Neurology Endorsement Maintenance, Phase I
Brief summary of the August 27th post-comment call

Three major themes emerged from the 53 comments submitted by NQF members and the public, as follows:

1. Feasibility
2. Harmonization of stroke rehabilitation measures
3. Inclusion of a stroke severity indicator in risk-adjustment models for stroke mortality and readmission measures

Committee decisions around these themes are summarized below. No other comments were identified as needing further discussion. The Committee agreed to add the specified suggestions for measure development to the report and to make the suggested edit on page 13 of the report.

Theme 1: Feasibility
The Committee agreed with the proposed Committee response.

Theme 2- Harmonization
The Committee agreed with the proposed Committee response, but also recommended continued and aggressive efforts at harmonization and requested a progress update at the annual review.

Theme 3: Severity of stroke in risk-adjustment models
Background: NQF received 18 comments expressing the concern that an indicator of stroke severity (particularly, the value of the NIH Stroke Scale) is not included in the risk-adjustment models for stroke mortality and readmissions. Most of the comments specifically cited a recent article by Fonarow[1] and colleagues. The comments on stroke severity pertain to the following measures:

- 0467: Acute Stroke Mortality Rate (IQI 17) (AHRQ)
- 2026: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following an acute ischemic stroke hospitalization (CMS/Yale)
- 2027: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization (CMS/Yale)

The majority of the post-comment call was devoted to this theme. Please see the call transcript, which is posted on the project SharePoint site, for the full text of the discussion. We have received supplemental materials from Yale and the GWTG team/JAMA paper authors. These materials have been posted to SharePoint for your consideration.

> **Committee response**: The Committee agreed to re-vote on measures #0467, #2026, and #2027. Voting is open through the end of the day on Wednesday, September 5.

[1] Fonarow, et al. (July 18, 2012). Comparison of 30-day mortality models for profiling hospital performance in acute ischemic stroke with vs without adjustment for stroke severity. *JAMA, 308(3)*, 257-264.

Measure Changes:
Background: CMS/Yale made some substantial revisions to their measures since the in-person meeting. When voting on those measures (#2026 and #2027), Committee members should consider the revised specifications in the decision to recommend the measures for endorsement.

<u>30-day mortality measure (#2026)</u>

- This measure now includes all-payer patients ages 18 and over (rather than Medicare FFS patient ages 65+ only)
  - The report "Testing Hospital-level Acute Ischemic Stroke 30-day Mortality & Readmission Measures in California All-Payer Data" is posted to the SharePoint site.
  - The analyses from Yale suggest that risk-model discrimination is slightly improved with the broader age group.

<u>30-day readmissions measure (#2027)</u>

- This measure now includes all-payer patients ages 18 and over (rather than Medicare FFS patient ages 65+ only)
  - The report "Testing Hospital-level Acute Ischemic Stroke 30-day Mortality & Readmission Measures in California All-Payer Data" is posted to the SharePoint site.
  - The analyses from Yale suggest that risk-model discrimination is slightly improved with the broader age group.
- This measure now incorporates an algorithm for identifying and excluding planned readmissions from the measure
  - The report "Respecifying the Hospital 30-Day Ischemic Stroke Readmission Measure by Adding a Planned Readmission Algorithm" is posted on the project SharePoint site.
  - Originally, the measure excluded readmissions that were planned for procedures that are related to follow-up care after an ischemic stroke (e.g., carotid endarterectomy). The revised algorithm identifies commonly planned readmissions for all types of patients, not just those that are planned as follow-up post-stroke (e.g., maintenance chemotherapy, rehabilitation).
  - Risk-model discrimination was very slightly improved.
  - Risk factors in the risk-adjustment model have a similar magnitude of effect as in the original model.
  - The new planned readmission algorithm harmonizes the stroke readmission measures with other CMS/Yale readmission measures.