NATIONAL QUALITY FORUM
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Memo

June 8, 2022

To: Surgery Standing Committee, Fall 2021

From: NQF staff

Re: Post-comment web meeting to discuss NQF member and public comments received and NQF member expression of support

Background

Surgical quality measures are essential to improving outcomes for individuals undergoing surgical procedures each year. Provider performance tools, such as patient-reported outcome performance measures (PRO-PMs), gather information directly from the patient without the interpretation of a healthcare provider on key quality indicators (e.g., function, quality of life, pain, and care experience). The use of PRO-PMs allows for a broad view of the patient experience and the opportunity for clinicians to improve their surgical practice. For the fall 2021 cycle of the Surgery project, the Standing Committee evaluated one newly submitted measure against NQF's standard evaluation criteria. The Standing Committee recommended the measure for endorsement:

- NQF #3639 Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (Centers for Medicare & Medicaid Services [CMS]/ Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation [Yale CORE])

Standing Committee Actions in Advance of the Meeting

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Brief).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Comments Received

NQF accepts 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 December 06, 2021, and closed on April 29, 2022. Comments received by January 19, 2022, were shared with the Standing Committee prior to the measure evaluation meeting. Following the Standing Committee's evaluation of the measure under review, NQF received two comments from two organizations (including two member organizations) and individuals pertaining to the draft report and the measure under review. This memo focuses on comments received after the Standing Committee's evaluation.

NQF members also had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration. Two NQF members submitted an expression of do not support. More information on the submitted expressions of support can be found in Appendix A.

NQF staff have included all comments that were received (both pre- and post-evaluation) in the Comment Brief. The Comment Brief contains the commenter's name, comment, associated measure, and draft responses (including measure steward/developer responses if appropriate) for the Standing Committee's consideration. Please review this table in advance of the meeting and consider the individual comments received and the proposed responses for each comment.

In order to facilitate the discussion, the post-evaluation comments have been categorized into action items and major topic areas or themes. Although all comments are subject to discussion, the intent is not to discuss each individual comment during the post-comment call. Instead, NQF staff will spend the majority of the time considering the themes discussed below and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit the Standing Committee's discussion, and the Standing Committee can pull any comment for discussion. Measure stewards/developers were asked to respond to comments where appropriate. All developer responses along with the proposed draft Standing Committee responses have been provided in this memo and the Comment Brief.

Comments and Their Disposition

Measure-Specific Comments

NQF #3639 Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Two commenters expressed support for the development and implementation of patient-reported outcomes performance measures (PRO-PMs) but expressed concerns about aspects of the measure. These included:

- Concerns with multiple PRO-PMs and the potential for survey fatigue among patients
- Concerns related to the case minimum and the minimum reliability threshold
- Concerns about the potential impact that additional PRO-PMs may have on the reporting of well-established measures such as Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPs) and Clinician and Group Consumer Assessment of Healthcare Providers and Systems Survey (CG-CAHPS)
- Concerns about data collection burden to clinicians, practice, and patients, particularly data points beyond typical clinical variables required for the risk adjustment model
- Concerns about the risk adjustment approach and the addition of social risk variables supplementary to clinical risk factors after the model is developed
- Concern with the differences in the post-operative timeline specified in this measure under endorsement consideration and the timeframe included in measures under consideration MUC2021-107

Measure Steward/Developer Response:

The developer provided detailed responses to both commenters emphasizing that the PROM instruments were chosen based their importance to clinicians and patients, feasibility, low burden, ability to be used to inform care management decisions, and ability to inform healthcare quality improvement efforts and that the measure specifications were based on a consensus-based approach and supported by testing. The developer also offered strategies for overcoming challenges and stated that it will continue to

evaluate the measure based on performance. Due to the length of the responses, the full responses have been placed in Appendix B.

Proposed Standing Committee Response:

Thank you for your comment. The Standing Committee recognizes the importance of improving outcomes for individuals undergoing surgical procedures and the opportunity for clinicians to enhance their surgical practice using provider performance tools, such as patient-reported outcome-performance measures (PRO-PMs). The Standing Committee recognizes the commenters' concerns and discussed these topics extensively during the measure evaluation meeting. While the Standing Committee maintains the measure meets NQF criteria and should be endorsed, it urges the developer to continue to monitor these issues as the measure is implemented and to make updates as needed.

NQF Response:

Thank you for your comment. NQF evaluates each measure as specified by the developer at submission. The Consensus Development Process (CDP) and Measures Application Process (MAP) are two distinct review processes with the potential to review measures with specification variance. However, we encourage those who implement measures to use the endorsed version.

Action Item:

Discuss and finalize Standing Committee response.

Appendix A: NQF Member Expression of Support Results

Two NQF members provided their expressions of support/nonsupport. Results are provided below.

NQF #3639 Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (Centers for Medicare & Medicaid Services [CMS]/ Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation [Yale CORE])

Member Council	Commenter Names, Organizations	Support	Do Not Support	Total
Health Professional Council	Koryn Rubin, American Medical Association	0	1	1
Provider Organization	Tilithia McBride, Federation of American Hospitals	0	1	1
Total	*	0	2	2

* Indicates cell intentionally left blank

Appendix B: Developer Responses to Concerns about NQF #3639

Developer Response to the Federation of American Hospitals (FAH): The Federation of American Hospitals (FAH) submitted a public comment on April 29, 2022 for the National Quality Forum (NQF) Measure #3639, stating support for patient-reported outcome-based performance measure (PRO-PM) development and implementation in general but noting concerns about the burden of data collection, survey fatigue, reliability, feasibility, and usability of the measure, timing of patient-reported outcome measure (PROM) and risk variable data collection, and approach to risk adjustment. We thank the Federation of American Hospitals for their comment and provide responses to their concerns below. This PRO-PM, based on the NQF endorsed hospital-level total hip and total knee arthroplasty (THA/TKA) PRO-PM (NQF# 3559), has been developed to assess improvement in pain and functional status for patients following an elective primary THA/TKA. Attribution to the clinicians performing the surgery was supported by the Technical Expert Panel (TEP), the expert clinical consultant, and the Patient Working Group members engaged in this measure's development. The PROM instruments chosen to measure the improvement outcome were supported for their importance to clinicians and patients, feasibility, low burden, ability to be used to inform care management decisions, and ability to inform healthcare quality improvement efforts. Patient-reported outcome (PRO) data collected at the hospital level in the Center for Medicare and Medicaid Innovation's (CMMI's) Comprehensive Care for Joint Replacement (CJR) Model were successfully linked to the clinicians conducting the THA and TKA procedures performed in these hospitals, which were selected to be representative of the case mix experienced at various hospitals nationwide. Variation in risk-standardized improvement rates for clinicians and clinician groups demonstrate meaningful differences in performance measure scores, with risk-standardized improvement rates ranging from 18.36% to 88.56% for clinicians and 20.86% to 85.90% for clinician groups. Measure score reliability across a range of minimum case volume thresholds was conducted for the Centers for Medicare & Medicaid Services' (CMS) consideration in future implementation planning.

We are confident in the reliability, feasibility, and usability of this measure based on these testing results and recommend continued assessment in reevaluation. During measure development we carefully considered the issue of burden and will continue to carefully consider burden for future measure implementation. The manner in which data collection for this measure is integrated into clinical workflows will be at the discretion of the clinician/clinician group, which allows them freedom and flexibility to choose an approach that meets their needs and considers their patients' needs. CMMI's CJR Model served as proof of concept for PRO data collection and submission. Challenges to PRO data collection can be mitigated by strong leadership support, flexibility in rearranging clinical workflows to accommodate PRO data collection, ability to access PRO data in real-time for clinical decision making, and universal staff buy-in on the value of PROs in improving care and quality. This approach also serves to increase patient engagement; patients have expressed to us the importance of knowing what PRO survey results will be used for and noted a greater willingness to complete surveys if they are collected by their provider and used in shared decision making. This integration benefits patients by engaging them in discussions about potential outcomes of their surgery. We do not anticipate that this measure will contribute to survey fatigue or negatively impact response to other measures such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) or the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS). This PRO-PM's eligible population is procedure-specific, which reduces the likelihood of the same patients receiving the HCAHPS/CG-CAHPS and the PROMs for this measure. Additionally, there is no overlap in the data collection timelines for these measures; the HCAHPS or CG-CAHPS are typically administered two weeks after a hospital or clinician visit, months before the postoperative data collection for this PRO-PM.

This measure utilizes the risk variables finalized for the hospital-level THA/TKA PRO-PM on which this measure is based. The hospital-level THA/TKA PRO-PM development team used a consensus-based approach to identify and vet clinically relevant risk variables important in predicting the improvement outcome, including a systematic literature review and environmental scan, a survey of orthopedists, consultation with an expert clinical consultant, extensive input from the TEP (which included patient members), and detailed public comments. Patient Working Group members were also strongly supportive of the risk variables included in this measure. The timing of preoperative PROM and risk variable data collection for this measure, intentionally aligned with the hospital-level measure, was determined with extensive TEP and stakeholder input and chosen to give flexibility for providers collecting these data. The commenter's support for including health literacy in the risk model is noted. During development of the hospital-level measure, the TEP supported inclusion of health literacy due to particular relevance for a measure based upon PRO data. In consideration of additional social risk factors, we recognize that patients with social risk factors may present later with more severity or greater comorbidity. The increased clinical risk this presents is addressed through the clinical risk factors in the model. When we evaluated the impact of social risk factors, it was in the context of what additional impact they may pose. Although neither dual eligibility, Agency for Healthcare Research and Quality (AHRQ) socioeconomic (SES) index lowest quartile, nor non-white race were statistically significantly associated with the measure outcome, they were included in the statistical approach to non-response adjustment of the measure due to their statistically significant association with survey response in measure development data and in the literature.

We will continue to evaluate the relationship between social risk factors and the measure outcome and evaluate the risk model over time. Finally, we appreciate the commenter's support of a postoperative PROM data collection timeframe of 300-425 days after the procedure. The PRO postoperative data collection period finalized for CJR was 270 to 365 days after the procedure; these were the data used in the development and testing of this measure and in the NQF submission. However, we have heard from multiple clinical experts strongly recommending a refinement to the postoperative data collection period to better align with clinical workflow and typical one-year follow-up scheduling, and to allow for better postoperative PRO data capture. Based on extensive input, we have proposed measure specifications for future measure implementation with a postoperative PRO data collection period representing this small shift to 300 to 425 days after the procedure. We do not anticipate that this will impact improvement results; we do anticipate an increase in PRO response.

Developer Response to the American Medical Association (AMA): The American Medical Association (AMA) submitted a public comment on April 20, 2022, for the National Quality Forum (NQF) Measure #3639, stating support for patient-reported outcome-based performance measure (PRO-PM) development but noting concerns about the burden of data collection and the multi-step approach to risk adjustment. We thank the American Medical Association for their comment and provide responses to their concerns below. During measure development we carefully considered the issue of burden and will continue to carefully consider burden for future measure implementation. The manner in which data collection for this measure is integrated into clinical workflows will be at the discretion of the clinician/clinician group, which allows them freedom and flexibility to choose an approach that meets their needs and considers their patients' needs. The Centers for Medicare and Medicaid Innovation's (CMMI's) Comprehensive Care for Joint Replacement (CJR) Model, the source of the data for measure development and testing of this PRO-PM, served as proof of concept for patient-reported outcome (PRO) data collection and submission.

Challenges to PRO data collection can be mitigated by strong leadership support, flexibility in rearranging clinical workflows to accommodate PRO data collection, ability to access PRO data in real-time for clinical decision making, and universal staff buy-in on the value of PROs in improving care and quality. This approach also serves to increase patient engagement; patients have expressed to us the importance of knowing what PRO survey results will be used for and noted a greater willingness to complete surveys if they are collected by their provider and used in shared decision making. This integration benefits patients by engaging them in discussions about potential outcomes of their surgery. In addition, during the development of the NQF endorsed hospital-level total hip and total knee arthroplasty (THA/TKA) PRO-PM (NQF #3559) on which this measure is based, the development team solicited extensive patient and provider feedback to ensure the measure included low burden patient-reported outcome measure (PROM) instruments. Extensive input from patients has indicated strong support for a PRO-based performance measure following elective primary THA and TKA. The Centers for Medicare & Medicaid Services (CMS) will carefully consider these concerns and comments during future implementation planning. Regarding the multi-step approach to risk adjustment, the clinician- and clinician group-level THA/TKA PRO-PM uses the same risk model as the hospital-level THA/TKA PRO-PM.

The hospital-level THA/TKA PRO-PM development team used a consensus-based approach to identify and vet clinically relevant risk variables important in predicting the improvement outcome, including a systematic literature review and environmental scan, a survey of orthopedists, consultation with an expert clinical consultant, extensive input from the Technical Expert Panel (TEP), and detailed public comments. During development of the hospital-level measure, the TEP and measure development team felt that health literacy held particular relevance for a measure based upon PRO data and this variable is included in the risk model. In consideration of additional social risk factors, we recognize that patients with social risk factors may present later with more severity or greater comorbidity. The increased clinical risk this presents is addressed through the clinical risk factors in the model. When we evaluated the impact of social risk factors, it was in the context of what additional impact they may pose. Although neither dual eligibility, Agency for Healthcare Research and Quality (AHRQ) socioeconomic (SES) index lowest quartile, nor non-white race were statistically significantly associated with the measure outcome, they were included in the statistical approach to non-response adjustment of the measure due to their statistically significant association with survey response in measure development data and in the literature. We will continue to evaluate the relationship between social risk factors and the measure outcome and evaluate the risk model over time.