National Quality Forum
Surgery Standing Committee
Tuesday, February 15, 2022

The Standing Committee met via Videoconference, at 2:00 p.m. EST, Vilma Joseph and Alex Sox-Harris, Co-Chairs, presiding.

Present:

Vilma Joseph, MD, MPH, Albert Einstein College of Medicine/Montefiore Medical Center; Co-Chair
Alex Sox-Harris, PhD, MS, Stanford University; Co-Chair
Ashrith Amarnath, MD, Sutter Valley Medical Foundation
Sherry Bernardo, CRNA, Atrium Health
Richard D'Agostino, MD, Lahey Clinic Medical Center
Michael Firstenberg, MD, The Medical Center of Aurora
Linda Groah, MSN, RN, Association of periOperative Registered Nurses
Miklos Kertai, MD, PhD, Vanderbilt University
Jaime Ortiz, MD, MBA, Baylor College of Medicine
Shawn Rangel, MD, Boston Children's Hospital
Kimberly Richardson, Patient Advocate
Christopher Saigal, MD, MPH, University of California, Los Angeles
Salvatore Scali, MD, University of Florida
Allan Siperstein, MD, Cleveland Clinic
Joshua D. Stein, MD, MS, University of Michigan
Mark A. Wilson, MD, PhD, National Director of Surgery, Veterans Health Administration, Department of Veterans Affairs

Patient Experience and Function Co-chairs (Non-voting:

Gerri Lamb, PhD, RN, Edson College of Nursing and Health Innovation, Arizona State University

NQF Staff:

Karri Albanese, Analyst
Taroon Amin, PhD, NQF Consultant
Poonam Bal, MHSA, Senior Director
Tricia Elliott, DHA, MBA, Senior Managing Director
Monika Harvey, MBA, Project Manager
Isaac Sakyi, MS, Manager
LeeAnn White, MS, RN, Director
Tristan Wind, MHA, Associate

Also Present:

Lisa Suter, MD, Yale Center for Outcomes Research & Evaluation (CORE)
Rachelle Zribi, Yale CORE

Contents

Proceedings

(2:02 p.m.)

Welcome and Review of Meeting Objectives

Ms. White: Greetings and good afternoon, everyone. For some of our colleagues on the west coast, still good morning.

My name is LeeAnn White, and I am the director supporting the surgery product team. I want to welcome you all to our first surgery measure evaluation web meeting of 2022. I am excited to be here and I very much look forward to our call today.

I want to also thank you for your time and participation, as I understand it is a significant amount of time and effort to review the measure and prepare for today's review. I'd also like to extend a thank you to our developer, Yale CORE, for being on the call today.

And we do recognize the significant time and effort that goes into the testing, the preparation of the materials and the measure submission, and so we want to highlight those efforts and thank them for their time as well. So thank you.

And then lastly, I appreciate your continued patience and understanding as we continue to meet virtually in the pandemic. We do understand the challenges that accompany virtual meetings, and we all look forward to when we can convene in person. However, in the meantime our team really truly does appreciate your understanding and thanks you for your continued support.

So next slide please. So I'm now going to hand it over to our esteemed co-chairs, Dr. Alex Sox-Harris and Dr. Vilma Joseph to provide their welcoming remarks. So, Alex.

Co-Chair Sox-Harris: Good afternoon, or morning, everyone. It's good to see people's Hollywood Square

faces. I look forward to being in person eventually.

Just a quick thanks to everybody on the standing committee for your continued commitment to the work of this group. I really want to thank the NQF staff for, just, I'm always impressed by how much effort and skill they bring to preparing us to have our discussions.

And also really thank Dr. Vilma Joseph who is joining me as co-chair. So I'm no longer the sole co-chair, which there was a few meetings where that was the case so I'm just look forward to partnering with her to help guide this Committee, so thank you very much.

Ms. White: Thank you, Alex.

Co-Chair Joseph: Um --

Ms. White: Vilma, oh, I'm sorry, Vilma, go ahead.

Co-Chair Joseph: Yes. Oh, I just want to say thank you so much, Alex, that's so kind of you. I'm welcoming this opportunity.

I've been embraced by all the NQF staff, so I am really looking forward to working with all the Committee members and the public and developers, to really look at these measures, look at this measure in detail, and come up with a good work product. So thank you so much.

Ms. White: Wonderful. Thank you, Vilma. Okay, next slide please. Oh no, just stay on the housekeeping reminders.

So I want to take a brief moment to quickly review a couple of housekeeping reminders. As most of you know, we're using the WebEx platform to host the measure evaluation meetings.

If you're having any difficulties, please let us know. Our team is standing by to, we're ready assist you. You can connect with us via the chat function, or you

can email us directly at surgery@qualityforum.org.

In the spirit of engagement and collaboration, I do encourage us all to use our video so that we can see each other's faces and we can bridge some of those virtual gaps.

If you're not actively speaking we do ask that you place yourself on mute, just to minimize the background noise and interruptions. We understand that things happen, but we just ask you to keep muted.

To mute yourself there is a button on your bottom screen, just click on it, it will mute your line. If you want it to come off mute, you just click that again.

Our NQF staff and our Co-Chairs will monitor discussions and highlight comments throughout our calls, so there is an opportunity to chat to the whole group, or you can chat to someone directly.

We also encourage the use of a hand raise feature. Raising your hand alerts the host. And a hand icon will appear in the square.

To raise your hand, please click on the participants list, and then you will find your name. And from your name you can click on the hand raise feature. Once you raise your hand, you do need to click on that raise hand feature again to lower your hand.

Once the meeting begins our Senior Managing Director of the Measurement Science and Application, Dr. Tricia Elliott, will conduct roll call and review the disclosures of interest. It is important to note that we are a voting body and therefore we do need to establish a quorum to vote on our meeting today.

If you do need to step away from the call, we ask that you send the NQF team a direct message using the chat function so that we're aware of our attendance and quorum.

Next slide please. So it's now my pleasure to

introduce our project team. Again, I'm LeeAnn White, I'm the director of the project. Our team manager is Isaac Sakyi, our project manager is Monika Harvey, our analysts are Karri Albanese and Tristan wind. And our support staff is listed here and also present on the call to help address your questions and provide additional support is our consultant, Dr. Taroon Amin, and our senior director Poonam Bal.

Next slide please. I want to touch on a few agenda items that we have listed here and what we'll be covering today.

We're going to begin by conducting a roll call and disclosures of interests. We had two disclosure forms that we sent to you. One is our annual disclosure form and the second is specifically relate to the measure that we are reviewing.

We must receive both of those forms to review any potential conflict. If we do not have those forms, unfortunately you will not be able to participate. But we do have emails ready to send those to any committee members that have outstanding disclosures. So we just ask that you promptly complete those and send those back to us.

After we complete our disclosures of interests, Isaac will be providing a brief overview of the evaluation and voting process. And then he will conduct a brief voting test.

You should have received a Poll Everywhere link in your inbox. It was sent about a quarter to the hour. About 1:45 eastern time. And that contains the link that we will be using our voting today.

Poll Everywhere is an online platform. And if you cannot find that email, please let us know in the chat and we're going to be happy to send that back out to you.

Okay, after the voting test I will briefly introduce our measure under review, and then hand the

discussions over to our Co-Chairs to facilitate the discussions.

Within our discussions today we'll vote, we'll discuss each criteria and then we'll have a vote on each criteria. The last vote will be the overall recommendation for endorsement of the measure.

Following the measure discussion, we will review related and competing measures. And then we will host an opportunity for NQF members and public comments, and then conclude with next steps and what to expect moving forward.

Lastly this cycle, we are pleased and excited to have our patient experience and function co-chairs join us today. We want to note that they are serving in a participatory role and we want to thank them for their willingness to prepare, review and participate in our measure review, alongside our surgery standing committee.

Okay, next slide please. I will now hand it over to Dr. Tricia Elliott for introductions and disclosures of interests.

Introductions and Disclosures of Interest

Dr. Elliott: Great. Thank you so much, LeeAnn. Great to see everybody today, and thanks for kicking off the call, LeeAnn. So far, so good.

So I'd like to thank everybody for their time today and their commitment to the NQF multi-stakeholder endorsement process and consensus convening. Today we will be combining introductions with disclosures of interests. As LeeAnn mentioned you received a two disclosure, received two disclosure of interests forms from us. One is our annual disclosure of interest and the other is disclosures specific to the measure or measures that we discuss during this review cycle.

In those forms we asked you a number of questions

about your professional activities. Today we will ask you to verbally disclose any information you've provided on either of those forms that you believe is relevant to this committee. We are especially interested in grants, research or consulting related to this Committee's work.

Just a few reminders before we begin. You sit on this group as an individual, you do not represent the interests of your employer or anyone who may have nominated you for this Committee. We are interested in your disclosures of both paid an unpaid activities that are relevant to the work in front of you.

Finally, just because you disclose does not mean that you have a conflict of interest. We do verbal disclosures in the spirit of openness and transparency.

I will now proceed around our virtual table. I'll start with the Committee Co-Chairs and call each person by name. Please state your name, what organization you are with and if you have anything to disclose.

If you do not have disclosures, please just state I have nothing to disclose to keep us moving along. If you experience trouble unmuting yourself, please raise your hand so that the staff can assist.

Next slide, please. Thank you. So I'll begin with our Co-Chairs, Alex Sox-Harris.

Co-Chair Sox-Harris: I'm Alex Sox-Harris. I'm a professor in the Department of Surgery at Stanford University. I'm a research career scientist within the VA system at VA Palo Alto.

I do research on quality measures, including surgical quality measures. And I have nothing else to disclose.

Dr. Elliott: Excellent. Thank you, Dr. Harris. Vilma Joseph.

Co-Chair Joseph: Hi. I am a professor of

anesthesiology at Albert Einstein College of Medicine, Montefiore Medical Center. I'm associating with the American Society of Anesthesiologists. I'm the vice chair for their committee on performance and outcomes measurement. And I have nothing to disclose.

Ms. White: Thank you very much, Dr. Joseph. Ashrith Amarnath.

Member Amarnath: Hi, everyone. I'm Ash Amarnath, medical director at Covered California, which is a state health benefits exchange. Nothing to disclose.

Ms. White: Excellent. Thank you very much. Sherry Bernardo.

Member Bernardo: I am Sherry Bernardo. I'm a certified registered nurse and anesthetist at Atrium Health. And also chair of the practice committee for the American Association of Nurse Anesthetists. And I have nothing to disclose.

Dr. Elliott: Thank you very much. Richard D'Agostino. Dr. D'Agostino, if you're speaking you're on mute. Okay, we'll circle back. I do see him on the participation list but we're unable to hear him.

TeMaya Eamton.

Okay, we'll circle back. Michael Firstenberg.

Member Firstenberg: Hello, everybody. Michael Firstenberg, I'm a cardiothoracic surgeon currently at St. Elizabeth Medical Center.

I have been involved, extensively, over the years written, lectured, researched on a variety of patient safety clinical outcome events. And I'm certainly on a variety of committees for our professional organizations aiming towards many of the initiatives that we talk about today.

As such, I don't have any relevant or even potential conflicts of interests. Or disclosures for the topics.

Thank you.

Dr. Elliott: Thank you. Next up is Linda Groah.

Member Groah: Good morning. I'm Linda Groah, CEO and executive director of the Association of periOperative Registered Nurses. And I have nothing to disclose.

Dr. Elliott: Thank you. Next, Miklos Kertai.

Member Kertai: Hello, everyone. My name is Miklos Kertai, I'm a professor of anesthesiologist at Vanderbilt University Medical Center. And I'm also serving as the assistant vice chair for patient safety, quality and outcomes in our department.

I have been involved with perioperative outcomes research as it pertains to patients undergoing cardiac surgery. And I have nothing to disclose.

Dr. Elliott: Excellent, thank you. Next, Shawn Rangel.

Member Rangel: Hey, everyone. I'm Shawn Rangel, I'm a pediatric surgeon at Boston Children's Hospital and the senior surgical advisory for quality and safety.

And for about a decade I've worked with the ACS to lead several quality initiatives and performance measurement initiatives as well. Largely with the Children's Surgery Verification and Pediatric NSQIP. Nothing to disclose.

Dr. Elliott: Thank you. Next, Kimberly Richardson.

Member Richardson: Good afternoon. I'm Kimberly Richardson, a patient advocate here in Chicago, Illinois. I have nothing to disclose.

Dr. Elliott: Thank you. Christopher Saigal.

Member Saigal: Hi. Chris Saigal here. Nothing to disclose.

Dr. Elliott: Okay, thank you. Salvatore Scali.

Member Scali: Hi, my name is Sal Scali. I'm a vascular surgeon with the University of Florida. I have no disclosures. I'm chair of the EVAR Quality Registry for the vascular quality initiative in the Society for Vascular Surgery.

Dr. Elliott: Thank you. Allan Siperstein.

Member Siperstein: Hi. I chair the Department of Endocrine Surgery at the Cleveland Clinic. And I have no disclosures.

Dr. Elliott: Excellent. Thank you. Joshua Stein.

Member Stein: Hi, everyone. I'm Joshua Stein, I'm an ophthalmologist and health services researcher at the University of Michigan. And I have no disclosures.

Dr. Elliott: Thank you. Kevin Wang. Okay, we'll circle back to Kevin. Mark Wilson.

Member Wilson: I'm Mark Wilson. VHA National Director of Surgery. And I have no disclosures.

Dr. Elliott: Thank you. Next up, we have two Patient Experience and Function co-chairs joining the call as non-voting members. So we have Gerri Lamb.

Member Lamb: Yes, I'm here. Tricia, I don't know that you need conflict of interests for me?

Dr. Elliott: No, you're not voting so I just wanted the opportunity to introduce. So thank you, Gerri.

Member Lamb: Thank you. So, Gerri Lamb. I'm a professor at Arizona State University.

Dr. Elliott: Okay, excellent. And Christopher Stille. Chris is, don't see him on the call.

I'm going to circle back and check to see, Richard D'Agostino, were you able to connect and unmute?

Member D’Agostino: Yes, I'm all set. And I'm Richard D'Agostino, I'm a cardiac surgeon at Lahey Hospital and Medical Center in Burlington, Massachusetts. And

I've been involved with the STS Adult Cardiac Surgery Database for the past 15 years. I have no disclosures.

Dr. Elliott: Okay. And I'm going to circle back to TeMaya Eatmon. Are you able to unmute and get connected? Okay.

So I think, just checking in with the team. So on my list, the one person, if we're able to connect with TeMaya, if she is having any connection issues we'll double check and then ask her, when she is able to join, to provide any disclosures, if needed.

Ms. White: Tricia?

Dr. Elliott: Yes.

Ms. White: Can we circle back to Dr. Ortiz? I believe he was, he's here, he just didn't come off the mute.

Dr. Elliott: Oh did I, I thought I heard Dr. Ortiz.

Ms. White: Oh, did he. I mean --

Dr. Elliott: Jamie Ortiz, did we call on you? Did I miss you? I'm sorry. Okay, I don't see him on the list, LeeAnn, do we need to maybe circle back as --

Ms. White: The team can reach out to him.

Dr. Elliott: Okay. As he's able to join. Okay. Excellent. So with that, LeeAnn, I believe I turn things over to Isaac to walk us through the overview of the evaluation process and voting process. So thank you.

Ms. White: Thank you, Tricia. So Isaac will, yes, go over the evaluation and voting process. So, Isaac, I am handing it over to you.

Overview of Evaluation Process and Voting Process

Mr. Sakyi: Thank you, LeeAnn, thank you, Tricia. I'm going to go over the evaluation process that we'll be following today.

So, as a Standing Committee member -- can we move on to the next slide? As a Standing Committee member you act as a proxy for the NQF stakeholder membership. You evaluate each measure against each criterion, and with that, indicate the extent to which each criterion is met and the rationale for the rating.

You also respond to comments submitted during the public commenting period. Which will be after the measure evaluation meeting, and staff has drafted the report.

You make recommendations regarding endorsement to the NQF membership and oversee the portfolio of surgery measures.

Next slide. To go over some ground rules, we'd like to emphasize that this is a shared space and there is no rank in the room. We encourage you to remain engaged in the discussion without distractions. And we hope you are prepared, and have already reviewed the measure before today's meeting.

Please base your evaluation and recommendations on the measure evaluation criteria and guidance. Please keep your comments concise and focused. Please be cognizant of others and make space for others to contribute to the conversation.

Next slide. In terms of how the discussion will proceed, we'll start with an introduction of the measure by the measure developer.

The lead discussant will then briefly explain the information provided by the developer on each criterion. Followed by a brief summary of the pre-evaluation comments from the committee emphasizing the areas of concern or differences of opinion.

The lead discussant will also note preliminary ratings by NQF staff, which is intended to be used as a guide to facilitate the discussion. Developers will be

available to respond to questions from the standing committee. Afterwards, the full standing committee will discuss, vote on the criterion, if needed, and move on to the next criterion.

Next slide. The following is a list of our endorsement criteria. Five areas are outlined here. Mainly, importance to measure and report, which includes evidence and performance gap. Scientific acceptability, which includes reliability and validity.

Please note that the first two bullet points are a must-pass criteria. We also have feasibility, usability and use. And also, the related or competing measures.

The use of criterion is a must-pass for maintenance measures. The measure being reviewed today is a new measure so it doesn't apply.

The next point of discussion is the comparison to related or competing measures. Which is simply a discussion and does not require a vote. And that discussion only takes place if the measure is recommended for endorsement.

Next slide. Again, these are the criteria if the measure is evaluated and voted on.

Next slide. If a measure fails on one of the must-pass criteria, there is no further discussion or voting on the subsequent criteria for that measure. The Committee's discussion will move on to the next measure if applicable.

In our case, we have one measure so it will be the end of our discussion. We would share next steps in the process. If consensus is not reached on the criterion, the discussion will continue to the next criterion, but there ultimately will not be a vote on the overall suitability for endorsement.

Next slide. As far as achieving consensus, quorum is 66 percent of active Standing Committee members. That is 12 out of 17 for this Committee. We have 18

Committee members, but one is recused for the measure under review, so that brings us to 17.

We need greater than 60 percent yes votes to pass the criterion or recommend a measure for endorsement. Yes votes are the total of high and moderate votes. Forty percent, 60 percent of Committee members voting yes will be a consensus not reached. A less than 40 percent voting yes means the criterion does not pass or the measure is not recommended. Depending on what we're voting on.

A consensus not reached criterion and the vote on overall suitability for endorsement would be postponed to the post comment meeting on June 8th. If a measure is not recommended, it will also move on to the public and NQF member comment. But the Committee will not revote on the measure during the post comment meeting, unless the Standing Committee decides to reconsider based on submitted comments or if the developer submits a reconsideration request.

Next slide. As mentioned before, please let us know if you need to step out of the meeting. We need quorum to vote on the measure and have at least 50 percent of the Standing Committee members on the call to continue the discussion.

If we lose quorum at any point in time, we will shift to an offline survey which will contain the same questions as the live voting platform in that situation. We will ask that you submit your vote within 48 hours of receiving the survey and the transcript of the meeting

If a Standing Committee member has to leave, and we still have quorum, the committee will continue with the votes. The Standing Committee member who left will not have the opportunity to vote on the measure evaluated in their absence.

That sums up the process for today's meeting. At this point I would like to pivot to have a demonstration of

our voting platform.

Ms. White: Isaac, can we just pause real quickly?

Dr. Elliott would like to just revisit some of the Standing Committee members that were not, for the disclosures of interest, to provide that opportunity for intros. And then we can do the test vote, if that's okay.

Dr. Elliott: Great. Thanks, LeeAnn. We believe that Jaime Ortiz has joined the meeting. We wanted to offer the opportunity for introductions and disclosure.

Member Ortiz: Yes. I'm Jaime Ortiz. I'm a professor of anesthesiology at Baylor College of Medicine. And I don't have anything to disclose.

Dr. Elliott: Excellent. Great, thank you. So that concludes our disclosures and we have reached quorum.

So I'd like to let you know that if you believe that you might have conflict of interest at any time during the meeting as topics are discussed, please speak up. You may do so in real-time during this web meeting, or you can send a message via to your chairs or to anyone on the NQF staff.

If you believe that a fellow committee member may have a conflict of interest or is behaving in a bias manner, you may point this out during the meeting. Send a message to your chairs or also to the NQF staff.

With that, I'll conclude the disclosures of interest. And does anyone have any questions or anything that you would like to discuss based upon the disclosures made today?

Okay, hearing none, we thank you for your cooperation. And we'll proceed with the meeting and hand things over for a test vote. Thank you all.

Mr. Sakyi: Thank you, Tricia. At this point I'd also like to pause to see if there are any questions about the process?

Okay, hearing none we will move forward to test the voting platform. So you should be able to see a very contentious question on your screen about pineapple and pizza or candy corn. Vote what your preference is.

Is everyone able to see my screen?

Ms. White: Yes.

Mr. Sakyi: I believe we're expecting exactly 17 votes.

Member Firstenberg: It says the poll is locked, am I looking at the wrong thing? Oh, there you go. Never mind. Thank you.

Mr. Sakyi: Okay, we're expecting 16 votes. We're waiting for two more. Waiting for one more vote.

At any point in time during the voting process, if you're having issues with the Poll Everywhere link or having issues with your votes being accepted, you can send your vote in a direct message to LeeAnn White on the chat, and she will share that information with the rest of the team. So please refrain from sharing your vote to the entire attendees on the call, send it directly to LeeAnn White.

Is there anyone having issues voting? We're waiting for one more person.

Ms. White: If you're having some challenges with your voting link please let us know and we're happy to, oh, we have 16. There we go. Let's see what it is. Oh, pineapple pizza.

Mr. Sakyi: Hey, we have 15 out of 16 prefer pineapple on pizza.

Ms. White: Okay. Pretty overwhelming. It passes.

Okay. All right. So we're going to pause a moment so we can pull back up our slide deck. Okay, next slide, please. Next slide. And next slide.

Measures Under Review

Ms. White: Okay, perfect. So there is one new measure for the Standing Committee to review for Fall 2021. That is measure 3639, Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure.

The measure steward is CMS and the measure developer is Yale CORE. I just wanted to pause a moment to see if we have our representatives from Yale CORE on the call this afternoon.

Ms. Zribi: Yes. Hi, this is Rachelle.

Ms. White: Hi, Rachelle. Thank you so much for joining us today, we appreciate your time and participation. Wonderful.

So, next slide, please. A quick review of the scientific methods panel here. Oh, can we go to the next slide. I'm sorry, had a little bit of a pause here.

Okay. So a quick review of the scientific methods panel. This is a group of researches, experts and methodologists in healthcare quality and quality improvement and measurement.

The panel reviews complex measures and provides comments and concerns to the developer. The developer has the opportunity to then provide further clarification and update their measure submission form before the Standing Committee evaluation.

The project team for fall 2021 received six new measures a cycle. The SMP evaluated five measures. Three measures did not pass the SMP evaluation and were determined to be ineligible for a re-vote. One

measure passed the panel, and two measures were withdrawn from the developer.

Next slide, please. The SMP independently evaluated the scientific acceptability of Measure 3639 and the measure process that's being reviewed.

The Standing Committee will vote on whether to uphold the SMP rating for the measure. If we have greater than 60 percent in favor, the SMP vote is upheld. If the Standing Committee does not vote to uphold the SMP vote, then there will be additional discussion and a poll vote will be held instead.

Okay, next slide, please. So with that, we will now begin the review of our fall 2021 measure. Our Co-Chairs will start us off by introducing the measure. The developer will have an opportunity to provide a brief three to five minute overview of their measure.

Our lead discussant, Linda Groah, will lead the measure discussion and review committee and public comment. And then invite our Patient Experience and Function co-chair, Dr. Gerri Lamb, to provide remarks and provide any information that she would like the Standing Committee to consider.

The full committee will then discuss and vote on the measure criteria. And with that, Alex, I will hand it over to you.

Consideration of Candidate Measure

Co-Chair Sox-Harris: Fantastic. Thank you, LeeAnn. So in a moment I'll be asking Yale CORE to present a three- to five-minute overview of the measure and then over to, because our committee mostly has looked at, at least in the past several cycles, on things like three-day complications and things of that nature.

At least in my experience we have not looked at a patient-reported outcome measure. And so, we're very fortunate to have the co-chairs of the Patient

Experience and Function Standing Committee, who deal with these kinds of measures more frequently, so they can give us some context and ways to think about this as we go through our review. And then back to my co-chair and the lead discussants to walk us through the evaluation process.

So with that, let me ask Yale CORE folks to give us a three- to five-minute overview of the measure under consideration.

3639 Clinician-Level and Clinician Group-Level THA and/or TKA PRO-PM

Ms. Zribi: Hello, everyone. This is Rachelle Zribi from the Yale Center for Outcomes Research and Evaluation. I'm the health outcomes researcher for CORE and the team lead for the Clinician- and Clinician Group-Level Total Hip Arthroplasty and Total Knee Arthroplasty Patient-Reported Outcome-Based Performance measure.

Thank you to the Committee members and NQF for reviewing this measure. And thank you to my team at CORE for all your contributions to this work.

The measure under consideration was developed under contract with the Centers for Medicare and Medicaid Services. With the exception of attribution of the measure outcome, this measure is exactly the same as the hospital level measure, which was developed by CORE and endorsed by NQF in 2020.

This measure attributes to the measure outcome to clinicians or clinician groups, while the hospital level measure attributes the measure outcome to hospitals.

This PRO-PM measures the risk standardized for portion of patients undergoing an elective primary THA or TKA who meet or exceed an a priori patient-defined substantial clinical benefit, or SCB, threshold of improvement. The measure cohort includes elective primary, THA and TKA procedures, which are

procedures commonly performed in older patients and Medicare direct payments to hospitals performing these procedures exceed $15 billion annually.

While many patients experience significant improvements in their pain function after their procedures, not all patients improve. Measurement of patient-reported data is a particularly effective approach to assessing improvements in patient's pain and function.

The outcome of this measure, SCB improvement, is calculated using preoperative and postoperative assessments on joint specific patient-reported outcome measure surveys. This PRO-PM measures improvement only and does not define an end-state that a patients must achieve. As such, there is no disincentive to treat patients with worse symptoms before their procedure.

The clinical-derived risk model was developed by the hospital level team and include comorbidities endorsed by clinical experts and health literacy as significant social risks factor. Like the NQF endorsed hospital level measure, other social risk factors are incorporated into our statistical approach to addressing potential bias and measure results due to non-response.

There is evidence in the literature and in our data of differential response due to dual-eligibility and social economic status. As well as race. And these factors were included in our propensity core models used to create stabilized inverse probability rates to address potential non-response bias.

PRO-PMs uniquely reflect patient outcomes but require voluntary patient response to surveys. And are impacted by some non-response. And CMS is engaged in strategic implementation planning to support PRO response rates.

Throughout the development of this measure, and

the hospital level measure, we met with and solicited extensive input from orthopedists. We saw input from a technical expert panel, or TEP, comprised of orthopedists, experts and patient-reported outcomes, as well as patients.

A clinical working group comprised of representatives from the American Academy of Orthopedic Surgeons, the American Association of Hip and Knee Surgeons, the Hip Society and the Knee Society. As well as our orthopedic expert consultant and public comments at orthopedic and medical societies. Orthopedic surgeons in orthopedic societies have expressed strong support for this measure.

And importantly, CORE met with and solicited extensive input from patients on the measure specifications throughout the development of this measure and the hospital measure. Patients on our TEP and our patient working group strongly support this measure. In particular, the measure outcome definition.

During the development of the hospital measure, patients told us they want a measure that reflects an expectation of substantial improvement following an elective primary, THA or TKA.

Our team has applied a rigorous approach to the development and testing of this measure and submits this measure to NQF for the confidence in its specifications, its reliability and validity and its importance. Particularly to patients. Thank you all.

Co-Chair Sox-Harris: Thank you so much for that excellent overview.

Ms. Zribi: Thanks.

Co-Chair Sox-Harris: And we'll now go to Dr. Lamb for some comments about patient-reported outcome measures.

Member Lamb: Thank you. Thanks also to all of you

for inviting us to attend and comment on the measure. Chris Stille, my co-chair, wasn't able to join me.

So I'm going to just talk very briefly about three things. Co-chairs have asked us to highlight issues that come up in the review of patient experience and function measures. And in particular one like this, the PRO-PMs.

Also, a few comments about our committee's review of the related measure, 3559. Which is the hospital level related measure that partners with the clinician level.

And then, and I might add there, the PEF committee recommended 3559 for endorsement in 2020. It is an NQF endorsed measure.

And then finally just a few comments on 3639, which you will be moving into that review. It's the same measure specifications, except as noted for the attribution at the clinician or clinician group level.

So, not, I probably won't surprise you all. The issues that we focus on, in addition to all of the usual criterion, because we go through exactly the same criteria that you will be going through, and do go through.

The things we look at particularly in PEF, and in the PRO-PMs are a couple of things. One is under the criterion of importance. The question we ask is, is this measure important to patients and families. Okay.

Another piece that increasingly we have focused on is performance gap and disparities. Has the instrument been tested in a sample representative of the general population undergoing the procedure or the general population out there.

Another area, another criterion we look at is validity. Have patients and families been consulted, are they involved in establishing content validity during the

development of the instrument, are they involved in the discussions of the instrument.

Certainly, and I'm sure you'll all go through this, is feasibility and burden to patients and families. And then the intended use. Will it improve care for patients and families.

And I imagine that the patient advocate on the surgical committee, surgery committee, will also have things to talk about there.

In terms of our review of 3559, which is the hospital level measure, as I mentioned, the PEF recommended this measure for endorsement. In those areas that I just covered, the issues that came up on 3559 related to importance and performance gaps.

You already heard that the related measure, patients were deeply involved in defining the numerator for the measure. There was some concern on the PEF that patients would be able to interpret the meaning of the thresholds selected for improvement.

And that our committee recommended that the measure of functional status be discussed as part of patient education. To make sure that patients anticipated that this outcome would be one that would be important to them.

We also looked at performance gap and disparities with 3559. And noted that there was low representation of non-White individuals in the sample.

The measure developers, at that time, noted that that might be due to differential access to care in elective procedures. And they spoke to statistical technics that they use to compensate for that. And then in public comments there was some concern about survey fatigue for patients.

Moving on then to 3639 to add to our review is, in

those same areas of importance, patient participation, validity, disparities and feasibility. As with 3559, and important to the review of PRO-PMs, the measure developer intentionally, specifically involved patients in the development.

And as noted earlier, patients find the measure important and simple to use. And also recommend it.

Performance gaps, I think that the, the data that was presented still has low numbers of testing with non-White populations as well as low SES. So, that seems to be a continuing issue. And it would be one that PEF would look at.

Lastly, burden was not identified, but it was raised in public comments. And a question that I had to add to the discussion is whether the data that are collected for 3559 and 3639 are the same, so it would not require duplicate data collection.

So thank you for inviting us. And I hope that was useful.

Co-Chair Joseph: Yes, that was excellent. That was excellent. We really appreciate your feedback.

Now, I would like to introduce our lead discussant, Linda Groah.

Ms. White: Linda, I think you're on mute.

Member Groah: All right, there we go. Thank you, Dr. Joseph. And this measure is 3639, the clinician-level and clinician group-level for total hip and total knee arthroplasty.

The developers are the Centers for Medicare & Medicaid Services, Yale New Haven Health Services Corporation and the Center for Outcomes Research and Evaluation.

This patient-reported outcome base performance measure uses the same measure specifications as the NQF endorsed 3559, or the hospital-level, risk-

standardized improvement rate following elective primary total hip and knee arthroplasty with the following exception.

This measure attributes the outcome to a clinician or clinician group. Specifically, this measure will estimate a clinician-level and/or clinician group-level RSIR following elective primary total hip/total knee for Medicare fee-for-service 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 zero days before surgery. And the postoperative data collection time frame will be 270 to 365 days following surgery.

The outcome is a PRO. And the data source will be the claims instrument data. The PROM surveys used to define the measures outcome or a hip dysfunction and osteoarthritis outcome score for joint replacement and for the total hip patients and the knee injury and osteoarthritis outcome score for joint replacement for the knee patients.

Level of analysis from the clinician is the group practice and the individual clinician. The primary ratings for the evidence from staff was a pass.

This is a new patient-reported outcome performance measure utilizing claims instrument based and Medicare enrollment data at the individual clinician and group practice level. It aims to improve patient outcomes by providing information to patients and clinicians about clinician and clinician group level, risk-standardized patient-reported outcomes, such as pain and functional status following elective primary total knee and total hip arthroplasty.

The logic model presented by the developer for this outcome measure links actions that can be taken by

the accountable entity. Such as the surgical approach and technique, preoperative planning, shared decision-making with the patient, communication among the providers, prevention of and response to complications, patient safety, and coordinated transitions to the outpatient environment with patient-reported outcomes.

For example, improved recovery and rehabilitative status, decreased pain and improved mobility and quality of life following the total hip or total knee procedure.

The developer highlighted those patients on both the developers technical expert panel and the patient working group. They indicated that they found the measure to be meaningful.

The developer noted evidence supports attributing patient-reported outcomes to the surgeons performing the procedure. Including data supporting that low surgeon case volume is associated with longer operating times, lengthier hospitalizations, high infection rates. And worse, PROs.

The developer noted supporting evidence that attributes patient-reported outcomes to the surgeons performing the procedure. Including data supporting that low surgeon case volume is associated with longer operating times, lengthier hospitalizations, higher infection rates and worse PROs.

In terms of the gap, we're looking at the primary rating as being moderate. The developer provided the mean and distribution of risk standardized improvement rates for clinicians, and clinician groups with greater than 25 total hip, total knee patients with a PRO data using the full sample database data set, which included 19,429 elective primary procedures from July 1st --

Ms. White: Linda?

Member Groah: Yes.

Ms. White: Oh, I'm so sorry. I'm sorry to interrupt, I was having trouble coming off mute. So, if it's okay, I'd like to have the Standing Committee discuss the evidence criteria, the importance to measure, prior, before going into gap, if that's okay?

Member Groah: Okay.

Ms. White: Okay, wonderful. Thank you. Sorry. Sorry, I didn't mean to interrupt.

Member Groah: No problem. So, discussion?

Dr. Joseph, will you be leading that discussion or --

Co-Chair Joseph: Okay, yes. So, does anyone have any issues or questions with regards to the evidence that's been presented at this point?

You can put something in the chat or you can raise your hand. And you would have to go to the actions icon, which is that smiley face, and then you would raise your hand that way. No comments, okay.

Now, do we have anything from the other discussants? Co-discussants. Did anyone want to say anything regarding the evidence?

Member Kertai: This is Miklos Kertai. There are no concerns from me. I was one of the co-faucet daters.

Co-Chair Joseph: Okay. I believe the other one was Dr. Ortiz.

Member Ortiz: I have no issues. It's good evidence.

Co-Chair Joseph: I have here in the chat, this is Dr. D'Agostino, no problems. Good supporting measure in terms of the evidence.

Another few seconds. Okay. Okay, we can move on since no one has any issues to discuss with regards to the level of evidence.

Member Groah: So I will go back to the gap.

Mr. Sakyi: With no questions or concerns we will open up the pole for voting on evidence.

Co-Chair Sox-Harris: Can I just ask a process question as we roll through this. So we need the lead discussant, the other discussants, full committee and then if necessary, or requested, an opportunity for the developer to clarify. And we'll use kind of that flow. Did I say that right?

Okay, so I think we've gone --

Ms. White: Hang on. Yes, that's correct.

Co-Chair Sox-Harris: -- through that.

Ms. White: Yes, absolutely.

Co-Chair Sox-Harris: Okay, thank you. Just making sure. We've had discussion about our process, I just want to make sure I absorb the right version.

So the only thing we've missed is an opportunity for the developer to comment on the discussion on evidence, which there wasn't much committee discussion. But just to, for completion. I don't know if the developer had anything they want to add.

Ms. Zribi: Nothing additional. Thank you so much.

Co-Chair Joseph: All right. I guess, Isaac, we can go and vote now.

Mr. Sakyi: Voting is now open for Measure 3639 on evidence. The options are A, for pass, and B, do not pass.

We're expecting exactly 16 votes. We're waiting for three more votes. One more.

Ms. White: Again, just a reminder, if you're having difficulties with your vote link you can also directly message me. Okay, Isaac, we can go ahead and lock the vote.

Mr. Sakyi: Voting is now closed for Measure 3639 on

evidence. With 15 votes for pass, 0, no pass, the measure therefore passes on evidence.

Co-Chair Joseph: Okay, great, thank you. All right, next we're going to be talking about the performance gap.

Member Groah: Thank you. The performance gap. The preliminary rating here is moderate by staff.

The developer provided the mean and distribution of the risk standardized improvement rates for clinicians and clinician groups with greater than 25 total hips, total knee patients with PRO data using the full sample data set, which included 19,429 elective primary knees and hip procedures from July 1st, 2016 to June 30th, 2018.

The mean for the clinician level RSIR combined data set and the clinician group level were 64.21 percent. And 64.74 percent respectively.

The distribution and performance for the 25th to the 75th percentile ranged from 56 to 73 percent for the clinician level RSIRs. And a similar distribution for the clinician group level.

The developer notes that the mean and distribution of the RSIRs, for both clinician and clinician groups from this measure supports the variability in clinician and clinician group performance. Therefore, there are opportunities for improving outcomes following elective primary hips and knees arthroplasties.

The disparities that were identified, the developer evaluated the distribution of the RSIRs by quartiles of proportions of patients with dual eligibility, low socioeconomic status, using the agency for healthcare research and quality SES index and of non-White race among patients with PROs for clinician and clinician groups with greater than 25 total hips and knee patients with PRO data, the distribution of RSIRs for clinician and clinician groups with the, by the proportion of patients with dual

eligibility with PROs.

The clinicians with zero dual eligible patients among patients with PROs, 25th percentile, 53.1 percent, and at the 75th percentile, 72.93 percent.

Clinicians with the highest proportion with dual eligible patients, among patients with PROs at the 25th percentile were 58.66 percent. And at the 76th percentile, 71.66 percent.

The distribution of the RSIRs for clinicians, by proportion of patients with low SES and of the index score lowest quartile with PROs. The clinicians with lowest proportions of low SES patients among patients were 25th percentile, 53.16 percent, and 75 percentile 72.88 percent.

Distribution of the RSIRs for clinicians, by proportion of non-White patients with PROs, clinicians with the lowest portion of non-White patients among patients with PROs, 25th percentile, 50.65 percent, 75th percentile, 72.93 percent.

And the clinicians with the highest proportion of non-White patients among the patients with the PROs, 25th percentile, 57.80 percent, and 75th percentile 73.52 percent.

Is there any discussion by the co-discussant? Okay.

Co-Chair Joseph: So I will open it up to the Committee, as well as the co-discussants. Any comments?

Member Kertai: This is Miklos Kertai. I just agree with Dr. Lamb about non-Whites and patients with low socioeconomic stages to be underrepresented. You know, these numbers are still kind of very small numbers.

This is kind of a recurring theme with all these different measures. Not only for this one, this is something that certainly in the future should be kind of thoroughly addressed. But other than that, I don't

have any other concerns.

Co-Chair Joseph: Okay. And we have a comment in the chat box from Dr. Lamb. There is low representation of non-White individuals and low socioeconomic status in the sample. Is propensity weighting being used to compensate as with Measure 3559? So I guess this is a question for the developer.

Ms. Zribi: Hi, this is Rachelle. Just making sure now is the right time to answer?

Member Groah: Yes, please. Go ahead.

Ms. Zribi: Thank you so much. And thank you all for raising these concerns. We acknowledge there are disparities in access to hip and knee procedures nationally for vulnerable populations. And in our testing sample we acknowledge there is limited proportion of hip and knee recipients from racial and ethnic minorities. It's approximately seven percent of the sample.

However, this is unfortunately representative of the national population of patients undergoing hip and knee procedures among fewer than nine to ten percent of patients undergoing these surgeries are from non-White racial groups and minority ethnicities.

And to answer the question in the chat, is propensity weighting used to compensate as with the hospital level measure, yes, we use the same approach. And as a reminder, in the propensity weighting we do include three variabilities. Dual eligibility, AHRQ SES lowest quartile, as well as non-White race. Thank you.

Co-Chair Joseph: Okay, thanks. That's helpful. All right. And I was curious, have you also looked at gender in terms of, is there a gap?

I know that somebody passed the hospital, it's interesting how, in terms of improvement, from a

patient's standpoint, was there a difference? Did you investigate that at all?

Ms. Zribi: We do have sex in the risk model. And I can look to see if we looked specifically if there were differential outcomes based on sex. Thank you.

Co-Chair Joseph: Dr. Siperstein.

Member Siperstein: Thanks, Vilma. So a question. My understanding is this metric is Medicare fee-for-service. And as we have more and more people shifting to Medicare advantage, how is that going to affect the issue that we're talking about in terms of sampling various populations?

Ms. Zribi: Can you repeat that last question, please?

Member Siperstein: It has to do with the population that's being studied. My understanding is, it's just Medicare fee-for-service, but does not include Medicare Advantage, which is becoming a bigger pot out of the Medicare pool. And obviously there are differences in disparities among those two groups. And as the shift continues, how is it going to affect the sampling of disparity?

Dr. Suter: Hi, this is Lisa Suter from Yale CORE. Are you able to hear me?

Co-Chair Joseph: Yes.

Dr. Suter: So you're correct, the measure only includes fee-for-service data. We do have Jennifer Robinson on the phone who is our contracting organization representative for our contract who can speak to this.

I will say that CMS has expressed interest in expanding in that direction. And the measure is amendable to expansion for CMS to move in that direction.

Obviously, that's a policy decision that I'll defer to Jennifer Robinson. Jennifer, are you on the line and

able to speak to whether CMS has an intention or potential plan in the future to incorporate Medicare advantage patients into its administrative claims measures? Excuse me, its patient-reported outcome measures.

I think we may have lost --

Co-Chair Joseph: She says she's double-muted.

Dr. Suter: Oh, she says she's double muted.

Co-Chair Joseph: Yes. So she's trying to get on via audio. Okay, give her a few minutes.

Dr. Suter: Could the NQF staff just make sure that she is joined through a line that has the ability to speak? I don't know if there are people who are called in that don't have that ability.

Co-Chair Joseph: Yes. She may be trying to get in via her computer. She can also dial in via the phone line that's in the chat box. The number is in the chat box.

Ms. Bal: Hi, everyone. She should be able to speak. We'll make sure that we get her line open.

Just a little bit of information though, we really should be voting and reviewing the measure as is, and not based off of any potential use or intended use. So right now I think the measure is justified to be in that program, unless the datas are showing so that's what we should be looking at.

And then the potential for expanding it further, I think Lisa spoke to, but it would be feasible to expand this population into that. But I think for now let's just focus on the measure as is.

Co-Chair Joseph: Okay. All right, does anyone else have any other comments? Any points for discussion?

Okay. So, Yale, the CORE group, do you want to add anything else before we vote? We had a few things we were talking about.

Ms. White: Only if the Committee feels like they have unanswered questions.

Co-Chair Joseph: Okay. I think that we're okay.

Co-Chair Sox-Harris: To vote.

Co-Chair Joseph: Ready to vote.

Mr. Sakyi: Voting is now open for Measure 3639 on performance gap. The options are A, for high, B, for moderate, C, for low, and D, insufficient.

And we are expecting 14 votes. We're expecting 14 votes because Dr. Saigal needed to step away.

Voting is now closed for Measure 3639 on performance gap. We have three votes for high, ten votes for moderate, one vote for low, zero insufficient. With 13 votes between high and moderate, the measure passes on performance gap.

Co-Chair Sox-Harris: Great.

Member Groah: Moving on to reliability. Dr. Harris.

Co-Chair Sox-Harris: Yes, Dr. Joseph and I are going to swap back and forth on the domain scientific acceptability. Linda, would you discuss. Thank you.

Member Groah: The reliability, this is a must-pass criterion. The preliminary rating is moderate. There are three highs. High was three, sorry, moderate, three, low, one, and insufficient, two.

The reliability testing conducted at the patient or the encountered level. Evidence for the data element reliability was provided through existing literature.

The PRO-PM was originally developed for an tested at the data element level for this population. The developer tested, retested an internal consistency to assess the reliability of both the PRO-PM instruments or the PROM-Ms, which is the HOOS, JR and KOOS, JR.

Internal consistency was calculated using the Pearson Separation Index for both instruments. The internal consistency ranged from 0.84 to 0.87.

Inter-class correlations for reliability were between four dimensions. Including pain, symptoms, activities of daily living, sport and recreation function and quality of life. The HOOS and the KOOS both with ranges from .75 to .97.

Reliability testing was also conducted at the accountable entity level. The developer performed reliability testing at the measures score level using a signal-to-noise ratio. And among clinician and clinician groups with five and ten cases.

At the SNR-yielded median reliability scores were ranging from .70 to .79. And .79 to .85 respectively. The mean reliability score was .69 for clinicians with at least five cases.

Among clinicians and clinician groups with at least 25 cases, the SNR ratio yielded median reliability scores ranging from .87 interquartile range to .92. The mean being .90 and the IQR .10 respectively. Is there discussion by the discussant corroborators?

Co-Chair Sox-Harris: Hearing no comment, additional comments from the other discussants, does anybody else on the Standing Committee have comments related to reliability?

And I think the vote that's ahead of us is whether we want to confirm the SMPs passing of this measure on reliability. Just to make that clear. I see Allan.

Member Siperstein: You're going to hate me after this comment, Alex. I've gotten this a little bit because I've developed a PRO for thyroid and parathyroid disease. And I have no problem with the validity of the metric itself, internally.

But then the other question is, the statistics for the methods used to determine a difference before and

after. And so, if, for example, after knee or hip surgery you either are on the basketball court or sitting on the bench. I mean, the patients kind of distribute themselves into two buckets.

Then you can have a cut point in the middle of 20, 22 points to separate those two buckets. Whereas if you really see a continuum of differences and if you were to say, well, that cut point is going to be 19, 20, 21 and you start to see significant differences, then the statistics become a little bit muddier in terms of identifying differences between one surgical group and another.

And from the material I couldn't sort out how the before and after differences are segregating themselves. Are these people are really in "two buckets." And so that cut point makes sense as a differentiator versus a more continuous difference where then it brings up this very much more muddy type of statistic to see if you've got a before and after difference.

So I don't know if the developer has any insight into that.

Co-Chair Sox-Harris: So maybe I can take a stab and the developer can correct me. So, you know, my understanding of the method was that it's, you know, patients vary in the amount of improvement that they experience and some kind of anchor-based approach was used to determine at what point, you know, as you go up in improvement your sensitivity and specificity and other accuracy measures will change in terms of identifying those patients who are, you know, satisfied with or happy with but considered their improvement to be clinically meaningful one year later.

There is probably nothing magical about the thresholds that were chosen. It's not two distinct populations, but a judgment as you, you know, slide up in the amount of improvement where, you know, this is point where people are mostly satisfied or

considering their improvement to be significant.

So I think, you know, I'm fairly confident that is the method. These aren't two wildly distinct groups, it's just a threshold that has been chosen in the distribution of improvement. Does that answer your question, Allan?

Member Siperstein: Yes, I guess, sort of. But I guess then the question is I mean if you have a bunch of people who are like just under or just over, you know, you can, you know, then you have a long discussion about whether the best statistic is to use a cut point versus some other statistic that looked to be an improvement.

Because when you have a real continuum then you start to get into, you know, either ceiling effect or floor effect, you know. Those people that start out the worst may realize "X" number of points of improvement versus people that are starting to do better may not have the ability to, you know, improve "X" number of points.

So I don't know if the developer has any insight into that.

Dr. Suter: Hi. This is Lisa Suter from Yale CORE. Alex, thank you, that was a great summarization.

And, yes, the original instrument was based off of a patient's satisfaction anchor and those empirically and patient-derived deltas were then published.

We used that information and then took it back to our patient group and walked through with them, you know, giving them scenarios of what different changes in question responses would translate to in terms of total score. They confirmed that they thought that the cutoffs were reasonable and important.

To get at the issue of ceiling and floor effect, actually the orthopedic group, the orthopedic working group

and the orthopedists on our TEP, Technical Expert Panel, actually appreciated this approach for two reasons.

One of which is often times in measurement the perception is the people who are not going to do well, especially for something where you need to encourage patient engagement to respond to the survey, that these patients, a measure like this would either encourage gaming by not offering surveys to those individuals that you thought were doing well, or not offering them surgery at all.

And by allowing individuals who have very poor function at the beginning who are oftentimes passed over for surgery because they are thought to be high risk or, you know, they won't have outcomes that look good on the report card, this measure allows people to perform surgery on those patients because they will see a change.

And we did see that, that actually people who started with a lower preoperative pain and function score, higher pain, lower function, tended to do better.

The other reason that the orthopedists and other TEP members appreciated the approach was actually because of the ceiling.

We are seeing a scope creep or indication creep in hip and knee replacements. They are being performed on younger and younger individuals and with individuals with less and less pain and disability.

The orthopedic surgeons actually felt that it was really important from an appropriate use standpoint that this measure actually disincentivizes performing surgery on someone with very mild symptoms because it is, you know, it is an elective surgery and it has, you know, a high rate of success, but it is not without risk.

And so that was actually considered a positive aspect of the measure, that it allows both those doing poorly

to do well and not to be, you know, not to have any reason for surgeons not to perform surgery on those populations, which I will just say traditionally in the United States those patients often have lower socioeconomic status or they are non-White race.

Co-Chair Sox-Harris: Right.

Dr. Suter: And on the flip side of that, being able to disincentivize surgery on people who have very mild symptoms and may benefit from less invasive treatment.

Co-Chair Sox-Harris: Thank you for that. I want to try to bring the discussion back to reliability.

I think, you know, this question of how the outcome is operationalized we may revisit a little bit in validity.

To summarize the results that were given to us on reliability, the entity level reliability to the way the measure is actually specified was quite good and especially good in cases over 25.

And so if -- again, for discussion does anybody on the Panel have other reliability-related questions, clarifications, or comments?

Now I am on the SMP so I don't know how conflicted I am to summarize some of the -- The SMP never works where people say, you know, slam dunk, this thing is reliability or slam dunk, it's valid. It's always a judgment on the continuum as well.

From re-reading the comments it seemed like the main issue was that the numbers were quite good and especially good if the minimum case number was 25 or more.

So I think it's an open question, whether at some point there needs to be minimum case numbers. That would be my only comment. So I am looking at the chat --

Ms. White: Alex, Dr. D'Agostino left a question but I

think we might need to table that for validity.

Co-Chair Sox-Harris: Okay. Thank you. Is that okay?

Great. So any other reliability-related discussion points?

Hearing none, so I think we are okay to move on to a vote on whether we want to uphold the SMP's passing of this measure on reliability.

Mr. Sakyi: That is correct. The voting is now open for Measure 3639. The question is do you accept the Scientific Methods Panel's moderate rating for reliability. The options are A for yes and B for no.

Voting is now closed for Measure 3639. We have 15 votes for yes to accepting the Scientific Methods Panel's moderate rating for reliability and zero votes for no.

The Standing Committee votes to uphold the SMP's moderate rating for reliability.

Co-Chair Sox-Harris: Thank you so much. And then back to Linda for a summary of issues related to validity and whether we want to uphold the SMP's passing of the measure on validity.

Member Groah: Thank you. On validity the SMP preliminary ratings were high zero, moderate seven, low one, and insufficient one.

The validity testing conducted at the patient or encounter level. The developer evaluated responses for both instruments using the standardized response means and then compared against two other previously validated PRO-Ms.

External validity was evaluated for both instruments using Spearman's Correlation. The correlation ranged from a 0.84 to 0.94 for HOOS and correlation ranged from 0.72 to 0.91 for KOOS.

The floor and the ceiling effect were 1.9 percent and

37 to 46 percent respectively, that was for the HOOS. For the KOOS it was 0.4 percent to 1.2 percent and 18.8 percent to 21.8 respectively.

The SMP stated a concern that the 22 point PRO-M improvement threshold will result in a substantial percentage of patients not meeting the target threshold even if they experience no complications and feel significantly better after surgery.

A subgroup member stated that a high percentage of preoperative patients in the sample will fail the measure based on very low or very high PRO-M scores.

For patients with high preoperative PRO-M scores the developer stated that this is one mechanism for reducing potentially unnecessary total hips or total knees.

The surgeries could be managed medically. The developer further added that from the orthopedics perspective the ceiling effect is not concerning because it encourages clinicians and clinician groups to only offer surgery to patients that have substantiated symptoms so that a benefit from surgery can be seen.

Validity testing conducted at the accountable entity level. Face validity was assessed by asking a 17-member TEP to respond to two statements using a six point scale.

Seventy-six percent either strongly or moderately agreed with the statement that this measure as specified will provide a valid assessment of improvement in functional status and pain following elective primary total knee and total hips.

Fifty-three percent either strongly or moderately agreed with the statement that this measure as specified can be used to distinguish between better and worse quality care among clinicians and the clinician groups.

Is there discussion?

Co-Chair Sox-Harris: Do the other assigned discussants have additions or comments?

Member Ortiz: This is Dr. Ortiz. I think my biggest thing that I took from this, the comments from the Panel and also the comments from our team here, was, you know, about 37 percent of the sample was found not to be included in the final and that is definitely a big threat to the validity, you know, and so what can be done, you know, to be able to, you know, consistently get better response rates in order to have good data down the road.

That's sort of a big concern and obviously that just depends on the actual practice as how they manage this going forward as far as, you know, pursing the data, getting the data collected from the patient, and following through.

But, you know, I think that's sort of like the biggest concern as far as validity for this specific measure.

Co-Chair Sox-Harris: Thank you for that important comment. Other discussant or Standing Committee comments on validity?

I might add so the SMP, as Allan previously raised the issue, one of the concerns was the use of the threshold for the outcome.

There are issues in any way you can think of to operationalize the outcome. There are going to be issues. So this is the one that is in front of us.

The missing data is a huge concern and the developers have tried with a non-response biased approach to account for this, but I think, you know, any experienced statistician would know it's just like what's the least bad method of trying to account for the fact that there is, you know, 40 percent missing data.

And that's not every clinician having 40 percent

missing data, there is a distribution of missingness. So some clinicians probably have 70 percent missing data and what does it mean to have performance on something when only 30 percent of your patients are represented.

And so there are different approaches and I noticed in the submission one of the approaches that is being considered but not in front of us is to in parallel give context information about what, you know, how much missingness there is for each clinician and maybe develop some kind of method to only include people who have a certain amount of data represented.

That is not what is in front of us today. It's a statistical method to try to deal with it.

I would say the last validity issue was that the TEP, the face validity method with the TEP, the TEP was tepid. There is very little strong agreement that the PRO-PM would be able to distinguish between quality between clinicians on those, some moderate agreement.

But a fair -- So it was a tepid response by the TEP is my summary of the SMP concern. The SMP passed it, but these are the conversations that went on.

So opening it up to others for comments and questions.

Co-Chair Joseph: I just had one comment with regards to the actual surveys, you know, the HOOS, JR. and the KOOS, JR.

They stated that, you know, for the hospital measure as well as for this clinician-based measure that it's primarily available in English and that they are working on validating the survey in other languages.

I am wondering if that would have an impact in terms of that, the number of patients that you have who are non-White, remember, again, we're going back

to, you know, disparities and it's like what do we -- Is this something that is going to be, something that is going to change the measure because now you're going to have a whole other group of people that you weren't able to communicate with before.

So I was curious what the developer thought about that and the timeframe with regards to when the validation of the HOOS, JR. and the KOOS, JR. surveys will be available.

Co-Chair Sox-Harris: Thank you for that comment. Other Standing Committee comments, concerns, questions about validity before we move to the developer to address some of these issues briefly?

Ms. White: Alex, there was a question from Dr. D'Agostino in the chat earlier. I don't know if we want to go and re-visit that prior to opening it up to the developer.

Co-Chair Sox-Harris: Thank you. Richard, was your question about missing data addressed or would you like to --

Member D'Agostino: No. Yes, it was. I am actually impressed that they were able to get 60 percent follow-up, because that's hard to do. We are wrestling with that in our Nation PRO project at STS.

Co-Chair Sox-Harris: Indeed. To just trying to get it done clinically just on the fat of the land and the regular clinical flow getting 60 percent is remarkable.

I've run research projects where I have hired people to do it and, you know, getting 80 percent when you've paid to have it done is difficult, so, yes.

Other comments from the Committee?

So seeing none, so maybe moving to the developer just to briefly discuss some of the issues that have come up. I would say missing data is now on my mind and other people's mind, on whether the instrument is in languages other than English, and the way the

outcome was operationalized.

Dr. Suter: This is Lisa Suter for Yale CORE. I will address some of the concerns and then pass it to Rachelle to address Dr. D'Agostino's concerns about, question about when the response rates are occurring over the postoperative window.

So first let me just acknowledge language and reflect that there are probably hundreds of pain and function surveys that are applicable to this population.

The patient-reported outcome surveys that we selected were both prioritized by the orthopedics community and developed specifically within joint replacement patients, not just general orthopedic groups.

They were derived from longer surveys that were focused on individuals with degenerative arthritis of the knee and hip.

There are translations of the source surveys across more than 30 languages. The translational validation in Spanish and other languages is ongoing.

I don't have a timeline, but the HOOS/KOOS, JR. developer is supportive of moving that work forward.

I think this is a tremendously important and challenging aspect of patient-reported outcome measures in that we are constantly trying to balance burden lengths, validity, language, acceptability, and the ability to actually see response.

I think it was important to the orthopedic and the patient people who weighed in our measure development that they could see, you know, real changes in pain and function and that's why we used joint-specific PROs for this measure as opposed to a more general physical function or pain measure, such as the PROM-Ms, which we do use in the mental health component of the risk adjustment.

In terms of the non-response and the missing data,

so a couple things to just reflect on, this data was collected as part of CMMI's CJR model which actually incentivized through a point system the voluntary collection of PRO data in a model that is really a proof of concept because it took a generalizable sample of hospitals across the entire United States and sort of, you know, moved rapidly to say, here, you want to collect this data and you'll get a couple extra points and you may get a higher reconciliation payment through the model.

And so we had any number of hospitals of, you know, rural, urban, small, large, who have never collected this data before work on collecting it.

And as those of you who have worked on collecting patient-reported outcome data it's challenging and it's very challenging because optimally to collect this data you need to integrate it entirely into the clinical workflow.

There are some institutions, for example in Austin at the Dell Medical School, their whole surgery department, their orthopedics has a patient-reported outcome flow that ensures that all patients are getting PROs and they are integrated at the point of care and they are involved in decision making and they have, you know, a completely cohesive system.

They have very, very high response rates. That's a challenging thing for everybody to do, but that CJR model was an incredible proof of concept to show us that almost every hospital could get to close to 50 percent response rates, you know, rapidly.

That I think is helpful in understanding what might be achievable with some sort of, you know, if this measure were implemented in a national program.

I think the other comment on the poor response gets at the fact that orthopedic surgeons are not universally collecting this data.

They freely admit that the surgery's purpose is to

reduce pain and increase function, but they are not really collecting that data in a standardized fashion.

The American Academy of Orthopedic Surgeons has actually submitted to a strong, you know, they strongly encourage patient-reported outcome data and they feel strongly that the Academy needs to get involved in helping their membership move forward in this space.

So while I think there is an uphill road for many practitioners, I think this will be aided by a professional society that is committed and other professional societies in the orthopedics community that are committed to patient-reported outcomes.

I think, you know, a really optimistic proof of concept with hospitals that were really, you know, trying this for the very first time, you know, with no, not necessarily any local leadership at their hospital level and it was challenging and maybe not optimal, but I think it's an important measure in this space.

And it's important to understand that the other thing we have heard from stakeholders, the hospital measure, was signaled in last year's hospital payment regulation and the public response from that urged CMS to think about a staged or phased implementation approach.

In the past CMS has either done dry runs or voluntary reporting prior to public reporting. So that is something that CMS might consider under these circumstances.

The other feedback we received was publishing or reporting response rates in addition to or in place of measure results at first so that there could be some incentive around achieving response rates and some transparency on that front.

So, again, I know Jennifer Robinson is on the line and I know she was having issues speaking before. Jennifer, if you want to put anything in chat I will be

happy to speak for you or --

(Simultaneous speaking.)

Co-Chair Sox-Harris: And thank you so much for that. Just in the name of time I think you've really addressed some of the concerns.

Dr. Suter: Okay.

Co-Chair Sox-Harris: It's very interesting that although the, you know, as you say it's a proof of concept that will leverage a potentially increased response rates going forward, so thank you for that.

Any other clarifications or questions from the Committee or direct questions to the developer before we move on to voting on whether to uphold the SMP passing of this measure on validity?

Okay, not seeing any hands. Great. I think we are okay to vote on whether to uphold SMP validity.

Mr. Sakyi: Voting is now open for Measure 3639 on accepting the Scientific Methods Panel's moderate rating for validity. The options are A for yes and B for no. Again, we are expecting 15 votes.

We are waiting for one more vote.

Is anyone having difficulty voting?

Participant: I am. I responded in the chat to you directly, Isaac.

Mr. Sakyi: Would you mind sending that to LeeAnn?

Participant: No worries.

Mr. Sakyi: No, let's actually wait for that vote.

Voting is now closed for Measure 3639 on accepting the Scientific Methods Panel's moderate rating for validity.

We have 15 votes for yes and zero for no. The

Standing Committee votes to uphold the SMP's moderate rating for validity.

Co-Chair Joseph: Okay, great. All right, now we are up to feasibility. So, Linda, would you like to give us a summary for feasibility.

Member Groah: Thank you. The preliminary rating on feasibility is high. The developer indicates that the methods used to generate the data elements needed to compute the measure score can be collected by and used by healthcare personnel during the provision of care.

This includes the blood pressure, lab values, diagnosis, depression scores. The patient and/or family reported data elements are also useful and may be available electronically or in paper form.

The developer explains that most, if not all, clinical data elements can feasibly be captured in the electronic health record as the PRO and clinical risk variable data represent standardized results that can be captured within discreet fields.

Administrative claims data can capture prior medical history and co-morbidities to augment the limited clinical risk values while reducing patient and provider burden.

The developer recognizes the importance of electronic data capture and that not all clinicians collect data in the electronic form.

The measure specifications have been harmonized with electronic clinical quality process measures, specifically the functional status outcomes for patients receiving the primary total knee replacements and the functional status outcomes for patients receiving the primary total knee replacements.

That incentivized collection of the PRO data needed to calculate the measure outcome. The developer

reported that advancement in mobile applications and other PRO data capture forms are likely feasible to move to an electronic format.

Do the co-discussants have any comments?

Co-Chair Joseph: Okay, all right. Committee members, does anyone have any comments to make? I am looking in the chat box or raise your hand.

So, co-discussants, do you have anything else to say about this, any other comments?

Okay. All right. So then we can go right to the developer. Do you want to add anything else? And if not then we can go right to the voting.

Ms. Zribi: Nothing else to add. Thank you so much.

Co-Chair Joseph: Okay, great. Perfect, all right. So let's go right to the voting.

Mr. Sakyi: Voting is now open for Measure 3639 on feasibility. The options are A for high, B for moderate, C for low, and D insufficient.

Please send your vote directly to LeeAnn if you are having issues with the voting platform.

We are waiting for one more vote.

We have exactly 15 votes. The voting is now closed for Measure 3639 on feasibility.

We have nine votes for high, six votes for moderate, zero for low, and zero insufficient. The measure passes on feasibility.

Co-Chair Joseph: Okay, great. All right, now we are up to use. So, Linda, do you want to give us a summary on use?

Member Groah: I will. Thank you. The preliminary rating on this is a pass. The developer noted that this PRO-PM is being submitted for initial endorsement

and is not currently used in any accountability program.

The developer noted that CMS may opt to implement this measure in the quality payment program through a rulemaking in the future.

The measure is currently not implemented in public reporting or accountability program. The developer noted that obtained input during the measure development by convening a technical expert panel the clinical working group and the patient working group between August 20th and July 21st.

The TEP was comprised of 21 total members, five of which were patients, a clinical working group with four clinical expert members representing each of the four national total hip and total knee professional societies, and a patient working group of six members.

The developer solicited feedback through teleconference meetings. With the TEP there were four meetings, with the clinical work group there were three meetings, and with the patient working group there were three meetings.

The developer noted that the TEP and the clinical working group indicated strong support of measure specifications and provided recommendations for ongoing evaluation, such as consideration of provider volume, handling of staged procedures, the impact of social risk, and the expansion of the postoperative timeframe.

Clinicians from the TEP and the clinical working group, along with the developer's clinical expert, recommended ongoing evaluation of the risk model and social risk factor analysis.

The patient working group indicated that a patient-reported outcomes based performance measure following elective total hip and knee procedures would be helpful for patients in selecting their

surgeon as well as supporting information on the informed decision making.

The hospital level total hip/total knee PRO-PM development team engaged with patients during the selection of the cohort, the measure outcome, data collection instruments, and risk adjustment model.

Are there any comments from the co-discussants?

Member Ortiz: No additional comments.

Member Kertai: No additional comments from me. Thank you.

Co-Chair Joseph: All right. And how about from the other Committee members, any questions with regards to --

Participant: Nothing from me. Thank you.

Co-Chair Joseph: Okay. I am looking at it, so nothing is in the chat. Anyone have any other comments to make? Because, again, this is the first time this measure is introduced. Does anyone from CORE want to say a few words in addition?

Ms. Zribi: Nothing additional.

Co-Chair Joseph: Okay. Okay, we're moving along. So let's open it up for voting.

Mr. Sakyi: Voting is now open for Measure 3639 on use. The options are A for pass and B no pass.

We have exactly 15 votes. Voting is now closed for Measure 3639 on use. We have 15 votes for pass and zero no pass. The measure passes on use.

Co-Chair Joseph: Thank you. Thank you. Okay, Linda, would you like to summarize usability?

Member Groah: Usability, the preliminary rating is high. This is a new PRO-PM not currently used in quality improvement programs and there are no performance results to assess.

There are no harms identified by the developer. Do the co-discussants have any comments?

Member Kertai: No questions or comments from me.

Co-Chair Joseph: Okay. Excellent, okay. Any comments from the other members?

Okay. Looking in the chat box, nothing. Hand raising, no. Okay. Anything else from the developers you want to say regarding this measure or this portion of the measure?

Ms. Zribi: Nothing additional. Thanks.

Dr. Suter: No, thank you.

Co-Chair Joseph: Okay. So let's vote on it.

Mr. Sakyi: Voting is now open for Measure 3639 on usability. The options are A for high, B for moderate, C for low, and D insufficient.

We have 15 votes. Voting is now closed for Measure 3639 on usability. We have nine votes for high, six votes for moderate, zero for low, and zero insufficient. The measure passes on usability.

Co-Chair Joseph: Okay. Thank you, Isaac. Now with regards to overall suitability for endorsement.

Mr. Sakyi: Voting is now open for Measure 3639 on the overall suitability for endorsement. The options are A for yes and B for no.

Co-Chair Sox-Harris: We don't have any discussion or option for discussion before this vote or are we just going straight to this?

Mr. Sakyi: Yes, we can go straight to that vote, but we can pause if there are any concerns or comments from both the developer and Standing Committee members prior to that vote.

Co-Chair Sox-Harris: Vilma, should we just offer an opportunity for any lingering comments or questions

before we --

Co-Chair Joseph: Sure. We are running early so definitely we have time. Does anyone have any comments at all regarding this measure as far as for suitability for approving it? You can put it in the chat, you can raise your hand, and using the reaction tab.

Co-Chair Sox-Harris: I know one of the questions that came up earlier was whether the data collection for this measure will be used also for the hospital-level measure or for some reason are they separate data collection elements.

I know some of the public comments were related to that. It just has to do with effort to implement these measures versus the value we'll get for them and if it's more efficient they're more valuable.

So folks from CORE could you clarify that? Is this the same data collection that's used for both of these measures?

Ms. Zribi: Yes. Thank you so much for that question. We think it is definitely important to consider.

So the data elements required for this measure are exactly the same as the hospital, so there is no differences in terms of what's required for collection and really comes down to data submission of the measure to CMS.

So the same data can be submitted for the hospital-level measure if CMS puts that through for a hospital reporting program as well as for a clinical-level measure.

So it's really just on the data submission side, but all of the data could be used for both measures. Thank you.

Co-Chair Sox-Harris: Just to emphasize the point as I am understanding it, the single patient will not have to fill out the KOOS, JR. twice for these two different measures, it will just be one that will be used for both

measures, right, which is very sensible but there seemed to be concern or lack of clarity on that point, so, thank you.

Co-Chair Joseph: Great point. Very great point. Any other comments at all?

Okay. Chat box, raising the hand, okay. All right, I think it's time for a vote on suitability for endorsement.

Mr. Sakyi: Voting is now open for Measure 3639 on the overall suitability for endorsement. The options are A for yes and B for no.

We are waiting for one more vote.

We have 15 votes. Voting is now closed for Measure 3639 on the overall suitability for endorsement.

We have 15 votes for yes and zero for no. The measure is, therefore, recommended for endorsement.

Co-Chair Joseph: All right. Thank you very much, Isaac. And now we are going to be talking about related and competing measures. LeeAnn, do you want to talk about that?

Related and Competing Measures

Ms. White: I will. So thank you to the entire Standing Committee for the rich discussions that we just had. Thank you to the Chairs, and also thank you to the developer and your input during those discussions.

So, yes, we will move on to related and competing. So next slide, please. We do not have any competing measures this cycle, yet the developer did indicate that we do have some related measures.

So I'm going to quickly go over a brief review of what is considered competing and what is considered related. A competing measure is the same concept in the same target population.

In these instances the Standing Committee would need to have a best-in-class discussion. We do not have any competing measures, as I mentioned before.

There are also related measures where there is a different target population or a different concept. If they are both different we don't have a competition between measures and no harmonization is needed.

But there are times when there are similarities and developers are asked to harmonize their measures with other related measures appropriately.

Okay, so next slide, please. Related and competing measures will be grouped and discussed after recommendations for all related and competing measures are determined.

Only those measures recommended for endorsement will be discussed. The Committee will not be asked to select a best-in-class measure if all related and competing measures are not currently under review.

Committees can discuss harmonization and make recommendations. Developers of each of those related and competing measures will be encouraged to attend the discussions.

If there are similarities, the point of this conversation is to see if the Standing Committee has any questions or concerns with what the developer has listed in their measure submission with regards to related measures, or if there is any recommendations you would like to offer the developer that would be included in the final report.

The overall goal of this discussion is to mitigate any potential burden to the system in the number of measures and differences across related measures.

Next slide, please. So these are the list of the related measures that the developer has identified during the measure submission. The measure developer has

indicated that the measure specifications are completely harmonized.

Remember that the recommendations will not change the endorsement vote in any way, but it will be noted in our final report and in future evaluations by the Standing Committee.

We do have slide decks for each of these related measures. So I am going to pause and allow an opportunity for the Standing Committee to voice if they would like to visit one of these related measures or if the Standing Committee feels that the related measures are harmonized to the extent possible. Now I am going to pause a moment.

Member Lamb: LeeAnn, I have a question. This is Gerri Lamb.

Ms. White: Hi, Gerri.

Member Lamb: Not related to harmonization, but related to related measures. Should I hold it then?

Ms. White: You can go ahead and ask that.

Member Lamb: Okay. I was just looking at 3559 and 3639, which are related measures, and as we were just saying it's a very efficient use of data where you can submit the same data for different target populations with the only switch being an attribution.

It seems like a great model that I haven't seen before and I wondered if the measure developer has any plans to continue looking at attribution for other professional groups that influence outcomes for this population, you know, I'm thinking particularly of therapists.

Ms. White: Thank you, Gerri. So --

Dr. Suter: So this is --

Ms. White: Oh, go ahead. Sorry about that.

Dr. Suter: No, I'm sorry, LeeAnn. I will wait for your or Alex to call on me.

Ms. White: No, go ahead. You can -- yes, if you could just --

Co-Chair Sox-Harris: Thank you, Lisa.

Dr. Suter: Thank you, Alex.

Co-Chair Sox-Harris: Thank you for being well-behaved.

Dr. Suter: Do you want me to go ahead?

Ms. White: Yes, please.

Dr. Suter: Okay. Okay. This is an incredibly well run meeting, so it is your, you know, all of your leadership that is allowing me to be well-behaved.

Jennifer Robinson is on the phone. I don't, you know, we don't have any information about expanding this measure to other clinician populations, such as physical therapists.

I will say that in public comment CMS received, and with our Technical Expert Panel, CMS received a lot of interest in ensuring that this measure captures every setting that these procedures are performed in, including outpatient hospital departments and ambulatory surgical centers.

Those right now are in different payment programs within CMS and, therefore, unlike the CJR model where it's a setting-agnostic payment model, other settings are oftentimes siloed in different payment programs.

So CMS has received those public comments related to ensuring that these outcomes and this measure is also measured in different settings.

We will definitely bring back to CMS, as well as Jennifer, the feedback of expanding it to other

clinician populations, such as physical therapists.

Ms. White: Thank you, Lisa. Gerri, did that answer your question?

Member Lamb: Definitely. Thank you.

Ms. White: Wonderful. So I do need to ask the Standing Committee are the differences justified and is there any concerns related to the harmonization of these measures with Measure 3639 before we proceed.

Co-Chair Sox-Harris: This is a just a verbal if anybody has concerns they should say it now, is that correct, LeeAnn?

Ms. White: Yes. We just need to make sure that we are considering the Standing Committee and their input on the harmonization with these measures.

Co-Chair Sox-Harris: Okay. Thanks. So people can speak up or chat.

Ms. White: Yes. And chatting works as well. A confirmation, that would be great.

Okay, seeing no concerns we will move on to the next slide. Okay, so I will now hand it over to Karri Albanese who will be going through our next steps.

We can go down a few slides because these are all the related measures, so keep scrolling. Perfect. Okay. Oh, I'm sorry, go back up to member comments.

NQF Member and Public Comment

Ms. White: There is a slight delay at virtual meetings. Okay, so now I am going to just pause here a moment and open the floor for NQF members and members of the public to provide their comments.

We definitely welcome your input. So, again, I am going to pause and open it up.

I am hearing none, and I don't see anything in the chat so we will move on to our next slide, please.

Okay, now I will hand it over to Karri Albanese who will go through our next steps. So, Karri.

Next Steps

Ms. Albanese: Thank you, LeeAnn. Thank you, Tristan for (audio interference) --

Ms. White: Karri, we are having trouble hearing you. Are you able to maybe adjust your mic?

Ms. Albanese: Can you hear me now?

Co-Chair Sox-Harris: It's very soft.

Ms. Albanese: Okay, maybe if I project.

Co-Chair Sox-Harris: Perfect.

Ms. Albanese: Perfect.

Ms. White: Oh, that's better, yes.

Ms. Albanese: Thank you. Next slide, please. And thank you, LeeAnn. All right, so I am going to briefly go over the measure evaluation process after the measure evaluation meeting.

So the staff with prepare a draft report detailing the Committee's discussion and recommendations.

This report will be released for a 30-day public and member comment period and then the staff will compile all comments received into a comment table which is shared with the developers and Committee members.

We will next hold a post-comment call where the Committee will reconvene to discuss all the comments submitted. The staff will incorporate comments and responses to comments into the draft report in preparation for the Consensus Standards Approval Committee meeting, known as the CSAC

meeting as well.

CSAC will meet to endorse measures and then there will be an opportunity for public to appeal the endorsement decision.

Next slide, please. So the upcoming activities and timeline for Fall 2021 Cycle, all times are Eastern Standard Time. So the draft report comment period is March 25th to April 25, 2022.

The Committee post-comment web meeting is June 8, 2022, 11:00 a.m. to 2:00 p.m., which we have sent the invitation out for this meeting so we would please ask the Committee members to RSVP or let us know if you cannot make the meeting.

We do need to have at least half of the Committee to hold the meeting, so we gently urge you to RSVP.

The CSAC review will be late July, and the appeals period, which lasts for 30 days, will be from July to August. All dates will be confirmed. We will tell you all the dates when they are confirmed via email.

Next slide, please. So the Spring 2022 Cycle updates, intent to submit deadline was January 5th and no measures are expected for Spring 2022 Cycle.

Next slide, please. And as always our project contact information is the same. Please feel free to email us at surgery@qualityforum.org or any of the team members who do respond, NQF phone, 202-783-1300, and our project page and Committee SharePoint site.

Next slide, please. I will hand it back to LeeAnn. Thank you.

Co-Chair Joseph: All right.

(Simultaneous speaking.)

Ms. White: Oh, sorry. Go ahead, Vilma. I was just going to give that back to you.

Co-Chair Joseph: Okay, yes, yes, yes. There is just one bit of unfinished business we want to discuss with regards to the related measures.

Does anyone have any issues with regards to harmonization of those measures with what we were presented with today, any issues with harmonization?

Okay, good. All right, good. I just wanted to make sure we concluded that aspect of it. I will hand it back to you, LeeAnn.

Ms. White: Okay, wonderful. Thank you, Vilma. So I am going to pause a moment for any questions.

Okay, hearing none, and I don't see any in the chat. So I would like to start off -- Oh, next slide, please -- by thanking everybody on the call today.

I really truly appreciate your patience, your engagement, and your participation, as does our entire project team, so thank you so much for your willingness to participate and support the surgery project.

I also want to thank our co-chairs, Alex and Vilma, for leading us through our first measure review of 2022. Exciting. I look forward to a strong 2022 year with you all.

I also want to thank our lead discussants for your facilitation and preparation leading up to our meeting. A big thank you as well to Dr. Gerri Lamb for joining us from PEF. We are happy to have you and we look forward to working with you in the future.

And then lastly I would like to thank our developer, Yale CORE, for your time and effort leading up to the meeting and also for your attendance today to present your measure and to address any questions that the Standing Committee has had, so thank you very much for being here.

Lastly, I want to give a big thank you to my team, Isaac, Karri, Tristan, Monika, Taroon, and Poonam for their hard work and dedication to the surgery project. A lot of work goes into it so I thank them so much.

I am going to turn it over for our co-chairs to provide their closing remarks, and so, Alex.

Co-Chair Sox-Harris: I just strongly echo all of the thanks that LeeAnn just provided, really a heartfelt thanks to everybody for their role in this.

I think we had a really critical, collegial, and thorough discussion on this measure, so good job, everybody. Thank you.

Co-Chair Joseph: Yes. I would love to echo what Alex said. We had so much guidance here. I really appreciate it. This is my first stint as being co-chair, so thank you, Alex, thank you, LeeAnn, the whole team.

I really enjoyed the interesting discussions we have had on this measure and I think it's an important step ahead for patients, so I thank you all.

Adjourn

Ms. White: Wonderful. Thank you. Thank you, everyone. Have a wonderful rest of your Tuesday. Take care, be safe, and be well. Thank you.

Co-Chair Sox-Harris: Thank you.

(Whereupon, the above-entitled matter went off the record at 4:17 p.m.)