



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 subcriterion 1b).

Brief Measure Information

NQF #: 0211

Corresponding Measures:

De.2. Measure Title: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life

Co.1.1. Measure Steward: American Society of Clinical Oncology

De.3. Brief Description of Measure: Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life

1b.1. Developer Rationale: Studies suggest that cancer treatments and care continue to be more aggressive than desired for patients at the end of life. Emergency department (ED) visits in the last 30 days of life are one indicator that supportive care may not be provided effectively to these patients (Guadagnolo, 2015). In general, unnecessary ED visits should be avoided for those concerns that can be addressed at the practice or clinic. For example, a study at Memorial Cancer Institute found that 48% of ED visits occurred during office hours in patients with cancer and many were for concerns that did not require the use of ED services (Hunis, 2016). For patients with cancer at the end of life, the use of unnecessary services such as the ED can negatively impact a patient and family's quality of life and satisfaction with end of life care (Barbera, 2010).

Barbera, L., C. Taylor, et al. (2010). "Why do patients with cancer visit the emergency department near the end of life?" CMAJ 182(6): 563-568.

Guadagnolo, B. A., K. P. Liao, et al. (2015). "Variation in Intensity and Costs of Care by Payer and Race for Patients Dying of Cancer in Texas: An Analysis of Registry-linked Medicaid, Medicare, and Dually Eligible Claims Data." Med Care 53(7): 591-598.

Hunis, B., A. J. Alencar, et al. (2016). "Making steps to decrease emergency room visits in patients with cancer: Our experience after participating in the ASCO Quality Training Program." J Clin Oncol 34, 2016 (suppl 7S; abstr 51) Presented at the ASCO Quality Care Symposium, February 26th, 2016, Phoenix, AZ.

S.4. Numerator Statement: Patients who died from cancer and had at least one emergency department visit in the last 30 days of life

S.7. Denominator Statement: Patients who died from cancer

S.10. Denominator Exclusions: None

De.1. Measure Type: Outcome: Intermediate Clinical Outcome

S.23. Data Source: Claims, Registry Data

S.26. Level of Analysis: Clinician : Group/Practice

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Aug 09, 2012

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 subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 0211_Evidence_Form_3.16.16.docx

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., the benefits or improvements in quality envisioned by use of this measure)

Studies suggest that cancer treatments and care continue to be more aggressive than desired for patients at the end of life. Emergency department (ED) visits in the last 30 days of life are one indicator that supportive care may not be provided effectively to these patients (Guadagnolo, 2015). In general, unnecessary ED visits should be avoided for those concerns that can be addressed at the practice or clinic. For example, a study at Memorial Cancer Institute found that 48% of ED visits occurred during office hours in patients with cancer and many were for concerns that did not require the use of ED services (Hunis, 2016). For patients with cancer at the end of life, the use of unnecessary services such as the ED can negatively impact a patient and family's quality of life and satisfaction with end of life care (Barbera, 2010).

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Hunis, B., A. J. Alencar, et al. (2016). "Making steps to decrease emergency room visits in patients with cancer: Our experience after participating in the ASCO Quality Training Program." J Clin Oncol 34, 2016 (suppl 7S; abstr 51) Presented at the ASCO Quality Care Symposium, February 26th, 2016, Phoenix, AZ.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Performance data on this measure was obtained from two independent integrated healthcare delivery systems in the United States. Both systems are located in the South.

The first integrated healthcare delivery system manually abstracted data from their EMR using the sampling methodology from ASCO's Quality Oncology Practice Initiative (QOPI®) Registry (a minimum of 40 cases twice each year).

Integrated delivery system #1

ED visits in the last 30 days of life

	Fall 2011	Spring 2012	Fall 2012	Spring 2013
Overall				
Performance %	35.00	47.50	55.00	43.90

Integrated delivery system #2

The second integrated healthcare delivery system's scores were derived from death notification data in a tumor registry combined with electronic clinical data for patients who died from cancer between June 2013 and May 2015:

Based on reported deaths 6/1/2013-5/31/2015 (2 years rolling)

ED visits in the last 30 days of life

Numerator	801
Denominator	15098
% of Total	5.31%
Mean (2 year)	5.38%
Standard Deviation (2 year)	0.91%
Minimum (2 year)	4.05%
Maximum (2 year)	7.68%

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use. Performance data on this measure was obtained from two independent integrated healthcare delivery systems in the United States. Both systems are located in the South.

The first integrated healthcare delivery system manually abstracted data from their EMR using the sampling methodology from ASCO's Quality Oncology Practice Initiative (QOPI®) Registry (a minimum of 40 cases twice each year). Data is reported at the practice level.

ED visits in the last 30 days of life

	Fall 2011	Spring 2012	Fall 2012	Spring 2013
Female	23.53	55.56	37.50	62.50
Male	43.48	40.91	66.67	17.65
Hispanic	53.85	65.00	70.59	45.45
White	18.75	31.25	45.45	35.71
Black	20.00	25.00	44.44	60.00
Other	33.33	0.00	50.00	0.00

The second integrated healthcare delivery system's scores were derived from death notification data in a tumor registry combined with electronic clinical data for patients who died from cancer between June 2013 and May 2015:

Based on reported deaths 6/1/2013-5/31/2015 (2 years rolling)

ED visits in the last 30 days of life

N Female	6903
N Male	8195
% of Total Female	5.49%
% of Total Male	5.15%
Medicare numerator	260
Medicare denominator	6249
% Medicare	4.16%
Non-Medicare numerator	541
Non-Medicare denominator	8849
% Non-Medicare	6.11%

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

1c.4. Citations for data demonstrating high priority provided in 1a.3

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

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 subcriteria 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, Palliative Care and End-of-Life Care

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

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.)

No webpage available

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.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

No changes have been made to the measure since the last endorsement

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)

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

Patients who died from cancer and had at least one emergency department visit in the last 30 days of life

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Last 30 days of life

S.6. 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, 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.

ED visits documented in MEDPAR claims

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

Patients who died from cancer

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, 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)

Claims: Patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

None

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, 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)

None

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)

Not applicable

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

Not applicable

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

S.16. Type of score:

Rate/proportion

If other:

S.17. 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 = Lower score

S.18. Calculation Algorithm/Measure Logic (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; aggregating data; risk adjustment; etc.)

Performance is calculated as:

1. Identify those patients that meet the denominator criteria defined in the measure.
2. Subtract those patients with a denominator exclusion from the denominator. Note: this measure does not have exclusions.
3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria.
4. Calculation: Numerator/Denominator-Denominator Exclusions

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Not applicable

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

Not applicable

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

This measure is specified with defined criteria and data elements. If a patient record does not include one or more of these components for the denominator, then patients are not considered eligible for the measure and not included.

If data to determine whether a patient should be considered for the numerator or exclusions is missing, then the numerator or exclusions not considered to be met and the practice will not get credit for meeting performance for that patient.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims, Registry Data

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Home Care, Inpatient/Hospital, Outpatient Services

If other:

S.28. 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.)

Not applicable

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

0211_MeasureTesting_MSF5.0_Data_Update.doc

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.

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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*)

[ALL data elements are in defined fields in electronic clinical data \(e.g., clinical registry, nursing home MDS, home health OASIS\)](#)

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.

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.

[No feasibility assessment](#) 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. Describe what you have learned/modified 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 a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

[The measure and its specifications have been in place for several years and ASCO continues to monitor and ensure that the measure and its specifications are up-to-date for widespread use.](#)

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*).

[Not applicable](#)

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.

Planned

Current Use (for current use provide URL)

Payment Program	Quality Improvement (Internal to the specific organization) Multiple Integrated Delivery Systems Not applicable
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4a.1. For each CURRENT use, checked above, provide:

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

Multiple integrated delivery systems:

In use in multiple integrated delivery systems across the United States for quality improvement purposes. Because it is internal to the specific organization, we are unable to provide any additional information.

4a.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?)

We are continuously seeking opportunities to advocate for expanded use of this measure in government or other programs, including those intended for accountability or public reporting. For example, this measure was recently selected for inclusion in a Medical Oncology Core Measure Set supported by America's Health Insurance Plans and CMS. See section 4a.3. below for additional details.

4a.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.)

This measure has also been included in America's Health Insurance Plans Medical Oncology Core Measure Set. The purpose of this program is to reduce variability in measure selection, specifications and implementation. The measures will be implemented nationally by private health plans using a phased-in approach. Contracts between physicians and private payers are individually negotiated and therefore come up for renewal at different points in time depending on the duration of the contract. It is anticipated that private payers will implement these core sets of measures as and when contracts come up for renewal or if existing contracts allow modification of the performance measure set. CMS is also working to align measures across public programs. They intend to include, for broad input, the agreed upon draft measure sets in the Physician Fee Schedule and other proposed rules. For measures that are not currently in CMS programs, CMS would go through the annual pre-rulemaking and rulemaking processes to solicit stakeholder and public input. Depending on public response, these measures will be included in a timeframe determined by the Agency.

4b. 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.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

The performance rates show variation with no trend of improvement. There are differences across each measurement period, but given the limited data available conclusions about the significance of these variations cannot be determined.

These rates indicate the opportunity for continued performance improvement.

4b.2. 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.

4c. 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).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

There have been no reports of unintended consequences with 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

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 completely harmonized?

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): American Society of Clinical Oncology

Co.2 Point of Contact: Tayyaba, Shehzadi, Tayyaba.Shehzadi@asco.org, 571-483-1673-

Co.3 Measure Developer if different from Measure Steward: American Society of Clinical Oncology

Co.4 Point of Contact: Tayyaba, Shehzadi, Tayyaba.Shehzadi@asco.org, 571-483-1673-

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.

[Palliative Measure Development Panel](#)

[The panel is responsible for reviewing evidence and maintaining measures](#)

[Tracey Evans, MD \(Chair\)](#)
[University of Pennsylvania](#)

[Craig Earle, MD, FASCO \(Co-Chair\)](#)
[Institute for Clinical Evaluative Science](#)

[Katherine Ast, MSW, LCSW](#)
[American Academy of Hospice and Palliative Medicine](#)

[Amy Berman](#)
[The John A. Hartford Foundation](#)

[Kathleen Bickel, MD, MPhil](#)
[White River Junction VA Medical Center](#)

[Eduardo Bruera, MD](#)
[The University of Texas MD Anderson Cancer Center](#)

[Sydney Dy, MD](#)
[Johns Hopkins](#)

[Esme Finlay, MD](#)
[University of New Mexico Cancer Research and Treatment Center](#)

[Arif Kamal, MD, MHS, FAAHPM](#)
[Duke University](#)

[Kristen McNiff, MPH](#)
[Dana-Farber Cancer Institute](#)

[Michael Neuss, MD, FASCO](#)
[Vanderbilt Ingram Cancer Center](#)

#0211 Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life, Last Updated: Mar 25, 2017

John Sprandio, MD
Consultant in Med Onc and Hem Inc

Holley Stallings, RN
Norton Cancer Institute

Jamie Von Roenn, MD, FASCO
American Society of Clinical Oncology

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2005

Ad.3 Month and Year of most recent revision: 11, 2015

Ad.4 What is your frequency for review/update of this measure? Every 3 years

Ad.5 When is the next scheduled review/update for this measure? 12, 2017

Ad.6 Copyright statement: Copyright © 2012-2016 American Society of Clinical Oncology. All right reserved.

Ad.7 Disclaimers: These clinical indicators and quality measures are not intended to and should never supplant independent physician judgment with respect to particular patients or clinical situations. Patient care is always subject to the independent professional judgment of the treating physician.

Accordingly, QOPI participants' adherence to quality measures contained in this research report is strictly voluntary and discretionary, with the ultimate determination regarding their application to be made by the treating physician in his or her professional judgment and in light of each patient's individual circumstances. ASCO does not endorse the QOPI® measures as guidelines for standards of practice or 'best practices.'

Ad.8 Additional Information/Comments: