NATIONAL QUALITY FORUM
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Neurology, Fall 2020 Cycle: CDP Report

TECHNICAL REPORT
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Contents

Executive Summary

According to the 2017 data from the Global Burden of Disease study, the three most burdensome United States (U.S.) neurological disorders were stroke, Alzheimer's disease and other dementias, and migraine headache.[1] Data also show that from 1990 to 2017, many neurological disorders appear to be increasing in prevalence, incidence, mortality, and disability-adjusted life years (DALYs) due to an increasingly aging population.[1] The Neurology Standing Committee oversees the measurement portfolio used to improve the quality of care for neurological conditions. The National Quality Forum's (NQF) portfolio of measures for this topic includes stroke and dementia. The background and description of NQF's most recent Neurology Standing Committee meeting, as well as previous meetings, are available on NQF's project webpage.

For the fall 2020 cycle, the Neurology Standing Committee evaluated one new measure against NQF's standard evaluation criteria. The Standing Committee did not recommend the measure for endorsement. The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendation.

Measure Not Endorsed:

- **NQF #3596** Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity (Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation [YNHHSC/CORE])

A comprehensive summary of the measure is included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for the measure are in Appendix A.

Introduction

In 2017, the Global Burden of Disease study found the three most burdensome neurological conditions in the U.S. with regard to absolute numbers of DALYs: (1) stroke (3.58 million DALYs), (2) Alzheimer's and other dementias (2.55 million DALYs), and (3) migraine headache (2.40 million DALYs).[1] Additionally, stroke is the fifth leading cause of death in the U.S., leading to 146,383 deaths in 2017.[2] It is a condition that has historically had few treatments; yet today, treatments including intravenous and intra-arterial thrombolysis, clot retrieval, and other technologies have revolutionized care.[3,4] Stroke prevalence increases with advanced age and demonstrates disparities. Specifically, stroke is more common among Blacks as compared to Whites, among people with lower socioeconomic status, and among people with fair or poor perceived health status.[2] Stroke is also the leading cause of long-term serious disability in the U.S.[2]

For the fall 2020 cycle, NQF's Neurology project focused on a new measure related to stroke care, specifically a measure of risk-adjusted inpatient mortality for stroke. The risk adjustment is based on the National Institutes of Health (NIH) Stroke Scale, which is used to assess stroke severity upon hospital arrival.

NQF Portfolio of Performance Measures for Neurology Conditions

The Neurology Standing Committee (Appendix C) oversees NQF's portfolio of Neurology measures (Appendix B), which includes measures for stroke, subarachnoid and intracerebral hemorrhage, dementia, and carotid stenosis. This portfolio contains 14 measures, and all 14 are process measures (see Table 1 below). There are no outcome, resource use, or composite measures in the portfolio.

Table 1. NQF Neurology Portfolio of Measures

Topic	Process
Stroke	10*
Subarachnoid and Intracerebral Hemorrhage	2
Dementia	1
Carotid Stenosis	1
Total	14

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

Neurology Measure Evaluation

On February 5 and 24, 2021, the Neurology Standing Committee evaluated one new measure against NQF's standard measure evaluation criteria.

Table 2. Neurology Measure Evaluation Summary

Topic	Maintenance	New	Total
Measure under review	0	1	1
Measure not recommended for endorsement	0	1	1

Topic	Maintenance	New	Total
Reasons for not endorsing		Importance – 1 Scientific Acceptability – 0 Use – 0 Overall – 0 Competing Measure – 0	

Comments Received Prior to Standing Committee Evaluation

NQF accepts 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 December 15, 2020, and closed on April 30, 2021. As of February 5, 2021, two comments were submitted and shared with the Standing Committee prior to the measure evaluation meetings (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on April 30, 2021. Following the Standing Committee's evaluation of the measure under review, NQF received nine comments from nine organizations (including four member organizations) and individuals pertaining to the draft report and to the measure under review. All comments for each measure under review have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations. This expression of support (or not) during the commenting period replaces the member voting opportunity that was previously held subsequent to the Standing Committee's deliberations. One NQF member expressed that they are in support of the measure. This information can be found in Appendix A of the post-comment meeting materials.

Summary of Measure Evaluation

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

NQF #3596 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity (Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation [YNHHSC/CORE]): Not Endorsed

Description: The measure estimates the hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. The outcome is all-cause, 30-day mortality, defined as death from any cause within 30 days of the index hospital admission date, including in-hospital death, for stroke patients. This is a re-specified measure with a cohort and outcome that is harmonized with the current publicly reported claims-based stroke mortality measure from the Centers for Medicare & Medicaid Services (CMS) and includes the National Institutes of Health (NIH) Stroke Scale as an

assessment of stroke severity upon admission in the risk adjustment model. This measure uses Medicare fee-for-service (FFS) administrative claims for the cohort derivation, outcome, and risk adjustment. **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other, Registry Data

While the evaluation for NQF #3596 began on February 5, 2021, the meeting length was insufficient to fully cover the Standing Committee's discussion; therefore, an additional meeting was held on February 24, 2021, to complete the evaluation. The Standing Committee's discussion began with an overview of NQF #3596. This measure was initially submitted in 2016 as NQF #2876 but did not pass endorsement due to the unavailability of the International Classification of Diseases, 10th Revision (ICD-10) codes for the NIH Stroke Scale, and it did not adjust for stroke severity of patients upon admission to the hospital. A major theme of the Standing Committee's discussion this cycle was whether stroke mortality, even when risk-adjusted for the NIH Stroke Scale, represented an appropriate way to assess the quality of stroke care. While several members of the Standing Committee expressed support, others expressed concern that solely measuring mortality without considering patient preferences or functional outcomes was incomplete and would not drive improvements in care. Specifically, there were concerns that mortality is often not the central goal of hospital-based stroke care and that functional outcomes are more important. Ultimately, the Standing Committee's voting resulted in a "consensus not reached" verdict for the evidence criterion.

The Standing Committee's discussion on performance gap centered on the two-percentage point gap in mortality between the hospitals in the 25th and 75th percentiles and whether this gap is wide enough to warrant national performance measurement. One Standing Committee member pointed out that the data presented a fair number of outliers, suggesting a wider performance gap in those instances. There were no additional discussions regarding performance gap, and the Standing Committee voted to pass the measure on the performance gap criterion with a moderate rating.

The Standing Committee then discussed the scientific acceptability criteria. During the pre-evaluation commenting period, the Federation of American Hospitals and the American Medical Association expressed concerns about the minimum measure score reliability results being 0.24 while using a minimum case number of 25 patients when measures should reach a minimum acceptable threshold of at least 0.7 for reliability. For the reliability criterion, the Standing Committee also expressed concerns about the 25-case hospital exclusion, use of reliability in small hospitals, and whether the reliability with a subset of hospitals can be generalized to a broader set of hospitals. The Scientific Methods Panel (SMP) evaluated this measure and passed it with a moderate rating for reliability with no discussion of concerns. The Standing Committee voted to uphold the SMP's decision. Concerning the validity criterion, the Standing Committee expressed concern about whether the measure might be omitting patient preferences on treatment depending on the race of the patient; they also questioned the accuracy of the NIH Stroke Scale. The measure developer acknowledged that patient preferences are a complicated issue and that survivor bias and access to care factors might be at work. The SMP passed the measure with a moderate rating for validity with no discussion of concerns. The Standing Committee voted to uphold the SMP's decision.

Before evaluating the measure against the feasibility criterion, NQF staff reminded the Standing Committee of the primary question surrounding the feasibility criterion: Are data for those hospitals that are reporting or could report readily available? The Standing Committee expressed that while the data needed to calculate the measure are contained in electronic claims, not all hospitals document the NIH Stroke Scale, which would exclude many hospitals from measurement. The Standing Committee shared no additional questions, held no additional discussion on the feasibility criterion, and passed the measure on feasibility with a moderate rating.

The Standing Committee did not pose any questions or discussion concerning the use of the measure and voted to pass the measure on this criterion. NQF staff offered clarification to the Standing Committee on the usability criterion and improvement assessment, advising the Standing Committee to focus on identifying evidence of benefits and harms, as provided by the developer. In addition, there were concerns regarding potential unintended consequences. Hospitals may prioritize survival over other outcomes and implement aggressive interventions in patients with little hope of good functional outcomes. This could lead to increased burden on the healthcare system and families. The Standing Committee passed the measure with a moderate rating for the usability criterion. Ultimately, since the Standing Committee did not reach consensus on the evidence criterion during the measure evaluation meeting, they re-voted on the evidence criterion during the post-comment meeting on May 25, 2021.

During the post-comment meeting, the Standing Committee discussed their previous concerns regarding the evidence criterion. A few of the Standing Committee members expressed their support of the measure, as mortality is an important measure of quality even if the measure itself is limited by the lack of functional outcome measures. Several other Standing Committee members highlighted their previous concerns about the measurement of stroke mortality in isolation failing to drive better healthcare quality. The Standing Committee noted that while there are multiple actions that could improve stroke mortality (e.g., hemicraniectomy), these interventions may not improve functional outcomes and may not be in the best interest of the patient or consider patient preferences. The Standing Committee re-voted on the evidence criterion, and the measure did not pass. Since evidence is a must-pass criterion, the measure was not recommended for endorsement.

After they re-voted on evidence, the Standing Committee considered the nine comments received on the draft report during the 30-day public commenting period (summarized in Appendix A). Multiple commenters agreed with the Standing Committee's concern that measuring mortality in isolation could have potential unintended consequences and suggested that either mortality measurement could be balanced with measuring improved functional status or that treatment decisions were aligned with patient preferences. One commenter highlighted that while 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 dependance after a stroke), which is not frequently performed at discharge and would therefore 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.

Additionally, the Standing Committee offered potential considerations the developer could explore for future consideration of the measure. One Standing Committee member recommended a validation study to evaluate stroke care quality that incorporated assessment of patient preferences and function outcomes. Another Standing Committee 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.

The CSAC upheld the Standing Committee's recommendation and did not endorse the measure.

References

1 GBD 2017 US Neurological Disorders Collaborators, Feigin VL, Vos T, et al. Burden of Neurological Disorders Across the US From 1990-2017: A Global Burden of Disease Study. *JAMA Neurol*. 2021;78(2):165.

2 Virani SS, Alonso A, Benjamin EJ, et al. Heart Disease and Stroke Statistics-2020 Update: A Report From the American Heart Association. *Circulation*. 2020;141(9):e139-e596.

3 Albers GW, Marks MP, Lansberg MG. Thrombectomy for Stroke with Selection by Perfusion Imaging. *N Engl J Med*. 2018;378(19):1849-1850.

4 Mullen MT, Pisapia JM, Tilwa S, et al. Systematic review of outcome after ischemic stroke due to anterior circulation occlusion treated with intravenous, intra-arterial, or combined intravenous+intra-arterial thrombolysis. *Stroke*. 2012;43(9):2350-2355.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable; **Y**=Yes; **N**=No

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present during the meeting for that vote as the denominator. Denominator vote counts may vary throughout the criteria due to intermittent Standing Committee attendance fluctuation. The vote totals reflect members present and eligible to vote at the time of the vote. Quorum (15 out of 22 Standing Committee members) was met and maintained for the entirety of both meetings.

Measure Not Recommended

NQF #3596 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity

Submission

Description: The measure estimates the hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. The outcome is all-cause, 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death, for stroke patients. This is a re-specified measure with a cohort and outcome that is harmonized with the current publicly reported claims-based stroke mortality measure from the Centers for Medicare & Medicaid Services (CMS) and includes the National Institutes of Health (NIH) Stroke Scale as an assessment of stroke severity upon admission in the risk adjustment model. This measure uses Medicare fee-for-service (FFS) administrative claims for the cohort derivation, outcome, and risk adjustment.

Numerator Statement: The outcome for this measure is 30-day, all-cause mortality. We define mortality as death from any cause within 30 days of the index admission for Medicare FFS patients ages 65 years and older with a principal discharge diagnosis of acute ischemic stroke.

Denominator Statement: The cohort includes inpatient admissions to all nonfederal, short-term, acute care or critical access hospitals for Medicare FFS patients ages 65 years and older with a principal discharge diagnosis of acute ischemic stroke.

Additional details are provided in S.7 Denominator Details.

Exclusions: The mortality measure excludes index admissions for patients in the following categories:

1. With inconsistent or unknown vital status or other unreliable data
2. Enrolled in the Medicare hospice program at any time in the 12 months prior to the index admission, including the first day of the index admission
3. Discharged against medical advice (AMA)

For patients with more than one admission for stroke in a given year, only one index admission for that condition is randomly selected for inclusion in the cohort.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Outcome

Data Source: Claims, Enrollment Data, Other, Registry Data

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [02/05/2021 and 02/24/2021]

1. **Importance to Measure and Report: The measure did not reach consensus for the Importance criteria.**

(1a. Evidence: 1b. Performance Gap)
1a. Evidence: **Total Votes: 17; Y-9**; **N-8** 1b. Performance Gap: **Total Votes: 17; H-2**; **M-10**; **L-3**; **I-2**
Rationale:

- The Standing Committee discussed two concepts related to evidence: whether in-hospital stroke mortality is an appropriate measure of quality and whether there is evidence that one or more clinical actions can be performed to change stroke mortality.
- In the measure submission, the developer described considerable literature linking post-stroke mortality rates to hospital organizational factors, such as the provider's response to complications, speediness of delivery of care, organization of care, coordinated transitions to the outpatient environment, antihypertensive and anticoagulant therapies, and appropriate imaging.
- This information included that hospitals participating in quality improvement registries, such as Get With The Guidelines (GWTG), had lower in-hospital mortality rates among stroke patients than hospitals not participating in similar programs (Fonarow et al, 2014).
- In another example, patients being treated at hospitals participating in the GWTG quality improvement registry for stroke were significantly more likely to receive multiple evidence-based care interventions, such as tissue plasminogen activator (tPA) administration and evaluation by a neurologist (Howard et al, 2018).
- During their discussion, the Standing Committee agreed that hospitals could have an impact on stroke mortality.
- However, several members of the Standing Committee were concerned that stroke mortality would not be a quality measure that would drive healthcare improvement and could lead to unintended consequences. This is because the major focus of in-hospital care in stroke is functional improvement of stroke symptoms, and measuring mortality in isolation could lead to unintended consequences of prolonging life through invasive interventions without considering functional outcomes.
- For performance gap, the developer used Medicare FFS administrative claims data from October 2016 to June 2019 using hospitals where the NIH Stroke Scale was coded for 60% of the claims. In 329 hospitals, the mean RSMR was 14.63% with a range of 10.05% to 17.83% and an interquartile range of 13.82% to 15.52%.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.
(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity
2a. Reliability: **Total Votes: 8; H-3**; **M-5**; **L-0**; **I-0** 2b. Validity: **Total Votes: 7; H-1**; **M-5**; **L-1**; **I-0**
Rationale:

- The SMP reviewed the measure and gave it moderate ratings for both reliability and validity.
- Reliability testing was conducted at the measure score level using Medicare Parts A and B claims as well as the Medicare Enrollment Database (EDB).
- Signal-to-noise ratio testing was performed for all hospitals and those hospitals that meet the minimum case count of at least 25 cases for public reporting.
- The reliability score was 0.72; however, the scores had a wide range from 0.01, meaning that it was unreliable at some hospitals, to 0.95, meaning that it was very reliable at others in the testing sample.
- The 25th and 75th percentiles were 0.51 and 0.83, respectively. Using the threshold of at least 25 cases, which will be used for public reporting, the median reliability score was 0.75, yet it still had a large range from 0.24 to 0.95. The 25th and 75th percentiles were 0.59 and 0.83, respectively.

- Data element validity was conducted, in which the developer compared scores of the Medicare claims with the scores from the GWTG-Stroke registry data using a sample size of 29,936 stroke hospitalizations. When comparing NIH Stroke scores to GWTG-Stroke Registry and administrative claims data, 93% of the data were within five points of each other, and 84% were within two points. The Pearson correlation coefficient between the two scores was 0.993, and the weighed Kappa was 0.842.
- For construct validity, the developer assessed the measure score correlation with the Overall Hospital Star Ratings Mortality measure group score. The overall correlation was 0.422.
- The Standing Committee voted to accept the SMP's vote for reliability and validity based upon the above results. The votes above reflect the SMP members' vote. The Standing Committee voted to accept the SMP's vote for reliability (Yes – 15, No – 2 [Denominator: 17]) and for validity (Yes – 11, No – 6 [Denominator: 17]).

3. Feasibility: Total Votes: 15; H-4; M-9; L-2; I-0

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

Rationale:

- The data used for this measure appear in electronic claims data.
- However, a limitation of measure feasibility is that the NIH stroke score data are not kept in a national database for all nonfederal, acute-care hospitals. Therefore, the feasibility of this measure depends on the hospital's measuring of NIH stroke scores and including those data in the claims. Collecting NIH Stroke Scale (NIHSS) information is a class I recommendation from the American Heart Association and American Stroke Association (AHA/ASA). Based on all acute-care hospitals from October 2016 to June 2019, NIHSS data were available in 37% of admissions for acute ischemic stroke. This increased from 13% in October 2016 to 55.6% in May 2019, demonstrating increased availability of these data.

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: **Total Votes: 15; Pass-14; No Pass-1** 4b. Usability*:* **Total Votes: 15; H-1; M-12; L-1; I-1**

Rationale:

- The measure is currently not in use.
- The developer plans to use this updated measure to replace the currently reported *Hospital 30-Day Mortality Following Acute Ischemic Stroke Hospitalization* measure. The earlier measure does not risk-adjust for stroke severity; as a result, the new measure was created to account for those factors.
- The developer compared the median hospital RSMR for stroke from 2013-2016 to 2016-2019. The median hospital RSMR in the 2013-2016 data set was 14.5%, and the median hospital RSMR in the 2016-2019 combined data set was 13.6% based on 520,432 admissions from 4,254 hospitals. This demonstrates improvement of this measure over time.

5. Related and Competing Measures

- There are no related or competing measures.

6. Standing Committee Recommendation for Endorsement: Not Endorsed

Rationale

- During the initial Standing Committee evaluation, consensus was not reached on a criterion required for endorsement (i.e., evidence). This criterion underwent a revote during the post-comment meeting and did not pass; therefore, the measure failed on overall suitability for endorsement and proceeded as not recommended for endorsement prior to the Consensus Standard Approval Committee (CSAC) review.

7. Public and Member Comment

- Two comments were submitted before the evaluation meeting, and both expressed concerns about the minimum measure score reliability results being 0.24 while using a minimum case number of 25 patients when measures should reach a minimum acceptable threshold of at least 0.7 for reliability.
- Nine comments were submitted after the evaluation meeting. Multiple commenters expressed concern that measuring mortality in isolation could have potential unintended consequences and suggested that mortality measurement could be balanced with measuring improved functional status or that treatment decisions were aligned with patient preferences. Additionally, multiple commenters also 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. Comments were also received that expressed concerns regarding the threshold minimum sample size and the impact of missing data. Most commenters also expressed their support of the measure and thought that the inclusion of the NIH Stroke Scale for risk adjustment was an improvement over the current measure being used by CMS.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-10; No-2 (June 29-30, 2021): Not Endorsed

The CSAC upheld the Standing Committee's decision to not recommend the measure for endorsement.

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

NQF #	Title	Federal Programs: Finalized or Implemented as of March 4, 2021
0434*	STK 01: Venous Thromboembolism (VTE) Prophylaxis	No federal program usage was specified for this measure.
0435*	STK 02: Discharged on Antithrombotic Therapy	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals
0436*	STK 03: Anticoagulation Therapy for Atrial Fibrillation/Flutter	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals
0437	STK 04: Thrombolytic Therapy	No federal program usage was specified for this measure.
0438*	STK 05: Antithrombotic Therapy by End of Hospital Day Two	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical-Access Hospitals and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical-Access Hospitals
0439*	STK 06: Discharged on Statin Medication	Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical-Access Hospitals and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical-Access Hospitals
0441*	STK 10: Assessed for Rehabilitation	No federal program usage was 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 was specified for this measure.

[a] Per CMS Measures Inventory Tool as of 3/4/2021

NQF #	Title	Federal Programs: Finalized or Implemented as of March 4, 2021
2863	CSTK-06: Nimodipine Treatment Administered	No federal program usage was specified for this measure.
2864	CSTK-01: National Institutes of Health Stroke Scale (NIHSS) Score Performed for Ischemic Stroke Patients	No federal program usage was 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 was specified for this measure.
2872e	Dementia: Cognitive Assessment	Merit-Based Incentive Payment System (MIPS) Program

*Endorsed with Reserve Status

Appendix C: Neurology Standing Committee and NQF Staff

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Appendix D: Measure Specifications

Specifications are not included. The measure was not endorsed.

Appendix E: Related and Competing Measures

There are no related or competing measures.

Appendix F: Pre-Evaluation Comments

Comments received as of February 5, 2021.

Topic

#3596 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity

Commenter

Submitted by the American Medical Association (AMA)

Comment

The American Medical Association (AMA) appreciates the opportunity to comment on #3596 *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity*. We are disappointed to see the minimum measure score reliability results of 0.24 using a minimum case number of 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability. We request that the Standing Committee evaluate whether the measure specifications with only a case minimum of 25 patients is acceptable and if the measure meets the reliability criterion.

Topic

#3596 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity

Commenter

Submitted by the Federation of American Hospitals

Comment

The Federation of American Hospitals (FAH) appreciates the opportunity to comment on measure #3596 *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity*. FAH is concerned that even though the median reliability score was 0.7 for hospitals with at least 25 cases, reliability ranged from 0.24 to 0.95 and believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g., 0.7 or higher). As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified meets the reliability criterion.

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