NATIONAL QUALITY FORUM
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Meeting Summary

Neurology Standing Committee Fall 2020 Post-Comment Web Meeting

The National Quality Forum (NQF) convened a public web meeting for the Neurology Standing Committee on May 25, 2021, to consider one "consensus not reached" measure and review comments received from the public. The web meeting was led by the Neurology project team:

- Chelsea Lynch, MPH, MSN, RN, CIC, director
- Oroma Igwe, MPH, manager
- Monika Harvey, PMP, project manager
- Ngozi Ihenacho, MPH, analyst
- Jesse Pines, MD, MBA, MSCE, consultant

Welcome, Introductions, and Review of Agenda

NQF welcomed the Standing Committee and participants to the web meeting and provided an overview of the agenda, which was to continue discussion of measure #3596 *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization*. The discussion continued due to the previous vote on the evidence criterion being consensus not reached (Total Votes: 17; Pass-9, No Pass-8; 9/17, 53 percent); the voting results were between 40 to 60 percent (> 60 percent is required to pass) for the previous Standing Committee vote during the meeting on February 5, 2021. With consensus not reached on evidence, a must-pass criterion, the Standing Committee discussed, voted, and passed the measure on the other evaluation criteria (i.e., performance gap, reliability and validity, and use and usability); however, they did not discuss or vote on overall suitability for endorsement. The purpose of this post-comment web meeting was to continue discussion on the concerns related to evidence, re-vote on evidence, and then, if the measure passes evidence, vote on overall suitability for endorsement.

Notably, between the measure evaluation web meetings and the post-comment web meeting, one Standing Committee member withdrew her participation. Quorum (14 Standing Committee members) was met and maintained throughout the web meeting (14 out of 21 Standing Committee members attended). The vote totals reflect members present and eligible to vote at the time of the vote.

Consideration of Consensus Not Reached Measure

During the meeting, the Neurology Standing Committee considered one measure that did not reach consensus. A detailed summary of the Standing Committee's deliberation will be compiled and provided in the draft technical report.

NQF #3596 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization

Measure Steward/Developer Representatives at the Meeting

Susannah Bernheim, MD, MHS, director, Quality Measurement Programs, CORE

Standing Committee Votes

- Evidence: Total Votes: 14; Pass-3, No Pass-11 (3/14 – 21 percent, No Pass)

Standing Committee Recommendation for Endorsement: Does Not Recommend Endorsement

During the measure evaluation meeting on February 5, 2021, the Standing Committee voted on evidence and did not reach consensus. The Standing Committee expressed concerns regarding evidence, specifically whether inpatient stroke mortality, even when risk-adjusted for the National Institutes of Health (NIH) Stroke Scale, which measures stroke severity, is an appropriate way to assess the quality of stroke care. While several Standing Committee members expressed support for the evidence surrounding the measure, several other members expressed concern with solely measuring mortality without considering patient preferences or functional outcomes, which they described as incomplete. There were also concerns regarding the potential for unintended consequences and that this measure would not drive improvements in care. The focal concern was that mortality in stroke is often not the central goal of stroke care. Rather, functional outcomes may be more important because stroke patients can be alive but permanently debilitated, and this outcome may be considered worse than death. The public comments received after the evaluation meetings related to the evidence criterion shared the same themes as the Standing Committee's discussion, with concerns about whether this measure would drive improvements in quality of care and the potential for unintended consequences.

At the start of the post-comment meeting, James Poyer, a representative from the Centers for Medicare & Medicaid Services (CMS), made an introductory statement. He acknowledged concerns about the measurement of stroke mortality in isolation without considering functional outcomes or patient preferences. He agreed that measuring outcomes from multiple perspectives was important to CMS in order to adequately capture quality. He provided an example of a total hip arthroplasty measure, which was paired with a patient-reported outcome measure (PROM).

Mr. Poyer also described this stroke mortality measure as part of CMS' strategy to maintain a broad assessment of hospital quality. A stroke mortality measure that did not include risk adjustment for stroke severity was previously reviewed by the Neurology Standing Committee and did not receive endorsement. The previous Standing Committee identified the lack of risk adjustment as a concern in the measure evaluation; therefore, risk adjustment for stroke severity was added to this measure as an improvement. Mr. Poyer also acknowledged the current limitation: Outcomes including disability and functional status are not directly measurable using a claims-based approach. However, he did describe efforts by CMS to potentially measure functional outcomes in the future with other sources of data, such as electronic health records (EHRs). He also reminded the Standing Committee that stroke is the fifth leading cause of mortality in the United States (U.S.), and mortality is an important outcome to patients.

Standing Committee Co-Chair David Tirshwell then lead a discussion on the evidence criterion for the measure. He first clarified with NQF that the measure should be evaluated based on what was submitted rather than what was submitted in comparison to another existing measure. This comment was referring to the earlier stroke mortality measure that did not include risk adjustment for the NIH Stroke Scale.

One Standing Committee member expressed support for the measure and appreciated the developer's attempts to clarify outstanding issues by sharing responses to questions from the Standing Committee via email in advance of the meeting. Another Standing Committee member also expressed support for the measure, stating that while it is limiting that there are functional outcomes measured, mortality is also an important measure of quality, particularly when risk-adjusted by the NIH Stroke Scale.

Another Standing Committee member expressed concern that stroke mortality in isolation would not drive healthcare quality improvement. This same member later noted that evidence-based stroke interventions, including tissue plasminogen activator (tPA) and thrombectomy, did not reduce mortality. He also expressed concern that this measure could create the wrong incentives for hospitals to keep patients alive without considering patient preferences. Another Standing Committee member asked why 30-day outcomes were considered rather than other important time periods, such as 14-days or 60-days post-hospital discharge; they were concerned that the measure did not address outcomes post-hospitalization or drive improvements in care coordination. Concerns were also raised with regard to stroke mortality not being especially high, particularly from ischemic stroke; however, it was later clarified that the risk-adjusted stroke mortality rate in this measure was slightly less than 15 percent.

A brief discussion was held about whether one or more actions could improve stroke mortality. It was clarified that several actions, such as the presence of stroke units, were associated with improved mortality. Other examples that influence stroke mortality were provided, including invasive procedures, such as hemicraniectomy and the use of percutaneous endoscopic gastrostomy (PEG) tubes. Yet there were concerns that while these interventions may improve mortality, they may not improve functional outcomes, and therefore, they may not be in the best interest of the patient or account for their preferences. It was later clarified that these interventions were only performed in a low percentage of stroke patients. There were also concerns that the developer had not demonstrated that a problem existed with excess mortality in stroke nationally. One Standing Committee member also asked whether there are lessons that can be learned about other mortality measures endorsed by NQF, such as for heart failure. The developer for this measure was also the developer for the heart failure mortality measure and stated that such concerns regarding functional outcomes or patient preferences were not raised during the evaluation of the heart failure mortality measure.

Additional concerns were raised regarding whether the inclusion of academic hospitals, which are more likely to use palliative care (which was unmeasured), confounded the results and whether certain patient populations, particularly African Americans, tend to prefer more aggressive care, which was also not measured.

Ultimately, the Standing Committee's vote on evidence did not pass (Total Votes: 14; Pass-3, No Pass-11; 3/14, 21 percent). Since evidence is a must-pass criterion, the Standing Committee did not recommend endorsement for this measure. The Standing Committee did not vote on overall suitability for endorsement or discuss related and competing measures.

Review and Discuss Public Comments Received

Following the February 2021 meetings, the draft report was posted for public and NQF member comment on April 1, 2021, for 30 days. During this time, nine comments were received from four member organizations and five nonmember organizations. In addition to the comments received regarding the evidence criterion, which were discussed earlier in the meeting, comments regarding the threshold minimum sample size and the impact of missing data were also received. One commenter stated the 25-case minimum for reliability analysis was reasonable since facility-level performance will

not be publicly reported for less than 25 cases. The commenter also thought imputing the NIH Stroke Scale when missing is a suboptimal yet reasonable starting point. Additionally, multiple commenters expressed their support of the measure and thought that the inclusion of the NIH Stroke Scale for risk adjustment was an improvement compared to the current measure being used by CMS. One commenter also suggested this inclusion could incentivize hospitals to routinely document the NIH Stroke Scale, which is recommended by evidence-based guidelines.

Notably, the public comments that related to the evidence criterion shared similar themes to the Committee's discussion. Multiple commenters agreed with the concern about the potential unintended consequences of measuring mortality in isolation and suggested that mortality measurement could be balanced with measuring improved functional status or treatment decisions aligned with patient preferences. One commenter highlighted that although mortality may not be the ideal measure, it is an easy outcome to measure, unlike the Rankin Scale (i.e., an assessment of a patient's degree of disability or dependence after a stroke), which is not frequently performed at discharge; therefore, it would be more difficult to measure. Additionally, multiple commenters approved of using the NIH Stroke Scale for risk adjustment, as it is an important prognostic factor for individual patients as well as a predictor of hospital-level performance on 30-day mortality.

The Standing Committee then discussed potential considerations that the developer could explore for future consideration of the measure. One Standing Committee member recommended a validation study to evaluate stroke care quality, which incorporated the assessment of patient preferences and function outcomes. Another member suggested evaluating unintended consequences after implementation of the measure in an accountability or public reporting program. The developer expressed their appreciation for the Standing Committee's suggestions and review of the measure but noted these suggestions may not address the Standing Committee's fundamental concerns about measuring stroke mortality.

Member and Public Comment

There were no public or member comments.

Next Steps

The Consensus Standards Approval Committee (CSAC) will consider the Standing Committee's recommendation to not endorse the measure during their meeting on June 29-30, 2021. The 30-day appeals period for fall 2020 will be July 7, 2021, to August 5, 2021.