



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 #: 0349

Corresponding Measures:

De.2. Measure Title: Transfusion Reaction Count (PSI 16)

Co.1.1. Measure Steward: Agency for Healthcare Research and Quality

De.3. Brief Description of Measure: The number of medical and surgical discharges with a secondary diagnosis of transfusion reaction for patients ages 18 years and older or obstetric patients. Excludes cases with a principal diagnosis of transfusion reaction or cases with a secondary diagnosis of transfusion reaction that is present on admission.

1b.1. Developer Rationale: The Transfusion Reaction indicator is intended to flag cases of major reactions due to transfusions (ABO and Rh).

S.4. Numerator Statement: Surgical and medical discharges, for patients ages 18 years and older or MDC 14 (pregnancy, childbirth, and puerperium), with any secondary ICD-10-CM diagnosis codes for transfusion reaction. Surgical and medical discharges are defined by specific MS-DRG codes.

S.6. Denominator Statement: Not applicable

S.8. Denominator Exclusions: Not applicable

De.1. Measure Type: Outcome

S.17. Data Source: Claims

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: May 15, 2008 **Most Recent Endorsement Date:** Aug 09, 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? 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 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

0349_Evidence_MSIF5.0_Data-636426298328177192.doc

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

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

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 COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

The Transfusion Reaction indicator is intended to flag cases of major reactions due to transfusions (ABO and Rh).

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 (4b1) under Usability and Use.*

This is a “sentinel event” indicator, which is described as a count rather than a rate. Accordingly, it is impossible to provide a distribution of scores across measured entities.

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.

[1] HCUP State Inpatient Databases (SID). Healthcare Cost and Utilization Project (HCUP). 2008. Agency for Healthcare Research and Quality, Rockville, MD. Includes approximately 30 million adult discharges for 4,000 hospitals.

[2]Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2007, and AHRQ Quality Indicators, version 3.1.

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 (4b1) under Usability and Use.*

This is a “sentinel event” indicator, which is described as a count rather than a rate. Accordingly, it is impossible to provide descriptive statistics for performance results across population groups.

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

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2007, and AHRQ Quality Indicators, version 3.1.

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):

Surgery : General Surgery

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

Safety : Complications

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

Populations at Risk, Women

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.)

For the most up to date technical specifications, visit http://www.qualityindicators.ahrq.gov/Modules/psi_resources.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: [PSI_16_Transfusion_Reaction_Count-636426298308802192.xlsx](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

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.

Yes

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.

As standard protocol, the AHRQ QI program annually updates all measures with Fiscal Year coding changes, refinements based on stakeholder input, refinements to improve specificity and sensitivity based on additional analyses, and necessary software changes. In addition, approximately every two years, AHRQ updates the risk adjustment parameter estimates and composite weights based on the most recent year of data (i.e., the most current reference population possible). The refined measures are tested and confirmed to be valid and reliable prior to release of the updated software.

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).

Surgical and medical discharges, for patients ages 18 years and older or MDC 14 (pregnancy, childbirth, and puerperium), with any secondary ICD-10-CM diagnosis codes for transfusion reaction. Surgical and medical discharges are defined by specific MS-DRG codes.

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).

[Appendix C - Medical Discharge MS-DRGs](#)

Appendix E - Surgical Discharge MS-DRGs

Transfusion reaction diagnosis codes: (TRANFID)

ICD-10-CM Description

- T8030XA ABO incompatibility reaction due to transfusion of blood or blood products, unspecified, initial encounter
- T80310A ABO incompatibility with acute hemolytic transfusion reaction, initial encounter
- T80311A ABO incompatibility with delayed hemolytic transfusion reaction, initial encounter
- T80319A ABO incompatibility with hemolytic transfusion reaction, unspecified, initial encounter
- T8039XA Other ABO incompatibility reaction due to transfusion of blood or blood products, initial encounter
- T8040XA Rh incompatibility reaction due to transfusion of blood or blood products, unspecified, initial encounter
- T80410A Rh incompatibility with acute hemolytic transfusion reaction, initial encounter
- T80411A Rh incompatibility with delayed hemolytic transfusion reaction, initial encounter
- T80419A Rh incompatibility with hemolytic transfusion reaction, unspecified, initial encounter
- T8049XA Other Rh incompatibility reaction due to transfusion of blood or blood products, initial encounter

Exclude cases:

- With a principal ICD-10-CM diagnosis code (or secondary diagnosis present on admission) for transfusion reaction (see above)
- With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

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

Not applicable

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).

Not applicable

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

Not applicable

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.)*

Not applicable

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.)*

Not applicable

<p>S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment) No risk adjustment or risk stratification If other:</p>
<p>S.12. Type of score: Count 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) 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.) Identify cases meeting the target outcome. Exclude cases meeting the exclusion criteria. Count the number of case at the hospital level.</p>
<p>S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.) IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. Not applicable</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.) Specify calculation of response rates to be reported with performance measure results.</p>
<p>S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED). If other, please describe in S.18. Claims</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 are collected.) IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration. HCUP State Inpatient Databases (SID). Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality, Rockville, MD.</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) URL</p> <p>S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED) Facility</p> <p>S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED) Inpatient/Hospital If other:</p>
<p>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.)</p>
<p>2. Validity – See attached Measure Testing Submission Form 0349_MeasureTesting_MSF5.0_Data-636426298331770942.doc</p> <p>2.1 For maintenance of endorsement</p>

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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

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.

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

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**.

ALL data elements are in defined fields in electronic claims

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).

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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

The AHRQ QI software has been publicly available at no cost since 2001; Users have over ten years of experience using the AHRQ QI software in SAS and Windows.

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).

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)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

4a1.1 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

4a1.2. 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?)

4a1.3. 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.)

4a2.1.1. 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.

The Agency for Healthcare Research and Quality (AHRQ) provides free software, in both SAS and Windows format, to calculate the AHRQ Quality Indicators. Users may use their own hospital administrative data to calculate the QIs using this software.

In addition, AHRQ provides technical assistance to users through a QI User Support email address, QISupport@ahrq.hhs.gov. AHRQ triages, troubleshoots and responds to technical inquiries related to methodology and rationale behind the indicator and general questions related to the use of the software. During a calendar year, AHRQ typically provides technical support to over 1,000 queries.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

The AHRQ QI software is updated annually. Technical support is available on an on-going basis. No data updates are necessary; users apply the AHRQ QIs to their own hospital administrative data.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Feedback is obtained from users through a variety of channels, in particular through a technical assistance support service described above. In addition, AHRQ incorporates input on QI implementation from technical workgroups convened to support QI development and maintenance, stakeholder committees such as NQF standing committees, and peer-reviewed or other research publications.

4a2.2.2. Summarize the feedback obtained from those being measured.

See the response to 4d2.1.

4a2.2.3. Summarize the feedback obtained from other users

See the response to 4d2.1.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

The AHRQ Quality Indicators are updated annually, including updating indicator technical specifications in accordance with the latest coding guidance; suggestions from users and other stakeholders obtained through Technical Assistance, committees, or workgroups; and the latest clinical and scientific research. AHRQ regularly reviews these sources, identifies possible indicator updates, and prioritizes updates for each indicator and software update based on expected impact on users.

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.

4b1. 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.

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

Coding professionals follow detail guidelines, are subject to training and credentialing requirements, peer review and audit

4b2.2. Please explain any unexpected benefits from implementation of this measure.

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.

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

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

5a. Harmonization of Related Measures

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 harmonized to the extent possible?

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

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.)

[Not applicable](#)

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.

[Attachment Attachment: 0349_Deliverable_28_QI_Empirical_Methods_v50_20141216-636426298335833442.docx](#)

Contact Information
<p>Co.1 Measure Steward (Intellectual Property Owner): Agency for Healthcare Research and Quality</p> <p>Co.2 Point of Contact: Pamela, Owens, Pam.Owens@ahrq.hhs.gov, 301-427-1412-</p> <p>Co.3 Measure Developer if different from Measure Steward: Agency for Healthcare Research and Quality</p> <p>Co.4 Point of Contact: John, Bott, John.Bott@ahrq.hhs.gov, 301-427-1317-</p>
Additional Information
<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. Multi-specialty Panel and Surgical Panel members are listed in the technical report: http://qualityindicators.ahrq.gov/Downloads/Modules_Non_Software/Modules%20Development%20Bullet/psi_development.zip</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: 2003 Ad.3 Month and Year of most recent revision: 08, 2011 Ad.4 What is your frequency for review/update of this measure? Annual Ad.5 When is the next scheduled review/update for this measure? 12, 2011</p>
<p>Ad.6 Copyright statement: Not applicable Ad.7 Disclaimers: Not applicable</p>
<p>Ad.8 Additional Information/Comments: Not applicable</p>