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Patient Experience and Function Spring 2020 Measure Review Cycle

Post-Comment Standing Committee Meeting

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September 17, 2020

Welcome

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Welcome

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Project Team — Patient Experience and Function Committee

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Agenda

- Attendance
- Review and Discuss Public Comments
- NQF Member and Public Comment
- Next Steps
- Adjourn

Attendance

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Patient Experience and Function Spring 2020 Cycle Standing Committee

- **Gerri Lamb**, PhD, RN, FAAN (Co-chair)
- **Christopher Stille**, MD, MPH, FAAP(Co-chair)
- **Richard Antonelli**, MD, MS
- **Adrienne Boissy**, MD, MA
- **Donald Casey**, MD, MPH, MBA, FACP, FAHA, FAAPL, DFACMQ
- **Ariel Cole**, MD*
- **Ryan Coller**, MD, MPH
- **Sharon Cross**, LISW-S
- **Christopher Dezii**, MBA, RN, CPHQ
- **Shari Erickson**, MPH
- **Dawn Hohl**, RN, BSN, MS, PhD
- **Sherri Kaplan**, PhD, MPH
- **Brenda Leath**, MHSA, PMP
- **Brian Lindberg**, BSW, MMHS
- **Lisa Morrise**, MA
- **Randi Oster**, MBA*
- **Charissa Pacella**, MD
- **Lenard Parisi**, RN, MA, CPHQ, FNAHQ
- **Debra Saliba**, MD, MPH
- **Ellen Schultz**, MS (Inactive)
- **Lisa Suter**, MD
- **Peter Thomas**, JD
- **Tracy Wong**, MBA*

Review and Discuss Public Comments

2614 CoreQ: Short Stay Discharge Measure

- **Measure Steward:** AHCA/NCAL
  - Maintenance measure
- **Brief Description of Measure:**
  - The measure calculates the percentage of individuals discharged in a six-month time period from a SNF, within 100 days of admission, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items.
- **Summary of Comments Received:** 3 comments Received
  - Intended use and inquiry concerning the relationship with CAHPS measures
  - Concerns with exclusions and testing of CoreQ scoring

See Appendix A, items 1 - 3 for full comments

2615 CoreQ: Long-Stay Resident Measure

- **Measure Steward:** American Health Care Association
  - Maintenance measure
- **Brief Description of Measure:**
  - The measure calculates the percentage of long-stay residents, those living in the facility for 100 days or more, who are satisfied (see: S.5 for details of the time-frame). This patient reported outcome measure is based on the CoreQ: Long-Stay Resident questionnaire that is a three-item questionnaire.
- **Summary of Comments Received:** 2 comments received
  - Intended use and inquiry concerning the relationship with CAHPS measures
  - Concerns with testing of CoreQ scoring

See Appendix A, items 1 and 3 for full comments

2616 CoreQ: Long-Stay Family Measure

- **Measure Steward:** AHCA/NCAL
  - Maintenance measure
- **Brief Description of Measure:**
  - 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 (see: S.5 for details of the timeframe). This consumer reported outcome measure is based on the CoreQ: Long-Stay Family questionnaire that has three items.
- **Summary of Comments Received:** 2 comments received
  - Intended use and inquiry concerning the relationship with CAHPS measures

See Appendix A, items 1 and 3 for full comments

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3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

- **Measure Steward:** Centers for Medicare & Medicaid Services (CMS)
  - New measure
- **Brief Description of Measure:**
  - This patient-reported outcome-based performance measure will estimate a hospital-level, risk-standardized improvement rate (RSIR) following elective primary THA/TKA for Medicare fee-for-service (FFS) patients 65 years of age and older. Improvement will be calculated with patient-reported outcome data collected prior to and following the elective procedure. The preoperative data collection timeframe will be 90 to 0 days before surgery and the postoperative data collection timeframe will be 270 to 365 days following surgery.
- **Summary of Comments Received:** 1 comment received (post-evaluation); 1 comment received (pre-evaluation)
  - Feasibility and implementation concerns: cost, administrative burden (providers) & survey fatigue (patients), process for data collection
  - Risk adjustment approach and multi-step inclusion of social risk factors
  - Concerns with the adequacy of Standing Committee discussion for validity and usability

See Appendix A, items 5 and 6 for full comments
See Appendix B, item 1 for Spring 2020 pre-evaluation comment

General Comment on Draft Report Related to NQF

- **Summary of Comments Received:** 2 comments received
  - Adherence to the Consensus Development Process
  - Standing Committee voting process for NQF 2614 – 2616
  - See Appendix A, items 7 and 8 for full comments

Appendix – Full Comments

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Appendix A

Draft Report Member and Public Comments

2614: CoreQ: Short Stay Discharge Measure

2615: CoreQ: Long-Stay Resident Measure

2616: CoreQ: Long-Stay Family Measure

1. I am commenting as a Patient/ Public individual interested and engaged in quality measurement and improvement. I find the 3 QC measures appropriate for use, though would like to add that I have heard on a number of occasions that patient experience does not equal patient satisfaction. Patient satisfaction is the outcome measured in these three measures. Are these designed to be used in place of CAHPS as they are more specific to stays in LTC/SNFs etc.? Family member identified for measurement query might vary as well. One family member might be pleased another not so much, just food for thought.

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Appendix A

Draft Report Member and Public Comments

2614: CoreQ: Short Stay Discharge Measure

2615: CoreQ: Long-Stay Resident Measure

2616: CoreQ: Long-Stay Family Measure

2. The American Geriatrics Society (AGS) wishes to provide comment on Measure 2614. The exclusion of those who are readmitted to acute care, transferred to another skilled nursing facility (SNF) or long-term acute care (LTAC) facility, or remain in an SNF longer than 100 days removes subsets of patients who are more likely to have lower satisfaction with their short term SNF stay. We believe that these exclusions make the current measure less meaningful.

3. The American Geriatrics Society (AGS) wishes to provide comment on Measure 2614-2616. We have reservations about the chosen cut-point for the score as 3 or above. A response of 2 is designated as 'average' in the Core Q questionnaire. We believe that this is not necessarily a negative response and could still indicate satisfaction with care.

Appendix A

Draft Report Member and Public Comments

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

4. As a patient/ public partner engaged in quality improvement my comments are following.

   I find it interesting that #3559 measure did not have an intended use identified pre NQF endorsement phase. It seems to me that having the use case open allows for ease for endorsement though also some might feel that the intended use of measure should be identified in development therefore decreasing opportunities for questions later

   I did appreciate the longevity of time for follow up as in these types of total hip/knee arthroplasty surgeries, the 30/60/90 day outcomes might not reflect actual patient experience of function post surgery that impacts their quality of life. Thank you for this.

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Appendix A

Draft Report Member and Public Comments

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

5. The American Medical Association (AMA) appreciates the opportunity to comment and vote on NQF #3559: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA). The AMA supports the assessment of patient-reported outcomes but believes that the burden of data collection both to the hospital and the patient must be adequately addressed and the continued multi-step approach to risk adjustment must be reconsidered. On review of the draft report, we were unable to find sufficient discussion of the validity and usability of this measure and ask that the Committee reconsider the proposed endorsement of this measure in light of our concerns outlined below. On review of the measure specifications, we note that the information required for the numerator and risk variables includes multiple data elements from additional patient-reported surveys and that these data are expected to be collected between 90 to 0 days prior to surgery. ***Continued***

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Appendix A

Draft Report Member and Public Comments

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

5. *Cont'd.* The AMA supports the inclusion of many of these variables within the risk model given their relevance to how patients may or may not be able to achieve improvement but questions whether the developer (CMS) adequately assessed the feasibility and potential data collection burden both to the hospital and patient. Specifically, the responses to the questions on feasibility do not discuss how the testing sites coordinated data collection across settings or whether the responsibility of the additional items was placed on the hospital.

   This question is particularly important since the specifications require hospitals to collect data for one measure from 90 days pre-operatively to up to one-year post-operative. Perhaps more importantly, we would have liked to see an assessment from the patient's perspective on whether the timing and number of items solicited throughout this process were appropriate and does not result in survey fatigue. For example, if these data were collected on the morning of the surgery, could stress and anxiety have impacted responses or would the number of surveys throughout the pre-, intra-, and post-operative timeframes lead them to be less likely to complete other surveys such as HCAHPS? We believe that it is critical to understand the potential impact and burden that could be experienced. ***Continued***

Appendix A

Draft Report Member and Public Comments

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

5. *Cont'd.* While it may seem reasonable for one measure, if this measure is an example of how future measures could be specified, what is the potential long-term impact on patients and hospitals as more and more patient-reported outcome performance measures are implemented?

   The AMA strongly supports the inclusion of health literacy in the risk model but remains concerned that CMS continues to test social risk factors after the assessment of clinical and demographic risk factors, and it is unclear why this multi-step approach is preferable. On review of the Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors report, [1] it is clear that the approaches to testing these data should be revised to strategies such as multi-level models or testing of social factors prior to clinical factors and that as access to new data becomes available, it may elucidate more differences that are unrelated to factors within a hospital's control. Additional testing that evaluates clinical and social risk factors at the same time or social prior to clinical variables rather than the current approach with clinical factors prioritized should be completed. The AMA believes that additional information on these concerns is needed prior to endorsement of this measure. We respectfully ask the Standing Committee to consider these comments and not recommend the measure for endorsement until they are adequately addressed.

[1] National Quality Forum. *Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors*. Final report. July 18, 2017. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=85635. Last accessed December 18, 2018.

Appendix A

Draft Report Member and Public Comments

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

6. The American Geriatrics Society (AGS) wishes to provide comment on Measure 3559. While this seems like a potentially useful PROM it's unclear how it would be implemented. There should be some consideration given to the amount of time hospital staff would devote to collecting this measure as well as the costs involved, both of which will be borne directly by the hospitals. We suggest that this measure could be replaced by data which hospitals may already be collecting (such as ADLs, IADLs, or pain scores) and therefore do not pose as much of a burden on reporting hospitals.

Appendix A

Draft Report Member and Public Comments

General Comments on the Draft Report

7. The Federation of American Hospitals (FAH) appreciates the opportunity to point out concerns over issues with the Consensus Development Process (CDP) outlined in this report. The FAH submitted comments on NQF #3559 at 9:33 am on June 12, 2020. Per NQF email communications and the web site, any comment received by June 12 would be provided to the Committee for consideration during the measure evaluations on June 23 and 24; yet, the report states on page 7 and in Appendix F that no comments were received as of June 12. The FAH requests that these comments be made available to the Committee for discussion and evaluation on whether the ratings on the measure evaluation criteria should be reconsidered for this measure in light of our concerns.

   In addition, the FAH notes that the votes for evidence, reliability, validity, feasibility, and use and usability were carried forward from NQF #2614 to two additional measures – NQF #2615 and #2616. As the additional measures addressed different populations (patients receiving care in short stay and long stay skilled nursing facilities [SNFs] and caregivers for those receiving care within long stay SNFs) and utilize different surveys to collect the patient-reported outcome data a simple carry forward might be undermining important issues. We understand that the testing approaches and data collection strategies are similar, but the underlying evidence, testing results and potential feasibility and usability of the performance scores are different. To our knowledge, this type of review where votes are carried forward with no discussion is not in alignment with the CDP. The FAH requests clarification on this interpretation of the CDP.

Appendix A

Draft Report Member and Public Comments

General Comments on the Draft Report

8. The American Medical Association (AMA) requests clarification on whether the Consensus Development Process (CDP) was followed correctly during the evaluation of NQF # 2615 and 2616. While we understand that the measures evaluated are from the same developer and use similar specifications and testing approaches, each examines experience of care from different populations and using different survey tools, which therefore yields different testing results and information on the measure's ability to track improvement (usability). For example, measuring experience with care from a caregiver's perspective should be evaluated separately from one that assesses the patient's experience. The evidence should be tailored to the outcome and population of interest. The sampling strategies, testing results, and feasibility of data collection would differ and the usability of the information would likely demonstrate improvement that is unique to the group being measured.

   As a result, we do not believe the Committee's evaluation of these measures are aligned with the CDP by assuming that the underlying evidence, reliability, validity, feasibility, use and usability is similar enough to carry forward votes from NQF #2614 with no discussion. The AMA requests that these concerns be carefully considered as we believe that the integrity of the CDP is in question.

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Appendix B

Pre-evaluation Public and Member Comments

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

1. The Federation of American Hospitals (FAH) appreciates the opportunity to comment on measure #3559, Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA), prior to the Standing Committee's evaluation. The FAH supports the development and implementation of patient-reported outcomes performance measures (PRO-PMs) but we also believe that additional questions and work remain before their widespread use. For instance, the degree to which multiple PRO-PMs could lead to survey fatigue for patients, the potential impact additional PRO-PMs may have on the reporting of well-established measures such as HCAHPs, and what level of data collection burden for an individual PRO-PM is acceptable for a hospital or other healthcare provider.

   Specifically, on review of the measure specifications, the FAH notes that multiple data points beyond the typical clinical variables are required to ensure that the measure results are adequately risk adjusted. The FAH supports the inclusion of these data points but we are concerned that the developer has not provided sufficient information on how these data are collected and what additional workload and time will be required. ***Continued***

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Appendix B

Pre-evaluation Public and Member Comments

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

1. *Cont'd.* For example, several of the data elements needed for risk adjustment are derived from patient-reported surveys, which must be collected within 0-90 days pre-operative. No information was provided on the processes used by the hospitals such as whether it required coordination with orthopedic practices or if the burden of the additional data collection was placed on hospital staff on the day of surgery.

   To what extent did these requirements impact clinical workflows and were additional staff resources required? What additional costs might an individual hospital encounter as a result of implementation of this PRO-PM? Alternatively, from the patient's perspective, did the additional questions seem relevant and was the point in time during which these additional data were collected appropriate? It would also be useful to understand whether there is a potential for individuals to prioritize the completion of one survey over another and therefore lead to negative unintended consequences on response rates for other PRO-PMs such as HCAHPS? The FAH believes that these questions should have been addressed during the development of this PRO-PM and this detail should have been provided within the measure submission rather than the generalized statements that we see in the responses under the feasibility criterion. ***Continued***

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Appendix B

Pre-evaluation Public and Member Comment

3559 Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

1. *Cont'd.* In addition, while the FAH strongly supports the inclusion of health literacy in the risk adjustment model, we believe that the risk adjustment approach used by many developers considers the identification and testing of social risk factors as supplementary to clinical risk factors. This approach was identified as a concern by the NQF Disparities Standing Committee. Given that this was a new measure, it provided an opportunity for the measure developer to include these factors within the testing of the model rather than the previous approach of "adding on" factors after the model is developed. This type of approach would assist hospitals and others in understanding how their inclusion could impact the model and provide additional information for groups examining this issue such as the NQF and Office of the Assistant Secretary for Planning and Evaluation. As a result, the FAH believes that this measure lacks sufficient information on the potential impact these social risk variables have on the risk adjustment model.

The FAH requests that the Standing Committee consider these important issues during the evaluation of this measure. Thank you for the opportunity to comment.

NQF Member and Public Comment

Next Steps

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Activities and Timeline – Spring 2020 Cycle

***All times ET**

Meeting	Date, Time
CSAC Review	November 17-18, 2020 • Nov 17: 9:00 am – 5:00 PM • Nov 18: 12:00 pm
Appeals Period (30 days)	November 18 – December 22, 2020

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Project Contact Info

- Email: patientexperience@qualityforum.org
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- SharePoint site: http://share.qualityforum.org/Projects/Patient%20Experience%20and%20Function/SitePages/Home.aspx

THANK YOU.

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