AHRQ Quality Indicators™

AHRQ QIs Fact Sheet: FAQs on the SAS QI and WinQI v2022 Software

Prepared for:

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Contract No. HHSA290201800003G

July 2022

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AHRQ Quality Indicators (QIs) Software Product Information

1. What year of data do the SAS QI and WinQI v2022 software support?

The v2022 software supports Fiscal Year (FY) 2022 (October 2021 to September 2022) data.

2. Is the v2022 software backwards compatible?

Yes, the software is backward compatible, meaning that it supports discharges classified under International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) retroactively through October 2015.

3. Does the v2022 software address the 2019 Novel Coronavirus (COVID-19)?

The AHRQ QI v2022 Software continues to include methodology to account for COVID-19 discharges for hospital-level indicators. Starting with AHRQ QI v2021 in modules that include hospital-level indicators (IQI, PDI, PSI), users have the following options to specify how to handle COVID-19 discharges in the CONTROL program for each module:

- Option 1: The user can exclude COVID-19 discharges. This is recommended and is therefore the default choice. The software will calculate risk-adjusted rates, smoothed rates, and composites.
- Option 2: The user can include all discharges, with and without COVID-19. The software will only calculate numerators, denominators, and observed rates.
- Option 3: The user can include only COVID-19 discharges. The software will only calculate numerators, denominators, and observed rates.

Because the 2019 HCUP reference population pre-dates the public health emergency, the software will suppress expected rates, risk-adjusted rates, smoothed rates, and composites for hospital indicators when a user includes COVID-19 discharges. In other words, users can only calculate expected, risk-adjusted, smoothed rates, or composites when they select the default to exclude COVID-19 discharges. This approach is consistent with previously published user guidance. We will continue to monitor published evidence on COVID-19 and update user guidance as necessary.

COVID-19 User Guidance is available here:
https://qualityindicators.ahrq.gov/Downloads/Resources/COVID19_UserNote_July2021.pdf

4. What processes does AHRQ follow when determining what changes and refinements to make when the QI software is updated?

Potential refinements to the QI software are based on user feedback, literature review and environmental scans, and diagnosis and procedure coding changes. AHRQ evaluates these potential changes for their feasibility and priority, and those selected for implementation are tested and reviewed before being incorporated into new releases of the AHRQ QI software.

Risk-Adjusted Software Information

5. Is the AHRQ QI v2022 software (SAS QI and WinQI) risk-adjusted?

Yes, risk adjustment is supported in the SAS QI and WinQI v2022 ICD-10-CM/PCS software. Risk adjustment is available for the following indicator groups by module:

- Prevention Quality Indicator (PQI) area-level indicators
- Inpatient Quality Indicator (IQI) hospital-level indicators
- Patient Safety Indicator (PSI) hospital-level indicators
- Pediatric Quality Indicator (PDI) area-level and hospital-level indicators

AHRQ QI software users continue to have the option to produce stratified rates. Starting in v2021, expected rates, risk-adjusted rates, smoothed rates, and composites will be suppressed in certain situations for hospital-level indicators, including all PSIs, IQIs, and hospital-level PDIs. Because age, gender, age in days, and birth weight are used in risk-adjustment models, it is inappropriate to produce risk-adjusted rates for any stratum that includes these variables. Additionally, the software will suppress expected rates, risk-adjusted rates, smoothed rates, and composites for hospital-level indicators for PSI and IQI modules when major diagnostic categories (MDC) are missing or incomplete. Users interested in calculating expected, risk-adjusted, smoothed, or composite values for hospital-level indicators must have MDCs assigned for each discharge on their input file. The AHRQ QI v2022 PSI and PDI modules will also suppress expected rates, risk-adjusted rates, smoothed rates, and composites for measures that use PRDAYn information (PSI 04, 09, 10, 11, 12, 14, 15, and PDI 08 and 09) when PRDAYn is missing or incomplete.

Specific Coding and Indicator Updates in v2022

6. What coding updates are included in the SAS QI and WinQI v2022 software?

The v2022 software release includes coding updates to align with the latest ICD-10-CM/PCS coding guidance. For a complete list of the indicator level changes, refer to the Change Logs for each module which are available at:

- Prevention Quality Indicators (PQIs): https://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2022/ChangeLog_PQI_v2022.pdf
- Inpatient Quality Indicators (IQIs): https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2022/ChangeLog_IQI_v2022.pdf
- Patient Safety Indicators (PSIs): https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2022/ChangeLog_PSI_v2022.pdf
- Pediatric Quality Indicators (PDIs): https://qualityindicators.ahrq.gov/Downloads/Modules/PDI/V2022/ChangeLog_PDI_v2022.pdf

7. Is there a log of code-specific changes for each indicator?

To address questions around identifying codes that changed, AHRQ developed a listing of code changes as a supplement to the change log beginning with v2022.

For a complete list of code set changes, please refer to Code Set Change Log for each module:

- Prevention Quality Indicators (PQIs): https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2022/AHRQ_PQI_v2022_Code_Set_Changes.xlsx
- Inpatient Quality Indicators (IQIs): https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2022/AHRQ_IQI_v2022_Code_Set_Changes.xlsx
- Patient Safety Indicators (PSIs): https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2022/AHRQ_PSI_v2022_Code_Set_Changes.xlsx
- Pediatric Quality Indicators (PDIs): https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2022/AHRQ_PDI_v2022_Code_Set_Changes.xlsx

Additionally, AHRQ has developed the Impact of Fiscal Year Coding Updates memo, detailing code sets changed resulting from annual fiscal year coding updates rather than indicator refinements. The memo is available at: https://qualityindicators.ahrq.gov/Downloads/Modules/V2022/v2022_FY_Coding_Updates.pdf

8. What are some of the major updates in the SAS QI and WinQI v2022 software?

Some major updates that are included in the v2022 QI software include:

- The v2022 SAS QI and WinQI software is risk adjusted using 2019 HCUP State Inpatient Databases (SID) data.
    - The IQI module removed the All-Patient Refined Diagnosis Related Groups (APR-DRGs) for the risk adjustment of procedure-based IQIs.
    - The IQI module utilizes the Clinical Classification Software Refined (CCSR) for ICD-10-CM Procedures.
    - An indicator for Do Not Resuscitate (DNR) was added to the condition-based IQIs for potential feature selection.
    - A risk category for non-ST-elevation myocardial infarction (non-STEMI) was added for potential feature selection to IQI 15 – Acute Myocardial Infarction (AMI) Mortality Rate.
    - A risk category for cardiac arrest, cardiogenic shock, or anoxic brain injury that is present on admission (POA) was added for potential feature selection to IQI 12 – Coronary Artery Bypass Graft Mortality Rate and IQI 30 – Percutaneous Coronary Intervention Mortality Rate.
    - Added risk categories based on the counts of minor and major diagnostic procedures and minor and major therapeutic procedures for PSI 15 – Abdominopelvic Accidental Puncture or Laceration Rate.
    - Added risk categories based on high-risk and intermediate-risk immune compromising conditions for PSI 13 – Postoperative Sepsis Rate.
- Implemented coding updates: (1) are based on fiscal year 2022 ICD-10-CM/PCS, (2) are compatible with ICD-10-CM/PCS hospital data for F16-FY22, and (3) coding changes impact all software modules.
- PQIs and area-level PDIs risk adjustment accounts for age and gender and include an optional adjustment for poverty.
    - Poverty is defined using the 2019 U.S. Census Small Area Income and Poverty Estimates (https://www.census.gov/programs-surveys/saipe/data.html).
    - Computes county-level risk adjustment

9. What are some of the improvements made to the v2022 SAS QI software?

- Improved labeling, comments, and consistency in names for variables, parameters, and files
- Provides options to address COVID-19 discharges for hospital-level indicators
- Updated measure calculation and risk adjustment suppression based on MDC information
- Added option to produce a text file from the COMPOSITE programs of the IQI and PSI modules
- Updated documentation for automating scheduled SAS QI runs is available at: https://qualityindicators.ahrq.gov/Downloads/Software/SAS/V2022/Automate_SAS_QI_Software_Runs_in_Windows.pdf
- Instructions for using the v2022 SAS QI software is available at: https://qualityindicators.ahrq.gov/Downloads/Software/SAS/V2022/Software_Inst_SASQI_v2022_July_2022.pdf

10. What are some of the improvements made to the v2022 WinQI software?

- Support for fiscal year 2022 code.
- WinQI's user interface (UI) was redesigned in v2022 to improve the screen layout and design.
- Common UI elements are used to make screens look modern and consistent across the entire application.
- On the home screen, the layout has been significantly changed to represent the process workflow explicitly and intuitively for users.
- The input data files can now be uploaded by dragging and dropping the input files.
- A new section has been added on the home screen to show the last run reports for users to quicky and easily re-run the reports if needed.
- On the input data import process wizard, the "Data Field Mapping" screen is re-organized so that the "required variables" and "missing recommended & other variables" blocks are now separated out for distinction and easy recognition.
- Additionally, on the input data import process wizard, separate cards are added for "Excluded QI values", "Missing QI values", and "Matched QI values" on top of the screen to help users identify and fix any data crosswalk mismatch issue easily and quickly.
- Users can now view additional reports, "Advanced Composite Reports" for IQI 90, 91, and PSI 90. This allows users to better understand the components used in the composite calculation.
- Automation features have been improved to allow users to call the automation batch script files with parameters that would overwrite the initial values included in the

automation batch file. These parameters include – 1) input data files, 2) mapping files, and 3) export location for your output. This will help users make their automation much more dynamic.

- Users can also now initiate the command line automation batch calls from within the application via the user interface (UI). The UI now also supports running WinQI as service so WinQI can run in the background as a service when automating your process.
- The software will notify users of all software updates. By accepting the v2022 update, it will automatically uninstall the prior version and install v2022.
- Updated measure calculation and risk-adjustment suppression based on MDC information provided by the user.
- Instructions for using the v2022 WinQI software is available at: https://qualityindicators.ahrq.gov/Downloads/Software/WinQI/V2022/Software_Inst_WINQI_V2022_July_2022.pdf

11. Were any indicators retired in the v2022 software?

No indicators were retired in the v2022 software.

12. What versions of Healthcare Cost and Utilization (HCUP) Tools are used for the AHRQ QI v2022 software?

v2022 AHRQ QI software uses:

- Agency for Healthcare Research and Quality. Elixhauser Comorbidity Software Refined for ICD-10-CM v2022.1. Healthcare Cost and Utilization Project (HCUP). October 2021. www.hcup-us.ahrq.gov/toolssoftware/comorbidityicd10/comorbidity_icd10.jsp.
- Agency for Healthcare Research and Quality. Clinical Classification Software Refined (CCSR) for ICD-10-PCS Procedures v2022.1. Healthcare Cost and Utilization Project (HCUP). October 2021. https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/prccsr.jsp.
- Agency for Healthcare Research and Quality. Procedure Classes Refined for ICD-10-PCS Procedures v2022.1. Healthcare Cost and Utilization Project (HCUP). December 2021. https://www.hcup-us.ahrq.gov/toolssoftware/procedureicd10/procedure_icd10.jsp.

13. Are Do Not Resuscitate (DNR) orders used as an exclusion in v2022?

DNR (ICD-10-CM diagnosis code Z66) with a present on admission status is used in risk-adjustment of IQI 15 Acute Myocardial Infarction (AMI) Mortality Rate, IQI 17 Acute Stroke Mortality Rate Stratum: Subarachnoid Hemorrhage strata, IQI 18 Gastrointestinal Hemorrhage Mortality Rate, IQI 19 Hip Fracture Mortality Rate, IQI 20 Pneumonia

Mortality Rate, PSI 04 Death Rate among Surgical Inpatients with Serious Treatable Complications strata and PSI 02 Death Rate in Low-Mortality Diagnosis Related Groups (DRGs). DNR is not used as an exclusion due to concerns over coding quality, but it was used as a risk factor as it may influence the course of treatment delivered in the inpatient setting.

14. Is MDC still a required data element in v2022?

The Major diagnostic categories (MDC) continue to be a required data element on the input data file for SAS QI and WinQI. MDC values are an expected part of the discharge records as MDCs are used in measure specifications and risk adjustment in the AHRQ QI Software.

Users interested in calculating expected, risk-adjusted, smoothed, or composite values for hospital-level PSIs and IQIs must have MDCs assigned for each discharge on their input file. The AHRQ v2022 software no longer imputes MDC as in v2021 since the calculation was error-prone when the correct classification software is not applied to the input data. Users who cannot supply data for the MDC field should take the following steps:

- SAS QI users: set %LET MDC_PROVIDED = 0 in the CONTROL program
- For WinQI users: indicate that MDC is not provided when generating the hospital-level report.

Upon taking these steps, the software will suppress expected rates, risk-adjusted rates, smoothed rates, and composites for hospital-level indicators for PSI and IQI modules given MDC is missing or incomplete. If MDC is available and fully coded, users should set the MDC_PROVIDED macro variables to "1". If users set the MDC_PROVIDED macro variable to "1" in the CONTROL program, but MDC values are missing on input data, the software will exclude those discharges with missing MDCs and output an error message – "ERROR: MDC_PROVIDED = 1 in CONTROL program but all MDC values are missing on input data". Thus, users MUST PROVIDE the MDC generated by the Centers for Medicaid Services (CMS) MS-DRG grouper software, without imputing or mapping from MS-DRGs. For accurate results, all eligible records should have an MDC between 01 and 25.

15. Why are records with MDC not deleted in the same way as records missing other variables, such as records missing a principal diagnosis?

The QI software uses Major Diagnostic Categories (MDCs) for certain denominator exclusions, and to risk-adjust many indicators. Some QI specifications do not use MDCs at all, whereas all QI specifications use age to restrict the denominator population, and the year and quarter of discharge to link to the correct ICD-10-CM/PCS code set. For this reason, users who do not have MDC in their data, and cannot run the appropriate CMS MS-DRG grouper version, should reset the default option in the CONTROL program to

MDC_PROVIDED=0. In this case, all otherwise eligible records are retained, but no risk-adjusted or smoothed rates are calculated. Users who DO have MDC in their data should review their data and minimize the number of missing values, because if the CMS MS-DRG grouper is correctly run-on data with valid ICD-10-CM principal diagnoses, then there should be no records with missing MDC. In the v2022 software, all records with missing MDC are deleted if the user indicates that they are providing MDC, because missingness on this variable indicates an unresolvable problem either with the input data or with how the user implemented the CMS MS-DRG grouper.

16. Are All-Patient Refined Diagnosis Related Groups (APR-DRGs) required for IQI risk adjustment?

Beginning with v2022, the risk-adjustment in the IQI module of procedure based IQIs (IQI 08 – Esophageal Resection Mortality Rate, IQI 09 – Pancreatic Resection Mortality Rate, IQI 11 – Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate, IQI 12 – Coronary Artery Bypass Graft (CABG) Mortality Rate, IQI 30 – Percutaneous Coronary Intervention (PCI) Mortality Rate, IQI 31 – Carotid Endarterectomy Mortality Rate, IQI 90 – Mortality for Selected Inpatient Procedures) no longer requires APR-DRGs. APR-DRGs have been replaced by AHRQ's Clinical Classification Software Refined (CCSR) for ICD-10-PCS Procedures.

17. Can the SAS QI Software run on a Unix/Linux environment?

In prior versions, users calculating All-Patient Refined Diagnosis Related Groups (APR-DRGs) for the risk-adjustment of Inpatient Quality Indicators (IQIs) using AHRQ's Limited License Grouper required a Windows environment due to the dynamic link library (DLL) configuration included with the Limited License Grouper. In v2022, the SAS IQI module no longer requires APR-DRGs for risk-adjustment and therefore omits the Limited License Grouper. As a result, users can now run the IQI module in a Unix/Linux environment. Other SAS QI modules can also run in a Unix/Linux based system.

18. Why was PSI 03 Pressure Ulcer Rate criteria updated to include site specific logic?

In the v2021 software, all discharges with any secondary ICD-10-CM diagnosis code for deep tissue injury (DTID) present on admission (POA) were excluded from the denominator. However, there were multiple cases where the DTID POA code was at a different anatomic site than the hospital-acquired Stage 3 or 4 (or unstageable) pressure ulcer (DECUBVD), indicating that the DECUBVD was unrelated to the previous DTI, and thus more likely to be preventable. The v2021 software excluded such cases, even though the clinical intent of the measure is to flag all hospital-acquired stage 3, stage 4, or

unstageable pressure injuries. In v2022, AHRQ addressed this issue by adding site specific logic for PSI 03, whereby a DTID POA only disqualifies a DECUBVD not POA at the same anatomic site.

19. Why are discharges with a deep tissue injury or unstageable pressure ulcer present on admission at the same anatomic site as stage 3 or 4 pressure ulcers not excluded from the denominator of PSI 03 Pressure Ulcer Rate?

The clinical intent of PSI 03 is to flag all hospital-acquired stage 3, stage 4, or unstageable pressure injuries. For this reason, patients who have a deep tissue injury or unstageable pressure ulcer present on admission are no longer excluded from the denominator, because these patients are at risk for hospital-acquired stage 3, stage 4, or unstageable pressure injuries at OTHER sites. A deep tissue injury or unstageable ulcer present on admission that is reported to be at the same anatomic site as a subsequent hospital-acquired stage 3 or 4 pressure ulcer excludes the numerator event, because deep tissue injuries are known to evolve (in some, but not all cases) into stage 3 or 4 ulcers despite pressure relief and optimal nursing care.

20. How has PSI 14 Postoperative Wound Dehiscence Rate changed in v2022?

The first refinement is about capturing the last occurrence of a reclosure procedure (RECLOIP*), instead of the first occurrence. The clinical intent of PSI 14 is to flag wound dehiscence after an index procedure requiring a return to the operating room for reclosure of the wound. Accordingly, the denominator should only exclude patients in whom ALL reclosure procedure(s) occur on or before the date of the first qualifying abdominopelvic procedure. In v2021, the procedure date of the first occurrence of the reclosure procedure was used for this purpose, which removed cases that had multiple reclosure procedures, with some on or before, and others after, the index procedure date. In v2022, AHRQ instead uses the last occurrence of the reclosure procedure to ensure more complete identification of patients who had wound dehiscence after an index procedure requiring a return to the operating room for reclosure of the wound.

In the second refinement, AHRQ removed ICD-10-CM diagnosis codes for disruption of internal surgical wound (ABWALLCD*) from the denominator exclusion logic for PSI 14. In v2021, PSI 14 excluded cases with a procedure code for abdominal wall reclosure (RECLOIP) occurring on or before the day of the first open abdominopelvic surgery procedure (ABDOMIPOPEN*), if any, and the day of the first abdominopelvic surgery, other than open approach (ABDOMIPOTHER*), only if the record had a diagnosis code for disruption of internal operation wound (ABWALLCD). However, this exclusion should not be conditioned on ABWALLCD, which is required to equal 1 for the PSI 14 numerator. This condition is a holdover artifact from the ICD-9-CM specification. In general, AHRQ has removed all denominator exclusions that are conditional on the

numerator value, because such conditions lead to subpopulations in the denominator that have zero risk of the event.

The third refinement involves updating the ABDOMIPOTHER code list. The rationale for this change is to focus only on laparoscopic and other percutaneous endoscopic procedures. The v2021 code list included many percutaneous procedures (e.g., imaging-guided needle biopsy or drainage) that had essentially zero risk of wound dehiscence. Removing these zero-risk procedures leads to better risk-adjustment models and more readily interpretable results. In v2022, 3 codes were added to ABDOMIPOTHER through annual ICD-10-PCS updates and 2,508 (mostly percutaneous procedure) codes were removed.

In the fourth refinement, the stratification logic was updated to resolve a problem whereby records were assigned to the OPEN stratum even if the only OPEN procedure was a repair procedure for dehiscence following a prior NONOPEN procedure. Such assignment is incorrect because reclosure is part of the outcome (i.e., numerator specification) and should not be used for stratification. If any of the denominator-qualifying abdominopelvic procedures occurring before the LAST RECLOIP procedure is open, or if any of the denominator-qualifying abdominopelvic procedures on a record WITHOUT a RECLOIP procedure is open, then the record should be in the OPEN stratum. If ALL denominator-qualifying abdominopelvic procedures prior to the LAST RECLOIP procedure are percutaneous endoscopic, or if ALL denominator-qualifying abdominopelvic procedures on a record WITHOUT a RECLOIP procedure are percutaneous endoscopic, then the record should be in the NON-OPEN stratum. In other words, open procedures are at much higher risk of dehiscence than percutaneous endoscopic procedures, so open procedures trump non-open procedures as the likely cause of the dehiscence.

Below is the overall PSI rate changed vs. v2021.

Refinement #	**Indicator**	**Ratio of Modified Software to v2021**		
		Numerator	**Denominator**	**Observed Rate**
All 4 Refinements	PSI 14	1.2046	0.6768	1.7798
	PSI 14_NONOPEN	2.0566	0.5222	3.9385
	PSI14_OPEN	1.1756	0.8665	1.3567

* For code lists and complete technical specification of PSI 14 please visit the AHRQ QI website at https://qualityindicators.ahrq.gov/measures/PSI_TechSpec.

21. Why are MDCs deleted in the PQI and PDI module, if MDCs are not used in risk-adjustment?

While MDCs are not used in risk adjustment for PQIs and PDIs, they are referenced in the measure specifications such as for PQI 16 – Lower-Extremity Amputation among Patients with Diabetes Rate. Therefore, if you wish to calculate PDIs and PQIs, your data must include valid MDCs. For example, PQI 16 excludes obstetric discharges, identified by MDC=14. Records containing any valid MDC value other than 14 will be eligible for use in PQI rate calculations.

22. Is PRDAY required in the IQI module?

In v2022, the IQI module requires PRDAYn to assign AHRQ Clinical Classifications Refined (CCSR) for ICD-10-PCS Procedures. These categories are a feature in the risk-adjustment of procedure-based indicators (IQI 08, 09, 11, 12, 30, 31, 90). Missing or incomplete PRDAYn information will impact risk-adjusted rates for these indicators. Thus, PRDAYn must be supplied on the input data in the IQI module.

Interpreting AHRQ QI Results

23. How does AHRQ recommend that users interpret QI rates calculated with the v2022 software?

All measures that use the ICD-10 CM/PCS coding standards may see some variation in rates resulting from the transition in coding systems. AHRQ recommends using v2022 rates as a starting point for internal assessment and not for comparison across providers. Users may review discharge-level results to determine if evidence in the administrative record indicates occurrence of an adverse event. Further information about the ICD-10-CM/PCS transition and use of administrative data is available at: https://www.hcup-us.ahrq.gov/datainnovations/icd10_resources.jsp

24. What do I need to know about the v2022 QI population file?

The updated QI population file contains intercensal and postcensal estimates of county-level populations from years 2000 – 2021 for use with area-level QIs. Population categories include single-year age group, sex, race, and Hispanic origin.

Details about the population methodology is available at: https://qualityindicators.ahrq.gov/Downloads/Software/SAS/V2022/AHRQ_QI_v2022_ICD10_Population_File.pdf

25. Can I use the v2022 QI population file with prior versions of SAS QI software?

The v2022 QI population file has the same structure as the previous population files. Therefore, it can be seamlessly used with all previous versions of SAS QI software.

26. Which indicators are endorsed by the National Quality Forum (NQF)?

AHRQ does not seek re-endorsement of its portfolio of measures in the QI Program. The AHRQ QI Program continues to focus its measurement efforts on quality improvement at local, state and national levels, and support of the science of rigorous measurement development and use of quality measures for improving the quality of healthcare.

To ensure that the measures meet the national standards for measure development, we will continue to engage with a wide variety of stakeholders, including national, state, and regional policymakers (Federal and state agencies), private decision-makers (hospitals, clinicians, purchasers), and researchers in various ways. We intend to focus on developing and maintaining measures and tools that facilitate system and area-level quality improvement. The program shall continue to disseminate unbiased scientific evidence and analyses related to the risk-adjustment methodology and the use of quality measures for improving the quality of healthcare.

Details on the rationale is available at:
http://qualityindicators.ahrq.gov/Downloads/News/AHRQ_Rationale4notseekingNQFendorsement-May2021.pdf

Using AHRQ Quality Indicators

27. Is technical assistance available for use of the AHRQ QIs?

Yes. Users may submit questions or comments to QISupport@ahrq.hhs.gov.