NATIONAL QUALITY FORUM
Driving measurable health improvements together

Memo

July 9, 2020

To: Geriatrics & Palliative Care Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comment received

COVID-19 Updates

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: Measures Continuing in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations will be reviewed by the CSAC on July 28 – 29.

- **Exceptions**
  Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures requiring further action or discussion from a Standing Committee were deferred to the Spring 2020 cycle. This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review will retain endorsement during that time. Track 2 measures will be reviewed during the CSAC's meeting in November.

During the Geriatrics & Palliative Care post-comment web meeting on July 9,2020 , the Geriatrics & Palliative Care Standing Committee will be reviewing a comment received on one Fall 2019 measure assigned to Track 2. The measure assigned to Track 1 can can be found in Appendix B.

Measure Recommended for Endorsement

- 2651 CAHPS® Hospice Survey (experience with care)

Purpose of the Call

The Geriatrics & Palliative Care Standing Committee will meet via web meeting on July 9,2020 from 3-5pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period;
- Provide input on proposed responses to the post-evaluation comments;
- Review and discuss NQF members' expression of support of the measures under consideration; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of the comment received and the proposed response to the post-evaluation comment (see comment table and additional documents included with the call materials).
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

1. Direct your web browser to the following URL: https://core.callinfo.com/callme/?ap=8007682983&ac=5599510&role=p&mode=ad
2. Under "Join a Conference," please enter your first and last name. The conference number will be **800-768-2983.** The access code is **5599510**. You may save the access code under "Geriatrics and Palliative Care." Please click "save" if you have not already.
3. Please then enter your phone number under the "Call Me at" feature to complete registration. Please enter the appropriate designation under the "Save this number as" text box. Please click "save" if you have not already. This feature will allow CenturyLink to call you and add you to the conference.
4. Click the "Call Me & Join Web Meeting" button to enter the meeting.
5. Alternative dial-in: Please dial **800-768-2983** from your mobile phone, and then enter the access code **5599510**.

Background

During its Fall 2019 evaluation cycle, the Geriatrics and Palliative Care Standing Committee evaluated two measures undergoing maintenance review. Due to the nature of one comment received, one measure (NQF 1623) will follow track 1 and one measure (NQF 2651) will follow track 2.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments via an online tool on the project webpage.

Pre-evaluation Comments

For this evaluation cycle, the pre-evaluation comment period opened on December 11, 2019 and closed on January 31, 2019 for the measures under review. NQF did not receive any pre-evaluation comments prior to the measure evaluation meeting.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment from March 30, 2020 to May 28, 2020. During this commenting period, NQF received one comment from one member organization. The stakeholder perspective of the NQF member who commented is show in the table below.

Member Council	# of Member Organizations Who Commented
Consumer	0
Health Plan	0
Health Professional	X
Provider Organization	0
Public/Community Health Agency	0
Purchaser	0
QMRI	0
Supplier/Industry	0

We have included all comments that we received in the comment table (excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, and draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table in advance of the meeting and consider the comment received and the proposed response.

Comments and Their Disposition

Measure-Specific Comment

2651: CAHPS® Hospice Survey (experience with care)

The commenter encouraged the measure developer to improve the specificity in the questionnaire with respect to person-centered care. The commenter suggested that communication may be too limiting a term to capture the dialogue that occurs between the healthcare team and the patient/proxy with respect to what matters most in hospice care. The commenter suggested that this recommendation can be done by using language that prioritizes the patient/caregiver, while minimizing the focus on academic person-centered care.The commenter provided a possible methodolgy to address this concern in the CAHPS Hosice Survey by: 1) identifing and empathizing with what matters most, specific to the

patient/primary caregiver; 2) distilling the priorities and care preferences into actionable healthcare activities; 3) communicating healthcare activities in a meaningful way; and 4) as illness progresses and changes in functional/cognitive/emotional status occur, priorities are reassessed, responded to, and clearly communicated. The commenter noted that the measures should address the complexity of person-centered care for older adults with multiple chronic conditions and emphasized the need to develop appropriate patient reported outcome measures.

Measure Steward/Developer Response:

CMS thanks the American Geriatrics Society for their thoughtful comments on the CAHPS Hospice Survey measures. In response to stakeholder feedback, CMS is currently drafting and preparing to field-test a revised version of the CAHPS Hospice Survey. CMS will be sure to consider AGS's suggestions when developing the revised content. Specifically, we will explore with a technical expert panel, and in patient interviews, survey items that assess the degree to which the team was able to communicate about what mattered most to the patient, and how care was tailored to meet patient preferences.

As a reminder, the CAHPS Hospice Survey is administered to the informal caregiver of the hospice patient 2 to 3 months following the patient's death. This approach allows for assessment of care for all hospice decedents, including those who may not have been able to respond to a survey themselves during the course of hospice care due to the acuity of their illness or the speed of their decline.

Proposed Committee Response:

Thank you for your comment. The Committee agrees with your suggestions for future measure development.

Appendix A: Fall 2019 Track 1 Measures

The following measures did not receive public comments or only received comments in support of the Standing Committees' recommendations and will be reviewed by the CSAC on July 28 – 29:

1623 Bereaved Family Survey

Submission | Specifications

Description: This measure calculates the proportion of Veteran decedent's family members who rate overall satisfaction with the Veteran decedent's end-of-life care in an inpatient setting as "Excellent" versus "Very good", "good", "fair", or "poor".

Numerator Statement: The numerator is comprised of completed surveys (at least 12 of 17 structured items completed), where the global item question has an optimal response. The global item question asks "Overall, how would your rate the care that [Veteran] received in the last month of life" and the possible answer choices are: Excellent, Very good, Good, Fair, or Poor. The optimal response is Excellent.

Denominator Statement: The denominator consists of all inpatient deaths for which a survey was completed (at least 12 of 17 structured items completed), excluding: 1) deaths within 24 hours of admission (unless the Veteran had a previous hospitalization in the last month of life); 2) deaths that occur in the Emergency Department (unless the Veteran had a prior hospitalization of at least 24 hours in the last 31 days of life); Additional exclusion criteria include: 1) Veterans for whom a family member knowledgeable about their care cannot be identified (determined by the family member's report); or contacted (no current contacts listed or no valid addresses on file); 2) absence of a working telephone available to the family member.

Exclusions: - Veterans for whom a family member knowledgeable about their care cannot be identified (determined by family member's report)

- Absence of a current address and/or working telephone number for a family member or emergency contact.
- Deaths within 24 hours of admission without a prior hospitalization of last least 24 hours in the last 31 days of life.
- Deaths that occur in the operating room during an outpatient procedure.
- Deaths due to a suicide or accident
- Surveys in which less than 12 items were answered.
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Adjustment/Stratification: Statistical Risk Model

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital, Post-Acute Care

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: Department of Veterans Affairs / Hospice and Palliative Care

STANDING COMMITTEE MEETING 2/20/2020 and 2/25/2020

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **No vote**; 1b. Performance Gap: **H-7**; **M-9**; **L-0**; **I-0**

Rationale:

- During the prior review in 2015, the developer provided a logic model stating that receiving a palliative care consult or dying in a hospice unit results in a greater likelihood of families rating end of life inpatient care as excellent. The developer included a recommendation from the 2009 version of the Clinical Practice Guidelines for Quality Palliative Care. In addition to the guideline recommendation, the developer stated that physical symptoms such as pain, nausea, constipation, and dyspnea are common at end of life and that clinicians do not always recognize these symptoms or manage them appropriately. The developer stated that studies have found that providers do not communicate with patients about patients' health care preferences and that providers' treatment decisions may not be consistent with patients' preferences.

1623 Bereaved Family Survey

- The Committee agreed there was no change in evidence from previous endorsement and agreed to accept the previous decision and vote, which was that the measure passes the evidence criterion.
- The developer provided results from 2017 (n=146 VA facilities) demonstrating a 65% mean overall score, a score range from 13% - 100%, and IQR of 85 and 72.The Committee felt that there is a clear performance gap that warrants a national performance measure.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Yes-16; No-0**; 2b. Validity: **H-2**; **M-11**; **L-2**; **I-1**

Rationale:

- The Committee noted that the Scientific Methods Panel (SMP) rated the measure high on reliability.
- The SMP's ratings for Reliability: H-3; M-2; L-0; I-1
- The Committee did not have any concerns with the measure meeting this criterion and voted unanimously to accept the SMP's rating.
- The SMP rated this measure low on validity. Standing Committee deliberations started with a discussion of the SMP's rating, the rationale for that rating, and a vote on whether the Committee chose to accept that rating. The two main concerns raised by the SMP were that the risk adjustment model did not include socio-demographic status (SDS), particularly race/ethnicity, and that the beta-binomial values presented as part of the construct validity were too low. Per NQF process, the SMP may recommend discussion points to the Committee regarding the use of SDS in risk adjustment models but may not fail a measure solely for this reason.
- In discussion with the Committee, the developer shared that they have updated testing results demonstrating stronger beta-binomial values and strong odds ratios and that they would be happy to share this formally during the post-meeting public comment period. The Committee felt this was sufficient rationale to overturn the SMP rating and continue discussion of the measure.
- The Committee voted to overturn the SMP's validity rating: Accept-2; Overturn-14
- The Committee asked for some clarifications on the measure specifications, including the use of male pronouns in the survey, the exact scope and inclusions of the survey, and the grade level of some survey questions. The developer clarified that there are separate surveys for male and female patients, each with corresponding pronouns. The developer further clarified that the measure encompasses all deaths in a VA facility (and only in a VA facility), regardless of setting of care (hospice vs intensive care). The developer noted that they offer an "unsure" option if caregivers are not sure how to answer a question but agreed that appropriate grade-level content is a worthy goal. The developer hopes to include more survey questions in future endorsement submissions and will review the readability.
- The Committee asked the developer to elaborate on the rationale for the measure's risk adjustment model. The developer clarified that this measure is developed for use by the US Department of Veterans Affairs (VA) and that the VA's strong preference is to not apply risk adjustment to measures. There is concern about obscuring the source of variation in measure performance. The developer noted that they felt some risk adjustment was necessary and they had developed their model to be closely aligned with the model for measure 2651. The Committee noted that 2651 does not include race/ethnicity in its risk adjustment model, yet this was not raised as a significant concern by either the SMP or the Committee. The Committee was satisfied with the explanation and rationale around risk adjustment and the discussion turned to the construct validity concern. The developer reported that they have updated testing results that show beta-binomial values of 0.13 – 1.57 at the facility level and odds rations of 1.44 – 19.16 at the national level between the measure under review and other accepted process measures. The developer stated they will be sharing these results through the commenting process. The Committee was satisfied that the measure meets the validity criterion.

3. Feasibility: H-2; M-15; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- Committee members noted that while some of the data elements are available in the EHR, the key responses have to be gathered through mail or telephone surveys. The developer stated they have

1623 Bereaved Family Survey
been refining both procedures for gathering electronic data and survey contact procedures for more efficient survey administration. • The Committee acknowledged that the measure developer is also the measure's main user and that this should result in a very feasible measure.
4. Use and Usability *4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)* 4a. Use: **Pass-14; No Pass-0** *4b. Usability:* **H-4; M-12; L-0; I-1** Rationale: • The Committee had questions for NQF staff about the use criterion and for the developer about the current use of the measure. NQF staff reported that there has been a lot of discussion around this criterion. They clarified that use is currently a must-pass criterion for maintenance measures such as this measure and that NQF defined use as publicly reported within six years of initial endorsement and use within an accountability program within three years. NQF staff further shared that they have seen some committees choose to be less strict in evaluating this criterion. • The developer reported that the measure is used for accountability across all VA facilities. They have been working to put a plan in place for public reporting. For VA patients, facility choice is based almost entirely on location. Publicly reporting the survey results would not assist in choosing care. • The developer has been working to expand use of the measure in private facilities and health systems. They are also working to report results for nursing homes, where there may be more patient choice available, especially since the enactment of the VA MISSION Act of 2018. This reporting will require Secretary authorization. A Committee member pointed out that veterans with Medicare coverage also have additional facility choices and this could be a potential focus area for reporting. • The Committee was willing to accept the developer's plan for public reporting but strongly stressed they feel the measure should be publicly reported. The Committee stated they expect to see the measure reported when it returns for its next maintenance endorsement. The Committee had no concerns about the usability of the measure.
5. Related and Competing Measures • This measure is related to NQF 2651 CAHPS Hospice Survey.   ○ The developer stated that the populations are different for these two measures, as 1623 is focused on deaths in a VA inpatient setting. • The Committee engaged in a brief discussion of 1623 and 2651 as related measures. The Committee felt there was a clear difference between the two measures and stated they are different measures with different populations. The Committee felt the differences between the VA and other health systems justified different measures. Committee members did identify areas, such as questions around supports, where the content of the questions could be more aligned, stating there is strong evidence around best-practices in these areas.
6. Standing Committee Recommendation for Endorsement: **Y-16**; **N-1**
7. Public and Member Comment • No public or member comments were received. • During the comment period, the developer provided updated testing results to support the committee's recommendation to endorse the measure.
8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
9. Appeals