	Measure 0330: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization (Centers for Medicare & Medicaid Services)
Description	The measure estimates a hospital-level risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of heart failure (HF). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The target population is patients age 65 and over. The Centers for Medicare & Medicaid Services (CMS) annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are patients hospitalized in Veterans Health Administration (VA) facilities.
Numerator	The outcome for this measure is 30-day readmissions. We define readmissions as any inpatient acute care admission, with the exception of certain planned readmissions, within 30 days from the date of discharge from an index admission with a principal discharge diagnosis of HF in patients 65and older. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only 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. Additional details are provided in S.5 Numerator Details.
Numerator Details	The measure counts readmissions to any acute care hospital for any cause within 30 days of the date of discharge of the index HF admission, excluding planned readmissions as defined below. Planned Readmission Algorithm (Version 4.0) The planned readmission algorithm is a set of criteria for classifying readmissions as planned using Medicare claims and VA administrative data. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. The Planned Readmission Algorithm has three fundamental principles: 1. A few specific, limited types of care are always considered planned (obstetric delivery, transplant surgery, maintenance chemotherapy/radiotherapy/ 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. For the HF readmission measure, CMS used the Planned Readmission Algorithm without modifications. The planned readmission algorithm and associated code tables are attached in data field S.2b (Data Dictionary or Code Table).
Denominator	The cohort includes admissions for patients aged 65years and older discharged from the hospital with a principal discharge diagnosis of HF, and with a complete claims history for the 12 months prior to admission. The measure is publicly reported by CMS for those patients 65 years and older who are Medicare FFS or VA beneficiaries admitted to non-federal or VA hospitals, respectively. Additional details are provided in S.7 Denominator Details
Denominator Details	To be included in the measure cohort used in public reporting, patients must meet the following additional inclusion criteria: 1. Principal discharge diagnosis of HF; 2. Enrolled in Medicare fee-for-service (FFS) Part A and Part B for the 12 months prior to the date of admission, and enrolled in Part A during the index admission, or those who are VA beneficiaries; 3. Aged 65 or over; 4. Discharged alive from a non-federal short-term acute care hospital or VA hospital; and, 5. Not transferred to another acute care facility.
Exclusions	The 30-day HF readmission measure excludes index admissions for patients: 1. Without at least 30 days of post-discharge enrollment in Medicare FFS (in the case of patients who are not VA beneficiaries); 2. Discharged against medical advice (AMA); 3. Admitted within 30 days of a prior index admission for HF; and 4. With a procedure code for LVAD implantation or heart transplantation either during the index admission or in the 12 months prior to the index admission.
Exclusion details	The HF readmission measure excludes index admissions for patients: 1. Without at least 30 days of post-discharge enrollment in Medicare FFS (in the case of patients who are not VA beneficiaries), which is identified with enrollment data from the Medicare Enrollment Database. 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. Discharges 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. 3. HF admissions within 30 days of discharge from a qualifying HF index admission are identified by comparing the discharge date from the index admission with subsequent admission dates.

	Rationale: Additional HF admissions within 30 days are excluded as index admissions because they are part of the outcome. A single admission does not count as both an index admission and a readmission for another index admission. 4. With a procedure code for LVAD implantation or heart transplantation either during the index admission or in the 12 months prior to the index admission, which are identified by the corresponding codes included in claims data (codes can be found in attached Data Dictionary). Rationale: Patients with these procedures are a clinically distinct group with a different risk of the readmission outcome.
Risk Adjustment	Statistical risk model
Stratification	N/A
Type	Outcome
Type of Score	Rate/proportion
Data Source	Claims, Enrollment Data, Other
Level	Facility
Setting	Inpatient/Hospital

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