Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital IQR Program Hybrid Hospital-Wide 30-Day Readmission Measure Core Clinical Data Elements for Calendar Year 2018 Voluntary Data Submission Questions and Answers

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Question 1: **For the weight value, what if only kilograms are available in the EHR?**

CMS would like hospitals to conform to the units of measure that were indicated in the webinar slide deck and the educational information posted on the eCQI Resource Center. CMS will revisit the capability to accept the weight value of kilograms and will communicate a final determination to the submitter community at a later date.

Question 2: **How is the admission defined? Is it the physician order for admission or physically arriving in the inpatient nursing unit?**

The admissions are defined using administrative claims data, so it is based on what is in the claims. And, if there is an admission to a short-term acute care hospital, that is used to define the admission.

Question 3: **Do all vitals need to be documented for a particular time period in order to use that time period or do you move to the next time period where all are complete?**

Vitals do not all need to be complete within one time period, as long as they are the earliest available value within the look-back period. A hospital can use, for example, a blood pressure that was taken at 9:30 a.m., if that is the first available or earliest available. Then, a hospital could have a blood pressure that was documented at 10 a.m. So, they do not need to all be batched or completed at the same time, if the values that you are using are the earliest available.

Question 4: **Would you use the time labs were drawn or the time labs were resulted?**

CMS would like hospitals to use the time labs were resulted, since that is the time that the information is clinically available to the clinicians.

Question 5: **When a hospital submits patient data from the EHR, but not all the patients are within the applicable population, will the non-matched patients be included in the results? If so, how will the non-matched patients be risk adjusted?**

If there is not a match between the administrative claims data and the EHR data, then the case will be excluded from the measure calculations. However, CMS intends to provide information on that particular case in the Hospital-Specific Report (HSR), so you can identify the reason why that case was excluded from the measured calculation.

Question 6: **In the look-back period, do you only include vitals from the same encounter/visit or, if the patient was in the emergency department (ED), went home, and then later returned within 24 hours, do we then consider the vitals from the previous ED visit?**

For this measure, submitters should look for the earliest available core clinical data elements in that 24-hour look-back period. So, in this example, we would consider the vitals from the first ED visit.

Question 7: **What if labs are resulted at a different time?**

It is acceptable for labs to result at a different time and this is an anticipated occurrence. It is important to consider that they are the earliest available within that look-back period.

Question 8: **Slide 26 shows a look-forward time of 24 hours, plus another eight hours. Would you use those?**

Our apologies. This is an error identified on the slide during the webinar. Slide 26 had a yellow star on values that should not be used. The box with the yellow star on it should have had a date time of 1/15/18 3 p.m., not 1/16/18, 3 p.m. Note, the slide deck was republished with the correction to

slide 26 on December 12 and is available on the QualityReportingCenter website under eCQM archived events.

Question 9: **If our electronic medical record (EMR) vendor is submitting Quality Reporting Document Architecture (QRDA) I files on our behalf for meaningful use, will we be allowed to let them submit the QRDA I files for the voluntary hybrid program?**

Yes, hospitals can use a vendor to submit QRDA I files on their behalf for the hybrid measure.

Question 10: **If, for whatever reason, labs or vitals are not available, or maybe one element of the list is not present, will we submit all of the data that are available, or would that patient be excluded from reporting? Are the elements mandatory?**

Yes, a hospital should submit all the information available. So, if you have the Core Clinical Data Elements (CCDE) information that is listed on the slide, then submit that information. For the CY 2018 reporting period (January 1, 2018 through June 30, 2018) we would request the data elements on at least 50 percent of these patients discharged over the same time period.

Question 11: **It was mentioned that a hospital will receive a specific report if they participate in the voluntary measure. What kind of information is anticipated in that HSR? Will there be any benchmarking data?**

At this point, we are not yet certain what information will be in that report. We envision it will look similar to the HSRs that are currently created for the claims-based version of the hospital-wide readmission measure, but final details are to be determined. The report could possibly contain the measure results, patient-level information, national information, but will not contain any benchmarking information. Once this is finalized, hospitals and

vendors will be notified by CMS.

Question 12: **Will this measure be used in the Hospital Readmissions Reduction Program (HRRP)?**

CMS has not indicated the future availability of the measure for HRRP. Any new measures for HRRP would be proposed in a future inpatient prospective payment system (IPPS) proposed rule.

Question 13: **Do you have a sense of what the timeline is for the hybrid measure to become mandatory?**

Any new measures would be proposed in a future IPPS proposed rule.

Question 14: **How do we create QRDA I files for this new measure if it is not a measure we have within our software?**

This process is similar to the process for creating QRDA Category I files for eCQM reporting. Along with referencing the resources available on the eCQI Resource Center, we encourage hospitals to work with their EHR vendor to create the QRDA Category I files.

Question 15: **Is there a monetary incentive to participating?**

Although currently there is no monetary incentive to participate, there are a number of benefits to participating, such as preparing for the future of potentially mandatory reporting of this or a similar hybrid measure, building your processes that will help you prepare for that future, and understanding what your performance on the hybrid measure might look like.

Question 16: **Does the weight need to be an actual weight or is a stated weight acceptable?**

As long as it is the earliest available weight within the timeframes previously discussed, actual or stated weight is appropriate.

Question 17: **To my knowledge, our lab does not report resulted time, it only reports the time a lab is drawn. How should we address this?**

It is recommended to check with your internal information technology or EHR support department to determine if there is, in fact, metadata or a data point available around the time when labs are posted to the EHR.

Question 18: **Is the Hybrid Hospital-Wide 30-Day Readmission (HWR) measure applicable to critical access hospitals (CAHs)?**

Yes. CAHs are invited to participate in the voluntary reporting of this measure. A reminder: participation will not impact payment to hospitals.

Question 19: **Is there a Clinical Quality Language (CQL) version of the specification?**

For the calendar year (CY) 2018 voluntary reporting effort, we are using the Quality Data Model (QDM)-based eCQM specifications. The specification is available for download from the eCQI Resource Center.

Question 20: **Will these be publicly reported?**

Voluntary reporting of the Hybrid HWR Measure will not be publicly reported on *Hospital Compare*.

Question 21: **Can we submit vitals obtained from the transferring hospital and vitals recorded during the ambulance transport?**

This is a great point because the core clinical data elements are really trying to capture a clinical snapshot of the status of the patient when they arrive at

your facility. So, to answer that question, no, we would not be looking for data points collected in an ambulance or when transferring from another hospital. We really want only those data elements that are collected at your facility once they arrive.

Question 22: **How crucial is it that a hospital indicates the correct discharge disposition to capture the transfer to another acute care facility? If we indicate discharge to home, but a patient actually went to another hospital, will that count against the discharging hospital?**

It is not important that hospitals record that information in the discharge disposition record. The measures do not use discharge dispositions, in general, to identify transfers between hospitals. We look at the dates to identify the transfer, so we are not using the discharge dispositions.

Question 23: **Are the hospitals only submitting times or are they also including the results?**

CMS is requesting the time and the actual results for all the core clinical data elements that your hospital will be reporting for each patient.

Question 24: **When is the deadline to commit to voluntarily reporting this measure?**

Hospitals do not need to signal to CMS if they intend to voluntarily report the measure. Hospitals have until the end of the submission period to report the data. We currently anticipate the submission period to end on late fall 2018. CMS will notify hospitals if the submission period changes.

Question 25: **Are there specific exclusions on the measures, (e.g., Do Not Resuscitate [DNR], Discharge Against Medical Advice [AMA], or elopement)? Are patients from Skilled Nursing Facilities (SNFs) and nursing homes included?**

AMAs are included in the exclusion criteria. So, if the patient is discharged against medical advice, they are excluded from the measure. In terms of DNR or elopements, they are not included in the exclusion criteria; therefore, patients who have DNRs or elopement will be included in the measure if they meet all the other criteria. The measures capture admissions to short term acute care facilities. So, admissions to SNFs and nursing home facilities are not included in the measure.

Question 26: **What is the goal of submitting this data? What is the purpose of the submitting this data?**

The goal of submitting the data is to provide the additional clinical information that can be used to risk adjust the measure for that patient. So, instead of using only claims data to risk adjust for the measure, we will also use clinical information to more accurately represent the patient's clinical status in the risk adjustment methodology.

Question 27: **Are there any ideas about including information on social determinants, such as homelessness?**

The measures have currently been endorsed by the National Quality Forum (NQF) without social determinant adjustments. So, now, it does not include any adjustments of those factors.

Question 28: **If an organization chooses to participate in this measure, must it begin doing so prior to January 1, 2018, or can it begin participation at any point within calendar year 2018?**

There is no deadline for choosing to participate. The only deadline is the submission deadline. If the hospital submits the data to CMS during the anticipated submission period of late summer through fall 2018, you will be participating in the program. If the submission deadline is modified, CMS

will notify participants.

Question 29: **Would the risk adjustment be based on the core clinical data from the index visit, the readmission visit, or both?**

It would be only on the data available during the index visit.

Question 30: **How do you suggest facilities, that are not using a vendor, identify the population in question (e.g., greater than 65 years old, Medicare-only beneficiary, etc.)?**

We suggest hospitals work with their current EHR vendor if they are interested in this voluntary effort but are unsure where to start. Vendors often support user groups or forums that could be a valuable resource for this effort. At this time, we are evaluating additional resources that may be needed for hospitals not engaging with their EHR vendors. Those resources will be available on QualityNet at a later time.

Question 31: **If we elect not to voluntarily report this year, and the measure remains voluntary next year, can we report then?**

Currently, there is no signal that we will be voluntarily reporting the measure the following year. However, if that did happen, then, yes, you can elect to participate in the subsequent year, not this year.

Question 32: **Where can we obtain the specification?**

The measure specifications are available on the eCQI Resource Center. Additional details regarding the Hybrid HWR measure are available on the *QualityNet* website under the claims and hybrid measure tab.

Question 33: **Do the QRDA I files need to be submitted monthly, quarterly, or at once at the end of the reporting period?**

There is no need to perform monthly or quarterly reporting. They can be submitted all at once during the anticipated submission period of late summer through fall 2018. CMS will notify submitters if the submission period changes.

Question 34: **Is it correct that we will not submit a diagnosis? (Slide 15)**

Yes, that is correct. A diagnosis is not required to be included in the QRDA I file that contains the CCDE data elements. The diagnosis will be captured in the claims data.

Question 35: **Is this a sampled population?**

This is not a sampled population and CCDE data elements should be submitted for all eligible patients who come in during that time period.

Question 36: **Will there be a risk adjustment associated with each data element listed on slide 19?**

Yes, a co-efficient odds ratio will exist for each of these data elements and they will risk adjust for them.

Question 37: **Would CMS want a hospital's data if the hospital could only provide a portion of the six months of data?**

As a voluntary reporting effort, submitting a portion of the data is acceptable as well. They will calculate the measure based on the six months of data available and provide your hospital with the results. The report should provide value for the data submitted.

Question 38: **If the readmission is part of a chain of readmissions, do the data only come from the index of the chain?**

Yes, because the data are only collected during the index submission, therefore they should only come from the index and the series of readmissions.

Question 39: **Does this measure only apply to those patients who are readmitted within 30 days?**

The readmission is the outcome and we are attempting to capture the CCDE information in the index. It will apply to the index submission regardless if any readmissions occur in the subsequent CCDEs.

Question 40: **Could we re-review the submission timeframe for the 2018 performance year period?**

The eligible period, or the performance year, is January 1, 2018, through June 30, 2018. We are also looking for hospitals to submit at least 50%, and up to 100%, of discharged hospitalizations for Medicare fee-for-service patients aged 65 or older. Then a hospital would submit that data from that performance year period during the anticipated submission period of late summer through fall 2018. Any changes to the submission period timeframe will be communicated by CMS.

Question 41: **Is there a CMS/National Quality Forum (NQF) number for the Hybrid HWR Measure?**

The NQF number is 2879 and the measure has been endorsed by the NQF committee.

Question 42: **Are we to assume that our EHR vendor will supply us with a method to pull this data, much like they do for our eCQM reports?**

We recommend contacting your vendor to discuss what is needed should

you choose to voluntarily report the Hybrid HWR measure for CY 2018.

Question 43: **Can you clarify what "Index Admission" means?**

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:

- Enrolled in Medicare fee-for-service (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

After selecting admissions meeting the above inclusion criteria, the cohort excludes index admissions for patients:

- Admitted to Prospective Payment System-exempt cancer hospitals
- 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

Note that hospitals should submit data for the voluntary hybrid HWR measure on all patients who meet the above inclusion criteria. Exclusion criteria will be applied at the time of measure calculation.

For more details on the criteria used to determine eligible index admissions, please refer to the 2017 Hospital-Wide Readmission Measure Updates and Specifications Report available on QualityNet, at: (www.qualitynet.org) >Hospitals – Inpatient > Claims-Based and Hybrid Measure > Readmission Measures > Measure Methodology.

Question 44: **Can you use vitals reported by a patient that were taken at home or clinic?**

Core clinical data element values must be taken at the facility. Values taken at home should not be reported. Values taken in an outpatient clinic at the hospital can be reported, but values taken in a clinic that is not part of the hospital should not be reported.

Question 45: **Data collection is used to drive quality improvement. What is the goal of submitting this data?**

The data collected in this effort will assist CMS in incorporating clinical electronic health record (EHR) data into outcome measures, in response to hospital feedback. Using this data in the risk adjustment methodology allows for more specific risk adjustment that accounts for patients' clinical status at the start of an inpatient encounter. It will also support hospitals in preparing for any future submissions of EHR data. Additionally, data submission will provide hospitals with opportunities to:

- Build processes to extract and report core clinical data elements
- Receive feedback on success of EHR data submission
- Receive data on measure performance and their hospital's performance relative to other hospitals that participate in voluntary reporting
- Receive detailed information about their Medicare fee-for-service beneficiaries who had an unplanned readmission within 30 days of hospital discharge; information that can be used to identify the factors that increase patients' risk of readmission and inform their quality improvement strategies to reduce unplanned readmissions.

Additional rationale behind this measure and the reengineering of the original HWR measure is discussed in Section 1 of the measure methodology report posted on QualityNet at: (www.qualitynet.org) > Hospitals – Inpatient > Claims Based and Hybrid Measure > Hybrid Measure > Measure Methodology

Question 46: **If the vitals worsen during an observation stay, which leads to inpatient conversion, is it OK to use those vitals, rather than the earliest values taken?**

Facilities should always report the earliest values taken at the facility for each core clinical data element within the timing window (look back 24 hours, then look forward 2 or 24 hours, depending on the core clinical data element).

Question 47: **If we use our vendor to submit the QRDA I file, would they need to incorporate the specifications to create this data for the hybrid measure?**

Any facility or vendor submitting the core clinical data elements for the Hybrid HWR measure should use the specifications to map its data and to extract the core clinical data elements from the electronic health record to create a QRDA Category I file. Please work with your vendor to determine next steps if you are interested in this voluntary reporting effort.

Question 48: **It was previously stated that if a patient was at the ED, then went home, and then came back within 24 hours, we would use the vital signs obtained during the previous ED visit. Then it was said that we should not use vitals from an ambulance because they want to know a patient picture at the time of admission. These two seem to contradict each other. Please clarify.**

We apologize for any confusion. Facilities should look back 24 hours from time of admission (and then look forward 2 or 24 hours depending on the core clinical data element) to find the earliest value obtained at the facility for each core clinical data element. Values taken in an ambulance are not eligible since they were not taken at the facility.

Question 49: **We do not understand how we can use distinct QRDA I files for this.**

This process is similar to the process for creating QRDA Category I files for eCQM reporting. Along with referencing the resources available on the

eCQI Resource Center, we encourage hospitals to work with their EHR vendor to create the QRDA Category I files.

Question 50: **Our clinic visit documentation and our hospital visits are viewed in the same EMR. If the patient is seen at the clinic for an unrelated issue and then presents to the ED within 24 hours for something else (motor vehicle accident (MVA), fall, etc.) are the vitals from the outpatient visit (when the patient was not on the path to hospitalization) used or the earliest vitals from the ED visit, when the patient is on the way to hospitalization?**

Facilities should report the earliest values that were taken at the facility for each core clinical data element, regardless of where in the facility the values were recorded. Whether or not a patient is perceived to be on the path to an inpatient admission is not relevant. Values taken at an outpatient clinic are only eligible if the outpatient clinic is part of the facility. Additionally, it is important to note that one should look back 24 hours from the time of admission (not from the time of presentation to the ED) for core clinical data elements.

Question 51: **If you are using the data to risk adjust for the measure, will the risk adjustments have bearing in the current Hospital Readmissions Reduction Program (HRRP) or only for the voluntary participation program?**

The core clinical data elements being extracted and submitted for calendar year 2018 will be used only for risk adjustment in the voluntary hybrid HWR measure under the IQR program. These data will not affect the risk adjustment methodology that is used for the measures included in the current (FY 2018) HRRP (namely, acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, coronary artery bypass graft surgery, and total hip/knee arthroplasty; note that the claims-based HWR measure is not included in HRRP). Significant changes to

measures are typically announced via rulemaking**.**

Question 52: **Will this program also consider those readmissions that go to another hospital or just those that return to the reporting hospital?**

For the hybrid hospital-wide readmission measure, a patient is considered to be readmitted if they have an unplanned inpatient admission at a short-term acute care hospital or critical access hospital within 30 days of discharge from the original index admission, regardless of whether the readmission occurred at the same or a different hospital.