# CENTERS OF EXCELLENCE/HOSPITAL VALUE TOOL
# 2011 METHODOLOGY

**Introduction**

CIGNA annually evaluates hospital Patient Outcomes and Cost-efficiency information through the CIGNA Centers of Excellence program. The 2011 hospital profiles will be available in the online provider directory on the secure CIGNA website for covered individuals, beginning Nov 15, 2010.

The profiles, containing information for up to 29 procedures/conditions, are available for most hospitals participating in the CIGNA network. A score of up to three stars (*) each for both Patient Outcomes and Cost-efficiency measures can be received for each procedure/condition evaluated. Hospitals that attain a three star score for both Patient Outcomes and Cost-efficiency receive the CIGNA Center of Excellence designation for that procedure/condition.

Approximately 75.2% (3,557) of the 4,731 hospitals participating in the CIGNA network, including those in third party vendor networks, met the defined volume criteria for evaluation of at least one procedure or condition.

Because the Centers of Excellence program reflects only a partial assessment of quality and Cost-efficiency for select hospitals, it should not be the sole basis for decision-making, and we encourage covered individuals to consider all relevant factors and to speak with their treating physician when selecting a hospital. The profile is informational only and is not used to provide performance based payments to CIGNA contracted hospitals.

**Surgical Procedures/Medical Conditions**

The 29 surgical procedures/medical conditions used for the 2011 hospital profiles**,** listed in Table 1, are determined by volume, variability of outcome, and consumer interest.

Table 1: 2011 Surgical Procedures/Medical Conditions

| Cardiac Care | Gastroenterology | General Surgery |
|---|---|---|
| ● Angioplasty- with and without stent<br>● Cardiac Catheterization<br>● Cardiac Pacemaker Implant<br>● Coronary Artery Bypass Surgery<br>● Heart Attack<br>● Heart Failure<br>● Heart Valve Replacement<br>● Irregular Heartbeat | ● GI Hemorrhage<br>● Gastric Bypass | ● Colon Surgery**<br>● Laparoscopic Gallbladder Removal<br>● Transurethral Prostatectomy<br>● Total Abdominal Hysterectomy |
| **Neurologic** | **Obstetrics**** | **Orthopedics** |
| ● Craniotomy – Adult<br>● Stroke<br>● Head & Neck Endarterectomy | ● Cesarean Section<br>● Vaginal Delivery<br>● Infant-Premature<br>● Infant-Premature Major Problems | ● Disc Surgery<br>● Spinal Fusion<br>● Total Hip Replacement<br>● Total Knee Replacement |
| **Respiratory** | | |
| ● Acute Bronchitis - Pediatric**<br>● Chronic Obstructive Pulmonary Disorder (COPD)<br>● Pediatric Asthma**<br>● Pneumonia – Adult | | |

**Procedures not included in reporting for states where MedPar data is the only source.

**Patient Outcomes**

Patient Outcomes is a measure of a hospital's relative effectiveness in treating a selected surgical procedure/medical condition. The information is based on publicly available, self-reported patient data. The Patient Outcomes score is compiled using both All Payor and MedPar data. All Payor data is available in the 22 states listed in Table 2.

Table 2: All Payor Data States

| | |
|---|---|
| Arizona (2007/2008) | New York (2007/2008) |
| California (2007/2008) | North Carolina (2007/2008) |
| Colorado (2007/2008) | Oregon (2007/2008) |
| Florida (2007/2008) | Pennsylvania (20072008) |
| Illinois (2007/2008) | Rhode Island (2007/2008) |
| Iowa (2007/2008) | Texas (2006/2007) |
| Maryland (2007/2008) | Utah (2007/2008) |
| Massachusetts (2007/2008) | Vermont (2007/2008) |
| Nevada (2007/2008) | Virginia (2007/2008) |
| New Hampshire (2006/2007) | Washington (2007/2008) |
| New Jersey (2007/2008) | Wisconsin (2007/2008) |

All Payor states and the measurement periods vary by state based on data availability. MedPar only data from 2007/2008 is used where All Payor data is not available. Note: Tennessee and Maine are All Payor states. However, only MedPar data was used for these states due to the age of Tennessee and Maine All Payor data.

**Patient Outcomes – Quality Indexes**

The Patient Outcomes quality stars are displayed in the online provider directory on the secure website for individuals. A hospital could be included in the one star (below average), two star (average) and three star (above average) designations depending on the number of procedures that were able to be scored for a particular hospital.

The following indexes determine the Quality Composite Score, depending on data availability.

1. Major and Obstetrics Complications
   The major and obstetric complications data is obtained through All Payor and Medicare (MedPar) databases. The complications rates, both outcome and surgical based, and the mortality rate are severity adjusted using 3M's All Patient Refined-DRGs (APR-DRGs). The complication index accounts for either 30 or 60 percent of the Quality Composite Score, where applicable.

2. Mortality
   The mortality data is obtained through All Payor and Medicare (MedPar) databases. It is severity adjusted and reflects the incidence of death after a procedure or treatment for a condition. Refer to Table 4 for information about weight distribution when calculating the Quality Composite Score.

3. Leapfrog Patient Safety Measure**s**
   The Leapfrog Patient Safety Measure incorporates hospital compliance with four Leaps:
   - Computer Physician Order Entry (CPOE)
   - Intensive Care Unit (ICU) Physician Staffing (IPS)
   - Evidence-Based Hospital Referral (EBHR)
   - The Leapfrog Safe Practices Score (based on 20 of the the National Quality Forum's 34 safe practices in 2010)

   The CPOE, IPS, and EBHR measures review the estimated avoidable deaths per thousand. A separate score is calculated by hospital for the Leapfrog Safe Practices measure, which is then combined with the score tabulated for the other three Leapfrog Patient Safety measures. The Leapfrog index accounts for 15 percent of the Quality Composite Score.

4. CIGNA Hospital Quality Index Based on Medicare CMS Quality Measures

   The CIGNA hospitals quality index, based on the CMS Overall Hospital Quality Measure, is applied to the 29 surgical procedures and medical conditions listed in Table 1. The CMS index for conditions other than Heart Attack, Heart Failure and Pneumonia Care is calculated using the CMS Overall Hospital Quality Index or the CMS Overall Hospital Quality Measure and Surgical Infection Prevention combined index for surgical

conditions. Heart Attack, Heart Failure and Pneumonia Care CMS Indexes are calculated using the CMS specific condition measures indexes listed in Table 4. The appropriate CMS index accounts for 25 percent of the Quality Composite Score where applicable.

5. Medicare CMS Hospital Condition Specific Quality Measure

The CMS Hospital Condition Specific Measures are applied to those procedures/conditions where applicable and as listed in Table 3.

Table 3: CMS Hospital Condition Specific Measures

| CMS HOSPITAL QUALITY MEASURES | PROCEDURE/CONDITION IMPACTED |
|---|---|
| **Heart Attack Care** | |
| Percent of Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) | Heart Attack |
| Percent of Patients Given Smoking Cessation Advice/Counseling | Heart Attack |
| Percent of Patients Given Aspirin at Arrival | Heart Attack |
| Percent of Patients Given Aspirin at Discharge | Heart Attack |
| Percent of Patients Given Beta Blocker at Arrival | Heart Attack |
| Percent of Patients Given Beth Blocker at Discharge | Heart Attack |
| Percent of Patients Given Percutaneous Coronary Intervention (PCI) within 90 minutes of Arrival | Heart Attack |
| Percent of Patients Given Fibrinolytic Medication within 30 minutes of Arrival | Heart Attack |
| 30 Day Risk Adjusted Mortality (Death) | Heart Attack |
| **Heart Failure Care** | |
| Percent of Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) | Heart Failure |
| Percent of Patients Given Smoking Cessation Advice/Counseling Heart Failure | Heart Failure |
| Percent of Patients Given Assessment of Left Ventricular Function | Heart Failure |
| Percent of Patients Given Discharge Instructions | Heart Failure |
| 30 Day Risk Adjusted Mortality (Death) | Heart Failure |
| **Pneumonia Care** | |
| Percent of Patients Assessed and Given Pneumococcal Vaccination | Pneumonia |
| Percent of Patients Given Smoking Cessation Advice/Counseling | Pneumonia |
| Percent of Patients Given Initial Antibiotic(s) within 6 Hours After Arrival | Pneumonia |
| Percent of Patients Given the Most Appropriate Initial Antibiotic(s) | Pneumonia |
| Percent of Patients Whose Emergency Room Blood Culture was Performed Prior to First Antibiotic Received in Hospital | Pneumonia |
| Percent of Patients Assess for Influenza Vaccination and Given Vaccination if None Previously Administered | Pneumonia |
| 30 Day Risk Adjusted Mortality (Death) Pneumonia | Pneumonia |
| **Surgical Infection Prevention** | |

| CMS HOSPITAL QUALITY MEASURES | PROCEDURE/CONDITION IMPACTED |
|---|---|
| Percent of Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision | All Surgical Procedures |
| Percent of Surgery Patients Whose Preventative Antibiotic(s) are Stopped within 24 Hours After Surgery | All Surgical Procedures |
| Percent of Surgery Patients That Received the Appropriate Preventive Antibiotic(s) for Their Surgery | All Surgical Procedures |
| Percent of Surgery Patients Where Doctors Ordered Treatments to Prevent Blood Clots for Certain Types of Surgeries | All Surgical Procedures |
| Percent of Surgery Patients Who Were Taking Beta Blockers Prior to Hospitalization Who Are Kept On Beta Blockers During the Period Just Before and After Surgery | Surgical Procedures |
| Percent of Surgery Patients Needing Hair Removed from the Surgical Area Before Surgery Who Had the Hair Removed Using Safer Methods (electric clippers, hair removal cream – not a razor) | All Surgical Procedures |
| Percent of Surgery Patients Who Got Treatment at the Right Time (Within 24 Hours Before or After Surgery) to Help Prevent Blood Clots After Certain Types of Surgery | All Surgical Procedures |
| **Heart Surgical Procedures** | |
| Percent of All Heart Surgery Patients Whose Blood Sugar (Blood Glucose) is Kept in Good Control in the Days Right After Surgery | Surgical Procedures |

**Patient Outcomes – Quality Index Incident Volume and Weighting**

Two calendar years of data was used for the 2011 release. Hospital admission volume for each surgical procedure/medical condition must meet a minimum of 100 incidences during the measurement period to be evaluated. Patient Outcome scores are determined using four to five of the quality indexes depending on data availability, and weighted to total 100%.

The 12 surgical procedures/medical conditions listed below use a different incidence volume for assessing Patient Outcomes. Refer to Table 4 for the stable volume thresholds.

| | | |
|---|---|---|
| ● Angioplasty | ● Cardiac Catheterization | ● Cardiac Pacemaker Implant |
| ● Cesarean Section | ● COPD | ● Heart Failure |
| ● GI Hemorrhage | ● Irregular Heartbeat | ● Pneumonia – Adult |
| ● Prostatectomy – Transurethra | ● Stroke | ● Vaginal Delivery |

Table 4 Patient Outcomes – Stable Volume Threshold and Quality Index Weighting

| Procedure/ Condition | Stable Volume Threshold | Total Hospitals Rated | Mortality Index Weight | Complication Index Weight | Leapfrog Index Weight | CMS Overall Hospital Quality Measure Index Weight | CMS Condition Specific Index Weight |
|---|---|---|---|---|---|---|---|
| Acute Bronchitis, Pediatric * | 100 | 404 | n/a | n/a | n/a | n/a | n/a |
| Asthma, Pediatric * | 100 | 351 | n/a | n/a | n/a | n/a | n/a |
| Infant-Premature* | 100 | 631 | n/a | n/a | n/a | n/a | n/a |
| Infant-Premature-Major Problems * | 100 | 308 | n/a | n/a | n/a | n/a | n/a |
| Angioplasty | 150 | 1254 | - | 60% | 15% | 25% | - |
| CABG | 100 | 934 | - | 60% | 15% | 25% | - |

| Procedure/ Condition | Stable Volume Threshold | Total Hospitals Rated | Mortality Index Weight | Complication Index Weight | Leapfrog Index Weight | CMS Overall Hospital Quality Measure Index Weight | CMS Condition Specific Index Weight |
|---|---|---|---|---|---|---|---|
| Cardiac Catheterization | 400 | 538 | - | 60% | 15% | 25% | - |
| Cardiac Pacemaker Implant | 200 | 490 | - | 60% | 15% | 25% | - |
| Cesarean Section*** | 150 | 1308 | - | 60% | 15% | 25% | - |
| Colon Surgery | 100 | 1103 | - | 60% | 15% | 25% | - |
| COPD | 800 | 225 | 60% | - | 15% | 25% | |
| Craniotomy, Adult | 100 | 432 | - | 60% | 15% | 25% | - |
| Disc Surgery | 100 | 927 | - | 60% | 15% | 25% | - |
| Gall Bladder Removal, Laparoscopic | 100 | 1321 | - | 60% | 15% | 25% | - |
| Gastric Bypass ** | n/a | 634 | n/a | n/a | n/a | n/a | n/a |
| GI Hemorrhage | 450 | 387 | 30% | 30% | 15% | 25% | - |
| Head and Neck Endarterectomy | 100 | 640 | - | 60% | 15% | 25% | |
| Heart Attack | 100 | 1760 | 60% | - | 15% | - | 25% |
| Heart Failure | 300 | 1712 | 60% | - | 15% | - | 25% |
| Heart Valve Replacement | 100 | 487 | - | 60% | 15% | 25% | - |
| Hip Replacement, Total | 100 | 1663 | - | 60% | 15% | 25% | - |
| Hysterectomy, Abdominal Total*** | 100 | 889 | - | 60% | 15% | 25% | - |
| Irregular Heartbeat | 600 | 324 | - | 60% | 15% | 25% | - |
| Knee Replacement, Total | 100 | 1958 | - | 60% | 15% | 25% | - |
| Pneumonia, Adult | 300 | 1599 | 60% | - | 15% | - | 25% |
| Prostatectomy, Transurethral*** | 150 | 94 | - | 60% | 15% | 25% | - |
| Spinal Fusion | 100 | 1143 | - | 60% | 15% | 25% | - |
| Stroke | 150 | 1595 | 60% | - | 15% | 25% | - |
| Vaginal Delivery*** | 200 | 1412 | - | 60% | 15% | 25% | - |

* Only Cost-efficiency will be displayed for pediatric and infant conditions.
** Patient Outcomes stars for Gastric Bypass are based on CIGNA bariatric certification. Three Patient Outcomes stars will be displayed for CIGNA bariatric certified hospitals. There are no one or two or star Patient Outcomes indicators for Gastric Bypass.
*** Only two or three Patient Outcomes stars will be displayed due to small volume or no statistically significant differences between one and two stars.

**Patient Outcomes – Calculating the Index**

The Leapfrog Index
The Leapfrog Quality Index is calculated using a differential mortality calculation to determine what the likelihood of death would be if the Leapfrog measure is not met by the hospital. The first three Leaps (EBHR, CPOE, and IPS) each have a mortality probability that is factored into the hospital's success in meeting the measure. If the hospital meets the measure, the probability decreases to zero. If the hospital does not meet the measure's requirements, the non-zero probability is included in calculating the overall estimated avoidable deaths per

thousand. This figure is divided by the average avoidable deaths per thousand for all hospitals for that surgical procedure/medical condition to derive an index.

The fourth Leap measures the success of the hospital meeting 20 of the 34 National Quality Forum goals and avoiding those hospital complications and patient safety events that are avoidable. Each of these measures is converted to an index by dividing the score for the hospital by the average for all hospitals for the procedure, and the indices are averaged together to form an overall index for the fourth Leap.

The index for the first three Leaps is averaged with the index for the fourth Leap to produce the overall Leapfrog index score. To allow for hospitals that may have excessively high or low scores, the data are trimmed, or winsorized, to thresholds of .5 or 1.3 to mitigate the effect of outlier scores. The leapfrog index is calculated as follows:

- Leapfrog Index = Average of first three Leaps divided by the national average for the Leaps combined with the average for the fourth Leap divided by the national average for the fourth leap.

Complications, Mortality and Quality Composite Score
Quality is assessed using surgical procedure/medical condition-specific complications and mortality data supplied by WebMD. The complications rate, reflecting the most common complications by surgical procedure/medical condition, is severity adjusted. The mortality rate, also severity adjusted, reflects the incidence of death after a procedure or treatment for a condition.

The complications, mortality, Leapfrog, and CMS indexes are calculated, compared and re-calibrated to 1.0 using the national average for all hospitals for that procedure/condition. The indexes are then combined with the Leapfrog and CMS indexes using a weighting system to calculate the Quality Composite Score. The Quality Composite Score is used to determine the number of Patient Outcomes stars a hospital will receive for the surgical procedure/medical condition.

The complications, mortality and CMS indexes are calculated as follows:
- Complications Index = Actual complications rate percentage per procedure by hospital divided by the average complications rate percentage per procedure for all hospitals, and is severity adjusted).
- Mortality Index = Actual mortality rate per percentage per condition by hospital divided by the average mortality rate percentage per condition for all hospitals, and is severity adjusted.
- CMS Index = Average of CMS measures divided by the CMS measures national average
  *Example: A hospital's complication rate for CABG% is 10% and the national average for all hospitals for CABG complications is 8% = 10 divided by 8 = 1.25 complications index*

Once the actual percentage rate is divided by the average rate, any data point that exceeds 1.5 or is less than .5 will be brought up or down to these thresholds. This method (winsorizing) helps normalize the data and decrease the occurrence of data extremes caused by outliers.

*Example: A hospital's complication rate for CABG is 5% and the national average for all hospitals for CABG complications is 15% = 5 divided by 15 = .33, which is automatically assigned to .5 since it was below the lower threshold.*

Indexes less than 1.0 indicate scores higher than the national average while indexes greater than 1.0 indicate scores lower than the national average.

**Patient Outcomes – Scoring**

The quality composite score calculation is:
Quality Composite Score = (Complications Index)*(Complications weighting) + (Mortality Index)*(Mortality Weighting) + (Leapfrog Index)*(Leapfrog weighting) + (CMS Index)*(CMS Weighting)

The following distribution around the average determines the quality category for display and was used for approximately 2,668 hospitals participating in the CIGNA network that had data for which valid scores could be generated:

- Bottom 5% - One Quality Star (*)
- Middle 50% - Two Quality Stars (**)
- Top 45% - Three Quality Stars (***)

The Patient Outcomes score in the directory will display a 'not rated' indicator for conditions that do not have at least three quality factors weighted.

Approximately 2,668 hospitals participating in the CIGNA network had data for which valid scores could be generated. The following distribution was used: 45% - three star, 50% - two star and 5% - one star for each procedure/condition. The volume of hospitals achieving a designation in at least one procedure/condition is:

| Designation | Description | Volume of Hospitals |
|---|---|---|
| One star | Below average | 687 |
| Two stars | Average | 2366 |
| Three stars | Above average | 2225 |

A hospital could be included in the one star, two star and three star designations depending on the number of scored procedures/conditions. One star for quality is assigned if a procedure/condition does not show a significant difference between the one star and two star outcome categories or if there is a procedure that has a small volume of ranked hospitals.

To be sure hospital data is annually stable, a stable volume threshold is established. This threshold helps mitigate the variation in the hospital rankings from year to year and provides a volume baseline that can be used when comparing data in future years.

Volume has been suggested to be an indirect indicator of quality. There is evidence that suggests that "hospitals performing more of certain intensive, high-technology, or highly complex procedures may have better outcomes for those procedures" (AHRQ IQI Guide, V 2.1, Rev 4, Dec 22, 2004). Having credible volume thresholds helps ensure that hospitals that have "suspect" or "questionable" quality due to low volumes are eliminated from consideration since lower volumes of admissions lead to more variation in the outcomes of those admissions.

In an effort to reduce this variation, the threshold was developed using the Centers of Excellence (COE) hospital data from the 2007 and 2008 COE projects. The mortality and complication rates for all hospitals included in the 2006-2007 COE were compared to the mortality and complication rates for the same hospitals in the 2007-2008 COE data. The volume threshold was set at 100 and the R-Squared computed on the mortality or complication index. If the R-Squared was greater than .4 and created 10 or more events (volume * complications percent or volume * mortality percent), the volume was assumed to be stable. If the R-Squared was less than .4, the volume threshold was increased by 100 and the R-Square re-run; this process continued until the R-Square is above .4. However, if the r-square does not appear that it will exceed .4 and the procedure will not yield at least 10 events after increasing the volume past 800 admissions, or if the number of hospitals eligible for ranking was low (100-200 hospitals nationwide), the mortality or complications measure for that procedure would not be used.

**Cost-Efficiency**

Cost-efficiency is a measure of a hospital's average cost for a particular procedure/condition, severity adjusted for national comparison. Physicians' fees and outpatient services are not included.

The Cost-efficiency score reflects both the rates that a hospital charges and the average time spent in the hospital for a specific surgical procedure/medical condition. The Cost-efficiency score for a procedure may be affected by a variety of factors, including geographic cost differences (e.g., major metropolitan areas typically have higher costs as compared to rural areas) and the cost information we use to calculate the national average cost.

CIGNA uses the hospital-specific Open Access Plus contracted rates in effect as of January 1, 2010 to model an average cost per day for each specific procedure or condition. The rate calculations include diagnosis related group (DRG) exceptions, stop loss language or available carve-outs. A random sample of 1,000 cases per surgical procedure/medical condition is assessed to calculate an average cost per day per hospital and

procedure/condition, taking into consideration the samples' average length of stay (ALOS). Costs by hospital and surgical procedure/medical condition are determined using the modeled average cost per day or percent of charges contract and HealthShare Technology/WebMD's publicly available charge and length of stay data. No severity-adjustment is applied for case rate contracts.

**Cost-efficiency - Scoring**

The average Cost Index distribution determines the Cost-efficiency stars displayed online. Approximately 3,479 hospitals participating in the CIGNA network had data for which valid scores could be generated. The following distribution was used: 33% - three star, 33% - two star, 33% - one star for each surgical procedure/medical condition. The volume of hospitals achieving a Centers of Excellence designation in at least one surgical procedure/medical condition is shown in the table below.

| Designation | Description | Volume of Hospitals |
|---|---|---|
| One star | Highest cost | 1842 |
| Two stars | Average cost | 2481 |
| Three stars | Lowest cost | 2246 |

A hospital could be included in the one star, two star and three star designations depending on the number of scored procedures/conditions. Each cost-efficiency designation also includes estimated average cost ranges and the participant's estimated average out-of-pocket cost range when accessed through the secure CIGNA website for covered individuals, www.mycigna.com.

**Grandfathering Hospital Patient Outcome Scores**

A grandfathering methodology is used to be sure that hospitals that have good ratings one year aren't penalized in their ratings due to a methodology change or some factor outside of the hospitals' control in subsequent years. Grandfathering is a process that will change the quality score of a hospital one star rating if certain criteria are met. This process applies to hospitals whose results have fallen either one or two stars, and does not apply to Cost-efficiency star ratings.

The process begins by identifying the hospital's surgical procedures/medical conditions that decreased either one or two quality stars from the previous year's ratings. These hospitals are grouped together and the percent variance is calculated between the hospital procedure's/condition's z-score and both the one and three star z-score limits.

For one star limit variances, the variance is changed to zero if the z-score of the surgical procedure/medical condition is greater than the one star z-score limit. Grandfathering at this z-score level only considers procedure z-scores that exceeded the one star z-score limit which gave the procedure a one star rating). The standard deviation of the variances is calculated and the procedure/condition is grandfathered if the variance is less than the standard deviation of the variances.

For the three star limit variances, the variance is changed to zero if the z-score of the procedure is greater than zero. Z-scores greater than zero indicate below average scores, with average being zero. The standard deviation of the variances is calculated and the procedure/condition is grandfathered if the variance is less than the standard deviation of the variances.

This process increases ratings for 10% to 15% of the surgical procedures/medical conditions, leading to greater annual ratings stability. The use of standard deviations ensures that only those surgical procedures/medical conditions that are not true outliers, greater than one standard deviation, are considered for grandfathering. The grandfathering process is reviewed as new methodologies are developed for the Centers of Excellence program to be sure that ratings are fair and accurate.

**Additional Information**

**No Results Shown**

Hospital data may not display in the online provider directory for many reasons, including but not limited to:

● Insufficient patient volume or MedPar data available for that procedure/condition,
● A surgical procedure is not performed or a condition is not treated at the hospital, or
● Hospital has requested their data not be displayed.

**Academic/Teaching and Community Hospitals**

A hospital's Patient Outcomes results are compared to the hospital's peer group, either community hospitals or teaching/academic hospitals. The results are combined together for display purposes within the online search results. The community versus teaching/academic hospital comparison only applies to the Patient Outcomes scores.

**Updating Centers of Excellence/Hospital Value Tool Data**

Centers of Excellence/Hospital Value Tool data is analyzed and refreshed annually. While every attempt is made to use the best available data and nationally recognized standards, we acknowledge that Patient Outcomes and Cost-Efficiency standards continue to evolve. Accordingly, individuals are encouraged not to use this information as the sole basis for decision-making and to consult with their treating physician when selecting a hospital.

Data for the Centers of Excellence program is reviewed annually to decrease the number of surgical procedures/medical conditions and hospitals that do not display. Various methods, including adjusting the minimum volumes to encouraging hospitals to display their data, are used.

**Process for Hospitals to Request Results**

Hospitals can email COEInfo@cigna.com to obtain your specific results. The hospital contact should include their name, facility name, tax identification number, city, state and zip code. The Regional Network Product Integration (NPI) team will coordinate responses.

**Process for Hospitals to Correct Errors or Request Reconsideration**

A hospital can request to review data, Patient Outcomes and Cost-efficiency ratings, or request reconsideration, correct errors, or submit additional information for review and reconsideration by email to PhysicianEvaluationInformat@cigna.com, or fax to 1.866.448.5506. The facility name, tax identification number, and your contact information should be included in the request. A Network Clinical manager will reach out to discuss your request and to initiate the Selection Review Committee review process. The Selection Review Committee will meet within 30 days of receipt of submitted documentation and provide a written response to the requested review.

**Process to Provide Feedback**

Individuals with CIGNA coverage, clients, and participating physicians and hospitals are encouraged to provide feedback and improvement suggestions. Clients and individuals with CIGNA administered coverage should call the telephone number listed on the back of their ID card. Participating physicians and hospitals may provide feedback through email to PhysicianEvaluationInformat@CIGNA.com, or by fax to 1.866.448.5506. Methodology changes are reviewed and implemented annually.