Direct Difference Digest

Turning Quality Data into Confident Submissions

Fall Edition | November 2026

News, Insights, and Announcements

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Executive Brief

Note from the Editor

Welcome to the second edition of the Direct Difference Digest. This issue focuses on the operational decisions that protect data integrity, support confident submissions, and strengthen quality performance across today's increasingly complex reporting environment.

Inside, we explore high-impact priorities for quality leaders: sepsis bundle timing, GWTG-Stroke abstraction, EHR-driven data shifts, data validation readiness, and CMS reporting trends. Each article helps teams identify risks earlier, align stakeholders, and act with greater confidence.

Leadership Call to Action: Do not wait for a missed deadline, validation finding, or unexpected performance shift to uncover reporting risk. Use this issue to convene your quality, clinical, IT, CDI, coding, and abstraction partners; confirm where documentation, workflow, mapping, or interpretation gaps may exist; and engage your Direct Difference team early to strengthen confidence before submission.

Data, Measures & Performance Improvement

Measure Up – Andrea Romo, Clinical Liaison

A. Sepsis Bundle Compliance: Why Timing Matters

SEP-1 performance depends on timely care and documentation that aligns with the measure's abstraction rules. Because those rules may establish a presentation time that differs from when a provider recognized sepsis or signed the note, every relevant event must be linked to a clear, supportable time.

Timing Elements to Validate

- Presentation time
- Sepsis identification time
- Lactate collection
- Blood culture collection
- Antibiotic administration
- Fluid resuscitation
- Repeat lactate, when required

Operational Risks to Watch

1. Documentation timing may differ from clinical recognition
   Infection and explicit severe sepsis documentation follow different timing rules. Abstractors must evaluate each qualifying pathway and apply the earliest supported presentation time.

Real-world scenario:

- An ED note is opened early in the encounter. The provider later documents severe sepsis without specifying when it began. The applicable rules may associate that untimed diagnosis with the earlier note-open/start time, changing the windows used to evaluate bundle compliance. Arrival time is not automatically the presentation time.
- **DD Insight:** Clearly associate times with the events being documented. A later diagnosis entry or signature does not necessarily move the abstraction clock forward.

2. Reduced fluid volume requires complete documentation

Real-world scenario:

- A patient receives less than 30 mL/kg because of fluid-overload concerns. A smaller bolus is ordered, but the ordering provider does not document both the reduced target volume and the reason in the same note or order. If the required target is not otherwise met, the fluid element may fail despite a valid clinical rationale.
- Documentation example: "Administer 500 mL normal saline IV over 1 hour as the reduced target volume instead of 30 mL/kg because of concern for fluid overload."
- **DD Insight:** The ordering physician/APN/PA must document the specific or weight-based lesser volume and its reason together. "Give a bolus and reassess" alone does not establish the reason for less fluid. This example illustrates documentation, not a recommended treatment volume; all applicable ordering, timing, and administration requirements still apply.

Key Takeaway: Providers, nurses, and abstraction teams should collaborate, so the record clearly supports both the care delivered and the applicable measure requirements.

SEP-1 reference: CMS inpatient specifications. Use the version applicable to the discharge period: v5.18a for 2026 discharges and v5.19 for 2027 discharges.

Why This Matters for Leaders

SEP-1 abstraction is most reliable when clinical care, documentation timing, and measure requirements are aligned. Even strong care can be underrepresented when documentation is delayed, incomplete, or inconsistent.

B. GWTG-Stroke: Why the Details Behind the Data Matter

Accurate stroke abstraction requires consistent application of registry rules to the documentation source, clinical timeline, and applicable treatment window.

1. Which Last Known Well time applies?

   Last Known Well (LKW) is the time the patient was last known to be free of the current stroke symptoms or at their baseline. It is not automatically the symptom-discovery time or the earliest time documented in the chart.

   Real-world scenario:

- Neurology documents LKW as 10:00 a.m., the ED physician as 9:30 a.m., and ED nursing as 9:15 a.m. The GWTG hierarchy prioritizes neurology, followed by the admitting physician, ED physician, ED nursing, and EMS. Neurology's 10:00 a.m. therefore takes precedence. If the same provider documents conflicting values, use the value with the earliest recorded date and time.
- **DD Insight:** Apply the instructions for specific circumstances. If symptoms are fully resolved, the patient is documented as returning to baseline, and symptoms later recur, GWTG uses the most recent episode. TJC certification fields may require different values, so verify auto-populated responses.

2. The reason for non-treatment may change

   Real-world scenario:

- During the 0–3-hour window, the physician documents that IV thrombolytic therapy is withheld because of elevated blood pressure. After treatment, systolic pressure falls to 150 mm Hg at 3.5 hours, but no additional reason for non-treatment is documented.
- **DD Insight:** When the clinical condition changes, the earlier reason does not automatically extend into the 3–4.5-hour window. Apply the documentation requirements and allowable exceptions to each window; do not infer a reason from diagnoses or vital signs alone.

Key Takeaway: Reliable abstraction depends on source hierarchy, precise documentation, and recognition of changing circumstances. The abstraction result alone does not determine whether treatment should have been administered.

GWTG-Stroke reference: AHA registry resources. Refer to the applicable coding instructions in the participating site's registry library.

From Chart to Change

When the EHR Changes, Does Your Quality Data Change?

EHR upgrades may improve workflows, but every upgrade, optimization, interface change, or redesigned template should prompt one essential reporting question: **Did the change affect what we report?**

This question is increasingly important as CMS continues expanding electronic quality reporting expectations and publishing annual eCQM specification and implementation updates.

Quality leaders must confirm that the EHR continues to capture **the right data, in the right format, at the right time.**

A Hospital Scenario: The EHR Upgrade That Changed the Numbers

A hospital completed a major EHR upgrade that improved workflows, updated documentation templates, and streamlined physician and nursing processes.

Months later, the Quality Department noticed a significant eCQM performance-rate change compared with the previous reporting period.

The initial review showed that the change did not reflect a clear shift in clinical performance. Instead, the team identified several changes in EHR workflows:

- The documentation field had moved to a different location.
- A previously structured data element was now being captured differently.
- Several codes had been remapped.
- A workflow change affected how certain clinical information was entered.
- The quality team had not been notified that the measure-related data elements were affected by the upgrade.

The result? Care had not necessarily changed; the way the EHR captured it had.

The quality team partnered with IT, clinical leadership, HIM/CDI, and EHR analysts to trace the measure from CMS specification to patient record, correct the source issue, and validate the results.

Leadership Lesson: EHR implementation is not complete at go-live; reporting integrity must be validated after the system changes.

For quality reporting, the key question is: **Did the new system preserve data integrity?**

What Quality Leaders Should Watch

1. Data Mapping

A clinically correct data element can produce an incorrect measure result if it is mapped to the wrong code or value set. Review EHR-to-value-set mapping,

duplicate encounters, and missing key data elements when investigating QRDA submission issues.

2. Changes in Documentation Workflows

When clinicians begin documenting information in a new location—or using a new template—the data may no longer flow into the measure as expected.

Ask: Did the clinical workflow change, or did only the EHR workflow change?

3. Structured vs. Unstructured Data

The fact that information exists somewhere in the medical record does not necessarily mean that it is available to the eCQM. Quality teams should understand whether required data elements are being captured as discrete, structured data and whether those elements remain available to the measure logic.

4. Measure Specification Updates

CMS updates eCQMs annually, including measure logic, terminology, value sets, and technical requirements. Teams should review release notes, complete gap analyses, address workflow impacts, and educate clinicians when data-entry workflows change.

5. Unexpected Changes in Numerators and Denominators

A sudden change in performance should prompt a question:

Did patient care change—or did the data change? Unexpected shifts in denominators, exclusions, numerator performance, or case volume may signal an EHR, mapping, workflow, or measure-implementation issue.

6. Validation After Go-Live

Validate early rather than waiting for the reporting deadline. Review QRDA Category I test files, submit early, when possible, monitor system messages, and compare observed performance rates with submitted data.

7. Communication Across Departments

Quality, IT, clinical informatics, HIM/CDI, coding, clinical leadership, and EHR analysts each bring an important view of the process. The strongest approach is to bring those perspectives together before and after major system changes.

A Simple Quality Check

When your hospital implements a major EHR change, ask:

Before Go-Live

- Which quality measures are affected?
- Which data elements feed those measures?
- Are any codes, fields, templates, or workflows changing?
- Has data mapping been reviewed?
- Have clinicians been educated about documentation changes?

After Go-Live

- Did numerator and denominator volumes change unexpectedly?
- Are exclusions occurring as expected?
- Are required data elements still being captured discretely?
- Do electronic results match the underlying medical record?
- Were test files validated?
- Have unexpected results been investigated before submission?

Key Takeaway:

- An EHR upgrade is also a quality reporting event.
- When data shifts, ask whether the data, documentation, measure logic, or all three changed.
- Reliable reporting depends on alignment among CMS specifications, EHR configuration, clinical documentation, and validation.

Data to Difference

Building Defensible Abstraction Practices

Defensible abstraction depends on a standardized process that reduces variation, supports consistent decisions, and protects reporting integrity across reviewers.

Common Operational Challenges

- Variability in interpretation of exclusion logic
- Inconsistent use of abstraction notes
- Documentation scattered across scanned records and multiple systems
- Late provider documentation affecting measure outcomes
- Lack of formal escalation pathways for ambiguous cases

Direct Difference Approach

- Conduct monthly Inter-Rater Reliability (IRR) reviews
- Maintain standardized abstraction guidance tools
- Perform secondary reviews on high-risk abstraction scenarios
- Provide validation support and chart review assistance
- Collaborate directly with client teams on documentation clarification trends

Key Takeaway: Standardized guidance, formal escalation pathways, secondary review, and monthly IRR monitoring help leaders reduce compliance risk and support defensible reporting.

Partners in Accuracy: Supporting You Through External Data Validation – Brenda Clemens, Chief Quality Officer

An external data validation notice can create immediate urgency for the hospital's quality department. Reviews through CMS's Clinical Data Abstraction Center (CDAC) or national registries, such as the American College of Cardiology's National Cardiovascular Data Registry (NCDR) and the Society of Thoracic Surgeons (STS), help confirm the accuracy of submitted data. These data support public reporting, national benchmarks, and, in many cases, payment. Validators re-abstract a sample of cases to confirm that reported information matches the medical record.

At Direct Difference (DD), external validation is a shared responsibility. Your team maintains medical records and oversees submissions; we provide guidance, preparation, and ongoing support. Together, we can resolve discrepancies, strengthen data integrity, and help ensure reported results accurately represent the care delivered.

Support from Selection Through Final Results

Responding to selection

Validation notices may come with tight deadlines. Contact your Direct Difference Account Manager as soon as you receive one. DD also checks CMS-published hospital selection lists against our client roster to identify CDAC selections promptly. Your Account Manager will explain the process, timelines, and next steps.

Preparing cases for review

After the validator selects cases, your Account Manager helps coordinate the submission packet and confirm that it includes all required medical records and supporting documentation. Complete records help prevent avoidable discrepancies and additional work.

Assessing validation findings

Share your accuracy report with your Account Manager promptly. DD reviews the findings with you, compares reported mismatches with available documentation and applicable specifications, and considers relevant clarifications. We help identify issues that may merit further review and discuss the next appropriate steps.

Exploring appeals and educational reviews

Review and dispute procedures differ by program and may have short deadlines. An educational review or adjudication may be available, depending on the program and circumstances. DD can help assess review options, develop supporting rationale, and prepare documentation. Program-specific requirements and deadlines must guide the final decision and submission.

Turning findings into improvements

Each validation offers lessons that can strengthen processes beyond the review. DD shares relevant findings and lessons with your team and our Clinical Liaison, Account Management, and Abstraction teams. Together, we can identify ways to improve documentation, clarify workflows, and reduce recurring discrepancies.

How You Can Support the Process

- Maintain prompt communication and timely documentation throughout validation.
- Alert your Account Manager promptly when a validation notice arrives and share all applicable deadlines.
- Share the selected case list as soon as it is available.
- Supply requested medical records and supporting documentation in time for submission deadlines.
- Send accuracy reports immediately upon receipt to preserve available review or appeal windows.
- Work with DD to coordinate applicable review or appeal submissions and meet their deadlines.
- Provide the final report, including post-review or post-appeal results, to complete the process and capture lessons learned.

Early communication, complete documentation, and coordinated support can make external data validation more manageable—and turn it into an opportunity to demonstrate data integrity, improve reporting processes, and build confidence in your quality results.

The Direct Difference commitment: As your partners in accuracy, we support you from the first notice through final results—helping you navigate validation, address discrepancies, and translate findings into opportunities for improvement.

Compliance Corner

Deadline Watch: Important Reporting Reminders

Hospital IQR & OQR Reporting
Organizations should continue monitoring:

- Quarterly chart-abstracted data submission deadlines
- eCQM annual submission timelines
- HCAHPS submission requirements
- Structural measure reporting deadlines
- NHSN reporting requirements for HAI measures

Key Operational Reminder:
Internal abstraction and validation timelines should allow sufficient time for:

- Secondary review
- Re-abstraction if needed
- Documentation clarification
- Final submission quality checks

Recommended Action:

Review internal reporting calendars quarterly so abstraction, validation, documentation clarification, and final submission checks have adequate time built into the process.

Finalized: New Measures

Measure	Finalized Performance Period/ Payment Determination
Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes	July 1, 2025–June 30, 2027/FY 2029
Hospital Harm (HH) – Postoperative Venous Thromboembolism (VTE) eCQM	CY 2028/FY 2030
Advance Care Planning eCQM	CY 2028/FY 2030

Reference: Hospital Outpatient Quality Reporting Program Newsletter, Fall 2026. Confirm current program-specific deadlines on QualityNet before submission.

Finalized Adoption: EDAC After Hospitalization for Diabetes

- **Measure Rationale:** Assesses the number of days a patient spends in acute care within 30 days of discharge from an inpatient hospitalization for a diagnosis of diabetes mellitus with complications
- **Numerator:** The number of days a patient spends in acute care for any cause, within 30 days of discharge from the index hospitalization for diabetes
- **Denominator** includes:
  1) Principal diagnosis of diabetes;
  2) Medicare Fee for Service or Medicare Advantage;
  3) 65 or older;
  4) Discharged alive from a non-federal short-term acute care hospital: and
  5) Not transferred to another acute care facility

Finalized Adoption: HH-Postoperative VTE eCQM

- **Measure Rationale**: Risk-adjusted measure of postoperative VTE during hospitalization or within 30 days of the first operating-room procedure among inpatients age 18 and older
- **Numerator**: Number of inpatient hospitalizations for adult patients who had a surgical procedure performed in the operating room during the hospitalization and experienced a VTE within 30 days of the surgical procedure
- **Denominator**: Number of adult patients who had a surgical procedure performed in the operating room during an inpatient hospitalization

Finalized Removal of Current Hospital IQR program Measures

Measure Name	Finalized Timeline for Removal
Venous Thromboembolism Prophylaxis eCQM	Beginning with the CY 2028 reporting period/FY 2030 payment determination
Intensive Care Unit Venous Thromboembolism Prophylaxis eCQM	
Discharged on Antithrombotic Therapy eCQM	

Finalized: eCQM Reporting and Submission Requirement

Reporting Period/ Payment Determination	Total # of eCQMs Reported	Required eCQMs	Self-Selected eCQMs
CY 2028/FY 2030 and CY 2029/FY 2031	14	• Safe Use of Opioids • Perinatal Care (PC)-07 • PC-02 • MCS • HH-Severe Hyperglycemia (HYPER) • HH-Severe Hypoglycemia (HYPO) • HH-Opioid-Related Adverse Events (ORAE) • HH-Pressure Injury (PI) • HH-Acute Kidney Injury (AKI) • HH-Falls with Injury (FI) • HH-Postoperative Respiratory Failure (RF)	• Stroke (STK)-03 • STK-05 • IP-Excessive Radiation (ExRad) • Advance Care Planning • HH-VTE
CY 2030/FY 2032	15	• Safe Use of Opioids • PC-07 • PC-02 • MCS • HH-HYPER • HH-HYPO • HH-ORAE • HH-PI • HH-AKI • HH-FI • HH-RF • HH-VTE	• STK-03 • STK-05 • IP-ExRad • Advance Care Planning

Finalized Updates: Additional Mandatory eCQM

- Require mandatory reporting of the Malnutrition Care Score (MCS) eCQM beginning with the CY 2028 reporting period/FY 2030 payment determination.
- Finalized a policy to automatically make Hospital Harm eCQMs mandatory after two years of "self-selected" reporting beginning with CY 2028 reporting period/FY 2030 payment determination.
- Finalized the public reporting of the Hospital Harm measures with modification.
  - First year of mandatory reporting, data will display on the Production Data Catalog only.
  - Second year of mandatory reporting, data will be moved to Care Compare and be included in Star Ratings.

Reference: Hospital Outpatient Quality Reporting Program Newsletter, Fall 2026. Confirm current program-specific deadlines on QualityNet before submission.

CMS Compass: CMS Reporting Trends to Watch

CMS continues focusing on:

- Reducing administrative burden while maintaining accountability
- Expanding use of electronic quality reporting
- Increasing reliance on claims-based methodologies
- Enhancing patient safety and hospital harm reporting
- Improving data interoperability and reporting standardization

Areas Receiving Increased Attention:

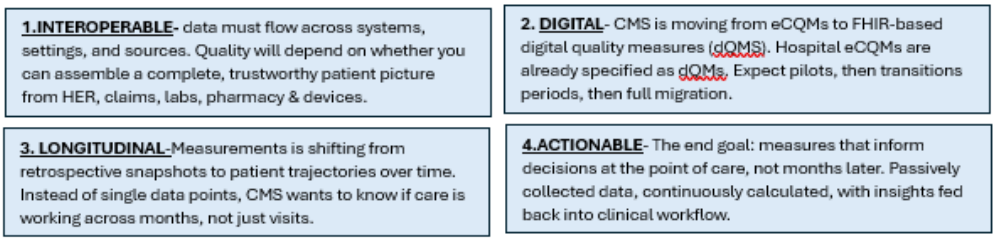
- Healthcare-associated infection reporting
- Hospital harm eCQMs
- Hybrid measure implementation
- Medicare Advantage inclusion within claims-based measures
- Changes to structural and patient safety measures, including removal of the Hospital Commitment to Health Equity and social drivers of health screening measures from the Hospital IQR Program

What This Means for Leaders: Protect reporting integrity by bringing quality, clinical, IT, CDI, coding, and abstraction teams together before and after system changes. Early alignment supports compliance, protects reimbursement, and reduces the risk of discovering reporting issues close to submission.

The Regulatory Landscape: Where CMS is Heading

Quality measurement is moving toward a more interoperable, digital, longitudinal, and actionable model. Leaders should distinguish finalized requirements from

broader strategic trends and confirm the reporting period and payment year associated with each change.



Reference: CMS Hospital IQR Specifications Manual, v5.18a addendum, September 19, 2025; eCQI Resource Center, 2026 eCQM specifications and implementation resources.

Key Updates

Information Transfer PRO-PM: Preparing for Mandatory Reporting in CY 2027

The Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery PRO-PM (Information Transfer PRO-PM) assesses a patient's understanding of clear, personalized recovery information provided following an outpatient procedure or surgery. Clear discharge and recovery instructions can help improve patient safety, support recovery, and reduce avoidable complications and follow-up visits.

What is measured?

The measure evaluates patient ratings on a nine-item survey covering three domains. The survey is administered 2–14 days after the procedure and assesses the clarity of information provided before, during, and after the outpatient surgery or procedure:

- Patient Needs: Whether information was tailored to the patient's health needs and personal circumstances.
- Medications: Whether instructions regarding medications, side effects, and medication discontinuation were clear.
- Daily Activities: Whether guidance about diet, physical activity, returning to work, and driving was clear and easy to understand.

Measure performance is based on the percentage of the most positive responses ("Yes" or "Very Clear"), with higher scores indicating better patient understanding of recovery information.

Who is included?

- Patients aged 18 years and older.
- Patients with eligible outpatient procedures and surgeries performed in a Hospital Outpatient Department (HOPD) using procedures billed with CPT codes 10004-69990, or G-codes G0104, G0105, G0121, or G0260.
- Patients who left the HOPD alive and responded to the survey.

Reporting Requirements

- Mandatory reporting begins with the CY 2027 reporting period (January 1–December 31, 2027).
- The first submission deadline is May 15, 2028. Data must be submitted through the HQR system.
- HOPDs must offer the survey to all eligible patients or caregivers.
- Facilities should obtain a minimum of 300 complete surveys through random sampling when feasible. Facilities unable to obtain 300 complete surveys must submit all completed survey responses received.

Preparing for Implementation

Hospitals are encouraged to review patient education, discharge instruction, and survey administration processes to support successful implementation. Additional information, including measure specifications, methodology, submission

requirements, and reporting timelines, is available in the Hospital Outpatient Specifications Manual on the *QualityNet website*.

Program Support

For additional information, tools, and submission checklists, visit the "Participation" section of the Hospital OQR Program QualityNet website. The Quality Reporting Center also provides program resources and webinars.

Office Hours: Your Questions Answered

Office Hours highlight practical questions from client teams and shares lessons from real-world abstraction and reporting scenarios.

Have a question about abstraction, quality measures, documentation, or reporting requirements? Contact your Direct Difference representative or email **ASKDD@directdifference.com**. Your question may help shape a future issue or Office Hours topic.

Common Client Question of the Month

Q: What should we do when provider documentation conflicts across multiple notes?

A: Start with the current measure specifications and your organization's guidance to determine which documentation source should be prioritized. If ambiguity remains, use the defined escalation pathway and document the rationale consistently.

The Difference Update

A Message from Misti Pacheco, COO, Direct Difference

Team Strategy: Strengthening the Direct Difference Partnership

Healthcare quality reporting places significant demands on hospital teams. As measures, timelines, and documentation requirements evolve, Direct Difference supports clients with more than abstraction—we listen, share expertise, answer questions, and work alongside teams to strengthen accuracy, clarity, and patient-centered quality.

To make that support easier to access, we have strengthened our team structure around one goal: helping clients connect with the right person at the right time. Our model brings together operational coordination, clinical expertise, infection prevention knowledge, and quality oversight so teams receive clear communication, thoughtful guidance, and dependable support throughout the reporting process.

One Team. Multiple Perspectives. One Goal.

This approach reflects how we want every partnership to feel: responsive, collaborative, and solution focused. By aligning abstraction support, clinical interpretation, quality oversight, and client communication, we can answer questions sooner, identify concerns earlier, and strengthen confidence in the data.

Most importantly, this structure is an investment in the client relationships we value. We look forward to learning what matters most to your teams, offering practical guidance when questions arise, and providing steady support as you prepare, validate, and submit quality data.

Your Direct Difference Support Team

Account Manager | AM: Serves as your primary contact for day-to-day needs, coordinating abstraction services, workflows, communication, and follow-up.

Clinical Liaison | CL: Offers clinical and measure-specific expertise, promotes data quality and reporting accuracy, and leads clinical workflow design and education.

Quality Officer | QO: Provides strategic quality oversight, monitors performance and compliance risks, addresses escalated concerns, and promotes alignment with regulatory/contractual requirements and continuous improvement goals.

Meet Our Difference Makers

Behind every confident submission is a team committed to accuracy, partnership, and meaningful improvement. In each issue, we introduce Difference Makers whose clinical knowledge, quality experience, and service mindset help support the clients and communities we serve.

⭐ Difference Maker Spotlight



Andrea Romo, BSN, RN
Clinical Liaison | Direct Difference

Andrea Romo is a registered nurse and healthcare quality professional experienced in clinical data abstraction, hospital quality reporting, measure implementation, and operational leadership. She supports hospitals and health systems nationwide with large-scale abstraction services, clinical registries, and education aligned with organizational quality goals.

Andrea earned her BSN from the University of Texas in 2011. Her background includes emergency, critical, cardiac, and stroke care, ICU Director experience, and prior CCRN certification. At Direct Difference, she advanced from Clinical Data Abstractor to Account Manager, Senior Account Manager, and Clinical Liaison.

Her CMS measure expertise includes sepsis, and she translates specification updates into practical guidance.

Andrea educates abstraction teams, providers, and hospital clients; develops CMS CDAC validation protocols for inpatient and outpatient reporting; and supports challenges to inaccurate findings and related annual payment update reductions. She also identifies printed-chart and data-presentation issues affecting validation and has helped hospitals across multiple states maintain Get with The Guidelines Honor Roll and Gold recognition.

As Clinical Liaison and Multi-Clinical Measure Lead, Andrea provides clinical and operational guidance on accurate abstraction, regulatory compliance, documentation, and performance improvement—from individual case reviews to health-system implementations.



Holly Rotan, MSN, APRN, AGACNP-BC
Clinical Data Specialist & Account Manager, Direct Difference

Holly Rotan brings a practical, highly experienced clinical perspective to her work with Direct Difference. Her background spans emergency medicine, trauma, hospital medicine, critical care, and healthcare quality improvement, giving her a strong understanding of how bedside care, documentation, abstraction, and quality reporting connect.

Holly began her nursing career in emergency and trauma care after earning her Bachelor of Science in Nursing from the University of South Carolina. She later moved into a quality-focused role supporting sepsis measure implementation, where she helped develop compliance processes and led provider education on sepsis recognition, documentation, and evidence-based care.

After earning her Master of Science in Nursing in 2015, Holly began practicing as an Acute Care Nurse Practitioner. Her advanced practice experience in hospital medicine and critical care gives her a valuable perspective on the connection between bedside care, documentation, quality measures, and regulatory requirements.

Today, Holly serves as an Account Manager and Clinical Data Specialist with Direct Difference, partnering with healthcare organizations and abstraction teams to support accurate abstraction, measure compliance, validation, education, and performance improvement. Her clinical background helps translate complex requirements into practical, actionable conversations for hospital teams.



Patricia Walker, RN-BC, BSN, CPHQ, CVAHP
Clinical Data Specialist & Account Manager, Direct Difference

Patricia Walker is a Registered Nurse and healthcare quality leader with more than 25 years of experience in patient safety, quality improvement, clinical data analysis, and evidence-based organizational performance improvement.

She has held quality and patient safety leadership roles at UC Irvine Medical Center, Ronald Reagan UCLA Medical Center, Cedars-Sinai Medical Center, Providence Saint Joseph Medical Center, and Children's Health. At UC Irvine, she led nurse and business analysts in eCQM development, readmission and mortality review, regulatory readiness, and physician–nursing collaboration. Her leadership contributed to a Vizient Top 10 Patient Safety and Quality Award and the #1 Vizient mortality performance ranking.

Patricia earned her BSN from Western Governors University and holds certifications in Healthcare Quality (CPHQ), Value Analysis (CVAHP), and Gerontological Nursing (RN-BC). Her expertise includes CMS compliance, Core Measures, clinical documentation improvement, regulatory readiness, and clinical value analysis.

As an Account Manager at Direct Difference, Patricia partners with hospital clients and leadership teams to support quality initiatives, interpret performance data, identify improvement opportunities, and strengthen data reliability.

Closing Note

Thank you for reading this edition of Direct Difference Digest. We hope these insights help your team feel prepared, supported, and confident in the quality data behind every submission. If a topic in this issue raises a question—or if there is something you would like us to cover next—please contact your Direct Difference representative or email **ASKDD@directdifference.com**. We are always glad to hear from you.