Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

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

Presentation Transcript

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Artrina Sturges: Thank you very much, Matt, and good afternoon everyone. My name is Artrina Sturges and I'm your host for today's event. We have a few announcements for you before we get started. This presentation is being recorded. The transcript of the presentation, along with the questions and answers, will be posted to the inpatient website, which is the *QualityReportingCenter.com* website, and it'll also be posted to *QualityNet* in the coming weeks. If you've registered for the event, a reminder email, as well as the link to the slides, was distributed yesterday. If you did not receive the email, the slides are available for download on our inpatient website, again, *QualityReportingCenter.com*. Next slide, please?

At this time, I'd like to introduce our speakers for today. Tamara Mohammed is the Project Lead for the Yale New Haven Health Services Corporation, Center for Outcomes Research and Evaluation. Juliet Rubini joins us as well and she is the Lead Program Analyst for Mathematica Policy Research. Next slide, please?

For today's presentation, our intent is to provide an overview of the Hybrid Hospital-Wide 30-Day Readmission Measure, review frequently asked questions, and encourage you to submit your questions into the chat box to be addressed by the subject matter experts. Next slide, please?

Now, in terms of the objectives, our intent is that, by the end of the webinar, you'll have the ability to define the Hybrid HWR Measure, and that's how you'll hear it referenced in shorter terms - Hybrid HWR, understand why it's been official for your hospital to voluntarily submit the measure for Calendar Year 2018 reporting, and quickly locate resources related to the Hybrid HWR Measure. So, at this time, Tamara Mohammed will join us to provide the Hybrid Hospital-Wide 30-Day Readmission Measure overview. Tamara?

Tamara Mohammed: Sure. Thanks, Artrina. Hi everyone. As of today, as Artrina mentioned, I am going to be providing you with a brief introduction to the Hybrid Hospital-Wide Readmission Measure. We can move to the next slide, please?

So, I want to start off by pointing out that the Hybrid Hospital-Wide Readmission Measure is the first Hybrid Measure to be implemented in the Inpatient Quality Reporting, or IQR, Program and, for 2018, this measure has been added to the program has a voluntary measure. What this means is that hospitals may, but are not required to, submit data for the voluntary reporting to CMS this year. During 2018, this is entirely optional for hospitals. Regardless of whether or not you choose to actually participate and submit your information, there will be no impact on payment determinations as a result of this decision. However, for those hospitals that do chose to participate, they will receive confidential Hospital-Specific Reports, or HSRs, although the results of information contained in those reports will not be publicly displayed on *Hospital Compare*. Next slide, please?

So, for those of you a bit more familiar with the IQR Program, you may have recognized that a Hospital-Wide Readmission Measure already exists in that program. So, that measure that's been in the IQR Program for several years now is what I'm going to be referring to as the claims-based only or the original Hospital-Wide Readmission Measure. I'm going to use this measure as a reference point because it is very similar to the Hybrid Hospital-Wide Readmission Measure. If you understand one of these measures, you generally have a really good understanding of the other measure. Both measures are really similar. They are both risk-standardized measures and they are both measures that look for an outcome for an unplanned readmission for any reason within a 30-day time period. Both measures include Medicare fee-for-service beneficiaries who patients age 65 years or older and who are discharged alive from a non-federal acute care hospital without having been transferred to another acute care facility. Now, the two measures are very similar, but the main difference between them lies in the risk adjustment of the model. So specifically, the Hybrid Hospital-Wide Readmission Measure has additional risk adjustment variables in comparison to the claims-based only hospital-wide readmission measure. To be extremely clear, both measures, both the Hybrid Hospital-Wide Readmission Measure as well as the original claims-based only measure, use claims data to risk adjust for

patient comorbidities. However, the Hybrid Hospital-Wide Readmission Measure adds to this. In addition to using claims data to risk adjust, it also risk adjusts for core clinical data elements, or CCDE, that are found in a hospital's electronic health records and this truly is the major difference between these two measures - the additional risk variables that are contained in the Hybrid Hospital-Wide Readmission Measure. Next slide, please?

So, what are these core clinical data elements, or CCDEs, that we are including in the Hybrid Hospital-Wide Readmission Measure and that are not included in the original claims-based hospital-wide readmission measure? These CCDEs are really data elements that reflect or say something about the patient's clinical status when they actually arrive at the hospital for the first time. They are data elements that are routinely captured on all patients by all hospitals, and they are generally stored in a format in hospital EHRs to allow them to be easily extracted. CCDEs are typically things like temperature, weight, respiratory rate, things like that. Before I move on, I'm going to take a minute to pause and make sure you actually have a really good understanding of what the value is of including CCDE in the risk adjustment of the Hybrid Hospital-Wide Readmission Measure. If we use an example where we have two patients, they're coming to the hospital for the exact same reason. They have the same medical history, the same diagnosis, the same comorbidities. They are, in essence, the exact same patient; but, the difference between these two patients is the fact that one of them waited, let's say, 20 minutes after a heart attack to arrive at a hospital, or, another one, where the other patient waited around 20 hours after their heart attack to come to the hospital. You could imagine that these patients have different levels of risk as a result of the difference in the clinical presentation when they actually arrive at the hospital.

So, the claims-based hospital-wide readmission measure will look at these patients and see, in essence, no difference in risk and we'll look at them and see the same patient with the same diagnoses, the same medical history, the same comorbidities, and we'll assign to them the same level of

risk. The Hybrid Hospital-Wide Readmission Measure, though, is able to look at these patients and the friendship between the risk that they have as a result of the difference in their clinical presentations when they arrive at the hospital. So, it is able to assess the risk due to differences in blood pressure or heart rates, et cetera, when they arrive at the hospital and this is truly the difference in the two measures. Next slide, please?

So, on slide 12 here, we list for you the exact core clinical data elements, CCDEs, we are including in the measure. So, there are 13 CCDEs, six of these 13 units CCDE are vital signs, so they are things like heart rate, respiratory rate, weight, et cetera. The remaining seven of the 13 CCDEs are things like laboratory test results. There are things like hematocrit white blood cell columns, glucose levels, et cetera. So, in order to actually calculate the results from the Hybrid Hospital-Wide Readmission Measure, hospitals will need to submit to CMS for each patient to be included in the measure, these 13 CCDEs or 13 core clinical data elements, as well as the six linking variables that you see in the third column of the table. So, the linking variables are things like the hospital's CMS certification number, the patient's health insurance claim, or the patient's date of birth. The importance of actually submitting this information to CMS is that it allows CMS to match the CCDE information that you are submitting with a corresponding claim for that patient, or that admission, that they can calculate the measure accurately. We can go to the next slide, please?

So, as I mentioned in 2018, this measure is a voluntary measure and for hospitals that do choose to participate, the measurement period is from January 1, 2018, to June 30, 2018. So, what this means is that, for every patient who's discharged between January and June 2018, hospitals will need to submit the 13 CCDE elements that I had listed on the previous slide, as well as the six linking variables and, although CMS had not announced the exact date of the end of submission, they will need to submit this information to CMS sometime in the late summer 2018 to fall 2018. Next slide, please?

For this slide, we discuss how you can actually submit the data to CMS. At a very high level, there are really three steps just to submit these to CMS. First, you will need to extract the data on the CCDE and linking variables from your EHR and then, secondly, populate them into what is known as a QRDA Category I file. For the purpose of the simplicity of QRDA Category I file, it can just be thought of as a different type of file format. I guess like the distinction between a Word or PDF file. There's a small hyperlink there at the bottom of Step 2 and, if you follow that link, you will be able to access some guidelines that CMS has made available to help you actually create a QRDA Category I file. In interim, we strongly recommend that you would work with your IT or EHR vendor to build the processes and systems that you will need to automate the ability for you to extract information from your EHRs and populate them into QRDA Category I files later at the end. The third step, finally, is just submit the QRDA Category I file to CMS. Again, sometime in the late summer, or it'll be fall this year, and you will be able to do that via the *QualityNet Secure Portal*. Next slide, please?

So, as this is a voluntary measure, hospitals may be wondering what are the benefits to actually participating in this voluntary initiative. There are actually a number of key benefits and I've listed them all on the slide here, but I'm not going to go through all of them in detail. I will highlight a few key points though. Firstly, as I pointed out, this is the first hybrid measure to be included in the IQR Program and we anticipate that in the future, additional hybrid measures will be added to the program, and these, the future hybrid measures, I expect them to rely on similar processes or structures to extract CCDE information from your EHR and then submit them to CMS. That's really why participating now has benefits. It's because it allows hospitals a chance to gradually integrate into the world of EHR-based quality measurements. It gives them time to adopt the internal processes, build their capacity to report CCDEs, and hone the process by which you submit the information to CMS. Participating now, in a voluntary environment, allows all hospitals to do this in an era when there is no real risk to them in participating. So, that even if they make errors along the way, there's no real penalty associated with this. Another

a key benefit, I think, is that there is no real additional information hospitals need to collect on patients. So, there's no need to adapt any of their purposes of care. They are already collecting this information and the additional would lie in actually submitting that information to CMS in the right format. Lastly, I want to point out that for hospitals that do choose to participate, they will receive a confidential Hospital-Specific Report at some point, at the beginning of next year, I believe. And in this report, they will be able to get information that will help them understand or gain insight into what their performance might look like on those Hybrid Hospital-Wide Readmission Measure. Hopefully, it provides them with an opportunity to prepare for an era when this maybe becomes a mandatory measure in the IQR Program. Next slide, please?

Now, I'm going to have Juliet go through the frequently asked questions with you.

Juliet Rubini: Great. Thanks for much, Tamara. I just want to highlight that the next few slides that I'll be stepping through were all questions that were received over the JIRA question projects that we have currently open and it is a link on the resource slide that I'll go over at the end. So, just so you all know, there is a great resource for getting questions answered as you participate in voluntary reporting. So, next slide, please?

So, one of the first questions that we had come in was regarding the timing of the encounter for the CCDE specification. So, the question is, is the intent for the measurement period to ensure that the admission start date and time, and the discharge date and time, are within the measurement period? The answer here is that the intent of the logic is that the discharge date and time is within the measurement periods. So, for example on this slide, we show an instance which should not be included since the patient was discharged on July 1 of 2018. Next slide, please?

What is an index submission? An index submission 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

submission must meet all the measure inclusion and exclusion criteria that are highlighted here on the slide. Next slide, please?

So, CCDEs for the index submission. Do the first CCDE need to be submitted for both the index and readmissions visits? The answer for this is that the collection of CCDE, as Tamara mentioned, 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 submission and, therefore, collection and submission of the clinical data will be necessary. Next slide, please?

The question here is regarding the timing of the results. 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? And the answer here is that, no, results for CCDEs that are documented at the time of admission are eligible values and qualify for inclusion if they are also the earliest values available within the timing window. Next slide, please?

We have a second question here regarding timing of results. This one is regarding if labs that occur during a preop testing in a hospital outpatient department be included in the 24-hour look back period? These labs, as many of you know, can occur within or outside of that 24-hour preadmission window. The answer here is that you should report both lab results and vitals the first time they are captured within the 24-hours of the admission, even if they occur in an outpatient department. If all vitals and labs are captured in the outpatient department outside of the 24-hour look back, they would not count for submission and you would have to use the first vitals within two hours of the admission and the first labs within 24 hours of admission. Please note that the Hybrid HWR surgical specialty cohort does not use any laboratory results in the risk adjustment. However, you should still submit all the requested variables on patients for these, for this cohort. Next slide, please?

We had a question about data mapping. Should submitted data be mapped to the QDM data element value sets, or may facilities send the raw data elements? The answer here is yes, you should map. 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 you LOINC codes, your local codes, for example, glucose, to the LOINC codes in the glucose value set. Next slide, please?

Electronic versus manual data collection. So, the question here, should data be electronically extracted or should records be manually abstracted to retrieve the data necessary for CCDE? What kind of file can the data be entered into that could be converted into a QRDA Category I file format? The answer is that the data should be electronically extracted from your facility's EHR via computer programming and it should be extracted into the QRDA Category I file format. CCDEs should definitely not be manually abstracted. We recommend working with your specific EHR and health information technology vendors to define the appropriate process for extracting the data and developing the QRDA Category I files for submission to CMS. Next slide, please?

We had a question around submitting payor information. So, it was noticed that the supplemental data element section is blank but value sets are listed under the supplemental data elements section of the logic. Is the intent to still submit the data in addition to the Medicare payer? This is a great question. The answer here is to please only submit payer information once for QRDA Category I files. Payer information should align with the Medicare payer value set included in the initial population. Do not include payer information in the supplemental data elements. The intent of the specifications is to capture Medicare fee for service patients only. Please keep in mind that Medicare fee for service does exclude Medicare HMO patients. In addition, if your hospital captures a significant volume of Medicare fee for service patients under a different code that is also contained in the associated value set, we suggest including that code in your reporting as well. In addition, it does not matter if Medicare fee for

service is listed as a primary or secondary insurer for the patient. Next slide, please?

We had a question about the linking variables. We collect both 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? For the linking variables and for the sex variable, please submit the historical or DNA sex rather than the sex the patient identifies with at the current point in time. Next slide, please?

Another question about the linking variables was the age 65 requirement. Is that at the time of admission or time of discharge? Patients should be 65 years old or at the time of the admission. Please note that a patient must be enrolled in Medicare fee for service at the time of admission because the measure uses Medicare claims data to identify the cohort, risk variables, and the outcome, as Tamara mentioned earlier. The age criteria is in place to exclude patients that qualify for Medicare due to disability. Next slide, please?

A question about transfer patients was raised. Are we excluding patients transferred to another acute care facility from the initial population? As Tamara mentioned earlier, 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, it is not required because they will be excluded once the patients are linked to the Medicare administration 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 date or the next calendar day. Next slide, please?

Units of measurement. Which units of measurement should be used to report temperature and weight? 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. We provide a reminder here on the slide as to the 13 core clinical data elements. Next slide, please?

When generating the QRDA I files, which QRDA CMS program names should be selected? We ask that everybody use HQR underscore IQR underscore VOL. This is the correct selection when submitting. More guidance on data submission is available at *QualityNet* at this link, and as Artrina mentioned at the beginning, slides are available for download. Next slide, please?

We had a final question about the planned readmission algorithm, which pertains to the HWR portion of the measure. Where can I find the Hybrid HWR measure planned readmission algorithm? The Hybrid HWR measure uses the planned readmission algorithm that is currently used by the original or 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. That's available on *QualityNet* at that link and also at the measure methodology link. Again, slides are available for download, so you'll have these links available to you.

Lastly, next slide, please, our resource slide. So, as I mentioned, we've pulled together some great resources for this voluntary reporting effort. The top left square is the eCQI Resource Center. This is where you can go and get the CCDE technical specifications and the link is provided here. In the top middle, we have a link to *QualityNet*, where you can get more on hybrid measures. For information on the hybrid measures, the top right is the link to the final rule, where the voluntary reporting was introduced. Then, at the bottom left, we have a link to the introductory webinar that we did back in December. In the bottom middle is our link to the QRDA Category I Implementation Guide. Keep in mind, this is CMS's 2018 version. Then on our bottom right, are our two great resources as I mentioned before, the JIRA project that we have which is up and running for questions to be answered as you go through the CCDE specifications.

Again, as I mentioned, the slides that I just ran through, many of those questions came from JIRA. So, we wanted to show you the answers that you'll already see and you can pose more questions there as you review specifications. Then, lastly, the Measure Inbox, which is cmshybridmeasures@yale.edu and you can get more information about hybrid measures from that inbox as well. So, for now, I will say, "Thank you for listening." I'll pass it back to Artrina to facilitate our question and answer period. Thank you.

Artrina Sturges: Thank you so much Juliet and thank you Tamara. At this time, Veronica Dunlap will join us, and she'll review the questions entered into the chat box.

Veronica Dunlap: Thank you, Artrina. Hello everyone. This is Veronica. Thank you again for submitting your questions. So, let's get started. Our first question: Can you please clarify which Medicare insurances are included in the Hybrid HWR measure, or is it truly just the Medicare fee for service patients?

Tamara Mohammed: Hi. This is Tamara from Yale and I think Juliet expanded a bit on this on slide 24 of the presentation. You are correct that the measure only includes Medicare fee for Service patients. So, that's the patients we would like you to submit information on. However, as Juliet points out, if you are capturing pieces of information under a different core, then we encourage you to submit that information, but the intent here is that you always submit information for the Medicare fee for service patients. Juliet, do you have anything to add to that?

Juliet Rubini: No. That sounds like the best explanation. Thanks.

Veronica Dunlap: Just a follow-up to that question, just for clarification. Are Medicare HMOs supposed to be included?

Tamara Mohammed: No. So, patients who are paid through Medicare HMOs are not included in this measure, only Medicare fee for service patients.

Veronica Dunlap: Great. Thank you. Our next question: Within the e-measure, HWR specs, the description states, "laboratory results obtained," but within the actual

algorithm under numerator, it states, “performed blank,” which implied collection date time and not resulted time of the actual lab results. The specs algorithm is not calling out the “results.”; however, the algorithm is calling out “performed”. Please clarify.

Tamara Mohammed: Sure. I’m going to have Juliet answer the question, please.

Juliet Rubini: Sure. This is Juliet. So, I think that the question is getting at which date time stamp associated with the results would be used and that’s a great question. The result date time, So, when the results are available for the clinical staff would be the date time stamp you would want to use for the results, so, not the collection time, but after the lab has performed the test and results of the information went back to the clinical staff. That’s the date time stamp that should be associated with the result.

Veronica Dunlap: Thank you. Our next question: If a patient has two arterial or venous bicarbonate draw flash results collected on the same date or time, how do we determine which one to submit?

Tamara Mohammed: This is Tamara again. Juliet, I’m going to turn this over to you.

Juliet Rubini: We’re going to have to circle back on this one because I know that this happens occasionally, and I want to make sure that we consult and give the correct answer here. So, we will provide a concrete answer in the Q&A.

Veronica Dunlap: Thank you. Our next question: Is the data for this measure abstracted or submitted electronically?

Tamara Mohammed: Hi. This is Tamara from Yale. This is not an abstracted measure, it will be submitted electronically.

Veronica Dunlap: Next question: Will there be anything from the EHR data that reduces the risk factors sourced from the claims data?

Tamara Mohammed: This is Tamara again from Yale. I interpret this to be asking whether or not we will be reducing the risk variables we are using from the claims data and the answer is no. We will still be using all the risk variables that we

identified that we're sourcing from the claims data, but we will also be using the risk variables from the CCDE in the EHR data.

Veronica Dunlap: Thank you. Next question: Will the CCDE be used for the readmission versus index submission?

Tamara Mohammed: Again, this is Tamara from Yale. So, technically, we will be using index admission, but I would encourage you to submit this information for every admission because, for the Hybrid Hospital-Wide Readmission measure, readmissions can also be indexed submissions. So, you should be submitting it for every admission.

Veronica Dunlap: Next question: Can you explain why you chose to use weight instead of BMI, which adds the perspective of height?

Tamara Mohammed: Sure. This is Tamara again from Yale. So, the height variable it not routinely captured by all hospitals, only if consistently captured, it wouldn't be a viable variable for us to use.

Veronica Dunlap: Thank you. If we could advance to slide 12? It looks like we have a question on Slide 12. Are the vital signs the first vital signs on presentation documented and the lab results the first results of these tests performed?

Tamara Mohammed: This is the first documented vital signs and, yes, the first results of the lab tests.

Veronica Dunlap: Okay. Thank you. Next question: Will we be able to use the PSVA tool to validate and submit our file?

Tamara Mohammed: This is Tamara again from Yale. I'm going to let Jen Stephens potentially weigh in on this question.

Jen Seeman: Yes. For the QRDA I files that were submitted for CDDE will have the same validations that eCQM QRDA files undergo. So, there still will be no measure information considered in that validation. It will be file format only but, yes, you will utilize the PSVA.

Veronica Dunlap: Great. Thank you. If you could advance to slide 13, please? It looks like we have a question here. Here it states, "for every patient discharged." Is it all patients or only patients readmitted within the 30 days?

Tamara Mohammed: This is Tamara again from Yale. It would be every patient discharged, not necessarily only those patients readmitted, so, every patient discharged.

Veronica Dunlap: Thank you. Next question: Can you address whether this measure will be mandatory in the future?

Tamara Mohammed: This is Tamara again from Yale. Unfortunately, at this point in time, we don't have direction from CMS on whether this will be a mandatory measure in the future. I think you should pay attention to maybe potentially the future communications from CMS as well as the rule that will be issued this year, or next year perhaps, to see.

Veronica Dunlap: Next question, do you have to have a certified to make the QRDA files?

Tamara Mohammed: This is Tamara again from Yale. I will hand this off to Juliet to answer.

Juliet Rubini: You should work with your EHR vendor if you have that question. Our understanding is that QRDA can be produced from certified EHRs, but they can also be produced by non-certified EHRs. So, you should confirm with your EHR vendor.

Veronica Dunlap: Next question: For the core clinical data elements, the CCDE info, is it the initial value or the latest value in the patient chart that is used?

Tamara Mohammed: This is Tamara again from Yale. It will be in the initial value as long as that value occurs within the specified time period, before or after the admission.

Veronica Dunlap: Thank you. Next question: Our ER does not use the same EHR as acute care. So, what is considered when the patient first presents? We have had issues with this when building other eCQM data. Is this first set of vitals or a certain number of hours?

Tamara Mohammed: This is Tamara again from Yale. The intent here is to capture the CCDE, the first of CCDE capture on the patient, within the specified time period. So, if the CCDEs are captured in the ER, then we would be looking to have you report that information to us.

Veronica Dunlap: Thank you. Next question: Do hospitals submit one quarter, or do they submit the full six months?

Tamara Mohammed: This is Tamara again from Yale. They will be submitting the full six months once the submission period opens.

Veronica Dunlap: Next question: What is the overall intent of CMS in collecting labs and some vital signs? How will this correlate to a readmission?

Tamara Mohammed: This is Tamara again from Yale. So, each of the vitals, the CCDE, will be listed there to identify because they do have a correlation with the outcome for all patients, including all patients and generally included in the Hospital-Wide Readmission measure, the Hybrid Hospital-Wide Readmission measure.

Veronica Dunlap: Thank you. Will this hybrid risk adjustment be used in CMS' HRRP Program to identify which hospitals will receive a reimbursement adjustment?

Tamara Mohammed: This is Tamara again from Yale. At this point in time, we have no direction from CMS on this and it is not currently slated to be in that program as far as I'm aware.

Veronica Dunlap: Thank you. Next question: How will the patients be identified, through CMS' algorithm or an internal process?

Tamara Mohammed: This is Tamara again from Yale. So, hospitals will need to use their internal processes to identify the patients that they need to submit to CMS. So, again, those Medicare fee for service patients, age 65 years and older, et cetera. Then, CMS will apply additional exclusion criteria to the measures to find the right patients and this is to help reduce the burden of work on hospitals.

Veronica Dunlap: Thank you. Next question: What will the data file coming back to us have in it? Comparative data? What we look like before and after the adjustment? How will we find the value in the report after participating?

Tamara Mohammed: This is Tamara again from Yale. Unfortunately, at this point in time, we don't have the answer to that question. The report has not yet been generated, so we are not sure what the fields will be in that report.

Veronica Dunlap: Okay. Thank you. Is vendor submission permitted?

Tamara Mohammed: This is Tamara again from Yale. Yes, your vendor can submit on your behalf.

Veronica Dunlap: Next question: Our facility captures the blood pressure as a whole value, systolic blood pressure and diastolic blood pressure, not as separate values. Is this a problem? This is due to being pulled in from monitors.

Tamara Mohammed: This is Tamara again. I'm going to hand it over to Juliet to answer.

Juliet Rubini: Hi. This is Juliet. So, it sounds like you may need to work with your vendor to figure out to splice those into two numbers because the CCDE for HWR is only looking for that systolic number. I do suggest working with either your monitor vendor or your EHR vendor to find out how those numbers can be spliced out.

Veronica Dunlap: Okay. Great. Thank you. Will participation impact our traditional claims-based penalty?

Tamara Mohammed: This is Tamara again from Yale. While the measures are voluntary measures, the answer to that is no, it will not.

Veronica Dunlap: Next question: Can we choose to send in a subset only to participate, for example, heart failure or AMI only?

Tamara Mohammed: This is Tamara again from Yale. Certainly this is a hospital-wide readmission measure, so the preference would be yes, you just submit for all patients, but not a subset of patients.

Veronica Dunlap: Next question: Are there ways to generate a QRDA file without having a vendor?

Tamara Mohammed: This is Tamara again from Yale. I can turn this over to Juliet to answer.

Juliet Rubini: So, this is Juliet and I was going to actually pass it to Jen. As we are aware, working with your EHR vendor is the best way to get that done if you don't have the ability in house but, I'd like to see if Jen has additional information there.

Jen Seeman: Yes. Thanks Juliet. So, you're correct. I think, in most cases, facilities would work with their vendors to create that QRDA file. However, there are facilities who have standalone IT departments that do perform that for them. So, it really is dependent on the facility and what their resources are.

Veronica Dunlap: Great. Thank you. Will this impact Medicare ACO scoring for the all-cause measure?

Tamara Mohammed: This is Tamara again from Yale. I don't think so. I'm not familiar with the Medicare ACO scoring, but as far as I'm aware, it will not.

Veronica Dunlap: Next question: how do we choose to participate in this voluntary reporting?

Tamara Mohammed: This is Tamara again from Yale. You can participate just by submitting the information. There is no sign up or confirmation of any kind. You just submit the information when the submission period opens.

Veronica Dunlap: Next question: if a site is currently transitioning from one EHR to another, will you accept less than six months of CCDE?

Tamara Mohammed: This is Tamara again from Yale. I think this will be fine. We certainly have no way of knowing, I think, while I guess we could match to claims but, if you do submit less than six months, we will certainly accept it. I'm hoping to hear thoughts from Juliet on this as well.

Juliet Rubini: I agree. If you would like to participate but don't have the six months of data, we welcome having your data.

Veronica Dunlap: Okay. Great. Thank you. If a patient comes into the ER close to midnight and is admitted after midnight. As an inpatient, what would be the admit date?

Tamara Mohammed: This is Tamara again from Yale and I'm certainly not experienced on what sort of dates you should be putting into your claims. I presume the date that they are admitted as an inpatient is what you put into your claims. I would presume it would be the date after midnight. Juliet, do you have anything to add there?

Juliet Rubini: Yes. The admission date would be the date they're admitted to the inpatient facility. Whether that creates a new encounter or whether the status of the ER encounter is switched to an inpatient status, that date and time is when we would consider the admit date.

Veronica Dunlap: Okay. Great. It looks like we have one more question here. Where should we submit our questions concerning the Hybrid HWR measure? Is there an email support box?

Tamara Mohammed: This is Tamara again from Yale. On slide 31, Juliet outlined, I think, there are two places that you can go to submit questions. It would be the JIRA tool about the technical questions about the electronic aspects of the measure and then the Measure Inbox for the general questions about the hybrid measure.

Veronica Dunlap: Great. Well, thank you and that concludes today's question and answer session, as well as our presentation. We would like to thank everyone for listening in to our webinar today and thank you and enjoy the rest of your day. Good-bye.