	Measure 2879e: Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and Electronic Health Record Data (Centers for Medicare & Medicaid Services (CMS))
Description	This measure estimates a hospital-level, risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission within 30 days of hospital discharge for any eligible condition. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. The measure also indicates the hospital-level standardized readmission ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of readmissions are planned and do not count in the readmission outcome. The target population is Medicare Fee-for-Service (FFS) beneficiaries who are 65 years or older, and hospitalized in non-federal hospitals. This Hybrid HWR measure is a re-engineered version of the HWR measure 1789, the Hospital-Wide All-Cause Unplanned Readmission Measure, which was developed for patients 65 years and older using Medicare claims and is currently publicly reported in the Hospital Inpatient Quality Reporting Program. This reengineered measure uses clinical data elements from patients' electronic health records in addition to claims data for risk adjustment.
Numerator	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. 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.
Numerator Details	Outcome definition The measure counts readmissions to any acute care hospital for any cause within 30 days of the date of discharge from an eligible index admission, excluding planned readmissions as defined below. Rationale Planned readmissions are generally not a signal of quality of care. Including planned readmissions in a readmission measure could create a disincentive to provide appropriate care to patients who are scheduled for elective or necessary procedures within 30 days of discharge. From a patient perspective, an unplanned readmission from any cause is an adverse event. Outcomes occurring within 30 days of discharge can be influenced by hospital care and the early transition to the non-acute care setting. The 30-day time frame is a clinically meaningful period for hospitals to collaborate with their communities to reduce readmissions. Planned Readmission Algorithm (Version 4.0) The Planned Readmission Algorithm is a set of criteria for classifying readmissions as

	planned among the general Medicare population using Medicare administrative claims 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 HWR measure. In 2013, CMS applied the algorithm to its other readmission measures. For more details on the Planned Readmission Algorithm, please see the report titled “2018 All-Cause Hospital-Wide Measure Updates and Specifications Report: Hospital-Level 30-Day Risk-Standardized Readmission Measure – Version 7.0” Simoes J, Grady J, Purvis D, et al. 2018 All-Cause Hospital Wide Measure Updates and Specifications Report. http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841. Accessed November 6, 2018.
Denominator	The measure includes admissions for Medicare beneficiaries who are 65 years and older and are discharged from all non-federal, acute care inpatient US hospitals (including territories) with a complete claims history for the 12 months prior to admission. Additional details are provided in S.7 Denominator Details.
Denominator Details	To be included in the measure cohort, patients must meet the following additional inclusion criteria: 1. Enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and during the index admission; 2. Aged 65 or over; 3. Discharged alive from a non-federal short-term acute care hospital; and, 4. Not transferred to another acute care facility. The measure first assigns admissions with qualifying Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software (CCS) procedure categories to the Surgery/Gynecology Cohort. This cohort includes admissions likely cared for by surgical or gynecological teams. The measure then sorts admissions into one of the four remaining specialty cohorts based on the AHRQ CCS diagnosis category of the principal discharge diagnosis: The Cardiorespiratory Cohort includes several condition categories with very high readmission rates such as pneumonia, chronic obstructive pulmonary disease, and heart failure. These admissions are combined into a single cohort because they are often

	clinically indistinguishable and patients are often simultaneously treated for several of these diagnoses. The Cardiovascular Cohort includes condition categories such as acute myocardial infarction that in large hospitals might be cared for by a separate cardiac or cardiovascular team. The Neurology Cohort includes neurologic condition categories such as stroke that in large hospitals might be cared for by a separate neurology team. The Medicine Cohort includes all non-surgical patients who were not assigned to any of the other cohorts. The full list of the specific diagnosis and procedure AHRQ CCS categories used to define the specialty cohorts are attached in the data dictionary.
Exclusions	The Hybrid HWR measure excludes index admissions for patients: 1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals; 2. Without at least 30 days post-discharge enrollment in Medicare FFS; 3. Discharged against medical advice (AMA); 4. Admitted for primary psychiatric diagnoses; 5. Admitted for rehabilitation; or 6. Admitted for medical treatment of cancer.
Exclusion details	The Hybrid HWR measure excludes index admissions for patients: 1. Admitted to PPS-exempt cancer hospitals Rationale: These hospitals care for a unique population of patients that cannot reasonably be compared to patients admitted to other hospitals. 2. Without at least 30 days of post-discharge enrollment in Medicare FFS Rationale: The 30-day readmission outcome cannot be assessed in this group since claims data are used to determine whether a patient was readmitted. 3. Discharged against medical advice Rationale: Providers did not have the opportunity to deliver full care and prepare the patient for discharge. 4. Admitted for primary psychiatric diagnoses Rationale: Patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers that are not comparable to short-term acute care hospitals. 5. Admitted for rehabilitation Rationale: These admissions are not typically to a short-term acute care hospital and are not for acute care. 6. Admitted for medical treatment of cancer Rationale: These admissions have a different mortality and readmission profile than the rest of the Medicare population, and outcomes for these admissions do not correlate well

	with outcomes for other admissions. Patients with cancer admitted for other diagnoses or for surgical treatment of their cancer remain in the measure.
Risk Adjustment	Statistical risk model
Stratification	N/A
Type	Outcome
Type of Score	Rate/proportion
Data Source	Claims, Electronic Health Data
Level	Facility
Setting	Inpatient/Hospital

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