NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Patient Experience and Function Standing Committee – Spring 2020 Measure Evaluation Post-Comment Web Meeting

The National Quality Forum (NQF) convened the Patient Experience and Function (PEF) Standing Committee for a web meeting on September 17, 2020 to review measure-specific comments received during the post-measure evaluation commenting period.

Welcome, Introductions, and Review of Meeting Objectives

NQF leadership, staff, and Standing Committee co-chairs welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. Sixteen Committee members were present for the discussion, allowing the Committee to be able to revote should it elect to reopen the measures for discussion and evaluation based on comments received. Representatives from the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) and Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE) measure developer teams were also present on the call.

Review and Discussion of Public Comment

The draft report commenting period for the spring 2020 measure evaluation cycle closed on September 3, 2020. As of September 3, 2020, NQF received seven measure-specific and two general draft report comments from NQF members and individual members of the public to be reviewed by the Standing Committee.

Measure-Specific Comments

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

"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 Hospital Consumer Assessment of Healthcare Providers and Systems (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. For example, several of the data elements needed for risk adjustment are derived from patient-reported surveys, which must be collected within zero to 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. 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 NQF and the 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."

Committee Response

The Committee thanked the FAH for its thoughtful review of these measures. The Committee considered the FAH's comment as well the developer's response during the course of the meeting. The Committee agreed that the development and implementation of PRO-PMs is vital. However, the Committee did not agree that the measure would be especially burdensome to implement. The Committee noted that the results of this measure are being collected across the country and is a standard of care for surgeons. The Committee has discussed the risk model with the developer and is comfortable with their approach.

"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. 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. 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.

Committee Response

The Committee thanked the AMA for their comment. These concerns were addressed in the Committee response to the FAH comment above.

"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."

Committee Response

The Committee thanked the AGS for their comment. These concerns were addressed in the Committee response to the FAH comment above.

"As a patient/public partner engaged in quality improvement, my comments are as follows. 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 measures 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 or function post-surgery that impacts their quality of life. Thank you for this."

Committee Response

The Committee thanked the AGS for their comment. These concerns were addressed in the Committee response to the FAH comment above.

2614 Core Q: Short Stay Discharge Measure

"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. We have additional 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."

Committee Response

The Committee thanked the AGS for its thoughtful review of these measures. The Committee considered their comment as well the developer's response during the course of our meeting. The Committee has discussed the exclusions with the developer and is comfortable with their approach. The Committee also discussed the chosen cut-points for the measure and is satisfied with the scoring methodology used by the developer.

2615 Core Q: Long-Stay Resident Measure

"The American Geriatrics Society (AGS) wishes to provide comment on Measure 2615 and 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."

Committee Response

The Committee thanked the AGS for its thoughtful review of these measures. The Committee considered their comment as well the developer's response during our meeting and is satisfied with the response and does not wish to take further action in reconsideration of the measure.

2616 Core Q: Long-Stay Family Measure

"I am commenting as a Patient/Public individual interested and engaged in quality measurement and improvement. Thank you for offering the public opportunity to comment on this PEF NQF set of measures. 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 = 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."

Committee Response

The Committee acknowledged the patient/public individual's comment and discussed it during the meeting. The Committee agreed with the commenter and the developer that NQF #2614-#2616 are satisfaction measures rather than patient experience measures, and that these satisfaction measures should not be conflated with patient experience measures.

Next Steps

NQF will hold the Spring 2020 Consensus Standards Approval Committee (CSAC) review meeting on November 17-18, 2020. The CSAC meeting will be followed by the appeals period, which will occur from November 18, 2020 through December 22, 2020.