



Measure Information - Composite

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0707

De.2. Measure Title: 30-day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure

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

De.3. Brief Description of Measure: This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of PNA for three types of events: readmissions, ED visits and evaluation and management (E&M) services.

These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase II project's call for measures. Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.

1d.3. Developer Rationale: Measurement that extends a hospital's performance from its inpatient setting to requisite outpatient delivery systems facilitates acknowledgement of shared accountability in achieving optimal patient outcomes and results in the active transfer of accountability for the patients' treatment. This application extends the precedent set by 30-day time intervals (for mortality and readmission rates) to include other important indicators or criteria for inferring better versus worse care coordination. NQF has identified transitions or "hand-offs" as the fifth domain in their definition and framework for measuring care coordination (NQF, 2006). Transitions between care settings involve multiple providers and patients with complex needs, resulting in care that is often unsafe, disconnected, and uncoordinated. Furthermore, pilot programs and evaluations of efforts to improve care transitions often use service utilization as signals or indicators or performance, and criteria for whether the intended improvements are realized (Brown et al., 2006; Coleman & Berenson, 2004; Coleman, Parry, Chalmers, & Min, 2006; DeJonge, Taler, & Boling, 2009; Naylor, 2004; Naylor et al, 2004; Peikes, Chen, Schore, & Brown, 2009; Moore et al, 2003; Dudas et al, 2001; Forester et al, 2003) .

Hospital readmissions are recognized as system failures at least in part (Jencks, 2009). Ultimately, a composite measure examining the care trajectories of Medicare beneficiaries with PNA for the 30-days following hospital discharge would provide a more comprehensive picture of care provision during this critical window of time. It should be noted that two-thirds of elders admitted to the hospital with PNA have co-morbid chronic illness (HF, COPD/asthma, and DM being the most prevalent conditions) (Kaplan et al, 2002) that must be managed actively post a serious acute-care episode of PNA. Therefore, we examine the outcome of non-prescriptive, system-individualized and patient/family needs-based collaborative efforts to intervene appropriately with these high-risk patient cohorts at the lowest possible level of resource intensity. A hospital performance measure of E & M follow-up on Medicare beneficiaries discharged following acute treatment for PNA may encourage hospitals to develop discharge risk scores for specific cohorts that inform the most appropriate time frame for scheduled outpatient follow-up (Coleman & Williams, 2007). Although recently updated clinical practice guidelines for Community-Acquired Pneumonia and Hospital-Acquired Pneumonia do not specifically address appropriate ambulatory follow-up after a hospitalization given the high rate of readmissions for PNA (second in frequency only to HF, identified as a co-existing condition in many cases) and the recidivism following hospitalization with PNA in patients at highest risk a follow-up E&M service appears intrinsically valuable and evidence of optimal transfer of patient accountability from inpatient to ambulatory care or SNF.

S.4. Numerator Statement: The numerator is the weighted sum of the three deviations from their expected values for the individual measures comprising the component measure. The question of appropriate weights on the deviations is difficult and would

probably lead to a wide variation in opinion. The weights of -4, -2, and 1 are selected to represent order of magnitude differences in seriousness of the three outcomes, which most would agree to (that is to say: readmission is more important than ED which is more important in a negative way than E & M service is in a positive way). The idea on not using weights was also considered, but this was noted to be itself a de facto weight scheme (with all weights the same), and as such, a weight scheme that was less appropriate than the one chosen.

S.7. Denominator Statement: N/A The composite measure is the weighted of three individual measures. Thus, the denominator is one.

S.10. Denominator Exclusions: N/A

De.1. Measure Type: Composite

S.23. Data Source: Claims

S.26. Level of Analysis: Other

IF Endorsement Maintenance – Original Endorsement Date: Oct 02, 2012 **Most Recent Endorsement Date:** Jan 17, 2011

1d.1. Composite Measure Construction:

Component Measures (if endorsed or submitted for endorsement):

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

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

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

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

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.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

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

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

The measure addresses:

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

1c.1. Demonstrated high priority aspect of healthcare

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

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

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

1d. Composite Quality Construct and Rationale

1d.1. A composite performance measure is a combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.

For purposes of NQF measure submission, evaluation, and endorsement, the following will be considered composites:

- Measures with two or more individual performance measure scores combined into one score for an accountable entity.
- Measures with two or more individual component measures assessed separately for each patient and then aggregated into one score for an accountable entity:
 - all-or-none measures (e.g., all essential care processes received, or outcomes experienced, by each patient);
or
 - any-or-none measures (e.g., any or none of a list of adverse outcomes experienced, or inappropriate or unnecessary care processes received, by each patient).

1d.1. Please identify the composite measure construction:

1d.2. Describe the quality construct, including:

- the overall area of quality
- included component measures and
- the relationship of the component measures to the overall composite and to each other.

Having derived hospital-level risk-adjusted expected rates for E & M services, ED visits and readmissions following index hospitalizations for PNA patients, we propose to combine these three measures into a weighted, post-hospital discharge care transition composite measure. If timely care transition is facilitated by the discharge hospital, one would expect to avoid preventable Emergency Department visits or readmissions to the hospital. As the E & M service is the link that presumably transfers physician accountability for treatment back to the primary care physician or specialist in the outpatient setting, the E & M service should be the first event observed following hospital discharge, and our proposed composite measure credits and weights positively such E & M services. Conversely, hospital readmissions and outpatient ED visits are considered negative events and weighted accordingly, as described below.

Due to their implicit seriousness as well as high level of resource use, any readmission within 30 days following a hospital PNA stay, identified by NQF-endorsed criteria, contributes negatively to our composite measure. An ED visit contributes, again negatively, if it occurs within 30 days and prior to any readmission. An E & M service contributes, but positively, if the E & M service is the first service received following the index hospitalization during the time period. Risk adjusted predicted rates for E & M services, ED visits and hospitalizations are calculated for each hospital and compared with risk-adjusted expected rates (designated as 'popavg' in our formulas). Deviations in readmission rate, ED visit rate and E & M service rate, derived by subtracting risk-adjusted expected rate (popavg) from risk standardized rate (RSR) are combined into a composite rate using the weights of -4, -2, and 1 respectively to reflect the presumed relative seriousness of the three events. That is:

Post-discharge care composite measure = $-4*(RSR-popaverage)-2*(RSR-popaverage)+1*(RSR-popaverage)$.

In addition, to help interpret the resulting measure values, the hospitals are also percentile ranked.

1d.3. Describe the rationale for constructing a composite measure, including how the composite provides a distinctive or additive value over the component measures individually.

Measurement that extends a hospital's performance from its inpatient setting to requisite outpatient delivery systems facilitates acknowledgement of shared accountability in achieving optimal patient outcomes and results in the active transfer of accountability for the patients' treatment. This application extends the precedent set by 30-day time intervals (for mortality and readmission rates) to include other important indicators or criteria for inferring better versus worse care coordination. NQF has identified transitions or "hand-offs" as the fifth domain in their definition and framework for measuring care coordination (NQF, 2006). Transitions between care settings involve multiple providers and patients with complex needs, resulting in care that is often unsafe, disconnected, and uncoordinated. Furthermore, pilot programs and evaluations of efforts to improve care transitions often use service utilization as signals or indicators of performance, and criteria for whether the intended improvements are realized (Brown et al., 2006; Coleman & Berenson, 2004; Coleman, Parry, Chalmers, & Min, 2006; DeJonge, Taler, & Boling, 2009; Naylor, 2004; Naylor et al, 2004; Peikes, Chen, Schore, & Brown, 2009; Moore et al, 2003; Dudas et al, 2001; Forester et al, 2003) .

Hospital readmissions are recognized as system failures at least in part (Jencks, 2009). Ultimately, a composite measure examining the care trajectories of Medicare beneficiaries with PNA for the 30-days following hospital discharge would provide a more comprehensive picture of care provision during this critical window of time. It should be noted that two-thirds of elders admitted to the hospital with PNA have co-morbid chronic illness (HF, COPD/asthma, and DM being the most prevalent conditions) (Kaplan et al, 2002) that must be managed actively post a serious acute-care episode of PNA. Therefore, we examine the outcome of non-prescriptive, system-individualized and patient/family needs-based collaborative efforts to intervene appropriately with these high-risk patient cohorts at the lowest possible level of resource intensity. A hospital performance measure of E & M follow-up on Medicare beneficiaries discharged following acute treatment for PNA may encourage hospitals to develop discharge risk scores for specific cohorts that inform the most appropriate time frame for scheduled outpatient follow-up (Coleman & Williams, 2007). Although recently updated clinical practice guidelines for Community-Acquired Pneumonia and Hospital-Acquired Pneumonia do not specifically address appropriate ambulatory follow-up after a hospitalization given the high rate of readmissions for PNA (second in frequency only to HF, identified as a co-existing condition in many cases) and the recidivism following hospitalization with PNA in patients at highest risk a follow-up E&M service appears intrinsically valuable and evidence of optimal transfer of patient accountability from inpatient to ambulatory care or SNF.

1d.4. Describe how the aggregation and weighting of the component measures are consistent with the stated quality construct and rationale.

The outcomes making up the composite measure, E&M service, ED visits and hospital readmissions, represent increasing levels of resource use to medically manage PNA post-hospital discharge. These measures do not measure care transitions themselves or care coordination, but instead they represent the expectant result from improvement in such processes as evidenced by the numerous intervention programs and studies that utilize these measures as evidence of program/process effectiveness. If this composite is measured and reported, hospitals would be more motivated to develop the system-specific, needs-based processes unique to their inpatient-outpatient networks to provide the appropriate level of medical care at the right time and in the right setting. The proposed composite measure builds upon the previously endorsed measure for 30-day All-Cause Readmission following hospitalization for PNA by incorporating two additional measures to differentiate hospital performance on the outcome of transitional care efforts.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

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

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.)

TBA

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)

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:

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

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

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

The numerator is the weighted sum of the three deviations from their expected values for the individual measures comprising the component measure. The question of appropriate weights on the deviations is difficult and would probably lead to a wide variation in opinion. The weights of -4, -2, and 1 are selected to represent order of magnitude differences in seriousness of the three outcomes, which most would agree to (that is to say: readmission is more important than ED which is more important in a negative way than E & M service is in a positive way). The idea on not using weights was also considered, but this was noted to be itself a de facto weight scheme (with all weights the same), and as such, a weight scheme that was less appropriate than the one chosen.

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

Each of the individual measures in the composite is computed annually, as a three year rolling average.

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

The details on each individual measure comprising the component measure are provided in their submission for NQF approval.

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

N/A The composite measure is the weighted of three individual measures. Thus, the denominator is one.

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

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

N/A

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

N/A

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

N/A

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

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

If other:

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

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

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

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

S.16. Type of score:

Weighted score/composite/scale

If other:

S.17. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*

Calculation Algorithm for 30-day Hospital Discharge PNA Care Transition Composite measure:

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 PNA Readmission Measure Methodology submitted by YNHH-CORE, the Hospital 30-Day Acute Myocardial Infarction 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 associated with or after the first 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 separately (a) the ratio of E&M service=1 events, (b) the ratio of ED visit=1 events, and (c) the ratio of Readmission=1 events over the total number of qualifying index admissions to get unadjusted E&M, ED visit, and Readmission rates, respectively. These ratios are for descriptive purposes only.

Step 6:

- Estimate separately risk adjustment regression models on (a) the E&M service indicator, (b) the ED visit indicator, and (c) the readmission indicator using the methodology developed for the CMS 30-day all cause readmission measure.

Step 7: Applying the CMS 30-day readmission measure methodology, compute separately the P/E ratio and corresponding risk standardized rates (the RSR is defined as P/E times overall population mean) for E&M service, ED visit, and readmission. It must be understood that the RSR for E&M services greater than expected (popavg) indicates better than anticipated performance, while RSR for ED visits and readmissions greater than expected indicates lower than anticipated performance. This explains why weights for E&M service deviation is positive (+1), while weights for ED visits and readmissions components are negative (-2 and -4 respectively).

Step 8: Create the composite measure as the weighted sum of the components for each hospital's E&M service, ED visit, and readmission RSR.

Step 9: For better interpretation of composite measures across hospitals, also rank their composite measures with the convention that a higher composite implies a better performance.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

N/A

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Other

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital

If other:

S.28. 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.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

0707_MeasureTesting_CompositeMSF1.0_Data.doc

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in

electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

ALL data elements are in defined fields in a combination of electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

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

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

As a completely claims-based measure once measure specification has been coded it is not difficult to derive.

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*).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	
Payment Program	
Quality Improvement (Internal to the specific organization)	

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

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

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

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

4b. Improvement

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

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

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

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

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

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

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.

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 The measure specifications are harmonized with related measures; OR The differences in specifications are justified 5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized? 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:
Contact Information
Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare & Medicaid Services Co.2 Point of Contact: Corette, Byrd, corette.byrd@cms.hhs.gov, 410-786-8532- Co.3 Measure Developer if different from Measure Steward: Brandeis University Co.4 Point of Contact: Christopher, Tompkins, tompkins@brandeis.edu, 781-736-3913-
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. 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:

- Supplement, and provide texture, to the knowledge gathered through the literature review prior to measure development;
- Discussing existing measures and providing input as to next steps for CMS to adopt, adapt, and/or develop measures of care coordination relevant to the hospital setting; and
- Reviewing and providing 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
Timothy Martin, PhD-Brandeis University
Grant Rltter, PhD-Brandeis University
Sue Lee, MS-Brandeis University
Marian Ryan, Ph.D.Candidate-Brandeis University

Workgroup Role:

The workgroup participated in development of measures, review of interim results during development, and the review of NQF submission forms. Listed members participated on the CMS project team working on the development of measures under a hospital VBP program.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released:

Ad.3 Month and Year of most recent revision:

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

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

Ad.6 Copyright statement: N/A

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: