Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

CMS QRDA Category I Implementation Guide Changes for CY 2020 Hospital Quality Reporting

Questions and Answers

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses. The questions and answers have been edited for grammar.

Question 1: **If we do not duplicate the (Quality Data Model) QDM data element by including sdtc:valueSet, does that mean we don't have to send the value set in data elements like *Encounter, Diagnosis, Medication,* etc.?**

Yes, that is correct. For example, if you submit data for Encounter Performed or Medication Discharged, you shall not include sdtc:valueSet. This change (not including sdtc:valueSet) was implemented starting from Quality Reporting Document Architecture (QRDA) I STU 5. However, some submissions for the 2019 reporting period still included sdtc:valueSet. By doing that, you may get unexpected results from the data receiving systems from both the *QualityNet* and The Joint Commission. Based on the consensus from the Health Level Seven International (HL7) community and also the teams from Hospital Quality Reporting (HQR) and the Joint Commission, the decision was to add this guidance about ensuring data uniqueness in the QRDA I Standard for Trial Use (STU) 5.1 and in the 2021 CMS QRDA IG to make sure submissions do not include sdtc:valueSet for value set object identifier (OID) (with the exception of negated data elements). The purpose of this is to prevent submissions from sending duplicate data, which may cause unexpected measured results.

Question 2: **When will the PSVA tool be available for testing calendar year (CY) 2020 submissions?**

The Pre-Submission Validation Application (PSVA) is used to test the file format of Quality Reporting Document Architecture (QRDA) Category I files. The PSVA is usually released shortly before the HQR System opens for Test and Production QRDA Category I files for submitters to test their QRDA Category I file format. The PSVA and HQR System are typically available in the fall. CMS uses Listserves, webinars, and other outlets to let users know when the PSVA tool and the HQR system are available.

Question 3: **Where do we go to download the errata package? Is it on the eCQI Resource Center?**

The link to download the errata package is on slides 11 and 24. Slide 24 includes past and current versions of the HL7 QRDA Category I IG.

Question 4: **What does medication "not discharged" mean?**

The QDM 5.4 specification provides detailed definition for Medication Discharge. The QDM specification can be found on the QDM page on the eCQI Resource Center for detailed descriptions for each QDM data type. The download link for the QDM 5.4 specifications is provided on slide 12 of the webinar presentation. Per the QDM specification, data elements that meet criteria using the Medication Discharge datatype should document that the medications indicated by the QDM category and corresponding value set should be taken by or given to the patient after being discharged from an inpatient encounter. The author dateTime attribute of Medication Discharge is the time the discharge medication list on the discharge instruction form is authored. Medication, Not Discharged means a medication is not on the discharge medication list. Please refer to the measure specifications for specific meaning when used in an eCQM.

There is no good way to tell an implementer how to find a Medication, Not Discharged. The challenge is measures require a justification (negation rationale) for why a specific medication class was not ordered at discharge. The discharge medication list will not include such medications and may not include the reason the medication is not on the list. Therefore, the use of Medication, Not Discharged requires identifying the reason the medication is not on the discharge medication list.

Question 5: **When do you think eCQMs will be publicly reported for the Hospital Inpatient Quality Reporting (IQR) Program?**

If CMS intends to publicly report any data, which includes eCQMs for the Hospital Quality Reporting (HQR) program, it will be signaled in an Inpatient Prospective Payment System (IPPS) proposed rule. The IPPS proposed rule is typically released in the *Federal Register* in April or May. At that time, the proposed rule is available for public review and feedback to CMS. After consideration of the feedback, CMS publishes the IPPS final rule in the fall in the *Federal Register*. In addition, CMS notifies the community via Listserve and published information that the proposed rule is available for comment and feedback. Visit the CMS.gov website to review archived and current IPPS rule publications.

Question 6: **Is the gathered information in our electronic health record (EHR) supposed to be accurate? Our software doesn't appear to collect data for patients receiving anticoagulants, but the patient is receiving anticoagulants.**

The patient is receiving apixaban, for example, an anticoagulant, but the software does not recognize the patient is receiving this. How can I work with my vendor to have the software better represent what is happening in the setting?

First, you can check to verify if that specific medication is in the medication value sets defined by the eCQMs. If Apixaban is represented in the anticoagulant value sets, then you could work with vendors to determine if mappings may need to be updated in the software to include Apixaban. If Apixaban is not represented in the eCQM defined anticoagulant value sets, then you could submit a Jira using the ONC Project Tracking eCQM Issue Tracker to report this to measure developers. You could also submit a Jira issue using the eCQM Issue Tracker for this question to receive further help.

Question 7: **When will eCQM submissions for CY 2020 begin? What do hospitals need to do to get started?**

For eCQM policy information, visit the *QualityNet* website. This site provides an overview of the start of eCQM reporting, requirements based on the reporting period, available eCQMs for reporting, etc.

The eCQI Resource Center is the one-stop shop for the most current resources to support electronic clinical quality improvement. Resources such as the implementation checklist, eCQM specifications, reporting standards, and measure flows (which define the numerator and denominator for the measure) are available to assist data submitters in updating their system to prepare for eCQM reporting. Contact the *QualityNet* Help Desk for additional assistance at qnetsupport@hcqis.org or (866) 288-8912.

Question 8: **What is the difference between "not ordered" and "not discharged"?**

Medication, Not Ordered requires a reason the medication was not ordered (the negation rationale). Most EHRs provide a method for practitioners to indicate the setting in which the prescription should be dispensed and taken. A medication order (prescription) written during an inpatient hospitalization with the setting "hospital" represent the QDM concept Medication, Not Ordered. A medication order (prescription) written during an inpatient hospitalization with the setting "ambulatory, or community" represent QDM Medication, Not Discharged. As long as that order with indication of reason not ordered is present in the clinical system, it qualifies for Medication, Not Discharged.

Such information may not be included in the discharge medication list. Please refer to the QDM 5.4 specification for details and refer to the measure specifications for specific meaning when used in an eCQM.

Question 9: **For stroke eCQMs that are for medications, such as discharged on a statin, are you not looking for the statin order at discharge, or should we look for the statin on the patient's medication list?**

The Medication Discharged QDM data type refers to the discharge medication list specifically and not to prescriptions/medication orders provided at discharge. Some EHRs auto-populate the discharge medication list with prescription (order) data intended to be dispensed after discharge. If that information is on the discharge medication list, it should be considered valid. Please refer to the measure specifications for specific meaning when used in an eCQM.