NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 1647 **NQF Project:** Palliative Care and End-of-Life Care

(for Endorsement Maintenance Review)
Original Endorsement Date: **Most Recent Endorsement Date:**

BRIEF MEASURE INFORMATION

De.1 **Measure Title:** Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.

Co.1.1 **Measure Steward:** Deyta, LLC

De.2 **Brief Description of Measure:** This measure reflects the percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver/family did not want to discuss.

2a1.1 **Numerator Statement:** Number of patient with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss.

2a1.4 **Denominator Statement:** Total number of patient's discharged from hospice care during the designated reporting period.

2a1.8 **Denominator Exclusions:** Testing has only been done with the adult population, but there is no reason to believe that this wouldn't be applicable to all hospice patients.

1.1 **Measure Type:** Process
2a1. 25-26 **Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records
2a1.33 **Level of Analysis:** Facility

1.2-1.4 **Is this measure paired with another measure?** No

De.3 **If included in a composite, please identify the composite measure** (*title and NQF number if endorsed*)**:**
N/A

STAFF NOTES (*issues or questions regarding any criteria*)

Comments on Conditions for Consideration:

Is the measure untested? Yes☐ No☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:

1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*)**:**
5. Similar/related endorsed or submitted measures (*check 5.1*)**:**
Other Criteria:

Staff Reviewer Name(s):

1. IMPACT, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.
Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.

(evaluation criteria)

1a. High Impact: H☐ M☐ L☐ I ☐
(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 **Subject/Topic Areas** *(Check all the areas that apply)*:
De.5 **Cross Cutting Areas** (*Check all the areas that apply)*: Palliative Care and End of Life Care

1a.1 **Demonstrated High Impact Aspect of Healthcare:** Affects large numbers, Patient/societal consequences of poor quality, Other

1a.2 **If "Other," please describe:** Spiritual care is a key element of quality of life at the end of life

1a.3 **Summary of Evidence of High Impact** *(Provide epidemiologic or resource use data)*:
Hospice care is an increasingly important piece of the healthcare continuum, both from the number of patients served and the financial benefits (reducing costs associated with end-of-life care and re-hospitalizations for home health care and hospitals). According to NHPCO Facts and Figures (2010), over 1.5 million patients received services from approximately 5000 hospice throughout the United States.

Spiritual care has been shown to be a critical element of quality of life at the end of life. This measure is in accordance with the Clinical Practice Guidelines for Quality Palliative Care, Guidelines 5.1, and the National Quality Forum-endorsed preferred practices #20 (Clinical Practice Guidelines for Quality Palliative Care, 2009; NQF Framework, 2006).

1a.4 **Citations for Evidence of High Impact cited in 1a.3:** National Quality Forum: A National Framework and Preferred Practices for Palliative and Hospice Care Quality. Washington, DC: National Quality Forum. 2006.

Clinical Practice Guidelines for Quality Palliative Care – 2nd Edition National Consensus Project
National Consensus Project for Quality Palliative Care. (2009). Clinical Practice Guidelines for Quality Palliative Care, Second Edition. Retrieved from http://www.nationalconsensusproject.org/guideline.pdf. October 2009. Pages 29-43.

Cohen SR, Mount BM, Tomas JJN, Mount LF. Existential well-being is an important determinant of quality of life. Cancer 1996; 77:576-86.

Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. JAMA 2000 Nov 15;284(19):2476-82.

Boston P, Bruce A, Schrieber R. Existential suffering in the palliative care setting: an integrated literature review. J Pain Symptom Manage. 2011 Mar;41(3):604-18. Epub 2010 Dec 8.

Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, Chochinov H, Handzo G, Nelson-Becker H, Prince-Paul M, Pugliese K, Sulmasy D. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference.

J Palliat Med. 2009 Oct;12(10):885-904. Review.

1b. Opportunity for Improvement: H☐ M☐ L☐ I ☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 **Briefly explain the benefits (improvements in quality) envisioned by use of this measure:**
One of the unique aspects of hospice care involves a true interdisciplinary approach providing care for both the physical and psychosocial and spiritual needs of the patient and caregiver. Discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met. This measure will help agencies improve processes for addressing spiritual/religious concerns for patients and families receiving hospice care.

1b.2 **Summary of Data Demonstrating Performance Gap** *(Variation or overall less than optimal performance across providers)*:
[*For Maintenance* – *Descriptive statistics for performance results for this measure - distribution of scores for measured entities by*

quartile/decile, mean, median, SD, min, max, etc.]

Deyta, LLC has been capturing data for this measure in the Quality Navigator since December 2008. In addition to enabling individual hospices compare and trend their own performance, comparative benchmarking for over 100 hospices is also available. Results over the past two years have been consistent year-to-year demonstrating a variation in performance:

	2009	2010
# records	12,857	13,803
10th percentile	20.0%	10.6%
25th percentile	47.0%	38.2%
Median	78.2%	73.6%
75th percentile	92.15%	90.9%
90th percentile	100%	97.0%
Mean	68.6%	63.7%

1b.3 Citations for Data on Performance Gap: [*For **Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]**

N/A

1b.4 Summary of Data on Disparities by Population Group: [*For **Maintenance –Descriptive statistics for performance results for this measure by population group*]**

N/A

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For **Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]**

N/A

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐ If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I☐ Quality: H☐ M☐ L☐ I☐ Consistency: H☐ M☐ L☐ I☐

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	**Yes**☐
L	M-H	M	**Yes**☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise **No**☐
M-H	L	M-H	**Yes**☐ IF potential benefits to patients clearly outweigh potential harms: otherwise **No**☐
L-M-H	L-M-H	L	**No** ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	**Does the measure pass subcriterion1c?** **Yes**☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)*:

As mentioned previously, a true interdisciplinary approach providing care for both the physical and psychosocial and spiritual needs of the patient and caregiver is a unique aspect of hospice care. A discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met.

1c.2-3 Type of Evidence *(Check all that apply)*:

Clinical Practice Guideline, Other

Expert Opinion

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body*

of evidence and identify any differences from the measure focus and measure target population):
In order to address hospice patients' spiritual distress, the hospice team must discuss any spiritual/religious concerns with the patient.

1c.5 **Quantity of Studies in the Body of Evidence** *(Total number of studies, not articles)*: No other known formal studies.

1c.6 **Quality of Body of Evidence** (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): Because there are no known studies on this topic, there is a low level of certainty regarding net benefit.

1c.7 **Consistency of Results across Studies** *(Summarize the consistency of the magnitude and direction of the effect):* No other known studies for comparison.

1c.8 **Net Benefit** *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:
Because there are no known studies on this measure, there is a low level of certainty regarding net benefit.

1c.9 **Grading of Strength/Quality of the Body of Evidence**. Has the body of evidence been graded? No

1c.10 **If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** Because there are no known studies on this measure, grading has not been performed.

1c.11 **System Used for Grading the Body of Evidence:** Other

1c.12 **If other, identify and describe the grading scale with definitions:** Grading has not been completed.

1c.13 **Grade Assigned to the Body of Evidence:** N/A

1c.14 **Summary of Controversy/Contradictory Evidence:** Comparative data is limited throughout the industry for this measure. Data for this measure comes solely from participation in Deyta´s proprietary system, Quality Navigator, however could be obtained from other sources. Participants include hospices with varied characteristics for a representative sample of hospices in the industry: for profit and not-for-profit, single and large multi-location agencies, small (ADC < 50) to very large (> 1000), representing multiple regions of the country, use of an EHR and those with paper documentation.

1c.15 **Citations for Evidence other than Guidelines*(Guidelines addressed below)*:**
N/A

1c.16 **Quote verbatim, <u>the specific guideline recommendation</u>** *(Including guideline # and/or page #)*:
National Consensus Project Guidelines (2009)
Guideline 5.1: Spiritual and existential dimensions are assessed and responded to based upon the best available evidence, which is skillfully and systematically applied.

National Consensus Project and National Quality Forum Framework and Preferred Practices for Palliative and Hospice Care
Preferred Practice 20: Develop and document a plan based on an assessment of religious, spiritual, and existential concerns using a structured instrument, and integrate the information obtained from the assessment into the palliative care plan.

1c.17 **Clinical Practice Guideline Citation:** National Consensus Project for Quality Palliative Care. Clinical practice guidelines for quality palliative care. 2nd ed. Pittsburgh (PA): National Consensus Project for Quality Palliative Care; 2009. 80 p.

1c.18 **National Guideline Clearinghouse or other URL:**
http://www.guideline.gov/content.aspx?id=14423&search=clinical+practice+guidelines+for+quality+palliative+care

1c.19 **Grading of Strength of Guideline Recommendation.** Has the recommendation been graded? No

1c.20 **If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:**

1c.21 **System Used for Grading the Strength of Guideline Recommendation:** Other

1c.22 **If other, identify and describe the grading scale with definitions:** According to the guidelines (www.guideline.gov/content.aspx), the rating scheme for strength of recommendations is not available.

1c.23 **Grade Assigned to the Recommendation:** N/A

1c.24 **Rationale for Using this Guideline Over Others:** N/A

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: Low 1c.26 Quality: Low1c.27 Consistency: Low

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & 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. **(evaluation criteria)**
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 **Measure Web Page** *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? No

S.2 **If yes, provide web page URL:**

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 **Numerator Statement** *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)*:
Number of patient with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss.

2a1.2 **Numerator Time Window** *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
Cases are eligible for inclusion upon admission to a hospice program. The numerator criteria must be met during the time the patient is enrolled in the hospice program and can be met anytime during that period. The numerator data is collected within 1 to 12 months following discharge from hospice services.

2a1.3 **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, codes with descriptors, and/or specific data collection items/responses*:

Examples of a discussion may include asking about patient's need for spiritual or religious support, questions about the cause or meaning of illness or death. Other examples include discussion of God or a higher power related to illness, or offer of a spiritual resource including a chaplain. Discussion of spiritual or religious concerns may occur between patient and/or family and clergy or pastoral worker or patient and/or family and member of the interdisciplinary team.

Documentation of only patient's religious or spiritual affiliation does not count for inclusion in numerator.

Data are collected via chart review. Criteria are:
1) evidence of a discussion about spiritual/religious concerns, or
2) evidence that the patient, and/or family declined to engage in a conversation on this topic.

Evidence may be found in the initial screening/assessment, comprehensive assessment, update assessments across the entire period of care, visit notes documented by any member of the team, and/or the spiritual care assessment. Note that these examples and not a complete list.

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
Total number of patient's discharged from hospice care during the designated reporting period.

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*: Adult/Elderly Care, Children's Health

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
Total number of patient's discharged from hospice care during the designated reporting period.Cases are eligible for inclusion on the denominator upon discharge from the hospice program.The denominator data is collected within 1 to 12 months following discharge from hospice services.

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
Total number of patient's discharged from hospice care during the designated reporting period.

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
Testing has only been done with the adult population, but there is no reason to believe that this wouldn't be applicable to all hospice patients.

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
N/A

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)*:
N/A – The measure does not require stratification.

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:
N/A

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL**.** Please supply login/password if needed**:**

2a1.17-18. Type of Score: Non-weighted score/composite/scale

2a1.19 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

2a1.20 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.)***:**
[(Number of discharged hospice patient records with documentation of a discussion of spiritual/religious concerns)+(Number of discharged hospice patient records with documentation that the patient/family did not want to discuss spiritual/religious concerns.)]/ Total number of patient's discharged from hospice care during the designated reporting period.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:
Attachment
Spiritual Care Measure - Calculation Algorithm.pdf

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)**:**
N/A

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe**:**
Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*)**:** Deyta, LLC's Quality Navigator; Clinical Processes & Outcomes Reporting Package; Care Planning & Delivery Module

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: Attachment
QNAV CPD - Sample.pdf

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
Attachment
QNAV CPD - Sample-634425372974245559.pdf

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)***:** Facility

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)***:** Hospice

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability*.)

2a2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
Inter-rater reliability was conducted on this measure in two independent studies, the PEACE Project and the AIM Project.

The PEACE Project assessed inter-rater reliability using two research nurse abstractors who independently recorded quality measures data on a random subset of 20 seriously ill patients. Abstractors used the pre-defined operational definitions and a structured chart abstraction tool to record numerator and denominator data separately. Inter-rater reliability between the two

abstractors was assessed using kappa statistics. The nurse abstractors achieved excellent inter-rater reliability for this measure with Kappa=1.0

The AIM Project conducted reliability on the entire data collection tool used in the AIM Project on which the measures are based. Inter-rater reliability between IPRO's medical record abstractor "the gold standard" and each agency's abstractor was calculated using alpha=0.05 and power=0.8 and a preset value of kappa as 0.8. A sample size of 10 clinical records per agency was required to detect a kappa test statistic of 0.8 or greater. A convenience sample of clinical records from discharged patients who met the inclusion criteria was utilized.
We used percent agreement to test the reliability for dates and we conducted a kappa test on all categorical variables. Responses that had the same value in the quality measure calculations were collapsed into one value when appropriate (e.g., no, not documented, and unable to determine).
Inter-rater reliability was assessed between "the gold standard" abstractor and each agency's abstractor. Data from all 10 records were pooled and each agency was analyzed against the gold standard.
The kappa test statistic for all categorical variables was 0.795 (95% CI 0.79-0.80) (agency range: .70-.90), indicating substantial agreement. There is no reason to believe that achieved reliability for the data items contained within this measure would be substantially different than other categorical items. In fact during structured interviews and evaluations site abstractors noted that abstraction of this item was easier to conduct than most other items.
Deyta, LLC has been capturing data for this measure in the Quality Navigator since December 2008. In addition to enabling individual hospices compare and trend their own performance, comparative benchmarking is available for the more than 100 hospice agencies participating in this measure. Patient-level data from 13,435 records was used for the testing for 2009 and 2010.

2a2.2 **Analytic Method** *(Describe method of reliability testing & rationale)*:
A test-retest bivariate correlation was used to assess the consistency of the measure from one period of time (2009) to another time (2010).

Please refer to 2a2.1 for a description of the analytic methods used for the AIM and PEACE data testing.

2a2.3 **Testing Results** *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
Pearson Correlation: 0.026
Correlation is significant at the 0.01 level (2-tailed)
Significance (2-tailed): 0.004

Please refer to 2a2.1 for a description of the testing results from the AIM and PEACE data testing.

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H☐ M☐ L☐ I ☐

2b1.1 **Describe how the measure specifications** *(measure focus, target population, and exclusions)* **are consistent with the evidence cited in support of the measure focus (***criterion 1c)* **and identify any differences from the evidence:**
This measure captures data on whether or not a discussion of spiritual care needs or concerns was documented, or if there was a refusal to discuss. In order for a spiritual care screening or assessment to be performed, a discussion between hospice staff and the patient/caregiver must occur.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

2b2.1 **Data/Sample** *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
Deyta, LLC has been capturing data for this measure in the Quality Navigator since December 2008. In addition to enabling individual hospices compare and trend their own performance, comparative benchmarking is available for the more than 100 hospice agencies participating in this measure. Patient-level data from 13,435 records was used for the testing for 2009 and 2010.

2b2.2 **Analytic Method** *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
PEACE Project: Construct validity was tested by comparing the PEACE quality measures for patients seen by specialty interdisciplinary palliative care consultants to those not receiving specialty palliative care services.

AIM Project: The AIM Project used the following methods to conduct face validity as follows: Following the first three quarters of

data collection, participating agencies were each given quarterly reports for the measure based on the analysis of each agency's data and the aggregate project data. Agencies were then given opportunities to provide feedback (via written evaluations, conference call, best practice learning sessions, or individual correspondence) on whether they thought the data matched their actual practices. Agencies were asked to review results with their clinical staff and to review a subset of records and report to IPRO any discrepancies between the results and actual practice. Based on this feedback, revisions of the data abstraction tool and data dictionary were made and presented to the agencies to determine accuracy, feasibility, and to be sure the questions/items/answers represented actual practice. Additionally extensive feedback was sought from both the Hospice AIM Technical Advisory Panel and the Palliative Care Technical Expert Panel.
Because the Quality Navigator tool uses retrospective data collection approach and is the first hospice quality improvement instrument developed for data collection on this measure, we only conducted face validity testing of the measure. Based on discussions with participants in this measure, the agencies are able to capture data for this measure and indicate if a discussion of spiritual care needs was documented in the chart.

2b2.3 **Testing Results** *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment)***:**
PEACE Project results for Construct Validity: Hypothesizing that specialty palliative care providers will be better trained to screen for spiritual concerns, data demonstrates this quality measure is more often met for patients with (64%) vs. without (40%, $p<0.01$) specialty palliative care added.

AIM Project supports that the items contained within this measure were valid.

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 **Data/Sample for analysis of exclusions** *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
N/A – This measure has no exclusions.

2b3.2 **Analytic Method** (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)***:**
N/A

2b3.3 **Results** *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
N/A

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 **Data/Sample** *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
N/A - This measure is not risk adjusted

2b4.2 **Analytic Method (***Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)***:**
N/A

2b4.3 **Testing Results** *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)***:**
N/A

2b4.4 **If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment:** This measure applies to all hospice patients. There are not any variables that would impact whether or not the

practice/process should be performed.

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
Deyta, LLC has been capturing data for this measure in the Quality Navigator since December 2008. In addition to enabling individual hospices compare and trend their own performance, comparative benchmarking is available for the more than 100 hospice agencies participating in this measure. Patient-level data from 13,435 records was used for the testing for 2009 and 2010. Additional data continues to be collected throughout 2011, but has not been included in testing or comparison at this time.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)***:**
By simple percentile rankings of results for agencies, variation in performance is clearly evident. (Refer to 2b5.3. Results below)

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:

	2009	2010
Mean	68.6%	63.7%
10th percentile	20.0%	10.6%
25th percentile	47.0%	38.2%
Median	78.2%	73.6%
75th percentile	92.15%	90.9%
90th percentile	100%	97.0%

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)***:**
No other known data sources are available for this measure.

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)***:**
N/A

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)***:**
N/A

2c. Disparities in Care: H☐ M☐ L☐ I ☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts)***:** N/A - This measure is not stratified.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:
N/A

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐

Provide rationale based on specific subcriteria:
If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. **(evaluation criteria)**

C.1 **Intended Purpose/ Use** *(Check all the purposes and/or uses for which the measure is intended)***:** Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3.1 **Current Use** *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. **Use in Public Reporting - disclosure of performance results to the public at large** *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[*For Maintenance* –** *If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.***]**
While this measure was not initially designed with the intention of reporting the results publically, it could be available for public reporting with a modifications including a comprehensive data dictionary to fully define:
- Spiritual care needs and concerns
- What constitutes a "discussion" of spiritual care concerns
- Developing/identifying a consistent location for capture of the required data elements across the industry

3a.2.**Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting**. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results**:** Hospice care is unique across the healthcare continuum with a true interdisciplinary approach providing care for both the physical and psychosocial and spiritual needs of the patient and caregiver. Discussion of spiritual concerns is the core of a rigorous assessment of spiritual care needs and is essential to assuring that these needs are met. This measure is easily understood and meaningful to both hospice agencies as well as to members of the community.

3.2 **Use for other Accountability Functions (payment, certification, accreditation).** If used in a public accountability program, provide name of program(s), locations, Web page URL(s)**:** N/A

3b. Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. **Use in QI.** If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[*For Maintenance* – *If not used for QI, indicate the reasons and describe progress toward using performance results for improvement***]**.
Hospices using this measure have been able to analyze their performance at various time frames (monthly, quarterly or annually) and can track and trend progress over time to demonstrate changes in performance.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
This measure is a clear, straightforward indicator of whether or not a discussion of spiritual care concerns has been documented in the chart. Participants have used their results easily inform staff, senior management and board members of their performance.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. **(evaluation criteria)**

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*
Data used in the measure are**:**
Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

4b. Electronic Sources: H☐ M☐ L☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)***:** ALL data elements in electronic health records (EHRs)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H☐ M☐ L☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:
Data elements are captured from an electronic health record for those agencies that currently have an electronic health record in place. For those participants that are currently using a paper medical record, data elements are captured as part of a clinical record review then transferred to the Quality Navigator system. For agencies that are not participating with Quality Navigator, data could be easily captured and transferred electronically via Excel or some other similar template/tool.

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I ☐

A.2 Please check if either of the following apply (*regarding proprietary measures*)**:**
4d.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 *(e.g., fees for use of proprietary measures)***:**
While this measure is currently part of a proprietary tool/system, it is not a proprietary measure. Any hospice could easily incorporate this measure into their QAPI program. The challenge identified by current participants relates to the ability to query this information out of their EHR. Other participants have been easily able to incorporate this single measure into their already existing chart review/audit processes.

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐
Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND 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 before a final recommendation is made.

5.1 **If there are related measures *(either same measure focus or target population)* or competing measures *(both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:**

5a. Harmonization

5a.1 **If this measure has 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 Measure(s)

5b.1 **If this measure has 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)*:
No known competing measures exist.

CONTACT INFORMATION

Co.1 **Measure Steward (Intellectual Property Owner):** Deyta, LLC, 7400 New LaGrange Road, Suite 200, Louisville, Kentucky, 40222

Co.2 **Point of Contact:** Liz, Silva, lsilva@deyta.com, 502-896-8438-

Co.3 **Measure Developer if different from Measure Steward:** Deyta, LLC, 7400 New LaGrange Road, Suite 200, Louisville, Kentucky, 40222

Co.4 **Point of Contact:** Liz, Silva, lsilva@deyta.com, 502-896-8438-

Co.5 **Submitter:** Liz, Silva, lsilva@deyta.com, 502-896-8438-, Deyta, LLC

Co.6 **Additional organizations that sponsored/participated in measure development:**

Co.7 **Public Contact:** Liz, Silva, lsilva@deyta.com, 502-896-8438-, Deyta, LLC

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 **Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**
As this and other measures were being developed, we sought input from several academic researchers, hospice providers and other representatives in the industry.

Ad.2 **If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:**

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 **Year the measure was first released:** 2008
Ad.4 **Month and Year of most recent revision:** 12, 2008
Ad.5 **What is your frequency for review/update of this measure?** Every 3 years

Ad.6 When is the next scheduled review/update for this measure? 12, 2011
Ad.7 Copyright statement:
Ad.8 Disclaimers:
Ad.9 Additional Information/Comments: In response to the committee's questions about how this proposed measure may relate to measurable outcomes, we conducted some additional data analysis. In addition to the data described in this measure submission, Deyta's Quality Navigator also offers clients the ability to capture, track and trend data on the intensity of spiritual distress – a measurable outcome related to spiritual care. We conducted an analysis of a subset of the 2009 and 2010 records that were used for this measure submission to determine whether patients who had documentation of a spiritual discussion were more likely to improve their spiritual distress scores (distress score measured as no distress, mild, moderate, severe and improvement defined as a decrease of at least one level in distress score) than patients who did not have documentation of spiritual discussion. Data were retrospectively abstracted by trained personnel at each of the agencies and submitted to Deyta's system for trending and reporting. Patient records were abstracted from agencies that utilize both spiritual care measures. Records were excluded due to patients reporting that they were not experiencing any spiritual distress or due to missing data (patient was unable to report at least one spiritual distress score while on service). A total of 652 records were included in the analysis. Findings revealed that a greater proportion of patients who had documentation of a spiritual discussion (63%) showed improvement in their spiritual distress score than patients who did not have a documented spiritual discussion (48%). These findings help support the importance of the spiritual discussion and the existence of a relationship between the occurrence of the spiritual discussion and reduction in spiritual distress scores. Documentation of spiritual discussion; Improvement in spiritual distress score: 330 (63%) Documentation of discussion; No improvement in distress score: 194 (37%) No documentation of discussion; Improvement in distress score: 62 (48%) No documentation of discussion; No improvement in distress score: 62 (52%)
Date of Submission (*MM/DD/YY*)**:** 06/03/2011

QNAV Hospice & Palliative Care
(*Customized with your hospice name*)

Care Planning & Delivery
Complete audit after patient is discharged; enter data into QAPI Navigator system.

GENERAL INFORMATION

Patient ID Number: _____ **Patient Full Name:** _____

Admit Date (Date of election): ___ / ___ / ___ **Discharge Date:** ___ / ___ / ___ Type: ○ Death ○ Live Disch.

If the patient died, was the patient's death attended by hospice staff? ○ Yes ○ No

Primary Diagnosis: ○ ALS ○ Cancer ○ Decline in Health Status ○ Dementia (Alzheimer's and Related Disorders) ○ Heart Disease ○ HIV Disease ○ Liver ○ Pulmonary Disease ○ Renal Disease ○ Stroke and Coma ○ Other (please specify):

Team ID: _____ **Primary Nurse/Case Manager:** _____

COMPREHENSIVE ASSESSMENT COMPLETION

Date of completion of the comprehensive assessment: ___ / ___ / ___ ☐ Check here if not complete prior to discharge

OPIOID USE

Did the patient have opioid analgesics prescribed? ○ Yes ○ No Did patient have a bowel protocol initiated within 24 hr of the first opioid prescription? ○ Yes ○ No

PATIENT / FAMILY PREFERENCES FOR CARE

Preferences for hospitalization

On initial assessment: ○ Avoid hospitalization ○ OK to hospitalize ○ Undecided ○ No information on chart

Last recorded preference: ○ Avoid hospitalization ○ OK to hospitalize ○ Undecided ○ No information on chart

Was hospitalization documented at any time? *(any inpatient bed – hospice or other)* ○ Yes ○ No

Number of hospitalizations: _____

Were any hospitalizations unplanned? ○ Yes ○ No ○ No information on chart

Preferences for CPR

On initial assessment: ○ DNR ○ Full Code ○ Undecided ○ No information on chart

Last recorded preference: ○ DNR ○ Full Code ○ Undecided ○ No information on chart

Was there a documented resuscitation? ○ Yes ○ No

If yes, was the resuscitation unplanned? ○ Yes ○ No ○ No information on chart

Advance care planning

Was there a living will or documented surrogate decision-maker on the chart within 2 weeks of the date of election / admission? ○ Yes ○ No ○ Date not available

SPIRITUAL CARE

Was there a documented discussion of spiritual/religious concerns, or documentation that patient/family did not want to discuss? ○ Yes ○ No

FACTORS AFFECTING CARE

Was patient or PCG deaf or a non-English speaker? ○ Yes ○ No ○ No info on chart

If yes, was a non-family translator or interpreter used to communicate with the patient or PCG? ○ Yes ○ No ○ No info on chart

SYMPTOM MANAGEMENT PROCESS

Symptom	Not identified in this patient	Date first identified	No intervention	Date first intervention documented for symptom
Symptom 1	○	___ / ___ / ___	○	___ / ___ / ___
Symptom 2	○	___ / ___ / ___	○	___ / ___ / ___
Symptom 3	○	___ / ___ / ___	○	___ / ___ / ___
Symptom 4	○	___ / ___ / ___	○	___ / ___ / ___

Select up to 4 symptoms from the following:

Anxiety	***Insomnia***
Constipation	***Nausea***
Depression	***Pain***
Diarrhea	***Spiritual distress***
Dyspnea	***Skin impairment***

Data element	Definition/Instruction
Patient ID	The unique ID assigned to the patient by your agency.
Patient Name	First name, last name.
Admission Date (Date of Election)	Date that the hospice became responsible for the patient; also called "start of care date." For Medicare patients, it is the date of election of the Medicare Hospice Benefit.
Attended death	Indicate if hospice staff was present at the time of the patient's death.
Diagnosis	The patient's primary hospice diagnosis.
Team ID	The name or number for the care team assigned by your agency (choose from drop down menu).
1° Nurse/Case Mgr	The RN assigned to manage the patient's care (choose from drop-down menu).
Date of Completion of the Comprehensive Assessment	The earliest date that ALL elements of the patient's comprehensive assessment are complete; must include Initial assessment, Comprehensive nursing assessment (with nature and condition causing admission, complications and risk factors that affect care planning, functional status, imminence of death, severity of symptoms/symptom screening), Drug profile/review, Initial bereavement assessment, Need for referrals and further evaluation; depending on the initial assessment findings, may include Comprehensive psychosocial assessment, Comprehensive spiritual assessment, assessments by ancillary providers. If comprehensive assessment was not completed prior to the patient's discharge, check the box.
Opioid Use	1. Indicate whether patient had opioid analgesics prescribed at any time during the course of care; fill in the date of the first prescription of opioids. (*Exclude opioids in a "comfort pack".*) 2. Indicate whether patient had a bowel protocol (as defined by your hospice) initiated within 24 hr of the opioid prescription.
Preference for Hospitalization	1. Indicate preference regarding hospitalization. • On admission means at the first assessment. • Last recorded preference means the preference recorded closest to the time of discharge; note that this may be the documentation at the first assessment or at any assessment update up to the day of discharge. 2. Indicate whether the patient was hospitalized at any time and the number of hospitalizations during the course of hospice care. Hospitalization includes any time spent in an inpatient setting even if it was a hospice inpatient stay; also includes hospitalization concurrent with discharge or revocation. 3. Indicate whether the hospitalization was planned; "planned" means that the hospice was involved in planning the transfer before the patient went to the inpatient setting.
Preference for CPR	1. Indicate preference regarding resuscitation • On admission means at the first assessment • Last recorded preference means the preference recorded closest to the time of discharge; note that this may be the documentation at the first assessment or at any assessment update up to the day of discharge. 2. Indicate whether the patient was resuscitated at any time during the course of hospice care, no matter who conducted the CPR. 3. Indicate whether the resuscitation was planned; "planned" means that the hospice was involved in planning for the resuscitation (planning who would conduct it and how they would be called/notified) before the patient required CPR; a planned CPR cannot occur for a patient who is DNR on admission and for the duration of care.
Advance Care Planning Documentation	Answer "yes" only if chart contains copy of living will, or copy of surrogate designation form, or copy of a Durable Power of Attorney for Healthcare designation, or contact information for a designated surrogate/proxy decision-maker within the first two weeks of care.
Spiritual Care	Answer "yes" only if chart contains documentation of a discussion about spiritual issues or documentation showing that patient/Primary Caregiver/family declined to discuss.
Factors Affecting Care	1. If either patient or Primary Caregiver (PCG) was deaf or did not speak English, answer "yes" to first question. 2. Answer "yes" to second question only if use of a non-family member translator (for non-English speakers) or interpreter (for deaf) was documented.
Symptom Management Process	1. First column: check if the symptom was NEVER identified for the patient. 2. Second column: enter date that the symptom was first identified on an assessment form; may be nursing, psychosocial or spiritual assessment. 3. Third column: check if no interventions were documented for this symptom. 4. Fourth column: enter date that the first delivery of any intervention directed at this symptom is documented; may be on the plan of care, drug profile, or in clinical notes.

QNAV Hospice & Palliative Care
(*Customized with your hospice name*)

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If the patient died, was the patient's death attended by hospice staff? ○ Yes ○ No

Primary Diagnosis: ○ ALS ○ Cancer ○ Decline in Health Status ○ Dementia (Alzheimer's and Related Disorders) ○ Heart Disease ○ HIV Disease ○ Liver ○ Pulmonary Disease ○ Renal Disease ○ Stroke and Coma ○ Other (please specify):

Team ID: _____ **Primary Nurse/Case Manager:** _____

COMPREHENSIVE ASSESSMENT COMPLETION

Date of completion of the comprehensive assessment: ___ / ___ / ___ ☐ Check here if not complete prior to discharge

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Did the patient have opioid analgesics prescribed? ○ Yes ○ No Did patient have a bowel protocol initiated within 24 hr of the first opioid prescription? ○ Yes ○ No

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Was hospitalization documented at any time? *(any inpatient bed – hospice or other)* ○ Yes ○ No

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Were any hospitalizations unplanned? ○ Yes ○ No ○ No information on chart

Preferences for CPR

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Was there a documented resuscitation? ○ Yes ○ No

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Advance care planning

Was there a living will or documented surrogate decision-maker on the chart within 2 weeks of the date of election / admission? ○ Yes ○ No ○ Date not available

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Symptom 4	○	___ / ___ / ___	○	___ / ___ / ___

Select up to 4 symptoms from the following:

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Diagnosis	The patient's primary hospice diagnosis.
Team ID	The name or number for the care team assigned by your agency (choose from drop down menu).
1° Nurse/Case Mgr	The RN assigned to manage the patient's care (choose from drop-down menu).
Date of Completion of the Comprehensive Assessment	The earliest date that ALL elements of the patient's comprehensive assessment are complete; must include Initial assessment, Comprehensive nursing assessment (with nature and condition causing admission, complications and risk factors that affect care planning, functional status, imminence of death, severity of symptoms/symptom screening), Drug profile/review, Initial bereavement assessment, Need for referrals and further evaluation; depending on the initial assessment findings, may include Comprehensive psychosocial assessment, Comprehensive spiritual assessment, assessments by ancillary providers. If comprehensive assessment was not completed prior to the patient's discharge, check the box.
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Symptom Management Process	1. First column: check if the symptom was NEVER identified for the patient. 2. Second column: enter date that the symptom was first identified on an assessment form; may be nursing, psychosocial or spiritual assessment. 3. Third column: check if no interventions were documented for this symptom. 4. Fourth column: enter date that the first delivery of any intervention directed at this symptom is documented; may be on the plan of care, drug profile, or in clinical notes.

Documentation of Discussion of Spiritual Care Concerns Measure Calculation Algorithm