

NATIONAL QUALITY FORUM

Measure Evaluation 4.1 January 2010

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The sub-criteria and most of the footnotes from the [evaluation criteria](#) are provided in Word comments and will appear if your cursor is over the highlighted area (or in the margin if your Word program is set to show revisions in balloons). Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each sub-criterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the sub-criteria (yellow highlighted areas).*

Steering Committee: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the sub-criterion, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few sub-criteria as indicated)

(for NQF staff use) NQF Review #: OT2-004-09	NQF Project: Patient Outcomes Measures: Phases I and II
MEASURE DESCRIPTIVE INFORMATION	
De.1 Measure Title: 30-day Post-hospital PNA Discharge Evaluation & Management Service Visit Measure	
De.2 Brief description of measure: This measure estimates the percentage of eligible Medicare hospital discharges with a diagnosis of pneumonia (PNA) for which beneficiaries receive an Evaluation and Management (E&M) service within 30 days of hospital discharge and prior to a hospital readmission or ED visit.	
1.1-2 Type of Measure: outcome	
De.3 If included in a composite or paired with another measure, please identify composite or paired measure The proposed measure is one component of a three component composite measure, 30-day Post-hospital PNA Discharge Care Transition measure, being submitted concurrently under the Patient Outcomes Measures Phase II call for measures.	
De.4 National Priority Partners Priority Area: care coordination	
De.5 IOM Quality Domain: efficiency	
De.6 Consumer Care Need: Getting Better	

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i>	A Y <input type="checkbox"/> N <input type="checkbox"/>
A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes	
A.2 Indicate if Proprietary Measure (<i>as defined in measure steward agreement</i>):	

A.3 Measure Steward Agreement: government entity- public domain- No Agreement	
A.4 Measure Steward Agreement attached:	
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	B Y <input type="checkbox"/> N <input type="checkbox"/>
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► Purpose: public reporting, quality improvement Accountability	C Y <input type="checkbox"/> N <input type="checkbox"/>
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: Yes, fully developed and tested D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes	D Y <input type="checkbox"/> N <input type="checkbox"/>
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (<i>if submission returned</i>):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (<i>issues or questions regarding any criteria</i>):	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. <i>Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)</i> 1a. High Impact	Eval Rating
(for NQF staff use) Specific NPP goal :	
1a.1 Demonstrated High Impact Aspect of Healthcare: a leading cause of morbidity/mortality, affects large numbers, high resource use, severity of illness 1a.2 1a.3 Summary of Evidence of High Impact: PNA is a frequently occurring and high cost acute infection resulting in about 500,000 hospital admissions annually among elders (Martinez, 2009; Niederman, 1998); two-thirds of all PNA hospitalizations occurring in elders with high cost co-morbid conditions such as HF, COPD/asthma, and diabetes (Kaplan, 2002). PNA is responsible for the second highest rate of hospital readmission following HF (Jencks et al, 2009); rehospitalizations are cited as potential preventable costs to the Medicare program and PNA specifically has been identified as a priority condition (MedPac, 2007). The receipt of an E&M service within 30-days of a hospital discharge for PNA provides evidence of the requisite transition between high-intensity acute care in the hospital setting and continuity of care in the ambulatory or SNF setting whereby assessment of the continued resolution of PNA and its influence on co-morbidity among the elderly is possible. A great deal of empirical research has demonstrated the potential benefit of medical evaluation during this high risk critical transition period among the elderly (Benbassat et al, 2000; Coleman et al, 2004, 2006; Jack, 2009; Naylor, 1999, 2004). Additionally the critical importance of information transfer between hospital and outpatient or SNF care setting has been recognized (Sherman, 2009; Kripalani, 2007) and contributes to avoidable readmissions. A measure of E&M service promotes	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

shared accountability between hospitals and outpatient care settings providing an opportunity to prevent an adverse medical event.

1a.4 Citations for Evidence of High Impact:

1. Martinez R, Reyes S, Lorenzo MJ, Menendez R: Impact of guidelines on outcome: the evidence. *Semin Respir Crit Care Med* 2009; 30(2): 172-8.
2. Niederman MS, McCombs JS, Unger AN, Kumar A, Popovian R: The cost of treating community-acquired pneumonia. *Clin Ther* 1998; 20(4): 820-37.
3. Kaplan V, Angus DC, Griffin MF, Clermont G, Scott Watson R, Linde-Zwirble WT: Hospitalized community-acquired pneumonia in the elderly: age- and sex-related patterns of care and outcome in the United States. *Am J Respir Crit Care Med* 2002; 165(6): 766-72.
4. Jencks SF, Williams MV, Coleman EA: Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009; 360(14): 1418-28.
5. MedPac: Promoting Greater Efficiency in Medicare. Medicare Payment Advisory Commission, 2007.
6. Benbassat J, Taragin M: Hospital readmissions as a measure of quality of health care: advantages and limitations. *Arch Intern Med* 2000; 160(8): 1074-81.
7. Coleman EA, Berenson RA: Lost in transition: challenges and opportunities for improving the quality of transitional care. *Ann Intern Med* 2004; 141(7): 533-6.
8. Coleman EA, Parry C, Chalmers S, Min SJ: The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med* 2006; 166(17): 1822-8.
9. Jack BW, Chetty VK, Anthony D, et al.: A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. *Ann Intern Med* 2009; 150(3): 178-87.
10. Naylor MD: Transitional care for older adults: a cost-effective model. *LDI Issue Brief* 2004; 9(6): 1-4.
11. Naylor MD, Brooten D, Campbell R, et al.: Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. *JAMA* 1999; 281(7): 613-20.
12. Sherman FT: Rehospitalizations: packaging discharge and transition services to prevent "bounce backs". *Geriatrics* 2009; 64(5): 8-9.
13. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW: Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA* 2007; 297(8): 831-41.

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<p>information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA 2007; 297(8): 831-41.</p>	
<p>1b. Opportunity for Improvement</p> <p>1b.1 Benefits (improvements in quality) envisioned by use of this measure: The E&M measure may promote a shared accountability for patient short-term outcomes between in-patient and out-patient providers by encouraging the active transfer of medical accountability for the patient's treatment following an acute hospitalization. The measure is non-prescriptive via a specific process and allows innovation on the part of provider networks.</p> <p>1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers: Jencks and colleagues recently provided a current profile of readmissions among the Medicare population and found that one in five hospitalized patients were readmitted to the hospital within 30 days and that half of these patients had no ambulatory visit before subsequent hospitalization. While it might be argued that not all elders would require an E&M service within 30-days of hospital discharge the severity of illness (requiring acute hospitalization), and PNA's influence on other co-morbid conditions and nuanced presentation in the elderly warrants follow-up E&M service to ensure continued resolution of the PNA and the prevention of an adverse event.</p> <p>1b.3 Citations for data on performance gap: Jencks SF, Williams MV, Coleman EA: Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009; 360(14): 1418-28.</p> <p>1b.4 Summary of Data on disparities by population group: Variation in health care utilization and spending has been well-documented by the Dartmouth research group. There has been some mixed evidence of racial/ethnic differences in hospital readmissions (Jiang et al, 2005). Empirical evaluation of the racial/ethnic differences in elder E&M visits following hospital discharge for PNA however has not been conducted.</p> <p>1b.5 Citations for data on Disparities: Jiang HJ, Andrews R, Stryer D, Friedman B: Racial/ethnic disparities in potentially preventable readmissions: the case of diabetes. Am J Public Health 2005; 95(9): 1561-7.</p>	<p>1b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>1c. Outcome or Evidence to Support Measure Focus</p> <p>1c.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population): NQF has identified transitions or "hand-offs" as the fifth domain in their definition and framework for measuring care coordination. Transitions between care settings involve multiple providers and often compromised patients with complex needs resulting in care that is often unsafe, disconnected, and uncoordinated. Experts agree that breakdown in medical information occurs frequently during transitions between care settings especially hospital to home. While no current hospital follow-up measure yet exists for high frequency chronic conditions or complex surgical procedures the National Committee for Quality Assurance (NCQA) has endorsed a 7-day and 30-day follow-up after hospitalization for mental illness (HEDIS, 2002). NCQA describes the measure as assessing the continuity of care for psychiatric patients after discharge from high-intensity acute care to ambulatory follow-up within 7 and 30 days. While an E&M service measure does not guarantee that the comprehensive needs of transition across settings are met (improvement in condition, patient/family understanding of self-management, the recognition of deterioration, and the steps to take, medication reconciliation, etc.) it does provide readily available administrative claims evidence of a face-to-face medical encounter between the recently seriously ill elder and the ambulatory physician managing the patient's outpatient care. The E&M measure may also facilitate acknowledgment of shared accountability in achieving optimal patient outcomes that results in the active transfer of medical accountability for patient's treatment following hospitalization.</p>	<p>1c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

1c.2-3. Type of Evidence: expert opinion**1c.4 Summary of Evidence** (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):

The latest clinical practice guideline (CPG) on the treatment of Community-Acquired Pneumonia (CAP) is silent with regards to specific monitoring following a hospitalization. CAP is treated largely as an outpatient illness however when hospitalization is required the CPG specifies differential antibiotic therapy and the need for subsequent monitoring to ensure adequate response. Elders hospitalized constitute a frail population with high disease burden. Moreover, as the clinical presentation of CAP can differ in the elderly and is often accompanied by altered mental status medical follow-up after discharge would appear appropriate. Given the incidence of co-morbidity in elders hospitalized for PNA (HF, COPD and diabetes being the most frequent) medical follow-up after hospital discharge provides the opportunity to prevent a subsequent serious negative event. Coleman and others have identified care transitions as critical junctures for elderly patients with complex medical conditions (Coleman et al, 2004; Naylor 2004; Chiu et al, 2007; Epstein, 2009; Sherman, 2009).

Patients hospitalized with PNA may have had usual medication regimes altered during hospitalization and would have received new medications during the hospital stay. Upon hospital discharge especially in elders it is important to assess continued response to inpatient therapy and the maintenance or modification to medications prior to admission (two-thirds of elders admitted to the hospital for PNA have one or more chronic conditions). Reducing adverse drug events (In: Evidence-based geriatric nursing protocols for best practice-http://www.guidelines.gov/summary/summary.aspx?doc_id=12258) advocates for hospital follow-up by a provider in the presence of a medication-related condition. This clinical practice guideline further recommends follow-up that includes medical monitoring to ensure that the older adult is responding to therapy as expected (Follow-Up Monitoring, Edelberg et al., 2000 [Level IV]-http://www.guidelines.gov/summary/summary.aspx?doc_id=12258).

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*):

Expert opinion

1c.6 Method for rating evidence: Consensus**1c.7 Summary of Controversy/Contradictory Evidence:** None identified

1c.8 Citations for Evidence (*other than guidelines*): 1. Coleman EA, Berenson RA: Lost in transition: challenges and opportunities for improving the quality of transitional care. *Ann Intern Med* 2004; 141(7): 533-6.

2. Naylor MD: Transitional care for older adults: a cost-effective model. *LDI Issue Brief* 2004; 9(6): 1-4.

3. Chiu WK, Newcomer R: A systematic review of nurse-assisted case management to improve hospital discharge transition outcomes for the elderly. *Prof Case Manag* 2007; 12(6): 330-6; quiz 337-8.

4. Sherman FT: Rehospitalizations: packaging discharge and transition services to prevent "bounce backs". *Geriatrics* 2009; 64(5): 8-9.

5. Epstein AM: Revisiting readmissions--changing the incentives for shared accountability. *N Engl J Med* 2009; 360(14): 1457-9.

6. Zwicker D, Fulmer T. Reducing adverse drug events. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). *Evidence-based geriatric nursing protocols for best practice*. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 257-308. [104 references including Edelberg et al, 2000]

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number*):

The clinical practice guideline further recommends follow-up that includes medical monitoring to ensure that the older adult is responding to therapy as expected (Edelberg et al., 2000 [Level IV]).

1c.10 Clinical Practice Guideline Citation: NA

<p>1c.11 National Guideline Clearinghouse or other URL: http://www.guideline.gov/summary/summary.aspx?doc_id=12258&nbr=006342&string=hospital+AND+follow-up+AND+elders</p> <p>1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom): NA</p> <p>1c.13 Method for rating strength of recommendation (If different from USPSTF system, also describe rating and how it relates to USPSTF): NA</p> <p>1c.14 Rationale for using this guideline over others: There are no CPGs on follow-up care of elders after hospitalization for PNA</p>	
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Importance to Measure and Report</i>?</p>	<p>1</p>
<p>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met? Rationale:</p>	<p>1 Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</p>	
<p>Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>2a. MEASURE SPECIFICATIONS</p>	
<p>S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:</p> <p>2a. Precisely Specified</p>	
<p>2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome): The numerator is the number of eligible discharges in the target population who have evidence of an Evaluation and Management (E&M) service within 30 days of a hospital discharge with the principal diagnosis of PNA and prior to any hospital readmission or ED visit.</p> <p>2a.2 Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator): The opportunity for each eligible Medicare discharge is 30 days following an eligible hospitalization.</p> <p>2a.3 Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions): The following five methods were applied to identify E&M services in the Part B line item and Part A outpatient revenue center files. The claim "from date" was then set as the E&M service date.</p> <ol style="list-style-type: none"> HCPCS E&M codes as specified in answer 1 of the following document. http://www.cms.hhs.gov/HospitalOutpatientPPS/downloads/OPPS_Q&A.pdf (99201-99215, 99241-99245 (note: only codes 99210-99205 and 99211-9915 occurred in the range of 99201-99215)) HCPCS E&M codes as specified for home health visits: 99324-99345 Revenue codes 0550, 0551, 0552, and 0553 for skilled nursing services provided in the home and/or G code G0154. The HCPCS codes corresponding to the BETOS E&M codes, as specified by CMS. http://www.cms.hhs.gov/hcpcsreleasecodesets/20_betos.asp BETOS and HCPCS E&M codes specified for SNFs and LTC facilities (BETOS='M4B') 	<p>2a- specs C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2a.4 Denominator Statement (Brief, text description of the denominator - target population being</p>	

measured):

Total hospital discharges among Medicare Fee-For-Service beneficiaries 65 years of age and older during the measurement period with a principal discharge diagnosis of PNA.

2a.5 Target population gender: Female, Male

2a.6 Target population age range: Medicare Fee-For-Service beneficiaries 65 years of age and older

2a.7 Denominator Time Window (*The time period in which cases are eligible for inclusion in the denominator*):

Computed as a three-year rolling average (January through December of each year)

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions*):

Identify admissions for Medicare beneficiaries 65 years of age and older with a principal discharge diagnosis of PNA and a complete history for 12 months prior to admission. As a first step, identify all index hospitalizations for any condition per calendar year among Medicare beneficiaries. Second flag, all hospital readmissions within 30-days of an admission as a hospitalization cannot be both an index and readmission. Once true index hospitalizations are identified, count hospitalizations with principal discharge diagnosis of PNA using one or more of the qualifying ICD-9 codes in CMS's Inpatient Standard Analytic File. ICD-9 codes for pneumonia include the following: 480.0, 480.1, 480.2, 480.3, 480.8, 480.9, 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, and 487.0)

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population*): 1) In-hospital mortality

2) Transfers-out to another acute care facility

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions*):

1) In-hospital mortality does not permit for any post-hospital follow-up; identify exclusion via the patient status discharge table, code='20'

2) If the patient is transferred to another acute care facility during the hospitalization then receiving hospital is accountable for the post-hospital follow-up; identify exclusion via the patient discharge table, code='02'

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions*):

NA

2a.12-13 Risk Adjustment Type: risk adjustment method widely or commercially available

2a.14 Risk Adjustment Methodology/Variables (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method*):

We employ the Yale risk-adjusted methodology used in the NQF-endorsed Hospital 30-day PNA Readmission Measure. It consists of a modified approach to the Hierarchical Condition Category (HCC) clinical classification system (Pope et al, 2000) and incorporates 1) Part A secondary diagnoses from the index admission; 2) Part A principal diagnosis from any hospitalization in the 12 months prior to the index admission; 3) Part A secondary diagnoses from any hospitalization in the 12 months prior to the index admission; 4) diagnoses from hospital outpatient services in the 12 months prior to the index admission; 5) diagnoses from Part B physician encounters in the 12 months prior to the index admission. Diagnoses identified from all sources are grouped into single CC indicator flags. Secondary diagnoses identified on the index admission that are potential complications as identified by the Yale-convened team of medical experts are removed as potential CC flags. Age and sex are entered as risk adjusters into the final statistical models.

2a.15-17 Detailed risk model available Web page URL or attachment: URL

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228695492636>

2a.18-19 Type of Score: rate/proportion

2a.20 Interpretation of Score: better quality = higher score

2a.21 Calculation Algorithm (*Describe the calculation of the measure as a flowchart or series of steps*):

Step 1: Claims for all beneficiaries (regardless of clinical condition) from 2003-2007 Medicare Inpatient files were combined and cleaned to create a claims file with one claim per inpatient per provider stay. Next, a single-stay claims file for all beneficiaries (regardless of clinical condition) in which transfer claims are combined into a single inpatient stay record was created. This process is described in the "Input File Processing for 2009 CMS 30-day Mortality and Readmission Measures" documentation.

Step 2: Each stay in the five year period is then defined as either an index admission or a 30-day readmission. A single stay cannot count as both an index admission and a readmission for another index admission. Thus, additional admissions within 30-days of an index admission are not counted as index admissions. Index admissions with a qualifying primary discharge diagnosis from beneficiaries meeting the inclusion criteria were included in this measure. This process is described in the Hospital 30-Day Pneumonia Readmission Measure Methodology submitted by YNHH-CORE, and the Hospital 30-Day Heart Failure Readmission Measure Methodology submitted by YNHH-CORE.

Step 3: For each qualifying index admission, the beneficiary's inpatient and outpatient claims in the 12-months prior to the hospitalization are examined. All diagnoses from non-DME, non-diagnostic testing claims are used to construct flags for 184 clinical Condition Categories (CCs). Secondary diagnoses (excluding diagnoses associated with potential complications) from the index admission are used also to assign the 184 CCs. The process for creating the CC flags is described in the RiskSmart Stand Alone Users Guide, v2.2. These flags are used for risk adjustment.

Step 4: The following three flags (0/1 indicators) are then set for each index admission.

- Readmission=1 if a subsequent readmission occurs within 30 days of discharge from the qualifying index admission
- ED visit=1 if an ED visit occurs in the 30 days after discharge from the index admission, and the ED visit is not after the first readmission (or associated with a readmission)
- E&M service=1 if an E&M service occurs in the 30 days after discharge from the index admission, and the E&M service is not after the first readmission, and is not after the first ED visit.

Step 5: Calculate the ratio of E&M service=1 event over the total number of qualifying index admissions to get unadjusted E&M rate. This is for descriptive purposes only.

Step 6: Estimate risk adjustment regression model on E&M service indicator using methodology developed for CMS 30-day all cause readmission measure.

Step 7: Applying the CMS 30-day readmission measure methodology, compute P/E ratio and corresponding risk standardized rate (the RSR is defined as P/E times overall population mean).

Step 8: Rank computed RSR rates across all hospitals and calculate percentile values.

2a.22 Describe the method for discriminating performance (*e.g., significance testing*):

Individual hospital 30-day post discharge E&M service measures are standardized and all hospitals are ranked on the resulting standardized percentile; may be converted to star rating based upon quintile.

2a.23 Sampling (Survey) Methodology *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):*
All eligible cases are included in the measure.

2a.24 Data Source (*Check the source(s) for which the measure is specified and tested*)

Electronic administrative data/claims

2a.25 Data source/data collection instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*):

CMS' Outpatient Standard Analytic File (SAF) and Inpatient SAF or MEDPAR files

2a.26-28 Data source/data collection instrument reference web page URL or attachment:

2a.29-31 Data dictionary/code table web page URL or attachment:

2a.32-35 Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and*

tested)
 Population: national

2a.36-37 Care Settings (*Check the setting(s) for which the measure is specified and tested*)
 Hospital

2a.38-41 Clinical Services (*Healthcare services being measured, check all that apply*)

TESTING/ANALYSIS

2b. Reliability testing

2b.1 Data/sample (*description of data/sample and size*): The reliability testing and other analyses described in this submission use the Dartmouth Atlas 20% sample of Medicare Carrier Claim files for 2003-2007. Data from 2003 are used only for pre-admission information for risk-adjustment for patients admitted during 2004, and are not included directly in any of the analysis presented. December 2007 is used only for information about the 30-day post-discharge period; hence December 2007 index admissions are not in the results presented.

Reliability testing used only pneumonia index admissions to the 2,571 hospitals having 10 or more pneumonia index admissions in 2006. This sub-sample has 61,453 pneumonia index admissions for 2006 and 199,852 for the three year period 2004-2006. The 30-day E&M service rates for these patients were 0.859 in 2004, 0.838 in 2005 and 0.837 in 2006.

2b.2 Analytic Method (*type of reliability & rationale, method for testing*):
 Reliability was examined two ways: using correlations across years, and using kappa statistics for hospitals divided into quintiles based on risk-standardized rates in years being compared. In the case of correlations, both Pearson and Spearman (rank) correlations were computed.

Both correlations and kappa statistics were each computed for two periods: (1) between years 2006 and 2007; and (2) between 2007 and the average of three years (2004 through 2006). The proposed measure uses the second, i.e., three years of data, updated annually, in order to increase the signal-to-noise ratio relative to simple annual calculations. We also present here the one-year statistics to show what is gained in exchange for the loss of 'currentness' resulting from the three-year approach.

Both statistics were also computed for risk-standardized rates based on observed-to-expected (O/E) ratios as well as the proposed predicted-to-expected (P/E) ratios. The O/E rate for three years is a weighted average of three one year rates, with weights of 0.5 for the most recent year, 0.3 for the prior year and 0.2 for the first year. This and other approaches will be investigated during the provisional period, seeking to improve the ability of the measure to discriminate among hospitals while drawing on power of persistence in performance over time.

2b.3 Testing Results (*reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
 Correlations to check reliability over time were always highly significant ($p < 0.001$). Pearson correlations between single years (2007 and 2006) were 0.297 using P/E and 0.252 using O/E. Spearman correlations (which are less sensitive to outliers) were 0.227 and 0.185 respectively. Pearson correlations between 2007 and the three year average (2004-2006) were even stronger: 0.352 for P/E and 0.309 for O/E. For the same measures Spearman correlations were 0.299 and 0.250 respectively.

Weighted kappas measuring agreement within quintiles showed the same pattern of reliability. The weighted kappa was 0.188 ($p < 0.001$) for 2007 predicted compared with the prior three year average and 0.178 ($p < 0.001$) for 2007 observed compared with the prior three year average. For single years (2007 compared to 2006) the weighted kappas were 0.135 and 0.127 respectively (both $p < 0.001$).

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<p>In contrast, these correlations over time and weighted kappas are considerably higher than those computed for the 30-day readmission measure using the same sample of pneumonia index admissions. For example, the Pearson correlations on the readmission measure between 2007 and the three year average (2004-2006) are 0.139 using P/E and 0.114 using O/E. The weighted kappas for the same period are 0.081 using P/E and 0.090 using O/E.</p>	
<p>2c. Validity testing</p> <p>2c.1 Data/sample (<i>description of data/sample and size</i>): NA (see discussion under Analytic Method)</p> <p>2c.2 Analytic Method (<i>type of validity & rationale, method for testing</i>): Our E&M service measure is not a direct measure of care coordination, but rather an indication of the outcome of care coordination. Indeed, correlation of other, more direct measures of care coordination with our proposed E&M service indicator (within a specified time period) is used as a test of the direct measure's predictive validity. As such, we would argue that our E&M service measure is intrinsically valid.</p> <p>2c.3 Testing Results (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>): NA (see discussion under Analytic Method)</p>	<p>2c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2d. Exclusions Justified</p> <p>2d.1 Summary of Evidence supporting exclusion(s): This measure follows the previously NQF endorsed cohort specification for index admissions for PNA among Medicare FFS beneficiaries 65 years of age. Cohort specification becomes the measure denominator and includes defensible exclusions identified by the Yale research team in their development of the NQF endorsed Hospital 30-Day Pneumonia Readmission measure.</p> <p>2d.2 Citations for Evidence: Krumholtz HM, Normand SL, Keenan PS, et al. Hospital 30-Day Pneumonia Readmission Measure Methodology. Subcontract report for Centers for Medicare & Medicaid Services (CMS), 2008.</p> <p>2d.3 Data/sample (<i>description of data/sample and size</i>): NA (see discussion under the Summary of Evidence Supporting Exclusions)</p> <p>2d.4 Analytic Method (<i>type analysis & rationale</i>): NA (see discussion under the Summary of Evidence Supporting Exclusions)</p> <p>2d.5 Testing Results (<i>e.g., frequency, variability, sensitivity analyses</i>): NA (see discussion under the Summary of Evidence Supporting Exclusions)</p>	<p>2d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample (<i>description of data/sample and size</i>): The risk adjustment method was assessed and applied using the 20% Medicare sample described in the section on reliability testing. However, for model estimation we used all index admissions, regardless of hospital volume. The total sample was 239,266 pneumonia index admissions for 2004-2006.</p> <p>2e.2 Analytic Method (<i>type of risk adjustment, analysis, & rationale</i>): Since the risk adjustment method is the same as that used for an existing NQF approved measure, and is used for public reporting by CMS, the primary question examined in our analysis was the appropriateness of using the fixed covariates selected for 30-day readmissions for 30-day E&M services, both following IP pneumonia care. Our method was to estimate the same GLM model used by the YNHH-CORE developers of the model, using our sample of index admissions for 2004-2006 and the E&M service outcome, and to</p>	<p>2e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>

compute the same performance statistics. To gauge the potential for improvement by selecting different covariates for E&M services we estimated an alternate model in which all DxCG condition categories (CCs) were used in lieu of the CC-based covariates in the readmission model.

2e.3 Testing Results (risk model performance metrics):

The maximum re-scaled R2 is 0.014 and the c-statistic 0.570. The decile with the lowest predicted E&M service rate had an actual rate of 0.763 whereas the highest decile had an actual rate of 0.881. Additional statistics are presented in Table 2 of the attached supporting document.

The CC model's maximum re-scaled R2 is 0.033 and its c-statistic 0.606. The decile with the lowest predicted E&M service rate had an actual rate of 0.728 whereas the highest decile had an actual rate of 0.908. The alternate model performs somewhat better, but the improvement was judged not sufficient to justify further development at this time, though revision of the set of covariates representing co-morbid conditions may be an area for future refinement of the measure specification.

The attached supporting document also provides the incidence in our sample of each co-morbid condition used for risk adjustment and the parameter estimates.

2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: NA

2f. Identification of Meaningful Differences in Performance

2f.1 Data/sample from Testing or Current Use (description of data/sample and size): The distribution of performance was assessed using the 20% Medicare sample described in the section on reliability testing.

2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale):

We calculated the intra-hospital correlation coefficient (ICC) to estimate the proportion of overall variance in 30-day post discharge E&M services which is variation between hospitals. We also examined the distribution of risk-standardized rates, and compared it to the distribution for the existing 30-day readmission measure.

2f.3 Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):

For the three year period 2004-6 the between hospital variance estimate is 0.188 (se=0.008), residual variance estimate is 0.963 (se=0.003) and the resulting ICC was 0.163, indicating that differences among hospitals account for approximately 16% of total variation. The result is similar for 2006 alone. The between hospital variance estimate is 0.177 (se=0.014), residual variance estimate is 0.941 (se=0.005), with a resulting ICC of 0.158.

This is substantially more variation among hospitals than observed for the 30-day post-discharge readmission measure, for which the between-hospital variance using this sample of index admissions is 0.025 (ICC is also 0.025) and that reported by the developers of the measure using all 2006 admissions was 0.029.

The median hospital with 10 or more admissions in 2006 has a risk-standardized E&M service rate for 2004-6 of 0.846. The inter-quartile range is 0.818 to 0.871 and the range of the 5th percentile to the 95th is 0.762 to 0.898. The 25th percentile hospital is predicted to have 1.4 times as many patients with a pneumonia discharge not receive an E&M service with 30 days of discharge as the 75th percentile hospital.

For 2006 alone the median rate is 0.843, the inter-quartile range is 0.795 to 0.888 and the range of the 5th percentile to the 95th is 0.694 to 0.935.

The distribution is similar for hospitals with smaller and larger volumes. For example the 2004-6 inter-quartile range of the quartile of hospitals with the fewest cases (10-13 index admissions in the 2006 sample) is 0.808 to 0.862, which though shifted down is the same magnitude as the 0.829 to 0.883 inter-quartile range of the quartile of hospitals with the most cases (30-160 index admissions in the 2006 sample).

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<p>As described elsewhere in this submission, we also computed risk-standardized rates using observed-to-expected (O/E) ratios instead of predicted-ot-expected (P/E). These rates are somewhat more dispersed. For example, the inter-quartile range of the risk-standardized rates using the 2004-6 weighted O/E average is 0.801 to 0.894 and the range of the 5th percentile to the 95th is 0.697 to 0.940.</p> <p>The attached support document has more detail, including histograms for a visual representation of these distributions.</p>	
<p>2g. Comparability of Multiple Data Sources/Methods</p> <p>2g.1 Data/sample (<i>description of data/sample and size</i>): NA</p> <p>2g.2 Analytic Method (<i>type of analysis & rationale</i>): NA</p> <p>2g.3 Testing Results (<i>e.g., correlation statistics, comparison of rankings</i>): NA</p>	<p>2g C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p> <p>2h.1 If measure is stratified, provide stratified results (<i>scores by stratified categories/cohorts</i>): We examined the mean hospital score by race/ethnicity quartiles (the ranked proportion of white, black, and "other" [non-white, non-black] patients served). Very small differences in the mean hospital scores were observed by the lowest quartile of "other" and black patients versus the highest quartile. A two percent difference was observed between the hospital mean scores serving the lowest quartile of "other" patients versus the highest quartile of "other" patients; a mean score of 0.85 for hospitals serving the highest proportion of "others", versus the mean score of 0.83 for hospitals with the lowest quartile. Among hospitals serving the highest proportion of black patients the mean score was 0.83 versus the mean score of 0.84 for hospitals serving the lowest proportion of black patients. These mean scores can be compared to hospitals serving the highest proportion of white patients by quartile versus those serving the lowest proportion of white patients - no difference observed, mean score was 0.84 in both cases.</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans: We recommend continued monitoring of disparities in measure results. We did not evaluate the measure at the individual patient level but rather stratified the measure by the proportion of ethnic minorities served by hospitals. Our preliminary findings suggest a relationship between performance on the measure and the proportion of non-white patients served. Additional evaluation is warranted to examine the distribution of scores within each race/ethnic quartile.</p>	<p>2h C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Scientific Acceptability of Measure Properties</i>?</p>	<p>2</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met? Rationale:</p>	<p>2 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
3. USABILITY	
<p>Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>3a. Meaningful, Understandable, and Useful Information</p> <p>3a.1 Current Use: not in use but testing completed</p>	<p>3a C <input type="checkbox"/> P <input type="checkbox"/></p>

<p>3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years): NA</p> <p>3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years): NCOA has an endorsed HEDIS measure for the Medicare product line of business that examines an ambulatory mental health visit within 30-days after discharge from the hospital for selected mental health diagnosis. http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2008/2008_Measures.pdf</p> <p>Testing of Interpretability (Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement)</p> <p>3a.4 Data/sample (description of data/sample and size): This proposed measure has not yet been tested for interpretation by potential users - providers, consumers, etc. Such testing would be recommended as part of measure implementation and use.</p> <p>3a.5 Methods (e.g., focus group, survey, QI project): NA</p> <p>3a.6 Results (qualitative and/or quantitative results and conclusions): NA</p>	<p>M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>3b/3c. Relation to other NQF-endorsed measures</p> <p>3b.1 NQF # and Title of similar or related measures:</p>	
<p>(for NQF staff use) Notes on similar/related endorsed or submitted measures:</p>	
<p>3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population):</p> <p>3b.2 Are the measure specifications harmonized? If not, why?</p>	<p>3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>3c. Distinctive or Additive Value</p> <p>3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:</p> <p>5.1 Competing Measures If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), describe why it is a more valid or efficient way to measure quality:</p>	<p>3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Usability</i>?</p>	<p>3</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Usability</i>, met? Rationale:</p>	<p>3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
4. FEASIBILITY	
<p>Extent to which the required data are readily available, retrievable without undue burden, and can be</p>	<p>Eval</p>

<p>implemented for performance measurement. (evaluation criteria)</p>	<p>Rating</p>
<p>4a. Data Generated as a Byproduct of Care Processes</p> <p>4a.1-2 How are the data elements that are needed to compute measure scores generated? coding/abstraction performed by someone other than person obtaining original information,</p>	<p>4a</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>4b. Electronic Sources</p> <p>4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) Yes</p> <p>4b.2 If not, specify the near-term path to achieve electronic capture by most providers.</p>	<p>4b</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>4c. Exclusions</p> <p>4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No</p> <p>4c.2 If yes, provide justification.</p>	<p>4c</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences</p> <p>4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. Several methodologies might be employed to produce the measure denominator (Medicare FFS beneficiaries 65 years of age and older with a principal discharge diagnosis of PNA). As hospital readmissions would not be counted as an index admission differing approaches to indexing the PNA hospital discharges could be used with differing results. Once measure specification has been endorsed rates for E&M measure following hospital discharge with the principal diagnosis of PNA can be validated; it would be important to validate consistency in denominator specification.</p>	<p>4d</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>4e. Data Collection Strategy/Implementation</p> <p>4e.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/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: NA-administrative claims-based measure</p> <p>4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>): NA</p> <p>4e.3 Evidence for costs: NA</p> <p>4e.4 Business case documentation: NA</p>	<p>4e</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Feasibility</i>?</p>	<p>4</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:</p>	<p>4</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p>

	M <input type="checkbox"/> N <input type="checkbox"/>
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	Time-limited <input type="checkbox"/>
Steering Committee: Do you recommend for endorsement? Comments:	Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/>
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) Co.1 Organization Centers for Medicare and Medicaid Services 7500 Security Blvd. Baltimore Maryland 21244	
Co.2 Point of Contact Shaheen Halim, Ph.D. Shaheen.Halim@cms.hhs.gov 410-786-0641	
Measure Developer If different from Measure Steward Co.3 Organization Brandeis University 415 South Street Waltham Massachusetts 02454	
Co.4 Point of Contact Christopher Tompkins, Ph.D. Tompkins@brandeis.edu 781-736-3913	
Co.5 Submitter If different from Measure Steward POC Marian Ryan, PhD mryan@brandeis.edu 781-736-8493- Brandeis University	
Co.6 Additional organizations that sponsored/participated in measure development	
ADDITIONAL INFORMATION	
Workgroup/Expert Panel involved in measure development Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. Technical Expert Panel (TEP): Lisa Latts, MD, MBA -WellPoint Julie Bynum, MD, MPH -Dartmouth Medical School Joanne Lynn, MD -DC Department of Health - Chronic Disease and Cancer Community Health Administration Anthony Armada, MHA, MBA -Henry Ford Hospital TEP Role: The Technical Expert Panel assisted our workgroup developing measures by providing input to: 1) Supplement, and provide texture, to the knowledge gathered through the literature review prior to measure development; 2) Discuss existing measures and provide input as to next steps for CMS to adopt, adapt, and/or develop measures of care coordination relevant to the hospital setting; and 3) Review and provide input on draft measures and measure development testing. Workgroup: Kristine Martin Anderson, MBA -Booz Allen Hamilton Sandra Lesikar, PhD-Booz Allen Hamilton Arlene Ash, PhD-Boston University James Burgess, PhD-Boston University Gary Young, MD-Boston University Christopher Tompkins, PhD-Brandeis University John Chapman, PhD-Brandeis University	

<p>Grant Ritter, PhD-Brandeis University Timothy Martin, PhD-Brandeis University Sue Lee, MS-Brandeis University Marian Ryan, PhD - Brandeis University</p> <p>Workgroup Role: The workgroup participated in development of measures, review of interim results during development, and reviewing NQF submission forms. Listed members participated on the CMS project team working on the development of measures under a hospital VBP program.</p>
<p>Ad.2 If adapted, provide name of original measure: 30-day Post-hospital PNA Discharge Evaluation & Management Service Measure Ad.3-5 If adapted, provide original specifications URL or attachment</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.6 Year the measure was first released: Ad.7 Month and Year of most recent revision: Ad.8 What is your frequency for review/update of this measure? Ad.9 When is the next scheduled review/update for this measure?</p>
<p>Ad.10 Copyright statement/disclaimers: NA</p>
<p>Ad.11 -13 Additional Information web page URL or attachment: Attachment NQF Pneumonia Eval and Mgmt Services Measure Support (Sci Accept) - 28Oct2009.doc</p>
<p>Date of Submission (MM/DD/YY): 04/14/2010</p>