Standing Technical Expert Panel for the Development, Evaluation, and Maintenance of Post-Acute Care (PAC) and Hospice Quality Reporting Program (QRP) Measurement Sets

Summary Report

December 15, 2023

July 2024

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EXECUTIVE SUMMARY

Under contract with the Centers for Medicare & Medicaid Services (CMS), Acumen, LLC and Abt Global LLC convened a Technical Expert Panel (TEP) for the purposes of soliciting feedback on the development of additional cross-setting measures for the Post-Acute Care (PAC) and Hospice Quality Reporting Programs (QRPs), and filling measurement gaps with CMS' Universal Foundation[1] measures. In preparation for the cross-setting TEP, Acumen, LLC and Abt Global LLC, together referred to as the PAC and Hospice QRP Team, gathered the patient and family caregiver advocate (PFA) perspective through a listening session on November 8, 2023. Subsequently, feedback was solicited from the TEP over the course of four topic-driven sessions on December 15, 2023.

Throughout the course of these sessions, TEP panelists voiced their thoughts on adding measures to the PAC and Hospice QRPs to fill measurement gaps in the following domains: (i) behavioral and mental health, (ii) patient experience of care, (iii) pain management, and (iv) immunization. The PAC and Hospice QRP Team also solicited feedback on the Universal Foundation measures applicable to the behavioral and mental health, patient experience of care, and immunization domains. During each session, panelists discussed the appropriateness of the existing measure set and potential new measures (including Universal Foundation measures where available), setting-specific considerations, data sources, and other topics tailored to each domain.

During the behavioral and mental health discussion, panelists provided feedback on two Universal Foundation measures and the feasibility of external tools designed to assess behavioral and mental health and provider burden. While panelists generally supported the Universal Foundation measure concepts for Screening for Depression and Follow-Up Plan and for Initiation and Engagement of Substance Use Disorder Treatment, some panelists shared additional measure development considerations. Some panelists recommended that social drivers of health be considered within the depression screening measure, and others raised concerns about the feasibility of the substance use disorder (SUD) measure in low-resource communities with limited access to SUD treatment programs. PFAs shared that, especially in hospice, any added burden to participate in assessment would have to be beneficial to patients and contribute value to their overall care.

During the patient experience of care discussion, the TEP provided feedback on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Overall Experience

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[1] Centers for Medicare & Medicaid Services. "Aligning Quality Measures Across CMS – The Universal Foundation" in *CMS National Quality Strategy* (CMS, accessed April 2024), https://www.cms.gov/medicare/quality/cms-national-quality-strategy/aligning-quality-measures-across-cms-universal-foundation

Universal Foundation measure, as well as other aspects of patient satisfaction/patient experience surveys, including length, format of survey administration, response rates, and the timing of survey delivery. Overall, panelists agreed that the patient experience of care domain should be prioritized. However, panelists also agreed that many surveys, including the CAHPS survey, may be too long, and as a result, response rates may be impacted. The majority of panelists agreed that decreasing survey length and improving the format used to administer surveys could potentially increase survey response rates. Additionally, the TEP was generally in agreement that surveys should be sent out to respondents within a week of discharge, with the exception of the hospice setting, where timing should account for bereavement.

During the pain management discussion, panelists provided feedback on the existing PAC and Hospice QRP measure set and potential new measure concepts addressing pain management. Though panelists recognized that existing measures that indirectly capture care related to pain management are useful, the current PAC and Hospice QRP measure set should be supplemented with measures that directly address pain management. Panelists also favored a measure that addresses the needs of a varied PAC and hospice population regardless of cognitive function or status and focuses on addressing pain's effect on daily activities. A few panelists recommended that the pain management measures should focus on addressing patient goals around pain management instead of unrealistic targets of all patients experiencing no pain. Many panelists felt that measures should use standardized data elements where feasible, and that all measures should address patient goals around pain management.

During the discussion on immunization, panelists provided feedback on the expansion of immunization measures for PAC and hospice, including the Universal Foundation measure concept of Adult Immunization Status. Several panelists raised concerns about expanding the existing patient/resident measures due to data collection challenges, the appropriateness of primary care providers (PCPs) versus PAC facilities/agencies collecting vaccination information, and potential increase in provider burden. Additionally, most panelists did not support the expansion of healthcare personnel (HCP) immunization measures for PAC and hospice due to the potential burden caused by direct costs of administering vaccines, and to workforce considerations. However, both PFAs on the panel strongly disagreed and highlighted that they would like as much information as possible for both patient/resident and HCP vaccination rates. Finally, the majority of panelists agreed that immunization measures should not be expanded to include hospice patients.

The remaining sections of this report provide further detail on each of the discussion topics.

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ACRONYMS AND ABBREVIATIONS

The following list defines acronyms and abbreviations used during the Technical Expert Panel (TEP) and included in this report:

ACA: Patient Protection and Affordable Care Act
ADL: activity of daily living
AHRQ: Agency for Healthcare Research and Quality
ASA: Society of Anesthesiologists
AHCA: American Health Care Association
ASRA: American Society of Regional Anesthesia and Pain Medicine
BPS: Behavioral Pain Scale
CAH: critical access hospital
CAHPS®: Consumer Assessment of Healthcare Providers and Systems
CAUTI: catheter-associated urinary tract infection
CBE: Consensus-Based Entity
CBT: cognitive behavioral therapy
CDC: Centers for Disease Control and Prevention
CDI: Clostridium difficile infection
CLABSI: central line-associated bloodstream infection
CMIT: CMS Measures Inventory Tool
CMS: Centers for Medicare & Medicaid Services
COVID-19: coronavirus disease 2019
CPOT: Critical-Care Pain Observation Tool
CPT: Current Procedural Terminology
CY: calendar year
DC: discharge
ECHO: Experience of Care and Health Outcomes (Survey)
FFS: fee for service
FR: Federal Register
FY: fiscal year
HAI: healthcare-associated infection
HCI: Hospice Care Index
HCP: healthcare personnel
HCPCS: Healthcare Common Procedure Coding System
HepA: hepatitis A
HepB: hepatitis B
HH: home health
HHA: home health agency
Hib: *Haemophilus influenzae* type b
HIS: Hospice Item Set
HPV: human papillomavirus
HVLDL: Hospice Visits in Last Days of Life
IMPACT– Improving Medicare Post-Acute Care Transformation Act of 2014
IPPS: Inpatient Prospective Payment System
IRF: inpatient rehabilitation facility
IRF-PAI: Inpatient Rehabilitation Facility Patient Assessment Instrument
LCT: licensed clinical therapist
LOS: length of stay
LTC: long-term care
LTCH: long-term care hospital
MA: Medicare Advantage
MBHO: Managed Behavioral Healthcare Organization
MCO: managed care organization
MDS: Minimum Data Set
MenACWY: meningococcal A, C, W, Y
MenB: meningococcal B
MIPS: Merit-based Incentive Payment System

MMF: Meaningful Measures Framework
MMR: measles, mumps, rubella
MMS: Measure Management System
MQRS: Marketplace Quality Rating System
MSPB: Medicare Spending Per Beneficiary
NCAL: National Center for Assisted Living
NHCAHPS-D: CAHPS Nursing Home Survey: Discharged Resident Instrument
NHSN: National Healthcare Safety Network
NIH: National Institutes of Health
NMDA: N-methyl-D-aspartate
NQS: National Quality Strategy
NSAID: non-steroidal anti-inflammatory drug
NVPS: Nonverbal Pain Scale
OASIS: Outcome and Assessment Information Set
OBRA ’87: Omnibus Budget Reconciliation Act of 1987
PAC: post-acute care
PCP: primary care provider
PFA: patient and family caregiver advocate
PHQ: Patient Health Questionnaire
PPS: Prospective Payment System
PROM: patient-reported outcome measure
PROMIS®: Patient Reported Outcomes Measurement Information System
QR: Quick Response (code)
QRP: Quality Reporting Program
RFI: request for information
RSV: respiratory syncytial virus
RZV: zoster recombinant virus
SBT: spontaneous breathing trial
SES: socioeconomic status`
SNF: skilled nursing facility
SPACE: Standardized Patient Assessment Data Element
SSA: Social Security Act
SSM: Summary Survey Measure
SUD: substance use disorder
Td or Tdap: tetanus, diphtheria, pertussis
TEP: Technical Expert Panel
VAR: varicella
VBP: Value-Based Purchasing

1 INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) contracted with Acumen, LLC and Abt Global LLC to support the development, evaluation, and maintenance of quality and cost measures for use in the Post-Acute Care (PAC) and Hospice Quality Reporting Programs (QRPs) as mandated by the Patient Protection and Affordable Care Act (ACA) of 2010 and the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014). Acumen, LLC supports the *Quality Measure & Assessment Instrument Development & Maintenance & QRP Support for the Long-Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Quality Reporting Programs, & Nursing Home Compare* contract (75FCMC18D0015, Task Order 75FCMC19F0003). Abt Global LLC supports the *Home Health and Hospice Quality Reporting Program Quality Measures and Assessment Instruments Development, Modification and Maintenance, & Quality Reporting Program Oversight Support* contract (75FCMC18D0014, Task Order 75FCMC19F0001; 75FCMC19F0011).

This report provides a summary of the feedback shared by panelists during the December 15, 2023 Technical Expert Panel (TEP), which focused on filling measurement gaps in the PAC and Hospice QRPs with Universal Foundation measures and identifying additional measure concepts to prioritize for future measure development in the PAC and hospice settings. The remainder of this section provides additional information on the composition and context of the TEP. Specifically, Section 1.1 introduces the project context and Section 1.2 lists the panelists who served on the TEP. Section 2 outlines the meeting structure and materials for the patient and family caregiver listening session, TEP orientation, and the TEP. Section 3 summarizes the pre-TEP meetings, including both the listening session with patients and family caregivers and the orientation. Section 4 summarizes the presentation along with the discussions and key findings for each measurement gap area included in this TEP. Finally, Section 5 outlines the next steps for this project that take into account the feedback obtained from the TEP.

1.1 Project Context

Acumen, LLC and Abt Global, together referred to as the PAC and Hospice QRP Team, support CMS in the development and maintenance of quality measures for use in the PAC and Hospice QRPs. Acumen, LLC develops and maintains Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) QRP measures, and Abt Global develops and maintains Home Health (HH) and Hospice QRP measures. Measures included in the PAC and Hospice QRPs are designed to improve care quality and to enable Medicare beneficiaries and their caregivers to make informed choices when selecting healthcare providers. CMS routinely evaluates and refines the PAC and Hospice QRP measure sets to ensure that they remain parsimonious while still addressing key clinical services and dimensions of quality in each setting as care practices change and CMS priorities evolve over time. CMS identified measurement gap areas for future measure development and maintenance using a systematic approach that relies on four principles: (i) actionability, (ii) comprehensiveness and conciseness, (iii) a focus on provider responses to payment systems, and (iv) alignment with statutory requirements and CMS initiatives such as the Universal Foundation of measures.[2] The PAC and Hospice QRP Team convened this TEP to gather input on the prioritization, feasibility, and cross-setting alignment of measurement concepts that could be used to fill four measurement gap areas in the PAC and Hospice QRPs; specifically, behavioral and mental health, patient experience of care, pain management, and immunization. This cross-setting TEP is a standing TEP that will reconvene annually, or on an as-needed basis, to support the evaluation, development, and maintenance of the PAC and Hospice QRP measurement sets until 2028.

1.2 TEP Panelists

The PAC and Hospice QRP Cross-Setting TEP included 17 stakeholders from the PAC and hospice settings. The TEP panelists represent a broad range of perspectives across healthcare, from physicians, administrators, policy experts, to patients and families/caregivers. Table 1-1 below provides the name, organizational affiliation, setting(s) of expertise, and conflict of interest disclosures for each panelist. Additionally, while their names are not provided in this report, the TEP included two PFAs who provided their unique perspectives.[3]

Table 1-1: TEP Composition

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Setting(s) of Expertise	Conflict of Interest Disclosure
Bruce A. Pomeranz, MD, MMM Chief Quality Officer	Select Medical/Kessler Institute for Rehabilitation West Orange, NJ	IRF, Quality Measurement, Clinical Researcher	No
Joseph E. Daly, PT, MBA, MHA, FACHE Executive Director	Stanford Health Care, Palo Alto, CA	LTCH, IRF, SNF/NH, Acute Care Hospital, HH	No
Rebecca Montross, MS, GCAS Assistant Vice President	Allied Services Integrated Health Systems Tunkhannock, PA	IRF, HH, Hospice, Quality Measurement	No

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[2] Centers for Medicare & Medicaid Services. "Aligning Quality Measures Across CMS – The Universal Foundation." *CMS National Quality Strategy* (CMS, accessed April 2024). https://www.cms.gov/medicare/quality/cms-national-quality-strategy/aligning-quality-measures-across-cms-universal-foundation

[3] The term "panelist(s)" is used throughout this report and is meant to represent all TEP panelists including the PFAs. However, this report occasionally refers specifically to PFAs in order to amplify their unique perspective on particular subjects.

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Setting(s) of Expertise	Conflict of Interest Disclosure
Janet P. McMillan, DSN, APRN, PMHNP-BC Psychiatric Nurse Practitioner/QAPI Coordinator	Forrest General Home Care and Hospice Hattiesburg, MS	Acute Care Hospital, HH, Hospice, Rural Practice, Quality Measurement, Measurement Developer, Clinical Researcher	No
Barbara "Barb" Hansen, **MA, RN** CEO and Executive Director	Oregon Hospice and Palliative Care Association Marylhurst, OR	SNF/NH, HH, Hospice, Rural Practice	No
Sireesha Koppula, MD, MPH, MBA, CPE, CMQ Associate Professor of Nephrology	University of New Mexico Albuquerque, NM	LTCH, IRF, SNF/NH, Acute Care Hospital, HH, Hospice, Quality	No
Michele Cournan, DNP, RN, CRRN, ANP-BC, FNP, FARN Director of Quality Improvement	Association of Rehabilitation Nurses Chicago, IL	IRF	No
Edward W. Martin, MD, MPH, FACP, FAAHPM Chief Medical Officer	HopeHealth Providence, RI	LTCH, SNF/NH, HH, Hospice	No
Jennifer L. Kennedy, EdD, MA, BSN, RN, CHC Vice President, Quality and Standards	Community Health Accreditation Partner (CHAP) Arlington, VA	HH, Hospice, Quality Measurement	No
Chloe Slocum, MD, MPH Medical Director for Quality and Safety and Attending Physician, and Assistant Professor and Director of Health Policy	Spaulding Rehabilitation – Mass General Network, and Harvard Medical School Charlestown, MA	LTCH, IRF, SNF/NH, Quality Measurement	No
Robert J. Rosati, PhD Vice President of Research and Quality	Visiting Nurse Association Health Group Holmdel, NJ	HH, Hospice, Quality Measurement, Clinical Researcher	No
Eugene A. Gonsiorek, PT, NHA, PhD Vice President of Clinical Regulatory Standards	PointClickCare Baltimore, MD	SNF/NH, Quality Measurement, Measurement Developer, Clinical Researcher	No
Amy J. Stewart, MSN, RN, RAC-MT, RAC-MTA, DNS-MT, QCP-MT Chief Nursing Officer	American Association of Post-Acute Care Nursing Denver, CO	SNF/NH, Quality Measurement	No
April Diaz RN, BS Vice President of Clinical Services	Marquis Companies Milwaukie, OR	SNF/NH	No
Rebecca Cartright, FACHE Chief Medical Officer	Midlands Regional Rehabilitation Hospital Elgin, SC	IRF, Acute Care Hospital, HH, Hospice, Rural Practice	No

2 MEETING OVERVIEW

This section provides an overview of the structure and schedule of the patient and family caregiver listening session, the TEP orientation, and the main TEP. Section 2.1 provides an overview of the overall TEP structure and the sessions that were held, and Section 2.2 briefly summarizes the meeting materials provided to the panelists in advance of the meeting.

2.1 Structure of TEP Meetings

The PAC and Hospice Cross-Setting TEP consisted of three meetings held between November and December 2023 (Table 2-1). First, the PAC and Hospice QRP Team, in coordination with Patient & Family Centered Care Partners (PFCCpartners),[4] held a one-hour listening session with PFAs on November 8, 2023. This session included participants with experience as patients or caregivers in PAC and hospice settings. The session covered types of services provided by each PAC and hospice care setting, and participants responded to questions relevant to quality measurement. Participants also provided feedback on the utility of the Universal Foundation measures in the PAC and Hospice QRPs. Next, the PAC and Hospice Team provided a one-hour orientation meeting for TEP panelists on November 9, 2023. This meeting included formal introductions, an overview of TEP logistics, and a detailed background presentation on the PAC and Hospice QRPs. Finally, the four-hour TEP took place on December 15, 2023. In this meeting, the PAC and Hospice QRP team sought feedback on several measurement concepts to fill measurement gap areas[5] in the PAC and Hospice QRPs.

Table 2-1 below provides the agenda items from the patient and family caregiver listening session, the TEP orientation, and the TEP. The Section column indicates the section in this report where detailed information for each session can be found.

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[4] PFCCpartners is an organization which utilizes a network of healthcare providers, administrators, patients, and caregivers in order to convene focus groups and listening sessions to design policies and programs that improve patient health and the patient experience. More information on PFCCpartners and their work can be found at: https://pfccpartners.com.

[5] Measurement gap areas were identified by applying the guiding principles outlined in appendix C.2.2.

Table 2-1: Overview of Pre-TEP Meetings and TEP Agenda

Session	Topic	Section
	Patient and Family Caregiver Listening Session (November 8, 2023)	
1-A	Introductions	--
1-B	PAC and Hospice Care Goals by Setting	3.1
1-C	Discussion and Input on Future Measure Concepts and Universal Foundation Measures	3.1
1-D	Next Steps/Closing Remarks	--
	TEP Orientation (November 9, 2023)	
2-A	Welcome and Introductions	--
2-B	Logistics	3.2
2-C	TEP Charter	3.2
2-D	TEP Agenda Preview	3.2
2-E	Background	3.2
2-F	Next Steps/Closing Remarks	--
	TEP Meeting (December 15, 2023)	
3-A	Welcome and Introductions	--
3-B	Overview of Discussion Topics and Scope of Today's TEP	--
3-C	Addressing Measurement Gaps: Behavioral and Mental Health	4.1
3-D	Addressing Measurement Gaps: Patient Experience of Care	4.2
3-E	Addressing Measurement Gaps: Pain Management	4.3
3-F	Addressing Measurement Gaps: Immunization	4.4
3-G	Next Steps/Closing Remarks	--

2.2 Meeting Materials

Prior to the TEP, panelists reviewed the TEP Charter, which outlined the purpose of the TEP and the level of commitment expected for participation (see Appendix B). The PAC and Hospice QRP Team also distributed an environmental scan, presentation slides, and a supplemental document containing background information on the discussion topics for review. Appendix C.1 includes excerpts from the environmental scan, and Appendix C.2. includes the supplemental materials document.

3 SUMMARY OF PRE-TEP MEETINGS

This section summarizes the two meetings held before the TEP. The information below is organized into two sections. Section 3.1 covers the listening session convened with PFCCpartners on November 8, 2023, which was used to inform subsequent TEP discussions on PFA perspectives. Section 3.2 summarizes the TEP orientation meeting held on November 9, 2023.

3.1 Session 1-B and 1-C: Listening Session with Patient and Family Caregivers

During this hour-long listening session on November 11, 2023, the PAC and Hospice QRP Team met with a group of nine PFAs convened by PFCCpartners.[6] This session was held in order to inform the TEP discussion with viewpoints from PFAs who have PAC and hospice experience. PFAs were asked general questions about the key attributes PFAs consider when selecting facility/agencies, specific questions regarding the four measurement gap areas to be covered in the TEP, and their thoughts on the importance of several Universal Foundation measure concepts. The listening session included PFAs from different regions of the country with experience as PAC and hospice patients, family of patients, caregivers, and/or healthcare volunteers.

Section 3.1.1 lists the key findings of the discussion, and Section 3.1.2 provides more detail about the specific questions asked and subsequent discussions.

3.1.1 Key Discussion Takeaways

- The most important factors PFAs identified when selecting a facility/agency are reputation in the community, and, if possible, their impression when visiting the facility/agency.
- Many PFAs did not feel included in care planning and decisions, and several were unaware of the existence of their loved one’s care plan. Several PFAs also felt their involvement was insufficient and did not reflect their loved one’s desires and needs.
- Several PFAs expressed the view that hospice care was not personalized to each patient and are looking for a wider range of services from hospices.

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[6] PFCCpartners staff who organized and led the listening session include Libby Hoy (Founder/CEO), and Laura Jackson (Community Director).

- When presented with CMS' prioritized Universal Foundation measure concepts, several PFAs expressed strong interest in behavioral health, vaccination, cognitive function, and patient experience measures.

3.1.2 *Listening Session Discussion Details*

To begin the session, the PAC and Hospice QRP Team first reviewed the care goals for each setting (See Table 3-1), then posed a series of questions to the group for discussion.

Table 3-1: PAC and Hospice Medicare Benefits

LTCH	IRF	SNF	HH	Hospice
• Provide an acute-care level of care for ongoing treatment of chronically ill patients. • Specialize in treating patients who may have more than one serious condition, but who may improve with time and care. • Patients, on average, stay more than 25 days.	• Provide intensive rehabilitation services, such as physical, occupational, or speech therapy, for 3 or more hours/day 5 days/week. • IRFs primarily focus on treating one of 13 conditions that typically require intensive rehabilitation (e.g., stroke, spinal cord injury).	• Provide daily skilled nursing and/or rehabilitation services to persons who require medical, nursing, or rehabilitation services on a temporary basis. • Patients require medical and rehabilitation services to regain their ability to do activities of daily living and return to their prior place of residence.	• Provide treatment for an illness or injury and, where possible, help patients recover, regain independence, and become more self-sufficient. • May also help patients maintain their current condition or level of function, or slow decline.	• Comprehensive, holistic program of care for terminally ill patients and their families: physical, psychosocial, spiritual, and emotional needs. • Focus on comfort with pain and symptom palliation instead of curative care.

Question 1: When you are selecting a facility/agency, what are the three top pieces of information for you?

A number of factors influenced PFA decisions, including, but not limited to, reputation, in-person impressions, and accessibility. Several PFAs discussed searching the internet for reviews and complaints, reaching out to others in the community, and how on-site visits are often the most useful factor. A few PFAs felt useful information could be gained by talking with families while onsite (either through approaching them in the parking lot or being connected through the facility) and by observing features of care including cleanliness, staff interactions, care transitions, frequency of checking in on patients, reactions to call lights, and length of time spent with patients. These PFAs spent as much time in the facility as feasible and also directly engaged providers. Lastly, one PFA drew attention to the lack of care choices in rural parts of the country. This PFA added that after discharge from an acute care facility, patients and caregivers in rural areas look for care in the closest PAC facility. If no bed is available, their inclination is to accept a bed at the next closest, which is often substantially farther away. This PFA also felt that physical facility considerations (e.g., age of the facility) are not a useful indicator of performance.

Question 2: If you were looking for a hospice provider in particular, would you be looking for the same things?

Two PFAs provided broad considerations for choosing a hospice provider. One of these PFAs offered respect for the patient's cultural and spiritual beliefs, patient safety, and a comprehensive care team. The other PFA, with experience working in hospice and coordinating hospice services on behalf of loved ones, noted that there is always a care plan for each patient, and it is important for caregivers to understand how to access the supervising physician. Lack of access to the supervising physician can make challenging situations even more difficult as certain decisions (even in crises) may need approval.

Three PFAs added to this discussion by sharing their difficulties with hospice, including not feeling involved in care planning, being unaware a care plan existed, and desiring more personalized care. One PFA reported that they did not receive a care plan from the hospice provider and that the patient, caregiver, and hospice provider were not on the same page. This PFA also cited persistent communication issues, including that the hospice provider expected them always to be at home and would drop by with minimal notice, and reported that the hospice provider became upset when the PFA called 911 before reaching out to hospice. Two PFAs echoed these sentiments and expressed dissatisfaction with hospice's standardized symptom management approach. Both recommended that hospice care should be more personalized, better-inform PFAs about existing services, and offer a wider overall range of services.

Question 3: What kinds of information would be important to you in making a decision regarding hospice (understanding that some communities don't have a choice)?

One PFA with a rural perspective noted that the choice of a hospice provider is often driven by geography and interpersonal connections. This PFA reported that although they asked only a few questions about the hospice provider recommended by their acute care facility, they felt comforted by connections through their tight-knit community.

Question 4: With regards to pain management, what's important for you to know about a facility/agency's approach to pain?

One PFA highlighted the importance of a facility/agency respecting the patient's desires, recommending that patients/residents place their spiritual needs and healthcare preferences in writing and coordinate with their healthcare proxy/loved ones while in a clear state of mind. When the time comes, this information can be communicated to the facility/agency so the needs of patients/residents can be observed.

Question 5: Would you want a facility that is going to engage with you in care planning?

Two PFAs confirmed that they would want a PAC or hospice to engage with them in care planning. One suggested that having information about how caregivers can interact in these settings would be beneficial.

Question 6: How do you see caregivers fitting into this equation?

Several PFAs stated that they wanted to be involved in their loved ones' care, with a few noting healthcare providers' time constraints. One PFA also added that the patient/caregiver advocate role differs among settings. This PFA noted that comfort is the goal in hospice, and another PFA agreed, adding that both PAC and hospice providers should actively engage with caregivers to understand what is most important to the patient.

Question 7: What does cognitive function mean to you? And what information are you interested in regarding a facility/agency and cognitive function?

One PFA responded that based on their husband's experience with Alzheimer's disease, they interpreted cognitive function to entail whether an individual can make rational or reasonable decisions on their own. This PFA also mentioned that it would be helpful to have a caregiver to help the patient make important decisions.

Question 8: Do you want information regarding how a facility performs in memory changes, speaking ability, speech-language pathology (SLP), and activities of daily living (ADLs)?

Two PFAs responded affirmatively. One PFA noted the link between these and higher-level executive function. Another agreed, while also drawing attention to the difficulty of care transitions for patients with cognitive decline. This PFA stated that often, facilities/agencies do not know a patient's baseline or receive reports on ADLs. Additionally, in transitions of care, patients often develop conditions that may not be part of their baseline, such as urinary tract infections (UTIs), and may go unnoticed. This information could help provide more context, signal a problem, and ease care transitions.

Question 9: How important is information regarding cognitive function and decline in the hospice setting? Is this information different when compared with other settings?

Several PFAs recommended increased training for providers to support patients with declining memories, and noted the importance of behavioral health services. One PFA expressed that most patients have some level of decreased memory in hospice, whether due to dementia, pain, or recovery from acute care, while also experiencing a range of emotions associated with end of life. This PFA added that training and education for providers, along with the presence of a PFA, would likely help in these situations. Another PFA emphasized the importance of behavioral health services in all settings, especially hospice, given the emotional and mental changes patients face in hospice.

Question 10: Show of hands, how many folks would like information on behavioral health services in choosing a facility/agency?

The majority of PFAs expressed that they would find this information helpful in selecting a facility/agency.

Question 11: When selecting a facility/agency do you want information on vaccination rates? Staff/residents? Specific vaccinations?

Several PFAs were interested in a variety of vaccination rates, with one PFA also focusing on the importance of overall cleanliness to prevent infections. One PFA was interested in vaccination rates for both staff and residents. Another PFA asked for facility-level vaccination rates and wanted this information displayed like a health department score. One PFA also requested that facilities/agencies require visitors to produce vaccination cards.

Question 12: Looking at hospice, given its considerations, are patient safety measures important (e.g., falls)?

One PFA agreed, and wanted this information displayed publicly.

Question 13: What does seamless care coordination in the hospice environment look like to you?

One PFA shared that seamless care coordination should include interdisciplinary providers communicating with each other weekly and a robust handoff process from acute care (or other setting) to hospice, including the care plan.

CMS Universal Foundation Measure Concepts Presented to the Listening Session: Which do you feel are most meaningful/useful to you?

a. *Cancer Screening*
    i. *Colorectal Cancer*
    ii. *Breast Cancer*
b. *Adult Immunization Status*
c. *Controlling High Blood Pressure*
d. *Hemoglobin A1c Poor Control (>9%)*
e. *Depression Screening and Follow-up Plan*
f. *Initiation and Engagement of Substance Use Disorder Treatment*

g. *Readmission Measures*
h. *Patient Experience (CAHPS)*

Following consideration of the above list, panelists voiced support for the four Universal Foundation measures listed below:

- Depression Screening and Follow-up Plan: Two PFAs supported.
- Controlling High Blood Pressure: One PFA supported.
- Adult Immunization Status: One PFA supported.
- Patient Experience (CAHPS): Three PFAs voiced support for patient experience surveys. One PFA added that they would prioritize patient experience over all other measures outlined, given that patient experience is overarching and that patients are all different and have different needs. Another PFA shared that they remain skeptical about whether CAHPS accurately captures patient experience, and emphasized the importance of collecting meaningful information.

Finally, two PFAs highlighted that social drivers of health should be considered when evaluating all measures.

3.2 Session 2-B through 2-E: TEP Orientation

The orientation meeting on November 9, 2023 included introductions, an overview of TEP logistics, and a detailed background presentation on the PAC and Hospice QRPs. Section 3.2.1 summarizes meeting logistics, including the review of the TEP Charter and preview of the agenda for the upcoming TEP. Section 3.2.2 includes a summary of the content covered during the background presentation.

3.2.1 TEP Orientation Logistics

During the orientation meeting, the PAC and Hospice QRP Team presented the TEP Charter, which covered (i) the goals of the panel, (ii) brief distinctions and considerations that should be made for the hospice setting, and (iii) an overview of the format of the standing TEP. Panelists were also reminded of their commitment to serve on the panel on an annual or as-needed basis for up to five years. The panelists did not have objections to the charter. Next, the PAC and Hospice QRP Team previewed the planned topics for the upcoming TEP, detailed in Section 4.

3.2.2 Background

During the one-hour orientation meeting held on November 9, 2023, the PAC and Hospice QRP Team provided an overview of the PAC and Hospice QRPs. The presentation provided panelists with background information on the QRPs to support cross-setting alignment discussions and parameters to keep in mind when evaluating new measure concepts intended for use in the QRPs. The remainder of this section covers the legislative background of the PAC and Hospice QRPs, the structure and overall goals of QRPs, and relevant data sources.

PAC and Hospice QRPs, as they exist today, rely on previous legislation, initiatives, and policies. The Nursing Home Reform Act/Omnibus Budget Reconciliation Act of 1987 (OBRA '87) revised the nursing home survey and enforcement standards and also introduced the requirement for a standardized resident assessment. The Balanced Budget Act of 1997 required the implementation of Prospective Payment Systems (PPSs) in PAC, which necessitated the development of patient/resident assessment instruments to facilitate the calculation of a standardized payment amount based on patient characteristics. Data elements related to care quality were subsequently added and were ultimately used to calculate quality measures. Public reporting of PAC quality measures began in 2002 as part of the Nursing Home Quality Initiative and in 2003 as part of the Home Health Quality Initiative.[7,8] By 2005, the Deficit Reduction Act established the HH QRP, and in 2010, the ACA established the LTCH QRP, IRF QRP, and Hospice QRP.[9] The IMPACT Act of 2014 established the SNF QRP and also mandates development and implementation of cross-setting measures in specific domains for IRF, LTCH, SNF, and HH QRPs.[10]

CMS established the QRPs and designed quality measures with the goal of improving health outcomes across these settings, which is achieved through the public display of data consumers use to make more informed decisions about their healthcare. Measures also encourage providers to improve the quality and cost of care provided to all patients and drive quality improvement through measurement and transparency. QRPs are pay-for-reporting programs, where providers are financially penalized should they fail to meet program-specific data reporting thresholds and submission requirements. Quality data is routinely published on public-facing CMS websites.[11] Prior to public reporting, providers have the opportunity to review their quality data through various internal provider reports.

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[7] Centers for Medicare & Medicaid Services. "Nursing Home Quality Initiative Overview." (CMS, accessed May 29, 2024). https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/NHQIOverView20030731.pdf

[8] Centers for Medicare & Medicaid Services. "Home Health Quality Initiative Overview." (CMS, accessed May 29, 2024). https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/downloads/01_overview.pdf

[9] The ACA of 2010 also established the HH Value-Based Purchasing Program (HH VBP). The SNF Value-Based Purchasing (VBP) Program was established by the Protecting Access to Medicare Act (PAMA) of 2014 and expanded through the Consolidated Appropriations Act (CAA) of 2021.

[10] The IMPACT Act of 2014 and its requirements do not apply to the Hospice QRP.

[11] Quality data appear on Care Compare (https://www.medicare.gov/care-compare) for use by consumers, and appear in the Provider Data Catalog (https://data.cms.gov/provider-data/) for use by researchers and other agencies.

PAC and hospice quality measures use up to five distinct data sources: assessment instruments, the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN), chart abstraction, Medicare fee-for-service (FFS) claims, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Assessment data is used for measures in the IRF, LTCH, SNF, and HH QRPs.[12] Hospice QRP utilizes data from the Hospice Item Set (HIS) that is abstracted from hospice clinical records. Measures in the IRF, LTCH, and SNF QRPs also include measures based on the CDC's NHSN data. Measures in all PAC settings and hospice use Medicare FFS claims data. Finally, CAHPS survey data is used only for measures in HH and hospice. Table 3-2 below indicates the measures used in the PAC and Hospice QRPs by data source.

Table 3-2: Data Sources Used for Quality Measures in the PAC and Hospice QRPs

QRP Measure	Setting
Assessment-Based and Chart Abstraction Measures	
Application of Percent of Residents Experiencing One or More Falls with Major Injury	IRF, LTCH, SNF, HH
Drug Regimen Review Conducted with Follow-Up for Identified Issues	IRF, LTCH, SNF, HH
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	IRF, LTCH, SNF, HH
Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	LTCH
Ventilator Liberation Rate	LTCH
Transfer of Health Information to the Patient-Post Acute Care	IRF, LTCH, SNF, HH [13]
Transfer of Health Information to the Provider-Post-Acute Care	IRF, LTCH, SNF, HH [14]
Discharge Self-Care Score for Medical Rehabilitation Patients	IRF, SNF
Discharge Mobility Score for Medical Rehabilitation Patients	IRF, SNF
Discharge Function (DC Function) Score	IRF, LTCH, SNF, HH [15]
Change in Mobility Among LTCH Patients Requiring	LTCH
Patient/Resident COVID-19 Vaccine	IRF, LTCH, SNF, HH [16]
Improvement in Ambulation-Locomotion	HH
Improvement in Bed Transferring	HH
Improvement in Bathing	HH
Improvement in Management of Oral Medications	HH
Improvement in Dyspnea	HH
Influenza Immunization Received for Current Flu Season	HH

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[12] CMS is developing the Hospice Outcomes and Patient Evaluation (HOPE) assessment tool, with plans to be proposed in future rulemaking (https://www.cms.gov/medicare/quality/Hospice/hope).

[13] Public reporting on Care Compare begins with the September 2024 (IRF/LTCH)/October 2025 (SNF)/January 2025 (HH) Care Compare refreshes (or as soon as technically feasible).

[14] See footnote 12.

[15] Public reporting on Care Compare begins with the September 2024 (IRF/LTCH)/ October 2024 (SNF)/January 2025 (HH) Care Compare refreshes (or as soon as technically feasible).

[16] Data collection begins on October 1, 2024 (IRF/LTCH/SNF)/January 1, 2025 (HH), and will be publicly reported beginning with the September 2025 (IRF/LTCH)/October 2025 (SNF)/January 2026 (HH) Care Compare refreshes (or as soon as technically feasible).

QRP Measure	Setting
Timely Initiation of Care	HH
Hospice and Palliative Care Composite Process Measure – HIS Comprehensive Assessment at Admission[17]	Hospice
CDC National Healthcare Safety Network (NHSN) Measures	
COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)	IRF, LTCH, SNF
NHSN Influenza Vaccination among Healthcare Personnel	IRF, LTCH, SNF
NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	IRF, LTCH
NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	IRF, LTCH
NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	LTCH
Medicare Fee-for-Service Claims-Based Measures	
Medicare Spending per Beneficiary (MSPB)	IRF, LTCH, SNF HH
Discharge to Community	IRF, LTCH, SNF, HH
Potentially Preventable 30-Day Post-Discharge Readmission Measure	IRF, LTCH, SNF, HH
Potentially Preventable Within Stay Readmission Measure	IRF
SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization	SNF
Acute Care Hospitalization During the First 60 Days of Home Health	HH
Emergency Department Use without Hospitalization During the First 60 Days of Home Health	HH
Home Health Within-Stay Potentially Preventable Hospitalization Measure	HH
Hospice Visits in Last Days of Life (HVLDL)	Hospice
Hospice Care Index (HCI)	Hospice
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	
CAHPS® Hospice Survey	Hospice
HH CAHPS®	HH

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[17] This measure is calculated using data abstracted from clinical records.

4 SUMMARY OF TEP PRESENTATION AND DISCUSSION

This section summarizes the TEP meeting held on December 15, 2023. The information presented is organized into four sections, aligning with the session structure of the meeting. Each subsection summarizes the material presented to the TEP, key findings extracted from TEP discussions, and details on the discussion among TEP panelists. Sections 4.1 through 4.4 summarize the sessions focused on behavioral and mental health, patient experience of care, pain management, and immunization, respectively.

4.1 Session 3-C: Behavioral and Mental Health

This section summarizes discussion around developing behavioral and mental health measures in PAC and hospice as presented to the panel to consider potential patient-level measures. Section 4.1.1 summarizes the content presented to the panel during this session to facilitate the discussion, Section 4.1.2 lists the key takeaways from the discussion, and Section 4.1.3 covers the TEP discussion in greater detail, including the questions presented and a summary of the responses.

4.1.1 Summary of Presentation

The PAC and Hospice QRP Team began by providing justification for the development of behavioral and mental health measures. First, behavioral health is one of six domains CMS outlined in its Universal Foundation approach to aligning quality measures. Second, PFAs have agreed that behavioral health is often overlooked in PAC and hospice settings and have voiced support for measure development, including screening for depression. The HH QRP previously assessed the extent to which patients were screened for depression, but this measure was removed from the HH QRP in the calendar year (CY) 2019 HH PPS final rule because HHA measure performance could not be meaningfully differentiated. The Hospice QRP will soon begin collecting information on the extent to which anxiety and agitation impacts hospice patients.

The PAC and Hospice QRP Team then introduced two Universal Foundation measures for panelists to consider as potential cross-setting behavioral and mental health measures: (i) Screening for Depression and Follow-up Plan[18] and (ii) Initiation and Engagement of Substance Use Disorder Treatment[19]. The Screening for Depression and Follow-up Plan measure would capture the percentage of patients ages 12 and older screened for depression on the date of the

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[18] Centers for Medicare & Medicaid Services. "Screening for Clinical Depression and Follow-up." *Measures Inventory Tool* (CMS, accessed April 2024). https://cmit.cms.gov/cmit/#/FamilyView?familyId=672

[19] Centers for Medicare & Medicaid Services. "Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment." *Measures Inventory Tool* (CMS, accessed April 2024). https://cmit.cms.gov/cmit/#/FamilyView?familyId=394

encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool. If positive, a follow-up plan must be documented on the date of or up to two days after the date of the qualifying encounter. The Initiation and Engagement of Substance use Disorder Treatment measure would utilize two rates to report the percentage of new SUD episodes that result in treatment initiation and the engagement of treatment, respectively.

Further, the PAC and Hospice QRP Team summarized existing instruments that may be adapted to assess the management of behavioral or mental health in PAC settings. The Patient Mood Interview (PHQ-2 to 9) that is currently available on the PAC assessment tools was presented.

Table 4-1: Patient Mood Interview (PHQ-2 to 9)

Item	Question	Response Values		Setting(s)
D0150. Patient Mood Interview **(PHQ-2 to 9)**	**“Over the last 2 weeks, have you been bothered by any of the following problems?"** Little interest or pleasure in doing things Feeling down, depressed, or hopeless Trouble falling or staying asleep, or sleeping too much Feeling tired or having little energy Poor appetite or overeating Feeling bad about yourself – or that you are a failure or have let yourself or your family down Trouble concentrating on things, such as reading the newspaper or watching television Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. Thoughts that you would be better off dead, or of hurting yourself in some way	**Column 1. Symptom Presence** 0. No 1. Yes 9. No response	**Column 2. Symptom Frequency** 0. Never or 1 day 1. 2-6 days 2. 7-11 days 3. 12-14 days	IRF, LTCH, SNF, HH

The PAC and Hospice QRP Team presented additional tools that could address this measure domain. First, the CAHPS Experience of Care and Health Outcomes Survey (ECHO) includes standardized instruments for adults who received mental health or substance abuse services in the previous 12 months through a managed care organization (MCO) or Managed Behavioral Healthcare Organization (MBHO). Second, the Patient-Reported Outcomes Measurement Information System (PROMIS) consists of several modules allowing comparison across specialties with respect to mental, physical, and social health. The PROMIS Anxiety Module measures emotional distress caused by fear, anxious misery, hyperarousal, and related somatic symptoms. The PROMIS Depression Module captures patients' negative mood, views of self, affect, and social cognition. Additionally, the PROMIS Quality of Life in Neurological Disorder module assesses self-reported levels of anxiety, depression, and other behavioral health concerns in patients with neurological conditions. Third, the National Institutes of Health (NIH) Toolbox® for the Assessment of Neurological and Behavioral Health Function assesses health and function in four core domains: cognitive, emotional, motor, and sensory. The items in the NIH Toolbox® are applicable across a range of study settings and are intended to be multidimensional within each domain area, methodologically sound, and dynamic to accommodate changes over time.

The PAC and Hospice QRP Team noted that adding new assessment items translates to an increased reporting burden on clinicians, so CMS must weigh clinician burden against collecting comprehensive patient data when developing potential measures. To address this burden consideration, the PAC and Hospice QRP Team presented the potential use of alternative data sources such as claims data associated with the receipt of Medicare claims for Parts A and B services to determine the extent to which beneficiaries with behavioral or mental health conditions receive needed care. Additionally, information on behavioral and mental counseling services can also be captured using Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes and Z codes.

Finally, the PAC and Hospice QRP Team summarized the challenges associated with addressing the behavioral and mental health quality domain for the PAC QRPs. There are questions about the clinical utility of existing behavioral and mental health tools (PROMIS). Some behavioral and mental health items are self-reported, which may not be feasible for all patients receiving services in PAC and hospice settings. Additionally, while incorporating claims data into measures can limit clinician burden, the information claims data provides is limited by billing practices. Relevant data may be identifiable only via physician professional claims, which would exclude a considerable number of beneficiaries and result in measure validity/reliability challenges.

4.1.2 Key Discussion Takeaways

- The TEP indicated that both universal measures discussed could offer valuable insights, albeit with certain considerations, and acknowledged that potential challenges such as clinician burden and a shortage of community resources could be a barrier to measure implementation.
- Panelists shared that assessment items addressing behavioral and mental health need to be beneficial to patients and contribute value to their overall care.

- Panelists noted that the three external tools that were presented by the team as potential resources to inform measure construction may not be the best approach for PAC and hospice in instances where TEP members indicated a preference for simpler, shorter tools to address behavioral and mental health.

4.1.3 Panelist Discussion Details

The following questions were posed to the TEP panelists:

1. *Should measures that directly address behavioral and mental health be developed for PAC and hospice?*
2. *Is a cross-setting measure that directly addresses behavioral and mental health feasible, or would setting-specific measures be more appropriate?*
3. *Do any of the tools discussed previously have promise for being the basis of a strong cross-setting or setting-specific measure addressing behavioral and mental health?*
4. *In terms of data sources, are there other limitations or additional considerations associated with claims versus assessment-based data to develop behavioral and mental health measures?*

Overall, panelists expressed support for developing measures addressing behavioral and mental health in PAC and hospice, acknowledging potential challenges and the need for setting-specific considerations. Panelists noted that a cross-setting measure may be feasible but highlighted the unique nature of hospice service delivery, where families and caregivers play a crucial role in providing information. Panelists also mentioned the importance of timing for assessment interactions in hospice, as questions of a sensitive nature can potentially trigger more anxiety rather than a calming response.

Regarding depression screening, panelists noted the issues of difficulties in differentiating depression from demoralization and the shortage of behavioral health specialists. One panelist suggested that telehealth may be useful to address some of the challenges with staff shortages but also noted that telehealth has limitations since it is dependent on access to quality internet services. Several panelists noted that the follow-up component of the depression screening measure would require significant support and infrastructure to track social drivers of health and other influences impacting behavioral and mental health before it could be implemented. The panelists suggested that because social drivers of health can influence depressive symptoms, they should be considered within measures assessing for depression rather than as a separate issue.

Panelists acknowledged the potential benefits of the SUD measure but highlighted challenges establishing follow-up in communities with limited access to SUD treatment programs and in SNF settings. Panelists mentioned that length of stay (LOS) and timing of the interview for the patient/resident should be considered, along with an opt-out option for patients/residents.

The TEP shared concerns about the value of potential measures to both patients/residents and clinicians. The patient and family representatives on the TEP shared that, especially in the hospice setting, any added burden to participate in assessment would have to be offset by some benefit to the patient/resident or their caregivers. They also indicated that they would like the potential measures to be actionable at the patient/resident level. For example, the nature of claims-based data and the delay in receipt of this data means that it is not beneficial to patients/residents as it is not derived in real time. They also noted that providers such as social workers, licensed clinical therapists (LCTs), and counselors may not be captured by claims data.

Panelists indicated that the three external resources presented to them were not the most appropriate for adaptation in PAC and hospice in their current forms. Most panelists did not have experience seeing the ECHO survey employed in a clinical setting and noted that it may be too challenging to operationalize broadly for a mental health context. They also noted several challenges in adapting PROMIS for PAC. First, for shorter stays, the burden of doing the assessment is high and could be especially burdensome for hospice. Second, adding PROMIS may be frustrating for staff in gathering assessment information that they don't believe benefits the patients/residents. They further agreed that this assessment would not be applicable for the hospice setting. One TEP member proposed the Generalized Anxiety Disorder 7-item[20] (GAD-7) as a simple, short alternative to PROMIS to gauge elements of anxiety that are impacting life and recovery.

4.2 Session 3-D: Patient Experience of Care

This section summarizes session 3-D, which covered current progress and measure development options in the patient experience of care domain. Section 4.2.1 summarizes the content the PAC and Hospice QRP Team presented to the panel during this session in order to facilitate the discussion. Section 4.2.2 lists the key takeaways from the panelist discussion. Section 4.2.3 summarizes the discussion, including the questions presented to the panelists and responses received.

4.2.1 Summary of Presentation

At the beginning of the presentation, the PAC and Hospice QRP Team indicated that person-centered care is a priority area in the Meaningful Measures Initiative 2.0 and a domain in

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[20] Spitzer R, Kroenke K, Williams J, Löwe B. "A brief measure for assessing generalized anxiety disorder: the GAD-7." *Archives of Internal Medicine.* 2006;166(10):1092-1097. https://doi.org/10.1001/archinte.166.10.1092

the Universal Foundation. Measures that reflect a patient/resident's experience of care are valuable in that they provide patients and caregivers with information on what they can expect their care to look like in facilities/agencies. They also encourage providers to improve the patient/resident experience of care, which has also been shown to improve health outcomes.

CMS defines person-centered care as "Integrated healthcare services delivered in a setting and manner that is responsive to the individual and their goals, values, and preferences, in a system that supports good provider-patient communication and empowers individuals receiving care and providers to make effective care plans together."[21] In facility-based settings, an example of person-centered care may be providing patients/residents choice in the kinds of medications prescribed, or allowing more input into their dining times and food choices. For HH and hospice, an example of person-centered care might include providing choice about who is involved in creating patient care plans and care delivery, along with preferences for the timing of agency staff visits. Studies have demonstrated a link between improved patient satisfaction and improved clinical outcomes by finding positive associations between patient experience and objectively measured health outcomes, such as adherence to recommended clinical practice and medication, preventive care, and resource use such as hospitalization and LOS.[22,23,24,25,26,27]

CMS has made progress incorporating patient experience of care measures into the QRPs. Currently, patient experience data is collected in both HH and hospice through CAHPS surveys developed and owned by the Agency for Healthcare Research and Quality (AHRQ). The HH survey contains 34 questions in the following categories; results are reported publicly on CMS' Care Compare and Provider Data Catalog websites:[28]

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[21] Centers for Medicare & Medicaid Services. "Person Centered Care." *Innovation Center – Key Concepts* (CMS, accessed April 2024). https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care

[22] Barnsteiner J. "Medication Reconciliation: Transfer of medication information across settings—keeping it free from error." *American Journal of Nursing*. 2005;105(3 Suppl):31-36. https://doi.org/10.1097/00000446-200503001-00007

[23] Arbaje A, Kansagara D, Salanitro A, Englander H, Kripalani S, Jencks S, Lindquist L. "Regardless of age: incorporating principles from geriatric medicine to improve care transitions for patients with complex needs." *Journal of General Internal Medicine*. 2014;29(6):932-939. https://doi.org/10.1007/s11606-013-2729-1

[24] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program." *New England Journal of Medicine.* 2009;360(14):1418-1428. https://doi.org/10.1056/NEJMsa0803563

[25] Institute of Medicine, Board on Healthcare Services. *Preventing medication errors: Quality Chasm Series.* 2007 (National Academies Press):1-480

[26] Kitson NA, Price M, Lau FY, Showler G. "Developing a medication communication framework across continuums of care using the Circle of Care Modeling approach." *BMC Health Services Research*. 2013;13(1):1-10. https://doi.org/10.1186/1472-6963-13-418

[27] Mor V, Intrator O, Feng Z, Grabowski DC. "The revolving door of rehospitalization from skilled nursing facilities." *Health Affairs.* 2010;29(1):57-64. https://doi.org/10.1377/hlthaff.2009.0629

[28] Agency for Healthcare Research and Quality. "CAHPS Hospice Survey." *Surveys and Guidance* (AHRQ, accessed April 2024). https://www.ahrq.gov/cahps/surveys-guidance/hospice/index.html

- Care of patients
- Communication between providers and patients
- Specific care issues
- Rating of care provided by the agency
- Willingness to recommend the agency to friends and family

The CAHPS Hospice Survey includes 47 questions divided into the following categories; survey results are published on CMS' Care Compare and Provider Data Catalog websites:[29]

- Communication with family
- Getting timely help
- Treating patient with respect
- Emotional and spiritual support
- Help for pain and symptoms
- Training family to care for patient
- Rating of this hospice
- Willing to recommend this hospice

The Universal Foundation CAHPS measure, as specified for the Merit-based Incentive Payment System (MIPS) and not currently in use in the PAC QRPs, includes 10 Summary Survey Measures (SSMs) in the following categories:[30]

- Getting timely care, appointments, and information
- How well providers communicate
- Patient's rating of provider
- Access to specialists
- Health promotion and education
- Shared decision making

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[29] Agency for Healthcare Research and Quality. "CAHPS Hospice Survey." *Surveys and Guidance* (AHRQ, accessed April 2024). https://www.ahrq.gov/cahps/surveys-guidance/hospice/index.html

[30] Specifications for the patient experience of care Universal Foundation measure vary across programs. The MIPS measure specifications can be accessed at (https://cmit.cms.gov/cmit/#/MeasureView?variantId=1581&sectionNumber=1).

- Health status and functional status
- Courteous and helpful office staff
- Care coordination
- Stewardship of patient resources

Currently, there are no equivalent nationalized standardized satisfaction questionnaires required for use in IRFs, LTCHs, and SNFs, and thus there are no patient satisfaction measures. CMS wants to fill this measurement gap in order to provide clinical teams with critical information regarding the results of their clinical care. Additionally, data collected through these surveys would provide patients and caregivers with information about aspects of care important to them, such as communication between the patient, their caregivers, and the provider.

Table 4-2 below indicates other instruments that could be considered for IRF, LTCH, and SNF to assess patient experience.

Table 4-2: Other Instruments to Assess Patient Experience that Could be Considered for IRF, LTCH, and SNF Measure Development

Instrument Includes Questions Related To:	**Instrument**				
	CAHPS Nursing Home Survey: Discharged Resident Instrument (NHCAHPS-D)	**CAHPS Family Member Survey**	**CoreQ Short-Stay Discharge (CoreQ)**	**IRF Experience of Care Survey**	**LTCH Experience of Care Survey**
Number of questions	50	50	4	57	50
Environment	✓	✓		✓	✓
Care rendered	✓	✓		✓	✓
Communication	✓			✓	✓
Autonomy	✓			✓	✓
Available activities	✓				
Quality of life	✓				
Availability of staff		✓			✓
Overall rating of facility			✓	✓	✓
Overall rating of staff			✓		
Overall rating of care received		✓	✓		
How well DC needs met			✓	✓	✓

Additional patient experience of care survey tools are available for IRF, LTCH, and SNF quality measure development. The CAHPS Nursing Home Survey: Discharged Resident Instrument (NHCAHPS-D) survey was developed specifically for short-stay SNF residents by AHRQ in collaboration with the CAHPS consortium[31] and CMS. Due to the length of the survey

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[31] The CAHPS consortium included Harvard Medical School, the RAND corporation, and Research Triangle Institute International (RTI).

and the potential burden that would be imposed on SNFs and residents if it were implemented as an SNF QRP measure, the NHCAHPS-D survey has not garnered wide support among SNF stakeholders. Additionally, the original testing and validation of the survey is nearly two decades old and would need to be repeated. The AHRQ CAHPS Family Member survey assesses family and caregivers' experience with nursing homes, rather than a resident's experience. The CoreQ Short Stay Discharge survey (CoreQ) has been endorsed by the Consensus Based Entity (CBE) since 2016, and several states have already incorporated the survey into their Medicaid quality incentive programs. Experience of care surveys are also available for use in IRFs and LTCHs. These measures were developed according to the Blueprint for the CMS Measures Management System[32] and Getting the CAHPS Trademark: a Guide for Survey Developers.[33] CMS has not proposed incorporating these surveys into the IRF and LTCH QRPs but has made the surveys and accompanying materials available for public use. The IRF and LTCH experience of care surveys would have to undergo additional testing for use in patient experience of care measures for QRPs.

There are major challenges in addressing the patient experience of care measurement gap in the PAC QRPs. First, obtaining consensus on a single standardized patient experience assessment tool would be difficult. Second, any patient experience measure would require facilities to put additional systems in place to gather survey data. This may require that facilities contract with third-party vendors to administer surveys. Finally, it may also be challenging to adopt new patient measures quickly because all survey tools, with the exception of CoreQ, would need to undergo additional testing before they could be implemented.

4.2.2 Key Discussion Takeaways

- Panelists agreed that the CAHPS surveys may be too long and as a result, response rates may be impacted. However, two panelists also noted that while shorter surveys are more desirable, they should not be too short so that key aspects of care are left out. Several panelists agreed that the ideal survey length is around 20 questions.
- Panelists agreed that alternative survey administration formats should be considered for new survey tools. These might consist of surveys administered through Quick Response (QR) codes, text, or available online.

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[32] Centers for Medicare and Medicaid Services. "CMS Measures Management System Blueprint." *CMS MMS Blueprint* (CMS, accessed April 2024). https://www.cms.gov/sites/default/files/2021-09/Blueprint.pdf

[33] These measures never received the CAHPS trademark.

- Many panelists agreed that the ideal time to administer surveys is within a week of discharge, with the exception of the hospice setting, where timing should account for bereavement.

4.2.3 Panelist Discussion Details

The PAC and Hospice QRP Team presented the following questions to the TEP panelists:

1. *Do the currently available survey tools provide an adequate method to begin measuring patient experience?*
2. *Given the timeline for testing additional CAHPS survey tools for IRF, LTCH, and SNF, should other patient experience measures be developed for these settings to use in the interim?*
3. *Do you think the length of CAHPS survey tools is a barrier to use across the PAC settings? For our patient/family partners on the TEP, have you found the length of the CAHPS survey tools in HH or hospice to be a barrier to completing them?*
4. *Are there specific aspects of patient experience that are important to measure in IRF, LTCH, and SNF, and would these differ among the settings?*
5. *Are there other methods of measuring patient experience that were not discussed?*

Overall, TEP panelists agreed that it would be beneficial to capture patient experience of care in PAC settings, and discussed aspects of administering and responding to surveys, including: length of surveys and response rates, format of survey administration, survey content, setting-specific considerations, and timing of survey administration.

Length of Surveys and Response Rates

Many panelists stated that the current CAHPS surveys were too long and as a result may negatively impact response rates. One panelist with experience using CAHPS Hospice Survey data added that their agencies do not use the information obtained from all 47 questions and recommended condensing the survey to a few questions. Another panelist noted that some questions add to the survey's length without providing valuable information to providers, and while providers may look at the responses to these questions, they do not result in actionable feedback. One panelist with experience using a private vendor to administer surveys in the IRF setting found that surveys of around 20 questions may be ideal, and added that surveys may appear longer when they arrive in a thick booklet. Two panelists added that a four-question survey would be too short. However, one panelist noted that the CoreQ, a four-question survey, would be more respectful of individuals' time compared to the CAHPS survey, which may be overwhelming to those who have recently discharged from a PAC setting to home. This panelist also recommended that the length of surveys should be determined through statistical data on successful completion rates.

Panelists also discussed the response rates associated with existing survey tools, including factors contributing to response rates and options for improving survey participation. In response to a question regarding the response rates for the existing survey tools, the PAC and Hospice QRP Team noted that the CoreQ response rate is at 30%, the Hospice CAHPS response rate is trending around high 20s/low 30s, and the HH CAHPS rate varied between 19% and 31% in 2019 and 2022, where results vary by survey format (e.g., phone, mail, or both). The same panelist questioned whether the goal of achieving patient-centered care is being met if response rates are low. Another panelist stated that many hospices are not publicly reported, which may be a result of not meeting the minimum threshold of respondents due to the Hospice CAHPS Survey length. Another panelist was concerned that because of the low response rates, patients who fill out the surveys disproportionately impact measure scores. The same panelist recommended that CMS should place more emphasis on the patients' responsibility for completing surveys and that patients be offered an incentive for responding to surveys to increase response rates. This panelist also raised concerns that people's attention spans for completing lengthy surveys are less today for a variety of reasons, and therefore it may not be feasible to expect high response rates for surveys that take more than five minutes to complete. Another panelist agreed, and provided an example of a survey comprised of 20 questions that had a 77.8% response rate in 2007 but a 52.7% response rate in 2021. This panelist suggested that in addition to the type and number of questions influencing response rates, the burden on patients receiving surveys from multiple settings should also be considered.[34] One PFA also noted that filling out a long survey in the days immediately following discharge is difficult when a person is recuperating.

Format of Survey Administration

Panelists also discussed the format of the surveys, with many in support of surveys administered electronically or via text message, as opposed to paper surveys mailed to patients. One PFA noted that administering electronic surveys may be a challenge in rural areas because patients may not have access to the necessary electronic devices to complete surveys. Another panelist mentioned that they had success increasing response rates using text message-based surveys from 50% to 60%, and that patients who only have access to flip phones can complete them. One panelist reported their success with increasing response rates by using QR codes that patients can scan with their cell phones to access surveys. Another panelist added that telephonically administered surveys must give respondents sufficient time to select numbers on the keypad.

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[34] The survey tool discussed was the Medicare Modified Health Outcome Survey (HOS-M) that is used in Programs for All-Inclusive Care for the Elderly (PACE).

Survey Content

Panelists discussed survey content, including interpretation of questions and responses, recommendations for survey response options, and the potential burden caused when similar surveys are given to patients who move between more than one care setting. A few panelists raised concerns about different interpretations of the CAHPS scale, and the potential confusion respondents may face when drawing the line between “excellent” and “very good” on surveys that use scale-type questions. One panelist added that scale-type questions are not meaningful in rural settings where patients do not have options when choosing providers and either receive care or do not receive care. Three panelists added that comment boxes are more useful than standardized response options because they provide more actionable information that can be used to improve care quality, with one panelist adding that comment boxes also help providers interpret overall survey scores. Two panelists raised concerns that patients may not be able to understand survey questions, and another panelist raised a concern that many patients may not have the requisite education level to fill out long surveys, particularly in some rural areas. One panelist recommended that surveys leave the first question open-ended, and another panelist recommended that all survey questions be written at a fifth-grade reading level. A third panelist commented that if survey tools use the same questions across settings, patients who spend time in multiple settings may be unlikely to respond to similar surveys for each individual setting. Finally, two panelists agreed that there should be care coordination between facilities so that patients are tasked with completing fewer surveys.

Setting-Specific Considerations

Panelists discussed setting-specific considerations for patient experience surveys. One panelist raised concerns that the structural differences between care settings may contribute to how a patient perceives satisfaction with the quality of care they received. For example, IRFs are likely to receive higher scores given the intensive therapy provided and the high rate of patients who return home. SNFs may receive lower scores for not responding immediately to call lights, especially when patients need to relieve themselves. This panelist also noted that aligning survey tools across settings would be challenging given the different care goals across settings. In the example this panelist provided, pain management is very different in an IRF compared to pain management in hospice, where patients are terminally ill. Another panelist suggested that in SNF settings, patients on Medicare Advantage (MA) plans should be excluded from survey measures because patients may be dissatisfied with discharge decisions made by their MA plan, rather than with the care provided in the SNF.

Timing of Survey Administration

Panelists discussed the timing of survey administration, noting that surveys received too soon may be put aside during recuperation, but details of the care received may be lost if a survey is received weeks after discharge. One PFA recommended that surveys be administered within five to seven days of discharge. However, another panelist recommended that surveys be administered at the point of discharge. The general consensus among the remaining panelists and PFAs was that surveys should be administered within a week of discharge, with the exception of hospice, where timing should account for the loss of the respondent's loved one.

4.3 Session 3-E: Pain Management

This section outlines a summary of pain management measures and tools presented to the TEP. Section 4.3.1 summarizes the content presented during the session, Section 4.3.2 lists the key takeaways from the discussion, and Section 4.3.3 covers the questions presented to the TEP and a summary of the discussion related to each question.

4.3.1 Summary of Presentation

The PAC and Hospice QRP Team explained that developing pain management measures in PAC settings and hospice aligns with CMS' priorities. CMS has committed to expanding the collection, reporting, and analysis of standardized data to understand pain management in all patient populations. While measures may indirectly capture care related to pain management (e.g., falls measures and functional outcome measures), establishing measures that directly address pain management is a CMS priority. Person-centered care is one of eight domains highlighted in CMS' Meaningful Measures Initiative 2.0. Success in the person-centered care domain is measured by patient-reported outcomes measures (PROMs).

The team discussed the data elements that have been recently added to the IRF, LTCH, SNF, and HH assessment tools that address pain management: pain effect on sleep; pain interference with therapy activities, and pain interference with day-to-day activities (see Table 4-3 below). Minimum Data Set (MDS) items that also capture resident/patients' pain presence, frequency, and intensity were also outlined. Additional tools to consider are the PROMIS Pain Interference Short Form, which is self-reported; the Behavioral Pain Scale (BPS), and the Non-Verbal Pain Scale, both completed by a clinician.

Table 4-3: Standardized Pain Items Added to PAC Assessments

Item	Question	Response Values	Setting(s)
J0510. Pain Effect on Sleep	"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"	1 = Rarely or not at all 2 = Occasionally 3 = Frequently 4 = Almost constantly 9 = Unable to answer	IRF, LTCH, SNF, HH
J0520. Pain Interference with Therapy Activities	"Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"		
J0530. Pain Interference with Day-to-Day Activities	"Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"		

The PAC and Hospice QRP Team shared existing pain management measures currently in use across various programs. These include the Multimodal Pain Management measure and the Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain measure. The team outlined key findings from an environmental scan related to pain management that emphasized that pain management measures under consideration should focus on the assessment of pain, treatment of pain, and treatment follow-up after a baseline level of pain has been established.

The PAC and Hospice QRP Team concluded by outlining important considerations related to pain assessment items and potential measures for PAC and hospice assessment tools. Self-reported pain is considered the gold standard for pain assessment, although it may not always be feasible to collect this information from patients/residents treated in PAC or hospice settings (e.g., patients who are on ventilation support or non-communicative). Additionally, some scales are less reliable because of the nature of the tools. For example, clinician-focused tools such as the BPS have lower inter-rater reliability when administered on intubated patients versus non-intubated patients.

Pain management measure development considerations include the CY 2020 HH PPS Final Rule cycle, when concerns about implications of pain measures and their relationship to the opioid crisis impacted CMS policy decisions. CMS removed the HH CAHPS Survey question that addressed pain, and the HH QRP removed the Pain Interfering with Activity measure following concerns related to opioid prescription practices. CMS' current consideration is to balance issues of supporting patients' valid concerns with pain and their overall clinical experience with managing the unintended consequences of pain management.

4.3.2 *Key Discussion Takeaways*

- It is critical to address pain management directly to support the needs of patients/residents and their caregivers. Indirect assessment using current PAC and hospice measures is insufficient.
- A pain management measure should be suitable to address the needs of a range of patients/residents regardless of cognitive function or status.
- TEP members favored pain management measures that focused on addressing issues around pain's effect on daily activities.
- Any pain management measure should use standardized data elements where feasible while also considering setting-specific patient/resident population needs.
- Development of pain management measures should be pursued with a focus on measures that address patient goals around pain management instead of unrealistic targets involving all patients experiencing no pain.

4.3.3 *Panelist Discussion Details*

The PAC and Hospice QRP Team posed the following questions to the TEP panelists:

1. *While measures may indirectly capture care related to pain management (e.g., falls measures and functional outcome measures), would measures that directly address pain management be useful?*
2. *Should measures encouraging the use of specific care processes or pain management techniques be developed? How would these techniques differ across the care continuum?*
3. *Should a potential new measure utilize the standardized items in the PAC assessment or use new items?*
4. *Are there concerns with potential unintended consequences associated with outcome measures for pain management? In hospice? Other settings?*

TEP members expressed that while measures that may indirectly capture care related to pain management have some usefulness (e.g., falls measures and functional outcome measures), measures that directly address pain management would be the most useful measures for PAC and hospice. They emphasized a need to consider the range of patient experience of pain for any new measure. Some TEP members shared the importance of accounting for the voice of the patient as well as family members and personal care assistants when planning for a pain measure across all care settings. Additionally, panelists considered it critical to pursue information about the patient and family's belief system for a more holistic approach to supporting pain management interventions versus solely a focus on medication intervention. Specific to the hospice setting, TEP panelists believed that the HIS currently is too general in addressing pain management issues. The Hospice CAHPS items were believed to better address pain-related issues.

The TEP described the requirement for measures with enough sensitivity to address the pain management needs for a range of patients. The intersection of mental health and pain management is also an important factor. One example offered during the discussion was that of a SNF measure based on self-reported data that may capture only a small segment of the broader SNF population. A well-constructed measure should be able to account for the needs of patients/residents with significant cognitive impairment as well as those of cognitively intact patients/residents. The TEP also suggested the importance of considering the intersection of mental health and pain issues.

When considering the use of standardized data elements, the TEP supported focusing on items that addressed pain interfering with activities of daily living and not only the patient/resident's level of pain. A TEP member suggested that it was important to educate the individuals administering questions about pain to elicit information for pain interference with activities rather than just the level of pain. This would be a valuable step in ensuring a consistent measure. When assessing pain interference in daily activities, a TEP member suggested there would be value in providers understanding the change in score between the beginning and the end of a stay. Another member noted that for some patients/residents, the goal of no pain is not expected, or reduction in pain may not be a linear process that would be captured in a scale. It is important to measure whether the pain is disruptive. The TEP noted that there is value in considering the use of pain scales but that scales are less appropriate for use in the creation of measures.

The TEP discussed the balance of having standardized items and assessing pain with instruments that will be relevant for both the PAC and hospice settings. One consideration was to adjust the wording of questions to address care for patients, such as those in hospice care who are not participating in rehabilitation therapy. A panelist added the importance of understanding the goals of patients/residents and caregivers for addressing pain and its impact on the patient/resident's activities of daily living. Panelists considering hospice's context noted that hospice providers are regularly balancing the sedative effects of pain medications with the patient's desire to remain alert. Assessment tools should work to address this nuance. A final consideration raised by a TEP member was around ensuring that information is transferred between care settings so that prior information useful to the current care setting is not lost and can inform the providers in their management of pain.

The TEP discussed issues of implementing pain management measures and potential unintended consequences. One panelist shared that quality measures focused on a patient/resident's pain management goals are likely better to address this measure domain, and that this focus would also lead to less oversedation concerns tied to addressing pain. Another added to this discussion, noting that often a goal around pain management isn't "zero on the pain scale." A panelist also mentioned that it is critical to consider who is setting the pain management goal: the patient/resident, the family, or the clinicians. A TEP member reminded the group that there can also be interactions with other medications outside of opioids. The TEP believed it was feasible to implement the pain management measures in PAC and hospice while accounting for concerns relating to the overuse of opioids.

4.4 Session 3-F: Immunization

This section summarizes session 3-F, which provided a summary of the current measure landscape and development options for the immunization domain, including the Adult Immunization Status Universal Foundation Measure. Section 4.4.1 provides a summary of the presentation provided to panelists on this domain prior to the TEP's discussion, Section 4.4.2 summarizes key discussion takeaways, and Section 4.4.3 provides a full summary of the TEP discussion and questions presented to the TEP.

4.4.1 Summary of Presentation

The PAC and Hospice QRP Team began this session with a brief introduction highlighting the importance of immunization. Evidence has shown that patients without recommended vaccinations face decreased health outcomes, and vaccination status of HCP has been linked to a variety of improved patient outcomes.[35,36,37] Overall, vaccination is one of the safest ways to protect health, and increasing vaccination is particularly important for PAC settings due to the vulnerable populations they serve. Additionally, immunization measures align with CMS' priorities through the Wellness and Prevention domain, as highlighted in the Meaningful Measures Initiative 2.0 and Universal Foundation.

Next, the PAC and Hospice QRP Team reviewed the current Universal Foundation Adult Immunization Status measure specifications with the TEP. This measure is notable for two reasons: the inclusion of "up to date" language, and specification as a "composite measure". Inclusion of the "up to date" language allows this measure not to be tied to a particular frequency or cadence of vaccines, but rather whether the individual meets the criteria for being "up to date" given their age and medical conditions. This ensures that even as vaccine recommendations

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[35] Greenberg GM, Koshy PA, Hanson MJS. "Adult Vaccination." *American Family Physician* 2022;106(5):534-542. https://pubmed.ncbi.nlm.nih.gov/36379499

[36] Hayward AC, Harling R, Wetten S, et al. "Effectiveness of an influenza vaccine programme for care home staff to prevent death, morbidity, and health service use among residents: cluster randomised controlled trial." *BMJ* 2006;333(7581):1241. https://doi.org/10.1136/bmj.39010.581354.55

[37] Helms J, Reinbeck D. "Improving rates of pneumococcal vaccination in a skilled nursing facility." *Journal of Gerontological Nursing.* 2022;48(12):52-56. https://doi.org/10.3928/00989134-20221108-02

change over time, the measure would not be at risk of becoming outdated. This measure also contains five different vaccines bundled together as a “composite” measure, versus having five individual measures for each vaccination. Development of an “up to date” composite measure would allow for creation of a single metric to represent overall immunization status (based on age and other factors) at the facility/agency level. Additionally, a composite immunization measure at the provider or facility/agency level could represent patients, HCP, or both.

The PAC and Hospice QRP Team then presented a summary of existing QRP vaccination measures (Table 4-4) and their implementation across the QRPs. Existing patient measures are assessment-based, with HCP measures stewarded by the CDC and reported through the NHSN.

Table 4-4: PAC and Hospice QRP Vaccination Measures

Vaccination Measure	Data Source	LTCH QRP	IRF QRP	SNF QRP	HH QRP	Hospice QRP
Patient/Resident COVID-19 Vaccine	Assessments	**X***	**X***	**X***	**X***	**N/A**
Influenza Immunization Received for Current Flu Season	Assessment				**X**	**N/A**
COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)	NHSN	**X**	**X**	**X**		
Influenza Vaccination Among Healthcare Personnel	NHSN	**X**	**X**	**X**		

*Data collection begins on October 1, 2024 (IRF/LTCH/SNF)/January 1, 2025 (HH) and will be publicly reported beginning with the September 2025 (IRF/LTCH)/October 2025 (SNF)/January 2026 (HH) Care Compare refreshes (or as soon as technically feasible).

To support the TEP in considering potential immunization measures, the PAC and Hospice QRP Team also reviewed the existing CDC Adult Vaccination Recommendations in addition to coronavirus disease 2019 (COVID-19), influenza, and pneumococcal disease (Table 4-5) with the TEP. Given that recommendations vary by age, medical conditions, immunity, and other risk factors, this table provides only a general overview.

Table 4-5: CDC Recommended Vaccines for Adults in Addition to COVID-19, Influenza, and Pneumococcal Disease

Vaccinations	Recommendations
Respiratory Syncytial Virus (RSV)	Recommendations for each vaccination vary by age, documentation of vaccination, evidence of immunity, additional risk factors, indications, and other factors.[38]
Tetanus, Diphtheria, Pertussis (Tdap or Td)	
Measles, Mumps, Rubella (MMR)	
Varicella (VAR)	
Zoster Recombinant (RZV)	
Human Papillomavirus (HPV)	
Hepatitis A (HepA)	
Hepatitis B (HepB)	
Meningococcal A, C, W, Y (MenACWY)	
Meningococcal B (MenB)	
Haemophilus influenzae type b (Hib)	
Mpox	

The PAC and Hospice QRP Team asked panelists to consider the following when looking to fill the immunization gap in the PAC and hospice measure sets:

- Relevant data sources: PAC providers currently use their facility-specific assessment tools and the NHSN to report immunization status. This could remain constant, or panelists could consider alternative data sources.
- Clinical guidance: Panelists should consider relevant clinical guidance in crafting immunization measures, including what source(s) this guidance would originate from.
- Provider actionability: Will the measure provide information on which the provider can act, or will it quickly top out and be irrelevant?
- LOS: Given the cross-setting nature of this TEP, settings have varied care goals and LOS patterns. Hospice stays often have a LOS less than 20 days, and by the time a patient chooses hospice, they are likely to experience decline.
- Patient and family/caregiver input: In our Listening Session, we heard that immunization status, and information about what vaccines they had received, was very important to them. Patient and family/caregivers were interested in these rates for both HCP and other patients being cared for by the facility/agency.

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[38] For more information on the CDC's adult vaccination recommendations, please visit: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

4.4.2 *Key Discussion Takeaways*

- Several panelists raised concerns about expanding the existing patient/resident immunization measure set due to data collection challenges, the appropriateness of PCPs collecting vaccination information versus PAC facilities/agencies, and potential burden caused by factors such as the direct costs of administering vaccines and challenges implementing "up to date" requirements.
- Most panelists did not support additional HCP immunization measures for PAC and hospice due to the potential burden caused by direct costs of administering vaccines, and from workforce considerations such as shifting vaccination attitudes among HCP, challenges implementing "up to date" requirements, staffing shortages, and concerns about actionability of the information.
- PFAs strongly disagreed with the majority of other panelists, and recommended as much information as possible about patient/resident and HCP vaccination rates to inform care decisions for all PAC settings.
- The majority of panelists agreed that there should not be any immunization measures for hospice patients, noting the lack of relevance to improving quality outcomes, the need to respect patient preferences, and the potential burden caused by collecting patient-level vaccination information.

4.4.3 *Panelist Discussion Details*

The PAC and Hospice QRP Team presented the following questions to the TEP panelists:

1. *Does the current PAC measure set adequately address immunization?*
2. *Is the Adult Immunization Status Universal Foundation measure appropriate for PAC and hospice settings?*
3. *What are the trade-offs associated with composite versus individual immunization measures?*
4. *If a composite immunization measure is pursued, should it combine HCP and patients/residents in one measure?*

Provider Burden and Related Workforce Considerations

Most panelists did not support additional immunization measures for PAC and hospice due to the potential burden caused by direct costs of administering vaccines, and from workforce considerations. A few panelists working in SNFs raised concerns about the higher costs of the latest COVID-19 vaccine for patients/residents and HCP. The PAC and Hospice QRP Team mentioned that providers may bill patient/resident-level COVID-19 and influenza vaccines separately through Part B claims but acknowledged that this may still result in additional provider burden. Several panelists also raised workforce considerations related to immunization including, (i) shifting vaccination attitudes among HCP, (ii) challenges implementing “up to date” requirements for both patients/residents and HCP (iii) staffing shortages, and (iv) concerns about actionability of the information. Both PFAs on the panel strongly disagreed with the majority of other panelists, and highlighted that they would like as much vaccination information as possible for both patients/residents and HCP. These PFAs also expressed their strong desire for additional facility/agency immunization measures, drawing a direct link between vaccination and patient safety.

PAC Immunization Data Collection Challenges Related to Patient/Resident Immunization Measures

Several panelists raised concerns about expanding the existing patient/resident immunization measure set due to data collection challenges. Several panelists discussed how PAC facilities/agencies are not the appropriate locations to collect vaccination information because these records are usually stored with patients/residents’ PCPs. One panelist discussed the difficulty of relying on vaccination information provided by the patient/resident without access to centralized registries. Another panelist shared their experience with previous influenza vaccination requirements and found that most patients/residents received the requisite vaccinations either in acute care or from their PCP. A few panelists also discussed that many patients/residents, especially in rural areas, may not have a PCP, but still felt that PAC and hospice facilities/agencies were not appropriate locations for vaccine administration.

Individual versus Composite Vaccination Measures

Panelists also discussed other cross-setting considerations including composite versus individual vaccinations. When asked about composite versus individual immunization measures, two panelists supported composite immunization measures. One panelist mentioned that a composite immunization measure would allow the flexibility to include a tailored list of vaccinations.

Immunization Measures for Hospice Patients

The majority of panelists agreed that immunization measures should not be implemented for hospice patients. Two panelists highlighted that adding immunization measures for hospice patients would not be relevant to improving quality outcomes. One PFA emphasized the importance of respecting patient preferences, and that hospices should not subject patients to anything they do not want to do, including vaccinations. One panelist noted burden-related concerns associated with collecting patient-level vaccination information.

Additional Vaccination Measures in PAC

A few panelists voiced support for an expanded immunization measure set. Two panelists expressed support for additional influenza, respiratory, or seasonal measures for HCP across settings. One panelist stressed that this support was contingent on new HCP measures including clear specifications rather than “up to date” or “current” language. Another panelist recommended expanding the measure set such that all facility/agencies report on the same immunization measures by aligning HH and hospice with the other settings. A third panelist asked for the pertussis vaccine to be included in a new immunization measure. PFAs supported new HCP and PAC patient/resident measures that would provide additional immunization information to inform care decisions.

5 NEXT STEPS

The input provided by this TEP meeting will help CMS and the PAC and Hospice QRP Team prioritize new measure development efforts to address PAC and hospice measurement gaps. As next steps, the PAC and Hospice QRP Team envisions (i) adapting some of the new measure concepts discussed to the PAC and hospice settings and (ii) conducting analyses to develop measure specifications and concepts for consideration at future occurrences of the standing TEP.

APPENDIX A: CROSS-SETTING TEP TEAM

The PAC and Hospice QRP Team is multidisciplinary and includes individuals with knowledge and expertise in the areas of measure development, payment policy, health economics, clinical practice, public reporting, pay-for-performance, value-based purchasing (VBP), and quality improvement. The following individuals from the project team attended the TEP:

Acumen Team:

- Sri Nagavarapu, Co-Project Director
- Stephen McKean, Co-Project Director
- Sana Zaidi, Project Manager
- Ellen Strunk, Clinical Lead
- Alan Levitt, Clinical Lead
- Kris Mattivi, Clinical Lead
- Nathaniel Anderson, Policy Associate
- Josh Coopersmith, Data and Policy Analyst
- Lidya Tadesse, Data and Policy Analyst
- Hugh O'Connor, Data and Policy Analyst

Abt Team:

- Allison Muma, Project Director
- Alrick Edwards, Home Health Project Manager
- Jennifer Riggs, Home Health Clinical Lead
- Nicole Keane, Home Health Clinical Lead
- Mariana Sarango Cancel, Home Health and Hospice Health Equity Lead
- Morris Hamilton, Home Health Quality Measure Development and Analytic Lead
- Derek Hoodin, Home Health Data Analytic Associate
- Zinnia Harrison, Hospice Project Manager
- Brenda Karkos, Hospice Clinical Lead
- Thomas (T.J.) Christian, Hospice Quality Measure Development and Analytic Lead

APPENDIX B: PAC AND HOSPICE CROSS-SETTING TEP CHARTER

All TEP panelists formally ratified the TEP Charter, which outlines the TEP objectives, requirements, scope of responsibilities, and estimated meeting schedule. The full text of the TEP Charter is below:

Project Title:

Standing Technical Expert Panel (TEP) for the Development, Evaluation, and Maintenance of Post-Acute Care (PAC) and Hospice Quality Reporting Program (QRP) Measurement Sets

TEP Expected Time Commitment and Dates:

Selected nominees will serve on a standing committee to support the evaluation and maintenance of PAC QRP measurement sets for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), Skilled Nursing Facility (SNF), Home Health (HH) and Hospice settings. Selected nominees can expect to be contacted on an annual, or as needed, basis for up to five years.

Selected nominees will be expected to attend the first TEP meeting in November 2023 (specific dates to be determined) and a pre-TEP webinar approximately 1-2 week(s) prior to meeting date. All meetings will be held virtually.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC and Abt Associates Inc. (hereafter referred to as Acumen and Abt) to support the development, evaluation, and maintenance of quality and cost measures for use in the Post-Acute Care (PAC) and Hospice Quality Reporting Program (QRP) and Nursing Home Compare as mandated by the Patient Protection and Affordable Care Act (ACA) of 2010 and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. Acumen's contract name is "Quality Measure & Assessment Instrument Development & Maintenance & QRP Support for the Long Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Quality Reporting Programs, & Nursing Home Compare." The contract number is 75FCMC18D0015, Task Order 75FCMC19F0003. Abt's contract name is "Home Health and Hospice Quality Reporting Program Quality Measures and Assessment Instruments Development, Modification and Maintenance, & Quality Reporting Program Oversight Support." The contract number is 75FCMC18D0014, Task Order 75FCMC19F0001.

As part of its measure development process, Acumen and Abt convene groups of stakeholders and experts who contribute direction and input during measure development and maintenance.

Project Objectives:

PAC QRPs aim to characterize provider performance across various dimensions of care. With the support of Acumen and Abt, CMS refines and develops QRP measures to ensure that (a) Medicare beneficiaries and their caregivers have high-impact, meaningful performance data to assist in making informed healthcare decisions; and (b) providers have actionable information to guide performance improvement efforts without being overburdened by reporting requirements. Acumen and Abt are convening this TEP to evaluate the measurement sets across the IRF, LTCH, SNF, HH, and Hospice setting, with a focus on identifying measurement gaps, and ensuring measures align with CMS program requirements and goals. Acumen and Abt will organize a panel of stakeholders from a broad base of expertise (e.g., clinical, policy and program, measure development, technical, etc.) and solicit their input regarding the PAC and Hospice QRP measurement sets and future measure concepts. This input will be used to inform new measure development and maintenance of PAC and Hospice quality measures.

Technical Expert Panel (TEP) Objectives:

The TEP will provide input and guidance on the evaluation of the PAC and Hospice QRP measurement sets and inform new measure development and maintenance of PAC and Hospice quality measures. Specifically, we will seek guidance on the following:

- *Input on the framework used to assess PAC and Hospice Measurement gaps;*
- *Input on new measure domains and future measure concepts identified;*
- *Input on the alignment of the PAC and Hospice QRPs and Hospice QRPs with the Universal Foundation Measures*

TEP Requirements:

A TEP of approximately 12-15 individuals will provide guidance on concepts related to the evaluation of the PAC measurement sets and new measure development and maintenance of PAC and Hospice quality measures. The TEP will be composed of individuals with differing areas of expertise and perspectives, including but not limited to:

- *Clinical experts with knowledge or experience working in the IRF, LTCH, SNF/NH, HH and Hospice settings;*
- *Other subject matter experts or independent researchers with expertise or working knowledge of IRF, LTCH, SNF/NH, HH and Hospice settings;*
- *Clinical experts or independent researchers with expertise in healthcare disparities;*
- *Independent researchers or representatives from consumer stakeholder organizations;*
- *Measure development experts;*
- *Quality improvement specialists;*
- *Patient/Family (Caregivers) who received care in a PAC and Hospice setting; and*

- *Clinical experts or independent researchers with expertise using the assessment tools or Medicare claims data.*

Scope of Responsibilities

The TEP's role is to provide input and advice to Acumen and Abt on the evaluation and maintenance of the PAC and Hospice quality measurement sets, new measure development and maintenance of PAC and Hospice quality measures. Holding a TEP allows Acumen and Abt to leverage the members' experience, which increases the clinical and face validity of the measures and helps to maximize the number of critical dimensions of care being addressed. As such, members are expected to attend all meetings and to notify Acumen and Abt should circumstances change where they no longer wish to participate. Acumen and Abt will work with members to schedule meetings at least one month in advance. In the case of last-minute scheduling conflicts, Acumen and Abt ask members to provide any feedback or thoughts on the materials and discussion questions for Acumen and Abt to share with the panel. In some circumstances, a TEP member may designate a temporary replacement from their organization. Any substitute is subject to approval, as we strive to ensure a balanced and diverse composition.

If a TEP member is no longer able to meet membership commitments, Acumen and Abt will identify a replacement from the nominees from the most recent call for nominations or by working with the TEP member's affiliated professional society to nominate another member. Upon identification of an appropriate alternate member any TEP obligations will transfer to the replacement TEP member.

Guiding Principles:

Participation as a TEP member is voluntary and the measure developer records the participant's input in the meeting minutes, which the measure developer will summarize in a report that they may disclose to the public. If a participant has chosen to disclose private, personal data, then related material and communications are not covered by patient-provider confidentiality. Patient/caregiver participants may elect to keep their names confidential in public documents. TEP organizers will answer any questions about confidentiality.

All potential TEP members must disclose any significant financial interest or other relationships that may influence their perceptions or judgment. It is unethical to conceal (or fail to disclose) conflicts of interest. However, there is no intent for the disclosure requirement to prevent individuals with particular perspectives or strong points of view from serving on the TEP. The intent of full disclosure is to inform the measure developer, other TEP members, and CMS about the source of TEP members' perspectives and how that might affect discussions or recommendations.

Input, advice, and recommendations by TEP members will be considered by the measure developer. An appointed TEP chair will help facilitate discussion and build consensus.

Estimated Number and Frequency of Meetings:

Selected nominees can expect to be contacted on an annual, or as needed, basis for up to five years.

The first TEP will be scheduled to meet virtually in **October and November 2023:**

- ***One-hour*** *pre-TEP webinar in* **October 2023** *(specific date to be determined). This meeting serves as an orientation and will be held approximately 1-2 week(s) prior to the TEP meeting date.*
- ***Two four-hour*** *TEP Meetings in* **November 2023** *(specific dates to be determined based on availability of selected members.)*
- *If necessary and feasible, follow-up webinars will be held to present decisions made on TEP input.*

Date Approved by TEP:

TBD

TEP Membership:

TBD

APPENDIX C: BACKGROUND MATERIALS

Appendix C includes the materials that were distributed to TEP panelists ahead of the TEP on December 15, 2023. Section C.1 includes excerpts from the *SNF, IRF, LTCH, HH, and Hospice Quality Reporting Measurement Sets Environmental Scan,* which informed TEP scope and discussions. Section C.2 includes the supplemental materials document that was provided to panelists prior to the meeting.

C.1 IRF, LTCH, SNF, HH, and Hospice Quality Reporting Measurement Sets Environmental Scan

The PAC and Hospice measurement sets environmental scan provides a systematic framework for identifying measurement gaps in the PAC and Hospice QRPs and existing measures or measure concepts that have the potential to fill recognized gaps. This framework establishes four principles for identifying measurement gaps: (i) actionability, (ii) comprehensiveness and conciseness, (iii) provider responses to payment systems, and (iv) compliance with statutory requirements and CMS initiatives. These principles were included as a request for information (RFI) in the FY 2024 proposed rules for IRF, LTCH, SNF, and HH, with comment summaries in the final rules. Panelists were also provided with slides explaining these principles prior to the TEP, available in appendix C.2.2.

The remainder of this section includes excerpts from the environmental scan. Section C.1.1 covers the document's introduction, Section C.1.2 presents the relevant PAC and hospice statutory authorities, Section C.1.3 includes the measures represented in PAC and Hospice QRPs, Section C.1.4 introduces the Universal Foundation measures, Section C.1.5 presents measurement concepts that could fill identified measurement gaps, and Section C.1.6 summarizes the stakeholder input gathered during the RFIs on future measure concepts.

C.1.1 Introduction

The purpose of this report is to identify measurement gaps in the PAC and Hospice QRPs and suggest either fully developed PAC or hospice measures, or measurement concepts that could be developed into PAC or Hospice QRP measures. This document serves as a roadmap for the next stages of PAC and Hospice QRP measure maintenance and development. Acumen begins by outlining a set of principles to guide identification of QRP measurement gaps, and then introduces prospective measures and measure concepts to fill them. In theory, it may be possible to identify numerous clinically meaningful measures for inclusion in QRPs developed for each setting under consideration. However, the number of possible measures could quickly become unwieldy and overwhelming without a framework with which to evaluate and prioritize suggestions. Outlining these principles is, therefore, of particular importance given the large number and broad scope of PAC- and hospice-related quality measures that have been developed by public and private stakeholders. The principles described in this report emphasize the development of measures that focus on the range of services and types of care most relevant to each PAC setting and hospice; align with CMS statutory requirements (e.g., the Improving Medicare Post-Acute Care Transformation [IMPACT] Act of 2014) and program goals (e.g., reduce provider burden, conform to the Meaningful Measures Framework [MMF]); and protect against provider responses to PAC payment systems that could adversely impact health outcomes.

Acumen assesses LTCH, IRF, and SNF QRP measures, and Abt assesses HH and Hospice QRP measures relative to these principles to identify areas to focus measure maintenance and development activities. A review of the literature and the measure landscape is conducted to help determine the availability of measures and/or to identify measure concepts to fill identified gaps.

C.1.2 PAC and Hospice Statutory Authorities

Section 3004 of the Patient Protection and Affordable Care Act (ACA) of 2010 mandated the creation of QRPs for LTCHs and IRFs. Section 1888(e)(6) of the Social Security Act (SSA) authorized a QRP for SNFs, to include freestanding SNFs, SNFs affiliated with acute care facilities, and all non–critical access hospital (CAH) swing-bed rural hospitals. Section 1895 of the SSA authorized a QRP for home health agencies (HHAs). These four settings comprise PAC. Subsequently, the IMPACT Act reformed the data collection and measure development process for PAC QRPs. First, it established a list of domains from which additional QRP measures are to be developed, including five quality domains, a resource use domain, a discharge-to-community domain, and a re-hospitalization domain. Second, to support measure development, it required the standardization of data collected by facilities and agencies via their assessment instruments. The Hospice QRP was established separately under section 1814(i)(5) of the SSA and was effective beginning with fiscal year (FY) 2014. The SSA required the Department of Health and Human Services Secretary to establish and maintain a QRP for hospices and required public reporting of quality measures that relate to the care provided by hospice programs.

Over the past decade, and as these programs entered their current mature state, the PAC and Hospice QRPs have incorporated an increasing number of measures to better characterize provider performance across various dimensions of care, and to align payment across PAC settings. As the PAC QRPs further evolve, CMS continues to evaluate, and as deemed necessary, refine or develop new QRP measures to ensure that (i) Medicare beneficiaries and their caregivers have high-impact, meaningful performance data to assist in making informed healthcare decisions and (ii) providers have actionable information to guide performance improvement efforts without being overburdened by reporting requirements.

For these purposes, CMS contracted with Acumen to support measure development, maintenance, implementation, and reporting for the SNF, IRF, and LTCH QRPs, and with Abt Global LLC to support measure development, maintenance, implementation, and reporting for the HH and Hospice QRPs. This report provides a critical foundation for these efforts going forward. In 2022, Acumen developed the framework for identifying measurement gaps and delivered an earlier version of this report to CMS. This document has been adapted and updated to account for (i) the addition of the HH and hospice settings, (ii) updates per the FY/ CY 2024 rulemaking cycles, and (iii) the addition of new CMS initiatives. This document may be updated on an annual or as-needed basis to facilitate future measure development and maintenance activities.

C.1.3 Measures Represented in PAC and Hospice Quality Reporting Systems

Reviewing the PAC and Hospice QRP measure sets provides a starting point for the discussion of measurement gaps and redundancies. The existing PAC QRP measure sets consist of measures derived from data sources that include claims, PAC assessment records, CAHPS Surveys, and the (NHSN of the CDC. The existing Hospice QRP measure set consists of measures derived from three different data sources (HIS, Medicare FFS claims, and the CAHPS Hospice Survey). As shown in Table C.1, there is a mix of publicly reported measures, some of which are cross-setting (applicable to two or more PAC settings) and others unique to a specific setting. Although measure specifications may differ across settings, several measures are currently included in the SNF, IRF, LTCH, and HH QRPs (e.g., falls with major injury, changes in skin integrity) or two PAC settings (e.g., discharge mobility score and discharge self-care score for patients treated in a SNF or IRF). Several measures apply to only one setting, particularly in the HH and hospice settings.

Table C.1: PAC and Hospice Quality Reporting Program Measure Sets

No.	Measure*	CMIT Measure ID Number[39]	SNF	IRF	LTCH	HH	Hospice
1	Application of Percent of Residents Experiencing One or More Falls with Major Injury	00520 (not endorsed)	x	x	x	x	
2	Discharge Self-Care Score for Medical Rehabilitation Patients	00404 (CBE-endorsed)	x	x			
3	Discharge Mobility Score for Medical Rehabilitation Patients	00403 (CBE-endorsed)	x	x			
4	Drug Regimen Review Conducted with Follow-Up for Identified Issues	00225 (not endorsed)	x	x	x	x	

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[39] Refer to the CMS Measures Inventory Tool (CMIT; https://cmit.cms.gov/cmit/#/) for the CMIT Measure ID and other detailed measure information. CBE endorsement status is determined by the CMS CBE, which endorses quality measures through a transparent, consensus-based process that incorporates feedback from diverse groups of stakeholders to foster healthcare quality improvement. The CMS CBE endorses measures only if they pass a set of measure evaluation criteria. For more information, refer to the document titled CMS Consensus-Based Entity (CBE) Endorsement and Maintenance (https://mmshub.cms.gov/sites/default/files/Blueprint-CMS-CBE-Endorsement-Maintenance.pdf). Please note that measures are marked as "CBE-endorsed" if they are endorsed in any of the SNF, IRF, LTCH, HH, or Hospice settings.

No.	Measure*	CMIT Measure ID Number[39]	SNF	IRF	LTCH	HH	Hospice
5	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	00121 (not endorsed)	x	x	x	x	
6	Transfer of Health Information to the Provider–Post-Acute Care	00728 (not endorsed)	x	x	x	x	
7	Transfer of Health Information to the Patient–Post-Acute Care	00727 (not endorsed)	x	x	x	x	
8	Catheter Associated Urinary Tract Infection Outcome Measure	00459 (CBE-endorsed)		x	x		
9	Influenza Vaccination Coverage among Healthcare Personnel	00390 (CBE-endorsed)	x	x	x		
10	Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection Outcome Measure	00462 (CBE-endorsed)		x	x		
11	COVID-19 Vaccination Coverage among Healthcare Personnel	00180 (CBE-endorsed)	x	x	x		
12	Medicare Spending per Beneficiary (MSPB) – Post-Acute Care	00434 (CBE-endorsed)	x	x	x	x	
13	Discharge to Community	00210 (CBE-endorsed)	x	x	x	x	
14	Potentially Preventable 30-Day Post-Discharge Readmission Measure	00575 (not endorsed)	x	x	x	x	
15	Potentially Preventable Within Stay Readmission Measure	00576 (not endorsed)		x			
16	Healthcare-Associated Infections (HAI) Requiring Hospitalization	00680 (CBE-endorsed)	x				
17	Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support	00275 (CBE-endorsed)			x		
18	Compliance with Spontaneous Breathing Trial by Day 2 of the LTCH Stay	00143 (not endorsed)			x		
19	Ventilator Liberation Rate	00759 (not endorsed)			x		
20	Central Line-Associated Bloodstream Infection Outcome Measure	00460 (CBE-endorsed)			x		
21	Cross-Setting Discharge Function Score	01698 (not endorsed)	x	x	x	x	
22	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	01699 (not endorsed)	x	x	x	x	
23	Improvement in Ambulation-Locomotion	00364 (CBE-endorsed)				x	
24	Improvement in Bed Transferring	00366 (CBE-endorsed)				x	
25	Improvement in Bathing	00365 (CBE-endorsed)				x	
26	Improvement in Management of Oral Medications	00371 (CBE-endorsed)				x	
27	Improvement in Dyspnea	00369 (not endorsed)				x	
28	Influenza Immunization Received for Current Flu Season	00389 (CBE-endorsed)				x	
29	Timely Initiation of Care	00719 (not endorsed)				x	

No.	Measure*	CMIT Measure ID Number[39]	SNF	IRF	LTCH	HH	Hospice
30	Home Health Within-Stay Potentially Preventable Hospitalization Measure	01222 (not endorsed)				x	
31	Home Health CAHPS® Survey	00153 (not endorsed)				x	
32	HIS Comprehensive Assessment Measure at Admission	00322 (CBE-endorsed)					x
33	Hospice Visits in Last Days of Life (HVLDL)	00329 (CBE-endorsed)					x
34	Hospice Care Index	00328 (not endorsed)					x
35	CAHPS® Hospice Survey	00154 (CBE-endorsed)					x
Measures Finalized for Removal**							
…	Change in Self-Care Score for Medical Rehabilitation Patients	–	x	x			
…	Change in Mobility Score for Medical Rehabilitation Patients	–	x	x			
…	Application of Percent of LTCH Patients with Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	–	x	x	x	x	
…	Percent of LTCH Patients with Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	–			x		
…	Acute Care Hospitalization During the First 60 Days of Home Health	00012 (CBE-endorsed)				x	
…	Emergency Department Use without Hospitalization During the First 60 Days of Home Health	00233 (CBE-endorsed)				x	

CBE: Consensus-Based Entity; CMIT: CMS Measure Inventory Tool.
* Indicates new measures for FY2024 QRPs.
** These measures were finalized for removal in the HH Prospective Payment System (PPS), IRF PPS, LTCH PPS, and SNF PPS CY/FY 2023 or 2024 final rules.

C.1.4 Universal Foundation Measures

The Universal Foundation is a CMS initiative that aims to consolidate and align quality measures across all QRPs for the adult and pediatric populations.[40] The Universal Foundation was created as part of CMS' National Quality Strategy (NQS)[41] to develop a core set of measures focused on promoting equity, prioritizing measures for transition to interoperable digital data measures, allowing for cross-comparisons from one QRP to another, and potentially improving patient outcomes by focusing provider attention.

To align with these goals, CMS selected 10 adult measures across six domains (Table C.2). The Universal Foundation measures set was not specifically designed for PAC and hospice

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[40] Jacobs DB, Schreiber M, Seshamani M, Tsai D, Fowler E, Fleisher LA. Perspective: Aligning quality measures across CMS – The Universal Foundation. *New England Journal of Medicine.* 2023;388(9):776-779. https://doi.org/10.1056/NEJMp2215539

[41] Schreiber M, Richards AC, Moody-Williams J, Fleisher LA. The CMS National Quality Strategy: A Person-Centered Approach to Improving Quality. CMS.gov blog. June 6, 2022. https://www.cms.gov/blog/cms-national-quality-strategy-person-centered-approach-improving-quality.

settings and may need to be modified for use considering available data sources, PAC and hospice patient populations, and PAC and hospice key areas of care.

In selecting Universal Foundation measures, CMS used seven criteria.[42] Several of these criteria align with the measurement gap identification principles. For example, the "benchmarked nationally and globally" selection criterion falls under the actionability principle, and the "high national impact" criterion aligns with the comprehensiveness and conciseness principle. Criteria such as scientific acceptability and feasibility are used to assess measure concepts through the measure development lifecycle. The seven Universal Foundation selection criteria are:

- The measure is of high national impact.
- The measure can be benchmarked nationally and globally.
- The measure is applicable to multiple populations and settings.
- The measure is appropriate for stratification to identify disparity gaps.
- The measure has scientific acceptability.
- The measure is feasible and computable (or capable of becoming digital).
- The measure has no unintended consequences.

Table C.2: Universal Foundation Measures (Excluding Children's Measures)

Domain	Measure
Chronic Conditions	Controlling High Blood Pressure
	Diabetes: Hemoglobin A1c Poor Control
Wellness and Prevention	Colorectal Cancer Screening
	Breast Cancer Screening
	Adult Immunization Status
Behavioral Health	Screening for Depression and Follow-up Plan
	Initiation and Engagement of Substance Use Disorder Treatment
Seamless Care Coordination	Hospital or Plan All Cause Readmission
Person-Centered Care	CAHPS: Overall Experience
Equity	Social Drivers of Health Screening

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[42] Centers for Medicare & Medicaid Services. Aligning Quality Measures Across CMS – the Universal Foundation. https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation.

C.1.5 Measurement Concepts that Could Fill Identified Gap Areas

CMS prioritized four measurement gap areas[43] from the environmental scan for this TEP. These include behavioral and mental health, patient experience of care, immunization, and pain management. The sections for each measurement gap area include narrative on why the measurement domain is relevant to PAC and/or hospice settings, the extent to which the current measure sets cover these domains, and measure development options.

Behavioral and Mental Health

A considerable proportion of Medicare patients treated in a SNF, IRF, HHA, or LTCH are affected by behavioral or mental health conditions that include depression, anxiety, and bipolar disorders. In some instances, such as following a knee replacement or stroke, patients may develop depression and anxiety. In other instances, patients may have been dealing with behavioral or mental health issues long before their post-acute or community referral admission to PAC services. Left unmanaged, however, these conditions make it difficult for affected patients to actively participate in medical rehabilitation or to adhere to the prescribed treatment regimen, thereby contributing to poor health outcomes.

Information on the availability and appropriateness of behavioral health measures in post-acute settings is limited. In a review of the literature on the quality of mental health care provided to nursing home residents, Grabowski et al.[44] noted the need to develop and validate additional mental health quality measures based on existing data (e.g., CMS assessment files). The HH QRP previously assessed the extent to which patients were screened for depression, but this measure was removed from the HH QRP in the CY 2019 HH PPS final rule.[45]

Substance abuse is an issue in the older adult community, and per qualitative findings, specifically an issue in HH care.[46,47] Currently there is no way to determine how large of an issue this is, as these data are not collected in the Outcome and Assessment Information Set (OASIS), and no assessment for SUD is conducted. Despite this, HH nurses report that SUD is a frequent comorbidity among Medicare HH patients, and that it exacerbates other medical conditions and health outcomes, including physical function, infection risk, and rehospitalization risk. Currently,

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[43] Immunizations were not included in this section of the environmental scan because a number of vaccination measures already exist in the QRPs. For this TEP, CMS sought feedback on a narrow list of immunization related measure options, such as HCP- versus patient-level measures, and the CDC list of recommended vaccines.

[44] Grabowski DC, Aschbrenner KA, Rome VF, Bartels SJ. Quality of mental health care for nursing home residents: a literature review. *Medical Care Research and Review*. 2010;67(6):627-656. https://doi.org/10.1177/1077558710362538

[45] Centers for Medicare & Medicaid Services. CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Health Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations. Federal Register (FR) 56552-56553. November 13, 2018.

[46] Cabin W. In the realm of haunting ghosts: Denying the existence of substance abuse in Medicare home health. *Journal of Evidence-Based Social Work*. 2020;17(2):226-236. https://doi.org/10.1080/26408066.2020.1723770

[47] Fairman KA, Early NK. Treatment needs and service utilization in older U.S. adults evidencing high-risk substance use. *Journal of Aging and Health*. 2020;32(10):1363-1375. https://doi.org/10.1177/0898264320929537

there are no OASIS questions related to SUD, its assessment, and/or treatment.[48] In terms of care provision, HH does not offer services related to the treatment of SUD. However, facilitating connection to services such as transportation, behavioral health referrals, and SUD treatment programs is one way in which HH services could respond to SUD and improve outcomes.

Among older adults, anxiety and depression often coexist, and there is a connection between depression and cognitive issues such as dementia among older adults receiving in-home care.[49] Depression and anxiety are underdiagnosed and undertreated among older adults, leading to increased use of health and social care services and increased mortality.[50] In particular, homebound older adults are at increased risk for decreased social interaction and increased depression.[51] Evidence indicates that telehealth and telehealth behavioral health interventions can have a positive effect on depression and social isolation among homebound older adults,[52,53,54] but these interventions are not currently part of standardized HH practice, and further research is needed to determine if they could be a part of an HH plan of care.

Other instruments that may be adapted to assess management of behavioral or mental health in PAC settings:

- The CAHPS ECHO Survey, which is currently used by state Medicaid programs and MCOs, consists of questions that may be used to understand patients' perspectives concerning mental health services received, including the receipt of counseling and treatments, types of treatment received, and perceptions of treatment outcomes.[55] Among the specific domains addressed in ECHO are getting care quickly, information about treatment options, rating of counseling and treatment, information provided to manage conditions, and information

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[48] Similarly, assessment instruments used for IRF, LTCH, and SNF do not include items for SUD.

[49] Helvik AS, Barca ML, Bergh S, Šaltytė-Benth J, Kirkevold Ø, Borza T. The course of depressive symptoms with decline in cognitive function – a longitudinal study of older adults receiving in-home care at baseline. *BMC Geriatrics.* 2019;19(1):231. https://doi.org/10.1186/s12877-019-1226-8

[50] Kingstone T, Bartlam B, Burroughs H, et al. Can support workers from AgeUK deliver an intervention to support older people with anxiety and depression? A qualitative evaluation. *BMC Family Practice.* 2019;20(1):16. https://doi.org/10.1186/s12875-019-0903-1

[51] Kim YR, Jung HS. Effects of social interaction and depression on homeboundness in community-dwelling older adults living alone. *International Journal of Environmental Research and Public Health*. 2022;19(6):3608. https://doi.org/10.3390/ijerph19063608

[52] Choi NG, Pepin R, Marti CN, Stevens CJ, Bruce ML. Improving social connectedness for homebound older adults: randomized controlled trial of tele-delivered behavioral activation versus tele-delivered friendly visits. *American Journal of Geriatric Psychiatry*. 2020;28(7):698-708. https://doi.org/10.1016/j.jagp.2020.02.008

[53] Göransson C, Wengström Y, Hälleberg-Nyman M, Langius-Eklöf A, Ziegert K, Blomberg K. An app for supporting older people receiving home care – usage, aspects of health and health literacy: a quasi-experimental study. *BMC Medical Informatics and Decision Making.* 2020;20(1):226. https://doi.org/10.1186/s12911-020-01246-3

[54] Goodarzi Z, Holroyd-Leduc J, Seitz D, et al. Efficacy of virtual interventions for reducing symptoms of depression in community-dwelling older adults: A systematic review. *International Psychogeriatrics*. 2023;35(3):131-141. https://doi.org/10.1017/S1041610222000412

[55] Agency for Healthcare Research and Quality. CAHPS Mental Health Care Surveys. May 2022. https://www.ahrq.gov/cahps/surveys-guidance/echo/index.html

provided about medication side effects. ECHO tools include programs that score individual measures, composite measures, and ratings.

- PROMIS[56] includes a suite of instruments that may be used to monitor and evaluate mental health and quality of life. The PROMIS adult instrument, developed for a general population, includes assessments of emotional distress (such as anger, anxiety, and depression) and life satisfaction that may be identified from available item banks, and is scored using a free web-based scoring service. The PROMIS Global Health instrument, which includes items related to mental health, quality of life, and social functioning, was a part of the IMPACT Act's National Beta Test (2017-2018) for the Development and Evaluation of Candidate Standardized Patient Assessment Data Elements (SPADEs). Findings from this test suggested that this instrument has only some or moderate clinical utility and imposes a moderate burden on respondents.[57]
- The PROMIS Neuro-QoL assesses self-reported levels of anxiety, depression, and other behavioral health concerns in patients with neurological conditions, such as stroke or Parkinson's disease, that are often treated in a PAC setting. Among the advantages of the PROMIS suite of tools is that surveys, which are available in several languages, address domains of relevance to different patient populations. Potentially limiting the feasibility of PROMIS tools for public reporting is the added burden to providers if they are required to collect additional patient data.
- Related to PROMIS, the NIH Toolbox® for the Assessment of Neurological and Behavioral Health Function,[58] which was commissioned by the NIH Blueprint for Neuroscience Research, includes both stand-alone measures and batteries of measures to assess cognition, emotion, motion, and sensation. Although the NIH Toolbox® largely includes performance-based items, items pertaining to emotion are self-reported. The Toolbox® includes a manual that describes measure (item)-specific and domain-specific scoring; normative scores are also available.

In addition to the above-named instruments, claims records are another potential source of information about the care rendered to patients in PAC settings. Claims records associated with the receipt of Part A and Part B services could be used to determine the extent to which beneficiaries with a mental health or behavioral health condition (determined from PAC assessment instruments) receive needed care. However, with SNF consolidated billing, most

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[56] HealthMeasures. Intro to PROMIS®. August 5, 2022. https://www.healthmeasures.net/explore-measurement-systems/promis/intro-to-promis.

[57] Edelen MO, Rodriguez A, Ahluwalia SC, et al. Development and evaluation of candidate Standardized Patient Assessment Data Elements. RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3004z1.html.

[58] HealthMeasures. NIH Toolbox®. https://www.healthmeasures.net/explore-measurement-systems/nih-toolbox

SNF services, including behavioral and mental health services rendered by a SNF employee, for example, may not be identifiable. Data to determine the receipt of behavioral and mental health services may only be identified from physician professional claims, as these Part B services are exempt from consolidated billing. Given these limitations, claims data may not provide comprehensive information on how well PAC providers address patients' behavioral and mental health needs.

Patient Experience of Care

Information on patient experience of care is typically collected via a number of instruments that rely on patient self-reported data. The most prominent among these is the CAHPS suite of surveys. Each CAHPS survey is structured to be relevant to the care setting to which it applies. For example, the CAHPS Nursing Home Survey consists of three standardized instruments designed for long-stay residents (100 days or more), discharged residents, and family members. The CAHPS Hospice Survey, on the other hand, consists of a questionnaire containing 47 questions covering topics of interest to family caregivers and hospice patients. CAHPS surveys capture patient experience related to concepts from which it is possible to identify several patient experience measures. For example, among the concepts included in the Nursing Home CAHPS discharged resident survey, respondents are asked to rate:

- Environment, e.g., cleanliness, noisiness, quality of food, temperature in the facility
- Care rendered, e.g., assistance provided by staff, therapy services, alleviation of pain
- Communication, e.g., respectfulness, staff explanations of care, listening to patient needs
- Autonomy, e.g., personal privacy, ability to reach for items
- Available activities
- Quality of life, e.g., feelings of worry and happiness, quality of life while in facility

The CAHPS Hospice Survey has been in use and publicly reported since 2018. It is available in several languages and is administered using three modes (mail only, telephone only, and mail with telephone follow-up). The CAHPS Hospice Survey is a national survey of family members or friends who cared for a patient who died while under hospice care. The survey is conducted monthly. The questionnaire contains 47 questions covering topics of interest to family caregivers and hospice patients. Survey results are published as part of Care Compare on the www.Medicare.gov website. All eight of the CAHPS Hospice Survey measures are endorsed under CBE #2651. The eight topics covered in the survey include:

- Communication with family

- Getting timely help
- Treating patient with respect
- Emotional and spiritual support
- Help for pain and symptoms
- Training family to care for patient
- Rating of this hospice
- Willingness to recommend this hospice

The CAHPS Home Health Care Survey has been in use since 2010, and results have been publicly reported since 2012. The CAHPS Home Health Care Survey is designed to measure the experiences of people receiving HH care from Medicare-certified HH care agencies. It is available in several languages and is administered using three modes (mail only, telephone only, and mail with telephone follow-up). The questionnaire contains 34 questions covering topics of interest to HHA patients, their family, and their caregivers. The CAHPS Home Health Care Survey received CBE endorsement in 2009 and re-endorsement in 2015. The survey uses the following measures of patient experience:

- Care of patients
- Communication between providers and patients
- Specific care issues
- Rating of care provided by the agency
- Willingness to recommend the agency to friends and family

Although CAHPS instruments have not been developed for use in IRFs or LTCHs, CMS has developed experience-of-care surveys for both of these settings.[59,60] These surveys query beneficiaries about their experiences upon initial admission (e.g., whether goals had been set and explanations of expectations for stay); experiences with staff (e.g., courtesy, respect, consistency of information provided, discussion of patient progress, encouragement and support offered); experience in unit (e.g., cleanliness, availability of needed rehabilitation equipment, personal privacy); and preparing to leave (e.g., discussion of discharge and ongoing needs).

A CAHPS patient experience survey was developed in 2007 for nursing home residents but has not been adopted into the SNF QRP. The CoreQ, which was developed by the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), is a set of SNF and assisted living patient experience instruments that is gaining in popularity. Separate

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[59] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facility (IRF) Experience of Care. September 6, 2023. https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-patient-experience-care

[60] Centers for Medicare & Medicaid Services. Long-Term Care Hospital (LTCH) Experience of Care. September 6, 2023. https://www.cms.gov/medicare/quality/long-term-care-hospital/ltch-experience-care

versions of the CoreQ were developed to capture the experiences of short-stay residents, long-stay residents, families of long-stay residents, and families and residents in assisted living. The CoreQ instruments assess healthcare experiences along several domains: patient satisfaction, care quality, safety, cleanliness, care coordination, communication, and timeliness of care. The CoreQ short-stay instrument comprises four ratings: the overall facility, staff, care received, and extent to which discharge needs were met. The conciseness of these instruments reduces burden on SNF residents and their families. The consistent questions and a comparable response scale facilitate provider benchmarking of results.[61] Concerns about the CoreQ are that the survey does not provide granular-level detail and may not fully reflect the patient experience, and that selected items may be open to interpretation. The April 2022 SNF proposed rule requested stakeholder feedback on the inclusion of the CoreQ patient experience measure in the SNF QRP.[62] CoreQ was also proposed for inclusion in the SNF VBP.

CMS received a number of comments both in favor of and against the adoption. Some of the commenters questioned why NHCAHPS-D was not selected to fill the patient experience measurement gap in the program. Others were concerned with the increased provider burden associated with using third parties to administer the survey. Some commenters were concerned with the actionability of the patient experience survey data, and one commenter called the measure's reliability into question, citing the small number of questions as the reason for consistent repeated results during testing.[63]

Other commenters supported the adoption of the measure and highlighted the fact that unlike some other patient experience surveys that have 50+ questions, the CoreQ uses only four core questions. Commenters also supported the measure because of its CBE endorsement and support by the Measures Application Partnership PAC/LTC Workgroup for rulemaking.

After reviewing these public comments, CMS decided not to adopt CoreQ into the SNF QRP program in the FY 2024 SNF PPS Final Rule. In the rule, CMS states that it remains committed to "the timely adoption of a meaningful measure that addresses resident satisfaction or resident experience for the SNF QRP."[64] This leaves the door open for future patient experience of care measures in PAC QRPs.

Pain Management

Pain management has been identified as a key area of care in PAC and hospice settings, and developing pain management quality measures aligns with CMS' program goals. CMS' Meaningful Measures Initiative identifies person-centered care as a priority area for measure

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[61] CoreQ. What Is CoreQ? 2019. http://coreq.org/
[62] 88 FR 53246-53256.
[63] 88 FR 53246-53256.
[64] 88 FR 53256.

development. Person-centered care may be evaluated through patient-reported outcome measures, which can include self-reported pain severity or impact on sleep and daily living. Furthermore, the National Academy of Medicine lists physical comfort, which includes pain relief, as one of six dimensions of person-centered care.[65] Prioritizing pain management is also connected to CMS' goals of advancing health equity, as evidence points to several disparities in access to pain management services. Generally, non-White patients are less likely to receive care for pain than White patients.[66-68] Moreover, lower socioeconomic status (SES), limited access to treatment, and lower educational levels have been associated with higher racial and ethnic chronic pain disparities.[69] Likewise, women are less likely to have their pain treated even though chronic pain conditions are more prevalent among women.[70]

Despite the importance of pain management, and despite pain contributing to performance on existing PAC measures, no existing PAC measure directly addresses this area. The hospice setting, on the other hand, has been reporting measures focused on care processes at admission, including pain, since 2018. Potential measure concepts to fill this gap for the other PAC settings could focus on three areas: pain assessment, pain treatment, and treatment follow-up. Each of these areas are addressed in the following paragraphs.

Pain assessment measures could be developed using items currently in use in PAC assessment tools or using external assessment tools. For example, the Hospice QRP's Comprehensive Assessment at Admission includes two components measuring care processes around pain (Pain Screening and Pain Assessment). Pain interference items were also recently introduced into Section J of the PAC assessment tools,[71] facilitating the collection of patients' self-reported pain interference. Future measures could use these items to evaluate a provider's ability to impact pain interference. The PROMIS Pain Intensity and Interference Short Forms are similar item sets that quantify pain intensity and the extent to which pain interferes with

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[65] Tzelepis F, Sanson-Fisher RW, Zucca AC, Fradgley EA. Measuring the quality of patient-centered care: why patient-reported measures are critical to reliable assessment. *Patient Preference and Adherence*. 2015;9:831-835. https://doi.org/10.2147/PPA.S81975

[66] Burgess DJ, Gravely AA, Nelson DB, et al. A national study of racial differences in pain screening rates in the VA health care system. *Clinical Journal of Pain*. 2013;29(2):118-123. https://doi.org/10.1097/AJP.0b013e31826a86ae

[67] Green CR, Anderson KO, Baker TA, et al. The unequal burden of pain: confronting racial and ethnic disparities in pain. *Pain Medicine*. 2003;4(3):277-294. https://doi.org/10.1046/j.1526-4637.2003.03034.x

[68] Craig KD, Holmes C, Hudspith M, Moor G, Moosa-Mitha M, Varcoe C, Wallace B. Pain in persons who are marginalized by social conditions. *Pain*. 2020;161(2):261-265. https://doi.org/10.1097/j.pain.0000000000001719

[69] Kim HJ, Yang GS, Greenspan JD, et al. Racial and ethnic differences in experimental pain sensitivity: systematic review and meta-analysis. *Pain*. 2017;158(2):194-211. https://doi.org/10.1097/j.pain.0000000000000731

[70] Weimer MB, Macey TA, Nicolaidis C, Dobscha SK, Duckart JP, Morasco BJ. Sex differences in the medical care of VA patients with chronic non-cancer pain. *Pain Medicine*. 2013;14(12):1839-1847. https://doi.org/10.1111/pme.12177

[71] Section J items ask patients how often over the past five days did pain interfere with their (i) sleep, (ii) participation in rehabilitation therapy sessions, and (iii) other day-to-day activities.

engagement in social, cognitive, emotional, physical, and recreational activities.[72] Additional pain assessment measures could also be developed from adapting these item sets.

A limitation of self-reported pain assessment items is that they do not capture pain in patients who are unable to speak (e.g., patients on ventilation support, patients with neurological impairments). However, existing pain assessment instruments developed for use with nonverbal patients could be adapted to capture pain in this population. These instruments include:

- The **Behavioral Pain Scale (BPS)**, which assess pain using body language (facial expression, upper limb movements), and patient-ventilator interactions for intubated patients[73]
- The **Pain Assessment in Advanced Dementia (PAINAD)** scale, a five-item observational scale used for patients with dementia[74]
- The **Nonverbal Pain Scale (NVPS)**, which assesses pain using body language (facial expression), physiology (vital and respiratory signs), and patient activity/movement[75]
- The **Critical-Care Pain Observation Tool (CPOT)**, which assesses pain based on facial expressions, muscle tension, patient movement, ventilated breaths for intubated patients, and vocalized pain for non-intubated patients[76]

Beyond pain assessment, CMS could adopt comprehensive pain treatment measures, which would capture both pharmacological and non-pharmacological therapies. The American Society of Anesthesiologists (ASA), the American Society of Regional Anesthesia and Pain Medicine (ASRA), and the American Pain Society all recommend clinicians treat patients using "multimodal analgesia," an approach to pain management that combines multiple classes of pain medications, each of which has different modes of action, to treat pain.[77] The MIPS program includes a Multimodal Pain Management measure, which captures the percentage of adult patients undergoing selected surgical procedures who were managed with multimodal pain

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[72] HealthMeasures. Intro to PROMIS®. August 5, 2022. https://www.healthmeasures.net/explore-measurement-systems/promis/intro-to-promis

[73] Ahlers SJGM, van der Veen AM, van Dijk M, Tibboel D, Knibbe CAJ. The use of the Behavioral Pain Scale to assess pain in conscious sedated patients. *Anesthesia & Analgesia*. 2010;110(1):127-133. https://doi.org/10.1213/ANE.0b013e3181c3119e

[74] Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *Journal of the American Medical Directors Association*. 2003;4(1):9-15. https://doi.org/10.1097/01.JAM.0000043422.31640.F7

[75] Odhner M, Wegman D, Freeland N, Steinmetz A, Ingersoll GL. Assessing pain control in nonverbal critically ill adults. *Dimensions of Critical Care Nursing*. 2003;22(6):260-267. https://doi.org/10.1097/00003465-200311000-00010

[76] Gélinas C, Fillion L, Puntillo KA, Viens C, Fortier M. Validation of the critical-care pain observation tool in adult patients. *American Journal of Critical Care*. 2006;15(4):420-427.

[77] Schwenk ES, Mariano ER. Designing the ideal perioperative pain management plan starts with multimodal analgesia. *Korean Journal of Anesthesiology*. 2018;71(5):345-352. https://doi.org/10.4097/kja.d.18.00217

medicine. Examples of classes of medications used in a multimodal pain management approach include:

- Non-steroidal anti-inflammatory drugs (NSAIDs)
- N-methyl-D-aspartate (NMDA) antagonists
- Acetaminophen
- Gabapentinoids
- Regional blocks
- Steroids
- Local anesthetics

Additionally, CMS could evaluate use of non-pharmacological therapies, which can be employed in place of, or in conjunction with, pharmacological treatments. Examples of non-pharmacological approaches to pain treatment include:[78]

- Physical and/or occupational therapy interventions (e.g., manual therapy, neuromuscular reeducation)
- Cognitive behavioral therapy (CBT)
- Behavioral health integration services
- Chiropractic services
- Acupuncture
- Physical agent modalities (e.g., electrical nerve stimulation)

Other care management measures currently in use in PAC settings can be adapted to focus on pain management specifically. This includes the Drug Regimen Review Conducted with Follow-Up with Identified Issues cross-setting measure, and the Improvement in Management of Oral Medications HH QRP measure. Similarly, pain management measures that were previously in use in other care settings could be reintroduced and adapted for the PAC patient population. An example is the Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain measure, which captured the percentage of cancer patients who reported having pain and had documented plans of care to address that pain.

C.1.6 Stakeholder Input on Future Measure Concepts

CMS presented the framework for identifying measurement gaps to stakeholders in the FY 2024 Inpatient Prospective Payment System (IPPS)/LTCH PPS, IRF PPS, and SNF PPS proposed rules and the CY 2024 HH PPS proposed rule as an RFI. The RFI included a description of the identified measurement gaps and the principles for selecting and prioritizing

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[78] Centers for Medicare & Medicaid Services. Pain management. https://www.medicare.gov/coverage/pain-management

measures. CMS sought comments on the measurement gaps identified and included chronic condition and pain management in the RFI as distinct measure domains.

Overall, commenters were generally supportive of the measure selection and prioritization criteria, noting they are consistent with the principles inherent in the CMS Measure Management System (MMS).[79,80,81] Commenters emphasized the importance of prioritizing measures that are meaningful to residents and their caregivers; support shared decision-making; promote continuity or consistency across a range of accountability programs; are constructed from data that are clearly defined, validated, and standardized; have potential outcomes that can be influenced by the SNF; and are consensus-based. Several commenters expressed concern about the addition of measures to the QRP and specifically requested that CMS consider the administrative burden associated with measure reporting. To reduce administrative burden, commenters suggested that CMS remove measures that are not tied to strategic quality improvement aims. Commenters were generally in agreement with the measurement gaps and identified and provided recommendations, expressed setting-specific considerations, and pointed out limitations related to the data sources available. Some additional concepts that commenters provided were measures of health equity, quality of life, malnutrition, psychosocial issues, caregiver status, smoking cessation, and vaccination status for vaccines not included in the measurement set. Detailed comment summaries by measure concepts are available in the FY 2024 IPPS/LTCH PPS, IRF PPS, and SNF PPS final rules.[82,83,84] The CY 2024 final rule for the HH PPS is forthcoming.

C.2 Supplemental Materials Provided to TEP Panelists

This section includes the supplemental materials document distributed to panelists ahead of the main TEP. Section C.2.1 includes the Universal Foundation measure specifications for the measures covered during the TEP, and Section C.2.2 includes the slides on the guiding principles used to identify measurement gaps. This document also included a copy of Exhibit 1 from the environmental scan, presented as Table C.1 in Section C.1.3 of this report. It also included the full list of discussion questions, which can be found in Sections 4.1.3, 4.2.3, 4.3.3, and 4.4.3.

C.2.1 Universal Foundation Measure Specifications

This section contains the measure specifications for the following measures: Preventative Care and Screening: Screening for Depression and Follow-up Plan, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, Adult Immunization Status, and

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[79] 88 FR 51035-51037.
[80] 88 FR 21353-21355.
[81] 88 FR 59250-59251.
[82] 88 FR 51035-51037.
[83] 88 FR 21353-21355.
[84] 88 FR 59250-59251.

CAHPS: Overall Experience. These were included in the materials distributed to panelists prior to the main TEP.

Preventative Care and Screening: Screening for Depression and Follow-up Plan

CMIT Measure ID: 672

Program: Merit-based Incentive Payment System (MIPS)

Description: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Numerator: Patients screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Denominator: All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period.

Denominator Exclusions: Patients with an active diagnosis for depression or a diagnosis of bipolar disorder.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

CMIT Measure ID: 394

Program: Marketplace Quality Rating System (MQRS)

Description: The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
- Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Numerator:

- Numerator 1 (Initiation of SUD Treatment): Initiation of SUD treatment within 14 days of the SUD diagnosis.

- Numerator 2 (Engagement of SUD Treatment): Initiation of SUD treatment and SUD episodes that had at least one of the following: at least one weekly or monthly opioid treatment service with medication administration on the day after the initiation encounter through 34 days after the initiation event; long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event; or had at least two services (e.g., engagement visit, engagement medication treatment event) on the day after the initiation encounter through 34 days after the initiation event.

Denominator: Encounter with a new diagnosis of substance use disorders (SUD) during the intake period (November 15 of the year prior to the measurement period-November 14 of the measurement period) among patients 13 years of age and older.

Denominator Exclusions: Exclude SUD episodes if there was an encounter in any setting other than an ED visit or a medically managed withdrawal (i.e., detoxification) event with a diagnosis of SUD during the 194 days prior to the SUD episode date; Exclude SUD episodes if any of the following occurred during the 194 days prior to the SUD episode date: SUD medication treatment dispensing event or SUD medication administration event; Exclude SUD Episodes that do not meet continuous enrollment criteria; Exclude patients whose hospice care overlaps the measurement period.

Adult Immunization Status

CMIT Measure ID: 26

Program: Merit-based Incentive Payment System (MIPS)

Description: Percentage of patients 19 years of age and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.

Numerator:

- Submission Criteria 1: Patients in Denominator 1 (D1) who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period.
- Submission Criteria 2: Patients in D2 who received at least 1 Td vaccine or 1 Tdap vaccine between 9 years prior to the encounter and the end of the measurement period.

- Submission Criteria 3: Patients in D3 who received at least 1 dose of the herpes zoster live vaccine or 2 doses of the herpes zoster recombinant vaccine anytime on or after the patient's 50th birthday.
- Submission Criteria 4: Patients in D4 who were administered any pneumococcal conjugate vaccine or polysaccharide vaccine, on or after their 60th birthday and before the end of the measurement period.

Denominator:

- Submission Criteria 1: Patients 19 years of age and older on the date of the encounter with a visit during the measurement period.
- Submission Criteria 2: Patients 19 years of age and older on the date of the encounter with a visit during the measurement period.
- Submission Criteria 3: Patients 50 years of age and older on the date of the encounter with a visit during the measurement period.
- Submission Criteria 4: Patients 66 years of age or older on the date of the encounter with a visit during the measurement period.

Denominator Exclusions: Denominator Exclusion: All submission criteria:

Active chemotherapy during the measurement period; or bone marrow transplant during the measurement period; or history of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia, and HB-S disease or cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period; or in hospice or using hospice services during the measurement period.

CAHPS Overall Experience

CMIT Measure ID: 158 (varies by program)

Program: Merit-based Incentive Payment System (MIPS)

Description: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Clinician/Group Survey is comprised of 10 Summary Survey Measures (SSMs) and measures patient experience of care within a group practice.

- Getting Timely Care, Appointments, and Information;
- How Well Providers Communicate;
- Patients' Rating of Provider;

- Access to Specialists;
- Health Promotion and Education;
- Shared Decision-Making;
- Health Status and Functional Status;
- Courteous and Helpful Office Staff;
- Care Coordination;
- Stewardship of Patient Resources

Numerator: We recommend that CG-CAHPS Survey items and composites be calculated using a top box scoring method. The top box score refers to the percentage of patients whose responses indicated that they always received the desired care or service for a given measure.

The top box numerator for the Overall Rating of Provider is the number of respondents who answered 9 or 10 for the item, with 10 indicating best provider possible .

For more information on the calculation of reporting measures, see Robert Wood Johnson Foundation's How to Report Results of the CAHPS Clinician & Group Survey, available at https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf, and The CAHPS Clinician and Group Survey Database: How Results Are Calculated (AHRQ, 2017) accessible at https://cahpsdatabase.ahrq.gov/cahpsidb/Public/Files/Doc6_How_Results_are_Calculated_CG_2016.pdf

Denominator: The measure's denominator is the number of survey respondents. The target populations for the surveys are patients who have had at least one visit to the selected provider in the target 6-month time frame. This time frame is also known as the look back period. The sampling frame is a person-level list and not a visit-level list.

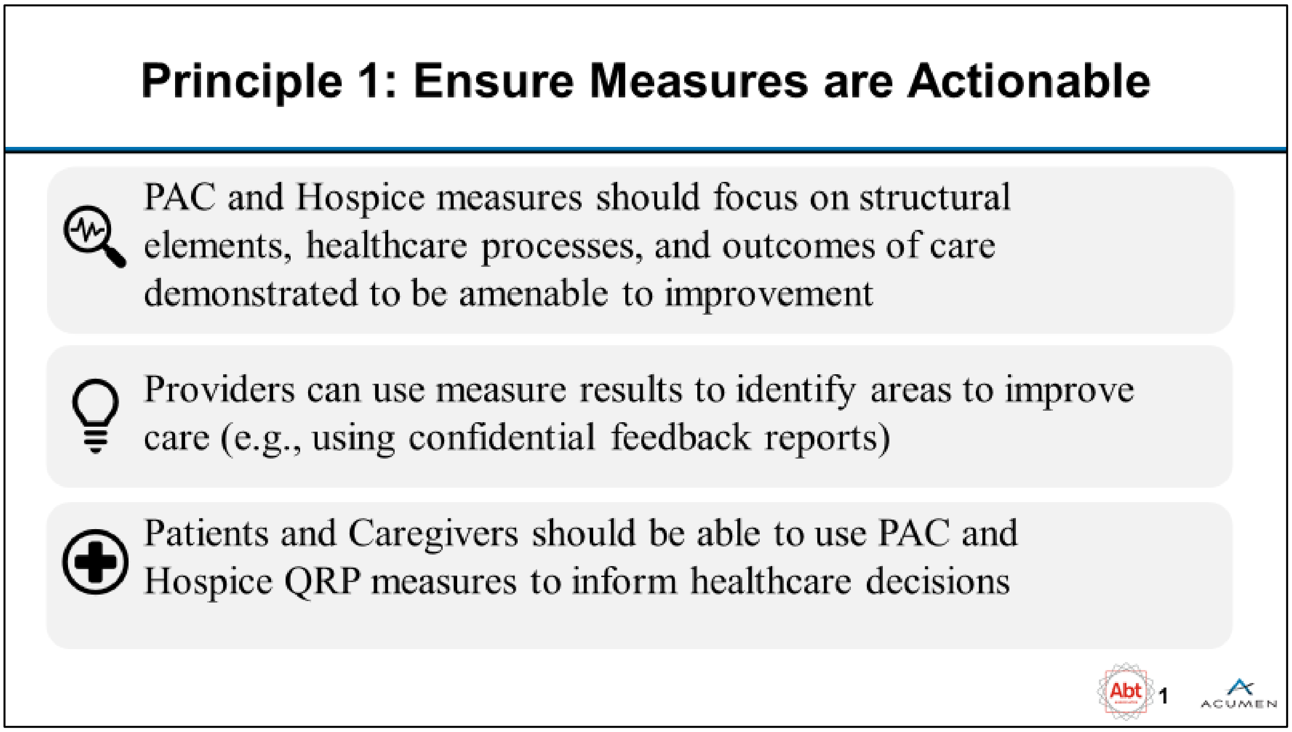
Denominator Exclusions: The following are excluded when constructing the sampling frame:

- Patients that had another member of their household already sampled.
- Patients who are institutionalized (put in the care of a specialized institution) or deceased

C.2.2 Guiding Principles Used to Identify Measurement Gaps

The following slides were presented to panelists during the main TEP, and were also provided as part of the supplemental handout.

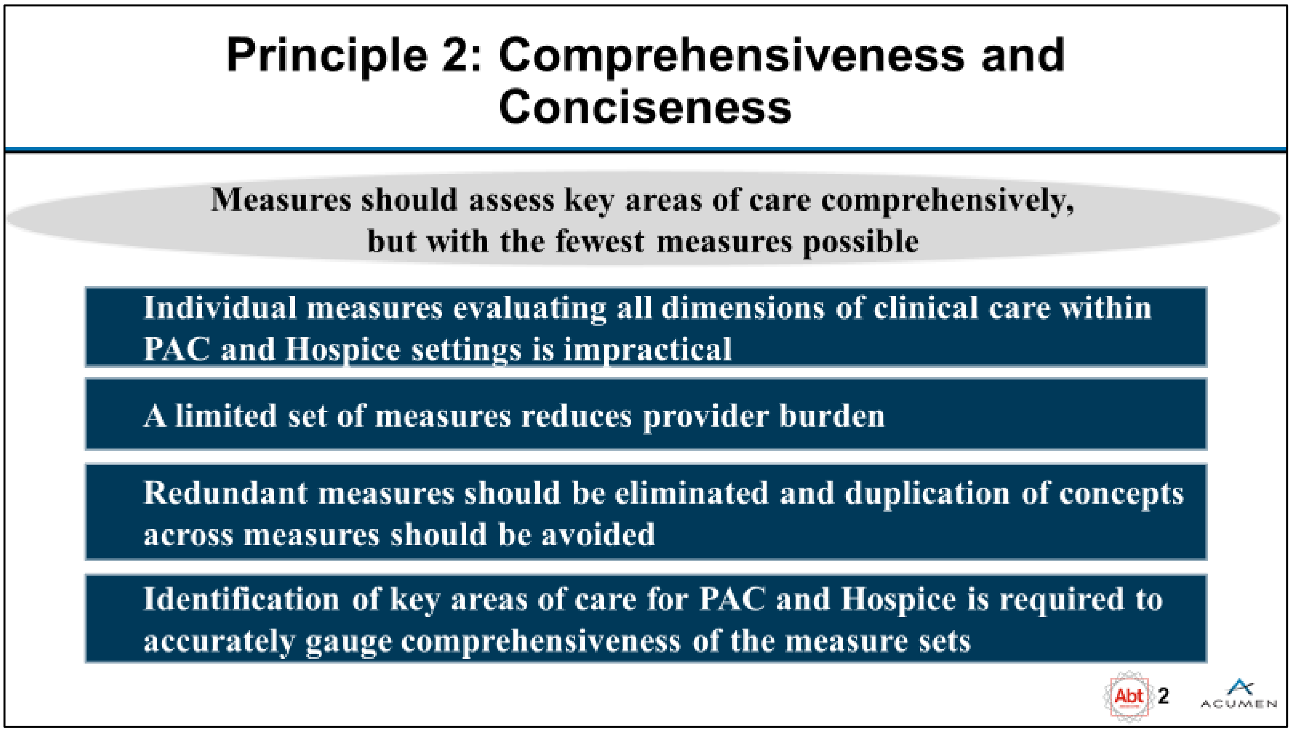
Figure C.1: Principle 1 – Ensure Measures are Actionable



Principle 1: Ensure Measures are Actionable

- PAC and Hospice measures should focus on structural elements, healthcare processes, and outcomes of care demonstrated to be amenable to improvement
- Providers can use measure results to identify areas to improve care (e.g., using confidential feedback reports)
- Patients and Caregivers should be able to use PAC and Hospice QRP measures to inform healthcare decisions

Figure C.2: Principle 2 – Comprehensiveness and Conciseness

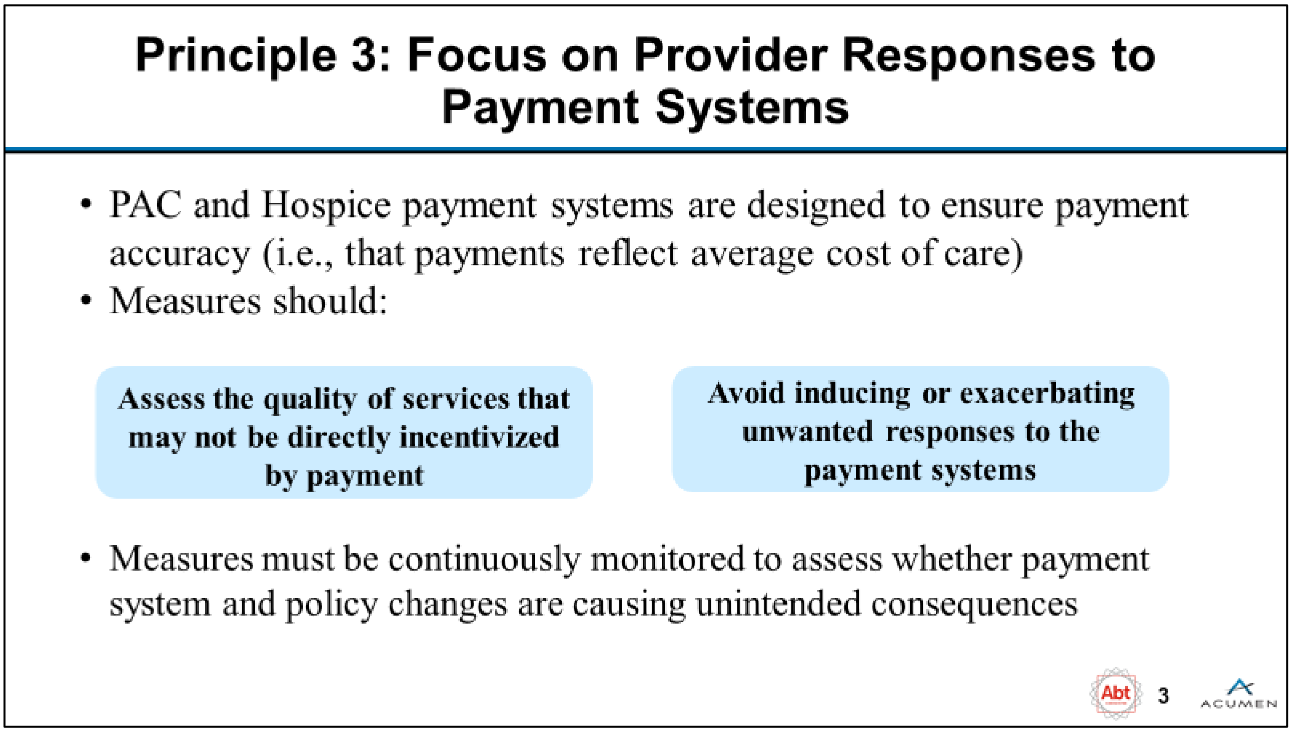


Principle 2: Comprehensiveness and Conciseness

Measures should assess key areas of care comprehensively, but with the fewest measures possible

- Individual measures evaluating all dimensions of clinical care within PAC and Hospice settings is impractical
- A limited set of measures reduces provider burden
- Redundant measures should be eliminated and duplication of concepts across measures should be avoided
- Identification of key areas of care for PAC and Hospice is required to accurately gauge comprehensiveness of the measure sets

Figure C.3: Principle 3 – Focus on Provider Responses to Payment Systems



Principle 3: Focus on Provider Responses to Payment Systems

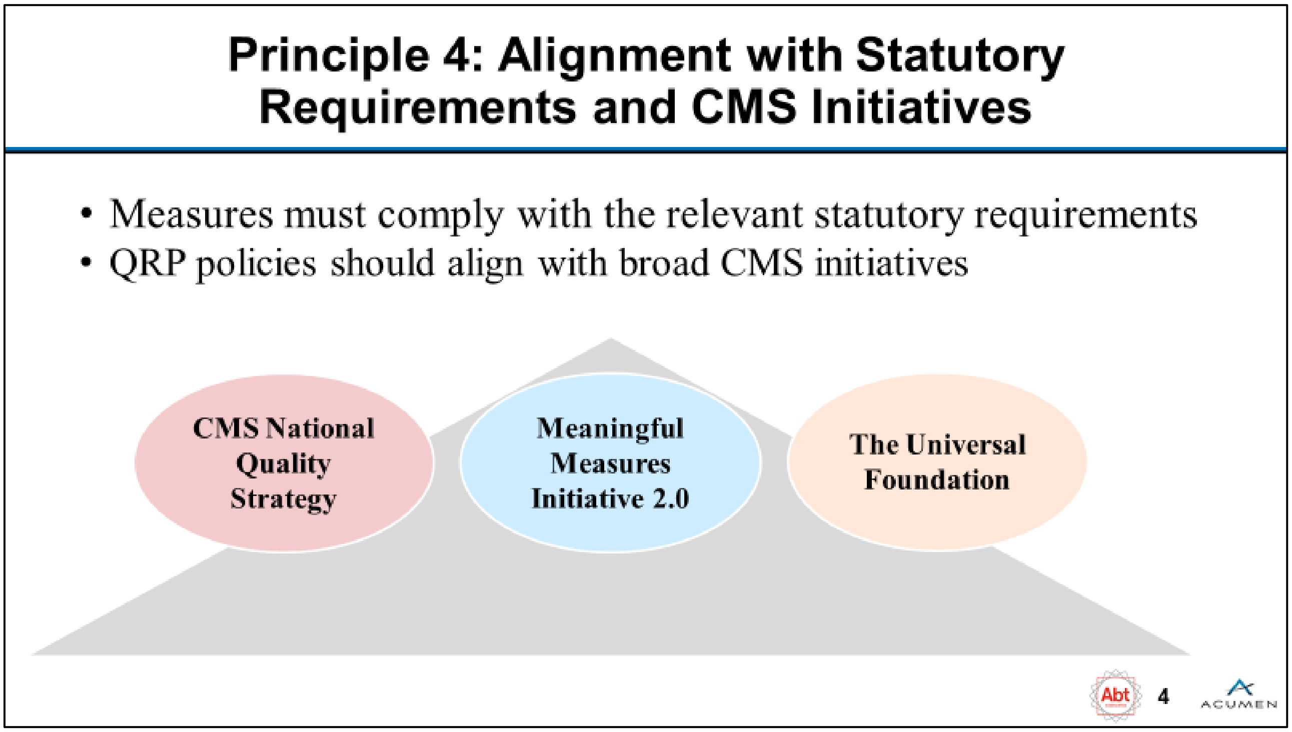
- PAC and Hospice payment systems are designed to ensure payment accuracy (i.e., that payments reflect average cost of care)
- Measures should:

Assess the quality of services that may not be directly incentivized by payment

Avoid inducing or exacerbating unwanted responses to the payment systems

- Measures must be continuously monitored to assess whether payment system and policy changes are causing unintended consequences

Figure C.4: Principle 4 – Alignment with Statutory Requirements and CMS Initiatives



Principle 4: Alignment with Statutory Requirements and CMS Initiatives

- Measures must comply with the relevant statutory requirements
- QRP policies should align with broad CMS initiatives

CMS National Quality Strategy

Meaningful Measures Initiative 2.0

The Universal Foundation