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Memo

July 28, 2020

To: Consensus Standards Approval Committee (CSAC)

From: Patient Experience and Function Project Team

Re: Patient Experience and Function Fall 2019, Track 1 Measures

COVID-19 Updates

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: Measures Continuing in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations will be reviewed by the CSAC.

- **Exceptions**
  Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures requiring further action or discussion from a Standing Committee were deferred to the Spring 2020 cycle. This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review will retain endorsement during that time. Track 2 measures will be reviewed during the CSAC's meeting in November.

During the CSAC meeting on July 28-29, the CSAC will review Fall 2019 measures assigned to Track 1. Evaluation summaries for measures in track 1 have been described in this memo and related Patient Experience and Function draft report. A list of measures assigned to Track 2 can be found in the Executive Summary section of the Patient Experience and Function draft report for tracking purposes and will be described further in a subsequent report. Measures in track 2 will be reviewed by the CSAC on November 17-18, 2020.

CSAC Action Required

The CSAC will review recommendations from the Patient Experience and Function, Track 1 project at its July 28-29, 2020 meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following documents accompany this memo:

1. Patient Experience and Function Fall 2019, Track 1 Draft Report. The draft report includes measure evaluation details on all measures that followed Track 1. Measures that followed Track 2 will be reviewed during the CSAC's meeting in November. The complete draft report and supplemental materials are available on the project webpage.

Background

Over the past decade, there have been increasing efforts to change the healthcare paradigm from one that identifies persons as passive recipients of care to one that empowers individuals to participate actively in their care.[1-3] Healthcare treatments can be tailored to individual patients in terms of patient preferences and individual clinical factors when the patient voice is captured as part of routine care. Capturing patient experience and evaluating patient function are two important components of patient-centered measurement.[4] The Centers for Medicare & Medicaid Services (CMS) Meaningful Measures Initiative includes the identification of measures that capture patients' experiences with clinicians and providers—one of 19 measurement areas for focusing our healthcare quality improvement efforts as a country.[5] This falls under the measurement priority associated with strengthening person and family engagement as partners in their care. Ensuring that each person and family is engaged within a care partnership is critical to achieving better patient outcomes.[6]

Patient Experience and Function (PEF) is a National Quality Forum (NQF) measure topic area encompassing patient functional status, satisfaction, and experience of care, as well as issues related to care coordination. Central to the concepts associated with patient experience with their overall care is the patient's health-related quality of life and many factors that influence it, including communication, care coordination, transitions of care, and use of health information technology.[7-9]

The care coordination measures within the Committee portfolio represent a fundamental component for the success of this integrated approach, providing a multidimensional framework that spans the continuum of care and ensures quality care, better patient experiences, and more meaningful outcomes.[10-12] Well-coordinated care encompasses effective communication between patients, caregivers, and providers, and facilitates linkages between communities and healthcare systems. It also ensures that accountable structures and processes are in place for communication and integration of comprehensive plans of care across providers and settings that align with patient and family preferences and goals.[13-15]

The NQF PEF Committee was established to evaluate measures within this topic area for NQF endorsement. NQF has endorsed over 50 measures addressing patient experience of care, patient functional status, mobility and self-care, shared decision making, patient activation, and care coordination. The majority of the measures within this portfolio are patient-reported outcomes performance measures.

Draft Report

The Patient Experience and Function Fall 2019, Track 1 draft report presents the results of the evaluation of one measure considered under the Consensus Development Process (CDP). One measure is recommended for endorsement.

The measures were evaluated against the 2019 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	1	0	1
Measures recommended for endorsement	1	0	1

CSAC Action Required

Pursuant to the CDP, the CSAC is asked to consider endorsement of one candidate consensus measure.

Measures Recommended for Endorsement

- NQF 0425 Functional Status Change for Patients with Low Back Impairments (Focus on Therapeutic Outcomes (FOTO))

Overall Suitability for Endorsement: Yes-17; No-2

Comments and Their Disposition

NQF did not receive comments pertaining to the draft report or to the measures under consideration.

Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. NQF did not receive any expressions of support.

References

[1] CMS. *Medicare Beneficiary Characteristics.* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Medicare_Beneficiary_Characteristics. Last accessed February 2020.

[2] United Health Foundation. America's Health Rankings website. https://www.americashealthrankings.org/explore/senior/measure/hospital_readmissions_sr/state/ALL. Last accessed February 2020.

[3] Institute of Medicine Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, eds. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary.* Washington, DC: National Academies Press; 2010.

[4] Agency for Healthcare Research and Quality (AHRQ). Priorities of the national quality strategy website. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/priorities.html. Last accessed February 2020.

[5] Centers for Medicare & Medicaid Services. Meaningful Measures Hub website. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page#Measurement_Areas. Last accessed February 2020.

[6] Frandsen BR, Joynt KE, Rebitzer JB, et al. Care fragmentation, quality, and costs among chronically ill patients. *AJMC.* 2015; 21(5):355-362.

[7] Schultz EM, Pineda N, Lonhart J, et al. A systematic review of the care coordination measurement landscape. *BMC Health Serv Res*. 2013;13:119.

[8] Rosenthal MB, Alidina S, Friedberg MW, et al. A difference-in-difference analysis of changes in quality, utilization and cost following the Colorado multi-payer patient-centered medical home pilot. *J of Gen Intern Med*. 2016;31(3):289-296.

[9] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *New Engl J Med*. 2009;360(14):1418-1428.

[10] Tricco AC, Antony J, Ivers NM, et al. Effectiveness of quality improvement strategies for coordination of care to reduce use of health care services: a systematic review and meta-analysis. *CMAJ*. 2014;186(15):E568-578.

[11] Turchi RM, Antonelli RC, Norwood KW Jr, et al. Patient-and family-centered care coordination: a framework for integrating care for children and youth across multiple systems. *Pediatrics*. 2014;133(5):e1451-e1460.

[12] Pronovost P, Weast B, Schwarz M, et al. Medication reconciliation: a practical tool to reduce the risk of medication errors. *J Crit Care.* 2003;18(4):201-205.

[13] Gnanasakthy A, Mordin M, Evans E, et al. A review of patient-reported outcome labeling in the United States (2011-2015). *Value Health.* 2017;20(3):420-429.

[14] Shay LA, Lafata JE. Where is the evidence? A systematic review of shared decision making and patient outcomes. *Med Decis Making*. 2015;35(1):114-131.

[15] Berkowitz SA, Parashuram S, Rowan K, et al. Johns Hopkins Community Health Partnership (J-CHiP) Team. Association of a care coordination model with health care costs and utilization: the Johns Hopkins Community Health Partnership (J-CHiP). *JAMA Netw Open*. 2018;1(7): e184273.

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	Yes	The Committee observed that there are several related measures to this metric that Focus on Therapeutic Outcomes (FOTO) has developed but did not consider these measures to be competing.
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Measures Not Recommended for Endorsement

Not applicable.

Appendix C: NQF Member Expression of Support Results

No NQF expressions of member support received.

Appendix D: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measures Recommended

0425 Functional Status Change for Patients with Low Back Impairments

Submission | Specifications

Description: This is a patient-reported outcome performance measure (PRO-PM) consisting of an item response theory-based patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14 years and older with low back impairments. The change in FS is assessed using the Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. Scores are reported on a 0 to 100 continuous scale with higher scores indicating better FS. The Low Back FS PROM maps to the Mobility and Self-care constructs within the Activities and Participation domain of the International Classification of Functioning, Disability and Health.

Numerator Statement: The numerator is based on residual scores (actual change scores - predicted change after risk adjustment) of patients receiving care for Low Back impairments and who completed the Low Back PRO-PM.

The numerator, as it applies to the 3 levels, is defined as follows:

Patient Level: The residual functional status score for the individual patient with a low back impairment.

Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12-month time period for a low back impairment.

Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12-month time period for a low back impairment.

Denominator Statement: The target population is all patients 14 years and older with a Low Back impairment who have initiated an episode of care and completed the Low Back FS PROM.

Exclusions: Patients who are not being treated for a Low Back impairment.

Patients who are less than 14 years of age.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Outpatient Services

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: Focus on Therapeutic Outcomes, Inc

STANDING COMMITTEE MEETING 02/12/2020, 02/26/2020

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Pass-19; No Pass-2**; 1b. Performance Gap: **H-2; M-13; L-1; I-3**

Rationale:

- The Committee noted that the developer analyzed the relationship between their measure's score at discharge (the outcome) compared to the clinical process of administering the PROM assessment within the first two weeks of patient care.
- The Committee discussed how the developer used three quality categories as well as deciles for clinicians and clinics to demonstrate performance gap.
    - The Committee noted that there was a significant performance spread.
    - Difference in mean residual scores between the 1st and 10th decile for clinicians and clinics also showed a range of performance scores.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

0425 Functional Status Change for Patients with Low Back Impairments

2a. Reliability: **Yes-17; N-2**; 2b. Validity: **H-7; M-10; L-1; I-1**

Rationale:

- This measure was deemed complex and was evaluated by the SMP.
  - Vote for reliability – High (H-3, M-1, L-0, I-1)
  - Vote for validity – High (H-4, M-1, L-0, I-0)
- Committee members did not express concerns related to the reliability of the measure.
- Committee comments showed some validity concerns on specification and subjectivity of patient response
- The Committee expressed some additional validity concerns related to patients who are younger than 18 years of age.
  - The Committee noted that the developer examined the measure for patients who are 14-17 years old and performed several analyses to determine if the risk adjustment model fit that age demographic as well.
  - Age was also noted as a covariate within the risk model.

3. Feasibility: H-11; M-6; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee noted that there are costs to access the FOTO platform.
- The developer noted that the measure is free to use; it is FOTO's services that are not.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-16; No Pass-3** 4b. Usability: **H-3; M-14; L-0; I-0**

Rationale:

- The Committee noted that the measure is used in a variety of accountability applications with good measure feedback.
- The Committee also noted improvement over time and no significant unintended consequences.

5. Related and Competing Measures

- The Committee noted several related endorsed FOTO measures related to functional status, but none that were considered to compete with this measure.

6. Standing Committee Recommendation for Endorsement: **Yes-17; No-2**

- The Committee recommended this measure for continued endorsement.

7. Public and Member Comment

- No comments were received during the public commenting period.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

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Patient Experience and Function Fall 2019 Review Cycle

CSAC Review and Endorsement

July 28 -29, 2020

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Standing Committee Recommendations

- Two measures reviewed for Fall 2019
  - No measures reviewed by the Scientific Methods Panel
- One measure recommended for endorsement
  - NQF 0425 Functional Status Change for Patients with Low Back Impairments
- One measure deferred to Spring 2020 due to COVID-19 extended commenting periods
  - NQF 0291 Emergency Transfer Communication Measure

Public and Member Comment and Member Expressions of Support

- No comments received
- No NQF member expressed support or concern for the measure

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Timeline and Next Steps

Process Step	Timeline
CSAC Endorsement Meeting	July 28 – 29, 2020
Appeals Period	August 3 – September 1, 2020

Questions?

- Project team:
  - Samuel Stolpe, PharmD, MPH, Senior Director
  - Oroma Igwe, MPH, Manager
  - Yemsrach Kidane, PMP, Project Manager
  - Udobi Onyeuku, MSHA, Analyst

- Project webpage: http://www.qualityforum.org/Project_Pages/Patient_Experience_and_Function.aspx

- Project email address: patientexperience@qualityforum.org

THANK YOU.

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Patient Experience and Function, Fall 2019 Cycle Track 1: CDP Report

DRAFT REPORT FOR CSAC REVIEW
JULY 28, 2020

This report is funded by the Department of Health and Human Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001

http://www.qualityforum.org

Contents

Executive Summary

Over the past decade, there have been increasing efforts to change the healthcare paradigm from one that identifies persons as passive recipients of care to one that empowers individuals to participate actively in their care.[1-3] Healthcare treatments can be tailored to individual patients in terms of patient preferences and individual clinical factors when the patient voice is captured as part of routine care. Capturing patient experience and evaluating patient function are two important components of patient-centered measurement.[4] The Centers for Medicare & Medicaid Services (CMS) Meaningful Measures Initiative includes the identification of measures that capture patients' experiences with clinicians and providers—one of 19 measurement areas for focusing our healthcare quality improvement efforts as a country.[5] This falls under the measurement priority associated with strengthening person and family engagement as partners in their care. Ensuring that each person and family is engaged within a care partnership is critical to achieving better patient outcomes.[6]

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The care coordination measures within the Committee portfolio represent a fundamental component for the success of this integrated approach, providing a multidimensional framework that spans the continuum of care and ensures quality care, better patient experiences, and more meaningful outcomes.[10-12] Well-coordinated care encompasses effective communication between patients, caregivers, and providers, and facilitates linkages between communities and healthcare systems. It also ensures that accountable structures and processes are in place for communication and integration of comprehensive plans of care across providers and settings that align with patient and family preferences and goals.[13-15]

The NQF PEF Committee was established to evaluate measures within this topic area for NQF endorsement. NQF has endorsed over 50 measures addressing patient experience of care, patient functional status, mobility and self-care, shared decision making, patient activation, and care coordination. The majority of the measures within this portfolio are patient-reported outcomes performance measures.

During this cycle, the Committee's discussion remained primarily focused on the measures under consideration for maintenance review, but this led to broader measurement discussions related to NQF evidence and scientific acceptability submission requirements. During the discussion of the scientific acceptability of the measures considered for maintenance of endorsement, the Committee noted an important dependence of score-level reliability upon strong data element-level reliability. They also noted an important distinction between outcome measures and other measure types as it pertains to the evidence submission requirement and discussed when it may be necessary to grant an exception to evidence for non-outcome measures.

Due to circumstances around the COVID-19 global pandemic, commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered into one of two tracks:

Track 1: measures continuing its review in Fall 2019 Cycle:

Recommended for Endorsement

- **NQF 0425** Functional Status Change for Patients with Low Back Impairments

Track 2: measures deferred to Spring 2020 Cycle:

- **NQF 0291** Emergency Transfer Communication Measure

This report contains details of the evaluation of measures assigned to *Track 1* and are continuing in the Fall 2019 cycle. The detailed evaluation summary of measures assigned to *Track 2* and deferred to the Spring 2020 cycle will be included in a subsequent report. Brief summaries of the Fall 2019 *Track 1* measures currently under review are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

Patient experience, function, and coordination of care are key elements to patient-centered measurement. Patient-centered measurement aids in the delivery of high-quality care that aims to engage patients and families, leading to improved health outcomes, better patient and family experiences, and lower costs. The implementation of patient-centered measures is one of the most important approaches to ensure that the healthcare that Americans receive reflects the goals, preferences, and values of care recipients. Patient- and family-engaged care is planned, delivered, managed, and continually improved in active partnership with patients and their families (or care partners as defined by the patient) to ensure integration of their health and healthcare goals, preferences, and values.[16] As such, effective engaged care must adapt readily to individual and family circumstances, as well as differing cultures, languages, disabilities, health literacy levels, and socioeconomic backgrounds.[4]

The coordination of care is an essential component to the improvement of patient experiences and outcomes. Poorly coordinated and fragmented care not only compromises the quality of care patients receive, but may also lead to negative, unintended consequences, including medication errors and preventable hospital admissions.[7] For patients living with multiple chronic conditions—including more than two-thirds of Medicare beneficiaries—poor care transitions between different providers can contribute to poor outcomes and hospitalizations.[1] Nearly 15 percent of Medicare beneficiaries discharged from the hospital are readmitted within 30 days, with half of the patients not having yet seen an outpatient doctor for follow-up, and most of these readmissions occur through an emergency department (ED).[2,9] The existing evidence suggests that care in the U.S. is largely uncoordinated, even though evidence also suggests that quality improvement strategies within care can improve performance.[11] Care coordination is positively associated with patient- and family-reported receipt of family-centered care, resulting in greater satisfaction with services, lower financial burden, and fewer ED visits.[1,3,6,12,15]

A variety of tools and approaches can promote effective patient-provider communication, increase coordination of care, and improve patient experience and engagement. Electronic health records (EHRs) and interoperable health information can ensure that current and useful information follows the patient and is available across every setting and at each health interaction, which in turn reduces unnecessary and costly duplication of patient services. Patient education and the reconciliation of medication lists can also reduce costs by decreasing the number of serious medication events.[13] Shared decision making has been shown to promote better outcomes for patients and to support patients in choosing less costly, more effective interventions.[14,15] Innovative care models such as patient-centered medical homes (PCMHs), which invest in care coordination infrastructure, have led to sustained decreases in the number of ED and primary care visits.[16]

NQF Portfolio of Performance Measures for Patient Experience and Function

The Patient Experience and Function Standing Committee (Appendix C) oversees NQF's portfolio of Patient Experience and Function measures (Appendix B) that includes measures for functional status, communication, shared decision making, care coordination, patient experience, and long-term services

and supports. This portfolio contains 51 measures: three process measures, one composite measure, and 47 outcome measures, of which 29 are patient-reported outcome performance measures (see table below).

Table 1. NQF Patient Experience and Function Portfolio of Measures

	Process	Outcome/Patient-Reported Outcome	Composite
Functional status change and assessment	1	23	-
Shared decision making	–	3	-
Care coordination	2	5	-
Patient experience	–	12	1
Long-term services and supports	–	4	-
Total	3	47	1

The remaining measures have been assigned to other portfolios. These include healthcare-associated infection measures (Patient Safety), care coordination measures (Geriatrics and Palliative Care), imaging efficiency measures (Cost and Resource Use), and a variety of condition- or procedure-specific outcome measures (Cardiovascular, Cancer, Renal, etc.).

Patient Experience and Function Measure Evaluation

On February 12 and February 26, 2020, the Patient Experience and Function Standing Committee evaluated two measures undergoing maintenance review against NQF's standard measure evaluation criteria. The Committee did not achieve quorum during the February 26 meeting and therefore voted asynchronously following the meeting. One measure was assigned to *Track 1* and is continuing in the Fall 2019 cycle. The detailed evaluation summary of the one measure assigned to *Track 2* and deferred to the Spring 2020 cycle will be included in a subsequent report.

Table 2. Patient Experience and Function Measure Evaluation Summary – Track 1

	Maintenance	New	Total
Measures under consideration	1	0	1
Measures recommended for endorsement	1	0	1

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on March 26, 2019 and closed on May 24, 2020. No comments were submitted and shared with the Committee prior to the measure evaluation meetings (Appendix F).

Comments Received After Committee Evaluation

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: Measures Continuing in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations will move forward to the CSAC for review and discussion during its meeting on July 28-29.

- **Exceptions**
  Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures requiring further action or discussion from a Standing Committee were deferred to the Spring 2020 cycle. This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review will retain endorsement during that time.

During the Fall 2019 CSAC meeting on July 28-29, the Consensus Standards Approval Committee (CSAC) will review all measures assigned to Track 1. A list of measures assigned to Track 2 can be found in the Executive Summary section of this report for tracking purposes, but these measures will be reviewed by CSAC on November 17 and 18, 2020.

The extended public commenting period with NQF member support closed on May 24, 2020. Following the Committee's evaluation of the measures under consideration, NQF did not receive any comments from organizations and individuals pertaining to the draft report and to the measure under consideration.

Throughout the extended public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided their expression of support.

Summary of Measure Evaluation: Fall 2019 Measures, Track 1

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

0425 Functional Status Change for Patients with Low Back Impairments (Focus on Therapeutic Outcomes, Inc): Recommended

Description: This is a patient-reported outcome performance measure (PRO-PM) consisting of an item response theory-based patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14 years and older with low back impairments. The change in FS is assessed using the Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. Scores are reported on a 0 to 100 continuous scale, with higher scores indicating better FS. The Low Back FS PROM maps to the Mobility and Self-care constructs within the Activities and Participation domain of the International Classification of Functioning, Disability and Health. **Measure Type**: Outcome: PRO-PM; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Instrument-Based Data

The Standing Committee recommended the measure for continued endorsement. The Committee observed that this patient-reported outcome performance measure is risk-adjusted. Originally endorsed in 2008, and most recently endorsed in 2015, the focus of the measure concerns patients who are receiving physical therapy. The Committee agreed that this is an important focus area of measurement. Concerning the evidence criterion, the Committee determined that an interim assessment serves as a structure, process, service, or intervention that a measured entity could deploy to improve their performance on the measure. The Committee observed that there is an appropriate measure performance gap and did not express any concerns. The Committee noted that this measure has been evaluated by the Scientific Methods Panel (SMP) and was given high ratings for both reliability and validity. However, the Committee expressed some concern related to patients who are younger than 18 years of age. The Committee noted that the developer examined the measure for patients who are 14-17 years old and performed several analyses to determine if the risk adjustment model fit that age demographic as well. Age was also noted as a covariate within the risk model. The measure was regarded as feasible by the Committee, with no concerns. In their discussions related to usability and use, the Committee noted that the measure is used in a variety of accountability applications with good measure feedback. The Committee also noted improvement over time and no significant unintended consequences. The Committee observed that there are several related measures to this metric that

Focus on Therapeutic Outcomes (FOTO) has developed but did not consider these measures to be competing.

References

[1] CMS. *Medicare Beneficiary Characteristics.* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Medicare_Beneficiary_Characteristics. Last accessed February 2020.

[2] United Health Foundation. America's Health Rankings website. https://www.americashealthrankings.org/explore/senior/measure/hospital_readmissions_sr/state/ALL. Last accessed February 2020.

[3] Institute of Medicine Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, eds. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary.* Washington, DC: National Academies Press; 2010.

[4] Agency for Healthcare Research and Quality (AHRQ). Priorities of the national quality strategy website. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/priorities.html. Last accessed February 2020.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Track 1 – Measures Recommended

0425 Functional Status Change for Patients with Low Back Impairments

Submission | Specifications

Description: This is a patient-reported outcome performance measure (PRO-PM) consisting of an item response theory-based patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14 years and older with low back impairments. The change in FS is assessed using the Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. Scores are reported on a 0 to 100 continuous scale with higher scores indicating better FS. The Low Back FS PROM maps to the Mobility and Self-care constructs within the Activities and Participation domain of the International Classification of Functioning, Disability and Health.

Numerator Statement: The numerator is based on residual scores (actual change scores - predicted change after risk adjustment) of patients receiving care for Low Back impairments and who completed the Low Back PRO-PM.

The numerator, as it applies to the 3 levels, is defined as follows:

Patient Level: The residual functional status score for the individual patient with a low back impairment.

Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12-month time period for a low back impairment.

Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12-month time period for a low back impairment.

Denominator Statement: The target population is all patients 14 years and older with a Low Back impairment who have initiated an episode of care and completed the Low Back FS PROM.

Exclusions: Patients who are not being treated for a Low Back impairment.

Patients who are less than 14 years of age.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Outpatient Services

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: Focus on Therapeutic Outcomes, Inc

STANDING COMMITTEE MEETING 02/12/2020, 02/26/2020

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Pass-19; No Pass-2**; 1b. Performance Gap: **H-2; M-13; L-1; I-3**

Rationale:

- The Committee noted that the developer analyzed the relationship between their measure's score at discharge (the outcome) compared to the clinical process of administering the PROM assessment within the first two weeks of patient care.
- The Committee discussed how the developer used three quality categories as well as deciles for clinicians and clinics to demonstrate performance gap.
    - The Committee noted that there was a significant performance spread.
- Difference in mean residual scores between the 1st and 10th decile for clinicians and clinics also showed a range of performance scores.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

0425 Functional Status Change for Patients with Low Back Impairments

2a. Reliability: **Yes-17; N-2**; 2b. Validity: **H-7; M-10; L-1; I-1**

Rationale:

- This measure was deemed complex and was evaluated by the SMP.
  - Vote for reliability – High (H-3, M-1, L-0, I-1)
  - Vote for validity – High (H-4, M-1, L-0, I-0)
- Committee members did not express concerns related to the reliability of the measure.
- Committee comments showed some validity concerns on specification and subjectivity of patient response
- The Committee expressed some additional validity concerns related to patients who are younger than 18 years of age.
  - The Committee noted that the developer examined the measure for patients who are 14-17 years old and performed several analyses to determine if the risk adjustment model fit that age demographic as well.
  - Age was also noted as a covariate within the risk model.

3. Feasibility: H-11; M-6; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee noted that there are costs to access the FOTO platform.
- The developer noted that the measure is free to use; it is FOTO's services that are not.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-16; No Pass-3** 4b. Usability: **H-3; M-14; L-0; I-0**

Rationale:

- The Committee noted that the measure is used in a variety of accountability applications with good measure feedback.
- The Committee also noted improvement over time and no significant unintended consequences.

5. Related and Competing Measures

- The Committee noted several related endorsed FOTO measures related to functional status, but none that were considered to compete with this measure.

6. Standing Committee Recommendation for Endorsement: **Yes-17; No-2**

- The Committee recommended this measure for continued endorsement.

7. Public and Member Comment

- No comments were received during the public commenting period.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X (July 28-29, 2020): [Endorsed or Not Endorsed])

The CSAC upheld [or did not uphold] the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

Appendix B: Patient Experience and Function Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	• Merit-based Incentive Payment System (MIPS) Program (Implemented) Physician Compare (Implemented)
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)	• Medicaid (Implemented)
0166	HCAHPS	• Hospital Compare (Implemented) • Hospital Inpatient Quality Reporting (Implemented) • Hospital Value-Based Purchasing (Implemented) • Prospective Payment System-Exempt Cancer Hospital Quality Reporting (Implemented)
0258	CAHPS In-Center Hemodialysis Survey	• End-Stage Renal Disease Quality Incentive Program (Implemented)
0291	EMERGENCY TRANSFER COMMUNICATION MEASURE	• N/A
0422	Functional status change for patients with Knee impairments	• Merit-based Incentive Payment System (MIPS) Program (Implemented)
0423	Functional status change for patients with Hip impairments	• Merit-based Incentive Payment System (MIPS) Program (Implemented)
0424	Functional status change for patients with Foot and Ankle impairments	• Merit-based Incentive Payment System (MIPS) Program (Implemented)
0425	Functional status change for patients with lumbar impairments	• Merit-based Incentive Payment System (MIPS) Program (Finalized)
0426	Functional status change for patients with Shoulder impairments	• Merit-based Incentive Payment System (MIPS) Program (Implemented)
0427	Functional status change for patients with elbow, wrist and hand impairments	• Merit-based Incentive Payment System (MIPS) Program (Implemented)
0428	Functional status change for patients with General orthopedic impairments	• Merit-based Incentive Payment System (MIPS) Program (Implemented)
0517	CAHPS® Home Health Care Survey (experience with care)	• Home Health Quality Reporting (Implemented) • Home Health Value Based Purchasing (Implemented)

[a] Per CMS Measures Inventory Tool as of 1/13/2020

NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	• N/A
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey	• N/A
2286	Functional Change: Change in Self Care Score	• N/A
2287	Functional Change: Change in Motor Score	• N/A
2321	Functional Change: Change in Mobility Score	• N/A
2483	Gains in Patient Activation (PAM) Scores at 12 Months	• N/A
2548	Child Hospital CAHPS (HCAHPS)	• N/A
2612	CARE: Improvement in Mobility	• N/A
2613	CARE: Improvement in Self Care	• N/A
2614	CoreQ: Short Stay Discharge Measure	• N/A
2615	CoreQ: Long-Stay Resident Measure	• N/A
2616	CoreQ: Long-Stay Family Measure	• N/A
2631	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	• Long-Term Care Hospital Quality Reporting (Implemented)
2632	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	• Long-Term Care Hospital Quality Reporting (Implemented)
2633	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	• Inpatient Rehabilitation Facility Quality Reporting (Implemented)
2634	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	• Inpatient Rehabilitation Facility Quality Reporting (Implemented)

NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
2635	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	• Inpatient Rehabilitation Facility Quality Reporting (Implemented)
2636	Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	• Inpatient Rehabilitation Facility Quality Reporting (Implemented)
2643	Average change in functional status following lumbar spine fusion surgery	• Merit-based Incentive Payment System (MIPS) Program (Finalized)
2653	Average change in functional status following total knee replacement surgery	• Merit-based Incentive Payment System (MIPS) Program (Finalized)
2769	Functional Change: Change in Self Care Score for Skilled Nursing Facilities	• N/A
2774	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	• N/A
2775	Functional Change: Change in Motor Score for Skilled Nursing Facilities	• N/A
2776	Functional Change: Change in Motor Score in Long Term Acute Care Facilities	• N/A
2777	Functional Change: Change in Self Care Score for Long Term Acute Care Facilities	• N/A
2778	Functional Change: Change in Mobility Score for Long Term Acute Care Facilities	• N/A
2958	Informed, Patient Centered (IPC) Hip and Knee Replacement Surgery	• N/A
2962	Shared Decision-Making Process	• Medicare Shared Savings Program (Implemented)
2967	CAHPS® Home- and Community-Based Services Measures	• Medicaid (Implemented)
3227	CollaboRATE Shared Decision-Making Score	• N/A
3420	CoreQ: AL Resident Satisfaction Measure	• N/A
3422	CoreQ: AL Family Satisfaction Measure	• N/A
3455	Timely Follow-Up After Acute Exacerbations of Chronic Conditions	• N/A
3461	Functional Status Change for Patients with Neck Impairments	• Merit-Based Incentive Payment System (MIPS) Program (Finalized)

NQF #	Title	Federal Programs: Finalized or Implemented as of January 13, 2020
3477	Discharge to Community-Post Acute Care Measure for Home Health Agencies	• N/A
3479	Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities	• Inpatient Rehabilitation Facility Quality Reporting (Implemented)
3480	Discharge to Community-Post Acute Care Measure for Long-Term Care Hospitals	• Long-Term Care Hospital Quality Reporting (Implemented)
3481	Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities	• Skilled Nursing Facility Quality Reporting (Implemented)

Appendix C: Patient Experience and Function Standing Committee and NQF Staff

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Appendix D: Measure Specifications

	0425 Functional Status Change for Patients with Low Back Impairments
Steward	Focus on Therapeutic Outcomes, Inc
Description	This is a patient-reported outcome performance measure (PRO-PM) consisting of an item response theory-based patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients aged 14 years and older with low back impairments. The change in FS is assessed using the Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality. Scores are reported on a 0 to 100 continuous scale with higher scores indicating better FS. The Low Back FS PROM maps to the Mobility and Self-care constructs within the Activities and Participation domain of the International Classification of Functioning, Disability and Health.
Type	Outcome: PRO-PM
Data Source	Instrument-Based Data The data source is the Focus on Therapeutic Outcomes measurement and reporting system. The instruments are the Low Back FS PROM and risk adjustment questions (as described in the measure Testing Form). A patient completes the FS PROM and respond to risk adjustment questions at the start of an episode of care. The patient again responds to the FS PROM, at a minimum, at or near the time of discharge from the episode of care. The Low Back FS PROM may be administered via computer adaptive testing (CAT) or a 10-item short form (static/paper-pencil). CAT administration is preferred as it reduces patient response burden by administrating the minimum number of items needed to achieve the targeted measurement accuracy. The components needed to complete NQF 0425 are publicly available on the FOTO website at no charge. Proxy and Recorder modes of administration are described above in section S.15. Sampling.
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Outpatient Services
Numerator Statement	The numerator is based on residual scores (actual change scores - predicted change after risk adjustment) of patients receiving care for Low Back impairments and who completed the Low Back PRO-PM. The numerator, as it applies to the 3 levels, is defined as follows: Patient Level: The residual functional status score for the individual patient with a low back impairment. Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12-month time period for a low back impairment. Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12-month time period for a low back impairment.
Numerator Details	Patient Level: The residual score for the individual patients with low back impairments is derived by applying the statistical risk adjustment model described in S.10 and applying steps 1-5 as described in S.14. Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12-month time period for low back impairment. Average scores are calculated for all clinicians, but performance is evaluated only for those clinicians that had a minimum of 10 patients in the previous 12 months to maximize stability of the benchmarking estimates. The score is derived by applying steps 1-6 as described in S.14. Clinic Level: The average of residuals in functional status scores in patients who were treated within a clinic in a 12-month time period for lumbar impairments. Average scores are calculated for all clinics, but performance is evaluated only for large clinics (5 or more

	0425 Functional Status Change for Patients with Low Back Impairments
	clinicians) that had a minimum of 40 patients, and small clinics (1-4 clinicians) that had a minimum of 10 patients per clinician, in the previous 12 months to maximize stability of the benchmarking estimates. The score is derived by applying steps 1-6 as described in S.14. Items and response options are provided in the attachment in section S.2c. above.
Denominator Statement	The target population is all patients 14 years and older with a Low Back impairment who have initiated an episode of care and completed the Low Back FS PROM.
Denominator Details	The ICD-10 codes relevant for this measure are: G54.1, G54.4, G57.0, M43.06, M43.07, M43.08, M43.16, M43.17, M43.18, M43.26, M43.27, M43.28, M43.5X6 , M43.5X7, M43.5X8, M43.8X6, M43.8X7, M43.8X8, M45.6, M45.7, M45.8 M46.1, M46.46, M46.47, M46.48, M47.16, M47.26, M47.27, M47.28, M47.816, M47.817, M47.896, M47.897, M47.898, M48.06, M48.07, M51.06, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.46, M51.47, M51.86, M51.87, M51.9, M53.2X6, M53.2X7, M53.2X8, M53.88, M54.16, M54.17, M54.18, M54.3, M54.4, M54.5, M99.73, S32.0, S32.1, S32.2, S33.0, S33.1, S33.2, S33.3, S33.5, S33.10, S33.11, S33.12, S33.13, S39.002, S39.012
Exclusions	Patients who are not being treated for a Low Back impairment. Patients who are less than 14 years of age.
Exclusion details	NA
Risk Adjustment	Statistical risk model
Stratification	This measure is risk-adjusted, not risk-stratified. The methods used to develop the FOTO risk-adjustment Low Back model were the same as the methods described in detail in a recent publication by Deutscher et at, 2018 [Deutscher, D., Werneke, M. W., Hayes, D., Mioduski, J. E., Cook, K. F., Fritz, J. M., et al. (2018). Impact of Risk Adjustment on Provider Ranking for Patients with Low Back Pain Receiving Physical Therapy. J Orthop Sports Phys Ther, 48(8), 637-648] Briefly, we used data from adult patients with Low Back pain treated in outpatient rehabilitation clinics during 2014-2016, that had complete outcomes data at admission and discharge, to develop the risk-adjustment model. The data included the following patient factors that could be evaluated for inclusion in a model for risk-adjustment: FS at admission (continuous); age (continuous); sex (male/female); acuity as number of days from onset of the treated condition (6 categories); type of payer (10 categories); number of related surgeries (4 categories); exercise history (3 categories); use of medication at intake for the treatment of LBP (yes/no); previous treatment for LBP (yes/no); treatment post-surgery (low back fusion, laminectomy or other); and 31 comorbidities. For further details, please see Measure Testing Form section 2b3. Risk Adjustment/Stratification for Outcome or Resource Use Measures. The model variables and coefficients are contained in the document attached above in section S.2b. Data Dictionary, Code Table, or Value Sets.
Type Score	Continuous variable, e.g. average better quality = higher score
Algorithm	DEFINITIONS: Patient's Functional Status Score. A Functional Status (FS) Score is produced when the patient completes the FOTO Low Back FS PROM administered via computer adaptive testing or short form. Patient's FS Change Score. An FS Change Score is calculated by subtracting the Patient's FS Score at the Initial Evaluation (i.e., the start of the care episode) from the Patient's FS Score at Discharge (i.e., the end of the care episode). Predicted FS Change Score. FS Change Scores for patients are risk adjusted with a model developed using multiple linear regression methods that account for the following independent variables: Patient's FS Score at Initial Evaluation, patient age, symptom acuity, surgical history, gender, specific co-morbidities, payer type, use of medication for the low

	0425 Functional Status Change for Patients with Low Back Impairments
	back impairment at Initial Evaluation, previous treatment for the low back impairment, exercise history, and post-surgical category if applicable. The Patient's FS Change Score is the dependent variable. The statistical regression method provides a set of coefficients that accounts ("adjusts") for the association of each variable with the FS outcome as it applies to each patient, resulting in a risk-adjusted Predicted FS Change Score. Residual Score: The Residual Score is calculated as the difference between the actual change and risk-adjusted predicted change scores and should be interpreted as the unit of FS change different than predicted given the risk-adjustment variables of the patient being treated. As such, the risk-adjusted Residual change score represents risk-adjusted change corrected for patient characteristics. Risk-adjusted Residual change scores of zero (0) or greater (>0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient. Risk-adjusted residual change scores less than zero (<0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Residual Scores: The average of Residual scores of FS (actual change - predicted change after risk adjustment) from a provider (clinician or clinic). The aggregated scores are used to make comparisons between clinicians or clinics. STEPS TO CALCULATE THE PRO-PM SCORE, APPLYING THE ABOVE DEFINITIONS: Patient level measures use steps 1-5. Clinician and clinic level measures use steps 1-6. 1) The patient is identified as age 14 or older and presenting for an episode of care for a low back impairment and completing the FOTO Low Back FS PROM which generates the Patient's FS Score at Initial Evaluation. 2) The patient completes the FOTO Low Back FS PROM at or near Discharge, which generates the Patient's FS Score at Discharge. 3) The Patient's FS Change Score (raw, non-risk-adjusted) is generated. 4) A Predicted FS Change Score is generated for the patient using the risk-adjustment model. 5) A Residual Score is generated for the patient. 6) The average Residual Scores per clinician and/or clinic are calculated, and scores for all clinicians/clinics in the database are ranked. The quality score is the percentile of the clinician and/or clinic ranking. The quality scores and its 95% CI can be compared to the benchmark (a score of zero) to determine if the performance is below, at, or above the predicted average. FOTO recommends that clinicians have a minimum of 10 patients/year and clinics have a minimum of 10 patients/therapist per year for small clinics or 40 patients per year for larger clinics (5 or more clinicians) in order to obtain stable estimates of provider performance. 108114| 131447| 109921| 145733| 141015
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Appendix E: Related and Competing Measures

No related and competing measures identified.

Appendix F: Pre-Evaluation Comments

No NQF member comments were received during the pre-commenting period.

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