

Measure at a Glance

CBE #5592: Percentage of Patients who Died with Cancer with More Than One Emergency Department and/or Observation Visit in the Last 30 Days of Life (lower score – better)

Measure Summary (Where does this measure seek to improve care?)

This measure looks at how often patients with cancer have more than one emergency department (ED) visit or observation visit in the last 30 days of life. An ED visit is care for urgent medical needs in a hospital. An observation visit is a short hospital stay used to monitor a patient's condition.

The measure focuses on patients aged 18 years and older who died with cancer. It counts patients who had at least two of these visits close to the end of life.

The measure compares this group to all eligible patients with cancer who died. The measure excludes patients if their visits were linked to specific treatments, such as bone marrow transplant or chimeric antigen receptor (CAR) T-cell therapy, within 60 days before death.

A lower score means better performance, because it shows fewer repeated urgent visits near the end of life.

Meaningfulness (Why does this matter to patients, and how could it improve their care?)

This measure focuses on care near the end of life for patients with cancer. Evidence shows that many patients nearing the end of life prefer to die at home. Hospitalizations, ED visits, and intensive care unit (ICU) stays in the last 30 days of life are associated with lower quality of care based on reports from family caregivers. In a national study, family caregivers rated care provided at home with hospice (care focused on comfort at the end of life) more highly than care provided in hospital settings.

Patients and families helped shape this measure. Focus groups that included patients with advanced cancer and family members of deceased patients identified outcomes that matter most to them. Their input was used to validate this measure.

Additional input came from a public comment period and expert panel review. Most respondents agreed that the measure captures quality of end-of-life care and can distinguish between higher and lower quality care.

Usability (How will providers use this measure to improve care delivery?)

This measure is at the clinician group or practice level. It uses data from outpatient care settings, such as clinics and offices.

The results show how often patients had more than one ED or observation visit near the end of life. A lower score means a lower percent of patients had more than one ED or observation visit near the end of life, which reflects better performance.

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This type of result can help practices compare their performance and identify areas for improvement. For example, guidelines suggest using palliative care (care focused on comfort and symptom relief) earlier in serious illness. Guidelines also suggest hospice and improving advance care planning, which means talking with patients and families about care goals. These steps may help reduce avoidable hospital visits near the end of life.

Feasibility (How can this measure be implemented without adding burden for providers and patients while still improving care?)

This measure uses claims data, which is a type of information that comes from billing records—not from the doctor’s notes themselves. Health care providers collect claims data during routine care. Electronic systems already contain the data needed for this measure and store them in structured fields. Structured fields arrange data inputs so users can enter them in a standard, organized way. Because of this, the measure does not require new data collection. It also does not rely on providers typing in their own words (free-text notes), which can be harder to use. These features may make the measure easier to apply across different health care settings.

The measure has very low burden for health care providers. There is no added cost to use it, and no extra work is needed from staff. It does not change how clinicians document care or interact with patients. The data are also checked for accuracy through standard insurance processes, and personal details are removed to protect privacy. These features suggest the measure can be used without disrupting care or increasing workload.

Impact (How will using this measure improve patient experiences and outcomes?)

This measure focuses on reducing repeated ED visits and observation stays near the end of life. These visits may be linked to aggressive care, which may not improve comfort or quality of life.

The measure may also affect health care use and costs. Studies show that palliative care may lower health care costs and reduce hospital use near the end of life. The measure encourages earlier use of palliative care.

Earlier palliative care may help improve symptom control and support patient and family needs during serious illness. Palliative care is linked to fewer emergency department visits, hospital stays, and ICU stays. Palliative care is linked to higher satisfaction for patients, families, and caregivers.

Performance Gap (Based on current performance, where and how much care can improve?)

This measure shows variation in performance across clinician group or practice-level entities based on testing data from 2023-2024. The analysis included 563 entities and represented 15,683 patients. Performance ranged from 0% to 80%, with a mean (average) of 24.8%.

Deciles divide clinician group or practice-level entities into 10 equal parts based on scores. Decile 1 includes entities with the lowest scores, and Decile 10 includes entities with the highest scores. Performance worsens in the higher deciles.

Decile 1 has a score of 2.5%, and Decile 10 has a score of 55.0%. These results show variation across entities.

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The data highlight gaps in care that may be associated with differences in care coordination or palliative care use. The variation in data may help organizations reduce unnecessary end-of-life acute care and help drive improvement by making it easier to identify which entities may need targeted support.

Disclaimer: Battelle used generative artificial intelligence in the initial drafting of this document. Actual humans with relevant expertise subsequently validated and revised the content.