



## 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 #:** 2515

**Corresponding Measures:**

**De.2. Measure Title:** Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery

**Co.1.1. Measure Steward:** Centers for Medicare & Medicaid Services

**De.3. Brief Description of Measure:** The measure estimates a hospital-level risk-standardized readmission rate (RSRR), defined as unplanned readmission for any cause within 30-days from the date of discharge for a qualifying index CABG procedure, in patients 65 years and older.

An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the readmission outcome.

**1b.1. Developer Rationale:** The goal of this measure is to improve patient outcomes. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures.

Readmissions following CABG surgery are influenced by complex and critical aspects of care, such as: communication between providers; prevention of, and response to, complications; patient safety; coordinated transitions to the outpatient environment; all contribute to patient outcomes but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk adjust for patients' conditions at the time of hospital admission and then evaluate patient outcomes. This measure was developed to identify institutions whose performance is better or worse than would be expected based on each institution's patient case mix, and therefore promote hospital quality improvement and better inform consumers about care quality.

By providing patients, physicians, hospitals, and policy makers with information about hospital-level, risk-standardized readmission rates following hospitalization for a qualifying isolated CABG procedure, CABG readmissions are a priority area for outcome measure development. It is an outcome that is likely attributable to care processes and is an important outcome for patients. Measuring and reporting readmission rates will inform healthcare providers and facilities about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care received by Medicare patients. The measure will also provide patients with information that could guide their choices, as well as increase transparency for consumers.

**S.4. Numerator Statement:** The outcome for this measure is 30-day readmissions. We define readmission as an inpatient acute care admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from the index admission for an isolated CABG surgery in patients 65 and older. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only the first one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.

**S.6. Denominator Statement:** The cohort includes admissions for patients who are age 65 and older with a qualifying isolated CABG procedure and complete claims history for the 12 months prior to the index admission.

**S.8. Denominator Exclusions:** For all cohorts, hospitalizations are excluded if they meet any of the following criteria, for admissions:

1. Without at least 30 days post-discharge enrollment in FFS Medicare
2. Discharged against medical advice (AMA)
3. Admissions for subsequent qualifying CABG procedures during the measurement period

**De.1. Measure Type:** Outcome

S.17. Data Source: [Claims, Enrollment Data](#)

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

IF Endorsement Maintenance – Original Endorsement Date: [Dec 23, 2014](#) Most Recent Endorsement Date: [Jul 12, 2017](#)

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?** [This measure is not formally paired with another measure, however it is harmonized with a measure of hospital-level, all-cause, 30-day, risk-standardized mortality following a qualifying isolated CABG procedure.](#)

## 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

[NQF\\_evidence\\_CABGreadmission\\_Fall2020\\_final\\_7.22.20.docx](#)

#### 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.

[Yes](#)

### 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 goal of this measure is to improve patient outcomes. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Readmissions following CABG surgery are influenced by complex and critical aspects of care, such as: communication between providers; prevention of, and response to, complications; patient safety; coordinated transitions to the outpatient environment; all contribute to patient outcomes but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk adjust for patients' conditions at the time of hospital admission and then evaluate patient outcomes. This measure was developed to identify institutions whose performance is better or worse than would be expected based on each institution's patient case mix, and therefore promote hospital quality improvement and better inform consumers about care quality. By providing patients, physicians, hospitals, and policy makers with information about hospital-level, risk-standardized readmission rates following hospitalization for a qualifying isolated CABG procedure, CABG readmissions are a priority area for outcome measure development. It is an outcome that is likely attributable to care processes and is an important outcome for patients. Measuring and reporting readmission rates will inform healthcare providers and facilities about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care received by Medicare patients. The measure will also provide patients with information that could guide their choices, as well as increase transparency for consumers.](#)

**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.*

#2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery, Last Updated: Nov 25, 2020

Variation in readmission rates indicates opportunity for improvement. We conducted analyses using data from July 1, 2016 to June 30, 2019 Medicare claims data (n=131,592 admissions from 1,160 hospitals). As shown below, the three-year hospital-level risk standardized readmission rates (RSRRs) have a mean of 12.8% and a range of 8.6% - 22.6% in the study cohort. The median RSRR is 12.7%. The distribution of RSRRs across hospitals is shown below:

Distribution of Hospital CABG RSRRs over Different Time Periods

Results for each data year

Characteristic//07/2016-06/2017//07/2017-06/2018//07/2018-06/2019//07/2016-06/2019

Number of Hospitals//1,135//1,114//1,091//1,160

Number of Admissions//44,306//44,009//43,277//13,1592

Mean(SD)//12.9(0.7)//12.9(1)//12.3(1)//12.8(1.3)

Range(Min-Max)//10.3-17.2//9.8-18.8//8.7-17.2//8.6-22.6

Minimum//10.3//9.8//8.7//8.6

10th percentile//12.1//11.8//11.2//11.1

20th percentile//12.4//12.2//11.6//11.7

30th percentile//12.6//12.5//11.8//12.1

40th percentile//12.7//12.7//12.1//12.5

50th percentile//12.9//12.9//12.3//12.7

60th percentile//13.0//13.1//12.5//13.0

70th percentile//13.2//13.3//12.8//13.3

80th percentile//13.4//13.6//13.1//13.8

90th percentile//13.7//14.1//13.6//14.3

Maximum//17.2//18.8//17.2//22.6

**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.**

N/A

**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.**

Distribution of 30-day CABG RSRRs by Proportion of Dual Eligible Patients:

Data source: Medicare FFS claims and Master Beneficiary Summary File (MBSF) data

Dates of Data: July 2016 through June 2019

Variation in RSRRs across hospitals (with at least 25 cases) by proportion of patients with social risk//

Description of Social Risk Variable//Dual Eligibility

Quartile//Q1//Q4

Social Risk Proportion(%)//0-7.96//24.44-84.38

# of Hospitals//248//248

100% Max//17.5//22.6

90%//14.2//14.8

75%//13.4//14.0

50%//12.5//13.1

25%//11.7//12.1

10%//10.8//11.5

0% Min//8.7//9.5

Distribution of 30-day CABG RSRRs by Proportion of Patients with AHRQ SES Index Scores:

Data source: Medicare FFS claims and The American Community Survey (2013-2017) data

Dates of Data: July 2016 through June 2019

Variation in RSRRs across hospitals (with at least 25 cases) by proportion of patients in lower and upper social risk quartiles//

Description of Social Risk Variable //AHRQ SES Index

Quartile//Q1//Q4

Social Risk Proportion(%)//((0-2.52)//(7.73-82.28)

# of Hospitals//248//247

100% Max//18.6//17.9

90%//14.4//14.6

75%//13.5//13.7

50%//12.6//12.9

25%//11.6//12.0

10%//10.9//11.4

0% Min//8.6//9.6

**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):

Cardiovascular, Cardiovascular : Coronary Artery Disease, Surgery : Cardiac Surgery

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

Care Coordination, Care Coordination : Readmissions, Care Coordination : Transitions of Care, Safety : Complications, Safety : Healthcare Associated Infections

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

Elderly, Populations at Risk

**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://qualitynet.org/inpatient/measures/readmission/methodology>

**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: NQF\_datadictionary\_CABGreadmission\_Fall2020\_final\_7.22.20.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.

No, this is not an instrument-based measure 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.

Not an instrument-based measure

**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.

No

**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.

Updates consisted of updating the specifications to include new and modified ICD-10 CM/PCS codes.

**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).

The outcome for this measure is 30-day readmissions. We define readmission as an inpatient acute care admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from the index admission for an isolated CABG surgery in patients 65 and older. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only the first one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.

**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).

The measure counts readmissions to any acute care hospital for any cause within 30 days of the date of discharge after undergoing isolated CABG surgery, excluding planned readmissions as defined below. Although clinical experts agree that planned readmissions are rare after CABG, they likely do occur. Therefore, to identify these planned readmissions we have adapted and applied an algorithm originally created to identify planned readmissions for a hospital-wide (i.e., not condition-specific) readmission measure.

#### Planned Readmission Algorithm (Version 4.0)

The planned readmission algorithm is a set of criteria for classifying readmissions as planned using Medicare claims data. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital.

In brief, the algorithm identifies a short list of always planned readmissions (those where the principal discharge diagnosis is major organ transplant, obstetrical delivery, or maintenance chemotherapy) as well as those readmissions with a potentially planned procedure (e.g., total hip replacement) AND a non-acute principle discharge diagnosis code. For example, a readmission for colon resection is considered planned if the principal diagnosis is colon cancer but unplanned if the principal diagnosis is abdominal pain, as this might represent a complication of the CABG procedure or hospitalization. Readmissions that included potentially planned procedures with an acute principal diagnosis or procedures that might represent specific complications of CABG, such as PTCA or repeat CABG are not excluded from the measure outcome as they are considered unplanned in this measure.

The planned readmission algorithm has three fundamental principles:

1. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy/immunotherapy, rehabilitation);
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and,
3. Admissions for acute illness or for complications of care are never planned.

The algorithm was developed in 2011 as part of the Hospital-Wide Readmission measure. In 2013, CMS applied the algorithm to its other readmission measures.

In applying the algorithm to condition- and procedure-specific measures, teams of clinical experts reviewed the algorithm in the context of each measure-specific patient cohort and, where clinically indicated, adapted the content of the algorithm to better reflect the likely clinical experience of each measure's patient cohort. The planned readmission algorithm is applied to the CABG measure with modifications.

The planned readmission algorithm and associated code tables are attached in data field S.2b (Data Dictionary or Code Table).

It should be noted that this approach differs from that adopted by STS for their registry-based measure, in which all 30-day readmissions were considered to be unplanned.

#### Outcome Attribution

Attribution of the outcome in situations where a patient has multiple contiguous admissions, at least one of which involves an index CABG procedure (i.e., the patient is either transferred into the hospital that performs the index CABG or is transferred out to another hospital following the index CABG) is as follows:

- If a patient undergoes a CABG procedure in the first hospital and is then transferred to a second hospital where there is no CABG procedure, the readmission outcome is attributed to the first hospital performing the index CABG procedure and the 30-day window starts with the date of discharge from the final hospital in the chain.

Rationale: A transfer following CABG is most likely due to a complication of the index procedure and that care provided by the hospital performing the CABG procedure likely dominates readmission risk even among transferred patients.

- If a patient is admitted to a first hospital but does not receive a CABG procedure there and is then transferred to a second hospital where a CABG is performed, the readmission outcome is attributed to the second hospital performing the index CABG procedure and the 30-day window starts with the date of discharge from the final hospital in the chain.

Rationale: Care provided by the hospital performing the CABG procedure likely dominates readmission risk.

-If a patient undergoes a CABG procedure in the first hospital and is transferred to a second hospital where another CABG procedure is performed, the readmission outcome is attributed to the first hospital performing the index (first) CABG procedure and the 30-day window starts with the date of discharge from the final hospital in the chain.

Rationale: A transfer following CABG is most likely due to a complication of the index procedure, and care provided by the hospital performing the index CABG procedure likely dominates readmission risk even among transferred patients.

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

The cohort includes admissions for patients who are age 65 and older with a qualifying isolated CABG procedure and complete claims history for the 12 months prior to the index admission.

**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).*

In order to create a clinically coherent population for risk adjustment, and in accordance with existing NQF-approved CABG measures and clinical expert opinion, the measure is intended to capture isolated CABG patients (i.e., patients undergoing CABG procedures without concomitant valve or other major cardiac or vascular procedures).



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

For all cohorts, hospitalizations are excluded if they meet any of the following criteria, for admissions:

1. Without at least 30 days post-discharge enrollment in FFS Medicare
2. Discharged against medical advice (AMA)
3. Admissions for subsequent qualifying CABG procedures during the measurement period

**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.)

The CABG readmission measure excludes hospitalizations if they meet any of the following criteria:

1. Without at least 30 days post-discharge enrollment in FFS Medicare

Rationale: The 30-day readmission outcome cannot be assessed in this group since claims data are used to determine whether a patient was readmitted.

2. Discharged against medical advice (AMA) are identified using the discharge disposition indicator in claims data.

Rationale: Providers did not have the opportunity to deliver full care and prepare the patient for discharge.

2. Admissions for subsequent qualifying CABG procedures during the measurement period.

Rationale: CABG procedures are expected to last for several years without the need for revision or repeat revascularization. A repeat CABG procedure during the measurement period likely represents a complication of the original CABG procedure and is a clinically more complex and higher risk surgery. Therefore, we select the first CABG surgery admission for inclusion in the measure and exclude subsequent CABG surgery admissions from the cohort.

**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.)

N/A

**S.11. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)

Statistical risk model

If other:

**S.12. Type of score:**

Rate/proportion

If other:

**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.)

The measure estimates hospital-level 30-day, all-cause RSRRs following hospitalization for isolated CABG surgery using hierarchical logistic regression models. In brief, the approach simultaneously models data at the patient and hospital levels to account for variance in patient outcomes within and between hospitals (Normand and Shahian, 2007). At the patient level, it models the log-odds of readmission within 30 days of index admission using age, sex, selected clinical covariates, and a hospital-specific intercept. At the hospital level, it models the hospital-specific intercepts as arising from a normal distribution. The hospital intercept represents the underlying risk of a readmission at the hospital, after accounting for patient risk. The hospital-specific intercepts are given a distribution to account for the clustering (non-independence) of patients within the same hospital. If there were no differences among hospitals, then after adjusting for patient risk, the hospital intercepts should be identical across all hospitals. The RSRR is calculated as the ratio of the number of “predicted” to the number of “expected” readmissions at a given hospital,

multiplied by the national observed readmission rate. For each hospital, the numerator of the ratio is the number of readmissions within 30 days predicted on the basis of the hospital's performance with its observed case mix; and the denominator is the number of readmissions expected based on the nation's performance with that hospital's case mix. This approach is analogous to a ratio of "observed" to "expected" used in other types of statistical analyses. It conceptually allows for a comparison of a particular hospital's performance given its case mix to an average hospital's performance with the same case mix. Thus, a lower ratio indicates lower-than-expected readmission rates or better quality, and a higher ratio indicates higher-than-expected readmission rates or worse quality.

The "predicted" number of readmissions (the numerator) is calculated by using the coefficients estimated by regressing the risk factors and the hospital-specific intercept on the risk of readmission. The estimated hospital-specific intercept is added to the sum of the estimated regression coefficients multiplied by the patient characteristics. The results are transformed and summed over all patients attributed to a hospital to get a predicted value. The "expected" number of readmissions (the denominator) is obtained in the same manner, but a common intercept using all hospitals in our sample is added in place of the hospital-specific intercept. The results are transformed and summed over all patients in the hospital to get an expected value. To assess hospital performance for each reporting period, we re-estimate the model coefficients using the years of data in that period.

This calculation transforms the ratio of predicted over expected into a rate that is compared to the national observed readmission rate. The hierarchical logistic regression models are described fully in the original methodology report posted on QualityNet: (<https://qualitynet.org/inpatient/measures/readmission/methodology>).

References:

Normand S-LT, Shahian DM. 2007. Statistical and Clinical Aspects of Hospital Outcomes Profiling. Stat Sci 22(2): 206-226.

**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. This measure is not based on a sample or survey.

**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.

N/A

**S.17. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Enrollment 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.

Data sources for the Medicare FFS measure:

Medicare Part A Inpatient and Part B Outpatient Claims: This data source contains claims data for FFS inpatient and outpatient services including Medicare inpatient hospital care, outpatient hospital services, as well as inpatient and outpatient physician claims for the 12 months prior to an index admission.

Medicare Enrollment Database (EDB): This database contains Medicare beneficiary demographic, benefit/coverage, and vital status information. This data source was used to obtain information on several inclusion/exclusion indicators such as Medicare status on admission as well as vital status. These data have previously been shown to accurately reflect patient vital status (Fleming et al., 1992). The Master Beneficiary Summary File (MBSF) is an annually created file derived the EDB that contains enrollment information for all Medicare beneficiaries including dual eligible status. Years 2016-2019 were used.

The American Community Survey (2013-2017): We used the American Community Survey (2013-2017) to derive an updated AHRQ SES index score at the patient nine-digit zip code level for use in studying the association between our measure and SRFs.

References:

Fleming C., Fisher ES, Chang CH, Bubolz D, Malenda J. Studying outcomes and hospital utilization in the elderly: The advantages of a merged data base for Medicare and Veterans Affairs Hospitals. Medical Care. 1992; 30(5): 377-91.

**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)

No data collection instrument provided



**S.20. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

**S.21. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital

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.)

N/A

**2. Validity – See attached Measure Testing Submission Form**

[NQF\\_testing\\_CABGreadmission\\_Fall2020\\_final\\_11.02.20-637419147547622773.docx](#)

**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.*

Yes

**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.*

Yes

**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.*

Yes - Updated information is included

**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).

N/A

**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.

This measure uses administrative claims and enrollment data and as such, offers no data collection burden to hospitals or providers.

**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).**

N/A

## 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)
Not in use	<p>Public Reporting</p> <p>Hospital Compare  <a href="https://www.medicare.gov/hospitalcompare/search.html?">https://www.medicare.gov/hospitalcompare/search.html?</a></p> <p>Payment Program  Hospital Readmission Reduction (HRRP) Program  <a href="https://www.qualitynet.org/inpatient/hrrp">https://www.qualitynet.org/inpatient/hrrp</a></p>

**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

**Public Reporting**

Program Name, Sponsor: Hospital Compare, Centers for Medicare and Medicaid Services (CMS)

Purpose: Under Hospital Compare and other CMS public reporting websites, CMS collects quality data from hospitals, with the goal of driving quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their health care. It is also intended to encourage hospitals and clinicians to improve the quality and cost of inpatient care provided to all patients. The data collected are available to consumers and providers on the Hospital Compare website at: <https://www.medicare.gov/hospitalcompare/search.html>. Data for selected measures are also used for paying a portion of hospitals based on the quality and efficiency of care, including the Hospital Value-Based Purchasing Program, Hospital-Acquired Condition Reduction Program, and Hospital Readmissions Reduction Program.

**Payment Program**

Program Name, Sponsor: Hospital Readmission Reduction Program (HRRP), Centers for Medicare and Medicaid Services (CMS)

Purpose: Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

Geographic area and number and percentage of accountable entities and patients included: The HRRP program includes only Subsection (d) hospitals and hospitals located in Maryland. Subsection (d) hospital encompasses any acute care hospital located in one of the fifty states or the District of Columbia which does not meet any of the following exclusion criteria as defined by the Social Security Act: psychiatric, rehabilitation, children's, or long-term care hospitals, and non-IPPS cancer hospitals. Critical access hospitals, non-IPPS cancer hospitals, and hospitals located in U.S territories are not included in the calculation. The number and percentage of accountable entities included in the program, as well as the number of patients included in the measure, varies by reporting year.

**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?)**

N/A. This measure is currently publicly reported.

**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.)**

N/A. This measure is currently publicly reported.

**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 exact number of measured entities (acute care hospitals) varies with each new measurement period. For the period between 2016-2019, all non-federal short-term acute care hospitals (including Indian Health Service hospitals) and critical access hospitals (1,160) were included in measure calculation. Only those hospitals performing at least 25 qualifying isolated CABG procedures were included in public reporting.

Each hospital receives their measure results in April/May of each calendar year through CMS's QualityNet website. The results are

then publicly reported on CMS's Hospital Compare website in the summer of each calendar year. Since the measure is risk-standardized using data from all hospitals, hospitals cannot independently calculate their score.

However, CMS provides each hospital with several resources that aid in the interpretation of their results (described in detail below). These include Hospital-Specific Reports with details about every patient from their facility that was included in the measure calculation (for example, dates of admission and discharge, discharge diagnoses, outcome [died or not], transfer status, and facility transferred from). These reports facilitate quality improvement activities such as review of individual deaths and patterns of deaths; make visible to hospitals post-discharge outcomes that they may otherwise be unaware of; and allows hospitals to look for patterns that may inform quality improvement (QI) work (e.g. among patient transferred in from particular facilities). CMS also provides measure FAQs, webinars, and measure-specific question and answer inboxes for stakeholders to ask specific questions.

The Hospital-Specific Reports also provide hospitals with more detailed benchmarks with which to gauge their performance relative to peer hospitals and interpret their results, including comorbidity frequencies for their patients relative to other hospitals in their state and the country.

Additionally, the code used to process the claims data and calculate measure results is written in SAS (Cary, NC) and is provided each year to hospitals upon request.

**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.**

During the Spring of each year, hospitals have access to the following list of updated resources related to the measure which is provided directly or posted publicly for hospitals to use:

1. Hospital-Specific Reports (HSR): available for hospitals to download from QualityNet in April/May of each calendar year; includes information on the index admissions included in the measure calculation for each facility, detailed measure results, and state and national results.
2. HSR User Guide: available with the HSR and posted on QualityNet; provides instructions for interpreting the results and descriptions of each data field in the HSR.
3. Mock HSR: posted on QualityNet; provides real national results and simulated state and hospital results for stakeholders who do not receive an HSR.
4. HSR Tutorial Video: A brief animated video to help hospitals navigate their HSR and interpret the information provided.
5. Public Reporting Preview and Preview Help Guide: available for hospitals to view from QualityNet in Spring of each calendar year; includes measure results that will be publicly reported on CMS's public reporting websites.
6. Annual Updates and Specification Reports: posted in April/May of each calendar year on QualityNet with detailed measure specifications, descriptions of changes made to the measure specifications with rationale and impact analyses (when appropriate), updated risk variable frequencies and coefficients for the national cohort, and updated national results for the new measurement period.
7. Frequently asked Questions (FAQs): includes general and measure-specific questions and responses, as well as infographics that explain complex components of the measure's methodology, and are posted in April/May of each calendar year on QualityNet.
8. The SAS code used to calculate the measure with documentation describing what data files are used and how the SAS code works. This code and documentation are updated each year and are released upon request beginning in July of each year.
9. Measure Fact Sheets: provides a brief overview of measures, measure updates, and are posted in April/May of each calendar year on QualityNet.

During the summer of each year, the publicly-reported measure results are posted on CMS's public reporting websites, a tool to find hospitals and compare their quality of care that CMS created in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other federal agencies. Measure results are updated in July of each calendar year.

**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.**

Questions and Answers (Q&A)

The measured entities (acute care hospitals) and other stakeholders or interested parties submit questions or comments about the

measure through an email inbox (CMSreadmissionmeasures@yale.edu). Experts on measure specifications, calculation, or implementation, prepare responses to those inquiries and reply directly to the sender. We consider issues raised through the Q&A process about measure specifications or measure calculation in measure reevaluation.

#### Literature Reviews

In addition, we routinely scan the literature for scholarly articles describing research related to this measure. We summarize new information obtained through these reviews every three years as a part of comprehensive reevaluation as mandated by the Measure Management System (MMS) Blueprint.

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

Summary of Questions or Comments from Hospitals submitted through the Q & A process:

For the CABG readmission measure, we have received the following inquiries from hospitals since the last endorsement maintenance cycle:

1. Requests for detailed measure specifications including the ICD-9 and ICD-10 codes used to define the measure cohort or in the risk-adjustment model;
2. Requests for the SAS code used to calculate measure results;
3. Requests about the data source used to calculate the measure;
4. Questions about how transfers are handled in the measure calculation;
5. Requests for hospital-specific measure information such as HSRs; and
6. Requests for clarification of how inclusion and exclusion criteria are applied
7. Queries about how cohorts and outcomes are defined;
8. Queries about how to calculate the measure and to interpret the statistical model including the interpretation of coefficients for risk variables;
9. Requests for hospital-specific measure information, such as data included in the HSRs;
10. Questions on how readmissions are capture for patients admitted for an AMI and have a CABG procedure during the index admission; and
11. Questions about technical specifications of the measure as it pertains to the payment programs.

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

Summary of Question and Comments from Other Stakeholders:

For the CABG readmission measure, we have received the following feedback from other stakeholders since the last endorsement maintenance cycle:

1. Requests for detailed measure specifications including the narrative specifications for the measure, CC-to-ICD-9 code crosswalks, and ICD-9 and ICD-10 codes used to define the measure cohort or in the risk-adjustment model;
  2. Requests for the data source and the SAS code used to calculate measure results;
  3. Requests for clarification of how inclusion and exclusion criteria are applied;
  4. Queries about how cohorts and outcomes are defined, including how planned readmissions are defined;
  5. Questions about how transfers are handled in the measure calculation; and
  6. Requests for clarification on measure national rates.
- Queries about the implementation of the measure in CMS initiatives and payment programs; and
10. Requests about hospital-specific measure information including mock Hospital-Specific Reports.

Summary of Relevant Publications from the Literature Review:

Since the last endorsement cycle, we have reviewed more than 300 articles related to readmissions following isolated CABG surgery. Relevant articles shared key themes related to: considerations for additional risk adjustment variables, including social risk factors and other clinical comorbidities; exploration of potential association between hospital surgical volume and CABG readmissions; reasons for readmission; and trends in patient characteristics and readmission rates over the last two decades.

#### **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.**

Each year, issues raised through the Q&A or in the literature related to this measure are considered by measure and clinical experts. Any issues that warrant additional analytic work due to potential changes in the measure specifications are addressed as a part of

annual measure reevaluation. If small changes are indicated after additional analytic work is complete, those changes are usually incorporated into the measure in the next measurement period. If the changes are substantial, CMS may propose the changes through rulemaking and adopt the changes only after CMS received public comment on the changes and finalizes those changes in the IPPS or other rule. There were no questions or issues raised by stakeholders requiring additional analysis or changes to the measure since the last endorsement maintenance cycle.

#### 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.

The median hospital 30-day, all-cause, RSRR for the CABG readmission measure for the 3-year period between July 1, 2016 and June 30, 2019 was 12.7%. The median RSRR decreased by 0.6 absolute percentage points from July 2016-June 2017 (median RSRR: 12.9%) to July 2018-June 2019 (median: RSRR: 12.3%).

#### 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.**

N/A

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

N/A

## 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)

0114 : Risk-Adjusted Postoperative Renal Failure

0115 : Risk-Adjusted Surgical Re-exploration

0119 : Risk-Adjusted Operative Mortality for CABG

0129 : Risk-Adjusted Postoperative Prolonged Intubation (Ventilation)

0130 : Risk-Adjusted Deep Sternal Wound Infection

0131 : Risk-Adjusted Stroke/Cerebrovascular Accident

0330 : Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization

0505 : Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.

1789 : Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)



2558 : Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery  
3494 : Hospital 90-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

**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?**

Yes

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

The CABG readmission measure, which was developed in close collaboration with STS, has a target population (i.e., isolated CABG patients) that is harmonized with the above measures to the extent possible given the differences between clinical and administrative data. The exclusions are nearly identical to the STS measures' cohort exclusions with the exception of epicardial MAZE procedures; STS excludes these procedures from the registry-based CABG readmission measure cohort because the version of registry data used for measure development did not allow them to differentiate them from open maze procedures. The age range for the proposed CABG readmission and existing NQF-endorsed STS measure cohorts differs; STS measures are specified for age 18 and over, and the CABG readmission measure is currently specified for age 65 and over. The proposed CABG readmission measure is harmonized with the above measures to the extent possible given the different data sources used for development and reporting.

**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.)**

This measure was developed concurrently with a clinical registry data-based readmission measure (Risk-adjusted readmission measure for coronary artery bypass graft (CABG)). The measure steward for the registry-based readmission measure for CABG is also CMS; STS developed the measure. Effort was taken to harmonize both the registry-based and administrative-based measures to the extent possible given the differences in data sources.

CMS developed these two "competing" measures at the same time to allow for maximum flexibility in implementation for quality improvement programs across different care settings. The STS cardiac surgery registry currently enrolls most, but not all, patients receiving CABG surgeries in the U.S. The proposed CABG readmission measure will capture all qualifying Medicare FFS patients undergoing CABG regardless of whether their hospital or surgeon participates in the STS registry.

This claims-based CABG readmission measure was developed with the goal of producing a measure with the highest scientific rigor and broadest applicability. The measure is harmonized with the above existing and proposed measures to the extent possible given the different data sources used for development and reporting.

**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.

Available at measure-specific web page URL identified in S.1 **Attachment:**

### Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** Centers for Medicare & Medicaid Services

**Co.2 Point of Contact:** Helen, Dollar-Maples, Helen.Dollar-Maples@cms.hhs.gov, 410-786-7214-

**Co.3 Measure Developer if different from Measure Steward:** Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE)

**Co.4 Point of Contact:** Doris, Peter, doris.peter@yale.edu

### 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.**

Technical Expert Panel Members:

Joseph V. Agostini, MD, Aetna

Tanya Alteras, MPP, National Partnership for Women and Families

Mary Barton, MD, MPP, National Committee for Quality Assurance (NCQA)

Carol Beehler, RN, NEA-BC, Pricewaterhouse Coopers

Todd Michael Dewey, MD, Southwest Cardiothoracic Surgeons

Lee Fleisher, MD (Served from March 30, 2012 to May 25, 2012), American Society of Anesthesiologists, University of Pennsylvania School of Medicine

Paul Kurlansky, MD, Florida Heart Research Institute, Inc

Frederic Masoudi, MD, MSPN, University of Colorado-Denver, Senior Medical Office of National CV Data Registries

Christine McCarty, MD, Cardiovascular Surgical Institute

Joseph Parker, PhD, State of California: Office of Statewide Health Planning and Development,

Kenneth Sands, MD, MPH, Beth Israel Deaconess Medical Center

Ed Savage, MD, Cleveland Clinical Florida

Stephen Schmaltz, PhD, The Joint Commission

Richard Shemin, MD, UCLA Medical Center

Alan Speir, MD, Inova Fairfax Hospital

Working Group Panel Members:

Arnar Geirsson, MD, Yale School of Medicine

David Shahian, MD, STS Workforce on National Databases, Harvard Medical School, Massachusetts General Hospital

**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2015

**Ad.3 Month and Year of most recent revision:** 09, 2019

**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?** 2020

**Ad.6 Copyright statement:** N/A

**Ad.7 Disclaimers:** N/A

**Ad.8 Additional Information/Comments:** N/A