

Meeting Summary

Orthopedics Workgroup Web Meeting 1

The National Quality Forum (NQF) convened a web meeting for the Orthopedics Workgroup on July 9, 2021.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting, as well as introducing the co-chairs of the Orthopedics Workgroup (Dr. Robin Neil Kamal and Mr. John Zetzche). The co-chairs provided welcoming remarks. NQF staff reviewed the antitrust statement, as well as acknowledging that CQMC is a member-funded effort with additional support from the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

NQF staff facilitated roll call and reminded the group that the roster includes both voting and non-voting members; while both types of members can participate in discussion, only voting members will be asked to cast votes on any changes to the core set. NQF staff reviewed the meeting objectives:

- Review the CQMC's work from last year, including the 2020 Orthopedics Core Set
- Discuss potential additions and removals to the Orthopedics Core Set as part of ad-hoc maintenance
- Discuss future considerations for the content and characteristics of the Orthopedics Core Set

Last Year's Work

NQF staff provided a brief overview of the CQMC's achievements in 2019-2020. During the past year, the CQMC workgroups reviewed and released updated versions of the eight original condition-specific core sets, including the ACO/PCMH/Primary Care, Cardiology, Gastroenterology, HIV/Hepatitis C, Medical Oncology, OB/GYN, Orthopedics, and Pediatrics core sets. The CQMC also created two new condition-specific core sets, the Behavioral Health and Neurology core sets. Finally, the CQMC released several guiding documents including an updated description of approaches for future core set prioritization, a compilation of measurement gap areas identified by the workgroups and opportunities for alignment, and an implementation guide intended for stakeholders looking to implement core sets as part of value-based payment programs. NQF staff shared that in 2021, the CQMC will build on prior work by developing new guides on measure model alignment and digital measurement, developing a new cross-cutting measure set, updating the Implementation Guide, and maintaining the current core sets.

NQF shared an overview of the Orthopedics Workgroup's updates to the core set last cycle. During the last cycle of maintenance, the Orthopedics workgroup met six times to discuss and update the core set before the final core set was published in November 2020. The final core set included 15



measures in the areas of Total Joint Replacement (Hip and Knee), Spine, and Other.

The core set also listed the following measurement gap areas for future consideration:

- Measures for orthopedic procedures performed outside of the hospital setting (e.g., ambulatory surgical center)
- Measures across the full spectrum of spine and back care, including surgery measures, non-operative care, and functional assessment and outcome measures
- Joint procedure measures
- Pre-operative and post-operative care measures
- Measures that assess patient outcomes rather than if assessments are performed
- Cost measures
- Measures related to pain and opioids

Considerations for Ad-Hoc Maintenance

NQF staff opened the discussion on ad-hoc maintenance of the core sets by reminding Workgroup members of the measure selection principles for the CQMC core sets. Maintaining the core sets annually helps ensure that the measures in the core sets remain person-centered and holistic; relevant, meaningful, and actionable; parsimonious; scientifically sound; feasible; and unlikely to promote unintended adverse consequences. NQF also reminded the Workgroup that the final core set is intended to align quality measures that are used by public and private payers in value-based programs. Workgroup members should consider if the measures should be used for accountability. During ad-hoc maintenance, NQF will flag major updates (e.g., measures that have lost endorsement, newly-endorsed measures that fit a gap area) and review any measures that Workgroup members note should be urgently considered for addition or removal based on the core set selection principles.

NQF shared the process for discussion, where NQF staff will introduce the measure and then the co-chairs will facilitate discussion by the Workgroup. NQF staff asked that to best organize these discussions, voting members offer their opinions first, followed non-voting members. NQF reminded the Workgroup that formal voting will not be conducted during the meeting. If the Workgroup is able to reach consensus that a measure should stay in the set or a measure should not be considered for addition, these items do not need to be voted on. Any proposed changes to the core set will go through a formal electronic vote after the meeting and will need to achieve a supermajority vote (at least 60% affirmative votes and at least one affirmative vote from each voting category).

Measures Considered for Removal

N/A: Unplanned Reoperation Within the 30-Day Postoperative Period (MIPS 355)

NQF staff noted that this is an outcome measure. Outcome measures had previously been noted by the Workgroup as important for the core set. NQF staff commented that this measure was identified as being topped out in the Merit-Based Incentive Payment System (MIPS) based on Clinical Quality Measures (CQM) data but is still currently active within the program. NQF staff passed the discussion to the co-chairs to discuss whether there was still room for improvement on the measure and whether it should stay in the core set.

The Workgroup discussed that including outcome measures is important it would not be ideal to remove this measure. A Workgroup member noted that the measure may have additional utility outside the Medicare population, which would make it appropriate for the core set.

NQF staff thanked the group for their discussion and shared that since no members were in favor of removing the measure, it will remain in the core set.

Measures for Potential Addition

NQF staff noted that as part of the ad hoc maintenance process, staff identified five measures that were either newly endorsed or previously endorsed but not discussed by the Workgroup related to core set gaps.

NQF 3470: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures

3470: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures was last endorsed in Fall 2018 by the All-Cause Admissions and Readmissions project. This measure is an outcome measure and focused on the ambulatory setting ; both measure characteristics were previously identified as important for the core set. NQF staff noted that this measure is currently used in the CMS' Ambulatory Surgical Center Quality Reporting (ASCQR) Program. After this introduction, NQF staff asked the co-chairs to facilitate Workgroup discussion on this measure.

A co-chair noted that there are clinical reasons patients may go to an emergency room after a procedure that are not related to the procedure itself. The co-chair asked the developer whether there were specific clinical conditions that would constitute an unplanned visit or specific visit codes that would be excluded. The measure developer, Yale Center for Outcomes Research & Evaluation (CORE), answered that there are no exclusions or specific clinical conditions the measure includes. Instead, the measure reflects all emergency room visits within seven days post-procedure as a proxy for unintended complications.

The other co-chair asked for clarification about the timeframe of seven days used in this measure and why another timeframe, such as fourteen days, was not chosen instead. The developer noted that the seven-day period was based on the decay model for known complications of the measured procedures. The model assumed that events happening within the first seven days post-procedure are much more likely to represent complications of these events than another timeframe. The developer added that this model is in use while Medicare develops another model that will harmonize measuring complications across procedure settings.

A Workgroup member noted that this measure appeared to be specific for the Medicare fee-for-service patients. The member asked if the measure could be used for other populations considering this limitation. The developer responded that this measure has not been assessed in another payer population. Assessment was limited to Medicare members who were sixty-five years of age and older. It was further shared that ongoing assessment may be needed to see how this measure performs in populations with private insurance.

A member asked for clarity regarding whether an urgent care visit would count as part of the numerator for this measure. They also asked for clarification regarding what variables were considered in the measure specifications. The developer responded that urgent care visits would not be counted; only emergency department observations or inpatient stays count. They noted as well that opioid use, obesity, tobacco use, and other variables in the risk adjustment model.

A Workgroup member commented that this measure seems to be trying to capture failure of discharge between Ambulatory Surgery Centers (ASCs) and hospitals. The member asked the developer if a one- or two-day post-procedure period would be a better metric to use for this measure. The developer responded that the seven-day period was preferred because it could capture both discharge failure and surgery complications.

A Workgroup member indicated concern that this measure was not tested using privately insured or other patient populations. They expressed concern that this measure is not sufficiently parsimonious to include in the core set.

The co-chairs ended the discussion indicating support for including this measure in the core set to stratify information regarding outpatient care.

NQF staff indicated that there was broad support for the measure but some stated concerns. Accordingly, the measure will be included in the formal voting process.

NQF 3493: Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups

NQF staff presented details of this measure and noted it is an outcome measure. NQF staff shared that this measure is a re-specified version of NQF 1550: Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) which is already in the core set. This measure was re-specified to focus on clinician groups/clinicians rather than facilities and is currently used in MIPS.

The co-chairs began the discussion by asking the developer to clarify how the measure differed from measure 1550 and if the measure applied beyond the Medicare population. Yale CORE responded that the measures are essentially identical, with the distinguishing difference being whether outcomes are attributed at the facility level (1550) or the clinician level (3493).

A Workgroup member asked if either measure 1550 or 3493 were in use by collaboratives or other groups. The developer noted that measure 3493 was only recently completed. Future use would be accomplished by rulemaking through Medicare.

A Workgroup member requested clarification from the developer on which complications were included for both measures. The developer responded that both 1550 and 3493 look at the same factors: medical complications (pneumonia, sepsis), index admission, readmissions, surgical

complications (mechanical complications, infection), and death.

NQF noted that this measure will move to the formal voting process. Before ending discussion, NQF staff asked the Workgroup whether the measure should be proposed as a replacement to measure 1550 or if both measures should be in the core set simultaneously. The co-chairs suggested both options be proposed in the formal vote. NQF staff noted they would include all relevant options in the voting process.

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

NQF staff reviewed details of the measure and shared that this outcome measure was recently endorsed in the Spring 2020 Consensus Development Process cycle by the Patient Experience Standing Committee. Staff noted that this measure is a facility-level measure focused on the Medicare fee-for-service population. NQF staff then opened the measure for discussion.

A Workgroup member asked the developer about the timeframe for post-operative procedures and the anticipated loss rate to follow-up. Yale CORE noted that this measure was developed and tested with a post-procedure timeframe of 270-365 days. They recognized that patient-reported outcomes have some level of non-response. The developer shared that future recommendations for this measure include a shift to 10-14 months post-procedure for more accurate and to clinically align with one-year follow-up appointments.

CMS asked the developer to share what psychosocial properties were used in the development of the risk model for this measure. The developer noted that the PROMIS Global Mental Health Score and Veteran's Rand 12-Item Health Survey (VR-12) were used to establish a mental health baseline score, as well as using claims co-morbidity data.

A Workgroup member from Minnesota Community Measurement (MNCM) shared that they have a similar measure currently included in the core set (NQF 2653: Functional Status After Primary Total Knee Replacement). This measure is attributable to the surgeon (clinician-level) and measures if total knee replacement patients achieve certain score requirements. They noted that they attempted to use pre-and post-operative patient-reported metrics, but these were difficult to collect 100% of the time.

A co-chair asked the developer how their measure was substantially different from 2653, MNCM's measure. YALE Core noted that the measure under discussion, 3559, measures both knee and hip procedures and is an improvement-based measure. Measure 2653 measures only knee replacements and is an absolute target. A co-chair noted that specific targets can be problematic for those with disabilities or behavioral health concerns because the targets are not flexible or tailored to patients. However, he noted that pre- and post-operative scores can be prohibitively difficult to collect.

MNCM also noted that their measure is attributed on a clinician-level while measure 3559 is attributed on a hospital-level. The Workgroup concluded that having a table comparing these two measures would be helpful in deciding their individual merits for the core set.

NQF staff will create a side-by-side comparison of NQF 2653 from MNM and NQF 3559 from Yale CORE. Staff indicated this measure would go to a formal vote and this comparison would be included for reference.

NQF 3461: Functional Status Change for Patients with Neck Impairments and NQF 0425: Functional Status Change for Patients with Low Back Impairments

These two measures, both stewarded by Focus on Therapeutic Outcomes (FOTO), were presented together due to similar focus and methodologies. NQF 3461 is a newly endorsed PRO-PM that is similar to NQF 0425. They also focus on spine and back care, a topic which was previously flagged as a core set gap. NQF staff then opened the measures for discussion.

A co-chair asked the developer to clarify which providers were included in the measure. FOTO responded that testing involved mostly physical therapists, but some orthopedists were included as well. The developer noted that surgical status is included in the risk adjustment model, which allows the metric to be used for both surgical and non-surgical patients.

A Workgroup member expressed their support for the measures. NQF staff noted that these measures would be included in the formal voting poll.

Additional Measures and Updates from the Workgroup

NQF 2653: Functional Status After Primary Total Knee Replacement and 2643: Functional Status After Lumbar Fusion

NQF staff noted that these two measures are still endorsed but maintenance is being deferred. The measure developer is building a new data collection system. NQF shared that this maintenance deferral does not impact their endorsement status with NQF, nor the program use.

Additional Notes in the Core Set Presentation

NQF staff asked the Workgroup whether the information in the “Notes” column of the current core set presentation was still accurate and relevant, or if any of the notes should be updated or removed. MNM noted that their measures relying on pain scales currently use the visual analog pain scale. They noted they are in discussions to incorporate numeric scales, which would allow data to be collected during virtual visits. NQF staff thanked MNM and invited other Workgroup members to send any notes regarding other measures to NQF staff after the meeting.

New Orthopedics Cost/Resource Use Measures

NQF staff noted that the Workgroup previously identified cost measures as a gap in the core set. Two newly endorsed measures that relate to cost and resource use are:

- 3474: Hospital-level, risk-standardized payment associated with a 90-day episode of care for elective primary total hip and/or total knee arthroplasty (THA/TKA) (Resource Use Measure)
- 3512: Knee Arthroplasty (Resource Use Measure)

NQF staff stated that the CQMC does not currently include cost measures within the core sets, as cost may be a component of value-based models in which the measures are used. These measures will not be considered during the year of ad hoc maintenance as CQMC continues to discuss the role of cost measures in the creation and implementation of the core sets.

Future Considerations for the Orthopedics Workgroup

NQF provided background on the current state of the Orthopedics core set, including an overview of the characteristics of the Orthopedics core set in 2015 and 2020. From 2015 to 2020, the total number of measures in the core set increased from three to fifteen; outcome measures rose from three to thirteen, PRO-PMs rose from one to ten, cross-cutting measures stayed the same at one, eQCMs rose from zero to two, and clinician-level measures rose from one to twelve. NQF shared that the CQMC's future goals include increasing the following types of measures:

- Outcome measures
- Patient-reported outcome performance measures (PRO-PMs)
- Cross-cutting measures
- Measures that address disparities or social determinants of health (SDOH)
- Digital measures
- Clinician-level measures

NQF staff asked how the Workgroup or CQMC can promote progress in these measure areas in their future work. A co-chair expressed gratitude that social determinants of health were highlighted. The co-chair noted we should consider whether this is a specific type of measure or a broader way to understand and report on measures.

NQF staff then asked which outcomes should be prioritized for measurement at the clinician level and general thoughts about level of analysis. A Workgroup member noted that several programs have measures focused on discussing advance care directives with patients. The member noted that these measures are helpful in transforming practice for providers and are easy to code for on a provider level. A co-chair noted that shared decision-making measures are important for future work of the Workgroup. NQF staff thanked the Workgroup for their discussion.

Next Steps

NQF staff shared that the Workgroup's discussion will be summarized and posted on the CQMC SharePoint page. NQF will circulate a survey as well as additional information to aid in voting on additions or removals from the core set discussed today. Once distributed, voting will be open for a 4-week period. The Steering Committee will review any changes to the core set recommended by the Workgroup and NQF staff will reach out with any clarifications. NQF staff thanked the co-chairs and Workgroup for their work.