2025 Quality ID PIMSH9: Oncology: Supportive Care Drug Utilization in Last 14 Days of Life

--**High Priority Type:** Efficiency
--**Measure Type**: Appropriate Use

2025 COLLECTION TYPE:
QCDR-- Practice Insights by McKesson in Collaboration with The US Oncology Network

DATA SOURCE USED FOR THE MEASURE:
Practice Insights by McKesson in Collaboration with The US Oncology Network - QCDR - EHR; Other: Medical record, medication lists.

DESCRIPTION:
Percentage of patients receiving supportive care drugs (including colony stimulating factors, bone health, supplemental iron medications, and neurokinin 1 (NK1) receptor antagonist antiemetics) during the 14 days prior to and including the date of death.

DENOMINATOR:
All cancer patients (solid or hematologic tumor) with a documented cancer-related date of death within the reporting period.

DENOMINATOR EXCEPTION:
Failure of 5-HT3 receptor antagonists to treat nausea where NK1 receptor antagonists may be an appropriate course of patient care.

DENOMINATOR EXCLUSION:
None

NUMERATOR:
Patients who received supportive care drugs (including colony stimulating factors, bone health, supplemental iron medications, and neurokinin 1 (NK1) receptor antagonist antiemetics) during the 14 days prior to and including the date of death.

NUMERATOR EXCLUSION:
None

TELEHEALTH:
Included

MIPS REPORTING OPTIONS:
Traditional MIPS

CLINICAL RECOMMENDATION STATEMENTS:

This measure is endorsed by the US Oncology Network Steering Committee. Certain supportive care medications applied in the last 14 days of life have minimal benefit to the patient and should be avoided at a time in the care trajectory where focus should turn to comfort measures and effective transition to hospice care. Guidelines include ASCO - Recommendations for the Use of WBC Growth Factors: American Society of Clinical Oncology Clinical Practice Guideline Updates (2015)

QCDR MEASURE RATIONALE:

Clinically, there is little need for supportive care drug use in the last 14 days of life. Current studies show that chemotherapy and supportive care drugs continue to be the highest cost drivers, and it is critical to monitor appropriate use. By routinely reporting to practices and individual providers where supportive care drug spend is occurring in the last 14 days of life, there is opportunity to reduce total cost of care, aside from monitoring chemotherapy and other treatment/interventions, at the end of life. It is critical to identify for practices and physicians where end-of-life supportive care drug prescribing is occurring, highlighting potential for prescribing behavior change. References: Bhuvana S, et al. (2017) Cost drivers for breast, lung, and colorectal cancer care in a commercially insured population over a 6-month episode: an economic analysis from a health plan perspective. J Med Econ, DOI: 10.1080/13696998.2017.1339353 Buiting HM, et al. Understanding provision of chemotherapy to patients with end stage cancer: qualitative interview study. BMJ. 2011; 342: d1933. Cheung, et al. Impact of aggressive management and palliative care on cancer costs in the final months of life. Cancer 2015; 121: 3307-3315. Goodman DC, et al. Trends in cancer care near the end of life: A Dartmouth Atlas of Health Care Brief. The Dartmouth Institute for Health Policy and Clinical Practice. Published September 4, 2013.

These performance measures are not clinical guidelines and do not establish a standard of medical care and have not been tested for all potential applications.

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