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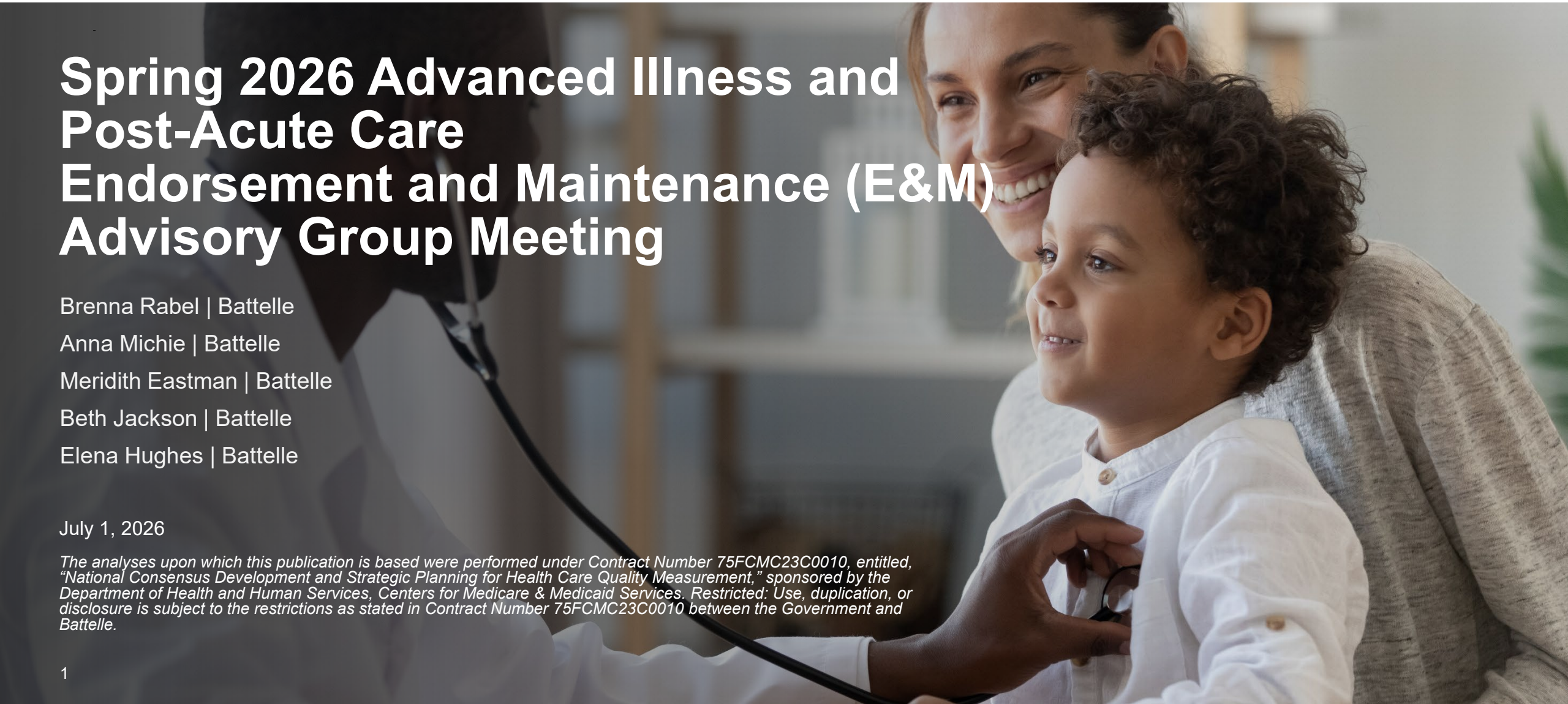

Spring 2026 Advanced Illness and Post-Acute Care Endorsement and Maintenance (E&M) Advisory Group Meeting

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Agenda

- Welcome and Ground Rules
- Roll Call
- Overview of E&M Process and Advisory Group Meeting Procedures
- Public Comment
- Discussion of Spring 2026 Measures
- Next Steps
- Adjourn

Housekeeping Reminders

- State your first and last name if you are a call-in user.
- We encourage you to keep your video on; however, the system will allow you to turn your video off/on throughout the event.
- Use the raise hand button if you have a question/comment; when called on, unmute yourself.
- Lower your hand and mute yourself following your question/comment.
- If you are experiencing technical issues, please contact the project team via the chat feature on the virtual platform or at PQMsupport@battelle.org.

Meeting Ground Rules

- Respect all voices
- Remain engaged and actively participate
- Keep your comments concise and focused
- Allow others to contribute
- Share your experiences
- Learn from others

Roll Call

Advanced Illness and Post-Acute Care Committee

Advisory Group Members

- James Austin^
- Joshua Calliste, MHA
- Sarah Chuzi, MD, MSC, FACC
- David Clayman, DPM, MBA
- Elizabeth Coleman, BA
- Katherine Di Palo, MS, MBA, PharmD
- Paul Galchutt, MDiv, MPH, BCC^
- Kimberly Geoffrey, BS, MPH^
- Cameron Gettel, MD, MHS
- Sarah Godfrey, MPH, MD
- Laura Green, MHA, CRHCP
- Morris Hamilton
- Dorothy Hiersteiner, BA, MPP
- Maria Jaramillo Catalina, BA
- Victoria Johnson, MHSA
- Raymond Jones, BS, MS, PhD
- Lisa Kitko, PhD, RN, FAHA, FAAN
- Elizabeth Marfeo, PhD, MPH, OTR/L
- Kay Miller Temple, MD, MMC
- Amy Pease, MS
- Silvia Perez-Protto, MS, MBA, FCCM
- Lori Piltz, BS, MSN^
- Heather Raygoza, BSN, RN, CWOCN, CFCN
- Lauri Redus, BS RT, BA HM, MHL
- Patricia Rowan, MPP, PMP
- Karl Sandin, MD
- Andrea Schweiger, RN, CEA, QCP, CCE
- Marcia Spoto, PT, DC
- Samuel Stolpe, MPH, PharmD
- Michelle Stuercke, BSN, MPH
- Sarah Thirlwell, MSc, MSc(A), RN, ACONS, CHPN, CHPCA, CPHQ
- Janice Tufte^
- Ronald Walters, MD, MBA, MHA, MS

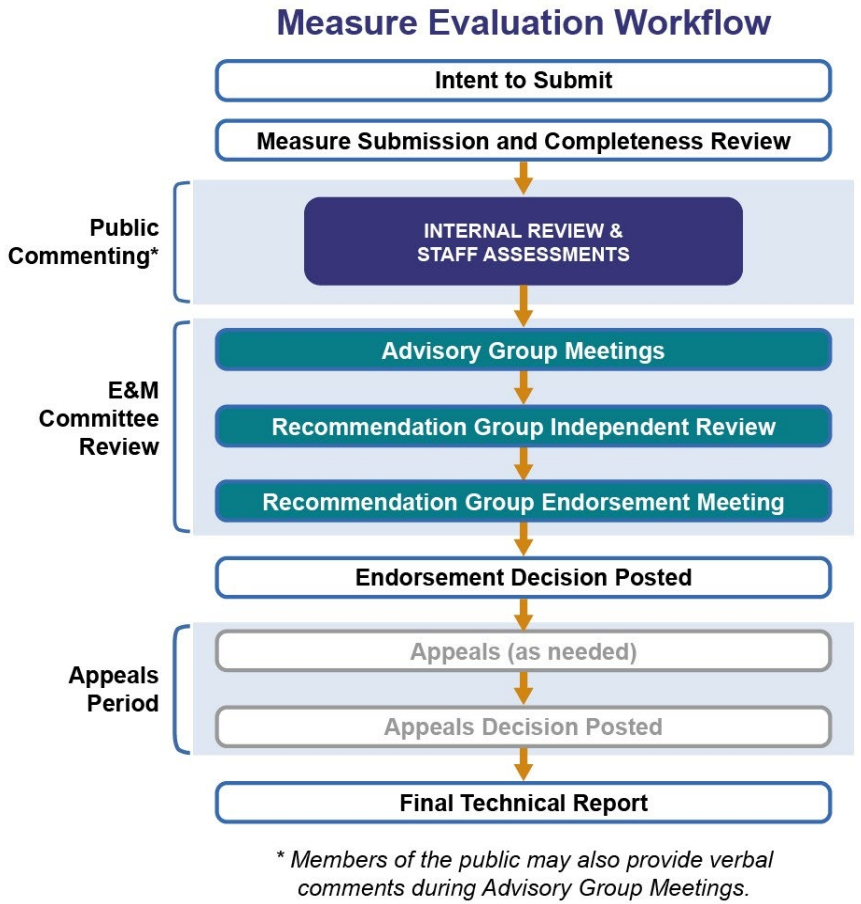
^Denotes committee member is a patient participant.

Overview of E&M Process and Meeting Procedures

E&M Process

Six major steps:

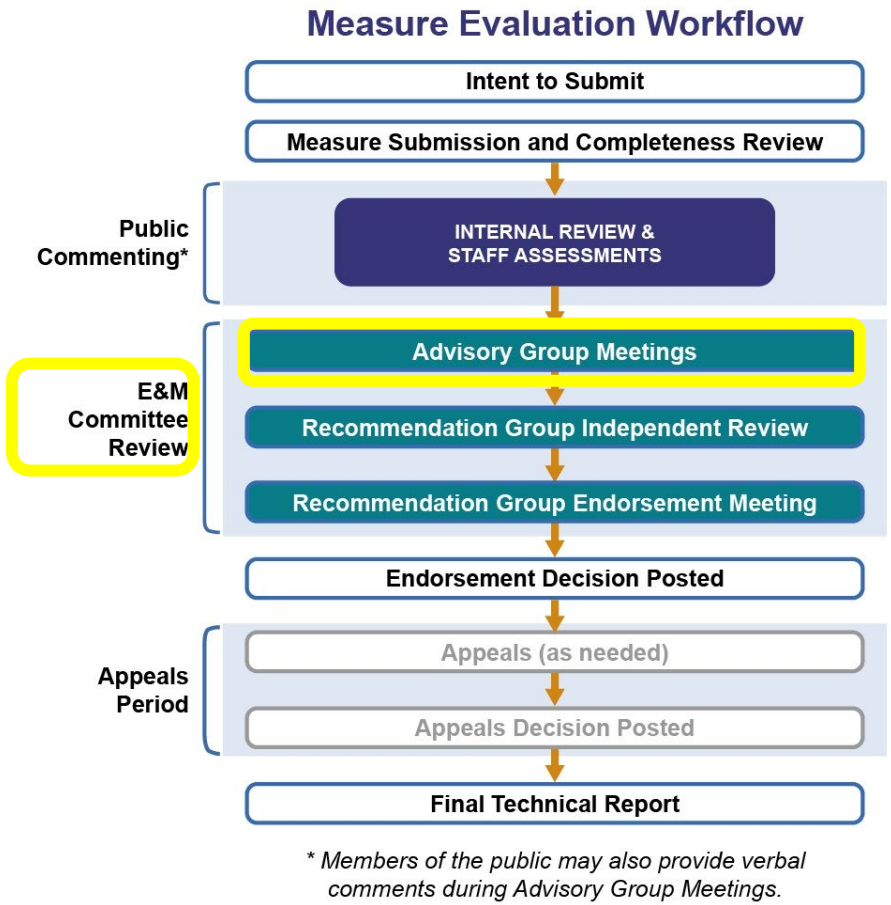
1. Intent to Submit
2. Full Measure Submission
3. Staff Internal Review and Measure Public Comment
   - Public Comment
4. E&M Committee Review
   - Advisory Group Meetings
   - Recommendation Group (RG) Independent Review
   - Recommendation Group Meetings
5. Appeals Period (as warranted)
6. Final Technical Report



** Members of the public may also provide verbal comments during Advisory Group Meetings.*

E&M Committee Review
Advisory Group Meeting

- **Steps:**
  - The Advisory Group from each E&M committee convenes to comment on strengths and limitations of submitted measure(s) and ask questions of developers.
  - We encourage developers to attend and respond to questions/feedback from the Advisory Group members.
- **Timing:**
  - Early January (Fall) and June/July (Spring)
- **Outputs:**
  - Summary of Advisory Group member feedback, questions, and developer/steward responses on the PQM website.



PQM Measure Evaluation Rubric

1

Importance - Extent to which the measure is evidence based AND is important for making significant gains in health care quality or cost where there is variation in or overall less-than-optimal performance.

2

Closing Care Gaps (optional) - Extent to which the measure can distinguish differences in care for certain patient subpopulations, which can be used to close gaps in care across those identified subpopulations.

3

Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

4

Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

5

Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high-quality, efficient health care for individuals or populations.

Advisory Group Meeting

Measure Review Procedures

1. Measure introduction by Battelle

- Battelle introduces the measure, highlighting basic information about the measure (e.g., description, measure type, target population, current/planned use).

2. Advisory Group discusses

- Patient partners have the floor first, then members assigned the relevant measure, and then the wider AG.
- We encourage members to note risks to the measure's safety and effectiveness for the RG to consider and discuss.

3. Developer/steward responds to feedback and questions

- Developer/steward respond to questions by topic.
- Before moving to next measure, developer/stewards provide final response to the discussion.

Patient Partner Feedback

- Have you had experiences related to this measure that you would like to share?
- Do you believe this measure is meaningful and can enhance patient care?
- Does this measure respect and respond to your individual preferences, needs, and values?
- Are there parts of this measure that might be hard to understand or burdensome?
- Would knowing your provider's performance on this measure be helpful to you?

Developer Response

Throughout the course of the measure discussion, developers will have the opportunity to respond to committee feedback and questions.

Developers may also choose to provide additional clarification or detail offline after the meeting.

If you have questions for the developer to address offline, you may share them in the chat following the discussion so they can provide detailed responses.

Advisory Group Meeting

Your Feedback in Action

Advisory Group

The Advisory Group raises potential major concerns about a measure.

Example: Maintenance measure shows minimal performance improvement (0.3 increase in performance scores from 2021-2022) despite multi-year use in a national accountability program.

Shared Feedback

The endorsement meeting materials flag the Advisory Group concerns.

The committee co-chairs present concerns as key discussion points to the RG.

Outcome

After RG discussion of major concern, if RG members agree, they may **place a condition on the measure**.

Example: When the measure returns for maintenance in 5 years, the developer should have worked with accountable entities to identify challenges and reasons for limited improvement over time as well as strategies to address them.

Public Comment

Public Comment Guidance

Public comment is now open. To comment on any of the project's measures:

✋ Raise hand — Use the **"raise hand"** feature to be recognized.

Please state your **name** and any **affiliation**. Please also state **the measure(s)** on which you intend to comment.

We kindly ask commenters to keep their comments to **2 minutes or less**.

Developers/stewards: Do not respond to commenters directly. You will have an opportunity to address feedback during the Advisory Group discussions.

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Discussion of Spring 2026 Measures

Spring 2026 Measures for Committee Review

The Advanced Illness and Post-Acute Care committee received 15 measures for endorsement consideration.

NUMBER OF MEASURES:

15

AREAS OF FOCUS

- ID/DD HCBS
- Cancer
- CoreQ Satisfaction

NEW VS. MAINTENANCE

- 5 New Measures
- 10 Maintenance Measures

Spring 2026 Measures for Committee Review
(cont., 1)

CBE Number	Measure Title	New/Maintenance	Developer/Steward
#0210	Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14/30 Days of Life (lower score – better) (Registry Version)	Maintenance	American Society of Clinical Oncology (ASCO)
#5594	Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14/30 Days of Life (lower score – better) (Claims Version)	New	ASCO
#0216	Percentage of Patients who Died with Cancer Enrolled in Hospice For At Least 3 Days Immediately Before Death (Registry Version)	Maintenance	ASCO
#5595	Percentage of Patients who Died with Cancer Enrolled in Hospice For at Least 3 Days Immediately Before Death (Claims Version)	New	ASCO
#5593	Percentage of Patients who Died with Cancer with More Than One Hospitalization, in an Acute Care Hospital or Critical Access Hospital, in the Last 30 Days of Life (lower score – better)	New	ASCO
#5591	Percentage of Patients who Died with Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)	New	ASCO
#5592	Percentage of Patients who Died with Cancer with More Than One Emergency Department and/or Observation Visit in the Last 30 Days of Life (lower score – better)	New	ASCO

Spring 2026 Measures for Committee Review
(cont., 2)

CBE Number	Measure Title	New/Maintenance	Developer/Steward
#2614	The Percent of CoreQ Satisfaction among Short Stay Discharged Residents in Skilled Nursing Facilities	Maintenance	American Health Care Association/National Center for Assisted Living (AHCA/NCAL)
#2615	The Percent of CoreQ Satisfaction among Long-Stay Residents in Skilled Nursing Facilities	Maintenance	AHCA/NCAL
#2616	The Percent of CoreQ Satisfaction among Long-Stay Families in Skilled Nursing Facilities	Maintenance	AHCA/NCAL
#3622-1	NCI for ID/DD HCBS: Community Job Goal	Maintenance	Human Services Research Institute (HSRI)
#3622-2	NCI for ID/DD HCBS: Activities of Daily Living (ADL) Goal	Maintenance	HSRI
#3622-3	NCI for ID/DD HCBS: Satisfaction with Community Inclusion Scale	Maintenance	HSRI
#3622-4	NCI for ID/DD HCBS: Social Connectedness	Maintenance	HSRI
#3622-5	NCI for ID/DD HCBS: Has Friends (Non-Staff, Non-Family)	Maintenance	HSRI

CBE #0210 Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14/30 Days of Life (lower score- better) (Registry Version)

Item	Description
Measure Description	Percentage of patients, aged 18 years and older, who died with cancer receiving systemic cancer-directed therapy in the last 14/30 days of life.
Developer/ Steward	ASCO
Current Use	Payment Program; Professional Certification or Recognition Program
Measure Specification Changes	• Implementers can also look at systemic cancer-directed therapy in the last 30 days of life. • Note: The 14-day version is the only one used in the Merit-based Incentive Payment System (MIPS).

Measure Type

Intermediate Outcome

Target Populations

Adults (18-64 years); Older Adults (65 years and older)

Care Setting

Ambulatory Care: Clinic; Ambulatory Care: Clinician Office; Ambulatory Care: Office; Clinician Office/Clinic

Level of Analysis

Clinician: Group/Practice; Clinician: Individual

New or Maintenance

Maintenance (Last reviewed: Spring 2022)

Initial Endorsement

Fall 2009

CBE #0210 Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed in the Last 14/30 Days of Life (lower score- better) (Registry Version)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Not Met, but Addressable*	*Reliability: Not Met* *Validity: Not Met, But Addressable*	*Met*
Strengths	• Addresses a significant problem, has a robust evidence base, a documented performance gap at the individual clinician level, and well-articulated logic model.	• Provides evidence of gaps in care related to the measure focus for subgroups, including systematic study, meta-analysis, retrospective cohort study, and literature review.	• All required data elements are routinely generated and licensing and other requirements for use are described and justified.	• Required testing was performed. • Validity results demonstrate expected, statistically significant correlations with related hospice and therapy measures.	• Currently used in MIPS, with expansion to additional CMS programs under consideration. • Includes actionable strategies for performance improvement, including care planning, treatment de-escalation, and hospice use.
Limitations	• Limited performance variation at the clinician group level based on a small sample (10 practices). • Limited direct patient input, relying primarily on caregiver and representative perspectives.	• Lacks description of methods used to assess subgroup gaps and recommended actions to address them.	• Unclear cost and feasibility for non-profit vs. for-profit clinicians, particularly in rural/safety-net settings. • Uncertainty around electronic implementation outside the McKesson registry.	• Low signal-to-noise reliability at the clinician level, with most entities below expected thresholds and limited justification provided. • Measure score testing results partially support validity; interpretation of stronger practice-level correlations is limited. • No risk adjustment or stratification, with insufficient justification or supporting evidence for comparability across patient populations.	• No reported feedback on measure performance or implementation. • Lacks clarity on whether a systematic feedback process exists to identify challenges and inform improvement

*Currently optional.

CBE #5594 Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14/30 Days of Life (lower score – better) (Claims Version)

Item	Description
Measure Description	Percentage of patients, aged 18 years and older, who died with cancer receiving systemic cancer-directed therapy in the last 14 days of life. Percentage of patients, aged 18 years and older, who died with cancer receiving systemic cancer-directed therapy in the last 30 days of life.
Developer/ Steward	ASCO
Planned Use	Payment Program; Professional Certification or Recognition Program
Measure Specification Changes	N/A

Measure Type
Intermediate Outcome
Target Populations
Adults (18-64 years); Older Adults (65 years and older)
Care Setting
Ambulatory Care: Clinic; Ambulatory Care: Clinician Office; Ambulatory Care: Office
Level of Analysis
Clinician: Group/Practice
New or Maintenance
New
Initial Endorsement
N/A

CBE #5594 Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14/30 Days of Life (lower score – better) (Claims Version)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met, but Addressable*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Strong logic model and high-quality evidence demonstrate improved outcomes and reduced costs. • Addresses a high-burden gap with demonstrated performance variation. • Adds value beyond existing measures and incorporates patient-centered input.	• Includes credible evidence of care gaps and potential to improve end-of-life cancer care.	• Claims-based with low burden and readily available data. • Minimal workflow disruption; data collection is passive. • Privacy protections and implementation considerations well addressed.	• Provides some evidence for data element reliability, though it is outdated and limited. • Provides prior evidence supporting numerator validity (high sensitivity/specificity), though based on older research.	• Clear plan for CMS program use (e.g., MIPS, PCHQR, IQR). • Includes actionable guidance to improve performance.
Limitations	• Limited direct patient engagement.	• Lacks clear, actionable strategies to close identified gaps.	• Unclear cost for non-profits vs. others, with potential access concerns for rural/safety-net settings.	• Missing required, current data element–level reliability testing • No separate code file provided, which limits measure interpretation.	• None identified.

*Currently optional.

CBE #0216 Percentage of Patients who Died with Cancer Enrolled in Hospice For At Least 3 Days Immediately Before Death (Registry Version)

Item	Description
Measure Description	Percentage of patients, aged 18 years and older, who died with cancer and were enrolled in hospice for at least 3 days immediately before death.
Developer/ Steward	ASCO
Current Use	Payment Program; Professional Certification or Recognition Program
Measure Specification Changes	• This denominator has been broadened to capture all adult patients who died with cancer instead of solely looking at patients admitted to hospice. This change harmonizes this measure with ASCO's other end-of-life measures. • The intent of the numerator has not changed, but the language has been modified to encourage hospice, which now makes the measure proportional instead of inverse.

Measure Type

Intermediate Outcome

Target Populations

Adults (18-64 years); Older Adults (65 years and older)

Care Setting

Ambulatory Care: Clinic; Ambulatory Care: Clinician Office; Ambulatory Care: Office; Clinician Office/ Clinic

Level of Analysis

Clinician: Group/Practice; Clinician: Individual

New or Maintenance

Maintenance (Last reviewed: Spring 2022)

Initial Endorsement

Spring 2007

CBE #0216 Percentage of Patients who Died with Cancer Enrolled in Hospice Care For At Least 3 Days Immediately Before Death (Registry Version)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Not Met, but Addressable*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Not Met, but Addressable*
Strengths	• Clear logic model linking inputs, activities, and outcomes to improved end-of-life care and reduced utilization. • Strong clinical and policy relevance with high-quality evidence showing improved quality of life, satisfaction, and reduced aggressive care. • Performance gap shows wide variation across clinicians and practices.	• Cites literature indicating disparities and gaps in care among subgroups.	• Uses routinely collected EHR data and aligns with interoperability standards. • Demonstrates low administrative burden and high feasibility within MIPS reporting. • There is no risk to patient confidentiality and licensing is described.	• Required testing was conducted. Most entities meet accepted reliability thresholds. • Conducts empirical validity testing showing expected, significant correlations with related measures.	• Defines planned use in MIPS. • Describes actionable use for improving hospice referral and goals-of-care processes. • Incorporates stakeholder feedback into measure updates..
Limitations	• Limited direct patient engagement.	• Subgroup differences were not tested empirically.	• Does not clearly define fee structure for non-profit vs. other entities, raising access concerns. • Provides unclear generalizability beyond a single registry (McKesson/USON).	• Results use a two-year data period; shorter performance periods may reduce reliability for some entities. • Measure scores partially support validity. • Does not assess or justify lack of risk adjustment with supporting evidence or analysis.	• Does not include evidence of improvement in the measure score over time.

*Currently optional.

CBE #5595 Percentage of Patients who Died with Cancer Enrolled in Hospice For at Least 3 Days Immediately Before Death (Claims Version)

Item	Description
Measure Description	Percentage of patients, aged 18 years and older, who died with cancer and were enrolled in hospice for at least 3 days immediately before death.
Developer/ Steward	ASCO
Planned Use	Payment Program; Professional Certification or Recognition Program
Measure Specification Changes	N/A

Measure Type
Intermediate Outcome
Target Populations
Adults (18-64 years); Older Adults (65 years and older)
Care Setting
Ambulatory Care: Clinic; Ambulatory Care: Clinician Office; Ambulatory Care: Office
Level of Analysis
Clinician: Group/Practice
New or Maintenance
New
Initial Endorsement
N/A

CBE #5595 Percentage of Patients who Died with Cancer Enrolled in Hospice For at Least 3 Days Immediately Before Death (Claims Version)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met, but Addressable*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Defines a clear logic model and demonstrates strong evidence base showing improved quality, satisfaction, and lower costs. • Identifies a substantial performance gap (1.0%–70.7%). • Addresses an unmet need with a cancer-specific, claims-based measure that reduces burden and improves case identification.	• Identifies care gaps through literature and presents a credible pathway to improve end-of-life care via timely palliative referral.	• Uses routinely collected claims data with negligible burden and no implementation cost. • Confirms data availability, interoperability, and no confidentiality risks. • Clearly documents measure components and requirements.	• Provides accountable-entity reliability estimates showing acceptable performance for many entities using a large dataset. • Demonstrates strong numerator validity (high sensitivity and specificity) using prior research on claims data.	• Describes clear use across multiple federal and private programs. • Provides actionable pathways to improve performance (e.g., hospice referral, goals of care). • Incorporates stakeholder input and acknowledges appropriate performance expectations.
Limitations	• Limited direct patient engagement.	• Does not clearly define actionable strategies to close identified care gaps.	• Does not specify fee structure for non-profit vs. other entities, raising potential access concerns.	• Uses outdated or unverifiable reliability evidence. • Lacks valid, generalizable evidence for denominator validity. • Omits validation of denominator exceptions (e.g., specific cancer treatments). • Does not justify absence of risk adjustment.	• None identified.

*Currently optional.

CBE #5593 Percentage of Patients who Died with Cancer with More Than One Hospitalization, in an Acute Care Hospital or Critical Access Hospital, in the Last 30 Days of Life (lower score – better)

Item	Description
Measure Description	Percentage of patients, aged 18 years and older, who died with cancer with more than one hospitalization, in an acute care hospital or critical access hospital, in the last 30 days of life.
Developer/ Steward	ASCO
Planned Use	Payment Program; Professional Certification or Recognition Program
Measure Specification Changes	N/A

Measure Type
Intermediate Outcome
Target Populations
Adults (18-64 years); Older Adults (65 years and older)
Care Setting
Ambulatory Care: Clinic; Ambulatory Care: Clinician Office; Ambulatory Care: Office
Level of Analysis
Clinician: Group/Practice
New or Maintenance
New
Initial Endorsement
N/A

CBE #5593 Percentage of Patients who Died with Cancer with More Than One Hospitalization, in an Acute Care Hospital or Critical Access Hospital, in the Last 30 Days of Life (lower score – better)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met, but Addressable*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Demonstrates clear logic and strong evidence linking palliative care to improved outcomes and reduced utilization. • Identifies a meaningful performance gap (0.0%–38.1%) and unmet need in end-of-life cancer care.	• Provided evidence of gaps in care, including a literature review.	• Uses routinely available data with low burden and no implementation cost. • Ensures feasibility through electronic data capture and confidentiality safeguards.	• Provides some data element reliability evidence for numerator exclusions. • Demonstrates strong numerator validity with high sensitivity and specificity.	• Defines clear use across multiple programs and care settings. • Provides actionable pathways to improve palliative care and advance care planning. • Incorporates stakeholder input and acknowledges realistic performance expectations.
Limitations	• Limited direct patient engagement.	• Does not clearly define actionable strategies to close identified care gaps.	• Does not specify fee structure for non-profit vs. other entities, raising potential access concerns.	• Fails to test all critical data elements and relies on outdated or unverifiable sources. • Lacks generalizable evidence for denominator and exceptions validity. • Does not assess or justify lack of risk adjustment.	• None identified.

*Currently optional.

CBE #5591 Percentage of Patients who Died with Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)

Item	Description
Measure Description	Percentage of patients, aged 18 years and older, who died with cancer admitted to the ICU in the last 30 days of life.
Developer/ Steward	ASCO
Planned Use	Payment Program; Professional Certification or Recognition Program
Measure Specification Changes	N/A

Measure Type
Intermediate Outcome
Target Populations
Adults (18-64 years); Older Adults (65 years and older)
Care Setting
Ambulatory Care: Clinic; Ambulatory Care: Clinician Office; Ambulatory Care: Office
Level of Analysis
Clinician: Group/Practice
New or Maintenance
New
Initial Endorsement
N/A

CBE #5591 Percentage of Patients who Died with Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met, but Addressable*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Demonstrates a clear logic model and strong evidence linking palliative care to improved outcomes and reduced utilization. • Identifies a meaningful performance gap (0.0%–38.8%) and addresses an unmet need with a cancer-specific, claims-based approach.	• Provided evidence of gaps in care, including a literature review.	• Uses routinely available claims data with low burden and no implementation cost. • Ensures feasibility through electronic data capture and confidentiality safeguards.	• Provides accountable-entity reliability testing using a large dataset. • Demonstrates adequate numerator validity with acceptable sensitivity and specificity.	• Defines clear use across multiple programs, settings, and accountable entities. • Provides actionable pathways to improve hospice referral, palliative care, and advance care planning. • Incorporates stakeholder input and acknowledges realistic performance expectations.
Limitations	• Direct engagement from patients is limited.	• Does not clearly define actionable strategies to close identified care gaps	• Does not clearly define fee structure for non-profits, raising access concerns.	• Fails to test data element–level reliability for all critical elements and relies on outdated sources. • Lacks generalizable evidence for denominator and exceptions validity. • Does not assess or justify lack of risk adjustment.	• None identified.

*Currently optional.

Break

Meeting Resumes at 1:00 PM ET

CBE #5592 Percentage of Patients who Died with Cancer with More Than One Emergency Department and/or Observation Visit in the Last 30 Days of Life (lower score – better)

Item	Description
Measure Description	Percentage of patients, aged 18 years and older, who died with cancer with more than one emergency department and/or observation visit in the last 30 days of life.
Developer/ Steward	ASCO
Planned Use	Payment Program; Professional Certification or Recognition Program
Measure Specification Changes	N/A

Measure Type
Intermediate Outcome
Target Populations
Adults (18-64 years); Older Adults (65 years and older)
Care Setting
Ambulatory Care: Clinic; Ambulatory Care: Clinician Office; Ambulatory Care: Office
Level of Analysis
Clinician: Group/Practice
New or Maintenance
New
Initial Endorsement
N/A

CBE #5592 Percentage of Patients who Died with Cancer with More Than One Emergency Department and/or Observation Visit in the Last 30 Days of Life (lower score – better)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met, but Addressable*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Demonstrates a clear logic model and strong evidence linking palliative care to improved outcomes and reduced utilization. • Identifies a meaningful performance gap (2.5%–55%) and addresses an unmet need in end-of-life cancer care.	• Provides evidence of gaps in care, including a literature review.	• Uses routinely available claims data with low burden and no implementation cost. • Ensures feasibility through electronic data capture and confidentiality safeguards.	• Provides accountable-entity reliability testing using a large dataset. • Demonstrates adequate numerator validity with acceptable sensitivity and specificity.	• Defines clear use across multiple programs and care settings. • Provides actionable pathways to improve palliative care and advance care planning. • Incorporates stakeholder input and acknowledges realistic performance expectations.
Limitations	• Direct engagement from patients is limited.	• Does not clearly define actionable strategies to close identified care gaps.	• Does not clearly define fee structure for non-profits, raising access concerns.	• Fails to test data element–level reliability and relies on outdated or unverifiable sources. • Lacks generalizable evidence for denominator and exceptions validity. • Does not assess or justify lack of risk adjustment.	• None identified.

*Currently optional.

CBE #2614 The Percent of CoreQ Satisfaction among Short-Stay Discharged Residents in Skilled Nursing Facilities

Item	Description
Measure Description	The measure calculates the percentage of individuals discharged in a six-month time period from a Skilled Nursing Facility (SNF), within 100 days of admission, who are satisfied. This patient reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items.
Developer/ Steward	AHCA/NCAL
Current Use	Public Reporting; Payment Program; Professional Certification or Recognition Program; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type

Patient-Reported Outcome Performance Measure (PRO-PM)

Target Populations

Older Adults (65 years and older)

Care Setting

Nursing Home/Skilled Nursing Facility

Level of Analysis

Facility

New or Maintenance

Maintenance (Last reviewed: Spring 2020)

Initial Endorsement

Fall 2016

CBE #2614 The Percent of CoreQ Satisfaction among Short-Stay Discharged Residents in Skilled Nursing Facilities

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Demonstrates a clear logic model linking care processes to improved resident satisfaction and quality outcomes. • Identifies a substantial performance gap (8%–98.7%) indicating wide variation in nursing home performance. • Incorporates resident and caregiver input supporting measure relevance.	• None identified.	• Uses routinely collected survey data with minimal burden and strong confidentiality protections. • Demonstrates flexible implementation (e.g., integration with existing surveys) and low cost.	• Conducts signal to noise reliability estimation. • Conducts required measure-level validity testing with national data and supports results with a strong logic model.	• The measure is actively used in at least one accountability application and demonstrates a positive trend in performance results, affirming its ongoing usability.
Limitations	• Relies primarily on outdated literature and older patient input without clear timing or updated evidence.	• Attempts to assess gaps in care across race subgroups, but statistical methods and results are not reported.	• Minor cost and collection burden, though mitigated.	• Lacks entity-level testing detail; the reliability metrics provided by the developer do not allow for determining whether established thresholds were met. • Omits methodological validity details, uses outdated or unclear comparators, and lacks risk adjustment or clear rationale for correlations.	• The developer did not provide a specific timeframe for performance data.

*Currently optional.

CBE #2615 The Percent of CoreQ Satisfaction among Long-Stay Residents in Skilled Nursing Facilities

Item	Description
Measure Description	The measure calculates the percentage of long-stay residents, those living in the skilled nursing facility for 100 days or more, who are satisfied. This patient reported outcome measure is based on the CoreQ: Long-Stay Resident questionnaire that is a three-item questionnaire.
Developer/ Steward	AHCA/NCAL
Current Use	Public Reporting; Payment Program; Professional Certification or Recognition Program; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type

PRO-PM

Target Populations

Older Adults (65 years and older)

Care Setting

Nursing Home/Skilled Nursing Facility

Level of Analysis

Facility

New or Maintenance

Maintenance (Last reviewed: Spring 2020)

Initial Endorsement

Fall 2016

CBE #2615 The Percent of CoreQ Satisfaction among Long-Stay Residents in Skilled Nursing Facilities

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Demonstrates a clear, coherent logic model linking inputs, activities, and outcomes. • Aligns with established improvement priorities and shows meaningful performance variation. • Incorporates patient input to support outcome relevance.	• None identified.	• Uses routinely available electronic data with no major feasibility issues. • Demonstrates low burden and integrates with existing survey processes. • Ensures confidentiality with clear data collection safeguards.	• Conducts signal to noise reliability estimation. • Conducts required measure-level validity testing with national data and supports results with a strong logic model.	• The measure is actively used in at least one accountability application and demonstrates a positive trend in performance results, affirming its ongoing usability.
Limitations	• Relies on outdated literature (10+ years old) and does not specify timing of patient input.	• While the developer attempted to assess gaps in care across race subgroups, statistical methods and results for their analyses were not reported.	• Minor cost and collection burden, though mitigated.	• Lacks entity-level testing detail; the reliability metrics provided by the developer do not allow for determining whether established thresholds were met. • Omits key methodological validity details (e.g., correlation methods, comparator definitions). • Lacks clarity on correlation interpretation and supporting rationale.	• The developer did not provide a specific timeframe for performance data.

*Currently optional.

CBE #2616 The Percent of CoreQ Satisfaction among Long-Stay Families in Skilled Nursing Facilities

Item	Description
Measure Description	The measure calculates the percentage of family or designated responsible party for long stay residents (i.e., residents living in the facility for 100 days or more), who are satisfied. This consumer reported outcome measure is based on the CoreQ: Long-Stay Family questionnaire that has three items.
Developer/ Steward	AHCA/NCAL
Current Use	Public Reporting; Payment Program; Professional Certification or Recognition Program; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type

PRO-PM

Target Populations

Older Adults (65 years and older)

Care Setting

Nursing Home/Skilled Nursing Facility

Level of Analysis

Facility

New or Maintenance

Maintenance (Last reviewed: Spring 2020)

Initial Endorsement

Fall 2016

CBE #2616 The Percent of CoreQ Satisfaction among Long-Stay Families in Skilled Nursing Facilities

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Not Met, but Addressable*	*Met*
Strengths	• Demonstrates a clear logic model linking inputs, activities, and outcomes. • Aligns with established priorities and shows meaningful performance variation across facilities. • Incorporates patient input to support outcome relevance.	• None identified.	• Uses routinely available electronic data with no major feasibility issues. • Demonstrates minimal burden and integrates with existing workflows. • Ensures confidentiality through anonymous data collection and safeguards.	• Conducts signal to noise reliability estimation. • Conducts required measure-level validity testing with national data and supports results with a strong logic model.	• The measure is actively used in at least one accountability application and demonstrates a positive trend in performance results, affirming its ongoing usability.
Limitations	• Relies on outdated literature (10+ years old) and does not specify timing of patient input.	• While the developer attempted to assess gaps in care across race subgroups, statistical methods and results for their analyses were not reported.	• Minor cost and collection burden, though mitigated.	• Lacks entity-level testing detail; the reliability metrics provided by the developer do not allow for determining whether established thresholds were met. • Omits key methodological validity details (e.g., correlation methods, comparator definitions). • Lacks clarity on correlation interpretation and supporting rationale.	• The developer did not provide a specific timeframe for performance data.

*Currently optional.

Break

Meeting Resumes at 3:00 ET

Endorsement Review of Instrument-Derived Measure Sets

- Instrument-derived clinical quality measures (IDMs) are derived from instruments or surveys.
- The CBE endorses IDMs, not the instruments, allowing for specific evaluations and feedback.
- Instrument and IDM information are submitted for evaluation, with the committee reviewing aspects of both (Table 1).

Table 1. Evaluation Considerations for Instruments and IDMs

Domain	Instrument Level (Overarching Tool/Survey)	IDM Level (Measure Focus)
Importance	• Logic model	• Evidence of gap in care • Anticipated impact of measure • Meaningfulness to patients
Closing Care Gaps	• N/A	• Measure identifies care gaps amongst different patient populations and can be used to close those gaps.
Feasibility	• Feasibility of survey administration	• N/A
Scientific Acceptability	• Testing of the instrument or survey (i.e., person/encounter level)	• Testing of the measure score (i.e., accountable entity level) • Risk adjustment or stratification
Use and Usability	• Current/planned use	• Actions entities can take to improve the measure • Progress over time (if in use)

CBE #3622 National Core Indicators for Intellectual and Developmental Disabilities Home- and Community-Based Services (NCI for ID/DD HCBS)

Item	Description
Instrument Description	National Core Indicators for Intellectual and Developmental Disabilities Home- and Community-Based Services Measures ("NCI for ID/DD HCBS Measures" hereafter) originate from NCI(R) In-Person Survey (IPS), an annual multi-state cross-sectional survey of adult recipients of state developmental disabilities systems' supports and services. First developed in 1997 by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) in collaboration with Human Services Research Institute (HSRI), the main aims of NCI for ID/DD HCBS Measures were to evaluate person-reported outcomes and assess state developmental disabilities service systems performance in various domains and sub-domains accordingly. The unit of analysis is "the state," and the accountable entity is the state-level entity responsible for providing and managing developmental disabilities services. Currently, 48 states and the District of Columbia are members of the NCI program. To align with member states' fiscal schedules, the annual survey cycle typically starts on July 1 and ends on Jun 30 of the following year. Gathering subjective information and data from people with ID/DD poses unique challenges due to potential intellectual and developmental limitations experienced by the population. As such, extensive work went into the processes of developing NCI IPS administration methods, survey methodology and measure design and revisions. The original development built on direct consultation with members of the target population and their advocates, as well as extensive literature review and testing.

CBE #3622 National Core Indicators for Intellectual and Developmental Disabilities Home- and Community-Based Services (NCI for ID/DD HCBS) *(cont., 1)*

Item	Description
Developer/ Steward	HSRI
Current Use	Public Reporting; Quality Improvement with Benchmarking (external benchmarking to multiple organizations); Quality Improvement (internal to the specific organization)

Measure Type
Instrument + Derived Measure Set (Patient-Reported Experience Performance Measures [PRE-PM])
Care Setting
Home Health; Nursing Home/Skilled Nursing Facility; Other (Home- and Community-Based Services)
Level of Analysis
Population or Geographic Area (State)
New or Maintenance
Maintenance (Last reviewed: Spring 2021)
Initial Endorsement
Fall 2021

CBE #3622-1 NCI for ID/DD HCBS: Community Job Goal

Item	Description
Measure Description	The NCI for ID/DD HCBS Community Job Goal measure calculates the proportion of people who express they want a job and who have a related goal in their service plan. It is intended to capture the alignment between expressed desire for work and formal planning supports, and to support monitoring of person-centered practices and progress toward competitive, integrated employment for people with intellectual and developmental disabilities.
Developer/ Steward	HSRI
Current Use	Public Reporting; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type

PRE-PM

Target Populations

Adults (18-64 years); Older Adults (65 years and older)

Care Setting

Home Health; Nursing Home/Skilled Nursing Facility; Other (Home- and Community-Based Services)

Level of Analysis

Population or Geographic Area (State)

New or Maintenance

Maintenance (Last reviewed: Spring 2021)

Initial Endorsement

Spring 2021

CBE #3622-1 NCI for ID/DD HCBS: Community Job Goal

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Met*
Strengths	• Demonstrates strong conceptual relevance by linking employment to improved outcomes for individuals with IDD. • Uses recent evidence and a clear, aligned logic model to support the measure. • Shows meaningful performance variation across states, indicating opportunity for improvement.	• The developer did not address this optional domain.	• Describes the NCI-IDD data collection process including formal agreements among states and defined rolls for program management, technical assistance, and data reporting, supported for an annual participation fee.	• Demonstrates strong reliability with most entities meeting established thresholds. • Conducts required validity testing using multiple data sources and hypotheses. Uses external comparators (e.g., state characteristics) to strengthen analyses. • Supports validity with a well-developed logic model and acceptable reliability.	• Provides actionable recommendations for states to improve performance. • Shows real-world performance trends and contextual factors affecting results. • Enables stratified analysis to support targeted improvement.
Limitations	• Relies on outdated or indirect evidence for patient meaningfulness. • Does not quantify employment need or demand among the target population.	• The developer did not address this optional domain.	• Does not quantify burden (e.g., cost, staff time) for data collection and integration. • Raises concerns about variability in data completeness due to reliance on case manager follow-up.	• Uses limited sample sizes, reducing statistical power and significance. • Relies on outdated or weak supporting literature for key validity assumptions.	• Inconsistent information about program use.

*Currently optional.

CBE #3622-2 NCI for ID/DD HCBS: Activities of Daily Living (ADL) Goal

Item	Description
Measure Description	This measure assesses the extent to which person-centered service planning reflects individual preferences to increase independence in activities of daily living (ADLs) among people receiving home- and community-based services. It calculates the proportion of people who express they want to increase independence in ADLs who have a related goal in their service plan. This measure is intended to capture alignment between expressed preferences and formal service planning and to support monitoring of person-centered practices that promote independence and self-determination.
Developer/ Steward	HSRI
Current Use	Public Reporting; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type
PRE-PM
Target Populations
Adults (18-64 years); Older Adults (65 years and older)
Care Setting
Home Health; Nursing Home/Skilled Nursing Facility; Other (Home- and Community-Based Services)
Level of Analysis
Population or Geographic Area (State)
New or Maintenance
Maintenance (Last reviewed: Spring 2021)
Initial Endorsement
Spring 2021

CBE #3622-2 NCI for ID/DD HCBS: Activities of Daily Living (ADL) Goal

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Met*	*Met*
Strengths	• Uses recent literature to establish relevance of ADL support and person-centered planning. • Demonstrates a performance gap across states, indicating opportunity for improvement.	• The developer did not address this optional domain.	• Describes the NCI-IDD data collection process including formal agreements among states and defined rolls for program management, technical assistance, and data reporting, supported for an annual participation fee.	• The required reliability testing results demonstrate sufficient reliability at the accountable entity-level. • Conducts required validity testing using survey data and external comparators. • Supports validity with a strong logic model and acceptable reliability.	• Provides actionable recommendations to improve performance. • Shows modest performance trends and contextual drivers. • Enables stratification to support targeted improvement.
Limitations	• Does not provide evidence linking ADL goal alignment to improved outcomes or skill development. • Relies on outdated or indirect evidence for patient meaningfulness..	• The developer did not address this optional domain.	• Does not quantify burden (e.g., cost, staff time) for data collection and integration. • Raises concerns about variability in data completeness due to reliance on case manager follow-up.	• Does not explain why a subset of survey responses was used in testing. • Does not report included states, limiting assessment of representativeness for validity testing.	• Inconsistent information on program use.

*Currently optional.

CBE #3622-3 NCI for ID/DD HCBS: Satisfaction with Community Inclusion Scale

Item	Description
Measure Description	This measure assesses satisfaction with participation in community inclusion activities among people receiving home and community-based services. It calculates the proportion of people who report satisfaction with the level of participation in community inclusion activities. The measure is derived from a series of National Core Indicators survey items that ask respondents whether they would like to participate more, less, or the same amount as they currently do in activities such as shopping, entertainment, going to restaurants or coffee shops, attending religious or spiritual practices, and participating in community groups. Responses are recoded to reflect satisfaction when individuals indicate that their current level of participation is about the same as desired. This measure is intended to capture perceived adequacy of community participation and support evaluation of community inclusion outcomes within HCBS.
Developer/ Steward	HSRI
Current Use	Public Reporting; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type

PRE-PM

Target Populations

Adults (18-64 years); Older Adults (65 years and older)

Care Setting

Home Health; Nursing Home/Skilled Nursing Facility; Other (Home- and Community-Based Services)

Level of Analysis

Population or Geographic Area (State)

New or Maintenance

Maintenance (Last reviewed: Spring 2021)

Initial Endorsement

Spring 2021

CBE #3622-3 NCI for ID/DD HCBS: Satisfaction with Community Inclusion Scale

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Met*
Strengths	• Uses recent literature to establish the importance of social inclusion and its link to health outcomes. • Demonstrates a meaningful performance gap across states, indicating opportunity for improvement.	• The developer did not address this optional domain.	• Describes the NCI-IDD data collection process including formal agreements among states and defined rolls for program management, technical assistance, and data reporting, supported for an annual participation fee.	• Demonstrates acceptable reliability with most entities meeting thresholds. • Conducts required validity testing using survey data and external comparators. • Demonstrates expected relationships for key variables (e.g., autonomy, choice).	• Demonstrates inclusion in CMS HCBS measure set and provides improvement guidance. • Shows performance trends and contextual factors affecting change. • Enables stratification to support targeted improvement.
Limitations	• Does not demonstrate measure-specific meaningfulness for individuals with IDD in HCBS.	• The developer did not address this optional domain.	• Does not quantify burden (e.g., cost, staff time) for data collection and integration. • Raises concerns about variability in data completeness due to reliance on case manager follow-up.	• Does not explain why only a subset of survey responses was used. • Uses limited or non–peer-reviewed evidence to support key assumptions (e.g., spending).	• Inconsistent information about program use.

*Currently optional.

CBE #3622-4 NCI for ID/DD HCBS: Social Connectedness

Item	Description
Measure Description	This measure assesses social connectedness by examining the frequency with which people receiving home and community-based services experience loneliness. It calculates the proportion of people who report that they do not feel lonely often. The measure is derived from a National Core Indicators survey item that asks whether the respondent ever feels lonely or feels like they do not have anyone to talk to. Responses of “no” or “yes, sometimes” are recoded to indicate the desired outcome, while responses of “yes, often” indicate frequent loneliness. This measure is intended to capture perceived social connectedness and to support monitoring of social well-being and inclusion among people receiving HCBS.
Developer/ Steward	HSRI
Current Use	Public Reporting; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type

PRE-PM

Target Populations

Adults (18-64 years); Older Adults (65 years and older)

Care Setting

Home Health; Nursing Home/Skilled Nursing Facility; Other (Home- and Community-Based Services)

Level of Analysis

Population or Geographic Area (State)

New or Maintenance

Maintenance (Last reviewed: Spring 2021)

Initial Endorsement

Spring 2021

CBE #3622-4 NCI for ID/DD HCBS: Social Connectedness

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Met*
Strengths	• Uses recent literature to link social connectedness to health and wellbeing outcomes. • Demonstrates measurable variation across states, indicating opportunity for improvement.	• The developer did not address this optional domain.	• Describes the NCI-IDD data collection process including formal agreements among states and defined rolls for program management, technical assistance, and data reporting, supported for an annual participation fee.	• Conducts required reliability testing and results demonstrate sufficient reliability at the accountable entity-level. • Conducts required validity testing with multiple related measures. • Demonstrates strong correlation with satisfaction-based comparator.	• Demonstrates inclusion in CMS HCBS measure set and provides actionable improvement strategies. • Provides performance trends and context for system-level challenges.
Limitations	• Does not demonstrate measure-specific meaningfulness for individuals with IDD.	• The developer did not address this optional domain.	• Does not quantify burden (e.g., cost, staff time) for data collection and integration. • Raises concerns about variability in data completeness due to reliance on case manager follow-up.	• Does not explain why only a subset of survey responses was used. • Does not include independent external comparators to assess external validity. • Provides limited interpretation of weaker or non-significant correlations.	• Inconsistent information about program use.

*Currently optional.

CBE #3622-5 NCI for ID/DD HCBS: Has Friends (Non-Staff, Non-Family)

Item	Description
Measure Description	This measure assesses social relationships by examining whether people receiving home and community-based services report having friends who are not staff or family members. It calculates the proportion of people who indicate that they have friends they like to talk to or do things with who are neither paid staff nor family members. This measure is intended to capture the presence of organic, non-paid social relationships and to support monitoring of community integration and social well-being among people receiving HCBS.
Developer/ Steward	HSRI
Current Use	Public Reporting; Quality Improvement with Benchmarking (External Benchmarking to Multiple Organizations); Quality Improvement (Internal to the Specific Organization)
Measure Specification Changes	None

Measure Type

PRE-PM

Target Populations

Adults (18-64 years); Older Adults (65 years and older)

Care Setting

Home Health; Nursing Home/Skilled Nursing Facility; Other (Home- and Community-Based Services)

Level of Analysis

Population or Geographic Area (State)

New or Maintenance

Maintenance (Last reviewed: Spring 2021)

Initial Endorsement

Spring 2021

CBE #3622-5 NCI for ID/DD HCBS: Has Friends (Non-Staff, Non-Family)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Met*
Strengths	• Uses recent literature to establish the importance of friendships and social connections for health. • Demonstrates variation across states, indicating opportunity for improvement.	• The developer did not address this optional domain.	• The developer describes the NCI-IDD data collection process including formal agreements among states and defined rolls for program management, technical assistance, and data reporting, supported for an annual participation fee.	• Demonstrates acceptable reliability with most entities meeting thresholds. • Conducts required validity testing using multiple related measures and hypotheses. • Demonstrates expected directional relationships (e.g., inclusion, loneliness).	• Provides actionable recommendations to improve performance. • Shows performance trends and contextual drivers of limited improvement.
Limitations	• Does not demonstrate measure-specific meaningfulness for individuals with IDD in HCBS.	• The developer did not address this optional domain.	• Does not quantify burden (e.g., cost, staff time) for data collection and integration. • Raises concerns about variability in data completeness due to reliance on case manager follow-up.	• Does not explain why only a subset of survey responses was used. • Shows weak or non-significant correlations for key external variables (e.g., funding). • Relies on comparators from the same survey, limiting assessment of external validity.	• Inconsistent information about program use.

*Currently optional.

Next Steps

Next Steps for Spring 2026 E&M Cycle

Compiled Comments

- We will post all comments from today to the respective measure pages on the PQM website.
- We will share all public comments, Advisory Group feedback and questions, along with developer/steward clarifications, publicly and with the Recommendation Group in advance of the endorsement meetings.

Upcoming Meetings

- **Endorsement Meeting:** August 7 and August 10, 2026
- **Appeals Committee Meeting (if needed):** September 30, 2026

Upcoming Webinars

- **Enhancements to the Endorsement and Maintenance (E&M) Guidebook and Processes:** July 27, 2026

Questions:

Contact us at p4qm.org/contact
or by emailing PQMsupport@battelle.org

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