Summary of Technical Expert Panel (TEP) Meeting 3:

Patient Understanding of Key Information Related to Recovery from an Outpatient Procedure or Surgery Patient-Reported Outcome-Based Performance Measure (PRO-PM)

December 2021

Prepared by:
Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE)

This material was prepared by CORE under contracts to the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
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The materials within this document do not represent final measure specifications.
Background

The Centers for Medicare & Medicaid Services (CMS) is developing a Patient-Reported Outcome Performance Measure (PRO-PM) to assess “Patient Understanding of Key Information Related to Recovery from an Outpatient Procedure or Surgery.” Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) is leading the work under contract to CMS. The contract name is Development, Reevaluation, and Implementation of Outpatient Outcome/Efficiency Measures, Option Period 2. The contract number is HHSM-75FCMC18D0042, Task Order Number HHSM-75FCMC19F0002.

CORE is obtaining expert and stakeholder input on the measure under development. The CORE Measure Development Team is composed of experts in the development and implementation of quality outcome measures. As is standard with all measure development processes, CORE has convened a technical expert panel (TEP) of clinicians, patient advocates, and other stakeholders. Collectively, the TEP members provide expertise in performance measurement, quality improvement, outpatient surgery, clinical care, care coordination, and the patient experience.

This report summarizes the feedback and recommendations received from the TEP during the third meeting, which focused on the results of the first pilot test and potential modifications to the survey in anticipation of the second pilot test. The summary reports of the first and second meetings are/were previously posted on cms.gov

Measure Development Team

Steven Spivack, PhD leads the CORE Measure Development Team. Dr. Spivack is an Associate Research Scientist for the Quality Measurement Team at CORE and has supported several Measure Development teams. The Measure Development Team is also composed of individuals with a range of expertise in outcome measure development, health services research, clinical medicine, and measurement methodology. See Appendix A for the full list of members for the CORE Measure Development Team.

Janis Grady, CCSQ-QVMIG/DQM, the project’s Contracting Officer’s Representative, and CMS staff are overseeing the HOQR and ASQCR programs, including Shaili Patel, CCSQ, and Anita Bhatia, PHD, have provided input.

The Technical Expert Panel

In alignment with the CMS Measures Management System (MMS), CORE held a 30-day public call for nominations and convened a TEP for the development of a Patient Receipt of Key Information Following Outpatient Procedure PRO-PM. CORE solicited potential TEP members via emails to individuals and organizations recommended by the Measure Development Team and stakeholder groups, email blasts sent to CMS physician and hospital email listservs, and through a posting on CMS’s website. The TEP is composed of 15 members, listed in Table 1.
The role of the TEP is to provide feedback and recommendations on key methodological and clinical decisions. The appointment term for the TEP is from March 2021 to May 2023.

Specific Responsibilities of the TEP Members

- Complete and submit all nomination materials, including the TEP Nomination Form, statement of interest, and curriculum vitae
- Review background materials provided by CORE prior to each TEP meeting
- Attend and actively participate in TEP conference calls
- Provide input on key clinical, methodological, and other technical decisions
- Provide feedback on key policy or other non-technical issues
- Review the TEP summary report prior to public release
- Be available to discuss recommendations and perspectives following TEP meetings and public release of the TEP Summary Report to CMS

Table 1. TEP Member Name, Affiliation, and Location

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization (title); clinical specialty, if applicable</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nichole Bostic</td>
<td>Patient/Caregiver Representative</td>
<td>Augusta, GA</td>
</tr>
<tr>
<td>Jill Dietz, MD, FACS</td>
<td>Formerly, Univ. Hospitals of Cleveland Seidman Cancer Center (Director, Breast Program); Breast surgery</td>
<td>Bentleyville, OH</td>
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<td>Richard Dutton, MD, MBA</td>
<td>US Anesthesia Partners (Chief Quality Officer); Anesthesiology</td>
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<td>Patricia Franklin, MD, MBA, MPH</td>
<td>Northwestern Univ. School of Medicine (Professor; Co-Director, Outcomes &amp; Measurement Hub); Research; Preventive medicine</td>
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<td>Caitlin Gillooley, MSPH</td>
<td>American Hospital Association (Sr. Associate Director, Quality Policy)</td>
<td>Washington, DC</td>
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<td>Beth Godsey, MS, MBA</td>
<td>Vizient Inc. (Sr. Vice President, Data Science &amp; Methodology)</td>
<td>Dallas, TX</td>
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<tr>
<td>Charles Goldfarb, MD</td>
<td>Washington University School of Medicine, Department of Orthopedic Surgery (Executive Vice Chair); Orthopedic surgery</td>
<td>St. Louis, MO</td>
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<tr>
<td>Sherrie Kaplan, PhD, MPH</td>
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<td>Irvine, CA</td>
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<td>James Moore, MD</td>
<td>UCLA Health (Physician); Anesthesiology</td>
<td>Los Angeles, CA</td>
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<td>Ann O’Connor</td>
<td>Patient/Caregiver Representative</td>
<td>Larchmont, NY</td>
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<td>Carol Raphael, MPA</td>
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<td>Kevin Schuster, MD, MPH, FACS, MCCM</td>
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</tr>
</tbody>
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<tr>
<th>Name</th>
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<tbody>
<tr>
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<td>Ann Arbor, MI</td>
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<td>Jorge Villegas, PhD, MBA</td>
<td>University of Illinois at Springfield (Associate Professor of Marketing, Patient Advocate, Research/Consultant of Health Communication and Access); Research/Advocate</td>
<td>Springfield, IL</td>
</tr>
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**TEP Meetings**

Since recruiting the TEP in 202, CORE has held three meetings with the TEP:

1) The objectives of the first TEP meeting, held on April 23, 2021, were to present the project background and measure concept, and obtain TEP input on the concept for measurement.
2) The objectives of the second TEP meeting, held on June 30, 2021, were to finalize the pilot survey instrument and process.
3) The objectives of the third and most recent TEP meeting held on December 16, 2021, were to examine the results of the first pilot and update the survey for the second pilot.

CORE anticipates holding one additional TEP meeting between May 2021 and May 2023 (see Appendix B for the TEP meeting schedule). This report contains a summary of the December 2021 TEP meeting. A summary report of the previous TEP meetings are available separately.

TEP meetings follow a structured format: updates on measure development and project status; key issues identified during measure development; CORE’s proposed approaches to addressing the issues; and an open discussion of these issues with the TEP.

**Overview of Third TEP Meeting (December 16, 2021)**

Prior to the third TEP meeting, CORE provided TEP members with meeting materials outlining the project status, results from the first pilot test; Patient Work Group (PWG) input on the first pilot; feedback from patients who filled out the survey during the first pilot test; and HOPD staff feedback; as well as proposed survey changes based on results and this feedback.

During the third TEP meeting, CORE presented the results of the pilot test previously shared with TEP members, as well as a summary of feedback from patients, pilot test participants, and HOPD staff. CORE asked the TEP to provide input on the pilot test results and considerations for the second pilot test, potential survey instrument changes considering feedback from all stakeholders and results.
Following the meeting, CORE provided TEP members who were unable to join the TEP teleconference with a recording and meeting minutes and welcomed these TEP members to provide any additional feedback by email. Their feedback is included in this document. In addition, CORE further plans to refine the draft survey instrument based on the TEP’s input during the meeting and provide the updated version to the TEP following the meeting for any final feedback prior to beginning the second pilot.

The following bullets represent a high-level summary of what was presented and discussed during the third TEP meeting. For further details, please see Appendix C.

Welcoming Remarks and Project Status

- CORE presented an overview of the project status and discussed updates since the previous meeting.
- CORE reviewed:
  - Results from the first pilot test completed in October 2021. During the first pilot, the survey was implemented at two hospital outpatient departments (HOPDs). As part of the pilot, CORE also conducted interviews with patients who completed the survey and HOPD staff involved in its administration.
  - Feedback from the third Patient Work Group (PWG) meeting from November 2021.
  - Potential survey changes, for input from the TEP. CORE noted its plans to implement the revised survey is planned in a second, larger pilot test of the measure in 2022.
    - TEP Feedback:
      - No TEP members had questions about the project status.
      - No TEP members reported any updates to their COI.

First Pilot Test

- CORE summarized testing results from the first pilot for TEP input.
- CORE reviewed the pilot test process at the two participating HOPD sites. One individual at each HOPD would send the survey vendor, a weekly excel file of data on all patients who had an outpatient procedure that week. The survey vendor then sent the survey to patients directly, ultimately meeting CORE’s goal of 300 responses, receiving 350 responses between August and October of 2021 for the first pilot, a response rate of 22%.
- CORE presented survey results, first outlining those patients 55 years and older had the highest response rate. CORE shared response rates broken down by patient characteristics including sex, primary language, insurance type, and surgery type; male patients were significantly less likely to respond (44%, p-value = 0.036); English speaking patients were significantly more likely to respond (93%, p-value = 0.029), despite a version of the survey offered in Spanish, however the survey prompt was not in Spanish.
Next, CORE shared average scores by question, which were generally similar, though scores for the daily activities domain were slightly lower than other domains. Survey scores varied significantly by some patient characteristics (health status, sex, procedure type) but not others (education, number of prior surgeries, language, gender, age).

Missingness was also evaluated, broken down by question, with 17% of patients skipping at least one survey question; CORE is considering ways to improve this result by modifying the survey. Review of inter-item correlation depicted the highest correlations in the general understanding domain.

- **TEP Feedback:**
  - One TEP member commented that the response rate agreed with their experience with electronic surveys, including a higher response rate in older patients.
  - One TEP member noted differences in scores between male and female participants.
  - One TEP member considered difference in scores between patients with scope and non-scope procedures, stating that many outcome measures do not consider this, and it may affect results and induce bias.
  - Two TEP member appreciated the high response rate but would like to see more Spanish speaking participants and questioned whether the survey is available in other languages.
  - One TEP member commented on mean scores by education.
  - One TEP member asked if urology procedures were included as scopes.
  - One TEP member asked if the measure will be specified and submitted to the National Quality Forum (NQF) using an electronic survey technique.

- **CORE Response:**
  - CORE appreciated the TEP’s input and stated that risk adjusting by gender and education will be considered in outcome measure development. CORE noted that clinical staff felt the information in the survey is just as important for patients getting scope procedures. CORE will consider other language options depending on patient populations of HOPDs in the second pilot. CORE confirmed that scope procedures range widely (ENT, urology, gastrointestinal). CORE responded that implementation could be through FHIR API or Electronic Health Records (EHR) to minimize provider burden.
CORE then presented results of qualitative testing conducted as part of the first pilot. CORE interviewed 10 patients who responded to the survey about their experiences with the information they were provided and the survey itself. Patients felt that the information they received was generally clear and easy to understand. Most did not feel they were missing key information from their provider/facility, and they also reported that they got information from multiple sources. The clearest information they received was about medications and warning signs, though a few patients undergoing major surgeries noted a lack of clarity about instructions for motility and movement.

CORE summarized the input from patients who completed the survey during the first pilot. Patients appreciated the three response options (not clear, somewhat clear, very clear), the survey length, electronic format (especially text message). Several patients explained that they chose to respond to the survey because it asked about a recent healthcare experience. A few patients felt the survey was not applicable, and some were hesitant to provide negative feedback even when the information they received after their procedure was unclear.

- **TEP Feedback:**
  - One TEP member asked if many patients undergoing minor procedures received the survey, and if there is data to correlate understanding to outcomes. They further indicated high correlation of patient satisfaction with outcomes, based on their own research.
  - One TEP member asked if CORE reviewed information packets provided to patients from each facility.
  - One TEP member commented on correlation between patients remembering their anesthesia provider and increased satisfaction, and that sending the survey itself is a form of patient engagement that may increase patient satisfaction.

- **CORE Response:**
  - CORE responded that all patients receiving outpatient surgery, including minor operations, received the survey and patient outcomes cannot be assessed since data could not be linked to claims data. CORE confirmed the conceptual model correlates increased understanding to improved patient experience. CORE confirmed that this work did not include reviewing the actual information that was provided to patients because the measure focuses on how patients rate, they clarity of information, not CORE’s rating. CORE thanked the TEP member for the last comment on patient engagement.
CORE summarized quotes shared from patients representing themes of honesty, enthusiasm, and convenience; concerns of negative feedback impacting their provider were verbalized, as well as sharing honest feedback to allow their provider to improve. Patients felt the survey was legitimate, encouraging their response, and they noted how much they preferred an electronic versus a paper survey.

- **TEP Feedback:**
  - One TEP member asked how the survey is labeled when sent, which may influence response rates.
  - One TEP member was concerned that marginalized patients may be hesitant to provide negative feedback.
  - One TEP member commented that in their survey research, text messages have received the best response rates and other methods have been abandoned.

- **CORE Response:**
  - CORE confirmed that their survey is a message from their provider that validates the message’s intention. CORE provided specific background on the patient who was quoted stating they were hesitant to provide negative feedback because they had their procedure at the only facility in the area, and they have long, positive history with their provider. CORE wants to encourage honest feedback but recognizes the common floor effect in healthcare survey research, with positively skewed data. With feedback from the PWG, CORE will consider how to emphasize that survey results will be used constructively.

**HOPD Staff Input**

- CORE then presented input received from HOPD staff interviews, which included individuals in the QI department and clinicians. QI staff stated there was minimal burden to implement the survey, and clinicians often did not know the pilot survey was happening. Providers favored the survey, the questions, the content, and found it of great importance for patients’ benefits and as data to collect, noting a gap in data they currently collect. CORE asked TEP members (clinicians, specifically) if feedback is provided on how patients understand their information.
  - **TEP Feedback:**
    - Several TEP members agreed that the information captured in the survey is often lacking and can be beneficial to improve quality via education without punitive efforts.
• One TEP member stated he receives this feedback in his practice and it does change practice and has helped improve care. They regularly conduct surveys and offer space for free text.

• One TEP member strongly recommended including an optional free-text box, noting high value in sharing such feedback on an institutional or individual level.

  ▪ **CORE Response:**

    • CORE noted that patients often report gratitude, and the mutual benefits of this feedback for providers. CORE did not include a free-text option in the first pilot survey but may reconsider as a method to provide feedback for providers, without it contributing to the measure scores.

**Potential Changes to Survey in Preparation for Second Pilot**

  o CORE then presented survey changes for discussion, noting minor changes and high confidence in the survey and pilot data. Changes proposed are updating the introduction language, removal of one or two questions in the General Understandings domain, and removal of one question from Medication’s domain, noting high correlation between the questions in each domain.

  ▪ **TEP Feedback:**

    • One TEP member asked if patients would misunderstand ‘caregiver’?

    • Several TEP members agreed the misunderstanding of caregiver is possible and suggested asking the PWG.

    • Several TEP members agreed that ‘5-7 minutes’ is oddly specific and recommends rewording to say, ‘about 5 minutes’, noting that shorter is better, ending the introduction after the phrase “if there are ways we can improve”.

    • Several TEP members asked for clarity on where patients see the survey introduction, noting concerns of length.

    • Several TEP members noted concerns of the term ‘provider’ and possible confusion with a parent or spouse, or employer.

    • One TEP member asked if patients would understand what a multiple-choice survey is.

    • Several TEP members questioned the use of backslashes in the introduction, noting that they do not read well (‘surgery/procedure’), and the terms surgery or procedure, suggesting ‘visit’ instead.

  ▪ **CORE Response:**

    • CORE responded that traditionally a caregiver is a parent or spouse, for example, and this is feedback CORE has not heard
before. CORE can ask the PWG and consider use of parenthetical examples to clarify the meaning. CORE agrees that it can be edited to a ‘5 minute’ estimate.

- CORE agreed to explore an alternative to ‘provider’ (i.e., healthcare team, doctor, or nurse) and agreed to use plain language as much as possible, but explained terminology concern over surgery versus procedure, which are inherently different (i.e., total knee replacement vs. colonoscopy). CORE responded that ‘visit’ may be too vague.

- CORE then presented changes to the General Understanding Domain, noting high correlation between the three questions and requested the removal of one or two questions. The three questions currently included in the general understanding domain on the survey are: “the information you got about your recovery helped you:”; “easily know what you needed to do each day”; and “answer questions you may have had”.

  - TEP Feedback:
    - Several TEP members agreed that question #2 is important to keep as it describes behaviors that best relate to the other questions.
    - Several TEP members suggested reorganizing the order of the questions and/or revising the length to improve brevity.

  - CORE Response:
    - CORE thanked commentators and reiterated the high correlation between these questions, which helped triangulate the concepts being asked. CORE summarized that TEP members generally agreed in removal of question #3 while adjusting the order of questions #1 and #2.

- CORE presented the Medication domain for discussion, stating question #2 is being considered for removal, ‘why you had to start or stop medications’.

  - TEP Feedback:
    - Several TEP members agreed with removal of question #2 and suggested simplifying question #3 to ‘possible side effects of new medications’.
    - Several other TEP members debated what was most pertinent of medications to understand: the rationale for why a patient is taking a medication, and what it is for, or instructions for starting and stopping medications.

  - CORE Response:
    - CORE acknowledged the TEP’s input to revise the wording of question #3 and analyze it after the second pilot.
Dr. Steven Spivack asked TEP members (clinicians, specifically), if there are concerns over certain medications starting or stopping after surgery to prevent bleeding.

- **TEP Feedback:**
  - Several TEP members stated there are different medications depending on the surgery, but common medications include those for pain management and antibiotics.

**Survey Updates: Cohort Limitation**

- **CORE** presented the last discussion topic, cohort limitations, reminding TEP members that in the first pilot, the survey was sent to every patient receiving a procedure or surgery in the HOPD. The question posed to TEP members was whether to limit this based on CMS’ definition of major or minor surgery, or scope, or to exclude anyone in the ‘neither’ category (i.e., phlebotomy). Dr. Spivack outlined advantages of limiting the cohort: patients have lower odds of receiving an irrelevant survey; and survey results may hold more meaning. Cons included a reduced sample size, possible arbitrary definition of the cohort, and risk of losing information from ineligible patients.

- **TEP Feedback:**
  - One TEP member suggested using CPT or ICD-10 codes to structure the methodology.

- **CORE Response:**
  - Dr. Spivack stated that CORE appreciates this suggestion but prefers to rely on a definition that is updated and maintained on an annual basis, preferably by a payor like CMS.

- **TEP Feedback:**
  - Two TEP member agreed on the suggestion of using clinical classification software (250 codes, 125 of which correlate with major or minor surgery, or scope); another option included taking all anesthesia codes (0-9999) from the CPT book.

- **CORE Response:**
  - CORE acknowledged the TEP’s input

- **CORE** concluded with closing remarks, summarizing the next steps in measure development including refining the introduction and survey, discussing TEP feedback with the PWG, and holding a public comment period in the winter of 2022. The second pilot test will be conducted in the spring and summer of 2022, with a plan to reconvene the TEP in the fall of 2022. Dr. Steven Spivack reviewed a visual timeline for reconvening and invited participants to email cmsoutpatientpropm@yale.edu with comments or questions.
Next Steps

Ongoing Measure Development

Following the third TEP meeting, CORE will further revise the survey to incorporate feedback from the TEP members. CORE will distribute the revised survey to the TEP members, the Patient Work Group, and to select quality measurement experts within CORE as a final opportunity for feedback. With these responses, CORE will finalize the survey for the second pilot testing and share the final version with the subcontractor responsible for implementing the pilot survey.

CORE will pilot the survey in fifteen to thirty HOPDs in spring/summer of 2022. The pilot will also include interviews with patients and providers about their experiences with the survey.

CORE will analyze the results of the survey once the pilot is complete. This will include examining correlation coefficients between questions as well as other analyses to determine how responses group together. CORE will also conduct additional analyses on response rates, missingness, skip patterns, response bias, and sub-analyses for different patient groups. CORE will engage again with the TEP, and the Patient Work Group following the survey to discuss these results and further discuss the measure specifications.

CORE thanked the TEP members for their participation. The TEP has provided valuable feedback to CORE regarding the measure progress, the survey instrument, measure specifications, measure cohort, and pilot testing approach. CORE will continue to engage and seek input from the TEP as the measure is developed.
# Appendix A. CORE Measure Development Team

## Table A. Center for Outcomes Research and Evaluation (CORE) Team Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Team Role</th>
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<tbody>
<tr>
<td>Steven Spivack, PhD, MPH</td>
<td>Project Lead</td>
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<tr>
<td>Iman Simmonds, MD, MPH</td>
<td>Associate Research Scientist</td>
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<td>Clarissa Myers, DPT, MPH</td>
<td>Project Coordinator</td>
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<td>Kyle Bagshaw, MPH</td>
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<td>Rachel Johnson-DeRycke, MPH</td>
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<td>Leiana Dolce, BS</td>
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<td>Rose Hu, MS</td>
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<td>Phylicia Porter, MPH, MSL</td>
<td>Contract Manager</td>
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<td>Faseeha Altaf, MPH</td>
<td>Division Lead, Outpatient Research and Development</td>
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<td>Elizabeth E. Drye, MD, MS</td>
<td>Senior Director</td>
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<td>Zhenqiu Lin, PhD</td>
<td>Analytic Director</td>
</tr>
<tr>
<td>Ricardo Pietrobon, MD, PhD, MBA</td>
<td>Psychometric Consultant</td>
</tr>
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Appendix B. TEP Call Schedule

**TEP Meeting #1**
Friday, April 23, 2021 – 3:00-5:00PM EST (Zoom Teleconference)

**TEP Meeting #2**
Wednesday, June 30, 2021–3:30-5:30PM EST (Zoom Teleconference)

**TEP Meeting #3**
Thursday, December 16, 2021–12:00-2:00PM EST (Zoom Teleconference)

**TEP Meeting #4**
TBD