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Memo

To: Minnesota Community Measurement and Minnesota Department of Health
From: Jeanne Rash, director of Quality Improvement Initiatives, and Rachel Callanan, senior advocacy director
Re: Quality Measures Comment to Include Stroke Measures
Date: May 27, 2010

Cardiovascular diseases, including heart disease and stroke, are the leading cause of death in Minnesota and a significant cause of disability. Monitoring and improving care for cardiovascular diseases through a focus on quality will have a positive impact by saving lives and health care dollars.

The American Heart Association appreciates the level of attention that the Legislature and the Minnesota Department of Health are giving to quality improvement in your efforts to reform health care in Minnesota. The American Heart Association works to ensure that hospital treatment is aligned with the most current scientific guidelines and evidence-based treatments and therapies for cardiovascular diseases. We are pleased that the current recommendations for quality measures include diabetes and vascular care under the ambulatory care. We are also pleased to see the attention to heart attack and heart failure under the hospital care measures.

One area that was not yet covered in your measures is stroke. We urge the Minnesota Department of Health to consider adding stroke as a measure under hospital care. Stroke is the third leading cause of death in Minnesota, causing nearly 3,000 deaths in Minnesota annually. Numerous studies have shown that certain treatments have been effective in decreasing mortality and disability and secondary prevention decreases the incidence of second strokes from occurring.

Utilizing performance measures are effective to ensure adherence to treatment guidelines ultimately improving patient outcomes and lessening the burden on the health care system. Therefore, we again reiterate that appropriate measures for stroke be considered in this next phase of measurement development.

Specifically we recommend the following quality measures be included in the Minnesota Statewide Quality Reporting and Measurement System:

- IV tPA administered within 3 hours of onset of stroke symptoms (in eligible patients). Studies have shown tPA to be beneficial in achieving complete or partial neurological recovery following a stroke.
- Antithrombotic therapy initiated within 48 hours of the onset of stroke symptoms. This therapy can reduce stroke mortality and morbidity.

- Prophylactic measures to prevent deep venous thrombosis (DVT) should be implemented in patients who are non-ambulatory. This is a noted recommendation in numerous clinical practice guidelines. DVT prophylaxis has shown to lower the risk of DVT and pulmonary embolism by 70-80% in clinical trials. This measure is also endorsed by the National Quality Forum.
- Antithrombotic therapy should be prescribed at discharge following acute ischemic stroke to reduce mortality and mortality in patients without contraindications to this therapy. This measure is also endorsed by the National Quality Forum.
- Patients with ischemic stroke or TIA with persistent or paroxysmal atrial fibrillation are recommended to receive anticoagulation therapy. This is known to be effective in preventing recurrent stroke or TIA. This measure is also endorsed by the National Quality Forum.
- All ischemic stroke or TIA patients who have smoked in the past year should be strongly encouraged not to smoke.
- All patients with ischemic stroke should have lipid profile measurement performed within 24-48 hours of admission (unless outpatient results are available from within the past 30 days.) Treatment for secondary prevention should be initiated in patients who meet NCEP ATP III criteria in the presence of LDL> 100 mg/dL, or continued for patients who were previously on lipid-lowering therapy and have an LDL< 100 mg/dL.

These quality measures are used routinely by the Joint Commission, Center for Medicare and Medicaid Services (CMS), Centers for Disease Control (CDC), American Heart Association, American Stroke Association and the Minnesota Department of Health Stroke Registry. CMS is proposing new quality measures for the FY 2012 Payment Determination and subsequent years. The rule also identifies stroke care quality measures hospitals could be required to report for reimbursement beginning in 2012. CMS is also considering including a measure of hospital stroke mortality derived from claims data. This reiterates the importance and usefulness of measuring these aspects of stroke care.

For further information, and supporting evidence on these quality measures, please contact:

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