Care coordination	• Timely communication of patients goals, preferences upon transfer • *Transition planning* • Other?
Affordable care	• *Inappropriate medicine use* • *Infection rates* • *Avoidable readmissions* • Other?

Available NQF-endorsed Hospice/EOL/Palliative Care Measures

49 NQF-endorsed measures address the following areas: pain and symptom management, safety, care transitions, utilization of hospital services for advanced illness, care preference and experience, and quality of care at the end of life

Summary of Available Measures	
0097 Medication Reconciliation	0171 Acute care hospitalization (risk-adjusted)
0173 Emergency department Use without Hospitalization	0179 Improvement in dyspnea
0181 Increase in number of pressure ulcers	0182 Residents whose need for more help with daily activities has increased
0185 Recently hospitalized residents with symptoms of delirium (risk-adjusted)	0208 Family Evaluation of Hospice Care
0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	0210 *(Under Review)* Proportion receiving chemotherapy in the last 14 days of life
0211 *(Under Review)* Proportion with more than one emergency room visit in the last days of life	0212 *(Under Review)* Proportion with more than one hospitalization in the last 30 days of life
0213 *(Under Review)* Proportion admitted to the ICU in the last 30 days of life	0214 *(Under Review)* Proportion dying from Cancer in an acute care setting
0215 *(Under Review)* Proportion not admitted to hospice	0216 *(Under Review)* Proportion admitted to hospice for less than 3 days
0228 3-Item Care Transition Measure (CTM-3)	0326 Advance Care Plan
0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
0646 Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	0647 Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)
0648 Timely Transition of Transmission Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care[Home/Self Care] or Home Health Care)

* *Under Review* denotes a measure that is currently in review for maintenance of endorsement.

**Under Consideration denotes a measure that CMS is considering for 2012 rulemaking; MAP provided input on these measures.

Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Summary of Available Measures	
0673 Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem	0674 Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
0677 Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)	0679 Percent of High Risk Residents with Pressure Ulcers (Long Stay)
0684 Percent of Residents with a Urinary Tract Infection (Long-stay)	0685 Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)
0686 Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay)	0687 Percent of Residents Who Were Physically Restrained (Long Stay)
0689 Percent of Residents Who Lose Too Much Weight (Long-Stay)	0690 Percent of Residents Who Have Depressive Symptoms (Long-Stay)
0719 Children Who Receive Effective Care Coordination of Healthcare Services When Needed	1617 Patients Treated with an Opioid who are Given a Bowel Regimen
1623 Bereaved Family Survey	1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated
1626 Patients Admitted to ICU who Have Care Preferences Documented	1630 Hospitalized Patients Who Die an Expected Death Who Have Dyspnea Addressed
1632 CARE - Consumer Assessments and Reports of End of Life	1634 Hospice and Palliative Care -- Pain Screening
1637 Hospice and Palliative Care -- Pain Assessment	1638 Hospice and Palliative Care -- Dyspnea Treatment
1639 Hospice and Palliative Care -- Dyspnea Screening	1641 Hospice and Palliative Care – Treatment Preferences
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.	1894 Cross-cultural communication domain of the Communication Climate Assessment Toolkit
1898 Health literacy domain of Communication Climate Assessment Toolkit	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
0097 Medication Reconciliation	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented The medical record must indicate that the physician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.	All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office	Under consideration for use in Meaningful Use and Value-Based Payment Modifier Programs **(MAP Supports)**
0171 Acute care hospitalization (risk-adjusted)	Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.	Home Health	Finalized for use in Home Health Quality Reporting Program **(MAP Supports)**
0173 Emergency department Use without Hospitalization	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.	Home Health	
0179 Improvement in dyspnea	Percentage of patients who are short of breath less often	Number of home health episodes where the value recorded for the OASIS-C item M0492 on the discharge assessment is numerically less than the value	All home health episodes except those where either of the following conditions applies: (1) The value	Home	Finalized for use in Home Health Quality Reporting Program

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Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		recorded on the start (or resumption) of care assessment, indicating less serious condition at discharge compared to start of care. Improvement in Dyspnea is coded as follows: 1 (YES) IF: The value recorded for the OASIS-C item M0492 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less serious condition at discharge compared to start of care. 0 (NO) IF: The value recorded for the OASIS-C item M0492 on the discharge assessment is numerically greater than or equal to the value recorded on the start (or resumption) of care assessment, indicating the same or worse condition at discharge compared to start of care. Please note also generic exclusions under Q6, Denominator Exclusions. OASIS C item: (M0492) When is the patient dyspneic or noticeably Short of Breath? • 0 - Patient is not short of breath • 1 - When walking more than 20 feet, climbing stairs • 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20	recorded for the OASIS-C item M0492 on the start (or resumption) of care assessment is zero, indicating patient is not short of breath. These patients are excluded because it would be impossible for them to show measurable improvement. OR (2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home		**(MAP Supports)**

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		feet) • 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation • 4 - At rest (during day or night)			
0181 Increase in number of pressure ulcers	Percentage of patients who had an increase in the number of pressure ulcers	Number of home health episodes where [(a) the value recorded for the total number of stageable pressure ulcers [(M0462 – number at stage 1) + (M0452 - number at stage 2) + (M0452 - number at stage 3) + (M0452 number at stage 4) or (b) "0" if M0448=0 and M0462=0] on the discharge assessment is numerically greater than the value resulting from the same calculation using the responses on the start (or resumption) of care assessment - indicating an increase in the number of pressure ulcers OASIS C items: (M0448) Does this patient have at least one unhealed (non-epithelialized) Pressure Ulcer at Stage II or higher or designated as "not stageable"? 0- No 1- Yes (M0452) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: (Enter “0” if none; enter “4” if “4 or more”; enter “UK” for rows d.1 – d.3 if “Unknown”)	All home health episodes except those where: (1) The total number of pressure ulcers reported on the start (or resumption) of care assessment is 16 These patients are excluded because it would be impossible for them to show increase in the number of pressure ulcers. OR (2) The patient did not have a discharge assessment because the episode of care ended in transfer to inpatient facility or death at home	Home	Finalized for use in Home Health Quality Reporting Program **(MAP Supports)**

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. d.1 Unstageable: Known or likely but not stageable due to non-removable dressing or device d.2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar. d.3 Unstageable: Suspected deep tissue injury in evolution. (M0462) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. 0,1, 2, 3, 4 or more			

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
0182 Residents whose need for more help with daily activities has increased	Percentage of residents with a valid target and a valid prior assessment whose need for more help with daily activities has increased	Residents with worsening (increasing MDS item score) in Late-Loss ADL self-performance at target relative to prior assessment. 1.Bed mobility – [Level at target assessment (G1a(A)[t]] – [Level at previous assessment (G1a(A)[t-1]] > 0, or 2.Transfer - [Level at target assessment (G1b(A)[t]] – [Level at previous assessment (G1b(A)[t-1]] > 0, or 3.Eating - [Level at target assessment (G1h(A)[t]] – [Level at previous assessment (G1h(A)[t-1]] > 0, or 4.Toileting - [Level at target assessment (G1i(A)[t]] – [Level at previous assessment (G1i(A)[t-1]] > 0, OR at least one of the following is true: 1.Bed mobility – [Level at target assessment (G1a(A)[t]] – [Level at previous assessment (G1a(A)[t-1]] > 1, or 2.Transfer - [Level at target assessment (G1b(A)[t]] – [Level at previous assessment (G1b(A)[t-1]] > 1, or 3.Eating - [Level at target assessment (G1h(A)[t]] – [Level at previous assessment (G1h(A)[t-1]] > 1, or 4.Toileting - [Level at target assessment (G1i(A)[t]] – [Level at previous assessment (G1i(A)[t-1]] > 1.	All residents with a valid target and a valid prior assessment	Nursing home (NH) /Skilled Nursing Facility (SNF)	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
0185 **Recently hospitalized residents with symptoms of delirium (risk-adjusted)**	Percentage of recently hospitalized patients, with a valid SNF PPS 14-day assessment with symptoms of delirium	Patients at SNF PPS 14-day assessment with at least one symptom of delirium that represents a departure from usual functioning (at least one B5a through B5f=2).	All patients with a valid SNF PPS 14-day assessment (AA8b=7).	Nursing home (NH) /Skilled Nursing Facility (SNF)	
0208 **Family Evaluation of Hospice Care**	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.	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. Global Score: Numerator is the number of best possible responses (excellent) to the overall rating question on the FEHC survey.	Composite Score: 100 (100 is the best possible composite score which indicates 0% incidence of problem scores). Global Score: Total number of responses to the overall rating of care quality on the FEHC survey, question G1.	Hospice	Under consideration for use in Hospice Quality Reporting Program **(MAP Supports)**
0209 **Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment**	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.	Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment (after admission to hospice services).	Patients who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment (after admission to hospice services).	Hospice	Finalized for use in Hospice Quality Reporting Program
0210 ***(Under Review)*** **Proportion receiving chemotherapy in the last 14**	Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life	Patients who died from cancer and received chemotherapy in the last 14 days of life	Patients who died from cancer.	Ambulatory Care : Clinician Office, Hospital/Acute Care Facility	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
days of life					
0211 *(Under Review)* Proportion with more than one emergency room visit in the last days of life	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life	Patients who died from cancer and had >1 ER visit in the last 30 days of life	Patients who died from cancer.	Hospital/Acute Care Facility	
0212 *(Under Review)* Proportion with more than one hospitalization in the last 30 days of life	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life	Patients who died from cancer and had >1 hospitalization in the last 30 days of life	Patients who died from cancer.	Hospital/Acute Care Facility	
0213 *(Under Review)* Proportion admitted to the ICU in the last 30 days of life	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life	Patients who died from cancer and were admitted to the ICU in the last 30 days of life	Patients who died from cancer.	Hospital/Acute Care Facility	
0214 *(Under Review)* Proportion dying from Cancer in an acute care setting	Percentage of patients who died from cancer dying in an acute care setting	Patients who died from cancer in an acute care hospital	Patients who died from cancer.	Hospital/Acute Care Facility	
0215 *(Under Review)* Proportion not admitted to hospice	Percentage of patients who died from cancer not admitted to hospice	Patients who died from cancer without being admitted to hospice	Patients who died from cancer.	Hospice	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
0216 *(Under Review)* Proportion admitted to hospice for less than 3 days	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there	Patients who died from cancer and spent fewer than three days in hospice.	Patients who died from cancer who were admitted to hospice	Hospice	
0228 3-Item Care Transition Measure (CTM-3)	Uni-dimensional self-reported survey that measure the quality of preparation for care transitions.	The 15-item and the 3-item CTM share the same set of response patterns: Strongly Disagree; Disagree; Agree; Strongly Agree (there is also a response for Don't Know; Don't Remember; Not Applicable). Based on a subject's response, a score can be assigned to each item as follows: • Strongly Disagree = 1 • Disagree = 2 • Agree = 3 • Strongly Agree = 4 Next, the scores can be aggregated across either the 15 or 3 items, and then transformed to a scale ranging from 0 to 100. Thus the denominator is 100 and the numerator can range from 0 to 100. Time Window = recommended within 30 days of event		Hospital	Under consideration for use in Hospital Inpatient Quality Reporting Program **(MAP Supports)**
0326 Advance Care Plan	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	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	All patients aged 65 years and older	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinic/Urgent Care, Ambulatory	Finalized for use in Physician Quality Reporting Program **(MAP Supports)**

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
				Care : Clinician Office, Home Health, Hospice, Hospital/Acute Care Facility, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post-Acute/Long Term Care Facility : Rehabilitation	
0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain	Patient visits that included a documented plan of care* to address pain Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain	Ambulatory Care : Clinician Office, Other	Finalized for use in Physician Quality Reporting Program. Under consideration for use in Meaningful Use. **(MAP Supports)**
0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Patient visits in which pain intensity is quantified* * Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	Ambulatory Care : Clinician Office, Other	Finalized for use in Physician Quality Reporting Program. Under consideration for

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
Oncology (paired with 0383)					use in Meaningful Use. **(MAP Supports)**
0646 Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications to be TAKEN by patient: - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge * Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed Medications NOT to be Taken by patient: - Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND - Allergies and Adverse Reactions Medications administered during the	All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care. Time Window: Each time a patient is discharged from an inpatient facility	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post-Acute/Long Term Care Facility : Rehabilitation	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued			
0647 **Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)**	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care.	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Post-Acute/Long Term Care Facility : Rehabilitation	
0648 **Timely Transition of Transmission Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)**	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	Ambulatory Care : Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		follow-up care, AND • List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each		Facility, Post-Acute/Long Term Care Facility : Rehabilitation	
0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care[Home/Self Care] or Home Health Care)	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: • Major procedures and tests performed during ED visit, AND • Principal diagnosis at discharge OR chief complaint, AND • Patient instructions, AND • Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND • List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each	All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self-care) or home health care	Ambulatory Care : Clinic/Urgent Care, Hospital/Acute Care Facility	Finalized for use in Hospital Outpatient Quality Reporting Program **(MAP Supports)**
0673 Physical Therapy or Nursing Rehabilitation/ Restorative	Long-stay patients in the denominator who received physical therapy or nursing rehabilitation/restorative care	Long-stay patients in the denominator who received physical therapy or nursing rehabilitation/restorative care	Long-stay nursing home patients 65 years or older with a new balance problem	Nursing home (NH) /Skilled Nursing Facility (SNF)	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
Care for Long-stay Patients with New Balance Problem					
0674 **Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)**	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	The numerator is based on the number of long-stay nursing facility residents who experienced one or more falls that resulted in major injury (J1900c = 1 or 2) on any non-admission MDS assessment in the last 12 months which may be an annual, quarterly, significant change, significant correction or discharge assessment. In the MDS 3.0, major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma.	The denominator is the total number of long-stay residents in the nursing facility who were assessed during the selected time window and who did not meet the exclusion criteria.	Nursing home (NH) /Skilled Nursing Facility (SNF)	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**
0677 **Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)**	The numerator is the number of long-stay residents with an MDS assessment (which may be an annual, quarterly, significant change or significant correction assessment) during the selected quarter and who self-report (v200=1) almost constant or frequent pain on a scale of 1 to 4 (J0400 =1 or 2) AND at least one episode of moderate to severe pain (item J0600A = 5, 6, 7, 8, or 9 on a scale of 1–10, with 10 being the worst pain you can imagine, OR item J0600B = 2 or 3 on a scale of 0–4, with 4 being very severe, horrible pain) OR very severe/horrible pain of any frequency (item J0600A = 10 on a scale of 1 to 10 OR item J0600B = 4 on a scale of 0–4) in the 5 days prior to the assessment.	The numerator is the number of long-stay residents with an MDS assessment (which may be an annual, quarterly, significant change or significant correction assessment) during the selected quarter and who self-report (v200=1) almost constant or frequent pain on a scale of 1 to 4 (J0400 =1 or 2) AND at least one episode of moderate to severe pain (item J0600A = 5, 6, 7, 8, or 9 on a scale of 1–10, with 10 being the worst pain you can imagine, OR item J0600B = 2 or 3 on a scale of 0–4, with 4 being very severe, horrible pain) OR very severe/horrible pain of any frequency (item J0600A = 10 on a scale	The denominator is the total of all long-stay residents in the nursing facility who have an MDS assessment which may be an annual, quarterly, significant change or significant correction assessment during the selected quarter and who do not meet the exclusion criteria.	Nursing home (NH) /Skilled Nursing Facility (SNF)	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**

Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		of 1 to 10 OR item J0600B = 4 on a scale of 0–4) in the 5 days prior to the assessment.			
0679 **Percent of High Risk Residents with Pressure Ulcers (Long Stay)**	The numerator is the number of long-stay residents who have been assessed with annual, quarterly, significant change or significant correction MDS 3.0 assessments during the selected time window and who are defined as high risk with one or more Stage 2-4 pressure ulcer(s). High risk populations are those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition.	The numerator is the number of long-stay residents who have been assessed with annual, quarterly, significant change or significant correction MDS 3.0 assessments during the selected time window and who are defined as high risk with one or more Stage 2-4 pressure ulcer(s). High risk populations are those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition.	The denominator includes all long-stay residents who received an annual, quarterly, or significant change or significant correction assessment during the target quarter and who did not meet exclusion criteria.	Nursing home (NH) /Skilled Nursing Facility (SNF)	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**
0684 **Percent of Residents with a Urinary Tract Infection (Long-stay)**	This measure updates CMS' current QM on Urinary Tract Infections in the nursing facility populations. It is based on MDS 3.0 data and measures the percentage of long-stay residents who have a urinary tract infection on the target MDS assessment (which may be an annual, quarterly, or significant change or correction assessment). In order to address seasonal variation, the proposed measure uses a 6-month average for the facility. Long-stay nursing facility residents are those whose stay in the facility is over 100 days. The measure is limited to the long-stay population because short-stay residents (those who are discharged within 100 days of admission) may have developed their urinary tract infections in the hospital rather than the nursing facility.	The numerator is the number of long-stay nursing facility residents who have an annual, quarterly, or significant change or correction assessment during the selected time window with reported urinary tract infections in the last 30 days (Item I2300 of the MDS 3.0 is checked).	All MDS target assessments (which may be an annual, quarterly, significant change or significant correction assessment) over the last two quarters. The total number of assessments is then divided by two to report an average quarter count.	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
0685 **Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)**	The numerator is the number of long-stay residents who have been assessed with an annual, quarterly, significant change or significant correction MDS 3.0 assessment during the selected time window and who are frequently or almost always incontinent of bowel or bladder.	The numerator is the number of long-stay residents who have been assessed with an annual, quarterly, significant change or significant correction MDS 3.0 assessment during the selected time window and who are frequently or almost always incontinent of bowel or bladder.	The denominator is the total of all long-stay residents in the nursing facility who have been assessed with an annual, quarterly, significant change or significant correction MDS assessment during the quarter and who do not meet the exclusion criteria.	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**
0686 **Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay)**	The numerator statement refers to a catheter that was inserted and left in the bladder by the facility during the assessment period. During MDS 3.0 field testing, look-back periods were highlighted as a significant issue across the assessment tool. For clinical assessment items, longer look-back periods served to increase the amount of record review, increasing assessment burden and leading to more opportunities for error. During national testing of look-back periods for the MDS 3.0 proposed items, the 5-day look-back period performed well and likely contributed to the improved reliability of this item.(1) 1. Saliba D, Buchanan J. Development and Validation of a Revised Nursing Home Assessment Tool: MDS 3.0. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf.	The numerator statement refers to a catheter that was inserted and left in the bladder by the facility during the assessment period. During MDS 3.0 field testing, look-back periods were highlighted as a significant issue across the assessment tool. For clinical assessment items, longer look-back periods served to increase the amount of record review, increasing assessment burden and leading to more opportunities for error. During national testing of look-back periods for the MDS 3.0 proposed items, the 5-day look-back period performed well and likely contributed to the improved reliability of this item.(1) 1. Saliba D, Buchanan J. Development and Validation of a Revised Nursing Home Assessment Tool: MDS 3.0. Contract No. 500-00-0027/Task Order	The denominator is the total of all long-stay residents in the nursing home who have been assessed with an annual, quarterly, significant change or significant correction MDS 3.0 assessment during the quarter (3-month period) and who do not meet the exclusion criteria.	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
	The numerator is the number of long-stay residents who have/had a urinary catheter in the last 7 days (H0100A is checked).	#2. Santa Monica, CA: Rand Corporation, Apr 2008. Available from http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf. The numerator is the number of long-stay residents who have/had a urinary catheter in the last 7 days (H0100A is checked).			
0687 Percent of Residents Who Were Physically Restrained (Long Stay)	The numerator is the number of long-stay residents (those who have been in the facility for over 100 days) who have been assessed with annual, quarterly, significant change or significant correction MDS 3.0 assessments during the selected time window and who have experienced restraint usage during the 7 days prior to the assessment, as indicated by MDS 3.0, Section P, Item 100, subitems b (P0100B – Trunk restraint used in bed), c (P0100C – Limb restraint used in bed), e (P0100E – Trunk restraint used in chair or out of bed), f (P0100F – limb restraints used in chair or out of bed), or g (P0100G – Chair prevents rising).	The numerator is the number of long-stay residents (those who have been in the facility for over 100 days) who have been assessed with annual, quarterly, significant change or significant correction MDS 3.0 assessments during the selected time window and who have experienced restraint usage during the 7 days prior to the assessment, as indicated by MDS 3.0, Section P, Item 100, subitems b (P0100B – Trunk restraint used in bed), c (P0100C – Limb restraint used in bed), e (P0100E – Trunk restraint used in chair or out of bed), f (P0100F – limb restraints used in chair or out of bed), or g (P0100G – Chair prevents rising).	The denominator is the total of all long-stay residents in the nursing facility who have received an annual, quarterly, significant change or significant correction MDS 3.0 assessment during the quarter and who do not meet the exclusion criteria.	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Finalized for use in Nursing Home QIP and Nursing Home Compare. Under consideration for use in LTCH Quality Reporting Program **(MAP Supports)**
0689 Percent of Residents Who Lose Too Much Weight (Long-Stay)	The numerator is the number of nursing home residents with an MDS assessments (which may be an annual, quarterly, significant change or significant correction MDS assessment) that indicate a weight loss of 5% or more of resident's body weight in the last 30 days or 10% or more in the last 6 months that is not a result of a physician-prescribed weight-loss regimen.	The numerator is the number of nursing home residents with an MDS assessments (which may be an annual, quarterly, significant change or significant correction MDS assessment) that indicate a weight loss of 5% or more of resident's body weight in the last 30 days or 10% or more in the last 6 months that is not a result of a	The denominator uses MDS assessments (which may be an annual, quarterly, significant change or significant correction assessments), except for residents with only an admission (OBRA) assessment and residents	Nursing home (NH) /Skilled Nursing Facility (SNF)	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**

Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		physician-prescribed weight-loss regimen.	for whom data on weight loss is missing. Residents with only an admission (OBRA) assessment are excluded because they have not been in the facility long enough to have had weight loss assessed or attributed to care in the facility.		
0690 Percent of Residents Who Have Depressive Symptoms (Long-Stay)	Using the PHQ-9 items in the MDS 3.0, for the Resident Interview Measure (Item D0200), the numerator is based on the total sum severity score (D0300) on the most recent MDS assessment in the selected quarter (which may be an annual, quarterly, significant change, or significant correction assessment). The total severity score reflects resident responses to questions asking about the frequency of nine symptoms over the last 2 weeks, including interest, mood, energy, appetite, self-value, ability to concentrate, change in responsiveness, or patience. The Staff Assessment Measure (Item D0500) is similar, except the judgment is being made by observers rather than the residents themselves. The numerator is calculated by using data from item D0300, the total self-reported depression severity score. While the self-report data are preferred, if data from D0300 are incomplete or unavailable then the numerator will be calculated using data from item D0600.	Using the PHQ-9 items in the MDS 3.0, for the Resident Interview Measure (Item D0200), the numerator is based on the total sum severity score (D0300) on the most recent MDS assessment in the selected quarter (which may be an annual, quarterly, significant change, or significant correction assessment). The total severity score reflects resident responses to questions asking about the frequency of nine symptoms over the last 2 weeks, including interest, mood, energy, appetite, self-value, ability to concentrate, change in responsiveness, or patience. The Staff Assessment Measure (Item D0500) is similar, except the judgment is being made by observers rather than the residents themselves. The numerator is calculated by using data from item D0300, the total self-reported depression severity score. While the self-report data are preferred, if data from D0300 are incomplete or unavailable then the numerator will be calculated using data from item D0600.	The denominator is the total number of all long-stay residents in the nursing facility who have received an MDS assessment (which may be an annual, quarterly, significant change or significant correction assessment) during the selected quarter (3-month period) and who do not meet the exclusion criteria.	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Finalized for use in Nursing Home QIP and Nursing Home Compare **(MAP Supports)**

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
0719 **Children Who Receive Effective Care Coordination of Healthcare Services When Needed**	This is a composite measure used to assess the need and receipt of care coordination services for children who required care from at least two types of health care services which may require communication between health care providers, or with others involved in child's care (e.g. school).	"Patients or their caregiver(s) who received a reconciled medication list at the time of discharge including, at a minimum, medications in the following categories: Medications to be TAKEN by patient: - Continued* Medications prescribed before inpatient stay that patient should continue to take after discharge, including any change in dosage or directions AND - New* Medications started during inpatient stay that are to be continued after discharge and newly prescribed medications that patient should begin taking after discharge * Prescribed dosage, instructions, and intended duration must be included for each continued and new medication listed Medications NOT to be Taken by patient: - Discontinued Medications taken by patient before the inpatient stay that should be discontinued or held after discharge, AND - Allergies and Adverse Reactions Medications administered during the inpatient stay that caused an allergic reaction or adverse event and were	Children age 0-17 years who used two or more health services in the past 12 months	Other	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
		therefore discontinued"			
1617 Patients Treated with an Opioid who are Given a Bowel Regimen	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed	Vulnerable adults who are given a new prescription for an opioid	Ambulatory Care : Clinician Office, Hospital/Acute Care Facility	Under consideration for use in Hospice Quality Reporting Program **(MAP Supports)**
1623 Bereaved Family Survey	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. 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	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 your 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.	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	Hospice, Post-Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
	Affairs Health Care system because he 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 year, 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		addresses on file); 2) absence of a working telephone available to the family member.		

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
	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 adddditional 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.				
1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	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	Patients from the denominator who have their ICDs deactivated prior to death or have documentation of why this was not done	Patients who died an expected death who have an ICD in place	Hospital/Acute Care Facility	
1626 Patients Admitted to ICU who Have Care Preferences Documented	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.	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.	All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission.	Hospital/Acute Care Facility	
1630 Hospitalized Patients Who	Percentage of hospitalized patients who died an expected death who had dyspnea in the last 7 days of life and who had documentation that	Percentage of patients with dyspnea from the denominator who on any day(s) during the denominator time	Hospitalized patients who died an expected death and who had dyspnea in the 7	Hospital/Acute Care Facility	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
Die an Expected Death Who Have Dyspnea Addressed	they received dyspnea care and follow up	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	days prior to death		
1632 **CARE - Consumer Assessments and Reports of End of Life**	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	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.	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	Home Health, Hospice, Hospital/Acute Care Facility, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	

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Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
	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.				

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
	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				

Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	**Measure Description**	**Numerator**	**Denominator**	**Care Setting**	**Use in Federal Programs**
	Website. J Pain Symptom Manage. 2005 Jul 2005;30(1):9-17.				
1634 **Hospice and Palliative Care -- Pain Screening**	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.	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.	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.	Hospice, Hospital/Acute Care Facility	Under consideration for use in Hospice Quality Reporting Program **(MAP Supports)**
1637 **Hospice and Palliative Care -- Pain Assessment**	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.	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.	Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.	Hospice, Hospital/Acute Care Facility	Under consideration for use in Hospice Quality Reporting Program **(MAP Supports)**
1638 **Hospice and Palliative Care -- Dyspnea Treatment**	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.	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.	Hospice, Hospital/Acute Care Facility	Under consideration for use in Hospice Quality Reporting Program **(MAP Supports)**
1639 **Hospice and Palliative Care -- Dyspnea Screening**	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.	Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.	Hospice, Hospital/Acute Care Facility	Under consideration for use in Hospice Quality Reporting Program **(MAP Supports)**
1641 **Hospice and Palliative Care – Treatment Preferences**	Percentage of patients with chart documentation of preferences for life sustaining treatments.	Patients whose medical record includes documentation of life sustaining preferences	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.	Hospice, Hospital/Acute Care Facility	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
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.	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.	Number of patients with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss.	Total number of patients discharged from hospice care during the designated reporting period.	Hospice	
1894 Cross-cultural communication domain of the Communication Climate Assessment Toolkit	Site score for "cross-cultural communication" domain of Communication Climate Assessment Toolkit (C-CAT), 0-100.	Cross-cultural communication component of patient-centered communication (aka socio-cultural context): an organization should create an environment that is respectful to populations with diverse backgrounds; this includes helping its workforce understand sociocultural factors that affect health beliefs and the ability to interact with the health care system. Measure is scored on 3 items from the C-CAT patient survey and 16 items from the C-CAT staff survey. Minimum of 100 patient responses and 50 staff responses.	There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure must obtain at least 50 staff responses and at least 100 patient responses.	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Hospital/Acute Care Facility	
1898 Health literacy domain of Communication Climate Assessment	Site score on the domain of "health literacy" of the Communication Climate Assessment Toolkit (C-CAT), 0-100.	Health literacy component of patient-centered communication: an organization should consider the health literacy level of its current and potential populations and use this information to	There are two components to the target population: staff (clinical and nonclinical) and patients. Sites using this measure	Ambulatory Care : Clinic/Urgent Care, Ambulatory	

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Available NQF-endorsed Hospice/EOL/Palliative Care Measures

Measure Title / Number	Measure Description	Numerator	Denominator	Care Setting	Use in Federal Programs
Toolkit		develop a strategy for the clear communication of medical information verbally, in writing and using other media. Measure is scored based on 15 items from the patient survey of the C-CAT and 13 items from the staff survey of the C-CAT. Minimum of 100 patients responses and 50 staff responses.	must obtain at least 50 staff responses and at least 100 patient responses.	Care : Clinician Office, Hospital/Acute Care Facility	

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MEASURE GAPS

Identified by *National Voluntary Consensus Standards: Palliative Care and End of Life Care: A Consensus Report: Appendix C (2011)*

Cross-Cutting Issues
The need for a common denominator to identify palliative care patients across settings would enable measurement of important aspects of care (e.g., pain in cancer patients, pain in hospice patients, and pain in the vulnerable elderly) and further promote harmonization.
The systematic exclusion of patients who have died, who have very serious illness, or are discharged to hospice from many hospital-specific measures limits the applicability of important measures to populations for whom the focus of the measure is appropriate. These exclusions should be examined to determine whether they unintentionally exclude very relevant populations.
Composite measures of outcomes and process.
Measures that assess the narrative skills of healthcare providers to ensure that the values and goals of patients are addressed and integrated into their care.

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

Quality of Life
Measures that assess quality of life for all patients, and not just those seen by palliative care or hospice teams.
Measures that look at quality of life across the continuum of care, including the outpatient setting or nursing homes.
Outcome measures on end-of-life care that allow for benchmarking.
Measures that incorporate the use of post-mortem surveys.
Process measures related to communication of critically ill patients; for example, ICU family meetings.
Measures addressing children or young adults, for example, minors with decision making capacity; the presence or availability of hospices with expertise to care for children; the availability of functional services such as occupational therapy (OT), physical therapy (PT), and child life educational support services in the community for critically ill children and families.
Measures of cultural and linguistic competence in delivering palliative and end-of-life care.
Measures addressing psychosocial and spiritual end-of-life care.
Measures that assess earlier and more holistic integration of palliative care into patients' treatment regimens.
Measures addressing patients' functional status.

Family/Caregiver Experience of Care
Measures of after-death care regarding treatment of the body and treatment of the patient’s family.
Measures reflecting education of the patient’s family on the signs and symptoms of imminent death.
Measures about education and support of caregivers, particularly regarding the dying episode.

Process Measures in Palliative and End of Life Care
Measures of resource use and efficiency in hospice care.
Measures of artificial hydration and nutrition.
Communication measures reflecting clarity of prognosis.
Measures reflecting the interdisciplinary nature and training of the palliative care team, including spiritual and psychosocial care needs.
Measures of palliative care for chronically ill patients who are not at the end of life.

The Workgroup will also use "*Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care*" an article in The Milbank Quarterly by Diane E. Meier as background material.

You can access the article at the following:
http://www.milbank.org/quarterly/8903feat.pdf

National
Priorities
Partnership
*Convened by the
National Quality Forum*

PALLIATIVE CARE AND END-OF-LIFE CARE CONVENING MEETING

SYNTHESIS REPORT

NOVEMBER 2010

NATIONAL PRIORITIES PARTNERSHIP
Convened by the National Quality Forum

PALLIATIVE CARE AND END-OF-LIFE CARE CONVENING MEETING SYNTHESIS REPORT

This report provides a high-level synthesis of a meeting conducted as part of the efforts of the National Priorities Partnership workgroups. The purpose of this meeting was to identify actions that drive toward improved assessment and management of patients' physical symptoms and the patients' and families' psychosocial needs, as well as improve communication and coordination of care across healthcare settings for patients with chronic, advanced, and terminal illnesses.

I. INTRODUCTION

In its 2008 report, *National Priorities & Goals—Aligning Our Efforts to Transform America's Healthcare*,[1] the National Priorities Partnership (NPP) identified six National Priorities that, if addressed, would significantly improve the quality of care delivered to Americans. Palliative care and end-of-life care were included amongst these priorities with the aim of guaranteeing appropriate and compassionate care for patients with chronic, advanced, and terminal illnesses. More specifically, NPP identified goals emphasizing access to palliative care and end-of-life care; effective provider-patient communications; relief of physical suffering; and psychological, social, and spiritual support for patients with chronic and life-limiting illnesses.

Identifying priority areas is only the first step in improving the care experience. For real change to occur, effective action steps must be identified, shared, and implemented widely. To address the goals of each priority area, NPP established workgroups to provide guidance for developing comprehensive action plans to drive change. In response to this charge, the Palliative Care and End-of-Life Care Workgroup convened a meeting of key stakeholders on November 2, 2010, in Washington, DC. Appendix A includes the list of meeting participants. The purpose of the workshop was to develop specific actions for NPP Partners and others to consider—actions that would have the greatest potential to address the palliative care and end-of-life care goals. The workshop participants used this two-part strategy to develop their action plan:

- identify environmental barriers to achieving these goals and develop a plan to address these barriers, including specific actions that NPP and other stakeholders can take, focusing on identified drivers; and
- address infrastructure issues, including performance measurement, workforce competencies, and health information technology (health IT).

In preparation for this meeting, Diane Meier, MD, authored a context-setting white paper titled *Improving Healthcare Quality through Increased Access to Palliative Care and Hospice Services,* which is included in Appendix B. The paper provided background on the current state of hospice care and palliative care and identified actions to improve access to care for all patients in need of such services. It also noted opportunities to strengthen access to quality palliative care and hospice services included in the Affordable Care Act (ACA). Broadly, these opportunities include the development and implementation of programs to educate and train healthcare professionals in pain management; new requirements for hospices, long-term care hospitals, and rehabilitation hospitals to publicly report quality information; and the establishment of a value-based purchasing program pilot for hospices and long-term care hospitals. Participants received the paper before the workshop to stimulate discussion during the meeting and to help them lay out an evidence-based approach to use as a basis for developing their recommended action plan.

Informed by Dr. Meier's white paper, this report offers a high-level synthesis of the workshop, including key drivers and concrete action steps for NPP Partners and other stakeholder groups that promote shared accountability and that can foster change. For the purposes of this paper, the term "palliative care" will be used to represent the continuum of palliative care services including the management of patients with complex and chronic conditions upstream as well as those approaching end-of-life.

II. KEY MEETING THEMES

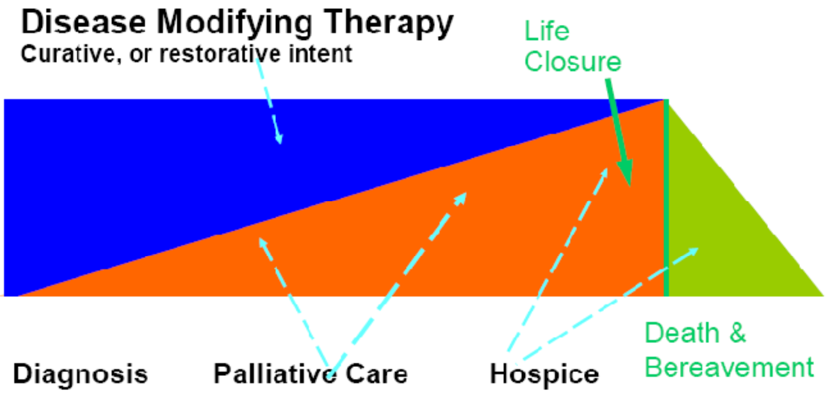
Defining Palliative Care and Improving Public Understanding

Perhaps the most important theme to emerge during the workshop was the importance of clarity of message around the goals of palliative care. Having a clear and unified message is central to changing current public views that palliative care is equivalent to end-of-life care and to dispelling misconceptions that arose during the health reform debate that palliative care involves healthcare rationing and “death panels.” If such fears and misperceptions persist, efforts to improve access and quality will fail as a result of continued underutilization. It is important that a precise, consistent, and shared definition of palliative care is embraced and conveyed by all healthcare professionals and communicated effectively to patients and their families and to the public as a whole. To improve public understanding, palliative care must be accurately portrayed as care that espouses patient- and family-centered care, with the goal of optimizing quality of life by anticipating, preventing, and treating suffering throughout the full continuum of an illness.

A comprehensive definition of palliative care must balance the standardization of core tenets but also allow for customization that is responsive to patient and family caregiver values and preferences, which vary greatly based on many issues, including ethnic and cultural background. Patient- and family-centered palliative care must include a plan of care that emphasizes relief from pain and other debilitating physical symptoms but also attends to emotional, social, and spiritual needs. All of these aspects must be addressed to ensure that high-quality palliative care is being delivered to promote the best possible quality of life. Additionally, it is important to convey that the provision of palliative care services occurs along a continuum, with initiation taking place relatively early in the disease process and continuing throughout an illness, whether the illness is chronic, advanced, or terminal in nature.

As illustrated in Figure 1 below, in the early stages following a diagnosis of a serious illness, therapy is largely curative, with palliative care introduced when necessary to ensure the patient is able to maintain a good quality of life. During the majority of time along the palliative care continuum, patients continue to receive life-prolonging treatment. As an illness progresses, however, palliative therapies may increase as curative interventions decrease to coincide with the patient’s choices and preferences. Once a patient reaches a point at which the decision is made to forego life-prolonging therapies and instead focus on comfort at the end-of-life, hospice care is the form of palliative care provided.

Figure 1
Conceptual Shift for Palliative Care[2]



Importantly, regardless of when palliative care is initiated in the disease process, it is imperative that providers ensure that the goals and values of the patients and their families are jointly made, incorporated in all healthcare decisions, and fully documented in a plan of care. The palliative care plan should follow a patient throughout the illness and be updated regularly to ensure his or her needs and preferences continue to be met, as they may change over time. Doing so will foster a seamless palliative care experience for patients and their families.

Access to Quality Palliative Care

Although multiple factors contribute to variability in access to high-quality palliative care, a primary barrier is the lack of healthcare professionals in the current workforce trained in core elements of palliative care. Current data suggest a significant shortage of palliative medicine specialists, with only one palliative specialist for every 31,000 people with serious advanced illness[3] compared to one cardiologist for every 71 heart attack victims.[4] Additionally, availability of palliative care services varies widely across states, making access even more difficult depending on where patients live. To counter this shortage, it is important to move toward a workforce of health professionals with basic competencies in palliative care and an increased number of specialists in this discipline.

Taking workforce issues a step further, it is essential that healthcare professionals are trained to deliver palliative care services in a culturally competent manner to address variation in use of palliative care and hospice services across ethnic and racial groups. In 2009, 80 percent of hospice patients were white (whites make up only 66 percent of the general population[5]), compared to 8.7 percent African American, and 1.9 percent Asian, Hawaiian, or Pacific Islander.[6] Patients' cultural or religious beliefs may prevent them from fully considering palliative care due to misperceptions about what it entails. Healthcare practitioners need to be able to discuss patients' religious faith and personal beliefs and values early in the disease process, taking into account their unique values and perspectives so they can make informed decisions about the initiation of palliative care and the extent of services to receive. In addition to sensitizing and educating providers to issues of cultural diversity, a more diverse workforce should be recruited.

It is important to acknowledge that the palliative care continuum applies to the pediatric patient population as well. Although the pediatric model of care inherently supports the provision of palliative care services through its support of the physical, developmental, emotional, and social needs of patients and their families, there is a greater lack of palliative care specialists for the pediatric population. The pediatric workforce also should have basic palliative care competencies and be able to access specialists when necessary, particularly to address the needs of children facing illnesses—which are inherently different from those of adults—as well as their parents due to the complexity and particularly sensitive nature of parental grief and bereavement.

Community Partnerships

The needs of patients with complex illnesses and their family members are not just healthcare issues, but also community issues with far-reaching implications. To provide palliative care as outlined above—care that addresses physical, emotional, social, and spiritual needs of patients—supports outside of the traditional settings of the healthcare delivery system and within the broader community are necessary.

A convincing argument was made at the workshop that palliative care is a workplace issue for employees with chronic illness or for employees who are caregivers of patients, whether children, elderly parents, or other family members. With the average age of retirement climbing, more people in the workplace will be faced with a personal illness or need to care for a sick or aging loved one. This situation poses challenges for the employee, but also for the employer in terms of productivity and absenteeism. The challenge is to identify ways to incorporate these issues into corporate conversations. It was acknowledged that the workplace may not be the ideal setting for comprehensive discussions about serious illness or end-of-life care, but conversations can certainly start there. An employer can begin simply by building awareness around palliative care services and resources and then expand to include more specific offerings to support employees, such as coping mechanisms and skills to help in handling grief. Building palliative care into employee assistance programs can connect employees to available support services that may otherwise go untapped. Employers are recognizing that offering such resources—and relieving some of the burden on patients or caregivers—actually can benefit both the employee and the organization.

Collaborating with community-based organizations, such as churches or senior centers, offers another opportunity for developing partnerships to improve public health through an improved understanding of palliative care. Engaging leaders in the religious community and educating them about palliative care, for example, may encourage them to discuss such services openly when approached by a congregant facing an illness. Additionally, since many family caregivers seek the support of religious institutions and pastoral care, having well-educated staff and clergy offers an opportunity for open and informed conversations about palliative care and hospice care.

III. DRIVERS OF CHANGE AND MOVING TOWARD ACTION

Informed by workshop presentations and the commissioned white paper, participants identified a set of action steps to be taken across stakeholder groups to improve access to high-quality palliative care. Participants focused on NPP’s key drivers of change—payment, public reporting, performance measurement, and through a facilitated, iterative group process identified drivers and associated actions with the maximum potential to move toward desired outcomes. The following is a synopsis of the action plan formulated by the group. Appendix C provides a snapshot of the recommended action steps.

Driver: Informed Consumer Decisionmaking

Patients and their families encountering the healthcare system often feel ill equipped to involve themselves actively in their own care. Patients in need of palliative care services are no exception and, due to their complex needs, may require even greater assistance. To make the best decisions about their care, patients and their families need a fundamental and accurate understanding of palliative care, access to information that helps them to select care providers, and encouragement to be actively engaged in making decisions about their care.

Communication

Improving patient engagement and shared decisionmaking must start upstream by ensuring that the general public has a good understanding of palliative care. A multifaceted public education strategy must be developed that emphasizes the tenets of palliative care and its goals—from onset of illness through end-of-life care—and supports open communication between patients and their healthcare providers. Due to the sensitivities currently surrounding palliative care and end-of-life care issues, a campaign also would benefit from the stories of actual patients and caregivers who are often the strongest advocates for palliative care.

Public Reporting

In addition to a basic understanding of palliative care, patients need timely access to performance information to make informed choices. Information on the quality of palliative care programs and services needs to be available and oriented so that the information is meaningful to patients and helpful in making decisions about their care. Comparisons of alternative settings and providers are crucial in supporting informed decisionmaking about where to receive care and from whom. Having data available about patient outcomes and/or experience with hospice services in the home versus at a hospice center, for example, may help patients and their families determine the care setting that is best for them. Coupling objective comparative data with qualitative stories of patient and family experience may provide the most comprehensive picture of an organization’s care practices and therefore offer the most valuable information for making informed decisions about care.

Shared Decisionmaking

Finally, once patients have made a well-informed choice regarding their care provider, it is incumbent upon the healthcare professional to develop and maintain an open dialogue with the patient to ensure that all healthcare decisions are made together and with full knowledge of available options, including risks, benefits, and potential side effects. Working in partnership, the patient and provider establish and refine goals based on a mutual understanding of the trade-offs of more or less aggressive care as the disease progresses. Only with a full understanding of the anticipated outcomes can patients become actively engaged participants in selecting a preferred course of treatment and in making adjustments along the way.

Driver: Payment Incentives and Performance Measurement

To fully integrate palliative care into the healthcare system, structures must be established to support providers in delivering this care. High-quality palliative care needs to be incentivized and rewarded through existing payment models and those emerging from health reform and the Affordable Care Act. For this to happen, palliative care performance measures must be included in payment and public reporting programs to drive toward high-quality patient-centered care.

Payment Incentives

As new healthcare delivery and payment models take shape, integrating access to high-quality palliative care into new and existing models such as accountable care organizations (ACO) and patient-centered medical homes (PCMH) will be critical. These models can support the delivery of palliative care because of their emphasis on a multidisciplinary and multi-setting approach. Palliative care should be hardwired into payment programs, and performance metrics specific to palliative care incorporated into care delivery models. Importantly, the palliative care model offers key elements for consideration as requirements for the ACO and PCMH are further developed, including an uncompromising commitment to patient- and family-centered care, team-based care, and quality of life.

Additionally, there must be recognition of the value of shared decisionmaking and advance care planning, which are central to the palliative care model. Recent studies have shown that meaningful discussions between patients and providers on prognosis and patient goals demonstrably reduce costs and family burden.[7] The findings within this growing scientific evidence base need to be translated into emerging reimbursement structures and payment incentives. New and existing payment programs will need to support the necessary time and capacity required for health professionals to deliver this kind of care, which is inherently time-consuming but critical for the delivery of patient-centered care.

Performance Measurement

Workshop participants agreed there is a need for general palliative care measures—not related to any particular condition or diagnosis or setting—to measure quality and effectiveness of care over time. Such measures would include process measures aligning with workflows, longitudinal measures of outcomes and cost, measures of shared decisionmaking, and composite measures that capture multiple aspects of care. They should address the continuum of the patient's care from screening and assessment to determine the need for and appropriateness of palliative care services to patient-reported outcomes such as functional status and health-related quality of life.

Participants recognized the importance of collecting patient-derived data throughout an episode of care, acknowledging that this can be a delicate undertaking, particularly when obtaining feedback from patients who are very near the end of life or from family members who have lost a loved one. These perceptions and experiences offer insightful feedback as has been demonstrated by the Family Evaluation of Hospice Care survey.[8] Such information will help paint a more complete picture of the patient's palliative and end-of-life care experience, and offer continued opportunities for learning and improvement.

Driver: Accreditation, Certification, and Workforce Development

To provide high-quality palliative care to patients, a dedicated multidisciplinary team with an understanding of palliative care must be available and accessible. This team of health professionals must have the capacity to spend focused time with patients and family members to discuss the patient's values and preferences and then develop a comprehensive plan of care based on the stated needs and preferences. Developing such a plan would include offering clarity about the patient's diagnosis, setting realistic expectations regarding the disease process, ensuring shared and informed decisionmaking, and addressing any outstanding questions or concerns.

As noted earlier, there is a significant shortage of palliative medicine specialists as well as palliative care training programs—currently fellowship training for palliative medicine is unavailable in 20 states.[9] Outside of the palliative care community, many professionals within the healthcare industry do not fully understand palliative care, yet they are expected to initiate this care appropriately and make proper referrals. It is important to realize that addressing a shortage of this magnitude cannot be accomplished exclusively by expanding the number of palliative care specialists—it will require a two-pronged approach that promotes palliative competencies for all health professionals and provides incentives for specialty certification. For both basic and specialist training, it is critically important to develop innovative ways to reach mid-career professionals.

Specialized Training

To support the provision of high-quality palliative care as well as ensure a talented pool of faculty to train the healthcare workforce, developing new ways to support the education and training of healthcare professionals is essential, particularly for those already practicing in the field. Creative approaches to mid-career training and more flexible ways of obtaining board certification need to be considered. An alternative pathway could include a parallel path to an executive MBA program—a program with flexibility in coursework structure and minimal disruption of a professional's current practice. Another way of supporting the education of practicing health professionals could be to increase the allocation of funds for continuing and graduate medical education focusing on palliative care. Offering medical and graduate school loan forgiveness for physicians, advance practice nurses, and clinical social workers who seek subspecialty training in palliative medicine also may be an effective tactic to encourage health professionals to consider further specialization.

Core Competencies

With a persistent and severe shortage of palliative care specialists, developing a workforce with basic knowledge and competencies in palliative care will be necessary to impact access to palliative care in the near term. Increasing the number of fellowship programs and faculty to educate students and professionals about culturally competent palliative care is paramount. Employing a more business-like approach for faculty qualifications, such as years of experience in the palliative field in lieu of fellowship training, may offer an approach to increase the number of available faculty. In addition to incorporating core competencies into formal curricula, healthcare organizations can incorporate basic knowledge of palliative care into staff training and education programs, and professional organizations can offer programs on palliative care in their educational opportunities for their members.

Accreditation Programs

An alternative approach to addressing workforce concerns more broadly is to develop and implement palliative care accreditation programs, which can offer a formal structure to reinforce the importance of these services through incentives and recognition. Accreditation in palliative care can be further promoted through health plan contracting and benefit design for preferred providers, and the pursuit and maintenance of accreditation would encourage organizations to ensure a well-trained staff that is competent to provide high-quality palliative care on a day-to-day basis.

Driver: Research

In recent years, the research infrastructure has been growing and has demonstrated important links between palliative care and improved patient outcomes, improved patient and family experience of care, and reduced family burden and healthcare costs. Studies have shown that palliative care improves physical and psychosocial symptoms; family caregiver well-being; and patient, family, and physician satisfaction, while others illustrate that effective communication regarding prognosis and patient goals demonstrably reduces costs and family burden. More recent evidence even suggests that palliative care may be associated with a prolongation of life among certain patient populations.[10]

Despite these positive findings, inadequate funding is a major barrier to advancing this work and translating research into practice. Currently less than 1 percent of National Institute of Health funded grants focusing on cancer, dementia and diseases of the heart, lung, and kidney goes toward research related to palliative care.[11] Additional research funding would allow for the identification of approaches to address workforce and access issues; strategies for effective communication, messaging, and patient/family engagement; and approaches to integrating palliative care into new and existing care delivery models. The research community is an essential partner to further advance palliative care, particularly given the still relatively small number of health researchers dedicated to identifying effective and innovative ways to provide this care to diverse populations. Others in the healthcare community can support this effort through research grant funding, participating in clinical trials of new interventions, and serving as test sites for field studies.

Workshop participants cautioned against focusing only on quantitative research and stressed that qualitative research can contribute greatly to the evidence base. Health professionals may feel insensitive requesting a patient or family member to complete a survey on experience of care, particularly in a hospice setting, so gathering anecdotal feedback can help to fill those gaps. Storytelling by patients and their families as well as providers and health professionals can support the establishment of a strong, comprehensive evidence base. This information then can be used to educate consumers more broadly regarding palliative care and its benefits. As the evidence base supporting palliative care continues to grow, it is imperative to address barriers to translating proven approaches and methods into widely disseminated practice.

IV. PATH FORWARD

As the Secretary of Health and Human Services finalizes the National Quality Strategy as required under the Affordable Care Act, NPP intends to offer its full support of the priorities and goals that will support the three aims to promote better care, affordable care, and healthy people/healthy communities. NPP's Palliative Care and End-of-Life Care Workgroup recognizes the opportunity to support these three aims through improved access to high-quality palliative care, particularly given the demonstrated links between palliative care and improved patient outcomes and satisfaction; evidence of improved outcomes and better use of resources at end of life through a patient-centered approach to care; and opportunities for partnerships within communities to improve population health through care that is concordant with patient preferences and that emphasizes high quality of life.

The key drivers and associated actions presented in this report are offered as a starting point to improve provider-patient communications, relief of physical suffering, and psychological, social, and spiritual support for patients with chronic, advanced, and terminal illnesses. Opportunities exist to further align efforts with provisions put forth in the Affordable Care

Act, particularly in response to requirements to establish a value-based purchasing program pilot for hospices. Additional opportunities exist under ACA for the development and implementation of programs to educate and train healthcare professionals in pain care and to address cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations.

The path forward will require further exploration and operationalization of the identified action steps to improve access to high-quality palliative care and end-of-life care. It is hoped, however, that any stakeholder group can identify an opportunity for implementation and subsequently take specific and immediate action.

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[1] National Priorities Partnership, *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare,* Washington, DC: National Quality Forum; 2008.

[2] NHWG; Adapted from work of the Canadian Palliative Care Association and Frank Ferris, MD.

[3] Morrison RS, Dietrich, J and Meier DE. America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals. Center to Advance Palliative Care: 2008. Available at: http://www.capc.org/reportcard/state-by-state-report-card.pdf. Last accessed December 2010.

[4] Ibid.

[5] US Census Bureau. Available at www.census.gov/newsroom/releases/archives/population/cb07-70.html. Last accessed January 2011.

[6] National Hospice and Palliative Care Organization Facts and Figures: Hospice Care in America; 2010. Available at www.nhpco.org/files/public/Statistics_Research/Hospice_Facts_Figures_Oct-2010.pdf. Last accessed January 2011.

[7] Zhang B, Wright AA, Huskamp HA, et al. Health care costs in the last week of life: associations with end-of-life conversations. Arch Intern Med. Mar 9 2009;169(5):480-488.

Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. Jama. Oct 8 2008;300(14):1665-1673.

[8] FEHC

[9] Morrison RS, Dietrich, J and Meier DE.

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

[11] Gelfman LP, Morrison RS. Research funding for palliative medicine. J Palliat Med. Jan-Feb 2008;11(1):36-43.

APPENDIX A
NATIONAL PRIORITIES PARTNERSHIP

PALLIATIVE CARE AND END-OF-LIFE CARE CONVENING MEETING ATTENDEES
NOVEMBER 2010

NATIONAL PRIORITIES PARTNERSHIP
Convened by the National Quality Forum

PALLIATIVE CARE AND END-OF-LIFE CARE CONVENING MEETING

INVITED PARTICIPANTS

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Helen Darling (Co-Chair)
National Business Group on Health, Washington, DC

Kevin Bain
Pharmacy Quality Alliance, Inc., Fairfax Station, VA

Ahmed Calvo
Department of Health and Human Services, Rockville, MD

Susan Cox
Hospice and Palliative Care of Greensboro, Greensboro, NC

Joyce Dubow
AARP, Washington, DC

Lynn Feinberg
National Partnership for Women & Families, Washington, DC

Nancy Foster
American Hospital Association, Washington, DC

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NATIONAL PRIORITIES PARTNERSHIP
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APPENDIX B
NATIONAL PRIORITIES PARTNERSHIP

Improving Healthcare Quality through Increased Access to Palliative Care and Hospice

Diane Meier, MD

(Pending submission for publication--to be included upon acceptance)

APPENDIX C
NATIONAL PRIORITIES PARTNERSHIP

PALLIATIVE CARE AND END-OF-LIFE CARE DRIVERS AND ACTIONS

National Priorities Partnership
Palliative Care and End-of-Life Care Workgroup Draft Action Plan

	Drivers				
	Informed Consumer Decisionmaking	**Payment Incentives**	**Performance Measurement**	**Accreditation, Certification, and Workforce Development**	**Research**
Recommended Actions	Increase consumer awareness, education, and access to palliative care and hospice program information through the dissemination resources that better equip patients to be actively involved in their care. Increase consumer awareness to dispel myth that death panels are included in the Affordable Care Act. Formulate comparative information across alternative settings that is available to the public (e.g., quality of palliative care across home health, hospital, nursing home). Tailor public reporting to be more actionable for patient decisionmaking. Target inconsistent messaging to stress that palliative care: » emphasizes the matching of treatment to patient goals; » is not only limited to those who are dying; and » is a continuum that includes, but is not limited to end-of-life care. Create an outlet for the sharing of patient and family experience stories and lessons learned.	Align payment incentives with accountable care organization (ACO) and patient-centered medical home (PCMH) requirements for the capacity to deliver quality palliative care and end-of-life care. Create incentives for the development of advance care planning that is shared and honored across settings (i.e., advance care planning is not another legal document but rather a plan that is jointly developed, and shared and honored across settings). Align payment incentives to ensure completion of advance care planning (e.g., failure to execute advanced care planning should be seen as an error). Promote the formation and support of collaborative and strategic public-private partnerships between providers, health plans, employers, and others.	Advise all stakeholders on which measures most salient to palliative care and end-of-life care should be integrated into ACOs, PCMHs, and bundled payment models. Emphasize the collection of health-related qulaity of life (HRQoL) and functional status data from patients, clinicians and health systems and couple electronic health records (EHR) that contain provider-reported data with patient-generated data on HRQoL and experience. Develop a balanced set of metrics along a continuum that includes: » screening, assessment, care planning, monitoring, and outcomes; » longitudinal measures; » composites (roll up and drill down); » process measures concordant with workflows; and » monitoring of unintended consequences of simplifying a complex interaction. Link process (assessment) and outcome (improvement) measures, e.g., routine pain assessment not associated with higher quality management.	Increase the hospice care and palliative care workforce across settings, (e.g., medical centers, hospices, and long term care settings) to address extremely low patient:provider ratios (1 palliative care medicine specialist per 31,000 people with life limiting illness). Establish alternate pathways for mid-career physicians and allow board certification pathways to be more flexible (e.g., parallel path to executive MBA program). Direct graduate medical education funding to support palliative care training. Establish medical and graduate school loan forgiveness for physicians, advance practice nurses, and clinical social workers who seek subspecialty training in palliative care medicine. Develop expectations of basic palliative care skills for all clinicians (e.g., through maintenance of certification and upstream training).	Increase proportion of National Institutes of Health (NIH) and Agency for Healthcare Research and Quality (AHRQ) funding for palliative care and hospice research (e.g., increase from current 1 percent NIH funding). Conduct translational research to move research into practice. Develop tools and incentives to enable and encourage individuals to have in- depth conversations about their care (e.g., What are triggers for palliative care or hospice care? When should an in-depth conversation take place? Who should initiate it?).
Implementers	Consumer groups Healthcare professionals and providers Health plans Public and private purchasers	Employers Large provider organizations and hospitals Consumer groups Health plans Public and private purchasers Federal, state, and local government agencies	Measure developers Specialty societies Research community accreditors NQF Public and private funders Quality alliances	Communities and public health agencies Healthcare professionals and providers Health plans Public and private purchasers Policymakers Universities	Communities and public health agencies Consumer groups Healthcare professionals and providers Health plans Public and private purchasers Policymakers

NQF

NATIONAL QUALITY FORUM

A National Framework and Preferred Practices for Palliative and Hospice Care Quality

A
CONSENSUS
REPORT

A National Framework and Preferred Practices for Palliative and Hospice Care Quality

Executive Summary

The number of palliative care and hospice programs has grown rapidly in recent years, as a result of the recognition of the unique constellation of skills that are required to manage the symptoms and needs of seriously sick patients, including those who are terminally ill, and the growth in the population living with chronic, debilitating diseases. Although the provision of this specialized care occurs at all levels of the healthcare system, it frequently requires the input of specialized teams. The National Quality Forum (NQF) acknowledged the importance of palliative care and hospice programs when it made them national priority areas for healthcare quality improvement.[1]

In order to ensure that palliative care and hospice services are of the highest quality, NQF envisions a quality measurement and reporting system focused on these critical areas. As a first step in deriving this system, NQF, with support from the Robert Wood Johnson Foundation and the Department of Veterans Affairs, has endorsed a framework to guide the selection of a comprehensive measure set and a set of preferred practices related to palliative and hospice care. Also identified are areas where research is required to fill the gaps in a measurement system.

In developing the framework, which used the National Consensus Project for Quality Palliative Care's (NCP's) *Clinical Practice Guidelines for Quality Palliative Care* as the starting point, NQF used the following definitions:

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[1] National Quality Forum (NQF), *National Priorities for Healthcare Quality Measurement and Reporting: A Consensus Report,* Washington, DC: NQF; 2004.

> *Palliative care* refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.
>
> *Hospice care* is a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition. It also supports family members coping with the complex consequences of illness, disability, and aging as death nears. Hospice care further addresses the bereavement needs of the family following the death of the patient.

Of particular importance, palliative care services are indicated across the entire trajectory of a patient's illness and its provision should not be restricted to the end-of-life phase.

The palliative care and hospice framework that is presented in the first chapter of this report provides the foundation upon which a quality measurement and reporting system should be built. It identifies 12 structural and programmatic elements as essential to the performance of sound programs: interdisciplinary teams; diverse models of delivery, bereavement programs; educational programs; patient and family education; volunteer programs; quality assessment/performance improvement; community outreach programs; administrative policies; information technology and data gathering; methods for resolving ethical dilemmas; and personnel self-care initiatives.

The framework served as a road map for the identification of a set of NQF-endorsed™ preferred practices, presented in chapter 2, that should fulfill the needs of a comprehensive evaluation and reporting program and ensure that palliative and hospice care are safe, beneficial, timely, patient centered, efficient, and equitable. Over the past three decades, barriers and facilitators to the provision of optimal palliative and hospice care have been studied, developed, and identified. And although palliative and hospice care programs ultimately respond to the unique demands of their local communities, a set of preferred practices can serve as the building blocks for high-quality programs across many practice settings and as the basis for developing performance measures.

The 38 preferred practices presented in this report (see table 1) have been endorsed as suitable for implementation by palliative care and hospice programs. They were derived from NCP's eight domains of quality palliative and hospice care:

- structures and processes of care;
- physical aspects of care;
- psychological and psychiatric aspects of care;
- social aspects of care;
- spiritual, religious, and existential aspects of care;
- cultural aspects of care;
- care of the imminently dying patient; and
- ethical and legal aspects of care.

Finally, during the course of this study, gaps in the knowledge base addressing palliative and hospice care were identified. An agenda for further research is presented in chapter 3 in the hope that this will expedite the development of a comprehensive measurement and reporting system for palliative care and hospice services.

Table 1 – Preferred Practices

1. Provide palliative and hospice care by an interdisciplinary team of skilled palliative care professionals, including, for example, physicians, nurses, social workers, pharmacists, spiritual care counselors, and others who collaborate with primary healthcare professional(s).
2. Provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, 7 days a week.
3. Provide continuing education to all healthcare professionals on the domains of palliative care and hospice care.
4. Provide adequate training and clinical support to assure that professional staff are confident in their ability to provide palliative care for patients.
5. Hospice care and specialized palliative care professionals should be appropriately trained, credentialed, and/or certified in their area of expertise.
6. Formulate, utilize, and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals, and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.
7. Ensure that upon transfer between healthcare settings, there is timely and thorough communication of the patient's goals, preferences, values, and clinical information so that continuity of care and seamless follow-up are assured.
8. Healthcare professionals should present hospice as an option to all patients and families when death within a year would not be surprising and should reintroduce the hospice option as the patient declines.
9. Patients and caregivers should be asked by palliative and hospice care programs to assess physicians'/healthcare professionals' ability to discuss hospice as an option.
10. Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.
11. Provide education and support to families and unlicensed caregivers based on the patient's individualized care plan to assure safe and appropriate care for the patient.
12. Measure and document pain, dyspnea, constipation, and other symptoms using available standardized scales.
13. Assess and manage symptoms and side effects in a timely, safe, and effective manner to a level that is acceptable to the patient and family.
14. Measure and document anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms using available standardized scales.
15. Manage anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms in a timely, safe, and effective manner to a level that is acceptable to the patient and family.
16. Assess and manage the psychological reactions of patients and families (including stress, anticipatory grief, and coping) in a regular, ongoing fashion in order to address emotional and functional impairment and loss.
17. Develop and offer a grief and bereavement care plan to provide services to patients and families prior to and for at least 13 months after the death of the patient.
18. Conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, to discuss goals of care, disease prognosis, and advance care planning, and to offer support.
19. Develop and implement a comprehensive social care plan that addresses the social, practical, and legal needs of the patient and caregivers, including but not limited to relationships, communication, existing social and cultural networks, decisionmaking, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, and access to medicines and equipment.
20. Develop and document a plan based on an assessment of religious, spiritual, and existential concerns using a structured instrument, and integrate the information obtained from the assessment into the palliative care plan.

Table 1 – Preferred Practices (continued)

21. Provide information about the availability of spiritual care services, and make spiritual care available either through organizational spiritual care counseling or through the patient's own clergy relationships.
22. Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.
23. Specialized palliative and hospice spiritual care professionals should build partnerships with community clergy and provide education and counseling related to end-of-life care.
24. Incorporate cultural assessment as a component of comprehensive palliative and hospice care assessment, including but not limited to locus of decisionmaking, preferences regarding disclosure of information, truth telling and decisionmaking, dietary preferences, language, family communication, desire for support measures such as palliative therapies and complementary and alternative medicine, perspectives on death, suffering, and grieving, and funeral/burial rituals.
25. Provide professional interpreter services and culturally sensitive materials in the patient's and family's preferred language.
26. Recognize and document the transition to the active dying phase, and communicate to the patient, family, and staff the expectation of imminent death.
27. Educate the family on a timely basis regarding the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate, and culturally appropriate manner.
28. As part of the ongoing care planning process, routinely ascertain and document patient and family wishes about the care setting for the site of death, and fulfill patient and family preferences when possible.
29. Provide adequate dosage of analgesics and sedatives as appropriate to achieve patient comfort during the active dying phase, and address concerns and fears about using narcotics and of analgesics hastening death.
30. Treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.
31. Facilitate effective grieving by implementing in a timely manner a bereavement care plan after the patient's death, when the family remains the focus of care.
32. Document the designated surrogate/decisionmaker in accordance with state law for every patient in primary, acute, and long-term care and in palliative and hospice care.
33. Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as conditions change.
34. Convert the patient treatment goals into medical orders, and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital care, through a program such as the Physician Orders for Life-Sustaining Treatment (POLST) program.
35. Make advance directives and surrogacy designations available across care settings, while protecting patient privacy and adherence to HIPAA regulations, for example, by using Internet-based registries or electronic personal health records.
36. Develop healthcare and community collaborations to promote advance care planning and the completion of advance directives for all individuals, for example, the Respecting Choices and Community Conversations on Compassionate Care programs.
37. Establish or have access to ethics committees or ethics consultation across care settings to address ethical conflicts at the end of life.
38. For minors with decisionmaking capacity, document the child's views and preferences for medical care, including assent for treatment, and give them appropriate weight in decisionmaking. Make appropriate professional staff members available to both the child and the adult decisionmaker for consultation and intervention when the child's wishes differ from those of the adult decisionmaker.

http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_Preferred_Practices_for_Palliative_and_Hospice_Care_Quality.aspx