

Palliative and End-of-Life Care Off-Cycle Measure Review 2017

TECHNICAL REPORT

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**NATIONAL
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Executive Summary

The NQF Palliative and End-of-Life Standing Committee oversees NQF's palliative and end-of-life care measure portfolio. This oversight function includes evaluating both newly submitted and previously endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing input on how the portfolio should evolve, and serving on any ad hoc, off-cycle, or expedited projects in the palliative and end-of-life care topic area. When not involved in the more traditional endorsement project activities, which usually include evaluation of 20 to 25 measures over a seven-month timeframe, the Committee is available for "off-cycle" activities. These can include any of the actions noted above, but are accomplished through an abbreviated format (e.g., evaluation of one or two measures over a shorter timeframe, quarterly web-based meetings to discuss various measurement issues).

This report summarizes the three tasks of the Committee's 2017 off-cycle activities: evaluation of one new measure against NQF's standard evaluation criteria, refinement of the measurement framework for palliative and end-of-life care, and pilot testing NQF's new prioritization criteria and framework for measures and gaps. The following measure was endorsed during these off-cycle activities:

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

A brief summary of the measure evaluated in this off-cycle review is included in the body of the report; a detailed summary of the Standing Committee's discussion and ratings of the criteria for the measure is included in [Appendix A](#).

Introduction

Consensus Development Process Off-Cycle Activities

Volunteer, multistakeholder committees are a key component of NQF's Consensus Development Process (CDP), and thus the success of the process is due in large part to the participation of its committee members. In 2013, NQF began transitioning to the use of standing committees for CDPs. These standing committees oversee NQF's various measure portfolios. This oversight function includes evaluating both newly submitted and previously endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing feedback on how the portfolio should evolve, and serving on any ad hoc or expedited projects in their designated topic areas.

When not involved in the more traditional endorsement project activities, which usually include evaluation of 20 to 25 measures over a seven-month timeframe, standing committees are available for “off-cycle” activities. These can include any of the actions noted above, as well as other activities such as serving as clinical or technical experts for other standing bodies (e.g., Measure Applications Partnership or cross-cutting measurement areas), collaborating with measure developers on gap filling, and participating in thoughtful discussion and activities on prospecting for new measures and addressing strategic measurement issues in the topic area. Typically, these off-cycle activities will be conducted via quarterly, two-hour web meetings or conference calls for each standing committee, as needed.

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

Refining NQF’s Measurement Framework for Palliative and End-of-Life Care

As part of its work in the 2015-2016 project, the Palliative and End-of-Life Care Standing Committee drafted a simplified version of the NQF measurement framework that was developed in 2006. The revised framework is a series of concentric circles that places the patient and family at the center of care. The next ring of the framework includes the various domains of care (e.g., psychological aspects, physical aspects). The third ring recognizes the various models of palliative and end-of-life care. Finally, the outside ring recognizes the overlapping nature of palliative, end-of-life, and bereavement care.

As part of its 2017 off-cycle work, the Committee revisited the framework and made the following changes (see [Appendix B](#)):

- Further described palliative care by differentiating two “types” of palliative care (“curative” and “chronic”) in the outer ring of the framework.
 - **Curative palliative care** is care provided alongside curative care, and includes care to help manage the disease or condition until it is cured, as well as manage side effects of curative treatment.
 - **Chronic palliative care** is care provided to those with noncurable conditions who are not near the end of life.
- Switched the label from “Models of Care” back to “Settings of Care” and combined hospice, nursing facility, and assisted living under an “institutional facility” entry. The Committee had previously chosen the “models” label primarily because of the inclusion of “hospice,” which is both a setting of care as well as a system of care. However, the Committee agreed that it would be difficult to include a comprehensive listing of the various models of care and was not convinced that various models of care would require different measures.
- Added two new domains: a *Safety* domain and the *Structure and Processes of Care* domain from the National Consensus Project. The Committee had initially omitted the *Structure and Processes of Care* domain from the framework because it seemed somewhat redundant with other elements in the framework. However, on further consideration, the Committee agreed that the domain is necessary because it reflects the need for a well-trained and supported

interdisciplinary team that develops and executes a plan of care in concert with the stated preferences, values, and goals and of the patient and family.

- Emphasized the need for measurement focused on the caregiver by adding the word “caregiver” to the middle ring of the framework.

The Committee also recognized that many important avenues for measurement may not be explicitly depicted in the current framework. For example, the concept of shared decision making is crucial, yet it is subsumed in the existing domains, particularly in the ethical/legal and structure and processes of care domains. Likewise, the Committee agreed that the concept of cost is included in the “Financial” domain, yet members also noted the need to consider measurement of cost from various perspectives, including the individual perspective of the patient and family as well as for the healthcare system as a whole. The Committee also agreed that concepts such as communication, transitions of care, and care coordination are important for measurement, as is the ability to measure longitudinally, although these are not explicitly included in the framework.

Palliative and End-of-Life Care Measure Evaluation

On March 8, 2017 the Palliative and End-of-Life Care Standing Committee evaluated one new measure against [NQF’s standard evaluation criteria](#).

Table 1. Palliative and End-of-Life Care 2017 Off-Cycle Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	0	1	1
Measures endorsed	0	1	1

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the [Quality Positioning System \(QPS\)](#). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. The pre-evaluation comment period was open from February 21, 2017 to March 27, 2017. NQF did not receive any pre-evaluation comments.

Comments Received After Committee Evaluation

The 30-day post-evaluation public and member commenting period was open from April 10, 2017 to May 10, 2017. During this period, NQF received a total of three comments from three member organizations. Comments included support for the measure recommended by the Committee, concern about the utility of the measure to drive improvement, and suggestions for amending the measurement framework.

Summary of Measure Evaluation

The following brief summary of the measure evaluation highlights the major issues that were considered by the Committee. Details of the Committee’s discussion and ratings of the criteria for the measure are included in [Appendix A](#).

3235 Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission (Centers for Medicare & Medicaid Services): Recommended

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

Because symptom management is the focus of care for patients enrolled in hospice, the assessment and treatment of physical, emotional, spiritual, and social needs must be both comprehensive and timely. This all-or-none composite measure assesses whether hospices perform all of seven critical care processes on admission (i.e., pain screening and assessment, dyspnea screening and treatment, ensuring receipt of a bowel regimen for patients on opioids, discussing spiritual or religious concerns, and discussing preferences for life-sustaining treatments). While the Committee recognized the empirical evidence base linking dyspnea treatment, bowel regimens, and communication regarding treatment preferences to improved patient outcomes, members acknowledged the lack of similar evidence for the other components of the measure and therefore agreed to invoke the exception to the evidence subcriterion for this composite measure. With almost one-quarter of hospices unable to meet the measure in 2016, the Committee agreed that there is an opportunity for improvement. The Committee agreed with the rationale behind the construct of the measure as an all-or-none composite and accepted the empirical analyses that supported its construction. The Committee agreed that the measure was reliable and valid. The Committee noted the feasibility of the measure, as well as the caregiver focus group results that suggested higher interpretability of the composite measure score. Because the seven components of the composite also are individual NQF-endorsed measures, NQF staff asked the Committee to consider whether endorsement of the individual measures is still needed if the composite is also endorsed. The Committee agreed that the individual measures hold considerable value as indicators of quality care on their own and should retain endorsement.

NQF received two comments on this measure. One commenter supported the measure. The second commenter suggested that performance on the measure was disproportionately driven by the “pain assessment” component and also noted that several of the components of the measure are not proximal to desired patient outcomes. The Committee agreed that that performance on the pain assessment component will drive a substantial amount of variation in performance for this composite. However, members also agreed that each of the components contributes to the overall composite and that the all-or-none construction of the composite will help to incentivize hospice providers to complete all of the care processes included in this measure.

Prioritizing Measures and Gaps

NQF's 2016-2019 Strategic Plan urges NQF to lead, prioritize, and collaborate to drive measurement that can result in better, safer, and more affordable healthcare for patients, providers, and payers. The plan also aims to reduce the redundancy and cost of measurement.

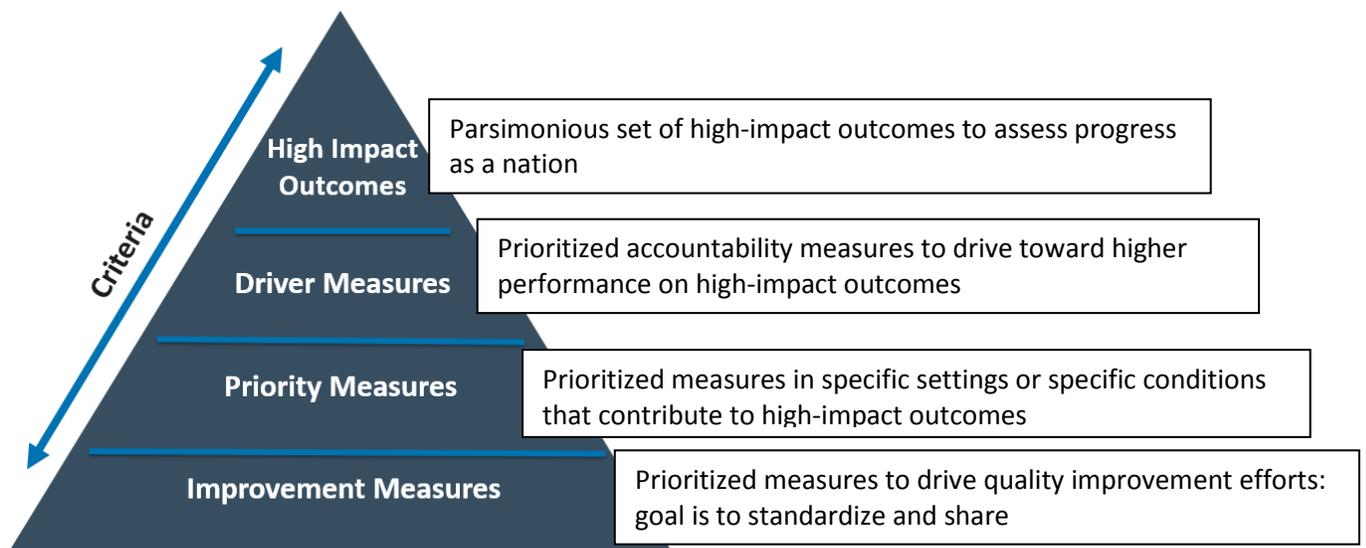
One of the key tasks of Strategic Plan is to identify the most important measures to improve U.S. healthcare. By identifying priority measures for the nation as a whole as well as for specific settings or populations, NQF can focus the quality community on specific metrics needed to improve the quality, safety, and affordability of care. This prioritization effort holds promise to yield fewer, more meaningful measures overall.

To accomplish this task, NQF staff identified four criteria for prioritizing measures and gaps in measurement, based on an environmental scan of prioritization efforts across the U.S. and the world:

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

To aid in prioritizing those measures that will effect the strongest change, NQF has proposed a pyramid-shaped organizing framework that includes high-impact outcomes at the apex, supported by driver measures, priority measures, and improvement measures (see Figure 1 below).

Figure 1. NQF Measurement Framework



The framework connects a small set of national, high-impact outcomes to accountability measures that will help drive performance improvement, as well as more micro-targeted quality improvement measures that should be standardized across settings.

NQF has identified an initial set of seven high-impact outcomes:

- Health outcomes (including functional/well-being and survival)
- Patient experience (including care coordination, shared decision making)
- Preventable harm/complications
- Prevention/healthy behaviors
- Total cost/low-value care
- Access to needed care
- Equity of care

During its May 30, 2017 post-comment call and via e-mail discussions after the call, the Palliative and End-of-Life Care Standing Committee pilot tested the prioritization criteria and approach by applying them to measures in NQF's Palliative and End-of-Life Care portfolio.

Committee responses to the approach was generally positive, although the application of the approach to palliative care measures helped to identify areas in need of greater clarity going forward. NQF staff is working to refine and finalize definitions for driver and priority measures and plans to develop driver diagrams for each high-impact outcome to ensure that the approach is replicable and adds value to NQF's core processes.

The following table presents the results of the pilot for palliative and end-of-life care measures. The number and title of NQF-endorsed measures that were prioritized by the Committee are included in the table; if an endorsed measure for a particular prioritized measurement concept is not available, the concept itself is listed in the table under the Gaps subheading. Not surprisingly, given the relatively few measures for this topic area, the Standing Committee identified many more gaps than currently endorsed driver, priority, or improvement measures. The Committee will re-visit the prioritization exercise in future discussions.

Table 2. Results of Pilot Testing of NQF Prioritization Criteria and Framework for Palliative and End-of-Life Care

High-impact outcome	Driver measures	Priority measures	Improvement measures
<p>Health outcomes (function/well-being and survival)</p>	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Preservation of functional status • Total pain (including spiritual pain) • Psychosocial health • Unmet need (e.g., through iPOS instrument) 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Quality of life (e.g., through single item self-report of quality of life as in McGill QOL Survey) 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • #3235 Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Screening for depression, anxiety, etc. • Access to nutritional support
<p>Patient experience</p>	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Goal-concordance • Shared decision making • Comfort with decisions that are made (e.g., less decisional conflict) • Patient/family engagement 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • #0326 Advance Care Plan • #1626 Patients Admitted to ICU Who Have Care Preferences Documented • #1623 Bereaved Family Survey • #2651 Experience with Care Measures from the Hospice CAHPS Survey <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Values conversation that elicits goals of care • Good communication (e.g., prognosis, health literacy, clarity of goals for all parties) 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Use of decisional conflict scale • Dying in preferred site of death

High-impact outcome	Driver measures	Priority measures	Improvement measures
<p>Preventable harm/ complications</p>	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • <i>Potentially</i> #2888 Hospital Admissions for Those with Multiple Chronic Conditions (NOTE: Committee discussed readmissions, not admissions) <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Unwanted care/care that is not goal-concordant • Symptomatology due to use of excess/poor value medications/interventions • Unmet psychosocial and spiritual need 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • #0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Medication reconciliation (<i>potentially</i> #0097, #2988, #0646) • Safe medication use (<i>potentially</i> #2993, #0022) • Safe medication disposal • Feeding tube placement in dementia patients • Discussion about and potential discontinuation of available interventions in terminal patients (e.g., statin, aspirin, multivitamins, memory drugs, ICDs, CPR, chemo in last 2 weeks) 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Assessment of psychosocial and spiritual issues/needs • POLST form completion according to patient values
<p>Prevention/ healthy behaviors</p>	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Caregiver support • Caregiver stress • Good communication (early, open/shared) 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Basic caregiver skills training provided (e.g., how to lift patient without injury to caregiver's back, changing sheets when patient is bedridden, etc.) 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Assessing family/caregivers for risk (e.g., depression, complicated bereavement, etc.)

High-impact outcome	Driver measures	Priority measures	Improvement measures
Total cost/low-value care	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • None identified 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • #0213 Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life • #0210 Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Potentially avoidable ED visits and hospitalizations • Proportion of elderly chronic kidney disease patients with multiple comorbidities who were started on dialysis • Proportion of dialysis patients admitted to ICU in last 30 days of life 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Percentage of elderly patients with chronic kidney disease and multiple comorbidities admitted to an “active medical management without dialysis” pathway of care
Access to needed care	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Geographic access to hospice and palliative care (both hospital and community) • Access to home and community-based services 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Time to palliative care consult OR Timeliness of palliative care consultation (>48 hours prior to death) • Access to specialty palliative care team • Nursing load or chaplain load 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Number of patients in a hospice or palliative care program who are getting chaplain visits
Equity of care	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Standard/minimum service offerings 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • Materials offered at appropriate education levels/languages 	<p><u>Endorsed measures</u></p> <ul style="list-style-type: none"> • None identified <p><u>Gaps</u></p> <ul style="list-style-type: none"> • None identified

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

Measure Endorsed

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

[Submission](#) | [Specifications](#)

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

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

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

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

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Hospice

Type of Measure: Composite

Data Source: Other

Measure Steward: Centers for Medicare and Medicaid Services

STANDING COMMITTEE MEETING 3/8/2017

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

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

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

Rationale:

- The developer cited the 2013 Institute for Clinical Systems Improvement (ICSI) Palliative Care for Adults guidelines to support the components in the composite. All of the recommendation statements from the ICSI guideline refer to inclusion of the measured components in the palliative care plan.
- The Committee concluded that the evidence presented is tangential to the foci of the measure, which assesses actual screening, assessment, discussions, or treatment not simply inclusion of these processes in the palliative care plan. The Committee recognized the evidence base linking dyspnea treatment, bowel regimens, and communication regarding treatment preferences to improved patient outcomes. However, members acknowledged that similar evidence for the other components of the measure (pain screening, pain assessment, dyspnea screening, and addressing spiritual and religious concerns) does not exist and likely would not be forthcoming. The Committee agreed that empirical evidence is not needed to hold providers accountable for those components of the measure, and agreed to invoke the exception to the evidence subcriterion.
- Data presented by the developer from the FY2015-2016 Hospice Item Set (HIS)—used to collect data from the more than 90% of hospices that participate in the CMS Hospice Quality Reporting Program—indicate an average performance rate for the composite of 71.8% in 2015 and 76.2% in 2016.
- The developers described this all-or-none measure as designed “to reflect the overall quality of comprehensive assessment at hospice admission for each patient stay.” They noted that the seven components included in the measure “address high-priority aspects of quality hospice care as identified by the National Consensus Project, are required by the Medicare Hospice Conditions of Participation, and are supported by hospice stakeholders.” Finally, the developers supported the composite itself and its all-or-none aggregation and weighting approach by suggesting it will help to incentivize hospices to complete all of the critical care processes included in the measure, set a higher bar for performance compared to the individual measures, and provide summary results that can be more easily understood by consumers and providers.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

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

Rationale:

- The Committee questioned how the measure is calculated when a patient screens negative for pain or for dyspnea (as only those who screen positive would then receive a pain assessment or dyspnea treatment, respectively). The developer clarified that all patients are included in the measure and that those whose screens are negative for pain or dyspnea are “given credit” for receiving the pain assessment and dyspnea treatment, respectively. Similarly, patients who are not receiving opioid treatment are “given credit” for receiving a bowel regimen.
- Reliability testing of the measure score was conducted on FY2015 HQRP data using a split-half analysis and a signal-to-noise analysis. The split-half analysis yielded an intra-class correlation coefficient of 0.94, while the signal-to-noise ratio was 0.99.
- The developer tested the validity of the measure score with a non-parametric Spearman rank correlation analysis between the composite measure and the seven individual NQF-endorsed

measures that correspond to the components of the composite. Correlations ranged from .43 to .64, and were statistically significant.

- The developers provided the results of three analyses to support the construction of the composite as all-or-none measure with seven components. First, they noted the moderate correlations between the composite measure and the individual measures, which were high enough to infer consistency with the quality construct yet not so high as to indicate that the composite is redundant to the individual measures. Next, they noted how the average performance of the combined seven components differed from the average performance seen when each of the seven components were excluded one at a time. They also noted that removal of each of the components identified a different, although overlapping, group of outliers than that identified when using all seven components.
- Committee members also noted that a caregiver focus group convened by the developer supported the construction of a composite measure, believing it would alleviate confusion they had in interpreting the results from the individual measures.

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

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

Rationale:

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

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

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

Rationale:

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

5. Related and Competing Measures

- This measure is related to its seven component measures, all endorsed by NQF:
 - Hospice and Palliative Care – Pain Screening (NQF #1634),
 - Hospice and Palliative Care – Pain Assessment (NQF #1637),
 - Hospice and Palliative Care – Dyspnea Screening (NQF #1639),
 - Hospice and Palliative Care – Dyspnea Treatment (NQF #1638),
 - Patients Treated with an Opioid Who Are Given a Bowel Regimen (NQF #1617),
 - Hospice and Palliative Care – Treatment Preferences (NQF #1641), and

- Beliefs and Values - Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss (NQF #1647).
- Measures are harmonized to the extent possible.
- The Committee agreed that the individual measures should retain endorsement, particularly since most of the individual measures also assess care at the clinician group level in the hospital setting.

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

6. Public and Member Comment: April 20 – May 10, 2017 Comments received:

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

Developer response (summarized):

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

Committee response:

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

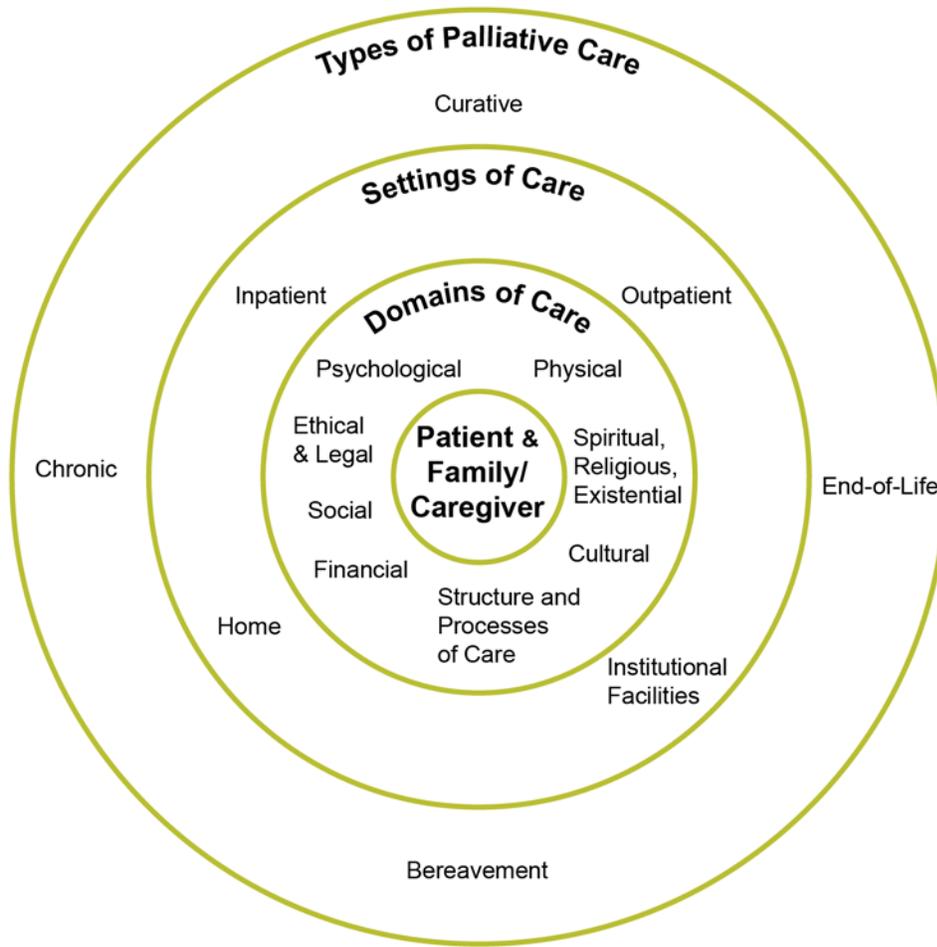
7. Consensus Standards Approval Committee (CSAC) Vote: Y-14; N-0

8. Appeals:

No appeals received

Appendix B: NQF Palliative and End-of-Life Care Portfolio and Related Measures

Measurement Framework for Palliative and End-of-Life Care



Measures in the Portfolio

Physical Aspects of Care

0177 Improvement in Pain Interfering with Activity

0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment

0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)

0384 Oncology: Medical and Radiation - Pain Intensity Quantified (paired with 0383)

0420 Pain Assessment and Follow-Up

0676 Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)

0677 Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits

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

1822 External Beam Radiotherapy for Bone Metastases

Psychological and Psychiatric Aspects of Care

0700 Health-related Quality of Life in COPD patients before and after Pulmonary Rehabilitation

Cultural Aspects of Care

1894 Cross-Cultural Communication Measure Derived from the Cross-Cultural Communication Domain of the C-CAT

Spiritual, Religious, and Existential Aspects of Care

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Ethical and Legal Aspects of Care

0326 Advance Care Plan

1626 Patients Admitted to ICU who Have Care Preferences Documented

1641 Hospice and Palliative Care – Treatment Preferences

Care of the Patient at the End of Life

0208 Family Evaluation of Hospice Care

0210 Proportion Receiving Chemotherapy in the Last 14 Days of Life

0213 Proportion Admitted to the ICU in the Last 30 Days of Life

0215 Proportion Not Admitted to Hospice

0216 Proportion Admitted to Hospice for Less Than 3 Days

1623 Bereaved Family Survey

1625 Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated

2651 CAHPS Hospice Survey (Experience with Care): 8 PRO-PMs: (Hospice Team Communication; Getting Timely Care; Getting Emotional and Religious Support; Getting Hospice Training; Rating of the Hospice Care; Willingness to Recommend the Hospice; Treating Family Member with Respect; Getting Help for Symptoms)

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

Social Aspects of Care

There are no NQF-endorsed measures for this domain.

Appendix C: Palliative and End-of-Life Care Portfolio—Use in Federal Programs

NQF #	Title	Federal Programs: Finalized as of March 29, 2017
0177	Improvement in Pain Interfering with Activity	Home Health Quality Reporting Program (HH QRP), Home Health Value-Based Purchasing(HH VBP)
0326	Advance Care Plan	Merit-based Incentive Payment System (MIPS), Home Health Value-Based Purchasing Program
0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Merit-based Incentive Payment System (MIPS), PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
0384	Oncology: Medical and Radiation - Pain Intensity Quantified	Merit-based Incentive Payment System (MIPS), PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
0420	Pain Assessment and Follow-Up	Merit-based Incentive Payment System (MIPS)
1617	Patients Treated with an Opioid who are Given a Bowel Regimen	Hospice Quality Reporting Program (HQRP)
1634	Hospice and Palliative Care — Pain Screening	Hospice Quality Reporting Program (HQRP)
1637	Hospice and Palliative Care — Pain Assessment	Hospice Quality Reporting Program (HQRP)
1638	Hospice and Palliative Care — Dyspnea Treatment	Hospice Quality Reporting Program (HQRP)
1639	Hospice and Palliative Care — Dyspnea Screening	Hospice Quality Reporting Program (HQRP)
1641	Hospice and Palliative Care – Treatment Preferences	Hospice Quality Reporting Program (HQRP)
1647	Believes and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss	Hospice Quality Reporting Program (HQRP)
1822	External Beam Radiotherapy for Bone Metastases	PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR) Hospital Outpatient Quality Reporting Program (HOQR)
2651	CAHPS Hospice Survey (Experience with Care): 8 PRO-PMs: (Hospice Team Communication; Getting Timely Care; Getting Emotional and Religious Support; Getting Hospice Training; Rating of the Hospice Care; Willingness to Recommend the Hospice; Treating Family Member with Respect; Getting Help for Symptoms)	Hospice Quality Reporting Program (HQRP)

Appendix D: Project Standing Committee and NQF Staff

STANDING COMMITTEE

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Appendix E: Measure Specifications

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

STEWARD

Centers for Medicare and Medicaid Services

DESCRIPTION

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

TYPE

Composite

DATA SOURCE

Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014.

Available in attached appendix at A.1 No data dictionary

LEVEL

Facility

SETTING

Hospice

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQRP quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are:

1. NQF 1634: Patient stays that include a screening 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.
2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening.
5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed
6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences
7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.

Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria:

1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^])

AND

2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^])

AND

3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient's pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4])

AND*

4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B

and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^])

AND

5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^])

AND*

6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^])

AND*

7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^])

NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be 'given credit' for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.

DENOMINATOR STATEMENT

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

DENOMINATOR DETAILS

The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.

EXCLUSIONS

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

EXCLUSION DETAILS

The exclusion criteria are:

1. Patients under 18 years of age as indicated by the birth date (A0900) and admission date (A0220)
2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Continuous variable, e.g. average better quality = higher score

ALGORITHM

Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria.

Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs.

Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100.

Please see Appendix A.1 for a flow chart of the measure logic.

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N/A

Appendix F1: Related and Competing Measures (tabular format)

Comparison of NQF #3235 and NQF #1617, #1634, #1637

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1617 Patients Treated with an Opioid who are Given a Bowel Regimen	1634 Hospice and Palliative Care — Pain Screening	1637 Hospice and Palliative Care — Pain Assessment
Steward	Centers for Medicare and Medicaid Services	RAND Corporation/UCLA	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill
Description	The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.	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.
Type	Composite	Process	Process	Process
Data Source	Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014. Available in attached appendix at A.1 No data dictionary	Paper Records Medical record abstraction tool No data collection instrument provided No data dictionary	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool with separate collection of numerator and denominator data values. Available in attached appendix at A.1 No data dictionary	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool with separate collection of numerator and denominator values. Available in attached appendix at A.1 No data dictionary
Level	Facility	Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice
Setting	Hospice	Clinician Office/Clinic, Hospice, Hospital	Hospice, Hospital	Hospice, Hospital
Numerator Statement	The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive assessment measure numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed	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 who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
Numerator Details	The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as	Patients from the denominator given a bowel regimen (or one is already in place) defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR	Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized tool during the admission evaluation for hospice / initial	Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1617 Patients Treated with an Opioid who are Given a Bowel Regimen	1634 Hospice and Palliative Care — Pain Screening	1637 Hospice and Palliative Care — Pain Assessment
	<p>captured in the current HQRP quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are:</p> <ol style="list-style-type: none"> 1. NQF 1634: Patient stays that include a screening 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. 2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain. 3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care. 4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening. 5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed 6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences 7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date. <p>Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria:</p> <ol style="list-style-type: none"> 1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^]) <p>AND</p> <ol style="list-style-type: none"> 2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^]) 	<p>documentation of why such a bowel regimen is not needed.</p>	<p>encounter for hospital-based palliative care. Screening may be completed using verbal, numeric, visual analog, rating scales designed for use the non-verbal patients, or other standardized tools.</p>	<p>relieves or worsens the pain, and the effect on function or quality of life.</p>

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1617 Patients Treated with an Opioid who are Given a Bowel Regimen	1634 Hospice and Palliative Care — Pain Screening	1637 Hospice and Palliative Care — Pain Assessment
	<p>AND</p> <p>3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient’s pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4])</p> <p>AND*</p> <p>4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^])</p> <p>AND</p> <p>5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^])</p> <p>AND*</p> <p>6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^])</p> <p>AND*</p> <p>7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^])</p> <p>NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be ‘given credit’ for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While</p>			

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1617 Patients Treated with an Opioid who are Given a Bowel Regimen	1634 Hospice and Palliative Care — Pain Screening	1637 Hospice and Palliative Care — Pain Assessment
	NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.			
Denominator Statement	The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.	Vulnerable adults who are given a prescription for an opioid	Patients enrolled in hospice OR patients receiving specialty palliative care in an acute hospital setting.	Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation / initial encounter.
Denominator Details	The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.	All vulnerable adults >17 years old prescribed an opioid as: <ul style="list-style-type: none"> - An inpatient - A hospice patient (inpatient or outpatient) - A non-hospice outpatient in patients who are not already taking an opioid "Vulnerable" is defined as any of the following: <ul style="list-style-type: none"> - >74 years of age - Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001) - Poor prognosis/terminal illness defined as life expectancy of <6 months - Stage IV cancer - Patients receiving hospice care in any setting Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699	The Pain Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Pain Assessment quality measure (NQF #1637) to ensure that all patients who report significant pain are clinically assessed.]	The Pain Assessment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number >0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care. For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted in screening (response of moderate or severe on verbal scale, >4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator. [NOTE: This quality measure should be paired with the Pain Screening quality measure (NQF #1634) to ensure that all patients are screened and therefore given the opportunity to report pain and enter the denominator population for Pain Assessment.]
Exclusions	Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).	Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription	Patients with length of stay < 1 day in palliative care.	Patients with length of stay < 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.
Exclusion Details	The exclusion criteria are: 1. Patients under 18 years of age as indicated by the birth date (A0900) and admission date (A0220) 2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)	Patients who are prescribed an opioid in the outpatient setting are excluded if they are NOT hospice patients AND at the time of the opioid prescription that occurred during the study period, they were already taking an opioid. This exclusion does NOT apply to inpatients or to hospice patients treated in any setting. Non-hospice outpatients who are prescribed an opioid who may have been on an opioid in the past, but are not taking an opioid at the time of the study period	Calculation of length of stay: discharge date is identical to date of initial encounter.	Calculation of length of stay; discharge date is identical to date of initial encounter.

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1617 Patients Treated with an Opioid who are Given a Bowel Regimen	1634 Hospice and Palliative Care — Pain Screening	1637 Hospice and Palliative Care — Pain Assessment
		opioid prescription are NOT excluded.		
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A		N/A	N/A
Type Score	Continuous variable, e.g. average better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria.</p> <p>Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs.</p> <p>Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100.</p> <p>Please see Appendix A.1 for a flow chart of the measure logic. 144877 141015</p>	<p>Note that edits placed in brackets []</p> <p>1. Identify vulnerable adults with a prescription for an opioid. For inpatients, identify ALL patients with an order for [standing (not prn)] opioid treatment on admission or during the hospitalization. For hospice patients, identify ALL patients with an order for opioid treatment on admission or during the episode of hospice care. For outpatient non-hospice patients, identify patients with a "new" prescription for an opioid. "New" prescription for a non-hospice outpatient means that the patient is not already taking an opioid.</p> <p>2. Include only patients who are vulnerable (age >74, VES-13 score >2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care).</p> <p>3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 113885 136569 110832 141057</p>	<p>Screened for pain:</p> <p>a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting.</p> <p>b. Step 2- Exclude palliative care patients if length of stay is < 1 day.</p> <p>c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) using a standardized tool.</p> <p>Quality Measure = Numerator: Patients screened for pain in Step 3 / Denominator: Patients in Step 1-Patients excluded in Step 2 123213 129544</p>	<p>Clinical assessment of Pain:</p> <p>a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting</p> <p>b. Step 2- Exclude palliative care patients if length of stay is < 1 day.</p> <p>c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care)</p> <p>d. Step 4- Identify patients who screened positive for pain [any pain if hospice; moderate or severe pain if palliative care].</p> <p>e. Step 5- Exclude patients who screened negative for pain</p> <p>f. Step 6- Identify patients who received a clinical assessment for pain within 24 hours of screening positive for pain</p> <p>Quality Measure= Numerator: Patients who received a clinical assessment for pain in Step 6 / Denominator: Patients in Step 4 123213 129544</p>

Comparison of NQF #3235 and NQF #1638, #1639, #1641, #1647

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1638 Hospice and Palliative Care -- Dyspnea Treatment	1639 Hospice and Palliative Care -- Dyspnea Screening	1641 Hospice and Palliative Care – Treatment Preferences	1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss
Steward	Centers for Medicare and Medicaid Services	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill	University of North Carolina-Chapel Hill
Description	The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.	Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.	Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.	Percentage of patients with chart documentation of preferences for life sustaining treatments.	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.
Type	Composite	Process	Process	Process	Process
Data Source	Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014. Available in attached appendix at A.1 No data dictionary	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data Available in attached appendix at A.1 No data dictionary	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data Available in attached appendix at A.1 No data dictionary	Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure. Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data Available in attached appendix at A.1 No data dictionary	Electronic Health Record (Only), Other The Hospice Item Set (HIS) is the data source used to calculate the quality measure. Available in attached appendix at A.1 Attachment QNAV CPD - Sample-634425372974245559.pdf
Level	Facility	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice	Facility
Setting	Hospice	Hospice, Hospital	Hospice, Hospital	Hospice, Hospital	Hospice
Numerator Statement	The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive assessment measure	Patients who screened positive for dyspnea who received treatment within 24 hours of screening.	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 whose medical record includes documentation of life sustaining preferences	Patients whose medical record includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1638 Hospice and Palliative Care -- Dyspnea Treatment	1639 Hospice and Palliative Care -- Dyspnea Screening	1641 Hospice and Palliative Care – Treatment Preferences	1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss
	numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.				
Numerator Details	<p>The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQRP quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are:</p> <ol style="list-style-type: none"> 1. NQF 1634: Patient stays that include a screening 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. 2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain. 3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care. 4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening. 5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed 	<p>Treatment is administered if within 24 hours of the positive screen for dyspnea, medical treatment plan, orders or pharmacy records show inhaled medications, steroids, diuretics, or non-medication strategies such as oxygen and energy conservation. Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.</p>	<p>Patients who are screened for the presence or absence of dyspnea during the admission evaluation for hospice / initial encounter for hospital-based palliative care, and asked to rate its severity. Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients.</p>	<p>Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as “Full Code” or “DNR/DNI” do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.</p>	<p>Examples of a discussion may include asking about patient’s need for spiritual or religious support, questions about the cause or meaning of illness or death. Other examples include discussion of God or a higher power related to illness, or offer of a spiritual resource including a chaplain. Discussion of spiritual or religious concerns may occur between patient and/or family and clergy or pastoral worker or patient and/or family and member of the interdisciplinary team. This item is meant to capture evidence of discussion and communication. Therefore, documentation of patient’s religious or spiritual affiliation by itself does not count for inclusion in numerator. Data are collected via chart review. Criteria are:</p> <ol style="list-style-type: none"> 1) evidence of a discussion about spiritual/religious concerns, or 2) evidence that the patient, and/or family declined to engage in a conversation on this topic. <p>Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments within 5 days of admission to hospice, visit notes documented by any member of the team, and/or the spiritual care assessment.</p>

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1638 Hospice and Palliative Care -- Dyspnea Treatment	1639 Hospice and Palliative Care -- Dyspnea Screening	1641 Hospice and Palliative Care – Treatment Preferences	1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss
	<p>6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences</p> <p>7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.</p> <p>Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria:</p> <ol style="list-style-type: none"> 1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^]) AND 2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^]) AND 3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient’s pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4]) AND* 4. A comprehensive pain assessment was completed within 1 day 				

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1638 Hospice and Palliative Care -- Dyspnea Treatment	1639 Hospice and Palliative Care -- Dyspnea Screening	1641 Hospice and Palliative Care – Treatment Preferences	1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss
	<p>of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^])</p> <p>AND</p> <p>5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^])</p> <p>AND*</p> <p>6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^])</p> <p>AND*</p> <p>7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^])</p> <p>NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be ‘given</p>				

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1638 Hospice and Palliative Care -- Dyspnea Treatment	1639 Hospice and Palliative Care -- Dyspnea Screening	1641 Hospice and Palliative Care – Treatment Preferences	1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss
	credit' for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.				
Denominator Statement	The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.	Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.	Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.	Seriously ill patients 18 years of age or older enrolled in hospice.
Denominator Details	The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.	The Dyspnea Treatment quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. For patients enrolled in hospice or palliative care, a positive screen is indicated by any dyspnea noted as other than none on a verbal screen, any number > 0 on a numeric scale or any observational or self-report of dyspnea. [NOTE: This quality measure should be paired with the Dyspnea Screening quality measure (NQF #1639) to ensure that all patients are screened and therefore given the opportunity to report dyspnea and enter the denominator population for Dyspnea Treatment.]	The Dyspnea Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: This quality measure should be paired with the Dyspnea Treatment quality measure (NQF #1639) to ensure that all patients who report dyspnea are clinically considered for treatment.]	The Treatment Preferences quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.	This quality measure is intended for patients with serious illness who are enrolled in hospice care. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.
Exclusions	Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).	Patients with length of stay < 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.	Patients with length of stay < 1 day in palliative care.	Patients with length of stay < 1 day in hospice or palliative care	Testing has only been done with the adult population; thus patients younger than 18 are excluded.
Exclusion Details	The exclusion criteria are: 1. Patients under 18 years of age as indicated	Calculation of length of stay; discharge date is identical to date of initial encounter.	Calculation of length of stay; discharge date is identical to date of initial encounter.	Calculation of length of stay; discharge date is identical to date of initial encounter.	N/A

	3235 Hospice and Palliative Care Composite Process Measure— Comprehensive Assessment at Admission	1638 Hospice and Palliative Care -- Dyspnea Treatment	1639 Hospice and Palliative Care -- Dyspnea Screening	1641 Hospice and Palliative Care – Treatment Preferences	1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss
	by the birth date (A0900) and admission date (A0220) 2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)				
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	N/A	N/A	N/A	N/A	N/A
Type Score	Continuous variable, e.g. average better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	<p>Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria.</p> <p>Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs.</p> <p>Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100.</p> <p>Please see Appendix A.1 for a flow chart of the measure logic. 144877 141015</p>	<p>Dyspnea treatment:</p> <p>a. Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care</p> <p>b. Step 2- Identify admission evaluation / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days</p> <p>c. Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) / initial encounter (palliative care)</p> <p>d. Step 4- Identify patients who screened positive for dyspnea</p> <p>e. Step 5- Identify patients who received treatment within 24 hours of screening positive for dyspnea</p> <p>Quality Measure= Numerator: Patients who received treatment for dyspnea in Step 5 / Denominator: Patients in Step 4 123213 129544</p>	<p>Screened for dyspnea:</p> <p>a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice care or who receive specialty palliative care in an acute hospital setting</p> <p>b.Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day.</p> <p>c.Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) OR during the initial encounter (palliative care)</p> <p>Quality measure = Numerator: Patients screened for dyspnea in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 123213 129544</p>	<p>Chart documentation of life sustaining preferences:</p> <p>a.Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital</p> <p>b.Step 2- Exclude patients if length of stay is < 1 day.</p> <p>c.Step 3- Identify patients with documented discussion of preference for life sustaining treatments.</p> <p>Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 123213 129544</p>	<p>Step 1- Identify all patients with serious, life-limiting illness who were discharged from hospice care during the designated reporting period.</p> <p>Step 2- Exclude patients who are less than 18 years of age.</p> <p>Step 3- Identify patients with documented discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss spiritual/religious concerns.</p> <p>Quality measure = Numerator: Patients with documented discussion or who responded they did not want to discuss in Step 3 / Denominator: patients in Step 1 – Patients excluded in Step 2 123241 127411 123213 129544</p>

Appendix F2: Related and Competing Measures (narrative format)

Comparison of NQF #3235 and NQF #1617, #1634, #1637

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

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

1634 Hospice and Palliative Care — Pain Screening

1637 Hospice and Palliative Care — Pain Assessment

Steward

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

Centers for Medicare and Medicaid Services

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

RAND Corporation/UCLA

1634 Hospice and Palliative Care — Pain Screening

University of North Carolina-Chapel Hill

1637 Hospice and Palliative Care — Pain Assessment

University of North Carolina-Chapel Hill

Description

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

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

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

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.

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.

Type

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

Composite

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Process

1634 Hospice and Palliative Care — Pain Screening

Process

1637 Hospice and Palliative Care — Pain Assessment

Process

Data Source

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

Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014.

Available in attached appendix at A.1 No data dictionary

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Paper Records Medical record abstraction tool

No data collection instrument provided No data dictionary

1634 Hospice and Palliative Care — Pain Screening

Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.

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

Available in attached appendix at A.1 No data dictionary

1637 Hospice and Palliative Care — Pain Assessment

Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.

Palliative Care: Structured medical record abstraction tool with separate collection of numerator and denominator values.

Available in attached appendix at A.1 No data dictionary

Level

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

Facility

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual

1634 Hospice and Palliative Care — Pain Screening

Facility, Clinician : Group/Practice

1637 Hospice and Palliative Care — Pain Assessment

Facility, Clinician : Group/Practice

Setting

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

Hospice

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Clinician Office/Clinic, Hospice, Hospital

1634 Hospice and Palliative Care — Pain Screening

Hospice, Hospital

1637 Hospice and Palliative Care — Pain Assessment

Hospice, Hospital

Numerator Statement

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

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

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed

1634 Hospice and Palliative Care — Pain Screening

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.

1637 Hospice and Palliative Care — Pain Assessment

Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.

Numerator Details

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

The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQRP quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are:

1. NQF 1634: Patient stays that include a screening 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.
2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening.
5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed
6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences
7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.

Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria:

1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^])

AND

2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^])

AND

3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-

,^]), the patient's pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4]))

AND*

4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^])

AND

5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^])

AND*

6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^])

AND*

7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^])

NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be 'given credit' for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Patients from the denominator given a bowel regimen (or one is already in place) defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR documentation of why such a bowel regimen is not needed.

1634 Hospice and Palliative Care — Pain Screening

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

1637 Hospice and Palliative Care — Pain Assessment

Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life.

Denominator Statement

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

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

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Vulnerable adults who are given a prescription for an opioid

1634 Hospice and Palliative Care — Pain Screening

Patients enrolled in hospice OR patients receiving specialty palliative care in an acute hospital setting.

1637 Hospice and Palliative Care — Pain Assessment

Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation / initial encounter.

Denominator Details

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

The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

All vulnerable adults >17 years old prescribed an opioid as:

- An inpatient
- A hospice patient (inpatient or outpatient)
- A non-hospice outpatient in patients who are not already taking an opioid

"Vulnerable" is defined as any of the following:

- >74 years of age
- Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001)
- Poor prognosis/terminal illness defined as life expectancy of <6 months
- Stage IV cancer
- Patients receiving hospice care in any setting

Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699

1634 Hospice and Palliative Care — Pain Screening

The Pain Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting.

Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

[NOTE: This quality measure should be paired with the Pain Assessment quality measure (NQF #1637) to ensure that all patients who report significant pain are clinically assessed.]

1637 Hospice and Palliative Care — Pain Assessment

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

For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number >0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care.

For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted in screening (response of moderate or severe on verbal scale, >4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator.

[NOTE: This quality measure should be paired with the Pain Screening quality measure (NQF #1634) to ensure that all patients are screened and therefore given the opportunity to report pain and enter the denominator population for Pain Assessment.]

Exclusions

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

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

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription

1634 Hospice and Palliative Care — Pain Screening

Patients with length of stay < 1 day in palliative care.

1637 Hospice and Palliative Care — Pain Assessment

Patients with length of stay < 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.

Exclusion Details

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

The exclusion criteria are:

1. Patients under 18 years of age as indicated by the birth date (A0900) and admission date (A0220)
2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Patients who are prescribed an opioid in the outpatient setting are excluded if they are NOT hospice patients AND at the time of the opioid prescription that occurred during the study period, they were already taking an opioid. This exclusion does NOT apply to inpatients or to hospice patients treated in any setting. Non-hospice outpatients who are prescribed an opioid who may have been on an opioid in the past, but are not taking an opioid at the time of the study period opioid prescription are NOT excluded.

1634 Hospice and Palliative Care — Pain Screening

Calculation of length of stay: discharge date is identical to date of initial encounter.

1637 Hospice and Palliative Care — Pain Assessment

Calculation of length of stay; discharge date is identical to date of initial encounter.

Risk Adjustment

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

No risk adjustment or risk stratification

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

No risk adjustment or risk stratification

1634 Hospice and Palliative Care — Pain Screening

No risk adjustment or risk stratification

1637 Hospice and Palliative Care — Pain Assessment

No risk adjustment or risk stratification

Stratification

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

N/A

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

1634 Hospice and Palliative Care — Pain Screening

N/A

1637 Hospice and Palliative Care — Pain Assessment

N/A

Type Score

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

Continuous variable, e.g. average better quality = higher score

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Rate/proportion better quality = higher score

1634 Hospice and Palliative Care — Pain Screening

Rate/proportion better quality = higher score

1637 Hospice and Palliative Care — Pain Assessment

Rate/proportion better quality = higher score

Algorithm

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

Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria.

Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs.

Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100.

Please see Appendix A.1 for a flow chart of the measure logic. 144877 | 141015

1617 Patients Treated with an Opioid who are Given a Bowel Regimen

Note that edits placed in brackets []

1. Identify vulnerable adults with a prescription for an opioid. For inpatients, identify ALL patients with an order for [standing (not prn)] opioid treatment on admission or during the hospitalization. For hospice patients, identify ALL patients with an order for opioid treatment on admission or during the episode of hospice care. For outpatient non-hospice patients, identify patients with a "new" prescription for an opioid. "New" prescription for a non-hospice outpatient means that the patient is not already taking an opioid.
2. Include only patients who are vulnerable (age >74, VES-13 score >2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care).
3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 113885 | 136569 | 110832 | 141057

1634 Hospice and Palliative Care — Pain Screening

Screened for pain:

- a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting.

- b. Step 2- Exclude palliative care patients if length of stay is < 1 day.
- c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care) using a standardized tool.

Quality Measure =

Numerator: Patients screened for pain in Step 3 / Denominator: Patients in Step 1-Patients excluded in Step 2 123213 | 129544

1637 Hospice and Palliative Care — Pain Assessment

Clinical assessment of Pain:

- a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR received specialty palliative care in an acute hospital setting
- b. Step 2- Exclude palliative care patients if length of stay is < 1 day.
- c. Step 3- Identify patients who were screened for pain during the admission evaluation (hospice) OR initial encounter (palliative care)
- d. Step 4- Identify patients who screened positive for pain [any pain if hospice; moderate or severe pain if palliative care].
- e. Step 5- Exclude patients who screened negative for pain
- f. Step 6- Identify patients who received a clinical assessment for pain within 24 hours of screening positive for pain

Quality Measure= Numerator: Patients who received a clinical assessment for pain in Step 6 / Denominator: Patients in Step 4 123213 | 129544

Comparison of NQF #3235 and NQF #1638, #1639, #1641, #1647

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

1638 Hospice and Palliative Care -- Dyspnea Treatment

1639 Hospice and Palliative Care -- Dyspnea Screening

1641 Hospice and Palliative Care – Treatment Preferences

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Steward

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

Centers for Medicare and Medicaid Services

1638 Hospice and Palliative Care -- Dyspnea Treatment

University of North Carolina-Chapel Hill

1639 Hospice and Palliative Care -- Dyspnea Screening

University of North Carolina-Chapel Hill

1641 Hospice and Palliative Care – Treatment Preferences

University of North Carolina-Chapel Hill

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

University of North Carolina-Chapel Hill

Description

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

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

1638 Hospice and Palliative Care -- Dyspnea Treatment

Percentage of patients who screened positive for dyspnea who received treatment within 24 hours of screening.

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.

1641 Hospice and Palliative Care – Treatment Preferences

Percentage of patients with chart documentation of preferences for life sustaining treatments.

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

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.

Type

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

Composite

1638 Hospice and Palliative Care -- Dyspnea Treatment

Process

1639 Hospice and Palliative Care -- Dyspnea Screening

Process

1641 Hospice and Palliative Care – Treatment Preferences

Process

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Process

Data Source

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

Other Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQRP as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014.

Available in attached appendix at A.1 No data dictionary

1638 Hospice and Palliative Care -- Dyspnea Treatment

Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.

Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data

Available in attached appendix at A.1 No data dictionary

1639 Hospice and Palliative Care -- Dyspnea Screening

Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.

Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data

Available in attached appendix at A.1 No data dictionary

1641 Hospice and Palliative Care – Treatment Preferences

Electronic Health Record (Only), Other Hospice: Hospice analysis uses the Hospice Item Set (HIS) as the data source to calculate the quality measure.

Palliative Care: Structured medical record abstraction tool, with separate collection of denominator and numerator data

Available in attached appendix at A.1 No data dictionary

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Electronic Health Record (Only), Other The Hospice Item Set (HIS) is the data source used to calculate the quality measure.

Available in attached appendix at A.1 Attachment QNAV CPD - Sample-634425372974245559.pdf

Level

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

Facility

1638 Hospice and Palliative Care -- Dyspnea Treatment

Facility, Clinician : Group/Practice

1639 Hospice and Palliative Care -- Dyspnea Screening

Facility, Clinician : Group/Practice

1641 Hospice and Palliative Care – Treatment Preferences

Facility, Clinician : Group/Practice

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Facility

Setting

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

Hospice

1638 Hospice and Palliative Care -- Dyspnea Treatment

Hospice, Hospital

1639 Hospice and Palliative Care -- Dyspnea Screening

Hospice, Hospital

1641 Hospice and Palliative Care – Treatment Preferences

Hospice, Hospital

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Hospice

Numerator Statement

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

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

1638 Hospice and Palliative Care -- Dyspnea Treatment

Patients who screened positive for dyspnea who received treatment within 24 hours of screening.

1639 Hospice and Palliative Care -- Dyspnea Screening

Patients who are screened for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.

1641 Hospice and Palliative Care – Treatment Preferences

Patients whose medical record includes documentation of life sustaining preferences

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Patients whose medical record includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.

Numerator Details

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

The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQRP quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are:

1. NQF 1634: Patient stays that include a screening 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.
2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening.
5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed
6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences
7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.

Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria:

1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^])

AND

2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^])

AND

3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient's pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4])

AND*

4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^])

AND

5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^])

AND*

6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath (J2040B – J2030B = 1 and J2040B and J2030B ? [-,^])

AND*

7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^])

NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be 'given credit' for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.

1638 Hospice and Palliative Care -- Dyspnea Treatment

Treatment is administered if within 24 hours of the positive screen for dyspnea, medical treatment plan, orders or pharmacy records show inhaled medications, steroids, diuretics, or non-medication strategies such as oxygen and energy conservation. Treatment may also include benzodiazepine or opioid if clearly prescribed for dyspnea.

1639 Hospice and Palliative Care -- Dyspnea Screening

Patients who are screened for the presence or absence of dyspnea during the admission evaluation for hospice / initial encounter for hospital-based palliative care, and asked to rate its severity. Screening may be completed using verbal, numeric, visual analog, or rating scales designed for use with non-verbal patients.

1641 Hospice and Palliative Care – Treatment Preferences

Documentation of life-sustaining treatment preferences should reflect patient self-report; if not available due to patient loss of decisional capacity, discussion with surrogate decision-maker and/or review of advance directive documents are acceptable. The numerator condition is based on the process of eliciting and recording preferences, whether the preference statement is for or against the use of various life-sustaining treatments such as resuscitation, ventilator support, dialysis, or use of intensive care or hospital admission. This item is meant to capture evidence of discussion and communication. Therefore, brief statements about an order written about life-sustaining treatment, such as "Full Code" or "DNR/DNI" do not count in the numerator. Documentation using the POLST paradigm with evidence of patient or surrogate involvement, such as co-signature or description of discussion, is adequate evidence and can be counted in this numerator.

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Examples of a discussion may include asking about patient's need for spiritual or religious support, questions about the cause or meaning of illness or death. Other examples include discussion of God or a higher power related to illness, or offer of a spiritual resource including a chaplain. Discussion of spiritual or religious concerns may occur between patient and/or family and clergy or pastoral worker or patient and/or family and member of the interdisciplinary team.

This item is meant to capture evidence of discussion and communication. Therefore, documentation of patient's religious or spiritual affiliation by itself does not count for inclusion in numerator.

Data are collected via chart review. Criteria are:

- 1) evidence of a discussion about spiritual/religious concerns, or
- 2) evidence that the patient, and/or family declined to engage in a conversation on this topic.

Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments within 5 days of admission to hospice, visit notes documented by any member of the team, and/or the spiritual care assessment.

Denominator Statement

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

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

1638 Hospice and Palliative Care -- Dyspnea Treatment

Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.

1639 Hospice and Palliative Care -- Dyspnea Screening

Patients enrolled in hospice OR patients receiving hospital-based palliative care for 1 or more days.

1641 Hospice and Palliative Care – Treatment Preferences

Seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting.

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Seriously ill patients 18 years of age or older enrolled in hospice.

Denominator Details

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

The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.

1638 Hospice and Palliative Care -- Dyspnea Treatment

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

For patients enrolled in hospice or palliative care, a positive screen is indicated by any dyspnea noted as other than none on a verbal screen, any number > 0 on a numeric scale or any observational or self-report of dyspnea.

[NOTE: This quality measure should be paired with the Dyspnea Screening quality measure (NQF #1639) to ensure that all patients are screened and therefore given the opportunity to report dyspnea and enter the denominator population for Dyspnea Treatment.]

1639 Hospice and Palliative Care -- Dyspnea Screening

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

[NOTE: This quality measure should be paired with the Dyspnea Treatment quality measure (NQF #1639) to ensure that all patients who report dyspnea are clinically considered for treatment.]

1641 Hospice and Palliative Care – Treatment Preferences

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

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

This quality measure is intended for patients with serious illness who are enrolled in hospice care. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

Exclusions

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

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

1638 Hospice and Palliative Care -- Dyspnea Treatment

Patients with length of stay < 1 day in palliative care, patients who were not screened for dyspnea, and/or patients with a negative screening.

1639 Hospice and Palliative Care -- Dyspnea Screening

Patients with length of stay < 1 day in palliative care.

1641 Hospice and Palliative Care – Treatment Preferences

Patients with length of stay < 1 day in hospice or palliative care

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Testing has only been done with the adult population; thus patients younger than 18 are excluded.

Exclusion Details

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

The exclusion criteria are:

1. Patients under 18 years of age as indicated by the birth date (A0900) and admission date (A0220)
2. Patients with Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

1638 Hospice and Palliative Care -- Dyspnea Treatment

Calculation of length of stay; discharge date is identical to date of initial encounter.

1639 Hospice and Palliative Care -- Dyspnea Screening

Calculation of length of stay; discharge date is identical to date of initial encounter.

1641 Hospice and Palliative Care – Treatment Preferences

Calculation of length of stay; discharge date is identical to date of initial encounter.

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

N/A

Risk Adjustment

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

No risk adjustment or risk stratification

1638 Hospice and Palliative Care -- Dyspnea Treatment

No risk adjustment or risk stratification

1639 Hospice and Palliative Care -- Dyspnea Screening

No risk adjustment or risk stratification

1641 Hospice and Palliative Care – Treatment Preferences

No risk adjustment or risk stratification

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

No risk adjustment or risk stratification

Stratification

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

N/A

1638 Hospice and Palliative Care -- Dyspnea Treatment

N/A

1639 Hospice and Palliative Care -- Dyspnea Screening

N/A

1641 Hospice and Palliative Care – Treatment Preferences

N/A

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

N/A

Type Score

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

Continuous variable, e.g. average better quality = higher score

1638 Hospice and Palliative Care -- Dyspnea Treatment

Rate/proportion better quality = higher score

1639 Hospice and Palliative Care -- Dyspnea Screening

Rate/proportion better quality = higher score

1641 Hospice and Palliative Care – Treatment Preferences

Rate/proportion better quality = higher score

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Rate/proportion better quality = higher score

Algorithm

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

Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria.

Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs.

Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100.

Please see Appendix A.1 for a flow chart of the measure logic. 144877 | 141015

1638 Hospice and Palliative Care -- Dyspnea Treatment

Dyspnea treatment:

- a. Step 1- Identify all patients with serious, life-limiting illness who received either specialty palliative care in an acute hospital setting or hospice care
- b. Step 2- Identify admission evaluation / initial encounter dates; exclude palliative care patients if length of stay is less than one day. Exclude hospice patients if length of stay is less than 7 days
- c. Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) / initial encounter (palliative care)
- d. Step 4- Identify patients who screened positive for dyspnea
- e. Step 5- Identify patients who received treatment within 24 hours of screening positive for dyspnea

Quality Measure= Numerator: Patients who received treatment for dyspnea in Step 5 / Denominator: Patients in Step 4 123213 | 129544

1639 Hospice and Palliative Care -- Dyspnea Screening

Screened for dyspnea:

- a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice care or who receive specialty palliative care in an acute hospital setting
- b. Step 2- Identify admission / initial encounter dates; exclude palliative care patients if length of stay is less than one day.
- c. Step 3- Identify patients who were screened for dyspnea during the admission evaluation (hospice) OR during the initial encounter (palliative care)

Quality measure = Numerator: Patients screened for dyspnea in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 123213 | 129544

1641 Hospice and Palliative Care – Treatment Preferences

Chart documentation of life sustaining preferences:

a. Step 1- Identify all patients with serious, life-limiting illness who are enrolled in hospice OR who received specialty palliative care in an acute hospital

b. Step 2- Exclude patients if length of stay is < 1 day.

c. Step 3- Identify patients with documented discussion of preference for life sustaining treatments.

Quality measure = Numerator: Patients with documented discussion in Step 3 / Denominator: Patients in Step 1 – Patients excluded in Step 2 123213 | 129544

1647 Beliefs and Values - Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Step 1- Identify all patients with serious, life-limiting illness who were discharged from hospice care during the designated reporting period.

Step 2- Exclude patients who are less than 18 years of age.

Step 3- Identify patients with documented discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss spiritual/religious concerns.

Quality measure = Numerator: Patients with documented discussion or who responded they did not want to discuss in Step 3 / Denominator: patients in Step 1 – Patients excluded in Step 2 123241 | 127411 | 123213 | 129544

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