NATIONAL QUALITY FORUM
Driving measurable health improvements together

# All-Cause Admissions and Readmissions, Spring 2022 Cycle CDP Report

## TECHNICAL REPORT FOR COMMENT
## JANUARY 30, 2023

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

https://www.qualityforum.org

# Contents

## Executive Summary

Quality improvement has a critical goal of reducing avoidable hospital admissions and readmissions. Avoidable admissions and readmissions affect patients' daily lives and contribute to unnecessary healthcare spending. However, concerns about the unintended consequences of using measures of admissions and readmissions in accountability programs have prompted important study and discussion to meet quality goals while protecting access to necessary and appropriate care. The National Quality Forum's (NQF) All-Cause Admissions and Readmissions (ACR) Standing Committee oversees a portfolio of quality measures that continue to address inefficiencies in readmissions and improve transitions and care coordination between care settings. The ACR portfolio of measures includes all-cause and condition-specific admissions and readmissions.

For this cycle, the Standing Committee evaluated two measures undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended two measures for endorsement, and the Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendations.

The Standing Committee endorsed the following measures:

- NQF #2375 PointRight® Pro 30™ (American Health Care Association [AHCA], PointRight, Inc.)
- NQF #2827 PointRight® Pro Long Stay ™ (AHCA/PointRight, Inc.)

Brief summaries of the measures and their evaluations are included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for each measure are in Appendix A.

## Introduction

Unplanned hospital readmissions are associated with poor health outcomes and are a leading healthcare concern in the United States (U.S.) due to the implications for the quality of care provided to hospitalized patients as well as the healthcare costs associated with readmission.[1,2] Readmission is defined as having at least one subsequent hospital admission within 30 days of hospital discharge because it is clinically related to the initial hospitalization.[3] In 2018, the U.S. had a total of 3.8 million adult hospital readmissions within 30 days among all payers, of which Medicare accounted for 60.3 percent (2.3 million readmissions) and Medicaid accounted for 19.0 percent (721,300 readmissions).[4] Furthermore, the average readmission rate for the U.S. is 14 percent with an average readmission cost of $15,200, accounting for more than $17 billion in Medicare expenditures annually.[1,4]

To begin tackling inefficiencies in the healthcare system, U.S. healthcare reform identified hospital readmission as a key area for improving transitions and care coordination between care settings and achieving potential savings.[5] Many preventable hospital readmissions can be attributed to structural and process issues that are not directly related to clinical conditions.[6–8] The ACR Standing Committee reviewed two measures focused on unplanned readmissions among patients who enter a skilled nursing facility (SNF) from an acute care hospital and hospitalizations among long-term residents of SNFs. The unnecessary patient harms that ensue due to a hospital readmission offer additional motivation for reducing hospitalization rates of SNF residents, further establishing the need for a comprehensive set of performance measures related to this problem.

## NQF Portfolio of Performance Measures for All-Cause Admissions and Readmissions Conditions

The ACR Standing Committee (Appendix C) oversees NQF's portfolio of admissions and readmissions measures (Appendix B), which includes measures for all-cause and condition-specific admissions and readmission measures addressing numerous settings (e.g., hospital, hospital outpatient, ambulatory surgical center [ASC], SNF, home health, and Accountable Care Organizations [ACOs]). This portfolio contains 37 measures: 20 all-cause measures and 17 condition-specific measures.

Additional measures have been assigned to other portfolios. These include healthcare-associated infection measures (Patient Safety), care coordination measures (Geriatrics and Palliative Care), imaging efficiency measures (Cost and Efficiency), and a variety of condition-or procedure-specific outcome measures (e.g., Cardiovascular, Cancer, and Renal).

## All-Cause Admissions and Readmissions Measure Evaluation

On June 24, 2022, the ACR Standing Committee evaluated two measures undergoing maintenance review against NQF's standard measure evaluation criteria.

**Table 1. All-Cause Admissions and Readmissions Measure Evaluation Summary**

| Measure | Maintenance | New | Total |
|---|---|---|---|
| **Measures under review for endorsement** | 2 | 0 | 2 |
| **Measures endorsed** | 2 | 0 | 2 |

## Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 10, 2022, and pre-meeting commenting closed on June 7, 2022. No comments were received prior to the measure evaluation meeting (Appendix F).

## Comments Received After Standing Committee Evaluation

The continuous public commenting period with NQF member support closed on September 6, 2022. Following the Standing Committee's evaluation of the measures under review, NQF did not receive any comments from organizations or individuals pertaining to the draft report and the measures under review.

NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations during the commenting period.. No NQF members expressed "support" or "do not support" for the two measures undergoing maintenance review.

## Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

### NQF #2375 PointRight® Pro 30™ (American Health Care Association [AHCA]/PointRight, Inc.): Endorsed

**Description**: PointRight Pro-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which a patient (regardless of payer status or diagnosis) who enters a skilled nursing facility (SNF) from an acute hospital and is subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post-Acute Care; **Data Source**: Assessment Data, Electronic Health Records: Electronic Health Records

This facility-level measure was originally endorsed in 2014 and retained endorsement in 2016. It is publicly reported on the AHCA website and is utilized in the state of California's Quality and Accountability Supplemental Payment (QASP) and Hawaii Nursing Facility pay-for-performance (P4P) programs.

The developer attested that no change had occurred in the evidence since its last endorsement. The Standing Committee agreed that the evidence continues to support structural and process interventions accountable entities can take to reduce the likelihood of rehospitalizations. One Standing Committee member highlighted two recent peer-reviewed publications; one focuses on 30-day readmissions among Medicare Advantage versus Medicare fee-for-service (FFS) beneficiaries, and the other focuses on racial disparities, which supported the previous evidence and aligned with the current disparities data provided by the developer. While the Standing Committee did note that the gap in disparities is narrowing, it agreed that a performance gap exists in care that warrants a national performance measure. The Standing Committee ultimately passed the measure on evidence and performance gap.

The Standing Committee agreed that the reliability testing provided by the developer was sufficient. During the discussion on validity, the Standing Committee requested clarification on whether the c-statistic of 0.67 for the Pro30 model was adequate. The developer confirmed that the risk model's c-statistic of 0.67 is adequate to predict that a case (i.e., a person who is readmitted to an acute inpatient facility from the SNF) has a higher predicted risk than a non-case. The Standing Committee also agreed that the validity testing was sufficient and passed the measure on both reliability and validity.

The Standing Committee agreed that the data elements required for the measure are readily available and could be captured without undue burden. During the Standing Committee's discussion of use, one member noted that patients and families might have challenges understanding the raw data and recommended the developer incorporate a more user-friendly format to present data for consumer use. The developer appreciated the Standing Committee's feedback from the patient perspective and agreed that it is important to consider consumers and patient feedback when making improvements to the measure. Regarding usability, the Standing Committee recommended that the developer further assess the impact of coronavirus disease 2019 (COVID-19) on the measure, specifically for the next maintenance review. Ultimately, the Standing Committee passed the measure on feasibility, use, usability, and overall suitability for endorsement.

The Standing Committee recommended the measure for continued endorsement. Since the quorum for live voting was not achieved, the Standing Committee was unable to discuss related and competing measures during the measure evaluation meeting; consequently, the discussion was moved to the post-comment meeting. In consultation with the Standing Committee co-chairs, the All-Cause Admissions and Readmissions project team canceled the post-comment meeting since no comments were submitted for this measure and only related measures were identified. The Standing Committee maintained its recommendation for continued endorsement without a discussion on related measures. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received.

### NQF #2827 PointRight® Pro Long Stay™ (AHCA/PointRight, Inc.): Endorsed

**Description**: The PointRight Pro Long Stay Hospitalization Measure is an MDS-based, risk-adjusted measure of the rate of hospitalization of long-stay patients (also known as "residents") of skilled nursing facilities (SNFs) averaged across the year, weighted by the number of stays in each quarter; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Post-Acute Care; **Data Source**: Electronic Health Records: Electronic Health Records, Assessment Data

This facility-level measure was originally endorsed in 2016. It is publicly reported on the AHCA website and is used in the New Mexico value-based purchasing (VBP), Colorado Medicaid Nursing Facilities P4P, and Hawaii Nursing Facility P4P programs.

The developer attested that no change had occurred in the evidence since its last endorsement. The Standing Committee agreed that the evidence continues to support structural and process interventions accountable entities can take to reduce hospitalizations. One Standing Committee member noted that the developer included antipsychotic use within the logic model and questioned whether there was new evidence to support the addition of antipsychotic medications. The developer confirmed that there is evidence that the use of antipsychotic medications increases the risk of hospitalization over time. The Standing Committee accepted the developer's response and passed the measure on evidence.

During the discussion on performance gap, the Standing Committee noted that the difference in average readmission rates between high and low social vulnerability index (SVI) facilities has narrowed over time. The developer responded by stating that it is unclear what is driving the change in readmission rates between populations. The Standing Committee emphasized the importance of knowing which factors influence readmission rates and what interventions are proving to be successful. The Standing Committee agreed that a gap exists in care that warrants a national performance measure.

The Standing Committee reviewed the scientific acceptability of the measure. A Standing Committee member noted that the previous testing data were from 2013–2014 and questioned why the developer did not use more recent data for the maintenance endorsement review. The developer explained that significant changes have not occurred in facility demographics data (i.e., part of chain, for profit, government, hospital-based, Medicare-certified facilities, and resident count) since the measure's initial endorsement review; therefore, they did not perform new testing. Next, the Standing Committee reviewed validity testing and noted that while 98 percent of acute inpatient Medicare FFS claims found near a Minimum Data Set (MDS) discharge have an acute hospitalization MDS discharge code, only 86 percent of Medicare FFS hospitalizations identified by the MDS are confirmed by Medicare FFS claims. The Standing Committee questioned whether observation stays would cause an overstating of the MDS readmission rate and whether planned readmissions were captured as a readmission in the measure, which the developer subsequently confirmed. In addition, a Standing Committee member questioned whether planned readmissions could be parsed from the overall readmission data. The developer responded by explaining that there are very few planned hospitalizations for long-stay residents overall (i.e., residents with a cumulative length of stay in the facility of more than 100 days); therefore, it is unlikely for those types of residents to be included in the measure. Ultimately, the Standing Committee passed the measure on reliability and validity.

The Standing Committee agreed that the data elements required for the measure are readily available and could be captured without undue burden. After confirming that the measure results are provided on the AHCA website, a Standing Committee member noted that patients and families might have challenges understanding the raw data and recommended the developer incorporate a more user-friendly format to present data for consumer use. In terms of usability, the Standing Committee questioned how the developer will account for COVID-19 and its impact on determining future progress toward achieving the goal of high quality, efficient healthcare for long-term residents. The developer

explained that data collection has continued throughout the pandemic without interruption. Additionally, the developer noted that they would consider an update to the scientific acceptability testing, which would include both acute infection and a history of previous COVID-19 infection within the risk adjustment model. The Standing Committee did not have any further questions and ultimately passed the measure on feasibility, use, usability, and overall suitability for endorsement.

The Standing Committee recommended the measure for continued endorsement. Since the quorum for live voting was not achieved, the Standing Committee was unable to discuss related and competing measures during the measure evaluation meeting; consequently, the discussion was moved to the post-comment meeting. In consultation with the Standing Committee co-chairs, the All-Cause Admissions and Readmissions project team canceled the post-comment meeting since no comments were submitted for this measure and only related measures were identified. The Standing Committee maintained its recommendation for continued endorsement without a discussion on related measures. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received.

## Measures Withdrawn From Consideration

Three measures previously endorsed by NQF either have not been resubmitted for maintenance of endorsement or were withdrawn during the endorsement evaluation process. Endorsement for these measures has been removed.

**Table 2. Measures Withdrawn From Consideration**

| Measure | Reason for Withdrawal |
|---|---|
| **NQF #2513 Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Vascular Procedures** | Measure is no longer in use. |
| **NQF #2858 Discharge to Community** | Retired by developer. |
| **NQF #3449 Hospitalization for Ambulatory Care Sensitive Conditions for Dual-Eligible Beneficiaries** | Retired by developer. |

## References


1 Jencks SF, Williams MV, Coleman EA. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*. 2009;360(14):1418-1428. https://doi.org/10.1056/NEJMsa0803563. Last accessed July 2022.

2 Zohrabian A, Kapp JM, Simoes EJ. The economic case for US hospitals to revise their approach to heart failure readmission reduction. *Ann Transl Med*. 2018;6(15):298. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6123214/. Last accessed July 2022.

3 Potentially Preventable Readmission Reports. https://dshs.texas.gov/thcic/hospitals/Potentially-Preventable-Readmission-Reports/. Last accessed July 2022.

4 Overview of Clinical Conditions With Frequent and Costly Hospital Readmissions by Payer, 2018 #278. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp. Last accessed July 2022.

5 Orszag PR, Emanuel EJ. Health Care Reform and Cost Control. *N Engl J Med*. 2010;363(7):601-603.

6 Dharmarajan K, Hsieh AF, Lin Z, et al. Hospital readmission performance and patterns of readmission: retrospective cohort study of Medicare admissions. *BMJ*. 2013;347:f6571. https://www.bmj.com/content/347/bmj.f6571. Last accessed July 2022.

7 Ouslander JG, Maslow K. Geriatrics and the Triple Aim: Defining Preventable Hospitalizations in the Long-Term Care Population. *J Am Geriatr Soc*. 2012;60(12):2313-2318.

8 Ouslander JG, Berenson RA. Reducing Unnecessary Hospitalizations of Nursing Home Residents. *New England Journal of Medicine*. 2011;365(13):1165-1167. https://doi.org/10.1056/NEJMp1105449. Last accessed July 2022.

# Appendix A: Details of Measure Evaluation

**Rating Scale: H**=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

NQF ensures that quorum is maintained for all live voting. Quorum is 66 percent of active Standing Committee members minus any recused Standing Committee members. Due to the exclusion of recused Standing Committee members from the quorum calculation, the required quorum for live voting may vary among measures. During the meeting, the quorum required for voting was not achieved (14 out of 20 Standing Committee members). Therefore, the Standing Committee discussed all criteria for each measure and voted after the meeting using an online voting tool. The post-comment call was not held for the spring 2022 cycle, as NQF did not receive any comments from organizations or individuals pertaining to the draft report and the measures under review. The Standing Committee received a recording of the meeting and a link to submit online votes. Voting closed after 48 hours with the minimum number of votes required for quorum. Voting results are provided below.

A measure is recommended for endorsement by the Standing Committee when greater than 60 percent of voting members select a passing vote option (i.e., Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40 percent of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement.

## Measures Endorsed

### NQF #2375 PointRight® Pro 30™

Measure Worksheet | Specifications

**Description**: PointRight Pro-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which a patient (regardless of payer status or diagnosis) who enters a skilled nursing facility (SNF) from an acute hospital and is subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.

**Numerator Statement**: The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during a 12 month measurement period.

**Denominator Statement**: The denominator is the number of all admissions, regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the 12 month measurement period.

**Exclusions**: Individuals with incomplete MDS assessments are excluded. Payer status and clinical conditions are not used for any exclusions.

**Adjustment/Stratification**: No additional risk adjustment analysis included.

**Level of Analysis:** Facility

**Setting of Care:** Post-Acute Care

**Type of Measure**: Outcome

**Data Source**: Assessment Data, Electronic Health Records: Electronic Health Records

**Measure Steward**: American Health Care Association (AHCA)

**STANDING COMMITTEE MEETING June 24, 2022**

**1. Importance to Measure and Report:**

*(1a. Evidence, 1b. Performance Gap)*

1a. Evidence: **Total votes-16**; **Y-16**; **N-0**; 1b. Performance Gap: **Total votes- 16; H-1**; **M-15**; **L-0**; **I-0**

**Rationale:**

- The Standing Committee acknowledged that the evidence had not changed since the previous review and agreed that the measure continues to support structural and process interventions accountable entities can take to reduce the likelihood of rehospitalizations.
- A Standing Committee member highlighted two recent peer-reviewed publications; one focuses on 30-day readmissions among Medicare Advantage versus Medicare FFS beneficiaries, and the other focuses on racial disparities, which supported the previous evidence and aligned with the current disparities data provided by the developer.
- The Standing Committee noted that rehospitalization rates are steadily declining with an average improvement rate of 10.4 percent between quarter four (Q4) of 2011 through Q3 of 2020.
- While the Standing Committee did note that the average readmission rate between low SVI counties and high SVI counties is narrowing (2.7 percent [Q4 2011] and 1.4 percent [Q4 2020]), it agreed that a performance gap exists in care that warrants a national performance measure.
- The Standing Committee agreed that an opportunity for improvement remains and passed the measure on evidence and performance gap.

**2. Scientific Acceptability of Measure Properties:**

*(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)*

2a. Reliability: **Total votes-16**; **H-0**; **M-16**; **L-0**; **I-0**; 2b. Validity: **Total votes-16**; **H-1**; **M-15**; **L-0**; **I-0**

**Rationale:**

- The Scientific Methods Panel (SMP) did not review this measure.
- The Standing Committee noted that the developer conducted parallel forms of reliability testing, demonstrating that the MDS 3.0 data from the Centers for Medicare & Medicaid Services (CMS) are reliable when compared to data gathered directly from participating SNFs.
- The Standing Committee agreed that the reliability testing conducted was robust and passed the measure on the reliability criterion.
- The Standing Committee reviewed the developer's previous testing at the patient/encounter level and noted that 82.9 percent of MDS 3.0 discharge assessments indicating an acute care hospital discharge location could be verified with inpatient claims data.
- The Standing Committee noted that this measure had a statistically significant positive correlation with both the Medicare claims-based rehospitalization measures: *Number of Hospitalizations per 1,000 Long-Stay Resident Days* and *Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNR-RM)*.
- The Standing Committee requested clarification on whether the c-statistic of 0.67 for the Pro30 model was considered adequate. The developer confirmed that the risk model's c-statistic of 0.67 is adequate to predict that a case (i.e., a person who is readmitted to an acute inpatient facility from the SNF) has a higher predicted risk than a non-case.
- The Standing Committee noted that the mean risk-adjusted performance rate for SNFs nationwide was 16.3 percent (standard deviation [SD] 5.2 percent), ranging from 0 percent to 81.9 percent.
- The Standing Committee agreed that the validity testing was sufficient and passed the measure on the validity criterion.

**3. Feasibility: Total votes-16**; **H-0; M-16; L-0; I-0**

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)*

**Rationale:**

- The Standing Committee acknowledged that the data elements required for the measure are readily available and could be captured without undue burden.
- The Standing Committee acknowledged that computation of the measure requires a license to use the software for large-scale data management and calculation of risk estimates using logistic regression models.
- The Standing Committee acknowledged that while utilization of the measure specifications does not require a fee, the display, disclosure, or publication of the measure must include the measure's trademark. It also acknowledged that the measure specifications are copyrighted by PointRight®.

**4. Usability and Use:**

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

4a. Use**: Total votes-16**; **Pass-16; No Pass-0**; 4b. Usability: **Total votes-16**; **H-1; M-15; L-0; I-0**

**Rationale:**

- The Standing Committee acknowledged that the measure is currently used in two state Medicaid programs (California and Hawaii) as part of their VBP or P4P and individual providers and networks.
- While the Standing Committee did acknowledge an average improvement of 10.4 percent in rehospitalization rates from Q4 2011 through Q4 2020, it noted that a slight increase occurred in the national average rate between Q4 of 2019 and Q4 of 2020, which the developer attributed to the COVID-19 pandemic.
- A Standing Committee member expressed concerns about the potential for readmission measures to become cost measures when they are utilized in VBP settings. The developer explained that the measure is used in Medicaid VBP programs in conjunction with other clinical and utilization measures and does not serve as the sole source of evaluation.
- A Standing Committee member noted that the use of the measure could go beyond the facility and be used by the facility to communicate to the residents and their families, thus creating a pathway to provide meaningful and helpful information for them to use.
- A Standing Committee member noted that patients and families might have challenges understanding the raw data and recommended the developer incorporate a more user-friendly format to present data for consumer use. The developer appreciated the Standing Committee's feedback from the patient perspective.
- Regarding usability, the Standing Committee recommended that the developer further assess the impact of COVID-19 on the measure's performance, specifically for the following maintenance review.
- Ultimately, the Standing Committee passed the measure on the use and usability criteria.

**5. Related and Competing Measures**

- This measure is related to the following measures:
    - NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
    - NQF #2827 PointRight® Pro Long Stay(TM) Hospitalization Measure
- Since the quorum for live voting was not achieved, the Standing Committee was unable to discuss related and competing measures during the measure evaluation meeting; consequently, the discussion was moved to the post-comment meeting. In consultation with the Standing Committee co-chairs, the All-Cause Admissions and Readmissions project team canceled the post-comment meeting since no comments were submitted for this measure and only related measures were identified. The Standing Committee maintained its recommendation for continued endorsement without a discussion on related measures.

**6. Standing Committee Recommendation for Endorsement**: **Total votes- 16**; **Yes-16**; **No-0**

**7. Public and Member Comment**

- No NQF member or public comments were received.

**8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total Votes-15; Yes-15; No-0**

**December 9, 2022: Endorsed**

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

**9. Appeals**

- No appeals were received.

## NQF #2827 PointRight® Pro Long Stay (TM) Hospitalization Measure

Measure Worksheet | Specifications

**Description**: The PointRight Pro Long Stay Hospitalization Measure is an MDS-based, risk-adjusted measure of the rate of hospitalization of long-stay patients (also known as "residents") of skilled nursing facilities (SNFs) averaged across the year, weighted by the number of stays in each quarter.

**Numerator Statement**: The numerator for the measure is the sum over four quarters of the counts of hospitalizations of the quarterly denominator populations, where hospitalizations comprise discharges directly from the SNF to an acute care hospital.

**Denominator Statement**: The quarterly denominator population consists of those patients present in the SNF on the first day of the quarter (the "snapshot date") who meet the criterion for long stay on that date. The denominator for a quarter is the number of patients in the quarterly denominator population. The denominator for the measure is the sum of the quarterly denominators for the four quarters in the 12 month measurement period. The criterion for a patient's having a long stay is a cumulative length of stay in the facility of more than 100 days as of the snapshot date. The cumulative length of stay of a patient is the length of the current stay as of the snapshot date and plus the full lengths of stay of any previous stays that are linked to it. According to the criteria for linkage of stays used in the present measure, a stay in a SNF is linked to a subsequent stay in the SNF if the patient was discharged from the SNF to the community and was readmitted to the SNF within 10 days or fewer. All stays in a sequence of linked stays are included in the sum of days used to determine a patient's cumulative length of stay. In these criteria the term "community" comprises private residences and all organized settings that are primarily residential in character, including senior housing, independent living facilities, board and care homes, and assisted living facilities. A patient can contribute multiple times to the denominator for a 12-month measure period. For example, a resident continuously present in the facility for a full year would contribute four to the denominator.

**Exclusions**: There are no exclusions from the denominator; all patients in the facility on the snapshot date who meet the long stay criterion on that date are included.

**Adjustment/Stratification**: No additional risk adjustment analysis included.

**Level of Analysis:** Facility.

**Setting of Care:** Post-Acute Care

**Type of Measure**: Outcome

**Data Source**: Electronic Health Records: Electronic Health Records, Assessment Data

**Measure Steward**: American Health Care Association

**STANDING COMMITTEE MEETING June 24, 2022**

**1. Importance to Measure and Report:**

*(1a. Evidence, 1b. Performance Gap)*

1a. Evidence: **Total votes-18**; **Y-18**; **N-0**; 1b. Performance Gap: **Total votes- 18; H-2**; **M-16**; **L-0**; **I-0**

**Rationale:**

- The Standing Committee acknowledged that the evidence had not changed since the previous review and agreed that the measure continues to support structural and process interventions accountable entities can take to reduce the likelihood of hospitalizations.
- One Standing Committee member noted that the developer included antipsychotic use within the logic model and questioned whether there was new evidence to support the addition of antipsychotic medications.
- The developer confirmed that there is evidence that the use of antipsychotic medications increases the risk of hospitalization over time.
- The Standing Committee member noted that the national average hospitalization rate has increased by 6.5 percent.
- During the discussion on the performance gap, the Standing Committee noted that the difference in average readmission rates between high and low SVI facilities has narrowed over time.
- The developer responded by stating that it is unclear what is driving the change in readmission rates between populations. The Standing Committee emphasized the importance of knowing which factors influence readmission rates and what interventions are proving to be successful.

- The Standing Committee noted facilities with less than 5 percent of minority residents have a lower risk-adjusted Pro Long Stay hospitalization rate (12.3 percent) compared to facilities with greater than or equal to 35 percent of minority residents (17.9 percent).
- The Standing Committee agreed that disparities across races and high SVI counties exist and passed the measure on the evidence and performance gap criteria.

**2. Scientific Acceptability of Measure Properties:**

*(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)*

2a. Reliability: **Total votes-18**; **H-1**; **M-17**; **L-0**; **I-0**; 2b. Validity: **Total votes-18**; **H-1**; **M-17**; **L-0**; **I-0**

**Rationale:**

- The SMP did not review this measure.
- The Standing Committee noted that the measure specifications have not changed since the last review and the developer did not conduct new reliability testing.
- A Standing Committee member questioned whether patients with planned admissions would be included in the numerator. The developer confirmed that planned readmissions would be considered an admission and count in the measure's numerator if the resident has a stay in a long-term facility over 100 days.
- The Standing Committee member responded by asking the developer whether it was possible to drill down the data at the facility level to parse out the planned admissions to identify which actions to take for improvement. The developer explained that the planned admissions for long-stay residents are rare and occur in less than 10 planned admissions in a 12-year period.
- A Standing Committee member noted that the reliability data used for patient/encounter level-testing were from 2013–2014 and questioned why the developer did not update the reliability testing using more recent data for this maintenance endorsement review.
- The developer explained that insignificant changes have occurred in facility demographics data (e.g., part of chain, for profit, government, hospital-based, Medicare-certified facilities, and resident count) since the measure's initial endorsement review; therefore, it did not perform new testing.
- The Standing Committee agreed that the reliability testing that was previously conducted was robust and passed the measure on the reliability criterion.
- The Standing Committee noted that the developer conducted validity testing at the patient or encounter level and the accountable entity-level. It also highlighted that while 98 percent of acute inpatient FFS claims found near an MDS discharge have an MDS discharge code of acute hospitalization, only 86 percent of hospitalizations of Medicare FFS patients identified by the MDS are confirmed by Medicare FFS claims.
- The Standing Committee questioned whether observation stays would lead to overstating MDS readmission rates and whether planned readmissions were captured as a readmission in the measure.
- The developer confirmed that planned readmissions were captured as a readmission and observation stays would lead to overstating MDS readmission rates.
- A Standing Committee member questioned why the measure is not reported for an SNF if the denominator population over the measure period's four snapshot dates is less than 30. The developer responded by explaining that this would mainly affect the reliability if there was a lot of variation in the performance rates; however, the developer noted that members have access to their actual performance rates on the website.
- A Standing Committee member questioned whether planned readmissions could be parsed from the overall readmission data. The developer responded by explaining that there are very few planned hospitalizations for long-stay residents overall (i.e., residents with a cumulative length of stay in the facility of more than 100 days); therefore, it is unlikely for those types of residents to be included in the measure.
- The Standing Committee agreed that the validity testing was sufficient and passed the measure on the validity criterion.

**3. Feasibility: Total votes-18**; **H-1; M-17; L-0; I-0**

*(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)*

**Rationale:**

- The Standing Committee acknowledged that the data elements required for the measure are readily available and could be captured without undue burden.
- The Standing Committee acknowledged that computation of the measure requires a license to use the software for large-scale data management and calculation of risk estimates using logistic regression models.
- The developer emphasized that the ProRight® software allows users to download and use the data elsewhere, such as on another website, while also noting the public data are displayed as raw data.
- The Standing Committee acknowledged that while utilization of the measure specifications does not require a fee, the display, disclosure, or publication of the measure must include the measure's trademark. It also acknowledged that the measure specifications are copyrighted by Point Right®.

**4. Usability and Use:**

*(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)*

4a. Use**: Total votes-18**; **Pass-18; No Pass-0**; 4b. Usability: **Total votes-18**; **H-2; M-15; L-1; I-0**

**Rationale:**

- The Standing Committee acknowledged that the measure is publicly reported on the AHCA website and is used in the New Mexico VBP program, the Colorado Medicaid Nursing Facilities P4P programs, and the Hawaii Nursing Facility P4P programs.
- The Standing Committee questioned how the developer will account for COVID-19 and its impact on determining future progress toward achieving the goal of high quality, efficient healthcare for long-term residents.
- The developer explained that data collection has continued throughout the pandemic without interruption. Additionally, the developer noted that they would consider an update to the scientific acceptability testing, which would include both acute infection and a history of previous COVID-19 infection within the risk adjustment model.
- A Standing Committee member questioned how the data are presented on the public website (i.e., snapshot number, trend chart) and whether the developer intends to make it so that the data are truly useful and understandable to consumers, particularly those living in SNFs where it can be posted. The developer explained that the raw data are presented in spreadsheet form and acknowledged the Standing Committee's recommendation to incorporate a more user-friendly format to present data for consumer use.
- A Standing Committee member questioned whether the developer monitored mortality among vulnerable patients in the long-term care facilities. The developer responded by stating that mortality among vulnerable patients was not assessed.

**5. Related and Competing Measures**

- This measure is related to the following measures:
    - NQF #2375 PointRight ® Pro 30™
    - NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- Since the quorum for live voting was not achieved, the Standing Committee was unable to discuss related and competing measures during the measure evaluation meeting; consequently, the discussion was moved to the post-comment meeting. In consultation with the Standing Committee co-chairs, the All-Cause Admissions and Readmissions project team canceled the post-comment meeting since no comments were submitted for this measure and only related measures were identified. The Standing Committee maintained its recommendation for continued endorsement without a discussion on related measures.

**6. Standing Committee Recommendation for Endorsement**: **Total votes- 18**; **Yes-18**; **No-0**

**7. Public and Member Comment**

- No NQF member or public comments were received.

**8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total Votes-15; Yes-15; No-0 December 9, 2022: Endorsed**

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

**9. Appeals**

- No appeals were received.

## Appendix B: All-Cause Admissions and Readmissions Portfolio—Use in Federal Programs*

| NQF# | Title | Federal Programs (Finalized or Implemented) |
|---|---|---|
| #0171 | Acute Care Hospitalization During the First 60 Days of Home Health | Care Compare<br>Home Health Quality Reporting |
| #0173 | Emergency Department Use Without Hospitalization During the First 60 Days of Home Health | Care Compare<br>Home Health Quality Reporting |
| #0330 | Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization | Care Compare<br>Hospital Readmissions Reduction Program |
| #0505 | Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization | Care Compare<br>Hospital Readmission Reduction Program |
| #0506 | Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization | Care Compare |
| #0695 | Hospital 30-Day Risk-Standardized Readmission Rates Following Percutaneous Coronary Intervention (PCI) | None |

| NQF# | Title | Federal Programs (Finalized or Implemented) |
|---|---|---|
| #1463 | Standardized Hospitalization Ratio for Dialysis Facilities (SHR) | Dialysis Facility Compare<br>End-Stage Renal Disease Quality Incentive Program |
| #1551 | Hospital-Level 30-Day Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) | Care Compare<br>Hospital Readmission Reduction Program |
| #1789 | Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) | None |
| #1891 | Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization | Care Compare<br>Hospital Readmission Reduction Program |
| #2375 | PointRight® Pro 30™ | None |
| #2393 | Pediatric All-Condition Readmission Measure | None |
| #2414 | Pediatric Lower Respiratory Infection Readmission Measure | None |
| #2503 | Hospitalizations per 1,000 Medicare Fee-for-Service (FFS) Beneficiaries | None |
| #2504 | 30-Day Rehospitalizations per 1,000 Medicare Fee-for-Service (FFS) Beneficiaries | None |

| NQF# | Title | Federal Programs (Finalized or Implemented) |
|---|---|---|
| #2510 | Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) | None |
| #2514 | Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate | None |
| #2515 | Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery | Care Compare |
| #2539 | Facility Seven-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy | Ambulatory Surgical Center Quality Reporting<br>Care Compare<br>Hospital Outpatient Quality Reporting (OQR) |
| #2827 | PointRight® Pro Long Stay (TM) Hospitalization Measure | None |
| #2858 | Discharge to Community | None |
| #2860 | 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) | Care Compare<br>Inpatient Psychiatric Facility Quality Reporting |
| #2879e | Hybrid Hospital-Wide Readmission (HWR) Measure With Claims and Electronic Health Record Data | Care Compare<br>Hospital Inpatient Quality Reporting |
| #2880 | Excess Days in Acute Care (EDAC) After Hospitalization for Heart Failure (HF) | Hospital Inpatient Quality Reporting |

| NQF# | Title | Federal Programs (Finalized or Implemented) |
|---|---|---|
| #2881 | Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) | Care Compare<br>Hospital Inpatient Quality Reporting |
| #2882 | Excess Days in Acute Care (EDAC) After Hospitalization for Pneumonia | Care Compare<br>Hospital Inpatient Quality Reporting |
| #2888 | Risk-Standardized Acute Admission Rates for Patients With Multiple Chronic Conditions | Medicare Shared Savings Program |
| #3188 | 30-Day Unplanned Readmissions for Cancer Patients | None |
| #3366 | Hospital Visits After Urology Ambulatory Surgical Center Procedures | Ambulatory Surgical Center Quality Reporting |
| #3457 | Minimizing Institutional Length of Stay | None |
| #3470 | Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures | Ambulatory Surgical Center Quality Reporting |
| #3495 | Hospital-Wide 30-Day, All-Cause, Unplanned Readmission Rate (HWR) for the Merit-Based Incentive Payment System (MIPS)-Eligible Clinician Groups | None |
| #3565 | Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities | None |

| NQF# | Title | Federal Programs (Finalized or Implemented) |
|---|---|---|
| #3566 | Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities | None |
| #3597 | Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients With Multiple Chronic Conditions Under the Merit-Based Incentive Payment System | None |
| #3612 | Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients With Heart Failure Under the Merit-Based Incentive Payment System | None |
| #3656 | Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) | None |

*Adapted from CMS Measures Inventory Tool. Last Accessed on July 18, 2022.

## Appendix C: All-Cause Admissions and Readmissions Standing Committee and NQF Staff

STANDING COMMITTEE

**Chloe Slocum, MD, MPH (Co-Chair)**
Director of Health Policy for the Harvard Medical School Department of Physical Medicine and Rehabilitation and Associate Director of Quality for Spaulding Rehabilitation Network in Boston; Physician, Harvard Medical School
Charlestown, Massachusetts

**Amy O'Linn, DO, FHM, FACP (Co-Chair)**
Physician Lead, Cleveland Clinic Enterprise Readmission Reduction
Cleveland, Ohio

**John Bulger, DO, MBA**
Chief Medical Officer, Geisinger Health Plan, Chief Medical Officer for Population Health, Geisinger Health
Danville, Pennsylvania

**Edward Davidson, PharmD, MPH, FASCP**
Partner, Insight Therapeutics
Norfolk, Virginia

**Richard James Dom Dera, MD, FAAFP**
Medical Director, Ohio Family Practice Centers and New Health Collaborative
Akron, Ohio

**Lisa Freeman**
Executive Director, Connecticut Center for Patient Safety
Fairfield, Connecticut

**Kellie Goodson, MS, CPXP**
Chief Experience and Engagement Officer, ATW Health Solutions
Chicago, Illinois

**Dinesh Kalra, MD**
Director, Rush University
Chicago, Illinois

**Michelle Lin, MD, MPH, MS**
Assistant Professor, Attending Physician Emergency Medicine, Icahn School of Medicine at Mount Sinai
New York, New York

**Dheeraj Mahajan, MD, MBA, MPH, FACP**
CEO, Chicago Internal Medicine Practice and Research (CIMPAR, SC)
Columbia, Maryland

**Jack Needleman, PhD, FAAN**
Professor, University of California, Los Angeles School of Public Health
Los Angeles, California

**Janis Orlowski, MD, MACP**
Chief Health Care Officer, Association of American Medical Colleges
Washington, District of Columbia

**Sonya Pease, MD, MBA**
Chief Quality, Safety, Patient Experience Officer, Cleveland Clinic
Florida Weston, Florida

**Gaither Pennington, RN, BSN**
Product Owner, Bravado Health
West Palm Beach, Texas

**Rebecca Perez, MSN, RN, CCM**
Sr. Manager of Education and Strategic Partnerships, Case Management Society of America
Brentwood, Tennessee

**Sheila Roman, MD, MPH**
Independent Healthcare Consultant Associate Professor of Medicine, Part-Time, Johns Hopkins Medical Institutions
Baltimore, Maryland

**Teri Sholder, RN, BSN, MHA, CPHQ, CPC**
Senior Vice President/Chief Quality Officer, BayCare Health System
Clearwater, Florida

**Lalita Thompson, MSN, RN, CRRN**
Baclofen Pump Program Coordinator, TIRR Memorial Hermann
Houston, Texas

**Cristie Travis, MSHHA**
Chief Executive Officer, Memphis Business Group on Health (MBGH)
Memphis, Tennessee

**Milli West, MBA, CPHQ**
Quality System Director, Patient Experience, Intermountain Healthcare
Salt Lake City, Utah

NQF STAFF

**Elizabeth Drye, MD, SM**
Chief Scientific Officer, Measurement Science and Application

**Tricia Elliot, DHA, MBA, CPHQ, FNAHQ**
Vice President, Measurement Science and Application *(Former)*

**Matthew Pickering, PharmD**
Managing Director, Measurement Science and Application

**Poonam Bal, MHSA**
Senior Director, Measurement Science and Application *(Former)*

**Laura Blum Meisnere, MA**
Senior Director, Measurement Science and Application

**Udara Perera, DrPHc, MPH**
Director, Measurement Science and Application

**LeeAnn White, MS, BSN**
Director, Measurement Science and Application *(Former)*

**Isaac Sakyi, MSGH**
Manager, Measurement Science and Application

**Tristan Wind, BS, ACHE-SA**
Analyst, Measurement Science and Application

**Karri Albanese, BA**
Analyst, Measurement Science and Application *(Former)*

**Matilda Epstein, MPH**
Associate, Measurement Science and Application

**Kate Murphy, BS**
Associate, Measurement Science and Application

**Victoria Quinones, AA, PMP**
Project Manager, Program Operations

**Taroon Amin, PhD**
Consultant

# Appendix D: Measure Specifications

## NQF #2375 PointRight® Pro 30™

### STEWARD

American Health Care Association

### DESCRIPTION

PointRight Pro-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which a patient (regardless of payer status or diagnosis) who enters a skilled nursing facility (SNF) from an acute hospital and is subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.

### TYPE

Outcome

### DATA SOURCE

Assessment Data, Electronic Health Records: Electronic Health Records

Resident Assessment Instrument Minimum Data Set (MDS) version 3.0

### LEVEL

Facility

### SETTING

Post-Acute Care

### NUMERATOR STATEMENT

The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during a 12-month measurement period.

### NUMERATOR DETAILS

The numerator is the number of patients that are discharged from a SNF to an acute hospital within 30 days of entry from an acute hospital as indicated by MDS item A2100=03 (indicating ‘discharge to acute hospitals’) and MDS item A0310F=10/11 (indicating discharge status). The length of stay before rehospitalization is calculated by subtracting MDS item A1600 (entry date) from MDS item A2000 (discharge date).

### DENOMINATOR STATEMENT

The denominator is the number of all admissions, regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the 12-month measurement period.

### DENOMINAT**OR DETAILS**

The total number of admissions to the facility, from an acute hospital, during the 12-month measurement period is determined using the MDS item A1800=03, indicating 'entered from hospital'. The entry date is determined using two MDS variables: A1600 (entry date) and A0310F=01 (indicating entry tracking record').

### EXCLUSIONS

Individuals with incomplete MDS assessments are excluded. Payer status and clinical conditions are not used for any exclusions.

### EXCLUSION DETAILS

Admissions that do not have either a discharge assessment or a quarterly (annual or change of status) assessment within 120 days of admissions are excluded, as they are considered incomplete.

### RISK ADJUSTMENT

No additional risk adjustment analysis included Statistical risk model with risk factors (specify number of risk factors)

The formula for a facility's adjusted rehospitalization rate is as follows

(Observed Rate of Rehospitalization within 30 days) / (Expected Rate of Rehospitalization within 30 days) * (National rate).

1. Observed Rate Calculation

The formula for a facility's observed Rehospitalization rate is as follows:

(Observed count of discharges to hospitals within 30 days of admission) / (Observed count of admissions from hospitals)

The denominator is the number of any admissions from a hospital during a 12 month measurement period. (This is a count of events, not of residents.) The numerator is the number of all admissions to the SNF during a 12 month measurement period who then went back to the hospital within 30 days of their admission date. (This is a count of events, not of residents.)

2. Expected Rate Calculation

2.1 First the expected rate for every single resident admission is calculated using the formula below.

The calculation must be performed at least 45 days after the end of the target 12-month measurement period. This is to allow 30 days to elapse to capture rehospitalizations that occur from admission to the SNF on the last day of the target period and another 14 days to allow facilities to submit data to CMS. We recommend waiting an additional 2 to 3 weeks to ensure maximum data availability for MDS assessments not submitted during the 14 day period.

VARIABLE CALCULATION USING MDS

Intercept: -2.8252

Age Under 65: if age<65 then Variable=1; else Variable=0; (If Date of Birth is missing, then Variable=0)

End Stage Prognosis: if J1400=1 then Variable=1; else Variable=0;

Hospice Care: if O0100K2=1 then Variable=1; else Variable=0;

Male: if A0800=1 then Variable=1; else Variable=0;

Medicare: if A0310B = 01 or 06, then Variable=1;else Variable=0;

SNF Admission is Return to Same SNF Following Hospitalization: if A0310B=06 AND A1600 minus A2000 (on a previous MDS where A2100=3) < 30 then Variable=1; else if A1700=2 then Variable=1; else Variable=0;

Diagnoses

Anemia: if I0200=1 then Variable=1; else Variable=0;

Asthma: if I6200=1 then Variable=1; else Variable=0;

Diabetes Mellitus: if I2900=1 then Variable=1; else Variable=0;

Diabetic Foot Ulcer: if M1040B=1 then Variable=1; else Variable=0;

Pressure Ulcer Stage 2: if M0300B2>0 then Variable=1; else Variable=0;

Pressure Ulcer Stage 3: if M0300C2>0 then Variable=1; else Variable=0;

Pressure Ulcer Stage 4: if M0300D2>0 then Variable=1; else Variable=0;

Pressure Ulcer Unstageable: if M0300E2>0 or M0300F2>0 or M0300G2>0 then Variable=1; else Variable=0;

Respiratory Failure: if I6300=1 then Variable=1; else Variable=0;

Septicemia: if I2100=1 then Variable=1; else Variable=0;

Vascular Ulcer: if M1030>0 then Variable=1; else Variable=0;

Viral Hepatitis: if I2400=1 then Variable=1; else Variable=0;

Heart Failure: if I0600=1 then Variable=1; else Variable=0;

Internal Bleeding:if J1550D=1 then Variable=1; else Variable=0;

Functional Status:

Daily Pain: if J0400=1 or J0850=3 then Variable=1; else Variable=0;

Eating Dependence- Total: if G0110H1 = 4,7, or 8, then Variable=1; else Variable=0;

Two Person assist Needed with One or More ADLs: if G0110A2=3 or G0110B2=3 or G0110C2=3 or G0110D2=3 or G0110E2=3 or G0110F2=3 or G0110G2=3 or G0110H2=3 or G0110I2=3 or G0110J2=3 then Variable=1; else Variable=0;

Cognition not Completely Intact: if C0100=1 AND if C0500=15 then Variable=0; if C0100=1 AND if C0500 <>15 then Variable=1;if C0100=0 AND if C0700=0 AND C0800=0 AND C1000=0 AND C0900A=1 AND C0900B=1 AND C0900C=1 AND C0900D=1 then Variable=0; else Variable=1;

Total Bowel Incontinence: if H0400>0 then Variable=1; else Variable=0;

Treatment

Cancer Chemotherapy: if O0100A1=1 then Variable=1; else Variable=0;

Dialysis: if O0100J1=1 then Variable=1; else Variable=0;

Insulin: if N0350A>0 or N0350B>0 then Variable=1; else Variable=0;

IV Medications Continuing from Hospital: if O0100H1=1 and O0100H2=1 then Variable=1; else Variable=0;

Ostomy Care: if H0100C=1 then Variable=1; else Variable=0;

Oxygen Continuing from Hospital: if O0100C1=1 and O0100C2=1 then Variable=1; else Variable=0;

Radiation Therapy: if O0100B1=1 then Variable=1; else Variable=0;

Tracheostomy Continuing from Hospital: if O0100E1=1 and O0100E2=1 then Variable=1; else Variable=0;

FORMULA

| | | | | |
|---|---|---|---|---|
| LogOdds | = | - | 2.8252 | |
| - | 0.7846 | * | End Stage Prognosis | |
| - | 1.5085 | * | Hospice_care | |
| + | 0.0923 | * | Anemia | |
| + | 0.1033 | * | Asthma | |
| + | 0.0611 | * | Daily Pain | |
| + | 0.0462 | * | Diabetes_Mellitus | |
| + | 0.1459 | * | Diabetic Foot Ulcer | |
| + | 0.6038 | * | Dialysis | |
| + | 0.1777 | * | Insulin | |
| + | 0.3263 | * | Ostomy Care | |
| + | 0.167 | * | Pressure Ulcer Stage 2 | |
| + | 0.1334 | * | Pressure Ulcer Stage 3 | |
| + | 0.1569 | * | Pressure Ulcer Stage 4 | |

| | | | |
|---|---|---|---|
| + | 0.181 | * | Pressure Ulcer Unstageable |
| + | 0.0891 | * | Septicemia |
| + | 0.1848 | * | Total Bowel Incontinence |
| + | 0.1862 | * | Venous Arterial Ulcer |
| + | 0.4017 | * | Viral Hepatitis |
| + | 0.177 | * | Age Under 65 |
| + | 0.6001 | * | Cancer Chemotherapy |
| + | 0.188 | * | IV Medication Continued from Hospital |
| + | 0.3395 | * | Oxygen Continuing from Hospital |
| + | 0.1336 | * | Tracheostomy Continuing from Hospital |
| + | 0.4718 | * | Eating Dependency |
| + | 0.2004 | * | Heart Failure |
| + | 0.892 | * | Internal Bleeding |
| + | 0.1622 | * | Male |
| + | 0.14 | * | Return to Same SNF Following Hospitalizations |
| + | 0.5543 | * | Medicare |
| + | 0.2389 | * | Two Person Assist Required for One or More ADLs |
| + | 0.6111 | * | Radiation Therapy |
| + | 0.1159 | * | Respiratory Failure |
| + | 0.3327 | * | Cognition Not Completely Intact |

30-day Rehospitalization Probability= 1/(1+exp(-LogOdds))

2.2 Once the above calculation is performed for all admissions within the measurement period, the results are averaged to obtain the facility's expected rate of rehospitalization. Hence, the expected rate for a facility is the average of the expected rehospitalization probabilities for each admission during the target time period.

Procedure for Calculating the Measure

1. Establish the 12-month period and collect all assessments with entry dates that fall within the period. The count of these entries is the observed denominator.

2. For each entry date, determine whether the resident was discharged to an acute hospital within 30 days of the entry date. The count of these discharges is the observed numerator.
3. Divide the numerator by the denominator to obtain the observed rate for the SNF.
4. Calculate the expected rate for the facility using the expected probability model for admissions during the sample period, then average them for the 12-month period.
5. Divide the observed rate by the expected rate and multiply by the national average rate to obtain the adjusted all-cause rehospitalization rate for the facility.

### STRATIFICATION

N/A

### TYPE SCORE

Rate/proportion

Better quality = Lower score

### ALGORITHM

The formula for a facility's adjusted rehospitalization rate is as follows:

(Observed Rate of Rehospitalization within 30 days) / (Expected Rate of Rehospitalization within 30 days) * (National rate).

Note- the national rate is updated annually, while the observed and expected rates are updated quarterly.

1. Observed Rate Calculation

The formula for a facility's observed Rehospitalization rate is as follows:

(Observed count of discharges to hospitals within 30 days of admission) / (Observed count of admissions from hospitals)

The denominator is the number of any admissions from a hospital during the 12 month measurement period. (This is a count of events, not of residents.) The numerator is the number of all admissions to the SNF during the 12 month measurement period who then went back to the hospital within 30 days of their admission date. (This is a count of events, not of residents.)

2. Expected Rate Calculation

2.1 First the expected rate for every single resident admission is calculated using the formula below. The calculation must be performed at least 45 days after the end of the target 12-month measurement period. This is to allow 30 days to elapse to capture rehospitalizations that occur from admission to the SNF on the last day of the target period and another 14 days to allow facilities to submit data to CMS. We recommend waiting an additional 2 to 3 weeks to ensure maximum data availability for MDS assessments not submitted during the 14 day period.

VARIABLE CALCULATION

Intercept: -2.9736

Age Under 65: if age<65 then Variable=1; else Variable=0; (If Date of Birth is missing, then Variable=0)

End Stage Prognosis: if J1400=1 then Variable=1; else Variable=0;

Hospice Care: if O0100K2=1 then Variable=1; else Variable=0;

Male: if A0800=1 then Variable=1; else Variable=0;

Medicare: if A0310B = 01 or 06, then Variable=1; else Variable=0;

SNF Admission is Return to Same SNF Following Hospitalization: if A0310B=06 AND A1600 minus A2000 (on a previous MDS where A2100=3) < 30 then Variable=1; else if A1700=2 then Variable=1; else Variable=0;

Diagnoses

Anemia: if I0200=1 then Variable=1; else Variable=0;

Asthma: if I6200=1 then Variable=1; else Variable=0;

Diabetes Mellitus: if I2900=1 then Variable=1; else Variable=0;

Diabetic Foot Ulcer: if M1040B=1 then Variable=1; else Variable=0;

Pressure Ulcer Stage 2: if M0300B2>0 then Variable=1; else Variable=0;

Pressure Ulcer Stage 3: if M0300C2>0 then Variable=1; else Variable=0;

Pressure Ulcer Stage 4: if M0300D2>0 then Variable=1; else Variable=0;

Pressure Ulcer Unstageable: if M0300E2>0 or M0300F2>0 or M0300G2>0 then Variable=1; else Variable=0;

Respiratory Failure: if I6300=1 then Variable=1; else Variable=0;

Septicemia: if I2100=1 then Variable=1; else Variable=0;

Vascular Ulcer: if M1030>0 then Variable=1; else Variable=0;

Viral Hepatitis: if I2400=1 then Variable=1; else Variable=0;

Heart Failure: if I0600=1 then Variable=1; else Variable=0;

Internal Bleeding: if J1550D=1 then Variable=1; else Variable=0;

Functional Status

Daily Pain: if J0400=1 or J0850=3 then Variable=1; else Variable=0;

Eating Dependence- Total: if G0110H1 = 4,7, or 8, then Variable=1; else Variable=0;

Two Person assist Needed with One or More ADLs: if G0110A2=3 or G0110B2=3 or G0110C2=3 or G0110D2=3 or G0110E2=3 or G0110F2=3 or G0110G2=3 or G0110H2=3 or G0110I2=3 or G0110J2=3 then Variable=1; else Variable=0;

Cognition not Completely Intact: if C0100=1 AND if C0500=15 then Variable=0;

if C0100=1 AND if C0500 <>15 then Variable=1;if C0100=0 AND if C0700=0 AND C0800=0 AND C1000=0 AND C0900A=1 AND C0900B=1 AND C0900C=1 AND C0900D=1 then Variable=0; else Variable=1;

Total Bowel Incontinence: if H0400>0 then Variable=1; else Variable=0;

Treatment

Cancer Chemotherapy: if O0100A1=1 then Variable=1; else Variable=0;

Dialysis: if O0100J1=1 then Variable=1; else Variable=0;

Insulin: if N0350A>0 or N0350B>0 then Variable=1; else Variable=0;

IV Medications Continuing from Hospital: if O0100H1=1 and O0100H2=1 then Variable=1; else Variable=0;

Ostomy Care: if H0100C=1 then Variable=1; else Variable=0;

Oxygen Continuing from Hospital: if O0100C1=1 and O0100C2=1 then Variable=1; else Variable=0;

Radiation Therapy: if O0100B1=1 then Variable=1; else Variable=0;

Tracheostomy Continuing from Hospital: if O0100E1=1 and O0100E2=1 then Variable=1; else Variable=0;

FORMULA

LogOdds = - 2.8252

- 0.7846 * End Stage Prognosis

- 1.5085 * Hospice_care

+ 0.0923 * Anemia

+ 0.1033 * Asthma

+ 0.0611 * Daily Pain

+ 0.0462 * Diabetes_Mellitus

+ 0.1459 * Diabetic Foot Ulcer

+ 0.6038 * Dialysis

+ 0.1777 * Insulin

+ 0.3263 * Ostomy Care

+ 0.1670 * Pressure Ulcer Stage 2

+ 0.1334 * Pressure Ulcer Stage 3

+ 0.1569 * Pressure Ulcer Stage 4

+ 0.1810 * Pressure Ulcer Unstageable

+ 0.0891 * Septicemia

+ 0.1848 * Total Bowel Incontinence

+ 0.1862 * Venous Arterial Ulcer

+ 0.4017 * Viral Hepatitis

+ 0.1770 * Age Under 65

+ 0.6001 * Cancer Chemotherapy

+ 0.1880 * IV Medication Continued from Hospital

+ 0.3395 * Oxygen Continuing from Hospital

+ 0.1336 * Tracheostomy Continuing from Hospital

+ 0.4718 * Eating Dependency

+ 0.2004 * Heart Failure

+ 0.8920 * Internal Bleeding

+ 0.1622 * Male

+ 0.1400 * Return to Same SNF Following Hospitalizations

+ 0.5543 * Medicare

+ 0.2389 * Two Person Assist Required for One or More ADLs

+ 0.6111 * Radiation Therapy

+ 0.1159 * Respiratory Failure

+ 0.3327 * Cognition Not Completely Intact

30day_Rehospitalization_Probability= 1/(1+exp(-LogOdds))

2.2 Once the above calculation is performed for all admissions within the measurement period, the results are averaged to obtain the facility's expected rate of rehospitalization. Hence, the expected rate for a facility is the average of the expected rehospitalization probabilities for each admission during the target time period.

Procedure for Calculating the Measure

1. Establish the 12 month time period and collect all assessments with entry dates that fall within the time period. The count of these entries is the observed denominator.
2. For each entry date, determine whether the resident was discharged back to an acute hospital within 30 days of the entry date. The count of these discharges is the observed numerator.
3. Divide the numerator by the denominator to obtain the observed rate for the SNF.
4. Calculate the expected rate for the facility using the expected probability model for admissions during the sample period, then average them for the 12-month period.
5. Divide the observed rate by the expected rate and multiply by the national average rate to obtain the adjusted al

### COPYRIGHT / DISCLAIMER



## NQF #2827 PointRight® Pro Long Stay™ Hospitalization Measure

### STEWARD

American Health Care Association

### DESCRIPTION

The PointRight Pro Long Stay Hospitalization Measure is an MDS-based, risk-adjusted measure of the rate of hospitalization of long-stay patients (also known as "residents") of skilled nursing facilities (SNFs) averaged across the year, weighted by the number of stays in each quarter.

### TYPE

Outcome

### DATA SOURCE

Assessment Data, Electronic Health Records: Electronic Health Records

Resident Assessment Instrument Minimum Data Set (MDS) version 3.0

### LEVEL

Facility

### SETTING

Post-Acute Care

### NUMERATOR STATEMENT

The numerator for the measure is the sum over four quarters of the counts of hospitalizations of the quarterly denominator populations, where hospitalizations comprise discharges directly from the SNF to an acute care hospital.

### NUMERATOR DETAILS

The numerator for a quarter is the number, during the quarter, of discharges from the SNF directly to an acute care hospital of patients in the denominator population for that quarter as indicated by MDS item A2100=03 'discharge status = acute hospital'. A patient in the quarterly denominator population can contribute multiple times to the quarterly numerator.

Discharges to LTACHs, IRFs, and mental hospitals are not included in the numerator, nor are acute hospital admissions directly following a discharge from the SNF to a setting other than an acute care hospital. As noted above, if a patient is discharged from a SNF directly to an acute care hospital during a quarter at risk, the hospitalization will be counted in the numerator even if the patient was discharged to a setting other than an acute care hospital earlier in that quarter.

The numerator for the measure is the sum of the quarterly numerators for the four quarters in the 12-month measurement period.

### DENOMINATOR STATEMENT

The quarterly denominator population consists of those patients present in the SNF on the first day of the quarter (the "snapshot date") who meet the criterion for long stay on that date. The denominator for a quarter is the number of patients in the quarterly denominator population. The denominator for the measure is the sum of the quarterly denominators for the four quarters in the 12-month measurement period. The criterion for a patient's having a long stay is a cumulative length of stay in the facility of more than 100 days as of the snapshot date. The cumulative length of stay of a patient is the length of the current stay as of the snapshot date and plus the full lengths of stay of any previous stays that are linked to it. According to the criteria for linkage of stays used in the present measure, a stay in a SNF is linked to a subsequent stay in the SNF if the patient was discharged from the SNF to the community and was readmitted to the SNF within 10 days or fewer. All stays in a sequence of linked stays are included in the sum of days used to determine a patient's cumulative length of stay. In these criteria the term "community" comprises private residences and all organized settings that are primarily residential in character, including senior housing, independent living facilities, board and care homes, and assisted living facilities. A patient can contribute multiple times to the denominator for a 12-month measure period. For example, a resident continuously present in the facility for a full year would contribute four to the denominator.

### DENOMINATOR DETAILS

The denominator population for a quarter is a subset of the patients present in the SNF on the snapshot date (the first day of the quarter). A patient is in that subset if his or her cumulative length of stay as of the snapshot date is more than 100 days. The cumulative length of stay is calculated by taking the length of stay of the current admission as of the snapshot date and adding the lengths of stay of any linked stays at the same SNF. The length of the current admission as of the snapshot date is the snapshot date minus the entry date for the current admission, which is MDS item A1600. A stay is linked to a subsequent stay if the patient is discharged to the community (A2100=01) and admitted to the same SNF within 10 days or less

(i.e., A1600 for the second stay minus A2100 for the first stay is less than or equal to 10 days). The denominator for a quarter is the number of residents in the denominator population for that quarter. The denominator for the measure, which reports on a full year's performance, is the sum of the denominators for the four quarters that constitute that year.

### EXCLUSIONS

There are no exclusions from the denominator; all patients in the facility on the snapshot date who meet the long stay criterion on that date are included.

### EXCLUSION DETAILS

An outcome is regarded as unknown if it cannot be reasonably inferred or conservatively imputed.

The quarterly unknown outcome count is the number of patients in the quarterly denominator for whom it is not known and cannot be reasonably inferred or imputed that the patient was or was not hospitalized during the quarter. It would be known that a patient was hospitalized during the quarter if he or she had a discharge MDS with an acute care hospital as a discharge disposition. It would be known that a patient was not hospitalized during the quarter if he or she had an MDS assessment with an assessment reference date (item A2300) following the end of the quarter at risk and had an admission date (item A1600) on or prior to the snapshot date. If the patient has a discharge MDS during the quarter at risk and is subsequently readmitted to the same SNF within the same quarter it is assumed that there was a second discharge during that quarter (whether to an acute care hospital or elsewhere) if and only if there is a discharge MDS with an assessment reference date within that quarter. If there is an admission to the SNF from an acute care hospital during the quarter at risk but no preceding discharge MDS the inference is made that the preceding discharge was directly to an acute care hospital and the inferred discharge is counted in the numerator of the measure. If a patient has no MDS assessment of any kind with an assessment reference date 100 days or fewer after the latest MDS in the interval starting 10 days before the snapshot date and ending one day before the end of the quarter the patient's outcome is regarded as unknown. If the count N of patients with unknown outcomes is 10% or less of the denominator, N*0.8 is added to the numerator. If N is more than 10% of the denominator the measure is not reported.

The denominator of the annual unknown outcome rate is the sum of the four quarterly denominators. The numerator of the annual unknown outcome rate is the sum over the four quarters of the numbers of quarterly denominator patients with an unknown outcome in the quarter at risk.

### RISK ADJUSTMENT

No additional risk adjustment analysis included Statistical risk model with risk factors (specify number of risk factors) The formula for a facility's adjusted PointRight ProLong Hospitalization Rate is: [Observed rate of all hospitalizations]/[Expected rate of all hospitalizations]*[National average rate of all hospitalizations].

Procedure for calculating the adjusted rate

1) Calculate the observed rate.

The observed PointRight Pro Long Stay Hospitalization Rate is the sum of the four quarterly numerators divided by the sum of the four quarterly denominators.

The denominator for a quarter is the number of residents present in the facility on the first day of a calendar quarter who qualify as long stay on that day

The numerator for a quarter is number of hospitalizations of residents in the denominator population for that quarter, where hospitalization means discharge from the SNF directly to an acute care hospital, either with no return to the SNF or with return to the SNF after at least one midnight outside the SNF.

2) Calculate the expected rate.

Calculate the expected number of first hospitalizations of the quarterly denominator population for each of the four quarters in the measure period and sum them; multiply the sum by 1.25248 to obtain the expected number of total hospitalizations for the 12-month measurement period. Divide this number by the sum of the quarterly denominators to get the expected rate for the measure period.

The risk factors and coefficients are found in Table 17 below

3) Calculate the national benchmark rate

The national benchmark rate is the observed PointRight Pro Long Stay Hospitalization Rate for a denominator population consisting of the denominator populations for all SNFs in the largest available national sample that have complete non-discharge MDS data for all of their patients for all four quarters in the measurement period and have 100% known outcomes for all patients in their denominator populations for all four quarters in the measure period.

For a given member of a quarterly denominator population a known outcome means either that the patient had a discharge MDS submitted with a discharge date within the quarter and a discharge destination filled in, that the patient was readmitted from an acute care hospital during the quarter, or that the patient had a quarterly or other MDS submitted in the 100 days following the end of the quarter that gave an admission date prior to the snapshot date for the given quarter.

### STRATIFICATION

N/A

### TYPE SCORE

Rate/proportion

Better quality = Lower score

### ALGORITHM

The formula for a facility's adjusted PointRight ProLong Hospitalization Rate is: [Observed rate of all hospitalizations]/[Expected rate of all hospitalizations]*[National average rate of all hospitalizations]. The observed and expected rates are updated quarterly and the national benchmark rate is updated annually; the national benchmark rate used in the calculation is the most recently calculated benchmark rate at the time the observed and expected rates are calculated.

Procedure for calculating the adjusted rate:

1) Calculate the observed rate.

The observed PointRight ProLong Stay Hospitalization Rate is the sum of the four quarterly numerators divided by the sum of the four quarterly denominators. The denominator for a quarter is the number of residents present in the facility on the first day of a calendar quarter who qualify as long stay on that day. The numerator for a quarter is number of hospitalizations of residents in the denominator population for that quarter, where hospitalization means discharge from the SNF directly to an acute care hospital, either with no return to the SNF or with return to the SNF after at least one midnight outside the SNF.

The numerator excludes:

1. Hospitalizations occurring after a patient has been discharged somewhere other than an acute care hospital and
2. Hospitalizations at psychiatric hospitals, rehabilitation hospitals, or LTACHs.

The numerator includes:

1. “observations stays” if these involve at least one midnight away from the SNF and
2. “planned” hospitalizations.

2) Calculate the expected rate.

Calculate the expected number of first hospitalizations of the quarterly denominator population for each of the four quarters in the measure period and sum them; multiply the sum by 1.25248 to obtain the expected number of total hospitalizations for the 12-month measure period. Divide this number by the sum of the quarterly denominators to get the expected rate for the measure period.

3) Calculate the national benchmark rate

The national benchmark rate is the observed PointRight Pro Long Stay Hospitalization Rate for a denominator population consisting of the denominator populations for all SNFs in the largest available national sample that have complete non-discharge MDS data for all of their patients for all four quarters in the measure period and have 100% known outcomes for all patients in their denominator populations for all four quarters in the measure period. For a given member of a quarterly denominator population a known outcome means either that the patient had a discharge MDS submitted with a discharge date within the quarter and a discharge destination filled in, that the patient was readmitted from an acute care hospital during the quarter, or that the patient had a quarterly or other MDS submitted in the 100 days following the end of the quarter that gave an admission date prior to the snapshot date for the given quarter.

Procedure for Calculating the Measure:

1. Establish a 12-month measure period comprising of four calendar quarters (each three months in length). For each quarter, the (quarterly) denominator is the number of residents who qualify as long stay for that quarter, i.e. whose cumulative length of stay as of the snapshot date (the first day of the quarter) is more than 100 days. (Cumulative length of stay is defined as the sum of the lengths of stay of the current stay and all stays linked to it.) The sum of the quarterly denominators for the four quarters constitutes the denominator for the measure period.

2. For the quarterly denominator population determine the number of (direct) acute care hospitalizations of the residents in that quarter (the quarterly numerator). The count of the hospitalizations is the quarterly numerator. The sum of the quarterly numerators for the four quarters constitutes the numerator for the measure. As noted above the count includes only admissions to acute care hospitals directly from the SNF. Planned (or presumptively planned) hospitalizations are included, as are observation stays. Hospitalizations subsequent to a discharge somewhere other than an acute care hospital, and hospitalizations at LTACHs and specialty hospitals are excluded.
3. Divide the total numerator by the total denominator to obtain the observed rate for the SNF.
4. Calculate the estimated probability of a first hospitalization for each member of each quarterly denominator population using the predictive model described above, and sum these probabilities to get the expected number of first hospitalizations per quarter for the total 12 month denominator population. Sum these expected numbers over the four quarters of the measure period to get the expected number of first hospitalizations for the measure period. Multiply this result by 1.25248 to get the expected number of total hospitalizations for the total measure period denominator population and divide this by the total measure period denominator to get the expected PointRight Pro Long Stay Hospitalization Rate for the measure period.
5. Divide the observed rate by the expected rate and multiply by the most recent national benchmark rate to obtain the Adjusted PointRight Pro Long Stay Hospitalization Rate.

## COPYRIGHT / DISCLAIMER

# Appendix E: Related and Competing Measures

## Comparison of NQF #2375 and NQF #2510

### Steward/Developer

#### NQF #2375 POINTRIGHT ® PRO 30™

American Health Care Association

#### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Centers for Medicare & Medicaid Services

### Description

#### NQF #2375 POINTRIGHT ® PRO 30™

PointRight Pro-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which a patient (regardless of payer status or diagnosis) who enters a skilled nursing facility (SNF) from an acute hospital and is subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.

#### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

The SNFRM estimates the risk-standardized rate of all-cause, unplanned hospital readmissions for Skilled Nursing Facility (SNF) Medicare fee-for-service (FFS) beneficiaries within 30 days of discharge from a prior proximal acute hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, psychiatric, or cancer hospital. The measure is risk-adjusted for patient demographics, principal diagnosis from the prior hospitalization, comorbidities, and other health status variables that affect the probability of a hospital readmission. The SNFRM includes Medicare FFS beneficiaries who were admitted to a SNF within 1 day of discharge from a hospital. The measure is calculated annually using a 12-month period.

### Numerator

#### NQF #2375 POINTRIGHT ® PRO 30™

The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during a 12 month measurement period.

#### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

The outcome for this measure is 30-day unplanned all-cause hospital readmissions of SNF patients. We define readmission as an inpatient admission for any cause, with the exception of certain planned admissions, within 30 days from the date of discharge from the patient's prior proximal acute hospitalization. The prior proximal hospitalization is defined as an admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or PPS-exempt psychiatric or cancer hospital. Because the measure denominator is based on SNF admissions, it is possible that Medicare beneficiaries with more than one eligible admission may be included in the measure multiple times within a given year.

### Denominator

NQF #2375 POINTRIGHT ® PRO 30™

The denominator is the number of all admissions, regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the 12 month measurement period.

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

The measure includes admissions for SNF Medicare fee for service (FFS) beneficiaries who have been admitted to a SNF within 1 day of discharge from a prior proximal hospitalization. Additional details are provided in sp.15, Denominator Details.

### Measure Type

NQF #2375 POINTRIGHT ® PRO 30™

Outcome

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Outcome

### Data Source

NQF #2375 POINTRIGHT ® PRO 30™

Assessment Data, Electronic Health Records: Electronic Health Records

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Claims, Enrollment Data

### Target Population

NQF #2375 POINTRIGHT ® PRO 30™

Elderly (Age >= 65), Dual eligible beneficiaries, Individuals with multiple chronic conditions

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Elderly (Age >= 65)

### Care Setting

NQF #2375 POINTRIGHT ® PRO 30™

Post-Acute Care

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Post-Acute Care, Other

### Level of Analysis

NQF #2375 POINTRIGHT ® PRO 30™

Facility

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Facility

## Comparison of NQF #2375 and NQF #2827

### Steward/Developer

#### NQF #2375 POINTRIGHT ® PRO 30™

American Health Care Association

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

American Health Care Association

### Description

#### NQF #2375 POINTRIGHT ® PRO 30™

PointRight Pro-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which a patient (regardless of payer status or diagnosis) who enters a skilled nursing facility (SNF) from an acute hospital and is subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The PointRight Pro Long Stay Hospitalization Measure is an MDS-based, risk-adjusted measure of the rate of hospitalization of long-stay patients (also known as “residents”) of skilled nursing facilities (SNFs) averaged across the year, weighted by the number of stays in each quarter.

### Numerator

#### NQF #2375 POINTRIGHT ® PRO 30™

The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during a 12 month measurement period.

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The numerator for the measure is the sum over four quarters of the counts of hospitalizations of the quarterly denominator populations, where hospitalizations comprise discharges directly from the SNF to an acute care hospital. 

### Denominator

#### NQF #2375 POINTRIGHT ® PRO 30™

The denominator is the number of all admissions, regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the 12-month measurement period.

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The quarterly denominator population consists of those patients present in the SNF on the first day of the quarter (the “snapshot date”) who meet the criterion for long stay on that date. The denominator for a quarter is the number of patients in the quarterly denominator population. The denominator for the measure is the sum of the quarterly denominators for the four quarters in the 12-month measurement period. The criterion for a patient’s having a long stay is a cumulative length of stay in the facility of more than 100 days as of the snapshot date. The cumulative length of stay of a patient is the length of the current stay as of the snapshot date and plus the full lengths of stay of any previous stays

that are linked to it. According to the criteria for linkage of stays used in the present measure, a stay in a SNF is linked to a subsequent stay in the SNF if the patient was discharged from the SNF to the community and was readmitted to the SNF within 10 days or fewer. All stays in a sequence of linked stays are included in the sum of days used to determine a patient's cumulative length of stay. In these criteria the term "community" comprises private residences and all organized settings that are primarily residential in character, including senior housing, independent living facilities, board and care homes, and assisted living facilities. A patient can contribute multiple times to the denominator for a 12-month measure period. For example, a resident continuously present in the facility for a full year would contribute four to the denominator.

**Measure Type**

NQF #2375 POINTRIGHT ® PRO 30™

Outcome

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Outcome

**Data Source**

NQF #2375 POINTRIGHT ® PRO 30™

Assessment Data, Electronic Health Records: Electronic Health Records

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Electronic Health Records: Electronic Health Records, Assessment Data

**Target Population**

NQF #2375 POINTRIGHT ® PRO 30™

Elderly (Age >= 65), Dual eligible beneficiaries, Individuals with multiple chronic conditions

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Individuals with multiple chronic conditions, Elderly (Age >= 65), Dual eligible beneficiaries

**Care Setting**

NQF #2375 POINTRIGHT ® PRO 30™

Post-Acute Care

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Post-Acute Care

**Level of Analysis**

NQF #2375 POINTRIGHT ® PRO 30™

Facility

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Facility

## Comparison of NQF #2827 and NQF #2375

### Steward/Developer

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

American Health Care Association

#### NQF #2375 POINTRIGHT ® PRO 30™

American Health Care Association

### Description

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The PointRight Pro Long Stay Hospitalization Measure is an MDS-based, risk-adjusted measure of the rate of hospitalization of long-stay patients (also known as “residents”) of skilled nursing facilities (SNFs) averaged across the year, weighted by the number of stays in each quarter.

#### NQF #2375 POINTRIGHT ® PRO 30™

PointRight Pro-30 is an all-cause, risk adjusted rehospitalization measure. It provides the rate at which a patient (regardless of payer status or diagnosis) who enters a skilled nursing facility (SNF) from an acute hospital and is subsequently rehospitalized during their SNF stay, within 30 days from their admission to the SNF.

### Numerator

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The numerator for the measure is the sum over four quarters of the counts of hospitalizations of the quarterly denominator populations, where hospitalizations comprise discharges directly from the SNF to an acute care hospital.

#### NQF #2375 POINTRIGHT ® PRO 30™

The numerator is the number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during a 12-month measurement period.

### Denominator

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The quarterly denominator population consists of those patients present in the SNF on the first day of the quarter (the “snapshot date”) who meet the criterion for long stay on that date. The denominator for a quarter is the number of patients in the quarterly denominator population. The denominator for the measure is the sum of the quarterly denominators for the four quarters in the 12 month measurement period. The criterion for a patient’s having a long stay is a cumulative length of stay in the facility of more than 100 days as of the snapshot date. The cumulative length of stay of a patient is the length of the current stay as of the snapshot date and plus the full lengths of stay of any previous stays that are linked to it. According to the criteria for linkage of stays used in the present measure, a stay in a SNF is linked to a subsequent stay in the SNF if the patient was discharged from the SNF to the community and was readmitted to the SNF within 10 days or fewer. All stays in a sequence of linked stays are included in the sum of days used to

determine a patient's cumulative length of stay. In these criteria the term "community" comprises private residences and all organized settings that are primarily residential in character, including senior housing, independent living facilities, board and care homes, and assisted living facilities. A patient can contribute multiple times to the denominator for a 12 month measure period. For example, a resident continuously present in the facility for a full year would contribute four to the denominator.

NQF #2375 POINTRIGHT ® PRO 30™

The denominator is the number of all admissions, regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the 12 month measurement period.

**Measure Type**

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Outcome

NQF #2375 POINTRIGHT ® PRO 30™

Outcome

**Data Source**

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Electronic Health Records: Electronic Health Records, Assessment Data

NQF #2375 POINTRIGHT ® PRO 30™

Assessment Data, Electronic Health Records: Electronic Health Records

**Target Population**

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Individuals with multiple chronic conditions, Dual eligible beneficiaries, Elderly (Age >= 65)

NQF #2375 POINTRIGHT ® PRO 30

Dual eligible beneficiaries, Individuals with multiple chronic conditions, Elderly (Age >= 65)

**Care Setting**

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Post-Acute Care

NQF #2375 POINTRIGHT ® PRO 30™

Post-Acute Care

**Level of Analysis**

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Facility

NQF #2375 POINTRIGHT ® PRO 30™

Facility

## Comparison of NQF #2827 and NQF #2510

### Steward/Developer

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

American Health Care Association

#### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Centers for Medicare & Medicaid Services

### Description

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The PointRight Pro Long Stay Hospitalization Measure is an MDS-based, risk-adjusted measure of the rate of hospitalization of long-stay patients (also known as “residents”) of skilled nursing facilities (SNFs) averaged across the year, weighted by the number of stays in each quarter.

#### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

The SNFRM estimates the risk-standardized rate of all-cause, unplanned hospital readmissions for Skilled Nursing Facility (SNF) Medicare fee-for-service (FFS) beneficiaries within 30 days of discharge from a prior proximal acute hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, psychiatric, or cancer hospital. The measure is risk-adjusted for patient demographics, principal diagnosis from the prior hospitalization, comorbidities, and other health status variables that affect the probability of a hospital readmission. The SNFRM includes Medicare FFS beneficiaries who were admitted to a SNF within 1 day of discharge from a hospital. The measure is calculated annually using a 12-month period.

### Numerator

#### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The numerator for the measure is the sum over four quarters of the counts of hospitalizations of the quarterly denominator populations, where hospitalizations comprise discharges directly from the SNF to an acute care hospital.

#### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

The outcome for this measure is 30-day unplanned all-cause hospital readmissions of SNF patients. We define readmission as an inpatient admission for any cause, with the exception of certain planned admissions, within 30 days from the date of discharge from the patient’s prior proximal acute hospitalization. The prior proximal hospitalization is defined as an admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or PPS-exempt psychiatric or cancer hospital. Because the measure denominator is based on SNF admissions, it is possible that Medicare beneficiaries with more than one eligible admission may be included in the measure multiple times within a given year.

## Denominator

### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

The quarterly denominator population consists of those patients present in the SNF on the first day of the quarter (the "snapshot date") who meet the criterion for long stay on that date. The denominator for a quarter is the number of patients in the quarterly denominator population. The denominator for the measure is the sum of the quarterly denominators for the four quarters in the 12 month measurement period. The criterion for a patient's having a long stay is a cumulative length of stay in the facility of more than 100 days as of the snapshot date. The cumulative length of stay of a patient is the length of the current stay as of the snapshot date and plus the full lengths of stay of any previous stays that are linked to it. According to the criteria for linkage of stays used in the present measure, a stay in a SNF is linked to a subsequent stay in the SNF if the patient was discharged from the SNF to the community and was readmitted to the SNF within 10 days or fewer. All stays in a sequence of linked stays are included in the sum of days used to determine a patient's cumulative length of stay. In these criteria the term "community" comprises private residences and all organized settings that are primarily residential in character, including senior housing, independent living facilities, board and care homes, and assisted living facilities. A patient can contribute multiple times to the denominator for a 12 month measure period. For example, a resident continuously present in the facility for a full year would contribute four to the denominator.

### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

The measure includes admissions for SNF Medicare fee for service (FFS) beneficiaries who have been admitted to a SNF within 1 day of discharge from a prior proximal hospitalization. Additional details are provided in sp.15, Denominator Details.

## Measure Type

### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Outcome

### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Outcome

## Data Source

### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Electronic Health Records: Electronic Health Records, Assessment Data

### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Claims, Enrollment Data

## Target Population

### NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Individuals with multiple chronic conditions, Dual eligible beneficiaries, Elderly (Age >= 65)

### NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Elderly (Age >= 65)

**Care Setting**

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Post-Acute Care

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Other, Post-Acute Care

**Level of Analysis**

NQF #2827 POINTRIGHT® PRO LONG STAY(TM) HOSPITALIZATION MEASURE

Facility

NQF #2510 SKILLED NURSING FACILITY 30-DAY ALL-CAUSE READMISSION MEASURE (SNFRM)

Facility

## Appendix F: Pre-Evaluation Comments

No comments were received during the pre-evaluation public commenting period.

## Appendix G: Post-Evaluation Comments

No comments were received during the post-evaluation public commenting period.

National Quality Forum
1099 14th Street NW, Suite 500
Washington, DC 20005
https://www.qualityforum.org