



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 sub criterion 1b).

Brief Measure Information

NQF #: 0335

Corresponding Measures:

De.2. Measure Title: [PICU Unplanned Readmission Rate](#)

Co.1.1. Measure Steward: [Virtual PICU Systems, LLC](#)

De.3. Brief Description of Measure: The total number of patients requiring unscheduled readmission to the ICU within 24 hours of discharge or transfer.

1b.1. Developer Rationale: This measure is a critical balancing measure for use with measure 0334 (severity adjusted LOS). Theoretically, units who have lower severity adjusted LOS due to premature discharge of patients would not be identified without pairing the LOS measure with a measure of unplanned readmissions.

S.4. Numerator Statement: Total number of unplanned readmissions within 24 hours after discharge/transfer from the PICU.

S.6. Denominator Statement: 100 PICU Discharges, <18 yrs of age

S.8. Denominator Exclusions: Patients =>18 years of age,

De.1. Measure Type: [Outcome](#)

S.17. Data Source: [Registry Data](#)

S.20. Level of Analysis: [Facility](#)

IF Endorsement Maintenance – Original Endorsement Date: [May 15, 2008](#) **Most Recent Endorsement Date:** [Jul 31, 2012](#)

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? [N/A](#)

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0335_Evidence_MSF5.0_data.123115..doc](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

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.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

This measure is a critical balancing measure for use with measure 0334 (severity adjusted LOS). Theoretically, units who have lower severity adjusted LOS due to premature discharge of patients would not be identified without pairing the LOS measure with a measure of unplanned readmissions.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (*This is required for maintenance of endorsement.* 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 include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

Current performance:

The data from 82 PICUs submitting data for patients discharged in 2014. In total 101,295 individual PICU discharges and transfers were recorded; of those cases, 882 were unscheduled readmissions within 24 hours.

The unit-level unscheduled readmission rate ranges between 0% and 1.67%. Over 2014, the median unit-level unscheduled readmission rate was 0.79% with interquartile rate of 0.40% - 1.09%. The mean unit-level unscheduled readmission rate was 0.78% with standard deviation of 0.42%.

The patient-level mean unscheduled readmission rate for 2014 was 0.87% (95% CI, 0.81%-0.93%)

Performance overtime:

An analysis of 294,204 cases discharged between 1/1/2012 and 12/31/2014 showed no monotonic trend (i.e. no increasing or decreasing trend) for unscheduled readmission by quarter (Spearman's correlation test p=0.78).

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.

The lack of evidence for improvement does not invalidate the importance of this measure. Instead, this measure serves as a balancing measure for severity adjusted ICU length of stay. The lack of trend in unplanned readmissions provides reassurance that the severity adjusted ICU length of stay does not reflect gaming of the measure by institutions.

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 maintenance of endorsement.* Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

Historically population differences have not been found to be variable in pediatric intensive care therapies. A study examined whether medical resources and outcomes for children admitted to pediatric intensive care units differed according to race, gender, or insurance status. After adjustment for differences in illness severity, standardized mortality ratios and overall resource use were similar with regard to race, gender, and insurance status, but uninsured children had significantly shorter lengths of stay in the pediatric intensive care unit. Uninsured children also had significantly greater physiologic derangement on admission (mortality probability, 8.1%; 95% confidence interval [CI], 6.2-10.0) than did publicly insured (3.6%; 95% CI, 3.2-4.0) and commercially insured patients (3.7%; 95% CI, 3.3-4.1). Consistent with greater physiologic derangement, hospital mortality was higher among uninsured children than insured children.

<http://pediatrics.aappublications.org/content/127/3/e588.short>

<http://link.springer.com/article/10.1007/s10900-014-9823-0#page-1>

We stratify by race/ethnicity, age groups, gender, and insurance payer.

Except for two categories, no statistically significant differences were observed for the age categories ('<1 Month', '1 Month - 23 Month', '2 Years - 5 Years', '6 Years - 12 Years', '13 Years - 18 Years'). First, the age group '1 month-23 months' (n=30,130) had a higher unscheduled readmission rate (1.1%; 95% CI, 1.0% - 1.2%, p<0.0001) than all other age groups. Second, the age group '13 years-18 years' (n=23,236) had a lower unscheduled readmission rate (0.67%; 95% CI, 0.57% - 0.78%, p=0.0002) than all other age groups.

No statistically significant differences for the rate of unscheduled readmission was found for the following race/ethnic groups: 'African American', 'American Indian/Indigenous', 'Asian/Indian/Pacific Islander', 'Caucasian/European Non-Hispanic', 'Hispanic', and 'Other/Mixed'. Race and ethnicity is reliably collected by 85% of sites.

No statistically significant differences for the rate of unscheduled readmission was found for the following insurance statuses: 'Managed Care', 'Commercial/Indemnity Insurance', 'Medicaid & Medicaid Managed Care', 'Self-pay', and 'Other'. Primary payer is reliably collected by 38% of sites.

The fact that younger age groups had a higher rate of unplanned readmission is not surprising in light of their increased vulnerability as well as physiological differences. The measure itself is not currently stratified by age. This may provide the ability for enhancement of the measure by age stratification.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Limitations to evaluations of disparities are common in the research. Literature has shown variations in data by factors associated with differing population groups.

Epstein D, Reibel M, Unger J, et al. The Effect of Neighborhood and Individual Characteristics on Pediatric Critical Illness. *Journal of Community Health* 2014; 39(4). 753-759.

Epstein D, Wong C, Khemani R, et al. Race/Ethnicity is Not Associated with Mortality in the PICU. *Pediatrics* 2011; 127(3). e588-e597. <http://pediatrics.aappublications.org/content/127/3/e588.short>.

Lopez A, Tilford J, Anand K, et al. Variation in pediatric intensive care therapies and outcomes by race, gender and insurance status. *Ped Crit Care Med* 2006; 7(1). 2-6.

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 sub criteria 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):

Critical Care, Respiratory

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination : Transitions of Care

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Children

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.)

<https://s3.amazonaws.com/vpspublic/NQFMeasures.pdf>

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)

No data dictionary Attachment:

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

[none, there has been no change in the risk model over time](#)

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) **DO NOT** include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

[Total number of unplanned readmissions within 24 hours after discharge/transfer from the PICU.](#)

S.5. 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, time period for data collection, 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 (S.14).

[Inclusion: All PICU patients < 18 years of age](#)

[Exclusions:](#)

- [Patients = 18 years of age](#)
- [Readmissions > 24 hours following discharge/transfer from PICU](#)
- [All planned readmissions](#)

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

[100 PICU Discharges, <18 yrs of age](#)

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

[All PICU patients <18 years of age](#)

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

[Patients =>18 years of age,](#)

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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.)

<p>Patients not yet discharged from PICU</p>
<p>S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.)</p> <p>N/A</p> <p>S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)</p> <p>No risk adjustment or risk stratification</p> <p>If other:</p>
<p>S.12. Type of score:</p> <p>Rate/proportion</p> <p>If other:</p> <p>S.13. 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)</p> <p>Better quality = Lower score</p> <p>S.14. Calculation Algorithm/Measure Logic (Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)</p> <p>First, identify all discharges/transfers from PICU who are readmitted, limited to children <18 years of age.</p> <p>Second, exclude all planned readmissions.</p> <p>Third, use above number as numerator over denominator of PICU discharges/transfers.</p> <p>Report per 100 PICU discharges</p>
<p>S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</p> <p>IF a PRO-PM, identify whether (and how) proxy responses are allowed.</p> <p>No sampling used. All discharges meeting inclusion criteria as included in measure.</p> <p>S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)</p> <p>IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.</p> <p>N/A</p>
<p>S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</p> <p>If other, please describe in S.18.</p> <p>Registry Data</p> <p>S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data is collected.)</p> <p>IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.</p> <p>No mandatory data source or collection instrument for PICU community. Potential resources include PICU-specific databases or the VPS database (myvps.org).</p> <p>S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</p> <p>Available at measure-specific web page URL identified in S.1</p> <p>S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)</p> <p>Facility</p> <p>S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)</p> <p>Inpatient/Hospital</p>

If other:

S.22. 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.)*

2. Validity – See attached Measure Testing Submission Form

[0335_MeasureTesting_MSF5.0_Data..01142016..doc](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

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.

[Abstracted from a record by someone other than person obtaining original information \(e.g., chart abstraction for quality measure or registry\), Other](#)

If other: [capture from electronic sources \(eg, time of discharge orders\)](#)

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) Update this field for **maintenance of endorsement**.

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. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

The availability of data in electronic sources depends on each individual organization's resources. There is no reason the data could not be readily available in an implemented EHR.

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. Describe difficulties (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 PRO data (patients, service recipients, respondents) and those whose performance is being measured.

The identification of unplanned readmissions within 24 hours is a straightforward process that requires minimal resources.

The current VPS cohort indicates that during the time of 1/1/2009-6/30/2015, VPS has 598,598 unique pediatric ICU admissions (<18 years old), from 145 PICUs (includes 12 CICUs) located in the US. Individual sites manage the data collection process within their own institutions and submit data to VPS quarterly.

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 to collect and calculate this proportion. There are potential fees associated with using available software products such as the VPS (see Appendix A1).

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.

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting Children's Hospital Wisconsin http://www.chw.org/ Cleveland Clinic Children's Hospital http://my.clevelandclinic.org/ccf/media/files/outcomes/2013/outcomes-peds.pdf Texas Children's Hospital http://www.texaschildrens.org/About-Us/Quality-Measures/Pediatric-Intensive-Care-Unit/</p> <p>Payment Program California Children's Health Services http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx</p> <p>Quality Improvement (Internal to the specific organization) 116 pediatric ICUs currently receive VPS data as part of their internal QI evaluation. http://myvps.org</p>

4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

VPS currently provides data to 128 U.S. PICUs/CICUs from 116 hospitals which use the measure to benchmark against a VPS reference group of other participants. This measure is used for internal Quality Improvement at the individual site level. Many of these facilities report patient safety data. An example of three of the participating hospitals listed above list this benchmark data on their hospital-specific web sites.

California Children's Health Services(CCHS/CCS) includes 28 California based PICUs which participate in VPS and contribute data specific to this measure. In 2014, 14 of the 28 sites contributed data by the California deadline resulting in a state specific performance report to California Children's Services.

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?)

N/A

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.)

N/A

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. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)

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.

Previously, analysis of data from 80 PICUs submitting data in Q3 2011 to the VPS system revealed unplanned readmission rates ranging from 0% to 3.14% of discharged patients.

Current analysis displays data from 82 PICUs submitting data from 2014 to the VPS system revealed unplanned readmission rates range from 0 % to 1.67%.

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. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

Theoretically, there is a risk of miscapturing the time of original discharge and this incorrectly including or excluding a patient. Additionally, there is a risk for potential error related to misidentifying readmissions as either planned or unplanned.

4c.2. Please explain any unexpected benefits from implementation of this measure.

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4d2.2. Summarize the feedback obtained from those being measured.

4d2.3. Summarize the feedback obtained from other users

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

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.

No

<p>5.1a. List of related or competing measures (selected from NQF-endorsed measures)</p> <p>5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.</p>
<p>5a. Harmonization of Related Measures The measure specifications are harmonized with related measures; OR The differences in specifications are justified</p> <p>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 harmonized to the extent possible?</p> <p>5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.</p>
<p>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.</p> <p>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.) All existing and potentially competing measures endorsed by NQF are 1) focused on adults and 2) focused on hospital populations with an emphasis on readmission to the hospital, not the ICU. They are fundamentally different in their intent.</p>

<p>Appendix</p> <p>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. Attachment Attachment: VPS_Fee_Schedule_CY16-635883941256952289.pdf</p>
<p>Contact Information</p> <p>Co.1 Measure Steward (Intellectual Property Owner): Virtual PICU Systems, LLC Co.2 Point of Contact: Nancy, Brundage, nbrundage@myvps.org, 888-999-4850-103 Co.3 Measure Developer if different from Measure Steward: Virtual PICU Systems, LLC Co.4 Point of Contact: Matt, Scanlon, mscanlon@mcw.edu, 888-999-4850-</p>
<p>Additional Information</p> <p>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.</p> <p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: 2008 Ad.3 Month and Year of most recent revision: 12, 2015</p>

Ad.4 What is your frequency for review/update of this measure? 3 years Ad.5 When is the next scheduled review/update for this measure? 12, 2016
Ad.6 Copyright statement: Ad.7 Disclaimers:
Ad.8 Additional Information/Comments: