**Release Notes:** Data Dictionary

Version 2010 Initial Date: 5/21/2010

 Modification Date: 6/21/2010

Data Dictionary for HCO-level

Consolidated version for HL7 review

The first 5 data elements are collected by both the Joint Commission and CMS for inpatient and outpatient hospital measures.

The rest of the data elements are collected by the Joint Commission for inpatient and outpatient hospital measures, long-term care measures, home care measures, and behavioral health measures.

**Data Element Name:** *Initial Patient Population Size – Medicare Only*

**Used For:** Data Quality

**Definition:** Indicates the number of episode of care (EOC) records identified for a hospital with Medicare listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of Medicare EOC records for a measure set, stratum, or sub-population. *Initial Patient Population Size – Medicare Only* includes all patients that are billed under Medicare or Title 18. Medicare can be listed as a primary, secondary, tertiary or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMO/Medicare Advantage are included in the Medicare counts, e.g., Medicare Blue, Humana Gold, Secure Horizons, AARP, Coventry Advantra, etc. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis and procedure codes, admission date, and birthdate.

For specific measure set, stratum, or sub-population definitions, refer to the appropriate Initial Patient Population discussion in the Measure Information section of this manual.

**Note**: If the hospital’s data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

**Format:**

**Length:** 6

**Type:** Numeric

**Occurs:** Non-stratified Measure Sets: One *Initial Patient Population Size Medicare Only* per hospital’s measure set (e.g., AMI, GLB, HF, PN, and STK).

Stratified Measure Sets: One *Initial Patient Population Size – Medicare Only* per measure set stratum or sub-population the hospital is participating in:

The SCIP measure set has eight occurrences, one for each stratum.

The CAC measure set has three occurrences, one for each age stratum.

The VTE measure set has three occurrences, one for each sub-population

(No VTE, Principal VTE, and Other VTE Only).

NOTE: This does not include the OP, HBIPS, and PC measure sets.

**Allowable Values:** 0 through 999,999

**Notes for Abstraction:**

*Initial Patient Population Size – Medicare Only* must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

**Data Element Name:** *Initial Patient Population Size – Non-Medicare Only*

**Used For:** Data Quality

**Definition:** Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of non-Medicare EOC records for a measure set, stratum, or sub-population. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis and procedure codes, admission date, and birthdate. For specific measure set, stratum, or sub-population definitions, refer to the appropriate Initial Patient Population discussion in the Measure Information section of this manual.

**Note:** If the hospital’s data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

**Format:**

**Length:** 6

**Type:** Numeric

**Occurs:** Non-stratified Measure Sets: One *Initial Patient Population Size Medicare Only* per hospital’s measure set (e.g., AMI, GLB, HF, PN, and STK).

Stratified Measure Sets: One *Initial Patient Population Size – Medicare Only* per measure set stratum or sub-population the hospital is participating in:

The SCIP measure set has eight occurrences, one for each stratum.

The CAC measure set has three occurrences, one for each age stratum.

The VTE measure set has three occurrences, one for each sub-population

(No VTE, Principal VTE, and Other VTE Only).

NOTE: This does not include the OP, HBIPS, and PC measure sets.

**Allowable Values:** 0 through 999,999

 **Notes for Abstraction:**

*Initial Patient Population Size – Non-Medicare Only* must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

**Data Element Name:** *Sample Size – Medicare Only*

**Used For:** Data Quality

**Definition:** Indicates the number of episode of care (EOC) records identified

for a hospital with Medicare listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

**Notes:**

If the hospital **is** sampling the measure set, then the *Sample Size – Medicare Only* should be equal or less than the *Initial Patient Population Size – Medicare Only* for the set, stratum, or sub-population.

If the hospital **is not** sampling the measure set, then the *Sample Size – Medicare Only* will equal the *Initial Patient Population Size – Medicare Only* for the set, stratum, or sub-population. For CMS, there may be instances where the *Sample Size – Medicare Only* may be lower than the Initial Patient Population Size. Hospitals selecting sample cases must ensure that it’s Initial Patient Population(s) and sample size(s) meet the conditions stated in the measure set’s Sample Size Requirements.

Hospitals must submit the same case for all applicable measure sets (i.e., ED, IMM, SUB and TOB) under the Global Initial Patient Population. Example:

o For every ED case that is submitted to the QIO Clinical Warehouse the same case must also be submitted as an IMM case to the QIO Clinical Warehouse.

o If a hospital has elected to submit ED, TOB and IMM to The Joint Commission, for every ED case that is submitted the same case must also be submitted as a TOB case and an IMM case to The Joint Commission’s Data Warehouse. The same holds true regardless of the combination of measure sets (ED, IMM, SUB, TOB) the hospital has elected to submit to The Joint Commission.

**Format:**

**Length:** 6

**Type:** Numeric

**Occurs:** Non-stratified Measure Sets: One *Initial Patient Population Size Medicare Only* per hospital’s measure set (e.g., AMI, GLB, HF, PN, and STK).

Stratified Measure Sets: One *Initial Patient Population Size – Medicare Only* per measure set stratum or sub-population the hospital is participating in:

The SCIP measure set has eight occurrences, one for each stratum.

The CAC measure set has three occurrences, one for each age stratum.

The VTE measure set has three occurrences, one for each sub-population

(No VTE, Principal VTE, and Other VTE Only).

NOTE: This does not include the OP, HBIPS, and PC measure sets.

**Allowable Values:** 0 through 999,999

 **Notes for Abstraction:**

When *Sampling Frequency* equals *‘N/A’* because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, *Sample Size – Medicare Only* should equal zero.

**Data Element Name:** *Sample Size – Non-Medicare Only*

**Used For:** Data Quality

**Definition:** Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

**Notes:**

If the hospital **is** sampling the measure set, then the *Sample Size – Non-Medicare Only* should be equal or less than the *Initial Patient Population Size – Non-Medicare Only* for the set, stratum, and sub-population.

If the hospital **is not** sampling the measure set, then the *Sample Size – Non-Medicare Only* will equal the *Initial Patient Population Size – Non-Medicare Only* for the set, stratum, and sub-population. For CMS, there may be instances where the *Sample Size – Medicare Only* may be lower than the Initial Patient Population Size. Hospitals selecting sample cases must ensure that it’s Initial Patient Population(s) and sample size(s) meet the conditions stated in the measure set’s Sample Size Requirements.

Hospitals must submit the same case for all applicable measure sets (i.e., ED, IMM, SUB and TOB) under the Global Initial Patient Population. Example:

o For every ED case that is submitted to the QIO Clinical Warehouse the same case must also be submitted as an IMM case to the QIO Clinical Warehouse.

o If a hospital has elected to submit ED, TOB and IMM to The Joint Commission, for every ED case that is submitted the same case must also be submitted as a TOB case and an IMM case to The Joint Commission’s Data Warehouse. The same holds true regardless of the combination of measure sets (ED, IMM, SUB, TOB) the hospital has elected to submit to The Joint Commission.

**Format:**

**Length:** 6

**Type:** Numeric

**Occurs:** Non-stratified Measure Sets: One *Initial Patient Population Size Medicare Only* per hospital’s measure set (e.g., AMI, GLB, HF, PN, and STK).

Stratified Measure Sets: One *Initial Patient Population Size – Medicare Only* per measure set stratum or sub-population the hospital is participating in:

The SCIP measure set has eight occurrences, one for each stratum.

The CAC measure set has three occurrences, one for each age stratum.

The VTE measure set has three occurrences, one for each sub-population

(No VTE, Principal VTE, and Other VTE Only).

NOTE: This does not include the OP, HBIPS, and PC measure sets.

**Allowable Values:** 0 through 999,999

 **Notes for Abstraction:**

When *Sampling Frequency* equals *‘N/A’* because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, *Sample Size – Non-Medicare Only* should equal zero.

**Data Element Name:** *Sampling Frequency*

**Used For:** To validate the Sample Size values

**Definition:** Indicates if the data being transmitted for a hospital has been sampled (either monthly or quarterly), or represents an entire population for the specified time period.

**Format:**

**Length:** 6

**Type:** Numeric

**Occurs:** Non-stratified Measure Sets: One *Initial Patient Population Size Medicare Only* per hospital’s measure set (e.g., AMI, GLB, HF, PN, and STK).

Stratified Measure Sets: One *Initial Patient Population Size – Medicare Only* per measure set stratum or sub-population the hospital is participating in:

The SCIP measure set has eight occurrences, one for each stratum.

The CAC measure set has three occurrences, one for each age stratum.

The VTE measure set has three occurrences, one for each sub-population

(No VTE, Principal VTE, and Other VTE Only).

NOTE: This does not include the OP, HBIPS, and PC measure sets.

**Allowable Values: *(CMS has different allowable values for their OP measure set)***

1 Yes, the hospital is sampling data monthly.

2 Yes, the hospital is sampling data quarterly.

3 No, the hospital is not sampling.

4 N/A, submission of patient level data is not required.

 **Notes for Abstraction:**

*Sampling Frequency* must be consistent across a discharge time period. ***(or event for HBIPS and encounter for OP).***

Example: If the *Sampling Frequency* for April is monthly, then the S*ampling Frequency* for May and June must also be monthly.

Hospitals with five or fewer discharges (both Medicare and non-Medicare combined) in a quarter are not required to submit patient level data.

***Number of Denominator Cases***

**Measure Type:** Proportion and Ratio measures

**Used For:** Control Chart, Target Analysis, Data Quality

**Calculated from patient-level data**

**Definition:** Summation of denominator cases (proportion) or the denominator

 component (ratio) for the measure's population for the health care

 organization during the specified time period.

Current TJC definition: This is the count of all patient-level records in the Denominator AND Numerator of the measure.

Should it be changed to this? This is the count of all patient-level records in the Denominator

Aggregate all case-level records that are members of a measure's population. **Do not** eliminate or suppress outliers.

**Format:** Length = 15

 Type = Decimal Number

**Allowable Values: Proportion measures:** 1 to 999,999,999 (whole numbers only)

 **Ratio measures:** .000001 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for proportion and ratio measures.

* Data element invalid for continuous variable measures.
* If proportion measure, data element must be >=

 *Number of Numerator Cases*

* When *Number of Denominator Cases* = 0, this data element is not

submitted. Refer to the data element *Data Received for Health Care Organization* for information on how to transmit HCO-level data in this situation. The statistical data **is not** submitted.

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***Number of Numerator Cases***

**Measure Type:** Proportion and Ratio measures

**Used For:** Control Chart, Target Analysis, Data Quality

**Calculated from patient-level data**

**Definition:** Summation of numerator cases (proportion) or the numerator

 component (ratio) in a measure's population for the health care

 organization during the specified time period.

This is the count of all patient-level records with in the Numerator of the measure.

Aggregate all case-level records that are members of a measure's population. **Do not** eliminate or suppress outliers.

**Format:** Length = 15

 Type = Decimal Number

**Allowable Values: Proportion measures:** 0 to 999,999,999 (whole numbers only)

 **Ratio measures:** 0 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for proportion and ratio measures.

* Data element invalid for continuous variable measures.
* If proportion measure, data element must be <=

 *Number of Denominator Cases*

* When *Number of Numerator Cases* = 0, this data element is still submitted. **Do not** suppress the statistical data.

## *Observed Rate*

**Measure Type:** Proportion and Ratio measures

**Used For:** Control Chart, Target Analysis, Data Quality

**Calculated from other aggregate data elements**

**Definition:** The measure's *Observed Rate* for the health care organization during

 the specified time period.

*Observed Rate* =

The HCO-level data element *Number of Numerator Cases* for the health care organization divided by the HCO-level data element *Number of Denominator Cases* for the same health care organization

 ***OR***

 

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values: Proportion measures:** 0 to 1 (decimals allowed)

 **Ratio measures:** 0 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for proportion and ratio measures.

* Data element invalid for continuous variable measures.
* When *Number of Denominator Cases* = 0, this data element cannot be calculated. Refer to *Number of Denominator Cases* programming notes for more information.

HL7 note:

If Category III captures the separate counts of number of denominator cases and number of numerator cases, then the Observed Rate equation is:

count of numerator cases / (count of numerator cases + count of denominator cases)

***Risk-Adjusted Rate***

**Measure Type:** Risk-adjusted Proportion and Ratio measures

**Used For:** Control Chart, Target Analysis, Data Quality

**Calculated from patient-level data – “case-level risk-adjusted rate” is the predicted rate calculated for each patient from the application of the risk model. Feel free to change the definition/equation to use ‘predicted rate’ to match Category I**

**Definition:** The measure's arithmetic average of all case-level risk-adjusted rates

 for the health care organization during the specified time period.

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** **Risk-Adjusted Proportion measures:**

 0 to 1 (decimals allowed)

 **Risk-Adjusted** **Ratio measures:**

 0 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for risk-adjusted proportion and ratio

 measures.

* Data element invalid for:
	+ Non-risk-adjusted proportion and ratio measures. Transmit a null.  **Do not** transmit a zero (0) as a default.
* Continuous variable measures.
* When Number of Denominator Cases = 0, this data element cannot be calculated. Refer to Number of Denominator Cases programming notes for more information.

***Standard Deviation of Risk-Adjusted Rate***

**Measure Type:** Risk-adjusted Proportion measures

**Used For:** Target Analysis

**Calculated from patient-level data – “case-level risk-adjusted rate” is the predicted rate calculated for each patient from the application of the risk model. Feel free to change the definition/equation to use ‘predicted rate’ to match Category I**

**Definition:** For the health care organization during the specified time period:

 *Standard Deviation of Risk-Adjusted Rate* =

Square root of the [sum of the (risk-adjusted rate for each case within the health care organization times) (\*) (1 - risk-adjusted rate for each case within the health care organization)] divided by the *Number of Denominator Cases* ***OR***

 

 where m = Number of Denominator Cases

**Format:** Length = 7 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** - 0 to 0.5 (decimals allowed)

**Programming Notes:** - Mandatory data element for risk-adjusted proportion measures.

 - Data element invalid for:

* + Non-risk-adjusted proportion measures and ratio

 measures.

 Transmit a null.  **Do not** transmit a zero (0) as a default.

* + Continuous variable measures.
* This data element **must be** calculated and transmitted even if there is only one (1) Denominator Case for the health care organization.

Number of Cases for Ratio

**Measure Type:** Ratio measures

**Used For:** Target Analysis, Data Quality

**Calculated from patient-level data**

**Definition:** In most instances, the Denominator should be used to value the data

element *Number of Cases for Ratio*. However, for the HBIPS core measure set, this is the number of unique patients represented in the data element *Number of Numerator Cases*. If no event occurred, send a zero (0).

Aggregate all case-level records that are members of a measure's population. **Do not** eliminate or suppress outliers.

**Format:** Length = 9

 Type = Numeric

**Allowable Values:** 0 to 999,999,999 (whole numbers only)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for ratio measures

 - Data element invalid for continuous variable and proportion

 measures.

***Standard Deviation of Observed Ratio***

**Measure Type:** Ratio measures

**Used For:** Target Analysis

**Calculated from patient-level data – “case-level numerator component” = the observed value calculated by the numerator portion of the equation. “case-level denominator component” = the observed value calculated by the denominator portion of the equation. Remember, this is a ratio measure!**

**Definition:** For the health care organization during the specified time period:

 *Standard Deviation of Observed Ratio* =

Square root of the [sum of the (numerator component for each case within the health care organization minus (-) (*Observed Rate* times (\*) case-level denominator component))2 divided by ((mean of all case-level denominator components)2 times (\*) (*Number of Cases For Ratio* - 1))] ***OR***

 

 where m = *Number of Cases For Ratio*

**Format:** Length = 15 (6 decimals)

 Type = Decimal Number

**Allowable Values:** 0 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for ratio measures.

 - Data element invalid for:

* + Proportion and ratio measures.

 Transmit a null.  **Do not** transmit a zero (0) as a default.

* + Continuous variable measures.
* When *Number of Cases For Ratio* = 1, this data element

cannot be calculated. Transmit a null. **Do not** transmit a zero (0) as a default.

## *Standard Deviation of Risk-Adjusted Ratio*

**Measure Type:** Risk-adjusted Ratio measures

**Used For:** Control Chart, Target Analysis

**Calculated from patient-level data – “case-level numerator component” = the observed value calculated by the numerator portion of the equation. “case-level denominator component” = the observed value calculated by the denominator portion of the equation. Remember, this is a ratio measure!**

**Definition:** For the health care organization during the specified time period:

 *Standard Deviation of Risk-Adjusted Ratio* =

Square root of the [sum of the (numerator component for each case within the health care organization minus (-) (*Risk-Adjusted Rate* times (\*) case-level denominator component))2 divided by ((mean of all case-level denominator components)2 times (\*) (*Number of Cases For Ratio* - 1))] ***OR***



 where m = *Number of Cases For Ratio*

*Note:* When risk adjusting numerator and /or denominator

components, replace the observed values with corresponding risk-adjusted values in the formula.

**Format:** Length = 15 (6 decimals)

 Type = Decimal Number

**Allowable Values:** 0 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for risk-adjusted ratio measures.

 - Data element invalid for:

* + Non-risk-adjusted ratio measures and proportion

 measures.

 Transmit a null.  **Do not** transmit a zero (0) as a default.

* + Continuous variable measures.

 - When *Number of Cases For Ratio* = 1, this data element cannot be

calculated. Transmit a null. **Do not** transmit a zero (0) as a

 default***Number of Cases***

**Measure Type:** Continuous Variable measures

**Used For:** Target Analysis

**Calculated from patient-level data**

**Definition:** The total number of cases that are members of a measure's

 population for the health care organization during the specified time

 period.

Aggregate all case-level records that are members of a measure's population. **Do not** eliminate or suppress outliers.

**Format:** Length = 9

 Type = Numeric

**Allowable Values:** 1 to 999,999,999 (whole numbers only)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for continuous variable measures

* Data element invalid for proportion and ratio measures.

- If the *Number of Cases* = 0, refer to the data element *Data Received*

*for Health Care Organization* for information on how to transmit HCO-level data. Statistical information is not submitted.

***Maximum of All Case-Level Observed Values***

**Measure Type:** Continuous Variable measures

**Used For:** Control Chart

**Calculated from patient-level data – used the observed value calculated by the algorithm**

**Definition:** The measure's largest observed value for the health care organization

during the specified time period.

For core measures, the observed value is the *Measurement Value* calculated for each case as it is processed through the measure algorithm.

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for continuous variable measures

* Data element invalid for proportion and ratio measures
* Must be >= *Minimum of All Case-Level Observed Values*
* Must be >= *Median of All Case-Level Observed Values*

Mean of All Case-Level Observed Values

**Measure Type:** Continuous Variable measures

**Used For:** Control Chart

**Calculated from patient-level data – used the observed value calculated by the algorithm**

**Definition:** The measure's average observed value for the health care

 organization during the specified time period.

For core measures, the observed value is the *Measurement Value* that is calculated for each case as it is processed through the measure algorithm.

 *Mean of All Case-Level Observed Values* =

 Sum of the observed values for all cases within the health

care organization divided by the HCO-level data element *Number of Cases* ***OR***

 

 where m = *Number of Cases*

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for continuous variable measures.

* Data element invalid for proportion and ratio measures.

Median of All Case-Level Observed Values

**Measure Type:** Continuous Variable measures

**Used For:** Control Chart

**Calculated from patient-level data – used the observed value calculated by the algorithm**

**Definition:** The measure's midpoint observed value when all observed values for

the health care organization are sorted in ascending or descending order during the specified time period.

For core measures, the observed value is the *Measurement Value* that is calculated for each case as it is processed through the measure algorithm.

 *To determine the Median* -

 Sort the case-level records for the health care organization by their

 observed values:

 **If** the total number of records is odd

 **then** Median = the value associated to the middle record

 ELSE

 **If** the total number of records is even

 **then** Median = the average of the values of the two

 middle records

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for continuous variable measures.

* Data element invalid for proportion and ratio measures.
* Must be >= *Minimum of All Case-Level Observed Values*
* Must be <= *Maximum of All Case-Level Observed Values*

Minimum of All Case-Level Observed Values

**Measure Type:** Continuous Variable measures

**Used For:** Control Chart

**Calculated from patient-level data – used the observed value calculated by the algorithm**

**Definition:** The measure's smallest observed value from among all observed

 values for the health care organization during the specified time

 period.

For core measures, the observed value is the *Measurement Value* that is calculated for each case as it is processed through the measure algorithm.

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for continuous variable measures

* Data element invalid for proportion and ratio measures.
* Must be <= *Median of All Case-Level Observed Values*
* Must be <= *Maximum of All Case-Level Observed Values*

Standard Deviation of All Case-Level Observed Values

**Measure Type:** Continuous Variable measures

**Used For:** Control Chart, Target Analysis

**Calculated from patient-level data – used the observed value calculated by the algorithm**

**Definition:** For the health care organization during the specified time period:

 *Standard Deviation of All Case-Level Observed Values* =

Square root of the [sum of the (observed value for each case within the health care organization minus (-) HCO-level data element *Mean of All Case-Level Observed Values*)2 for the health care organization divided by the HCO-level data element (*Number of Cases* - 1) ] ***OR***

 

 where m = *Number of Cases*

For core measures, the observed value is the *Measurement Value* that is calculated for each case as it is processed through the measure algorithm.

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** 0 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for continuous variable measures.

 - When *Number of Cases* = 1, this data element cannot be

calculated. Transmit a null. **Do not** transmit a zero (0) as a

default.

* Data element invalid for proportion and ratio measures.

## *Maximum of All Case-Level Risk-Adjusted Values*

**Measure Type:** Risk-adjusted Continuous Variable measures

**Used For:** Data Quality

**Calculated from patient-level data – risk-adjusted rate value = predicted value**

**Definition:** The measure's largest risk-adjusted value for the health care

 organization during the specified time period.

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for risk-adjusted continuous variable

 measures

* Data element invalid for:
	+ Non-risk-adjusted continuous variable measures. Transmit a null.  **Do not** transmit a zero (0) as a default.
	+ Proportion and ratio measures.
* Must be >= *Minimum of All Case-Level Risk-Adjusted Values*
* Must be >= *Median of All Case-Level Risk-Adjusted Values*

## *Mean of All Case-Level Risk-Adjusted Values*

**Measure Type:** Risk-adjusted Continuous Variable measures

**Used For:** Target Analysis

**Calculated from patient-level data – risk-adjusted rate = predicted value**

**Definition:** The measure's average risk-adjusted value for the health care

 organization during the specified time period.

 *Mean of All Case-Level Risk-Adjusted Values* =

 Sum of the risk-adjusted values for all cases within the health

 care organization divided by the HCO-level data element

 *Number of Cases* ***OR***

 

 where m = *Number of Cases*

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for risk-adjusted continuous variable

 measures

* Data element invalid for:
	+ Non-risk-adjusted continuous variable measures. Transmit a null.  **Do not** transmit a zero (0) as a default.
	+ Proportion and ratio measures.

Median of All Case-Level Risk-Adjusted Values

**Measure Type:** Risk-adjusted Continuous Variable measures

**Used For:** Target Analysis

**Calculated from patient-level data – risk-adjusted rate = predicted value**

**Definition:** The measure's midpoint risk-adjusted value when all risk-adjusted

values for the health care organization are sorted in ascending or descending order during the specified time period.

 *To determine the Median* -

 Sort the case-level records for the health care organization by their

 risk-adjusted values:

 **If** the total number of records is odd

 **then** Median = the value associated to the middle record

 ELSE

 **If** the total number of records is even

 **then** Median = the average of the values of the two

 middle records

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for risk-adjusted continuous variable

 measures

* Data element invalid for:
	+ Non-risk-adjusted continuous variable measures. Transmit a null.  **Do not** transmit a zero (0) as a default.
	+ Proportion and ratio measures.
* Must be >= *Minimum of All Case-Level Risk-Adjusted Values*
* Must be <= *Maximum of All Case-Level Risk-Adjusted Values*

Minimum of All Case-Level Risk-Adjusted Values

**Measure Type:** Risk-adjusted Continuous Variable measures

**Used For:** Data Quality

**Calculated from patient-level data – risk-adjusted rate = predicted value**

**Definition:** The measure's smallest risk-adjusted value from among all

risk-adjusted values for the health care organization during the

specified time period.

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** -999,999,999.999999 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for risk-adjusted continuous variable

 measures

* Data element invalid for:
	+ Non-risk-adjusted continuous variable measures. Transmit a null.  **Do not** transmit a zero (0) as a default.
	+ Proportion and ratio measures.
* Must be <= *Median of All Case-Level Risk-Adjusted Values*
* Must be <= *Maximum of All Case-Level Risk-Adjusted Values*

Standard Deviation of All Case-Level Risk-Adjusted Values

**Measure Type:** Risk-adjusted Continuous Variable measures

**Used For:** Target Analysis

**Calculated from patient-level data – case-level risk-adjusted value = predicted value**

**Definition:** For the health care organization during the specified time period:

 *Standard Deviation of All Case-Level Risk-Adjusted Values* =

Square root of the [sum of the (risk-adjusted value for each case within the health care organization minus (-) HCO-level data element *Mean of All Case-Level Risk-Adjusted Values*)2 for the health care organization divided by the HCO-level data element (*Number of Cases* - 1) ] ***OR***

 

 where m = *Number of Cases*

**Format:** Length = 15 (6 decimal places)

 Type = Decimal Number

**Allowable Values:** 0 to 999,999,999.999999 (decimals allowed)

 Note: Do not submit commas as part of the data value.

**Programming Notes:** - Mandatory data element for risk-adjusted continuous variable

 measures.

 - Data element invalid for:

* + Non-risk-adjusted continuous variable measures.

 Transmit a null.  **Do not** transmit a zero (0) as a default.

* + Proportion and ratio measures.

 - When *Number of Cases* = 1, this data element cannot be

calculated. Transmit a null. **Do not** transmit a zero (0) as a default.

Data Received for Health Care Organization (DR Code)

**Measure Type:** Proportion, Ratio, and Continuous Variable measures

**Used For:** Control Chart, Target Analysis, Data Quality

**Determined from the measure results for each patient. I’m assuming DR5 isn’t possible since we are saying there is no “missing data”. The DR1 is the default code and is submitted whenever at least one patient was in the denominator or numerator. DR2 is used when all cases are in the excluded from the algorithm. DR3 is used when the hospital does not provide data to the vendor to transmit – it is the vendors way of saying they are not at fault for there being no data.**

**Definition:** Defines if the ORYX Performance Measurement System received data from the health care organization

(*Health Care Organization Identifier*) for the specified measure (*Performance Measurement Identifier*) for the associated *Reporting Time Period / Year*.

**Format:** Length = 1

 Type = Alphanumeric

**Allowable Values:** 1 – Data for this measure were received for the *Reporting Time*

 *Period / Year* from the health care organization and the number of

 cases**1** are > 0

* Risk Adjusted measures:
	+ Risk adjustment data are **required** for all non-core and core measures that are risk adjusted.

*Core Measure Notes:*

* Discharge and Encounter Measures:
	+ Proportion measure: Use this allowable value if there is **at least one** episode of care record with a *Measure Category Assignment***2** = **‘D’ or ‘E’**.
	+ Continuous Variable measure: Use this allowable value if there is **at least one** episode of care record with a *Measure Category Assignment***2** = **‘D’**.
* Event Measures:
	+ Ratio measure: Use this allowable value if: HBIPS-2 and 3: *Number of Denominator Cases* = [(*Psychiatric Inpatient Days-Medicare Only – Leave Days-Medicare Only*) + (*Psychiatric Inpatient Days-Non-Medicare Only – Leave Days-Non-Medicare Only*)] > 0

2 – Data for this measure were received for the *Reporting Time*

 *Period / Year* from the health care organization and the number of

cases**1** are = 0.

 *Core Measure Notes for 4Q2007* data and forward:

* All measure types:
	+ If the organization has no patients in the population of the measure set, then by default the number of cases1 = 0.
* Discharge and Encounter Measures:
	+ Proportion measures: Use this allowable value if **all** of the episode of care records have a *Measure Category Assignment***2** = **‘B’**. There are **no** *Measure Category Assignment***2** = **‘X’, ‘D’, or ‘E’**.
	+ Continuous Variable measures: Use this allowable value if **all** of the episode of care records have a *Measure Category Assignment***2** = ‘B’. There are **no** *Measure Category Assignment*2 = **‘X’ ‘D’, or ‘Y’.**
* Event Measures:
	+ Ratio measure: Use this allowable value if: HBIPS-2 and 3: *Number of Denominator Cases* = [(*Psychiatric Inpatient Days-Medicare Only – Leave Days-Medicare Only*) + (*Psychiatric Inpatient Days-Non-Medicare Only – Leave Days-Non-Medicare Only*)] = 0

 **Five or fewer cases during the quarter- starting with**

**1/1/2009 discharge and encounters for inpatient and outpatient core measures:**

* Discharge and Encounter Measures: Use allowable value ‘2’ when a hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter for the entire measure set and the hospital has decided to not submit patient data to The Joint Commission. The DR2 must be transmitted for all months in the quarter for all measures in the set.
* Event Measures: Not eligible – hospitals must report patient data for event measures regardless of the number of discharges or events they have during the quarter.

 3 – The health care organization is participating in the measure for

 ORYX purposes, but no data for this measure were received for the

 *Reporting Time Period / Year*.

 *Core measures notes*:

* For Discharge and Encounter measures, a DR3 is used only when the hospital has submitted no patient data associated to the measure set. See below for DR3 usage with core Event measures.
* Refer to the definition of DR5 if any patient data are submitted for the organization and **all** of the episode of care records have a *Measure Category Assignment***2** = **‘X’** or **‘Y’**.

 *Core Event Measure Notes:*

* Use this allowable value if:

HBIPS-2 and 3: No applicable patient data for the measure set **and/or** no monthly unit/facility-level aggregate data were received. No monthly unit/facility-level aggregate data means that *Psychiatric Inpatient Days***3** and/or *Leave Days***3** are missing.

 4 – RETIRED VALUE

5 – Data for this measure were received for the R*eporting Time*

 *Period / Year* from the health care organization, however data

 analysis could not be completed due to missing or other data

 quality issues.

 *Core Measure Notes*:

* As long as one or more of the cases for a measure from a HCO can be used, all relevant data elements should be aggregated and transmitted with an allowable value = 1. This is true regardless of the percentage of “unusable” cases for the measure.

*Core Measure Notes for 4Q2007 data and after:*

* Discharge Measures:
* Proportion measures:
* Use this allowable value when there are **no** episode of care records with a *Measure Category Assignment***2** = **‘D’ or ‘E’** **and** there is **at least one** episode of care record with a *Measure Category Assignment*2 = **‘X’**.

 **-- OR --**

* Use this allowable any time the ORYX Performance Measurement System has concerns over the data quality of the episode of care data. The code may be used for data that contains any combination of category assignments.
* Continuous Variable measures:
* Use this allowable value when there are **no** episode of care records with a *Measure Category Assignment***2** = **‘D’ and** there is **at least one** episode of care record with a *Measure Category Assignment***2** = ‘**Y**’ or **‘X’**.

 **-- OR --**

* Use this allowable any time the ORYX Performance Measurement System has concerns over the data quality of the episode of care data. The code may be used for data that contains any combination of category assignments.
	+ Event Measures:
	+ Ratio measure: Use this allowable value when there are **no** episode of care records with a *Measure Category Assignment***2** = **‘E’ and** there is **at least one** episode of care record with a *Measure Category Assignment***2** = **‘Y’ or ‘X’.**

 **1** **number of cases** is defined as:

*Number of Denominator Cases* (proportion measure), *Number of Cases for Ratio* (ratio measure), and *Number of Cases* (continuous variable measure)

**2 *Measure Category Assignment***:

Refer to the applicable version of the Specifications Manual for the core measure that is being submitted.

The discussions related to *Measure Category Assignment* uses the “base” allowable values for that data element. For example, the discussions concerning *Measure Category Assignment* = ‘D’ is applicable to ‘D’, ‘D`’, and ‘D(#)’.

**3***Psychiatric Inpatient Days* (medicare only and non-medicare only) and *Leave Days* (medicare only and non-medicare only) data elements are defined in the *Specifications Manual for Joint Commission National Quality Core Measures*.

**Programming Notes:** - Mandatory for all measures

 - When *Data Received for Health Care* Organization = 2, 3, or 5:

No statistical data is submitted

For seasonal measures, a *Data Received for Health Care Organization* = 2 may be transmitted during the off-season. Data transmitted during the off-season will be rejected if the *Data Received for Health Care Organization* is anything other than ‘2’ (no cases).

 - When *Data Received for Health Care* Organization = 1:

Statistical data must be submitted

## *Reporting Data Point Qualifier*

## *Reporting Time Period*

## *Reporting Year*

**Measure Type:** Proportion, Ratio, and Continuous Variable measures

**Used For:** Control Chart, Target Analysis, Data Quality

**Reporting data elements – just included so you can see how we define.**

**Definition:** Defines the time period of the event or patient's end-of-service.

 The time period the event or patient's end-of-service is based on:

* Hospitals, Inpatients –

 Based on patient's Discharge Date or the Event Date

* Hospitals, Outpatients –

Based on the date the patient is Released from Service or the Encounter Date

* Long Term Care facilities – Based on Resident Activity
* Home Care agencies – Based on Client Activity

**Format:** *Reporting Data Reporting Time Reporting Year*

 *Point Qualifier Period*

 Length = 1 Length = 2 Length = 4

 Type = Alphanumeric Type = Numeric Type = Numeric

**Allowable Values:** *Reporting Data Point Qualifier*

 Please note that at this time only monthly measures are being

 accepted for ORYX purposes.

 Comparison Group

 M – Monthly data points

 HCO-Level Group

 M – Monthly data points

 Z – Seasonal data points

*Reporting Time Period for Comparison Group Data and HCO-level Monthly Data* when *Reporting Data Point Qualifier* = “M”

 1 – January, 2 – February

 3 – March, 4 – April

 5 – May, 6 – June

 7 – July, 8 – August

 9 – September, 10 – October

 11 – November, 12 – December

*Reporting Time Period for HCO-level Seasonal Data* when *Reporting Data Point Qualifier* = “Z”

 1 – January, 2 – February

 3 – March, 4 – April

 5 – May, 6 – June

 7 – July, 8 – August

 9 – September, 10 – October

 11 – November, 12 – December

The exact values that are allowable are dependent upon the definition of the seasonal measure. Refer to the appropriate core measure information form in applicable version of the Specifications Manual for more information. Note: Non-core measures may not report seasonal data – data for all twelve months are required.

 *Reporting Year*

 4-Digit Year associated with the *Reporting Time Period*

**Programming Notes:** - All 3 data elements are mandatory for all measures

 - *Reporting Time Period* = ‘Z’ is only valid for seasonal core measures

 - *Reporting Year* must be <= the Current Year

 - *Reporting Time Period* / *Reporting Year* must be <= the

 System Date

 - *Reporting Time Period* / *Reporting Year* must be <= the

Transmission Deadline1 for the associated Accreditation Program

 - HCO-level data:

* *Reporting Time Period* / *Reporting Year* must be >= the associated Health Care Organization's (*Health Care Organization Identifier)* Reported Data Collection Start Date2
* *Reporting Time Period* / *Reporting Year* must be <= the associated Health Care Organization's (*Health Care Organization Identifier)* Reported Data Collection End Date3

 *Note*: 1Transmission Deadline - The last calendar date on which

a ORYX Performance Measurement System can update and retransmit performance measure data for any given data collection time period to the Outcomes database for the associated accreditation program.

2Health Care Organization's Reported Data Collection Start Date – The date on which the health care organization begins to collect case-level data for the specified measure (*Performance Measure Identifier*). The health care organization reports this date to The Joint Commission.

3Health Care Organization's Reported Data Collection End Date –The date on which the health care organization stops collecting case-level data for the specified measure

(*Performance Measure Identifier*). The health care organization reports this date to The Joint Commission.