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Meeting Summary

Geriatrics and Palliative Care Standing Committee – Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Geriatrics and Palliative Care Standing Committee for a web meeting on February 23, 2023, to evaluate six measures for the fall 2022 cycle.

Welcome, Review of Meeting Objectives, Introductions, and Overview of Evaluation and Voting Process

Kathryn Goodwin, NQF senior director, welcomed the Standing Committee and participants to the web meeting. After the co-chairs provided welcoming remarks, Ms. Goodwin informed the Standing Committee that the Centers for Medicare & Medicaid Services' (CMS) contract to serve as the consensus-based entity is set to end on March 26 of this year. CMS recently completed a competitive process to award the next phase of work and announced its award decision: NQF was not awarded the contract, so its work will conclude on March 26, 2023. Ms. Goodwin further mentioned that NQF will be working with CMS and the successor contractor in the weeks ahead to make a smooth transition, which will include further communication with this Standing Committee and other NQF Committee volunteers. However, Ms. Goodwin underscored that this does not change the Standing Committee's focus for the measure evaluation meeting, and NQF looks forward to working with the Committee to review the fall 2022 measures.

NQF staff reviewed the meeting objectives. Following the review, the Standing Committee members each introduced themselves and disclosed any conflicts of interest. None of the Standing Committee members disclosed a conflict with any of the measures under review; therefore, there were no recusals. Additionally, Elizabeth Flashner, NQF manager, reviewed the Consensus Development Process (CDP) and the measure evaluation criteria.

Some Standing Committee members were unable to attend the entire meeting due to early departures and late arrivals. The vote totals reflect members present and eligible to vote. A quorum of 13 members was met and maintained for the entirety of the meeting. Voting results are provided below.

Measure Evaluation

During the meeting, the Geriatrics and Palliative Care Standing Committee evaluated six measures (two maintenance and four new) for endorsement consideration. Prior to the review of the measures, Ms. Goodwin noted that for the fall 2022 cycle, measures were reviewed by the Scientific Methods Panel (SMP) if they were deemed as complex (i.e., outcome, cost, composite, or instrument-based measures) and/or if they included testing methods that are not commonly used. For the Geriatrics and Palliative Care measures under review, two of the six measures, NQF #2651 and NQF #3726, were evaluated by the SMP.

A measure is recommended for endorsement by the Standing Committee when greater than 60 percent of eligible voting members select a passing vote option (i.e., Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40 percent of voting members select a passing vote option on any must-

pass criterion or overall suitability for endorsement. If a measure does not pass on a must-pass criterion, voting during the measure evaluation meeting will cease. The Standing Committee will not re-vote on the measures during the post-comment meeting unless the Standing Committee decides to reconsider the measure(s) based on submitted comments or a formal reconsideration request from the developer. The Standing Committee has not reached consensus on the measure if between 40 and 60 percent of eligible voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement. The Standing Committee will re-vote on criteria that did not reach consensus and potentially on overall suitability for endorsement during the post-comment web meeting.

Voting Legend:

- *Evidence (Outcome Measures) and Use:* Pass/No Pass
- *Accepting the SMP Rating and Overall Suitability for Endorsement*: Yes/No
- *All Other Criterion:* H – High; M – Moderate; L – Low; I – Insufficient; NA – Not Applicable
- *Maintenance Criteria for Which the Standing Committee Decided Additional Discussion/Vote Was Not Needed (Evidence, Reliability, Validity only):* Accepted Previous Evaluation

NQF #3726 Serious Illness Survey for Home-Based Programs (RAND Corporation [RAND])

Description: The proposed measures are derived from the Serious Illness Survey for Home- Based Programs, a 36-item questionnaire designed to measure the care experiences of patients receiving care from home-based serious illness programs. Home-based serious illness programs provide care for seriously ill patients at their private residences (i.e., in their homes or assisted living facilities, not in institutions like skilled nursing facilities). Programs are staffed by interdisciplinary teams that provide support for palliation of symptoms, assist with coordination of care, answer questions after-hours, provide medication management, and assist with advance care planning (Cohn et al., 2017). Teams consist of clinicians (e.g., physicians, nurse practitioners) that oversee care, as well as clinical and supportive staff that make home visits (e.g., registered nurses, social workers, CNAs). Programs serve patients with a life expectancy that ranges from 1-5 years and have enrollment criteria based on diagnosis, symptom burden, functional status, and/or prior health care utilization. The five proposed multi-item measures are communication, care coordination, help for symptoms, planning for care, and support for family and friends. The two proposed single-item measures and overall rating of the program and willingness to recommend the program; **Measure Type**: Patient Reported Outcome Measure; **Level of Analysis**: Other; **Setting of Care**: Home Care; **Data Source**: Instrument-Based Data.

Measure Steward/Developer Representatives at the Meeting

- Rebecca Anhang Price, RAND Corporation (RAND)
- Maria DeYoreo, RAND

Standing Committee Votes

- **Evidence**: Total Votes-16; Pass-15; No Pass-1 (15/16 – 93.7%, Pass)
- **Performance Gap**: Total Votes-16; H-11; M-4; L-0; I-1 (15/16 – 93.7%, Pass)
- **Reliability**: Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)
    - This measure was evaluated by the SMP.
    - The Standing Committee accepted the SMP's rating for Reliability: Moderate (Total Votes-11; H-4; M-4; L-2; I-1).
- **Validity**: Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)
    - This measure was evaluated by the SMP.

    - The Standing Committee accepted the SMP's rating for Validity: Moderate (Total Votes-11; H-3; M-6; L-2; I-0).

- **Feasibility**: Total Votes-16; H-2; M-13; L-1; I-0 (15/16 – 93.7%, Pass)
- **Use**: Total Votes-16; Pass-16; No Pass-0 (16/16 – 100%, Pass)
- **Usability**: Total Votes-15; H-2; M-13; L-0; I-0 (15/15 – 100%, Pass)
- **Standing Committee Recommendation for Endorsement**: Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)

The Standing Committee recommended the measure for initial endorsement.

This instrument-based measure was newly submitted for endorsement. Although this measure is not currently implemented in a quality or accountability program, RAND has future plans to administer an adapted version of the survey to select Medicare Advantage members of Blue Cross Blue Shield of Massachusetts in 2023. The developer reported additional ongoing conversations with various stakeholders regarding future survey implementation.

The Standing Committee passed the measure on evidence with no concerns. During the discussion on evidence, the Standing Committee noted that while many measures document institutional care, this measure fills an important gap in palliative care by targeting home-based programs.

When discussing performance gap, the Standing Committee noted that the developer calculated top-box scores for 28 programs, of which the Planning for Care measure received the lowest mean score. Disparities based on sex, race, ethnicity, age, and Medicare and Medicaid status were also noted. The Standing Committee's pre-evaluation comments expressed that the measure demonstrated disparities among survey respondents and opportunity for improvement. The Standing Committee passed the measure on performance gap with no concerns.

During the discussion on reliability and validity, the Standing Committee noted that one pre-evaluation comment mentioned that the survey response rates were low but within the typical range. The SMP reviewed the measure prior to the measure evaluation meeting. The Standing Committee accepted the SMP's ratings for reliability and validity without further discussion.

When discussing feasibility, the Standing Committee noted that the survey can be administered via mail, telephone, and email. Some Standing Committee members acknowledged that some of the pre-evaluation comments expressed concern regarding the ease of survey collection. The Standing Committee passed the measure on feasibility without further discussion.

During the discussion on use and usability, the developer noted that the data collected by Blue Cross Blue Shield of Massachusetts would not be publicly reported but that the results would be included in a peer-reviewed journal publication. The Standing Committee requested clarification on how home-based serious illness programs are identified and how they are distinguished from other types of palliative care programs. The developer stated that there is no comprehensive list or accreditation of home-based serious illness programs and elaborated that RAND sourced their list of programs for field testing from previous publications and the Center to Advance Palliative Care's registry, in which organizations self-identify as having home-based serious illness programs. The developer distinguished home-based serious illness programs as providing interdisciplinary medical care with discussions and planning for daily living, whereas home health provides direct assistance with daily living. The programs were broadly defined by the services they provide rather than by their respective eligibility criteria. The Standing

Committee acknowledged the distinction between home-based serious illness programs and home health, hospice, and home-based primary care. The Standing Committee also recognized the need for quality structure and measures for home-based serious illness programs. The Standing Committee passed the measure on use and usability.

The Standing Committee passed the measure on overall suitability for endorsement. One member expressed that the measure is a step forward for patient-reported outcome measures in palliative care. Other members highlighted the need for similar measures that address the pediatric population.

The Standing Committee reviewed three related measures (i.e., NQF #2651, #3665, and #3666) and determined them to be harmonized to the extent possible. However, some Standing Committee members expressed concern that some patients may fall under multiple measure denominators, particularly those newly enrolled in home-based serious illness programs who may also be seen by a palliative care physician at a clinic. Other Standing Committee members stated that the potential overlap was small and that each measure addresses unique programs.

NQF #0091 COPD: Spirometry Evaluation (American Thoracic Society/Northfield Associates LLC)

Description: Percentage of patients aged 18 years and older with a diagnosis of Chronic Obstructive Pulmonary Disease, (COPD), who had spirometry results documented; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice; **Setting of Care**: Outpatient Services; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

- Mark Meterski, American Thoracic Society
- Joseph Ruminjo, American Thoracic Society

Standing Committee Votes

- **Evidence**: Total Votes-16; H-2; M-14; L-0; I-0 (16/16 –100%, Pass)
- **Performance Gap**: Total Votes-16; H-3; M-13; L-0; I-0 (16/16 – 100%, Pass)
- **Reliability**: Total Votes-16; H-0; M-15; L-1; I-0 (15/16 – 93.7%, Pass)
- **Validity**: Total Votes-16; H-2; M-8; L-4; I-2 (10/16 – 62.5%, Pass)
- **Feasibility**: Total Votes-16; H-3; M-12; L-1; I-0 (15/16 – 93.7%, Pass)
- **Use**: Total Votes-16; Pass-15; No Pass-1 (15/16 - 93.7%, Pass)
- **Usability**: Total Votes-16; H-2; M-5; L-3; I-6 (7/16 = 43.7%, Consensus Not Reached)
- **Standing Committee Recommendation for Endorsement**: Total Votes-16; Yes-15; No-1 (15/16 – 93.7%, Pass)

The Standing Committee recommended the measure for continued endorsement. This clinician group/practice-level measure was originally endorsed in 2009 and last retained endorsement in 2016. It was previously used in the Medicare's Physician Quality Reporting Systems (PQRS) through 2016 and transitioned to a successor, the Merit-Based Incentive Payment System (MIPS), through 2019. CMS removed the measure from MIPS starting in performance year 2020, as documentation of spirometry is a required component of another measure: #0102 *Appropriate Use of Long-Acting Bronchodilators*. The developer explained that #0091 is used to ensure proper diagnosis of COPD, while #0102 only captures the appropriate use of a specific treatment. The developer is working with CMS to discuss future use in MIPS or another accountability program.

During the discussion of the evidence criterion, the Standing Committee agreed that the updated evidence provided by the developer supports the use of spirometry to confirm the diagnosis of COPD. The Standing Committee voted to pass the measure on evidence without additional discussion. During discussion on performance gap, the Standing Committee highlighted data from the measure submission, which showed that less than 50 percent of individuals diagnosed with COPD underwent a spirometry test to confirm the diagnosis. Additionally, rates of spirometry declined during the COVID-19 pandemic because COVID-19 testing results were required prior to the administration of spirometry. When discussing disparities, the Standing Committee agreed that gender and race disparities exist in the diagnosis of COPD, which may be linked to a disparity in performing spirometry on at-risk populations. A Standing Committee member asked how disparities in care could be addressed. The developer suggested increasing access to spirometry in primary care clinics with a higher percentage of underserved populations as one solution. The Standing Committee passed the measure on performance gap.

The Standing Committee noted the developer did not submit updated reliability testing and asked them for clarification on how reliability was reviewed. The developer stated that a former measure developer created and tested the measure and that they only have access to the information provided in prior submissions to NQF for review. NQF staff clarified that NQF does not require updated reliability testing. The developer explained that to report and receive credit for the measure, the provider must either review documentation of prior spirometry results or conduct a new test if older documentation is not available. The developer stressed that the measure only requires spirometry to be performed once and not on an ongoing basis. The Standing Committee passed the measure on reliability.

When discussing the validity criterion, the Standing Committee noted concerns regarding the potential lack of using Current Procedural Terminology (CPT) codes related to the review of prior spirometry testing during the visit. The Standing Committee discussed that while practices are likely to include the CPT codes for the actual administration of a spirometry test, potential barriers to coding the review of an older spirometry test may lead to missing data or under-reporting. A Standing Committee member stated that some practices will have processes such as pop-ups in the coding system to ensure the code is added appropriately; however, practices with less robust billing staff or systems may be hindered. The Standing Committee voted to pass the measure on validity.

Related to feasibility, the Standing Committee noted the following: The measure is free to use, it is reported using International Classification of Diseases (ICD) codes for diagnosis and CPT codes for spirometry, and both clinical and billing systems can include decision support to assist practices in reporting all data required for the measure. The Standing Committee voted to pass the measure on feasibility. The Standing Committee's discussion on the use criterion focused on the removal of the measure from the MIPS program in 2020 because it was considered redundant, given that another measure includes the use of spirometry to determine appropriate inhaler use. The developer again reiterated that the measure CMS retained in MIPS only captures patients who underwent a spirometry test and received treatment compared with NQF #0091, which uses the measure for the appropriate diagnosis of COPD. CMS is engaging with the developer regarding potential use of the measure in a reporting program. The Standing Committee passed the measure on use based on the rationale that it was used in an accountability program and publicly reported during the time frame NQF requires for measures undergoing maintenance of endorsement review. When discussing usability, the Standing Committee noted that the developer did not provide any user experience or feedback related to reporting on the measure or using the measure in patient care. Data to support progress on improvement or trends in performance results were also not provided. The Standing Committee did not

reach consensus on usability, which is not a must-pass criterion. Without further discussion, the Standing Committee voted to recommend the measure for endorsement.

The Standing Committee reviewed one related measure (NQF #0577) and suggested the developers consider harmonizing the age and lookback time frame of the spirometry testing used in the two measures.

NQF #3707 Ratio of Observed Over Predicted Rates for Diagnosis of Mild Cognitive Impairment (University of Southern California [USC])

Description: Ratio of the number of patients 65 and older diagnosed with mild cognitive impairment attributed to a clinician or practice over the number predicted based on the demographic profile of that clinician or practice. Once the clinician's or practice's O/E ratio (i.e., ratio of the observed and expected rates) is calculated, a computation of its associated standard error (SE) can be used to draw inference whether the O/E ratio is significantly different from 1 or not.; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Ambulatory Care; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

- Soeren Mattke, University of Southern California (USC)

Standing Committee Votes

- **Evidence**: Total Votes-15; H-1; M-0; L-8; I-6 (1/15 – 6.7%, No Pass)
- **Performance Gap**: Vote Not Taken
- **Reliability**: Vote Not Taken
- **Validity**: Vote Not Taken
- **Feasibility**: Vote Not Taken
- **Use**: Vote Not Taken
- **Usability**: Vote Not Taken
- **Standing Committee Recommendation for Endorsement**: Vote Not Taken

The Standing Committee did not vote on the recommendation for endorsement during the meeting because it did not pass the measure on evidence—a must-pass criterion.

This clinician group/practice-level measure was newly submitted for endorsement and is not yet implemented in a quality or accountability program. The developer stated that the measure may be considered for use in a public-reporting/payment program in the future.

During the discussion of the evidence criterion, the Standing Committee acknowledged the importance of the early detection of mild cognitive impairment (MCI) to provide treatment and interventions to keep patients safe as they continue to age. The Standing Committee recognized that cognitive impairment remains underdiagnosed and that the measure can help identify gaps in diagnosis. However, it noted that due to the current challenges of diagnosing cognitive impairment and therefore limited available data, there are concerns regarding whether the treatment of MCI would be effective or beneficial. Challenges have included the ethical considerations of accomplishing trials to assess interventions and medications. Additionally, the evidence did not demonstrate that the proposed process of care would lead to a positive patient outcome, and the Standing Committee agreed that the

evidence presented did not support the focus of the measure. The Standing Committee also noted that much of the evidence presented was either not graded or graded moderately.

The Standing Committee did not pass the measure on evidence—a must-pass criterion; therefore, the Standing Committee did not discuss or vote on any proceeding criteria, nor did it discuss related and competing measures.

NQF #3672 Ratio of Observed Over Predicted Rates for Diagnosis of Dementia (USC)

Description: Ratio of the number of patients 65 and older diagnosed with dementia attributed to a clinician or practice over the number of cases predicted based on the demographic profile of that clinician or practice. Once the clinician's or practice's O/E ratio (i.e., ratio of the observed and expected rates) is calculated, a computation of its associated standard error (SE) can be used to draw inference whether the O/E ratio is significantly different from 1 or not; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Ambulatory Care; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

- Soeren Mattke, USC

Standing Committee Votes

- **Evidence**: Total Votes-16; H-0; M-1; L-12; I-3 (1/16 – 6.3%, No Pass)
- **Performance Gap**: Vote Not Taken
- **Reliability**: Vote Not Taken
- **Validity**: Vote Not Taken
- **Feasibility**: Vote Not Taken
- **Use**: Vote Not Taken
- **Usability**: Vote Not Taken
- **Standing Committee Recommendation for Endorsement**: Vote Not Taken

The Standing Committee did not vote on the recommendation for endorsement at the meeting because it did not pass the measure on evidence—a must-pass criterion.

This clinician group/practice-level measure was newly submitted for endorsement and is not yet implemented in a quality or accountability program. The developer stated that the measure may be considered for use in a public-reporting/payment program in the future.

The evidence presented by the developer for NQF #3672 was the same evidence presented for NQF #3707, which was previously discussed. The Standing Committee acknowledged that the measure would necessarily highlight gaps in diagnoses of dementia but had concerns about whether the process of care would lead to improved patient outcomes.

The Standing Committee did not pass the measure on evidence—a must-pass criterion; therefore, the Standing Committee did not discuss or vote on any proceeding criteria, nor did it discuss related and competing measures.

NQF #3729 Ratio of Observed Over Predicted Rates for Diagnosis of Cognitive Impairment of Any Stage (USC)

Description: The measure captures the ratio of the number of patients, who are attributed to a clinician or practice, with a diagnosis of any stage of cognitive impairment over the expected number of cases based on a predictive model. Once the clinician's or practice's O/E ratio (i.e., ratio of the observed and expected rates) is calculated, a computation of its associated standard error (SE) can be used to draw inference whether the O/E ratio is significantly different from 1 or not; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: individual; **Setting of Care**: Ambulatory Care; **Data Source**: Claims

Measure Steward/Developer Representatives at the Meeting

- Soeren Mattke, USC

Standing Committee Votes

- **Evidence**: Total Votes-16; H-0; M-2; L-14; I-0 (2/16 – 12.5%, No Pass)
- **Performance Gap**: Vote Not Taken
- **Reliability**: Vote Not Taken
- **Validity**: Vote Not Taken
- **Feasibility**: Vote Not Taken
- **Use**: Vote Not Taken
- **Usability**: Vote Not Taken
- **Standing Committee Recommendation for Endorsement**: Vote Not Taken

The Standing Committee did not vote on the recommendation for endorsement during the meeting because it did not pass the measure on evidence—a must-pass criterion.

This clinician group/practice-level measure was newly submitted for endorsement and is not yet implemented in a quality or accountability program. The developer stated that the measure may be considered for use in a public-reporting/payment program in the future.

The Standing Committee recognized the importance of identifying cognitive impairment early. However, it had similar concerns regarding the evidence, just as it did for NQF #3707 and NQF #3672. The Standing Committee noted that the evidence is not strong enough to indicate that the differences in diagnosis of cognitive impairment at any stage would result in differences in treatment outcomes.

The Standing Committee did not pass the measure on evidence—a must-pass criterion; therefore, the Standing Committee did not discuss or vote on any proceeding criteria, nor did it discuss related and competing measures.

NQF #2651 CAHPS® Hospice Survey, Version 9.0 (CMS/RAND)

Description: The measures submitted here are derived from the CAHPS® Hospice Survey, Version 9.0, a 39-item standardized questionnaire and data collection methodology. The survey is intended to measure the care experiences of hospice decedents and their primary caregivers. Survey respondents are the primary informal caregivers (i.e., family members or friends) of patients who died while receiving hospice care.

- The proposed measures include the following six multi-item measures:

  - Hospice Team Communication
  - Care Preferences
  - Getting Timely Care
  - Treating Family Member with Respect
  - Getting Emotional and Religious Support
  - Getting Help for Symptoms
- In addition, there are three single-item measures:
  - Getting Hospice Training
  - Rating of the Hospice
  - Willingness to Recommend the Hospice
- Following is a list of the survey items included in each measure.
- Hospice Team Communication (5 items)
  - How often did the hospice team keep you informed about when they would arrive to care for your family member?
  - How often did the hospice team explain things in a way that was easy to understand?
  - How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?
  - How often did the hospice team keep you informed about your family member's condition?
  - While your family member was in hospice care, how often did the hospice team listen carefully to you?
- Care Preferences (2 items)
  - Did the hospice team make an effort to listen to the things that mattered most to you or your family member?
  - Did the hospice team provide care that respected your family member's wishes?
- Getting Timely Care (2 items)
  - When you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?
  - How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?
- Treating Family Member with Respect (2 items)
  - How often did the hospice team treat your family member with dignity and respect?
  - How often did you feel that the hospice team really cared about your family member?
- Getting Emotional and Religious Support (3 items)
  - While your family member was in hospice care, how much emotional support did you get from the hospice team?
  - In the weeks after your family member died, how much emotional support did you get from the hospice team?
  - Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?
- Getting Help for Symptoms (4 items)
  - Did your family member get as much help with pain as he or she needed?
  - How often did your family member get the help he or she needed for trouble breathing?
  - How often did your family member get the help he or she needed for trouble with constipation?
  - How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness?

- Getting Hospice Care Training (1 item)
  - Hospice teams may teach you how to care for family members who need pain medicine, have trouble breathing, are restless or agitated, or have other care needs. Did the hospice team teach you how to care for your family member?
- Rating of Hospice Care (1 item)
  - Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?
- Willingness to Recommend Hospice (1 item)
  - Would you recommend this hospice to your friends and family?
- A complete list of proposed CAHPS Hospice Survey measures, including response options for each item, is available in Appendix B.

Measure Type: Outcome: PRO-PM; **Level of Analysis**: Facility; **Setting of Care**: Home care, Inpatient/Hospital, Other; **Data Source**: Instrument-Based Data

Measure Steward/Developer Representatives at the Meeting

- Rebecca Anhang Price, RAND
- Maria DeYoreo, RAND
- Lauren Fuentes, CMS

Standing Committee Votes

- **Evidence**: Total Votes-16; Pass-16; No Pass-0 (16/16 – 100%, Pass)
- **Performance Gap**: Total Votes-16; H-2; M-13; L-1; I-0 (15/16 – 93.7%, Pass)
- **Reliability**: Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)
  - This measure was evaluated by the SMP.
  - The Standing Committee accepted the SMP's rating for Reliability: Moderate (Total Votes-11; H-6; M-3; L-2; I-0).
- **Validity**: Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)
  - This measure was evaluated by the SMP.
  - The Standing Committee accepted the SMP's rating for Validity: Moderate (Total Votes-10; H-1; M-5; L-2; I-2).
- **Feasibility**: Total Votes-15; H-1; M-14; L-0; I-0 (15/15 – 100%, Pass)
- **Use**: Total Votes-16; Pass-16; No Pass-0 (16/16 – 100%, Pass)
- **Usability**: Total Votes-15; H-0; M-15; L-0; I-0 (15/15 – 100%, Pass)
- **Standing Committee Recommendation for Endorsement**: Total Votes-15; Yes-15; No-0 (15/15 – 100%, Pass)

The Standing Committee recommended the measure for continued endorsement. This facility-level measure was originally endorsed in 2016 and last retained endorsement in 2020. It is publicly reported in the Hospice Quality Reporting Program.

The developer stated that since the prior review in 2019, updates have been made in response to stakeholders' requests for the survey instrument to be shortened and simplified. New content related to

Care Preferences was added in response to the feedback received. Minor updates were also made to reflect the important role that hospice has in explaining care options, formulating goals of care that reflect patient and family preferences, and creating a plan of care that aims to achieve those goals. All proposed changes were tested with caregivers of hospice decedents via cognitive interviews. CMS tested the revised survey instrument among caregivers from 56 hospices during a 2021 mode experiment.

The developer attested that the underlying evidence for the measure has not changed since the last NQF endorsement review. The Standing Committee agreed that the evidence basis for the measure has not changed and that repeated discussion was not needed. During the discussion of the opportunity for improvement criterion, one Standing Committee member asked whether there is a way to look at the disparities based on geographical location or neighborhood-level data along with where disparities based on race have been identified. The developer replied that although differences in care by race and ethnicity have been analyzed, considering geography in future analyses could be an option. Another Standing Committee member questioned how religious support is qualified or quantified into being measured as excellent, very good, good, fair, etc. The developer clarified that the survey asks the caregiver respondent to describe their own experiences and whether that family caregiver felt they received the right amount of support. Like all questions on the survey, the caregiver's perspective on what happened defines what is "right" for them in the context of those questions. Lastly, the Standing Committee pointed out that emotional and spiritual care are lumped together in the survey; however, they are actually two separate domains in palliative care and hospice. Overall, the Standing Committee agreed a gap exists in care that warrants a national performance measure.

The developer provided updated testing to reflect the revisions made to the instrument to shorten and simplify the instrument and to add a new two-item Care Preferences measure. The SMP reviewed the updated testing prior to the Standing Committee meeting. The Standing Committee accepted the SMP's ratings for reliability and validity and agreed that a discussion and separate vote were not needed. One Standing Committee member suggested narrowness is present in the provided definitions of the type of caregiver that is eligible to fill out the survey, which is something that could be revisited in the future.

During the discussion of the feasibility criterion, some of the Standing Committee members noted that the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey process has been in place since 2015 and that although it relies on family caregiver versus patient experience, it appears to be the best method available to obtain data on the patient's hospice experience. During the discussion of the use criterion, the Standing Committee asked how the transition from reporting top-box scores to the Star Rating addresses trends in performance. The developer clarified that the Star Rating is meant to be a public-reporting tool that helps consumers differentiate one organization from another by aiding the decision on selecting a hospice. The Standing Committee passed the measure on feasibility, use, and usability.

The Standing Committee reviewed one related measure (NQF# 1623) and agreed that the measures were harmonized to the extent possible.

Public Comment

Ms. Goodwin opened the lines for NQF member and public comments. No public or NQF member comments were provided at this time or during the measure evaluation meeting.

Next Steps

Mary McCutcheon, NQF analyst, provided an overview of the next steps. NQF will begin drafting a meeting summary of the Standing Committee's deliberations and will post it to the project webpage. Ms. McCutcheon iterated the earlier statement about the transition of the endorsement and maintenance work to the new successor. Ms. Goodwin thanked the Standing Committee for its time, engagement, and participation in this work and adjourned the call.