National Quality Forum

Geriatrics and Palliative Care Measure

Evaluation Web Meeting Fall 2021 Cycle

Friday, February 18, 2022

The Committee met via Videoconference, at 10:00 a.m. EST, Sean Morrison and Deborah Waldrop, Co-Chairs, presiding.

Present:

R. Sean Morrison, MD, Co-Chair
Deborah Waldrop, PhD, LMSW, ACSW, Co-Chair
Sree Battu, MD, FAAPMR, FAAHPM, Veteran Affairs Health System
Samira Beckwith, LCSW, FACHE, LHD, Hope HealthCare Services
Amy Berman, BSN, LHD, FAAN, John A. Hartford Foundation
Cleanne Cass, DO, FAAHPM, FAAFP, Hospice of Dayton
Jeff Garland, DMin, EdS, BCC - PCHAC, VNA Health
Group Barnabas Health Home and Hospice & Palliative Care Center
Marian Grant, DNP, ACNP-BC, ACHPN, Coalition to Transform Advanced Care (C-Tac)
George Handzo, BCC, CSSBB, HealthCare Chaplaincy
Arif Kamal, MD, MBA, MHS, FACP, FAAHPM, American Cancer Society
Christopher Laxton, CAE, AMDA - The Society for Post-Acute and Long-Term Care Medicine
Katherine Lichtenberg, DO, MPH, FAAFP, Anthem Blue Cross and Blue Shield
Kelly Michelson, MD, MPH, FCCM, FAP, Ann and Robert H. Lurie Children's Hospital of Chicago
Laura Porter, MD, Cancer Research United Kingdom
Tracy Schroepfer, PhD, MSW, University of Wisconsin, Madison, School of Social Work
Linda Schwimmer, JD, New Jersey Health Care Quality Institute
Christine Seel Ritchie, MD, MSPH, Harvard

Medical School; Massachusetts General Hospital
Janelle Shearer, RN, BSN, MA, CPHQ, Stratis Health
Karl Steinberg, MD, CMD, HMDC, HEC-C, Mariner Health Central
Sarah Thirlwell, MSc, MSc(A), RN, AOCNS, CHPN, CHPCA, CPHQ, LifePath Hospice, a Chapters Health System Affiliate

NQF Staff:

Peter Amico, PhD, Consultant
Poonam Bal, MHSA, Senior Director
Tricia Elliott, MBA, CPHQ, FNAHQ, Senior Managing Director
Paula Farrell, MSHQS, BSN, RN, CPHQ, Director
Oroma Igwe, MPH, Manager
Gabrielle Kyle-Lion, MPH, Analyst
Adam Vidal, PMP, Project Manager

Also Present:

Sangeeta Ahluwalia, PhD, Rand Corporation
Katherine Ast, MSW, LCSW, American Academy of Hospice and Palliative Medicine
Thomas Christian, Abt Associates
Jordan Harrison, PhD, Rand Corporation
Alan Levitt, MD, Centers for Medicare and Medicaid Services
Amy Melnick, National Coalition for Hospice and Palliative Care
Jessica Phillips, Rand Corporation
Brian Vegetabile, PhD, Rand Corporation
Anne Walling, MD, PhD, Rand Corporation

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10:01 a.m.

Welcome and Review of Meeting Objectives

Ms. Farrell: Hello, everyone. Welcome and thank you for joining our Geriatric and Palliative Care Fall 2021 Measure Evaluation Meeting. I'm Paula Farrell, the director for the project.

And today we have three measures that we're going to be reviewing. But before we start the evaluation of the measures, I wanted to go over the agenda for today. And we will also do committee introductions and disclosures of interests.

I'm going to quickly turn it over to our co-chairs, Dr. Deborah Waldrop and Dr. Sean Morrison, to provide some quick welcoming remarks.

Co-Chair Waldrop: So good morning, everyone. Thank you so much for being here. It's really good to share this space with you. And I want to mostly say thank you for your commitment to quality measures and the development of improved end of life and geriatric care. So thanks so much for being here today.

Co-Chair Morrison: And good morning, everybody. And I just wanted to echo Deborah's words, also thank the NQF staff for really preparing a great meeting, and also the excitement of having some three new measures, which we haven't seen in a very long time on this committee, from different measure developers, so very excited about that.

And also a word of apology, this is going to be the, Dr. Waldrop's show today because I am in conflict I am told with all three measures for various reasons coming up. So you're going to hear a lot of Deborah and nothing from me. Lucky all of you.

Co-Chair Waldrop: Just bear with me on that one.

Ms. Farrell: Great. Thank you. Next slide, please.

So next I'm going to go through just a few housekeeping reminders. And then we'll get to our introductions and the disclosures of interest.

We are on a WebEx meeting with audio and video capabilities. So we do ask that if you could, please turn on your video if possible. It just helps make the conversation a little bit more enriching when we can see our colleagues. And when you're speaking, it gives us a little bit more of an in-person feeling to the meeting.

We also encourage you to use some of the following features that are available in WebEx. There is a chat box. And you can either message NQF staff individually or message the meeting attendees.

And using the chat is a good opportunity if you're just generally agreeing with the comment that had been made, or if there's something that you would like to share, you can type into the chat, and we'll make sure to either call on you or read what you have entered into the chat out loud.

We also do ask that you please use the raised hand function in WebEx to be called upon by the co-chairs instead of just speaking up, as this allows us to ensure that everyone who wants to speak has an opportunity to do so.

And also, if you're experiencing any technical issues or have any other questions, please feel free to contact the NQF project team at palliative@qualityforum.org. Next slide, please.

All right. So now I am going to introduce the NQF staff. Gabby, if we could, go to the next slide, please. Thank you.

As I said, I'm Paula Farrell, the director for the project. Also here today we have Oroma Igwe, who is our manager, Gabby Kyle-Lion, who is our analyst,

Adam Vidal, who is our project manager. Poonam Bal is our senior director, and Peter Amico is our consultant.

Adam, Poonam, and Peter are supporting staff for the project. But we just wanted to introduce them as they may be joining into the conversation during the meeting. Next slide, please.

All right. So our agenda for today includes introductions and disclosures of interest. And during that time, we'll also ensure that we have a quorum to hold the call. We'll also provide an overview of our evaluation and voting process. And we are also going to test our voting to ensure everyone has access and is able to vote.

So, standing committee members, you should have received an email with the voting link. And you will need that for this meeting. If you don't have that link or can't find it, please let us know via the chat function or send an email to palliative@qualityforum.org, and we'll make sure to get that link to you.

After our voting test, I'll provide a brief introduction to the measures under review. And then I'll hand it over to our co-chairs to lead the discussion by our standing committee on our first measure.

We do have about an hour planned for each measure discussion with NQF measure number 3645 going first. Then we're going to take a short lunch break around noon and reconvene in the afternoon to review the two additional measures.

Now, we'll also be reviewing any related and competing measures and will then end the meeting with NQF member and public comment to see if they have any additional input to provide. We'll then provide you with the next steps and what to expect going forward. All right. Next slide, please.

## Introductions and Disclosures of Interest

Okay. I am now going to turn the meeting over to our senior managing director, Tricia Elliott, for committee member introductions and disclosures of interest. Tricia.

Ms. Elliott: Thank you, Paula. And thank you all for attending our meeting today and providing your time and assistance with our NQF process.

Today we will combine introductions with the disclosures of interest. You received two disclosure of interest forms from us. One is our annual disclosure of interest, and the other is disclosures specific to the measures we are reviewing in this cycle.

In those forms, we asked you a number of questions about your professional activities. Today we will ask you to verbally disclose any information you've provided on either of those forms that you believe is relevant to this committee. We are especially interested in grants, research, or consulting related to this committee's work.

Just a few reminders. You sit on this group as an individual. You do not represent the interests of your employer or anyone who may have nominated you for this committee. We are interested in your disclosures of both paid and unpaid activities that are relevant to the work in front you.

Finally, just because you disclose does not mean that you have a conflict of interest. We do verbal disclosures in the spirit of openness and transparency.

I'll start by going around our virtual table with our committee co-chairs. I will call your name. Please state your name, what organization you are with, and if you have anything to disclose. If you do not have disclosures, you can say I have nothing to disclose to keep us moving along.

If you experience trouble unmuting yourself, please raise your hand so that our staff can assist.

Okay. First up, Sean Morrison.

Co-Chair Morrison: Sorry. Trying to find the unmute. Sean Morrison from the Icahn School of Medicine at Mount Sinai. I also serve as, or did up until this year, as treasurer of the National Coalition for Hospice and Palliative Care and on the technical advisory panel for Abt and working on the Medicare hospice measures. And so I have a conflict of interest I am told with all three being discussed.

Ms. Elliott: Okay. Thank you for the disclosure. Next is Deborah Waldrop.

Co-Chair Waldrop: Deborah Waldrop from the University of Buffalo School of Social Work. And I have no conflict of interest to disclose.

Ms. Elliott: Thank you, Deborah. Sree Battu.

Member Battu: Hello. My name is Sree Battu. I work for Veteran Affairs. And I have no disclosures.

Ms. Elliott: Thank you. Samira Beckwith.

Member Beckwith: Good morning. I am CEO of Hope HealthCare in southwest Florida. I serve on the board of directors of the National Hospice and Palliative Care Organization and on the board of directors of the National PACE Association. So those are some of my other activities. And I don't know if those are a conflict of interest. And I can't remember what I put on my form. But I wanted to mention those.

Ms. Elliott: Okay. Thank you. Amy Berman.

Member Berman: Good morning. I'm Amy Berman. I'm a senior program officer with the John A. Hartford Foundation and a nurse. And my background is in -- the healthcare foundation supports many of the major innovations in the space related to care of serious illness and end of life. I have no disclosures.

Ms. Elliott: Thank you. Cleanne Cass.

Member Cass: Hi. Good morning. Thank you. I am medical director at Ohio's Hospice where I serve as the program director for the hospice and palliative medicine fellowship and physician education and representing the American Osteopathic Association. However, I have no disclosures and no conflicts of interest. Thank you.

Ms. Elliott: Thank you. Jeff Garland.

Member Garland: Good morning, everyone. Jeff Garland. I work for VNA Home Health Hospice and Palliative Care Center of New Jersey. I also serve as president of the Association of Professional Chaplains. I have no disclosures.

Ms. Elliott: Thank you. Marian Grant.

Member Grant: Hello. Marian Grant, Coalition to Transform Advanced Care, no conflicts or disclosures.

Ms. Elliott: Thank you. George Handzo.

Member Handzo: Yes. Good morning, everyone. I'm George Handzo. I'm the director of Health Services Research and Quality at HealthCare Chaplaincy Network in New York.

As a disclosure, I served on the technical advisory and patient experience advisory group for the two macro and academy measures that will come up second and third on the agency. And so I have a conflict with those measures.

Ms. Elliott: Okay. Thank you for that disclosure. Arif Kamal.

Member Kamal: Good morning, everybody. I'm Arif Kamal. I am the new chief patient officer of the American Cancer Society and previously of Duke University and on the board of directors at American Academy of Hospice and Palliative Medicine and on the technical expert panel for the measures

stewarded by them, so have conflicts related and will recuse myself.

Ms. Elliott: Thank you. Kate Lichtenberg.

Member Lichtenberg: Good morning. Kate Lichtenberg. I am with Anthem Blue Cross Blue Shield in the St. Louis area. And I have nothing to disclose.

Ms. Elliott: Thank you. Kelly Michelson.

Member Michelson: Yeah, hi. I'm Kelly Michelson. I am professor of pediatrics at Lurie Children's Hospital, which is part of Northwestern University. I also direct their Center for Bioethics and Medical Humanities.

I received grant funding from the National Palliative Care Research Center in the last couple of years, otherwise, which is for work unrelated to any of these measures. And I have no other disclosures related to the measures.

Ms. Elliott: Thank you. Janice Knebl. Okay. I don't see Janice on the call yet. We'll circle back to her. Christopher Laxton.

Member Laxton: Yes. Good morning. Chris Laxton. I'm the executive director of the AMDA Society for Post-Acute and Long-Term Care Medicine. And I have nothing to disclose.

Ms. Elliott: Thank you. Douglas Nee. Okay. We'll circle back to Douglas. Laura Porter.

Member Porter: Yes. I'm Laura Porter. I'm an independent patient advocate. And I have nothing to disclose.

Ms. Elliott: Thank you. Tracy Schroepfer. Circle back to Tracy. Linda Schwimmer.

Member Schwimmer: Good morning, everyone. I'm Linda Schwimmer. I am president and CEO of the

New Jersey Health Care Quality Institute. And I have nothing to disclose.

Ms. Elliott: Okay. Thank you. Christine Seel Ritchie.

Member Ritchie: Greetings, everybody. I am Christine Ritchie. I'm professor of medicine at Harvard Medical School at Mass General Hospital. I was also part of the technical panel for two of our measures and will recuse myself at that time. Thank you.

Ms. Elliott: Thank you. Next we have Janelle Schearer.

Member Schearer: Hi, everybody. I'm Janelle Schearer. I am from Stratis Health, which is based in Bloomington, Minnesota. It's a quality and safety organization. And I have nothing to disclose.

Ms. Elliott: Thank you. Karl Steinberg.

Member Steinberg: Yes, hi. Karl Steinberg. I'm a geriatrician and palliative care physician, president of AMDA, The Society for Post-Acute and Long-Term Care Medicine for like one more month. And I'm also a vice president of National POLST. I'm in San Diego, and nothing to disclose.

Ms. Elliott: Thank you. Paul Tatum. Okay. Sarah Thirlwell.

Member Thirlwell: Good morning, everyone. I'm Sarah Thirlwell. I'm a nurse and serve as the clinical administrator for LifePath Hospice. It's part of the Chapters Health System in Florida.

Ms. Elliott: And I believe you have --

Member Thirlwell: Excuse me. Yes, thank you.

(Simultaneous speaking.)

Member Thirlwell: Yes, conflict of interest, my former role, I was at one of the test sites for measures 3665

and 3666. So I will excuse myself from those discussions, recuse myself from those discussions.

Ms. Elliott: Thank you. Appreciate the disclosure. I'm going to circle back on three folks just to call their names again and see if they were able to join. First, Janice Knebl. Okay. Douglas Nee. Okay. Tracy Schroepfer. Okay. And one last call, Paul Tatum.

And of note, I believe Paul is recused on all three measures. So, if he does join, we'll make sure to call out the conflict as well. If Tracy joins, she also has conflicts. So we'll make sure to call those out.

Team, I think we're good. We got through the roll call. Any additions of note that we need to make?

Ms. Farrell: I think we're good. Thank you, Tricia.

Ms. Elliott: Okay. Thanks, Paula.

Member Grant: I realize I need to recuse myself. This is Marian Grant. I was also on the TEP for the two AAHPM macro measures.

Ms. Farrell: Okay. Great. Thank you. All right. So next I'm going to turn the call over to our project manager, Oroma. And she is going to do an overview of our evaluation process and the voting process. Oroma.

Overview of Evaluation Process and Voting Process

Ms. Igwe: Great. Thank you, Paula. Good morning, everyone. So now we will transition to a brief overview of the evaluation and voting process.

Your role as the standing committee is to act as a proxy for the NQF multi-stakeholder membership. So, as the Geriatrics Committee, you not only see the portfolio of the measures themselves, but you work collaboratively with us as NQF staff to provide recommendations for endorsement of the measures based on our criteria and evaluation guidance.

You are also tasked to respond to comments that are submitted during our public commenting period. And today you will be asked to evaluate these measures against each criterion and subsequently make recommendations according to your evaluation. Next slide, please.

So, a reminder on the meeting ground rules, we want to remind you that this is a shared space of interdisciplinary multi-stakeholder committee members. You know, every voice is important. And we want to emphasize that each committee member holds equal value on this call. Also, keep in mind, you all hold value in the broader scope of the work that you bring to this work.

As NQF staff, we do do our due diligence to encourage committee members to adequately review the measure information in advance. As a result of that, we invite you to remain actively engaged today and cognizant of the varying experiences of your colleagues.

Please remember to allow space for others to comment. And do keep your comments concise and focused to the criterion. Next slide.

So here on the screen is the process by which we will conduct today's measure discussion and evaluation. Many of you are quite familiar with this. But it definitely doesn't hurt to refresh.

So each measure discussion will begin with a brief developer introduction. And the facilitation will be led by our co-chair, Dr. Waldrop. And the discussion will be stewarded by our assigned lead discussant and supporting discussant. A special thank you to those who we designated as the lead and supporting discussants today.

The lead discussant will briefly explain information on the criterion. He or she will emphasize notable areas of concern. And you are welcome to note the preliminary staff rating if needed.

The full committee discussion will then commence, followed by the criterion votes. And then this process will be repeated with the subsequent criteria.

Do know that the developers are available on the call today to respond to questions at the discretion of the co-chairs. Next slide.

So the measures, as we know, are evaluated for their suitability based on these listed main and sub-criteria in the order depicted on the screen. So just take a moment to observe this order.

I will say a brief note about related and competing. But the assessment of each criterion is a matter of degree.

However, if either a new or returning what we call maintenance measure, either of those are judged as not passing for importance to measure and report, scientific acceptability, and use, particularly for maintenance measures, it cannot be recommended for endorsement and will not be evaluated with the remaining criteria.

But if a measure meets the above criteria and there are endorsed or new related or competing measures, a discussion will be held to identify those measures.

Today there will be no best in class voting activity as it concerns related and competing measures, as none of the identified related or competing measures that you'll see later are being reviewed at the same time under this cycle. So we'll simply do an overview, and we'll open it up for discussion. Next slide.

So here's the breakdown of the main endorsement criteria and sub-criteria that we just looked at. And votes will be taken after the discussion of each criterion. And we would like you to make special note of the must pass nature of several of these criteria here.

If the measure progresses to the very, very last item

that you see here, overall suitability for endorsement, and we get through all of the criteria, then that overall suitability is actually the very last vote.

Continue on with voting on endorsement criteria, the NQF staff will provide, like I said earlier, a brief overview of the related and competing measures. And we will invite the committee to weigh in with any further commentary.

It is important to reiterate that measures that fail on one of the must pass criteria will not proceed to additional discussion or voting on the subsequent criteria.

In the event that you all are not able to reach consensus and consensus not reached status, the discussion will continue to the next criterion, but a vote on the overall suitability will be deferred to the post-comment meeting. Next slide.

So achieving consensus is an integral part of this call. In order to conduct live voting today, the standing committee must achieve and maintain a quorum. And according to our attendance, we are, at least so far, at quorum. And we're definitely at the 50 percent attendance threshold.

But I want to note that quorum is actually 66 percent of the active committee membership. We have 23 active members.

But it will get a bit variable as we get to the measures, because for measure 3645, we have 3 recusals, for 3665, we have 7 recusals, and the same goes for 3666. So, for 3645, our voting body reduces to 20, and the measure is at 16. So we will be doing a lot of calculations to ensure that we are maintaining a quorum throughout those votes.

The chart that you see again, it displays generally the margins within which voting outcomes are indicated. But again, we will also be monitoring the actual votes

that are coming in according to how many people are actively voting.

A measure does not reach consensus if it's within that 40 to 60 percent range. And if that happens, like I said earlier, the measure will move forward to the draft report commenting period. And the committee will reconvene in subsequent months to revote on that particular measure criterion and overall suitability as well.

When you get to the post-comment call, the committee moves any CNR measures outside of that gray zone. It must either be pass or not pass.

If a measure is not recommended for endorsement, it too will proceed to the draft report commenting period. But the difference here is that the committee will not be necessarily called to revote on the measure unless the committee decides to reconsider their recommendation based on either comments that come in during the draft report commenting period or a formal reconsideration request that may come in from the developer. Next slide.

So, on the last slide, we talked through the head count for quorum. We also confirmed that we have 50 percent attendance. So we are ready to proceed with this call and all the procedures that come with it.

You know, attendance is a significant part of this process. So, if at any point during the call you need to step away or you anticipate a change in your attendance status, just shoot us a chat in the chat feature, or you can let us know live on the call. We do want to keep careful observation of our attendance today.

In the event that the attendance does drop below quorum, we will resume the discussion accordingly and respective to the measure at hand. But we will defer voting activity to an offline voting survey after the call. Next slide.

So, before we proceed to the voting test, I'm going to pause here and ask if there are any questions on our evaluation and voting process.

Member Garland: Yes, this is Jeffery Garland. Can you please clarify for me? I know that we're on WebEx now. But the voting is something totally different. So we would have to go to another location to vote. Is that -- am I correct?

Ms. Igwe: So you're absolutely right. WebEx is the platform that we're hosting this presentation on. The voting activity will be taking place on Poll Everywhere.

And so the link that you have, it will require you to either view it on the same device in a different window or a different device altogether, whichever one you have. But as long as you have the link, you can access it.

Member Garland: Thank you.

Ms. Igwe: You're welcome. Any other questions? Okay. Thank you for that question. And I don't see additional questions in the chat. Also hearing none on the call, I will now turn the presentation over to my colleague, Gabby. Thank you.

Ms. Elliott: And actually, Gabby, before you bring up the voting test, this is Tricia again. I just want to close out the disclosure of interest. And thank you, Oroma, for describing quorum and everything. So we're in good shape there.

But I want to let the committee know that if you believe that you might have a conflict of interest at any time during the meeting as topics are discussed, please speak up. You may do so in real time during this web meeting, or you can send a message via the chat to your chairs or to anyone on the NQF staff.

If you believe that a fellow committee member may have a conflict of interest or is behaving in a biased

manner, you may point this out during the meeting and send a, or send a message to your chairs or to the NQF staff. I just want to make sure that nobody has any questions based on what we have discussed.

Okay. Seeing none, as a reminder, NQF is a non-partisan organization. Out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making any comments, innuendos, or humor relating to, for example, race, gender, politics, or topics that otherwise may be considered inappropriate during the meeting.

While we encourage discussions that are open, constructive, and collaborative, let's all be mindful of how our language and opinions may be perceived by others.

With that, I'll turn it back to Gabby to do the voting test.

Voting Test

Ms. Kyle-Lion: And just give me one second to pull up my screen. Can everyone hear me? I just want to make sure --

Ms. Elliott: Yes, we can hear you.

Ms. Kyle-Lion: Okay. Perfect. Sorry. Thank you. Okay.

So, just as a reminder, Oroma did send the voting link via email. And this is only for committee members. The polls should be open. The voting test should be open.

And the question is, has it snowed where you live? The options are A for yes or B for no. And I believe we're looking for 17 votes here. So I think we're at nine at the moment.

Member Garland: I'm sorry. This is Jeff Garland. It says for me waiting for presentation to begin. I'm not sure.

Ms. Kyle-Lion: Jeff, it might help if you were to refresh the Poll Everywhere page.

Member Garland: Okay.

Ms. Kyle-Lion: That helps when that happens.

Member Garland: Yes, it did. Thank you.

Ms. Kyle-Lion: Okay. Great. I think we're at 16 votes right now. I believe we're looking for a couple more --

Member Schwimmer: This is Linda. It's making me reinstall it on my computer. So I don't want to hold you up, but I'm in the process of doing that.

Ms. Kyle-Lion: Okay. Linda, if you run into this issue again, you can also send a message in the chat --

Member Schwimmer: Okay. Thank you.

Ms. Kyle-Lion: -- to me or Oroma. And we will count your vote for you.

Member Beckwith: And, Gabby, I'm -- this is Samira. And I don't know if my vote counted or not --

Ms. Kyle-Lion: Okay. Samira, let me just -- let me take a look. I can see you --

Member Beckwith: Can you --

Ms. Kyle-Lion: Yep, I'll see if your vote --

Member Beckwith: Okay.

Ms. Kyle-Lion: -- is shared. Give me one second.

Member Beckwith: Thank you. I'm doing it on the phone. And --

Ms. Kyle-Lion: No, that's --

Member Beckwith: -- trying to link it in.

Ms. Kyle-Lion: No problem. It did, Samira. You're

good to go. Thank you.

Member Beckwith: Thank you. I couldn't tell. Thanks.

Ms. Kyle-Lion: Okay. We are still at 16 votes.

Co-Chair Morrison: Gabby, it's Sean. I sent you a chat. You don't want me to vote, because I'm not voting on anything, do you?

Ms. Kyle-Lion: Correct. Sean, you and Arif are completely recused from voting at all. So you guys will not --

Co-Chair Morrison: That's what I figured. So I just didn't want you to count me in a denominator.

Ms. Kyle-Lion: Yep, no problem. But I believe the last person is just Linda. So, once she gets it, I just want to make sure she's good to go before we move forward.

Member Schwimmer: And I'm not good to go. But I don't want to hold this up. I'm still trying to finish this update. So, but I'll --

Ms. Kyle-Lion: All right.

Member Schwimmer: Yeah --

Ms. Kyle-Lion: If you just want to send your chat, that way we can --

Member Schwimmer: Okay.

Ms. Kyle-Lion: -- count it. That will be good. That should be good for us.

Okay. So, with that then, I will go ahead and lock the poll and pull up the responses. So we have 75 percent saying yes and 25 percent saying no. I am definitely jealous of those 25 percent. But I think we are good to go. So I'll go ahead and pass it back over to my colleagues.

Ms. Farrell: Thank you, Gabby. Again, if you are

experiencing any issues, please follow up with us in the chat on the voting poll, and we'll continue to work with you as we move through the meeting.

Measures Under Review

All right. So next I'm going to review the measures that we're going to be discussing today during our call. And we have three new measures that were submitted for evaluation. And they are listed here on the slide. Next slide, please.

The Scientific Methods Panel evaluated the scientific acceptability of two of the measures, and because they were considered complex. NQF measure number 3645 was not reviewed by the Scientific Methods Panel because it was determined to be non-complex. Next slide, please.

Now, two measures, NQF number 3665 and 3666 were evaluated by the Scientific Methods Panel, and both measures passed review. Next slide, please.

All right. So let's start our review of our first measure, NQF number 3645, Hospice Visits in the Last Days of Life.

And before we get started, I wanted to mention that we have developed a new process and designated a specific timeframe for developers to provide any clarification and respond to questions that the standing committee might ask.

So, to begin our discussion on each of the measures, the developers are going to be giving about a three to five minute window to provide introductory remarks to their measure. And then the standing committee will discuss the measure.

And any questions that come up at that time that the standing committee cannot address during its discussion will be collected by the co-chairs and NQF staff for the developer to then respond to after the standing committee's discussion has ended.

And once the standing committee has been able to discuss and answer all questions that have come up on a specific criterion that we're reviewing, developers will then be able to have an opportunity to address any of those questions that remain and provide any clarifying information.

As a reminder, we also ask any, if anyone on the standing committee has a question as we discuss the criterion to please enter those questions into the chat or raise your hand to be called on to verbally, verbalize your question.

We do have three recusals for this measure. And those recused will not be able to discuss or vote on the measure. And the recusals are Sean Morrison, Paul Tatum, and Arif Kamal.

And now I'm going to turn the call over to our co-chair, Dr. Deborah Waldrop, to lead our discussion. Dr. Waldrop.

Co-Chair Waldrop: Thank you, Paula. And thank you to the NQF staff for this really thorough orientation to our meeting today. It really helps everyone get grounded. So thank you for that.

So I just wanted to briefly mention the process that we are going to use. First, I'll ask the measure developer in each of the three measures to give us a brief overview. Then I will turn to the lead discussant and ask for that person's review. Then I'll turn to the supporting discussants for anything additional they would like to share. And then I'll open it to the committee in general for a discussion.

After we finish the general overview discussion, we'll take each criteria one by one. And we'll discuss them and then vote on each of the criteria, just so you know how we're going to proceed.

Consideration of Candidate Measures

3645 Hospice Visits in the Last Days of Life (Centers

for Medicare and Medicaid Services/Abt Associates)

So we'll start with 3645, Hospice Visits in the Last Days of Life. Our steward is the Centers for Medicare and Medicaid and Abt Associates.

And the purpose of this measure is really to the proportion of hospice patients who have received visits from a registered nurse or medical social worker on at least two out of the three final days the patient's life.

So I'd like to begin by asking our discussant, Thomas Christian, if he would be willing to present a three to five minute overview of this measure for us.

Mr. Christian: I'd be happy to. Thank you so much.

Yes, so as we just mentioned, Hospice Visits in the Last Days of Life, it captures the percent of hospice patients in a hospice receiving an in-person visit by a registered nurse or a social worker in at least two of the last three days of life.

So this measure replaces a measure concept previously developed by CMS, Hospice Visits When Death is Imminent, which was calculated using the hospice item set, or HIS.

So, in contracts, sorry, in contrast, our new measure is calculated using Medicare hospice claims, which are already submitted for payment by the hospices and thereby eliminates a data collection burden.

Hospice Visits in the Last Days of Life is calculated using eight quarters or two years of data. So the reason for this is more data ensures that more hospices meet minimum reporting requirements thereby increasing reportability among smaller hospices.

So this eight quarter approach is already being used elsewhere in CMS's quality program by, for example, the CAHPS hospice, you know, QMs. So, as a process measure, just as long as I'm mentioning that,

Hospice Visits in the Last Days of Life is not risk-adjusted.

So, also, the two staff types that Hospice Visits in the Last Days of Life focuses on in specification again are registered nurses and social workers. We chose these two because these were the only two staffing disciplines exhibiting consistently strong associations at the end of life with CAHPS hospice scores, which was our method of validation.

So, with our measure, higher scores indicate better quality of care provided. It means more beneficiaries are receiving consistent supportive services at the end of life when symptoms of dying are increasing near the patient's death.

We found hospices with more beneficiaries receiving end of life visits have higher percentages of caregivers of those patients reporting high ratings for the hospice and recommendations overall for the hospice, again, as measured by CAHPS hospice ratings.

You know, we found very strong correlation coefficients in the range of .17 to .28 between Hospice Visits in the Last Days of Life, our new measure, and the 8 CAHPS Hospice Survey items.

So certainly this concordance between, you know, CAHPS hospice and our measure concept, it supports the validity of our measure. It just indicates hospices providing end of life visits are perceived by caregivers as providing higher quality of care.

I also want to mention the measure exhibits strong potential as a differentiator between providers and for our ultimate use in public reporting.

Nationwide scores are about 63 percent on average. It's certainly very far from being topped out. Actually only 2 hospices out of like 4,000 had perfect scores. There's a very broad interquartile range, about 30

percent, indicating a very large degree of variation between hospices.

And really just lastly I just want to point out very high reliability scores for this measure. Ninety-five percent had signal-to-noise ratios reliability statistics above .9. Everything was above .8. And just considering the standard for good reliability was above a .7, so, you know, certainly a very high reliability there.

So that's just, that's an overview. As we get to it, I'd be happy to answer any further questions you might have. And I appreciate your consideration. Thank you.

Co-Chair Waldrop: Thank you very much. We'll come, too, at the end of our discussion with any questions that are raised. So thank you so much.

I want to next say thank you to our lead discussant and also to our supporting discussants. So thank you, Janelle, and thank you, George and Kelly.

And I'm wondering, Janelle, if you'd be willing to give us your overview discussion about summarizing the measure, so the committee survey, public comments, and any other issues that you think are really important for us to hear.

Member Schearer: Thank you. And I will say this is my first time for this role, so I might need a little coaching.

But the measure is a new one. It's a process measure. Data comes from CMS claims. And so it's looking at whether people are receiving visits by a nurse or a social, medical social worker within the last three days of life. So they want two out of three days to have a visit.

What I noticed in the comments from the committee, a couple things that people were concerned about, one was that there might be times that families or

caregivers do not wish to have two visits out of the last three days of life.

Another question was related to the telephonic for social workers. It seemed like it was only limited to social workers where that was excluded. And the question was, were virtual, do virtual visits count or at least that's how I interpreted it.

And then I also noted that there were comments about not including spiritual care in the last three days of life, because that's really important for people, and maybe specifically more for certain cultures.

So those were the main things that I noted through the comments. I don't believe there were any public comments at this point.

Co-Chair Waldrop: Thanks, Janelle. So I'd like to ask George and Kelly if you have any additional thoughts or comments you'd like to make about 3645.

Member Michelson: I have one other thing to say that came up from some of the comments, which is that it -- someone noted I think appropriately so that the measure only accounts for visits from certain, in addition to chaplains that weren't included, it doesn't, it seemed to not include physicians.

So, if a physician came to visit the home, I don't think that would count as fulfilling this measure. So I thought that was a good point that someone brought up in that regard.

Co-Chair Waldrop: Thank you. George, any thoughts from you? I think you're muted.

Member Handzo: Sorry. Sorry about that.

I think this is an important measure. I applaud CMS for moving forward with this. I understand the evidence base and why they came out where they did. However, I think some of the comments that were just mentioned were mine. So I'll just reinforce

that I think there's a couple of downsides here that I'd love CMS to address.

You know, one is mentioned the downside that families would be encouraged to have a visit when they really don't want one culturally, or they'll be encouraged to have one from a social worker when what they really want is a chaplain.

And so they're not getting the service that they, that the patient wants. They're getting the service that the reg mandates.

I also had a question about the telephonic. If that means just telephone, then that's one thing. If it means all virtual, it's another thing.

And I would like CMS to clarify, you know, what they mean by that, because if it means all virtual visits, that's kind of out of step with current process and paid process. And maybe they ought to look at that again.

And I had the same comment about the, you know, the visits, you know, visits by, you know, non-physicians, chaplains, whoever, expanded to pharmacists, whoever might be doing it.

So a good measure, a good concept. The evidence is there. But it could use a little tweaking.

Co-Chair Waldrop: Okay. So this is a specifications question. And maybe what we can do is when we get through the criteria we'll take these one at a time shortly. But thank you for that. I appreciate your comments.

I want to open it to the standing committee to see if there are other issues that were raised for you. Amy, I can see your hand raised. Thanks.

Member Berman: Thank you, Deborah. And, thank you very much, CMS, for putting forward this measure. I think it's really important to have this measure.

I just wanted to expand for a moment on George Handzo's point. It is incredibly important for a person who is actively dying, and I say this as a person who lives with stage IV cancer, so it's coming from a person who at one point, will be the recipient of the use of this measure.

It depends upon the goal of care, and the reason for the care, who would be coming into that home.

And, I do agree spiritual care is part of a palliative care approach, and end of life.

So, I really hope that we can expand what the appropriate response is. If it's a response to pain, it may be one person. If it's a response to, you know, to other kinds of needs, it may be a different member of the team.

So, consideration for what those visits are, I think really is really important here.

The other thing that I just wondered. In the measure, the way that it's written it's last day of, you know, last three days of care.

Could somebody visit after the person has died, and would that have counted? So, that is their last day, but they could arrive afterward.

So, I just want to, you know, look at is there any gaming that could go on, of the measure in terms of the response and not being there for the person, but still meet the mandate by sending somebody afterwards.

So, just technical question.

Co-Chair Waldrop: Thanks, Amy.

I see Samira, and then Karl. Samira?

Member Beckwith: Thank you.

I'd like to just broaden the concept of who should be

counted in this last three days.

In addition to spiritual care, you know, a nurse practitioner is mentioned in the comments. And, I think we really have to think about advance practice nurses. Also, LPNs, aides.

People have such various degrees of needs during those days, and I'd like to see a much broader counting of visits. But definitely an LPN, an aide, chaplain, APRN, physician, need to really be included, as well as the chaplain.

Also, just to follow up on Amy's comment. We could be on our way to visit before the person died, get there right at the time of death, or right after they've died, and it's critically important to have our staff there at the time, to meet the family. To prepare the person for the family to say goodbye, et cetera.

So, I'd like to see that count. I wouldn't see that as gaming. Gaming, and also I'd like to see telephonic included.

A great deal can be done on the phone in terms of helping to sort out the situation, to calm down the family, to interpret what the needs are. So, I think telephone also needs to be included.

Co-Chair Waldrop: Okay. Many of these comments, really important comments are part of the specifications.

So, I'm going to take, I'm going to ask for Karl's question, and think we're going to, I'm going to direct us to taking each of the criteria one-by-one.

So we'll start with the evidence and we'll really focus on that just to really, to guide us.

So, Karl, you want to add something to our conversation?

Member Steinberg: I guess yes, Samira said a lot of what I was going to say. And, I also think that it just

seems a little arbitrary, two visits in three days. Why two visits, why three days? Why can't it be a licensed nurse? Why couldn't a physician visit?

And, also the fact that if somebody shows up post-death, sometimes really, somebody, the family doesn't want somebody there.

So, I guess I'm really just saying other stuff that other people have already said, so I will shut up, yes.

Member Berman: No, that's fine. It's all part of I think, the specifications that we're talking about.

But so that we can really work our way through the framework, let me begin by asking if we can discuss important, the importance to measure and report.

And, so specifically, both of these are most, we'll talk about evidence and we'll talk about the performance gap. And, these are both must-pass measures.

So let me first open the floor by saying evidence. What kind, what thoughts did you have as you read through the measure worksheet about the evidence for the need to measure? For the need for this measure, I should say. Seeing none.

Member Grant: This is Marian, Marian Grant.

I think the evidence suggests that (audio interference) often not as well controlled as it needs to be are symptoms at the end of life.

And, I believe that there is some evidence that that would prompt having for instance, a nurse to come and do a physical assessment.

So, I believe that one of the reasons for this measure is people who all of a sudden, in the last moments as they go into an active dying process have new symptoms, and might require a visit to the home.

And, you need to send somebody out to do that.

Co-Chair Waldrop: You were breaking up a little bit on my end.

I think I'm hearing you say that the evidence should point to the, which discipline should go. Is that, am I, did I hear you correctly?

Member Grant: Yes, it should point to what, what are the issues that might be the experience. And, in many cases, it would be physical symptom management.

So you would need to someone from a discipline who could assess and manage a symptom. A physical symptom.

Co-Chair Waldrop: Okay. Other thoughts about the evidence that we're presented with? Let me pause here --

(Simultaneous speaking.)

Member Garland: This is Jeffrey. I guess part of it, too, could be, and is subjective, how religious and faithful is the person? Is it important for them to have last rites, prayer at the bedside?

And, before they make that transition, confession and prayer. And, where is that as part of the care plan? Would they want it before transition?

So, I agree, the physical, as well as the spiritual pain, has to be assessed.

Co-Chair Waldrop: Okay. I'm going to pause here and ask for guidance from NQF staff. Paula, are we ready to vote if there aren't any additional comments on evidence, or should I continue to?

Ms. Bal: Sorry, Paula, I'm just going to jump in here really quickly.

We can start voting if we want. I just want to emphasize you know, as Deb stated so eloquently, a lot of these comments have been about the

specifications of the measure and, you know, where we think things are missing. The focus of this vote really should be on evidence.

And, you know, as you're going to the algorithm for evidence, seeing that there is, you know, just reminding everyone that while they didn't provide a systematic review or grades, there was empirical evidence provided.

And, really the decision point at this point, is do the benefits outweigh any undesirable effort, effects of having this measure move forward without a systematic review?

So, I definitely hear all the thoughts about specifications, and I, you know, we really want to hear those thoughts in that section, but I just wanted to remind everyone to vote on evidence with those items in mind.

Co-Chair Waldrop: Thank you so much. That's the redirection I needed. Thanks, Poonam, I appreciate it.

Amy, you had a thought to share?

Member Berman: Yes, it's a question. So, just if NQF could clarify for us. Can we review the measure as it exists, and still make recommendations for revision of an accepted measure?

Ms. Bal: Yes. We should always review the measure as is, as what's been provided in front of us. And, we can have options to suggest improvements for the next time the measure comes forward.

So, if you think the measure on its own is good, but there are improvements that you would like to see, then we should document those. And, we'll include them in the draft report.

So, when it comes back for maintenance review, we'll make sure to ask the developer, did you look into this, what was your decision ultimately based on

whatever research you could do.

Co-Chair Waldrop: And, I will also ask at the end of our conversation, if there are plans for CMS to expand the specifications of this measure, so.

Christine?

Member Ritchie: Just getting back to the evidence question. I mean, I do think that the evidence that the measure seems to align with patient and caregiver satisfaction scores, is compelling. And, I think that's one thing that is worth noting.

And, that there is profound variation among the hospice community, also suggests that there are gaps in practice standards.

Co-Chair Waldrop: Thank you for that.

Are we ready to vote on the evidence that's been presented to us about 3465?

Can I get a thumbs up or, unless there's any other comments people would like to make about the evidence we're presented with?

Okay, seeing none, I just want to remind us, we are voting on the evidence as it is presented to us in this measure worksheet. And, we need a pass for this.

So I think, staff, are we -- NQF staff, are we ready to vote on evidence?

Ms. Farrell: We are, yes. We'll turn it over to Gabby to run the vote.

Ms. Kyle-Lion: All right, everyone, bear with me as I pull up my screen.

Okay, voting is now open for measure 3645 on evidence. The options are A for moderate; B for low; or, C for insufficient.

I believe we're looking for 12 votes for this measure. Well, there's 14.

Fifteen. Oh, sorry, 17 votes. We're looking for 17. My bad. Apologies, everyone. We're just waiting on one more.

We're still at 16 votes. I believe we're still waiting on one more.

Member Cass: This is Dr. Cass. I'm just having a little trouble finding my voting again. I had to step away to take a call.

Ms. Kyle-Lion: That's okay, Dr. Cass. Would you like us to resend you the link?

Member Cass: I'm thinking it might be faster. I don't know where it went, but that's not surprising here.

Ms. Kyle-Lion: Okay, I'll ask Oroma to --

(Simultaneous speaking.)

Member Cass: I just don't want to hold. You know, you start to panic and then you can't find any -- oh, wait a minute. There it is. I've got it. I'm sorry.

Ms. Kyle-Lion: Oh, okay perfect. We'll just wait one more.

Member Cass: Yes, yes.

Ms. Kyle-Lion: We'll just wait one moment. Okay.

Member Cass: Okay, so do I have the right one, importance to measure, or did we move on?

Ms. Kyle-Lion: No, we are on that one. Importance to measure and report 1A for evidence.

Member Cass: Okay, great. Okay, I've got it but it doesn't seem to want to take my vote.

Ms. Kyle-Lion: Okay, Dr. Cass, if you don't mind, it would be, I think it will be good if you go ahead and just chat me your vote. That will work.

Member Cass: Yes, I can do that. Thank you very

much.

Ms. Kyle-Lion: Okay, I'll wait to share your votes until I get Dr. Cass's chat. Just give me one moment.

Member Cass: Do I just put it to everyone, is that all right? Or do I put it specifically to you?

Ms. Kyle-Lion: Please put it specifically to me, so that the voting remains anonymous.

Member Cass: Okay. Okay, I sent it.

Ms. Kyle-Lion: Okay, thank you so much.

Member Cass: I apologize, and we'll figure this out.

Ms. Kyle-Lion: No.

Member Cass: Thank you for your help and patience.

Ms. Kyle-Lion: Oh, it's okay. It happens; no worries.

All right, so I'm going to go ahead and lock the vote.

So, voting is now closed on measure 3645 on evidence.

There were 16 votes for moderate. We got one in the chat; and, one vote for low. Therefore, the measure passes on evidence.

Thank you so much, and I'll pass it back over to Dr. Waldrop.

Co-Chair Waldrop: Thank you, Gabby. Thank you for walking us through the voting process.

Ms. Kyle-Lion: No problem.

Co-Chair Waldrop: So, next we need to consider the performance gap. Is there evidence, is there the importance to measure this because there's a gap in performance?

And, so I would like to ask us first of all, if there is any more discussion about that. Do we see this as

addressing a gap, first of all?

Seeing no comments, are we ready to vote on whether or not there's a performance gap that's evident?

Ms. Bal: Deb, could we just add the, ask the lead discussants just to provide a description of the gap first?

Co-Chair Waldrop: Okay, sure.

Janelle, would you be able to address the performance gap?

Member Shearer: Yes, sure. The performance gap is, shows an average nationwide of 63.2 percent. And, so I guess my opinion is there is a gap.

Co-Chair Waldrop: Thank you.

Any other comments about a gap, the gap that this demonstrates?

Member Handzo: Yes, and it also looked to me looking at it like there was a racial gap, a disparity, and a urban, urban/non-urban gap that they documented.

Co-Chair Waldrop: Absolutely.

Anything else you saw, Kelly, that you want to add? Okay, thank you.

Are we ready to vote on the existence of a performance gap here, that this measure will address? I'm taking that as a yes.

Gabby, can you help us work through this?

Ms. Kyle-Lion: You got it. Let me just share my screen. Give me one second.

All right, voting is now open for measure 3645 on performance gap.

Your options are A for high; B for moderate; C for low; or, D for insufficient.

And, I'll just reiterate again that if anybody's having any trouble with voting, please just go ahead and message me your vote. Privately.

Member Cass: Tell me the options again because I am going to have trouble. It's still not wanting to take my vote.

Ms. Kyle-Lion: Okay, A for high; B for moderate; C for low; or, D for insufficient.

Member Cass: Thank you.

Ms. Kyle-Lion: We are at 15 votes right now, and I do believe that this one is also going to be with, we're looking for 17.

I will just wait to get Dr. Cass's vote and then I can share.

Member Cass: Yes. Funny, it won't take it on the thing, okay.

Ms. Kyle-Lion: Okay, we have received Dr. Cass's vote, so just give me one moment to pull up the slide.

Voting is now closed on measure 3645 for performance gap.

We have 11 votes for high, and 6 votes for moderate. Therefore, the measure passes on performance gap.

All right, Dr. Waldrop, back to you.

Co-Chair Waldrop: Thanks, Gabby.

Ms. Farrell: Dr. Waldrop if I could just, sorry, jump in here --

(Simultaneous speaking.)

Co-Chair Waldrop: Of course.

Ms. Farrell: -- our developer would like to clarify their specifications. So, if you could allow them a chance to go ahead and do that?

Co-Chair Waldrop: Certainly. I just, I was thinking if we were doing it at the very end. But if we're doing that now, that's great.

So, Thomas, if you you'd be willing to address the questions of specifications, that would be great.

Mr. Christian: Yes, sure, I'd be happy to. I'll try to remember them all, and if someone can remind me if that wasn't the case.

So, you know, I think there were a lot of questions about the disciplines we used. As I mentioned in the overview, you know, it was very evidence based.

We found that these two disciplines, registered nurses and social workers, were the ones with the, kind of the strongest you know, relation with, with you know, caregiver approval just measured by using you know, CAHPS scores.

Again, I don't think we're trying to necessarily negate the importance of the other disciplines.

It just showed that at this particular time in you know, in hospice care, at the last couple days of life, these are the disciplines that really seemed to, to resonate with you know, with the families.

So, I mean, as I also mentioned, the earlier version of the measure, we had a earlier version of the measure that included more disciplines. Those just actually didn't, you know, it wasn't the, the other evidence and kind of validity scores that this measure has.

Some of those other, there wasn't sort of the empirical evidence supporting them when using those.

So, again, I don't think those disciplines aren't

important, but just at this particular time in the hospice stay, these are the disciplines that tend to, that tend to be important.

And, I think there was questions about sort of like, you know, the timing of why we chose three days, you know, two days, et cetera.

I think again, that was somewhat you know, empirical based, also guided by the literature.

There were papers showing that the last two to three days of life is really when symptoms of dying tend to increase. So, this is the actively dying portion. When sort of additional support would be needed, that's sort of why we focused on those.

Looking at just two of the last three days of life, you know, we started, we were trying to give an allowance that you know, every three days might not be desired by the family, who might want privacy.

So, just sort of and you know, also there could be an instance where the, you know, the person dies before the staff reaches the house on one of the days, or you know, for example.

I'm trying to think. There was a question if you know, do visits after the person death's count. I think as is recorded, they do not.

So, it would just be those visits that occur while the patient is still alive, but in the last you know, couple days of their life.

I will say though that post mortem visits are probably very important for, you know, just sort of you know, checking in on the family generally. And, that could be perhaps a separate quality concept to look at in the future.

So, I think there is some separate value to that. But this particular, you know, measure concept, it's just those visits you know, during, well, before the patient dies.

Concerning anything else I can address, I'm trying to remember.

Co-Chair Waldrop: So, I think that we will have some ideas that will come in our final report, but I'm wondering if you could say whether or not CMS would be open to changing the specifications going forward, if some of these other disciplines seemed important?

Mr. Christian: Yes, sure. I certainly, well again, I think it would have to, we could look at anything really. Again, our reason for this was just based on the evidence.

So certainly we can explore looking at --

(Simultaneous speaking.)

Co-Chair Waldrop: Okay.

Mr. Christian: -- other disciplines.

Dr. Levitt: Yes, this is Alan Levitt from CMr. Christian: I don't know if you can hear me?

Co-Chair Waldrop: Yes, we can.

Dr. Levitt: Can you hear me? Yes, okay, good.

Yes, just to give background, to clarify. As T.J., as Thomas Christian said, this measure was originally a HIS based measured pair that was developed with use of a technical expert panel of hospice experts.

Two different measures. One was visits by nurse/doctor last three days of life. The other one was visit by all the disciplines the last seven days of life. So, LPNs, aides, chaplains, all included.

As we did the monitoring and evaluation of that measure after we began collecting data on it, we found that the visits measure in the last three days of life correlated with our other hospice visits positively, in terms of both the CAHPS scores.

So, in other words, visits were associated with

improved satisfaction. Whereas the all disciplines over the seven days, did not.

When we looked at it further and started breaking it down as to okay, well, let's start looking which disciplines seemed to matter and which ones don't, during this last days of life, which we consider almost like the ICU days of hospice care.

So, we're not talking about overall hospice stay for you know, the entire length of stay where use of multiple disciplines may matter. We're talking about this last piece of life.

We found the correlations were strong with RNs and not as strong, but also strong, with social workers. And, otherwise, were not.

In fact, LPNs and nurse's aides, were negative. Those visits were associated with less satisfaction with the hospice services, and care that was provided.

And, when we looked at that further, it was believed it was from substitution. So actually, if RN visits were substituted with LPN or aides, that was negative.

And, so again these measures were developed with the idea of the holistic, multi-disciplinary approach.

But then when we looked at them, and we actually looked at the monitoring evaluation, these are the services that matter in those last two or three days of life.

Does that mean that we won't continue to look at it? We will. We continue to do monitoring evaluation then of this measure, to see how it's going because things are changing. We've still got telehealth. I mean there are all factors that are going on that we need to continue to look at.

But what we needed to really emphasize, and needed to try to ensure to be available during these last days of life, were these two services.

The other services could continue to come in as well, but they should not be substitutes for these services. This is what we learned.

We learn all these things in medicine, too. All the things that we think you know, are true. When we actually look and study them, may not necessarily be true.

I used to do effects of bed rest in the elderly, and point out all the things that bed rest used to be prescribed for in medicine, that were no longer prescribed.

It's the same thing with all other settings, and all other services. And, that's what we're seeing here in hospice. At least from what we're exploring.

And, luckily we're able to have the data behind that, to actually to start to look at things that, you know, can help us to try to unwind what should be given, and at what time.

Co-Chair Waldrop: Thank you very much.

Dr. Levitt: I hope that helps.

Co-Chair Waldrop: Thank you very much for your comments, both T.J. and Alan. We appreciate it.

There are three hands up. I'm going to ask to do those three comments and then move us on to the next criteria.

So, I think Kelly was first.

Member Michelson: Yes, this comment is maybe sort of minor, but someone made the comment that what happens if someone is coming to the house, and the patient has already died.

And, I guess I just wonder if that would not be included as if it was a visit to the house, because it's coming from these claims data, and it would be sort of presumably the same date.

So, that was the only comment I was made, going to make. It's, I feel a fairly minor point.

Co-Chair Waldrop: Okay, thank you.

Linda, and then Karl. And, then we'll move on.

Member Schwimmer: Just had a comment that's kind of more of a question for CMS.

But in reading the discussion in the documents around evidence, it seemed like part of this was patient satisfaction, but part of this was the evidence in the field that these specific visits reduced hospital, risk of hospitalization or ED use, or dying in the hospital. And, we didn't really talk about that.

So, I don't know if there was specific evidence that connected these types of health care providers with those results.

But reading the document, it sounded like that's really what it was, and that was an important piece of the evidence behind the way this was structured.

Co-Chair Waldrop: Okay, and we've already voted on that, so I'm going to just ask Karl, and then we'll move on to scientific acceptability.

Member Steinberg: Yes, and I want to thank CMS for the additional kind of clarification there.

I just, I'm still skeptical. I just, to me to say that somehow, and the difference between an RN people are happy with, and an LVN people are unhappy with. It just doesn't make sense to me, right?

It's not bed rest in seniors. This is, I understand that an RN has better assessment skills and what not, but it just seems, so I don't even really know what I'm asking other than, I mean I looked at what got submitted and I'm just, I'm not convinced by it.

I mean, a home health aide, sure, maybe there's a difference there. But I can't account for why the

satisfaction level would be lower even though perhaps it would be higher with somebody with a higher.

So, I don't know if you can answer the question. I didn't look at the actual raw data. I'm not a statistics person, but it just doesn't meet my sniff test.

Co-Chair Waldrop: We have voted on this already, so it at this point, it's I'm being told it's moot.

So, we kind of, we need to move on.

Member Steinberg: Okay.

Co-Chair Waldrop: I don't want to cut you off, but that's kind of where we are in the process.

I wanted to move us to scientific acceptability where we have to have must-pass for both votes. We'll vote on reliability and validity separately.

And, so let me first ask Janelle if you have any, anything you want to share about scientific acceptability about this measure?

Member Shearer: No, not really, other than the researchers state that it's high for reliability. And, I believe I also read it high for validity as well.

Co-Chair Waldrop: Okay. George and Kelly. George?

Member Handzo: Did I miss something? I was under the impression we were going to vote on specifications, but we seem to have done with that.

Ms. Farrell: We don't vote specifically on specifications now.

Ms. Bal: It is part of reliability, so the discussion on --

Member Handzo: Okay.

Ms. Bal: -- on classifications should be grouped into reliability, along with reliability testing.

And, so the comments right now should focus on any concerns with specifications, and then also any concerns or comments about the reliability testing that was done.

So, we would focus on those two things first, then take a vote. And, then we'll focus on validity.

And, I think while we normally wouldn't have the developers go first, since there was so much specification discussion in evidence, we wanted to give them an opportunity to respond to your questions before we jumped into the actual discussion.

Co-Chair Waldrop: Thanks, Poonam.

Any comments on reliability? Any discussion about the reliability of this measure?

Member Thirlwell: I just wanted some clarification of, related to that of, and the specifications are on why respite care was excluded. From the denominator of patients.

Co-Chair Waldrop: Poonam, am I allowed to ask the developer to address that?

Ms. Bal: Yes.

Co-Chair Waldrop: Okay, either T.J. or Alan, would you like to address that question?

Mr. Christian: Yes, sure, I can take a quick pass at it.

So, at least in the Medicare hospice benefit, respite care is inpatient respite care. So, the, you know, the patient would be institutionalized, and presumably there would be you know, staff present.

So, they're being seen by folks, which might not be the case if they were in their own homes.

Member Thirlwell: But not necessary on our end, or a social worker.

Mr. Christian: That's true, yes. Respite care is also very, extremely rare, especially in the last couple days of life.

Co-Chair Waldrop: Okay, thank you. Are we ready to vote on reliability?

Okay, Gabby, can you help us with that, please?

Ms. Kyle-Lion: No problem.

Okay, voting is now open for measure 3645 on reliability.

Your options are A for high; B for moderate; C for low; D for insufficient.

And, once again, if anybody has any trouble voting, you're welcome to message me in the chat.

I did notice that Tracy Schroepfer joined the call. So, Tracy, if you could just unmute for one second and give us your disclosures, or message them in the chat, that would be great.

Member Schroepfer: Okay. What is it exactly?

Ms. Kyle-Lion: Do you have any disclosures to give? Sorry, before you vote, do you have any disclosures? For this measure.

Member Schroepfer: No, not for this measure.

Ms. Kyle-Lion: Okay.

Member Schroepfer: And, then I'll just need help with how to get to the voting. I'm sorry for --

(Simultaneous speaking.)

Ms. Kyle-Lion: No, that's okay. No problem.

You should have received a link this morning via email.

Member Schroepfer: Okay.

Ms. Kyle-Lion: If you can't access it, again, feel free to, Oroma also said she'll chat you the link.

If you still can't access it, please feel free to just chat me a message with your vote.

Member Schroepfer: Thank you all.

Ms. Kyle-Lion: Sorry, Tracy, could you actually give your disclosures for all the measures that we're reviewing? My apologies. If you have any.

Member Schroepfer: For the last two, I actually worked on the actual project that developed those measures.

Ms. Kyle-Lion: Okay, so you are, I believe you're recused on those two. Okay, thank you.

All right, I'm seeing 17 votes. I believe we're still waiting on one more.

Member Cass: I've gotten mine fixed. This is Dr. Cass. I reinstalled.

Ms. Kyle-Lion: Thank you, Dr. Cass, I appreciate that.

I'll just give it one more moment.

Member Schroepfer: I'm signing in now.

Ms. Kyle-Lion: Okay, thank you Dr. Schroepfer, Tracy.

Member Schroepfer: Okay, and I just clicked on the link and that took care of it, right?

Ms. Kyle-Lion: Yes, I do see your vote. Thank you so much.

Member Schroepfer: You're welcome.

Ms. Kyle-Lion: Voting is now closed for measure 3645 on reliability.

There were five votes for high; 11 votes for

moderate; two votes for low; and, zero votes for insufficient. Therefore, the measures passes on reliability.

So, I'll go ahead and pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thank you, Gabby.

All right, so let's move on to validity. Janelle, or any of the reviewers, any thoughts about the validity of this measure, that you would like to share?

Member Shearer: I don't have anything additional to share.

Co-Chair Waldrop: Okay, thanks.

Kelly?

Member Michelson: Yes, I just want to make a comment as a pediatrician in the group. And, if I'm, if this is incorrect, someone can correct me.

But my understanding is that all the data from this measure is coming from Medicare data.

And, I don't believe that Medicare data pays for a single pediatric hospice patient, which therefore, by definition, would completely exclude the entire pediatric palliative care-hospice population from this quality measure.

And, I have concerns about that.

Co-Chair Waldrop: Thank you.

Any other comments about the validity of this measure? Okay, are we ready to vote on the validity of this measure?

Member Michelson: Before we vote, can I just ask a question? To what extent do these comments go back? Do they all go back to the, I mean I know there are some measure developers on the line.

But do they all go back in some kind of written form,

or how do we know that these go back to the measure developers?

Like I just am, I guess I just need a little review of that process. Sorry. I realize that's in the middle of everything.

Ms. Bal: No worries.

So, as you stated, they are on the call to hear these comments. There's also a recording and transcript that will document you know, all these discussions.

And, then in the draft report, we'll highlight any areas of improvement that this committee has recommended. And, we'll summarize the discussions that occurred.

So, the draft report will highlight the high level comments. May not have everything included, but the transcript will have everything recorded. And, as you stated, the developer is on the call to hear this as well.

Member Michelson: Thank you.

Co-Chair Waldrop: Okay, do we need any additional discussion about validity, about the, what the measure evaluation worksheet said about validity, or does everyone feel ready to vote on that?

We will look at the criteria following, but before we vote, anything else on validity that needs to be discussed?

Okay, are we ready to vote? Gabby, can you help us?

Ms. Kyle-Lion: Yes, no problem.

Voting is now open for measure 3645 on validity.

The options are A for high; B for moderate; C for low; and, D for insufficient.

And, again, we're looking for 18 votes here. At the moment, I am seeing 16.

All right, we are at 18 votes.

Voting is now closed on measure 3645 for validity.

There were four votes for high; 13 votes for moderate; one vote for low; and zero votes for insufficient. Therefore, the measure passes on validity.

I will hand it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thank you, Gabby.

Okay, so we're moving on to feasibility. And, I'm going to ask Janelle, if you could give us an overview of what the measure evaluation worksheet said about feasibility. And, then we'll talk, see if there is any questions about that.

Member Shearer: Okay, well the data for this measure all comes from claims. So, it's electronic format. It's not collected by the person obtaining the original information.

To me, it should be fairly, I don't want to say easy, but feasible for, for it to collect.

Co-Chair Waldrop: Because of the electronic nature of it, is that what you're saying?

Member Shearer: Right, right. And, it's claims. So, agencies submit their claims, you know, to CMS, for billing, and then they'll pull the data from there.

Co-Chair Waldrop: Okay. Any other thoughts on feasibility from George or Kelly?

Member Handzo: No, I agree.

Co-Chair Waldrop: Okay. Any other conversation about the feasibility of this measure? Okay, I think we're ready to vote on feasibility.

Ms. Kyle-Lion: All right; pull up my screen here.

Voting is now open for measure 3645 on feasibility.

Your options are A for high; B for moderate; C for low; or, D for insufficient.

And, again, we're looking for 18 votes. And, we are at 17 at the moment. Just waiting on one more.

I'm still seeing 17 votes. Give it just a couple more seconds. All right, we are at 18 votes. Voting is now closed for measure 3645 on feasibility.

There were 12 votes for high; 6 votes for moderate; zero votes for low; and, zero votes for insufficient. Therefore, the measure passes on feasibility.

So, I'll go ahead and pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thank you, Gabby.

So, we'll move on to the usability and use of this measure, and we'll take them one at a time.

So, I would like to ask Janelle to begin. If you have something, anything from the measure evaluation worksheet you could share with us about, give us an overview about use of this measure?

Member Shearer: So, this is a new measure developed by CMS, and we see that there is a pretty good sized gap between having two visits by these, either an RN or an MSW, on the last two to three days of life.

So, it seems like it would be something useful for hospices to use to improve the quality of life for the people they serve.

Co-Chair Waldrop: Thank you. Anything from George or Kelly on the use on this measure?

Member Handzo: HANDZO: Yes, I'm not sure which category this goes in, but it's under usability someplace.

If I read this correctly, they say that it'll be implemented no earlier than May 22. I would be

much happier if there was a by something there. Because that's kind of open ended.

And, we want to get this if we approve it, then it should be used. And, there should be a, I start to wonder whether there's a concrete plan that's set to use or not.

Co-Chair Waldrop: Okay. Any other thoughts about the use of this measure?

Amy?

Member Berman: Is there a requirement to use a measure by a certain time? If I remember correctly, which would mean that when we, that the next round where this would be consider again if it were not implemented within that timeframe, that it couldn't then move forward? Or that would be part of those discussions?

Do I remember that correctly?

Co-Chair Waldrop: I need to defer to our NQF colleagues. I don't know the answer to that.

Paula or Poonam, could you, or Oroma, could you let us know about timeframe on this?

Ms. Farrell: Sure, for maintenance measures, so if the measure would be passed and it gains endorsement, then it comes up for review as a maintenance measure, we are looking to see that it's used in an accountability program.

Co-Chair Waldrop: Any other comments about the use of this measure?

Samira?

Member Beckwith: How long before it would come back as a maintenance measure? I've just forgotten that.

Co-Chair Waldrop: Paula, can you tell us how long it

would, how long it would be before it would come back?

Ms. Farrell: Sure, it's typically a three-year timeframe for endorsement, re-endorsement.

Member Beckwith: Did you say three?

Ms. Farrell: Three, yes.

Co-Chair Waldrop: Okay, anything else about the use of this measure?

Dr. Levitt lets us know this measure has been adopted in the hospice QRP. Thank you for that.

I'm believing we're ready to vote on the use of 3645. Gabby, can you help us, please?

Ms. Kyle-Lion: Yes, just give me one second.

Voting is now open for measure 3645 on use. Your options are A pass; or, B no pass. And again, we're looking for 18 votes here.

All right, so we are currently at 18 votes. Voting for measure 3645 on use is now closed.

There were 17 votes for pass; and one vote for do not pass. Therefore, the measure passes on use. I will go ahead and pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thank you, Gabby.

Okay, we are now going to focus on usability. I'm wondering, Janelle, if you could give us an overview of the criteria for usability, and what, what is evidenced in the measure evaluation worksheet.

Member Shearer: Okay, so the developer stated that this measure has not been implemented yet, and thereby, improvement results are not available.

They did not identify any unexpected findings or potential harms.

Co-Chair Waldrop: Thank you. Anything else from George or Kelly, on the usability?

Seeing none, any conversation about the usability of this brand new measure? Anything else anyone wants to raise for the good of our conversation?

Seeing none, are we ready to vote on usability? Please, Gabby, thank you.

Ms. Kyle-Lion: Okay. Voting is now open for measure 3645 on usability.

Your options are A for high; B for moderate; C for low; or, D for insufficient. And, once again, we are looking for 18 votes on this.

We are at 18 votes. Voting is now closed on measure 3645 for usability.

There were five votes for high; 12 votes for moderate; one vote for low; and, zero votes for insufficient. Therefore, the measures passes on usability.

I will pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Okay.

So, lastly we are, we need to consider the overall suitability for endorsement of this measure.

And, I'll turn again to Janelle, and ask if you could give us the overview of how that presents itself. How that is presented in the measure evaluation worksheet, and just what the parameters are. And then we'll open it.

Member Shearer: All right, I have to say I'm not sure what the parameters are from the worksheet, but I will make a comment.

So, as a previous director of a hospice organization, it was our policy I guess, or we always tried to make a visit at the time of death, or before death.

And, I've heard from just family and friends, that that's not always the case where the hospice says just call us when they die. Which doesn't, didn't feel good to me.

So, I think this measure encourages hospices to make a visit near end of life.

Co-Chair Waldrop: Thank you, that's what I meant. I was just really thinking about the overall use of this measure; the overall suitability.

Is there anything else that anyone has to say about the use of this measure that, you know, the, and we can just, or if no, we can just move on. Thanks, Janelle.

Okay, so can we just vote. And, we then vote on the overall suitability of this measure, Gabby, please.

Ms. Kyle-Lion: Yes. Okay, voting is now open for overall, for measure 3645 on overall suitability for endorsement.

Your options are A for yes; or, B for no. And, once again, we are looking for 18 votes. We're currently at 17; just waiting on one more.

We are still at -- okay, just got to 18.

Voting is now closed for measure 3645 on overall suitability for endorsement.

There were 18 votes for yes; and zero votes for no. Therefore, the standing committee recommends to endorse this measure.

Pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thank you everyone, for all of your thoughtful comments, for all of your review of this measure, and for a really interesting and thoughtful discussion.

I think I need to ask if there are any other questions

for the developer, that anyone has collected from the NQF staff.

Is there anything else we needed to ask of the developer?

Poonam or Paula?

Ms. Farrell: We have all of our voting completed, so we are good to go on this measure.

Co-Chair Waldrop: Okay. Thank you everyone.

Ms. Farrell: All right, yes, thank you.

So, we are running a bit early so we're going to go ahead and take our break, and we will ask that you please return at 12:30 Eastern Time, so that we can commence review of our last two measures.

So thank you everyone.

(Whereupon, the above-entitled matter went off the record at 11:35 a.m. and resumed at 12:31 p.m.)

## 3665 Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (American Academy of Hospice and Palliative Medicine)

Ms. Farrell: All right. Welcome back, everyone. I hope you enjoyed your break. We have two additional measures that we are going to review this afternoon.

Our next measure is going to be 3665 Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood.

We do have eight recusals from the Standing Committee for this measure and those that are recused will not be able to discuss or vote on the measure.

The recusals are Tracy Schroepfer, George Handzo, Sean Morrison, Christine Ritchie, Sarah Thirlwell, Paul Tatum, Arif Kamal, and Marian Grant.

All right. So with that I will turn the call over to our co-chair, Dr. Waldrop, to lead the discussion.

Co-Chair Waldrop: Okay. Thank you, everyone for being here. I am going to start by asking the measure developer, Dr. Anne Walling, if you would like to give us a brief overview of 3665.

Dr. Walling: Sure. Thank you so much for having us today. My name is Anne Walling. I am a palliative care physician and health services researcher.

I am here today as both part of the RAND Measure Development Team as well as a fellow of the American Academy of Hospice and Palliative Medicine and member of the AAHPM Quality Committee that oversaw the development of these measures.

The team joining us here today includes Katherine Ast, Director of Quality and Research for AAHPM, Amy Melnick, Executive Director of the National Coalition for Hospice and Palliative Care, and the following members of the RAND Measure Development Team, Sangeeta Ahluwalia, who is the Project Director, she is in transit but she is joining to the extent possible, Jessica Phillips, who is our Project Manager, Jordan Harrison, who is the Measure Endorsement Lead, and Brian Vegetabile, our Senior Statistician.

Thank you for the opportunity to present these two measures to the Committee. For the past three years AAHPM, RAND, and the Coalition have worked in conjunction with a 30-member technical expert clinical user patient panel and an 11-member clinical advisor team to develop Measure 3665, Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood, and Measure 3666, Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain.

This work was funded by CMS through a cooperative agreement with AAHPM under the 2015 MACRA legislation.

The central purpose of this agreement was to develop and test two patient reported performance measures for patients receiving ambulatory palliative care and submit the post-palliative care measures to CMS's measure under consideration list for the Quality Payment Program and the National Quality Forum for review and endorsement.

So all of us here know that palliative care has grown tremendously in the past 20 years, especially in the ambulatory setting.

I am sure we all can agree that at its core palliative care's patient-centered care where effective palliative care is about understanding and realizing the patient's preferences for treatments, how their symptoms are managed, and what their goals and values for care are.

The need for these two measures is driven by several factors, including, one, the importance of understanding patients' experience of our core palliative care practices and driving improvements and care based on that experience.

Two, the need to begin to systematically measure the quality of palliative care that is increasingly provided in ambulatory settings where patients often receive early or we might say more timely access to our services.

And, number three, a goal of explicitly incorporating the patient voice into how we measure the quality of palliative care.

So Measure 3665, or feeling heard and understand, draws on information from a four-item scale intended to measure the extent to which a patient feels heard and understood by their ambulatory palliative care provider and team, meaning they feel seen as a whole person, not just a patient, and that they are acknowledged, understood, and respected.

This complex construct of feeling heard and

understood is central to establishing a trust-based relationship between providers and patient and for a which a valued-centered care plan can be developed.

Measure 3666, or receiving desired help for pain, is similarly intended to assess the quality of symptom management from the patient's perspective of what is most important to them, specifically whether or not they got as much help they wanted for their pain from their ambulatory palliative provider and team and whether it be in the form of medication or alternative treatments or even no treatment at all as they weigh their own values-based tradeoffs.

Because these are fairly novel approaches to measuring clinical care both measures underwent rigorous cognitive testing with palliative care patients and caregivers as well as concept testing and focus groups with palliative care providers and team members.

Throughout the measure development process we have engaged key stakeholders in the palliative care community, including all members of the Interdisciplinary Team, patients, caregivers, payers, informaticists, and measure developers.

We have systematically and robustly gathered their input through various stakeholder engagement approaches through two primary venues, our TECUPP and our Advisory Panel.

In addition, the National Coalition has engaged in broad outreach efforts to ensure the community is kept apprised of our measure development work and has a direct link to provide input through this process.

We believe our proactive approach to stakeholder engagement through the measure development lifecycle as well as our explicit goal of incorporating patient voice in our measure makes these measures stand out significantly stronger and well supported.

So we would like to highlight a few important points about these measures and their development.

So one key point is that a total of 2,804 patients receiving care from 44 different ambulatory palliative care programs around the country contributed their experiences to inform the development of these measures.

In interviews we conducted with patients and family members, as well as with our participating palliative care programs, we heard strong support for both measures and for the need to measure the quality of palliative care services.

Another point here is that we conducted both an alpha field test with a sample of programs and patients to first finalize our data collection instrument and establish the support programs needed to successfully participate in the subsequent 15-month beta field test.

So through this nationally representative test we established, one, the psychometric properties of the data elements comprised in both quality measures, two, the scientific acceptability of the quality measures themselves, and, three, final measure technical specifications.

So as our documentation reflects, central to this process was establishing data element level and measure level reliability and validity.

Another key point is the data collection instrument I mentioned above was an enhanced mixed-mode survey that was carefully developed and refined during a pre-testing phase and fielded to eligible patients.

So this survey included data elements that were relevant to the two proposed performance measures as well as data elements that were necessary for testing and analysis.

It is important to note that we did not seek to develop and validate a patient experience survey, but instead we used the survey to collect the information we needed to test and validate two proposed quality measures we are discussing today.

Another important thing to note is that we paused data collection for this test from March 30, 2020 to September 2020 because of the COVID-19 pandemic.

We worked closely with our participating sites to restart data collection in the least disruptive manner possible. All but one site restarted as planned and we were able to meet sampling requirements despite the 5-month pause.

Finally, we view this 3-year measure development effort as a critical first step towards systematic measurement of palliative care quality for both quality improvement purposes as well as for accountability and value-based care programs.

This work is far from complete when considered as part of the larger effort among the palliative care community to improve quality and access to palliative care.

Future work directly related to these measures that we hope will proceed include testing the reliability and validity of these measures in other languages to reflect the growing diversity of the people we take care.

I will note that we have already developed and validated a Spanish language survey instrument that can be used in future work.

We also hope to include and evaluate virtual palliative care in our measurement, particularly considering the rapid expansion of telehealth during the pandemic, also the need to apply and modify these measures for pediatric palliative care and evaluate implementation of these measures into practice and

developing toolkits for programs seeking to improve quality of palliative care based on the measure outcomes.

So we look forward to the opportunity to discuss these measures with you. Thank you so much for having our team here today.

Co-Chair Waldrop: Thank you very much for being here and for your summary. I am going to turn over the discussion to our lead discussant, Dr. Laura Porter, and I want to thank you for being the lead discussant.

I also want to thank Amy Berman and Jeff Garland for being the supporting discussants.

Dr. Porter, I am wondering if you could begin us with your overview and then if you could turn us to evidence, please, and give us an overview of that criteria and what you found in the measure evaluation worksheet.

Member Porter: Yes. This is my first time, too, so --

Co-Chair Waldrop: Thank you.

Member Porter: I am not going -- What I won't do is go over the four questions because they were already addressed in the presentation.

So basically this is a new measure, it's an outcome PRO-PM and it is the level of analysis is clinician group practice. So what I would like to do is just talk about a few things that were pointed out by the developer in the summary.

So the providers can be one of many MIPS-eligible provider types ranging from doctor of medicine to clinical nurse specialists. Providers serve as the lead of the palliative care team and are there for a reference or named at the start of the survey instrument.

To identify the referenced provider named on the

survey instrument for each patient the dataset was first filtered to include only visits with MIPS-eligible providers that occurred in the three months prior to the anticipated start data date of survey fielding.

The then selected the MIPS-eligible provider whom the patient saw most often within the 3-month period with ties in numbers of visits broken by provider type giving preference to providers holding primary responsibility for patient care outcomes.

If patients had multiple visits with the (audio interference) we selected the most recent visit for each patient with the reference provider.

They did not conduct testing to specifically evaluate how patients differentiated between team members and their responses to the survey items.

So I will go on to evidence. The empirical data was submitted and demonstrates a relationship between the outcome in a healthcare structure.

For the structure process or intermediate clinical outcome measures there were numerous citations of literature supporting the measure and then for using the algorithm one the measure should pass with sufficient evidence.

And then for patient-reported measures, they have demonstrated that the measure is meaningful by conducting 30- to 60-minute interviews with patients, caregivers, and family members acknowledging the value of good communication between providers and palliative care patients.

Some of the Committee member comments were that the target audience values the outcome being measured, numerous literature citations supporting the measure, some participants emphasized the value of measuring the concept of feeling heard and understand, and then the developer provided a robust literature review that documents the importance of communication between patients and

palliative care providers.

Co-Chair Waldrop: Great. Thank you so much. I am going to stop there and ask if we have any additional comments from our supporting discussants, Amy or Jeff. Go ahead, Amy.

Member Berman: So I would just add to that wonderful overview that the literature supported the linkage between provider communication in a caring environment, information gathering, information sharing, responding to the needs of the person, and fostering a strong relationship, promoting end-of-life discussions, supporting and hearing symptoms so that they can be addressed, quality of life and satisfaction, so the literature was extraordinarily robust.

Co-Chair Waldrop: Thank you, Amy. Jeff, go ahead.

Member Porter: Sorry. I also want to say that the preliminary rating was a pass.

Co-Chair Waldrop: Great. Thank you. Jeff, would you have any additional comments you would like to share about evidence in the case of this measure?

I am not sure if Jeff is back. I don't see him so I will move on then and open it for the Committee. Are there questions for the good of our discussion that people would like to raise about this measure? Particularly about evidence, let me focus us on evidence here.

Any questions? Any comments about evidence, how the evidence was collected, what its quality is, the nature of the evidence?

Seeing none, thank you to each of our discussants for your thorough summaries, perhaps you have covered it all then.

I see no discussion. I am going to ask Gabby if we might be able to vote on evidence for this measure.

Ms. Kyle-Lion: Yes. Just give me one second to pull up my screen. Okay, voting is now open for Measure 3665 on evidence. The options are A for pass and B for do not pass.

I believe there is eight votes. There is ten votes now. We are expecting 11 votes so I will just wait one more moment to see if that eleventh vote comes in.

Okay, we have 11 votes. Voting is now closed for Measure 3645 on evidence. There were 11 votes for pass and zero votes for do not pass, therefore, the measure passes on evidence.

I will pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: I just want to clarify, you just said 3645, we are at 3665, correct?

Ms. Kyle-Lion: Yes. Yes, sorry, my apologizes. 3665, sorry.

Co-Chair Waldrop: I thought we were all on the same page. I just wanted to be sure.

Ms. Kyle-Lion: Yes.

Co-Chair Waldrop: Great. Thank you. So I will go back to Laura and ask if you could give us your view from the measure evaluation worksheet on the performance gap on what was found there.

Member Porter: Yes. So the developer cited literature highlighting the variability in care received in ambulatory clinics, which necessitates measures that are both broadly applicable to patients with serious illnesses and useful to clinicians and health systems in measuring and improving the quality of care in palliative care settings and the measures value in implementing innovative financial models for palliative care delivery.

So do you want me to go on to the data disparities, the whole section?

Co-Chair Waldrop: I think just everything that fits under the performance gap, yes, you can.

Member Porter: All right. So the developer did not identify a significant relationship between the variables of disparity in the measure.

They actually presented conflicting data on disparities that they noted that various patient characteristics and contextual factors may impact the experience of provider communication.

So some of the comments from the Committee, there is a large performance gap from 54.05 to 85.18 with multiple conflicting reasons for the gap.

This measure assures a maintenance of a desired outcome over time. Even without a gap would provide data on quality of care from perspective of patient and permit quality improvement.

In alignment with CMS Quality Performance Payment Program they cited the fact that there are few, if any, measures in the ambulatory setting, which I think is important, which demonstrates a need.

The developer also evaluated several social risk factors but they did not identify a significant relationship between the variable and the measure.

Co-Chair Waldrop: Great. Thank you so much. Amy, do you have any additional thoughts to add?

Member Berman: I do not.

Co-Chair Waldrop: Okay. And I think we don't have -- I am call out one more time, Jeff, if you are with us do you have any additional thoughts to share as a supporting discussant?

Member Garland: No. I apologize, my wifi went out and I had to go find another hotspot, so I'm on. Thank you, no.

Co-Chair Waldrop: Okay. Anything that you wish to

share about the performance gap of 3665?

Member Garland: No. Thank you.

Co-Chair Waldrop: Okay. All right. Great. Thank you. Any comments or questions or discussion from the Committee around the performance gap that is evidenced here?

I see no hands raised. I see no comments in the chat. So I would like to move us then to asking Gabby if we can please vote on this measure, on this criteria rather.

Ms. Kyle-Lion: Yes, we can. Okay. Voting is now open for Measure 3665 on performance gap. Your options are A for high, B for moderate, C for low, and D for insufficient.

With Jeff back we are looking for 12 votes here and we are currently at 11. So we just need -- Okay, we are at 12. Voting is now closed for Measure 3665 on performance gap.

There were four votes for high, nine votes for moderate, zero votes for low, and zero votes for insufficient, therefore, the measure passes on performance gap.

I will pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thank you, Gabby. So we will move on to the scientific acceptability of the measure, especially addressing the reliability and then the validity, but we'll start with the reliability.

I am wondering, Laura, if you have any comments you would like to share with us from the measure evaluation worksheet about the reliability of this measure.

Member Porter: Yes, quite a few actually.

Co-Chair Waldrop: Thank you.

Member Porter: They asked for the numerator statement, denominator statement, and exclusions for the measure, so I have addressed all of those based on the scoring sheet.

So the numerator statement, the feeling heard and understood measure is calculated using top box scoring. The top box score refers to the percentage of patient respondents that give the most positive response for all four questions.

In this measure the top box numerator is the number of respondents who answer completely true. An individual score can be considered an average of the four top box responses and these scores are adjusted for mode of survey, administration, and proxy assistance.

Individual scores are combined to calculate an average score for an overall palliative care program.

So the denominator statement is all patients aged 18 years and older who have had an ambulatory palliative care visit, which I think goes to the question of where are the pediatric patients.

The denominator exclusions include patients who do not complete at least one of the four items in a multi-item measure, patients who do not complete the patient experience survey within six months of the eligible ambulatory palliative care visit, patients who respond on the patient experience surveys that they did not receive care by the listed ambulatory care provider in the last six months, patients who were deceased when the survey reached them, patients for whom a proxy completed the entire survey on their behalf for any reason, which is one of the concerns that was brought up.

Report on the data source. The data source is instrument-based data. So the concerns from the Committee included multiple-method panel members, this was from the SMP, were concerned with the potential measure attrition, wait a minute,

measure attribution misalignment as an assessment of the provider rather than the patient outcome in the PRO-PM.

They specifically note the clinician group level of analysis with a numerator stating the accountable entity as an individual provider. One noted that patients will see multiple providers within six months of the denominator timeframe.

They also note that the survey does not specifically identify an anchor patient visit as the measure allows patients who transfer to home-based hospice also to reflect on their ambulatory hospice care.

Co-Chair Waldrop: Great. Thank you very much for all of those issues that you raised. I am going to ask Amy and Jeff if you have anything additional you would like to add to the reliability discussion?

(Simultaneous speaking.)

Member Berman: Oh, go ahead, Jeff.

Member Garland: No, not right now. Thank you. Thank you.

(Simultaneous speaking.)

Co-Chair Waldrop: I think you are both trying to -- I am going to ask Amy if you go first and then we'll follow-up with Jeff.

Member Berman: Thank you. So there were some Committee comments and so I just want to note that one Committee comment, a person had a concern about the methodology of identifying the specifications, that it seems unclear how the data is collected.

I am not quite sure what was meant by the comment, but I do want to point out the comment in case the person cares to share with more specificity so that the measure developer might be able to address.

Co-Chair Waldrop: Okay. Before I go to you, Jeff, I am going to ask if the commenter would like to go further in describing that issue and who raised this issue and wants to say more about that. Okay.

Member Beckwith: So I --

Co-Chair Waldrop: Jeff, did you want to add -- Oh, Samira, go ahead.

Member Beckwith: Okay. Well I --

(Simultaneous speaking.)

Member Beckwith: -- some more about, you know, how the actual survey is going to be sent to the patient, the person.

Yes, I would like to hear more about that because even though I didn't make the comment I am confused about it.

Co-Chair Waldrop: Okay. All right, we'll put that one in the list of questions for a second.

Member Beckwith: Thank you.

Co-Chair Waldrop: Jeff, did you have more to add to the --

Member Garland: No. I am just having problems with the wifi, but I have no comments at this time.

Co-Chair Waldrop: Okay, all right. Well thanks for continuing to try. Other questions or comments about reliability?

Okay. Do we want to -- Paula, is it all right for me to ask the developer to address this question? Dr. Walling, would you be able to address Samira's question about the reliability issue?

Dr. Walling: I believe Jessica from our team will respond to that.

Co-Chair Waldrop: Thank you. Jessica?

Ms. Phillips: Hi, everyone. This is Jessica Phillips from RAND. I'm sorry, did you want me to start with the reliability question?

Co-Chair Waldrop: The question that Samira is posing that Amy has --

(Simultaneous speaking.)

Co-Chair Waldrop: Yes.

Ms. Phillips: Okay. Yes, so let me just provide a little bit more description about the process that we followed for data collection and particularly the survey fielding.

So in our robust national beta field test the 44 programs that participated sent RAND, who served as a survey vendor, their data files for all visits that took place in the ambulatory palliative care program in the 3-month period.

RAND then identified visits with a MIPS-eligible provider and then fielded a survey, a survey to patients. We used a pretty robust survey fielding strategy.

We did an email, then mail, then phone follow up and, you know, if we received a survey after the email then they were done and we stopped reaching out. If we did not we continued through the process of mail then a follow-up phone call.

So the data elements for the items that were used to construct these measures were collected through a survey to patients.

Co-Chair Waldrop: Thank you. Any other questions or comments about the reliability on this measure? I do have to pause and ask my colleagues --

(Simultaneous speaking.)

Co-Chair Waldrop: Go ahead.

Member Beckwith: I'm sorry. I just need to ask some follow-up still. My question is really about, and maybe this is the wrong time to pose it, about how you conducted it through reliability, but how will the measure going forward, will the individuals send a survey after themselves and then how would it be reported?

That's really my question, and maybe that's better held till later.

Ms. Phillips: I can take a first pass at responding to that question.

Co-Chair Waldrop: Actually, I am going to hold that. I think that falls into usability and use by my understanding.

Member Beckwith: Thank you.

Co-Chair Waldrop: So can we hold that and remind me if I fail to bring that back, Samira, okay? And thank you, Jessica.

Member Beckwith: Yes. Thank you.

Ms. Phillips: Sure.

Co-Chair Waldrop: I do need to pause and ask my NQF colleagues, I believe that we have to vote on whether or not to accept the SMP vote. So that is our first vote, is that correct?

Ms. Farrell: That's correct, yes.

Co-Chair Waldrop: Okay. So we're ready to take the vote on whether we are willing to accept the SMP's recommendation.

Member Porter: Do you want me to review that?

Co-Chair Waldrop: Sure.

Member Porter: Okay. So they preliminarily gave it a moderate for reliability testing and they said that they are satisfied with the reliability testing for the

measure.

Then I can just -- We do that first and then we do validity, correct?

Co-Chair Waldrop: Right. Correct, yes.

Member Porter: Okay. Very good.

Co-Chair Waldrop: Perfect. Thank you. So I am going to ask Gabby if we can vote on receiving and accepting the SMP recommendation.

Ms. Kyle-Lion: Yes. Let me pull up my slide. Okay, voting is now open for Measure 3665 on whether you all as the Committee accept the Scientific Methods Panel's rating for reliability.

I believe that one person has had to drop off the call so we are looking for 12 votes this time.

Okay, we are at 12 votes. Voting is now closed for Measure 3665 on whether the Committee accepts the SMP's rating for reliability.

Ninety-two percent of the Committee said yes, 8 percent said no, therefore, the Committee does accept the Scientific Methods Panel's rating for reliability.

(Simultaneous speaking.)

Co-Chair Waldrop: And so that means we do not vote on reliability because we are accepting --

Ms. Kyle-Lion: Correct.

Co-Chair Waldrop: Okay. Thank you very much. All right, thank you. So I'm moving on validity. I am going to ask Laura if you would give us your overview on that criteria, please.

Member Porter: Yes. So validity was reviewed by the SMP and passed both. Well, it passed. We already know it passed reliability, so it passed validity.

So the majority of the comments from the Committee indicated that there were no concerns with the testing results. One concern did mention that the developer states that feeling heard and understood would correlate to getting help for pain needs and that this seemed shortsighted.

There an emotional psychosocial existential and spiritual ways that patients need to be heard and understood. So they gave it a -- So, yes, so that's it. That was it.

Co-Chair Waldrop: Okay. Thank you for that. Amy or Jeff? Well, I'll start with Amy. Let's get this straight here. Amy, do you have anything else to add around validity of this measure?

Member Berman: Nothing to add on validity.

Co-Chair Waldrop: Okay. And how about you, Jeff, any thoughts about validity that you would like to share?

Member Garland: No, thank you. It's been explained fairly well. Thank you.

Co-Chair Waldrop: Okay. Thank you. Let me open it to the Committee. Any discussion about the validity of this measure? Kelly?

Member Michelson: Yes. I never really know where to say this, but I think it's in validity is correct.

I just want to express my strong support for the developer's planned work to address the pediatric population, which this measure completely excludes 100 percent, and also make the comment that the pediatric population is not included in this measure.

This has been mentioned elsewhere, but just to repeat it because it's not valid in a population for which it has not been tested.

Co-Chair Waldrop: Thank you for always keeping that in our minds, we appreciate it. Any other comments

about the validity of this measure?

Then I would like to ask Gabby if we could move to accept, or move to vote on the SMP's recommendations about validity of this measure.

Ms. Kyle-Lion: Yes. Let me pull up my screen. Okay, voting is now open for Measure 3665 on whether you as the Standing Committee accept the Scientific Methods Panel's rating for validity. Again, we are looking for 12 votes.

We are at 11, so just waiting on one more. Okay, we are at 12. Voting is now closed on Measure 3665 on whether the Committee accepts the Scientific Methods Panel's rating for reliability.

One hundred percent of the Standing Committee said yes, 0 percent of the Standing Committee said no, therefore, the Standing Committee accepts the SMP's rating for validity.

Co-Chair Waldrop: Thank you.

Ms. Kyle-Lion: I will pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: All right. Thank you, Gabby. Moving right along to consideration of the feasibility of this measure. Laura, I am going to ask if you could give us the summary on that, please.

Member Porter: Sure. So the preliminary rating was high. The data source is instrument-based data.

The only concern that came up was the cost of hiring a vendor to field the surveys and process the data, but it was mentioned that it probably will not be a problem to do that. So that was really it for feasibility.

Co-Chair Waldrop: Okay. Thank you. Amy, anything you would like to add to the discussion of feasibility of this measure?

Member Berman: No additional comments.

Co-Chair Waldrop: Okay. Jeff?

Member Garland: No additional comments.

Co-Chair Waldrop: Okay. Thank you. So I'll open it to the floor, any comments or questions or discussion about the feasibility of using this measure in the field?

Member Shearer: Hi. This is Janelle. I just have a question. On my notes when I looked this over a few weeks ago I had a comment that the phone surveys were only available in English, is that correct?

Co-Chair Waldrop: I think I heard that it was translated into Spanish, but that was the survey. May I ask the developer?

Ms. Phillips: Yes. So we fielded, we tested the survey only in English, so the email, mail, and then the phone follow-up was only conducted in English.

However, we do have a translated Spanish version of the survey that we would love to further test and explore in the future.

Member Shearer: So are you saying the plans would be for Spanish-speaking people that they could do it over the phone with someone speaking to them in Spanish?

Ms. Phillips: Yes. If we were to implement in Spanish then all modes would be delivered in Spanish.

Member Shearer: Okay. Thank you.

Ms. Phillips: And that would typically, yes, be done through a survey vendor who has qualified Spanish-speaking interviewers.

Member Shearer: Thank you.

Co-Chair Waldrop: Great. Thank you. And pardon me for that coughing fit. I would like to move us then to vote on the feasibility of this measure, please, Gabby.

Ms. Kyle-Lion: Sure. Give me one second to pull it up. Okay, voting is now open for Measure 3665 on feasibility. Your options are A for high, B for moderate, C for low, and D for insufficient.

Once again we are looking for 12 votes and currently I am seeing ten, so we're just waiting on two more. We are still at ten votes.

We are at 11 votes, just waiting on one more. We are at 12 votes. Voting is now closed on Measure 3665 for feasibility.

There were five votes for high, six votes for moderate, one vote for low, and zero votes for insufficient, therefore, the measure passes on feasibility.

I will pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Okay. Thank you, Gabby. So we will move on to consider usability and use. We will first begin with use of the measure.

I am going to ask Laura if you could please give us an overview summary of this criteria.

Member Porter: Yes. So the preliminary rating was pass. The measure is not currently in use but has been submitted to 2021 MUC list for inclusion into CMS's Quality Payment Programs, including MIPS and APMS.

The performance data from the developer's test has been provided to all participating programs as well as key stakeholder groups.

All programs that participated in the beta field test will receive a summary report describing their performance on each survey item as well as their performance on the measure.

So the feedback by those being measured, based on feedback from the alpha pilot test programs the summary reports were refined to better suit the

needs of programs that participated in the beta field test.

The developer obtained feedback on potential implementation challenges and usefulness of the proposed measure for quality improvement during the 2021 public comment period.

Co-Chair Waldrop: Great. Thank you, Laura. So let me ask, Amy, if you have anything additional to the discussion about use of this measure.

Member Berman: My only comment is that this was proposed, so it's under the measures under consideration list, and when it would come up then for its review in the next go-round it would have to have been used.

So while it's proposed as a measure under consideration for MIPS or Alternative Payment Models it has to be used before it would be able to come back to be re-reviewed.

So even though it doesn't say that it's being used, there is a plan that clearly is, you know, in the works for it to be used according to the documentation we have received.

Co-Chair Waldrop: Great. Thank you. Jeff, anything you would like to add to the discussion about use of this measure?

Member Garland: No, no comment at this time. Thank you.

Co-Chair Waldrop: Okay. Any discussion from the floor, from the Committee, about the use of this measure?

Okay. Then I am going to ask Gabby if we can please vote on the use. We will get to Samira's question when we get to the usability piece, but let's go ahead and vote on the use of this measure to begin, please.

Ms. Kyle-Lion: Sure. Give me one second to pull up

my screen. Okay, voting is now open for Measure 3665 on use. Your options are A for pass or B for no pass.

Again, we are looking for 12 votes here. We are currently at 11, so just waiting on one more. We are at 12. Voting is now closed for Measure 3665 on use.

There were 12 votes for pass and zero votes for no pass, therefore, the measure passes on use. I will pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Great. Thank you, Gabby. Okay. And we'll move on to the usability of the measure. I am going to go back again to Laura and ask if you could just give us a brief overview of the usability criteria.

Member Porter: Yes. So the preliminary rating was moderate. So this is a new measure and not currently in use in Quality Improvement Programs.

So I do not personally have any experience with this, but does anyone have a personal experience with this or similar measures on the Committee that would like to talk about it?

Co-Chair Waldrop: I am going to hold that question until I give Amy and Jeff a chance to add to your summary and then we'll get right back to your question.

Member Porter: So this was before my final --

Co-Chair Waldrop: Oh, I'm sorry. I apologize.

Member Porter: I followed the script, so --

Co-Chair Waldrop: Okay. Pardon me, you are absolutely right.

Member Porter: Yes. So, anyway, the next question was about unintended consequences and this is a little bit of where there was more input.

So no harms were identified by the developer. The Committee expressed a concern about the repercussions of negative feedback, concerns that some patients may have unrealistic expectations for palliative care and patients whose expectations are not met may identify as not being heard and understood.

Also, hearing bad news could negatively influence their response and that providers need to ensure they are communicating in acceptable ways to the patient.

So I think this comes to the, you know, the, oh, my goodness, communicating with the patients appropriately. The negative feedback may reflect the situation more than it does the providers. Okay. Thank you.

Co-Chair Waldrop: That's a really good point. Thank you. I'm sorry that I interrupted you. So let me ask Amy if you have anything to add to this discussion of usability.

Member Berman: I just want to note that one of the comments was about the potential harm of hearing bad news and while that's not really specific to the measure, which is really whether that person feels heard, I just felt that it was helpful to share Tom Smith's research which shows that, you know, having realistic conversations that the data supported that people felt that somebody was on their side, you know, and supporting them.

So the data would actually be supportive of a different end, so that's all from me.

Co-Chair Waldrop: Okay. Thank you. A more global issue I think for sure, thanks. Jeff, anything you would like to add to the usability?

Member Garland: Yes. Advocating for the person, hearing their voices. I concur with Amy it's very important at that period of time.

Co-Chair Waldrop: Okay.

Member Garland: Thank you.

Co-Chair Waldrop: Thank you. So let me open it to the Committee, perhaps first to answer Amy's question about anyone who has had experience with, or not Amy, Laura, I'm sorry, with any experience with this type of survey.

Anyone, first of all, can address that? Has anyone had experience like that and would want to share it?

Okay. Hearing none, other questions, comments, or discussion about the usability of this issue, of this measure? Then I will circle -- Oh, go ahead, Amy.

Member Berman: I guess that I just wanted to make a more global comment akin to Jeffery's comment, which is how marvelous that people would even feel heard and that somebody might value it, you know.

It's really quite groundbreaking to me that we would value that and it's about time. So I just felt that I needed to add a comment here.

Co-Chair Waldrop: Right. Take off my co-chair hat and say yes I completely concur it's about time.

So let me then circle back to Samira's question about the usability of this measure. I am wondering if you can re-articulate that for us, Samira, and then I'll ask Jessica to address it.

Member Beckwith: Yes. I think it's wonderful as a beginning measure and agree with Amy and your comment also about how important this is.

I am just very interested in how this, will this be a separate survey that will go out or will it be a part of another survey and then how will it be collected as part of the MIPS through the EHR?

And maybe that's too specific, but those were my questions about usability.

Co-Chair Waldrop: Okay. Thank you. Jessica, would you be willing to take a chance to describe that for us?

Ms. Phillips: Certainly. So we do recommend that people follow the same process that we tested. So we did send a survey to patients.

Now we didn't develop a survey, we just used the survey as a way to collect the information for the measures, so in implementation it would not be a long survey of a lot of items, it would be the minimum required items in order to construct the measures.

We do recommend using a survey vendor to implement the survey. We did interview programs that did participate in our test to kind of explore, you know, how they felt about the feasibility of contracting with a survey vendor.

We did have programs of varying sizes participate in the test and they all did feel that it would be feasible to do.

Co-Chair Waldrop: Great. Thank you. Does that answer your question, Samira? Is there anything else, any follow-up to that?

Okay. All right. Any other -- yes, go ahead. I am afraid you are muted. Katherine, you are muted.

Ms. Ast: Oh, I apologize.

Co-Chair Waldrop: That's okay.

Ms. Ast: So, yes, I just wanted to add a couple of things. We talked a lot about usability and how to collect this data when we started the project.

What was most important, since it was CMS funded and really critical that we get the reliability and validity data that we needed, was to, you know, use a survey vendor and absolutely do everything perfectly aboveboard and without reproach.

In the future we really hope that these questions could be answered on a tablet, for example, or even by text. They have been tested by email as well, which would make it a lot easier to collect if people would answer by email.

It also is something about, you know, the population now versus the population in ten, 20 years, it's going to be very different possibly in their use of technology in order to answer these questions as well.

But currently, you know, we do have an implementation guide coming out to help programs look at the options for implementation and we have a guide to, you know, a short guide on how to choose a vendor and things like that.

And then we just wanted to say we were really excited by the results of our public comment process which showed, you know, we had a lot, 207 respondents, and Amy Melnick is going to talk about this a little later, but 71 percent said they were very likely to use receiving desired help for pain, sorry, jumping ahead, 82 percent said they were very or somewhat likely to use feeling heard and understood.

So we felt really encouraged that the field is ready, you know, to implement these measures even though hiring a vendor can be costly, but it is a much shorter survey than the longer CAHPS survey and it's meant to just be as short as possible to capture the information needed.

Co-Chair Waldrop: Thank you. Anything further before I ask for us to vote on usability?

Okay. Gabby, could you please make it possible for us to vote on usability?

Ms. Kyle-Lion: Yes, I can.

Co-Chair Waldrop: Thank you.

Ms. Kyle-Lion: Okay. Voting is now open for Measure 3665 on usability. Your options are A for high, B for

moderate, C for low, and D for insufficient.

Again, we are looking for 12 votes here. I am currently seeing nine.

Okay. We are at 12 votes. Voting is now closed for Measure 3665 on usability.

There was one vote for high, 11 votes for moderate, zero votes for low, and zero votes for insufficient, therefore, the measure passes on usability.

I will pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Great. Thank you, Gabby. So, lastly, I will just ask if there are any additional comments about the overall suitability for endorsement of this measure.

I will start with you, Laura, and then open it to anyone else who that has any additional comment about this measure.

Member Porter: Just that I feel that it's a real important measure, you know, being a physician and also a patient. Being heard is a problem and the fact that this is going to be addressed I think is extremely important, you know.

Even as a physician when I am the patient I am not heard and, you know, so I think that this is important. Thank you.

Co-Chair Waldrop: Yes. Great. Thank you. Any additional comments about this measure?

Okay. So I want to thank our discussants for all their feedback and I want to ask Gabby if we can vote on the overall suitability of this measure.

Ms. Kyle-Lion: Yes. Pulling up the slide now. Okay, voting is now open for Measure 3665 on overall suitability for endorsement.

Your answers are A for yes or B for no. We are looking

for 12 results and we have 12, so voting is now closed on Measure 3665 on overall suitability for endorsement.

There were 12 votes for yes and zero votes for no, therefore, the Standing Committee has recommended to endorse this measure. I will pass it back.

Co-Chair Waldrop: Okay. Thank you.

Ms. Farrell: All right, great. Thank you, Gabby. That ends our discussion and voting on 3665.

## 3666 Ambulatory Palliative Care Patients' Experience of Receiving Desire Help for Pain (American Academy of Hospice and Palliative Medicine)

Our next measure that we are going to review today is 3666, Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain.

We do again have eight recusals from the Standing Committee for this measure and those recused will not be able to discuss or vote on this measure.

The recusals are Tracy Schroepfer, George Handzo, Sean Morrison, Christine Ritchie, Sarah Thirlwell, Paul Tatum, Arif Kamal, and Marian Grant.

So now I am going to turn the call over to our co-chair, Dr. Waldrop, to lead the discussion.

Co-Chair Waldrop: Okay. Thank you, Paula. So I want to begin by asking, Dr. Walling, I know that you referenced 3666 in your beginning introduction, but I wondered if you had specific things you wanted to give us, tell us about this measure in addition to the overview?

Dr. Walling: I believe I included all the key aspects, but if anybody has questions we are here to answer them.

Co-Chair Waldrop: Okay. Thank you for that. Then we will move on and I will ask our lead discussant, I will first say thank you to Chris Laxton, and also to Samira Beckwith and to Cleanne Cass as our supporting discussants.

Thank you all for the work you have done in preparation for this. I will start with Chris and ask if you could give us an overview and then lead us into conversation of what you found in the measure evaluation worksheet about evidence, please.

Member Laxton: There. Sorry, I had to unmute myself. Also a first-timer, so I guess I am in good company.

Co-Chair Waldrop: Yes.

Member Laxton: I appreciate this measure of a patient's experience of receiving the desired help for pain.

Again, the overview here is this is for patients aged 18 years or older who had an ambulatory palliative care visit and reported getting the help they wanted for their pain from their palliative care provider and team within six months of the ambulatory palliative care visit.

There is a very extensive rationale for this measure really having to do with understanding the patient's experience of receiving the palliative care, which, of course, includes not receiving, you know, by choice, not receiving any additional palliative care or perhaps choosing to not take advantage of care because of other important values such as retaining mental acuity over controlling pain, for example.

So I think if I can move into the evidence, is that the appropriate thing, Dr. Waldrop?

Co-Chair Waldrop: Absolutely. Yes, thank you.

Member Laxton: So this is a new measure. There is an extensive body of evidence about this

performance, this patient-reported outcome-performance measure, or PRO-PM, and, you know, there is a logic model that the developer has provided that I think does address the top two boxes in the algorithm.

There is, you know, I think a preliminary rating of pass for this measure. I think beyond that I will pause and see if there are other comments from the co-discussants.

Co-Chair Waldrop: Okay, great. Thank you very much. So I will turn to Samira and -- I'll start with Samira and ask if you have anything additional you would like to add to our discussion of evidence.

Member Beckwith: Thank you. I do not.

Co-Chair Waldrop: Okay. How about you, Dr. Cass?

Member Cass: Yes. I would agree that the importance to measure and report the evidence is very strong.

Co-Chair Waldrop: Okay. Anything from our Committee members, any discussion about the evidence that was presented to us to consider? Amy?

Member Berman: Just one small but I think very important point, which is that this is the patient's desired support of their pain as opposed to our other measures which have been more arbitrary and clinician-facing.

This really is from the person so I just think that this is, you know, that context is really helpful.

Co-Chair Waldrop: It's a really important point, distinction to make. Thank you for that. Anything else from Committee members about the evidence that were presented of this measure?

Okay. Seeing none I am going to ask Gabby if we can please vote on the evidence for 3666. I think we lost Gabby for a minute, but are we -- oh, you are back.

Ms. Kyle-Lion: Yes, I'm back. Sorry.

Co-Chair Waldrop: No worries.

Ms. Kyle-Lion: Yes, give me one second to pull it up, apologies. Okay, I am pulling it up now.

Okay, voting is now open for Measure 3665 on evidence. Your options are A for pass and B for do not pass.

We are at 11 votes, which I believe is the number that we are looking for, so I will go ahead -- I'll just wait to have my team confirm that quickly, sorry.

Co-Chair Waldrop: I am concerned we have lost Chris. Oh, no, I do see him.

Ms. Kyle-Lion: We did. We did and I think he just logged back in.

Co-Chair Waldrop: Okay.

Ms. Kyle-Lion: I'm going to get --

Member Laxton: I apologize. My technology froze but I am back on.

Co-Chair Waldrop: Yes. Okay, great.

Ms. Kyle-Lion: Chris, did you have a chance to vote on the measure?

Member Laxton: I will do that immediately.

Ms. Kyle-Lion: Okay, perfect. Okay. We are at 12. Voting is now closed for Measure 3666 on evidence. There were 12 votes for pass and zero votes for do not pass. Therefore, the measure passes on evidence. I'll pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Great. Thank you so much, Gabby. So we've move in now to considering the performance gap of 3666. And I'll ask Chris. Thank you. I'm glad we have you back. I'm wondering if you could give us just your overview on the performance

gap of this measure.

Member Laxton: So performance gaps have to do with demonstrating quality problems and an opportunity to improve. I think there has been data gathered from 44 programs with some oversampling going forward.

There were 75 -- 7,500 survey, more or less, that were sent out. And, you know, I think what they showed is that there was high variability across programs that would indicate pretty clearly that there's an opportunity to improve here. Should I discuss disparities here as well?

Co-Chair Waldrop: Yes, I think that would be very -- it'd be timely. That'd be great. Thanks.

Member Laxton: So clearly there are longstanding disparities across both healthcare settings as well as within race, ethnicity, and socioeconomic status with respect to unmet needs and this measure and certainly demonstrate that those disparities exist and perhaps point to areas where improvement can take place if measured. There is a preliminary rating of moderate for the opportunity for improvement. And I'm just reviewing the comments. I think -- there's, I think, general agreement that there's a need and that there's a gap. So I'll pause there and see if my co-discussants have comments.

Co-Chair Waldrop: Great. Thank you very much for that. I'll start with Samira. Anything you would like to add about the performance gap here?

Member Beckwith: Nothing to add. I think this is very similar to our last measure in that it's a wonderful start.

Co-Chair Waldrop: Perfect. Thank you for that. And how about you, Dr. Cass? Any additional comments you'd like to add?

Member Cass: Yes, just a little clarification. So we do

all recognize the longstanding disparities in pain management across various healthcare settings. I'm wondering how the measure identifies those or filters that to make it -- to create more consciousness raising around that for the provider that's receiving the survey results.

Co-Chair Waldrop: Chris or Samira, do you have thoughts about that from the measure evaluation review?

Member Laxton: I do not. This may be a good question for the developer.

Co-Chair Waldrop: Okay. I'm going to ask is Jessica still with us or Dr. --

Ms. Phillips: I am.

Co-Chair Waldrop: Okay. Can you address that question?

Ms. Phillips: Certainly. I'm going to start by answering, and then I'm going to pass it to our statistician Brian to provide a little bit more information on the social risk factors that we explored. So I think in order to be successful in performance on this measure, the provider has to tailor their communication to the person.

And this measure is sensitive to person-centered differences. So I think successful performance, it will need to be tailored to whatever that individual's preferences are for care for paying. And so with that, I will pass it to Brian to provide just a little bit more information about some of the statistical exploration we did with some of the risk factors, looking at risk factors and differences in patients.

Dr. Walling: And before we do that, I just wanted to clarify the question.

Member Laxton: I think if I can speak for my co-discussant, this is more about how's this measure going to go about raising consciousness around the

differences, the socioeconomic and racial, ethnic, et cetera, disparities.

Dr. Walling: So I think that the fact that there is a gap, just measuring it at all is going to be the key here and making sure that we ensure that all patients are heard and understand and having their pain needs met. And the nice thing about the metric is because it is patient-centric, we can meet the patient's needs where they're at. So I think just the fact that it's being measured is sort of really the key piece here. I don't know. Does that answer the question?

Member Cass: Well, I guess my follow-up question would be then there'll be demographics that'll be involved in the survey that the provider can see the population that didn't feel served in this regard and didn't have their pain relieved. Might have been in underserved communities that they could see the disparities and work on that.

Dr. Walling: Yes.

Member Cass: I'm not sure that the goal of this is about that. But it is part of our evaluation that we look at the importance of disparities.

Dr. Walling: So yes, that can be part of the report to inform quality improvement, yes.

Member Cass: So the survey itself would include enough demographics that it could be sorted out about whether the responses were higher and lower in different demographic groups.

Dr. Walling: Exactly.

Member Cass: Okay. That makes sense. I wonder if it's pejorative at all against organizations that have a higher preponderance of their population being among underserved or populations that we usually think of as being ethnically or racially not recognized or not properly addressed.

Dr. Walling: Yeah, that's actually the question that I think Brian is prepared to respond to with details. I will pass to Brian.

Dr. Vegetabile: We did some risk adjustment in this space to kind of assess how different factors related to each of these measures. If I recall correctly, I don't believe race was correlated with this measure. But there is a lot of conflicting ideas on how to address for race in a lot of these measures because in some sense, you don't want to penalize for the groups that you're serving.

In another sense, you don't want to provide an avenue to game the system by providing care across different lines and different ways. So I think it's something that will have to be explored moving forward. But our original analysis here sort of kept demographic information out of it, outside of patient mode and proxy systems as variables based off of some of the guidance we got from our TECUPP and other places. And so it's definitely something that should be examined moving forward. But our risk adjustment now does not include patient demographics as a factor to adjust for, for a lot of the concerns I mentioned.

Member Cass: Okay. Thank you. So maybe disparities isn't part of this question in a way. It's the overall results. But it doesn't necessarily channel out where there could be problems.

Dr. Walling: So it's not -- just to -- it's not included in the risk adjustment. But results can be stratified to inform quality improvement, just to clarify. And I see another question.

Co-Chair Waldrop: Yes, I was going to get to that. Thank you for your answers to that question. So Sree Battu is asking, was there risk adjustment done for patients who have a history of substance abuse or chronic pain?

Dr. Walling: Jessica, do you want to take that?

Ms. Phillips: Sure. So we did not risk adjust for substance abuse. We really wanted to develop a measure that was inclusive of everyone. So it's not about the level of pain. It's about meeting the patient where they're at and providing support that aligns with what their preference is and the trade-offs that they're making.

We did think about exploring statistically looking at substance abuse risk and potentially risk adjusting. But to be honest, the data from the programs is just not -- it's not standardized across programs. And so we couldn't really take a really deep statistical look at that.

Co-Chair Waldrop: Thank you. Any other questions or comments about the performance gap that's demonstrated here?

Member Cass: I would just like to make another comment about the abuse -- substance abuse population because that is probably another group that is going to end up being underserved in a way. As we put these performance measures into place, it's potential for palliative care programs to self-select patients that are going to be more responsive and receptive to the care that's offered. And they may not want to take the challenging patients. It could actually skew their results.

Co-Chair Waldrop: Okay. That actually also seems to fit under usability and use. So perhaps we can get back to that in a little bit.

Member Cass: Yeah.

Co-Chair Waldrop: Thank you for raising that.

Member Cass: Thank you.

Co-Chair Waldrop: I'm going to ask if we can move to vote on performance gap, please.

Ms. Kyle-Lion: Yes, pull up my screen. Okay. Voting is now open for Measure 3666 on performance gap.

Your options are A for high, B for moderate, C for low, and D for insufficient.

And we did have another member join, so we should be at 13 votes for this one. I'm currently seeing 12. Just waiting on one more. I'm still seeing 12. Just give it another -- oh, we're at 13.

Voting is now closed for Measure 3666 on performance gap. There were 2 votes for high, 11 votes for moderate, zero votes for low, and zero votes for insufficient. Therefore, the measure passes on performance gap. I'll pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Okay. Thank you, Gabby. So we'll move on now to scientific acceptability. And we'll consider reliability and validity. And I'm going to go back to Chris and ask if you can just give us a brief summary about the criteria and for reliability.

Member Laxton: Just need to unmute again. So yes, reliability of course has to do with consistent credible results. Validity has to do with making sure that the data elements are correct and that the scores reflect quality of care provided.

So in terms of the summary here with respect to the preliminary rating, in both cases, those were rated moderate, both for reliability and validity. I think in terms of comments, this was a test reliability coefficient that was used through, as we've heard, a variety of different channels. I think in terms of validity, again, patient encounter level validity testing was done.

And I think there is, I think, good results showing in both cases. Just checking the comments again, I think some of the comments have to do with being a new measure. We'll need some experience before we'll really know about the reliability of it. But it's an important measure to go out and test. So I believe there's good support for going forward. And I think with that all, again, I'll pause for additional

comments.

Co-Chair Waldrop: Thank you, Chris. I appreciate it. I'll turn to Samira first and ask you have anything additional to add to the conversation about the reliability of the measure.

Member Beckwith: Just to highlight again, this will be self-reported by the person themselves. So I think that's just something to keep in mind as we're going through. No other comments.

Co-Chair Waldrop: Thank you. Yeah, it's a self-reported measure. That's important. Thank you. Dr. Cass, anything you'd like to add to the conversation about reliability?

Member Cass: Not at this time. Thank you.

Co-Chair Waldrop: Okay. Let me open it to the Committee. Any comments, questions, concerns about the reliability of this measure?

Okay. Seeing none, I believe we need to vote --

(Simultaneous speaking.)

Co-Chair Waldrop: Go ahead.

Member Cass: I guess I'm not sure where this is appropriate. I wanted to just raise a little bit of a question about this being a measure of pain. And then periodically through the description of the measure, they talk about the nature of pain and the very important factor that for palliative care doctors, pain is in multiple domains.

And it can be existential. It can be spiritual. It can be psychosocial. But when we send a survey to a layperson or somebody that's experiencing life challenging illnesses that do include physical pain, are they going to realize that we're wanting to look at all those? I sometimes see in this measure where we're supposed to be measuring whether the palliative care intervention improved quality of life

and overall psychosocial, emotional pain.

Co-Chair Waldrop: We'll need to probably move that to validity. So hold that and we'll get to that after we vote on reliability. So let me ask Gabby if we can please vote on whether to receive -- accept the SMP's recommendation on reliability.

Ms. Kyle-Lion: Yes, I'll go ahead and pull that up. Okay. Voting is now open for Measure 3666 on whether the standing committee accepts the Scientific Method Panel's rating for reliability. Again, we're looking for 13 votes here and we're at 12. So just looking for one more. We're at 13.

Voting is now closed on Measure 3666 on whether the standing committee accepts the Scientific Method Panel's rating for reliability. Ninety-two percent of the Committee said yes, eight percent said no. Therefore, the standing committee accepts the Scientific Method Panel's rating for reliability.

Co-Chair Waldrop: Great. Thank you, Gabby. So we'll move on to discussing validity. And I'm going to ask Chris if you could just give us a brief overview of this criteria related to 3666.

Member Laxton: Yeah, I'm sorry. I may have jumped the gun and already talked a bit about validity. I apologize for breaking the process there.

But yes, so validity in terms of its definitional quality has to do with the fact that the data elements are correct and actually correctly reflect the quality of care provided. And again, the review panel's preliminary recommendation was moderate. But there have been some questions raised in the comments that I think are worth pointing out.

The fact that it's a patient reported measure does raise questions about how do you measure accuracy when it's going to be highly variable from patient to patient across the population. There was an issue raised about, again, substance abuse risk, and once

again, to point out that this excludes pediatric patients. Other than that, again, I think the main point that was getting from these comments is that there's some inconsistencies that are built in to the results. But I think, again, understanding that this is a patient reported measure, it's understandable. So I'll pause there.

Co-Chair Waldrop: Thank you, Chris. I appreciate it. I'll go first to Samira and ask if you have anything else you'd like to add to the conversation about the validity of this measure.

Member Beckwith: Nothing to add.

Co-Chair Waldrop: Thank you. Dr. Cass, anything you'd like to --

Member Cass: I don't know if my comments previously are appropriate here or at some other point. But my only concern was the patient's understanding of what's being measured and our understanding of what's being measured.

Co-Chair Waldrop: Okay.

Member Cass: There were specific remarks that the palliative care experts in the TECUPP did not want pain further defined. They wanted it kept loose so that it could measure -- be multiple domains of measurement and yet does the patient understand that.

Co-Chair Waldrop: Any other comments or thoughts about the validity of this measure for pain? Okay.

Member Michelson: This is Kelly. Can I just make one very quick comment which will sound repetitive but I'm going to say it anyway? Thank you to identifying that this measure does not include pediatric patients. And I am hopeful that the developers will consider that strongly as they move forward with further testing.

Co-Chair Waldrop: Thank you, Kelly. Any other

comments about the validity of this measure?

And I'm going to ask Gabby if we can vote on whether or not to accept the SMP's recommendation.

Ms. Kyle-Lion: Yes, let me pull that up. Okay. Voting is now open for Measure 3666 on whether the standing committee accepts the Scientific Method Panel's rating for reliability -- or sorry, validity. Pardon. Your options are yes or no. And again, we're looking for 13 votes here. I'm seeing -- all right. We're at 13.

Voting is now closed for Measure 3666 on whether the standing committee accepts the Scientific Method Panel's rating for reliability. Ninety-two percent of the Committee said yes, eight percent said no. Therefore, the Committee does accept the Scientific Method Panel's rating for reliability -- sorry, validity. I'll pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thank you, Gabby. Okay. Moving right along, we'll now consider the criterion of feasibility. And I'll return to Chris and ask you could just give us a brief overview of this criteria related to 3666.

Member Laxton: Yes. So again, feasibility has to do with the burden of measurement and the degree to which it's readily available. This is an instrument-based measure. So that is essentially going to require somebody to deliver a survey, either on paper or through the web or the telephone.

The developer did a survey on the feasibility and found that 21.8 percent indicated it was very feasible, 42.7 percent that it was somewhat feasible. Of course, the burden here is the cost of hiring a survey vendor and the implementation of that. Preliminary rating on this is high for feasibility. And again, I'll pause there.

Co-Chair Waldrop: Thank you, Chris. I'll move to Samira and ask if there's anything you would like to

add to the conversation about feasibility.

Member Beckwith: No, thank you.

Co-Chair Waldrop: Thanks. Dr. Cass, how about you? Anything you want to add to the feasibility discussion?

Member Cass: No, I think I'm okay on feasibility. Thank you.

Co-Chair Waldrop: Okay. Let me open this conversation to the Committee and see if there are other issues that come to mind around the feasibility of using this measure.

Seeing none, I'm going to ask Gabby if we can vote on the feasibility issue, please.

Ms. Kyle-Lion: Yes, I will share my screen. Voting is now open for Measure 3666 on feasibility. The options are A for high, B for moderate, C for low, or D for insufficient.

And once again, we are looking for 13 votes. We're currently at 11. Just waiting for one more vote. We're at 12. We're still at 12 votes. We're now at 13.

Voting is now closed for Measure 3666 on feasibility. There were 2 votes for high, 11 votes for moderate, zero votes for low, and zero votes for insufficient. Therefore, the measure passes on feasibility. I'll pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Thanks, Gabby. Okay. We'll move on now to usability and use. And I'll begin with use and ask Chris to address this criteria as it was represented if you would, please.

Member Laxton: Yes, so again, use here evaluates the extent to which audiences use or could use performance results in either accountability or improvement activities. This is a new measure, so it's not publicly reported or currently used. But the intent is to begin using in the MIPS program. And it has

been submitted to the MUC list.

So I think what we're seeing is, I think as Amy pointed out, that is going to require some reporting once it is implemented. And so I think we can feel assured that it will have a use. It will be put in use and will be used for accountability.

My rating on this was pass. I believe we're seeing a lot of comments around this measure. So I'll just pause there for a concision and let you take it.

Co-Chair Waldrop: Thank you, Chris. I'll turn to Samira and see if you have anything additional to add to the discussion about use of this measure.

Member Beckwith: Maybe I'll just highlight or just make a comment about it. So the comment made about survey fatigue, I think that our entire society has survey fatigue. I don't know there's any way to address this in this particular situation because I think that's what it's become. I just had to comment about that.

Co-Chair Waldrop: Okay. Thank you. It's an important point. Dr. Cass, anything you want to add to the conversation about use of this measure?

Member Cass: No, I'm good with the use.

Co-Chair Waldrop: Thank you. Others on the Committee thinking about putting this measure into practice? Okay. I am seeing none, so I will ask Gabby if we can please vote on use.

Ms. Kyle-Lion: Yes, voting is now open for Measure 3666 on use. The options are A for pass or B for no pass. And once again, we are looking for 13 votes here.

We're currently at 11 so just looking for 2 more. Just looking for one more now. I'm still seeing 12 votes. We are still at 12. If anyone is having issues with voting, you're welcome to send me a direct message.

Okay. Seeing no chats and no 13th vote, we'll just move forward. Voting is now closed on Measure 3666 on use. There were 12 votes pass and zero votes for no pass. Therefore, the measure passes on use. And I'll pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Okay. Thank you. So we'll move on to usability, and I'll go back to Chris again and ask if you could please just give us a brief overview of that criteria related to 3666.

Member Laxton: Yes, so usability really had to do to the extent to which audiences could use this measure for performance results for accountability and performance improvement. Not a lot of additional feedback on this. The preliminary rating was moderate.

There were some interesting comments regarding potential misattribution in the case of patients who see multiple providers. And they also have to do with survey fatigue which was raised earlier. There is also a question about does this incentivize some gaming, in other words, some way of having people respond positively and possibly so what one commenter described as social desirability, patients feeling they needed to report positive results.

I think again this is a patient reported measure. It's difficult to control for that sort of thing. But in essence, usability -- and yes, usability appears to be again moderate to high. So I'll pause here.

Co-Chair Waldrop: Great. Thank you. I think there's a comment from Poonam. Go ahead.

Ms. Bal: Yes, I just wanted to provide more clarity. We're already on usability, so sorry for not jumping in faster. We just wanted to clarify one comment that was made for both 3665 and 3666.

The measure, they did apply to be on the measures and application list which is the MUC list. But that does not correlate with the measure being in use or

that it wouldn't be in use. I just want to make sure.

It seems like we all understood that. But I just wanted to provide that clarity. But as a new measure, we're really just trying to see that they're trying to be in use and none honestly are in use. But I just wanted to provide that clarity and make sure everyone understood.

Co-Chair Waldrop: Thank you, Poonam. I appreciate that. Okay. I move to submit and ask if you have anything additional to add to the conversation about the usability of this measure.

Member Beckwith: I don't.

Co-Chair Waldrop: Okay. Thank you. And how about you, Dr. Cass?

Member Cass: I do not. I'm good.

Co-Chair Waldrop: Okay. Thank you. So let me open the floor. Other thoughts or comments about the usability of this measure?

Okay. Seeing none, I'm going to ask Gabby if we can vote on the usability criteria, please.

Ms. Kyle-Lion: Okay. Voting is now open for Measure 3666 on usability. Your options are A for high, B for moderate, C for low, and D for insufficient. Again, you're looking for 13 votes here. We're at 12 votes. Just waiting on one more. We're at 13.

Voting is now closed for Measure 3666 on usability. There were 2 votes for high, 10 votes for moderate, 1 vote for low, and zero for insufficient. Therefore, the measure passes on usability. I'll pass it back to you, Dr. Waldrop.

Co-Chair Waldrop: Great. Thank you so much, Gabby. And so lastly, this brings us to the overall suitability for endorsement. And I'll start with Chris, and I'll just open the floor and ask if there are other comments about the general suitability of this

measure that anyone would like to add.

Member Laxton: Thanks. The only comment I'll make and I think is core to this measure is that it is the patient's voice. It's not a provider-centric. It's a patient-centric measure. So A, I think speaks to the importance of it to really hear the patient's experience. And B, I think must force us to recognize how highly variable those responses will be and the fact that we're asking is perhaps the most important part of this measure.

Co-Chair Waldrop: Absolutely. I couldn't agree more. Thank you for that comment. Any other comments about this measure from an overall perspective?

And I would ask us to be able to vote, ask Gabby if we can vote on the suitability of this measure.

Ms. Kyle-Lion: I have to unmute myself. Voting is now open for Measure 3666 on overall suitability for endorsement. Your options are A for yes or B for no.

And again, we're looking for 13 votes. We're currently on 11 votes, so just waiting on 2 more. We're at 12, 1 more. We're at 13. Voting is now closed for Measure 3666 on overall suitability for endorsement. There are 12 votes for yes and 1 vote for no. Therefore, the standing committee recommends to endorse this measure. Back to you, Dr. Waldrop.

Co-Chair Waldrop: So just in conclusion, I want to say thank you again to Chris for being our lead discussant and for Samira and Dr. Cass for being our supporting discussants. Thank you all for your work in preparing this, and thank you to the Committee for the thoughtful discussion about these two measures this afternoon. And with that, I'll turn it back to Paula.

Related and Competing Measures

Ms. Farrell: Great. Thank you. Gabby, if we could go back to our slides. Next, we're going to --

Ms. Kyle-Lion: Sorry. Just give me one second to

load.

Ms. Farrell: Sure. No problem. Once we get into the slides, we're going to be reviewing any identified relating and competing measures to address any harmonization aspects for the measures that we reviewed today. I'll wait till Gabby gets to the specific slide. All right. We can go on to the next slide.

So after reviewing the measures, the Committee can discuss any harmonization that's needed and make any specific recommendations. And none of the measures that we evaluated today have any competing measures. Next slide, please. So Measure 3645 has no related measures. So we'll go to the next slide.

NQF Measure No. 3665 has one related measure, and that is NQF No. 2651, the CAHPS Hospice Survey. And the developer stated in their submission that the measure specifications have been harmonized to the extent possible and that the two measures also have different targeted populations. So we just wanted to question to see if the Committee has any other opinions that we would like to discuss and if the Committee thinks that the measure specifications for the related measure is harmonized to the extent possible. Is there any discussion that anyone would like to have regarding the related measure?

Member Thirlwell: I guess I'll comment. It's related in subject but not a reporting person. It's quite a distinction that patients self-report versus bereaved caregiver's perception.

Ms. Bal: I think Paula is having some issue. It seems like her internet might be going down. So she might not have even heard that. Sorry. Could you repeat your concern there?

Member Thirlwell: I apologize. I realize it may not be appropriate. But I wanted to recuse myself on this measure. So I'm not sure if I'm permitted to speak to this.

But just the comment of it being related or unrelated that 3665 is a patient self-report. So the content is related, but the subject is very different. This is the CAHPS survey, the bereaved caregiver's perception of the care the patient received. That's quite distinct from a patient self-report.

Ms. Bal: Thank you, Sarah. But unfortunately since you are recused, you also can't comment on the measure. So if the Committee could view that comment as a public comment instead of a Committee comment, that would be preferred.

And sorry for not jumping in there earlier. So yes, we should really keep this -- if you are not recused from this measure, then feel free to jump in. If you have any thoughts on related for these two measures mainly around do they need to be harmonized further. Has the developer done sufficient work to make sure that these are not creating undue burden on the accountable entities for both these measures? And I see Amy has her hand up.

Member Berman: I was actually going to make a similar comment. So I think that they have been harmonized to the degree possible. But one is a survey of caregivers after the individual in hospice is deceased.

And the other goes to the individual receiving care. So these are very, very different populations. So the idea of creating undue burden on two different groups with two different measures I think they have been more than sufficiently harmonized and there is not a conflict here.

Can I just also add how important it is to hear directly from the care recipient as opposed to an indirect measure that comes from the caregiver of a decedent? So this is just such an important thing. And I'm just very pleased that the Committee had the opportunity to review these measures.

Ms. Bal: Thank you for sharing that, Amy. I want to

note that Karl did note that he agrees with these sentiments as well in the chat. Any other thoughts on harmonization? Is there anything else that we want to instruct the developer to do to better harmonize these two measures? Oh, I'm sorry. I believe, Samira, you have your hand up?

Member Beckwith: Thank you. Yes, I believe it's harmonized and I'm very comfortable with this. I just always have to speak to the perception of family members comes from watching your loved one and what they hear from them. And so I believe that both are important, and I had to speak up and say that. So I think we're just fine, this being harmonized. And I like seeing from both.

Ms. Bal: All right. Great. I'm not seeing any other comments or hand raises. So Gabby, I think we can move to the next measure. Paula, have you rejoined us?

Ms. Farrell: I'm back, I believe. Can you hear me?

Ms. Bal: Yes, we can hear you.

Ms. Farrell: Sorry about that. All right. So our next measure, NQF No. 3666 also has one related measures. And it is NQF No. 2651 and also the CAHPS Hospice Survey measure. And the developer on this submission also states that the measure specifications have been harmonized to the extent possible and that the two measures also have different targeted populations.

So again, we were wondering if the Committee would like to discuss any other options or if the measures need to be harmonized any further. Okay. Looks like Amy Berman in the chat has entered that she has the same comment as she did on 3666 -- or 3665. Any other thoughts or comments?

NQF Member and Public Comment

Okay. Well, we will move on and go to the next slide.

So before we jump into next steps, we would like to offer NQF members and the public an opportunity to comment. So if you're either an NQF member or part of the public and you wish to comment on the discussion that we've had today on the measures, please either raise your hand or put a comment in the chat. And we will pause just for a moment to make sure that we give everyone a chance to do that now. Amy Melnick, did you have a comment that you would like to make at this point?

Ms. Melnick: Yes, thank you so much. Can I go ahead?

Ms. Farrell: Go ahead. Yes, please.

Ms. Melnick: Okay, great. Thank you so much. Good afternoon. My name is Amy Melnick, and I serve as the executive director of the National Coalition for Hospice and Palliative Care. We are a member of NQF.

Our coalition is comprised of the 13 leading organizations representing the clinicians and programs providing palliative care in outpatient settings and all other settings. The organizations and the coalition work together to improve the quality and equitable access to hospice and palliative care. Our coalition is multi-disciplinary because palliative care is multi-disciplinary.

We represent physicians, nurses, social workers, chaplains, pharmacists, physician assistants, researchers, hospices, and palliative care programs. Our coalition and each one of our 13 national organizations fully support and endorse these measures and heard and understood and helped for pain measures, the last two on the agenda. The coalition was selected to provide stakeholder engagement as part of this project to ensure all stakeholder voices are heard and that essential communication efforts were conducted along the measure development continuum.

From the very beginning, we worked to ensure that these measures were co-created, not just with technical experts but with actual clinical end users and most importantly with patients and caregivers themselves. And I'm pleased to see that the members of the Committee noticed that for both measures. I believe this is one of the most unique and important aspect of these measures and can serve as a model for other measure developers.

From the very beginning, we created a partnership with the National Patient Advocate Foundation so that patients and caregivers could be at the table, not at the periphery, but with the measure developers together, almost as if we were a three-legged stool of measure development, each leg of the stool contributing their essential knowledge, expertise, and experience, including their lived experience. Measure developers, clinical end users, and patients and caregivers, we named this group the TECUPP because words do matter.

It wasn't a TEP. It was a Technical Expert Clinical User Patient Panel, the TECUPP. And it provided input and oversight throughout the measure development process.

The coalition has continuously been informing and educating the field about the development of these measures through newsletters, webinars, meetings, and presentations at scientific sessions. We know the interest is very high in measure utilization because of this strategic approach to continuous communication and feedback throughout the process. And because as Katherine Ast had noted, we held a public comment period last year.

And according to CMS, that public comment period received not only the highest number of public comments but also the widest distribution between clinicians, measure developers, and patients and caregivers themselves. Two hundred and seven members of the public submitted comments, 42

percent from clinicians, 36 percent from patients and caregivers, 22 percent for measure developers. Thank you for the opportunity to provide public comment.

In conclusion, the National Coalition for Hospice and Palliative Care and its 13 national organizations fully support the NQF endorsement of 3665, Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood, and 3666, Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain. As a side note -- a final side note, the National Pediatric Palliative Care Task Force, a new task force within our coalition, also fully supports the future development of measures inclusive of the pediatric population as noted by Dr. Michelson. The practicing clinicians our coalition represents very much look forward to using these future NQF endorsed measures to help improve serious illness care. Thank you.

Ms. Farrell: Great. Thank you so much. Anyone else who would like to make a comment?

Okay. And with that, I will turn the call over to our manager, Oroma. And she will talk through our next steps.

## Next Steps

Ms. Igwe: Great. Thank you, Paula. So we'll comment on next steps here in the next upcoming slides. So staff will prepare a draft report detailing you all's discussion today as a Committee as well as the recommendations. All three measures passed review today and are recommended for endorsement.

So all of the summary of statements and the activities detailed today will be captured in the draft report. And that report will be released for a 30-day public and member commenting period. After that, the staff will compile all the comments if there are comments that are received into a document.

We'll make that available to developers as well as the Committee. Now should there be a need for us to convene the Committee for our post-comment call, we will certainly reconvene for that on the date that will be detailed shortly. Staff will incorporate the comments and responses to comments should they be received into the draft report in preparation for the final convening body which is the Consensus Standards Approval Committee.

The CSAC will then make motions to endorse the measures, and then we will put the report out for the appeal endorsement decision period. Next slide, please. So here is a brief look at the rest of the cycle. We do have the follow-up meeting, but it will be canceled because we successfully completed the review today.

So that March 2nd calendar hold will be removed as soon as we get off this call. The draft report commenting period is officially on March 31st through April 29. And the Committee post-comment web meeting is scheduled for June 2nd.

The CSAC review as referenced earlier will be scheduled in late July and the appeals period held for 30 days on July 21st through August 19. So here is a brief look at what is ahead for the next cycle, spring 2022 cycle. The intent to submit deadline ended on January 5th, 2022, and we are anticipating six new measures, none of which will be reviewed by the Scientific Methods Panel because they are not complex in nature.

So this is what you can anticipate ahead for the next cycle. Here is a list of ways in which you can stay in touch with the project. Contact us if you have any questions or additional commentary.

The project team can be primarily reached via email at primarycare@qualityforum.org or by phone at 202-783-1300. The Committee, of course, is welcome to visit the SharePoint page to stay abreast of any materials or additional information.

And then to the public and all guests at large, the project page will keep you abreast of the latest developments for the geriatrics and palliative care project. Again, I want to say thank you to everyone. And I will now call on Paula for additional closing remarks and if you have any questions.

Adjourn

Ms. Farrell: Thank you, Oroma. Yes, we are at the end of our meeting. So I just wanted to provide one additional opportunity for anyone you would like to speak to have that option now. And so if you could please let us know either by making a comment or putting a comment in the chat and we'll just pause for a little bit.

Okay. I would like to thank the standing committee, our measure developers, the NQF members, and the public for their participation in our meeting today. Also, a very big thank you to our co-chair, Director Waldrop, for leading the meeting today and also for Dr. Morrison for his commitment to be on the meeting even though he wasn't able to help facilitate at all. We do appreciate all the work that you've done and meeting as co-chairs. So thank you to everyone. I hope you enjoy your evening, and good night.

(Whereupon, the above-entitled matter went off the record at 2:23 p.m.)