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Technical Expert Panel Summary Report: Development and Maintenance of Quality Measures for Skilled Nursing Facility Quality Reporting Program

Deliverables 11 and 14

Prepared for

Mary Pratt, MS
Tara McMullen, PhD
Charlayne D. Van, JD
Center for Clinical Standards and Quality
Division of Chronic & Post-Acute Care
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-02-01, Baltimore, MD 21244-1850

Prepared by

Qinghua Li, PhD
Andrea Ptaszek, PhD
Andrea Cool, BS
Anne Deutsch, RN, PhD, CRRN
Laura Smith, PhD
RTI International
3040 E. Cornwallis Road
Research Triangle Park, NC 27709

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TECHNICAL EXPERT PANEL SUMMARY REPORT: DEVELOPMENT AND MAINTENANCE OF QUALITY MEASURES FOR SKILLED NURSING FACILITY QUALITY REPORTING PROGRAM

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by
Qinghua Li, PhD
Andrea Ptaszek, PhD
Andrea Cool, BS
Anne Deutsch, RN, PhD, CRRN
Laura Smith, PhD

Project Director: Laura Smith, PhD

Federal Project Representatives:
Mary Pratt, MS (Director, DCPAC, Program Coordinator, SNF QRP)
Tara McMullen, PhD (Analyst, IMPACT Act lead)
Charlayne D. Van, JD (COR)

RTI International

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SECTION 1
INTRODUCTION AND OVERVIEW

1.1 Introduction

On August 21, 2017, RTI International convened an in-person technical expert panel (TEP) meeting to seek expert input on future directions for measure development of the Centers for Medicare & Medicaid Services (CMS) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). This report summarizes the TEP proceedings, detailing key issues for each focus area and the TEP discussion around those issues. In this section, we give an overview of the SNF QRP and the SNF QRP TEP process.

1.2 Background

CMS has contracted with RTI to develop and implement the SNF QRP, including the development and maintenance of quality measures in the SNF QRP to address current performance gaps in SNFs, measure implementation, and measure reporting. The contract name is Development and Maintenance of Symptom Management Measures and the CMS Contract number is HHSM-500-2013-13015I. As part of the measure development process, CMS asks measure developers to convene groups of stakeholders and experts to contribute thoughtful input and recommendations to the measure developer during the measure development and maintenance process.

Under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), post-acute care (PAC) settings are required to submit standardized patient assessment data to enable improvements in quality of care and patient outcomes, allow for comparisons of quality across PAC settings, and facilitate information exchange across PAC settings.[1] Additionally, these standardized assessment data are used to develop, implement, and report on quality measures from five quality measure domains: skin integrity and changes in skin integrity; functional status, cognitive function, and changes in function and cognitive function; medication reconciliation; incidence of major falls; and transfer of health information and care preferences. The IMPACT Act further established a statutorily mandated quality reporting program which requires SNFs to submit data to CMS. The SNFs that do not submit the required data may incur a two-percentage point reduction to their annual payment update (APU) for the applicable payment year. The SNF QRP was implemented in October 2016, and public reporting for the quality measures will begin in 2018. The SNF QRP currently consists of 11 finalized measures. Eight are assessment-based measures calculated from the Minimum Data Set (MDS), and three are claims-based measures calculated from Medicare Fee-for-Service (FFS) Claims data. The measures and their National Quality Forum (NQF) identification numbers are listed in ***Table 1***.

[1] 113th Congress. IMPACT Act of 2014. H.R. 4994. Available from https://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf.

Table 1
Finalized SNF QRP Quality Measures

NQF Number	Measure Name	Data Source
#0674 *	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	MDS
#0678 *	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) *(Will be replaced as of October 1, 2018, with modified measure #0678)*	MDS
N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury *(Effective October 1, 2018)*	MDS
#2631 *	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	MDS
#2633 *	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	MDS
#2634 *	Application of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	MDS
#2635 *	Application of the IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	MDS
#2636 *	Application of the IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	MDS
N/A	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program	MDS
N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP	Medicare FFS Claims
N/A	Discharge to Community–PAC SNF QRP	Medicare FFS Claims
N/A	Medicare Spending per Beneficiary (MSPB)–PAC SNF QRP	Medicare FFS Claims

*SNF measures that are endorsed by the NQF in other settings and are being used in the SNF setting.

For the current SNF QRP TEP task, RTI conducted an environmental scan to identify important domains for assessment of SNF care, which were identified as important areas for quality improvement or where a performance gap has been demonstrated. These areas are broad areas and are not limited to future quality measure work. Four broad care domains were identified from the environmental scan:

- Resident- and Caregiver-Centered Care.
- Communication and Coordination of Care Transitions.
- Symptom Management.
- Function.

Within each of these domains, the RTI team identified specific focus areas to discuss with the TEP where potential performance gaps could be addressed by quality measure development. ***Figure 1*** lists all focus areas under each domain for the TEP discussion. ***Figure 2*** illustrates the organizational framework for these concepts, providing examples of one of the domains, a focus area within the domain, and a potential measure concept that could be informed by the TEP discussion. Both figures were presented as slides in the TEP meeting.

The objective of this TEP was to seek input from the expert panel on the identified care domains and focus areas to inform directions for potential future measure development for the SNF QRP. Comments and recommendations gathered from the TEP will inform the next steps in potential measure development, such as developing and refining data elements needed for future measures.

Figure 1
Domains and Focus Areas for TEP Discussion

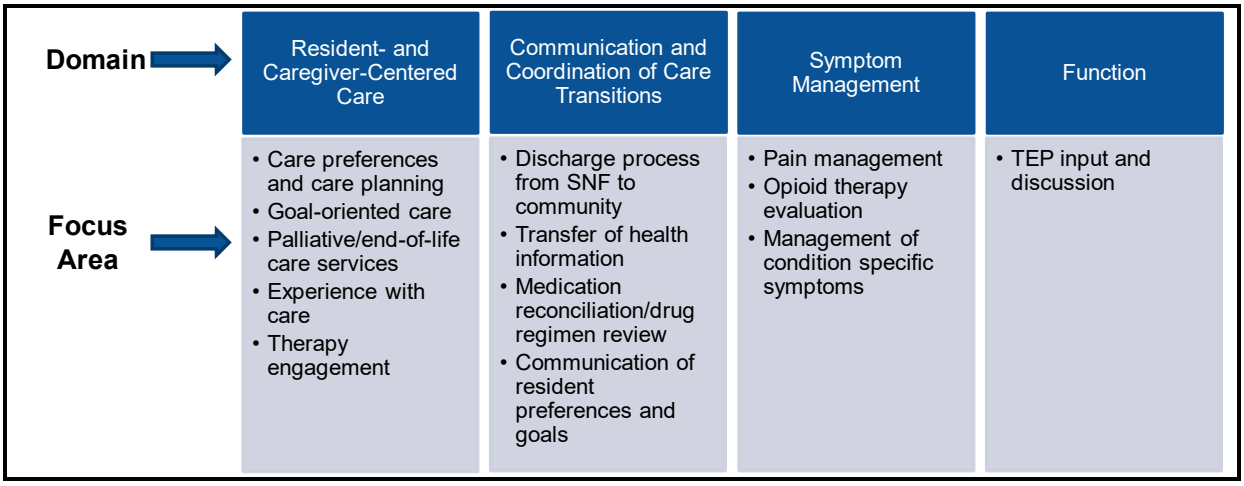
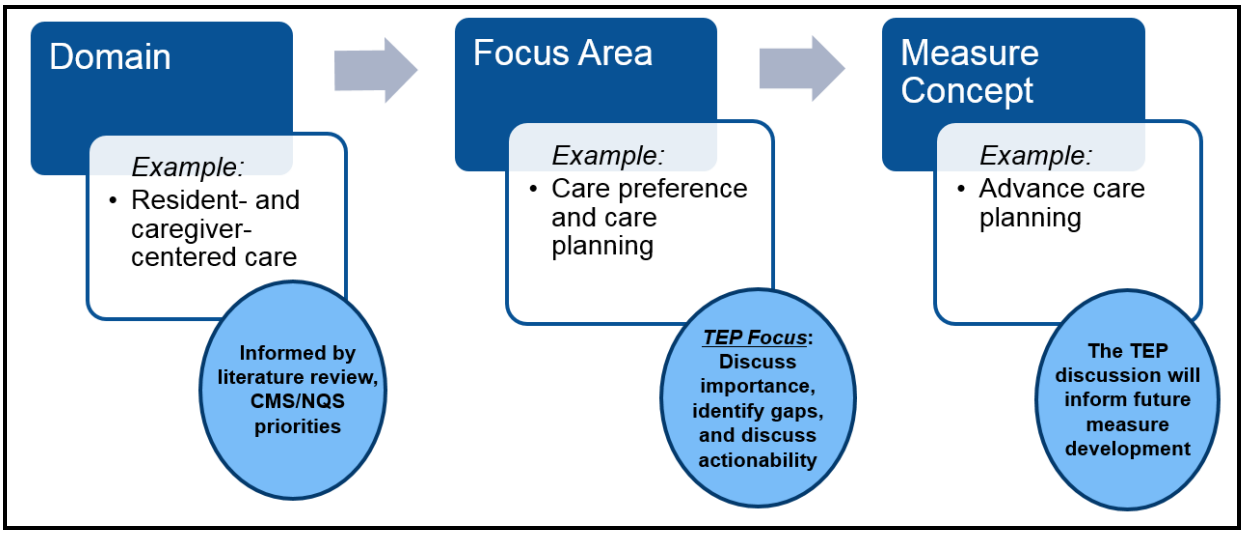


Figure 2
Organizational Framework



1.3 Process of TEP Meeting

On April 4, 2017, RTI posted a Call for TEP Nominations and a TEP Nomination Form on the CMS website to initiate recruitment of TEP members. At the close of the nomination period, CMS and RTI finalized the TEP composition by selecting 12 nominees who offered a diverse range of experience, including quality measurement expertise and clinical and research experience in policy and regulation, patient safety, care transitions, and patient-centered measurement (***Appendix A***). Before the TEP meeting, the TEP members received materials to review and complete to prepare for the discussion (***Appendix B***). Included in these materials was a pre-TEP survey to assess the TEP members' initial thoughts regarding the identified focus areas under each care domain for discussion (***Appendix B-2*** and ***Appendix B-3***). The pre-TEP survey included a summary description of each of the focus areas under each care domain for discussion and asked for the TEP members' input on the focus areas using three NQF measure evaluation criteria: importance, performance gap, and actionability, which are defined as follows:

- Importance: the extent to which the area addresses an established National Quality Strategy (NQS) priority area and a demonstrated high-impact aspect of health care and whether there is external evidence of importance and of disparities in the area.

- Performance Gap: whether there is considerable variation in quality of performance in the area across providers and/or populations, whether there is overall less-than-optimal performance in the area across providers and/or populations; and whether there are disparities in performance in the area across different population groups.

- Actionability: evidence related to the measure focus area demonstrates that there is potential for closing the performance gap.

The TEP members received the pre-TEP survey and survey instructions and were asked to rate each focus area on each of the three criteria using a standardized scoring sheet created by RTI (***Appendix B-3***). Responses from all TEP members were received before the TEP meeting. Their scores and accompanying comments were used to inform discussion topics for the TEP meeting (***Appendix C***).

The TEP meeting was organized around discussion of the four broad domains and the focus areas within each domain. Discussion was facilitated by the SNF QRP lead, Qinghua Li; the deputy SNF QRP lead, Andrea Ptaszek; and the function measure lead, Anne Deutsch as well as the Symptom Management project director, Laura Smith. The meetings were audio recorded.

1.4 Organization of Report

The following sections will introduce the care domains and focus areas within these domains that were identified through the environmental scan and discussed in the TEP meeting. The sections also will summarize the TEP members' feedback on the pre-TEP materials and the discussion during the TEP meeting. We discuss main takeaways and next steps in measure development. ***Section 2*** summarizes the key overall themes for the TEP discussion on SNF QRP quality measure development. ***Section 3*** addresses the domain of resident- and caregiver-centered care. ***Section 4*** addresses the domain of communication and coordination of care transitions. ***Section 5*** addresses the domain of symptom management. ***Section 6*** addresses the domain of function. We summarize the TEP members' recommendations for other measure focus areas in ***Section 7***.

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SECTION 2
COMMON THEMES FOR SNF QRP QUALITY MEASURE DEVELOPMENT

The TEP discussion covered many points and provided significant insight into the four domains and each focus area within these domains. The discussion identified three key common themes regarding quality measure development in SNFs: distinctions between SNF and nursing home populations, the significance of resident cognitive status, and socioeconomic differences.

- ***Distinction Between Sub-Populations in Nursing Homes***—Many of the TEP members noted the importance of accounting for the distinction between SNF residents and long-stay nursing home residents when developing SNF QRP quality measures. These TEP members emphasized the differences in PAC needs between these populations. Several TEP members further pointed out three major nursing home subpopulations based on resident need: rehabilitation/functional improvement, chronic illness management, and end-of-life care, and suggested that measure development be tailored towards different care needs and goals of these sub-populations.

- ***Importance of Resident Cognitive Status***—Resident cognitive status was brought up throughout the TEP discussion as a significant factor that should be considered as a baseline item before assessing other quality measures. Many of the TEP members noted the importance of considering cognitive status before addressing many of the focus areas presented throughout the discussion. For example, assessing cognitive status is particularly important before addressing the domain of resident- and caregiver-centered care, as residents with cognitive impairment may not be capable of communicating goals and preferences of care.

- ***Socioeconomic Status***—Many of the TEP members recommended taking into consideration the socioeconomic characteristics of both residents and facilities when developing quality measures. The TEP acknowledged that residents' goals of care, discharge plans, and experience of care, among many other factors, may be influenced by the resident's support system, socioeconomic status, or both. Furthermore, the TEP noted that the location of the facility itself—for example, whether it is in a rural or urban area—may also influence quality of care and should be taken into account in quality measure development.

These three themes were raised throughout the TEP discussion in relation to many of the domains and focus areas. More-detailed, in-depth summaries of the discussion related to each focus area are outlined in the following sections.

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SECTION 3
DOMAIN 1: RESIDENT- AND CAREGIVER-CENTERED CARE

3.1 Domain Description

The NQF defines person- and family-centered care as "an approach to the planning and delivery of care across settings and time that is centered on collaborative partnerships among individuals, their defined family, and providers of care."[2] Person- and family-centered care "supports health and wellbeing by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values" and "emphasizes the inclusivity of recipients of healthcare services and their families and caregivers."[3] Care quality initiatives across settings have begun emphasizing the need for a shift towards person- and family-centered care that is organized around the preferences and needs of individuals and their families/caregivers. Furthermore, in 2016, CMS published its Person and Family Engagement (PFE) Strategy which outlines the "meaningful and intentional implementation of person and family engagement throughout CMS policies and programs."[4] The key foundational principles of this strategy include informed, bi-directional decision making; communication of care preferences; collaborative care goal creation; promotion of PFE best practices; and encouragement of engagement and self-management.[5]

Evidence from studies in this area demonstrate that person- and family- centered care is associated with higher resident/stakeholder satisfaction;[6,7] improved health outcomes;[8,9]

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[2] National Quality Forum (NQF): Person- and Family- Centered Care 2015-2016. http://www.qualityforum.org/ProjectDescription.aspx?projectID=73867. 2017.

[3] National Quality Forum (NQF): Person- and Family- Centered Care 2015-2016. http://www.qualityforum.org/ProjectDescription.aspx?projectID=73867. 2017.

[4] Centers for Medicare & Medicaid Services (CMS): Person and Family Engagement Strategy: Final Report. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategic-Plan-12-12-16.pdf. 2016.

[5] Centers for Medicare & Medicaid Services (CMS): Person and Family Engagement Strategy: Final Report. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategic-Plan-12-12-16.pdf. 2016.

[6] Dykes, P.C., Samal, L., Donahue, M., et al.: A patient-centered longitudinal care plan: vision versus reality. J Am Med Inform Assoc. 21(6): 1082-1090, 2014. doi:10.1136/amiajnl-2013-002454

[7] Abrahamson, K., Myers, J., and Nazir, A.: Implementation of a person-centered medical care model in a skilled nursing facility: A pilot evaluation. J Am Med Dir Assoc. 18(6): 539-543, 2017.

[8] Dykes, P.C., Samal, L., Donahue, M., et al.: A patient-centered longitudinal care plan: vision versus reality. J Am Med Inform Assoc. 21(6): 1082-1090, 2014. doi:10.1136/amiajnl-2013-002454

[9] Abrahamson, K., Myers, J., and Nazir, A.: Implementation of a person-centered medical care model in a skilled nursing facility: A pilot evaluation. J Am Med Dir Assoc. 18(6): 539-543, 2017.

increased trust between residents, families, and providers;[10] reduced rates of hospital readmissions;[11,12] decreased costs due to a reduction in use of rehabilitative and life-prolonging care;[13] reduced resident and family distress;[14] and improved overall quality of life for residents.[15,16] However, despite initiatives and strategies to promote person- and family-centered care and PFE, the environmental scan identified potential areas for improvement within this domain. For instance, the NQF Measures Applications Partnership (MAP) 2017 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care report identified the need to make the SNF QRP measure set more person-centered, to improve patient and family engagement in SNF care, and recommended the development and implementation of measures of patient experience of care that are specific to the SNF setting and to incorporate advance directives into SNF care.[17]

The environmental scan identified five key focus areas within this domain: goal-oriented care, care planning and care preferences, palliative and end-of-life care, resident experience of care, and therapy engagement. These focus areas were presented to the TEP members through a pre-TEP survey and were then discussed in detail at the TEP meeting.

3.2 Focus Area 1: Goal-Oriented Care

3.2.1 Description

Goal-oriented care is care that focuses on a resident's individual health goals with or across a variety of dimensions and works to meet these goals. Goal-oriented care consists of two important components: understanding the resident's goals of care and providing care consistent with the resident's goals.

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[10] Abrahamson, K., Myers, J., and Nazir, A.: Implementation of a person-centered medical care model in a skilled nursing facility: A pilot evaluation. J Am Med Dir Assoc. 18(6): 539-543, 2017.

[11] Carpenter, J.G., Berry, P.H., and Ersek, M.: Nursing home care trajectories for older adults following in-hospital palliative care consultation. Geriatr Nurs. 2017.

[12] Lavernia, C.J., Villa, J.M., and Iacobelli, D.A.: Readmission rates in the state of Florida: a reflection of quality? Clin Orthop Relat Res. 471(12): 3856-62, 2013.

[13] Carpenter, J.G., Berry, P.H., and Ersek, M.: Nursing home care trajectories for older adults following in-hospital palliative care consultation. Geriatr Nurs. 2017.

[14] Dykes, P.C., Samal, L., Donahue, M., et al.: A patient-centered longitudinal care plan: vision versus reality. J Am Med Inform Assoc. 21(6): 1082-1090, 2014. doi:10.1136/amiajnl-2013-002454

[15] Carpenter, J.G., Berry, P.H., and Ersek, M.: Nursing home care trajectories for older adults following in-hospital palliative care consultation. Geriatr Nurs. 2017.

[16] Welsh, P.G.: Providing high-quality care in North Carolina nursing homes. North Carolina Medical Journal 75(5): 336-340, 2014.

[17] Measures Application Partnership (MAP): MAP 2017 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care. Washington, DC. 2017. Available from http://www.qualityforum.org/Publications/2017/02/MAP_2017_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

Evidence from the environmental scan demonstrated that current team care in SNFs is typically organized around routines rather than patients' needs and goals.[18] The literature suggests a lack of knowledge in SNFs of residents' long-term care goals or rare use of such care goals.[19,20] The environmental scan further identified performance gaps in incorporating goal-oriented care for residents with cognitive impairments and limited decision-making capabilities.[21]

3.2.2 Summary of TEP Scoring on Pre-TEP Materials

Before the TEP meeting, we asked TEP members to score this focus area using three main criteria (detailed scoring results are summarized in ***Table C-1*** in ***Appendix C***) and to provide written feedback on their rationale for their rating as well as any further comments, suggestions, or concerns related to the focus area.

Most of the TEP members agreed that this focus area is of high priority to SNF care, with nine out of twelve of the TEP members rating this area as high priority, one rating goal-oriented care as low priority, and two TEP members not providing a rating. One of the two TEP members who did not rate this criterion noted that further clarification of how "goal-oriented care" is defined is needed prior to providing a rating. The other TEP member who did not rate this criterion noted that goal-oriented care is not something that SNFs can self-report, as this issue is one of resident perception of whether their care goals were met during their stay. All TEP members rated this focus area's performance gap as medium to high, with three of the twelve TEP members rating it as high, two rating it as medium-high, four rating it as medium, and three TEP members not rating this criterion. There was less consensus across the TEP members about the focus area's actionability (five rated it as high or medium-high, three rated it as medium-high, and one rated it as low-medium).

3.2.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion covered the following topics related to goal-oriented care:

- ***Definition and Actionability***—One of the main concerns with this focus area was the lack of consensus on a definition of goal-oriented care for quality measurement, which in part drove concerns about actionability. To some TEP members, measuring goal-oriented care would mean measuring whether SNF care follows through on residents' defined care goals. However, other members suggested that the measure

[18] Abrahamson, K., Myers, J., and Nazir, A.: Implementation of a person-centered medical care model in a skilled nursing facility: A pilot evaluation. J Am Med Dir Assoc. 18(6): 539-543, 2017.

[19] Davidson, G.H., Austin, E., Thornblade, L., et al.: Improving transitions of care across the spectrum of healthcare delivery: A multidisciplinary approach to understanding variability in outcomes across hospitals and skilled nursing facilities. Am J Surg. 213(5): 910-914, 2017.

[20] Dykes, P.C., Samal, L., Donahue, M., et al.: A patient-centered longitudinal care plan: vision versus reality. J Am Med Inform Assoc. 21(6): 1082-1090, 2014. doi:10.1136/amiajnl-2013-002454

[21] Carpenter, J.G., Berry, P.H., and Ersek, M.: Nursing home care trajectories for older adults following in-hospital palliative care consultation. Geriatr Nurs. 2017.

should address resident and family/caregiver engagement in care planning. One TEP member felt that although this focus area is important to SNF care, it should not be assessed with a functional measure, but rather with resident and family feedback surveys. One TEP member further noted that implementing goal-oriented care can be extremely difficult because of unrealistic resident and family/caregiver expectations.

- ***Importance***—Many TEP members noted in their pre-TEP feedback that goal-oriented care is a very important aspect of SNF care and critical to patient outcomes. However, several TEP members noted that, although this focus area is central to the work in SNFs, it should not be measured with a quality measure.

- ***Performance Gap and Variability***—Several TEP members noted that, while goal-oriented care is an important aspect of SNF care, there is significant variability in the level and quality of goal-oriented care across SNF facilities. One TEP member pointed out that goal-oriented care is already addressed through regulations but that there is significant variation in how it is being carried out. Several TEP members acknowledged the existence of discrepancies between goals that are listed on resident care plans and the care that is being administered. A TEP member emphasized that this is an area of high performance gap because of the lack of effective interdisciplinary, individualized care planning processes.

- ***Feasibility of Quality Measurement and Reporting***—Several TEP members felt that goal-oriented care is not something that SNFs can self-report and that this issue may be better addressed through a resident satisfaction measure. However, one TEP member in their pre-TEP survey feedback said this area could in fact be measured through proper documentation of resident care goals throughout their care trajectory.

- ***Different SNF Populations***—TEP members emphasized the need to distinguish between the different SNF populations when discussing goals, as residents often have different goals for their SNF care. Three major categories of care goals were discussed, including functional rehabilitation care, symptom management, and palliative care. However, another TEP member emphasized that that the SNF quality measures only assess Medicare Part A stays, and therefore it would be appropriate for this measure to address functional rehabilitation goals.

- ***Cognitive Status—***Consistent with the results of the environmental scan, the TEP discussion addressed how this focus area differs when considering residents with cognitive impairments. The TEP members pointed out that care goal discussions are more complex when dealing with these residents; thus, cognitive status should be a baseline assessment before other items. One TEP member further emphasized the need for SNF providers to monitor patients with cognitive impairments closely to identify changing care needs.

- ***Expectations vs. Reality—***A potential concern about developing a measure in this area that TEP members raised in the discussion was the inconsistency between many resident's individual goals and the reality of their care needs. Many residents' goals

do not match their clinical need or expectation, and it is up to providers to make sure goals reflect their physical and cognitive condition.

3.3 Focus Area 2: Care Preferences and Care Planning

3.3.1 Focus Area Description

According to the Requirements of Participation for long-term care settings, nursing home facilities are required to develop and implement a baseline care plan for each resident. These care plans are required to include resident care preferences so facilities can provide effective, person-centered care. An organizing framework developed for CMS by the RAND Corporation for the IMPACT Act standardized patient assessment data element work (2016) that care preferences may include, but are not limited to, a resident's goals of care, the desired location for receipt of care, the type and amount of treatment the resident would like to receive, the importance of involvement of family and friends in care decisions, end-of-life preferences, and language and cultural preferences.[22] The environmental scan found that evidence that improved understanding of resident preferences and resident ability to make decisions regarding their care are crucial components of delivering resident-centered care.[23,24]

The literature further demonstrated that although many nursing home residents are aware of their personal preferences regarding care plans, they are often reluctant to discuss them, particularly regarding preferences around end-of-life care. Therefore, providers need to be better trained in discussing these sensitive matters with residents to accurately capture the resident's wants and needs in their plans of care.[25] Additionally, the MAP 2017 report emphasized the importance of advance directives in SNF care and noted the need to assess their use through quality measurement.[26]

3.3.2 Summary of TEP Scoring on Pre-TEP Materials

Most TEP members agreed that care preferences and care planning is a high priority in SNF care, with 10 of the TEP members scoring this area as medium to high priority (detailed scoring results are summarized in ***Table C-2*** in ***Appendix C***). There was less consensus across the TEP members about the existence of performance gaps within this focus area. Only three of the TEP members rated care preferences and care planning as having a medium-high or high level of performance gap. Five TEP members scored this criterion as medium-low or medium.

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[22] RAND Corporation. (2016). Technical expert panel summary/expert input report: development and maintenance of post-acute care cross-setting standardized patient assessment data. Santa Monica, CA.

[23] Bangerter, L.R., Van Haitsma, K., Heid, A.R., and Abbott, K.: "Make me feel at ease and at home": Differential care preferences of nursing home residents. Gerontologist 56(4): 702-713, 2015.

[24] Bangerter, L.R., Heid, A.R., Abbott, K., and Van Haitsma, K.: Honoring the everyday preferences of nursing home residents: Perceived choice and satisfaction with care. Gerontologist 57(3): 479-486, 2017.

[25] Towsley, G., Hirschman, K.B., and Ersek, M.: Mixed messages: Nursing home resident preferences about care at end of life (761). J Pain Symptom Manage 41(1): 310, 2011.

[26] Measures Application Partnership (MAP): MAP 2017 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care. Washington, DC. 2017. Available from http://www.qualityforum.org/Publications/2017/02/MAP_2017_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

Three TEP members did not respond for this criterion. Most TEP members rated this focus area as having medium-low to medium-high actionability, with only one individual scoring this area as having high actionability. Two of the TEP members did not provide ratings for any of the three criteria for this focus area.

3.3.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion regarding care preferences and care planning covered the following topics:

- ***Performance Gap and Variability***—TEP members pointed out that although residents' and families' engagement in care planning is required for nursing homes, the actual level and type of involvement in the care planning meetings vary across providers. Some TEP members also noted that there is disconnect between the care planning and the actual delivery. It is important to note that the care plan may not always be followed in the care delivery. Additionally, several TEP members noted in their pre-TEP survey feedback that the current Requirements of Participation require that facilities include residents and families in care planning; however, meeting these minimum requirements does not equate to having a quality discussion with residents and their families about realistic expectations and care plans. One TEP member pointed out in the discussion that many families note that they are not substantively included in the care planning process. This TEP member recommended developing a measure that would assess whether residents and their families/caregivers are engaged in care planning and whether they understand the care plan.

- ***Actionability***—Some TEP members noted significant barriers to getting residents and their families engaged in the care planning process. These TEP members suggested that the meaningful and accurate assessment of shared care planning highly depends on the valid measurement and documentation of residents' cognitive status. One concern for residents without sufficient cognitive function is that their proxy's understanding about their care preference may not be consistent with their own care preference.

- ***Residents' Cognitive Status—***The TEP discussed issues with care planning for residents with cognitive impairments. These residents are typically not able to discuss or make changes to their care plans. This is especially important to consider when including families and caregivers in the care planning process, as family and caregiver goals do not always align with the goals of the resident or realistic goals determined by the provider.

- ***Advance Care Planning—***Advance Care Planning was identified as a priority area for SNF quality measure development through the pre-TEP survey. Several TEP members stated that advance care planning is indeed an area of performance gaps in SNFs, noting that knowledge of care plan processes varies significantly across facilities. However, the TEP members had varying opinions on the need for advance care planning in SNFs. Some TEP member suggested that a quality measure to address advance care planning is not appropriate for the SNF setting, as the goal of

short-stay residents is to rehabilitate after an acute illness. However, another TEP member pointed out that many short-stay SNF residents are also managing chronic conditions that need to be addressed with a care plan that anticipates their care needs, provides education on their conditions, and outlines specific plans for the resident's care. The TEP discussion revealed the misperception of the objective of advance care planning.

- ***Sociodemographic/Socioeconomic Factors*—**A common issue raised during the TEP discussion on care planning was how sociodemographic and socioeconomic factors affect residents' care preferences and the care planning process and how a quality measure in this area may affect those with more challenging social environments. One TEP member pointed out that residents with a solid support network are more likely to be satisfied with their care and the care planning process than those with unstable support. Another TEP member countered that residents who previously had a very limited support network and limited resources are likely to be more satisfied with the activities, support, and resources made available to them during their SNF stay. Additionally, one TEP member noted that although the goal for most SNF residents is to rehabilitate and discharge to the community, providers and measure developers need to account for the home environment that residents are returning to and whether it is conducive to functional maintenance.

3.4 Focus Area 3: Palliative/End-of-Life Care Services

3.4.1 Focus Area Description

According to CMS, palliative care "focuses on relief from physical suffering" and "addresses the patient's physical, mental, social, and spiritual well-being for patients in all disease stages and accompanies the patient from diagnosis to cure."[27] A patient receiving palliative care services "may be being treated for a disease or may be living with a chronic disease, and may or may not be terminally ill."[28] The NQF defines end-of-life care as "comprehensive care for a life-limiting illness that meets the patient's medical, physical, psychological, spiritual, and social needs."[29] Palliative programs that are used across the trajectory of a patient's illness can improve patient satisfaction, quality of care, and communications; lead to fewer admissions to intensive care units, hospitals, and emergency departments; and reduce overall costs.[30] Public comment from the Fiscal Year (FY) 2018 SNF Prospective Payment System (PPS) final rule suggested the need for measures that include

[27] Centers for Medicare & Medicaid Services (CMS): Palliative Care vs. Hospice Care [Infographic] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/infograph-PalliativeCare-[June-2015].pdf. 2015.

[28] Centers for Medicare & Medicaid Services (CMS): Palliative Care vs. Hospice Care [Infographic] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/infograph-PalliativeCare-[June-2015].pdf. 2015.

[29] National Quality Forum (NQF): National Voluntary Consensus Standards: Palliative Care and End-of-Life Care: A Consensus Report. https://www.qualityforum.org/Projects/Palliative_Care_and_End-of-Life_Care.aspx. 2012.

[30] National Quality Forum (NQF): National Voluntary Consensus Standards: Palliative Care and End-of-Life Care: A Consensus Report. https://www.qualityforum.org/Projects/Palliative_Care_and_End-of-Life_Care.aspx. 2012.

language related to palliative and end-of-life care in SNFs.[31] Evidence from the literature review reinforced the need for these services in SNFs, as a 2016 study found that many SNF residents are admitted near the end of their lives.[32] However, the environmental scan found limited research on SNFs' capacity to provide palliative and end-of-life care, and to evaluate and understand residents' need for and the appropriateness of these services. Similarly, the scan found limited research on the quality of these services when provided.

3.4.2 Summary of TEP Scoring on Pre-TEP Materials

TEP member ratings on the three scoring criteria (importance, performance gap, and actionability) were relatively high for palliative care and end-of-life services in SNFs (detailed scoring results are summarized in ***Table C-3*** in ***Appendix C***). Eight out of eleven TEP members scored this focus area as a high priority, with three rating this criterion as a medium-high priority and one TEP member unresponsive. The survey results were similar for performance gap rating, with seven TEP members rating this focus area's performance gap as high, three rating it as medium to medium-high, and two unresponsive. For actionability, while one TEP member was unresponsive, six rated palliative care and end-of -life services as highly actionable, and five said it had medium to medium-high actionability. One of the TEP members who chose not to respond for this focus area maintained in her feedback that palliative and end-of-life care services are essential components of SNF care and are now addressed in the new Rules of Participation requirements.

3.4.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion covered the following topics related to palliative/end-of-life care services:

- ***Need of Palliative Care for Different SNF Subpopulations***—The TEP discussion revealed a widely varied understanding of what palliative care is and whether SNF residents need palliative care. There is a common misperception that palliative care is only for the end-of-life population, and therefore some TEP members suggested that palliative care measure should only be developed for the end-of-life residents. However, another TEP member suggested that palliative care services should occur concurrently with other treatments, rather than being treated as a separate care plan in the way that hospice is currently treated.

- ***Importance***—The importance of addressing palliative and end-of-life care in SNFs was a common theme throughout both the pre-TEP feedback and the TEP discussion. In the pre-TEP feedback, several TEP members noted the importance of making palliative and end-of-life services available for SNF residents. One TEP member pointed out that these services are becoming even more essential as alternatives grow for individuals to delay nursing home placement. However, in the TEP discussion,

[31] Centers for Medicare & Medicaid Services: Medicare finalizes fiscal year 2018 payment & policy changes for skilled nursing facilities. CMS-1679-F. July 31, 2017.

[32] Carpenter, J.G., Berry, P.H., and Ersek, M.: Nursing home care trajectories for older adults following in-hospital palliative care consultation. Geriatr Nurs. 2017.

several TEP members questioned whether SNFs should be obliged to provide palliative care, while others noted that all nursing homes should provide palliative care and comfort care services. One TEP member pointed out that facilities will soon be required to submit a facility assessment stating the types of services available. If palliative care is listed as an available service, then it is expected that staff demonstrate basic competence in this area.

- ***Performance Gap and Variability***—The TEP members differed in their opinions on the variability of palliative and end-of-life care services in SNFs and the existence of performance gaps in this area. In the pre-TEP feedback, several TEP members noted that access to palliative and end-of-life services in SNFs varies widely, with one noting that this availability varies by region. Another TEP member noted that although palliative care is important, it is currently under-represented in the SNF setting. Additionally, several TEP members noted that SNFs, especially those in collaboration with hospice providers, had significantly improved in this area, particularly in identifying palliative care patients. However, another TEP member noted that these services have only improved in facilities where there is better access to certified doctors and the necessary resources.

- ***Actionability***—The TEP provided several directions in their feedback for measurement and action to address this focus area. One TEP member recommended more effective processes for obtaining and documenting patient goals of care. This TEP member, along with several others, further recommended incorporating palliative services or palliative care discussions earlier in a resident's stay. Many TEP members stressed the need for increased provider and social worker training on palliative and end-of life services, as well as improved resident and family education on care services that are available. Another TEP member noted that a quality measure in this area could incentivize facilities that are currently lagging to develop protocols and programs to improve and incorporate palliative and end-of-life services into care. However, one TEP member stated that there is currently not enough evidence to determine the actionability of this area.

- ***Potential and/or Related Measures—***One TEP member raised the question of whether a quality measure to address this area should be developed at the facility level or the patient level. At the facility level, a measure would assess whether the facility provides palliative and end-of-life care specialties. At the patient level, a measure would assess whether patients have palliative care need that would lead to a palliative care code. Several TEP members pointed out that an important quality measure for assessing the availability and effectiveness of palliative and end-of-life care services is the return to hospitalization measure. One TEP member noted that successful palliative care should be associated with lower rates of hospital readmission. Another TEP member urged the need to incentivize nursing homes to not send residents back for rehospitalization and instead focus on improving palliative services, end-of life services, and management of some acute conditions, such as pneumonia.

- ***Other Considerations***—One TEP member expressed concerns over quality measures in this area, noting that when these measures are attached to particular reimbursements, they will inevitably affect how individuals are coded. Currently, many residents who should be coded as palliative care are instead coded as a skilled stay because skilled stay is associated with a more-generous reimbursement rate to the facility. One TEP member urged further exploration of how to balance care needs in a cost-effective manner that will not limit residents' care options. Several TEP members noted that we may be "jumping the gun" when considering the palliative care codes. Instead, these TEP members suggested focusing first on palliative care education and training in SNFs. Another TEP member emphasized the need to distinguish between specialty palliative care and primary palliative care if developing a measure in this area. Additionally, one TEP member noted the need to differentiate between palliative and hospice care in the exclusion criteria for these measures. Finally, another TEP member pointed out that hospice care is often used when not necessary for a resident. She suggested the implementation of a spiritual care department that could help encourage the use of palliative care and reduce unnecessary hospice care, as many palliative care decisions are influenced by spiritual and cultural values.

3.5 Focus Area 4: Experience of Care

3.5.1 Focus Area Description

Resident experience of care refers to an individual's personal perspective of and satisfaction with the care they receive during a SNF stay. Public comments submitted for the FY 2018 SNF PPS final rule recommended the development of measures to address resident satisfaction with SNF care.[33] Additionally, an NQF 2017 report noted the need for a Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure for SNF stays.[34] The environmental scan found a lack of measures and standardized assessments focused on resident satisfaction with SNF care. The environmental scan also found evidence that responses from nursing home resident and family satisfaction surveys were associated with several risk-adjusted quality measures, such as the percentage of residents with new or worsened pressure ulcers.[35]

3.5.2 Summary of TEP Scoring on Pre-TEP Materials

Most TEP members agreed that experience of care is a fairly high-priority area in SNF care, with nine TEP members rating this focus area as medium to high priority. One TEP member rated this focus are as a low priority, and two were unresponsive. For the performance gap criterion, most TEP members agreed on the existence of performance gaps in this area, with

[33] Centers for Medicare & Medicaid Services: Medicare finalizes fiscal year 2018 payment & policy changes for skilled nursing facilities. CMS-1679-F. July 31, 2017.

[34] Measures Application Partnership (MAP): MAP 2017 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care. Washington, DC. 2017. Available from http://www.qualityforum.org/Publications/2017/02/MAP_2017_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

[35] Li, Y., Li, Q., and Tang, Y.: Associations between family ratings on experience of care and clinical quality-of-care measures for nursing home residents. Med Care Res Rev. 73(1): 62-84, 2016.

nine rating this focus area as medium to high on this criterion. Three of the TEP members did not respond to the performance gap criterion. There was less consensus among the TEP on the actionability of this area. Two TEP members rated this area's actionability as high, four rated it as medium-high, two rated it as medium, and two rated it as medium-low. Two TEP members were unresponsive for all three criteria for this focus area. In her feedback, one of these unresponsive TEP members noted confusion over whether this area was referring to satisfaction or something else. The other member who did not rate this focus area recommended rephrasing this area to assess the "outcome" of resident experience. Detailed scoring results are summarized in ***Table C-2*** in ***Appendix C***.

3.5.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion covered the following topics related to experience of care:

- ***Importance***—Many TEP members noted in their feedback the importance of assessing resident experience of SNF care. Two TEP members wrote that resident experience and perception of care provides facilities with important feedback on the realities of care quality. Several TEP members stated that resident experience should be a driver for SNF quality improvement efforts, with one specifically noting the importance of a resident experience quality measure to help drive improvements in SNF care environments. One TEP member further pointed out that this area has been identified as very important for SNF care in materials and reports related to the Nursing Home Quality Initiative.

- ***Performance Gap and Variability***—Several TEP members noted the existence of performance gaps in SNFs in this area. For instance, one TEP member noted that resident experience may be underassessed in SNFs. Another TEP member stated that there is currently room for improvement in overall resident experience, noting that human resource factors may contribute to this issue. One TEP member pointed out that resident experience may have a lot of variability because of residents' different care needs and personalities.

- ***Feasibility***—TEP member feedback on the actionability of this focus area varied widely. One TEP member recommended specifying what is meant by resident experience before attempting to address this area. Several other TEP members argued that this area is not very actionable with the current instruments in place for assessing experience of SNF care and that a measure in this area may not help drive quality improvement. Another TEP member noted the difficulty of receiving feedback on care experiences from residents and expressed concerns about relying on feedback from families, as their feedback may differ from that of the residents. However, two TEP members noted the possibility of using models and instruments from other care settings, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, to assess resident experience of SNF care.

- ***Resident Satisfaction Surveys***—Several TEP members pointed out that resident satisfaction assessments are already in use in many facilities. The Nursing Home

Quality Campaign website lists the facilities that already use resident satisfaction surveys. Some TEP member suggested first encouraging more widespread use of satisfaction surveys and assessments before developing measures that would penalize facilities for having poor resident satisfaction scores.

During the TEP discussion on resident experience of care, many of the TEP members shared personal experiences and perspectives on assessing resident experience and satisfaction. One TEP member referenced an intervention he was a part of in which SNFs mailed surveys to residents and families after a SNF stay. Most respondents were pleased with the care and information provided during their stay and their engagement in the care. Another TEP member shared her experience of post-nursing home stay surveys in a hospital-based setting. The surveys included questions on provider responsiveness, staff attitude, housekeeping, and pain management. The survey had a 95% response rate; however, the population was mainly orthopedic patients without cognitive impairment. Another TEP member noted that facilities that distribute the Press-Ganey Nursing Home survey to all residents have about a 30 to 35% return rate.

- ***Other Considerations*—**Several TEP members expressed concerns over the generalizability of resident experience, as measuring resident experience quantitatively does not seem to address specific issues with care. One TEP member noted the importance of written feedback and comments from residents and their families to understand what about the service led to their numerical scores. Additionally, one TEP member encouraged including family and/or caregiver experience during and post-bereavement in satisfaction surveys. Another TEP member pointed out that if a quantitative process for measuring satisfaction were developed and standardized, the next issue would be appropriate staffing to implement this process.

3.6 Focus Area 5: Therapy Engagement

3.6.1 Focus Area Description

Results from the environmental scan found that effective engagement of residents and families/caregivers in SNF therapy, including physical, occupational, and speech and language therapies, may be associated with resident functional outcomes and thus indicative of the quality of SNF care. One study in particular found that residents treated with an intervention that incorporates increased patient engagement in physical therapy and occupational therapy sessions experienced higher mobility improvement.[36]

3.6.2 Summary of TEP Scoring on Pre-TEP Materials

There was little consensus across all three scoring criteria for therapy engagement. TEP members' ratings on the focus area's priority level, performance gap status, and actionability

[36] Lenze, E.J., Host, H.H., Hildebrand, M.W., et al.: Enhanced medical rehabilitation increases therapy intensity and engagement and improves functional outcomes in postacute rehabilitation of older adults: a randomized-controlled trial. J Am Med Dir Assoc. 2012. 13(8): 708-12, 2012.

varied widely. However, as was noted in TEP member feedback, this variability may be due in part to the lack of a clear definition of "therapy engagement" in the pre-TEP materials. Three of the TEP members were unresponsive on all criteria for this focus area. In her feedback, one of these TEP members noted that the definition of this area was very unclear. The other two noted the subjectivity of this area and instead recommended including this area as a component of goal-oriented care that should be assessed by measuring resident outcomes.

3.6.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion regarding therapy engagement covered the following topics:

- ***Clarity of Definition***—Many TEP members expressed the need for further clarification on the definition of "therapy engagement." One TEP member further expressed that, although therapy engagement is important, she is unsure how engagement could be determined.

- ***Importance***—In the pre-TEP feedback, several TEP members noted the importance of therapy engagement in SNF care. One TEP member in particular pointed out that providing patients and families with regular updates could assist with achieving rehabilitation goals and improving resident and family satisfaction.

- ***Performance Gap and Variability***—Several TEP members noted that SNF therapists are already successful in engaging residents and families in therapy. Several other TEP members added that it is not necessary to create a functional quality measure in this area, as physical therapists are already universally trained to engage patients in therapy sessions. However, many other TEP members noted the existence of performance gaps in this area. One TEP member noted that although some residents and families complain about not receiving enough therapy, there is little evidence of therapy that is not engaging.

- ***Feasibility***—Several TEP members expressed concerns over how therapy engagement could be measured in SNFs. Preferences and expectations for therapy engagement can vary greatly across residents; for example, some residents prefer that medical professionals make care decisions, whereas others would like to have a say in their care. Therapy engagement may even vary based on the resident's mood on a particular day. Some TEP members recommended focusing on resident outcomes instead of engagement to assess the quality of SNF therapy. One TEP member recommended measuring therapy efficiency, or the amount of functional improvement in the context of number of hours of therapy. Another TEP member suggested measuring resident outcomes to assess therapy engagement. Additionally, in both the pre-TEP feedback and TEP discussion, several TEP members recommended the use of resident satisfaction surveys and measures to assess this area, as many facilities currently focus on therapy time rather than engagement.

- ***Resident Cognitive Status***—One TEP member noted that cognitive status is an important factor to consider in therapy engagement, as comorbidities may affect a resident's engagement in their therapy.

3.7 Main Takeaways and Next Steps for Domain 1

According to TEP member feedback and the TEP discussion, within resident- and caregiver-centered care, an important area of focus for SNFs is the availability of and training and education on palliative and end-of-life care services. This issue ties in with both goal-oriented care and care planning, as identifying residents who need and desire palliative/end-of-life services requires discussing goals and as well as plans of care with residents and their families and following through on resident goals throughout the SNF stay.

Another important issue addressed throughout the resident- and caregiver-centered care discussion was how measures in this area would affect residents with cognitive impairments. Therefore, any future measure development efforts in this domain should take special consideration of cognitively impaired residents or residents with communication deficits.

Furthermore, the TEP discussion emphasized the importance of considering sociodemographic and socioeconomic factors in future measure development. Many resident preferences, goals, and experiences are heavily influenced by these factors, and quality measures should reflect these variations.

A common concern expressed throughout this section of the TEP discussion was how each of these areas and issues is being defined. According to feedback from the TEP, any future work in these focus areas would require further clarification of and direct connection to a specific aspect of SNF care.

TEP members also frequently raised concerns regarding how measures developed to address these focus areas would affect SNFs and SNF residents. Future measure development will require careful consideration of the purpose of each measure and whether the measure reliably and validly reflects the quality of SNF care.

SECTION 4
DOMAIN 2: COMMUNICATION AND COORDINATION OF CARE TRANSITIONS

4.1 Domain Description

According to a 2013 report by the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) Office of Disability, Aging and Long-Term Care Policy (DALTCP), care coordination is the "deliberate organization of patient care activities to facilitate the appropriate delivery of health care services" and involves activities to "promote, improve, and assess integration and consistency of care" across settings, patients, and providers, and includes "methods to manage care throughout an episode and during transitions."[37] The report further notes that coordination of care transitions may involve "discharge planning, setting up post-discharge follow-up appointments with primary care and specialty providers, coordinating medication and other therapy services post-discharge, in addition to arranging for other supports such as medical equipment that may be needed in the home."[38] Care coordination provides a longitudinal view of care that considers the past while monitoring delivery of care in the present and anticipating the needs of the future. Furthermore, care coordination promotes safe care transitions, continuity of necessary care services, and effective communication between patients and their families, caregivers, and health care providers. The NQF Measures Application Partnership Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care report of 2017[39] noted the need for continued focus on care coordination in SNFs, as this is an area of persisting performance gaps. In the report, the MAP noted that although current measures are helping improve quality in this area, further measure development in care coordination and care transition is needed. The report further identified several specific needs in this area, including the need to integrate measurement between PAC settings, acute care settings, and the community, to address the efficacy of transfers from acute hospitals to SNFs, and to address the transfer of information between attending clinicians.

In addition, studies included in the environmental scan provide evidence that enhanced communication and coordination of care in SNFs is associated with many positive outcomes,

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[37] Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) Office of Disability, Aging and Long-Term Care Policy (DALTCP): Long-Term and Post-Acute Care Providers Engaged in Health Information Exchange: Final Report https://aspe.hhs.gov/report/long-term-and-post-acute-care-providers-engaged-health-information-exchange-final-report/13-care-coordination-during-care-transitions-and-shared-care. 2013.

[38] Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) Office of Disability, Aging and Long-Term Care Policy (DALTCP): Long-Term and Post-Acute Care Providers Engaged in Health Information Exchange: Final Report https://aspe.hhs.gov/report/long-term-and-post-acute-care-providers-engaged-health-information-exchange-final-report/13-care-coordination-during-care-transitions-and-shared-care. 2013.

[39] Measures Application Partnership (MAP): MAP 2017 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care. Washington, DC. 2017. Available from http://www.qualityforum.org/Publications/2017/02/MAP_2017_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

including reduced rates of hospital readmissions,[40] improved clinical outcomes, reduced rates of medication discrepancies and drug diversion,[41] improved shared decision making, and improved overall resident quality of life.[42] The environmental scan identified four key focus areas of potential performance gaps in SNFs: discharge processes from SNFs to the community, transfer of health information, medication reconciliation and drug regimen review, and communication of resident preferences and care goals. These focus areas were presented to the TEP members through a pre-TEP survey and were then discussed in detail at the TEP meeting.

4.2 Current State of Domain in the SNF QRP

The SNF QRP, developed under the mandate of the IMPACT Act, consists of quality measures developed by CMS to meet the intent of standardization across PAC settings. These SNF QRP quality measures currently include several measures that address the communication and coordination of care transitions: two claims-based measures, Discharge to Community-PAC SNF QRP and Potentially Preventable 30-Day Post-Discharge Measure; and an assessment based measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program.

4.3 Focus Area 1: Discharge Processes from SNF to Community

4.3.1 Focus Area Description

Discharge from a SNF to the community is an important goal for many SNF residents. Discharge to the community is a resource use domain as mandated by under the IMPACT Act of 2014.[43] A 2017 study found that re-hospitalization rates within 30 days of discharge from SNF remain as high as 25%,[44] with 78% of these readmissions due to potentially avoidable conditions. The study notes that many of these potentially preventable readmissions are due to unsuccessful and non-standardized discharge processes, and a lack of adequate resident and caregiver education, referrals to community resources, and planned follow-up with residents. In the NQF Measures Application Partnership Families of Measures 2012 report, NQF Measures Application Partnership emphasized the need for measure development to address the role of

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[40] Davidson, G.H., Austin, E., Thornblade, L., et al.: Improving transitions of care across the spectrum of healthcare delivery: A multidisciplinary approach to understanding variability in outcomes across hospitals and skilled nursing facilities. Am J Surg. 213(5): 910-914, 2017. doi:10.1016/j.amjsurg.2017.04.002

[41] Kerstenetzky, L., Birschbach, M.J., Beach, K.F., et al.: Improving medication information transfer between hospitals, skilled-nursing facilities, and long-term-care pharmacies for hospital discharge transitions of care: A targeted needs assessment using the Intervention Mapping framework. Res Social Adm Pharm. S1551-7411(16): 30374-6, April 2017. doi:10.1016/j.sapharm.2016.12.013

[42] Dykes, P.C., Samal, L., Donahue, M., et al.: A patient-centered longitudinal care plan: vision versus reality. J Am Med Inform Assoc. 21(6): 1082-1090, 2014. doi:10.1136/amiajnl-2013-002454

[43] 113th Congress. IMPACT Act of 2014. H.R. 4994. Available from https://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf.

[44] Mileski, M., Topinka, J. B., Lee, K., et al.: An investigation of quality improvement initiatives in decreasing the rate of avoidable 30-day, skilled nursing facility-to-hospital readmissions: A systematic review. Clin Interv Aging 12: 213-222, 2017. doi:10.2147/CIA.S123362

referrals to necessary community resources.[45] According to the AHRQ, these community resources include "any service or program outside the health care system that may support a patient's health and wellness."[46] Results of the environmental scan further demonstrated the need for electronic tools that could connect residents to these community resources and enable a successful post-discharge transition to the community.[47]

4.3.2 Summary of TEP Scoring on Pre-TEP Materials

Most TEP members agreed that the transition from a SNF to the community is an area of high priority in SNFs. Three TEP members, however, rated this area as medium priority, and one TEP member rated it as medium-low. Ratings for performance gap were less consistent, with five TEP members scoring this area's performance gap as high, three scoring it as medium-high, one scoring it as medium-low, and one scoring it as low. TEP member ratings of actionability in this area varied greatly, with three TEP members scoring it as high, three scoring it as medium-high, three scoring it as medium, and two scoring it as medium-low. One TEP member did not provide any ratings for this focus area, noting in her comments that this focus area should be rephrased to indicate "Successful Transition from SNF to Patient Appropriate Level of Care or Independence."

4.3.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion covered the following topics related to discharge processes from SNF to community:

- ***Importance***—Several TEP members noted the importance of focusing on discharge processes during a resident's transition from a SNF to the community and developing a method to assess the quality of these discharge processes, rather than simply assessing the number discharged. One TEP member pointed out that a smooth transition to the community, including setting up all follow-up services and imparting essential information, is critical for resident outcomes post-discharge. One TEP member further noted that a discharge process measure could incentivize SNFs to network with the community of health care providers to ensure successful discharge of residents. Additionally, several TEP members noted the existence of significant performance gaps and variability in discharge processes across facilities and recommended assessment in this area. However, one TEP member stated that this is not an appropriate area for quality measurement in SNFs, and instead recommended focusing on residents' transition to an appropriate level of care or independence.

[45] Measures Application Partnership (MAP): MAP Families of Measure: Safety, Care Coordination, Cardiovascular Conditions, Diabetes. Washington, DC. 2012. Available from https://www.qualityforum.org/Publications/2012/10/MAP_Families_of_Measures.aspx.

[46] Agency for Healthcare Research and Quality: About the National Quality Strategy. http://www.ahrq.gov/workingforquality/about/index.html. Last updated March 2017.

[47] Samal, L., Dykes, P.C., Greenberg, J.O., et al.: Care coordination gaps due to lack of interoperability in the United States: A qualitative study and literature review. BMC Health Serv Res. 16: 143, 2016. doi:10.1186/s12913-016-1373-y

- ***Clear Definition of "Community"***—Several TEP members noted the need for clarification in the definition of "community." Two TEP members claimed the description provided in the pre-TEP survey was vague and unclear. It is important to provide a clear and appropriate definition of "community" before developing any metrics for assessing this area. One TEP member recommended removing the word "community" and instead focusing on a resident's "level of independence" after discharge.

- ***Actionability***—The TEP had varying opinions on the actionability of addressing this focus area through quality measurement. Several TEP members noted that measurement would be possible in this area if the proper education and training was in place. One TEP member pointed out the variety in possible metrics to address this area, including whether a discharge plan was initiated on admission. However, several TEP members noted difficulties with measurement in this area and concerns over the effectiveness of quality measure development. One TEP member pointed out that resident outcomes after discharge to community often depend on the resident themselves. In some cases, residents may be provided with adequate education and preparation for discharge to community but not follow recommendations. Another TEP member noted the barriers to successful discharge, including family and/or caregiver support, resident resistance, socioeconomic factors, the resident's home environment, access to home health services, and the physicians' ability to write prescriptions for discharge.

- ***Potential Areas for Improvement/Measurement***—Several TEP members recommended requiring that discharge planning occur at the beginning of a SNF stay, with one TEP member suggesting the conversation should begin on day one and another suggesting a process measure for discharge planning during the first three days of a stay. One TEP member noted that the most appropriate outcome measure for this area is whether an individual is still in the community within 30 days of their discharge from a SNF. This TEP member pointed out that, although SNF providers cannot prevent all adverse events post-discharge, effective discharge planning can significantly improve the likelihood of success after discharge. Another TEP member added that to prevent as many adverse events post-discharge as possible, discharge processes need to be made more consistent and need to occur at admission assessment.

- ***Sociodemographic/Socioeconomic Factors—***Several TEP members raised concerns in their pre-TEP feedback over measure development in this area, noting that SNFs should not be penalized for factors outside of their control, such as sociodemographic and socioeconomic factors that may affect a resident's success after discharge. The TEP discussion brought up questions of how to address these factors and other systemic issues and the role of SNF providers in addressing these issues. One TEP member shared his experience with New York facilities, which will soon be required to report discharge notices to an ombudsman because of past issues with inappropriate discharges from SNFs. There have been cases of residents discharged to homeless shelters that are not Americans with Disabilities Act (ADA)–compliant or other inappropriate community settings. These examples prompted questions

regarding SNFs' responsibility to residents who do not have a healthy home to return to after their Medicare stay benefit runs out. One TEP member noted that in cases like these, where a resident may need to extend their stay because of barriers to returning home after receiving notice of discharge, the SNF may have to write off the cost of the extended stay. Another TEP member noted that these instances are why we should caution against developing measures that would penalize SNFs if a resident must extend their stay in a facility. SNF providers should prioritize adequate treatment, education, and preparation for discharge to reduce rates of hospital readmission.

- ***Significance of Resident Cognitive Impairment*—**Consistent with the rest of the TEP discussion, several TEP members brought up how this focus area pertains to residents with cognitive impairment or mental health needs. One TEP member pointed out that although the current MDS item set has questions regarding a resident's expected discharge plan, residents with cognitive impairments may be unable to communicate this information. Another TEP member noted the need for mental health considerations in measures related to discharge, as some patients with chronic mental health disabilities are being discharged to inappropriate locations for their conditions.

4.4 Focus Area 2: Transfer of Health Information

4.4.1 Focus Area Description

Although health information technology (HIT), one of the levers of the NQS, is a current focus of quality improvement efforts, there is limited consistency and standardization of information transfer across care settings.[48] Furthermore, studies have found that the health information exchange that does occur between acute and post-acute care settings typically occurs unidirectionally and is often incomplete, ambiguous, or delayed.[49] Noted barriers to effective health information transfer include insufficient education and training for staff; insufficient staffing; lack of standards in content, communication, and messaging; lack of care plan governance; and lack of care team ownership and participation.

Two transfer of health measures are currently under development: (1) Transfer of Information at Post-Acute Care Admission, Start, and Resumption of Care from Other Providers/Settings, and (2) Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings. However, although transfer of health information was identified as a continued performance gap in SNFs, this area was not addressed in this SNF QRP TEP discussion, as two previous TEP meetings were convened in 2017 to specifically address transfer of health. For more information on this focus area, please refer to the reports from these TEP meetings, which can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

[48] Agency for Healthcare Research and Quality: About the National Quality Strategy. http://www.ahrq.gov/workingforquality/about/index.html. Last updated March 2017.

[49] Dykes, P.C., Samal, L., Donahue, M., et al.: A patient-centered longitudinal care plan: vision versus reality. J Am Med Inform Assoc. 21(6): 1082-1090, 2014. doi:10.1136/amiajnl-2013-002454

4.5 Focus Area 3: Medication Reconciliation and Drug Regimen Review

4.5.1 Focus Area Description

Medication reconciliation and drug regimen review are important processes for resolving any medication discrepancies during care transitions. According to a 2017 study, medication discrepancies occur in three-fourths of hospital-to-SNF admissions, with 2.5 to 3 discrepancies per resident.[50] Medication discrepancies during care transitions can lead to delays in symptom management following discharge to SNF and diverted or missing controlled substance prescriptions. Furthermore, results of the environmental scan demonstrated that older adults may be especially at risk for medication discrepancies post-discharge because of polypharmacy associated with chronic disease and comorbidities, which may become more prevalent with age.[51,52]

4.5.2 Summary of TEP Scoring on Pre-TEP Materials

Overall, the TEP agreed that medication reconciliation and drug regimen review are areas of high priority in SNF, with nine TEP members rating this area as having high importance and two rating this area as medium to medium-high. For the performance gap criterion, eight of the TEP members rated this area as either medium or medium-high, and only two TEP members rated this focus area as high. There was less consensus on the actionability of a measure to assess medication reconciliation and drug regimen review, with three TEP members rating this area as high, three rating it as medium-high, four rating it as medium, and one rating it as medium-low. One TEP member did not provide ratings for this focus area on any of the three criteria, noting the need for differentiation between the definitions of medication reconciliation and drug regimen review.

4.5.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion regarding medication reconciliation and drug regimen review covered the following topics:

- ***Importance and Performance Gap***—Most TEP members noted in their pre-TEP feedback the importance of medication reconciliation and drug regimen review for improving resident outcomes in SNFs. Several TEP members emphasized the importance of adequate medication reconciliation, noting how critical this process is for preventing medical errors, therapeutic duplication, drug-drug interactions, and polypharmacy. Another TEP member pointed out that medication errors can lead to

[50] Kerstenetzky, L., Birschbach, M.J., Beach, K.F., et al.: Improving medication information transfer between hospitals, skilled-nursing facilities, and long-term-care pharmacies for hospital discharge transitions of care: A targeted needs assessment using the Intervention Mapping framework. Res Social Adm Pharm. S1551-7411(16): 30374-6, April 2017. doi:10.1016/j.sapharm.2016.12.013

[51] Munshi, M.N., Florez, H., Huang, E.S., et al.: Management of diabetes in long-term care and skilled nursing facilities: A position statement of the American Diabetes Association. Diabetes Care, 39(2): 308-318, 2016. doi:10.2337/dc15-2512

[52] Enderlin, C.A., McLeskey, N., Rooker, J.L., et al.: Review of current conceptual models and frameworks to guide transitions of care in older adults. Geriatr Nurs. 34(1): 47-52, 2013. doi:10.1016/j.gerinurse.2012.08.003

both over- and under-treatment, which can lead to loss of life or hospital readmission. Additionally, several TEP members noted that inadequate medication reconciliation and drug regimen review continues to be a widespread problem in SNFs, with little being done to address this issue, despite national focus in acute care settings. However, several TEP members pointed out that medication reconciliation and drug regimen review are already an expectation for SNFs and that a drug regimen review measure already exists to address this area. One TEP member further noted that most SNFs have systems in place for ensuring adequate drug regimen review. Therefore, the feedback from the TEP members lacked consensus on the need for further measure development in this area.

- ***Information Transfer***—Several TEP members emphasized in both the pre-TEP feedback and the TEP discussion the need for improved HIT and interoperable health records between hospitals and SNFs to ensure the transfer of accurate medications and diagnoses. One TEP member pointed out that medication reconciliation and drug regimen review efforts are often hampered by poor-quality information communicated from hospitals. In addition, several TEP members emphasized the need to incentivize SNF providers to perform medication reconciliation for each resident at admission.

- ***Actionability***—Much of the feedback from the TEP members in the pre-TEP survey focused on the actionability of measures related to medication reconciliation and drug regimen review. Several TEP members questioned the validity and reliability of developing measures in these areas. However, many of the TEP members provided suggestions for ways to improve and assess these processes. For instance, one TEP member suggested requiring that electronic health records be portable to assist with medication reviews. Another TEP member recommended assessment of medication reconciliation at both discharge to SNF from hospital and discharge from SNF to community. This TEP member noted that medication reconciliation at discharge to SNF from hospital should include the documentation of medications taken before hospitalization and at time of hospital discharge, whereas medication reconciliation at discharge from SNF to community should include the documentation of medications taken at time of SNF discharge compared with home medications before hospitalization. Several TEP members emphasized the need to require a set schedule of medication reconciliation, with one TEP member noting that physicians should review medications during their monthly visits with residents. Additionally, one TEP member pointed out that a major focus area for this issue should be the monthly changeover of the medication administration sheet, as this is often when medication discrepancies occur.

- ***Appropriateness of Addressing This Issue in SNFs—***One TEP member argued that implementing medication reconciliation in SNFs correctly is very time consuming and costly, noting that the resources simply do not exist in most SNFs. However, several other TEP members countered that the SNF stay is the most appropriate time for providers to review medications because of the amount of inpatient monitoring in SNF care, and thus is the setting to target for this issue.

- ***Burden on Nurses, and Physician Engagement*—**Another prominent focus of the TEP discussion for this area pertained to who would be responsible for medication reconciliation and drug regimen review if these were to be required through a quality measure. Several TEP members noted that the burden would fall heavily on nurses, even though physicians are the ones who sign off on prescriptions. In response to this claim, one TEP member pointed out that regulations that require physicians to visit residents once a month do not incentivize them to do routine medication reviews with each resident. Most TEP members agreed that adequate medication reconciliation requires more physician engagement, especially at resident admission into a SNF. In addition, one TEP member noted that pharmacies also need to be more involved in medication reconciliation.

- ***Polypharmacy*—**Another significant point of discussion during this segment of the TEP meeting was how to address polypharmacy, or the number of prescription medications a resident is receiving, in SNFs. Several TEP members emphasized the need to address polypharmacy through quality measurement. One TEP member noted that the literature around polypharmacy shows evidence that, for residents with delirium, more medications are associated with lower rates of functional improvement. This TEP member further stated that without incentivization to address polypharmacy through a quality measure, SNF providers may be wary of disagreeing with medications ordered during the hospital stay. However, another TEP member argued that although polypharmacy is indeed a prominent issue, we need to be careful of quality measures that may limit medications for residents who need them.

- ***Differentiation Between Medication Reconciliation and Drug Regimen Review*—** Several TEP members pointed out the need to differentiate between medication reconciliation and drug regimen review when discussing measure development. One TEP member raised the question of whether this discussion is referring to true medication reconciliation for each resident or medication reconciliation that is triggered by drug regimen review. Another TEP member pointed out that we would need both of these to adequately review residents' medications. She added that full medication review would include knowing what residents were taking before acute illness and what the hospital recommendations were, paring down the medications through medication review, and developing a medication plan to allow the resident to discharge to community.

4.6 Focus Area 4: Communication of Resident Preferences and Care Goals

4.6.1 Focus Area Description

Care plans can be used to communicate resident preferences, values, and care goals between providers and between care settings. However, although care plans that function across settings are often envisioned, they are rarely put into place effectively. Gaps in documentation and communication of resident care preferences and care goals may lead to inadequate or inappropriate treatment plans and interventions. Furthermore, insufficient documentation and communication of resident preferences, values, and goals is especially harmful to residents with limited cognitive or communicative abilities.

4.6.2 Summary of TEP Scoring on Pre-TEP Materials

TEP member ratings on the importance of addressing the communication of resident preferences and care goals in SNFs varied greatly. Four of the TEP members scored this area as a high priority, three as medium-high, and four as either medium-low or medium. There was slightly less variability in the TEP member ratings of the performance gap criterion for this area: three scored this area as high, and seven rated this area as either medium or medium high. The TEP ratings were fairly neutral on actionability, with one rating the area as high, four rating it as medium-high, four rating it as medium, and two rating this area as medium-low. One TEP member did not provide responses for any of the three criteria for this focus area, noting in her feedback that she was unable to determine a reason for including this item in the list, as it is already addressed through the new Rules of Participation for SNFs.

4.6.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion covered the following topics related to communication of resident preferences and care goals:

- ***Importance***—Comments from the TEP members in the pre-TEP survey demonstrated varying opinions on the importance of focusing on this area through quality measurement. Several TEP members noted that this is not an area of significant importance for SNF quality, as goals are already communicated and documented. One TEP member pointed out that it is easy to validate whether care goals have been communicated through documentation in the resident's care plan. However, several TEP members pointed out that although documentation of resident goals and preferences may be occurring, many SNF providers are not sufficiently implementing these goals in the care. One of these TEP members emphasized the importance of improving this communication, as it is critical to resident quality of life, the quality of care, and residents' personal dignity.

- ***Actionability***—Several TEP members brought up difficulties in developing a quality measure that would address this issue beyond simply noting whether the resident's care goal has been coded in the MDS. It was also noted that the current Rules of Participation, as well as existing quality measures and programs, sufficiently address this issue. However, two TEP members noted in their feedback that this measure indeed could be improved through quality measurement and the enforcement of robust processes for obtaining and documenting resident goals and preferences.

- ***Distinction Between Care Goals and Care Preferences***—Another main point of discussion during the TEP meeting pertained to the distinction between treatment preferences and goals of care. One TEP member noted that treatment preferences refer to a resident's code status, whereas goals of care refer to the type of care received—for instance, curative care versus comfort care. Another TEP member added that the goals we should be focusing on are beyond the immediate preferences of care but are the goals of the treatment over time. She added that these goals may change; therefore, quality measurement in this area should be designed to address these goals over periods of time. In addition, another TEP member pointed out that we should also not focus on preferences for daily logistics, such as eating and

showering times, but rather should address treatment preferences, including preferences for hospitalization, feeding tube use, and ventilator use.

- ***Distinction Between Care Goals/Preferences and Care Needs***—One TEP member noted in their feedback that although it is very important to take resident goals and preferences into consideration, in many cases, residents' goals may be unreasonable or unachievable because of their condition or prognosis. Therefore, a quality measure to assess implementation of resident goals may not be equitable to providers. Another TEP member noted the instability of many residents' goals and preferences throughout the course of their care as they gain a better understanding of their potential for progress through therapy and medication management. Thus, goals and preferences should be reevaluated throughout a resident's stay.

- ***Interoperable Information Transfer—***The TEP discussion on communication of care preferences and care goals demonstrated a need to focus more on the transition between hospital and SNF care. One TEP member noted that, depending on the setting or facility, there may be different "languages" or "dialects" used to refer to goals and preferences; thus, documentation of goals and preferences should be made interoperable to ensure accurate communication between settings. In addition, this TEP member further pointed out that a resident's goals and preferences may even depend on the setting or situation, and, thus, documentation of goals and preferences may not be translatable even between providers within a setting. However, another TEP member pointed out that even though goals and preferences may not be stable, they can indeed be translated using advanced care plans and code statuses, which should be consistently reviewed and updated during a resident's stay. Furthermore, several TEP members emphasized the need for complete and accurate information from hospitals at patient discharge to SNF. One TEP member suggested hospital summary reports that state the reason for discharge to SNF as well as documentation that this reason was discussed with the patient and their caregiver. Another TEP member pointed out that thorough communication during the transition from acute to post-acute care is essential for improving resident outcomes and quality of life.

- ***Stratification by Resident Care Type—***Several TEP members pointed out that goals and preferences may vary by the type of resident. Several TEP members suggested categorizing residents based on care needs and other factors. In this focus area discussion, one TEP member noted that goals and preferences may also depend on the category a resident falls into. However, another TEP member warned against categorizing residents based on goals, instead recommending in-depth discussions with residents on their individual care needs and preferences. Furthermore, another TEP member emphasized the need to understand a resident's comorbid conditions when assessing resident goals and to ensure that these comorbidities are communicated between providers.

4.7 Main Takeaways and Next Steps

Overall, the TEP discussion of communication and coordination of care transitions revealed a need to address existing performance gaps in this area. Particularly, the TEP

emphasized the importance of improving communication of medical information, including medications, diagnoses, and resident preferences and goals, and incentivizing interoperability of HIT and electronic health records across settings. Additionally, a key takeaway from this portion of the discussion was the need to improve the quality of conversations between SNF providers and residents through measurement, rather than simply noting that a conversation took place. Ensuring that the resident and their caregivers are adequately informed, understand their care plans, and can communicate their personal goals and preferences is critical to resident quality of life and outcomes. Finally, the TEP discussion demonstrated a need to address and increase physician engagement with residents and improve communication between providers within a SNF. As was emphasized many times throughout the discussion, communication is key to improving resident outcomes, improving resident quality of life, and avoiding adverse events.

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SECTION 5
DOMAIN 3: SYMPTOM MANAGEMENT

5.1 Domain Description

According to the National Cancer Institute, the goal of symptom management is to "prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment."[53] Results from the environmental scan found that enhanced symptom management in SNF settings is associated with reduced rates of hospital-acquired conditions, improved health outcomes, increased rates of residents who achieve functional independence, and improved overall quality of life for residents.

5.2 Focus Area 1: Pain Management

5.2.1 Focus Area Description

Pain management was identified as a key component of symptom management and an area with wide variation in the SNF setting. According to the American Geriatrics Association (AGS), effective pain management "begins with a thorough assessment to determine its source, severity, and impact on functioning and well-being" and effective management of persistent pain "requires a collaborative and ongoing partnership between the clinician, the patient, and family."[54] The AGS further emphasized the importance of addressing pain in the older adult population, as studies have found that "25%–50% of community-dwelling older adults and 45%–80% of nursing-home residents have substantial pain."[55] The 2012 NQF Measures Application Partnership Families of Measures report emphasized the need to address pain management across settings, avoiding the under/over-treatment for pain while also understanding patient needs and goals.[56] Public comments submitted for the FY 2018 SNF PPS proposed rule expressed the continued need to address pain management in SNFs and suggested the further development of measures in this area.[57]

Results from the environmental scan identified pain management as a persistent performance gap area in SNFs, with evidence of nursing home residents having high risks of

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[53] National Cancer Institute: NCI Dictionary of Cancer Terms. https://www.cancer.gov/publications/dictionaries/cancer-terms?cdrid=269453. Last updated April 5, 2016.

[54] American Geriatrics Society (AGS): Geriatrics Review Syllabus (GRS): Pain Management. https://geriatricscareonline.org/FullText/B023/B023_VOL001_PART001_SEC002_CH016.

[55] American Geriatrics Society (AGS): Geriatrics Review Syllabus (GRS): Pain Management. https://geriatricscareonline.org/FullText/B023/B023_VOL001_PART001_SEC002_CH016.

[56] Measures Application Partnership (MAP): MAP Families of Measure: Safety, Care Coordination, Cardiovascular Conditions, Diabetes. Washington, DC. 2012. Available from https://www.qualityforum.org/Publications/2012/10/MAP_Families_of_Measures.aspx.

[57] Centers for Medicare & Medicaid Services: Medicare finalizes fiscal year 2018 payment & policy changes for skilled nursing facilities. CMS-1679-F. July 31, 2017.

delayed pain control and untreated/undertreated pain, particularly those with dementia.[58,59,60] Untreated/undertreated pain in older adults can have serious negative impacts on health, functioning, and quality of life. The literature further demonstrated significant performance gaps in pain management for residents with dementia and other cognitive impairments.[61,62] These populations are at increased risk of being under assessed, undertreated, and delayed for treatment.

5.2.2 Summary of Scoring on Pre-TEP Materials

With a focus on pain management, almost all of the TEP members agreed that the management of pain is a high priority area in SNF settings, with ten TEP members rating high for importance and only one rating this area as medium-low. One TEP member did not respond for this criterion. The majority of TEP members also rated this area high for performance gap, with six rating high, three rating medium to medium-high, and one rating medium-low. Two TEP members were unresponsive for the performance gap criterion. For actionability, the majority of the TEP members also rated this focus area fairly high, with five giving it the highest rating and five rating medium to medium-high. Two TEP members did not provide scores for this criterion. One TEP member, who did not provide ratings for any of the three criteria for this focus area noted in their feedback that pain management is already being addressed in SNFs in several ways including the Rules of Participation, survey, MDS completion, and standardized assessment items.

5.2.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion covered the following topics related to pain management:

- ***Priority, Performance Gaps, and Variability*—**While the TEP agreed that pain management is an area of high priority for SNF care, many TEP members noted that this is an area where there is a high performance gap with great disparities in pain management and treatment. Several TEP members recommended improved and more frequent staff training on pain management and treatment, as inadequately treated pain can lead to under- or over-medication, significant impacts on functional outcomes, and low resident satisfaction. However, one TEP member stated that this is

[58] Jones, K., Fink, R., Pepper, G., et al.: Improving nursing home staff knowledge and attitudes about pain. Gerontologist 44(4):469-478, 2004.

[59] Liao, S., and Weissman, D.E.: Pain Management in Nursing Homes: Analgesic Prescribing Tips, in Fast Facts and Concepts. Palliative Care Network of Wisconsin.

[60] Gilmore-Bykovskyi, A.L. and Bowers, B.J.: Understanding Nurses Decisions to Treat Pain in Nursing Home Residents with Dementia. Research in Gerontological Nursing 6(2):127-138, 2013.

[61] Kolanowski, A., Mogle, J., Fick, D.M., et al.: Pain, delirium, and physical function in skilled nursing home patients with dementia. J Am Med Dir Assoc.16(1):37-40, 2015.

[62] Burfield, A.H., and Cooper, J.W: Assessing pain and falls risk in residents with cognitive impairment: Associated problems with overlooked assessments. Annals of Long-Term Care: Clinical Care and Aging 22(5):36-41, 2014.

actually an area with a low performance gap, as many SNF residents tend to be prescribed as-needed pain medication regimens.

- ***Cognitive Impairment/Communication Difficulties***—A common theme in both the pre-TEP feedback and the TEP discussion on pain management was how pain assessment, management, and treatment are handled for patients with cognitive impairments or other communication difficulties. One TEP member noted that basic pain management in SNFs is not a performance gap, but rather the performance gap is with pain assessment and treatment for residents that are cognitively impaired. Another TEP member expressed concerns over developing quality measures in this area without addressing the ability of SNF populations to consistently and reliably provide this information. In addition, several TEP members pointed out the need for appropriate nonverbal assessment tools, such as the Abbey Pain Scale and the Pain Assessment in Advanced Dementia (PAINAD) Scale, for residents with cognitive impairments or limited communication ability. One TEP member noted that if we cannot appropriately assess pain, then we cannot appropriately assess pain management or the relief of pain.

- ***Risk Adjustment and Measure Exclusions Due to Residents' Differences—***While pain assessment and management are important for patient safety and functional improvement, many of the TEP members warned against developing quality measures that would penalize SNFs for taking in residents with more complex conditions. A TEP recommendation was that quality measures related to pain be risk-adjusted for resident acuity. One TEP member pointed out the need to exclude residents who are using end-of-life and palliative care services from a pain measure, as the experience of pain for these residents is often not indicative of the quality of SNF care.

- ***Potential Measure Areas—***Many of the TEP members pointed out that pain management in SNFs may not be fully addressed by quality measures that focus solely on pain assessment. Several TEP members expressed concerns over pain assessment measures, noting the difficulty of capturing a resident's personal experience of pain and the wide variation in experience and expression of pain. One TEP member pointed out that the expression of pain and verbal descriptors of pain vary greatly across different cultures and languages.

  Several TEP members encouraged addressing the type of pain intervention that is used in pain management. One TEP member noted that he would like to see increased use of pain interventions that are not medications, such as ice packs, hot packs, and repositioning. However, another TEP member pointed out that the current regulatory framework makes it difficult for or do not incentivize providers to use non-prescription interventions. Another TEP member added that an alternative would be to address whether facilities have an effective pain management process that includes pain evaluation and rehabilitation before resorting to pharmacological interventions.

  Instead of focusing quality initiatives on pain assessment, several TEP members recommended focusing on pain's interference with functioning and quality of life.

One TEP member encouraged the operationalization of pain interference in order to determine how an individual's experience of SNF care and is impacted by their pain and their pain management regimen. Finally, one TEP member noted that, when assessing pain, the residents should be the deciding factor; that is, the experience of pain should be offered by the residents themselves, offering their own perspective on how the pain and pain treatment are impacting their function and quality of life.

5.3 Focus Area 2: Opioid Therapy Evaluation

5.3.1 Focus Area Description

In its 2016 Opioid Misuse Strategy, CMS identified the opioid use disorder epidemic as a top public health priority. According to the report, 6 out of every 1,000 Medicare beneficiaries suffer from the disorder.[63] The report further outlines CMS's mission to promote safe and appropriate opioid utilization, improved access to treatment for opioid use disorders, and evidence-based practices for acute and chronic pain management. Furthermore, on October 26, 2017, HHS declared a public health emergency to address the national opioid crisis due to evidence from the Centers for Disease Control and Prevention (CDC) that more than 140 Americans die from drug overdoses each day, 91 specifically due to opioids.[64] HHS further unveiled a five-point Opioid Strategy to address this epidemic with the following priorities: improve access to prevention, treatment, and recovery support services; target the availability and distribution of overdose-reversing drugs; strengthen public health data reporting and collection; support cutting-edge research on addiction and pain; and advance the practice of pain management.[65] Results from the environmental scan demonstrated evidence that the older adult population is at a higher risk of adverse drug events and experiencing the side effects of opiates due to high rates of comorbidities and polypharmacy among this population, especially in nursing homes.[66,67]

5.3.2 Summary of TEP Scoring on Pre-TEP Materials

While two TEP members did not provide ratings for priority level of opioid therapy evaluation in SNFs, eight of 10 TEP members rated this concept as a medium-high to high-priority area. Two of the TEP members rated medium-low for this area. For performance gap, the majority of TEP members rated this area as medium-high for existence of performance gaps, two

[63] Centers for Medicare & Medicaid Services: Centers for Medicare & Medicaid Services (CMS) Opioid Misuse Strategy 2016. 2017.

[64] Department of Health and Human Services (HHS): HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis: Press Release. https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html. 26 October, 2017

[65] Department of Health and Human Services (HHS): HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis: Press Release. https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html. 26 October, 2017

[66] Chau, D.L., Walker, V., Pai, L., and Cho, L.M.: Opiates and elderly: Use and side effects. Clin Interv Aging 3(2):273-278, 2008.

[67] US Department of Health and Human Services. (2010). *Research Activities* (Vol. 357, Publication No. 357). Agency for Healthcare Research and Quality.

rated high, and two rated medium-low to medium for this area. There was less consensus on the actionability of this focus area, with three rating high for actionability, two rating medium-high, three rating medium, and two rating medium-low on this criterion. Two TEP members did not provide numerical scores for any of the criteria for this focus area. In his feedback, one TEP member noted that he did not feel he had enough expertise in this area to provide specific rankings. The other TEP member who did not provide a score for this focus area noted that opioid therapy should be viewed as a subsection of pain management.

5.3.3 Summary of Pre-TEP Feedback and TEP Discussion

Feedback from the TEP members on the pre-TEP materials and the TEP discussion covered the following topics related to opioid therapy evaluation:

- ***Importance for SNF Population***—Overall, the TEP agreed that while opioid abuse is currently a major public health issue, nursing homes may not be the appropriate setting to address this problem, as many nursing home providers currently struggle to adequately treat residents' pain. Many of the TEP members warned against quality measures that would inhibit opioid prescription in nursing homes. However, several TEP members noted that while this may be an issue in SNFs, it should not be addressed through quality measurement, but rather through improved training and education of providers and residents on opioids. One TEP member recommended that, rather than opioids, the focus should be on the overprescription of antipsychotics and psycho-pharmaceuticals because these are more widely used in SNFs. Another TEP member stated that opioid therapy in SNFs is an area with a low performance gap, as opioids in SNFs are typically ordered as needed and are discontinued once pain is resolved.

- ***Training and Education***—Several TEP members noted the existence of disparities in pain management and opioid therapies, and recommended improved staff and patient education on opioid use. One TEP member added that staff training would be an effective and easy way to monitor and evaluate this issue in SNFs. Another TEP member recommended providing further clarification on and differentiation between the definitions of use, misuse, and overuse of opioids. Additionally, several TEP members noted that this issue should be addressed through proper medication reconciliation, drug regimen review, and education of staff and residents on potential side effects and complications and the risk of addiction when using opioids long-term.

- ***Impact on Palliative and End-of-Life Residents***—Several TEP members expressed concerns over addressing opioid use in SNFs with a quality measure, as this may lead to inadequate pain management for residents using palliative and end-of-life care services. Therefore, they urged against inhibiting prescribing practices through quality measurement. One TEP member noted that if a measure is developed in this area, it would need to exclude palliative and end-of-life populations from the measure calculation.

5.4 Main Takeaways and Next Steps

The TEP discussion on symptom management revealed an overwhelming consensus over the need for further focus on pain management in the SNF QRP. Feedback from the TEP in the pre-TEP survey and the TEP discussion demonstrated a great need for improvements in pain assessment for nonverbal residents or residents with cognitive impairments. The TEP discussion also highlighted the importance of focusing not only on pain assessment, but also pain interference and the type of interventions used to treat pain. Additionally, a common concern raised in both the discussion and the pre-TEP feedback was how quality measures to address pain would potentially penalize SNFs. The TEP suggested first encouraging accurate and appropriate assessment of pain before penalizing SNFs for residents who experience pain. However, while the TEP agreed that pain management is a priority issue in SNFs, the TEP members expressed concern over specifically addressing opioid use in SNFs, noting that, while this issue is important, it would be more appropriately addressed in other settings. The TEP members recommended focusing on proper education and training of providers and residents on opioids rather than implementing policies that would inhibit opioid prescription.

SECTION 6
DOMAIN 4: FUNCTION

6.1 Domain Description

According to the National Committee on Vital and Health Statistics, "information on functional status is becoming increasingly essential for fostering healthy people and a healthy population."[68] Assessing resident functional status, such as the resident's ability to perform activities of daily living at both admission and discharge, is crucial for developing appropriate care plans as well as for measuring the quality of SNF services. In a 2008 study examining the impact of 10 days of bed rest, it was found that healthy adult participants experienced substantial loss of lower-extremity strength, power, and aerobic capacity, and a reduction in physical activity.[69] This study highlights the importance of addressing mobility and muscle function in SNFs to prevent functional decline. Public comment submitted for the FY 2018 SNF PPS proposed rule suggested the need for measures that address functional maintenance and functional decline, rather than solely addressing functional improvement. To better address the public comments, the purpose of the TEP discussion on this domain was to discuss if additional areas under function domain should be addressed in SNF QRP.

6.2 Current State of Domain in the SNF QRP

The SNF QRP currently has adopted five measures that address function: one process measure to assess whether residents have an admission and discharge functional assessment and a care plan that addresses function, and four outcome measures that address residents' self-care abilities and mobility at admission and discharge. Again, the TEP explored the idea of measures that could address functional decline and maintenance. TEP discussion is below.

6.3 Summary of TEP Discussion

The TEP discussion covered the following topics related to function:

- ***Potential Areas for Improvement/Measurement***—The TEP discussion for function was focused on ways to improve and expand quality measurement of function in SNFs. One TEP member recommended the development of quality measures to address efficiency of functional improvement, focusing on not only how much a resident improves in function but also how much they improve over how many days. Another TEP member pointed out that the current functional quality measures include two types of Medicare Part A short-stay resident: residents who are in the SNF for rehabilitative services and residents who are there for skilled nursing care, such as

[68] Subcommittee on Health National Committee on Vital and Health Statistics: Classifying and Reporting Functional Status. 2001. Available from https://www.ncvhs.hhs.gov/recommendations-reports-presentations/ncvhs-recommendations-reports-presentations-archive-1996-2003/july-17-2001-report-to-the-secretary-on-classifying-and-reporting-functional-status/.

[69] Kortebein, P., Symons, T.B., Ferrando, A., et al.: Functional impact of 10 days of bed rest in healthy older adults. J Geront A Biol Sci Med Sci. 63(10): 1076-1081, 2008.

antibiotic therapy. This TEP member recommended looking at functional assessment data for all SNF residents, including those not receiving therapy.

- ***Cognitive Function*—**Several TEP members emphasized the need for assessment of cognitive status in SNFs. One TEP member noted the need for meaningful and measurable metrics for cognitive status and recommended that cognitive status be addressed before focusing on any other issues in SNFs. It was noted that not all cognitive impairments can be improved, but residents can often be taught to compensate for impairments. When asked about whether cognitive function should be measured at the impairment level or at the activity level, TEP members noted that both were important.

- ***Bladder and Bowel Function*—**The TEP members were asked whether bladder and bowel function should be the focus of future quality measures. One TEP member noted that, although bowel and bladder function are important, cognitive status is the larger issue and needs to be addressed first.

6.4 Main Takeaways and Next Steps

The TEP discussion demonstrated a need to revisit the finalized SNF function measures and determine what gaps in functional assessment remain. Discussion centered on assessment of cognitive status and improvement of cognitive status among SNF residents. Cognitive assessment items are being tested as part of the IMPACT Act's standardized assessment work to address item reliability and validity in the post-acute care population.

SECTION 7
OTHER AREAS FOR FOCUS IN SNFS

Finally, TEP members spent time discussing specific conditions and symptoms that they suggested be addressed through future measure development as well as additional areas that are important for focus in SNF settings. These areas are outlined below.

- ***Behavioral and Neurologic Conditions***—Several TEP members noted the importance of addressing behavioral conditions such as depression, anxiety, suicidal ideation, and delirium through quality measurement. One TEP member noted that delirium in particular is a symptom that is often incorrectly assessed and underdiagnosed. Another TEP member suggested considering neurologic conditions such as Parkinson's disease and multiple sclerosis when developing quality measures. Many residents suffering from deteriorating diseases such as these are highly unlikely to improve in function or cognitive status; therefore, the TEP member suggested that facilities should not be penalized for proper management of these conditions, by quality measures addressing functional or cognitive improvement.

- ***Falls Without Major Injury***—Several TEP members also emphasized the need for quality measures that assess falls without major injury, rather than solely measuring falls with major injury. One TEP member pointed out that noninjurious falls are often predecessors to falls with major injury and thus providers should sufficiently assess patients after every fall using balance/rebalance tests, reviewing resident medications, and assessing the lighting and the resident's location in the facility. This TEP member added that quality measurement for noninjurious falls should include assessments of whether interventions were implemented after the fall, whether therapists were involved in resident assessment, and whether medications were reviewed. However, several other TEP members expressed concerns over measuring noninjurious falls and recommended differentiating between controlled falls and uncontrolled falls.

- ***Dental/Oral Care***—Two TEP members suggested more focus on dental and oral care in nursing homes and SNF stays, as dental and oral health are important for quality of life and health outcomes but are often ignored in these settings.

- ***Polypharmacy***—One TEP member emphasized the need to address polypharmacy in SNFs as this is an important issue for nursing home populations.

- ***Quality of Life/Resident Experience of Care***—Several TEP members suggested the development of quality measures to address quality of life and overall experience in SNFs. For instance, one TEP member noted the importance of preferences around bathing, dining, and other activities of daily living. Another TEP member added that social and spiritual domains are very important for many residents' quality of life and should be taken into account. This TEP member further noted the importance of families' bereavement experience.

- ***Hydration Status***—One TEP member suggested further focus on hydration status in SNFs, as current assessments look only at fluid overload. He noted that many patients have kidney failure or are taking kidney medications and thus would benefit from

increased assessment of hydration status. Another TEP member added that hydration status is connected to both incontinence and insomnia sweating, and supported the importance of residents' hydration status.

- ***Diabetic Footcare***—One TEP member recommended addressing diabetic foot care and surgical wound status through quality measurement, as this type of care is important for functional improvement in SNFs.

- ***Respiratory Care Services***—One TEP member added that respiratory care services need to be increased and improved in SNFs, as facilities with respiratory services available have been found to have fewer hospitalizations. Residents who can breathe better are more likely to improve in function and are thus less likely to return to hospital.

- ***Insomnia and Other Sleep Conditions***—Another TEP member pointed out the importance of addressing insomnia and other sleep conditions to improve outcomes in SNFs. He added that these conditions should be addressed by means other than sleep medications, such as small interventions that could include improvements to lighting, comfort, environment, and sleep practices.

- ***Ability to Come and Go from Facility***—One TEP member recommended a measure that would incentivize providers to encourage SNF residents who are capable to leave the facility for periods of time. He added that this measure would need to be risk adjusted for those who are not capable of leaving the facility.

- ***Cost of Care***—Another TEP member noted that cost of care itself should be a measure of SNF quality, as there is currently wide variation in cost of care for different conditions and for facilities in different locations.

Several TEP members concluded the discussion with concerns regarding the current SNF QRP and the topics of the TEP discussion. One TEP member noted that the QRP needs to address the diversity we see across facilities in order to improve the quality of SNF care everywhere. Another TEP member suggested attempting to pare down the assessments currently required and, when developing future measures, to utilize already existing items rather than adding to these assessments. Finally, one TEP member emphasized that much of what was discussed in the TEP meeting does not apply to the small Medicare Part A short-stay population that is being assessed in the SNF QRP. She recommended incorporating all applicable patients into the quality measure calculations rather than just the Medicare Part A population.

APPENDIX A:
TECHNICAL EXPERT PANEL (TEP) MEMBERS

❖ Susan Battaglia, RN-BC, RAC-CT

Director of Case-Mix Management & Clinical Services
Tara Cares
Orchard Park, NY

Susan Battaglia has worked in long-term care for 40 years in many roles. Her career began as a licensed practical nurse, later becoming a nurse manager after returning to school for an RN degree, assistant director of nursing, Minimum Data Set (MDS) coordinator, and then consultant. Presently, Ms. Battaglia is employed as the director of case mix management and clinical services for Tara Cares, a consulting firm that provides supportive services to 35 facilities in seven states. Her past job functions include lead educator on the Resident Assessment Instrument (RAI) process, with emphasis on accurate MDS coding; the creation of person-centered care planning; quality measure education on 5 Star, Value-Based Purchasing (VBP), and quality reporting program (QRP); and the new Requirements of Participation. Her current role encompasses providing continuing education regarding the above topics as well as monitoring compliance with Medicare/Medicaid regulations and reimbursement, assessing survey outcomes, and reviewing/creating policies and procedures. Ms. Battaglia is a 16-year active member of American Association of Nurse Assessment Coordinators (AANAC); she previously held master teacher status and served on numerous committees. She served as a past American Health Care Association (AHCA) webinar presenter and currently serves on the Clinical Practice Committee and chairs the MDS/IMPACT subcommittee.

Ms. Battaglia received her associate of applied science degree in nursing from SUNY: Erie Community College.

❖ Michelle Bellantoni, MD, CMD

Associate Professor of Medicine and Clinical Director
Division of Geriatric Medicine and Gerontology
Johns Hopkins University School of Medicine
Baltimore, MD

Dr. Michele Bellantoni is an associate professor and clinical director of the Division of Geriatric Medicine and Gerontology at Johns Hopkins University School of Medicine and medical director of the Specialty Hospital Programs of the Johns Hopkins Bayview Medical Center. She has 28 years of experience as an attending physician, medical director, educator, and researcher in post-acute and long-term care settings. Dr. Bellantoni is a member of the American Medical Director's Association's (AMDA) board of directors and the Society for Post-acute and Long-term Care Medicine, a member of the society's Public Policy Committee, co-chair of the Annual Meeting Program Committee, and secretary of the AMDA's Mid-Atlantic Chapter. She served 5 years on the Long-term Care Governing Council of the American Hospital Association and was committee chair in 2011. Currently, Dr. Bellantoni is a physician leader of the Johns Hopkins Medicine Skilled Nursing Facility Collaborative, and she represents Johns Hopkins in the Seniors Quality Leap Initiative, a North American collaborative of nursing homes with a mission

to share quality data and improve practices as a network of nursing facilities. She recently served as a faculty coach for AHRQ's Safety Programs for Long-term Care.

Dr. Bellantoni received her undergraduate degree from the University of Pennsylvania and her medical degree from Johns Hopkins University School of Medicine.

❖ Jason Cook, PT, LTCA

Administrator
Cardinal Hall Rehabilitation Hospital
Lexington, KY

Jason Cook has practiced in acute care and nearly every arena of the post-acute care spectrum, including skilled nursing facilities (SNFs), home care, inpatient rehabilitation facilities (IRFs), and outpatient over the past 15 years. Mr. Cook has worked in the SNF field specifically since 2006 in various roles, including administrator since 2013 at Cardinal Hill Rehabilitation Hospital in Lexington, Kentucky.

Mr. Cook received both his undergraduate degree and a master of science in physical therapy from the University of Kentucky.

❖ Dea Kent, DNP, RN, NP-C, CWOCN, QCP

Director of Nursing Home Oversight and Consulting
Wound Ostomy and Continence Nurses Society (WOCN)
Mt. Laurel, NJ

Dr. Dea Kent has practiced nursing for more than 29 years, spending the last 17 years as a certified wound ostomy and continence nurse and practicing as a nurse practitioner for the last 11 years. Dr. Kent has worked across the care continuum in all settings and is currently the director of Nursing Home Oversight & Consulting for Community Health Network, Indianapolis, Indiana. She oversees quality in 38 SNFs and is a resource for acute and post-acute settings, especially in closing the gap that exists between the areas of care. Dr. Kent serves as the wound section editor of the *Journal of Wound Ostomy and Continence* and has authored several peer-reviewed articles published in multiple journals. She has revised/developed several book chapters in relation to skin and wound care across the nursing continuum. Dr. Kent is not only an expert in skin and wound care, but also a highly respected resource for the Quality Assurance and Performance Improvement (QAPI) process. Dr. Kent holds membership in the American Nurses Association, Sigma Theta Tau (alpha chapter), the American Organization of Nurse Executives, the National Association for Healthcare Quality, the American Association of Directors of Nursing Services (AADNS), and the Wound Ostomy Continence Nurses Society, Specific to Long Term Care. Dr. Kent has held multiple professional jobs including staff development coordinator, corporate nurse aide program director, and director of nursing. She is certified in QAPI through the AADNS group and will shortly complete the requirement as a Team STEPPS master trainer.

Dr. Kent received both an associate's and bachelor's degree in nursing from Indiana University, a doctorate of nursing practice from Indiana University, and a master of science in nursing with a nurse practitioner focus from Ball State University.

❖ Richard Mollot, JD

Resident Advocate and Policy Researcher
Long-Term Care Community Coalition
New York, NY

Richard Mollot is the executive director of the Long-Term Care Community Coalition, a nonprofit organization dedicated to improving care for seniors and the disabled through legal and policy research, advocacy, and education. Mr. Mollot has served on a number of state and national consumer and government advisory groups relating to such issues as dementia care, nursing home and assisted living standards, mandatory managed long-term care, and nursing home financing and quality improvement. Mr. Mollot has written and presented trainings on a variety of long-term care issues, including Nursing Home Laws & Regulatory Standards; Assisted Living Law & Policy; Dementia Care & the Use of Antipsychotic Drugs; Caring & Planning for an Aging Person with Disabilities; and The Affordable Care Act: What Seniors Need to Know About Long Term Care & Elder Justice.

Mr. Mollot received his undergraduate degree from the State University of New York and a law degree from Howard University School of Law. He is a member of the Maryland Bar.

❖ Sheria G. Robinson-Lane, PhD, RN

Assistant Professor
University of Michigan School of Nursing
Ann Arbor, MI

Dr. Sheria G. Robinson-Lane is an assistant professor of nursing at the University of Michigan in the department of Systems, Populations, and Leadership. Dr. Robinson-Lane has a clinical practice history in both long-term care and hospice. Her expertise is in advanced illness management, long-term care, and nursing administration. She has focused her career on the care and support of older adults with cognitive and functional disabilities. To this end, she has developed and presented numerous presentations and publications on effective nursing practice and the care and symptom management of older adults. Dr. Robinson-Lane's research addresses the ways that older adults adapt to changes in health and particularly how health behaviors affect health outcomes. Her current work is focused on reducing health disparities for minority older adults with cognitive impairments and their informal caregivers.

Dr. Robinson-Lane received her undergraduate degree from the University of Wisconsin–Oshkosh, a master of science in nursing and a master of health administration from the University of Phoenix, and a doctorate in nursing from Wayne State University. She completed a postdoctoral advanced rehabilitation research training fellowship at the University of Michigan School of Medicine.

❖ Sainey Tambedou, MSHAI, BSN, DNS-CT, RAC-CT, CRNAC

Director of Clinical Assessment, Standards, and Compliance
Integrace
Sykesville, MD

Sainey Tambedou is a member of the American Health Information Management Association and AANAC and is a lifetime member of the Phi Kappa Phi Honor Society. He has more than 20 years of practical, managerial, and leadership experience in the SNF/long-term care industry. Mr.

Tambedou currently serves as the director of Clinical Assessment, Standards, and Compliance for Integrace. Over the last two decades, he held various positions at Sibley Memorial-Johns Hopkins Medicine and HCR-Manor Care.

Mr. Tambedou received a bachelor's degree in nursing from Bowie State University and a master of science degree in health administration informatics with a dual concentration in health care administration and health informatics from the University of Maryland. He is a licensed registered nurse in Maryland and the District of Columbia.

❖ Azlan Tariq, DO

Vice President of Medical Affairs
Integrated Rehab Consultants LLC
Chicago, IL

Dr. Azlan Tariq is board certified in physical medicine and rehabilitation (PM&R), also known as physiatry. After graduating from medical school, Dr. Tariq joined the Department of Internal Medicine at Mount Sinai Hospital Chicago as an intern and then completed a 3-year residency in PM&R at Marianjoy Rehabilitation Hospital in Wheaton, Illinois. Dr. Tariq was awarded the resident of the year honor by his residency program. He then went to the University of Wisconsin–Madison and completed additional training in pain and musculoskeletal medicine. Since then, he has practiced in many levels of rehabilitation care, including IRFs, SNFs, outpatient rehabilitation facilities, and pain clinics. Dr. Tariq has also contributed as a participant on the Centers for Medicare & Medicaid Services (CMS)/RTI TEP for the Development of Functional Outcome Quality Measures for Skilled Nursing Facilities. Dr. Tariq is currently the vice president of medical affairs at Integrated Rehab Consultants, the largest group of physiatrists in the country. His practice is primarily in the subacute rehabilitation department where he acts as a rehabilitation and pain consultant.

Dr. Tariq received his undergraduate degree from the State University of New York and a doctor of osteopathic medicine from Lake Erie College of Osteopathic Medicine.

❖ Helena Temkin-Greener, PhD, MPH

Professor
Department of Public Health Sciences
University of Rochester School of Medicine & Dentistry
Rochester, NY

Dr. Helena Temkin-Greener is a professor in the Department of Public Health Sciences and the co-director for palliative care research at the University of Rochester School of Medicine & Dentistry. She is a health services researcher with a long-standing interest in aging and health care outcomes. Dr. Temkin-Greener's research focuses on 1) quality of care: developing outcome measures and assessing quality of care in community-based, hospital, post-acute, and long-term care settings; 2) organizational performance: developing and validating care process and team performance measures; and 3) aging and long-term care: assessing the impact of individual and organizational risk factors on quality of care for vulnerable elderly people. Her research has been funded by the National Institutes of Health, the Patient-Centered Outcomes Research Institute, the Robert Wood Johnson Foundation, the Donaghue Foundation, and others.

Dr. Temkin-Greener received her undergraduate degree from Smith College, a master of science in anthropology from the University of Massachusetts, and a doctorate in biological anthropology and a master of public health in community and preventive medicine from the University of Rochester School of Medicine.

❖ Kathleen Unroe, MD, MHA

Associate Professor
Indiana University School of Medicine
Research Scientist
Regenstrief Institute
Investigator
Indiana University Center for Aging Research
Indianapolis, IN

Dr. Kathleen Unroe is an associate professor of medicine at Indiana University in Indianapolis and a nursing home physician. Her research, clinical, and policy interests are focused on improving quality of care, particularly access to palliative and end-of-life care, for long-stay nursing home residents. Dr. Unroe was awarded a 2014 Paul B. Beeson K23 Career Development Award to examine hospice use in nursing homes. She is the co-project director of OPTIMISTIC, a 4-year CMS-funded demonstration project aimed at improving quality of care in 19 Indiana nursing homes. She has also been funded by the National Palliative Care Research Center and was the American Academy of Hospice and Palliative Medicine 2014 Junior Investigator of the Year. She is vice-chair of the American Geriatrics Society Public Policy Committee. She was a 2009–2010 Health and Aging Policy Fellow and had a placement in Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy.

Dr. Unroe received her undergraduate degree from Miami University and both a medical degree and a master of health care administration from Ohio State University.

❖ Joanne M. Wisely, MA, CCC/SLP, FNAP

Vice President of Legislative Advocacy
Genesis Rehabilitation Services
Kennett Square, PA

Joanne Wisely serves as vice president-legislative advocacy for Genesis Rehabilitation Services (GSR)/Respiratory Health Services following 6 years as GRS vice president-regulation and compliance. Her responsibilities have included development of organizational Medicare and clinical services compliance programs; implementation of quality improvement initiatives; organizational policy maintenance and oversight; and industry representation to support federal legislation, regulation, and policy processes. As a speech-language pathologist, she has worked in all post-acute settings as a frontline clinician, a clinical and operational manager, and a health care administrator. As such, she has been actively engaged in clinical service improvements, financial stewardship, and statutory compliance. Ms. Wisely was inducted as a 2017 Public Policy Distinguished Fellow for the National Academies of Practice, is a life member of the American-Speech-Language-Hearing Association, and currently serves as the state advocate for Medicare policy on behalf of the Pennsylvania Speech-Language Hearing Association. Through CMS TEPs and focus groups, she has participated in the Development of Outpatient Therapy

Payment Alternative project, the Short-Term Alternative Therapy Payment System project, CARE tool development, quality measure development for Medicare spending per beneficiary in post-acute care and for post-acute standardized assessment, CMS panels focused on SNF payment models, and a MedPAC TEP addressing Medicare Part B payment. Ms. Wisely also served as a long-term care stakeholder representative during a session with the Congressional Bipartisan/Bicameral Work Group to develop the IMPACT Act of 2014.

Ms. Wisely received her undergraduate degree from Temple University and a master of arts in speech pathology from West Chester State College.

❖ Susan Yendro, RN, MSN

Project Director
The Joint Commission
Oakbrook Terrace, IL

Susan Yendro is a project director for the clinical team in the Department of Quality Measurement at The Joint Commission. In this position, she manages projects associated with the identification, development, and evaluation of performance measures for use by health care organizations and other relevant entities in their quality assessment and improvement activities. Ms. Yendro currently serves as the lead for perinatal care measures and palliative care measures. She works closely with The Joint Commission's Home Care, Nursing Care Centers, and Integrated Care Certification programs and advises on matters related to performance measurement. Ms. Yendro has served as the lead for a number of performance measure development and testing projects, using her clinical experience and project management skills to successfully achieve project goals. While at The Joint Commission, she has worked with a number of different care programs, including inpatient hospital quality measures, outpatient oncology measures, long-term care accreditation redesign and education, transitions of care, and home care. She has served as both a lead and team member on a number of technical expert and advisory panels to help achieve consensus regarding quality and patient safety issues. Ms. Yendro has extensive clinical and administrative experience in a variety of care settings including home care, hospice, ambulatory, nursing home, assisted living, and hospital inpatient and outpatient.

Ms. Yendro is a registered nurse with a master of science in nursing from Benedictine University and a bachelor of science nursing degree from Illinois Wesleyan University.

APPENDIX B:
PRE-TECHNICAL EXPERT PANEL (TEP) MATERIALS

The pre-TEP materials include the following:

1. Technical Expert Panel Meeting Agenda (***Appendix B-1***)
2. Technical Expert Panel Pre-TEP Survey Instructions (***Appendix B-2***)
3. Technical Expert Panel Pre-TEP Survey (***Appendix B-3***)

APPENDIX B-1:
TEP MEETING AGENDA

Development and Maintenance of Quality Measures for Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Technical Expert Panel Meeting Agenda

Wednesday, August 23, 2017 **Dial-in Information**
8:30 AM–4:30 PM EST AT&T line: 1-888-706-0584
BWI Marriot 1743 W Nursery Rd, Linthicum Heights, MD 21090 Access code: 6933118#

Time	Agenda Item	Lead(s)
8:30 AM–8:40 AM	**Welcome and Introductions** **Review of Agenda** **Goals of TEP Meeting** **Vote to Ratify TEP Charter**	**Tara McMullen** **Laura Smith** **Qinghua Li**
8:40 AM–8:50 AM	**General Overview of Skilled Nursing Facility Quality Reporting Program**	**Qinghua Li**
8:50 AM–11:10 AM	**Domain 1: Resident- and Caregiver-Centered Care** Background and Overview Discussion *(Breaks 9:45 AM–9:50AM; 11:00 AM–11:10 AM)*	**Qinghua Li**
11:10 AM–12:00 PM	**Domain 2: Communication and Coordination of Care Transitions (1/2)** Background and Overview Discussion	**Andrea Ptaszek**
12:00 PM–1:00 PM	**Lunch break**	
1:00 PM–2:20 PM	**Domain 2: Communication and Coordination of Care Transitions (2/2)** Background and Overview Discussion *(Break: 1:50 PM–2:00 PM)*	**Andrea Ptaszek**
2:20 PM–3:20 PM	**Domain 3: Symptom Management** Background and Overview Discussion *(Break: 3:20 PM–3:30 PM)*	**Laura Smith**
3:20 PM–4:10 PM	**Domain 4: Function** Background and Overview Discussion	**Anne Deutsch**
4:10 PM–4:30 PM	**Concluding Remarks & Meeting Summary**	**Laura Smith**

APPENDIX B-2:
TEP PRE-TEP SURVEY FOCUS AREA SUMMARY AND INSTRUCTIONS

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Quality Measure Development Technical Expert Panel: Pre-meeting Survey

We appreciate your participation in the SNF QRP TEP and are looking forward to our upcoming discussion on August 23. In preparation for our in-person meeting, please complete this pre-meeting survey and return to RTI by Monday, August 21, at 9:00 AM to acool@rti.org.

The survey results will help us prepare for the TEP meeting by hearing about some of your thoughts on measure focus areas identified through an environmental scan conducted by RTI as well as your ideas about possible measures for future development.

Please rate each of the measure focus areas listed below and list any of your ideas regarding potential future measures. The results of the survey will be used to guide the discussion during the SNF QRP quality measure development TEP meeting.

2017 SNF QRP Environmental Scan

Background and Methods

From June 2017 through August 2017, RTI International conducted an environmental scan on the current practices and areas of performance gaps in skilled nursing facilities to aid future measure development and maintenance for the SNF QRP. The scan included careful consideration of the aims and priorities identified by the Centers for Medicare & Medicaid Services (CMS). The scan also included measures currently finalized or in development for the SNF QRP. Results of the environmental scan identified current performance gaps in three broad priority areas (outlined in ***Table 1***): 1. Communication and Coordination of Care Transitions; 2. Resident- and Caregiver-Centered Care; and 3. Symptom Management.

Table 1:
Measure Focus Areas Identified through an Environmental Scan Conducted
June 2017–August 2017

Measure Focus Area	Description
Area 1: Communication and Coordination of Care Transitions	
Transfer of Health Information	• Exchange of health information between settings and providers • Use of health information technology in care transitions
Medication Reconciliation/Drug Regimen Review	• Review and evaluation of resident medication history and prescriptions at admission to SNF • Resolution of medication discrepancies during care transition
Communication of Resident Preferences and Care Goals	• Communication of resident preferences, values, and resident care goals between SNFs and other care settings at care transitions
Successful Transition from SNF to Community	• Education of residents and caregivers on self-care processes after discharge from SNF to community • Communication of community resources available to residents and caregivers upon discharge to community
Area 2: Resident- and Caregiver-Centered Care	
Shared Decision-Making and Care Planning	• Resident and/or caregiver engagement in decision-making regarding care plans
Goal-Oriented Care	• Communication and incorporation of resident goals along spectrum of care • Organization and processes that focus on resident needs and goals rather than routineness
Palliative/End-of-Life (EOL) Care Services	• Availability of palliative and end-of-life care services to SNF residents with poor prognoses and limited outlook for rehabilitation • Assessment of individual resident needs to determine necessity of rehabilitation services versus palliative/end-of-life services • Training of SNF staff on palliative/end-of-life care services
Resident Experience of SNF Care	• Assessment of resident and caregiver experience of SNF care
Therapy Engagement	• Engagement of residents in their therapy sessions through a resident-directed approach
Area 3: Symptom Management	
Resident Functional Independence	• Effectiveness of SNF care in increasing resident functional independence • Likelihood of resident transition to home or independent living

Measure Focus Area	Description
Pain Management	• Effectiveness of pain management intervention paired with resident experience and balanced by overuse/misuse monitoring • Assessment of pain for residents with cognitive impairment or limited verbal communication • Evaluation of pain intervention effectiveness and pain improvement • Measurement of pain management effectiveness that incorporates resident preferences
Management of Condition Specific Symptoms	• Assessment of condition-specific symptoms that may reflect quality of SNF care (i.e., depression, delirium, anxiety, incontinence)
Opioid Therapy Evaluation	• Evaluation of opioid use among SNF residents • Monitoring of and avoiding potential overuse/misuse/underuse of opioids in SNFs • Assessment of resident understanding of medication purpose, dosage, side effects, etc. • Appropriate training and education on safe disposal of medications

Directions for completing the SNF QRP Quality Measures Pre-Meeting Survey

CRITERIA AND SCORING DESCRIPTIONS

We are asking you to rate each of the listed measure focus areas using the following process:

Please review the descriptions for each measure focus area on page 3 and rate each area from 5 to 1 (where 5 is the highest score and 1 is the lowest score) on each of the following criteria: importance, performance gap, and actionability. Because there are multiple dimensions under some of the criteria, you may find that a measure has a high score on one dimension and a lower score on another. Please use your best judgment to determine a single score for the category. Use the comments column to share any additional thoughts, suggestions, or questions you have about the focus areas.

RATING SCALE:

5 = high, 4 = moderately high, 3 = neutral, 2 = moderately low, 1 = low

Below you will find guidance and examples on how to use the criteria to score the measures.

IMPORTANCE CRITERIA:

- High score (4–5) indicates that the focus area addresses one or more of the following:
  - an established priority area (National Quality Strategy)

  - a demonstrated high-impact aspect of health care (e.g., affects large numbers)
  - there is external evidence of importance, such as consensus standards
  - there is evidence of disparities for the quality domain
- Middle score (3) indicates that the focus area is important but that assessment of this area is not based on external evidence.
- Low score (1–2) indicates that the focus area is not important.

PERFORMANCE GAP CRITERIA:

- High score (4–5) indicates one or more of the following:
  - there is considerable variation in quality of performance in this area across providers/populations
  - there is overall less-than-optimal performance in this area across providers/populations
  - there are disparities in performance in this area across different population groups
- Middle score (3) indicates one or more of the following:
  - there is some variation in quality performance in this area across providers/populations/population groups
  - performance in this area is satisfactory across providers/populations
- Low score (1–2) indicates one or more of the following:
  - there is little or no variation in quality of performance in this area across providers/populations/population groups
  - performance in this area is at an optimal level

ACTIONABILITY CRITERIA:

- High score (4–5) indicates that evidence related to this measure focus area demonstrates that there is a potential for closing the performance gap through quality measure development.
- Middle score (3) indicates that evidence related to this measure focus area demonstrates that there is some potential for improving performance through quality measure development.
- Low score (1–2) indicates that evidence related to this measure focus area demonstrates that there is no potential for improvement through quality measure development.

APPENDIX B-3:
TEP PRE-TEP SURVEY

Measure Focus Area	Provide a numerical rating from 5 to 1 (5 = high and 1 = low) for each focus area (row) on each criterion (column) using the definitions on the instruction sheet.				
	Importance	**Performance Gap**	**Actionability**	**Rationale for your rating**	**Please provide any comments, suggestions, or questions pertaining to the measure focus area here**
Area 1: Communication and Coordination of Care Transitions					
Transfer of Health Information					
Medication Reconciliation/Drug Regimen Review					
Communication of Resident Preferences and Care Goals					
Successful Transition from SNF to Community					
Area 2: *Resident- and Caregiver-Centered Care*					
Shared Decision-Making and Care Planning					
Goal-Oriented Care					
Palliative/End-of-Life Care Services					
Resident Experience of SNF Care					
Therapy Engagement					

Measure Focus Area	Provide a numerical rating from 5 to 1 (5 = high and 1 = low) for each focus area (row) on each criterion (column) using the definitions on the instruction sheet.				
	Importance	**Performance Gap**	**Actionability**	**Rationale for your rating**	**Please provide any comments, suggestions, or questions pertaining to the measure focus area here**
Area 3: *Symptom Management*					
Resident Functional Independence					
Pain Management					
Management of Condition Specific Symptoms					
Opioid Therapy Evaluation					

Suggestions for Measure Focus Areas and Possible Future Quality Measures for the SNF QRP

1. In your opinion, what topics or domains of quality, not currently addressed in this survey or by the measures currently finalized or in development for the SNF QRP, would you recommend or like CMS to consider?

2. For each suggestion you listed, please provide a brief statement of evidence to support your rationale for suggesting a performance gap in this area and why this domain is important for CMS to consider.

3. Do you have any further suggestions of quality measures or domains that the SNF QRP should consider to better address these or any other performance gaps in SNF care?

Thank you for completing this Pre-TEP Survey. As a reminder, please return to acool@rti.org at this address by Monday, August 21, at 9:00AM.

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APPENDIX C:
TEP MEMBER SCORING ON FOCUS AREAS: RESULTS FROM THE PRE-MEETING SURVEY

Table C-1
Goal-Oriented Care

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	5	50	3	33.3	2	22.2
4	4	40	2	22.2	3	33.3
3 – Medium	0	0	4	44.4	3	33.3
2	1	10	0	0	1	11.1
1 – Low	0	0	0	0	0	0
Mean Score	4.3		3.89		3.67	

Table C-2
Care Preferences and Care Planning

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	4	40	2	25	1	11.1
4	5	50	1	12.5	2	22.2
3 – Medium	1	10	4	50	4	44.4
2	0	0	1	12.5	2	22.2
1 – Low	0	0	0	0	0	0
Mean Score	4.3		3.5		3.22	

Table C-3
Palliative/End-of-Life Care Services

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	8	72.7	7	70	6	54.6
4	3	27.3	1	10	4	36.4
3 – Medium	0	0	2	20	1	9.09
2	0	0	0	0	0	0
1 – Low	0	0	0	0	0	0
Mean Score	4.73		4.5		4.45	

Table C-4
Experience of Care

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	4	40	2	22.2	2	20
4	4	40	5	55.6	4	40
3 – Medium	1	10	2	22.2	2	20
2	0	0	0	0	2	20
1 – Low	1	10	0	0	0	0
Mean Score	4		4		3.6	

Table C-5
Therapy Engagement

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	2	22.2	2	25	2	22.2
4	3	33.3	0	0	2	22.2
3 – Medium	3	33.3	5	62.5	2	22.2
2	1	11.1	0	0	2	22.2
1 – Low	0	0	1	12.5	1	11.1
Mean Score	3.67		3.25		3.22	

Table C-6
Discharge Process from SNF to Community

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	4	63.6	5	50	3	27.3
4	0	0	3	30	3	27.3
3 – Medium	3	27.3	1	10	3	27.3
2	1	9.09	1	10	2	18.2
1 – Low	0	0	0	0	0	0
Mean Score	4.18		4.2		3.64	

Table C-7
Medication Reconciliation/Drug Regimen Review

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	9	81.8	2	20	3	27.3
4	1	9.09	4	40	3	27.3
3 – Medium	1	9.09	4	40	4	36.4
2	0	0	0	0	1	9.09
1 – Low	0	0	0	0	0	0
Mean Score	4.73		3.8		3.73	

Table C-8
Communication of Resident Preferences and Care Goals

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	4	36.4	3	30	1	9.09
4	3	27.3	3	30	4	36.4
3 – Medium	2	18.2	4	40	4	36.4
2	2	18.2	0	0	2	18.2
1 – Low	0	0	0	0	0	0
Mean Score	3.82		3.9		3.36	

Table C-9
Pain Management

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	10	90.9	6	60	5	55.6
4	0	0	1	10	3	33.3
3 – Medium	0	0	2	20	1	11.1
2	1	9.09	1	10	0	0
1 – Low	0	0	0	0	0	0
Mean Score	4.73		4.2		4.35	

Table C-10
Opioid Therapy Evaluation

Score	High Priority		Performance Gap		Actionability	
	n = 13	%	*n* = 13	%	*n* = 13	%
5 – High	4	40	2	22.2	3	30
4	4	40	5	55.6	2	20
3 – Medium	0	0	1	11.1	3	30
2	2	2	1	11.1	2	20
1 – Low	0	0	0	0	0	0
Mean Score	4		3.89		3.6	

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