NATIONAL QUALITY FORUM

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 #: 1768
Corresponding Measures:
De.2. **Measure Title:** Plan All-Cause Readmissions (PCR)
Co.1.1. **Measure Steward:** National Committee for Quality Assurance
De.3. **Brief Description of Measure:** For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays* (denominator)
2. Count of 30-Day Readmissions (numerator)
3. Average Adjusted Probability of Readmission

*An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).
1b.1. **Developer Rationale:** A plan based measure to reduce readmission rates will decrease readmissions rates by improving post-discharge planning and preventive health services.

This measure relies on data that is available to health plans and is intended to be used to hold health plans (or where Medicare data or cross health plan data is available, all providers) accountable for readmissions. In this sense it is complementary to hospital focused measures, since by taking this broader perspective, it can include hospitalizations that occur to different hospitals than the hospital to which the initial admission occurred, can be used to foster joint accountability across entities (hospital, home care, specialty and primary care ambulatory care) as might be present in an accountable care organization or integrated delivery system. It also takes into account that even where a problem in hospital care or transition out of the hospital may have contributed to a preventable readmission, care in other sites may have contributed to the readmission as well.

S.4. **Numerator Statement:** At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.
S.6. **Denominator Statement:** Patients age 18 and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.
S.8. **Denominator Exclusions:** Exclusions are included in the definition of the denominator (see S.9). Exclusions include discharges for death, pregnancy, prerinatal condition, or a discharge that is followed by a planned admission within 30 days.

De.1. **Measure Type:** Process
S.17. **Data Source:** Instrument-Based Data
S.20. **Level of Analysis:** Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Apr 24, 2012 **Most Recent Endorsement Date:** Apr 24, 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
1768_Evidence_MSF5.0_Data.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.
A plan based measure to reduce readmission rates will decrease readmissions rates by improving post-discharge planning and preventive health services.

This measure relies on data that is available to health plans and is intended to be used to hold health plans (or where Medicare data or cross health plan data is available, all providers) accountable for readmissions. In this sense it is complementary to hospital focused measures, since by taking this broader perspective, it can include hospitalizations that occur to different hospitals than the hospital to which the initial admission occurred, can be used to foster joint accountability across entities (hospital, home care, specialty and primary care ambulatory care) as might be present in an accountable care organization or integrated delivery system. It also takes into account that even where a problem in hospital care or transition out of the hospital may have contributed to a preventable readmission, care in other sites may have contributed to the readmission as well.

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.*
Medicare – Measurement Year 2010
Number of Health Plans 424
MEAN 0.164
STDEV 0.028
STDERR N/A
MIN 0.06
MAX 0.35
P10; 0.136
P25; 0.149
P50; 0.162
P75; 0.175
P90; 0.198

Commercial - Measurement Year 2010
Number of Health Plans 314
MEAN 0.083
STDEV 0.011

STDERR N/A
MIN 0.050
MAX 0.114
P10; 0.066
P25; 0.076
P50; 0.085
P75; 0.090
P90; 0.096

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.**
Section 1b.2 references NCQA's HEDIS data from the first year of measurement for this measure (2010). The data in section 1b.2 includes percentiles, mean, min, max, standard deviations and standard errors.

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.*
We collect the data separately by age and gender cohorts to permit monitoring of potential disparities, however there is no specific evidence of disparity for these groups. The measure is not stratified by race/ethnic group or cohorts. NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, and employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden without generating meaningful results. We believe that the measure specifications should NOT require this unless absolutely necessary since the data needed to determine disparities cannot be ascertained from the currently available sources.

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**
N/A

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):*
Genitourinary (GU)

De.6. **Non-Condition Specific***(check all the areas that apply):*
Care Coordination, Care Coordination : Readmissions, Care Coordination : Transitions of Care, Safety

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

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.)*

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:**

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.

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.

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).
At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.

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).
Step 1: Identify all acute inpatient stays with an admission date on or between the second day of the measurement year and the end of the measurement year (e.g., on or between January 2 and December 31 of the measurement year).

Step 2: Acute-to-acute transfers: Keep the original admission date as the admission date for the Index Hospital Stay, but use the transfer's discharge date as the discharge date for the Index Hospital Stay.

Step 3: Exclude acute inpatient hospital discharges with a principal diagnosis of pregnancy or a principal diagnosis for a condition originating in the perinatal period.

See corresponding Excel document for Pregnancy Value Set
See corresponding Excel document for Perinatal Conditions Value Set

Step 4: For each Index Hospital Stay, determine if any of the acute inpatient stays have an admission date within 30 days after the discharge date for the Index Hospital Stay.

S.6. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Patients age 18 and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.

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).
The denominator for this measure is based on acute discharges, not patients.

Step 1: Identify all acute inpatient stays with a discharge date (Index Hospital Stay) during the first 11 months of the measurement year (e.g., on or between January 1 and December 1 of the measurement year).

Step 2: If the discharge is an acute-to-acute transfer, keep the original admission date as the admission date for the Index Hospital Stay, but use the transfer's discharge date as the discharge date for the Index Hospital Stay.

Step 3: Exclude hospital stays where the admission date for the Index Hospital Stay is the same as the discharge date for the Index Hospital Stay.

Step 4: Exclude stays for the following reasons:
- Inpatient stays with discharges for death
- Acute inpatient discharge with a principal diagnosis of pregnancy (See corresponding Excel document for Pregnancy Value Set)
- Acute inpatient discharge with a principal diagnosis of a condition originating in the perinatal period (See corresponding Excel document for Perinatal Conditions Value Set)

Step 5: For all acute inpatient discharges identified using steps 1-4, determine if there was a planned hospital stay within 30 days using all acute inpatient stays. Exclude any acute inpatient discharge as an Index Hospital Stay if the admission date of the first planned hospital stay is within 30 days and includes any of the following.
- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set)
- A principal diagnosis of rehabilitation (Rehabilitation Value Set).
- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).
- A potentially planned procedure (Potentially Planned Procedure Value Set) without a principal acute diagnosis (Acute Condition Value Set).

(See corresponding Excel document for the value sets reference above.)

Step 6: Assign each acute inpatient stay to an age category (see S.12 for stratification details).

S.8. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Exclusions are included in the definition of the denominator (see S.9). Exclusions include discharges for death, pregnancy, prerinatal condition, or a discharge that is followed by a planned admission within 30 days.

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.)*
- Inpatient stays with discharges for death
- Acute inpatient discharge with a principal diagnosis of pregnancy (See corresponding Excel document for Pregnancy Value Set)
- Acute inpatient discharge with a principal diagnosis of a condition originating in the perinatal period (See corresponding Excel document for Perinatal Conditions Value Set)

- Admission followed by a planned readmission: Any acute inpatient discharge with a readmission within 30 days for maintenance chemotherapy (Chemotherapy Value Set), rehabilitation (Rehabilitation Value Set), organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set), or a potentially planned procedure (Potentially Planned Procedure Value Set) without a principal acute diagnosis (Acute Condition Value Set).

(See corresponding Excel document for the value sets above)

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.)*
The measure reported by age categories. The age stratifications are: 18-44, 45-54, 55-64, 65-74, 75-84, 85+, Total

RISK STRATIFICATION CATEGORIES
For each index hospital stay, use the following steps to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender. Tables to classify conditions based on the CMS HCC model are available at www.ncqa.org.

SURGERIES: Determine if the patient underwent surgery during the inpatient stay. Download the list of codes from the NCQA Web site www.ncqa.org (Table HCC-Surg) and use it to identify surgeries. Consider an index hospital stay to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

DISCHARGE CONDITION: Assign a discharge Clinical Condition (CC) category code to the index hospital stay based on its primary discharge diagnosis, using Table PCR-DischCC (available at www.ncqa.org). For acute-to-acute transfers, use the transfer's primary discharge diagnosis. Exclude diagnoses that cannot be mapped to Table PCR-DischCC.

COMORBIDITIES:
STEP 1: Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters: (Exclude the primary discharge diagnosis on the Index Hospital Stay)
-Outpatient visits (See corresponding excel document Outpatient Value Set).
-Observation visits (See corresponding excel document Observation Value Set).
-Nonacute inpatient encounters (See corresponding excel document Nonacute Inpatient Value Set).
-Acute inpatient encounters (See corresponding excel document Acute Inpatient Value Set).
-ED visits (See corresponding excel document ED Value Set).

STEP 2: Assign each diagnosis to one comorbid Clinical Condition (CC) category using Table CC—Comorbid (available at www.ncqa.org). Exclude all diagnoses that cannot be assigned to a comorbid CC category. For patients with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section. All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

STEP 3: Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank (available at www.ncqa.org). For each stay's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign: the ranking group, the rank and the HCC. For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. Note, one comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

STEP 4: Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the Rank column (1 is the highest rank possible). Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

STEP 5: Identify combination HCCs listed in Table HCC—Comb (available at www.ncqa.org). Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships. Compare each stay's list of unique HCCs to those in the HCC column in Table HCC—Comb and assign any additional HCC conditions. For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/ CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted. For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHR/renal/ diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted. Based on the combinations, a member can have none, one or more of these added HCCs.

S.11. **Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)
Stratification by risk category/subgroup
If other:

S.12. **Type of score:**
Other
If other: Rate/Proportion and Count: The Counts are the number of index hospital stays (denominator) and stays with a subsequent 30-day readmission (numerator). The Rate/Proportions are the average adjusted probability of readmission (expected rate) and the observed rate of readmission (numerator / denominator).

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

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.)*
Look at denominator details, numerator details and the risk adjustment methodology for the measure logic in sections S.6, S.9, S.12 and S.14.

CALCULATE THE OBSEVED RATE OF READMISSION
Step 1: Determine the eligible population: Patients ages 18+ as of the discharge date for the Index Hospital Stay.

Step 2: Determine number discharges meeting the denominator criteria as specified in Section S.9 above.

Step 3: Stratify the denominator by age and gender categories as specified in Section S.12 above.

Step 4: Determine the number of patients who meet the numerator criteria as specified in section S.6 above.

Step 5: Calculate the Observed Rate of Readmission as Numerator/Denominator for each age/gender category.

CALCULATE THE EXPECTED RATE OF READMISSION
STEP 1: For each index hospital stay in the denominator identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender as specified in Section S.12 above.

STEP 2: For each index hospital stay in the denominator identify risk adjustment weights based on risk adjustment categories defined in step 1. See Section S.14 for full details.

STEP 3: Use the formula below to calculate the adjusted probability of a readmission based on the sum of the weights for each index hospital stay. Adjusted probability of readmission = [exp (sum of weights for index hospital stay)] / [1 + exp (sum of weights for index hospital stay)] Note: “Exp” refers to the exponential or antilog function. This is the Expected Rate of Readmission
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CALCULATE THE OBSERVED/EXPECTED RATIO

STEP 1: Calculate the ratio: Observed Rate or Readmissions/Expected Rate of Readmissions

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.
N/A

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.

S.17. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.18.
Instrument-Based Data

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.
N/A

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)*

S.20. **Level of Analysis** *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*
Health Plan, Integrated Delivery System

S.21. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Other
If other: This measure does not specify a specific setting where care must be provided.

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
1768_MeasureTesting_MSF5.0_Data.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. 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 a combination of 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).

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.
NCQA´s multi-stakeholder advisory panels examined an analysis of the measure after its first year of reporting. The measure was deemed appropriate for public reporting. NCQA has processes to ensure coding and specifications are clear and updated when needed.
We have made the following modifications based on the first year of reporting:
- Added a step to collect variance (to support public reporting and related confidence intervals)
- Use the formula below and the adjusted probability of readmission calculated in Step 7 to calculate the variance for each IHS.

Variance = Adjusted probability of readmission x (1—Adjusted probability of readmission)
Example: If the adjusted probability of readmission is 0.1518450741, then the variance is 0.1518450741 x 0.8481549259 = 0.1287881476.
- For Medicare, we are re-estimating the risk adjustment model for age <65 and age 65 and older. Each age group will have its own risk adjustment model. Only the age 65 and older are being used in CMS this year and will be publicly reported by NCQA in 2012. These updated risk models/weights will be available Nov 15, 2011 and will be sent to NQF upon receipt from our data vendor.
- For commercial, we re-estimated the risk adjustment weights for the age <65 population. Commercial health plans will report the measure only for ages 18-65; we dropped the age 65 and older because of small numbers and representativeness problems in our reference data set. The risk model submitted contains the new risk adjustment weights for 2012.

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 Payment Program 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.

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.**

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.

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

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

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.**

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.**
All measures that are used in NCQA programs are audited.

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.
Yes

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?
No

5a.2. **If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**
NCQA harmonized nearly all components with the PacifiCare and Yale-CMS measures. The differences are that the measure focuses on all-cause discharges and incorporates risk weights for the index condition using the HCC system.

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.)
N/A

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:

Contact Information

Co.1 **Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance
Co.2 **Point of Contact:** Bob, Rehm, nqf@ncqa.org, 202-955-1728-
Co.3 **Measure Developer if different from Measure Steward:** National Committee for Quality Assurance
Co.4 **Point of Contact:** Kristen, Swift, Swift@ncqa.org, 202-955-5174-

Additional Information

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.
GMAP Members
Wade Aubry, BCBS Association
Arlene Bierman, University of Toronto and St. Michael's Hospital
Joyce Dubow, AARP
Peter Hollmann, BCBS of Rhode Island
Jerry Johnson, University of Pennsylvania
David Martin, Ovations
Adrienne Mims, Alliant Health Solutions | Georgia Medical Care
Steven Phillips, Sierra Health Services, Inc.
Scott Sarran, BCBS of Illinois
Eric G Tangalos, Mayo Clinic
Joan Weiss, Health Resources and Services Administration

Neil Wenger, UCLA Division of General Internal Medicine and RAND

Risk Adjustment Subgroup
Arlene Ash, University of Massachusetts Medical School
Peter Bach, Memorial Sloan-Kettering Cancer Center
Mary Kay Dugan, Battelle Centers for Public Health Research and Evaluation
Ann Elixhauser, AHRQ
Jeffrey Geppert, Battelle Centers for Public Health Research and Evaluation
Richard Kronick, University of California, San Diego
Patrick Romano, University of California, Davis
Jonathan Weiner, Johns Hopkins School of Public Health

The NCQA Geriatric Measurement Advisory Panel advised NCQA during measure development. They evaluated the way staff specified measures, assessed the content validity of measures, and reviewed field test results. As you can see from the list, the MAP consisted of a balanced group of experts, including representatives from CMS, AARP, universities and health plans. Note that, in addition to the MAP, we also vetted these measures with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders, in addition to the MAP.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 **Year the measure was first released:** 2010

Ad.3 **Month and Year of most recent revision:** 10, 2011

Ad.4 **What is your frequency for review/update of this measure?** Approximately every 3 years, sooner if the risk adjustment methodology requires dataset updates

Ad.5 **When is the next scheduled review/update for this measure?** 08, 2012

Ad.7 **Disclaimers:**

Ad.8 **Additional Information/Comments:** Added a step to collect variance:
Use the formula below and the adjusted probability of readmission calculated in Step 7 to calculate the variance for each IHS.
Variance = Adjusted probability of readmission x (1—Adjusted probability of readmission)
Example: If the adjusted probability of readmission is 0.1518450741, then the variance is 0.1518450741 x 0.8481549259 = 0.1287881476.

Changed measure to public reporting status for Commercial 18-64 years of age, and for Medicare 65 years of age and older.