

TEP Summary Report

December 23, 2020

Electronic Clinical Quality Measures Development and Maintenance for Eligible Clinicians (EC eCQM) (contract no. 75FCMC18D0032, TO 75FCMC19F0004)

Submitted to:

Centers for Medicare & Medicaid Services
Center for Clinical Standards and Quality
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Contract Number: 75FCMC18D0032/75FCMC19F0004

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Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Clinicians (EC eCQM)

Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica and its partners to develop, electronically specify, and maintain eCQMs for eligible clinicians for potential consideration and use in CMS quality programs. The contract name is Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Clinicians (CMS contract #75FCMC18D0032, Task Order #75FCMC19F0004). As part of its measure development process, Mathematica convenes groups of stakeholders and experts who contribute direction and thoughtful input to the measure developer during measure development and maintenance.

Project Objectives

The primary measure development objectives of this project include the following:

- Identifying, developing, specifying, and testing new quality measures for potential implementation in CMS quality programs that align with CMS quality goals
- Evaluating and preparing the measures for consideration and potential endorsement by the National Quality Forum

TEP Summary Reports

The EC eCQM team may convene the project’s TEP a few times a year. The TEP advises across multiple project development and testing activities. The topics for each TEP meeting are determined by CMS measure development and testing priorities for the year and thus can vary from meeting to meeting. The summary memos available for all EC eCQM TEP meetings since project inception are listed below. As of December 23, 2020, the EC eCQM TEP has met twice. The EC eCQM team will continue to add individual meeting summaries to this summary report following each meeting.

Table 1. EC eCQM TEP Meetings

Meeting #	Date	Discussion Topic	Members in Attendance
1	August 17, 2020	Preventive Care and Wellness (composite) measure	10
2	November 20, 2020 and November 30, 2020	Measure Concepts Generated for the Merit-based Incentive Payment System	8 on 11/20/2020; 8 on 11/30/2020
3	TBD	TBD	

Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Clinicians (EC eCQM)

Technical Expert Panel (TEP) Input Report for TEP Orientation and Discussion of the Preventive Care and Wellness composite measure

Meeting held on August 17, 2020; Submitted to CMS on October 1, 2020

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On August 17, 2020, the Electronic Clinical Quality Measures Development and Maintenance for Eligible Clinicians (EC eCQM) project convened the first meeting of its technical expert panel (TEP) via webinar. The goal of this meeting was twofold: (1) to orient the TEP members to their role on the project and to the EC eCQM project as a whole and (2) to solicit feedback on the face validity and usability of the Preventive Care and Wellness (PCW) composite measure specification. After the meeting, TEP members provided feedback via email on component measures that they would recommend, including in a revised PCW composite measure.

This memo summarizes the meeting discussion, including the TEP's comments on the face validity and usability of the current PCW composite measure, and describes the next steps for the PCW composite measure.

Part 1: TEP orientation

Mathematica described the measure development life cycle, the National Quality Forum (NQF) measure evaluation criteria, the TEP's role in measure development, and the EC eCQM project. One TEP member expressed concern with the charter's language regarding the TEP's charge to evaluate the "strength of evidence regarding measure concepts". Specifically, this member recommended this phrase be slightly altered to refer to the "quality" of the evidence being evaluated, rather than "strength". After making a few minor refinements to clarify this language and the scope of their responsibilities, members voted to ratify the EC eCQM TEP charter. Appendix A contains the full list of TEP members, and Appendix B contains the final charter.

Part 2: PCW composite measure

The PCW composite measure assesses the percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. The measure consists of eight component measures (Table 1), all currently in the Merit-based Incentive Payment System (MIPS). The component measures are based on recommendations by the:

- U.S. Preventive Services Task Force (USPSTF)
- Advisory Committee on Immunization Practices
- American Association of Clinical Endocrinologists
- American College of Endocrinology

This composite measure is intended to be reportable via a registry. Its score is calculated using a linear combination at the component level—that is, the average proportion of patients receiving each preventive service. The score can be interpreted as, on average, the percentage of an eligible clinician's patients who received each preventive service.

Table 1. Eight component measures of the PCW composite

Quality ID	Title	Description
39	Screening for Osteoporosis for Women 65–85 Years of Age	Percentage of female patients ages 65–85 years who ever had a central dual-energy X-ray absorptiometry to check for osteoporosis
110	Preventive Care and Screening: Influenza Immunization	Percentage of patients ages 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
111	Pneumococcal Vaccination Status for Older Adults	Percentage of patients ages 65 years and older who have ever received a pneumococcal vaccine
112	Breast Cancer Screening	Percentage of women ages 50–74 years who had a mammogram to screen for breast cancer in the 27 months before the end of the measurement period
113	Colorectal Cancer Screening	Percentage of patients ages 50–75 years who had appropriate screening for colorectal cancer
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients ages 18 years and older with a BMI documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters; a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients ages 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure reading, as indicated
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation	Percentage of patients ages 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Note: The 2020 measure titles, descriptions, and reporting modalities are based on those reported on the Quality Payment Program Explore Measures website: <https://qpp.cms.gov/mips/quality-measures>.

Measure specification discussion

We solicited input and recommendations from the TEP on whether the PCW composite measure as currently specified met the NQF evaluation criteria for face validity and usability. Ten of the 11 TEP members attended the meeting.

Overall, the TEP members expressed strong concerns about the face validity of including these component measures in a single composite and the usability of the composite measure score to improve care. An exception was one patient representative who acknowledged the concerns of the clinicians on the TEP but voiced strong support for the content of the measure; this person felt that the quality actions in the measure were important to patients.

Face validity

- **TEP clinicians indicated that the measures included in the composite lacked a cohesive conceptual focus.** In particular, TEP members questioned the component measures given the measure's intent to assess overall delivery of age- and sex-appropriate preventive screenings and wellness services. Members said that the composite included multiple disparate quality concepts, such

as cancer screening measures and immunization measures, and that the clinical focus of the composite was not clear (for example, it targeted multiple age-, gender-, and disease-specific risk factors).

To make the measure more useful for quality improvement, members suggested separating the components into distinct, conceptually focused composite measures, such as one for cancer screening measures and another for immunization measures.

- **Some TEP members recommended adding measures to the composite.** TEP members noted additional important preventive care and wellness measures that could be included in a PCW composite measure for overall delivery of preventive and wellness care. For example, one member suggested adding QID 134: Screening for Depression and Follow-Up Plan to the PCW composite.
- **Some TEP members recommended removing measures from the composite.** One member suggested removing QID 128: BMI Screening and Follow-Up Plan, from the composite, noting that providers routinely measure height and weight at appointments and that performance on this measure is likely to be uniformly high.¹ Another member suggested removing QID 317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented because the measure is not consistent with current clinical guidelines.² This TEP member would support including this measure in the PCW composite if it was consistent with current clinical guidelines.

Several TEP members were not comfortable proposing a full list of recommended measures during the meeting and offered to provide feedback once they were able to review a list of potential component measures and their corresponding benchmarks. Appendix C summarizes the measures that TEP members would prioritize for this composite, based on their feedback provided after the meeting.

- **One member expressed concern about equal weighting of components in the composite.** The TEP member said that linear combination may not be appropriate given the potential differences in prevalence and differences in benchmark rates for each component measure. However, this member was reluctant to suggest other weighting options. The team noted that multiple weighting approaches would be tested.
- **Some TEP members expressed concern about measures that required screening and follow-up actions.** One member said that capturing data on follow-up is difficult, and including measures with follow-up criteria will not encourage clinicians to improve quality of care. Another TEP member said that measures with follow-up components seem conceptually different from measures that only require screening, therefore including both screening and screening with follow-up capture distinct quality actions and were not appropriate for use in a single composite measure.
- **One patient representative on the TEP voiced strong support for the content of the measure.** In contrast to the above feedback, which was provided by both clinicians and health system representatives, one patient representative acknowledged the concerns of the clinicians on the TEP but emphasized the importance of the component measures from a patient perspective. This member recommended adding more component measures to the PCW composite, as she felt ‘the more measurement, the better,’ but did not provide specific concepts during the meeting.

¹ Among clinicians reporting as individuals, mean performance on QID 128 was 56.9 percent in 2018 and 70.2 percent in 2019. See Jacobs, E., D. Poznyak, H. Xu, X. Li, S. Wang, and S. Penoyer. “Preventive Care and Wellness Composite, Clinical Quality Measure. Base-Year Testing Report (Deliverable 6-2).” Woodlawn, MD: Mathematica, August 2020.

² The measure steward is aware of the guideline changes. Potential updates to QID 317 will be considered as part of the annual update cycle.

Usability and use

- **Most TEP members expressed concern about the burden of reporting the component measures as a composite.** There was consensus among TEP members that reporting these measures as a composite would not reduce burden. They said that a composite may increase burden on clinicians to report the equivalent of eight measures. Members said that the composite does not reduce the number of measures for reporting because it includes more measures than what is currently required for MIPS reporting.
- **Most TEP members noted concerns about the usefulness of the composite measure for quality improvement.** TEP members broadly agreed on the importance of the concept of preventive care and wellness but suggested that a composite score is not as useful as the individual component scores. One member said that composite measure scores are not actionable, and clinicians must drill down to the individual component measures to understand where to focus their quality improvement. One member said that some of the component measures are difficult to capture and will therefore not incentivize clinicians to improve quality of care. Another member said that low scores on the composite measure may hurt clinician morale and not encourage clinicians to improve.

Next steps

As requested by the TEP, the EC eCQM team circulated a list of the program year 2020 MIPS preventive care measures and their 2020 benchmark performance information for the TEP to review. The TEP prioritized and suggested groupings of components to include in a PCW measure. Appendix C summarizes the measures that the TEP would include in a PCW composite. We will discuss the TEP's recommendations with CMS.

In the interim, we will continue working with CMS to prepare the measure for submission to the 2020 Call for Measures cycle and Measure Application Partnership review. Concurrently, we will test the PCW composite measure using patient-level data. We have already tested the measure using historical data from MIPS at the provider level, but patient-level data will shed more light on how the measure performs for different patient subgroups, and it will provide information on performance on the component measures for providers who do not report those components to MIPS. Patient-level testing will also provide an opportunity to explore the recommendations from the TEP.

Appendix A

Table A.1. TEP members and affiliations

TEP member name	Credentials	Institutional affiliation/location
Donald Casey	M.D., M.B.A, M.P.H.	American College of Medical Quality; Chicago, IL
James Colbert	M.D.	Blue Cross Blue Shield of Massachusetts; Boston, MA
Fran Cunningham	Pharm.D.	Department of Veterans Affairs; Hines, IL
Barbara Kivowitz	Patient representative	San Francisco, CA
Luming Li	M.D.	Yale New Haven Psychiatric Hospital; New Haven, CT
Bridget Lynch	M.D., M.P.H.	Presbyterian Medical Group; Albuquerque, NM
Precious McCowan	Patient representative	Dallas, TX
Robert McClure	M.D.	MD Partners, Inc.; Lafayette, CO
Michael Perskin	M.D.	American Geriatrics Society; New York, NY
Lori Popejoy	Ph.D., R.N., F.A.A.N.	University of Missouri; Columbia, MO
Christa Starkey	Patient representative	Lone Oak, TX

Appendix B

TEP Charter

Project Title:

Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Clinicians

Dates:

The technical expert panel (TEP) will advise Mathematica and its partners over the course of the project. The project has been funded for one base period of 12 months with four optional 12-month periods of performance.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica and its partners to develop, electronically specify, and maintain eCQMs for eligible clinicians for potential consideration and use in CMS quality programs. The contract name is Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Clinicians (CMS Contract #75FCMC18D0032, Task Order #75FCMC19F0004). As part of its measure development process, Mathematica convenes groups of stakeholders and experts who contribute direction and thoughtful input to the measure developer during measure development and maintenance.

Project Objectives:

The primary measure development objectives of this project include the following:

- Identifying, developing, specifying, and testing new eCQMs for potential implementation in CMS quality programs that align with CMS quality goals
- Evaluating and preparing the measures for consideration and potential endorsement by the National Quality Forum

TEP Objectives:

As part of its measure development process, Mathematica and its partners (the project team) request input from a broad group of eCQM stakeholders to evaluate and provide guidance on the selection and development of eCQMs through participation in the project's TEP. Stakeholders include, but are not limited to, clinicians, electronic health record vendor representatives, clinical terminology experts, quality improvement experts, health system representatives, patients and their caregivers, and patients' representatives. Patients can provide unique and essential input on quality measures based on their own experience and perspective. A well-balanced representation of stakeholders on the TEP will help to ensure the consideration of key perspectives in the measure selection and development processes. The TEP will convene on a periodic basis and will provide input on the prioritization and development of eCQMs that support CMS's quality program goals throughout the development lifecycle.

Scope of Responsibilities:

The TEP will provide input to the project team to aid in prioritizing and developing eCQMs that will be considered for implementation in CMS quality programs. The TEP's specific duties include the following:

- Review, prioritize, and evaluate eCQM measure concepts for development. Dimensions for prioritization could include:
 - Alignment of concept with quality program goals
 - Technical feasibility
 - Workflow feasibility: patient and provider burden considerations
 - Measurement gap
 - Quality of evidence regarding measure concept and clinical actions that can be taken to improve measured outcome
 - Importance to providers
 - Importance to patients
 - Alignment with existing (competing) measures
 - Potential for unintended consequences
- Review and provide guidance on the measures in response to feedback from expert work groups, public comments, and testing results regarding eCQM feasibility, usability, validity, and reliability

Guiding Principles:

The TEP will provide input throughout the measure development process. The project team will consider the TEP's recommendations and will convey those recommendations to CMS; however, the project team and CMS will ultimately make decisions about measure selection and development. The project team will write and share summary reports of TEP proceedings following meetings to highlight discussions and document decisions.

The project team will ensure confidentiality in TEP reports by summarizing discussion topics and removing the names of TEP members who make specific comments during the meetings.

Estimated Number and Frequency of Meetings:

Members of the TEP will meet up to four times in a 12-month period via webinar, at the discretion of CMS. The TEP is intended to be a standing committee that meets throughout the duration of the Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Clinicians project, which has been funded for a 12-month period with four additional 12-month optional periods of performance.

Date Approved by TEP:

August 17, 2020

Appendix C

During the TEP meeting on the PCW composite measure, TEP members broadly agreed on the lack of conceptual focus among the component measures. In response to this feedback, we asked members to provide input via email after the meeting about which measures they would include in a PCW composite, choosing from a short list of CMS Quality Payment Program (QPP) preventive care and wellness measures. Four TEP members responded with recommendations to include or exclude measures from the PCW composite (summarized in ‘Feedback on prioritization of component measures’ section below), and an additional five members responded with general comments (summarized in ‘Additional feedback on measure prioritization’ section below) for a total of nine out of 10 members providing input.

Feedback on prioritization of component measures

Table B.1 lists preventive care and wellness measures currently included in the CMS QPP. Measures in this table are sorted by the number of TEP member votes for inclusion in a PCW composite.

Ten measures received three or more votes for inclusion, with four TEP members voting. Of these 10 measures, all 8 component measures currently specified in the composite received three or more votes for inclusion (Table B.1). Three of the component measures also received one vote each from three different TEP members for removal from the composite:

- QID 128: Body Mass Index (BMI) Screening and Follow-Up Plan. One TEP member expressed concern that the use of BMI is controversial from a patient’s perspective but did not provide additional context.
- QID 317: Screening for High Blood Pressure and Follow-Up Documented. One TEP member said that this measure is not consistent with USPSTF guidelines as currently specified. Another member agreed that the measure should be removed until it is consistent with the guidelines.
- QID 226: Tobacco Use: Screening and Cessation Intervention. One TEP member expressed concern that the measure is topped out. However, the measure was not topped out according to the 2020 MIPS Historical Quality Benchmarks.

In addition to the eight current component measures, two CMS QPP measures received three or more votes for inclusion in a PCW composite:

- QID 431: Unhealthy Alcohol Use: Screening and Brief Counseling. TEP members said that substance abuse screening is important for preventive care and wellness. This measure, along with QID 226: Tobacco Use: Screening and Cessation Intervention, would capture an additional type of substance abuse screening. However, one TEP member expressed concern about clinicians’ potential difficulty in improving on this measure because it depends on a change in patients’ behavior.
- QID 134: Screening for Depression and Follow-Up Plan. Three TEP members noted the importance of this measure for preventive care and wellness, citing increasing suicide rates and the treatability of depression. In contrast, one TEP member voted to not include this measure in the composite because historical variability in the measure’s results renders it inappropriate for use in this context.

Table B.1. TEP members' PCW measure prioritization (n = 4 respondents)

QID	Measure name	Current PCW specification	TEP votes for inclusion	TEP votes for removal
039	Screening for Osteoporosis for Women Ages 65–85 Years of Age	X	4	-
110	Preventive Care and Screening: Influenza Immunization	X	4	-
112	Breast Cancer Screening	X	4	-
113	Colorectal Cancer Screening	X	4	-
431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	-	4	-
111	Pneumococcal Vaccination Status for Older Adults	X	3	-
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	X	3	1
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	X	3	1
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	X	3	1
134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	-	3	1
154	Falls: Risk Assessment	-	2	-
048	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Ages 65 Years and Older	-	2	-
400	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	-	2	-
239	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	-	2	-
309	Cervical Cancer Screening	-	2	-
475	HIV Screening	-	2	1
181	Elder Maltreatment Screen and Follow-Up Plan	-	2	-
155	Falls: Plan of Care	-	1	1
387	Annual Hepatitis C Virus (HCV) Screening for Patients Who Are Active Injection-Drug Users	-	1	1
318	Falls: Screening for Future Fall Risk	-	1	1
240	Childhood Immunization Status	-	1	-
310	Chlamydia Screening for Women	-	1	-
379	Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists	-	1	1
402	Tobacco Use and Help with Quitting Among Adolescents	-	1	-
116	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	-	-	1

Additional feedback on measure prioritization

Patient representatives in the TEP provided additional concepts not listed in the CMS Quality Payment Program for consideration in a PCW composite. These screening concepts include cardiac health, inflammation, vision and hearing, current medications, social connections, physical activity (exercise), diet, family history, pain and chronic pain, diabetes and ongoing treatment, cognitive learning issues for children, and dementia for older adults.

One TEP member raised a concern about bias by clinician specialty. The TEP member expected the PCW composite as currently specified to favor clinicians who care for patients within a narrow age range. This member expected bias against family physicians, who care for people across the lifespan and who would need to excel in all screenings to improve on this composite score.

TEP members continued to express concerns raised during the TEP meeting regarding the lack of conceptual focus. Two TEP members said that some measures in the composite are related to each other based on the measure population or concept, but taken together, the eight component measures seem like a collection of individual measures.

Technical Expert Panel's Input on Measure Concepts Generated for the Merit-based Incentive Payment System

Electronic Clinical Quality Measures Development and Maintenance for Eligible Clinicians

Meetings held November 20, 2020, and November 30, 2020; report submitted to CMS December 23, 2020

Christopher Fleming, Jessica Saddler, Lauren Maul, Jayanti Bandyopadhyay, and Suzie Rastgoufard

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Introduction

The Electronic Clinical Quality Measures Development and Maintenance for Eligible Clinicians (EC eCQM) project convened its technical expert panel (TEP) via webinar for two meetings on November 20 and November 30, 2020. The objective of both sessions was to gather TEP feedback on the importance, usability, and feasibility of the draft measure concepts. The TEP reviewed concepts related to, at the first meeting, promoting wellness and managing chronic disease, and at the second, those related to cancer care and geriatric surgical outcomes. This memo summarizes feedback received from the TEP during the meetings as well as scoring information and additional comments received afterward, and extends the conversation to additional post-meeting notes from the project team. Appendix A lists the TEP attendees for both meetings and cites the members who provided scoring input.

Background

Under the EC eCQM project and as directed by the Centers for Medicare & Medicaid Services (CMS), Mathematica and its partners develop and maintain electronic clinical quality measures (eCQMs) for CMS's Merit-based Incentive Payment System, into which CMS directed the EC eCQM team to generate measure concepts for potential use. CMS requested that concepts (1) fill critical measure gaps in four clinical domains—promoting wellness, chronic disease management, cancer care, and geriatric surgical outcomes, (2) have a strong evidence base, and (3) be important to clinicians and patients. Mathematica started Day 1 by describing the process for generating draft measure concepts. Then, during both meetings, Mathematica reviewed each concept with the TEP, sharing the measure's description along with information gathered through the literature review and meetings with patients and medical specialty societies, and asked the TEP members to provide feedback on each concept.

After days 1 and 2, Mathematica asked TEP members to rate each measure concept on three criteria: (1) importance; (2) feasibility; and (3) usability on a scale of high, medium, low, or do not know (patients were not asked to rate feasibility, as their experience likely does not include understanding availability and structure of data in a clinician's electronic health record [EHR]). Because sources of expertise vary for clinicians and researchers versus those for patients, definitions of these criteria differed slightly (see Table R.1). Table R.2 provides the percentage and number of TEP members who rated each measure's criterion as moderate or high. For the paired cancer concepts (which are measure concepts the National Coalition for Cancer Survivorship [NCCS] developed and shared with the EC eCQM team), we used the scores from the measure focused on patients completing cancer treatment as an equal or higher number of TEP members scored those concepts compared to their paired counterpart.

We also raised two measures for potential retooling consideration, but because TEP members did not offer feedback on these measures during the meeting, we provide the post-meeting scores and associated notes on these measures in Appendix B.

Table 1. Evaluation criteria and associated definitions

TEP member expertise	Importance	Usability	Feasibility
Clinician and researchers	Is evidence based, addresses a performance gap, and improves health care quality and health outcomes	Can be used by stakeholders for accountability and performance improvement to achieve high quality, efficient health care	Can be implemented in existing electronic health record systems and clinical practices
Patient	Is this a topic that matters to patients?	Could or would patients use this measure's score to help themselves choose a provider?	n/a

Note: Patients were not asked to rate feasibility, as their experience likely does not include understanding availability and structure of data in a clinician's electronic health record.

Table 2. Measure concepts titles, descriptions, and TEP scores on importance, usability, and feasibility, by topic area

Potential measure concepts	Measure description	Importance rating	Usability rating	Feasibility rating
Promoting wellness				
Sexually Transmitted Infections (STIs): Screening	Patients who received age- and sex-appropriate screening for STIs (such as gonorrhea, chlamydia, syphilis, and HIV)	100% (7/7)	100% (7/7)	75% (3/4)
STIs: Counseling	Patients who were newly diagnosed with an STI (such as gonorrhea, chlamydia, syphilis, or HIV) who received moderate- to high-intensity counseling	86% (6/7)	71%(5/7)	20% (1/5)
STIs: Re-infection	Patients with an STI diagnosis who had a follow-up visit during the measurement period where they were diagnosed with a new or repeat infection	71% (5/7)	57% (4/7)	60% (3/5)
Hepatitis B Vaccination	Percentage of adult patients at high risk for hepatitis B who receive the vaccination	100% (7/7)	86% (6/7)	80% (4/5)
Chronic disease management				
Behavioral Risk Factors: Identification and Goal-Setting ("Set It")	Percentage of patients who have established at least one risk-reduction goal related to at least one identified risk (obesity, tobacco use, alcohol misuse, little physical activity, or falls)	88% (7/8)	63% (5/8)	33% (2/6)
Behavioral Risk Factors: Follow-Up on Goals ("Met It")	Percentage of patients who set a goal to reduce a behavioral risk (obesity, tobacco use, alcohol misuse, little physical activity, or falls) in prior year and who achieved their goal	88% (7/8)	38% (3/8)	0% (0/6)

Potential measure concepts	Measure description	Importance rating	Usability rating	Feasibility rating
Functional Status Assessment (FSA) for Heart Failure	Percentage of patients ages 18 years and older with heart failure for whom a score from one of a selected list of validated functional or global health assessments was recorded at least twice during the measurement period, and for whom a target was documented and linked to the initial assessment	83% (5/6)	67% (4/6)	50% (2/4)
Chronic Disease Self-Efficacy	Percentage of patients ages 18 years and older reported improvement on or consistently high levels of self-efficacy for managing their chronic conditions	100% (7/7)	57% (4/7)	40% (2/5)
Advancing cancer care				
Overall Colorectal Cancer Survival	Percentage of adult patients diagnosed with regional and distinct colorectal cancer who are still alive 2 years after diagnosis	100% (6/6)	67% (4/6)	40% (2/6)
Concepts related to physical function for patients with cancer <ul style="list-style-type: none"> Changes in Physical function: Improvement in Physical function for Patients Recently Completing Cancer Treatment Changes in Physical Function: Decline in Physical Function in Patients Undergoing Extended Treatment for Chronic Cancer 	<ul style="list-style-type: none"> Percentage of patients showing improvement in physical function assessed using the PROMIS Cancer Item Bank – Physical Function between completion of treatment and 12 months following Percentage of patients receiving treatment who report worsening physical function assessed using the PROMIS Cancer Item Bank – Physical Function in the past 12 months 	100% (7/7)	86% (6/7)	80% (4/5)
Concepts related to fatigue for patients with cancer <ul style="list-style-type: none"> Changes in Fatigue: Fatigue Improvement for Patients Recently Completing Cancer Treatment Changes in Fatigue: Worsening Fatigue in Patients Undergoing Extended Treatment for Chronic Cancer 	<ul style="list-style-type: none"> Percentage of patients showing improvement in fatigue interference assessed using the PROMIS Fatigue – Short Form 13a between completion of treatment and 12 months following Percentage of patients receiving treatment who report worsening fatigue interference using the PROMIS Fatigue – Short Form 13a in the past 12 months 	100% (7/7)	86% (6/7)	67% (4/6)

Potential measure concepts	Measure description	Importance rating	Usability rating	Feasibility rating
<p>Concepts related to cognitive function for patients with cancer</p> <ul style="list-style-type: none"> Changes in Cognitive Function: Cognitive Function Improvement for Patients Recently Completing Cancer Treatment Changes in Cognitive Function: Decline in Cognitive Function in Patients Undergoing Extended Treatment for Chronic Cancer 	<ul style="list-style-type: none"> Percentage of patients showing improvement in cognitive function assessed using the PROMIS Cognitive Function Short Form 8A between completion of treatment and 12 months afterward Percentage of patients receiving treatment who report worsening cognitive function using the PROMIS Cognitive Function Short Form 8A in the past 12 months 	100% (6/6)	83% (5/6)	80% (5/6)
<p>Concepts related to psychosocial effect for patients with cancer</p> <ul style="list-style-type: none"> Severe Psychosocial Effect: Severe Psychosocial Effect for Patients Recently Completing Cancer Treatment Severe Psychosocial Effect: Worsening Fatigue in Patients Undergoing Extended Treatment for Chronic Cancer 	<ul style="list-style-type: none"> Percentage of patients who were rated as having moderate or severe psychosocial effect assessed using the PROMIS Psychosocial Illness Impact – Negative Scale at 12 months following completion of treatment Percentage of patients receiving treatment who report worsening fatigue interference using the PROMIS Fatigue – Short Form 13a in the past 12 months 	86% (6/7)	57% (4/7)	33% (2/6)

Potential measure concepts	Measure description	Importance rating	Usability rating	Feasibility rating
<p>Concepts related to communication regarding late effects for patients with cancer</p> <ul style="list-style-type: none"> • Effective Communication about Late Effects of Cancer with Patients Recently Completing Cancer Treatment • Effective Communication about Late Effects of Cancer with Patients Undergoing Extended Treatment for Chronic Cancer 	<ul style="list-style-type: none"> • This measure includes three measures encompassing the percentage of patients who completed curative systematic cancer treatment and agreed or strongly agreed with the following statements: <ol style="list-style-type: none"> 1. Did your medical oncology providers educate and prepare you to understand and manage the side effects of your cancer treatment? 2. Since completing your cancer treatment, have medical oncology providers helped you understand whether new symptoms or problems might be related to your cancer? 3. Since completing your cancer treatment, have you felt safe and supported in bringing up concerns with your medical oncology providers? • Percentage of patients who received extended systemic cancer treatment in the previous 12 months who indicate that their medical oncology providers have offered guidance and support in managing side effects since the beginning of their treatment. 	100% (6/6)	83% (5/6)	40% (2/5)

Potential measure concepts	Measure description	Importance rating	Usability rating	Feasibility rating
<p>Concepts related to effective communication about financial effects of cancer</p> <ul style="list-style-type: none"> • Effective Communication about Financial Effects of Cancer with Patients Recently Completing Cancer Treatment • Effective Communication about Financial Effects of Cancer with Patients Undergoing Extended Treatment for Chronic Cancer 	<ul style="list-style-type: none"> • This measure includes three measures encompassing the percentage of patients who completed curative systematic cancer treatment and agreed or strongly agreed with the following statements (except the first statement below for which they would disagree or strongly disagree with the statement): <ol style="list-style-type: none"> 1. Has the financial effect of your cancer or cancer treatment reduced your quality of life? 2. Did your medical oncology team talk to you about potential financial effects of your cancer treatment? 3. Did your medical oncology team provide you with resources and assistance to deal with the financial effects of your cancer treatment? • The measure includes three measures encompassing the percentage of patients who received extended, systemic cancer treatment in the previous 12 months and agreed or strongly agreed with the following statements (except the first statement below for which they would disagree or strongly disagree with the statement): <ol style="list-style-type: none"> 1. Has the financial effect of your cancer or cancer treatment reduced your quality of life? 2. Does your medical oncology team talk to you about potential financial effects of your cancer treatment? 3. Does your medical oncology team provide you with resources and assistance to deal with the financial effects of your cancer treatment? 	100% (5/5)	50% (3/6)	20% (1/5)
Geriatric surgical outcomes				
Geriatric Surgical Safety Events (composite)	Percentage of all older adults who underwent surgery and had one or more potentially avoidable surgical safety events.	100% (6/6)	67% (4/6)	100% (5/5)

Note: For the paired cancer concepts, we used the scores from the measure focused on patients completing cancer treatment, as an equal or higher number of TEP members scored those concepts compared to their paired counterparts.

Discussion Details, Post-Meeting Survey Feedback, and Post-Meeting Response from Project Team

In this section, we summarize the meeting discussion, the post-meeting scores, and associated feedback and provide additional post-meeting notes to respond to some of the questions posed during the call. We do not respond to all comments, but for the measures CMS selects for continued development, we will consider all feedback and suggested measure concept revisions as we move the measures forward through development and testing.

Meeting introduction

At the beginning of Day 1 discussion, Mathematica described the environmental scan process, explained the National Quality Forum (NQF) measure evaluation criteria, and presented the clinical topic areas of interest: promoting wellness, chronic disease management, cancer care, and geriatric surgical outcomes. During the Day 1 meeting, the EC eCQM project's contracting officer's representative (COR) led a brief discussion regarding how the COVID-19 pandemic might affect the future of the CMS quality program; the EC eCQM COR noted that it is difficult to predict the effect of the pandemic on quality measurement in subsequent years, but the team will take relevant refinements into measure development to the extent possible. Following the COVID-19 discussion a TEP member asked for clarification on what is meant by *retooling* of measures. The EC eCQM team explained that the term refers to specifying a measure from one data source to another, for example, specifying a measure that is calculated using claims to one that can be calculated using data extracted from the EHR. A TEP member then asked whether the TEP should be envisioning primarily an older population of adults when considering measure concepts. The EC eCQM team responded by saying no, the TEP should not limit the review to older adults and should consider the full patient population for each concept.

Promoting wellness

STIs—Screening. Although there was limited discussion on this concept during the meeting, all seven of the TEP members who submitted their scoring-tool results on this concept rated its importance and usability as moderate or high, and 75 percent (3/4) rated its feasibility as moderate or high. During the meeting, one TEP member suggested that we refine the language used for this concept, mentioning that “age-appropriate” connotes a younger population. We noted that we will consider this comment and align the concept title and description with recommendations in scope of the measure.

- Post-meeting note: The concept included in our information-gathering task focuses on age- and sex-appropriate screenings and was derived from the recommendations of the United States Preventive Services Task Force (USPSTF). However, USPSTF recommends screenings based on risk factors beyond age and sex. If CMS were to move the concept forward, we would initiate development based on age and sex factors and discuss with the TEP and additional experts whether any further risk factors are needed and how they might affect the measure's feasibility. Risk factors outside age and sex were not discussed with the TEP during the November 2020 meetings. The USPSTF recommends screening for chlamydia and gonorrhea in all sexually active women 24 years and younger and in older women at increased risk; screening for HIV infection in all patients 15 to 65 years of age

regardless of risk, as well as in younger and older patients at increased risk of HIV infection; and screening for syphilis in persons at increased risk.^{3,4,5}

STI—Counseling. Eighty-six percent (6/7) of TEP members who submitted their assessments of this measure rated its importance as moderate or high. During the meeting, TEP members expressed concerns about the required counseling duration but shared that duration could vary depending on the STI and the specific patient. For instance, a patient with low health literacy may need more time than someone with high health literacy, or a person newly diagnosed with HIV may require more counseling than someone diagnosed with chlamydia. One TEP member indicated that expanding the population to sexual partners of the patient could improve the importance of this concept. Another member asked whether counseling has been shown to reduce re-infection rates. With regard to usability, 71 percent (5/7) of TEP members who submitted their assessments of this concept rated it as moderate or high. During the meeting, TEP members noted that many clinics and practices probably do not have a behavioral counselor on staff and may not have the budget to hire one. In addition, clinicians themselves may lack the time to conduct thorough counseling in their practices. One TEP member suggested expanding the measure to align with the associated guidelines. For example, he suggested defining *counseling* to include educational materials or virtual counseling and expanding the allowable types of people who can perform it, such as nursing professionals, researchers, and health educators. After the meeting, a second TEP memo echoed the benefits of expanding the allowable types of clinician. TEP members also expressed concerns about the effectiveness of counseling for STI prevention, as most of the research posits a heterosexual population and does not include data on sexually active boys; pregnant persons; or gay, lesbian, bisexual, nonbinary, or transgender persons. Twenty percent (1/5) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, TEP members noted that the available codes from Medicare are used infrequently and that clinicians might use such measures to fill “check-boxes.” Concerns were also raised about the use of general counseling code, which could be for STI counseling but also for marriage, drug addiction, trauma, and so on. After the meeting, one TEP member commented that he is concerned about how the clinicians will document counseling and how difficult it might be to track accurately.

- Post-meeting notes:
 - With regard to adding partners to the measure specifications, although we could explore this topic further during measure development, if CMS were to move this measure forward, the 2020 USPSTF guideline on behavioral counseling indicates that “research on interventions that engage couples, or sex partners of primary care patients, is also needed.”⁶

³ U.S. Preventive Services Task Force. “Final Recommendation Statement: Chlamydia and Gonorrhea: Screening.” September 2014. Available at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening>. Accessed November 6, 2020.

⁴ U.S. Preventive Services Task Force. “Final Recommendation Statement: Syphilis Infection in Nonpregnant Adults and Adolescents: Screening.” June 2016. Available at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-nonpregnant-adults-and-adolescents>. Accessed November 6, 2020.

⁵ U.S. Preventive Services Task Force. “Final Recommendation Statement: Human Immunodeficiency Virus (HIV) Infection: Screening.” June 2019. Available at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening>. Accessed November 6, 2020.

⁶ United States Preventive Services Task Force. “Sexually Transmitted Infections, Behavioral Counseling, 2020.” 2020. Available at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling>. Accessed on December 15, 2020.

- In terms of the effect of counseling on outcomes, it appears to reduce STI acquisition. The 2020 USPSTF guideline included several trials that enrolled persons who had current, recent, or suspected STI diagnosis or were attending STI clinics. “Behavioral counseling interventions were effective for reducing STI acquisition by approximately 30 percent based on pooled analysis of 19 trials in persons at increased risk for STIs. . . . Several trials found that interventions with high contact time were associated significantly with increased condom use or reductions in unprotected sex or the number of sex partners.”⁷
- If CMS were to continue development of this measure, we would also explore the feasibility of expanding the concept to include various types of counseling methods and providers that align with the guidelines and would continue to explore counseling’s effect on various patient populations and the specificity of counseling codes available for measure inclusion.
- STIs—Re-infection. Seventy-one percent (5/7) of TEP members who submitted their assessments of this measure rated its importance as moderate or high, and 60 percent (3/5) rated its feasibility as moderate or high. During and after the meeting, TEP members did not elaborate on the importance or feasibility of this concept. Fifty-seven percent (4/7) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, TEP members said that the re-infection measure concept alone may not be sufficient and suggested tying it more closely to behavioral counseling after diagnosis, for instance, measuring whether clinicians offer or recommend appropriate counseling after a patient was diagnosed with a re-infection. After the meeting, TEP members mentioned that this outcome is mostly patient driven and will undercount re-infections owing to lack of repeat testing. Another member suggested that this should be tracked by state department of health teams rather than the federal government.

Hepatitis B Vaccination. One hundred percent (7/7) of members who submitted their assessments of this concept rated its importance as moderate or high. TEP members said that it is important to vaccinate at-risk adults and asked for clarification on what factors include people in the at-risk category. The EC eCQM team shared that the Advisory Committee on Immunization Practices recommends vaccination of (1) children and adolescents aged <19 years who have not been vaccinated previously; (2) adults at risk of hepatitis B virus (HBV) infection, including universal vaccination of adults in settings in which a high proportion of risk factors for HBV infection exist; and (3) adults requesting protection from HBV without acknowledgment of a specific risk factor.⁸ The CDC also mentions specific additional groups at high risk, such as those undergoing dialysis and those with diabetes.⁹ Eighty-six percent (6/7) of TEP members who submitted assessments of this measure rated its usability as moderate or high. During and after the meeting, members did not elaborate on its usability. Eighty percent (4/5) of members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, TEP members questioned whether the measure should be considered met if the patient received the vaccine ever in their lifetime versus during the measurement period. This would require a patient attestation in the EHR and/or that the patient remember the date they received the vaccine. TEP members thought it unlikely that

⁷ United States Preventive Services Task Force. “Sexually Transmitted Infections, Behavioral Counseling, 2020.” 2020. Available at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling>. Accessed on December 15, 2020.

⁸ Schillie, S., C. Vellozzi, A. Reingold, A. Harris, P. Haber, J.W. Ward, and N.P. Nelson. “Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices.” *Morbidity and Mortality Weekly Report. Recommendations and Reports*, vol. 67, no. RR-1, 2018, pp. 1–31.

⁹ Centers for Disease Control and Prevention. “Hepatitis B Questions and Answers for Health Professional.” July 2020. Available at <https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm>. Accessed December 17, 2020.

patients would remember this information. The EC eCQM team mentioned that we could explore this modification if CMS selects this concept for continued development.

Chronic disease management

Goal Setting for Modifiable Behaviors: Set It. Eighty-eight percent (7/8) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, the TEP said that it addresses an important area for patient care, with one member noting that it represents a “patient-centered process” that is important to measure, that is, clinicians engaging patients who are willing and able to work on modifying behaviors that affect physical health. Members suggested removing falls from the behavioral risk factors proposed for measure inclusion. After the meeting, members mentioned that capturing goals is an important action for clinicians to take, but one member expressed that it will be hard to tell from the measure whether an important conversation occurred between the patient and clinician to set the goal or if the clinician just checked the box that a goal had been set. Sixty-three percent (5/8) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. The TEP supported the Set It concept but raised concerns regarding the variation in level of difficulty of goals set and the readiness of patients to move from setting a goal to achieving it. One TEP member noted that in some cases patients and providers may set “low bars” for goals but others may set unrealistic goals, making interpretation of measure scores difficult. TEP members also noted that patients’ willingness to move from contemplation to action in goal setting may vary, with one member concerned that the concept oversimplifies the process of patients becoming willing to set realistic goals upon which they will act. This member said that these concepts would be hard to track over time. During the meeting, members did not elaborate on the feasibility of this concept, but 33 percent (2/6) of those who submitted their assessments rated its feasibility as moderate or high. After the meeting, TEP members shared that few systems capture and allow monitoring of goals.

During the meeting, the EC eCQM team asked the TEP whether an expansion of the Set It measure to include clinician action to support the patient’s goal achievement would improve the measure. TEP members did not support this modification. They felt that patients would still be in variable stages of willingness to engage in behavioral change, regardless of the supporting clinical intervention, and the requirement of capturing the clinical intervention would add complexity and further burden the implementer. One TEP member noted that resources available for referral and community engagement would vary considerably.

Goal Setting for Modifiable Behaviors: Met It. Eighty-eight percent (7/8) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, TEP members indicated that they felt information related to goals met could be useful for patients and clinicians to track generally. One TEP member was concerned that the concept “oversimplifies things” but thinks it is an important area to develop. TEP members suggested removing falls from the behavioral risk factors proposed for measure inclusion. Thirty-eight percent (3/8) of members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, members expressed concerns about the variability of goals providers set and the implications it would have on interpreting scores on the measure. Another member said that clinicians should not be held accountable for whether patients meet goals, and by putting the responsibility on the clinician, you take away the autonomy of the patient to achieve his or her own goals. After the meeting, one TEP member said, “I worry that this is not the kind of measure where you can compare providers with one another, as there is no way I can imagine risk-adjusting it, but without risk adjustment, the differences between provider patient populations make it impossible to use the measure for provider accountability.” Another TEP

member mentioned that there may be medical conditions or medications that prevent patients from achieving their goals. A third TEP member mentioned that patients are the actors in this measure and that clinicians can only educate and recommend changes for the patient to consider. No (0/6) TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, the TEP members did not comment on the its feasibility. After the meeting, TEP members shared that few systems capture and allow monitoring of goals.

FSA for Heart Failure. Eighty-three percent (5/6) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. The TEP expressed general support for the concept but mentioned that there is significant variation in the severity of symptoms in heart failure patients. The TEP felt that it might be beneficial to link the assessments to an event, such as a hospitalization. A TEP member said that doing so would differentiate it from the functional status assessment offered during Medicare annual wellness visits. Another member noted that this concept aligns with a similar measure in the American College of Cardiology/American Heart Association’s measure set, Measurement of Patient-Reported Outcome-Health Status for Heart Failure (Quality Measure 2 or QM-2).¹⁰ The project team explained that the concept we are presenting would build on QM-2 by moving from an assessment measure to an assessment and target-setting measure. Should the concept be developed, it would require, as QM-2 does, assessment twice during the measurement period (typically one year) and documentation from a clinician that a target was set and linked to the initial assessment. This member also noted the importance of distinguishing between health-related quality of life and functional status. Sixty-seven percent (4/6) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, two TEP members expressed concern that repeated measurements across all patients may not be clinically useful (especially for those patients who have mild or no symptoms) and thus may not be helpful. Another TEP member mentioned that because the FSA instruments are used by clinicians who manage heart failure patients, repeated measurements are necessary. This member indicated that the information is useful to managing heart failure patients; therefore, reporting provider performance scores would be useful to heart failure patients who are considering a clinician. Fifty percent (2/4) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, several members noted that information similar to what the measure would capture is already collected in primary care settings. After the meeting, a TEP member suggested that setting a target will increase the complexity of the measure and make it difficult to capture.

Chronic Disease Self-Efficacy. One hundred percent (7/7) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, one member said the issue is very important, and another said that using a tool such as PROMIS makes the concept worth exploring further. A third member asked whether there was evidence supporting a relationship between self-efficacy and clinical outcomes. After the meeting, a TEP member mentioned that knowing the patient’s self-efficacy level can help the clinicians manage the patient more effectively. Fifty-seven percent (4/7) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the TEP meeting, a member speculated that perceptions of self-efficacy may differ across age groups, which could affect interpretations of performance scores across patients. After the meeting, a TEP member mentioned, “I worry about using this to compare providers for accountability

¹⁰ Heidenreich, P.A., G.C. Fonarow, K. Breathett, C.Y. Jurgens, B.A. Pisani, B.J. Pozehl, J.A. Spertus, et al. “2020 ACC/AHA Clinical Performance and Quality Measures for Adults With Heart Failure. A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures.” *Circulation: Cardiovascular Quality and Outcomes*, vol. 13, no. 11, 2020, pp. 919–956.

purposes, as I'm not sure how you could risk-adjust the results. Differences in patient populations will affect scores. Also, this is mostly beyond the control of provider." Forty percent (2/5) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, one TEP member said she was not sure how data from patient-reported outcome measure (PROM) tools would be captured in the medical record. Another member was also skeptical of the concept's feasibility but was reassured to hear that PROMIS tools would be used to gather data.

- Post-meeting note.
 - With regard to the question about self-efficacy reports differing across age groups, there is recent work reviewing factors affecting patient responses on report outcome measure instruments and effects on data quality.¹¹ If CMS selects this measure for continued development, we would pose a research question on this topic to address during testing.
 - With regard to the relationship between self-efficacy and clinical outcomes, upon reviewing the evidence further, we did not find research with strong methods that validated the relationship between self-efficacy and clinical outcomes.

Cancer care

Colorectal Cancer Overall Survival. One hundred percent (6/6) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, the TEP members found it important, but one member mentioned that the patient's quality of life within the survival time frame is just as, if not more, important as the general information of survival. After the meeting, another member echoed that sometimes patients choose quality over quantity of life. Sixty-seven percent (4/6) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. However, based on their comments in the rating tool and during the meeting, it appears that many respondents believe this could be a good measure at a national level but not at the clinician level. Their rationale was that if clinicians are measured on their survival rates, an unintended consequence might be that they choose not to provide care for patients with a lower likelihood of survival. However, TEP members shared that it is useful at an aggregate level, as it could help identify regional or urban-rural differences in survival. For example, one TEP member noted that there will be variability in types of treatments based on where patients receive care, for example, patients at a center that participates in the National Comprehensive Cancer Network will receive care different from that of patients in a rural area. When asked whether risk adjustment could help mitigate this potential unintended consequence, one TEP member mentioned that it might be possible, but that the information necessary for a robust model might not be available in the EHR. In addition, a TEP member inquired about how the information in this measure might duplicate information being captured in registries. Forty percent (2/5) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, one member commented that the solutions to the data availability issues identified and shared by the EC eCQM team during the call, such as limited longitudinal information on patients and lack of death information in an EHR, seemed appropriate.

Changes in Physical Function for Patients with Cancer (NCCS concept). One hundred percent (7/7) of TEP members who submitted their assessments of this concept rated its importance as moderate or

¹¹ Chang, E.M., E.F. Gillespie, and N. Shaverdian. "Truthfulness in Patient-Reported Outcomes: Factors Affecting Patients' Responses and Impact on Data Quality." *Patient Related Outcome Measures*, vol. 10, 2019, pp. 171–186.

high. During the meeting, the TEP members generally suggested that this concept is important. One member mentioned that it could be helpful for patients and caregivers to know what effects to expect when it comes to physical function after treatment. Another mentioned narrowing the population to specific cancer types that are likely to experience this symptom would improve the measure's face validity. After the meeting, A TEP member mentioned that helping patients return to their pre-treatment functioning levels is crucial. Eighty-six percent (6/7) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, members did raise concerns about it, suggesting that clinicians should be held accountable for capturing the information from the patient and perhaps working with the patient to try to improve their functioning. However, clinicians should not be held accountable (especially through a payment program) for improvement. The rationale for this feedback was that physicians would be measured on patient limitations or factors over which they have no control and that there are no national benchmarks against which to assess performance. One TEP member suggested assessing physical function using a test rather than a patient self-report via PROMs. Eighty percent (4/5) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, TEP members did not specifically comment on feasibility. After the meeting, one TEP member commented that he expects challenges with risk adjustment as well as with inconsistent PROM data collection patterns, and he questioned how the measure would account for patients who do not follow up.

Changes in Fatigue for Patients with Cancer (NCCS concept). One hundred percent (7/7) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, TEP members indicated that the topic was important, but they did not elaborate. After the meeting, one member commented that *fatigue* seems too general and hard to tie to cancer care. Another mentioned that getting patients back to their pre-treatment fatigue level is crucial. A third member mentioned that she would want to know what effects on fatigue level she could expect from cancer treatment to inform her treatment decisions. A fourth member suggested narrowing the patient population down to patients with cancers or treatments where they are more likely to experience fatigue. Eighty-six percent (6/7) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, one TEP member explained that the proposed PROM included in these concepts are being used in applications beyond their intended purposes. He explained that the Patient-Reported Outcomes Measurement Information System (PROMIS) instruments were developed to enhance communication between clinicians and patients and that their use in patient-reported outcome performance measures (PRO-PMs), specifically focused on improvement or changes in scores, is beyond their original intent. In addition, he did not believe that clinically meaningful differences have been established for these PROMs. Furthermore, the TEP member noted that for this particular PROMIS instrument, the only free language option appeared to be English, which will affect its feasibility and usability. One TEP member proposed focusing the concept on the process of completing the tool rather than requiring symptom improvement. Sixty-seven percent (4/6) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, the TEP did not specifically comment on its feasibility. After the meeting, one TEP member commented that he expects challenges with risk adjustment as well as with inconsistent PROM data collection patterns, and he questioned how the measure would account for patients who do not follow up.

Changes in Cognitive Function for Patients with Cancer (NCCS concept). One hundred percent (6/6) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, one member explained that he was cautious about how to weigh this symptom

against the benefits of cancer treatment, and another indicated that before choosing a treatment plan, she would want to understand the potential effects on cognition, as cognitive function is broad and complex. A third member suggested narrowing the patient population to those most likely to experience this symptom, such as patients undergoing chemotherapy. Eighty-three percent (5/6) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. One member expressed usability concerns, with reference to patient situations that are out of a physician's control, such as patients who continue to take sedatives (specifically benzodiazepines) even though they were asked to stop because of their potential to cause cognitive impairments. After the meeting, one member noted this measure is inappropriate for use at a clinician level and another member indicated that collecting information on this symptom is more appropriate than holding a clinician accountable for symptom improvement. 80 percent (4/5) of TEP members who submitted their assessments of this concept rated the feasibility of this concept as moderate or high. During the meeting, a TEP member mentioned that clinicians may not be currently tracking patient cognition over time, which would be required for the measure to assess changes in cognitive function. This TEP member also suggested focusing the measure on more objective analyses the clinician could perform instead of a patient's report of this symptom, such as the mini mental status exam. After the meeting, one TEP member commented that he expects challenges with risk adjustment as well as with inconsistent PROM data collection patterns, and he questioned how the measure would account for patients who do not follow up.

- Post-meeting note: Although we could explore the use of more objective measures if CMS selects this concept for continued development, the National Comprehensive Cancer Network (NCCN) states in their *Survivorship* guideline that “the Mini-Mental State Examination and similar screening tools lack adequate sensitivity to detect the subtle decline in cognitive performance seen in most cancer survivors.”¹² To clarify the symptoms, NCCN suggests specific questions, many of which align with those included in the PROMIS Cognitive Function PROM.

Severe Psychosocial Effects for Patients with Cancer (NCCS concept). Eighty-six percent (6/7) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, one TEP member suggested that the topic might be covered under existing measures on depression, and another noted concern regarding the length of the PROM, as the number of questions across versions varied from 4 to 8 to more than 30. After the meeting, one member mentioned that before choosing a treatment plan, she would want to understand the potential effects on her psychosocial functioning. Another member suggested an alternative PROM for consideration of measure inclusion. Yet another suggested extending the measure's time frame, as she thought a one-year follow-up is too short with this type of medical concern. Fifty-seven percent (4/7) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, TEP members felt the measure was unusable, as they were uncertain about how to improve the condition of a patient who reported severe psychosocial effects. One TEP member explained that merely starting the discussion with patients on how they are dealing emotionally with the realities of their cancer could help the patient. This member also suggested measuring the psychosocial function of caregivers, who are affected by the patient's cancer and influence the patient's well-being. After the meeting, a TEP member noted that this is not a clinician-level measure. Thirty-three percent (2/6) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, members did not specifically comment on feasibility. After the meeting, one TEP member commented that he expects

¹² NCCN Guidelines Version 2.2020 Survivorship.

challenges with risk adjustment as well as with inconsistent PROM data collection patterns, and he questioned how the measure would account for patients who do not follow up.

- Post-meeting note: After review of the measure (Quality ID 370/ CMS 159: Depression Remission at Twelve Months) and the PROM used in it (Patient Health Questionnaire – 9 item version [PHQ-9]), there appeared to be extensive overlap between this concept and the existing measure. Therefore, we removed the concept from our prioritization analysis.

Communication on Late Effects (NCCS concept). One hundred percent (6/6) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, members stated that the survey questions do have good face validity and could be useful in developing the patient-client relationship. Members mentioned that this information would be valuable and is currently the type that patients share by word of mouth. After the meeting, one member suggested that the measure could capture information from the caregiver as well. Another mentioned that it is more important to understand whether the information from the clinician helped the patient than to capture whether the clinician provided the information. Eighty-three percent (5/6) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. The TEP did not discuss usability during the meeting. Afterward, one TEP member mentioned that she felt the information was usable and could help improve care. Forty percent (2/5) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, one TEP member cautioned that the survey included in the measure has not been assessed for psychometric properties and will have to be developed and tested before it can be used in a quality measure. Afterward, a TEP member mentioned concerns with how to collect this information in the clinician’s EHR and possible inaccurate responses if the survey was implemented by the clinician’s practice.

Communication about Financial Effects (NCCS concept). One hundred percent (5/5) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, one member noted that in addition to treatment costs, there are supplementary costs that also affect patients and their families, such as travel and time off work for both patient and caregivers. Other members indicated that because of the financial effects of care, the measure would not capture the patients with the worst outcomes: those who never receive treatment because they cannot afford it. After the meeting, one TEP member suggested that the measure could capture information from the caregiver as well. Another member mentioned, “This is really important as it relates to trade-offs that patients must make in their lives. If they want this very expensive treatment, how does that affect their ability to live in their home, feed their families, and so on. We historically have not had these types of conversations in health care and tend to avoid them. I don't how prepared health care is to tackle this issue. That is why I rated it low in feasibility, but I would like to see us try to do something in this area.” Fifty percent (3/6) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, TEP members noted that this is a system-level, not provider-level, issue. They explained that individual clinicians can do little to affect the financial aspects of care. Another member added that treatment coverage varies by health insurance, which the clinician cannot influence. After the meeting, a member mentioned that this could be useful for the clinical practice because the billing side would be more directly engaged, and that although clinicians can push for less-expensive care, patients might choose otherwise. Twenty percent (1/5) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. During the meeting, TEP members said that this concept was on the leading edge of the conversation on financial effects, and thus information on this topic is not yet available for use in a quality measure. After the TEP meeting, one member said, “I have concerns

about how to collect the data for this measure. If this is based on a survey completed in an oncology office, I worry about patients giving inaccurate responses. It would have to be neutral, third-party survey.”

Geriatric surgical outcomes

Geriatric Surgical Safety Events (composite). One hundred percent (6/6) of TEP members who submitted their assessments of this concept rated its importance as moderate or high. During the meeting, one clinician wished that other clinicians would speak up, as they know which of clinicians are more likely to cause safety events, and by doing so it would result in measures like this one being unnecessary. Sixty percent (4/6) of TEP members who submitted their assessments of this concept rated its usability as moderate or high. During the meeting, members noted that having data on safety events is important in conducting a root cause analysis and identifying quality improvements to mitigate future events. However, the members suggested that using the information in a performance measure is less useful, as it is difficult to make distinctions of “good” and “bad” care with numerators so small owing to the rarity of these safety events. Multiple TEP members mentioned that combining all the noted events might not be useful for clinicians. After the meeting, a TEP member suggested that including a risk-adjustment model would be necessary and that involving a statistician to support the compositing method would be useful. One hundred percent (5/5) of TEP members who submitted their assessments of this concept rated its feasibility as moderate or high. The TEP found this measure concept to be feasible, with one member stating that information on these events is currently captured in the EHR.

Next Steps

Following this meeting, the EC eCQM team will summarize TEP feedback and conduct additional outreach as needed. The EC eCQM team will use the TEP feedback to support the prioritization of the measure concepts and the associated recommendations to CMS.

Appendix A: List of TEP Members

Table 3. TEP members and affiliations

TEP member name	Credentials	Institutional affiliation/location	Attend 11/20	Attend 11/30	Submitted scoring
Donald Casey	M.D., M.B.A., M.P.H.	American College of Medical Quality; Chicago, IL	X	X	X
James Colbert	M.D.	Blue Cross Blue Shield of Massachusetts; Boston, MA	X	X	X
Fran Cunningham	Pharm.D.	Department of Veterans Affairs; Hines, IL	X	X	
Barbara Kivowitz	Patient representative	San Francisco, CA	X	X	X
Luming Li	M.D.	Yale New Haven Psychiatric Hospital; New Haven, CT		X	X
Bridget Lynch	M.D., M.P.H.	Presbyterian Medical Group; Albuquerque, NM			
Precious McCowan	Patient representative	Dallas, TX	X		X
Robert McClure	M.D.	MD Partners, Inc.; Lafayette, CO		X	X
Michael Perskin	M.D.	American Geriatrics Society; New York, NY	X	X	X
Lori Popejoy	Ph.D., R.N., F.A.A.N.	University of Missouri; Columbia, MO	X	X	X
Christa Starkey	Patient representative	Lone Oak, TX	X		

Appendix B: TEP Member Feedback on Existing Measures Considered for Retooling

Table 4. TEP member scores and feedback on measures for potential retooling consideration

Potential measure concepts	Measure description	Importance rating	Usability rating	Feasibility rating	Verbatim TEP member comments
Proportion of patients with a chronic condition that has a potentially avoidable complication during a calendar year.	Percentage of adult population who were identified as having at least one of the following 6 chronic conditions, who were followed for at least one year, and had one or more potentially avoidable complications during the most recent 12 months	86% (6/7)	43% (3/7)	40% (2/5)	<ul style="list-style-type: none"> • Multimorbidity makes this complicated. Who gets targeted for the complication? If a heart failure patient has increased edema and develops a pressure sore, who gets credit for the wound? I am obviously making things up here—this is not easy to tease out. I think attribution is a problem. • I have concerns about grouping 6 chronic conditions together. Also concerns about risk adjustment for this measure as differences in patient populations could be responsible for differences in performance on the measure. • I worry that providers will avoid patients who are sicker. This already happens just because fees are low. • Would be interesting to know what caused complication.
MBHR2: Anxiety response at 6 months	The percentage of adult patients with an anxiety disorder (generalized anxiety disorder, social anxiety disorder, post-traumatic stress disorder, or panic disorder) who demonstrated a response to treatment at 6 months after an index visit	86% (6/7)	71% (5/7)	80% (4/5)	<ul style="list-style-type: none"> • I would caution that this may not be about change, but about stability of the condition. Initially, the goal may be change; over time it will be important to maintain progress. Both measurements will be important. • May be difficult to identify index visit, as many patients have somewhat chronic anxiety. • Many primary care physicians treat anxiety because there aren't enough behavioral health professionals. • Too many uncertain variables: are the right resources available? How frequent is treatment? How long has disorder existed? What kind of treatment (for example, family therapy)?

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