This form contains the information submitted by measure developers/stewards, organized according to NQF’s measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

### BRIEF MEASURE INFORMATION

**De.1 Measure Title:** Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

**Co.1.1 Measure Steward:** Centers for Medicare & Medicaid Services (CMS)

**De.2 Brief Description of Measure:** This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.

#### 2a1.1 Numerator Statement:

(Note: This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); thus, we use this field to define the measure outcome.)

The outcome for this measure is unplanned all-cause 30-day readmission. We defined a readmission as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

#### 2a1.4 Denominator Statement:

This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.

#### 2a1.8 Denominator Exclusions:

We exclude from the measure all admissions for which full data are not available or for which 30-day readmission by itself cannot reasonably be considered a signal of quality of care.

**Exclusions:**

1. Admissions for patients without 30 days of post-discharge data

   **Rationale:** This is necessary in order to identify the outcome (readmission) in the dataset.

2. Admissions for patients lacking a complete enrollment history for the 12 months prior to admission

   **Rationale:** This is necessary to capture historical data for risk adjustment.

3. Admissions for patients discharged against medical advice (AMA)

   **Rationale:** Hospital had limited opportunity to implement high quality care.

4. Admissions for patients to a PPS-exempt cancer hospital

   **Rationale:** These hospitals care for a unique population of patients that is challenging to compare to other hospitals.

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See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable
5. Admissions for patients with medical treatment of cancer (See Table 3 in Section 2a1.9)
Rationale: These admissions have a very different mortality and readmission profile than the rest of the Medicare population, and outcomes for these admissions do not correlate well with outcomes for other admissions.
(Patients with cancer who are admitted for other diagnoses or for surgical treatment of their cancer remain in the measure).

6. Admissions for primary psychiatric disease (see Table 4 in Section 2a1.9)
Rationale: Patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers which are not comparable to acute care hospitals.

7. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices”
Rationale: These admissions are not for acute care or to acute care hospitals.

Additionally, in the all-payer testing, we excluded obstetric admissions because the measure was developed among patients aged 65 years or older (approximately 500,000).

1.1 Measure Type: Outcome
2a1. 25-26 Data Source: Administrative claims
2a1.33 Level of Analysis: Facility
1.2-1.4 Is this measure paired with another measure? No
De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed): N/A

STAFF NOTES (issues or questions regarding any criteria)
Comments on Conditions for Consideration:
Is the measure untested? Yes ☐ No ☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:

1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (check De.5):
5. Similar/related endorsed or submitted measures (check 5.1):
Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.
Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact: ☐ H ☐ M ☐ L ☐ I ☑
(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply): Cardiovascular, Cardiovascular : Acute Myocardial Infarction, Cardiovascular : Atrial Fibrillation, Cardiovascular : Congestive Heart Failure, Cardiovascular : Hyperlipidemia, Cardiovascular : Hypertension, Cardiovascular : Ischemic Heart Disease, Coronary Artery Disease, Cardiovascular : Percutaneous Coronary Intervention (PCI), Endocrine, Endocrine : Diabetes, Gl, Gl : Appendicitis, Gl : Bleeding, Gl : Cirrhosis, Gl : Gall Bladder Disease, Gl : Gastroenteritis, Gl : Gastro-Esophageal Reflux Disease (GERD)/Peptic Ulcer, Gl : Polyps, GU/GYN, GU/GYN : Gynecology, GU/GYN : Incontinence, GU/GYN : Male Genito-Urinary, HEENT, Infectious Diseases, Infectious Diseases : Hepatitis, Infectious Diseases : Respiratory, Infectious Diseases : Sexually Transmitted, Infectious Diseases : Tuberculosis, Musculoskeletal, Musculoskeletal : Arthritis-Osteo, Musculoskeletal : Arthritis-Rheumatoid, Musculoskeletal : Functional Status, Musculoskeletal : Hip/Pelvic Fracture, Musculoskeletal : Joint Surgery, Musculoskeletal : Low Back Pain, Musculoskeletal : Osteoporosis, Neurology,
1a.1 Demonstrated High Impact Aspect of Healthcare:  Affects large numbers, A leading cause of morbidity/mortality, Frequently performed procedure, High resource use, Patient/societal consequences of poor quality, Severity of illness

1a.2 If “Other,” please describe:

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):
During 2003 and 2004, almost one fifth of Medicare beneficiaries – over 2.3 million patients – were rehospitalized within 30 days of discharge from an acute care hospital [1]. Jencks et. al. estimated that readmissions within 30 days of discharge cost Medicare more than $17 billion annually [1]. A 2006 Commonwealth Fund report further estimated that if national readmission rates were lowered to the levels achieved by the top performing regions, Medicare would save $1.9 billion annually [2]. In a 2007 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that in 2005, 17.6% of hospital patients were readmitted within 30 days of discharge and that 76% of these readmissions were potentially preventable; the average payment for a “potentially preventable” readmission was estimated at approximately $7,200 [3].


1b. Opportunity for Improvement:  H [ ] M [ ] L [ ] I [ ]
(There is a demonstrated performance gap - variability or overall less than optimal performance)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
The Hospital-wide All-Cause Unplanned Readmission Measure reports the hospital-level, risk-standardized rate of unplanned all-cause readmission within 30 days of hospital discharge. A hospital’s readmission rate is related to complex and critical aspects of care such as communication between providers; prevention of, and response to, complications; patient safety; and coordinated transitions to the outpatient environment. These are of importance to patients, physicians, hospitals and policymakers. While disease-specific measures of readmission are helpful to identify deficiencies in care for specific groups of patients, they account for only a small minority of total readmissions [1]. By contrast, a hospital-wide, all-condition readmission measure could provide a broad sense of the quality of care at hospitals. In this way, the measure can promote hospital quality improvement and better inform consumers about care quality.

Studies have estimated the rate of preventable readmissions to be as low as 12% and as high as 76% [2,3]. Some readmissions are unavoidable and result from inevitable progression of disease or worsening of chronic conditions. However, readmissions may also result from poor quality of care or inadequate transitional care. Randomized controlled trials have shown that improvement in the following areas can directly reduce readmission rates: quality of care during the initial admission; improvement in communication with patients, their caregivers and their clinicians; patient education; predischarge assessment; and coordination of care after discharge. Evidence that hospitals have been able to reduce readmission rates through these quality-of-care initiatives illustrates the degree to which hospital practices can affect readmission rates. Successful randomized trials have reduced 30-day readmission rates by 20-40% [4-14].

Since 2008, 14 Medicare Quality Improvement Organizations have been funded to focus on care transitions, applying lessons learned from clinical trials. Several have been notably successful in reducing readmissions. The strongest evidence supporting the efficacy of improved discharge processes and enhanced care at transitions is a randomized controlled trial by Project RED (Re-Engineered Discharge), which demonstrated a 30% reduction in 30-day readmissions. In this intervention, a nurse was assigned to each patient as a discharge advocate, responsible for patient education, follow-up, medication reconciliation, and preparing