

Public Comment Summary Report

Measure Name:

Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (Hybrid eHWR Measure)

Date of Report:

August 28, 2014

Contractor (Measure Developer) Name:

Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE)

Introduction

Dates of public comment period:

Thursday, July 7, 2014 through Friday, August 8, 2014

Website used:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html>

Methods used to notify stakeholders and general public of comment period:

- Email notification to Centers for Medicare and Medicaid Services (CMS) listserv groups including the eMeasures Interest Group (eMIG)
- Email to relevant stakeholders and stakeholder organizations, including:
 - Abt Associates (former CMS contractor for EH eCQMs)
 - Kaiser Permanente of Northern California
 - Health information technology experts from the CCDE Technical Expert Panel
- Posting on CMS Public Comment website

Volume of responses received:

We received comments from 7 commenters during the public comment period; specifically:

- 1 Hospital/health system (Hennepin County Medical Center)
- 1 Health insurance provider (Kaiser Foundation Health Plan, Inc.)
- 1 Health insurance association (America's Health Insurance Plans)
- 1 Hospital association (America's Essential Hospitals)
- 1 EHR vendor (Epic)
- 1 Professional society (The Infectious Diseases Society of America)
- 1 Other (Consultant to CMS and ONC)

Stakeholder Comments—GeneralSummary of general comments

Most comments were focused on the hybrid nature of the measure and on the risk-adjustment variables from the electronic health record (EHR) used in the measure. Although most comments did not include statements of support or arguments against the measure, one commenter stated that the work was valuable. Another stated that they “support CMS’ efforts in examining new approaches to provide a more accurate assessment and portrayal of services provided by clinicians and hospitals.” Another stated, “We believe it is very important that enriched clinical data from an EHR be used to supplement the clinically limited datasets available from claims.”

No specific questions or comments were submitted about the measure cohort, the data source used for measure development and testing, or the measure outcome (all-cause 30-day unplanned readmission). Comments and questions were focused on risk-adjustment, including the core clinical data elements (CCDE) from the electronic health records (EHR), the claims data elements used, and the risk-adjustment methodology. Other comments focused on various aspects of measure implementation, such as how best to communicate the importance of incorporating clinical data into hospital outcome measures, questions about how the measure is related to meaningful use, and concerns about the potential burden on providers who do not have an EHR.

Proposed action:

See proposed action under the measure-specific comment summaries below.

Measure-Specific Comment Summaries

Measure Name:

Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (Hybrid eHWR Measure)

General Comments

Three comments supported the measure overall.

Response: CMS thanks the commenters for their support for the current approach.

Risk Adjustment Methods and Variables

One comment requested clarification of the exact time stamp used to identify the time of arrival when extracting the first captured CCDE values. The commenter suggested that a more precise definition be provided in the technical report in order for hospitals to be able to accurately and consistently identify the correct data value.

Response: We recognize that clearly defining the appropriate time stamp for the start of an episode is a critical step for identifying the first-captured vital sign or laboratory test result. The definition currently states, "The time stamp that is captured closest to the moment a patient first reaches the hospital for care." In practice, the time of arrival requires two separate pieces of information: the time stamp associated with the first recorded contact patients have with hospital staff at the start of the episode; and the location where patients first appear (e.g., the emergency department, pre-operative area, inpatient floor or unit). As stated in the CCDE Technical Report (pg. 28), time of arrival stamps were derived from the Patient Management System and corresponded with the time a patient registered as "arrived" at the hospital. This was when a patient's insurance and contact information were first collected by the hospital administrative staff. This time was chosen because we believed that it would consistently precede capture of any vital signs and laboratory tests. These stamps will likely need to be mapped within a hospital's electronic database separately for each potential arrival location. CMS will develop human and machine readable logic statements to support mapping and extraction of the time stamps needed to identify first captured data values. These standard documents will also be released for public comment.

Two comments were requests for clarification of the exact data value chosen among all possible values for each data element in the CCDE.

Response: For each of the CCDE, the value used in the risk-adjusted models is the first captured value within 2 hours and 24 hours of arrival. For vital signs it is the first value captured in the EHR within 2 hours after a patient is registered as having arrived at the hospital in the patient management system (the patient has “checked in” and first provided their name, demographics, and insurance information to hospital personnel). For laboratory test results it is the first captured value within 24 hours after a patient has registered as having arrived at the hospital. We will clarify this in the final technical report.

One comment was a request that CMS consider including data elements related to medications ordered, administered, and prescribed at discharge in the CCDE for readmission measures. This commenter stated that in a readmission measure, these data elements “may be relevant and contribute to the accuracy of risk adjustments.”

Response: Our intention with the approach to risk adjustment is to include factors related to patients’ severity of illness prior to and at the start of each hospitalization. The risk-adjustment variables are chosen such that they only capture patients’ clinical status before treatment is provided and the effects of that treatment are realized. This approach allows the measure to compare outcomes across hospitals without obscuring potential differences in the care patients receive. This aligns with the approach of other CMS public reported measures. Therefore, we do not include information about medications ordered or administered during or at the conclusion of the hospitalizations. Although such information would likely be predictive of patients’ risk of readmission, it also might obscure differences among hospitals in the quality of care they provide and undermine the purpose of the measure.

One comment was a statement that if CMS intends to apply the CCDE to readmission measures in addition to mortality measures, the “reliability testing should be adequate to support validity.”

Response: We agree that it is important to establish the reliability of outcome measures when incorporating new risk variables. For this and other outcome measures that are reengineered to include the CCDE, reliability testing will be done using a larger and more representative set of hospitals prior to public reporting.

One comment suggested that the laboratory tests included in the CCDE should be compatible with the specific condition for which the patients were admitted.

Response: For certain conditions, there are specific tests that should be performed routinely upon the start of a hospital encounter, such as troponin values for patients with acute myocardial infarction. The CCDE, however, was developed to include data elements that are routinely captured on nearly all admitted patients regardless of their principal diagnosis. The intent was to then have a group of data elements that could be applied to cohorts of patients admitted for specific conditions as well as a hospital-wide cohort which encompasses multiple conditions. The expectation is that the CCDE could

be augmented by a few data elements relevant to risk adjustment of specific conditions as long as the additional data elements are feasible.

One comment was a statement that a mechanism should exist for sharing lab information across settings to avoid unnecessary repetition of a lab test to satisfy a reporting requirement.

Response: The CCDE was developed to include only data elements that are currently captured in nearly all adult hospitalized patients. The purpose of this selection criterion was to use data that clinicians already capture to avoid influencing or changing the way that hospitals and clinicians care for patients. It is not the intent of this measure to force or encourage clinicians to perform certain tests or capture vital signs in their patients. Participation in this measure will not require hospitals to perform unnecessary or repetitive testing.

We recognize that pre-operative laboratory testing is routinely performed outside of the hospital for patients with planned surgical procedures. Our analyses showed that these data are not consistently transcribed into the inpatient EHR when patients are admitted for surgical procedures. Due to missing data we excluded laboratory test results from risk adjustment of the surgical cohort in the Hybrid eHWR Measure. Ideally, test results could be made available if they were transcribed into the EHR upon admission. Testing should not be repeated unless clinically indicated. CMS will consider ways to support improved data capture and data availability across settings wherever possible.

Two comments stated that for many clinical risk variables listed in the measures specifications tables, the odds ratios from models of readmission were close to 1.0, thus suggesting little predictive value. They also noted that the CMS CCs from claims were most predictive of readmissions.

Response: We used a fixed, common set of variables in each of the 5 specialty cohort models for simplicity and ease of data collection and analysis. In the measure specifications tables in Appendix A, all of these fixed risk-adjustment variables are listed for each specialty cohort regardless of whether they were significant predictors of readmission for the specialty cohort. Thus, several variables that are not significant predictors or only weak predictors of readmission (odds ratio close to 1.0) are included in the models. In addition, some terms were forced into the models. For example, we forced in both the linear term and quadratic terms for several variables in the CCDE at the same time. We also forced in principal discharge diagnosis in our models. This approach is consistent with observing several odds ratios close to 1.0. There is no loss of model performance in including risk factors that have little predictive value. Some of these variables are important for face validity, in that even if they are not predictive, omitting them may raise concerns about the model. This approach does not bias the measure results or the hospital performance scores.

In the Hybrid eHWR Measure the CCs were slightly more predictive of readmission compared with the CCDE. The CCDE, however, were also predictive, and the model that used both comorbidity and the CCDE together showed the best discrimination.

One comment questioned whether the assertion in the technical report that a complication is a condition that occurs as a consequence of care is necessarily true.

Response: A complication is not necessarily or always a consequence of care. Certain complications can clearly be attributed to poor care. In many instances, however, when a complication occurs, it is impossible to determine definitively whether the complication was a result of the care received or a patient's underlying poor health. In the measure, complications are conditions that are considered likely to have been acquired during the hospitalization. We do not include any data that reflect events that occurred after the start of the hospitalization as risk-adjustment variables in the measure. We also always include readmissions for complications of care following procedures in the measure outcome because we do not consider these readmissions to be planned. A full list of the discharge diagnoses considered complications of care following a procedure can be found in the technical report for the claims-based 2014 Hospital-Wide All-Cause Readmission Measure Updates Report found here:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>.

One comment was a question about whether any of the CCDE were too highly correlated with one another to be included in the model.

Response: We examined correlation among the variables in the CCDE before developing the risk-adjusted models. This analysis resulted in removal of BUN, chloride, anion gap, hemoglobin, and diastolic blood pressure from the group of CCDE that were considered in the models because they were highly correlated with other data elements. For details see page 15 in the Draft 2014 Reengineered Hospital-Wide All-Cause Unplanned Readmission Measure Report.

Three comments questioned the exclusion of variables that reflect socioeconomic status from risk adjustment of the measure in light of the possible changes to the National Quality Forum (NQF) recommendations regarding the use of these variables in quality measures.

Response: Development of new NQF recommendations regarding socioeconomic status variables is ongoing. This measure is based on the Original Hospital-Wide All-Cause Readmission Measure methodology that did not account for socioeconomic status in risk adjustment. We will consider making an adjustment to this measure when the final recommendations from NQF are released.

Statistical Methods

One commenter suggested including negative log likelihood estimates and Akaike estimate for model fit in the measures specification tables in Appendix B of the technical report.

Response: We appreciate the suggestion of additional tests to demonstrate model performance. We do not include the negative log likelihood estimates and Akaike Information Criteria estimates because these statistics are only meaningful when comparing two or more models. The tables in Appendix B were used to show the association or effect between the model variables and the outcome of readmission as well as the difference of the effect over three different study samples. For the model performance, we have reported C-statistics, calibration, predictive ability, and chi-square residuals (Tables 3.7 and 3.8). These statistics provide information about model performance and model fit.

One commenter requested that we provide some context for interpreting the Intra-Class Correlation Coefficient (ICC).

Response: For the hospital event rate based on the patient binomial outcomes like readmission (Yes/No), an ICC value of 0-0.2 indicates poor agreement; 0.3-0.4 indicates fair agreement; 0.5-0.6 indicates moderate agreement; 0.7-0.8 indicates strong agreement; and >0.8 indicates almost perfect agreement.

eSpecification

One comment questioned whether the Hybrid eHWR Measure is an eSpecified version of the original claims-based measure currently in public reporting.

Response: The Hybrid eHWR Measure is not an e-specification of the current Hospital-Wide All-Cause Unplanned Readmission measure. Many of the data elements used to calculate this current measure, including the ICD-9 codes for patients' conditions as well as dates of admission and discharge, will still be collected from patient claims. The only difference between this Hybrid eHWR Measure and the HWR measure is the inclusion of the consideration of EHR data elements (the CCDE) in the risk adjustment model.

One comment was a statement of conditional support of the CCDE. The commenter noted that support depended on whether the EHR software systems used for feasibility testing represent the majority of systems used in hospitals. Support also depended on whether CMS recognizes that a significant number of hospitals do not use these systems.

Response: In testing and reporting on the feasibility of data elements, we sampled a subset of the EHR systems currently in use. The four EHR systems included in testing (Epic, Cerner, Meditech, and Allscripts) are the most common inpatient medical records. Together they are used in approximately 50% of hospitals attesting for Meaningful Use in 2013. We recognize that a substantial portion of

hospitals do not use these systems. CMS is developing an implementation strategy that will include ample opportunity for hospitals to test EHR database queries and reporting protocols.

Implementation

One comment was a question about whether the measure will be part of Meaningful Use.

Response: This measure is not a part of Meaningful Use. CMS plans to implement the measure through the Inpatient Quality Reporting Program separate from the Meaningful Use Measures for Eligible Hospitals. Details about the implementation of the measure will be forthcoming.

One comment was a question about how the Hybrid eHWR Measure will be integrated with the current Meaningful Use expectation that clinicians use SNOMED-CT codes rather than ICD-9 or ICD-10 codes to indicate patients' conditions. The commenter also asked whether CMS ever intends to use SNOMED-CT codes rather than ICD9 or ICD-10 billing codes to identify patient's conditions in the Hybrid eHWR Measure.

Response: The Hybrid eHWR Measure does not currently include data on patients' conditions from electronic health records (EHRs), or SNOMED-CT codes. Although CMS would like to incorporate data from EHRs into quality measures wherever possible, the data must meet feasibility criteria in order to be extracted and used in measure calculation (see the CCDE methodology report, page 13). The Technical Expert Panel engaged during the development of the CCDE agreed that data captured in EHRs on patients' principal discharge diagnoses and comorbid conditions did not currently meet these criteria. This was due, in part, to the consensus opinion that clinicians do not currently apply a standard definition to the concept of a principal discharge diagnosis, nor do they consistently capture comorbidity data in structured fields. However, we recognize that current efforts to improve identification and capture of conditions through Meaningful Use might improve the standard use of conditions data over time. Therefore, CMS intends to review the feasibility of these and other types of data elements relevant to outcome measures in the future.

One comment was a statement suggesting that a more compelling argument for using clinical data, instead of being less susceptible to gaming, was that clinicians are the source of clinical data which they derive from direct interaction with patients. Clinicians appreciate and value the accuracy of clinical data, and use it to assess patients' conditions to guide treatment.

Response: We agree that one important advantage to incorporating EHR data into hospital outcome measures is that the data are being recorded by clinicians who are interacting with the patient and who value the accuracy of the data to guide the care they provide.

One comment was a request for clarification about whether hospitals would be required to extract claims data from paper medical records. The commenter expressed concern that this would create an undue burden.

Response: Data about conditions, comorbidities, and readmissions will continue to be derived from inpatient claims and will not be extracted from paper medical records. CMS is developing an implementation plan which will address how hospitals that do not have EHRs can participate in the measure without being subject to undue burden. More information about this plan will be forthcoming.

One comment was a statement that by including data elements related to medications ordered, administered, and prescribed at discharge, CMS could standardize medication data capture and further the relational development of other electronic quality tools targeted at medication management such as real-time clinical decision support.

Response: We agree that the medication errors and inappropriate use are an important cause of unplanned readmission. These data elements, however, are not included in the CCDE or in risk-adjustment of the Hybrid eHWR Measure because they represent events that transpire after a patient first presents to the hospital for care and potentially reflect variation in the quality of care patients receive during hospital admissions.

Language and Formatting

One comment was a suggestion to add percent to the estimates in table 3.3 of the Hybrid eHWR Measure technical report.

Response: The values in the cells of this table are percentages. We will clarify this in the final report.

One comment suggested including figure 3.1 from the CCDE technical report in the Hybrid eHWR Measure technical report

Response: We will consider this change.

One comment was a suggestion to add the number of observations in Table 2.1 as a fourth column.

Response: We will take your suggestion under consideration.

Preliminary Recommendations

The measure developers are not recommending any changes to the measure specifications in response to public comments.

Overall Analysis of the Comments and Recommendations to CMS

Feedback on the Hybrid eHWR Measure was constructive and positive. Most commenters focused on the EHR data elements used in risk-adjustment and various aspects of measure implementation.

Many of the issues raised will be clarified with release of the machine and human readable logic for the CCDE, and the implementation plan for CCDE data reporting and Hybrid eHWR Measure implementation.

Public Comment Verbatim Report

Date Posted	Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization	Recommendations/Actions Taken
7/17/2014	Hybrid eHWR Measure	Just wanted to clarify that the Hospital-Wide All-Cause Unplanned Readmission Hybrid Electronic Clinical Quality Measure is just the e-specification for the current readmissions measure used for public reporting purposes? Also, is this measure a part of Meaningful Use?	Lauren M. McKown, Senior Healthcare Analyst, Clinical Affairs and Strategic Planning, America's Health Insurance Plans	lmckown@ahip.org	Health Insurance	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary document. No changes to the measure in response to public comment recommended.
7/21/2014	Hybrid eHWR Measure	Here are some minor comments on this draft report. This is very valuable work and I commend you for doing it. Thank you for your consideration. The Glossary contains the following definition of time of arrival: The time stamp that is captured closest to the moment a patient first reaches the hospital for care. I suggest that this definition can be made more precise, and that it is worthwhile doing so. When considering the Kaiser record, what time was being used? The time the patient physically arrived at the receiving unit and was placed in a bed (an ADT time?). The attribution time that any documentation was first recorded? Some other time?	Howard Bregman, MD, MS FAAP, Epic	Howard@epic.com	EHR Company	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary document. No changes to the measure in response to public comment recommended.

		<p>Also, I could not find any reference to what data was used if there were multiple values in the interval. Was it the first value or something else? Perhaps this was stated, but I could not find it.</p> <p>Also, in your definition of complication, it states that the condition occurred as a consequence of care. Is that necessarily true?</p> <p>Finally, on page 7 you state “In addition, many clinical data elements that are captured in real-time to support patient care are less susceptible to gaming, coding drift, and variations in billing practices compared with administrative data used for billing purposes.” Since you are also using diagnoses that are captured for billing purposes, it’s not clear that this is a very strong argument, or what kind of gaming or drift you are protecting against. I suggest that a stronger reason is that this data is recorded by clinicians who are in the room with the patient, who appreciate the value of the accuracy of the data, and are likely to record it with care.</p>				
7/22/2014	Hybrid eHWR Measure	<p>I've looked at the material available for review and am a bit confused on how the measure will integrate into the MU expectations for primary coding system use of SNOMED CT. In my short review it appears that the measure requires the use of AHRQ CCS which is currently based on ICD-9-CM (soon? ICD-10) principle diagnosis code. While this makes lots of sense as a billing-base measure, is it intended to in any way ever be based on non-billing code system content? I see in the CCDE_Technical_report_FINAL that all the</p>	Robert McClure, MD, Consultant to ONC/NLM on terminology	rmcclure@mdpartners.com	Consultant - EHR Terminology	<p>Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary document.</p> <p>No changes to the measure in response to public comment recommended.</p>

		Condition category elements were deemed to not be sufficiently robust to be included in feasibility testing. So help me understand the intent for MU inclusion going forward, will this measure always focus on billing coding and therefore should not be expected to use SNOMED CT?				
8/8/2014	Hybrid eHWR Measure	<p>America's Essential Hospitals appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) measure titled, Development of a Hybrid Hospital-Wide All-Cause Unplanned Readmission Electronic Clinical Quality Measure. We thank CMS for working to develop a quality measure that can be used to provide quality care to Medicare beneficiaries. We support efforts to improve quality among our membership and across the entire health care industry.</p> <p>Many of the clinical data elements in the models that are mentioned on page 64 through 79 have odds ratios of 1 thus show no difference and are not predictive. It appears that the hierarchical condition category (HCC) categories from claims are most predictive of readmissions.</p> <p>Additionally, the clinical data elements do not account for socioeconomic nor sociodemographic variables that have a large impact on readmissions, such as homelessness. There is a large body of emerging evidence that socioeconomic and sociodemographic factors can influence health outcomes. These studies have shown the impact including socioeconomic and sociodemographic factors into measures has on</p>	Ashley Henske, MPH, MA of America's Essential Hospitals	ahenske@essentialhospitals.org	Hospital Assoc.	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary document. No changes to the measure in response to public comment recommended.

		readmissions rates. One of the most compelling bodies of evidence that supports the use of risk adjustment for socioeconomic factors in performance measures is a technical report by a National Quality Forum's (NQF) expert panel in July 2014. Results on certain measures, such as readmissions measures, can be skewed by socioeconomic and sociodemographic factors and does not allow for comparable performance measures. Not risk adjusting for these factors could cause an even further injustice to an already vulnerable population. We appreciate the opportunity to comment on the above captioned report.				
8/8/2014	Hybrid eHWR Measure	Kaiser Permanente appreciates the opportunity to comment on CMS' proposed development of a hybrid hospital-wide all-cause unplanned readmission electronic clinical quality measure. We have worked with CMS to test the hybrid measure on some of our clinical data and we are supportive of the continued development and future refinement of this measure. We believe it is very important that enriched clinical data from an EHR be used to supplement the clinically limited datasets available from claims. We are working on providing severity scores in real time and look forward to working with CMS on a more refined severity model in the future as part of this effort.	Keavney F. Klein Counsel, Government Relations Kaiser Foundation Health Plan, Inc	keavney.f.klein@kp.org	Hospital Assoc.	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary document. No changes to the measure in response to public comment recommended.
8/8/2014	Hybrid eHWR Measure	The results strongly suggest that clinical data elements can be feasibly captured in the EMR among their Kaiser sample, however it is unclear how much they would improve the risk adjustment. Many of the clinical data elements in the models on p. 64-79 have odds ratios of	Scott Shimotsu, PhD MPH CPHQ, Senior Liaison for Research and Education, HCMC-	Scott.Shimotsu@hcm-ed.org	Research Foundation	Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are

	<p>1. Overall, it seems to be the HCC categories from claims that are most predictive of readmissions. In addition, the clinical data elements don't bring in sociodemographic variables that have a large impact on readmissions, such as homelessness. Table 2.1 has the core clinical data elements; it would be helpful if the number of observations needed would be noted as a 4th column (e.g., heart rate, collected X# times /period).</p> <p>Table 3.3, consider adding percents to estimates. Are any of the clinical data elements too highly correlated with one another to be included together in the models?</p> <p>Page 27 notes the high correlation between RSRR development and validation samples. Please provide the cutpoints and definition for what is defined as a highly correlated ICC (ICC=0.688, in section 3.5 for 1st paragraph of measure testing).</p> <p>For tables B.1—B.5 (pg 63-79) it would be helpful to see the negative log likelihood estimates and akaikie estimate for model fit.</p> <p>For the clinical measures parameter estimates in tables B1-B5, overall odds ratios across cohorts seem lower among the clinical measures as compared to the CC condition measures. It may be helpful to clarify these findings.</p> <p>From the 2013 Core Clinical Data Elements document, it may be good to reintroduce Figure 3.1 to provide a quick glance at that process to understand how the 21 clinical data elements were chosen.</p>	<p>Minneapolis Medical Research Foundation/ Senior Healthcare Analyst, Hennepin County Medical Center-ACE</p>			<p>provided in the Public Comment Summary document. No changes to the measure in response to public comment recommended.</p>
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8/8/2014	Hybrid eHWR Measure	<p>The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the Hospital-Wide All-Cause Unplanned Readmission Hybrid Electronic Clinical Quality Measure (HWR eMeasure). With a significant portion of IDSA members in clinical practice that are hospital-based, the HWR eMeasure may have bearing on quality performance ratings pertaining to the patient care provided by our members in hospitals and health systems across the nation. IDSA supports CMS' efforts in examining new approaches to provide a more accurate assessment and portrayal of services provided by clinicians and hospitals.</p> <p>An area of concern for IDSA is the lack of consistency with the recommendations made by the National Quality Forum (NQF) regarding risk adjustment for sociodemographic factors such as ethnicity and race. Although, the NQF's Consensus Standards Approval Committee (CSAC) has not finalized recommendations, CMS should take the necessary steps and align recommendations with NQF and include sociodemographic factors into risk adjustment. In contrast to the potential masking of disparities in care, the capture of sociodemographic clinical data can provide valuable insight into indicators of health within certain populations, which can lead to better population health management.</p> <p>Another cause for concern is the review and exclusion of the medication order, medication administration, and medication discharge data elements. Although</p>	Thomas Kim Program Coordinator for Clinical Affairs Infectious Diseases Society of America (IDSA)	tkim@idsoc iety.org	Specialty Medical Society	<p>Stakeholder comments reviewed by measure developers and will be reviewed with Technical Expert Panel; detailed responses are provided in the Public Comment Summary document.</p> <p>No changes to the measure in response to public comment recommended.</p>
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		<p>medication order, administration, and discharge are associated with treatment and rarely included in mortality indices, the three medication clinical data points may be relevant and contribute to the accuracy of risk adjustments depending on the context of the outcome measure such as readmissions.</p> <p>If the proposed clinical dataset for risk adjustment will be applied to outcome measures other than mortality, reliability testing should be adequately performed to ensure validity .</p> <p>The condition the patient presents with should be clinically compatible with the lab tests in the core clinical dataset.</p> <p>In addition, a mechanism for the sharing of lab result information should be incorporated to reduce unnecessary, repetitive medical testing.</p> <p>Regarding the extraction and feasibility testing of the core clinical data elements, IDSA supports the core clinical data elements if the installation versions of the EHR systems cited within the report (Epic, Cerner, Meditech, and Allscripts) represent the majority of EHR systems utilized in Medicare hospitals. As well, we conditionally support the dataset if it is recognized that approximately one-third of the hospitals in the United States do not use Epic, Cerner, or Meditech.</p> <p>IDSA would appreciate further information be shared regarding the process for paper medical record claims data extraction. We are concerned that in cases that require labor intensive chart reviewed-data extraction, an undue burden will be placed on hospital-based</p>				
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	<p>physicians as well as additional mandated cost for hospitals.</p> <p>With the aforementioned aim [of CCDE standardization], IDSA sees an opportunity for CMS to standardize medication data elements through this process, which can inform the further relational development of real-time clinical decision support with medication management. In light of widespread readmissions due to medication errors and inappropriate use of antimicrobials that have led to resistance, IDSA recommends further consideration to be given to expand the core clinical dataset to include elements that address these major concerns.</p>				
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