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 Presentation Transcript

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December 6, 2017
3 p.m. ET

Artrina Sturges: Thank you Matt and good afternoon everyone. My name is Artrina Sturges and I'm your host for today's event. We just have a few announcements for you. This presentation is being recorded. The transcript of the presentation, along with the questions and answers, will be posted to the inpatient web site, which is the *QualityReportingCenter.com* web site, and also posted to *QualityNet*. If you've registered for the event, a reminder email, as well as a link to the slides, was distributed yesterday. If you did not receive the email, the slides are available for download on our inpatient web site, again *QualityReportingCenter.com*.

I'd like to introduce our speakers for today. Tamara Mohammed is the Project Lead for Yale-New Haven Health Services Corporation Center for Outcomes Research and Evaluation. Juliet Rubini is the Lead Program Analyst for Mathematica Policy Research and Jason Smoot is the research analyst for NPR.

The purpose of today's presentation is to provide participants with an overview of the Hybrid Hospital-Wide 30-Day Readmission measure that hospitals may voluntarily report in calendar year 2018 for the Hospital Inpatient Quality Reporting Program. So, our purpose for today is that, after this webinar is over, you will be able to define the Hybrid HWR measure, understand the importance of voluntary submission in calendar year 2018, identify core clinical data elements for data submission of the Hybrid HWR measure, as well as locate resources related to the Hybrid HWR measure. At this time, Juliet will join us to continue the webinar. Thank you.

Juliet Rubini: Our agenda today is busy. We will give you an introduction into this voluntary effort and talk more about the hybrid hospital-wide readmission measure and its development. We will describe successful data submission and, in addition, we will provide a timeline for the reporting period, and answer some commonly asked questions about the hybrid specification. Finally, we will present the resources available to hospitals that choose to participate in this effort. Then, we will turn it over to you for your questions. Let's get started.

To make sure everyone is on the same playing field, we've identified some common acronyms and terms that you will hear throughout the presentation today. I'd like to particularly point out our definition of a hybrid measure on this slide. This is pertinent to the discussion moving forward today. A hybrid measure is a measure that uses a combination of claims and EHR data, to calculate a performance score. With that, I will pass the presentation over to Tamara, with Yale.

Tamara Mohammed: Thank you, Juliet. So, I'm on slide 11 and I'm going to be speaking a bit today about what the voluntary reporting of the hybrid measure is and then I'll talk a bit about what the actual hybrid measure is itself. So, to begin, the Hybrid HWR or hospital-wide readmission measure is being voluntarily reported under the IQR or Inpatient Quality Reporting Program and, what this means is that, hospitals may, but are not required to, submit the her, or electronic health record information, to CMS. Additionally, it means that participation in this program will not impact hospital payments. However, hospitals are still encouraged to voluntarily report their data because there are a number of benefits to doing so. Firstly, CMS is moving towards quality measures that use medical record detail to replace or supplement the use of administrative claims data when measuring hospital quality. So, if you participate in this program, it will give your hospital a head start in learning how to collect and report your EHR data and will better prepare you for a future with CMS as calculating measure results, using data for your medical records. Secondly, if you participate in the voluntary reporting program, it will give you an opportunity to learn to build the processes to extract and report core clinical data elements that CMS will later use to calculate your hybrid measure results. We'll speak a bit more later about what these core clinical data elements are. And lastly, voluntarily reporting information provides you with an opportunity to receive feedback on whether you are effectively submitting your EHR data to CMS. And importantly, as CMS intends to provide hospitals with confidential reports on the results of the hybrid measure calculations, it gives you an opportunity, to provide, to get

some insight into what your hospital's results might look like on this hybrid measure.

So, I've been talking about the voluntary reporting of the Hybrid HWR measure, but what exactly is the Hybrid HWR measure? Essentially, it's the same as the claims-based version of this measure. So, the - both measures - the hybrid measure and the claims-based measure are both risk-standardized measures, but look at readmissions for all causes in 30 days following an index submission. Both the claims-based and the hybrid versions of the measures include Medicare fee-for-service beneficiaries aged 65 or older who are discharged alive from non-federal acute care hospitals and who are not transferred to another acute care facility. However, the most significant difference between the Hybrid HWR measure and the claims-based version of the measure is in the risk adjustment. Specifically, the Hybrid HWR measure uses more than just claims data for risk adjustment. Instead, it also uses key clinical variables that are found in the EHR or the core clinical data elements to risk adjust for the measure and this is why it's deemed a hybrid measure, because it uses both claims data as well as EHR data to calculate the measure results.

For the voluntary reporting of the hybrid measures, hospitals are being asked to submit two types of data - one, information on the core clinical data elements and two, information on linking variables. The core clinical data elements provide clinical information about the patient's status, when they first present at the hospital. They represent other types of information that hospitals routinely collect and consistently capture on most adult patients and these types of information can be electronically extracted from the EHRs. In contrast, the linking variables, administrative not clinical data. These data are needed to link the core clinical data elements that you voluntarily submit to the claims data that you are already submitting to CMS. I'll now turn it over to Jason, who will describe how to submit the EHR data to CMS and will tell you what data you're being asked to submit, specifically.

Jason Smoot: Thank you. We're looking at the steps to successful submission of the core clinical data elements. First, you will need to extract or collect the data

and, as we note here, you will need to be sure to use the correct timing window, which I'll talk more about in a couple of slides, as well as the correct data standards, for example, SNOMED and LOINC, which are indicated in the value sets. The core clinical data elements will then need to be put into a QRDA Category 1 file and then submitted via the IQR program on *QualityNet*. You will have an opportunity to use the pre-submission validation application or PSVA tool. And we encourage you to use that tool to validate your QRDA file prior to your submission for the *QualityNet* site.

Here we have the 13 core clinical data elements and six linking variables to make up the voluntary EHR data submission for the Hybrid HWR measure. The core clinical data elements here are a mix of vitals and lab data. We refer to the first five core clinical data elements on the left, heart rate through oxygen saturation, as vitals. And we refer to the core clinical data elements, hematocrit through glucose, as lab data. This is an important distinction because the timing for collection of the data elements is a little different for vitals and for labs. Weight, while it is a vital, actually follows the decision rules for collection that lab results follow, not the decision rules for collection that vitals follow. Regarding the second bullet and the list of the six linking variables, please plan to send either the health insurance claim number or the Medicare beneficiary identifier.

And I mentioned that it's important to get the timing window correct for the different core clinical data elements. This slide gives a nice summary of how the timing works. The goal of all of this is to capture a clinical snapshot for patients; what sort of condition they're in when they first show up at the hospital. With all of the core clinical data elements in this voluntary submission, you should always start by looking back 24 hours prior to the inpatient admission time. And during this 24-hour look-back period, if you do find any core clinical data elements in the 24 hours prior to admission, you want to go with the earliest instance of a given data element. So, if there are two values for heart rate prior to admission, one that was ten hours prior to admission and another that was five hours prior to admission, you want to use the heart rate value that was ten hours prior

to admission. We'll go through some more specific examples of all of this in a few slides.

Okay, so that was the look-back period. But, what if you didn't find the given core clinical data element in the 24 hours prior to admission? In that case you need to look forward from the time of admission for that core clinical data element. This is where the distinction between vitals and labs, with the exception of weight, becomes important. Essentially, all vitals except weight, need to be captured within two hours after admission and all labs, along with weight, need to be captured within 24 hours after admission. And again, we have some nice examples of this coming up in a few slides.

Here we have a snippet of the electronic specifications. The logic circled in red is our look-back logic - 1440 minutes is 24 hours - and the logic in the blue circle at the bottom is the look-forward logic. This logic is repeated for each of the core clinical data elements. This, here, is the logic for heart rate.

This table shows us the timing window for the different data elements, based on that categorization, whether the data element needs to be found within two hours of admission or 24 hours of admission. It's also important to get the units of measurement right. So, for instance, temperature needs to be reported in degrees Fahrenheit, not Celsius.

This is the first of our example slides. You can see the top tier arrow to the left, pointing out the 24-hour look-back. These blue squares in the middle give you a sense of the progression of the patient through the hospital. And there will be a yellow star over the blue box that has the core clinical data element values that you want to use. So, this first step here is always to look back 24 hours and use the earliest value that you find for a given core clinical data element. In this example, the earliest values we see for the core clinical data elements heart rate and systolic blood pressure for this patient are 2 1/2 hours before admission at 9:30 p.m. We don't see any values for these core clinical data elements prior to those taken at 9:30 p.m., at least not within the 24-hour look-back period. So, these are the

values we use. Vitals are generally batched, but if, for instance, the earliest value for temperature for this example patient doesn't show up until 10 p.m., 30 minutes after the values for heart rate and systolic blood pressure, that's fine.

This slide shows a similar situation, but helps really drive home the fact that you want to take the earliest values for vitals you find during the 24-hour look-back. In this case, we're again looking for vitals, but there were two sets of vitals taken - one set at 9:30 p.m. and another set at 11:30 p.m. We always choose the earlier core clinical data elements, so in this example, we'll go with the vitals from 9:30 p.m.

This slide shows an example in which no vitals were taken for a patient at all in the 24 hours prior to admission. For vitals, with the exception of weight, whenever there are no values in the 24-hour look-back period, we look forward two hours and the earliest vitals we find, in the two hours after admission, were taken an hour and a half after admission at 1:30 p.m. So, we use those.

Next up, you have some examples for lab results. This is an important distinction that, at the time we care about - the time that, a given lab core clinical data element was resulted. In this case, we find lab values during the 24-hour look-back that have been resulted. There's nothing resulted prior to 9:00 a.m. in the 24-hour look-back, so we go with these. Again, there may be other lab values, perhaps even after the time of admission, but these are the earliest values we find, so we just stopped looking for more and go with these.

In this case here, there were two sets of lab values resulted during the 24-hour look-back period. One set resulted at 9:00 a.m. and another set at 10:00 a.m. We go with the earlier values. Those resulted at 9:00 a.m.

In this example, we didn't find any lab values resulted prior to the admission time, so we next look forward 24 hours. We find lab values resulted three hours after admission, nothing prior to this, so we go with these. And, just a quick reminder, all of these examples for lab results hold

true for weight, as well. We look forward a full 24 hours for weight, if there's no weight in the 24 hours prior to admission.

This slide looks at a case where a patient had labs resulted prior to admission, but these labs were resulted during a separate visit to the hospital that occurred well outside of the 24-hour look-back window. So, we don't consider these. The earliest lab values we find, that were resulted within our timing window, were resulted a few hours after admission, at 4:00 p.m. And this example is true for all of the clinical data elements – vitals, labs, weight. Values outside of the timing window should not be reported.

This last example slide considers the case of a patient in observation status before being admitted. We do want to consider these values taken during the observation period. These count as core clinical data elements. Since the vitals from 8:00 a.m. and the labs resulted at 11:00 a.m. are the earliest values, we use these earliest values.

The last thing I want to emphasize before turning the presentation back over to Juliet, is to just quickly point out that part of this data collection effort is to be sure to account for all of the potential pathways at your facility from which a patient can end up in an inpatient stay. Thank you very much. I'll now pass the presentation back to Juliet.

Juliet Rubini: Thank you, Jason. So, we've talked about the hybrid hospital-wide readmission measure and the data elements we'll need to report in a QRDA format. I'd like to talk a little bit more in-depth about the submission requirements for this voluntary effort. Our first step: It should define the reporting period, which is January 1st through June 30th of 2018, a reminder that your hospital should be submitting data for at least 50% of the discharged hospitalizations for Medicare fee-for-service patients, aged 65 or older, during the reporting period.

The second step includes creating a QRDA category one file for each patient, meeting the initial population. These files will be distinct from calendar year 2018 eCQM reporting files.

In step three, we define the submission period for this voluntary reporting. Submission will begin on September 1, 2018, and end November 30, 2018. There may be an opportunity to submit data prior to September 1st. We will provide further information on that, when it is available. An additional piece we are asking for in step three, is that you use the following naming convention in preparing to submit your QRDA files for this voluntary effort. This convention is: hospital name, CMS certification number, date, and version number. The date should be in a month, day, and year format. This naming convention will enable easier linking to the claims data. Please note that this naming convention does not apply to calendar year 2018 eCQM reporting.

The last portion of step three for data submission is where to submit your data for this voluntary effort. Please submit your files on *QualityNet* using the same path currently used for submitting eCQM for inpatient quality reporting. Now we'd like to discuss some common questions about the core clinical data element.

During the development and testing of the core clinical data element, we receive two common questions. The first is around mapping local codes in use at a hospital and the codes in a measure value set. We encourage you to map your local codes to the codes included in the core clinical data element value set. The second common question, here on the slide, we received, was about number of values to send for each core clinical data element. Hospitals should only submit one value per core clinical data element, the earliest one. Now let's talk about some resources available to hospitals participating in this voluntary effort.

On this slide, we've listed links to some resources. A reminder that a PDF version of these slides is attached to the meeting invite for today. We've provided you links to the final rule. We've outlined the voluntary effort, a link to the eCQI Resource Center, a link to the QRDA Category I Implementation Guide, and a link to the *QualityNet* site. In addition to these resources, we have developed a few others for participating hospitals that I will discuss in the next few slides.

We've created a new JIRA project for this voluntary effort, titled CMS Hybrid Measures, or CHM for short. Please use this JIRA project for submitting questions on the core clinical data elements. This JIRA project should only be used for technical questions on the core clinical data elements or on QRDA file creation. Any program or hybrid measures specific questions should be directed to the CMS Hybrid Measures inbox that we will discuss on the next slide.

In addition to the new JIRA project, for questions around the hybrid measure methodology, we created this CMS Hybrid Measures mailbox, listed here. Appropriate questions for this mailbox include questions around cohort inclusion, measure exclusion, and the approach to risk adjustment. As a reminder, the JIRA project referenced on the previous slide is for technical questions around the core clinical data element.

In addition to JIRA and the CMS Hybrid Measures mailbox, the VSAC has a new feature for CMS Hybrid Measures. The new landing page, not listed here, for the VSAC contains an area specifically for CMS Hybrid Measures and will allow you to quickly sort and export the relevant value sets for the core clinical data elements. This new search feature will be found on the bottom right corner of the landing page and will be titled CMS Hybrid Measures.

And finally, as we mentioned before, the eCQI Resource Center has a new link under the EH Measure section for the Hybrid Measure specifications.

In addition to these resources, we will be hosting an additional office hours-style webinar in the near future. This webinar will provide a forum for participants to ask questions that have come up as they've implemented the core clinical data element specifications. Please stay tuned for more information on the date. With that, we will now take your questions. Thank you so much for your interest in this voluntary reporting effort.

Veronica Dunlap: Thank you, Juliet. Let's get started. Our first question is for the weight value. What if only kilograms is available in the EHR?

Juliet Rubini: Hi. This is Juliet. I can respond to that question. As much as possible, we'd like hospitals to conform to the units of measure that were indicated, but, at this time, we're prepared to receive the units of measure that are available in your EHR.

Veronica Dunlap: Next question. How is the admission defined? Is it the physician order for admission or physically arriving in the inpatient nursing unit?

Tamara Mohammed: Hi. This is Tamara from Yale. The admissions are defined using administrative claims data, so it's based on what's in the claims, and as long as there's an admission to a short term acute care hospital, that's used to define the admission.

Veronica Dunlap: Thank you. Next question. Do all vitals have to be documented for a particular time period, to use that time period, or do you move to the next time period, where all are complete?

Juliet Rubini: Hi. This is Juliet. I can take that question and that's a great question. The answer is no, they don't all have to be complete within one time period. You can have, as long as they are the earliest available value within the look-back period, you can use, as Jason mentioned in one of the example slides, you can use for example, a blood pressure that was taken at 9:30 a.m., as long as that's the first available or earliest available. And then you could have a blood pressure that was for some reason documented at 10:00 a.m. So, they don't have to all be batched or completed at the same time, as long as the values that you're grabbing are the earliest available.

Veronica Dunlap: Great. Thank you. Next question. Would you use the time labs were drawn or the labs that were resulted?

Juliet Rubini: Hi. This is Juliet. I can take that question, as well, and also a great question. We would like you to use the time labs were resulted, since that's the time that the information is clinically available to the clinicians.

Veronica Dunlap: Next question. When a hospital submits patient data from the EHR, but not all the patients 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?

Tamara Mohammed: Hi. This is Tamara again from Yale. If there isn't matching between the administrative claims data and the EHR data, then the patient will be excluded. A case will be excluded from the measure calculations, but we intend to provide information on that particular case in your HSR. So, you can identify the reason why that case was excluded from the measured calculation.

Veronica Dunlap: Thank you. Next question. In the look-back period, do you only include vitals from the same encounter/visit? Or, if the patient was in the ED and went home, then later returned within 24 hours, do we then consider the vitals from the previous ED visit?

Juliet Rubini: This is Juliet with Mathematica. I can take that question. So, we always want to 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.

Veronica Dunlap: Thank you. Next question. What if labs are resulted at different times?

Juliet Rubini: This is Juliet. I can take that question as well. That's fine. We understand that that will happen and it's really important just to consider that they are the earliest available within that look-back period.

Veronica Dunlap: Next question. If we could advance to slide 26, it looks like we have two questions concerning slide 26. Our first question: Slide 26 shows a look-forward time of 24 hours plus another eight hours. Would you use those?

Jason Smoot: This is actually an error that someone caught on the slide. Slide 26 had a yellow star on values that should not be used. The box with the yellow star on it should have a date time of 1/15/18 3:00 p.m., not 1/16/18, 3:00 p.m. As this slide is currently constructed, you should not use these values from 1/16/18 3:00 p.m.

Veronica Dunlap: Thank you Jason for pointing that out. Okay. Our next question: If our EMR vendor is submitting QRDA files on our behalf for meaningful use, will we be allowed to let them submit the QRDA files for the voluntary hybrid program?

Tamara Mohammed: Hi. This is Tamara again from CORE. Yes. You can certainly use a vendor to submit your QRDA files if that's what you'd like to do.

Veronica Dunlap: Next question. If, for whatever reason, labs or vitals are not available or maybe one element of the list, will we submit all of the data that is available, or would that patient be excluded from reporting? Are the elements mandatory?

Tamara Mohammed: Hi. This is Tamara again from CORE. Yes. You should submit all the information that you have. So, if you have CCDE information that's listed on the slide, then certainly submit that information. In terms of mandatory, I think we'd like you to submit everything that you have, but we will post additional information later around the minimal amount required.

Veronica Dunlap: Thank you. Next question. 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 hospital-specific report, questionable any benchmarking data?

Tamara Mohammed: Hi. This is Tamara again from CORE. At this point, we're not yet certain what information will be in that report. We envision it will likely look like the HSRs that are currently created for the claims-based version of the measure, but that's to be determined. So, if it does look like the claims-based version of the measure, it will contain the measure results, patient-level information, national information, but does not contain any benchmarking information. But again, this is to be determined. And so once we finalize, I will let you know.

Veronica Dunlap: Thank you. Next question. Will this measure be used in the HRRP pay-for-performance program?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. There - CMS has not indicated the future use of the measure in HRRP. They have indicated that they may consider mandatory reporting of the measure in the future, but they have not signaled which program it will be in.

Veronica Dunlap: And that leads us to our next question. Do you have a sense of what the timeline is for moving forward with the hybrid measure being made mandatory?

Tamara Mohammed: This is Tamara again. I think that was the same question, so we don't have a timeline available as yet for that. What we have is a signal in the rule, in the 2018 rule, that CMS may make this mandatory in the future, but no timelines are associated with that.

Veronica Dunlap: Okay. Thank you. Next question. How do we create QRDA files for this new measure, if it is not a measure we have within our software?

Tamara Mohammed: Hi. This is Tamara from CORE. I'm going to let Juliet answer this question, I think.

Juliet Rubini: Yes. This is Juliet. So, you can work with your vendor to see if you can develop your own QRDA files. We know some sites have done that in the past for other efforts. So, that is one suggestion we have and we can circle back and come up with some other suggestions as well.

Veronica Dunlap: Okay. Thank you. Next question. Is there a monetary incentive to participating?

Tamara Mohammed: Hi. This is Tamara again from CORE. There is no monetary incentive to participate, although, as we've mentioned before, we think that there are a number of benefits to participating, such as preparing for the future of potentially mandatory reporting of this measure, and building your processes that will help you prepare for the future, as well as

understanding what your performance on the hybrid measure might look like, in comparison to a clean space version of the measure.

Veronica Dunlap: Thank you. Next question. Is the weight to be an actual weight or is a stated weight okay?

Tamara Mohammed: This is Tamara from Yale CORE. I presume they're referring to the CCD information, so I'll turn this over to Juliet.

Juliet Rubini: Yes. This is Juliet. As long as it's the earliest available weight within the timeframes that we've talked about. Actual or stated is appropriate. Either one is appropriate.

Veronica Dunlap: Thank you. Next question. To my knowledge, our lab does not report resulted time, only reports time lab is drawn. How should we address this?

Juliet Rubini: So, this is Juliet. I can. That sounds like you'll have to circle back with your internal stakeholders and see if there is, in fact, some metadata around the time when labs are posted to the EHR. To my knowledge, there should be some sort of a data point there for you to work with.

Veronica Dunlap: Next question. Is the Hybrid HWR measure applicable to critical access hospitals?

Tamara Mohammed: Hi. This is Tamara again from CORE. Yes. Critical access hospitals are invited to participate in the voluntary reporting of this measure. Although, again, participation will not impact payment to hospitals.

Veronica Dunlap: Next question. Is there a CQL version of the specs?

Juliet Rubini: Hi. This is Juliet. I can take that one. For this voluntary reporting effort, we are using the QDM-based HQMS specifications.

Veronica Dunlap: Next question. Will these be publicly reported?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. At this point in time, we don't anticipate that the voluntary reporting of these measures will be publicly reported. CMS has not indicated that this will be publicly reported.

Veronica Dunlap: Next question. Can we submit vitals obtained from a transferring hospital and vitals recorded during the ambulance transport?

Juliet Rubini: So, this is Juliet with Mathematica. I can take that question and 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 transferring from another hospital. We really want only those data elements that are collected at your facility, once they arrive to your facility.

Veronica Dunlap: Next question. How crucial is it that a hospital indicates the correct discharge disposition, in order 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 at the discharging hospital?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. It's really not important that you record that 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're not using the discharge dispositions. They really will not be important to identify a transfer.

Veronica Dunlap: Next question. Are the hospitals only submitting times, or are they also including the results?

Juliet Rubini: This is Juliet with Mathematica. I can take that question and great question. Yes. We want the times and the actual results for all the core clinical data elements that you'll be reporting for each patient.

Veronica Dunlap: Next question. When is the deadline to commit to voluntarily reporting this measure?

Tamara Mohammed: Hi. This is Tamara from Yale CORE. There is no real deadline to committing to report the measure. You have until the end of the submission period to report, to submit the data for the measure. So, if you decide to do it, the last date to refine is up to you, as long as you get the data in by November 30, 2018, which is the end of the submission period.

Veronica Dunlap: Next question. Are there specific exclusions on the measures (i.e., DNR, AMA, elopement)? Are patients from SNFs and nursing homes included?

Tamara Mohammed: Hi. This is Tamara again from Yale. AMAs are against - discharged against medical advice is an 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 exclusion criteria; therefore, patients who have DNRs or elopement will be included in the measure if they meet all the other criteria. Patients who are in nursing homes or SNFs, the measure captures admissions to short term acute care facilities. So, admissions to SNFs facilities are not included in the measure.

Veronica Dunlap: Next question. What is the goal of submitting this data and what's the purpose of submitting this data?

Tamara Mohammed: This is Tamara from Yale CORE. So, 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'll also use clinical information to risk adjust for that particular patient to more accurately represent the patient's clinical status in the risk adjustment methodology.

Veronica Dunlap: Next question. Is there any idea about putting in information on social determinants such as homelessness?

Tamara Mohammed: This is Tamara again at Yale. The measures have currently been endorsed by NQF without SDS adjustment, so social determinant adjustments. So, at this point in time, it does not include any adjustments of those factors.

Veronica Dunlap: Next question. If an organization chooses to participate in this measure, must they begin doing so prior to January 1, 2018, or can they begin participation at any point within calendar year 2018?

Tamara Mohammed: This is Tamara again at CORE. So again, there is no deadline for choosing to participate. The only real deadline is the submission deadline. So, as long as you submit the data by November 30, 2018, you will be participating in the program. Otherwise, it's up to you when you decide to choose to participate.

Veronica Dunlap: Next question. If results from a transferring location are available for the look-back time period, could those be used or should the data be limited to those results from your facility?

Juliet Rubini: This is Juliet with Mathematica and great question. The answer is the latter. You should only use the results that were captured within your facility.

Veronica Dunlap: Okay. Thank you. Next question. Would the risk adjustment be based on the core clinical data from the index visit, the readmission visit, or both?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. It would be only on the data available during the index visit.

Veronica Dunlap: Next question. How do you suggest facilities not using a vendor identify the population in question (i.e., greater than 65 years old, Medicare-only beneficiary, etc.)?

Juliet Rubini: This is Juliet with Mathematica. We can research that question and come up with some ideas and post them later with the rest of the questions that are coming in.

Veronica Dunlap: Great. Thank you. Our next question: If we elect not to voluntarily report this year and the measure remains voluntary next year, can we report then?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. At this point in time, there is no signal that we will be voluntarily reporting the measure the following year. But, if that did happen, then yes. You can elect to participate in the subsequent year, not this year. That would be fine.

Veronica Dunlap: Next question. Where can we obtain the specification?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. The measure specifications are available on the eCQI Resource Center and they were also recently posted on the *QualityNet* web site. If you go to the *QualityNet* web site and go to where it's now labeled the claims and hybrid measure tab, you will be able to find the specifications for the hybrid measures. They're under another subtopic of hybrid measures.

Veronica Dunlap: Next question. Our vendor has not created the QRDA file for this yet. Do the QRDA files have to be submitted monthly, quarterly, or can they be submitted all at once at the end of the reporting period?

Juliet Rubini: So, this is Juliet. They can be submitted all at once during the submission period, which is from September 1, 2018, through November 30, 2018. So, there's no need to do monthly or quarterly reporting. They can all just be reported during that timeframe.

Veronica Dunlap: Next question. If we could advance to slide 15, please, is it correct that we will not submit diagnosis?

Tamara Mohammed: Hi. This is Tamara from Yale CORE. Yes. That's correct and, for the CCDE elements, you will not be required to submit the diagnosis. Instead, that will come through the claims data that you will be linking to.

Veronica Dunlap: Thank you. Back to our questions. Our next question is: Is this a sampled population?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. No. This is not a sample population. The data should be submitted for all eligible patients who come in during that time period.

Veronica Dunlap: Next question. Will there be a risk adjustment associated with each data element listed on slide 19?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. Yes. A coefficient odds ratio will exist for each of these data elements. So, they will risk adjust for them.

Veronica Dunlap: Next question. Would CMS want a hospital's data if the hospital could only provide a portion of the six months of data?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. I think, yes. If you could only provide a portion of the data, please do submit that. Those - we will calculate the measure based on the six months of data that you at least have and provide you with results. So, it should be of some value to you as well.

Veronica Dunlap: If the readmission is part of a chain of readmissions, does the data only come from the index of the chain?

Tamara Mohammed: Hi. This is Tamara again from Yale. Yes. So, because the data is only collected during the index submission, then it should only come from the index and the series of readmissions.

Veronica Dunlap: Next question, does this measure only apply to those patients who are readmitted within 30 days?

Tamara Mohammed: This is Tamara again from Yale CORE. So, the readmission is the outcome and so we're looking to capture the CCDE information in the index. So, it will apply to the index submission regardless of whether or not any readmissions occur in the subsequent CCDEs.

Veronica Dunlap: Okay. Our next question. If we could move the slide to number 29 and if we could just re-review slide 29, please?

Juliet Rubini: Sure. This is Juliet. So, the submission - or the eligible period or the performance year- is January 1, 2018, through June 30, 2018. And we're 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 and then you would submit that data from that performance year period during that September 1 to November 30, 2018 time period.

Veronica Dunlap: Thank you. And it looks like we have time for one or two more questions. Our next question: How does a hospital sign up to be involved in the voluntary Hybrid HWR Measure?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. There is no official sign up to participate. Instead, you should just submit your data but, also, we invite you to attend the other webinars so you can learn more about how you may submit that data.

Veronica Dunlap: Okay. And our last question: Is there a CMS/NQF number for the Hybrid HWR Measure?

Tamara Mohammed: Hi. This is Tamara again from Yale CORE. There is an NQF number. It is number 2879 and has been endorsed by the NQF Committee.

Veronica Dunlap: Great. Thank you. I would like to conclude today's questions and answers for the webinar and I will now pass it over to Deb Price to review our continuing education process. Over to you, Deb.

Deb Price: Thank you. This event has been approved for one continuing education credit. You must report your own credit to your respective boards. Complete the survey and then register for your certificate. Registration is automatic and instantaneous. Therefore, if you do not get a response right away, there is a firewall blocking your link. You will need to register as a new user using your personal email and phone number. If you are a new

user or have had any problems getting your credits, use the new user link. If you have not had any issues getting your credits, use the existing user link. Thank you for joining us today. We hope you learned something. All questions will be answered and posted on our *QualityReportingCenter.com* web site at a later date. Enjoy the rest of your day. Goodbye.