

American Academy of Hospice and Palliative Medicine CMS MACRA COOPERATIVE AGREEMENT “PALLIATIVE CARE MEASURES PROJECT”

Summary of:
Technical Expert Clinical User Patient Panel (TECUPP)
Virtual Meeting
October 21, 2019



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Project, TECUPP, and MSP overview:

Through a Cooperative Agreement from the Centers for Medicaid and Medicare Services (CMS), the American Academy of Hospice and Palliative Medicine (AAHPM) is working with partners at the National Coalition for Hospice and Palliative Care (Coalition) and RAND Health (RAND) to create new palliative care patient reported outcome performance measures. The Palliative Care Measures Project Team is composed of staff members from AAHPM, the Coalition, RAND, the Center to Advance Palliative Care, and consultants Ellen Schultz (American Institutes of Research) and Rebecca Swain-Eng (Swain-Eng and Associates). Katherine Ast, MSW, LCSW, Director of Quality & Research for AAHPM, leads the team.

The AAHPM team convened a Technical Expert Clinical User Patient Panel (TECUPP) and Measure Specification Panel (MSP), which are chaired by Sydney Dy, MD, MS, FAAHPM, and Mary Ersek, PhD, RN, FPCN. The TECUPP and MSP contribute direction and thoughtful input on the development of the measures for patients with serious illness using their background as real-world clinical ‘end-users,’ patients, caregivers, family members, and experts in measure development and testing methodologies. The TECUPP and MSP members represent a broad array of stakeholders including measure development experts, palliative care clinicians from the interdisciplinary team, specialty society representatives, patient advocates, former patients, family members, caregivers, healthcare industry representatives, diversity experts, and others.

Members of the TECUPP were selected from nominations received from the public and include representatives from national organizations such as AAHPM, AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Association of Family Physicians (AAFP), American College of Physicians (ACP), American Geriatrics Society (AGS), American Society of Clinical Oncology (ASCO), Center to Advance Palliative Care (CAPC), Coalition to Transform Advanced Care (C-TAC), HealthCare Chaplaincy Network (HCCN), Hospice and Palliative Nurses Association (HPNA), National Hospice and Palliative Care Organization (NHPCO), National Patient Advocate Foundation (NPAF), Physician Assistants in Hospice and Palliative Medicine (PAHPM), Social Work Hospice and Palliative Network (SWHPN), Society of Pain and Palliative Care Pharmacists (SPPCP), and the Supportive Care Coalition (SCC).

In general, TECUPP members are expected to participate in the project over the course of three years and provide expertise and feedback on quality measures for patients with serious illness throughout the measure development lifecycle, as requested. In addition, from this TECUPP, a small subgroup of experts with highly technical measure development and specification expertise were selected to evaluate proposed measures for initial feasibility and review later testing results to guide decision-making regarding each measure. This subgroup is referred to as the Measure Specification Panel (MSP). The TECUPP and MSP had their first meetings, in-person, in Chicago on April 10 and April 11, 2019. On October 21, 2019 the TECUPP convened virtually for a second meeting. The topics discussed at this second meeting include Alpha field test results, cognitive interviews, and preparation for Beta testing.

TABLE 1 – TECUPP Composition:

Name	Organization	Member of the MSP	Present at Virtual TECUPP meeting (10/21/2019)	Additional COI disclosed during meeting
Steven M. Asch, MD, MPH	Stanford University and VA Palo Alto Healthcare System, Palo Alto, CA	Yes	Yes	None

Kathleen Bickel MD, MPhil, MS	University of Colorado School of Medicine, Aurora, CO	Yes	Yes	None
Lori Bishop, MHA, BSN, RN	National Hospice and Palliative Care Organization, Alexandria, VA	Yes	Yes	None
Brenda Blunt, DHA, MSN, RN	CVP Corp, Townson, MD	No	Yes	None
Amy Ciancarelli, BS, CPXP	Care Dimensions, Danvers, MA	No	Yes	None
Amy Davis, DO, MS, FACP, FAAHPM	Dr. Amy Davis Palliative Care and Symptom Support, Bala Cynwyd, PA	No	No	N/A
SaBrina Davis, patient advocate, family caregiver	National Patient Advocate Foundation	No	Yes	None
Sydney Dy, MD, MS, FAAHPM, *TECUPP Co - Chair	John Hopkins Bloomberg School of Public Health, Baltimore, MD	Yes	Yes	None
Mary Ersek, PhD, RN, FPCN, *TECUPP Co - Chair	Department of Veterans Affairs; U. of Pennsylvania Schools of Nursing and Medicine, Philadelphia, PA	Yes	Yes	None
Torrie Fields, MPH	Blue Shield of California, San Francisco, CA	Yes	Yes	None
Elizabeth Fricklas, PA - C	Duke Health, Durham, NC	No	Yes	None
Joy Goebel, RN, PhD, FPCN	California State University Long Beach, Long Beach, CA	No	Yes	None
Matthew Gonzales, MD, FAAHPM	Institute for Human Caring and St. John's Health, Gardena, CA	No	No	N/A
Anna Gosline, SM	Blue Cross Blue Shield of Massachusetts, Boston, MA	No	Yes	None
Marian Grant, DNP, CRNP, ACHPN, FPCN, RN	Consultant, Baltimore, MD	No	No	N/A
George Handzo, MA, MDiv, BCC, CSSBB	HealthCare Chaplaincy Network®, New York, NY	No	Yes	None

Denise Hess, MDiv, BCC - PCHAC	Supportive Care Coalition; Providence St. Joseph Health, Hillsboro, OR	No	Yes	None
Sarah Hetue Hill, PhD	Ascension Health Group, St. Louis, MO	Yes	Yes	None
Faye Hollowell, BS, BM, patient advocate, family caregiver	National Patient Advocate Foundation	No	Yes	None
Arif Kamal, MD, MBA, MHS, FAAHPM, FASCO	Duke University School of Medicine, Chapel Hill, NC	Yes	Yes	None
Rebecca Kirch, JD	National Patient Advocate Foundation, Washington, DC	No	Yes	None
Cari Levy, MD, PhD, CMD	AMDA –The Society for Post - Acute and Long -Term Care Medicine, Denver, CO	No	Yes	None
Hannah Luetke - Stahlman, MPA	Cerner Corporation, Kansas City, MO	No	Yes	None
Phillip Rodgers, MD, FAAHPM	University of Michigan Medical School, Ann Arbor, MI	Yes	Yes	None
Benjamin Schalet, PhD	Northwestern University, Chicago, IL	Yes	Yes	None
Tracy Schroepfer, PhD, MSW, MA	University of Wisconsin - Madison School of Social Work, Madison, WI	No	Yes	None
Cardinale B. Smith, MD, PhD	Icahn School of Medicine at Mount Sinai, New York, NY	Yes	Yes	None
Paul E. Tatum, III, MD, MSPH, CMD, FAAHPM, AGSF	Dell Seaton Medical Center at the University of Texas, Austin, TX	No	Yes	None
Martha Twaddle, MD, FACP, FAAHPM, HMDC	Northwestern Lake Forest Hospital Cancer Center, Lake Forest, IL	No	Yes	None
Kathryn Walker, PharmD, BCPS, CPE	University of Maryland; MedStar Health; Society of Palliative Care Pharmacists, Baltimore, MD	No	Yes	None

Project Team Staff Present: Katherine Ast, MSW, LCSW (AAHPM); Joe Rotella, MD, MBA (AAHPM); Kelly McKenna, MA (AAHPM); Sangeeta Ahluwalia, PhD (RAND); Carrie Farmer, PhD (RAND); Maria Edelen, PhD, MA (RAND); Jessica Phillips, MS (RAND); Amy Melnick, MPA (The Coalition); Gwynn Sullivan, MSN (The Coalition); Cozzie King (The Coalition); Rebecca Swain-Eng, MS, CAE (Swain- Eng Associates); Stacie Sinclair, MPP (CAPC)

Guests: Minet Javellana, RN (Reli Group), Sherly Binu, MBA, MS, RN (Reli Group)

Including TECUPP members, project team staff, and guests there were forty-one attendees at this meeting.

Preview of measures:

In alignment with CMS’s Meaningful Measures framework, which identifies high priorities for quality measurement and improvement, CMS identified gaps in the Quality Payment Program (QPP) measure set. One gap identified was in palliative care measures. CMS selected AAHPM, with partners the Coalition and RAND, to address this gap through the creation of new quality measures. AAHPM had done previous work to identify gaps in quality measurement for palliative care, and thus was well suited to lead this work.

TABLE 2 – Proposed Measures for Discussion during the Virtual TECUPP Meeting:

Measure Area:	Description:
Communication	Percent of patients who report feeling heard and understood by their palliative care provider and team, among all adult patients with at least 1 outpatient palliative care visit in a 3-month period, who answer a survey question about feeling heard and understood.
Symptom	Percent of patients who report getting the help they want for their pain from their palliative care provider and team, among all adult patients with at least 1 outpatient palliative care visit in a 3-month period, who report having pain AND wanting help for pain.

PALLIATIVE CARE MEASURES PROJECT
Technical Expert Clinical User Patient Panel (TECUPP) Virtual Meeting Summary
Monday October 21, 2019 11:00 am - 1:00 pm ET Meeting
Location: Virtual

8:00am PT/ 11am ET Welcome Remarks, Housekeeping, and Project Reorientation:

Presenter: Katherine Ast, MSW, LCSW, Director, Quality and Research, AAHPM

Katherine Ast welcomed the TECUPP members. She asked that comments and questions be typed into the chat box throughout the presentation and indicated that they will be answered during the designated Q&A time. Since the TECUPP is comprised of diverse expertise, Katherine reminded everyone that they have unique and valuable knowledge that will help provide strategic direction to this project.

A copy of the slide deck was shared prior to the meeting, along with a link to the project FAQ document. The TECUPP participants were also told to anticipate a blog post about this project on the Coalition website in the next month.

Project Reorientation:

TECUPP Roles and Responsibilities During This Meeting:

- Provide input on key decisions regarding data elements, testing design, testing results, and the proposed quality measures.
- Engage in group discussions with an open mind and critical eye.
- Share informed opinions freely.
- Remember the importance of a “by us, for us” quality measure development process for the palliative care field.

Project Goal:

To develop two patient-reported quality measures of outpatient palliative care experience for CMS’s Merit Based Incentive Payment System (MIPS) under the Quality Payment Program (QPP) created by MACRA.

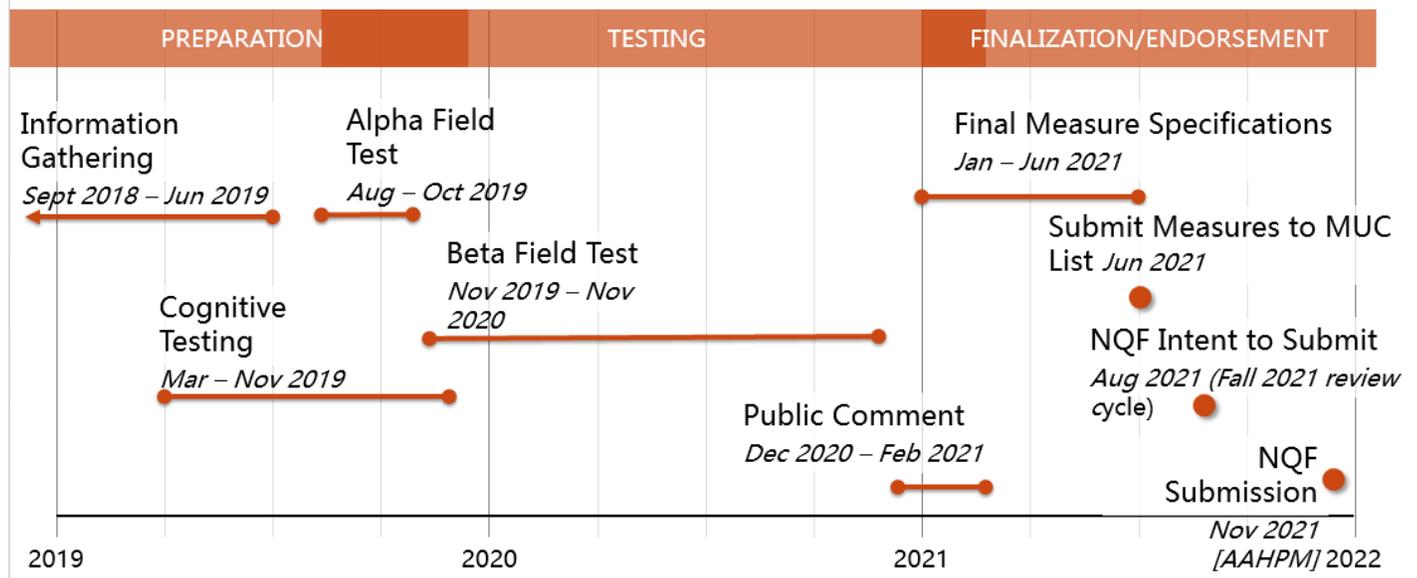
Meeting Goal:

After an overview of the cognitive test and Alpha field test results, the TECUPP was asked to provide feedback and discuss opportunities to improve the Beta test. The goal of this meeting was to gather feedback from the extensive expertise of the TECUPP panel and use that feedback to improve the testing plan. In addition, the group reviewed the two measures under development, which have evolved since the TECUPP’s last meeting in April 2019.

Reviewed abridged project timeline:

The TECUPP was reoriented to the project timeline. The graphical timeline shared does not include an exhaustive list of project tasks; it is primarily meant to show the preparation, testing, and finalization of measures at a high level. For example, the project team, led by the Coalition, will engage in stakeholder engagement throughout the duration of the project. Although the stakeholder engagement activities are not all included on the timeline, sharing information and soliciting feedback from stakeholder groups around key findings and decision points will take place throughout the duration of the project.

TABLE 3 – Abridged Project Timeline:



8:15am PT/ 11:15am ET Update on Cognitive Testing:

Presenter: Sangeeta Ahluwalia, PhD, Senior Policy Researcher Associate Director, Behavioral & Policy Science Department, RAND Corporation

An update was shared with TECUPP members about cognitive testing. For this measure development project, RAND conducted cognitive testing with patients and caregivers to help refine the items on the survey tool. Interviews began in March 2019. Eighteen cognitive interviews were conducted with English speaking patients, four with English speaking caregivers, and twelve with Spanish speaking patients.

One purpose of the cognitive interviews was to understand if the survey instructions made sense to the patients. During the cognitive interviews, patients were also asked about item wording (e.g., confusing language, interpretation of terms like “whole person” and “heard and understood”). Both patients and caregivers understood the concept of “heard and understood”; whereas, “whole-person” was a harder concept to understand. Participants were asked if they had preferences on statements verses questions for item wording and structure. Participants were able to answer the questions posed in different formats. Participants were asked about response options. Participants said they didn’t need a five-point scale and that they could answer using a three-point scale. Patients were also asked whether they could answer questions that looked at the reference period (e.g., during the last six months), and how they were attributing their experience (e.g., provider and team).

Caregivers were asked additional questions to understand if they were able to answer questions from the patient’s experience and not their own.

One interesting finding was when asked about “pain,” patients mostly thought of physical pain, with only a few including existential pain.

The Spanish interviews were all conducted in the Los Angeles area. The project team plans to conduct additional Spanish cognitive interviews in Texas and Florida and plans to complete these as soon as possible. The additional Spanish cognitive interviews will provide more perspectives and aim to include more Spanish dialects.

8:30am PT/ 11:30am ET Update on the Alpha Field Test:

Presenters: Sangeeta Ahluwalia, PhD, Senior Policy Researcher Associate Director, Behavioral & Policy Science Department, RAND Corporation

Maria Edelen, PhD, MA, Senior Behavioral Scientist and Psychometrician, RAND Corporation

The purpose of the Alpha test was to begin testing the measure concepts, instrument, and feasibility. Five outpatient palliative care programs participated in the Alpha field test. Of the Alpha test sites two programs were in North Carolina, one program was in Colorado, one program was in Ohio, and one program had patients in Oregon and Washington. Participating programs sent RAND sample files containing information on potentially eligible patients from the past six months. After applying eligibility criteria, a sufficient number of patients were identified using a three-month lookback instead of a six-month lookback (1,362 visits by 662 unique patients). This shows that there are enough patients within a three-month lookback period. Three-hundred patients were identified from these lists to be included in the Alpha test sample and were invited to complete a survey.

RAND administered the Alpha test survey using a traditional mixed mode design, which included a mailed survey with telephone follow-up. Prior to receiving the survey, patients received a letter in the mail, which explained that they would be receiving a survey.

The Alpha test data that was presented was from September 25. As of September 25, one-hundred and eleven surveys had been completed (by the TECUPP meeting, one-hundred and twenty-one had been completed). Of the one-hundred and eleven surveys, seventy-five had been completed by mail, and thirty-six had been completed by phone. Ten refused to complete the survey and seventeen had died. Initial analysis of the Alpha test results showed a thirty-seven percent (37%) response rate.

Questions/Group Discussion:

During the Alpha test discussion, the TECUPP discussed three key areas:

- The large portion of white respondents during the Alpha test
- Questions around attribution and the use of the word “provider”
- The possibility of refining survey response options

Eighty-seven percent of Alpha test respondents were white, and seventy-three percent had some college or more, indicating that the Alpha sample was largely white and well educated. TECUPP members asked, how can we increase the diversity of the patient population during Beta testing? How can the TECUPP members help with this as we are still recruiting programs for the Beta test? The group discussed reaching out to the special interest groups at AAHPM to see if they could help identify more diverse testing sites. Participants also expressed that it could be helpful to know the composition of the population in order to begin to understand the uptake of palliative care in that community among minorities. This low number may reflect who is being seen (e.g., referred). When asked if the samples from each site were representative of the demographic populations of each site, RAND explained that they requested race/ethnicity information from the Alpha sites and found that most sites provide incomplete information or no information about the race/ethnicity of their patient population.

The current survey instrument attributes questions to “Dr. X and team” and “this provider and team” with the term “provider” defined in the instructions of the survey. As we heard at the in-person TECUPP meeting in April, some TECUPP members would prefer not to use the term “provider” but there is a lack of consensus about an alternative word to use. Some preferred the word “clinician” while others felt that the words “doctor”, “nurse”, and “social worker” might be more familiar to patients. Others felt that “care team” or “members of the healthcare team” might work well in the survey. Others correctly pointed out that attribution must be made to an individual within the MIPS billing structure therefore “care team” and “members of the healthcare team” would not be accurate for this purpose. The terms “provider” and “clinician” were tested during the cognitive interviews and the patients favored “provider” and did not appear to be confused by this term. A definition of “provider” was added to the survey instructions after one cognitive interviewee pointed out that “provider” could be interpreted as a hospital or insurance company. Additionally, some patients saw the word “clinician” and only associated that with a “doctor” and not other providers such as a nurse or social worker.

For the heard and understood section of the Alpha test, respondents were provided with the response scale “very true, mostly true, somewhat true, a little bit true, not at all true.” TECUPP participants expressed concern that most of the respondents chose the top box answer of “very true.” Some TECUPP members did not feel that there was enough of a differentiation between “very true” and “mostly true” and recommended changing the language for the Beta test. The group felt that “completely true” instead of “very true” might better differentiate between the top two options and offer a more accurate response and a larger distribution. The group discussed that the concept of heard and understood is a strong tenet of palliative care, and if other specialties were to use this question, they might have lower scores in the top box. The project team will strongly consider these recommendations and may adjust the survey instrument for Beta testing.

9:15am PT/ 12:15pm ET Update on the Beta Field Test:

Presenters: Sangeeta Ahluwalia, PhD, Senior Policy Researcher, Associate Director, Behavioral & Policy Science Department, RAND Corporation

Carrie Farmer, PhD, Senior Policy Researcher, Director of the Health Care Quality Measurement and Improvement Program, RAND Corporation

The Beta field period is schedule to start in November 2019 and will run through November 2020. The Beta test will be administered in English and Spanish. RAND will administer the Beta test survey using an enhanced mixed mode design, which includes the mailed survey and telephone follow-up that was used during Alpha fielding, plus the addition of an email invitation to a web survey when possible.

The goal for Beta testing is 6,000 to 7,500 sampled patients for 2,400 to 3,000 completed surveys, which would be a forty percent response rate. To achieve the desired sample size, RAND aims to recruit fifty outpatient palliative care programs. To date, thirty-four programs have completed their data use agreement (DUA) paperwork. RAND has exceeded their goal for Hospice program recruitment. RAND is still looking for hospital and other programs. Even though the project is IRB exempt, some institutions still want to seek IRB approval, which might delay or prevent their ability to participate as a testing site.

The project team asked the TECUPP members if they could assist in Beta test site recruitment. If a TECUPP member has a relationship with one of the potential test sites and could reach out to them, that would be very helpful. RAND will follow-up with several of the participants after the meeting.

TABLE 4— Current Beta Test Site Recruitment Numbers and Geographic Distribution:

	Midwest	Northeast	South	West	TOTAL	
Hospice	Targeted Number of Programs	2	1	3	1	7
	Programs Recruited (with executed DUAs)	2	2	5	1	10
	Percent of Target	100%	200%	167%	100%	143%
	Midwest	Northeast	South	West	Total	
Hospital	Targeted Number of Programs	5	9	7	7	28
	Programs Recruited (with executed DUAs)	2	4	2	5	13
	Percent of Target	40%	44%	29%	71%	46%
	Midwest	Northeast	South	West	Total	
Other	Targeted Number of Programs	3	2	5	5	15
	Programs Recruited (with executed DUAs)	3	1	2	1	7
	Percent of Target	100%	50%	40%	20%	47%

9:30am PT/ 12:30pm ET Discussion:

Presenter(s): Amy Melnick, MPA, Executive Director, National Coalition for Hospice and Palliative Care
 Mary Ersek, PhD, RN, FPCN, Senior Scientist, Department of Veterans Affairs; Professor of Palliative Care, University of Pennsylvania Schools of Nursing and Medicine
 Sydney Dy, MD, MS, FAAHPM, Professor, John Hopkins Bloomberg School of Public Health

Discussion:

Two discussion questions were posed, then the floor was opened for comments –

- How do you think outpatient palliative care clinics will use these measures?
- To what extent do these measures balance patient and provider burden with information that will improve care?

The robust discussion about the “Heard and Understood” measure potentially topping out continued during this portion of the meeting. Since the AAHPM team intends to seek NQF endorsement for these measures, anything that appears to be already topped out could be challenging when trying to prove a performance gap. TECUPP participants approached this follow-up conversation from several different angles. Some members offered advice about changing the response options to more accurately capture the data, including adding numeracy to the response options (e.g., 100% of the time; 80% of the time, etc.). Another participant suggested using “always, usually, sometimes, never” as potential response options. Some expressed concern about providers focusing on scoring well on measures at the expense of all other important things they are supposed to be doing, which is a risk in any situation where you measure performance. Some participants offered counter arguments to the topping out concern. Since feeling heard and understood is arguably the most critical facet of specialty palliative care, some argued that if patients did not check the top-box, this could indicate harm; therefore if even 10% of respondents did not check the top box, this may be a significant gap. Furthermore, the gap is likely to be larger for providers that do not specialize in palliative care (e.g., in primary care), and the measure eventually may be useful in justifying a palliative care consult or outpatient

program at a healthcare organization. Other participants wondered if there could be a space for a qualitative response if a patient does not check the top box, which could help us understand how this affects the patient and gather more information.

Some participants sought to discuss how to use the information from survey responses to improve the quality of care patients receive. Even though quality improvement projects are beyond the scope of this project, participants wanted to begin to discuss ways to connect the measures to quality improvement and wondered if that would be through training or some other intervention. They also wanted to advocate that palliative care programs prioritize implementing these measures to decrease variability in the quality of care that palliative care patients receive. Participants thought it would be helpful to see non-risk adjusted testing data to identify connections between other health issues such as depression and how they relate to poor health outcomes, which would allow the provider to respond in a more holistic manner. Additionally, for implementation, one participant expressed concern over cost to administer the survey being a barrier to future use. One of our caregiver representatives felt that because of how important these measures are to patients, that providers will not hesitate to use the measures. In addition, AAHPM has developed strategies to mitigate the risk of cost being a barrier to measure implementation. Some of the strategies include convincing all parties involved that the small effort and investment is worthwhile by showcasing successful quality improvement projects using the measures. Another strategy could be to provide a small number of scholarships with limited start-up funds for sites to begin implementing the measures. A third strategy could be using PRO-PM implementation guides developed in conjunction with this project to help make incorporation of the new processes more streamlined and incorporated into workflow. Finally, to obtain the group/program perspective on the feasibility of implementing and using the proposed measures, we will collect qualitative feedback during the Beta field test via different approaches. First, we will invite providers and administrators (e.g., Quality Lead, Department Chair, Medical Informatics Chief) from participating programs to participate in one of two planned virtual focus groups held 6 months and 12 months after the start of the beta test. During the virtual focus groups we will elicit feedback from participants regarding the relevance of the measures to their practice and performance, perceived barriers and facilitators to implementation including information regarding anticipated costs of implementing (e.g., vendor costs, data management costs, staff time and resources, and patient burden), and thoughts regarding the harmonization of the proposed measures and survey instrument with other ongoing or anticipated efforts to collect quality performance data at the site-level. We also plan to convene two public webinars (one prior to the start of the Alpha test field period, and the other after the close the Beta test field period) open to patients, caregivers, and clinical end users (including but not limited to field test participants), as another avenue for collecting qualitative feasibility information from key stakeholders. We will open a project “Feedback Hotline” via email and telephone for participating sites to raise concerns and ask questions about both the testing process as well as future implementation of these measures. Finally, we will provide an opportunity for stakeholders and the public at large to provide input and feasibility information through a Public Comment period planned for immediately after the Beta test field period.

Participants asked about the Spanish language survey during Alpha testing. RAND shared that they got one or two requests for Spanish language surveys. The pre-notification letter provided a phone number where patients could call to request a Spanish language survey.

Participants asked how the project team identifies patients who have died, to ensure that communication about the survey is not upsetting to the family. RAND shared that they are providing a postcard that indicates that a patient has died, and the family is able to send the postcard to RAND, which would remove them from the list of patients to receive follow-up calls.

10:00 am PT/ 1:00pm ET Close:

Amy Melnick, MPA, Executive Director, National Coalition for Hospice and Palliative Care

The project team thanked the TECUPP for their time and valuable feedback. The project team will be sending a short survey after the call; the TECUPP was informed of the survey and was asked to complete it.

Summary and Next Steps:

Participants were provided a greater understanding of the project, cognitive and Alpha field test results, and progress to date. Participants had a robust discussion around the relationship between performance gap and response options, the terms “provider” vs. “clinician” vs. others, and identifying diverse testing sites for the Beta field test. Although the point of the TECUPP discussion was not to solidify decisions, the perspectives heard will help inform the decision-making process, and in some cases the discussion better centered the conversation on the needs of patients, family members, and caregivers (e.g., using the word “provider” because it makes sense to patients, regardless of how our experts feel about it). The TECUPP recommended that the response options be changed for the “Heard and Understood” measure from “very true, mostly true,” to “completely true, very true,” that the TECUPP members and AAHPM’s special interest groups be utilized to identify more diverse testing sites for the Beta field test, and that during rollout and implementation of the measures, emphasis should be placed on the importance of using the measures for quality improvement (QI).

After the TECUPP meeting, the project team will incorporate their recommendations, to the extent possible. Additionally, the TECUPP and MSP will be reconvened at strategic points throughout the project to inform critical decisions.

TABLE 5 – Key TECUPP Recommendations for Project Team Consideration:

Measure Area	Measure Description	Key TECUPP Recommendations
Communication	Percent of patients who report feeling heard and understood by their palliative care provider and team, among all adult patients with at least 1 outpatient palliative care visit in a 3-month period, who answer a survey question about feeling heard and understood.	<ul style="list-style-type: none"> -For the Beta field test, change top two response options from “very true, mostly true,” to “completely true, very true” -Utilize the TECUPP members and AAHPM’s special interest groups to identify more diverse testing sites for the Beta field test -Our patient advocates stressed that because of how important these measures are to patients, providers will not hesitate to use them
Symptom	Percent of patients who report getting the help they want for their pain from their palliative care provider and team, among all adult patients with at least 1 outpatient palliative care visit in a 3-month period, who report having pain AND wanting help for pain.	<ul style="list-style-type: none"> -For consideration in future projects: <ol style="list-style-type: none"> 1.Although in cognitive interviews, patients favored the word “provider” – TECUPP members requested that other terms be considered in future projects 2.Consider using the measures to differentiate quality of palliative care between specialists and non-specialists 3.TECUPP members emphasized the importance of using the measures for quality improvement (QI) and volunteered to assist in creating such projects