



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0208

Corresponding Measures:

De.2. Measure Title: Family Evaluation of Hospice Care

Co.1.1. Measure Steward: National Hospice and Palliative Care Organization

De.3. Brief Description of Measure: Derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 to 100 and is an indication of the hospice's overall performance on key aspects of care delivery.

Target Population: The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. **Timeframe:** The survey measures family member's perception of the quality of hospice care for the entire enrollment period, regardless of length of service. The computed hospice level performance score is calculated with once a quarter year.

1b.1. Developer Rationale: Use of this measure affords hospices a valid means of ensuring quality of care by providing useful, meaningful, and actionable information that can be incorporated into their Quality Assurance/Performance Improvement (QAPI) programs. Implementation of a QAPI program is a requirement in the Medicare Conditions of Participation for hospices. Use of the measure will facilitate improved quality in the following aspects of hospice care: symptom management, communication, provision of information, emotional support, and care coordination.

S.4. Numerator Statement: The numerator is the sum total of the weighted incidence of problem scores occurring in response to 17 specific items on each survey. The 17 questions focus on the following aspects of hospice care: symptom management, communication, provision of information, emotional support and care coordination.

S.6. Denominator Statement: The denominator represents the number of surveys with responses for at least 14 of the 17 questions required to compute the composite score in the FEHC survey.

S.8. Denominator Exclusions: If a survey has responses to fewer than 14 of the 17 FEHC survey questions included in calculation of the composite score, then a composite score will not be calculated for that survey and the survey will not be included in the calculation of a composite score for the hospice.

De.1. Measure Type: Outcome: PRO-PM

S.17. Data Source: Instrument-Based Data

S.20. Level of Analysis: Facility, Other

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Jan 07, 2015

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and

improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[MeasSubm_Evidence_05192014.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Use of this measure affords hospices a valid means of ensuring quality of care by providing useful, meaningful, and actionable information that can be incorporated into their Quality Assurance/Performance Improvement (QAPI) programs. Implementation of a QAPI program is a requirement in the Medicare Conditions of Participation for hospices.

Use of the measure will facilitate improved quality in the following aspects of hospice care: symptom management, communication, provision of information, emotional support, and care coordination.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

A sample of FEHC survey submissions was collected for the 2013 calendar year. During that year 1,551 hospices across the United States, provided 228,134 completed surveys. Composite scores were calculated for each of the surveys and then averaged to produce the overall hospice score. The mean Composite Score was 86.01% with a median of 86.03%. The lowest score recorded was 75.07% and the highest was 98.54% (SD = 3.13%), demonstrating a clear and significant range of scores. The inter quartile range of scores was 84.04% and 87.99% for the 25th and 75th percentiles respectively. The very low skewness and kurtosis of the measure also indicates good normality in the distribution of responses. Average Composite scores over the past three years have increased from 85.37% in 2011 to the current average of 85.51%.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

A statistically significant but non-substantial difference in Composite Score performances between racial and ethnic groups was observed. The average Composite Scores for Hispanic and non-Hispanic patients were 83.9% (95%CI: 83.6% to 84.2%) and 85.4% (95%CI: 85.3% to 85.4%) respectively. The average Composite Scores for patients who's race was identified as white, black, and all other races was 85.5% (95% CI: 85.4% to 85.5%), 86.0% (95% CI: 85.7% to 86.2%), and 82.0% (95% CI: 81.7% to 82.3%) respectively.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from

the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Cancer, Cardiovascular, Gastrointestinal (GI), Infectious Diseases (ID), Infectious Diseases (ID) : HIV/AIDS, Neurology, Palliative Care and End-of-Life Care, Renal, Respiratory : Chronic Obstructive Pulmonary Disease (COPD), Respiratory : Dyspnea, Respiratory : Pneumonia

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination, Person-and Family-Centered Care

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk : Individuals with multiple chronic conditions

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<http://www.nhpco.org/fehc-survey-materials>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [NQF2014_FEHC_DataCodes-635357610420429333.docx](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

No changes made

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The numerator is the sum total of the weighted incidence of problem scores occurring in response to 17 specific items on each survey. The 17 questions focus on the following aspects of hospice care: symptom management, communication, provision of information, emotional support and care coordination.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Responses to each of 17 questions are coded 0 or 1, where 0 represents the best possible response for that question and 1 represents all other responses. Each response is then multiplied by a weighting factor and summed. The sum of all 17 weighted scores is then multiplied by 14.00006. The product is then subtracted from 100 then divided by 100. This yields the Composite Score for an individual survey. The scores for each survey are added together to create the FEHC Composite Score numerator at the organization (hospice) level.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

The denominator represents the number of surveys with responses for at least 14 of the 17 questions required to compute the composite score in the FEHC survey.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Total number of survey with responses to at least 14 of the 17 FEHC questions needed to calculate the composite score.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

If a survey has responses to fewer than 14 of the 17 FEHC survey questions included in calculation of the composite score, then a composite score will not be calculated for that survey and the survey will not be included in the calculation of a composite score for the hospice.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

See S.10

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

No stratification

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Other (specify):

If other: Composite Score is a number expressed as a percent, on a range from 0% to 100%

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

1. Obtain data (responses to questions) for the 17 questions from the FEHC survey that comprise the Composite Score
2. Dichotomize all constituent questions into a) most desirable response; and b) all other responses for each question. "No answer" or non-valid responses = null.
3. Calculate composite score for each of the 17 questions for each survey using the following formula: $\text{Composite_Score} = (100 - (14.00006 * (F1 * 0.4125 + F2 * 0.2331 + F3 * 0.3659 + E2 * 0.3259 + E3 * 0.4792 + E4 * 0.4059 + D3 * 0.4766 + D4 * 0.5646 + D5 * 0.5295 + D7 * 0.5433 + D8 * 0.5819 + D9 * 0.5323 + B2 * 0.3236 + B6 * 0.3629 + B10 * 0.4435 + B80.4211 + B4 * 0.44379))) / 100$
4. Calculate composite score for hospice by averaging the composite scores for each survey

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

The expectation is that the FEHC survey is sent to the primary family caregiver for each deceased hospice patient served by a given hospice. The FEHC survey is specifically designed to allow those family caregivers who have first hand knowledge/experience with the care of the deceased patient to evaluate the care that they and the patient received. A proxy response for this survey is not allowed because the respondent must have first-hand knowledge of the care received by the patient. However, support in the form of translating questions, may be provided to respondents whose primary language is not English.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

1. Hospice downloads the survey from NHPCO web site (www.nhpc.org/fehc)
2. Administer FEHC survey: Hospice mails survey (on a rolling basis) to caregivers of all patients who died while enrolled in hospice services. NHPCO recommends mailing the surveys from 1 to 3 months post-death.
3. Data collection and submission: Surveys are returned to hospice. As soon as surveys are returned, data submission can begin. Data submission is performed online on a quarterly schedule through the FEHC web-based data submission system. The web-based system is accessed through the NHPCO Web site.

A hospice may also use a vendor for survey administration.

Response rates are calculated by dividing the number of surveys returned during a calendar quarter by the number of surveys mailed for that same quarter.

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Instrument-Based Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

The Family Evaluation of Hospice Care survey, a 62 question paper survey mailed to the primary family caregivers of deceased hospice patients. Surveys are mailed one to three months after the death of the patient. Respondents complete the survey and mail the response back to the hospice. In some cases, hospices contract with a third party vendor to perform survey administration and data collection. Surveys are administered via paper and pencil. The survey is available only in English.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available at measure-specific web page URL identified in S.1

S.20. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Other

S.21. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Home Care

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

There are multiple steps in the calculation of the FEHC Composite Score Measure for an individual hospice:

1. A FEHC composite score is calculated per the calculation formula in S.6 for each survey that meets the exclusion criteria
2. The composite scores for the individual surveys are summed
3. The sum of the composite scores is divided by the number of surveys that meet the exclusion criteria

The 17 questions on the FEHC survey that comprise the FEHC Composite Score, the best possible-responses to the questions, and their respective weights are as follows:

-Question

-Response

-Weight

B2 – How much medicine did the patient receive for his/her pain?

- Just the right amount
- 0.3236

B4 – Did you want more information than you got about the medicines used to manage the patient's pain?

- No
- 0.44379

B6 – How much help in dealing with his/her breathing did the patient receive while under the care hospice?

- Just the right amount
- 0.3629

B8 – Did you want more information than you got about what was being done for the patient's trouble with breathing?

- No
- 0.4211

B10 – How much help in dealing with these feelings did the patient receive?

- Right amount
- 0.4435

D3 – How confident did you feel about doing what you needed to do in taking care of the patient?

- Very confident
- 0.4766

D4 – How confident were you that you knew as much as you needed to about the medicines being used to manage the patient's pain, shortness of breath, or other symptoms?

- Very confident
- 0.5646

D5 – How often did the hospice team keep you or other family members informed about the patient's condition?

- Always
- 0.5295

D7 – Would you have wanted more information about what to expect while the patient was dying?

- No
- 0.5433

D8 – How confident were you that you knew what to expect while the patient was dying?

- Very confident
- 0.5819

D9 – How confident were you that you knew what to do at the time of death?

- Very confident

- 0.5323

E2 – Did you have as much contact of that kind as you wanted?

- Yes

- 0.3259

E3 – How much emotional support did the hospice team provide to you prior to the patient's death?

- Right amount

- 0.4792

E4 – How much emotional support did the hospice team provide to you after the patient's death?

- Right amount

- 0.4059

F1 – How often did someone from the hospice team give confusing or contradictory information about the patient's medical treatment?

- Never

- 0.4125

F2 – While under the care of hospice was there always one nurse who was identified as being in charge of the patient's overall care?

- Yes

- 0.2331

F3 – Was there any problem with hospice doctors or nurses not knowing enough about the patient's medical history to provide the best possible care?

- No

- 0.3659

The Composite Score equation is:

Composite_Score = (100-(14.00006*(F1*0.4125 + F2*0.2331 + F3*0.3659 + E2*0.3259 + E3*0.4792 + E4*0.4059 + D3*0.4766 + D4*0.5646 + D5*0.5295 + D7*0.5433 + D8*0.5819 + D9*0.5323 + B2*0.3236 + B6*0.3629 + B10*0.4435 + B80.4211 + B4*0.44379))))/100

2. Validity – See attached Measure Testing Submission Form

[MeasSubm_MeasTesting_05192014.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without

undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Other

If other: [Needed data elements are obtained through administration of the FEHC survey](#)

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

[No data elements are in defined fields in electronic sources](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

[Data elements are captured in a paper survey and returned to the hospice or a third-party survey vendor contracted by the hospice. Currently two options exist for electronic capturing of the data elements. The first is for hospices to manually enter their survey response into NHPCO's web-based secure data entry system. The second is for the vendor who administers the survey and collects responses, to forward the data to NHPCO for inclusion in the FEHC data repository.](#)

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

[NHPCO maintains ongoing support \(in the form of written materials and one-on-one guidance\) for hospice providers who use the measure for all aspects of the FEHC survey process, ranging from survey administration to results interpretation. Monitoring of support requests has not shown any trends in problems or issues that indicated the need for modifications in the approach to data collection. Hospices vary in size and resources, and data collection strategies employed tend to vary with the individual characteristics of the hospices. In general, it is the larger hospices \(because greater size allows a larger operating budget\) that contract with vendors for survey administration and data collection.](#)

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

[There are no fees for organizations to utilize the FEHC survey instrument or to perform their own analysis of FEHC survey data.](#)

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance

results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Quality Improvement (Internal to the specific organization) NHPCO's Performance Measure program http://www.nhpco.org/performance-measures/family-evaluation-hospice-care-fehc

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

a. Public Reporting: FEHC Composite Score is not currently used for public reporting, but results from several questions that are included in the FEHC Composite Score are in use. The American Hospice Foundation has a comparative hospice report card that uses results of many of the survey questions that comprise the FEHC Composite Score. The study group utilized to test the report card included 130 hospices across multiple states. It is unknown what their current utilization rate is. The state of Florida also has a state level hospice reporting program that includes results from several questions from the FEHC survey that are part of the FEHC Composite Score. The data collected by the state include 43 licensed hospice in Florida representing over 116,000 hospice patients.

The annual AHRQ Quality and Disparity also include results from FEHC survey questions. These data are provided by NHPCO and represent data collected from 217,000 hospice patients across all 50 States and Puerto Rico.

f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations).

NHPCO provides quarterly reports to member hospice organizations that participate in FEHC. These reports are specifically designed for quality improvement. In 2013 data from collected by NHPCO included over 1,500 hospice locations and 228,000 hospice patients from all 50 State.

G Quality Improvement (Internal to the specific organization)

NHPCO provides quarterly reports to member hospice organizations that participate in FEHC. These reports are specifically designed for quality improvement. In 2013 data from collected by NHPCO included over 1,500 hospice locations and 228,000 hospice patients from all 50 State.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

It has long been the intention and desire of NHPCO, in collaboration with Dr. Joan Teno, that the FEHC Composite be used for accountability as well as quality improvement. The Affordable Care Act (ACA) mandated the initiation of quality reporting for hospices, which began in 2012. In addition the ACA stipulated that CMS also make hospice quality information publically available, but no date was set. Subsequently, the FEHC survey has included in CMS proposed rulemaking multiple times for use in an accountability application. However, CMS ultimately decided to develop a Hospice CAHPS survey instead of adopting the FEHC survey and measures derived from the survey, for accountability.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for

implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

As explained in 41.2, CMS has chosen to develop and require the use of a CAHPS Hospice survey. However, hospices that have 50 or fewer deaths in a calendar year are exempt from this requirement. The CAHPS Hospice survey must be administered and data collected by a vendor, so the hospices that are exempt are not likely to use the CAHPS Hospice survey. The majority of hospices in the US utilize the FEHC survey, or a similar post-death evaluation of care survey, and use measures derived from these surveys as the foundation of their QAPI programs. Because of the proven value of the FEHC survey and the FEHC Composite Score, NHPCO will continue to support the survey for use by those hospices that will not be utilizing the Hospice CAHPS.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4a2.2.2. Summarize the feedback obtained from those being measured.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

To date, there have been no reported negative consequences to any individual or population utilizing the FEHC survey, or to hospices utilizing the FEHC Composite Score.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information
Co.1 Measure Steward (Intellectual Property Owner): National Hospice and Palliative Care Organization Co.2 Point of Contact: Carol, Spence, cspence@nhpco.org, 703-837-3137- Co.3 Measure Developer if different from Measure Steward: Co.4 Point of Contact: 3137-
Additional Information
Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. Joan Teno, MD Brown University, Center for Gerontology and Healthcare Research, Brown Medical School. Dr. Teno conducted the original research that served as the basis for the FEHC survey that is the data source for the measure. She also developed the measure in collaboration with the following NHPCO staff: Carol Spence, PhD Matthew Haskins, MPH
Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: 2003 Ad.3 Month and Year of most recent revision: 08, 2011 Ad.4 What is your frequency for review/update of this measure? Annual Ad.5 When is the next scheduled review/update for this measure?
Ad.6 Copyright statement: Copyright holder of the FEHC survey is Brown University which makes the survey available for use free of charge with the provision it is not modified or sold. Ad.7 Disclaimers:
Ad.8 Additional Information/Comments: