



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 #: 3235

Corresponding Measures:

De.2. Measure Title: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQR. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.

1b.1. Developer Rationale: The aim of this measure is to assess whether a comprehensive assessment is completed at hospice admission for each hospice patient based on seven QMs that assess high-priority care processes around admission as recognized by both leading hospice stakeholders and patients. Another key factor in creating a measure of comprehensive assessment at admission is to provide both consumers and providers with a single measure regarding the overall quality of the assessment of patient needs at hospice admission, which can then be easily used to compare quality across providers. Additionally, in the current HQR QMs hospice performance scores are high with scores of 97% or higher; hospices perform lower on the Pain Assessment QM (95.3%). On average, 93.2% of patient stays in a hospice had documentation that all of these critical care processes were completed at admission. Thus, the comprehensive assessment measure sets a higher standard of care for hospices, and consequently reveals a larger performance gap. The performance gap identified by the comprehensive assessment measure creates opportunities for quality improvement and may motivate providers to conduct a greater number of high priority care processes for as many patients as possible upon admission.

S.4. Numerator Statement: The numerator of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQR quality measures. To be included in the comprehensive assessment measure numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQR (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.

S.6. Denominator Statement: The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.

S.8. Denominator Exclusions: Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).

De.1. Measure Type: Composite

S.17. Data Source: Other

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Jul 13, 2017 **Most Recent Endorsement Date:** Jul 13, 2017

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

[NQF_Measure_Evidence_Form_3235_final.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.

The aim of this measure is to assess whether a comprehensive assessment is completed at hospice admission for each hospice patient based on seven QMs that assess high-priority care processes around admission as recognized by both leading hospice stakeholders and patients. Another key factor in creating a measure of comprehensive assessment at admission is to provide both consumers and providers with a single measure regarding the overall quality of the assessment of patient needs at hospice admission, which can then be easily used to compare quality across providers. Additionally, in the current HQRPs hospice performance scores are high with scores of 97% or higher; hospices perform lower on the Pain Assessment QM (95.3%). On average, 93.2% of patient stays in a hospice had documentation that all of these critical care processes were completed at admission. Thus, the comprehensive assessment measure sets a higher standard of care for hospices, and consequently reveals a larger performance gap. The performance gap identified by the comprehensive assessment measure creates opportunities for quality improvement and may motivate providers to conduct a greater number of high priority care processes for as many patients as possible upon admission.

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.*

2 Based on 1,418,348 patient stays discharged from 4,089 hospices between Q4 2018 and Q3 2019, on average, 89.3% of patient stays in a hospice had documentation that all of seven HQRPs desirable care process were completed at admission. Below we present the hospice-level score distribution for the comprehensive assessment measure based on the year of patient stay admissions, representing 4 four calendar years of data. This includes data from January 1, 2016 to December 31, 2019. Additionally, we assessed the QM's variability by focusing on the percentage of hospices with perfect scores (i.e., critical care processes performed for 100 percent of patients), the percentage of lower-performing hospices, and the interquartile range of the QM scores. A meaningful and useful QM should be able to distinguish between high- and low-quality hospices within a given reporting period and have sufficient variability across providers. This analysis produced the following results based on hospices meeting the minimum reporting threshold:

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- Over time, the hospice-level mean score for this QM increased from 77.8% for patient stays admitted in 2016 to 89.6% in 2019, the median increased from 82.3% to 94.1%, the interquartile range (IQR) decreased from 22.9% to 12.0%, and the standard deviation (SD) decreased from 18.2% to 12.7%.

- For patient stays admitted between January 1, 2016 and December 31, 2016, only 2.2 percent of hospices (81 of 3,745 hospices) had perfect scores, and 34.6% of hospices scored lower than 75% on this QM. In 2019, 8.4% percent of hospices (344 of 4,080 hospices) had perfect scores, and 11.0% of hospices scored lower than 75% on this QM.

Results from these trend analysis suggest that hospices' performance on this QM has been improving overtime. However, a performance gap still remains, supporting the importance of this measure.

CY of Admission	N	Percentile								
		Mean	Std. Dev	10th	25th	50th	75th	90th		
2016				3,745	77.8%	18.2%	51.7%	68.9%	82.3%	96.8%
2017				3,860	83.9%	14.8%	65.0%	77.5%	88.0%	98.3%
2018				4,041	88.1%	13.3%	70.6%	83.6%	92.6%	99.3%
2019				4,080	89.6%	12.7%	73.3%	86.0%	94.1%	99.7%

CY of Admission	N with Perfect Score	% with Perfect Score
2016	81	2.2%
2017	124	3.2%
2018	229	5.7%
2019	344	8.4%

CY of Admission	N with Average Less than 75% Score	% Less than 75%
2016	1,296	34.6%
2017	807	20.9%
2018	533	13.2%
2019	448	11.0%

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.

Data are available and described in 1b.2.

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.*

We conducted a series of disparity analyses at both the patient stay and the hospice levels to assess how the measures are affected by the sociodemographic characteristics of hospice patients. At the patient stay level, we compared the QM scores across sociodemographic groups. At the hospice level, we compared the distribution of QM scores between hospices with varying population sociodemographic characteristics. Analyses were conducted using HIS data from Q4 2018 through Q3 2019. Patient-level analyses encompassed 4,566 hospice organizations and 1,422,921 patient stays across the United States. Hospice-level analyses reflect 4,089 hospices that met the minimum reporting threshold. The results of these analyses are presented below.

Racial and ethnic disparity analysis. We conducted racial and ethnic disparity analyses at both the patient stay and hospice levels. At the patient stay level, we compared the percentage of patients who received all seven care process among different racial and ethnic groups. Patients were grouped by their racial and ethnic identification as follows: white non-Hispanic, black non-Hispanic, other non-Hispanic, or Hispanic. Other non-Hispanic includes patients who identify as American Indian or Alaska Native, as Asian, as Native Hawaiian or other Pacific Islander, or as more than one race. A Chi-square test was performed to determine if there were any statistically significant differences in completion of all seven care processes between groups. The lowest rate of completion of the comprehensive assessment was found for other non-Hispanic patients (90.9%), and the highest rate was among patients identifying

as White non-Hispanic (93.5%). Differences in the rate of completion of all seven care processes by racial identification were found to be statistically significant (p -value < 0.01).

Analyses at the hospice level examined the differences in this measure across two groups: hospices with proportions of nonwhite patients that are less than or equal to the national median (18.2%), and hospices with proportions of nonwhite patients that are greater than the national median. For this analysis, white non-Hispanic patients were included in the white group, and all other racial and ethnic identifications, as described above, were grouped as nonwhite. We ran a Wilcoxon-Mann-Whitney test for statistical dependence between group and QM score. The results showed that the QM score was significantly different between the two groups of hospices (88.1% for hospices with a proportion of nonwhite patients greater than the national median compared with 90.6% for hospices with a proportion of nonwhite patients less than or equal to the national median, p -value < 0.01).

Gender disparity analysis. We performed both the patient stay and hospice-level analyses on gender disparity using the same methods described in the racial and ethnic disparity analyses above. Females received all 7 care processes at a similar rate to male patients (93.17% and 93.22% respectively). Differences in the rate of completion of all 7 care processes by gender were not statistically significant (p -value = 0.314). At the hospice level, we examined the differences in this measure across two groups: hospices with proportions of female patients that are less than or equal to the national median (55.1%), and hospices with proportions of female patients that are greater than the national median. The results showed that the QM score was not statistically significantly different between the two groups of hospices (89.2% for hospices with a proportion of female patients above the national median compared with 89.5% for hospices with a proportion of female patients at or below the national median, p -value = 0.375).

Socioeconomic disparity analysis. We performed socioeconomic disparity analyses at both the patient stay and hospice levels using the same methods described in the racial and ethnic disparity analyses above. Medicaid status was used as a proxy measure of low socioeconomic status. There were similar rates of comprehensive assessment completion for non-Medicaid patients (93.0%) compared with Medicaid patients (93.2%) and the difference was not statistically significant at p -val < 0.01. At the hospice level, the results showed that the QM score was significantly different between hospices with proportions of Medicaid patients less than or equal to the national median (14.1%) and hospices with proportions of Medicaid patients greater than the national median (90.6% for hospices above the median compared with 88.2% for hospices below the median, p -value < 0.01). The statistically insignificant results at the patient stay level do not indicate that quality of hospice care for Medicaid patients, measured by the completion of the comprehensive assessment, is better than for non-Medicaid patients. The significant findings at the hospice level indicate that hospices with a greater proportion of Medicaid patients are more likely to complete all 7 care process for every patient at admission. Rural-urban disparity analysis. We compared the average QM score between rural and urban hospices using a Wilcoxon-Mann-Whitney test. The results showed that the average QM score was not significantly different between rural and urban hospices (89.1% for urban hospices compared with 89.4% for rural hospices, p -value = 0.377). This indicates that rural hospices and urban hospices perform similarly on the comprehensive assessment measure.

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

Data are available and described in 1b.4.

1c. Composite Quality Construct and Rationale

1c.1. A composite performance measure is a combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.

For purposes of NQF measure submission, evaluation, and endorsement, the following will be considered composites:

- Measures with two or more individual performance measure scores combined into one score for an accountable entity.
- Measures with two or more individual component measures assessed separately for each patient and then aggregated into one score for an accountable entity:
 - all-or-none measures (e.g., all essential care processes received, or outcomes experienced, by each patient);

1c.1. Please identify the composite measure construction: all-or-none measures (e.g., all essential care processes received, or outcomes experienced, by each patient)

1c.2. Describe the quality construct, including:

- the overall area of quality
- included component measures and

- the relationship of the component measures to the overall composite and to each other.

The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (herein after referred to as the 'Hospice Comprehensive Assessment Measure') is designed to reflect the overall quality of comprehensive assessment at hospice admission for each patient stay. This measure captures whether a comprehensive assessment is completed at hospice admission by assessing the number of individual care processes completed upon admission for each hospice patient stay. These individual care processes will be based on the seven NQF-endorsed quality measures (QMs) currently implemented in the Centers for Medicare & Medicaid Services (CMS) Hospice Quality Reporting Program (HQRP). These seven measures capture care processes for five different domain areas: pain screening (NQF #1634) and comprehensive pain assessment (NQF #1637), dyspnea screening (NQF #1639) and treatment (NQF #1638), patients treated with an opioid who are given a bowel regimen (NQF #1617), patient preferences for life-sustaining treatments (NQF #1641), and spiritual and existential concerns (NQF #1647). All seven measures address high-priority aspects of quality hospice care as identified by the National Consensus Project, are required by the Medicare Hospice Conditions of Participation, and are supported by hospice stakeholders. The Comprehensive Assessment Measure therefore, reflects the overall quality of comprehensive assessment at hospice admission for each patient stay.

1c.3. Describe the rationale for constructing a composite measure, including how the composite provides a distinctive or additive value over the component measures individually.

The Hospice Comprehensive Assessment Measure provides the overall quality of assessment of patient needs at hospice admission, quality information that cannot be determined from any single measure alone. By assessing whether a comprehensive assessment is performed at hospice admission in a single measure, this measure will (1) incentivize hospices to conduct all critical care processes for each patient; (2) set a higher standard of care for hospices, which will reveal a larger performance gap and thus room for improvement (discussed below); and (3) provide consumers and providers with a single measure representing the overall quality and completeness of assessment of patient needs at hospice admission, which can be easily used to compare quality processes across providers.

For all seven existing component measures, hospice performance scores are 95% or higher; most patients are receiving individual care processes recommended as part of high quality care at admission. For example, on average, 97.3% of patient stays in a hospice had documentation showing that the patient received a pain screening at admission. On the other hand, hospices on average score 89.3% on the Comprehensive Assessment Measure revealing still room for improvement and thus creating incentives for hospices to improve quality.

1c.4. Describe how the aggregation and weighting of the component measures are consistent with the stated quality construct and rationale.

The Hospice Comprehensive Assessment uses an all-or-none scoring approach. This scoring approach calculates the percentage of patients who received all seven HQRP care processes at admission. In other words, the seven component measures are equally weighted to create the composite measure. These seven QM components are a standard practice by any hospice provider for every patient, where each component should be conducted as part of the initial comprehensive assessment. Therefore, the all-or-none scoring approach sets a clear quality expectation that all care processes captured by the seven QM components are expected to be performed, and missing any one of these measures could be recognized as an indicator of suboptimal care. Our environmental scan and Technical Expert Panel (TEP) also supported the all-or-non scoring approach. The results from our analyses presented above demonstrate a performance gap and highlight the potential for quality improvement across hospice providers. The all-or-none scoring approach is most effective in ensuring that a multidimensional assessment has been completed for all patients on admission.

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):

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):

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.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>

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.

Yes, this is an instrument-based measure Attachment: [HQRP-HIS-v2000-Admission-637320621175353646.pdf](#)

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.

Clinician

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.

There are no significant changes to the measure specifications.

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 of this measure is the number of patient stays in the denominator where the patient received all 7 care processes which are applicable to the patient at admission, as captured by the current HQRP quality measures. To be included in the comprehensive assessment measure numerator, a patient must meet the numerator criteria for each of the individual component quality measure (QM) that is applicable to the patient. The numerator of this measure accounts for the three conditional measures in the current HQRP (NQF #1637 Pain Assessment, NQF #1638 Dyspnea Treatment, and NQF #1617 Bowel Regimen) as described below.

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).

The numerator of this measure is the number of patient stays in the denominator where the patient received all the 7 care processes which are applicable to the patient at admission, as captured in the current HQR quality measures. This includes patients who received all 7 care process which are applicable to them at admission, as well as patients for whom the three individual conditional component QMs do not apply. The numerator criteria for the individual measures are:

1. NQF 1634: Patient stays that include a screening for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.
2. NQF 1637: Patient stays who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.
3. NQF 1639: Patient stays that include a screening for the presence or absence of dyspnea and its severity during the hospice admission evaluation / initial encounter for palliative care.
4. NQF 1638: Patient stays that include a positive screening for dyspnea who received treatment within 24 hours of screening.
5. NQF 1617: Patient stays that are given a bowel regimen when appropriate or there is documentation as to why this was not needed
6. NQF 1641: Patient stays with a medical record that includes documentation of life sustaining preferences
7. NQF 1647: Patient stays with a medical record that includes documentation that the patient and/or caregiver was asked about spiritual/existential concerns within 5 days of the admission date.

Therefore, the numerator for this measure includes all patient stays from the denominator in which the patient meets the numerator criteria for all of the individual component QMs. Patient stays are included in the numerator if they meet the following criteria:

1. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (F2000A = [1,2]) OR preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) OR preference regarding hospitalization (F2200A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F2000B – A0220 = 5 and F2000B ? [-,^])

AND

2. The patient and/or caregiver was asked about spiritual/existential concerns (F3000A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (-7 = F3000B – A0220 = 5 and F3000B ? [-,^])

AND

3. The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]) and reported that they had no pain (J0900C = [0]) OR The patient was screened for pain within 2 days of the admission date (J0900B - A0220 = 2 and J0900B ? [-,^]), the patient's pain severity was rated mild, moderate, or severe (J0900C = [1,2,3]), and a standardized pain tool was used (J0900D = [1,2,3,4])

AND*

4. A comprehensive pain assessment was completed within 1 day of the initial nursing assessment during which the patient screened positive for pain (J0910B – J0900B = 1 and J0910B and J0900B ? [-,^]) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (5 or more items in J0910C1 – J0910C7 checked and not all J0910C boxes = [-,^])

AND

5. The patient was screened for shortness of breath within 2 days of the admission date (J2030B - A0220 = 2 and J2030B ? [-,^])

AND*

6. The patient declined treatment (J2040A = [1]) OR Treatment for shortness of breath was initiated prior to the initial nursing assessment or within 1 day of the initial nursing assessment during which the patient screened positive for shortness of breath

(J2040B – J2030B = 1 and J2040B and J2030B ? [-,^])

AND*

7. There is documentation of why a bowel regimen was not initiated or continued (N0520 = [1]) OR A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (N0520B – N0500B = [1] and N0520B and N0500B ? [-,^])

NOTE: *denotes paired measures. For some patient stays, the second component of the paired measure may not be applicable. In this instance, in the calculation of the comprehensive assessment measure, the patient will be included in the numerator for the composite measures as long as the patient meets the numerator criteria for the first measure in the pair as if hospices completed both care processes for the patients. For example, if a patient screened negative for pain, the comprehensive pain assessment measure will not be applicable, however, in the comprehensive assessment measure, the hospice would be 'given credit' for completing the comprehensive pain assessment. This logic also applies to NQF #1617 Bowel Regimen. While NQF #1617 is not a paired measure, the patient must have a scheduled opioid initiated or continued in order to complete item N0520, which assess whether a bowel regimen was initiated or continued.

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

The denominator for the measure includes all hospice patient stays enrolled in hospice except those with exclusions.

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).

The denominator for the measure includes all hospice patient stays except for those with exclusions as identified in S.8 and S.9 below.

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

Patient stays are excluded from the measure if they are under 18 years of age, or are a Type 2 (discharged stays missing the admission record) or Type 3 patient stay (active stays).

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.)

The exclusion criteria are:

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

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.)

N/A

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.)*

Step one: Calculate the total number of Type 1 stays that do not meet the exclusion criteria.

Step two: Calculate the number of patient stays where the patient meets the numerator criteria for all the individual component QMs, that is, the number of patient stays where each patient received all care processes at admission for which the patient is eligible. This includes patients who are eligible for and received all 7 care process at admission, as well as patients who may not be included in the individual paired component QMs.

Step three: Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step (2) by the result of step (1). The quality measure score is converted to a percent value by multiplying by 100.

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.

N/A

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.

N/A

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

If other, please describe in S.18.

Other

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.

Hospice Item Set (HIS). The HIS is a standardized, patient-level data collection instrument part of the HQR as finalized in the FY 2014 Hospice Wage Index final rule (78 FR 48234–48281). Medicare-certified hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission on or after July 1, 2014.

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 in attached appendix at A.1

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

Facility

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

Other

If other: Hospice

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.)*

All component measures included in the comprehensive assessment measure are weighted equally and have all received NQF endorsement.

2. Validity – See attached Measure Testing Submission Form

[NQF_Measure_Testing_Form_final_final.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.

Yes

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.

Yes

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 or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), 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) Update this field for maintenance of endorsement.

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. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

N/A

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.

Hospices administer the Hospice Item Set (HIS) to collect the information necessary to calculate the measure. The Hospice Quality Reporting Program employees a pay-for-reporting approach; since FY2020 and for all subsequent years, at least 90% of all required HIS records must be submitted and accepted within a 30-day submission deadline to avoid a 2 percentage-point payment rate increase reduction. Given the payment incentive, the vast majority of hospices submit information necessary to calculate the measure. Hospices are given 30 days after the patient's admission data to submit data (and each patient only has one HIS admission assessment). For several months after data submission, hospices are encouraged to review their submission records for data accuracies prior to measure calculation. The HIS admission record was implemented with the objective of calculating the seven component process measures from which this composite measure is calculated. As such, it is a shorter, lesser burdensome collection tool than those used in other care settings.

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, licensing, or other requirements to use any aspect of the measure as specified. The measure is part of CMS's Hospice Quality Reporting Program, implemented with the goal of providing free and useful information to the public to empower patients and caregivers to make informed health care decisions. The data collection tool and measure specifications used to calculate the measure are publicly-available through the CMS website. CMS's contractors calculate measure scores using data submitted by hospices. These scores are then publicly-reported with free access.

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)	Public Reporting https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures Hospice Quality Reporting Program

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

The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235) is currently publicly reported by the Centers for Medicare & Medicaid Services (CMS) on the Hospice Compare website. Hospice-level measure

scores are reported for all nationwide hospices certified for Medicare, and publicly reported if there are at least 20 individuals in the denominator (non-suppressed scores are provided to all hospices). The analyses in this testing form closely approximate the number of providers and individuals in 4 quarters of data that are publicly reported. Our testing included 1.4 million patient stays in over 4,500 hospices.

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?)

The comprehensive assessment measure is currently publicly reported.

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.)

The comprehensive assessment measure is currently publicly reported.

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.

The Hospice Comprehensive Assessment Measure was introduced to hospice providers at a National HQRP Provider Training on January 18, 2017. This training included information about the individual component measures and the measure specifications. Providers were given the opportunity to see a sample calculation of the Comprehensive Assessment Measure and ask questions about the measure. The materials and video recordings from this training session are accessible to providers on the HQRP website here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-Training-and-Education-Library.html>.

Providers have been able to view their performance results on the Comprehensive Assessment Measure in the Certification and Survey Enhanced Reporting (CASPER) system since February 2018. All Medicare-certified providers should have access to these CASPER QM reports. These CASPER QM reports provide hospice providers with feedback on their quality measure scores, both at the hospice and patient-stay level, helping them to improve the quality of care delivered. A factsheet is available to help hospice providers interpret these reports. The factsheet is available here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Fact-Sheet_CASPER-QM-Reports.pdf.

In advance of reporting on Hospice Compare, providers are given the opportunity to preview their HIS QM results during a 30-day preview period using a HIS Provider Preview Report. The purpose of these reports is to give providers the opportunity to preview their quality measure results on each quality measure prior to public display on Hospice Compare. The Comprehensive Assessment Measure was reported on HIS Provider Preview Reports in September 2018 and is regularly updated on Hospice Compare since 2018.

Finally, CMS provides a Help Desk to answer provider questions about all HQRP quality measures and reporting requirements. As part of the Help Desk functionality, CMS posts a HQRP Quarterly Update document at the end of each calendar year quarter that includes frequently asked Help Desk questions from the previous quarter and the corresponding responses on the CMS HQRP Requirements and Best Practices page here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html>.

Additionally, in November 2018, CMS posted a factsheet on the CMS HQRP website that explains how the Hospice Comprehensive Assessment Measure is calculated and how providers can use their CASPER QM reports to understand their hospice's performance on the Hospice Comprehensive Assessment measure. Also, in December 2018, CMS hosted a live webinar training to explain the background of the measure, how the measure is calculated, and how providers can use their CASPER QM reports to understand their hospice's performance on the Hospice Comprehensive Assessment measure as well as provide the opportunity for providers to ask questions about 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.

The CASPER QM reports allow providers to not only view national average scores on the Comprehensive Assessment Measure, but also specify a reporting period and view their own quality data at both the patient-stay level and hospice level. These reports are on-demand and thus enable providers to view and compare their performance on this measure to a national comparison group at any time and for any reporting period of their choice.

CMS has offered several education and support opportunities. First, the National HQRP Provider Training served as a large-scale venue to introduce and explain the Comprehensive Assessment Measure to providers. This training included education about the component measures, the measure numerator and denominator, exclusion criteria, and overall measure calculation. Providers were also able to ask questions about the measure and its reporting requirements. Second, the factsheet that accompanies the two QM reports, the Hospice Comprehensive Assessment Measure QM Background and Methodology factsheet, and the HQRP Help Desk will help providers interpret their results and have their questions about the Comprehensive Assessment Measure and its component QMs answered. A “Stay on Target” factsheet was posted online in November 2019 and can be accessed here: <https://www.cms.gov/files/document/hospice-comprehensive-assessment-measureone-pager.pdf>.

Finally, CMS offered a live webinar training in December 2018. The December live webinar training served as a large-scale opportunity to train providers on the Hospice Comprehensive Assessment Measure. The training included education about the background of the measure, the measure numerator and denominator, exclusion criteria, overall measure calculation, and how providers can use their CASPER QM reports to understand their performance on this measure. Providers were given the opportunity to ask questions about the measure during the training.

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.

CMS is committed to receiving feedback on measures implemented as part of the HQRP. CMS takes into consideration feedback and input on measure performance and implementation through the appropriate sub-regulatory communication channels, including but not limited to: NQF public comment periods held as part of endorsement processes, feedback from providers on the Hospice Quality HelpDesk, feedback from provider associations through quarterly provider association calls, and feedback from the provider community on ODFs and HQRP forum. CMS will continue to gather and review feedback on this measure.

CMS issued the FY 2020 Hospice Payment Rate Update Final Rule to include a discussion on the Hospice and Palliative Care Composite Process Measure.

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

CMS has received feedback from providers on the Hospice Comprehensive Assessment Measure following the addition of the measure to providers’ CASPER QM reports. Some providers asked for clarification about the specifications, specifically about the “all or none” (rather than average) scoring methodology used and the inclusion of conditional measures in calculation.

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

CMS monitors feedback from other, non-provider, users through the Help Desk, HQRP forum, and through rulemaking.

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.

CMS takes all feedback into account when considering future measure refinement. The questions asked to-date are largely related to providers seeking clarification on the specifications of this new measure, and do not point to any issues with the measure specifications. Provider questions about the measure appear to decrease when CMS clarifies the measure specifications through education and outreach activities.

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.

Performance results on this measure presented in 1b indicate that hospices have made significant improvements in completing a comprehensive assessment at hospice admission. These results suggest that this measure encourages hospices to conduct all critical care processes for each patient and also sets a higher standard of care for hospices.

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.

N/A

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.

N/A

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.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare & Medicaid Services

Co.2 Point of Contact: Helen, Dollar-Maples, Helen.Dollar-Maples@cms.hhs.gov, 410-786-7214-

Co.3 Measure Developer if different from Measure Steward: Abt Associates

Co.4 Point of Contact: T.J., Christian, Thomas_Christian@abtassoc.com, 617-520-2637-

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.

CMS convened a 13-member HQRP Composite Measure Technical Expert Panel (TEP) of nationally recognized experts with extensive experience in the following areas: medical or nursing expertise in hospice and palliative care, methods and instrumentation, and quality improvement. Using criteria provided by the NQF, TEP members rated this measure on four criteria: importance, scientific soundness, feasibility and usability. Please see the attached TEP Charter document for TEP members' organizational affiliation and areas of expertise.

Thomas Caprio, MD, MPH, CMD, HMDC, FACP

Cordt Kassner, PhD

Hazel Crews, MHA, MHS, CPHQ

Kama Ferryman, RN, CPHQ

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Ellen Martin, CPHQ, CHPCA

Dana Mukamel, PhD

Sharon-Lise T. Normand, PhD, MSc, FACC, FAHA, Fellow of American Statistical Association

Sally A. Norton, PhD, RN

Joan Piteo, RN, MSN, COS-C

Helena Temkin-Greener, PhD, MPH

Susan Wallace, MSW

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2017

Ad.3 Month and Year of most recent revision: 11, 2020

#3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission, Last
Updated: Nov 20, 2020

Ad.4 What is your frequency for review/update of this measure? Ad.5 When is the next scheduled review/update for this measure?
Ad.6 Copyright statement: Ad.7 Disclaimers:
Ad.8 Additional Information/Comments: