



Direct Difference Digest

Welcome Edition
August 2026

Turning Quality Data into Confident Submissions

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Highlights how a specific quality measure is interpreted and clarifies nuances of abstraction.

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"What this means for your team."

Before and after the abstraction of outcomes, audit findings led to improvements.

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Welcome to the inaugural issue of Direct Difference Digest, a newsletter created exclusively for our partners hospitals. At Direct Difference, we see firsthand how complex quality abstraction and government reporting can be. This newsletter is designed to break down that complexity into clear, practical guidance and actionable steps, ensuring your team can move from data collection to compliant submission and improved care delivery with confidence. Accurate quality reporting depends on more than just understanding measure specifications; it requires consistent application across charts, abstractors, and reporting periods. Each issue will focus on a core topic, highlight actual chart abstraction insights, and conclude with clear actions you can apply immediately to ensure accurate data collection, reliably demonstrate the care provided, and identify timely opportunities for care improvement.

❖ Executive Brief



- Inconsistent abstraction is a leading audit risk across quality programs
- Small interpretation differences can materially impact reported performance
- Proactive and consistent checks reduce rework, delays, and compliance exposure
- Direct Difference supports standardized, defensible, abstraction practices
- Direct Difference provides full validation support and document review prior to submission
- As part of Direct Difference commitment, we have strategically expanded our services to include Cancer Registry and Trauma Registry abstraction.



❖ Data, Measures & Performance Improvement

✓ Measure Up

Why ED Throughput Matters:

ED throughput is how quickly and efficiently patients move through the emergency department system. Efficient throughput improves patient outcomes, hospital capacity, staff workflow, and Hospital Efficiency Regulatory Reporting. Poor throughput can cause ED overcrowding, delayed treatment, and higher complication rates.

CMS Throughput Reporting

Electronic Health Records use timestamps to generate reports required for quality reporting programs, such as those of the Centers for Medicare & Medicaid Services. These measures rely heavily on accurate arrival and discharge timestamps.

- OP-18: Median time from ED arrival to ED departure for discharged patients
- OP-22: Median time from ED arrival to ED departure for admitted patients

Common EHR configuration mistakes can lead to incorrect ED discharge timestamps, which affect ED throughput metrics and quality reporting to CMS. Here are real-life ED workflow situations that commonly cause discharge time capture errors. These examples show how normal operational steps can lead to incorrect timestamps in EHR.

1. Provider places the DC order late

Real workflow scenario

- Pt evaluated and treated
- Provider verbally tells nurse, "Patient can go."
- RN begins discharge instructions
- Provider gets busy with another patient
- Discharge Order entered later in EHR

Event	Actual Time
Patient is ready to leave	01:29 am
Pt. transferred from ED to OTF	01:59 am
Provider enters discharge order	2:11 am
Provider entered addendum notes	2:12 am
Pt. Discharged	03:27 am

Error: System records 3:27 am as discharge time, increasing ED LOS instead
At 1:59 a.m., when the patient was transferred to OTF

2. Nurse Completes Documentation After Patient Leaves

Real workflow scenario

- Provider places discharge order
- Nurse gives verbal instructions and removes the IV
- Patient leaves quickly
- Nurse documents discharge later when workload allows

Event	Actual time
Discharge order placed	4 pm
Pt. leaves ED	4:10 pm
Nurse documents discharge	4:35 pm

Error: EHR may capture 4:35 PM instead of 4:10 pm.

3. Waiting for Discharge Instructions or Prescriptions

Real workflow scenario

- Provider decides to discharge
- Nurse waits for:
 - printed instructions
 - electronic prescriptions
 - follow-up paperwork
- Documentation may occur at different times

Event	Actual Time
Provider decision	5:10
DC order entered	5:20
Instructions ready	5:35
Patient leaves	5:40

Error: System might capture instruction completion time instead of actual departure time.

Why these errors matter: Incorrect discharge times affected Throughput Quality Measures, including:

- ED LENGTH OF Stay (LOS)
- Door to Discharge time
- CMS outpatient quality measures
- ED Crowding Analysis
- Operational performance reporting

Key Takeaway: These examples demonstrate that if an ED discharges 120 patients/day and each discharge is 20 minutes late, the reported ED throughput could be inflated by a total of 40 hours of patients' time per day.

✓ **From Chart to Change**

Here are recent scenarios regarding quality measure reporting and the importance of accurate documentation and re-abstraction.

Scenario 1: Cath Lab Documentation – NCDR Cath/PCI Registry Focus

Stress Test Documentation Requirements:

- Stress test performed before the procedure.
- Documented date of the stress test.
- Type of stress test noted (e.g., exercise stress, stress echo, stress nuclear, or Stress Image with CMR).
- Level of risk clearly documented (e.g., low, intermediate, or high risk).
- Results are described clearly and consistently with the risk assessment.

Key Takeaway: Complete stress test documentation, including the date performed and the level of risk, provides the necessary clinical context for correct Appropriate Use Criteria (AUC) classification in the NCDR Cath/PCI Registry. Clear documentation ensures that procedures are evaluated fairly and that clinical

decision-making is accurately reflected, whereas missing or vague entries may negatively impact scoring.

Scenario 2: A chart initially met the numerator for a quality measure.

Change: Post-discharge documentation clarified a condition that triggered an exclusion.

Outcome: The chart required a re-review to ensure accurate and compliant reporting.

Key Takeaway: Clear internal guidance on when re-abstraction is required is essential to prevent inaccurate submissions and potential audit findings.

✓ **Data to Difference**

Objective: to ensure that abstraction decisions are defensible, repeatable, and fully aligned with current specifications. Frequently encountered common challenges:

- Documentation Timeliness: We need to ensure documentation is completed promptly to accurately capture data fields that impact star ratings and outcome measures.
- Consistency in Interpretation: Inconsistent interpretation of exclusion logic across the abstraction team.
- Data Accessibility: Key details are frequently located in scanned documents rather than in structured fields or free-text notes, which complicates data retrieval.

Key Takeaway: If two abstractors reach different conclusions on the same chart, compliance risk increases. At Direct Difference, we conduct Inter-Rater Reliability (IRR) reviews monthly on abstracted charts, aiming for 95% accuracy or higher.

❖ **Compliance Corner**



Consistency is the foundation of compliance. Even small differences in interpretation can lead to missed exclusions, inconsistent results, and increased audit risks.

Helpful Tips:

- Review internal timelines to allow for re-abstraction before final submission
- Ensure abstraction notes clearly justify inclusion or exclusion decisions
- Maintain a centralized reference for the interpretation of measures
- Define a process for handling late documentation

✓ **Deadline Watch**

Hospital Quality Reporting Important Dates and Deadlines
(All dates are subject to change.)



Hospital IQR Program				IQR & HAC Reduction Programs	
Discharge Quarter	HCAHPS Submission	Population & Sampling Submission (Required for chart-abstracted measures only)	Clinical Submission (SEP-1)	NHSN HAI Submission	
				IQR: CAUTI- & CLABSI- Onc	HACRP: HAI ¹
Q3 2025	01-14-2026 ¹	02-02-2026 ²	02-17-2026 ²	NA	02-17-2026 ²
Q4 2025	04-08-2026 ¹	05-04-2026 ²	05-18-2026 ²	NA	05-18-2026 ²
Q1 2026	07-08-2026 ¹	08-03-2026 ²	08-17-2026 ²	08-17-2026 ²	08-17-2026 ²
Q2 2026	10-14-2026 ¹	11-02-2026 ²	11-16-2026 ²	11-16-2026 ²	11-16-2026 ²
Discharge Quarter	Validation				
	HACRP HAI Validation Templates		Estimated CDAC Record Request	Estimated Date Records Due to CDAC	
Q1 2025	Targeted: 03-30-2026		Targeted: 04-06-2026	Targeted: 05-05-2026	
Q2 2025	Targeted: 04-20-2026		Targeted: 05-05-2026	Targeted: 06-03-2026	
Q3 2025	Random: 02-17-2026 Targeted: 05-20-2026		Random: 02-28-2026 Targeted: 06-30-2026	Random: 03-27-2026 Targeted: 07-02-2026	
Q4 2025	Random: 05-15-2026 Targeted: 06-03-2026		Random: 05-25-2026 Targeted: 07-02-2026	Random: 06-23-2026 Targeted: 07-31-2026	
eCQM Validation					
Fiscal Year (FY)/Calendar Year (CY)			Estimated CDAC Record Request	Estimated Date Records Due to CDAC	
CY 2025/FY 2028			Spring 2026	Spring 2026	
FY 2027 APU					
Measure/Requirement			Reporting Period	Submission Deadline/Period	
Web-Based Structural/Process Measures ⁴			January 1, 2025–December 31, 2025	April 1, 2026–May 18, 2026	
DACA (Data Accuracy and Completeness Acknowledgement)			January 1, 2025–December 31, 2025	April 1, 2026–May 18, 2026	
eCOMs (Electronic Clinical Quality Measures)			January 1, 2025–December 31, 2025	March 2, 2026 ²	
FY 2028 APU					
Measure/Requirement			Reporting Period	Submission Deadline/Period	
Influenza HCP Vaccination			October 1, 2025–March 31, 2026	May 18, 2026	
Hybrid Hospital-Wide Mortality and Hybrid Hospital-Wide Readmission			July 1, 2025–June 30, 2026	October 1, 2026	
Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure Reporting					
FY			Reporting Period	Submission Deadline/Period	
2028 Mandatory Reporting			Procedure Performed: July 1, 2024–June 30, 2025 Post-op Data: April 27, 2025–August 29, 2026	Post-op Data: September 30, 2026	
2029 Mandatory Reporting			Procedure Performed: July 1, 2025–June 30, 2026 Pre-op Data: April 2, 2026–June 30, 2026	Pre-op Data: September 30, 2026	

¹The HCAHPS deadline has been extended by one week due to the new survey being implemented beginning with CY 2025 discharges.

²Submission deadline falls on a weekend or holiday and is moved to the next business day.

³Hospital Acquired Condition (HAC) Reduction Program Healthcare-Associated Infection (HAI) measures include Catheter-Associated Urinary Tract Infection (CAUTI), Central Line-Associated Bloodstream Infection (CLABSI), Colon and Abdominal Hysterectomy Surgical Site Infection (SSI), Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia, and Clostridium difficile Infection (CDI).

⁴Web-based structural measures include the mandatory reporting of Maternal Morbidity, Age-friendly, and Patient Safety. Q1 (Jan 1–March 31); Q2 (April 1–June 30); Q3 (July 1–September 30); Q4 (October 1–December 31)

Hospital Quality Reporting: Important Dates and Deadlines
(All dates are subject to change.)

- Generally, data must be submitted no later than 11:59 PST on the submission deadline, except for HCAHPS, which must submit HCAHPS by 11:59 CST
- Data for clinical measures, eCOMs, hybrid core clinical data elements, structural measures, population and sampling, DACA, and the THA/TKA PROM are transmitted within the HQR Secure Portal.
- HAI validation Template data are transmitted within the HQR Secure Portal via Unified File Management (UFM), Managed File Transfer (MFT)
- HAI, CAUTI-Onc, CLABSI-Onc, Influenza, and patient safety Structural measure data are submitted to the CDC through NHSN

Data Submission

Data Submissions must be timely, accurate, and complete.

- Collect chart-abstracted clinical data for each quarter and submit these data by the deadline.

- For the CY 2028 payment determination, the applicable patient encounter quarters for chart-abstracted data are as follows:

Patient Encounter Quarter	Clinical Data Submission Deadline
Q1 2026 (January 1–March 31)	Aug 3, 2026
Q2 2026 (April 1–June 30)	Nov 2, 2026
Q3 2026 (July 1–September 30)	Feb 1, 2027
Q4 2026 (October 1–December 31)	May 3, 2027

Note: Hospitals with fewer claims per quarter (Medicare and non-Medicare combined) for any measure (e.g., Stroke) will not be required to submit patient-level data for that measure for that quarter. However, they may voluntarily submit data,

- Collect data for web-based measures to be submitted via the HQR system and submit these data by the deadline
 - For CY 2028 payment determination, the data submission period opens on January 1, 2027, and extends through May 17, 2027, for encounters dated January 1- December 31, 2026.
- Collect data for patient survey measures for each quarter and submit these data by the deadline.
 - The data submission deadlines for survey measures are as follows:

Patient Encounter Quarter	Data Submission Deadline
Q1 2026 (January 1–March 31)	Jul 8, 2026
Q2 2026 (April 1–June 30)	Oct 14, 2026
Q3 2026 (July 1–September 30)	Jan 13, 2027
Q4 2026 (October 1–December 31)	Apr 14, 2027

- Collect data for electronic Clinical Quality Measures (eCQMs) to be submitted via the HQR system using Quality Reporting Document Architecture (QRDA) Category 1 files by the annual submission deadline
 - For CY 2028 payment determination, three self-selected quarters of data from the CY 2026 reporting period are required. The submission deadline is May 17, 2027.
- To calculate claims-based measures, CMS uses a hospital's Medicare claims data. Data submissions must be timely, complete, and accurate. A complete submission is determined based on whether the submitted data:
 - Satisfies the sampling criteria published and maintained in the Hospital OQR **Specification Manual** (found on QualityNet Website) and
 - Corresponds to both the aggregate number of patient encounters submitted by a hospital and the number of Medicare claims the hospital submits for payment.

Hospital Outpatient Quality Reporting (OQR) Program **Estimated Medical Record Request Dates for** **Calendar Year (CY) 2027 Data Validation Efforts**

Every year, the Centers for Medicare & Medicaid Services (CMS) selects up to 500 hospitals for data validation of chart-abstracted measures through the Hospital Outpatient Quality Reporting (OQR) Program. The selection of hospitals for the calendar year (CY) 2027 payment determination was completed in August 2025.

After the clinical data submission deadline for each quarter, cases for validation are selected, and hospitals will receive a case selection packet from the CMS Clinical Data Abstraction Center (CDAC). **It typically takes around 10-30 days after each quarter's clinical data submission deadline for cases to be selected and sent out.** The CDAC will mail a records request packet to the attention of the "Medical Records Director," which contains detailed instructions and a case listing. Hospitals must submit the requested documentation to the CDAC by the due date listed on the request packet.

The table below lists the quarters included in CY 2027 data validation efforts, along with an estimate of when the medical records requests might be sent.

Encounter Quarters	Estimated Medical Records Requests Sent
1Q 2025 (Jan 1 - Mar 31)	August 2025
2Q 2025 (Apr 1 - Jun 30)	November 2025
3Q 2025 (Jul 1 - Sep 30)	February 2026
4Q 2025 (Oct 1 - Dec 31)	May 2026

Direct Difference serves as your abstraction partner for all clinical data and provides full validation support for both randomly selected and targeted facilities at no extra cost. Collaboration between your facility and our staff, including a thorough document review before submission, is essential to ensure accurate validation. Please follow this process each quarter upon receiving your selected patient list:

- **Step 1: Post Case Selection-** Immediately upload the case selection Excel file to the shared drive and notify your Account Manager and Clinical Liaison. Direct Difference will then conduct a second review of each case.
- **Step 2: Share PDF Charts-** Once your HIM team has the PDF charts ready, post them to the shared drive. This allows us to locate all data elements, identify chart nuances, verify that all applicable information (EMS records) is included, and ensure no inappropriate documentation is present.
- **Step 3: Await Clearance-** Direct Difference will review all PDF charts and notify your facility when the charts are ready for submission for that quarter.
- **Step 4: Review Results Together-** Post your validation results to the shared drive immediately. In the event of a mismatch, Direct Difference will investigate and, if the validators are incorrect, prepare an educational review for your submission before the 30-day deadline.

✓ **CMS Compass**

Updates and clarifications, IQR OQR Measure retirement and additions.

CMS has updated the 2026 Hospital Inpatient Quality Reporting (IQR) Program. While the core reporting structure remains, several key changes are designed to ease the reporting burden while maintaining quality oversight.

Key updates for 2026 include:

- **Removed Measures:** COVID-19 vaccination coverage and health equity/SDOH measures are being removed.
- **New Requirements:** Two oncology-stratified Healthcare-Associated Infection (HAI) measures and additional hospital-harm eQMs have been added.
- **Hybrid Measures:** Reporting thresholds have been lowered, and rules now allow for limited missing data in response to feasibility feedback.
- **Claims-Based Measures:** Measures such as COMP-HIP-KNEE and MORT-30-STK will now include Medicare Advantage patients and utilize a shorter, two-year performance window with ICD-10 coding.
- **Future Adjustments:** CMS plans to remove COVID-19 exclusions from all relevant measures starting with the FY 2028 reporting year.

To remain compliant and protect Medicare reimbursement, hospitals must continue to meet all quarterly and annual reporting obligations across chart-abstracted measures, eQMs, hybrid and structural measures, and HCAHPS data.

❖ Office Hours: Your Questions Answered



This newsletter is one of the many ways Direct Difference supports our partners by sharing insights drawn from actual abstraction experience across hospitals nationwide.

If there are specific topics you would like us to cover in a future issue, or if you have questions, please reach out to your Direct Difference contact or email us at **ASKDD@directdifference.com**. We value your feedback and are always listening.

✓ Common Client Question of the month

Q: If documentation is clarified after abstraction, do we need to update the record?

A: If the new documentation affects eligibility, numerator status, or exclusions, the abstracted data should be updated to reflect the most accurate and compliant interpretation. When in doubt, consistency and documentation are your strongest defenses.

❖ The Difference Update

✓ Direct Difference New Service Capabilities

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Message from the CEO- Debra Aruffo

At the heart of Direct Difference, Inc. is a steadfast commitment to loyalty, integrity, and long-term partnership. We seek to cultivate enduring relationships with healthcare leaders—partnerships grounded in trust, transparency, and a shared responsibility to advance the quality of care.

As part of this commitment, we have strategically expanded our services to include abstraction of the Cancer Registry and the Trauma Registry. This expansion reflects our continued investment in supporting hospitals and health systems as they navigate increasing regulatory complexity, accreditation requirements, and quality improvement expectations.

High-quality cancer and trauma registry data are foundational to outcomes analysis, performance benchmarking, research advancement, and reimbursement integrity. Our expanded team brings deep expertise in registry standards, compliance frameworks, and rigorous clinical abstraction to ensure that data is accurate, reliable, and decision ready.

