NATIONAL QUALITY FORUM

Memo

July 26, 2019

To: NQF members and the public

From: NQF staff

Re: Commenting draft report: NQF-endorsed for Neurology, spring 2019

Background

This report reflects the review of measures in the Neurology project. Neurological conditions and injuries affect millions of Americans each year and take a tremendous toll on patients, families, and caregivers. This project aims to evaluate performance measures that will help guide quality improvement in the care and treatment of neurological conditions. The 17-person Neurology Standing Committee reviewed one measure. The Committee did not reach consensus for the measure under review.

Consensus Not Reached

- 2872e Dementia: Cognitive Assessment (PCPI Foundation)

The Committee requests comments on the measure where consensus was not reached.

NQF Member and Public Commenting

NQF members and the public are encouraged to provide comments via the online commenting tool on the draft report as a whole, or on the specific measure evaluated by the Neurology Standing Committee.

Please note that commenting concludes on August 26, 2019 at 6:00 pm ET—no exceptions.

Neurology, Spring 2019 Cycle: CDP Report

DRAFT REPORT FOR COMMENT

July 26, 2019

NATIONAL QUALITY FORUM

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DRAFT REPORT FOR COMMENT

Executive Summary

Neurological conditions and injuries affect millions of Americans each year, taking a tremendous toll on patients, families, and caregivers. For example, strokes are the fifth leading cause of death in the United States and cost billions of dollars in treatment, rehabilitation, and lost wages.[1] Similarly, Alzheimer's disease, the most common form of dementia, is the fifth leading cause of death for adults aged 65 to 85, with costs expected to rise to nearly $500 billion annually by 2040.[2]

The Neurology portfolio currently has 18 endorsed measures for neurological conditions addressing diagnosis, treatments, and procedures. The portfolio contains 16 measures for stroke which include six measures that are NQF-endorsed with reserve status, and two for dementia. Appendix B details the full portfolio of NQF-endorsed neurological measures.

For this project, the Neurology Standing Committee evaluated one maintenance eMeasure against NQF's evaluation criteria under review.

- 2872e Dementia: Cognitive Assessment (PCPI Foundation)

The Committee did not reach consensus on maintenance of endorsement for the eMeasure.

A brief summary of the measure currently under review is included in the body of the report; a detailed summary of the Committee's discussion and ratings of the criteria for the measure under review is in Appendix A.

Introduction

Neurological conditions and injuries affect millions of Americans each year and take a tremendous toll on patients, families, and caregivers. Additionally, billions of dollars are spent on treatment, rehabilitation, and lost or reduced earnings.

- Strokes are the fifth leading cause of death in the United States as well as a leading cause of disability. Each year, approximately 795,000 people suffer a stroke. Healthcare costs of stroke, including medications and missed days of work, are estimated at $34 billion annually.[3]

- Alzheimer's disease is the most common form of dementia with an estimated 5 million Americans living with the disease. An estimated 14 million people will have Alzheimer's by 2050. In 2010, the cost for Alzheimer's disease reached nearly $215 billion and is projected to rise to more than $500 billion annually by 2040.[4]

This NQF project aims to evaluate performance measures that will help guide quality improvement in the care and treatment of neurological conditions. On June 27, 2019, NQF convened the multistakeholder Neurology Standing Committee composed of 23 individuals to evaluate one NQF-endorsed measure due for maintenance review.

NQF Portfolio of Performance Measures for Neurological Conditions

The Neurology Standing Committee (Appendix C) oversees NQF's portfolio of Neurology measures (Appendix B) that includes measures for stroke, dementia, and epilepsy. This portfolio contains 18 measures: 16 process measures and two outcome and resource use measures (see table below).

Table 1. NQF Neurology Portfolio of Measures

	Process	Outcome/Resource Use
Stroke	14*	2
Dementia	2	–
Total	16	2

*Six of these measures are currently NQF-endorsed with reserve status.

Other measures related to neurological conditions can be found in other portfolios, including Patient Safety, Cardiovascular, and Surgery. Moreover, given neurologists' distinctive expertise to diagnose and treat persons with a broad and consequential constellation of illnesses and symptoms,[5] the neurology portfolio will likely expand in subsequent submission cycles to the following general domains of medical care:

- Dizziness, vertigo
- Epilepsy
- Pain, headaches, migraines
- Numbness, weakness
- Delirium

- Movement disorders (Tremors, Parkinson, tics)
- Spinal cord or traumatic brain injuries
- Stupor, coma, consciousness, brain death
- Sleep
- Vision, hearing
- Drugs and alcohol effects
- Psychosis
- Autism

Neurology Measure Evaluation

On June 27, 2019 the Neurology Standing Committee evaluated one measure undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Neurology Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	1	0	1
Measures where consensus is not yet reached	1	0	1
Reasons for not recommending	Importance – X Scientific Acceptability – X Use – X Overall Suitability – X Competing Measure – X	Importance – X Scientific Acceptability – X Overall Suitability – X Competing Measure – X	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on April 25, 2019 and closed June 19, 2019. As of June 27, NQF did not receive any member or public comments.

Overarching Issues

During the Standing Committee's discussion of the dementia measure, some general ideas about quality measurement emerged. First, the Committee observed that it is difficult to find evidence that affirms the connection between a relatively basic activity (e.g., symptom screening) and a targeted outcome (lower symptoms, better functioning). The second idea was that a measure is best cast only if it considers burden on patients and their families, not just the burden on the entity that has to report on the measure. The third idea was that an assessment of one symptom (e.g., cognition) may be important, but alternatively it may be less important than other symptoms (e.g., mood or basic functioning). Fourth, the Committee made two notable observations about validity: (1) finding a good "gold standard"

is challenging, and this requires some flexibility and imagination by developers, and (2) the requirement that an e-measure needs validation from a separate e-measure may be too restrictive. Finally, the Committee was generally concerned about the scarcity of measures in NQF's neurology pipeline, generally, and specifically for dementia measures as the portfolio presently has only two.

Summary of Measure Evaluation

The following brief summary of the measure evaluation highlights the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for the measure are included in Appendix A.

Dementia

2872e Dementia: Cognitive Assessment (PCPI Foundation): Consensus Not Reached

Description: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period; **Measure Type**: Process; **Level of Analysis**: Clinician : Group/Practice; **Setting of Care**: Inpatient/Hospital, Other, Outpatient Services; **Data Source**: Electronic Health Records

The Standing Committee did not reach consensus on the evidence used to support the continued endorsement of this eMeasure. Most of the discussion on this measure focused on the importance criteria, as the Committee was concerned by the absence of graded evidence from the guidelines presented, and by the more general absence of empirical studies that connect cognitive assessment of dementia cases to better outcomes for patients and their families. Committee members expressed concern that cognitive assessment alone may miss more general functional and behavioral indicators that are critical to optimizing dementia care, especially as the disease progresses.

Discussion regarding gap, reliability, and feasibility was brief as the Committee was not concerned that any of these aspects of the application were deficient. With respect to validity, the Committee discussed whether depression and suicide assessments were validating comparators to dementia cognitive assessment. They also asked the developer to provide some information regarding the comparators. The developer noted that these two comparator measures were electronic clinical quality measures (eCQMs), like the measure under consideration, and such parallel comparison choices are encouraged by NQF submission standards. The developer also argued that both the comparators selected are somewhat related to dementia assessment, though they could not explain why suicide screening had a markedly stronger validating correlation than depression assessment ($r = 0.52$ vs. $r = 0.26$, respectively). The Committee did not express concerns about the feasibility of the measure, since it has been successfully measured using electronic health record data for some time. Given the use of the measure as part of PQRS, the Committee also did not express any concerns related to use and usability of the measure.

Ultimately, a Committee member noted that a key voting decision would be deciding whether or not an exception to NQF's usual evidentiary requirements should be allowed in this case based on two conditions: (1) that the measure demonstrates marked potential to improve care, and (2) that deployment of the measure is not likely to result in unintended and/or negative consequences. In fact,

discussion surrounding this measure revealed two potential unintended consequences: (1) misplaced focus on cognition alone (at the expense of more general function or behavior), and (2) undue burden on patients who might not have time or otherwise want another assessment. The developer and a public commenter responded to the first concern by noting that the cognitive measure has historically been part of a set of assessment processes, and the developer addressed the second point by observing that they rarely have received any negative patient/family feedback about the use of the measure. Finally, it is notable that the Committee expressed some hesitancy to vote down this measure for the simple reason that the neurology portfolio currently has just one other measure in it which addresses dementia—and that the other measure focuses on a contraindicated treatment (antipsychotic use in dementia patients without psychosis), rather than a desirable one.

References

[1] Centers for Disease Control and Prevention (CDC). Stroke Facts and Statistics. http://www.cdc.gov/stroke/facts.htm. Last accessed July 2019.

[2] Centers for Disease Control and Prevention (CDC). Alzheimer's Disease and Healthy Aging. http://www.cdc.gov/aging/aginginfo/alzheimers.htm. Last accessed July 2019.

[3] Centers for Disease Control and Prevention (CDC). Stroke Facts and Statistics. http://www.cdc.gov/stroke/facts.htm. Last accessed July 2019.

[4] Centers for Disease Control and Prevention (CDC). Alzheimer's Disease and Healthy Aging. http://www.cdc.gov/aging/aginginfo/alzheimers.htm. Last accessed July 2019.

[5] Louis ED, Mayer SA, Rowland LP. *Merritt's Neurology Thirteenth Edition*. Philadelphia: Wolters Kluwer Health; 2015.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measure Where Consensus Is Not Yet Reached

2872e Dementia: Cognitive Assessment

Submission | Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period

Numerator Statement: Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period

Denominator Statement: All patients, regardless of age, with a diagnosis of dementia

Exclusions: Documentation of patient reason(s) for not assessing cognition

Adjustment/Stratification: No risk adjustment or risk stratification Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Inpatient/Hospital, Other, Outpatient Services

Type of Measure: Process

Data Source: Electronic Health Records

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING 06/27/2019

1. Importance to Measure and Report: The measure does not meet the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0; M-5; L-2; I-4**; Insufficient Evidence with Exception: **Yes-5; No-6**; 1b. Performance Gap: **H-4; M-6; L-0; I-1**

Rationale:

- 2 CPGs were cited to support cognitive assessment for Dementia.
- The developer submitted the following:
    - updated evidence from the Alzheimer's Association 2018 Dementia Care Practice Recommendations: Person-Centered Assessment and Care Planning.
    - Evidence from Examining models of dementia care (ASPE Final Report No. 0212704.017.000.001), which recommends and references guidelines and reports that consistently support cognitive screening as a best practice is provided.
- However, the lack of graded evidence from the guidelines presented along with a general absence of empirical studies that connect cognitive assessment of dementia cases to better outcomes for patients and their families, were cited as concerns for the Standing Committee.

- The Committee noted that one useful result of deploying this measure is that it encourages longitudinal (in this case annual) assessment of dementia.
- Ultimately, the Committee did not reach consensus on Evidence.
- The Committee noted a significant performance gap that still exists especially for underserved populations.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-0; M-8; L-3; I-0**; 2b. Validity: **H-1; M-6; L-4; I-0**

<u>Rationale</u>:

- Measure score-level reliability testing using data from Jan 2016 – Dec 2016 data for the PQRS program is provided. Given the required conversion to ICD-10 in late 2015, the testing was completed on the ICD-10 specified measure.
- Reliability testing provided on a total of 19,209 quality events for 511 providers.
- The developer showed that reliability and validity exist for group practices only. Thus, the Committee could only consider group level of analysis for endorsement. Individual practice level was not considered.
- The Committee noted that the exclusion provided is logical. No quantification of the impact of the exclusion on performance was provided.
- The developer noted that the PQRS dataset provided by CMS did not contain missing data so this test was not performed.
- The Committee also discussed limitations of correlation analysis, given the lack of an appropriate gold standard. The Committee discussed whether depression and suicide assessments were valid comparators for dementia assessment. In defense the developer noted that these two comparator measures were eCQMs, like the measure under consideration.

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3. Feasibility: H-0; M-9; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- Data are collected through electronic health records and the two entities assessed were not using a structured format for capturing feasibility, because exception information is extracted from documentation within the medical record, explaining why the patient did not receive the standard of care.
- The Committee did not express concerns about the feasibility of the measure, since it has been successfully measured using electronic health record data for some time.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-10; No Pass-1;** *4b. Usability:* **H-3; M-4; L-1; I-3**

Rationale: Given the use of the measure as part of federal reporting, the Committee also did not express any concerns related to use and usability of the measure.

- The measure is currently used for public reporting and the Merit-based Incentive Payment System (MIPS).
- The developer noted they have not received reports of unexpected findings resulting from the implementation of this measure.
- The developer did not identify any unintended benefits for this measure during testing or since implementation.

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5. Related and Competing Measures

- No related or competing measures noted.

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6. Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**

Rationale

- The Committee noted that the main decision-making point for consideration will be the lack of empirical evidence demonstrating a probable causal linkage between assessment and the ultimate goal of optimizing dementia care. Since the Committee did not reach consensus on Evidence, the Committee will vote on a recommendation for endorsement during the post-comment call.

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7. Public and Member Comment

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8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

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9. Appeals

Appendix B: Neurology Portfolio—Use in Federal Programs[a]

*Measures currently endorsed with reserve status.

NQF #	Title	Federal Programs: Finalized or Implemented as of May 31, 2019
0434e*	STK 01: Venous Thromboembolism (VTE) Prophylaxis	No federal program usage specified for this measure.
0435e*	STK 02: Discharged on Antithrombotic Therapy	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0436e*	STK 03: Anticoagulation Therapy for Atrial Fibrillation/Flutter	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0437	STK 04: Thrombolytic Therapy	No federal program usage specified for this measure.
0437e	STK 04: Thrombolytic Therapy	Hospital Inpatient Quality Reporting
0438e*	STK 05: Antithrombotic Therapy By End of Hospital Day Two	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0439e*	STK 06: Discharged on Statin Medication	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0441e*	STK 10: Assessed for Rehabilitation	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals
0467	Acute Stroke Mortality Rate (IQI 17)	No federal program usage specified for this measure.
0507	Diagnostic Imaging: Stenosis Measurement in Carotid Imaging Reports	Merit-Based Incentive Payment System (MIPS) Program
0661	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 minutes of ED Arrival	Hospital Compare; Hospital Outpatient Quality Reporting
1952	Time to Intravenous Thrombolytic Therapy	No federal program usage specified for this measure.
2111	Antipsychotic Use in Persons with Dementia	No federal program usage specified for this measure.
2863	CSTK-06: Nimodipine Treatment Administered	No federal program usage specified for this measure.

[a] Per CMS Measures Inventory Tool as of 07/15/2019

NQF #	Title	Federal Programs: Finalized or Implemented as of May 31, 2019
2864	CSTK-01: National Institutes of Health Stroke Scale (NIHSS) Score Performed for Ischemic Stroke Patients	No federal program usage specified for this measure.
2866	CSTK-03: Severity Measurement Performed for Subarachnoid Hemorrhage (SAH) and Intracerebral Hemorrhage (ICH) Patients (Overall Rate)	No federal program usage specified for this measure.
2872e	Dementia: Cognitive Assessment	Merit-Based Incentive Payment System (MIPS) Program
2877e	Hybrid hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute ischemic stroke hospitalization with risk adjustment for stroke severity	No federal program usage specified for this measure.

Appendix C: Neurology Standing Committee and NQF Staff

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Appendix D: Measure Specifications

2872e Dementia: Cognitive Assessment

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period

TYPE

Process

DATA SOURCE

Electronic Health Records Not applicable.

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Inpatient/Hospital, Other, Outpatient Services Occupational Therapy Services, Domiciliary, Rest Home or Custodial Care Services

NUMERATOR STATEMENT

Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the measurement period

DEFINITION:

Cognition can be assessed by the clinician during the patient's clinical history.

Cognition can also be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to:

-Blessed Orientation-Memory-Concentration Test (BOMC)

-Montreal Cognitive Assessment (MoCA)

-St. Louis University Mental Status Examination (SLUMS)

-Mini-Mental State Examination (MMSE) [Note: The MMSE has not been well validated for non-Alzheimer's dementias]

-Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

-Ascertain Dementia 8 (AD8) Questionnaire

-Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) [Note: Validated for use with nursing home patients only]

-Formal neuropsychological evaluation

-Mini-Cog

NUMERATOR GUIDANCE:

Use of a standardized tool or instrument to assess cognition other than those listed will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed": "Cognitive Assessment" included in the numerator logic below.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

DENOMINATOR STATEMENT

All patients, regardless of age, with a diagnosis of dementia

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

DENOMINATOR GUIDANCE:

The requirement of two or more visits is to establish that the eligible professional or eligible clinician has an existing relationship with the patient.

The DSM-5 has replaced the term dementia with major neurocognitive disorder and mild neurocognitive disorder. For the purposes of this measure, the terms are equivalent.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

EXCLUSIONS

Documentation of patient reason(s) for not assessing cognition

EXCLUSION DETAILS

Time Period for Data Collection: 12 consecutive months

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Dementia: Cognitive Assessment, exceptions may include patient reason(s) for not assessing cognition. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: patient reason(s) for not assessing cognition]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 140560| 135810| 141015

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