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F5 Key
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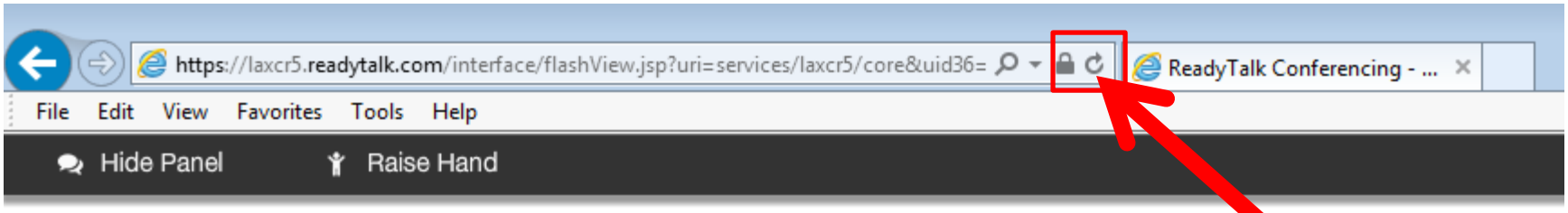

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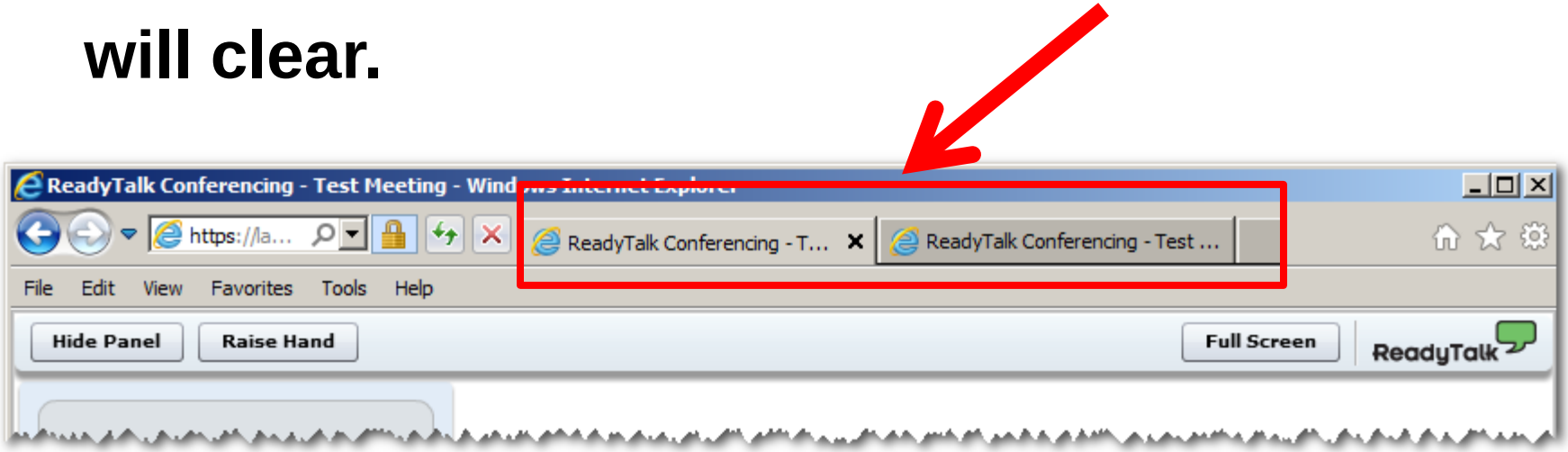

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Hospital IQR Program
CY 2018 Voluntary Reporting – Hybrid Hospital-Wide 30-Day Readmission Measure Overview

April 18, 2018

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Purpose

This presentation will provide participants with an overview of the Hybrid Hospital-Wide 30-Day Readmission (HWR) measure, review frequently asked questions, and allow stakeholders to ask additional questions regarding the measure.

Objectives

By the end of this presentation, participants will be able to:

- Define the Hybrid HWR measure.
- Understand the benefits of voluntary submission in Calendar Year (CY) 2018.
- Locate resources related to the Hybrid HWR measure.

Voluntary Reporting

- The Hybrid HWR measure was implemented in the Hospital Inpatient Quality Reporting (IQR) Program as a voluntary measure for 2018.
  - Providers are not required to submit data for voluntary reporting, and participation will not impact payments to hospitals.
- Hospitals that participate will receive confidential Hospital-Specific Reports (HSRs).
  - Results will not be publicly displayed on *Hospital Compare.*

Hybrid HWR Measure

- The original (claims-based only) and Hybrid HWR measures are both 30-day, all-cause, risk-standardized measures.
- Both include:
  - Medicare fee-for-service (FFS) beneficiaries.
  - Patients ages 65 years or older.
  - Patients discharged alive from non-federal acute care hospitals.
  - Patients not transferred to another acute care facility.
- The Hybrid HWR measure risk-adjusts using core clinical data elements (found in the electronic health record [EHR]) and claims data.
  - The original measure risk adjusts using only claims data.

Hybrid HWR Measure

The core clinical data elements:

- Are intended to reflect a patient's clinical status when the patient first presents to an acute care hospital for treatment.
- Are routinely and consistently captured in most adult inpatient records and can be electronically extracted from hospital EHRs.

Data Elements to be Reported

To calculate the Hybrid HWR measure and participate in voluntary reporting, hospitals need to submit the following:

- 13 core clinical data elements (CCDE)
- 6 linking variables

Core Clinical Data Elements		Linking variables
6 Vital Signs	7 Laboratory Test Results	6 Linking Variables to Match Patient EHR Data to CMS Claims Data
• Heart rate • Respiratory rate • Temperature • Systolic blood pressure • Oxygen saturation • Weight	• Hematocrit • White blood cell count • Sodium • Potassium • Bicarbonate • Creatinine • Glucose	• CMS Certification Number (CCN) • Health Insurance Claim (HIC) Number or Medicare Beneficiary Identifier (MBI) • Date of birth • Sex • Admission date • Discharge date

Performance Period and Dates for Submission

- Measurement period:
  - January 1–June 30, 2018
- For every patient discharged during the measurement period, hospitals need to submit the following:
  - 13 CCDE
  - 6 linking variables
- Submission period
  - Anticipated to be late summer through fall

How to Submit Data

1. Extract/collect the data
   (on CCDE and linking variables)

2. Populate the core clinical data
   elements into QRDA Category I file

   https://ecqi.healthit.gov/qrda

3. Submit the QRDA Category I file through *QualityNet* via the *QualityNet Secure Portal*

QRDA = Quality Reporting Document Architecture

Why Voluntarily Report

- **Eliminate hospital burden**
  - Gradually integrate into the world of EHR-derived quality measurement.
  - A low-risk environment to develop and test EHR-data collection and submission processes for hybrid measures in the future.
  - Develop capacity to report CCDE now reduces the burden hospitals will face in collecting and reporting EHR-based data in future.
- **Align with hospital's needs**
  - Utilizes data hospitals are already routinely collecting on patients.
  - Responds to hospital requests to include clinical data in accounting for patient risk.
- **Speak to the future of measurement**
  - Aligns with goal of meaningful use of EHR systems and capitalizes on investments made into EHRs.
  - Aligns with CMS efforts to measure quality health care data for people with Medicare.
  - Opportunity to gain insight into performance on the Hybrid HWR measure and receive HSR.
- **Risk adjustment**
  - Risk adjustment variables include labs, vitals, and administrative data.
  - Reporting CCDE assists CMS in identifying how sick a hospital's patients are.

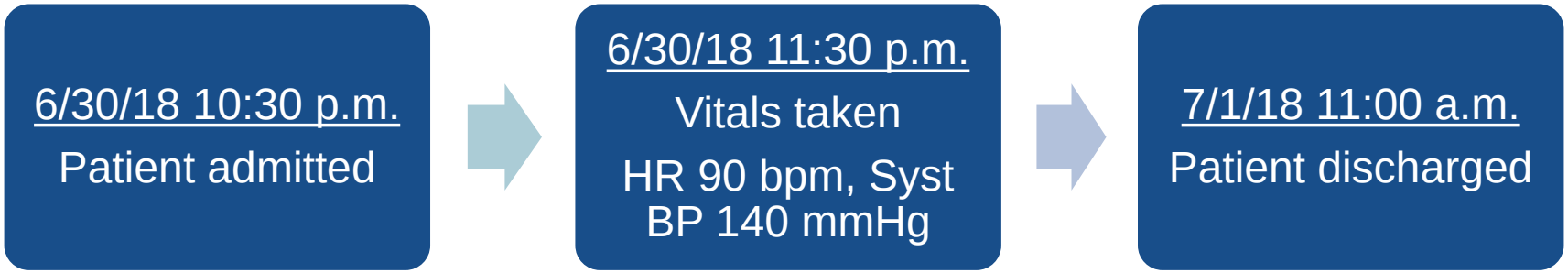
Frequently Asked Questions

Timing of Encounter

Question: Is the intent for the measurement period to ensure that the "admission start date/time" and the "discharge date/time" are within the measurement period?

Answer: The intent of the logic is that the **discharge** date/time is within the measurement period.

For instance, the following case should **not** be included, as the discharge falls outside of the January 1, 2018–June 30, 2018 measurement period.



Index Admission

Question: What is an "Index Admission"?

Answer: An index admission is the initial admission for an episode of care. It is the hospitalization to which the readmission outcome is attributed and includes admissions for patients. An index admission must meet all the measure inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
• Enrolled in Medicare FFS Part A for the 12 months prior to the date of the index admission, and during the index admission • Aged 65 years or over • Discharged alive from a non-federal short-term acute care hospital • Not transferred to another acute care facility	• Admitted to Prospective Payment System-exempt Cancer Hospital (PCH) • Without at least 30 days post-discharge enrollment in Medicare FFS • Discharged against medical advice • Admitted for primary psychiatric diagnoses • Admitted for rehabilitation • Admitted for medical treatment of cancer

CCDE for Index Admission

Question: Do the first CCDE need to be submitted for both the index and readmission visits?

Answer: The collection of CCDE is only used for risk adjustment of an eligible index admission and not the readmission outcome.

However, since a readmission may meet the Hybrid HWR measure inclusion criteria, it's possible that a readmission may qualify as a new index admission; therefore, collection of the clinical data will be necessary.

Timing of Results

Question: The specifications note that all results should "start before" or "start after" the admission start date time. Is the intent that results documented concurrently with the admission start date/time will not qualify?

Answer: Results for CCDEs that are documented at the time of the admission are eligible values and qualify for inclusion if they are also the earliest values available within the timing window.

Timing of Results

Question: Should labs that occur during a pre-op testing in a hospital outpatient department be included in the 24-hour look back period? For pre-op testing, these labs can occur either within or outside of the 24 hour pre-admission window. The testing would mostly include the lab metrics but could also include vitals.

Answer: You should report both lab results and vitals the first time that they are **captured within 24 hours of the pre-admission window, even if they occur in an outpatient department**. If all vitals and lab results are captured in the outpatient department outside of the 24-hour window, they would not count for submission, and you would have to use the first vitals within 2 hours of the admission and the first lab results within 24 hours of admission.

Please note that the Hybrid HWR measure's surgical specialty cohort does not use any laboratory results in the risk adjustment. You should still submit all the requested variables on patients in the pre-operative testing center; however, the accuracy will not impact their risk adjustment.

Data Mapping

Question: Should submitted data be mapped to the Quality Data Model (QDM) data elements value sets, or may facilities send the raw data elements?

Answer: Facilities should map local codes to the codes in the value sets included in the measure.

For example, if your hospital stores lab information in a format other than LOINC®, we ask that you map your local codes for glucose to the LOINC® codes in the glucose value set.

Electronic versus Manual Data Collection

Question: Should data be electronically extracted, or should records be manually abstracted to retrieve the data? What kind of file can the data be entered into that could be converted into a QRDA I file format?

Answer: The data should be electronically extracted from your facility's EHR via computer programming into a QRDA Category I file format. The CCDEs should not be manually abstracted. We recommend working with your specific EHR and health information technology (IT) vendors to determine the appropriate process for extracting the data and developing QRDA Category I files for reporting to CMS.

Submitting Payer Information

Question: I noticed the Supplemental Data Elements section is blank, but value sets are listed under the Supplemental Data Elements. Is the intent to still submit these data in addition to the Medicare payer?

Answer: Please only submit payer information once per QRDA I file. Payer information should align with the Medicare payer value set included in the initial population. Do not include payer in the supplemental data elements. The intent of the specifications is to capture Medicare FFS patients only. However, if your hospital captures a significant volume of Medicare FFS patients under a different code contained in the value set, we suggest including that code in your reporting as well.

Linking Variables

Question: We collect both a historical sex and a current point-in- time sex for those identifying differently than their DNA sex. Which value is the one that is required for the linking variable?

Answer: For the sex variable, please submit the historical/DNA sex rather than the sex the patient identifies with at the current point in time.

Linking Variables

Question: Is the age 65 requirement as of the time of admission or discharge?

Answer: The patient should be 65 years or older at the time of the admission.

Please note that a patient must be enrolled in Medicare FFS at the time of admission because the measure uses Medicare claims data to identify the cohort, risk variables (other than lab results and vitals), and the outcome. The age criteria is in place to exclude patients that qualify for Medicare due to a disability.

Transfer Patients

Question: Are we excluding patients transferred to another acute care facility from the initial population?

Answer: Patients transferred to another facility or not discharged alive will not be included in your hospital's cohort. You may exclude these patients from the initial population; however, this is not required because they will be excluded once the patients are linked to the Medicare administrative claims data. To clarify, for a patient to be considered transferred, both hospitals must be short-term acute care facilities, and the discharge and admission must occur on the same day or the next calendar day.

Units of Measurement

Question: Which units of measurement should be used to report temperature and weight?

Answer: For this voluntary submission of the CCDEs, facilities may report temperature in either Celsius or Fahrenheit and weight in either pounds or kilograms. In addition, hospitals should report vital signs and lab results in the units of measure used by your EHR. Please be sure to include the unit of measurement in your QRDA submission.

Core Clinical Data Elements		Linking Variables
6 Vital Signs	7 Laboratory Test Results	6 Linking Variables to Match Patient EHR Data to CMS Claims Data
• Heart rate • Respiratory rate • Temperature • Systolic blood pressure • Oxygen saturation • Weight	• Hematocrit • White blood cell count • Sodium • Potassium • Bicarbonate • Creatinine • Glucose	• CMS Certification Number (CCN) • Health Insurance Claim (HIC) Number or Medicare Beneficiary Identifier (MBI) • Date of birth • Sex • Admission date • Discharge date

Program Name for Submission

Question: When generating the QRDA I files, which “QRDA I CMS Program Name” should be selected?

Answer: "HQR_IQR_VOL" is the correct selection when submitting. More guidance on data submission is available on *QualityNet* at*:*

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228776337286

Planned Readmission Algorithm

Question: Where can I find the Hybrid HWR measure planned readmission algorithm?

Answer: The Hybrid HWR measure uses the planned readmission algorithm that is currently used by the original (claims-based) HWR measure.

Details on the planned readmission algorithm can be found in Section 2.2.3 and appendix E of the 2017 Hospital-Wide Readmission Measure Updates and Specifications Report available on *QualityNet :*

Hospitals – Inpatient > Claims-Based and Hybrid Measure > Readmission Measures > Measure Methodology.

Resources

eCQI Resource Center

Pathway: ecqi.healthit.gov > EH/CAH eCQMs > Hybrid Hospital-Wide Readmission*

QualityNet

Pathway: *QualityNet*.org > Hospitals - Inpatient > Claims-Based and Hybrid Measure

IPPS/LTCH PPS Final Rule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html

Introductory Webinar

Pathway: *QualityNet*.org > Hospitals - Inpatient > Claims-Based and Hybrid Measure > Hybrid Measure > > Resources

2018 CMS Implementation Guide for QRDA Category I

https://ecqi.healthit.gov/qrda

Refer to the Implementation Guide for QRDA Category I for proper QRDA file formatting.

JIRA

https://oncprojectracking.healthit.gov/support/projects/CHM/summary

Measure Inbox

cmshybridmeasures@yale.edu

Contact the hybrid measures inbox for more information

Questions

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