



## 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 #:** 0209

**Corresponding Measures:**

**De.2. Measure Title:** Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment

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

**De.3. Brief Description of Measure:** Percentage of patients who report being uncomfortable because of pain at the initial assessment who, at the follow up assessment, report pain was brought to a comfortable level within 48 hours.

**1b.1. Developer Rationale:** As a patient reported outcome (PRO) the measure captures and reflects patient goals for pain management. The use of a dichotomous rating, incorporating the patient's perception of his/her own degree of comfort, provides a means of assessing provider performance of initial pain management. Consequently, this measure provides a more comprehensive picture of pain management than a measure that relies on achieving a specific score on a pain intensity rating scale or change in pain intensity rating.

While it is recognized that pain scales have intra-individual validity and that mean values have importance for population studies, the utility of numerical pain scores for a concurrently evaluated outcome measure and for program/system accountability is problematic. Not all patients mean the same thing when they give a rating – one person's '3' may be another patient's '6.' The value of a numerical rating scale lies in comparison within subjects (comparing ratings over time) – and the fact that change is accomplished, or not, is more relevant than the absolute number achieved. However, change in scores alone does not demonstrate whether comfort was achieved. In addition, using a set numeric rating as goal loses, or at least undermines, the concept of patient self-determination. If pain is an individual experience with an individual response, then the decision of what is acceptable/comfortable

should be left up to the individual, not determined arbitrarily. It's more consistent with patient-centered care to care to ask the patient to decide how comfortable he/she wants to be. Because of its focus on comfort, the measure also allows for a broader conceptualization of pain than use of a measure that relies solely on a numeric intensity rating. The measure also has the advantage of identifying those patients who require intervention and at the same time allows the clinician to use the most appropriate means of pain assessment for each individual patient.

**S.4. Numerator Statement:** Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment.

**S.6. Denominator Statement:** Patients who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment.

**S.8. Denominator Exclusions:** Patients who do not report being uncomfortable because of pain at initial assessment (i.e., patients who reply "no" to the question "Are you uncomfortable because of pain?"

Patients under 18 years of age

Patients who cannot self report pain

Patients who are unable to understand the language of the person asking the initial and follow up questions

**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:** Oct 26, 2016

**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?**

## 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

[0209\\_Evidence\\_2016\\_2\\_29-635936604787753124-637372241260216405.docx](#), [NQF\\_evidence\\_attachment\\_Sep2017-637372241260216405-637417321973185371.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.

No

### 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.*

As a patient reported outcome (PRO) the measure captures and reflects patient goals for pain management. The use of a dichotomous rating, incorporating the patient's perception of his/her own degree of comfort, provides a means of assessing provider performance of initial pain management. Consequently, this measure provides a more comprehensive picture of pain management than a measure that relies on achieving a specific score on a pain intensity rating scale or change in pain intensity rating.

While it is recognized that pain scales have intra-individual validity and that mean values have importance for population studies, the utility of numerical pain scores for a concurrently evaluated outcome measure and for program/system accountability is problematic. Not all patients mean the same thing when they give a rating – one person's '3' may be another patient's '6.' The value of a numerical rating scale lies in comparison within subjects (comparing ratings over time) – and the fact that change is accomplished, or not, is more relevant than the absolute number achieved. However, change in scores alone does not demonstrate whether comfort was achieved. In addition, using a set numeric rating as goal loses, or at least undermines, the concept of patient self-determination. If pain is an individual experience with an individual response, then the decision of what is acceptable/comfortable

should be left up to the individual, not determined arbitrarily. It's more consistent with patient-centered care to care to ask the patient to decide how comfortable he/she wants to be. Because of its focus on comfort, the measure also allows for a broader conceptualization of pain than use of a measure that relies solely on a numeric intensity rating. The measure also has the advantage of identifying those patients who require intervention and at the same time allows the clinician to use the most appropriate means of pain assessment for each individual patient.

**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.**

Years

	2012	2013	2014	2015
Mean	66.4	61.4	61.4	64.7
Std. Dev.		21.1	20.2	20.4 24.5
n (facilities)		143	292	74 46
no. of patients		9077	16522	3750 2072

Quartiles of the facility scores

	2012	2013	2014	2015
min	0	0	20	0
1st	57	50	46	50
median	66	60	60	65
3rd	80	74	75	81
max	100	100	100	100

Deciles of the facility scores

	2012	2013	2014	2015
min	0%	0%	20%	0%
10 %ile	40%	37%	33%	31%
20 %ile	51%	46%	43%	48%
30 %ile	60%	53%	50%	51%
40 %ile	63%	58%	52%	57%
50 %ile	66%	62%	60%	65%
60 %ile	70%	65%	64%	69%
70 %ile	75%	70%	74%	74%
80 %ile	84%	78%	79%	87%
90 %ile	97%	88%	86%	100%
max	100%	100%	100%	100%

**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.**

**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.**

The initial testing included a total of 1409 patients, 463 (32.86 %) of whom responded that they were uncomfortable because of pain. On follow up, (13%) indicated their pain was not brought to a comfortable level; 87 (18.8%) were unable to self report; and 44 (9.5%) had missing data. Data were collected over a 6 month period from all patients on initial assessment enrolled in the hospices participating in the testing of the measure.

Of those patients in the sample who had a primary diagnosis of cancer, 81% had pain brought to a comfortable level and 19% did not. Of those patients in the sample who had a non-cancer primary diagnosis, 84.8% had pain brought to a comfortable level and 15.2% did not. There was no statistically significant difference (p 0.52) in the ethnic distribution of patients whose pain was not brought to a comfortable level compared to those who achieved comfort.

Subsequent, more recent (2014) testing used a sample of 2329 patients to examine possible disparities by age, gender, and race. 383 of those patients qualified for the denominator of the measure. The measure did not seem to show a tendency with age.

Patients younger than 75 had a similar score to those aged 75 and older (difference not statistically significant, p =0.54). Patients younger than 65 also had a similar score to that of the rest (41% vs 46%, p=0.68). The two genders had almost identical scores on the measure (45% vs 44%, p=0.92). There was not a statistically significant difference between the comfortable dying measures in

the Caucasian and other-than-Caucasian portions of the sample ( $p=0.29$ ). Thus there was no evidence in the sample for disparity by age, gender, or race.

**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), Musculoskeletal, Neurology, Palliative Care and End-of-Life Care, Renal, Respiratory : Chronic Obstructive Pulmonary Disease (COPD)

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

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

Populations at Risk

**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.)

<https://www.nhpco.org/pom/>

**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)

No data dictionary Attachment:

**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 Attachment: [ComfortableDyingWorkbook-637372241257560122.xls](#)

**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.

Patient

**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.

No

**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 to specifications. Explanatory phrase in parentheses removed: (after admission to hospice).

**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).

Patients whose pain was brought to a comfortable level (as defined by patient) within 48 hours of initial assessment.

**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).

Number of patients who replied "yes" when asked if their pain was brought to a comfortable level within 48 hours of initial assessment.

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

Patients who replied "yes" when asked if they were uncomfortable because of pain at the initial assessment.

**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).

Patients who are able to self report pain information and replied "yes" when asked if they were uncomfortable because of pain at the initial assessment.

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

Patients who do not report being uncomfortable because of pain at initial assessment (i.e., patients who reply "no" to the question "Are you uncomfortable because of pain?"

Patients under 18 years of age

Patients who cannot self report pain

Patients who are unable to understand the language of the person asking the initial and follow up questions

**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.)

Patients who replied 'No' to initial question: "Are you uncomfortable because of pain?"

Patients under 18 years of age

Patients who are unable to understand the language of the person asking the initial and follow up questions

Patients who cannot self report pain

**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.)

None

**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:**

Rate/proportion

If other:

**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.)

Calculation of measure score:

1. Identify number of patients admitted to hospice services during the timeframe of interest (e.g., CY quarter).
2. Identify number of admitted patients who were able to respond to the question "Are you uncomfortable because of pain?" during the initial assessment and were not excluded because they met the exclusion criteria.
3. Identify the number of patients who responded "yes" to the question "Are you uncomfortable because of pain?" during the initial assessment.
4. Identify the number of patients who were contacted between 48 and 72 hours of the initial assessment and responded "yes" to the question: "Was your pain brought to a comfortable level within 48 hours of the start of hospice services?" This number is the numerator.
4. Divide the number of patients whose pain was brought to a comfortable level within 48 hours after initial assessment by the number of patients who reported they were uncomfortable because of pain at the initial assessment.
2. Multiply this number by 100 to get the hospice's score as a percent. This is the proportion of patients who reported being uncomfortable because of pain at initial assessment whose pain was brought to a comfortable level within 48 hours of the start of hospice services.

NOTE: A Problem Score may also calculated as a complement to the measure score The Problem Score is calculated by dividing the number of patients whose pain was NOT brought to a comfortable level within 48 hours after the initial assessment by the number of patients who were uncomfortable on admission. Multiply this number by 100 to get the hospice's score as a percent. A lower score/percentile = better performance. The Problem Score is useful for assessing the proportion of patients for whom comfort was not achieved and subsequent root cause analysis for quality improvement purposes.

**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.

No sampling methodology required. All patients are assessed for eligibility for inclusion in the measure at the initial assessment.

**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.

**STEP 1: AT INITIAL ASSESSMENT**

Prior to performing a comprehensive pain assessment, the nurse first determines if the patient is eligible for inclusion in the measure.

If the patient meets the eligibility criteria, the nurse asks the question "Are you uncomfortable because of pain?"

If the patient responds "yes," the patient is included in the measure.

If the patient responds "no" the patient is not included in the measure.

The nurse documents the patient's response and proceeds with the comprehensive pain assessment using whatever pain scale or assessment tools are appropriate for the patient. Pain management strategies and interventions are instituted based on the pain assessment.

**STEP 2: FOLLOW-UP**

Between 48 and 72 hours after the initial assessment, the patient is contacted and asked: "Was your pain brought to a comfortable level within 48 hours of the start of hospice care?"

The patient's yes or no response to the question is then documented.

If the patient is unable to self-report, that should be documented. For quality improvement purposes, it is also desirable to document the reason that the patient is unable to self-report (discharged due to death, discharged alive, disease progression/unable to communicate, other reasons).

The follow-up assessment can be completed in person or by telephone, but the patient must self-report his/her own response to the question by answering "yes" or "no. The follow up assessment does not need to be done by the nurse who performed the initial assessment and can be done by any staff member who has experience communicating with patients.

If the patient seems to have difficulty understanding the 48 hour timeframe for achieving comfort, reframing the question using language that is more natural for the patient is permissible, as long as the question of achieving comfort within the prescribed timeframe of 48 hours of the initial assessment is kept intact.

Patient responses to the initial measure question and the follow up measure question should be recorded in the patient medical record.

**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.

Data specific to measure (initial question on admission and follow-up question asked between 48 and 72 hours of admission) recorded by hospice. Data can be part of patient record or recorded and tracked separately.

Data are aggregated and submitted quarterly by hospices to NHPCO which maintains a national data repository. NHPCO analyzes the data and produces a quarterly national level report for hospices as a source of comparative data for use in performance improvement initiatives.

**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.)

## 2. Validity – See attached Measure Testing Submission Form

NQF\_testing\_attachment\_Sep2017\_-1--637372241262404932\_-1-.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.

No

### 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.



No

### 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.*

No - This measure is not risk-adjusted

## 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.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition  
If other:

### 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**.

Some 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).

Not all providers may collect the measure data as part of the patient electronic record. Those providers who do not can keep separate paper records of the measure question responses for individual patients. Data are aggregated for submission to NHPCO which is done online. NHPCO provides a downloadable Data Submission Worksheet for providers to print out and complete before entering data online on the NHPCO website.

**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. Hospices vary in size and resources, and data collection strategies employed tend to vary with the individual characteristics of the hospices. We regularly plan and implement modifications to support materials to improve clarity and assist hospice with implementation of the measure.

When the measure was required by CMS for the first year of the Hospice Quality Reporting Program, many hospices reported difficulties with measure implementation. For example, understanding that the measure questions were separate from pain assessment proved problematic. However, hospices were not accustomed to implementing a quality measure with specification that could not be modified and also, unless a hospice was already using 0209, had no experience with a PRO measure. Had 0209 been implemented later in the HQR program and/or given more time along with education and support, hospices would likely have had more success with implementation.

**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 costs or other requirements imposed by NHPCO associated with use of this measure. There is open access from the NHPCO website for all materials provided for support of measure implementation.

## 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)
Regulatory and Accreditation Programs	Quality Improvement (Internal to the specific organization) NHPCO Patient Outcomes and Measures <a href="https://www.nhpc.org/pom/">https://www.nhpc.org/pom/</a>

#### 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

NHPCO is the sponsor of this voluntary measure which is part of our quality program. The purpose of the measure is to ensure timely recognition of discomfort due to pain and prompt and effective intervention. Currently, there are no other quality measures reported during hospice care. We no longer collect data on this measure but we still encourage use of the measure. We are engaging our members in a new quality program in 2021, so we may revisit the opportunity to collect data on this measure. This measure is included in MIPS. The level of utilization is unknown. NHPCO provides a manual for data collection but there is no comparative reporting since 2015. For 2014, 156 hospices provided aggregated measure data for 20,548 patients.

**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?)**

**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.)*

**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.**

NHPCO maintained ongoing support (in the form of written materials and one-on-one guidance) for hospice providers who use the measure. Hospices vary in size and resources, and data collection strategies employed tend to vary with the individual characteristics of the hospices. We regularly planned and implemented modifications to support materials to improve clarity and assist hospice with implementation of the measure.

**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.**

NHPCO provided quarterly national report to members through 2017. NHPCO has retired data submission and reporting; however, we continue to encourage hospice programs to use the measure as part of their QAPI program. The data collection and measurement tools continue to be available on our website.

**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.**

Feedback was obtained through survey and webinar meetings with participants.

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

When the measure was required by CMS for the first year of the Hospice Quality Reporting Program, many hospices reported difficulties with measure implementation. For example, understanding that the measure questions were separate from pain assessment proved problematic. However, hospices were not accustomed to implementing a quality measure with specification that could not be modified and also, unless a hospice was already using 0209, had no experience with a PRO measure. Had 0209 been implemented later in the HQR program and/or given more time along with education and support, hospices would likely have had more success with implementation.

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

N/A

**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.**

NHPCO continues to encourage use of the measure as part of QAPI program even though the measure is no longer required for public reporting.

#### **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.**

Because the results reflect national level means, improvements by individual providers are not reflected. Also, those hospice patients who are able to self-report at the time the first measure question is asked may not be able to self-report at the 48-72 hour period when the follow up question is asked. These patients remain in the denominator. Some hospice may have many such patients, which will depress their measure scores. Keeping patients in the denominator is included in the measure specifications to encourage hospices to make a strong effort to contact patients to ask the follow up question. A patient population that not a rapidly functionally declining as many hospice patients would be able to respond to both the initial and the follow up questions. This is likely to be true for the patients who are receiving palliative care who are more functional than the 1/3 of hospice patients who die within 7 days of admission to hospice services.

**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.**

N/A

**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.

No

**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.)**

N/A

## 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.

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

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** National Hospice and Palliative Care Organization

**Co.2 Point of Contact:** Lori, Bishop, lbishop@nhpco.org, 571-397-2687-

**Co.3 Measure Developer if different from Measure Steward:** National Hospice and Palliative Care Organization

**Co.4 Point of Contact:** Lori, Bishop, lbishop@nhpco.org, 571-397-2687-

## 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.**

Members of Outcomes Forum - a group of experts that was convened and worked together over a three year period (1998 through 2000) to develop and test measures derived from a common conceptual framework as delineated in the NHPCO publication: A Pathway for Patients and Families Facing Terminal Illness. Members included:

Carla Alexander, Ina Boyd, Deborah Childs, Stephen Clauser, Chis Cody, Stephen Connor, Gail Cooney, Jeanne Dennis, Kathy Egan, Perry Fine, Melinda Garverick, Barbara Head, Marcia Lattanzi-Licht, Judi Lund-Person, Dale Lupu, Susan Mann, Melanie Merriman, Naomi Naierman, Betty Oldanie, Peggy Parks, True Ryndes, Shareefa Sabur, Sherri Solomon, Janet Snapp, Sharon Sprenger, Carol Spence, Joan Teno, Patti Thielmann.

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2000

**Ad.3 Month and Year of most recent revision:** 06, 2011

**Ad.4 What is your frequency for review/update of this measure?** Annually

**Ad.5 When is the next scheduled review/update for this measure?** 09, 2020

**Ad.6 Copyright statement:** Copyright holder of the Comfortable Dying Measure is NHPCO which makes the measure available for use free of charge with the provision it is not modified or sold.

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**