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 #: 1617 **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:** Patients Treated with an Opioid who are Given a Bowel Regimen
Co.1.1 **Measure Steward:** RAND Corporation
De.2 **Brief Description of Measure:** Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed
2a1.1 **Numerator Statement:** Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed
2a1.4 **Denominator Statement:** Vulnerable adults who are given a new prescription for an opioid
2a1.8 **Denominator Exclusions:** None
1.1 **Measure Type:** Process 2a1. 25-26 **Data Source:** Electronic Clinical Data : Electronic Health Record, Paper Records, Patient Reported Data/Survey 2a1.33 **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan 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*)**:**

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, OPPORTUNITY, 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)*: Cancer, GI
De.5 Cross Cutting Areas (*Check all the areas that apply)*: Palliative Care and End of Life Care, Safety : Complications

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact *(Provide epidemiologic or resource use data)*:
Opioids are commonly used in the management of moderate to severe pain, and constipation is a common adverse effect. (Myotoku 2010; Tuteja 2010; Pappagallo 2001) A systematic review evaluating the extent and management of opioid-related side effects in both cancer and non-cancer patients indicated that tolerance is not developed to opioid-induced constipation and confirmed the need for prophylaxis. (McNicol 2003) Risk of constipation is further aggravated by immobility and dehydration in older people with pain. The American Pain Society and American Geriatrics Society as well as expert consensus opinion recognize the frequency of constipation with opioid use and the necessity for prophylactic therapy. (APS 2005; RANO 2002; AGS 2002; APS 2002; Weiner 2001; Davis 2003; Etzioni 2007; Dy 2008) A study of 194,017 emergency department visits made by 76,759 cancer patients in the final 6 months of life revealed that 3,392 visits were made for constipation. (Barbera 2010)

The denominator for this measure includes vulnerable adults as this was the population in which it was tested. However, the literature cites constipation as a significant problem in adults of all ages and including those taking opioids for chronic non-cancer pain as well. (Tuteja 2010) A Cochrane systematic review of 26 studies of patients at least 18 years old taking opioids for at least 6 months for non-cancer pain revealed gastrointestinal complaints (e.g., constipation, nausea, dyspepsia) as the most commonly reported side effect. (Noble 2010)

1a.4 Citations for Evidence of High Impact cited in 1a.3:
AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002;50(6 Suppl):S205-24

American Pain Society (APS). Guideline for the management of cancer pain in adults and children. 2005

American Pain Society (APS). Guideline of the management of pain in osteoarthritis, rheumatoid arthritis, and juvenile chronic arthritis. 2002.

Barbera L, Taylor C, Dudgeon D. Why do patients with cancer visit the emergency department near the end of life? Can Med Assoc J 2010;182(6):563-569

Davis MP, Srivastava M. Demographics, assessment and management of pain in the elderly. Drugs Aging 2003;20(1):23-57

Dy SM, Asch SM, Naeim A, et al. Evidence-based standards for cancer pain. J Clin Oncol 2008;26(23):3879-3885

Etzioni S, Chodosh J, Ferrell BA, et al. Quality indicators for pain management in vulnerable elders. JAGS 2007;55:S403-S408

McNicol E, Horowicz-Mehler N, Fisk RA et al. Management of opioid side effects in cancer-related and chronic noncancer pain: a systematic review. J Pain 2003;4(5):231-56

Myotoku M, Nakanishi A, Kanematsu M, et al. Reduction in opioid side effects by prophylactic measures of palliative care team may result in improved quality of life. J Pall Care 2010;13(4):401-406

Noble M, Treadwell JR, Tregear SJ, et al. Long-term opioid treatment for chronic noncancer pain. Cochrane Database Sys Rev 2010;(1):CD006605

Pappagallo M. Incidence, prevalence, and management of opioid bowel dysfunction. Am J Surg 2001;182(5A Suppl):11s-8s

Registered Nurses Association of Ontario (RNAO). Assessment and management of pain. 2002. (Nursing Best Practice Guideline: Shaping the Future of Nursing)

Tuteja AK, Biskupiak J, Stoddard GJ, et al. Opioid-induced bowel disorders and narcotic bowel syndrome in patients with chronic non-cancer pain. Neurogastroenterol Motil 2010;22:424-e96

Weiner DK, Hanlon JT. Pain in nursing home residents: management strategies. Drugs Aging 2001;18(1):13-29

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:
Reduction in opioid-induced constipation has the potential to result in improved opioid medication compliance, reduction in patient discomfort, and improved quality of life.

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.*]**
N, % measure performance
Assessing Care of Vulnerable Elders (ACOVE)(Wenger 2003): Community dwelling vulnerable elders. N=46, 0%

ACOVE3 (Walling 2010): Inpatients who died during admission. N=460, 61%

Assessing Symptoms Side Effects and Indicator of Supportive Treatment (ASSIST) (Dy 2011): Cancer Center and hospitalized patients with advanced cancer. N=39, 51%

ACOVE3/Tufts (unpublished data, in analysis): Community dwelling elders >74 years old. N=48, 17%

Hospice and Palliative Care PEACE (personal communication from Dr. Laura Hanson): Seriously ill patients with a palliative care consult or in hospice care. 44-52% met this measure in palliative care and hospice, respectively.

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*]**
Dy SM, Asch SM, Lorenz KA, et al. Quality of end-of-life care for patients with advanced cancer in an academic medical center. J Pall Med 2011;14(4):451-457

Walling AM, Asch SM, Lorenz KA, et al. The quality of life provided to hospitalized patients at the end of life. Arch Intern Med 2010;170(12):1057-1063

Wenger NS, Solomon DH, Roth CP, et al. The quality of medical care provided to vulnerable community-dwelling older patients. Arch Intern Med 2003;139:740-747

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance* –*Descriptive statistics for performance results for this measure by population group*]**
None available

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*]**

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)***:**
Measure focus is on the process of bowel prophylaxis initiated at the time of opioid prescription with the intent of improved outcomes with regard to opioid compliance, pain control, lower incidence of constipation, and consequential improved quality of life.

1c.2-3 Type of Evidence *(Check all that apply)***:**
Clinical Practice Guideline, Selected individual studies (rather than entire body of evidence), Systematic review of body of evidence (other than within guideline development)

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)***:**
There is no clinical trial directly linking the care process in this measure with outcomes. However, the clinical effect of the care process on opiate use is clear, as reflected in clinical guidelines recommending constipation prophylaxis.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)***:**

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*)**:**

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):*

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)***:**

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? Yes

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: AGS Panel on Persistent Pain in Older Persons

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

1c.12 If other, identify and describe the grading scale with definitions:

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

1c.14 Summary of Controversy/Contradictory Evidence:

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

See also 1a.4

Lorenz KA, Rosenfeld K, Wenger N. Quality indicators for palliative and end-of-life care in vulnerable elders. J Am Geriatr Soc. 2007;55 Suppl 2:S318-26.

Schenck AP, Rokoske FS, Durham DD, et al. The PEACE project: identification of quality measures for hospice and palliative care. J Pall Care 2010;13(12):1451-1459

1c.16 Quote verbatim, the specific guideline recommendation *(Including guideline # and/or page #)*:
Constipation is one of the most common opioid-related adverse effects. Most patients develop some degree of constipation after opioid initiation or dose increases, and resolution of constipating effects of opioids often does not occur with continued exposure. In older adults or other patients with additional reasons to develop constipation, we recommend routinely considering initiation of a bowel regimen before the development of constipation. Though most evidence is anecdotal, bowel regimens including increased fluid and fiber intake, stool softeners, and laxatives are often effective. There is insufficient evidence to recommend oral opioid antagonists to prevent or treat opioid-induced bowel dysfunction in persons with CNCP, though randomized trials suggest some potential benefits over placebo. (Chou 2009, page 121)

A prophylactic bowel regimen should be initiated at the commencement of persistent opiate therapy. (AGS, page S217)

1c.17 Clinical Practice Guideline Citation: Chou R, Fanciullo GJ, Fine PG, Adler JA, Ballantyne JC, Davies P, Donovan MI, Fishbain DA, Foley KM, Fudin J, Gilson AM, Kelter A, Mauskop A, O´Connor PG,
Passik SD, Pasternak GW, Portenoy RK, Rich BA, Roberts RG, Todd KH, Miaskowski C; American Pain Society-American Academy of Pain Medicine Opioids Guidelines Panel. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain. 2009;10:113-30.

AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc. 2002 Jun;50(6 Suppl):S205-24.

1c.18 National Guideline Clearinghouse or other URL:

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? Yes

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

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

1c.22 If other, identify and describe the grading scale with definitions:

1c.23 Grade Assigned to the Recommendation: 1A

1c.24 Rationale for Using this Guideline Over Others: No contradictory guidelines

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: Moderate **1c.26** Quality: High**1c.27** Consistency: High

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)*:
Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed

2a1.2 **Numerator Time Window** *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
Within 24 hours of new opioid prescription.

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*:
Patients from the denominator given a bowel regimen defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR documentation of why such a bowel regimen is not needed.

2a1.4 **Denominator Statement** *(Brief, narrative description of the target population being measured)*:
Vulnerable adults who are given a new prescription for an opioid

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

2a1.6 **Denominator Time Window** *(The time period in which cases are eligible for inclusion)*:
Any new prescription for opioid

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)*:
All vulnerable adults >18 years old prescribed an opioid as an inpatient OR as an outpatient in those patients who are not already taking this type of medication
"Vulnerable" is defined as any of the following:
- >74 years of age
- Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001)
- Poor prognosis/terminal illness defined as life expectancy of <6 months
- Stage IV cancer

Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699

2a1.8 **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*:
None

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)*:

None

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)*:

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.)*:

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: Rate/proportion

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.)*:
1. Identify vulnerable adults with a new prescription for an opioid. "New" prescription for an outpatient means that the patient is not already taking an opioid. "New" prescription for an inpatient would include ALL patients with an order for opioid treatment on admission or during the hospitalization.
2. Include only patients who are vulnerable (age >74, VES-13 score >2, or poor prognosis/terminally ill, advanced cancer).
3. Look for documentation within 24 hours of prescription of an offer/prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed

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

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):

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

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.*): Medical record abstraction tool

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

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)*: Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)*: Ambulatory Care : Clinician Office, Hospital/Acute Care Facility

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)*:
See 2a2.3

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)*:
See 2a2.3

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
ACOVE3 (Walling 2010) inpatient decedents (n=460), 47 reliability re-abstractions: Eligibility 98% agreement (unable to calculate kappa); specified care kappa=0.64.

ASSIST (Dy 2011) inpatient/outpatient decedents (n=39): Overall eligibility kappa=0.87; overall specified care kappa=0.86

PEACE (personal communication from Dr. Laura Hanson): Hospice and palliative care patients. Inter-rater reliability kappa=0.86

Dy SM, Asch SM, Lorenz KA, et al. Quality of end-of-life care for patients with advanced cancer in an academic medical center. J Pall Med 2011;14(4):451-457

Dy SM, Lorenz KA, O´Neill SM, et al. Cancer quality-ASSIST supportive oncology quality indicator set. Feasibility, reliability, and validity testing. Cancer 2010;116:3267-3275

Walling AM, Asch SM, Lorenz KA, et al. The quality of life provided to hospitalized patients at the end of life. Arch Intern Med 2010;170(12):1057-1063

2b. VALIDITY. Validity, Testing, <u>including all Threats to Validity</u>: 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:**
Populations tested reflect similar populations in the cited evidence (cancer patients, inpatients, patients with non-cancer pain).

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)*:
See 2b2.2

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
Validity of the process-outcome link was explicitly evaluated by the ACOVE, ACOVE3, ASSIST, and PEACE expert panels that reviewed the relevant literature and used a modified Delphi panel of voting on the validity of the measure. (Shekelle 2001; Wenger 2007; Lorenz 2009) Although validity has not been tested empirically for this measure alone, the process-outcome link of the set of quality measures including this measure has been tested. Process of care measured using the ACOVE quality indicator set is linked to patient function and survival. (Higashi 2007)

Higashi T, Shekelle PG, Adams J, et al. Quality of care is associated with survival in vulnerable older patients. Ann Intern Med 2005;143:274-281

Lorenz KA, Dy SM, Naeim A, et al. Quality measures for supportive cancer care: the cancer quality-ASSIST project. J Pain Symptom Manage 2009;37(6):943-964

Schenck AP, Rokoske FS, Durham DD, et al. The PEACE project: identification of quality measures for hospice and palliative care. J Pall Med 2010;13(12):1451-1459

Shekelle PG, MacLean CH, Morton SC, et al. Assessing care of vulnerable elders: Methods for developing quality indicators. Ann Intern Med 2001;135:647-652

Wenger NW, Roth CP, Shekelle P, et al. Introduction to the assessing care of vulnerable elders-3 quality indicator measurement set. J Am Geriatr Soc 2007;55:S247-S252

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)***:**

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)***:**
None

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

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

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)***:**
None

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

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)***:**

2b4.4 **If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment:**

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)***:**

2b5.2 **Analytic Method** *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)***:**

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)*:

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)***:**

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

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)***:**

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)***:**

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

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)*: 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.***]**

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**:**

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)**:**

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***]**.

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:
Clear process of care that can be addressed in quality improvement studies.

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)***:** Some data elements are in electronic sources

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:

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)***:**

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)***:**
This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle.

CONTACT INFORMATION

Co.1 **Measure Steward (Intellectual Property Owner):** RAND Corporation, 1776 Main Street, Santa Monica, California, 90407

Co.2 **Point of Contact:** Carol, Roth, RN, MPH, roth@rand.org, 310-393-0411-6794

Co.3 **Measure Developer if different from Measure Steward:** RAND Corporation, 1776 Main Street, Santa Monica, California, 90407

Co.4 **Point of Contact:** Neil, Wenger, MD. MPH, nwenger@mednet.ucla.edu, 310-794-2288-

Co.5 **Submitter:** Carol, Roth, RN, MPH, roth@rand.org, 310-393-0411-6794, RAND Corporation

Co.6 **Additional organizations that sponsored/participated in measure development:**
Co.7 **Public Contact:** Carol, Roth, RN, MPH, roth@rand.org, 310-393-0411-6794, RAND Corporation

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.**

ACOVE-3 project expert panel members, ACOVE-3 Clinical Committee members, ASSIST project expert panel members and Advisory Board as listed below.

ACOVE-3 project (Panel 2) expert panel members:

Helena Chang, MD
UCLA School of Medicine, Los Angeles, CA

Nick Fitterman, MD
Northshore Medical Group, Huntington, NY

Jean S. Kutner, MD, MSPH
University of Colorado Health Sciences Center, Aurora, CO

Patrick J. Loehrer, Sr., MD
Indiana University School of Medicine, Indianapolis, IN

Thomas Mattimore, MD
University of California at Los Angeles, Los Angeles, CA

Hyman B. Muss, MD
Vermont Cancer Center at University of Vermont, Burlington, VT

James L. Naughton, MD
Alliance Medical Group, Pinole, CA

Cheryl Phillips, MD
Sutter Medical Group, Sacramento, CA

Doron Schneider, MD
Muller Center for Senior Health, Abington Memorial Hospital, Abington, PA

Michael Stamos, MD
University of California, Irvine, CA

Ronald D. Stock, MD
Center for Senior Health, Eugene, OR

May Lin Tao, MD, MSPH
John Wayne Cancer Institute, Saint John´s Health Center, Santa Monica, CA and Valley Radiotherapy Associates Medical Group, El Segundo, CA

Role of ACOVE Expert Panel: Expanded and updated the Assessing Care of Vulnerable Elders (ACOVE) quality indicators via literature review, face-to-face discussion, and 2 rounds of anonymous ratings to evaluate whether the QIs were valid measures of

quality of care using a process that is an explicit combination of scientific evidence and professional consensus.

ACOVE-3 CLINICAL COMMITTEE MEMBERS:

Alpesh N. Amin, MD - Hospitalist
University of California, Irvine Medical Center, Irvine, CA

Richard W. Besdine, MD - Geriatrician and Clinical Committee Chair
Brown University Center for Gerontology and Health Care Research, Providence, RI

Dan G. Blazer, MD - Geriatric Psychiatrist
Duke University Medical Center, Durham, NC

Harvey J. Cohen, MD - Geriatric Oncologist
Duke University Medical Center, Durham, NC

Terry Fulmer, PhD, RN, FAAN - Nurse
New York University, New York, NY

Patricia A. Ganz, MD - Oncologist
UCLA Schools of Medicine & Public Health, Jonsson Comprehensive Cancer Center, Los Angeles, CA

Mark A. Grunwald, MD - Family Practitioner
Gunderson Lutheran Clinic, Prairie du Chien, WI

William J. Hall, MD, MACP - Geriatrician
Highland Hospital, Rochester, NY

Ira R. Katz, MD, PhD - Psychiatrist
University of Pennsylvania, Philadelphia, PA

Paul R. Katz, MD - Geriatrician
Monroe Community Hospital, Rochester, NY

Dalane W. Kitzman, MD - Geriatric Cardiologist
Wake Forest University School of Medicine, Winston-Salem, NC

Rosanne M. Leipzig, MD, PhD - Geriatrician
Mount Sinai School of Medicine, New York, NY

Ronnie A. Rosenthal, MD - Surgeon
Yale University School of Medicine, New Haven, CT

Role of ACOVE-3 Clinical Committee: Evaluated the coherence of the complete set of QIs that the experts rated as valid as well as determined exclusions for advanced dementia and poor prognosis.

ASSIST project expert panel members:
Kurt Kroenke, MD
Indiana University Cancer Center, Indianapolis, Indiana

Terry Altilio, LCSW
Beth Israel Medical Center, New York, New York

Lodovico Balducci, MD

H. Lee Moffitt Cancer Center & Research Institute, Tampa, Florida

Jeannine M. Brant PhD(c),
St. Vincent Healthcare, Billings, Montana

Eduardo Bruera, MD
UT M. D. Anderson Cancer Center, Houston, Texas

Peter Eisenberg, MD
California Cancer Care, Greenbrae, California

Pr Stein Kaasa
St. Olavs University Hospital HF, Trondheim, Norway

Sean Morrison, MD
Mt. Sinai Medical School, New York, New York

Mary Simmonds, MD
Family practice, New Cumberland, Pennsylvania

Role of ASSIST Expert Panel: Helped to develop and refine the quality indicators for the Addressing Symptoms Side effects and Indicators for Supportive Treatment (ASSIST) project via literature review, face-to-face discussion, and 2 rounds of anonymous ratings to evaluate whether the QIs were valid measures of quality of care using a process that is an explicit combination of scientific evidence and professional consensus.

ASSIST Project Advisory Board:

Neil S. Wenger, MD, MPH
UCLA Division of Gen Internal Med and Health Svcs Research, Los Angeles, CA

Steven B. Clauser, PhD
Chief, Outcomes Research Branch, Applied Research Program, Div of Cancer Control and Pop. Sciences, National Cancer Institute, Bethesda, MD

David Currow, MD
CEO, Cancer Australia, Flinders University, South Australia

Molla S. Donaldson, Dr.PH, MS
Adjunct Professor, Dept. of Medicine, George Washington University School of Medicine and Health Sciences and Principal, QuantaNet, Chevy Chase, MD

Betty Ferrell, PhD, RN, FAAN
City of Hope National Medical Center, Duarte, CA

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Copenhagen University Hospital Department of Oncology, Herlev, Denmark

Paul Hesketh, MD
Chief, Division of Hematology/Oncology, Caritas St. Elizabeth´s Medical Center, Boston, MA

Catherine H. MacLean, MD, PhD
Medical Director, Programs for Clinical Excellence Health Solutions, Wellpoint, Inc., Thousand Oaks, CA

Thomas J. Smith, MD
Division of Hematology/Oncology and Palliative Care, Virginia Commonwealth University, Massey Cancer Center, Richmond, VA

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: 2001
Ad.4 Month and Year of most recent revision: 07, 2010
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?

Ad.7 Copyright statement:

Ad.8 Disclaimers:

Ad.9 Additional Information/Comments:

Date of Submission (*MM/DD/YY*)**:** 05/18/2011