

## **POSITION STATEMENT**

### **Patient-Reported Outcomes Measures**

#### **Position Statements**

The American Orthopaedic Foot & Ankle Society (AOFAS) endorses the use of validated patient reported outcome (PRO) instruments to assess patient general health, functional status, and outcomes of treatment, such as the Patient-Reported Outcomes Measurement Information System (PROMIS) in any of its domains (physical, mental and social health).

The AOFAS is a medical specialty society whose 2,500 members are orthopaedic surgeons specializing in the operative and nonoperative treatment of injuries, diseases, and other conditions of the foot and ankle. The AOFAS promotes quality patient care through education, research and training of orthopaedic surgeons and other health care providers, and serves as a resource for government, industry and the health care community on issues concerning the medical and surgical care of the foot and ankle.

#### **Background**

Outcome instruments evaluate various aspects of patient health, and when appropriately utilized can provide valuable information in both clinical practice and research settings. In the past, there were few choices for evaluation of foot and ankle patients and the widely used clinical scales were clinician-based outcome measures (21). More recently, the orthopaedic community has placed emphasis on patient-reported outcome (PRO) measures, recognizing their value for understanding patients' perspectives of treatment outcomes (8, 35). There has been substantial growth in the number of instruments available with 139 unique PROMs identified in the foot and ankle literature over a ten-year period by a 2013 systematic review (22). Patient-reported outcomes (PROs) are information directly reported by patients regarding their perceptions of health, quality of life, or functional status without interpretation by healthcare providers (11).

PROMs are valuable because they are able to measure otherwise unquantifiable data. There are various types of PROMs, including generic, utility, region- or system-specific (e.g. lower extremity or musculoskeletal), disease-specific, and anatomic/joint-specific measures. They may focus on a single domain, such as pain and function, or assess multiple domains with overall scores and/or subscale scores. In a practical sense, PROMs are self-completed questionnaires, which can be administered electronically, in paper format, or over the telephone by a trained interviewer. Presently, there is variability in the use of PROMs and a lack of consensus as to which ones best describe the burden of a foot or ankle condition, and evaluate the effects of intervention. Selection of the optimum outcome measure for a particular study is not always clear, complicated by the fact that the quality of PROMs varies and many have been poorly or inadequately validated. Which is the most appropriate for a given situation? There is a need for health care providers to apply consistent instruments to evaluate patients with foot and ankle disorders in order to standardize outcome measurement (1, 21).

Previous investigators examined the measurement properties (e.g. validity, reliability, responsiveness) of outcomes measures for the foot and ankle (33, 38). Some investigators reported the frequency of use of various outcome measures in the literature, and others assessed

the methodological quality of studies reporting on the measurement properties of commonly used PROMs. These studies demonstrated that not all PROMs have measurement properties which meet recommended quality criteria. The appropriate PROM should be chosen based on measurement property evidence with consistent findings of good performance from good quality studies (42).

Unfortunately, the measurement properties of some instruments have been extensively tested, while others have not. PROMs with demonstrated measurement properties are available for evaluating outcomes of foot and ankle interventions. It is important to be familiar with the appropriate application of individual PROs, and understand concepts of validation and psychometric testing. The process of developing an outcome instrument is laborious, and the work of establishing their measurement properties even more so. Elements of sound outcomes instrument evaluation include 1) *content validity*--how well items accurately capture the complete spectrum of what patients experience relevant to the measurement aim or 'target construct' of the instrument; 2) *construct validity*-- whether items measure what they intend to measure (such as physical function), and scores of an instrument are consistent with pre-defined hypotheses (e.g. regarding relationships with scores of other instruments or differences between meaningful groups); 3) *criterion validity*--assessment of how an instrument compares to a gold standard test (if available) or pre-specified criterion or criteria; 4) *reliability*--measure of reproducibility or freedom from measurement error; 5) *responsiveness*--the ability to detect change over time in the target construct (5, 6); and 6) *minimum clinically important difference (MCID)*-- the smallest change in a treatment outcome that an individual patient would identify as important, which can provide meaningful interpretation of PRO scores.

## **Recommendations**

**PROMIS:** The Patient-Reported Outcomes Measurement Information System (PROMIS) (3, 39) was developed with support of the National Institutes of Health to improve PRO assessment and is administered with Computerized Adaptive Tests (CAT) using item response theory (IRT). The CAT draws items from an item bank relevant to a specific domain, such as physical function. The CAT targets the patient's ability so that a patient's response determines the next item asked, thereby reducing the number of questions required to assess outcome. This improves measurement precision and reduces floor/ceiling effects, administrative costs, and respondent burden (16, 21). Computer adaptive testing requires less than one third of the time of legacy (original) clinical scales (13, 21). The PROMIS domain framework divides all of "self-reported health" into the domain groups: (1) general health; (2) physical health; (3) mental health; and (4) social health. Each domain represents a specific trait or conceptual area that is the target of assessment, such as a symptom or functional capability, which can also be divided into sub-domains--further specifications of an aspect of health ([www.promis.org](http://www.promis.org), 2, 22). PROMIS has developed domain-specific PROMs within each domain group, which can be used individually or together to assess the impact of intervention on several aspects of health, which is recommended. The general health and physical health domain groups are the most commonly used in orthopaedics, with physical health consisting of domains, such as physical function, pain intensity, and pain interference, evaluating areas such as physical function, symptoms, social behavior, and treatment experience. They are available without charge ([www.promis.org](http://www.promis.org)).

A domain is a "specific feeling, function, or perception being measured" (25). Patient reported outcomes utilize domain-specific instruments such as physical function or pain interference. These

domains do not necessarily overlap, and do not provide disease specific data. The domain approach to patient outcome has the advantage of being useful for a broad array of disorders. However, domain instruments cannot entirely replace disease-specific outcome instruments that provide a level of detail that is important in characterizing specific aspects of disease; for example, an Achilles tendinopathy instrument (VISA-A questionnaire) asks how much pain occurs with ten heel raises (34). This information holds meaningful value in a specific patient population. The distinction of a domain instrument is its utility in assessing one specific aspect of health across multiple diseases. Describing patient outcomes with domain-based instruments can be combined with disease-specific validated measures whenever available. To this end, between 2013 and 2017, an increase in the reporting of PROMIS measures has been observed in a 2020 systematic review of orthopaedic outcome measurements (13).

The PROMIS Physical Function (PF) is available as a CAT and consists of 124 physical function items in five groups: upper extremity, lower extremity, axial, central, and instrumental activities of daily living. It was not designed for a specific disease or condition, but has been validated for a variety of foot and ankle conditions (17, 18, 20). This assessment tool underwent further testing for validity, reliability, responsiveness, and efficiency compared to other clinical rating systems (14). It has been shown that the PROMIS PF has a medium to high responsiveness to change (15). Assessment of the PROMIS PF CAT was performed by its developers and independent groups with similar results. Cohorts included patients who underwent treatment for hallux valgus, hallux rigidus, hammertoe, ankle arthritis, flatfoot, talar dome lesions, ankle instability, and trauma (14, 19, 24, 30, 40), however generalizability of results to specific populations has been raised as a concern. The PROMIS PF CAT is comparable or superior to legacy clinical scales including the AOFAS Clinical Rating Scores, Foot Function Index (FFI), Foot and Ankle Ability Measure (FAAM), Foot and Ankle Outcome Score (FAOS), and Short Form-12 (SF-12) with regards to validity, reliability, and responsiveness (14, 24). Additionally, it may be useful in a clinical context to identify patients who may benefit from surgery (11). In this regard, the MCID for the PROMIS PF is reported to range between 3 to 30 points, median 11.3. The MCID for the PROMIS PI is reported to range between 3 to 25 points, median 8.9. It has been suggested also that the interquartile range of the MCID values should be used for clinical decision making (16).

The PROMIS PF CAT and focus on the domain of physical function alone; consequently additional domains should be assessed to capture other important outcomes, such as pain intensity, pain interference, general health, or ability to participate in social roles and activities. Though domain-specific measures have many advantages, “specific” measures (e.g. disease-, region-, or joint-specific measures) are still valuable tools for measuring health aspects that are relevant or specific to a particular condition, region, or population of interest. Therefore, it is recommended that one or more domains should be considered for measurement of a foot or ankle intervention, and this can be combined with disease-specific validated measures whenever available.

**Other Patient-Reported Outcome Measures:** Use of validated anatomic/joint-specific, disease-specific, or system-specific measures is also recommended, such as the Foot and Ankle Ability Measure (FAAM), the Foot and Ankle Outcome Score (FAOS), the Musculoskeletal Function Assessment (MFA), and the Short Musculoskeletal Function Assessment (SMFA). *The Foot and Ankle Ability Measure (FAAM)* is comprised of 21 items of activities of daily living and 8 items of sports subscales (28). It was based upon the Foot and Ankle Disability Index (FADI) (10, 27) and found to be a reliable, responsive, and valid measure of physical function for individuals with a broad range of musculoskeletal disorders of the lower leg, foot, and ankle. The MCID for the FAAM Sports has been studied to range between 9 and 77 points, with a median of 32.5 (16). The

*Foot and Ankle Outcome Score (FAOS)* is a 42-item questionnaire of patient-relevant outcomes in five subscales (Pain, Other Symptoms, Activities of Daily Living, Sport and Recreation Function, Foot and Ankle-Related Quality of Life). It was validated for hallux valgus, sports injury, and adult acquired flatfoot disorder (4, 26, 30, 36). The *Musculoskeletal Function Assessment (MFA)* is a 101-item questionnaire for patients who have musculoskeletal disorders of the upper and lower extremities. It has been extensively tested and has well-established measurement properties (7). The *Short Musculoskeletal Function Assessment (SMFA)* is a shorter version of the MFA, retaining 46 items (42). It consists of two parts: the dysfunction index and the bother index, and was found to be reliable, valid, and responsive in patients who had a musculoskeletal disease or injury. Measurement evidence exists supporting its use for foot and ankle populations (9,33). These specific PROMs are promising for evaluation of patients with foot and ankle conditions, but evidence supporting all measurement properties is not yet sufficient and should be taken into account when interpreting results in the clinical setting (38). Additionally, population normative values for FAAM and SF-12 are not reflective of 100% full function, which merits consideration (29). This list of “other” PROMs is not meant to be comprehensive and may change over time.

**AOFAS Clinical Rating Systems (1994):** These rating scales were reported by a subcommittee of the AOFAS Research Committee and remain widely used (23). This has been confirmed to remain true in a 2019 systematic review (37). They are clinician-based outcome measures, which evaluate patients’ pain, function, and alignment based upon clinicians’ observations. Subsequent studies demonstrated their limitations and the AOFAS does not endorse the scales due to insufficient reliability and validity (32). Notably, one limitation is the variation in MCID among different patient population. That is, the MCID is less for older patients compared to younger patients, and those patients with middle-range disability generally have less MCID values compared to those with minimal and severe disability (41). Use of the AOFAS Clinical Rating Systems as the sole instrument is discouraged.

## **Conclusion**

It is not possible to recommend a single instrument to collect quality orthopaedic data as the selection is dependent upon the population being examined and the question being asked. We support the use of the PROMIS Physical Function Computerized Adaptive Test (PF CAT), which can be assessed with other domains (e.g. pain interference). In addition, a disease-specific measure can be used when available. Other PROMs supported for the foot and ankle are the FAAM, FAOS, MFA, and SMFA.

Validated PROMs are important measures of outcome along with clinical measures, such as strength and range of motion. They are crucial for demonstrating whether healthcare interventions are effective in improving symptoms or function from the patient’s perspective. They are useful for decision-making, encouraging patient-centered care, monitoring populations, and facilitating comparison of results across studies. The intention of PROMs is not, however, to measure patient satisfaction, which is often the intention of healthcare institutions and systems. Health-specific outcome measurements using PROMs must not be conflated with patient satisfaction. To this end, the Press Ganey surveys commonly used to assess patient satisfaction had demonstrated a weak correlation to PROMIS scores among patients with orthopaedic foot and ankle problems (31). PROMs such as PROMIS PF CAT have been well-studied and have demonstrated measurement properties for multiple foot and ankle conditions. Foot/ankle-specific and system-specific measures, such as FAAM and FAOS are valid, reliable, and responsive PROMs for multiple foot and ankle pathologies.

Clinicians and researchers should consider the appropriate PRO measure for their population based on the target domain(s) addressed by the PRO measure, and supplement with additional measures assessing domains of interest as recommended and “specific” health measures where appropriate. All PROMs should be appropriately referenced in manuscripts, including relevant studies about measurement properties, and the methods section should provide justification for the selection of the PROM(s) for the study’s purpose, including discussion of validity, reliability, and responsiveness. The support of the use of these outcomes instruments are of interest to health care providers and researchers. Incorporating patient-reported outcome measures in daily practice will benefit patients, and enable assessment of treatment.

Looking to the future, we encourage patient-centered care, and improving the quality of measurement of outcomes for the foot and ankle.

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