NATIONAL QUALITY FORUM
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# Meeting Summary

## Measure Applications Partnership Post-Acute Care/Long-Term Care Workgroup Web Review Meeting

The National Quality Forum (NQF) convened a public web meeting for the Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup on December 16, 2021.

### Welcome, Introductions, Disclosures of Interest, and Review of Web Meeting Objectives

Dr. Matthew Pickering, Senior Director, NQF, welcomed participants to the web meeting and reviewed the meeting agenda. Dr. Dana Gelb Safran, President and CEO, NQF, provided opening remarks to the Workgroup. MAP PAC/LTC Co-chairs, Dr. Gerri Lamb, and Dr. Kurt Merkelz, provided additional opening remarks and welcomed participants to the meeting. Dr. Pickering conducted roll call and facilitated Disclosures of Interest from the PAC/LTC Workgroup members. Nineteen of the 21 voting members were present for the meeting (see Appendix A for detailed attendance list).

One PAC/LTC Workgroup member disclosed membership and work on the Neurocritical Care Society quality committee that helps develop performance measures. Another PAC/LTC Workgroup member disclosed employment with a technology company who has contracts with Acumen. These two disclosures were deemed not to be a direct conflict with the measures under consideration, therefore no recusals from measure voting were necessary. Dr. Pickering reminded the Workgroup that conflicts of interest can be declared in real-time during the meeting, reported to the Co-chairs, or messaged directly to the NQF staff. Some PAC/LTC Workgroup members were unable to attend the entire meeting. The vote totals reflect members present and eligible to vote. Quorum was met and maintained for the entirety of the meeting (see Appendix B for full voting results).

### CMS Opening Remarks

Dr. Michelle Schreiber, Deputy Director of Quality and Value, Centers for Medicare & Medicaid Services (CMS), welcomed participants to the meeting. Dr. Schreiber gave particular thanks to patient advocates and the public, calling attention to the fact that their input is important. Dr. Schreiber noted MAP makes recommendations but does not have authority for rulemaking. However, Dr. Schreiber assured participants that MAP recommendations are considered and can change the course of CMS' decisions. Dr. Schreiber highlighted MAP's new additions including the Health Equity Advisory Group and the Measure Set Review process by the MAP Coordinating Committee.

Under the new administration, CMS' strategic priorities were released to the public. Dr. Schreiber reviewed the six pillars, sharing the directions that are important for CMS including health equity, access, and continued stewardship of public funds. Dr. Schreiber also presented CMS' key focus areas for quality including the COVID-19 public health emergency (PHE), emergency preparedness, and patient safety, along with workforce safety. Dr. Schreiber gave special thanks to the heroic efforts on part of PAC/LTC staff caring for patients during the COVID-19 pandemic and keeping communities safe.

Dr. Schreiber announced the upcoming retirement of Dr. Alan Levitt, Medical Officer, Division of Chronic and Post Acute Care, CMS. Dr. Schreiber shared special thanks for Dr. Levitt's dedication to the PAC/LTC

Workgroup. Several MAP PAC/LTC Workgroup members shared their comments of thanks and appreciation to Dr. Levitt voiced during the meeting. Dr. Levitt thanked Dr. Schreiber and the PAC/LTC Workgroup, noting particularly proud thoughts about the public private partnership of the Workgroup.

There were questions for Dr. Schreiber regarding the overview including measures and CMS' mindset on equity, along with CMS' recommitment to safety. Dr. Schreiber noted equity will be a multi-year process and to some degree an entire shift. Dr. Schreiber also noted CMS will have multiple strategies for equity including data collection and stratification. Dr. Schreiber reiterated CMS' focus on safety and the challenge of the COVID-19 pandemic, noting the PAC/LTC community can lead the way.

## Update on the Hospice Outcomes and Patient Evaluation (HOPE) Assessment Tool

Cindy Massuda, Program Lead Hospice Quality Reporting Program, CMS; Jennifer Riggs, Abt Associates; and Thomas (TJ) Christianson, Abt Associates, presented an update on the HOPE assessment tool. Ms. Massuda reviewed the successive phases of testing, including current beta testing. Ms. Massuda also presented the approach for collecting data using the hospice item set (HIS). Ms. Riggs provided information on the data collection and specifics of the HIS. Mr. Christianson concluded with details related to testing and TEP (Technical Expert Panel) discussion. Questions and comments were accepted from the Workgroup, including the suggestion of utilizing patient and family opinions, along with Electronic Medical Record (EMR) usage of the tool.

## Overview of Pre-Rulemaking Approach

Susanne Young, NQF Manager, provided an overview of the pre-rulemaking approach for the Measures Under Consideration (MUC). Ms. Young reviewed the seven assessment criteria included in the MAP preliminary analysis (PA) algorithm, the four decision categories, and the MAP voting process. Ms. Young facilitated questions regarding the MUC voting process and procedure, along with a test question for voting members (see Appendix B for complete voting results). Ms. Young also summarized the charge and the review process of the two advisory groups, the Rural Health Advisory Group and the Health Equity Advisory Group. The two advisory groups were polled on a one to five scale. For the Rural Health Advisory Group, a score of five indicates agreement that the measure is highly suitable for use with rural providers within the specific program of interest. For the Health Equity Advisory Group, a score of five indicates the greatest potential for positive impact on health equity.

## Measures Under Consideration

### Cross-Cutting Measure - MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure

Dr. Pickering explained that since this measure was submitted to more than one program for consideration, it is cross-cutting and the MAP PAC/LTC Workgroup would have the option to carryover votes from one program to another, barring no dissensions from the MAP PAC/LTC Workgroup (MAP).

#### *Public Comment*

Dr. Merkelz opened the meeting for public comment on the cross-cutting measure. No public comments were presented during the commenting period. MUC2021-098 was considered for multiple programs and each program is outlined below.

#### *Skilled Nursing Facility Quality Reporting Program (SNF QRP)*

Dr. Pickering presented a summary of SNF QRP, a brief overview of the measure and staff PA. General comments presented from the Rural Health Advisory Group review of the measure included concerns

with low case volumes in rural areas, which may cause penalties due to spikes in infection numbers relative to urban areas. The Rural Health Advisory Group agreed that the measure is an improvement on the current measure in the program. There were no SNF QRP program-specific comments. The final polling results from the Rural Health Advisory Group was an average score of 4.2, indicating the Advisory Group agreed the measure was suitable for use with rural providers within SNF QRP. For complete details from the Rural Health Advisory Group, please refer to the meeting summary (link).

Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the Health Equity Advisory Group meeting. The final polling results from the Health Equity Advisory Group was an average score of 3.5, indicating that there is some potential for this measure to have a positive impact on health equity by decreasing health disparities. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (link).

The MAP sought clarification on the reasoning for this measure when there is a current healthcare acquired infection measure in the SNF QRP program set. CMS noted that the current measure in the program is a global measure, and the new measure under consideration is infection specific. The MAP Workgroup questioned the timeframe for diagnosis and/or symptom onset prior to SNF admission. The measure developer clarified the measure does risk adjust data for patients who test positive for Clostridioides difficile (C. difficile) prior to day four of a facility stay. The MAP questioned the measure's risk-adjustment, specifically its lack of adjustment for the social determinants of health. The developer noted to conduct proper risk-adjustment, there must be data on the entire group. The stratification will take time, but it is a high priority. One MAP member specifically described C. difficile as a vexing situation and voiced positive feedback for the measure. The MAP voiced concern regarding data collection challenge with NHSN. The developer noted facilities are consistently utilizing NHSN with COVID-19 data.

Moving to a vote, the MAP recommended Conditional Support for Rulemaking, pending NQF endorsement and successful testing of reliability and validity. This measure adds value to the SNF QRP set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs utilizing a similar measure. The updated specifications of this healthcare associated Clostidioides difficile infection (HA-CDI) measure are intended to mitigate unintended consequences by only counting those cases where there is evidence of both a positive test for C. difficile and a treatment administered, which may have led to a historical under-counting of observed HA-CDI. Healthcare-associated infections (HAIs) are of importance to SNFs as seen by the recently adopted SNF HAIs Requiring Hospitalizations measure and safety is a CMS Meaningful Measures 2.0 focus.

### *Long-Term Care Hospital Quality Reporting Program (LTCH QRP)*

Dr. Pickering presented a summary of LTCH QRP, a brief overview of the measure, and the staff PA. The Rural Health Advisory Group did not have any LTCH QRP program-specific comments and scored the measure with an average of 4.2, indicating the Advisory Group agreed the measure was suitable for use with rural providers within LTCH QRP. For complete details, please refer to the meeting summary (link).

Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the Health Equity Advisory Group meeting. The Health Equity Advisory Group scored the measure with an average of 3.5, indicating that the measure has some potential to have a positive impact on health equity by decreasing health disparities. For complete details, please refer to the meeting summary (link).

There was a motion by the MAP PAC/LTC Workgroup to carryover the votes and decision category from SNF QRP to the LTCH QRP. This motion did not pass, as a MAP member expressed concern for reporting burden on behalf of infection control practitioners, citing hours and resources necessary for NHSN data

reporting. The same member noted the reporting data for C. Difficile is already low and this measure would require facilities to report data even if no clinical incidences occur. One MAP member noted facilities with low rates would want to brag about those numbers. The developer indicated that 391 of 397 LTCHs in 2020 had enough data to report a standardized infection ratio (SIR).

Moving to a vote, the MAP recommended Conditional Support for Rulemaking, pending NQF endorsement and successful testing of reliability and validity. This MUC would modify the existing HA-CDI surveillance measure in the LTCH quality reporting program by only counting cases where there was evidence of both a positive test and treatment. This may mitigate potential unintended consequences from the current measure's design, counting a case that is based on a positive test only, which may have led to a historical under-counting of observed HA-CDIs. This updated measure is consistent with the program's priority to measure healthcare associated infections, and Patient Safety Meaningful Measures 2.0 area.

### *Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)*

Dr. Pickering presented a summary of IRF QRP, a brief overview of the measure and staff PA. The Rural Health Advisory Group did not have any IRF QRP program-specific comments and scored the measure with an average of 4.0, indicating that the measure was suitable for use with rural providers within IRF QRP. For complete details, please refer to the meeting summary (link).

Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the Health Equity Advisory Group meeting. The Health Equity Advisory Group scored the measure with an average of 3.5, indicating that the measure has some potential to have a positive impact on health equity by decreasing health disparities. For complete details, please refer to the meeting summary (link).

There was a motion by the MAP PAC/LTC Workgroup to carryover the votes and decision category from LTCH QRP to IRF QRP. This motion did not pass, so the MAP PAC/LTC Workgroup voted separately for the IRF QRP program. The developer indicated that there were of the 502 IRFs, 110 had enough data to report an annual SIR in 2020, along with a total of 1,433 C. difficile events within IRFs. There were similar comments regarding reporting burden for IRF QRP as there were for the prior program (LTCH). One MAP member questioned the review of [reporting] burden during the NQF endorsement process. NQF staff explained that reporting burden is evaluated in conjunction with unintended consequences and burden during NQF-endorsement evaluation. The MAP sought clarification of whether this measure would replace or update a current measure in the program. CMS noted this measure would modify the existing measure.

Moving to a vote, the MAP recommended Conditional Support for Rulemaking, pending NQF endorsement and successful testing of reliability and validity. This Measure Under Consideration would modify the existing HA-CDI surveillance measure in the IRF QRP by only counting cases where there was evidence of both a positive test and treatment. This may mitigate potential unintended consequences from the current measure's design, counting a case that is based on a positive test only, which may have led to a historical under-counting of observed HA-CDI. This updated measure is consistent with the program's priority to measure healthcare associated infections and the Patient Safety Meaningful Measures 2.0 area.

## Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

Dr. Pickering provided an overview of the SNF VBP program and introduced Alexandre Laberge, Senior Policy Analyst PAC VBP, CMS.

### *Update on the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program*

Alexandre Laberge, Senior Policy Analyst PAC VBP, CMS, presented a SNF VBP program update. Mr. Laberge reviewed the history of the SNF VBP Program and the details of the Consolidated Appropriations Act of 2021 allowing CMS to expand the program to a total of 10 measures. Mr. Laberge provided an overview of the goals for program expansion, specifically adding meaningful measures from multiple data sources. The points presented in MAP's final report from the prior cycle included engagement from patients and caregivers, along with infection control as one of the highest stake areas. Mr. Laberge reviewed measures included in a recent Request for Information, including those measures that use the Minimum Data Set (MDS) and Fee for Service (FFS) data. There was one MAP comment regarding healthcare staffing as a measure gap area. Co-chair, Dr. Lamb, thanked Mr. Laberge for the presentation and overview.

### *Public Comment*

Dr. Lamb opened the meeting for public comment on SNF VBP. No public comments were presented during the commenting period.

### *MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*

Dr. Pickering provided an overview of the measure and staff PA. General comments presented from the Rural Health Advisory Group review of the measure included the value of the measure and its importance to reduce HAIs. Advisory Group members raised the issue of SIR, and the measure developer clarified the measure is not an SIR. The Rural Health Advisory Group scored the measure with an average of 3.9, indicating that the measure was suitable for use with rural providers. For complete details, please refer to the meeting summary (link).

The summary presented from the Health Equity Advisory Group review of the measure included discussion of members who noted this measure could be helpful for consumers to identify facilities with higher rates of HAIs and inform healthcare choices. The Health Equity Advisory Group members discussed risk adjustment of HAI data could mask SNFs with poor performance and make the reported data unhelpful for consumers. The developer indicated the measure is adjusted for age, sex, and original reason for Medicare enrollment, but no other social risk factors. The developer also noted the measure is intended to strike a balance and highlight poor performance without undue penalization. Advisory Group members commented that adjusting for age and sex could still pose an equity issue, and sex could be problematic for transgender or nonbinary individuals. The Health Equity Advisory Group scored the measure with an average of 2.9, indicating the Advisory Group was neutral on this measure's impact health equity and improving health disparities. For complete details, please refer to the meeting summary (link).

A MAP member voiced concern with the use of FFS claims data for a measure that affects payment. The MAP asked for clarification regarding timeframe for infection reporting and its reasoning. The developer and CMS noted the infection reporting begins on day four after admission. The timeframe was an element of initial testing and discussions with the TEP to balance the attribution concerns of picking up enough infections. The developer and CMS indicated the claims-based approach was the most reliable data source but noted EMR might be better in the future. The MAP sought clarification about the type and source of infection. The developer noted the HAI conditions are those likely to be acquired during SNF care and severe enough to require hospitalization. The developer clarified it does exclude those infections less likely to be attributed to care, such as chronic infections. A MAP member questioned whether the measure would be benchmarked nationally or within counties. The developer reiterated this is a measure of improvement relative to self and the focus is specifically on infection control. A MAP

member noted concern with rural partners who may have disadvantages due to capabilities. The developer noted that the stratification scores indicate, on average, rural facilities report the same or slightly better.

Moving to a vote, the MAP recommended Conditional Support for Rulemaking, pending NQF endorsement. This measure adds value to the SNF VBP program by adding an overall measurement of all HAIs acquired within SNFs requiring hospitalizations and was recently adopted within another PAC/LTC program. Meaningful Measures 2.0 indicates safety as a continued focus of CMS to build value-based care. Infection control and prevention can aid in reducing HAIs within SNFs. There is variation in the performance of this measure within SNFs and these facilities will have the ability to implement interventions to improve performance.

### *MUC2021-137: Total nursing hours per resident day*

Dr. Pickering introduced the measure and staff PA. The information presented from the Rural Health Advisory Group review of the measure included comments on the overall importance of the measure, citing staffing issues across all SNFs but noted the measure was not rural-specific. The Rural Health Advisory Group scored the measure with an average of 3.0, indicating that the Advisory Group was neutral on the suitability for use with rural providers. For complete details, please refer to the meeting summary (link).

The summary presented from the Health Equity Advisory Group review of the measure included comments about staffing issues in SNFs, especially considering the ongoing COVID-19 pandemic. The Health Equity Advisory Group members suggested stratifying the measure by resident demographics. The Advisory Group members underscored that this is an important measure to have as a baseline to help understand any differences in nursing hours by race, ethnicity, and socioeconomic status (SES) after adjusting for clinical need. Some Advisory Group members noted that communities of color are more concentrated in for-profit SNFs, which have, on average, lower nursing hours. The developer shared that the risk adjustment model for this measure is based on clinical needs only and does not include race, ethnicity, or SES; this is intended to incentivize nursing facilities to provide the appropriate level of care for all residents. The Health Equity Advisory Group scored the measure with an average of 3.5, indicating that there is some potential for this measure to have a positive impact on health equity by decreasing health disparities. For complete details, please refer to the meeting summary (link).

The MAP sought clarification on the type of nursing hours measured. The developer responded that the combination of registered nurse (RN), licensed practical nurse (LPN), and nurse aide hours to look at the whole picture. The MAP noted its support for the measure, indicating it is needed and not perfect, but a step in the right direction. One MAP member expressed concerns regarding the inappropriate timing of the measure due to nursing home staffing challenges in the current PHE environment. Another MAP member noted the potential to utilize different data sources besides administrative data. Other MAP members expressed the need to know what is happening in nursing homes, even with the current staffing challenges. Several MAP members voiced strong support for the measure within the SNF VBP Program.

Moving to vote, the MAP recommended Conditional Support for Rulemaking, pending NQF endorsement. This measure adds value to the SNF VBP program by adding a measure not currently addressed in the program, and it aligns across other PAC/LTC programs by working towards CMS' Meaningful Measures 2.0 overarching goal of value-based care. Per the Consolidated Appropriations Act of 2021, expansion of the measure set will assess the quality of care that SNFs provide to patients. Patients in skilled nursing homes are at greater risk for illness and staffing can aid or hinder patients' quality of care. The COVID-19 Public Health Emergency has brought nursing home staffing to the

forefront of an already frequently discussed topic. A recent 2021 report from the Office of Inspector General on CMS' use of data on nursing home staffing generated recommendations includes taking additional steps to strengthen the oversight of nursing home staff. There is variation in the performance of this measure within SNFs and these facilities will have the ability to address processes to improve staffing.

### *MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)*

Dr. Pickering described the measure and the staff PA. The information presented from the Rural Health Advisory Group review of the measure included some access to care concern for patients in rural communities with limited resources and that this would be a potential disadvantage for rural providers. The Advisory Group noted that the measure was not risk-adjusted for geographic location or distance from patient to provider. The Rural Health Advisory Group scored the measure with an average of 3.9, indicating that the Rural Health Advisory Group agreed that the measure was suitable for use with rural providers. For complete details, please refer to the meeting summary (link).

The summary presented from the Health Equity Advisory Group review of the measure included discussion that reporting on this measure may be skewed based on geography, as discharge from facilities located in areas with lower resources may be affected based on factors such as availability of home health care, social services, food delivery services, etc. The Health Equity Advisory Group suggested stratifying the measure by race, ethnicity, language, sexual orientation, gender identity, etc., which could be helpful for identifying disparities. One Advisory Group member commented that the group should consider the exclusions of vulnerable subpopulations. This exclusion is also ignoring the care experience of vulnerable patients. During the discussion, the developer also shared that during testing, non-White patients had slightly higher rates of expected discharge to the community after adjusting for other covariates (age, sex, clinical covariates). This suggests that risk adjusting for race and ethnicity could negatively impact non-White patients, so the developer decided not to use social risk factors in the measure's risk adjustment model. The Advisory Group commented that ideally, this measure would not be risk-adjusted based on social risk factors and further commented that the overall goal is to understand the actual rates of discharge to address factors for successful discharge back to the community. The Health Equity Advisory Group scored the measure with an average of 2.9, indicating that the Advisory Group was neutral on this measure's impact on health equity and ability to reduce health disparities. For complete details, please refer to the meeting summary (link).

The MAP sought clarification on exclusions within the measure, specifically with Medicare Advantage beneficiaries and nursing home residents. The developer clarified that the Medicare Advantage exclusion was due to a concern with data comprehensiveness but noted that CMS can consider this going forward. The developer also clarified that residents are excluded if they do not have a short-term acute care hospital discharge within 30 days preceding the SNF admission or are a long-term nursing home resident. A MAP member questioned the exclusion of those patients without an acute stay and noted the needs may be similar. The developer indicated that patient population may be different, along with discharge destination. The MAP questioned the availability of long-term services and supports (LTSS) in the community. The developer noted the measure does not account directly for LTSS. One MAP member noted this is a bigger question and more of a holistic policy question, as the services may not be enough support to return the patient back to the community.

Moving to a vote, the MAP recommended Support for Rulemaking. This measure adds value to the SNF VBP program set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs utilizing the same measure. The measure aligns with CMS' Quality

Measurement Action Plan to build value-based care by addressing several goals including measures focused on key quality domains, aligning measures across programs, prioritizing outcome measures, and implementing measures that reflect social and economic determinants.

The empirical evidence demonstrates improvement in successful discharge to community rates among PAC patients is possible through modifying provider-led processes and interventions within the PAC setting. With the continuing COVID-19 public health emergency, the desire and potential need for successful discharges may be necessary to ease healthcare facility burden. There is variation in the performance of this measure within SNFs and these facilities will have the ability to implement interventions to improve performance and care for patients.

### *MUC2021-095: CoreQ: Short Stay Discharge Measure*

Dr. Pickering provided an overview of the measure and staff PA. The Rural Health Advisory Group commented that the measure is applicable to rural settings and is not burdensome to implement for providers. The Advisory Group scored the measure with an average of 3.9, indicating that the Rural Health Advisory Group agreed that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group, please refer to the meeting summary (link).

The summary presented from the Health Equity Advisory Group review of the measure included feedback that there may be disparities in survey completion due to factors such as language barriers or payer type. However, the Health Equity Advisory Group noted data collected in the surveys will help identify disparities within the SNF setting by race, ethnicity, etc. and can help inform quality improvement efforts. One Advisory Group member noted overall satisfaction results are more difficult to act on and that cultural background could impact patients' interpretation of "satisfaction." Advisory Group members flagged that the exclusion criteria for the measure could exclude vulnerable populations, including patients with a caregiver/guardian and patients with dementia. The exclusion criteria also include patients discharged to another facility, but transfers could be related to SES. The Health Equity Advisory Group scored the measure with an average of 3.0, indicating the Health Equity Advisory Group was neutral on this measure's impact on health equity and its ability to improve health disparities. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (link).

The MAP asked for clarification regarding the completion of the survey via resident or proxy. The developer stated that the survey can be answered by either, but proxy answers will not be calculated into the measure. One MAP member gave an enthusiastic response for this patient reported measure and indicated positive feedback for the simple and straightforward questions within the survey. The one suggestion from the MAP member centered on the inability of the results to decipher why the score is high or low. The MAP questioned the measure's ability to discern health disparities. The developer noted race/ethnicity has been added to the survey and preliminary data indicates the scores are not statistically significant between races.

Moving to a vote, the MAP recommended Support for Rulemaking. This measure adds value to the SNF VBP Program set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs by working towards CMS' Meaningful Measures 2.0 overarching goal of value-based care. Per the Consolidated Appropriations Act of 2021, expansion of the measure set will add measures including those measuring patient experience. In the year 2016, the Centers for Disease Control and Prevention (CDC) estimated that there were 606,800 short-stay nursing home patients in the U.S. As the U.S. population has aged and increased over the years, the estimates have most likely increased. The ongoing COVID-19 PHE has brought about even more attention on nursing home patient satisfaction. There is a range of variation in the performance with this measure within

SNFs which will allow these facilities the opportunity to implement interventions and processes to improve performance.

Immediately following the vote, Dr. Schreiber requested feedback from the MAP regarding the CoreQ survey. CMS has discussed the short CoreQ survey versus the longer Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CMS would like feedback about survey preference and if the CoreQ four-question survey is enough. The MAP voiced several positive responses for the CoreQ survey but acknowledged there is a lack of guidance for facility improvement. The MAP noted the length of the CAHPS survey poses a poor return rate. Overall, MAP indicated the CoreQ was short, to the point, and gets at what consumers want to know. Dr. Schreiber thanked the MAP for the feedback.

### *Public Comment*

Dr. Merkelz opened the meeting for public comment on SNF QRP. No public comments were presented during the commenting period.

### *MUC2021-123: Influenza Vaccination Coverage among Healthcare Personnel*

Dr. Pickering presented an overview of the measure and staff PA. The information presented from the Rural Health Advisory Group review of the measure included general comments of support for the inclusion of the COVID-19 vaccination or a measure similar for healthcare personnel. The Rural Health Advisory Group scored the measure with an average of 4.5, indicating that the Advisory Group strongly agreed that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group, please refer to the meeting summary (link).

The summary presented from the Health Equity Advisory Group review of the measure included discussion that influenza vaccinations are a public health priority, noting Black and Indigenous populations have higher rates of hospitalizations and death, and lower rates of influenza vaccination. The Health Equity Advisory Group sought clarification on stratification and treatment of declinations in numerator or denominator. The developer indicated data reported to CMS are only for vaccination coverage, and declination is measured but not reported as part of compliance. The developer also noted that this measure is stratified by personnel type and stratified data are available to individual facilities. The Health Equity Advisory Group scored the measure with an average of 3.8, indicating that the measure has some potential for having a positive impact on health equity by decreasing health disparities. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (link).

The MAP sought clarification regarding which personnel are included in this measure. The developer clarified it is licensed practitioners, including physicians, nurses, and physician assistants who are in the facility for at least one day during the reporting period. The MAP voiced concern over the challenge to track down every licensed professional who comes into a facility. There were several back-and-forth dialogues between the MAP and CMS regarding the reporting challenge. CMS noted there is a degree of trust that the facility must track who has entered the building. Although the MAP acknowledged the challenge, the MAP voiced support for the documenting of vaccines.

Moving to a vote, the MAP recommended Support for Rulemaking. This measure adds value to the SNF QRP set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs utilizing the same measure. Vaccination coverage among healthcare personnel within SNFs is of importance as seen by the recently adopted COVID-19 Healthcare Personnel Vaccine measure. Influenza affects older adults disproportionately and healthcare personnel (HCP) can aid in this transmission. Estimates of recent years indicate 70 to 85 percent of seasonal flu-related death were those 65 years and older, and 50 to 70 percent of seasonal flu-related hospitalization were among the

same age group. Vaccination coverage among HCP within these facilities can decrease its viral transmission, along with a decrease in morbidity and mortality among patients. There is variation in the performance of this measure within SNFs and these facilities will have the ability to implement interventions to improve performance.

### Program Measure Gaps in the SNF QRP

Dr. Merkelz opened the meeting for discussion of gaps within SNF QRP. There were several comments and discussions regarding Patient Reported Outcome Measures (PROMs). The MAP agreed that person-centered and person-reported goals are important, along with family and caregiver perspective. The MAP noted that the definition of quality is different for each individual and unless that is integrated into measurement, individual needs will not be met. Further the MAP included mental health, specifically isolation, loneliness, and depression as potential program measure gaps. Several MAP members concurred with the prior statement and noted the heightened issues during the COVID-19 pandemic. MAP members noted the need for a focus on community re-integration, especially functional performance measures related to mobility.

The MAP noted the COVID-19 pandemic has uncovered a huge under-preparedness and lack of resources related to infection control. Resources are being added and there is a focus on infection control, mainly for nursing homes, but these have a limited timeframe view. The MAP noted the need to align ongoing measurement that reflects overall infection control performance. The MAP indicated this gap not only for SNFs, but also LTCHs.

The MAP commented on the difference between the short-stay and long-stay population, specifically the outcomes are different and thus the measure focus may be different. MAP members noted pain management would be a good measure to consider, noting that there are a lot of factors involving pain within this population.

### Program Measure Gaps in the SNF VBP Program

Dr. Merkelz opened the meeting for discussions of gaps within the SNF VBP Program. The MAP noted the importance of a balance of structure, process, and outcome measures, especially around patient experience. Several MAP members echoed the comments about the need for patient experience measures.

Dr. Schreiber posed a question to the MAP about the potential for opportunities to cross measures between different settings, such as PAC and hospital. The MAP noted work within interoperability on the information transfer between settings, not only hospital to SNF but also SNF to home health. MAP members echoed the need for information transfers and not just within the silos of care settings. Further comments around linkages included medication reconciliation and its impact on care, such as decreasing hospital readmissions. The MAP comments within the Webex chat platform echoed the prior statement about medication reconciliation.

CMS prompted another question to the MAP regarding medication measures and the need for a global medication measure. The MAP expressed mixed thoughts about medication measures from a provider perspective but noted the potential need through the lens of the patient. The MAP noted this discussion circles back to the earlier gap regarding patient experience. The MAP also circled back to medication reconciliation, specifically during a discharge timeframe. One MAP member noted concerns with patient experience involving medication use but noted the focus should be on the actual efficacy. The MAP suggested a hybrid data approach for medication usage, such as MDS and claims. The MAP noted an important area for the PAC/LTC group is the use of anti-psychotics.

Dr. Schrieber posed the question to MAP about digital measures and the capabilities of EMRs in PAC. The MAP expressed the challenges of EHR vendors in PAC settings and noted some progress was made pre-pandemic. The MAP members expressed the advantages of digital measures but noted that narrative comments may be more important for quality improvement.

## Public Comment

Dr. Pickering opened the meeting to allow for public comment of the day's proceedings. No public comments were presented during the public commenting period.

## Next Steps

Rebecca Payne, Senior Analyst, NQF, summarized the next steps. The Workgroup recommendations for the MAP PAC/LTC measures will be open for public comment from December 30, 2021 through January 13, 2022. The MAP Coordinating Committee will convene to finalize MAP recommendations for all measures on January 19, 2022, and the final recommendations will be submitted to the U.S. Department of Health & Human Services no later than February 1, 2022.

## Appendix A: MAP PAC/LTC Workgroup Attendance (Voting Only)

The following members of the MAP PAC/LTC Workgroup were in attendance:

***Co-chairs***

- Gerri Lamb, PhD, RN, FAAN
- Kurt Merkelz, MD, CMD

***Organization Members***

- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Geriatrics Society
- American Occupational Therapy Association
- American Physical Therapy Association
- ATW Health Solutions
- Encompass Health Corporation
- LeadingAge
- National Hospice and Palliative Care Organization
- National Partnership for Healthcare and Hospice Innovation
- National Pressure Injury Advisory Panel
- National Transitions of Care Coalition
- SNP Alliance

***Individual Subject Matter Experts***

- Dan Andersen, PhD
- David Andrews, PhD
- Paul Mulhausen, MD, MHS
- Sarah Livesay, DNP, APRN, ACNP-BC, ACNS-BC
- Terrie Black, DNP, MBA, CRRN, FAHA, FAAN

## Appendix B: Full Voting Results

| | Measure Name | Program | Yes | No | Total | Percent |
|---|---|---|---|---|---|---|
| 1 | MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure | Skilled Nursing Facility Quality Reporting Program (SNF QRP) | 16 | 3 | 19 | 84% |
| 2 | MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure | Long Term Care Hospital Quality Reporting Program | 15 | 3 | 18 | 83% |
| 3 | MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure | Inpatient Rehabilitation Quality Reporting Program | 14 | 2 | 16 | 88% |
| 4 | MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization | Skilled Nursing Facility Value Based Purchasing (SNF VBP) Program | 14 | 4 | 16 | 78% |
| 5 | MUC2021-137: Total nursing hours per resident day | SNF VBP Program | 13 | 5 | 18 | 72% |
| 6 | MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF) | SNF VBP Program | 11 | 5 | 16 | 69% |
| 7 | MUC2021-095: CoreQ: Short Stay Discharge Measure | SNF VBP Program | 15 | 2 | 17 | 88% |
| 8 | MUC2021-123: Influenza Vaccination Coverage among Healthcare Personnel | SNF QRP | 15 | 1 | 16 | 94% |

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