

The National Hospital at Home Quality Registry
Data Dictionary Version 2
Changes Highlighted
Published August 2025



The National Hospital at Home Quality Registry

Data Dictionary

Version 2

Please note, this version highlights the changes that were made from
Version 1.



Dear Hospital at Home (HaH) Program,

The goal of this work is to obtain basic data from HaH programs across the country on patients treated and their outcomes to develop benchmarks, support individual programs, support policy development, and support research to advance HaH and its implementation. Programs that participate will have access to national benchmarks to support their own growth.

The National Hospital at Home Quality Registry was developed by the HaH Users Group Quality Council and was open for public comment to the entire HaH Users Group in early 2022. The final product reflects substantial input from the HaH Users Group community.

A main goal of the Council was for HaH programs to be able to abstract data in an automated fashion as well as include current CMS data reporting requirements that align with those commonly used by payers and hospitals. We realize that the QR will not provide a complete picture of HaH. At this juncture, the collective wisdom of the group was to collect a discrete set of critical data elements with a high degree of accuracy. We anticipate that the QR will be refined over time with your input.

What are the next steps?

We are asking all HaH programs to collect and enter into the QR Excel sheet data on all acutely ill (not observation level) patients your program cared for in **2025**, regardless of whether they were cared for under the CMS Waiver. The data elements included do not contain HIPAA identifiers, and so they are not protected health information. As you collect data on the Excel sheet, please do not keep any file that links a patient's episode ID to their identity; doing so will render your data protected health information. We plan to ask for data annually.

We have developed and tested a Data Use Agreement (DUA) with attorneys in several health systems to ensure that the DUA would be acceptable to your institution. Please have the DUA reviewed by the appropriate attorney or contract reviewer at your institution and signed by an authorized organizational representative. **The signed contract should be e-mailed to Annabel Steiner (annabel.steiner@mssm.edu), copying Gabrielle Schiller (gabrielle.schiller@mssm.edu).** Once the DUA is countersigned, a digital version of the fully executed agreement will be emailed to you.

Thank you for all the work that you do and all that you do to advance the field of HaH.

Sincerely,

HaH Users Group Quality Workgroup

Please note that sites should use the most accurate data source available to them.

Patient ID

Domain:	Episode ID	Data Validation:	Number
Column:	A		
Description:	New unique numeric identifier assigned by your site for each patient episode (e.g. consecutive numbers like 1, 2, 3, 4, etc.). If the same individual is admitted more than once to your HaH program, each subsequent episode will be assigned a new Episode ID.		
	Do not use Medicare ID or a medical record number.		
	Do not create any file, whether electronic or hardcopy, that links the Episode ID to any of the patient's HIPAA identifiers.		

Age 90+

Domain:	Patient Demographics	Data Validation:	Excel dropdown
Column:	B		
Description:	Indicator for whether the patient is age 90 or greater.		
	Allowed Values: Yes No		

Age

Domain:	Patient Demographics	Data Validation:	Integer (max. 89)
Column:	C		
Description:	Patient's age in years when first admitted. This variable is only to be completed when Age 90+=No.		

Sex

Domain:	Patient Demographics	Data Validation:	Excel dropdown
Column:	D		
Description:	Patient's sex assigned at birth as listed in the medical record.		
	Allowed Values: Female Male		

Other
Unknown
Declined

Patient Race

Domain:	Patient Demographics	Data Validation:	Excel dropdown
Column:	E		
Description:	Patient's race.		

Allowed Values:

American Indian or Alaska Native
Asian
Black or African-American
Native Hawaiian or Other Pacific Islander
White
Some Other Race
Unknown
Declined

Patient Ethnicity

Domain:	Patient Demographics	Data Validation:	Excel dropdown
Column:	F		
Description:	Patient's ethnicity.		

Allowed Values:

Hispanic or Latino
Not Hispanic or Latino
Unknown
Declined

Waiver

Domain:	Hospital Episode	Data Validation:	Excel dropdown
Column:	G		
Description:	Indicator for whether the hospital at home patient was included in program's report to CMS regarding Acute Hospital Care at Home reporting.		

Allowed Values:

Yes
No

Admission Pathway

Domain:	Hospital Episode	Data Validation:	Excel dropdown
Column:	H		
Description:	Location from which the patient was admitted to Hospital at Home.		

Allowed Values:

Emergency Department to HaH
Inpatient Hospital to HaH
Observation Unit to HaH
Ambulatory/Office Clinic to HaH
Home to HaH
Other to HaH

Brick-and-Mortar Length of Stay

Domain:	Hospital Episode	Data Validation:	Integer > 0
Column:	I		
Description:	Total number of midnights a patient was admitted to the brick-and-mortar hospital. A part of a day , including the day of admission and day on which a patient returns from leave of absence, counts as a full day.		

However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

Allowed Values:

Integer

Hospital at Home Length of Stay

Domain:	Hospital Episode	Data Validation:	Integer > 0
Column:	J		
Description:	Total number of midnights a patient was admitted in the HaH setting. A part of a day , including the day of admission and day on which a patient returns from leave of absence, counts as a full day.		

However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

Allowed Values:

Integer

Total Episode Length of Stay

Domain:	Hospital Episode	Data Validation:	Integer > 0
Column:	K		
Description:	Total number of midnights a patient was admitted. A part of a day , including the day of admission and day on which a patient returns from leave of absence, counts as a full day.		

However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission. Length of stay includes HaH time and time patient was in the brick-and-mortar setting.

Allowed Values:

Integer

MSDRG Code

Domain:	Hospital Episode	Data Validation:	Numeric
Column:	L		
Description:	The Medicare severity diagnosis related group (MSDRG) assigned to the admission by the hospital. If an MSDRG was not assigned, the cell should be left empty.		

AP-DRG Code

Domain:	Hospital Episode	Data Validation:	Numeric
Column:	M		
Description:	The all patient diagnosis related group (APR DRG) assigned to the admission by the hospital. If an AP-DRG was not assigned, the cell should be left empty.		

APR DRG Code

Domain:	Hospital Episode	Data Validation:	Numeric
Column:	N		

Description: The all patient refined diagnosis related group (APR DRG) assigned to the admission by the hospital. If an APR DRG was not assigned, the cell should be left empty.

Discharged to Home

Domain: HaH Admission **Data Validation:** Excel dropdown
Column: O
Description: Indicator for whether a patient was discharged to home (including home with skilled home health care, assisted living, home hospice, or other) or to another geographic location that is NOT home such as: skilled nursing facility (SNF), nursing home (NH), long-term acute care hospital (LTAC), other) at the end of the acute hospital phase of care.

Allowed Values:

Yes
No
Unknown

Mortality

Domain: Adverse Events **Data Validation:** Excel dropdown
Column: P
Description: Indicator for whether the patient experienced mortality during the hospital episode, including time under HaH care and time patient was in the brick-and-mortar hospital if any.

Allowed Values:

Yes
No
Unknown

Unanticipated Mortality

Domain: Adverse Events **Data Validation:** Excel dropdown
Column: Q
Description: Indicator for whether the patient's death was unanticipated.

This indicator is used by CMS in Acute Hospital Care at Home waiver reporting.

Mortality of patients on hospice and those not on hospice but whose deaths were expected by the care team, the patient, and their family/caregivers are considered anticipated (Unanticipated Mortality = “No”).

Allowed Values:

Yes
No
Unknown

Escalation

Domain:	Adverse Events	Data Validation:	Excel dropdown
Column:	R		
Description:	Indicator for whether the patient was transferred to the brick-and-mortar hospital from HaH for continued acute care.		

This indicator is used by CMS in Acute Hospital Care at Home waiver reporting.

Include those transferred back for both clinical benefit and patient choice who were admitted to acute hospital care at home for any period of time. DO NOT include patients who were transferred to the hospital or ED only for a diagnostic test or other planned treatment and who then returned home for continued care.

Allowed Values:

Yes
No
Unknown

Fall with Major Injury

Domain:	Adverse Events	Data Validation:	Excel dropdown
Column:	S		
Description:	Indicator for whether the patient experienced a fall with death or major injury during the admission (including HaH time and time in the brick-and-mortar hospital). Major injuries include fractures, closed head injuries, internal bleeding, and death.		

Allowed Values:

Yes
No
Unknown

Other Serious Adverse Event

Domain:	Adverse Events	Data Validation:	Excel dropdown
Column:	T		
Description:	Indicator for whether the patient suffered any other adverse event that was not previously listed which occurred during the admission (including HaH time and time in the brick-and-mortar hospital). Examples include medication error, DVT/VTE, delirium, C. diff.		

Allowed Values:

Yes
No
Unknown