

April 2016

# Hospice Quality Reporting Program: Specifications for the Hospice Item Set- Based Quality Measures

Prepared for

**Center for Clinical Standards and Quality**  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

CMS Contract No. HHSM-500-2013-13015I





Hospice Quality Reporting Program:  
Specifications for Hospice Item Set-Based Quality Measures

RTI International

CMS Contract No. HHSM-500-2013-13015I

April 2016

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2013-13015I. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

## CONTENTS

Section 1 Background .....	1
Section 2 Quality Measures .....	3
2.1 Key Definitions .....	3
2.2 Quality Measure NQF #1641: Hospice and Palliative Care –Treatment Preferences .....	5
2.2.1 Quality Measure Description .....	5
2.2.2 Purpose/Rationale for Quality Measure .....	5
2.2.3 Denominator .....	5
2.2.4 Numerator .....	6
2.2.5 Measure Time Window .....	6
2.2.6 Risk Adjustment .....	6
2.2.7 Calculation Algorithm .....	6
2.3 Quality Measure modified NQF #1647: Beliefs/Values Addressed (If Desired by the Patient) .....	8
2.3.1 Quality Measure Description .....	8
2.3.2 Purpose/Rationale for Quality Measure .....	8
2.3.3 Denominator .....	8
2.3.4 Numerator .....	9
2.3.5 Measure Time Window .....	9
2.3.6 Risk Adjustment .....	9
2.3.7 Calculation Algorithm .....	9
2.4 Quality Measure NQF #1634 Hospice and Palliative Care – Pain Screening .....	10
2.4.1 Quality Measure Description .....	10
2.4.2 Purpose/Rationale for Quality Measure .....	10
2.4.3 Denominator .....	10
2.4.4 Numerator .....	10
2.4.5 Measure Time Window .....	11
2.4.6 Risk Adjustment .....	11
2.4.7 Calculation Algorithm .....	11
2.5 Quality Measure: NQF #1637 Hospice and Palliative Care – Pain Assessment .....	12
2.5.1 Quality Measure Description .....	12
2.5.2 Purpose/Rationale for Quality Measure .....	12
2.5.3 Denominator .....	12
2.5.4 Numerator .....	13
2.5.5 Measure Time Window .....	13

2.5.6	Risk Adjustment.....	13
2.5.7	Calculation Algorithm .....	13
2.6	Quality Measure NQF #1639: Hospice and Palliative Care – Dyspnea Screening.....	15
2.6.1	Quality Measure Description.....	15
2.6.2	Purpose/Rationale for Quality Measure.....	15
2.6.3	Denominator .....	15
2.6.4	Numerator .....	15
2.6.5	Measure Time Window.....	16
2.6.6	Risk Adjustment.....	16
2.6.7	Calculation Algorithm .....	16
2.7	Quality Measure NQF #1638: Hospice and Palliative Care – Dyspnea Treatment .....	16
2.7.1	Quality Measure Description.....	16
2.7.2	Purpose/Rationale for Quality Measure.....	17
2.7.3	Denominator .....	17
2.7.4	Numerator .....	17
2.7.5	Measure Time Window.....	18
2.7.6	Risk Adjustment.....	18
2.7.7	Calculation Algorithm .....	18
2.8	Quality Measure NQF #1617: Patient Treated with an Opioid who are Given a Bowel Regimen.....	19
2.8.1	Quality Measure Description.....	19
2.8.2	Purpose/Rationale for Quality Measure.....	19
2.8.3	Denominator .....	19
2.8.4	Numerator .....	20
2.8.5	Measure Time Window.....	20
2.8.6	Risk Adjustment.....	20
2.8.7	Calculation Algorithm .....	20
2.9	Proposed Quality Measure: Hospice Visits when Death is Imminent.....	21
2.9.1	Quality Measure Pair Description.....	21
2.9.2	Purpose/Rationale for Quality Measure Pair .....	21
2.9.3	Measure 1 .....	21
2.9.4	Measure 2.....	23
2.10	Proposed Quality Measure: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission.....	26
2.10.1	Quality Measure Description.....	26
2.10.2	Purpose/Rationale for Quality Measure.....	26

2.10.3 Components of the Quality Measure .....	27
2.10.4 Denominator .....	27
2.10.5 Numerator .....	27
2.10.6 Measure Time Window.....	28
2.10.7 Risk Adjustment.....	29
2.10.8 Calculation Algorithm .....	29

**Appendixes**

A: Proposed V2.00.0.....	31
B: Composite Measure Logic Flow Chart for All-or-None Approach Based on All 7 QM .....	45

*[This page intentionally left blank]*

## SECTION 1 BACKGROUND

Section 3004 of the Patient Protection and Affordable Care Act (ACA) authorizes the Secretary of Health and Human Services to establish a quality reporting program for hospices. The ACA specifies that, for fiscal year (FY) 2014 and each subsequent fiscal year, hospice programs shall submit to the Secretary data on quality measures (QMs); the ACA also describes measure endorsement requirements for any measures specified by the Secretary. The Centers for Medicare & Medicaid Services (CMS) implemented the Hospice Quality Reporting Program (HQRP) in the FY 2012 Hospice Wage Index final rule (76 FR 47302–47352). CMS implemented the Hospice Item Set (HIS), a standardized, patient-level data collection instrument, as part of the HQRP 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.

The current version of HIS (V1.00.0) collects individual-level data to calculate six QMs and one modified QM endorsed by the National Quality Forum (NQF). These 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. CMS proposes implementation of two new measures in the FY 2017 Hospice Wage Index Rule. CMS proposes the HIS V2.00.0 to fulfill the data collection requirements for the 7 currently adopted NQF measures and the 2 new proposed measures. The HIS V2.00.0 includes all items from the HIS V1.00.0, with the addition of one new item for measure refinement of the existing NQF #1637 Pain Assessment, new items to collect data for the proposed Hospice Visits when Death is Imminent Measure Pair, and new administrative items for patient record matching and future public reporting of hospice quality data (please refer to **Appendix A** for the Proposed HIS V2.00.0).

This document describes the measure specifications for the HIS-based quality measures previously adopted in the FY 2016 Hospice Wage Index Final Rule and two new measures proposed for adoption in the FY 2017 Hospice Wage Index Rule. The quality measures adopted in the FY 2016 Hospice Wage Index Final Rule are:

1. Hospice and Palliative Care – Treatment Preferences (NQF #1641);
2. Beliefs/Values Addressed (If Desired by the Patient) (modified NQF #1647);
3. Hospice and Palliative Care – Pain Screening (NQF #1634);
4. Hospice and Palliative Care – Pain Assessment (NQF #1637);
5. Hospice and Palliative Care – Dyspnea Screening (NQF #1639);
6. Hospice and Palliative Care – Dyspnea Treatment (NQF #1638); and
7. Patients Treated with an Opioid who are Given a Bowel Regimen (NQF #1617).

The two new quality measures proposed for adoption in the FY 2017 Hospice Wage Index Rule are:

1. Hospice Visits when Death is Imminent Measure Pair, and
2. Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

## SECTION 2 QUALITY MEASURES

### 2.1 Key Definitions

In describing the measures, the following definitions are used throughout the document:

**Stay.** The period of time between a patient's admission to a hospice and either (a) a discharge, or (b) the end of the target period, whichever comes first. A patient can have multiple stays assigned to a target period.

- A patient stay starts with an admission record. The *stay start date* is the admission date on the HIS-Admission record.
  - When the admission record that starts a stay is missing (i.e., when a discharge record has no matching admission record for the same patient with the same admission date and in the same hospice), the *stay start date* is the admission date on the discharge record.
- A patient stay ends with either (a) a HIS-Discharge record, or (b) the end of the target period, whichever comes first.
  - When a patient stay ends with a discharge record, the *stay end date* is the discharge date (A0270) on the discharge record.
    - The *stay end date* must be the same as or later than the *stay start date*.
    - Both the admission and the discharge records associated with the patient stay must have identical admission dates.
  - When a patient stay ends with the end of the target period (this typically indicates that the patient is still enrolled with the hospice at the end of the target period), the *stay end date* is the end of the target period.
    - The *stay end date* must be the same as or later than the *stay start date*.
- The admission and discharge records that define the start and the end of patient stays are paired by matching the patient identifier (State Code and Resident Internal ID), hospice identifier (Provider Internal Number) and admission date. If multiple admission records (or multiple discharge records) share the same information in these matching criteria, the last chronological submission is kept and used. The submission time is first determined by submission date and then, if multiple records are submitted on the same day, by the Hospice Assessment ID.
- The definitions above generate three types of stays for a target period:
  - **Type 1:** stays with both the admission and the discharge records (i.e., discharged stays)

- **Type 2:** stays with the discharge record but no admission record (i.e., discharged stays but missing the admission records)
- **Type 3:** stays with the admission record but no discharge record (i.e., active stays as of the end of the target period)

**Length of Stay.** Length of stay is the number of days within a stay, that is, from a patient's *stay start date* through *stay end date*.

- When counting the number of days, include the *stay start date* but not the *stay end date*, unless the start and end of the stay occurred on the same day in which case the number of days in the stay is equal to 1.

## 2.2 Quality Measure NQF #1641: Hospice and Palliative Care –Treatment Preferences<sup>1</sup>

### 2.2.1 Quality Measure Description

This quality measure reports the percentage of hospice patients with chart documentation that the hospice discussed (or attempted to discuss) preferences for life-sustaining treatments. The measure is calculated using data from the HIS assessment instrument for hospice patients. Patients are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see section 2.1 *Key Definitions* for additional information on Type 2 and 3 patient stays).

### 2.2.2 Purpose/Rationale for Quality Measure

The aim of this measure is to ensure that all patients nearing the end of life are able to express preferences that guide the use of invasive or life-sustaining forms of treatment. The National Priorities Partnership has identified palliative and end-of-life care as a national priority.<sup>2</sup> Patient and family satisfaction outcomes can improve by giving seriously ill and dying patients the opportunity to express life-sustaining treatment and receive care consistent with their values. Approximately 1.56 million people received hospice care in 2009 and national trends show steady expansion of these services<sup>3,4</sup>. Patients and family caregivers consider control over treatment decisions as a high priority for those with life-limiting illnesses.<sup>5</sup> Moderate evidence from a systematic review of clinical trials supports interventions to increase advance directives including engaging care planning involving skilled facilitators who help focus on key decisions. The same studies found improved satisfaction with care, better communication between of patients and physicians, and increased hospice enrollment.<sup>6</sup> The Hospice and Palliative Care – Treatment Preferences measure promotes autonomy and gives the patient or caregiver the opportunity to express life-sustaining treatment for patients enrolled in hospice.

### 2.2.3 Denominator

The denominator for the measure includes all patient stays except for those that meet any exclusion criteria.

The exclusion criteria are:

---

<sup>1</sup> Note that the length of stay criterion has been removed from the exclusions. This modification will be submitted to and reviewed by the NQF.

<sup>2</sup> <http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?id=608>

<sup>3</sup> NHPCO Facts and figures: hospice care in America 2010 edition  
[http://www.nhpc.org/files/public/Statistics\\_Research/Hospice\\_Facts\\_Figures\\_Oct-2010.pdf](http://www.nhpc.org/files/public/Statistics_Research/Hospice_Facts_Figures_Oct-2010.pdf)

<sup>4</sup> Center to Advance Palliative Care <http://www.capc.org/news-and-events/releases/04-05-10>

<sup>5</sup> Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspective. JAMA 1999; 281: 163-168.

<sup>6</sup> Lorenz KA, Lynn J, Dy SM et al. Evidence for improving palliative care at the end of life: a systematic review. Ann Intern Med 2008; 148:147-159.

1. Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**)

**OR**

2. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

#### **2.2.4 Numerator**

The numerator for the measure includes all patient stays from the denominator in which the patient is asked about preferences about CPR, life-sustaining treatments other than CPR, or hospitalization. These preference items are asked no more than 7 days prior to admission or within 5 days of the admission date.

The numerator for this measure includes all Type 1 patient stays from the denominator in which the patient meets the following numerator criteria:

1. The patient and/or responsible party were asked about preference regarding the use of cardiopulmonary resuscitation (**F2000A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date ( $-7 \geq \mathbf{F2000B} - \mathbf{A0220} \leq 5$  and  $\mathbf{F2000B} \neq [-,^]$ );

**OR**

2. The patient and/or responsible party were asked about preferences regarding life-sustaining treatments other than CPR (**F2100A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date ( $-7 \geq \mathbf{F2100B} - \mathbf{A0220} \leq 5$  and  $\mathbf{F2100B} \neq [-,^]$ );

**OR**

3. The patient and/or responsible party were asked about preference regarding hospitalization (**F2200A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date ( $-7 \geq \mathbf{F2200B} - \mathbf{A0220} \leq 5$  and  $\mathbf{F2200B} \neq [-,^]$ ).

#### **2.2.5 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

#### **2.2.6 Risk Adjustment**

This measure is not risk-adjusted or stratified.

#### **2.2.7 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of NQF #1641, Treatment Preferences, quality measure is as follows:

1. Calculate the denominator count:
  - Calculate the total number of Type 1 stays that do not meet the exclusion criteria.
2. Calculate the hospice's overall numerator:
  - Calculate the total number of patient stays that indicate that the patient and/or responsible party was asked about preference regarding the use of cardiopulmonary resuscitation, life-sustaining treatments other than CPR, or hospitalization. Preference items are asked no more than 7 days prior to admission or within 5 days of the admission date.
3. Calculate the hospice's overall observed score:
  - 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.

## 2.3 Quality Measure modified NQF #1647: Beliefs/Values Addressed (If Desired by the Patient)<sup>7</sup>

### 2.3.1 Quality Measure Description

This quality measure reports the percentage of hospice patients with documentation of a discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss their spiritual/existential concerns. The measure is calculated using data from the HIS. Patients are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see Section 2.1 *Key Definitions* for additional information on Type 2 and 3 patient stays).

### 2.3.2 Purpose/Rationale for Quality Measure

Care for spiritual needs is a critical element of quality of life at the end of life. Patients and/or caregivers should be given the opportunity to express their needs for spiritual care to help ensure their needs are met. One of the unique aspects of hospice care is an interdisciplinary approach toward providing care for the physical, psychosocial, and spiritual needs of the patient and caregiver(s). Discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met. This measure is in accordance with the Clinical Practice Guidelines for Quality Palliative Care and National Quality Forum-endorsed preferred practices.<sup>8,9</sup>

### 2.3.3 Denominator

The denominator for the measure includes all patient stays except for those that meet any exclusion criteria.

The exclusion criteria are:

1. Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**)
- OR**
2. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

---

<sup>7</sup> Note that the length of stay criterion has been removed from the exclusions. This modification will be submitted to and reviewed by the NQF.

<sup>8</sup> Clinical Practice Guidelines for Quality Palliative Care – 2nd Edition National Consensus Project National Consensus Project for Quality Palliative Care. (2009). Clinical Practice Guidelines for Quality Palliative Care, Second Edition. Retrieved from <http://www.nationalconsensusproject.org/guideline.pdf>. October 2009. Pages 29-43.

<sup>9</sup> National Quality Forum: A National Framework and Preferred Practices for Palliative and Hospice Care Quality. Washington, DC: National Quality Forum. 2006.

### **2.3.4 Numerator**

The numerator for this measure includes all patient stays from the denominator in which the patient and/or caregiver was asked about spiritual/existential concerns within a timeframe that is no more than 7 days prior to and no more than 5 days after admission.

The numerator for this measure includes all Type 1 patient stays from the denominator in which the patient meets the following numerator criteria:

1. The patient and/or responsible party 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 ( $-7 \geq \text{F3000B} - \text{A0220} \leq 5$  and  $\text{F3000B} \neq [-,^]$ )

### **2.3.5 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

### **2.3.6 Risk Adjustment**

This measure is not risk-adjusted or stratified.

### **2.3.7 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of the modified NQF #1647, Beliefs/Values Addressed (If Desired by the Patient), is as follows:

1. Calculate the denominator count:
  - Calculate the total number of patient stays that do not meet the exclusion criteria.
2. Calculate the numerator count:
  - Calculate the total number of patient stays in the denominator in which the patient and/or caregiver was asked about spiritual/existential concerns no more than 7 days prior to and no more than 5 days after the admission date.
3. Calculate the hospice's overall observed score:
  - Divide the hospice's numerator count by its denominator count to obtain hospice's observed score; that is, divide the result of step (2) by the result of step (1). Each quality measure is converted to a percent value by multiplying by 100.

## 2.4 Quality Measure NQF #1634 Hospice and Palliative Care – Pain Screening<sup>10</sup>

### 2.4.1 Quality Measure Description

This quality measure reports the percentage of hospice patients who were screened for pain during the initial nursing assessment. The measure is calculated using HIS data. Patients are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see Section 2.1 *Key Definitions* for additional information on Type 2 and 3 patient stays).

### 2.4.2 Purpose/Rationale for Quality Measure

The aim of this measure is to ensure that all patients with serious and incurable illnesses have access to effective treatment for symptoms such as pain. Pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses.<sup>11</sup> Research shows that patients with serious incurable illness and nearing end of life show high rates of pain including other causes of distress.<sup>12</sup> The consequences of inadequate screening for pain include physical suffering, functional limitation, and development of apathy and depression. Inclusion of pain screening items will improve awareness of the presence of pain, which is the first essential step for quality pain management and treatment.

### 2.4.3 Denominator

The denominator for the measure includes all patient stays except for those that meet any exclusion criteria.

The exclusion criteria are:

1. Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**)

**OR**

2. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

### 2.4.4 Numerator

The numerator for this measure includes all patient stays from the denominator that meet one of two criteria: The first criterion is if the patient was screened for pain within 48 hours of their admission date and reported that they had no pain on the patient severity item. The second

---

<sup>10</sup> Note that the length of stay criterion has been removed from the exclusions. This modification will be submitted to and reviewed by the NQF.

<sup>11</sup> Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspective. *JAMA* 1999; 281: 163-168.

<sup>12</sup> Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. *J Palliat Med.* 2008;11(2):180–190.

criterion is if the patient was screened for pain within 48 hours from the admission date, the patient's pain severity was rated mild, moderate, or severe, and a standardized pain tool was used.

The numerator for this measure includes all Type 1 patient stays from the denominator in which the patient meets the following numerator criteria:

1. 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**

2. 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]**)

#### **2.4.5 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

#### **2.4.6 Risk Adjustment**

This measure is not risk-adjusted or stratified.

#### **2.4.7 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of NQF #1634, Pain Screening, is as follows:

1. Calculate the denominator count:
    - Calculate the total number of Type 1 stays that do not meet the exclusion criteria.
  2. Calculate the numerator count:
    - Calculate the total number of stays in the denominator that meet any of the following criteria:
      - i. The patient was screened for pain within 2 days of the admission date and reported that they had no pain;
- OR**
- ii. The patient was screened for pain within 2 days of the admission date; the patient reported a pain severity of mild, moderate, or severe; and a standardized pain tool was used.

3. Calculate the hospice's overall observed score:

- 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.

## 2.5 Quality Measure: NQF #1637 Hospice and Palliative Care – Pain Assessment<sup>13</sup>

### 2.5.1 Quality Measure Description

This quality measure reports the percentage of hospice patients who screened positive for pain and received a comprehensive pain assessment within 1 day of the pain screening. The measure is calculated using HIS data. Patients are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see Section 2.1 *Key Definitions* for additional information on Type 2 and 3 patient stays).

### 2.5.2 Purpose/Rationale for Quality Measure

The aim of this measure is to ensure effective assessment of pain. Pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses.<sup>14</sup> Research shows that patients with serious incurable illness and nearing end of life show high rates of inadequate pain and symptom management.<sup>15</sup> The consequences of such inadequate assessment and treatment for pain include physical suffering, functional limitation, and development of apathy and depression. Inclusion of pain assessment items will improve awareness of assessment of pain severity, etiology, and effect on function, which is the second step for quality pain management and treatment.

### 2.5.3 Denominator

The denominator for the measure includes Type 1 patient stays, except for those with exclusions, in which the patient's pain severity was rated mild, moderate, or severe (**J0900C = [1,2,3]**).

The exclusion criteria are:

1. Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**)

---

<sup>13</sup> Note that the length of stay criterion has been removed from the exclusions. This modification will be submitted to and reviewed by the NQF.

<sup>14</sup> Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspective. *JAMA* 1999; 281: 163-168.

<sup>15</sup> Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. *J Palliat Med.* 2008;11(2):180–190.

**OR**

2. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

#### **2.5.4 Numerator**

The numerator for this measure includes all patient stays from the denominator (i.e. Type 1 patient stays with a pain severity rating of mild, moderate, or severe) in which the patient received a comprehensive pain assessment within 1 day of the positive pain screen. The pain assessment documentation must include at least 5 characteristics that describe the patient's pain (location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life).

The numerator for the measure includes all patient stays from the denominator in which the patient meets the following criteria:

1. 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**

2. The comprehensive pain assessment 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 = [-,^]**)

#### **2.5.5 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

#### **2.5.6 Risk Adjustment**

This measure is not risk-adjusted or stratified.

#### **2.5.7 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of NQF #1637, Pain Assessment, is as follows:

1. Calculate the denominator count:
  - Calculate the total number of Type 1 patient stays in the denominator that do not meet the exclusion criteria and where the patient's pain severity was rated mild, moderate, or severe during pain screening.
2. Calculate the numerator count:

- Calculate the total number of stays where a comprehensive pain assessment was completed within 1 day of the pain screening during which the patient screened positive for pain **and** the comprehensive pain assessment 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.
3. Calculate the hospice's overall observed score:
- 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.

## 2.6 Quality Measure NQF #1639: Hospice and Palliative Care – Dyspnea Screening<sup>16</sup>

### 2.6.1 Quality Measure Description

This quality measure reports the percentage of hospice patients who were screened for dyspnea during the initial nursing assessment. The measure is calculated using HIS data. Patients are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see Section 2.1 *Key Definitions* for additional information on Type 2 and 3 patient stays).

### 2.6.2 Purpose/Rationale for Quality Measure

Shortness of breath (dyspnea) is prevalent and often under-treated among patients nearing the end of life. Dyspnea is a more common symptom than pain in patients with serious illnesses such as chronic obstructive lung disease (COPD), lung cancer, cystic fibrosis, and restrictive lung diseases such as pulmonary fibrosis.<sup>17</sup> Dyspnea is persistent in under-treated patients with advanced cancer and other end-stage diseases.<sup>18</sup> Screening for shortness of breath is necessary to determine its presence and severity, and screening forms the basis for treatment decision-making.

### 2.6.3 Denominator

The denominator for the measure includes all patient stays except for those that meet any exclusion criteria.

The exclusion criteria are:

1. Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**)

**OR**

8. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

### 2.6.4 Numerator

The numerator for the measure includes all patient stays from the denominator screened for shortness of breath within 2 days of the admission date. A screening for shortness of breath must include evaluating the patient for presence/absence of shortness of breath, and if shortness of breath is present, rating of its severity.

---

<sup>16</sup> Note that the length of stay criterion has been removed from the exclusions. This modification will be submitted to and reviewed by the NQF.

<sup>17</sup> Luce JM, Luce JA. Management of dyspnea in patients with far-advanced lung disease. *JAMA* 2001; 285:1331-1337.

<sup>18</sup> Roberts DK, Thorne SE, Pearson C. *Cancer Nurs* 1993; 16:310-320.

The numerator for the measure includes all patient stays from the denominator in which the patient meets the following criteria:

1. The patient was screened for shortness of breath within 2 days of the admission date (**J2030B – A0220 ≤ 2 and J2030B ≠ [-,^]**).

### **2.6.5 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

### **2.6.6 Risk Adjustment**

This measure is not risk-adjusted or stratified.

### **2.6.7 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of NQF #1639, Dyspnea Screening, is as follows:

1. Calculate the denominator count:
  - Calculate the total number of Type 1 patient stays that do not meet the exclusion criteria.
2. Calculate the numerator count:
  - Calculate the total number of stays in the denominator where the patient was screened for shortness of breath within 2 days of the admission date.
3. Calculate the hospice's overall observed score:
  - 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.

## **2.7 Quality Measure NQF #1638: Hospice and Palliative Care – Dyspnea Treatment<sup>19</sup>**

### **2.7.1 Quality Measure Description**

This quality measure reports the percentage of hospice patients who screened positive for dyspnea who received treatment within 1 day of the screening. The measure is calculated using

---

<sup>19</sup> Note that the length of stay criterion has been removed from the exclusions. This modification will be submitted to and reviewed by the NQF.

HIS data. Patients are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see Section 2.1 Key Definitions for additional information on Type 2 and 3 patient stays).

### 2.7.2 Purpose/Rationale for Quality Measure

Shortness of breath can be functionally limiting and distressing to patients and their families/caregivers. Effective treatment is available to alleviate symptom distress. Treatment can include pharmacologic and non-pharmacologic interventions that have demonstrated efficacy in randomized controlled trials of dyspnea treatment, specifically in patients with cancer and other serious illness.<sup>20,21</sup> Treatment for shortness of breath will vary in severity and etiology, and with patient and caregiver preferences.

### 2.7.3 Denominator

The denominator for the measure includes Type 1 patient stays, except for those with exclusions, in which the dyspnea screening indicated that the patient had shortness of breath (**J2030C = [1]**).

The exclusion criteria are:

1. Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**)

**OR**

2. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

### 2.7.4 Numerator

The numerator for this measure includes all patient stays from the denominator in which the patients indicated a positive screening for shortness of breath that meet either one of two criteria: either the patient declined dyspnea treatment or treatment was initiated prior to or within one day of the dyspnea screening for the patient.

The numerator for the measure includes all patient stays from the denominator in which the patient meets the following criteria:

1. The patient declined treatment (**J2040A = [1]**)

**OR**

2. 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

---

<sup>20</sup> Ben-Aharon I, Gafter-Gvili A, Paul M et al. Interventions for alleviating cancer-related dyspnea: a systematic review. *J Clin Oncol* 2008; 26:2396-2404.

<sup>21</sup> Lorenz KA, Lynn J, Dy SM et al. Evidence for improving palliative care at the end of life: a systematic review. *Ann Intern Med* 2008; 148:147-159.

positive for shortness of breath (**J2040B – J2030B ≤ 1 and J2040B and J2030B ≠ [-,^)**)

### **2.7.5 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

### **2.7.6 Risk Adjustment**

This measure is not risk-adjusted or stratified.

### **2.7.7 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of NQF #1638, Dyspnea Treatment, is as follows:

1. Calculate the denominator count:
  - Calculate the total number of Type 1 patient stays that do not meet the exclusion criteria **and** where the patient screened positive for dyspnea.
2. Calculate the numerator count:
  - Calculate the total number of Type 1 patient stays in the denominator that indicates that the patient declined treatment for dyspnea **or** treatment was initiated prior to the screening for shortness of breath or within one day of the screening for shortness of breath during which the patient screened positive for shortness of breath.
3. Calculate the hospice's overall observed score:
  - 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). Each quality measure score is converted to a percent value by multiplying by 100.

## 2.8 Quality Measure NQF #1617: Patient Treated with an Opioid who are Given a Bowel Regimen<sup>22</sup>

### 2.8.1 Quality Measure Description

This quality measure reports the percentage of hospice patients treated with an opioid that are offered/prescribed a bowel regimen or documentation of why a bowel regimen was not initiated or continued. The measure is calculated using HIS data. Patients are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see Section 2.1 *Key Definitions* for additional information on Type 2 and 3 patient stays).

### 2.8.2 Purpose/Rationale for Quality Measure

The purpose of this quality measure is to ensure patients on opioids are offered or prescribed a bowel regimen. A side effect of opioids is constipation, in which older adults who are immobile and dehydrated are at increased risk for, though adults of any age, report constipation as a side effect from opioid use.<sup>23</sup> A meta-analysis evaluating the side effects of opioid use in both cancer and non-cancer patients indicate that tolerance is not developed to opioid-induced constipation, confirming the need for prophylaxis.<sup>24</sup> One study found that out of 194,017 emergency department (ED) visits, 76,759 cancer patients in the final 6 months of life made 3,392 of those ED visits because of constipation.<sup>25</sup> A Cochrane systematic review of 26 studies of patients ( $\geq 18$  years of age) taking opioids for at least 6 months for non-cancer pain revealed that the most commonly reported side effect of opioids were gastrointestinal complaints (e.g., constipation, nausea, dyspepsia).<sup>26</sup>

### 2.8.3 Denominator

The denominator for the measure includes Type 1 patient stays, except for those with exclusions, in which scheduled opioid was initiated or continued (**N0500A = [1]**).

The exclusion criteria are:

1. Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**)

---

<sup>22</sup> Note that this measure does not have the length of stay exclusion. No changes have been made to this measure

<sup>23</sup> Tuteja AK, Biskupiak J, Stoddard GJ, et al. Opioid-induced bowel disorders and narcotic bowel syndrome in patients with chronic non-cancer pain. *Neurogastroenterol Motil* 2010;22:424-e96

<sup>24</sup> McNicol E, Horowicz-Mehler N, Fisk RA et al. Management of opioid side effects in cancer-related and chronic noncancer pain: a systematic review. *J Pain* 2003;4(5):231-56

<sup>25</sup> Barbera L, Taylor C, Dudgeon D. Why do patients with cancer visit the emergency department near the end of life? *Can Med Assoc J* 2010;182(6):563-569

<sup>26</sup> Noble M, Treadwell JR, Tregear SJ, et al. Long-term opioid treatment for chronic noncancer pain. *Cochrane Database Sys Rev* 2010;(1):CD006605

**OR**

2. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

#### **2.8.4 Numerator**

The numerator for the measure includes all patient stays from the denominator in which the patients are given a bowel regimen or have a documented reason for why a bowel regimen was not initiated or continued.

The numerator for the measure includes all patient stays from the denominator in which the patient meets the following criteria:

1. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1])

**OR**

2. 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 ≠ [-,^])

#### **2.8.5 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

#### **2.8.6 Risk Adjustment**

This measure is not risk-adjusted or stratified.

#### **2.8.7 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of NQF #1617, Patients Treated with an Opioid who are Given a Bowel Regimen, is as follows:

1. Calculate the denominator count:
  - Calculate the total number of patient stays that do not meet the exclusion criteria **and** a scheduled opioid was initiated or continued.
2. Calculate the numerator count:
  - Calculate the total number of Type 1 patient stays that indicates a documentation of why a bowel regimen was not initiated or continued **or** a bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued.

3. Calculate the hospice's overall observed score:
  - Divide the hospice's numerator count by its denominator count to obtain 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.

## **2.9 Proposed Quality Measure: Hospice Visits when Death is Imminent**

\*\*Note: the information below presents draft measure specifications are subject to change.

### **2.9.1 Quality Measure Pair Description**

This measure pair assesses hospice staff visits to patients and caregivers at the end of life. This measure pair is specified as a set of two measures. Measure 1 assesses the percentage of patients receiving at least one visit from registered nurses, physicians, nurse practitioners or physician assistants in the last 3 days of life. Measure 2 assesses the percentage of patients receiving at least two visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses or hospice aides in the last 7 days of life. Items used to calculate this measure pair will be included in HIS-Discharge records of HIS version 2.00.0.

### **2.9.2 Purpose/Rationale for Quality Measure Pair**

The last week of life is typically the period in the terminal illness trajectory with the highest symptom burden. Particularly during the last few days before death, patients often experience an increase in physical and emotional symptoms, necessitating close care and attention from the integrated hospice team. Hospice responsiveness during times of patient and caregiver need is an important aspect of care for hospice consumers. Visits, in addition to telephonic consults, are an important element of responsiveness. In addition, clinician visits to patients at the end of life have been demonstrated to be associated with improved outcomes such as decreased risk of hospitalization, emergency room visit, and hospital death, decreased distress for caregivers, and higher satisfaction with care.

The ultimate goal of this measure set is to capture whether a hospice patient and their family's needs were addressed by the hospice staff during the last days of life, when patients and caregivers typically experience higher symptom and caregiving burdens and therefore an increased need for care. Measure 1 addresses case management and clinical care, while Measure 2 gives providers the flexibility to provide individualized care that is in line with the patient and family's preferences and goals for care and contributing to the overall well-being of the patient and family.

### **2.9.3 Measure 1**

Measure 1 assesses the percentage of patients receiving at least 1 visit from Registered Nurses, Physicians, Nurse Practitioners or Physician Assistants in the last 3 days of life.

### 2.9.3.1 Items Included in the Quality Measure

The quality measure consists of 6 items from the HIS, which collect the number of visits provided on each of the final 3 days of life by certain disciplines. Please refer to *Appendix A* for the exact items on the HIS.

1. Number of visits from a Registered Nurse on each of the final 3 days of life (**O5010A1**, **O5010A2**, and **O5010A3**);
2. Number of visits from a Physician (or Nurse Practitioner or Physician Assistant) on each of the final 3 days of life (**O5010B1**, **O5010B2**, and **O5010B3**).

### 2.9.3.2 Denominator

The denominator for the measure includes all patient stays except for those that meet any exclusion criteria.

The exclusion criteria are:

1. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

**OR**

2. Patient did not expire in hospice care as indicated by reason for discharge (**A2115 != 01**)

**OR**

3. Patient received any continuous home care, respite care, or general inpatient care in the last 3 days of life (**O5000 = 1**).

### 2.9.3.3 Numerator

The numerator of this measure will be the number of patients in the denominator who receive at least one visit from registered nurses, physicians, nurse practitioners or physician assistants in the last 3 days of life. A patient stay is included in the numerator if the sum of the following is greater than or equal to 1: **O5010A1 + O5010A2 + O5010A3 + O5010B1 + O5010B2 + O5010B3**  $\geq 1$ .

### 2.9.3.4 Measure Time Window

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator.

### 2.9.3.5 Risk Adjustment

This measure is not risk-adjusted or stratified.

### 2.9.3.6 Calculation Algorithm

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed.

1. Calculate the denominator count
  - Calculate the total number of stays that do not meet the exclusion criteria.
2. Calculate the numerator count:
  - Calculate the total number of stays in the denominator that the patient and/or caregiver received at least 1 visit from a Registered Nurse or physician (or Nurse Practitioner or Physician Assistant) in the final 3 days.
  - A patient stay is included in the numerator if the sum of the following is greater than or equal to 1: **O5010A1 + O5010A2 + O5010A3 + O5010B1 + O5010B2 + O5010B3**  $\geq 1$
3. Calculate the hospice's overall observed score:
  - Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score. That is, divide the result of step B by the result of step A. Convert the quality measure score to a percentage value by multiplying by 100.

### 2.9.4 Measure 2

Measure 2 assesses the percentage of patients receiving at least 2 visits from Medical Social Workers, Chaplains or Spiritual Counselors, Licensed Practical Nurses or Hospice Aides in the last 7 days of life.

#### 2.9.4.1 Items Included in the Quality Measure

The quality measure consists of 28 items from the HIS, which collect the number of visits provided on each of the final 7 days of life by certain disciplines. Please refer to **Appendix A** for the exact items on the HIS.

1. Number of visits from a Medical Social Worker on each of the final 7 days of life (**O5010C1, O5010C2, O5010C3, O5030C1, O5030C2, O5030C3, and O5030C4**);
2. Number of visits from a Chaplain or Spiritual Counselor on each of the final 7 days of life (**O5010D1, O5010D2, O5010D3, O5030D1, O5030D2, O5030D3, and O5030D4**);
3. Number of visits from a Licensed Practical Nurse on each of the final 7 days of life (**O5010E1, O5010E2, O5010E3, O5030E1, O5030E2, O5030E3, and O5030E4**);

4. Number of visits from an Aide on each of the final 7 days of life (**O5010F1, O5010F2, O5010F3, O5030F1, O5030F2, O5030F3, and O5030F4**).

#### 2.9.4.2 Denominator

The denominator for the measure includes all patient stays except for those that meet any exclusion criteria.

The exclusion criteria are:

1. Type 2 (discharged stays missing the admission record) and Type 3 patient stays (active stays)

**OR**

2. Patient did not expire in hospice care as indicated by reason for discharge (**A2115 != 01**)

**OR**

3. Patient received any continuous home care, respite care, or general inpatient care in the last 7 days of life (**O5020 = 1**)

**OR**

4. Patient had a length of stay of one day as indicated by admission date (**A0220**) and discharge date (**A0270**).

#### 2.9.4.3 Numerator

The numerator of this measure will be the number of patients in the denominator who receive at least two visits from Medical Social Workers, Chaplains or Spiritual Counselors, Licensed Practical Nurses and Hospice Aides in the last 7 days of life. A patient stay is included in the numerator if the sum of the following is greater than or equal to 2: **O5010C1 + O5010C2 + O5010C3 + O5030C1 + O5030C2 + O5030C3 + O5030C4 + O5010D1 + O5010D2 + O5010D3 + O5030D1 + O5030D2 + O5030D3 + O5030D4 + O5010E1 + O5010E2 + O5010E3 + O5030E1 + O5030E2 + O5030E3 + O5030E4 O5010F1 + O5010F2 + O5010F3 + O5030F1 + O5030F2 + O5030F3 + O5030F4  $\geq$  2**

#### 2.9.4.4 Measure Time Window

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator.

#### 2.9.4.5 Risk Adjustment

This measure is not risk-adjusted or stratified.

#### 2.9.4.6 Calculation Algorithm

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed.

1. Calculate the denominator count
  - Calculate the total number of stays that do not meet the exclusion criteria.
2. Calculate the numerator count:
  - Calculate the total number of stays in the denominator that the patient and/or caregiver received at least 2 visits from a Medical Social Worker, Chaplain or Spiritual Counselor, Licensed Practical Nurse, or Aide in the final 7 days.
  - A patient stay is included in the numerator if the sum of the following is greater than or equal to 2: **O5010C1 + O5010C2 + O5010C3 + O5030C1 + O5030C2 + O5030C3 + O5030C4 + O5010D1 + O5010D2 + O5010D3 + O5030D1 + O5030D2 + O5030D3 + O5030D4 + O5010E1 + O5010E2 + O5010E3 + O5030E1 + O5030E2 + O5030E3 + O5030E4 O5010F1 + O5010F2 + O5010F3 + O5030F1 + O5030F2 + O5030F3 + O5030F4  $\geq 2$**
3. Calculate the hospice's overall observed score:
  - Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score. That is, divide the result of step B by the result of step A. Convert the quality measure score to a percentage value by multiplying by 100.

## 2.10 Proposed Quality Measure: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

\*\*Note: the information below presents draft measure specifications are subject to change.

### 2.10.1 Quality Measure Description

This quality measure reports the percentage of hospice patients who received all seven care processes referenced in sections 2.2 through 2.8 at admission. The measure is calculated using data from the HIS. Patient stays are excluded from the measure if they are under 18 years of age as indicated by the birth date and admission date or are a Type 2 or Type 3 patient stay (see Section 2.1 *Key Definitions* for additional information on Type 2 and 3 patient stays).

### 2.10.2 Purpose/Rationale for Quality Measure

The aim of this measure is to assess whether a comprehensive assessment is completed at hospice admission for each hospice patient based on seven quality measures (QMs) that assess high-priority care processes around admission as recognized by both leading hospice stakeholders and patients. Another key factor in creating a composite QM for comprehensive assessment at admission is to provide both consumers and providers with a single measure regarding the overall quality and completeness of assessment of patient needs at hospice admission, which can then be easily used to compare quality across providers<sup>27,28</sup>. In the current HQRP QMs that capture individual care processes, hospice performance scores are high on almost six of the seven measures with a score of 90% or higher, and perform significantly lower on the Pain Assessment QM (65.7%). On average, only 68.9% of patient stays in a hospice had documentation that all of these desirable care process were done at admission<sup>29</sup>. Thus, by assessing hospices' performance of comprehensive assessment, the composite measure sets a higher standard of care for hospices, and consequently reveals a larger performance gap. A similar effect has been shown in the literature where many facilities are achieving more than 90% compliance with individual measures, but compliance numbers decrease when multiple measures are combined as one<sup>30,31</sup>. The performance gap identified by the composite measure creates opportunities for quality improvement and may motivate providers to conduct a greater number of high priority care processes for as many patients as possible upon admission.

---

<sup>27</sup> Hubbart, M., Ross, J., & Schmitz, R. (2011). Condition-Specific Composites Presentation: Mathematica Policy Research Inc.

<sup>28</sup> Peterson, E. D., DeLong, E. R., Masoudi, F. A., O'Brien, S. M., Peterson, P. N., Rumsfeld, J. S., . . . Shaw, R. E. (2010). ACCF/AHA 2010 Position Statement on Composite Measures for Healthcare Performance Assessment American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures (Writing Committee to Develop a Position Statement on Composite Measures). *Journal of the American College of Cardiology*, 55(16), 1755-1766. doi: 10.1016/j.jacc.2010.02.016.

<sup>29</sup> HIS data October 2014 - September 2015

<sup>30</sup> Nolan, T., & Berwick, D. M. (2006). All-or-none measurement raises the bar on performance. *JAMA* [H.W. Wilson - GS], 295(10), 1168.

<sup>31</sup> Agency for Healthcare Research and Quality. (2004). National Healthcare Quality Report.

### 2.10.3 Components of the Quality Measure

The quality measure consists of seven component measures. These measures are the six National Quality Forum (NQF)-endorsed QMs and one modified NQF-endorsed QM currently implemented in the Hospice Quality Reporting Program (HQRP) listed below. For more details on the individual component measures please refer to sections 2.2 through 2.8.

Seven Component Measures of the Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission measure:

1. Hospice and Palliative Care – Treatment Preferences (NQF #1641)
2. Beliefs/Values Addressed (If Desired by the Patient) (modified NQF #1647)
3. Hospice and Palliative Care – Pain Screening (NQF #1634)
4. Hospice and Palliative Care – Pain Assessment (NQF #1637)
5. Hospice and Palliative Care – Dyspnea Screening (NQF #1639)
6. Hospice and Palliative Care – Dyspnea Treatment (NQF #1638)
7. Patient Treated with an Opioid who are Given a Bowel Regimen (NQF #1617)

### 2.10.4 Denominator

The denominator for the measure includes all patient stays except for those that meet any exclusion criteria.

The exclusion criteria are:

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

### 2.10.5 Numerator

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.

Type 1 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 ≠ [-,^])

---

\* denotes paired measures. For paired measures, some patients may not qualify for the second component of the paired measure. In this instance, in the calculation of the composite measure, the patient will be eligible for the numerator as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, they are not eligible for the component pain assessment measure, however, in the composite measure, the hospice would be 'given credit' for completing the comprehensive pain assessment.

### **2.10.6 Measure Time Window**

The measure will be calculated quarterly using a rolling 12 months of data. All hospice stays, except those that meet the exclusion criteria, discharged during the 12 months are included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the 12-month time window, each stay is eligible for inclusion in the measure.

### **2.10.7 Risk Adjustment**

This measure is not risk-adjusted or stratified.

### **2.10.8 Calculation Algorithm**

This measure is not risk-adjusted or stratified, and therefore, only the hospice-level observed score is computed. The measure logic of the proposed quality measure “Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission,” is as follows:

1. Calculate the denominator count:
  - Calculate the total number of Type 1 stays that do not meet the exclusion criteria.
2. Calculate the numerator count:
  - 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.
3. Calculate the hospice’s overall observed score:
  - 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.

*Appendix B* presents a logic flow chart illustrating this approach.



**APPENDIX A:  
PROPOSED V2.00.0**

**Hospice Item Set - Admission**

<b>Section A</b>		<b>Administrative Information</b>
<b>A0050. Type of Record</b>		
Enter Code <input type="checkbox"/>	1. Add new record 2. Modify existing record 3. Inactivate existing record	
<b>A0100. Facility Provider Numbers. Enter code in boxes provided.</b>		
<b>A. National Provider Identifier (NPI):</b> <input type="text"/> <input type="text"/>		
<b>B. CMS Certification Number (CCN):</b> <input type="text"/> <input type="text"/>		
<b>A0205. Site of Service at Admission</b>		
Enter Code <input type="text"/> <input type="text"/>	01. Hospice in patient's home/residence 02. Hospice in Assisted Living facility 03. Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF) 04. Hospice provided in a Skilled Nursing Facility (SNF) 05. Hospice provided in Inpatient Hospital 06. Hospice provided in Inpatient Hospice Facility 07. Hospice provided in Long Term Care Hospital (LTCH) 08. Hospice in Inpatient Psychiatric Facility 09. Hospice provided in a place not otherwise specified (NOS) 10. Hospice home care provided in a hospice facility	
<b>A0220. Admission Date</b>		
	<input type="text"/> <input type="text"/> Month	<input type="text"/> <input type="text"/> Day
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	
<b>A0245. Date Initial Nursing Assessment Initiated</b>		
	<input type="text"/> <input type="text"/> Month	<input type="text"/> <input type="text"/> Day
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	
<b>A0250. Reason for Record</b>		
Enter Code <input type="text"/> <input type="text"/>	01. Admission 09. Discharge	



**Section A****Administrative Information****A1000. Race/Ethnicity**

↓ Check all that apply

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | A. American Indian or Alaska Native          |
| <input type="checkbox"/> | B. Asian                                     |
| <input type="checkbox"/> | C. Black or African American                 |
| <input type="checkbox"/> | D. Hispanic or Latino                        |
| <input type="checkbox"/> | E. Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> | F. White                                     |

**A1400. Payor Information**

↓ Check all that apply

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | A. Medicare (traditional fee-for-service)            |
| <input type="checkbox"/> | B. Medicare (managed care/Part C/Medicare Advantage) |
| <input type="checkbox"/> | C. Medicaid (traditional fee-for-service)            |
| <input type="checkbox"/> | D. Medicaid (managed care)                           |
| <input type="checkbox"/> | G. Other government (e.g., TRICARE, VA, etc.)        |
| <input type="checkbox"/> | H. Private Insurance/Medigap                         |
| <input type="checkbox"/> | I. Private managed care                              |
| <input type="checkbox"/> | J. Self-pay  |
| <input type="checkbox"/> | K. No payor source                                   |
| <input type="checkbox"/> | X. Unknown   |
| <input type="checkbox"/> | Y. Other   |

**A1802. Admitted From. Immediately preceding this admission, where was the patient?**

- |   |   |
|---|---|
| Enter Code<br><input type="text"/> <input type="text"/> | 01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care)<br>02. Long-term care facility<br>03. Skilled Nursing Facility (SNF)<br>04. Hospital emergency department<br>05. Short-stay acute hospital<br>06. Long-term care hospital (LTCH)<br>07. Inpatient rehabilitation facility or unit (IRF)<br>08. Psychiatric hospital or unit<br>09. ID/DD Facility<br>10. Hospice<br>99. None of the Above |
|---|---|

**Section F****Preferences****F2000. CPR Preference**

Enter Code

**A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?** - Select the most accurate response

0. No → Skip to F2100, Other Life-Sustaining Treatment Preferences

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

**B. Date the patient/responsible party was first asked about preference regarding the use of CPR:**

Month

Day

Year

**F2100. Other Life-Sustaining Treatment Preferences**

Enter Code

**A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR?** - Select the most accurate response

0. No → Skip to F2200, Hospitalization Preference

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

**B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:**

Month

Day

Year

**F2200. Hospitalization Preference**

Enter Code

**A. Was the patient/responsible party asked about preference regarding hospitalization?** - Select the most accurate response

0. No → Skip to F3000, Spiritual/Existential Concerns

1. Yes, and discussion occurred

2. Yes, but the patient/responsible party refused to discuss

**B. Date the patient/responsible party was first asked about preference regarding hospitalization:**

Month

Day

Year

**F3000. Spiritual/Existential Concerns**

Enter Code

**A. Was the patient and/or caregiver asked about spiritual/existential concerns?** - Select the most accurate response

0. No → Skip to I0010, Principal Diagnosis

1. Yes, and discussion occurred

2. Yes, but the patient and/or caregiver refused to discuss

**B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:**

Month

Day

Year

**Section I****Active Diagnoses****I0010. Principal Diagnosis**

Enter Code

- 01. Cancer
- 02. Dementia/Alzheimer's
- 99. None of the above

**Section J****Health Conditions****Pain****J0900. Pain Screening**

Enter Code

**A. Was the patient screened for pain?**

- 0. No → Skip to J0905, Pain Active Problem
- 1. Yes

**B. Date of first screening for pain:**

Month

Day

Year

Enter Code

**C. The patient's pain severity was:**

- 0. None
- 1. Mild
- 2. Moderate
- 3. Severe
- 9. Pain not rated

Enter Code

**D. Type of standardized pain tool used:**

- 1. Numeric
- 2. Verbal descriptor
- 3. Patient visual
- 4. Staff observation
- 9. No standardized tool used

**J0905. Pain Active Problem**

Enter Code

**Is pain an active problem for the patient?**

- 0. No → Skip to J2030, Screening for Shortness of Breath
- 1. Yes

**Section J****Health Conditions****J0910. Comprehensive Pain Assessment**

Enter Code

**A. Was a comprehensive pain assessment done?**

0. No → Skip to J2030, Screening for Shortness of Breath  
1. Yes

**B. Date of comprehensive pain assessment:**

Month

Day

Year

**C. Comprehensive pain assessment included:**

↓ Check all that apply

1. Location

2. Severity

3. Character

4. Duration

5. Frequency

6. What relieves/worsens pain

7. Effect on function or quality of life

9. None of the above

**Section J**

**Health Conditions**

**Respiratory Status**

**J2030. Screening for Shortness of Breath**

Enter Code

**A. Was the patient screened for shortness of breath?**

- 0. No → Skip to N0500, Scheduled Opioid
- 1. Yes

**B. Date of first screening for shortness of breath:**

Month

Day

Year

Enter Code

**C. Did the screening indicate the patient had shortness of breath?**

- 0. No → Skip to N0500, Scheduled Opioid
- 1. Yes

**J2040. Treatment for Shortness of Breath**

Enter Code

**A. Was treatment for shortness of breath initiated?** - Select the most accurate response

- 0. No → Skip to N0500, Scheduled Opioid
- 1. No, patient declined treatment → Skip to N0500, Scheduled Opioid
- 2. Yes

**B. Date treatment for shortness of breath initiated:**

Month

Day

Year

**C. Type(s) of treatment for shortness of breath initiated:**

↓ Check all that apply

1. Opioids

2. Other medication

3. Oxygen

4. Non-medication

**Section N****Medications****N0500. Scheduled Opioid**

Enter Code

**A. Was a scheduled opioid initiated or continued?**

0. No → Skip to N0510, PRN Opioid  
1. Yes

**B. Date scheduled opioid initiated or continued:**

Month

Day

Year

**N0510. PRN Opioid**

Enter Code

**A. Was a PRN opioid initiated or continued?**

0. No → Skip to N0520, Bowel Regimen  
1. Yes

**B. Date PRN opioid initiated or continued:**

Month

Day

Year

**N0520. Bowel Regimen**

Complete only if N0500A or N0510A = 1

Enter Code

**A. Was a bowel regimen initiated or continued?** - Select the most accurate response

0. No → Skip to Z0400, Signature(s) of Person(s) Completing the Record  
1. No, but there is documentation of why a bowel regimen was not initiated or continued → Skip to Z0400, Signature(s) of Person(s) Completing the Record  
2. Yes

**B. Date bowel regimen initiated or continued:**

Month

Day

Year

**Section Z****Record Administration****Z0400. Signature(s) of Person(s) Completing the Record**

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

**Z0500. Signature of Person Verifying Record Completion****A. Signature:**

\_\_\_\_\_

**B. Date:**

--	--

Month

--	--

Day

--	--	--	--

Year

## Hospice Item Set – Discharge

<b>Section A</b>	<b>Administrative Information</b>
<b>A0050. Type of Record</b>	
Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	1. Add new record 2. Modify existing record 3. Inactivate existing record
<b>A0100. Facility Provider Numbers. Enter code in boxes provided.</b>	
	<b>A. National Provider Identifier (NPI):</b> <input style="width: 100px; height: 20px;" type="text"/>
	<b>B. CMS Certification Number (CCN):</b> <input style="width: 100px; height: 20px;" type="text"/>
<b>A0220. Admission Date</b>	
	<input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 60px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
<b>A0250. Reason for Record</b>	
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	01. Admission 09. Discharge
<b>A0270. Discharge Date</b>	
	<input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 60px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
<b>A0500. Legal Name of Patient</b>	
	<b>A. First name:</b> <input style="width: 100px; height: 20px;" type="text"/>
	<b>B. Middle initial:</b> <input style="width: 30px; height: 20px;" type="text"/>
	<b>C. Last name:</b> <input style="width: 100px; height: 20px;" type="text"/>
	<b>D. Suffix:</b> <input style="width: 30px; height: 20px;" type="text"/>



**Section 0****Service Utilization****05000. Level of care in final 3 days**

Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code

Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life?

0. No

1. Yes → Skip to Z0400, Signature(s) of Person(s) Completing the Record

**05010. Number of hospice visits in final 3 days**

Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits on day of death (A0270)	Visits one day prior to death (A0270 minus 1)	Visits two days prior to death (A0270 minus 2)
A. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Physician (or Nurse Practitioner or Physician Assistant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Medical Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Chaplain or Spiritual Counselor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Licensed Practical Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**05020. Level of care in final 7 days**

Complete only if A2115, Reason for Discharge = 01 Expired

Enter Code

Did the patient receive Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life?

0. No

1. Yes → Skip to Z0400, Signature(s) of Person(s) Completing the Record

**05030. Number of hospice visits in 3 to 6 days prior to death**

Enter the number of visits provided by hospice staff from the indicated discipline, on each of the dates indicated.

	Visits three days prior to death (A0270 minus 3)	Visits four days prior to death (A0270 minus 4)	Visits five days prior to death (A0270 minus 5)	Visits six days prior to death (A0270 minus 6)
A. Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Physician (or Nurse Practitioner or Physician Assistant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Medical Social Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Chaplain or Spiritual Counselor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Licensed Practical Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section Z**

**Record Administration**

**Z0400. Signature(s) of Person(s) Completing the Record**

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

**Z0500. Signature of Person Verifying Record Completion**

<p><b>A. Signature:</b></p> <p>_____</p>	<p><b>B. Date:</b></p> <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>									Month		Day		Year			
Month		Day		Year													

**APPENDIX B:  
COMPOSITE MEASURE LOGIC FLOW CHART FOR ALL-OR-NONE APPROACH  
BASED ON ALL 7 QM**

