



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0441:3047

Corresponding Measures: 0441:2837

De.2. Measure Title: STK-10: Assessed for Rehabilitation

Co.1.1. Measure Steward: The Joint Commission

De.3. Brief Description of Measure: This measure captures the proportion of ischemic or hemorrhagic stroke patients assessed for or who received rehabilitation services during the hospital stay.

This measure is a part of a set of eight nationally implemented measures that address stroke care (STK-1: Venous Thromboembolism (VTE) Prophylaxis, STK-2: Discharged on Antithrombotic Therapy, STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter, STK-4: Thrombolytic Therapy, STK-5: Antithrombotic Therapy By End of Hospital Day 2, STK-6 Discharged on Statin Medication, and STK-8: Stroke Education) that are used in The Joint Commission's hospital accreditation and Disease-Specific Care certification programs.

1b.1. Developer Rationale: Stroke is a leading cause of serious, long-term disability, associated with significant costs. The primary goal of rehabilitation is to prevent complications, minimize impairments, and maximize function. Evidence suggests that better clinical outcomes are achieved when post-acute stroke patients receive coordinated, multidisciplinary evaluation and intervention through the provision of rehabilitation services. Therefore, the need for rehabilitation services after an ischemic or hemorrhagic stroke should be assessed prior to discharge from the acute care setting.

Healthcare organizations that track rehabilitation assessments for internal quality improvement purposes have seen an improvement in the measure rate over time. This measure has been included in the Hospital Inpatient Quality Reporting Program for three years (i.e., FY 2015, FY 2016, FY 2017) to promote improvements in quality at the national level.

S.4. Numerator Statement: Ischemic or hemorrhagic stroke patients assessed for or who received rehabilitation services.

S.7. Denominator Statement: Ischemic or hemorrhagic stroke patients.

S.10. Denominator Exclusions: • Less than 18 years of age

- Length of Stay > 120 days
- Comfort measures only documented
- Enrolled in clinical trials related to stroke
- Admitted for elective carotid intervention
- Discharged to another hospital
- Left against medical advice
- Expired
- Discharged to home for hospice care
- Discharged to a health care facility for hospice care

De.1. Measure Type: Process

S.23. Data Source: Electronic Health Record (Only), Paper Records

S.26. Level of Analysis: Facility, Other

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 **Most Recent Endorsement Date:** Sep 23, 2016

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not Applicable

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 0441_Evidence_MSF5.0_Data.doc

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)
Stroke is a leading cause of serious, long-term disability, associated with significant costs. The primary goal of rehabilitation is to prevent complications, minimize impairments, and maximize function. Evidence suggests that better clinical outcomes are achieved when post-acute stroke patients receive coordinated, multidisciplinary evaluation and intervention through the provision of rehabilitation services. Therefore, the need for rehabilitation services after an ischemic or hemorrhagic stroke should be assessed prior to discharge from the acute care setting.

Healthcare organizations that track rehabilitation assessments for internal quality improvement purposes have seen an improvement in the measure rate over time. This measure has been included in the Hospital Inpatient Quality Reporting Program for three years (i.e., FY 2015, FY 2016, FY 2017) to promote improvements in quality at the national level.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

In October, 2009, The Joint Commission added the stroke (STK) measure set as a new core measure option to meet performance measure requirements for Joint Commission hospital accreditation purposes. Below is the specified level of analysis for STK-10 Assessed for Rehabilitation beginning with discharges 4Q 2009 through December 31, 2014.

4Q 2009: 2555 denominator cases; 2473 numerator cases; 49 hospitals; 0.96791 national aggregate rate; 0.95212 mean of hospital rates; 0.07659 standard deviation; 1.0 90th percentile rate; 1.0 75th percentile rate/upper quartile; 0.97744 50th percentile rate/median rate; 0.95 25th percentile rate/lower quartile; and, 0.85294 10th percentile rate.

CY 2010: 23,875 denominator cases; 23,144 numerator cases; 138 hospitals; 0.96938 national aggregate rate; 0.95282 mean of hospital rates; 0.06331 standard deviation; 1.0 90th percentile rate; 1.0 75th percentile rate/upper quartile; 0.97731 50th percentile rate/median rate; 0.93333 25th percentile rate/lower quartile; and, 0.875 10th percentile rate.

CY 2011: 28,415 denominator cases; 27,731 numerator cases; 157 hospitals; 0.97593 national aggregate rate; 0.96355 mean of hospital rates; 0.06802 standard deviation; 1.0 90th percentile rate; 1.0 75th percentile rate/upper quartile; 0.98671 50th percentile rate/median rate; 0.96203 25th percentile rate/lower quartile; and, 0.89939 10th percentile rate.

CY 2012: 28,735 denominator cases; 28,272 numerator cases; 158 hospitals; 0.98389 national aggregate rate; 0.96919 mean of hospital rates; 0.06586 standard deviation; 1.0 90th percentile rate; 1.0 75th percentile rate/upper quartile; 0.98917 50th percentile rate/median rate; 0.96875 25th percentile rate/lower quartile; and, 0.92857 10th percentile rate.

CY 2013: 44,242 denominator cases; 43,527 numerator cases; 262 hospitals; 0.98384 national aggregate rate; 0.97722 mean of hospital rates; 0.05526 standard deviation; 1.0 90th percentile rate; 1.0 75th percentile rate/upper quartile; 0.99131 50th percentile

rate/median rate; 0.97605 25th percentile rate/lower quartile; and, 0.95652 10th percentile rate.

CY 2014: 210,075 denominator cases; 207,311 numerator cases; 1299 hospitals; 0.98684 national aggregate rate; 0.9772 mean of hospital rates; 0.06807 standard deviation; 1.0 90th percentile rate; 1.0 75th percentile rate/upper quartile; 0.99433 50th percentile rate/median rate; 0.98 25th percentile rate/lower quartile; and, 0.94737 10th percentile rate.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Not applicable

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Not applicable

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

According to a 2011 report from the American Heart Association/American Stroke Association, racial disparities in stroke care exist and are more predominant among people < 65 years of age. Evidence of disparities in stroke care between minority groups and whites include: lack of knowledge about the risk factors for stroke; lack of awareness about stroke signs and symptoms and the need for urgent treatment; and, access to care respecting prevention services, acute stroke treatment, and rehabilitation. Differences in care are also related to the socioeconomic status of minorities, insurance coverage, cultural beliefs and attitudes, language barriers, immigration status, mistrust of the healthcare system, and the number of providers representing minority groups. These are all factors contributing to the quality of stroke care (Cruz-Flores, et al. 2011).

Each year in the United States, ~ 55,000 more women than men have a stroke. Statistics reveal that women have a higher "life-time risk of stroke" than men. (Mozaffarian D, et al., 2015). In the Framingham Heart Study, lifetime risk of stroke among those 55 to 75 years of age was 1 in 5 for women (20% to 21%) and ~1 in 6 for men (14% to 17%).

The burden of stroke is higher in Blacks or African Americans and Hispanics than whites. Racial and ethnic minorities have excess deaths from stroke and also experience greater years of potential life lost than non-Hispanic whites. The risk ratio for stroke mortality in all racial and ethnic minorities is higher in the 35-to-64-year-old age group, however, this risk decreases as people age. After age 64 non-Hispanic whites have an equal risk for stroke when compared to Hispanics and American Indian-Alaskan Natives. This equalization of rate of stroke presents again after age 85 in blacks or African Americans (Cruz-Flores, et al., 2011).

In the national REGARDS cohort, 27,744 black and white men and women, aged > 45 years, followed over 4.4 years, and stroke-free at baseline, reported an overall age-adjusted and sex-adjusted black/white incidence rate ratio of 1.51. At ages 45 to 54 years, the rate ratio increased to 4.02 compared to 0.86 for > 85 years. A higher incidence of stroke is reported for blacks at younger ages.

The REGARDS investigators found that approximately half of racial disparity in stroke risk is attributable to traditional risk factors (primarily systolic blood pressure) and socioeconomic factors (Howard, et al., 2011). Brown and colleagues (2011) found a higher incidence of ischemic stroke in disadvantaged white neighborhoods, but found no significant associations between neighborhood socioeconomic status and ischemic stroke among blacks. A recent large population-based Canadian study examined gender-adjusted, age-adjusted prevalence of cardiovascular risk factors, heart disease and stroke in four ethnic groups: white (n=154,653); South Asian (N=3364); Chinese (n=3038) and, blacks (n=2742). Stroke incidence was highest in the South Asian group (1.7%) and lowest in the Chinese population (0.6%). The increased risk in the South Asian population was attributed to high susceptibility to insulin resistance and metabolic syndrome, and a tendency to develop diabetes mellitus at younger ages in both men and women as compared to other ethnic groups (Chiu, et al., 2010).

The BASIC (Brain Attack Surveillance in Corpus Christi) project (NINDS) demonstrated an increased incidence of stroke among Mexican Americans compared with non-Hispanic whites in a community in southeast Texas. The crude 3-year cumulative incidence (2000-2003) was 16.8 per 1000 in Mexican Americans and 13.6 per 1000 in non-Hispanic whites. Specifically, Mexican Americans had a higher cumulative incidence for ischemic stroke at younger ages (45-59 years of age: RR 2.04, 95% CI 1.55-2.69; 60-74 years if age:

RR 1.58, 95% CI 1.31-1.91) but not at older ages (> 75 years of age: RR 1.12, 95% CI 0.94-1.32). Mexican Americans also had a higher incidence of intracerebral hemorrhage and subarachnoid hemorrhage than non-Hispanic whites, adjusted for age.

Temporal trend data from the BASIC Project for the time period 2000 through 2010 demonstrated that ischemic stroke rates declined significantly in people aged ≥ 60 years but remained largely unchanged over time in those aged 45 to 59 years. Rates of decline did not differ significantly for non-Hispanic whites and Mexican Americans in any age group. Therefore, ethnic disparities in stroke rates in the 45- to 59-year-old and 60- to 74-year-old age groups persist (Morgenstern, et al., 2013).

Data from the most recent Greater Cincinnati Northern Kentucky Stroke Study (GCNKSS) show that compared with the 1990s, when incidence rates of stroke were stable, stroke incidence in 2005 was decreased for whites. A similar decline was not seen in blacks. These changes for whites were driven by a decline in ischemic strokes. There were no changes in incidence of ischemic stroke for blacks or of hemorrhagic strokes in blacks or whites (Kleindorfer, et al., 2010). In an analysis of temporal trends in ischemic stroke incidence stratified by age, the GCNKSS found an increased incidence of ischemic stroke over time for both blacks and whites aged 20 to 54 years, especially in 2005 compared with earlier time periods. There were declining incidence rates in the oldest age groups for both race groups (Kissela, et al., 2012).

Few studies have examined racial-ethnic disparities in stroke rehabilitation. Findings from the studies available are somewhat contradictory. With regard to access, a study from the Veterans Health Administration found no differences in referral to or receipt of inpatient rehabilitation (Horner RD, et al., 2003); however, another study found that urban-dwelling blacks or African Americans were more likely to be discharged from the hospital to inpatient rehabilitation facilities than whites (Gregory PC, et al, 2006). The VA study from Horner also reported that blacks or African Americans had a slightly longer time to initiation of rehabilitation than whites (4.4 days versus 3.8 days; $P < 0.05$).

Other studies have evaluated the effect of the Functional Independence Measure (FIM) score on the admission of minorities to inpatient rehabilitation facilities. No consistency of findings has been noted. A retrospective cohort study from Bhandari, et al. (2005) found no racial differences in admission FIM scores, but several other studies reported significant differences. One large study involving urban participants hospitalized at a county hospital reported that Hispanics had lower FIM scores than blacks or African Americans (Chiou-Tan FY, et al, 2006). Another study reported similar findings with whites having the highest FIM scores (Ottenbacher KJ, et al., 2008).

Rehabilitation length of stay has been studied with similarly inconsistent findings. One study of VA and non-VA inpatient rehabilitation facilities reported significantly longer lengths of stay for blacks or African Americans than for whites (Stineman MG, 2001). Another study from CDC (2007) using data from the BRFSS found that blacks or African Americans were more likely to be referred to outpatient rehabilitation services than whites (adjusted OR 1.49; 95% CI 1.1 to 2.0).

Results on the delivery of outpatient occupational and physical therapy are also conflicting with some reporting that whites are more likely to receive therapy than non-white minorities (Mayer-Oakes SA, 1992). Another study utilizing data from the Health and Retirement Study found no racial differences among patients receiving occupational or physical therapy (Cook C, 2005). Studies from Bhandari (2005), as well as Horner (1997), reported no racial differences in the intensity of occupational or physical therapy delivered to minorities when compared to whites.

A more recently published study (Qian F, et al, 2013) from the American Heart Association/American Stroke Association Get With The Guidelines (GWTG)-Stroke program from April 2003 through December 2008, ($n=200,900$), found racial disparities related to length of hospitalization and functional status. After multivariable adjustment for both patient-level and hospital-level characteristics, compared with non-Hispanic white patients, non-Hispanic black and Hispanic patients were more likely to have a longer hospital stay (i.e., length of stay greater than 4 days; black: AOR, 1.30; 95% CI, 1.22-1.39; $P < 0.001$; Hispanic: AOR, 1.12; 95% CI, 1.02-1.23; $P = 0.02$) and less likely to be ambulatory independent at discharge (black: AOR, 0.81; 95% CI, 0.76-0.87; $P < 0.001$; Hispanic: AOR, 0.89; 95% CI, 0.79-0.99; $P = 0.04$). Furthermore, non-Hispanic black patients were less likely to have a death at admission (black: AOR, 0.78; 95% CI, 0.68 to 0.89; $P < 0.001$) or to be discharged home (black: AOR, 0.87; 95% CI, 0.81-0.94; $P < 0.001$). Data from the Paul Coverdell National Acute Stroke Registry (PCNASR) found that other races were somewhat more likely to be assessed for rehabilitation services (98.9%) when compared to non-Hispanic white patients (98.1%) (Centers for Disease Control and Prevention - Division for Heart Disease and Stroke Prevention, 2014).

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Hailpern SM, Heit JA, Howard VJ, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD, Makuc DM, Marcus GM, Marelli A, Matchar DB, Moy CS, Mozaffarian D, Mussolino ME, Nichol G, Paynter NP, Soliman EZ, Sorlie PD, Sotoodehnia N, Turan TN, Virani SS, Wong ND, Woo D, and Turner MB. Heart disease and stroke statistics--2012 update: a report from the American Heart Association. *Circulation*. 2012;125:e78-e82.

• Stineman MG, Ross RN, Hamilton BB, Maislin G, Bates B, Granger CV, Asch DA. Inpatient rehabilitation after stroke: a comparison of lengths of stay and outcomes in the Veterans Affairs and non Veterans Affairs health care system. *Med Care*. 2001;39:123-137.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality, Severity of illness

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

Stroke ranks as the number four cause of death in the United States, following diseases of the heart, cancer, and chronic lung-related diseases. Each year, ~ 795,000 people experience a new or recurrent stroke. Approximately 610,000 of these are first attacks, and 185,000 are recurrent strokes. These numbers equate to one stroke victim every 40 seconds on average. From 2001 to 2011, the relative rate of stroke death fell by 35.1% and the actual number of stroke deaths declined by 21.2%; however, one of every 20 deaths in the United States remains attributable to stroke. More women than men die of stroke each year. Women accounted for almost 60% of US stroke deaths in 2008 (Mozaffarian D, et al., 2015).

Stroke is also a leading cause of long-term disability (George M, et al., 2009). Stroke was among the top 18 diseases contributing to years lived with disability in 2010; of these 18 causes, only the age-standardized rates for stroke increased significantly between 1990 and 2010 ($P < 0.05$) (US Burden of Disease Collaborators, 2013). Among Medicare patients discharged from the hospital after stroke, ~45% return directly home, 24% are discharged to inpatient rehabilitation facilities, and 31% are discharged to skilled nursing facilities. Of stroke patients returning directly home, 32% use home healthcare services. In 2011, the direct and indirect cost of stroke was \$33.6 billion (Mozaffarian D, et al., 2015).

The evidence indicates that patients do better with a well-organized, multidisciplinary approach to post-acute rehabilitation after stroke. The rehabilitation team may consist of a physician, nurse, physical therapist, occupational therapist, kinesiotherapist, speech and language pathologist, psychologist, recreational therapist, patient, and family members/caregivers. If an organized rehabilitation team is not available in the facility, the evidence indicates that patients with moderate or severe symptoms should be offered a referral to a facility with such a service.

Stroke rehabilitation should begin during the acute hospitalization, as soon as the diagnosis of stroke is established and life-threatening problems are controlled. The highest priorities of early stroke rehabilitation are to prevent recurrence of stroke, manage comorbidities, and prevent complications related to immobility, dysphagia, and bowel and bladder dysfunction. Rehabilitation services may include: dysphagia treatment and management; speech therapy for communication disorders (i.e., aphasia and dysarthria) and related cognitive impairments; lower-extremity strengthening and gait training; positioning, passive stretching, range-of-motion exercises, and pharmacotherapy for patients with paretic limbs and muscle spasticity; corrective measures (e.g., splinting, serial casting, surgery) for contractures; treatment interventions for post-stroke shoulder pain; treatment for depression and other cognitive and emotional disorders; and, other services. Recently published literature emphasizes the importance of identifying and managing cognitive-communication impairments after stroke since these impairments are associated with higher rate of death and higher risk of future stroke (Hinckley, 2014).

Living with disabilities after a stroke is a lifelong challenge during which people continue to seek and find ways to compensate for or adapt to persisting neurological deficits. For many, the real work of recovery begins after formal rehabilitation when the patient attempts to use newly learned skills without the support of the rehabilitation environment or team (Bates, 2005).

1c.4. Citations for data demonstrating high priority provided in 1a.3

- American Academy of Physical Medicine and Rehabilitation. Rehabilitation Helps Stroke Patients Recover Skills. AAPM&R Chicago, IL Office: Author.
- American Academy of Physical Medicine and Rehabilitation. Urgency Key But Perseverance Pays Off. AAPM&R Chicago, IL Office: Author.
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- National Institute of Neurological Disorders. Post-Stroke Rehabilitation Fact Sheet. National Institute of Neurological Disorders Bethesda, MD Office: Author.
- Post Stroke Rehabilitation, Clinical Practice Guideline No.16, Agency for Health Care Policy and Research (now known as Agency for Healthcare Research and Quality), 1995.
- VA/DoD Clinical Practice Guideline for the Management of Stroke Rehabilitation in the Primary Care Setting, 2010.
- Zorowitz RD, et al. the Post-Stroke Rehabilitation Outcomes Project (PSROP), *Top Stroke Rehabil*. 2005 Fall;12(4).

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)
Not applicable.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):
Neurology : Stroke/Transient Ischemic Attack (TIA)

De.6. Non-Condition Specific (check all the areas that apply):
Care Coordination, Health and Functional Status : Change

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)
http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [Appendix_A.1-635883794720981362.xls](#)

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

Since the last endorsement date, there have been no significant changes to STK-10 Assessed for Rehabilitation. Minor clarifications regarding the composition of the rehabilitation team have been made, and advanced practice nurse (APN) and physician assistant (PA) added to physician documentation as acceptable data sources for a rehabilitation assessment. Clarification was needed to prevent inclusion of other types of clinical assessments, e.g. activities of daily living, fall risk, etc., in the numerator population.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Ischemic or hemorrhagic stroke patients assessed for or who received rehabilitation services.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Episode of care

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

One data element is used to calculate the numerator:

- Assessed for Rehabilitation Services – Documentation that the patient was assessed for or received rehabilitation services during this hospitalization. Allowable values: Yes, No/UTD or unable to determine from medical record documentation.

Patients are eligible for the numerator population when the allowable value equals “yes” for the data element.

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

Ischemic or hemorrhagic stroke patients.

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

Eight data elements are used to calculate the denominator:

1. Admission Date – The month, day and year of admission to acute inpatient care.
2. Birthdate - The month, day and year the patient was born.
3. Clinical Trial - Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with stroke were being studied. Allowable values: Yes or No/UTD.
4. Comfort Measures Only – The earliest day the physician/APN/PA documented comfort measures only after hospital arrival. Allowable values: 1 (Day 0 or 1); 2 (Day 2 or after); 3 (Timing Unclear); 4 (Not Documented/UTD).
5. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.
6. Discharge Disposition – The place or setting to which the patient was discharged on the day of hospital discharge.
7. Elective Carotid Intervention – Documentation demonstrates that the current admission is solely for the performance of an

elective carotid intervention (e.g., elective carotid endarterectomy, angioplasty, carotid stenting).

Allowable values: Yes or No/UTD.

8. ICD-10-CM Principal Diagnosis Code - The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.

Population: Discharges with an ICD-10-CM Principal Diagnosis Code for ischemic or hemorrhagic stroke as defined in Appendix A, Table 8.1 or Table 8.2.

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

- Less than 18 years of age
- Length of Stay > 120 days
- Comfort measures only documented
- Enrolled in clinical trials related to stroke
- Admitted for elective carotid intervention
- Discharged to another hospital
- Left against medical advice
- Expired
- Discharged to home for hospice care
- Discharged to a health care facility for hospice care

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

- The patient age in years is equal to the Discharge Date minus the Birthdate. Patients less than 18 years are excluded.
- The Length of Stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is greater than 120 days, the patient is excluded.
- Patients with Comfort Measures Only allowable value of 1 (Day 0 or 1), 2 (Day 2 or after), and 3 (Timing unclear) are excluded.
- Patients are excluded if "Yes" is selected for Clinical Trial.
- Patients with ICD-10-PCS procedure codes for carotid intervention procedures as identified in Appendix A, Table 8.3, if medical record documentation states that the patient was admitted for the elective performance of this procedure.
- Patients with Discharge Disposition allowable value of 2 (Hospice-Home), 3 (Hospice-Health Care Facility), 4 (Acute Care Facility), 6 (Expired), or 7 (Left Against Medical Advice/AMA) are excluded.

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

Not applicable, the measure is not stratified.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

Not applicable

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

Not applicable

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

1. Start processing. Run cases that are included in the Stroke (STK) Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

2. Check Discharge Disposition

a. If Discharge Disposition equals 2, 3, 4, 6, 7, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing.

b. If Discharge Disposition equals 1, 5, 8, continue processing and proceed to Comfort Measures Only.

3. Check Comfort Measures Only

a. If Comfort Measures Only is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Comfort Measures Only equals 1, 2, or 3, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If Comfort Measures Only equals 4, continue processing and proceed to Clinical Trial.

4. Check Clinical Trial

a. If Clinical Trial is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Clinical Trial equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If Clinical Trial equals No, continue processing and proceed to Elective Carotid Intervention.

5. Check admitted for Elective Carotid Intervention

a. If Elective Carotid Intervention is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Elective Carotid Intervention equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If Elective Carotid Intervention equals No, continue processing and proceed to Assessed for Rehabilitation Services.

6. Check Assessed for Rehabilitation Services

a. If Assessed for Rehabilitation Services is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Assessed for Rehabilitation Services equals No, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

c. If Assessed for Rehabilitation Services equals Yes, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available at measure-specific web page URL identified in S.1

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter for the measure set cannot sample.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

Quarterly Sampling

The Quarterly Sample Size “n”, i.e., Minimum Required Sample Size, is based on the Initial Patient Population Size “N” for the STK Measure Set. Hospitals performing quarterly sampling for STK must ensure that their Initial Patient Population and sample sizes meet the following conditions:

If “N” \geq 900, then “n” 180

If “N” 226-899, then “n” 20% of Initial Patient Population size

If “N” 45-225, then “n” 45

If “N” 6-44, No sampling; 100% Initial Patient Population required

If “N” 0-5, Submission of patient level data is not required; if submission occurs, 100% Initial Patient Population required

Monthly Sampling

The Monthly Sample Size “n”, i.e., Minimum Required Sample Size, is based on the Initial Patient Population Size “N” for the STK Measure Set. Hospitals performing monthly sampling for STK must ensure that their Initial Patient Population and sample sizes meet the following conditions:

If “N” \geq 300, then “n” 60

If “N” 76-299, then “n” 20% of Initial Patient Population size

If “N” 15-75, then “n” 15

If “N” $<$ 15, No sampling; 100% Initial Patient Population required

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

Not applicable. This measure is not based on a survey or a PRO-PM.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

Any file with missing data will result in a measure category assignment of X and rejection of the file from the warehouse, unless the data are not used to process the measure. If the data are used to process the measure and have been reported by the abstractor as No/UTD, the case will result in a measure category assignment of D (i.e., failed measure, not rejected).

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Health Record (Only), Paper Records

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.26. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Other

S.27. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Hospital

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not applicable.

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

0441_MeasureTesting_MS5.0_Data_-1-.doc

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry), Other

If other: Data element allowable values are selected, either manually or electronically, from clinical and coded data available in medical record documentation. All medical record documentation is used in the abstraction process. Vendor data collection tools are used to import data elements needed for measure rate calculation.

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

The Joint Commission recognizes that not all hospitals currently have the capacity to abstract the electronic version of this measure, so continues to offer this chart-abstracted version which allows for data capture from unstructured data fields. All data elements needed to compute the STK-10 performance measure score have been retooled for capture from electronic sources. Annual updates are performed to match the eCQM specifications to the current version of the chart-abstracted specifications.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

At the present time, hospitals using this performance measure generally collect measure data via manual review of the paper medical record, the EHR or a combination of both. Collected data are submitted to The Joint Commission on a quarterly basis, by way of contracted performance measurement system vendors, as described previously. Specifications for this measure are freely available to anyone who wishes to use the measure. Feedback from hospitals using this measure indicates that required data elements are generally available in the medical record, and measure specifications are robust and easy to understand. As described above, as feedback from measure users has indicated the need for clarification or revision of measure specifications, this has taken place in the form of guidelines for abstraction. Specific revisions are detailed in the Release Notes section of this submission.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

There are no fees or licensing requirements to use the Joint Commission performance measures, all of which are in the public domain.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
	Public Reporting Quality Check® http://www.qualitycheck.org/consumer/searchQCR.aspx Hospital Compare https://www.medicare.gov/hospitalcompare/search.html Public Health/Disease Surveillance Paul Coverdell National Acute Stroke Registry http://www.cdc.gov/dhdsr/programs/stroke_registry.htm Payment Program Hospital Inpatient Quality Reporting Program https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html Regulatory and Accreditation Programs Hospital Accreditation Program http://www.jointcommission.org/ Quality Improvement (Internal to the specific organization) Disease-Specific Care Certification for Comprehensive Stroke Centers Disease-

Specific Care Certification for Primary Stroke Centers http://www.jointcommission.org/certification/dsc_home.aspx

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

•Name of program and sponsor: Quality Check®; The Joint Commission

•Purpose: A public website that allows consumers to: search for accredited and certified organizations by city and state, by name or by zip code (up to 250 miles); find organizations by type of service provided within a geographic area; download free hospital performance measure results; and, print a list of Joint Commission certified disease-specific care programs and health care staffing firms.

•Geographic area and number and percentage of accountable entities and patients included: Nationwide; 3300 Joint Commission-accredited hospitals (2014)

•Name of program and sponsor: Hospital Compare; Centers for Medicare & Medicaid Services

•Purpose: A public website that provides information that helps consumers decide where to obtain healthcare and encourages hospitals to improve the quality of care they provide.

•Geographic area and number and percentage of accountable entities and patients included: Nationwide; 4000+ medicare-certified hospitals (2015)

•Name of program and sponsor: Paul Coverdell National Acute Stroke Registry; Centers for Disease Control and Prevention

•Purpose: A national registry that measures, tracks, and improves the quality of care and access to care for stroke patients from onset of stroke symptoms through rehabilitation and recovery; decreases rate of premature death and disability from stroke; eliminates disparities in care; supports the comprehensive stroke system across the continuum of care; improves access to rehabilitation and opportunities for recovery after stroke; and, increases the workforce capacity and scientific knowledge of stroke care within stroke systems of care.

•Geographic area and number and percentage of accountable entities and patients included: 11 states; 403 hospitals (CDC, 2014)

•Name of program and sponsor: Hospital Inpatient Quality Reporting Program; Centers for Medicare & Medicaid Services

•Purpose: The Hospital Inpatient Quality Reporting (Hospital IQR) program was mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates.

•Geographic area and number and percentage of accountable entities and patients included: Nationwide; 3500 hospitals (2015)

•Name of program and sponsor: Annual Report-Improving America's Hospitals; The Joint Commission

•Purpose: The annual report summarizes the performance of Joint Commission-accredited hospitals on 46 accountability measures of evidence-based care processes closely linked to positive patient outcomes, and provides benchmarks from Top Performer on Key Quality Measures® hospitals.

•Geographic area and number and percentage of accountable entities and patients included: Nationwide; 3300 Joint Commission-accredited hospitals (2014)

- Name of program and sponsor: Disease-Specific Care Certification for Comprehensive Stroke Centers; The Joint Commission
- Purpose: A certification program that recognizes the specific capabilities of hospitals that treat the most complex stroke cases.
- Geographic area and number and percentage of accountable entities and patients included: Nationwide; 95 hospitals
- Name of program and sponsor: Disease-Specific Care Certification for Primary Stroke Centers; The Joint Commission
- Purpose: A certification program that recognizes hospitals that effectively manage and meet the unique and specialized needs of stroke patients, and make exceptional efforts to foster improved outcomes for better stroke care.
- Geographic area and number and percentage of accountable entities and patients included: Nationwide; 1079 hospitals
- Name of program and sponsor: Hospital Accreditation Program; The Joint Commission
- Purpose: An accreditation program that recognizes hospitals that meet standard requirements to provide safe and effective patient care.
- Geographic area and number and percentage of accountable entities and patients included: Nationwide; 3300 Joint Commission-accredited hospitals (2014)

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

Not applicable

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

Not applicable

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- **Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)**
- **Geographic area and number and percentage of accountable entities and patients included**

•Progress (trends in performance results, number and percentage of people receiving high-quality healthcare):

Over the past five years, there has been steady but small increases of ~1% per year in the percentage of patients assessed for rehabilitation services during the inpatient hospitalization based on Joint Commission ORYX performance measurement data. The national aggregate rate reported for 2014 was 98.7%. A modest gap of ~5% still exists for the lowest decile of hospitals. This trend is consistent with increases in the rate of assessment for rehabilitation services published by GWTG-Stroke and PCNASR. Racial disparities for secondary outcomes, i.e., length of stay > 4 days, ambulatory at discharge, death at admission, and discharges to home, have been reported (Qian, 2013; CDC 2014). Non-Hispanic black and Hispanic patients were more likely to have longer lengths of stay and less likely to be discharged home, according to Qian and associates. These disparities were statistically significant for non-Hispanic black patients ($P < 0.001$), and support the continued importance for early assessment of rehabilitation

needs prior to hospital discharge.

•Geographic area and number and percentage of accountable entities and patients included:
Nationwide; 1299 hospitals; 210,075 patients (The Joint Commission, 2014)

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Not applicable.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

Since the last endorsement date, questions from the field have reflected that other types of assessments, e.g., fall risk, activities of daily living, discharge planning, may be abstracted as rehabilitation assessments. Abstraction guidelines for the data element Assessed for Rehabilitation have been strengthened to prevent inference. Only assessments documented by a qualified member of the rehabilitation team may be accepted as a rehabilitation assessment.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0244 : Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

0244 : Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered – no longer NQF endorsed.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

NQF#0244 focuses on rehabilitation orders written prior to hospital discharge and not the rehabilitation assessment or services received by the patient.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Although both NQF#0441 STK10: Assessed for Rehabilitation and NQF#0244 target ischemic or hemorrhagic stroke patients in the acute inpatient setting, NQF#0441 is superior for two reasons. First, the numerator statement for NQF#0441 is a broader measure of quality and encompasses the total ischemic or hemorrhagic stroke inpatient population. The proportion of ischemic or hemorrhagic stroke patients who are assessed for or receive rehabilitation services during the acute inpatient hospitalization are captured in the numerator population. Patients must be assessed before services can be ordered. Rehabilitation services may be ordered but not implemented. Consequently, rehabilitation services are not received when orders are not carried out. NQF#0441 includes stroke patients who receive rehabilitation services in the numerator population. Second, NQF#0244 focuses on rehabilitation orders written prior to hospital discharge, but capture these data after hospital discharge in the outpatient setting.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Available at measure-specific web page URL identified in S.1 Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): The Joint Commission

Co.2 Point of Contact: JohnMarc, Alban, jalban@jointcommission.org, 630-792-5304-

Co.3 Measure Developer if different from Measure Steward: The Joint Commission

Co.4 Point of Contact: Karen, Kolbusz, kkolbusz@jointcommission.org, 630-792-5931-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The role of the Technical Advisory Panel (TAP) is to provide advisory oversight in literature review, measure content and maintenance of the specifications.

Members are:

Harold P. Adams, Jr., MD
University of Iowa Health Care
Iowa City, IA

Mark J. Alberts, MD
University of Texas Southwestern
Dallas, TX

Anne W. Alexandrov, RN
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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2009

Ad.3 Month and Year of most recent revision: 10, 2015

Ad.4 What is your frequency for review/update of this measure? Biannual

Ad.5 When is the next scheduled review/update for this measure? 07, 2016

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: