



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 #: 2455

Corresponding Measures:

De.2. Measure Title: Heart Failure: Post-Discharge Appointment for Heart Failure Patients

Co.1.1. Measure Steward: American Heart Association/American Stroke Association

De.3. Brief Description of Measure: Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified)

1b.1. Developer Rationale: As many as one in four heart failure patients are readmitted to the hospital within 30 days of discharge(1); this measure tracks the implementation of one possible factor in reducing HF-related readmissions. A meta-analysis of interventions aimed at modifying hospital discharge for older patients with heart failure concluded that "comprehensive discharge planning plus postdischarge support for older patients with [congestive heart failure] significantly reduced readmission rates and may improve health outcomes such as survival and quality of life (QOL) without increasing costs(2)."

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the medicare fee-for-service program. N Engl J Med. 2009; 360:1418-1428.

2. Phillips CO, Wright SM, Kern DE, Singa RM, Shepperd S, Rubin HR. comprehensive discharge planning and chronic disease management with postdischarge support for older patients with congestive heart failure: a meta-analysis. JAMA. 2004; 291:1358-1367.

S.4. Numerator Statement: Patients for whom a follow up appointment was scheduled and documented prior to discharge including either:

- an office visit for management for heart failure with a physician OR advanced practice nurse OR physician assistant OR
- a home health visit for management of heart failure

S.6. Denominator Statement: All patients, regardless of age, discharged from an inpatient facility (ie, hospital inpatient or observation) to ambulatory care (home/self care) or home health care with a principle discharge diagnosis of heart failure

S.8. Denominator Exclusions: Denominator exclusions include:

Patient was discharged to a health care facility for hospice care, to home for hospice care, or to a rehabilitation facility.
Patient left against medical advice.
Patient expired.

Denominator exceptions include:

Documentation of medical reason(s) for not documenting that a follow up appointment was scheduled
Documentation of patient reason(s) for not documenting that a follow up appointment was scheduled (eg, international patients, patients from state and/or local corrections facilities for whom scheduling the appointment is prohibited)

De.1. Measure Type: Process

S.17. Data Source: Registry Data

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Sep 08, 2014 **Most Recent Endorsement Date:** Sep 08, 2014

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? n/a

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

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

[1a_NQF_Measure_2455_Evidence_Attachment-636426315831302192.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.

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.

As many as one in four heart failure patients are readmitted to the hospital within 30 days of discharge(1); this measure tracks the implementation of one possible factor in reducing HF-related readmissions. A meta-analysis of interventions aimed at modifying hospital discharge for older patients with heart failure concluded that “comprehensive discharge planning plus postdischarge support for older patients with [congestive heart failure] significantly reduced readmission rates and may improve health outcomes such as survival and quality of life (QOL) without increasing costs(2).”

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the medicare fee-for-service program. N Engl J Med. 2009; 360:1418-1428.

2. Phillips CO, Wright SM, Kern DE, Singa RM, Shepperd S, Rubin HR. comprehensive discharge planning and chronic disease management with postdischarge support for older patients with congestive heart failure: a meta-analysis. JAMA. 2004; 291:1358-1367.

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.*

Overall mean performance on this measure is 44.63%, with a standard deviation of 32.24%. The data source is the Get with the Guidelines Registry, from calendar year 2012. The minimum score equals 0.00%, while the maximum score equals 100.00%. The interquartile score is equal to 60.60.

432 hospitals were measured, and the patient study sample equals 88,168. The mean age of patients included is 70.32 years and 53.79% of the sample is male. 59.01% of the sample is white, 20.65% is black, 6.66% Hispanic, 1.74% Asian, and 11.94% identified as “other.” The sample reached across all US regions, with 31.16% in the Northeast, 19.75% in the Midwest, 33.35% in the South, and 15.73% in the West; data was collected from hospitals in 28 States.

Decile Scores 2012 Mean

Decile 1 0.01%
Decile 2 3.78%
Decile 3 13.80%
Decile 4 24.90%
Decile 5 38.63%
Decile 6 51.18%
Decile 7 61.45%
Decile 8 73.17%
Decile 9 84.52%
Decile 10 94.92%

Data from the same Get with the Guidelines Registry, from 2011, shows that overall mean performance on this measure was 16.78%, with a standard deviation of 20.18%. The minimum score equals 0.00%, while the maximum score equals 95.28%. The interquartile score is equal to 25.73.

445 hospitals were measured, and the patient study sample equals 93,417. The mean age of patients included is 70.37 years and 53.27% of the sample is male. 55.03% of the sample is white, 19.99% is black, 6.38% Hispanic, 1.82% Asian, and 16.77% identified as "other." The sample reached across all US regions, with 30.70% in the Northeast, 19.42% in the Midwest, 34.18% in the South, and 15.69% in the West; data was collected from hospitals in 28 States.

Decile scores, 2011	Mean
Decile 1 0%	
Decile 2 0.00%	
Decile 3 0.85%	
Decile 4 2.92%	
Decile 5 6.19%	
Decile 6 11.10%	
Decile 7 18.24%	
Decile 8 26.98%	
Decile 9 39.67%	
Decile 10 62.41%	

Please see attachment A1 for additional performance information.

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.

Though heart failure hospitalizations have decreased by almost 30% in the past decade, there has not been a similar decrease in heart failure-related readmissions; rather, readmissions rates for heart failure patients have not fallen in two decades(1). Between 29 to 47 percent of elderly heart failure patients are readmitted for their condition within three to six months of an initial hospitalization(2). Of those patients rehospitalized for heart failure within 30 days after discharge, a recent analysis of Medicare claims data found that there was no associated bill for an outpatient visit for 52.0%(3).

1. Evidence-based Practice Center Systematic Review Protocol: Transitional Care Interventions To Prevent Heart Failure Readmissions. Agency for Healthcare Research and Quality. 2013. Available at: <http://effectivehealthcare.ahrq.gov/ehc/products/510/1409/heart-failure-readmission-protocol-130610.pdf>

2. Jessup M, McCauley KM. Heart Failure: Providing Optimal Care (First Edition), Published Online: 16 Nov 2007.

3. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009;360:1418-1428

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.

Get With The Guidelines®-Heart Failure is an in-hospital program for improving care by promoting consistent adherence to the latest scientific treatment guidelines. Data from the Get with the Guidelines Registry, calendar year 2012, shows that Hispanic patients have a much lower rate of post-discharge appointments than other races (42.78% vs 53.76%). The data also demonstrates a disparity in post-discharge appointments between Medicare and Medicaid beneficiaries, where only 49.53% of Medicare beneficiaries schedule a post-discharge appointment, as compared to 59.91% of Medicaid beneficiaries.

Get with the Guidelines registry data for 2011 shows "other" patients have a much lower rate of post-discharge appointments than other races (9.20% vs. 18.85%). The data also demonstrates a disparity in post-discharge appointments between Medicare and Medicaid beneficiaries, where only 22.84% of Medicare beneficiaries schedule a post-discharge appointment, as compared to 27.49% of Medicaid beneficiaries.

Please see attachment A1 for additional performance information.

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

Heart failure disproportionately affects minorities, where these populations experience a higher prevalence of heart failure, as well as higher related mortality rates. Per the ACCF/AHA guideline, the incidence rate of heart failure "per 1,000 person-years was lowest among white women and highest among black men, with blacks having a greater 5-year mortality rate than whites. HF in non-Hispanic black males and females has a prevalence of 4.5% and 3.8%, respectively, versus 2.7% and 1.8% in non-Hispanic white males and females, respectively (1)." Those diagnosed with heart failure then experience a very high rate of hospital readmission. As cited by the Agency for Healthcare Research and Quality (AHRQ), analysis of 2007 to 2009 Medicare claims data found that "that 24.8 percent of beneficiaries admitted with HF were readmitted within 30 days; 35.2 percent of those readmissions were for HF, and the remainder of readmissions were for diverse indications (2)." Finally, findings from Get With the Guidelines data, summarized in a 2011 article demonstrate disparities in post-discharge follow-up: "After multivariable adjustment for baseline characteristics of the study population, the odds of early follow-up were 13% lower in women compared to men and 16% lower in black patients compared to patients of other races(3)."

1. Drazner Jr, M. H., G. C. Fonarow, S. A. Geraci, T. Horwich, J. L. Januzzi, M. R. Johnson, E. K. Kasper et al. "2013 ACCF/AHA Guideline for the Management of Heart Failure." (2013).

2. Evidence-based Practice Center Systematic Review Protocol: Transitional Care Interventions To Prevent Heart Failure Readmissions. Agency for Healthcare Research and Quality. 2013. Available at:
<http://effectivehealthcare.ahrq.gov/ehc/products/510/1409/heart-failure-readmission-protocol-130610.pdf>

3. Kociol RD, Greiner MA, Fonarow GC, Hammill BG, Heidenreich PA, Yancy CW, Peterson ED, Curtis LH, Hernandez AF. Associations of Patient Demographic Characteristics and Regional Physician Density With Early Physician Follow-Up Among Medicare Beneficiaries Hospitalized With Heart Failure. Am J Cardiol 2011;108:985–991.

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 : Congestive Heart Failure

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

Care Coordination

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

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.)

The specifications for this measure are attached with this form. Additional measure information can be found at <http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>.

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: [S2b_HF_PostDischarge_ValueSets_Dec2013-635854420586955943-636426315830052192.xls](#)

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

Attachment:

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

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

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

not applicable

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).

Patients for whom a follow up appointment was scheduled and documented prior to discharge including either:

- an office visit for management for heart failure with a physician OR advanced practice nurse OR physician assistant OR
- a home health visit for management of heart failure

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).

Numerator Note:

Due to the nature of scheduling home health visits, the location and date of the follow-up appointment is sufficient for meeting the

measure.

For EHR options:

eSpecification developed and is included in this submission.

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

All patients, regardless of age, discharged from an inpatient facility (ie, hospital inpatient or observation) to ambulatory care (home/self care) of home health care with a principle discharge diagnosis of heart failure

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).

For EHR options:

eSpecification developed and is included in this submission.

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

Denominator exclusions include:

Patient was discharged to a health care facility for hospice care, to home for hospice care, or to a rehabilitation facility.

Patient left against medical advice.

Patient expired.

Denominator exceptions include:

Documentation of medical reason(s) for not documenting that a follow up appointment was scheduled

Documentation of patient reason(s) for not documenting that a follow up appointment was scheduled (eg, international patients, patients from state and/or local corrections facilities for whom scheduling the appointment is prohibited)

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 ACCF/AHA and PCPI distinguishes between measure exceptions and measure exclusions. Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For this measure, exclusions include patients discharged to a health care facility for hospice care, to home for hospice care, or to a rehabilitation facility. Exclusions also include patients that left against medical advice, and patients who expired. Exclusions, including applicable value sets, are included in the measure specifications.

Measure Exceptions

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s), patient reason(s) (eg, international patients, patients from state and/or local corrections facilities for whom scheduling the appointment is prohibited), or system reason(s) for the patient not receiving a post-discharge appointment. Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the ACCF/AHA and PCPI recommend that physicians

document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The ACCF/AHA and PCPI also advocate the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For EHR options:

eSpecification: developed and is included in this submission.

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.)*

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, payer and primary written and spoken language, and have included these variables as recommended data elements to be collected.

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

No risk adjustment or risk stratification

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 = Higher 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.)*

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).
- 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
- 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for exception when exceptions have been specified [for this measure: medical reason(s) (eg, patients who expired or patients who left against medical advice) or patient reason(s) (eg, international patients). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

Calculation algorithm is included in attachment (see A.1).

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
[Not applicable. The measure is not based on a sample.](#)

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.

[Not applicable. The measure is not based on a survey.](#)

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

If other, please describe in S.18.

[Registry 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.

[The data collection instrument is the Get With The Guidelines®-Heart Failure Patient Management Tool.](#)

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)

[Available in attached appendix at A.1](#)

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

[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.)

2. Validity – See attached Measure Testing Submission Form

[2455_HF_Post_Discharge_Appointment_MeasTesting_Form_FINAL-636426315836614692.pdf](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

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

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

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

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 clinical data (e.g., clinical registry, nursing home MDS, home health OASIS)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

We have not identified any areas of concern or made any modifications as a result of testing and operational use of the measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.

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).

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the ACC, the AHA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. CPT® contained in the measures specifications is copyright 2008 American Medical Association. LOINC® copyright 2004 Regenstrief Institute, Inc. SNOMED CLINICAL TERMS (SNOMED CT®) copyright 2004 College of American Pathologists (CAP). All Rights Reserved. Use of SNOMED CT® is only authorized within the United States.

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)

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

Get with the Guidelines-HF (GWTG-HF):

GWTG-HF, sponsored by the American Heart Association, is a national in-hospital program for improving care by promoting consistent adherence to the latest scientific treatment guidelines. Numerous published studies demonstrate the program's success in achieving significant patient outcome improvements. Among the proven results are reductions in 30-day readmissions. GWTG-HF also provides professional education opportunities, such as workshops and webinars, clinical tools and resources, patient education resources, QI field staff support, CMS data submission, performance feedback reporting for continuous quality improvement. As of December, 2013, more than 500 hospitals across the U.S are submitting data to GWTG-HF and it has over 900,000 patient records.

Get with the Guidelines-HF Recognition Program:

Hospitals that participate actively and consistently in Get With The Guidelines®-Heart Failure are eligible for public recognition. It's an opportunity to hone a competitive edge in the marketplace by providing tangible evidence of commitment to quality care. Silver, Gold, Silver Plus and Gold Plus award-winning Get With The Guidelines-HF hospitals are honored at national recognition events during Scientific Sessions and listed by name in advertisements that appear annually in Circulation and in the "Best Hospitals" issue of U.S. News & World Report. Hospitals are required to have GWTG-HF Recognition Program Bronze Level performance or higher to be eligible to pursue certification as an Advanced HF Center by The Joint Commission (URL: http://www.jointcommission.org/certification/heart_failure.aspx)

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?)

We are continuously seeking opportunities to advocate for expanded use of this measure in government or other programs, including those intended for accountability or public reporting. The ACC, AHA and PCPI do not have any policies that would restrict access to the performance measure specifications or results or that would impede implementation of the measure for any application. We would welcome its implementation in emerging applications such as accountable care organizations (ACO), Medicare Advantage insurance plans or health plans selling on the new insurance marketplace.

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.)

The ACCF/AHA and PCPI strongly encourages the use of its measures in quality improvement and accountability initiatives and

promotes their use in public reporting programs. The ACCF/AHA and PCPI plans to submit its measures for use in the CMS Physician Quality Reporting System (PQRS). NQF endorsement facilitates the submission and use of ACCF/AHA/PCPI measures in PQRS.

The PCPI works with relevant specialty societies to identify additional opportunities for implementation of measures in programs that can provide meaningful quality information and performance results to ensure continued improvements in the quality of patient care.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

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

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

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

Describe how feedback was obtained.

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

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

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

Improvement

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

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

While the ACCF/AHA and PCPI creates measures with an ultimate goal of improving the quality of care, measurement is a mechanism to drive improvement but does not equate with improvement. Measurement can help identify opportunities for improvement with actual improvement requiring making changes to health care processes and structure. In order to promote improvement, quality measurement systems need to provide feedback to front-line clinical staff in as close to real time as possible and at the point of care whenever possible. (1)

1. Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013 Jun 5;309(21):2215-6.

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.

We are not aware of any unintended consequences at this time, but we continuously monitor for them.

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

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

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

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

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

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

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_A1_HF_PostDischarge_SpecsAppendix_Dec2013-636426315838802192.pdf](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Heart Association/American Stroke Association

Co.2 Point of Contact: Melanie, Shahriary, melanie.shahriary@heart.org, 301-651-7548-

Co.3 Measure Developer if different from Measure Steward: American College of Cardiology

Co.4 Point of Contact: Jensen, Chiu, jensen.chiu@acc.org, 202-375-6285-

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.

Robert O. Bonow, MD, MACC, FAHA, FACP (Co-Chair) (cardiology)

Theodore G. Ganiats, MD (Co-Chair) (family medicine; measure methodology)

Craig T. Beam, CRE (patient representative)

Ileana L. Piña, MD, FACC (cardiology, heart failure)

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John B Wong, MD (internal medicine)

ACCF/AHA and PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the ACCF/AHA and PCPI strive to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2011

Ad.3 Month and Year of most recent revision: 05, 2012

Ad.4 What is your frequency for review/update of this measure? Coding/Specifications updates occur annually. See additional information section for more details.

Ad.5 When is the next scheduled review/update for this measure? 12, 2014

Ad.6 Copyright statement: This Physician Performance Measurement Set (PPMS) and related data specifications were developed by the Physician Consortium for Performance Improvement® (the Consortium) including the American College of Cardiology (ACC), the American Heart Association (AHA) and the American Medical Association (AMA) to facilitate quality improvement activities by physicians. The performance measures contained in this PPMS are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. While copyrighted, they can be reproduced and distributed, without

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Ad.8 Additional Information/Comments: The ACCF/AHA and PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other implementation issues are noted that materially affect the integrity of the measure.