



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 subcriterion 1b).

Brief Measure Information

NQF #: 2504

Corresponding Measures:

De.2. Measure Title: 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries

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

De.3. Brief Description of Measure: Number of rehospitalizations occurring within 30 days of discharge from an acute care hospital (prospective payment system (PPS) or critical access hospital (CAH)) per 1000 FFS Medicare beneficiaries at the state and community level by quarter and year.

1b.1. Developer Rationale: 1.Rehospitalizations are prevalent and costly

2.Current proportionate Rehospitalization measures do not reflect change capability

3. Hospitalization based measures (hospitalizations/discharges as the denominator) may not be useful in all settings, as it uses an unstable population for the denominator.

4.Hospital Compare does not currently offer an available measure for comparing communities over time

S.4. Numerator Statement: Number of rehospitalizations within 30 days of discharge from an acute care hospital (PPS or CAH).

S.7. Denominator Statement: Medicare FFS beneficiaries, prorated based on the number of days of FFS eligibility in the time period (quarter or year).

S.10. Denominator Exclusions: None

De.1. Measure Type: Outcome

S.23. Data Source: Claims (Only), Other

S.26. Level of Analysis: Population : Community, County or City, Population : Regional and State

IF Endorsement Maintenance – Original Endorsement Date: Dec 23, 2014 **Most Recent Endorsement Date:** Dec 09, 2016

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

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
[Rehospitalization_Evidence.docx](#)

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., the benefits or improvements in quality envisioned by use of this measure)

1. Rehospitalizations are prevalent and costly
2. Current proportionate Rehospitalization measures do not reflect change capability
3. Hospitalization based measures (hospitalizations/discharges as the denominator) may not be useful in all settings, as it uses an unstable population for the denominator.
4. Hospital Compare does not currently offer an available measure for comparing communities over time

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

We do not expect rehospitalization rates to reach zero. However, the variation in rehospitalization rates across states and communities suggests that rehospitalizations are related to local healthcare.

Please see the appendix for this data in a format that is easily read

Number of Beneficiaries in Annual Measures (prorated based on days of eligibility)

BENES

Year	N	Total
2009	327	15,560,653
2010	327	15,897,638
2011	327	16,047,291
2012	327	16,331,603

Number of Beneficiaries in Quarterly Measures (prorated based on days of eligibility)

BENES

Quarter	N	Total
2009 Q1	327	15,517,079
2009 Q2	327	15,504,212
2009 Q3	327	15,575,137
2009 Q4	327	15,644,639
2010 Q1	327	15,840,706
2010 Q2	327	15,843,446
2010 Q3	327	15,912,880
2010 Q4	327	15,991,711
2011 Q1	327	15,896,419
2011 Q2	327	15,966,300
2011 Q3	327	16,086,526
2011 Q4	327	16,235,764
2012 Q1	327	16,147,317
2012 Q2	327	16,274,320
2012 Q3	327	16,398,715
2012 Q4	327	16,503,437
2013 Q1	327	16,382,895

30-Day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries

Community 2009 to 2012 Rehospitalizations per 1000

Year	Communities	Mean	Std Dev	Min	Max	25th Percentile	75th Percentile	IQR
2009	327	57.44	18.81	22.78	136.08	45.61	67.12	21.51
2010	327	56.72	18.70	18.65	127.06	43.56	66.80	23.24
2011	327	55.10	18.00	24.38	128.88	42.21	64.68	22.47
2012	327	51.19	16.74	21.50	123.41	40.35	60.28	19.93

Deciles

Year	10th Percentile	20th Percentile	30th Percentile	40th Percentile	50th Percentile	60th Percentile	70th Percentile
	80th Percentile	90th Percentile					
2009	34.21	42.12	47.26	51.71	56.14	59.04	64.73
2010	32.54	41.56	46.97	51.11	56.54	59.64	63.84
2011	32.25	39.07	46.43	49.61	54.26	57.92	62.03
2012	29.54	37.43	43.39	45.97	49.19	53.89	57.46

Relative Improvement (2010 to 2012)

Analysis Variable : Rlreadm

N	Minimum	Maximum	Mean	25th Pctl	50th Pctl	75th Pctl
53	-2.42	16.45	8.83	6.47	9.17	11.91

Community Quarterly Rehospitalizations per 1000

Quarter	Communities	Mean	Std Dev	Min	Max	25th Percentile	75th Percentile	IQR
2009 Q1	327	15.02	4.92	6.08	36.85	11.65	17.67	6.02
2009 Q2	327	14.56	4.86	5.23	33.81	11.63	16.98	5.35
2009 Q3	327	13.88	4.81	3.94	35.05	10.62	16.42	5.80
2009 Q4	327	13.98	4.69	4.85	35.35	10.78	16.30	5.53
2010 Q1	327	14.56	4.88	5.26	33.89	11.43	17.32	5.90
2010 Q2	327	14.24	4.73	5.39	32.46	10.99	16.87	5.88
2010 Q3	327	14.02	4.88	2.71	34.18	10.78	16.52	5.74
2010 Q4	327	13.91	4.66	4.22	30.30	10.58	16.39	5.81
2011 Q1	327	14.66	4.86	5.11	32.80	11.44	17.43	5.99
2011 Q2	327	13.90	4.53	5.18	32.57	10.74	16.41	5.67
2011 Q3	327	13.36	4.56	4.76	32.82	10.19	16.01	5.82

2011 Q4 327	13.20	4.49	4.83	30.70	10.13	15.67	5.54
2012 Q1 327	13.73	4.63	4.71	33.30	10.97	16.43	5.46
2012 Q2 327	12.78	4.24	4.78	32.15	10.07	14.89	4.82
2012 Q3 327	12.30	4.21	4.42	30.47	9.35	14.63	5.28
2012 Q4 327	12.39	4.02	4.14	30.70	9.56	14.82	5.26
2013 Q1 327	12.56	3.98	4.00	28.17	9.58	14.87	5.29

Deciles

Quarter	10th Percentile 80th Percentile	20th Percentile 90th Percentile	30th Percentile	40th Percentile	50th Percentile	60th Percentile	70th Percentile		
2009 Q1	8.93	10.94	12.33	13.70	14.70	15.70	16.96	18.53	20.65
2009 Q2	8.68	10.39	12.13	13.12	14.16	15.15	16.22	18.00	20.27
2009 Q3	8.13	10.05	11.38	12.37	13.46	14.47	15.74	17.48	18.95
2009 Q4	8.21	10.23	11.20	12.52	13.83	14.69	15.76	17.03	19.33
2010 Q1	8.40	10.54	12.04	13.23	14.32	15.26	16.55	18.02	20.05
2010 Q2	8.08	10.37	11.99	13.09	14.12	14.92	16.16	17.19	19.82
2010 Q3	7.89	10.08	11.37	12.62	13.62	14.50	15.87	17.34	19.74
2010 Q4	8.08	9.92	11.46	12.76	13.71	14.65	15.57	16.89	19.91
2011 Q1	8.34	10.54	11.98	13.27	14.21	15.46	16.59	18.04	20.96
2011 Q2	8.12	9.91	11.71	12.53	13.74	14.73	15.74	17.33	19.33
2011 Q3	7.43	9.56	11.20	12.25	13.06	13.88	15.22	16.67	18.67
2011 Q4	7.54	9.06	10.85	11.98	12.89	13.97	14.76	16.42	18.52
2012 Q1	7.73	9.90	11.48	12.41	13.33	14.35	15.46	17.18	18.83
2012 Q2	7.66	9.35	10.66	11.41	12.28	13.43	14.32	15.76	17.77
2012 Q3	7.07	8.51	10.06	11.14	11.88	12.73	14.03	15.39	17.36
2012 Q4	7.10	8.98	10.39	11.31	12.30	13.00	14.06	15.57	16.90
2013 Q1	7.39	9.13	10.51	11.64	12.56	13.37	14.28	15.47	17.46

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.

Data Source: Medicare Part A Claims and Denominator File

Dates: 2012

Number of Entities: 53 states/territories and 327 communities

Number of Patients: 39,478,873 total FFS beneficiaries (state/territories)
15,814,412 total FFS beneficiaries (communities)

Population Group Characteristics: Sex, race/ethnicity, age group, dual eligibility, urban/rural.

****Note that beneficiary numbers may slightly differ from 1b.2 due to merging the Denominator file with the Part A Claims file. This is necessary for the disparity analysis. The disparities analysis was completed for only 2012.**

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

N/A

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, High resource use, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

An analysis of Medicare fee-for-service claims data by Jencks et al. found that during the period October 1, 2003-September 30, 2004, almost one of every five beneficiaries who were hospitalized during that time period were also readmitted within 30 days, resulting in more than 2.3 million rehospitalizations. Jencks et al. estimated that rehospitalizations within 30 days of discharge cost Medicare more than \$17 billion during that year. A 2011 report by the Dartmouth Atlas found that in 2009 there was substantial variation in the rehospitalization rates of Medicare FFS beneficiaries between hospital referral regions across the country and that furthermore there had been minimal change in rehospitalization rates since the time period examined in the Jencks et al analysis. A CMS analysis of Medicare FFS claims data from 2007-2012 found that the reduction in 30-day rehospitalization rates that occurred in 2012 resulted in about 70,000 fewer hospitalizations than would have occurred if this reduction had not occurred.

1c.4. Citations for data demonstrating high priority provided in 1a.3

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine* 2009;360(14):1418-28.
2. Goodman DC, Fisher ES and Chang C. After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries. Lebanon, N.H.: The Dartmouth Atlas Project, 2011.
3. Gerhardt, G, Yemane, A, Hickman, P, Oelschlaeger, A, Rollins, E, Brennan, N. Medicare Readmission Rates Showed Meaningful Decline in 2012. *Medicare & Medicaid Research Review* 2013;3(2):E1-E12.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

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 subcriteria 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):

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

Care Coordination, Care Coordination : Readmissions, Care Coordination : Transitions of Care, Safety : Overuse

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.)

<http://www.cfmc.org/integratingcare/> measure specifications:

http://www.cfmc.org/files/ACUuploads/MeasuresSpecs_final_020514.pdf

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [Seasonal_Adjustment_Rehospitalizations-635272075470039323.csv](#)

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

N/A

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)

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

Number of rehospitalizations within 30 days of discharge from an acute care hospital (PPS or CAH).

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Data are aggregated both quarterly and annually, based on the discharge date of the index hospitalization.

S.6. 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, 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.

Inclusions:

Any hospitalization to a PPS or CAH occurring within 30 days of the most recent prior hospitalization discharge from a PPS or CAH.

Exclusions:

Same-day hospital transfers; transfers are defined as any hospitalization, whether to the same hospital or not, where discharge date is the same as hospitalization date and are treated as one continuous long stay; the 30-day period starts at the end of the combined stay.

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

Medicare FFS beneficiaries, prorated based on the number of days of FFS eligibility in the time period (quarter or year).

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk : Dual eligible beneficiaries

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, 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)

To calculate the denominator, count the days each beneficiary was enrolled in FFS Medicare in the time period (quarter or year). For each beneficiary, number of days of FFS Medicare eligibility is determined by evaluating HMO enrollment (BENE_HMO_IND_XX) and time to death (BENE_DEATH_DT). Days enrolled in HMO and days after death are not counted. Eligible days for each beneficiary are summed over all beneficiaries. The total number of eligible days is then divided by the number of days in the time period to obtain the prorated number of beneficiaries. The denominator is the prorated number of beneficiaries divided by 1,000.

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

None

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, 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)

N/A

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)

N/A. This measure could be easily stratified.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

Other

If other: Seasonal adjustment for quarterly measurement

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

For the annual measure there is no risk adjustment.

For the quarterly measure we add a seasonal adjustment. This allows for comparison of any and all quarters (e.g., Q1 2011; Q2 2011; Q3 2012) and trending for a state/territory or community. Without the adjustment only like quarters (e.g., Q1 2010 and Q1 2011) can be compared. The seasonal adjustment was computed by calculating the quarterly rate for each quarter, then the average rate for each quarter of the year (e.g., the Q1 average was calculated as the average of all Q1 rates: Q1 2009, Q1 2010, Q1 2011, Q1 2012, and Q1 2013). The four quarter averages were then averaged to obtain the overall mean. Next, the overall mean is subtracted from the average rate for each quarter of the year to obtain the seasonal adjustments. Finally, the seasonally adjusted rates are computed as the observed rates minus the seasonal adjustments. The seasonal adjustments are computed separately for each state and community.

We did not adjust for any patient characteristics.

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

Available in attached Excel or csv file at S.2b

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

Seasonal adjustments are calculated for each quarter of the year (1,2,3, and 4) for each state/territory and community. They are computed separately for each state/territory and community since “seasonality” isn’t the same everywhere.

Please see the attachment at S2.b and additional seasonal adjustment details/graphics in the Appendix.

S.16. Type of score:

Rate/proportion

If other:

S.17. 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.18. Calculation Algorithm/Measure Logic (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; aggregating data; risk adjustment; etc.)

1. Calculate denominator

<p>a. Beneficiary days = Number of days enrolled in Medicare FFS during the time period of interest.</p> <p>i. Exclude days with HMO enrollment</p> <p>ii. Exclude days after Death</p> <p>b. Prorated number of beneficiaries = Sum of beneficiary days divided by number of days in time period of interest.</p> <p>c. Denominator = Prorated number of beneficiaries divided by 1,000.</p> <p>2. Calculate numerator</p> <p>a. Identify discharges within time period of interest</p> <p>i. Treat same day transfers as a single continuous hospitalization</p> <p>ii. Combine interim claims into a single continuous hospitalization</p> <p>S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment <i>(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i> No diagram provided</p>
<p>S.20. Sampling <i>(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</i> IF a PRO-PM, identify whether (and how) proxy responses are allowed. N/A</p> <p>S.21. Survey/Patient-reported data <i>(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)</i> IF a PRO-PM, specify calculation of response rates to be reported with performance measure results. N/A</p> <p>S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.) Required for Composites and PRO-PMs. N/A</p>
<p>S.23. Data Source <i>(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</i> If other, please describe in S.24. Claims (Only), Other</p> <p>S.24. Data Source or Collection Instrument <i>(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)</i> IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration. Medicare Part A claims and the denominator file (containing beneficiary enrollment data and death date).</p> <p>S.25. Data Source or Collection Instrument <i>(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i> No data collection instrument provided</p> <p>S.26. Level of Analysis <i>(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)</i> Population : Community, County or City, Population : Regional and State</p> <p>S.27. Care Setting <i>(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)</i> Other If other: Not setting specific</p>
<p>S.28. COMPOSITE Performance Measure - Additional Specifications <i>(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</i> N/A</p>
<p>2a. Reliability – See attached Measure Testing Submission Form</p> <p>2b. Validity – See attached Measure Testing Submission Form</p> <p>Rehospitalization_Testing-635272855890648638.docx</p>

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*)

[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.

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.

[No feasibility assessment](#) 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. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

[N/A](#)

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.

Planned	Current Use (for current use provide URL)
	Quality Improvement (Internal to the specific organization) Centers for Medicare and Medicaid Services Centers for Medicare and Medicaid Services Centers for Medicare and Medicaid Services http://www.cfmc.org/integratingcare/ct-efforts-map.htm

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- [Name of program and sponsor](#)
[Centers for Medicare and Medicaid Services](#)
- [Purpose](#)
[Quality Improvement efforts to improve care transitions and reduce hospitalizations](#)
- [Geographic area and number and percentage of accountable entities and patients included](#)
[Over 300 geographically defined communities by a contiguous set of ZIP codes and growing](#)
[The Measures are also calculated at the State level.](#)

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

[Community level measures can be posted on the CMS website. The intent of the community level measures is to show improvement over time and not to compare one community to another. Annual state level measures are currently posted at <http://www.cfmc.org/integratingcare/ct-efforts-map.htm>.](#)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

[N/A](#)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- **Progress (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**

[Progress: As implied in the State Relative Improvement Rate table \(1b.2\), there has been a general improvement, for states, with regard to rehospitalization rates over time. This improvement is also seen in communities as shown in 1b.2. The community tables show a decrease in the mean rehospitalization rate over time for both the annual and quarterly measures despite the increase in eligible Medicare FFS beneficiaries.](#)

[Geographic area and number and percentage of accountable entities and patients included:](#)

[Over 400 geographically defined communities by a contiguous set of ZIP codes and growing.](#)

The Measures are also calculated at the State and National level.

4b.2. 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.

N/A

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

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)

0329 : Risk-Adjusted 30-Day All-Cause Readmission Rate

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.

0506 : Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization

1551 : Hospital-level 30-day risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

1768 : Plan All-Cause Readmissions (PCR)

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

1891 : Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization

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

The three measures below are not found in the 5.1a drop down but should be included as NQF-endorsed measures.

0698: 30-Day Post-Hospital AMI Discharge Care Transition Composite Measure

0699: 30-Day Post-Hospital HF Discharge Care Transition Composite Measure

0707: 30-day Post Hospital Pneumonia Discharge Transition Composite Measure

5a. Harmonization

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 completely harmonized?

No

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

The proportionate measure and population-based measure are not comparable. They should not be interpreted as such. Proportionate measures can still be use to compare hospitals, but the population-based measure should be used to describe the health indicators for a community of providers working together to reduce Rehospitalizations.

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 Attachment: Appendix-635272855641204638.docx](#)

Contact Information

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

Co.2 Point of Contact: [Corette, Byrd, MMSSupport@Battelle.org](#), 202-786-1158-

Co.3 Measure Developer if different from Measure Steward: [CFMC](#)

Co.4 Point of Contact: [Kimberly, Irby, kirby@cfmc.org](#), 303-784-5710-

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.

Name and Credentials

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Please see Appendix for details.

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: 09, 2011

Ad.4 What is your frequency for review/update of this measure? Every two years

Ad.5 When is the next scheduled review/update for this measure? 08, 2014

Ad.6 Copyright statement: N/A

Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: None.