Hospital Inpatient Quality Reporting Program

Support Contractor

Specifications Manual, Version 4.4a, Changes & Hospital VBP Program Improvement Series: MSPB

A.M. Presentation Questions and Answers

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Question 1: What does MSPB stand for?

Answer 1: Medicare Spending per Beneficiary

Question 2: What are the time frames for baseline and performance periods?

Answer 2: The FY 2015 Hospital VBP Program MSPB Baseline Period was May 1, 2011 - December 31, 2011. The performance period was May 1, 2013 - December 31, 2013.

Question 3: Will voluntary reporting measures be posted for public reporting on the *Hospital Compare* website?

Answer 3: If the data are submitted to the warehouse, the measure will be reported on *Hospital Compare*.

Question 4: If a facility reports voluntary measures, do they have to be reported for every period?

Answer 4: No, if you are submitting the measures voluntarily, you can submit for all, none, or just some of the quarters.

Question 5: Is there any advantage to submitting data voluntarily?

Answer 5: The benefit of continuing to abstract the voluntary measures is to ensure that the highest quality of care is being provided to your patients and to continue to identify areas of quality improvement.

Question 6: If you are a Primary Stroke Center, can you submit part of your eight Stroke Core Measures by electronic submission, or do all eight have to be chart abstracted?

Answer 6: To meet IQR requirements you, can submit the Stroke measures as either chart abstracted or as electronic clinical quality measures (eCQMs).

Question 7: Will the voluntary measures specifications be translated into ICD-10 in October 2015?

Answer 7: All voluntary measures, except IMM-1, will be removed from the Specifications Manual beginning with October 1, 2015 discharges. At that time, they will no longer be accepted into the clinical warehouse as voluntary measures.

Question 8: What are the time frames for baseline and performance periods?

Answer 8: The baseline period ranged from May 1, 2011 - December 31, 2011, and the performance period ranged from May 1, 2013 - December 31, 2013.

Question 9: Can you recap what chart-abstracted measures are required for the IQR Program?

Answer 9: To clarify, today's presentation focused on submitting the chart-abstracted measures only and did not get into the integration of chart-abstracted measures versus the submission of the voluntary eCQMs. The required chart-abstracted measures for the Hospital IQR Program include AMI-7a, SCIP-Inf-4, VTE-1, VTE-2, VTE-3, VTE-5, and VTE-6, STK-1, STK-4, STK-5, STK-6, and STK 8, ED-1 and ED-2, IMM-2, and PC-01.

Question10: Is AMI-7a optional chart abstracted or electronic - the slides seemed to reference only chart abstraction. I just want to ensure there was no change to final rule

Answer 10: AMI-7a is required for the IQR Program. The measure can be submitted as either chart-abstracted or as an electronic clinical quality measure (eCQM) to meet the IQR Program submission requirements.

Question 11: Will CMS continue to support CART? When will upgrades be available?

Answer 11: That is correct. Yes, CMS will continue to support the CART tool.

Question 12: How long will CMS accept the voluntary measures? Is it only until September 30, 2015?

Answer 12: All measures that are now considered voluntary that are in the Specifications Manual except for IMM-1 will be removed from the Specifications Manual beginning with October 1, 2015 discharges. At that time, they will not be able to be submitted voluntarily to CMS.

Question 13: How many FTE do you have to support this system?

Answer 13a: That's a difficult question based on which hospitals we have in how we're doing the work. In the Dillon - on the Dillon campus, those are operational effectiveness work, and our service excellence work are staffed from our corporate office, so we dispatch them based on the biggest needs across the system. Although traditionally, they would have one Lean facilitator who works primarily with the Dillon campus a year and one service excellence FTE who would work there, and then they keep their own clinical improvement person who resides on their campus all the time as well as infection control. So on that campus in real numbers they have three to four FTEs who are doing nothing but improvement in clinical operation and service, as well as the associate

vice president on that campus (Jun Urban) who oversees the entire program.

Answer 13b: I guess overall hospital facility we have roughly about 400 employees in our organization. To support some of our improvement efforts and let's say quality specifically, we have me, a quality coordinator, and one other full-time quality analyst as well as a part-time quality analyst, and then a safety and compliance officer with whom we work very closely for our quality and safety initiative. So about roughly four total.

Question 14: Please explain refraining from providing services to those not likely to benefit.

Answer 14: Actually, it's refraining from - I think I put this in the Chat. It's refraining from providing services not from the - to the individual person, but refraining from providing wasteful services. One of the things I used as an example was in orthopedics. We were using a passive continuous motion machine that physicians have gotten in the habit of using. But when we really went to the evidence base, we could find their justification for that, we encouraged them to do a pilot of not using it because we were about to have to purchase more. They're about $250,000. They didn't find a difference in the outcomes with their patients, so they stopped providing that particular part of their care delivery. So it's really critiquing and going to the evidence to make sure that everything we're doing is evidence based and taking out the things that are not. Now, in the emergency room setting, there is some was of services, so that might - maybe where that was picked up is they're coming to the emergency department when in fact they would be better served if they would go to another facility, such as the federally qualified health clinic that could be a primary medical home and so is an episodic care provider. And so really connecting with those patients to make sure they’re in the right setting getting the right care. Instead of episodic care, they're getting more chronic disease management.

Question 15: How were the operational effective measures identified? Is there a longer list of measures?

Answer 15: There's a much longer list. It's really how we identify the opportunities to improve operations. And we also use Premier Products. There are multiple products, I'm not trying to just promote theirs, but we use that product and we looked at where the opportunities are operationally to

improve. Are we working too many man hours per surgery? Are we using too many man hours per procedure or are our supply costs too high per procedure? And that gives us directional data -- no different than the clinical data -- to go ask why, to go get deeper into that particular area just like we did in nutrition services to figure out where the waste is and where things that we might go are worked on. Then the individual teams -- after they've done that rapid improvement work in that particular area -- decide which metrics they would continue to monitor to make sure they maintain success. The real secret to all of these is, use data to tell you where to go work. Don't just go, "Hmm, I think, choose this." Use data. And there is enough of those out there now to figure out and prioritize your opportunities for improvement.

Question 16: MHSC - How did you get the providers to come and participate in the interdisciplinary meeting? Did you have one meeting with all providers or more of a one on one with providers?

Answer 16: Our interdisciplinary meetings currently are set up more - I guess it's a daily process. We have all of our care team there, and then we usually just have either our main hospitalist provider on who joins us or in addition to that we sometimes have some of our specialty providers who will hop in the room and join us as well. As far as getting them involved, it just became kind of a - say, more of a culture thing as we move forward with our quality initiatives. Mainly just saying, "You know, this is what time we're meeting. We really need you here," instead of them - some of those things that you have with miscommunication when all those people are not in the same room. Pretty much it came down to, you know, we can have 10 people asking you the same question 10 times throughout the day, or we can all meet at one time and, you know, kind of get through everything all at once.

Question 17: Is it recommended that we continue to do concurrent rounding on the retired measures starting in January such as PN and HF, in order to prevent the 30-day readmissions?

Answer 17: I guess I don't know truly how to answer that. I think it's kind of up to you and where you stand in your improvement efforts at your facility. I don't know that it can hurt to do kind of those concurrent roundings. Well, it's not a required measure anymore, but it does impact readmission rates and what not. For our facility, though, we do have our transition program, which focuses on a lot of those things that they

are able to pick up kind of the concurrent patients and take over that. So I don't know if necessarily concurrent abstraction or rounding to see if certain measures are met in that sense more so than focusing on education and discharge planning and those things for those types of patients.

Question 18: Curious if there exists any way to monitor MSPB more frequently than is publicly reported?

Question 18a: And to expand on this question, the MSPB measure is reported annually on *Hospital Compare* and then also annually through the Hospital Value-Based Purchasing Program.

Answer 18: Our facility does not have a system set up to monitor this more frequently -- as of right now.

Answer 18a: Not that we can monitor it more frequently, but we certainly can monitor our own cost, and we do that on a very regular basis to see the part that we're actually directly controlling and if there're any changes in that.

Question 19: For Donna, how are data dispersed throughout the healthcare system? Is there a central dashboard?

Answer 19: We have also put this one online, but we do have a central dashboard of what we call the board report, and it has almost all the value-based purchasing monitors on it as well as some others around global mortality rate for the particular institution. So those are what we call our big system measures, mortality rate, performance on core measures, and the percent of perfect care we deliver, the eight domain satisfaction. Some of those scores can roll up into a corporate one for all of McLeod Health, like the performance on satisfaction that you saw on the service excellence domain. But some of them are harder to do that, like mortality rate because our expected mortality rate at a primary tertiary care facility would be much different than that of a more rural hospital. We do try to do some of those in an index format observed versus expected and roll it up in that observed way. But really our data get down hospital specific or even now in our (MTA) practices specific. That we do at our quality and safety meetings every week. And it is of expectation that the senior most leaders attend these quality and safety meetings on every campus or within our McLeod

Physician Associates on a weekly basis. That's not an optional meeting; that is part of the work of an executive.

Question 20: Why would the SCIP measures be different than HF or PN regarding voluntary measures if as previously suggested that we would have to submit populations for all SCIP strata?

Answer 20: The only measures that are left for HF and PN (HF-2 and PN-6) are both voluntary. However, for SCIP, SCIP-Inf-4 is a required IQR measure and must be submitted to meet IQR requirements.

Question 21: If you submit the voluntary measures – are they going to be published on the *Hospital Compare* website?

Answer 21: CMS will report voluntary measures if data are submitted to the warehouse.

Question 22: If our hospital does not do cardiac surgery, are we required to submit SCIP-Inf-4?

Answer 22: Yes, that is correct. You will continue to submit the population and sample sizes for each of the eight SCIP strata. If there are any applicable cases in those eight strata, the cases in the sample for each of the SCIP strata will then be abstracted and submitted.

Question 23: MHSC - How did you get the providers to come and participate in the interdisciplinary meeting? Did you have one meeting with all providers or more of a one on one with providers?

Answer 23: Our hospitalists handle our interdisciplinary meetings so are much easier to engage because of easy availability. However, we have also worked with private practice groups to do some rounds as a group, too.

Question 24: Has McLeod tried this on their large facility?

Answer 24: McLeod Health uses this same strategy for all of our five hospitals. The work in the community has been most successful within the Dillon County because of ease of navigating the community size, but we are seeing similar results in readmissions in Florence, too.

Question 25: For Donna, how are data dispersed throughout the healthcare system? Is there a central dashboard?

Answer 25: We do a dashboard for each hospital and do roll up some measures such as the one you saw for patient satisfaction, but it is more difficult in some of the outcome measures because of risk adjustment needs unless we use ratios of actual to expected for mortality, etc. The opportunity assessments that you saw both clinically and operationally are presented at our weekly Quality & Safety meetings that take place on each campus. All senior executives are expected to attend.

Question 26: Donna, please explain: "refraining from providing services to those not likely to benefit."

Answer 26: We encourage our physicians to assess the evidence base and make sure that the care they are providing is appropriate and necessary. For example, many of our orthopedic physicians were using a CMP (continuous passive movement) for range of motion after surgery that was expensive but not evidence based. They agreed to try eliminating it and found equal results, and we saved capital outlay of approximately $250K to replace devices. In addition, they changed pain control during and post operatively that resulted in a 0.5-1.0 reduction in length of stay.

Question 27: I see that you were awarded the Zero Healthcare Assoc Infections Award! Who gives that award? Where can I find the other hospitals that received that award?

Answer 27: Our South Carolina Hospital Association gives our Zero Healthcare Association Infection Awards.

Question 28: Donna, where are interdisciplinary meetings conducted--meeting room, on the unit, patient room? Is the staff nurse a part of the interdisciplinary meetings if held off of the unit?

Answer 28: The interdisciplinary meetings daily are on the units, but our improvement meetings are usually not on the units. If we are doing operational improvement, then the staff are given the week to work with the operational effectiveness team to make improvements. For productivity, they actually record their time as an OE employee for that week instead of their time being charged to their home unit.

Question 29: For 2015 - if we choose pc-mom, do we have to answer all of the selections? Currently, we are just answering PC-01 elective delivery <39 weeks.

Answer 29: For CMS, only the PC-01 measure can be collected and submitted.

Question 30: Will you please provide clarification of FY 2016, FY 2017 for actual effective dates for those FY periods?

Answer 30: For FY 2016, the discharge periods include CY 2014 discharges; for FY 2017, the discharge periods include CY 2015 discharges.

Question 31: AMI-7a is optional chart abstracted or electronic?

Answer 31: For CY 2015 discharges, AMI-7a is a required Inpatient Quality Reporting (IQR) measure. To meet IQR requirements, it can either be submitted as chart abstracted or electronically.

Question 32: If you choose to participate in a voluntary measure, will it be reflected on *Hospital Compare*?

Answer 32: Yes, that is correct. If the voluntary measures are submitted, they will be displayed on *Hospital Compare*.

Question 33: Are voluntary reporting measures to be submitted electronically or manual abstraction?

Answer 33: The voluntary measures can be submitted either electronically or as chart abstracted.

Question 34: For SCIP, are you stating that concurrent review isn't required for any measure except SCIP-INF-4?

Answer 34: The chart-abstracted measures can either be done concurrently or retroactively. For the Inpatient Quality Reporting (IQR) Program, for discharges starting January 1, 2015, SCIP-Inf-4 will be the only required SCIP measure. All other SCIP measures can be submitted voluntarily.

Question 35: On the voluntary measures, I understood that these were voluntary ELECTRONIC measures only. Are they voluntary for chart abstraction as well?

Answer 35: The following measures can be voluntarily chart abstracted and submitted to the CMS clinical warehouse: AMI-1, AMI-3, AMI-5, AMI-7, AMI-8, AMI-8a, Hf-2, PN-6, IMM-1, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-6, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2, VTE-4, STK-2, STK-3, STK-5, and STK-10.

Question 36: And if voluntary electronic submission is allowed, can any or all the voluntary measures be submitted?

Answer 36: In CY 2014, there are 29 eCQMs that are specific to the EHR Incentive Program; 16 of those may be voluntarily reported for IQR Program credit. The 16 applicable to the IQR Program cover the STK, VTE, PC, and ED measure sets. For the EHR Incentive Program, hospitals can pick any 16 of the 29 eCQMs to report on as long as their EHR system is certified to report data on the measure and the 16 cover at least 3 of the 6 National Quality Strategy Domains. In 2015, 28 eCQMs are aligned for the IQR Program and the EHR Incentive Program.

Question 37: I just checked the final rule, and it reflects AMI-7a is chart abstracted or electronic optional. I understand SCIP-INF-4 is still required to be chart abstracted, but it seemed the presentation outlined chart abstracting AMI-7A as mandatory. Is that a change, or just not clear on the slide?

Answer 37: The presentation focused on submitting measures by chart abstraction only. To meet IQR requirements, AMI-7a must be submitted either electronically or as chart abstracted.

Question 38: Please verify VTE-3 – according to the IQR final regulations, VTE-3 is excluded from IQR. However, you have it as mandatory.

Answer 38: Per CMS direction, VTE-3 will continue to be required for the IQR Program.

Question 39: Why was reason for not initiating IV thrombolytics under VTE?

Answer 39: Answer: Thank you for your comment. The data element Reason for Not Initiating IV Thrombolytics is used for the Stroke measure set and was inadvertently included under VTE.

Question 40: Regarding outpatient AMI, Is there any way to avoid abstracting the first data element (initial ECG) for AMI if you do not have any cases in

which fibrinolytics were given? We are looking for a reasonable way to avoid needless element abstraction for these cases.

Answer 40: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 41: Does patient refusal of mechanical VTE also count for reason for no pharmacological?

Answer 41: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 42: INR and Monitoring was not a part of Stroke – should that be under VTE?

Answer 42: Thank you for your comment. The data elements INR Value and Monitoring Documentation were inadvertently listed under the Stroke section. You are correct; these elements are used for the VTE measure set.

Question 43: If we choose to abstract and report voluntary elements, will they be reported on *Hospital Compare*?

Answer 43: Yes, if submitted, those measures will be reported on *Hospital Compare*.

Question 44: According to the regulation, VTE-3 is included in IQR FY 2017, but it is missing from the measures table on 1622. Please clarify.

Answer 44: VTE-3 was inadvertently left off the table in the initial IPPS Final Rule. This was corrected in the addendum to the rule that was posted on October 3, 2014 (79 FR 59679).

Question 45: Slide #15 says that cases excluded from the denominator for SCIP-Inf-4 will continue to be submitted to the clinical warehouse. I don't understand this.

Answer 45: Cases may be excluded from the specific measure denominator; however, they are still considered part of the initial patient population.

Question 46: ED Decision to Admit date and time: does this mean any documentation, e.g., by RN, EMT, and Secretary?

Answer 46: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 47: For measures being deleted or changed to voluntary, are any of those measures required by CMS MU, VBP, and/or Joint Commission reporting?

Answer 47: Beginning with 01/01/2015 discharges, the voluntary measures are not required for CMS. For required Joint Commission measures, please submit your question to The Joint Commission.

Question 48: If a patient is discharged on Xaralto or Eliquis, is that sufficient documentation for no overlap therapy, as these drugs do not require overlap?

Answer 48: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 49: Are Tobacco measures required?

Answer 49: Tobacco measures are not required for the Inpatient Quality Reporting (IQR) Program.

Question 50: Why do we have to submit IMM-2 during the non-influenza season? I can see no possible improvement to patient care based on this information. Lots of busy work.

Answer 50: Thank you for your feedback; we will forward the feedback to CMS for its review and consideration. At this time, as IMM is part of the “Global” initial patient population, they are required for every quarter.

Question 51: I have submitted several questions recently and have not received answers from the Q&A tool. I have spoken to QualityNet Help Desk and the Help Desk verified that the tool is still active; however, we have not received any feedback or answers from the Q&A tool. How can we address this?

Answer 51: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 52: Our abstractors have submitted quite a few Q&As sent in back in August to now. Should we still be expecting an answer to those sometime soon?

Answer 52: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 53: Clarification on the Q&A tool: since there is not ability to ask a question of personnel, what is the expected time frame for receiving a response to a Question submitted through the Q&A tool?

Answer 53: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 54: Please clarify if the "reasons" listed under the "Inclusion Guidelines for Abstraction" are "stand alone" reasons for Reason to Discontinue Parenteral Anticoagulation Therapy: active bleeding, plan for surgery, plan for blood transfusion , thrombocytopenia, Xarelto, etc., if this is documented on the same day or the day before the order for the discontinuation of the parenteral anticoagulation therapy. For example, if the provider documents "thrombocyopenia" on the same day that parenteral therapy was discontinued, but it is NOT directly linked as a "reason," i.e., there is NOT documentation that Heparin was "discontinued due to thrombocytopenia," but rather a discontinue order (parenteral med) AND a separate entry in the progress notes of "thrombocytopenia," DOES THE ABSTRACTOR RESPOND YES TO "REASON FOR DISCONTINUATION OF PARENTERAL ANTICOAGULATION THERAPY"?

Answer 54: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 55: When submitting questions to *QualityNet*, we only get answers copied directly from the spec manual. We need clarification, of unclear definitions specific to documentation we see. Can this be done better? Thank you.

Answer 55: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 56: I have sent questions to QualityNet Q&A two weeks ago & have not received any response yet.

Answer 56: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by

several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 57: Is the SCIP-Inf-4 (Controlled Postoperative Blood Glucose) having to be collected on all patients who have a principal procedure code on Table 5.10 in Appendix A?

Answer 57: That is correct. The SCIP topic population continues to be all patients on Table 5.10. You will continue to identify the population and sample sizes for each of the eight strata. If you have population in any of the eight strata, those cases will be abstracted for SCIP-Inf-4.

Question 58: For a separate definition (Reason for no Overlap Therapy), the items listed under "Inclusion Guidelines for Abstraction" (active bleeding, plan for surgery, plan for blood transfusion, etc.) ARE "stand alone" reasons, and I would like to clarify if this also applies to the other definition (Reason for Discontinuation of Parenteral Anticoagulation Therapy) – please see above question.

Answer 58: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 59: For the AHRQ PSI measure varies depending on which CMS initiative is being reported. For IQR and HAC Programs, CMS uses 25 diagnoses and 25 procedures, but for the HVBP program, CMS only uses 9 diagnosis codes and 6 procedure codes. The other question is about the version of the AHRQ software utilized. The FY 2015 Hospital VBP Program calculations used Version 4.4 of the software, while the 2014 Hospital IQR and FY 2015 HAC Reduction Program used Version 4.5a.

Answer 59: If you have a question regarding the AHRQ PSI-90 Measure for the Hospital Value-Based Purchasing Program, please submit the question to the Inpatient Q&A tool on *QualityNet*.

Question 60: SCIP cases from all eight strata will continue to be submitted in order to get a count for the Population and sample sizes, but there will be no abstraction questions to answer if they are not in the SCIP-Inf-4 measure. Is this correct?

Answer 60: If the case(s) does not have a qualifying procedure on Table 5.11, then the only data elements that may be abstracted are the general/demographic elements, e.g., ICD-9-CM data elements, admission date, discharge date, race, etc.

Question 61: Why does CMS keep some of the measures voluntary for a period of time?

Answer 61: The reasons to keep the measures voluntary for a period of time is multi-facetted including the opportunity to assess the measures' feasibility and/or to allow programming time for data processing.

Question 62: Will we have to provide pop counts for AMI, HF, or PN (voluntary measures)?

Answer 62: You will be required to submit the AMI population and sampling if submitting AMI-7a as a chart-abstracted measure. At this time, as HF and PN are voluntary, you are not required to submit the population and sample sizes for those two measure sets.

Question 63: Our hospital has cath lab, so we do not do AMI-7a, so do we still need to submit any measure info for 2015?

Answer 63: AMI-7a is still a required IQR measure. You will continue to identify your AMI Initial Patient Population and Sample Sizes. Those cases that are in the AMI sample will then be abstracted accordingly for AMI-7a, regardless of whether fibrinolytics were administered.

Question 64: For clarification, if we have no charts that meet the CABG stratum, would we still have to participate in SCIP data submission for SCIP-Inf-4?

Answer 64: You are still required to submit the population and sample sizes for each of the eight strata and submit abstractions accordingly. If you have no cases for the Stratum 1 (CABG), then you would not any clinical data for those strata. However, if you have cases in any of the

other strata, then you would have to abstract and submit cases accordingly for SCIP-Inf-4.

Question 65: What are the page numbers in the *Federal Register* Inpatient Final Rule for these changes?

Answer 65: The Hospital Inpatient Quality Reporting (IQR) Program regulations begin on page 50202 in the *Federal Register*.

Question 66: What are the pros/cons of submitting the voluntary measures?

Answer 66: The benefit of continuing to abstract the voluntary measures is to ensure that the highest quality of care is being provided to your patients and to continue to identify areas of quality improvement. The con is that it does increase abstraction burden.

Question 67: Can Donna share the high-risk tool for assessing readmission risk?

Answer 67: We originally used the LACE tool but have since developed our own tool that is very similar and housed it within our case management workflow.

Question 68: We never do fibrinolytics for AMI patients. Are we still required to pay a vendor and take the time to submit our population for AMI when all cases will be excluded?

Answer 68: Even if you do not do fibrinolytics, you are still required to report the AMI Initial Population and Sample Sizes and submit clinical data to CMS. If you do not do fibrinolytics, the cases will be excluded from the measure denominator (will result in a measure category assignment of “B”) but will still be in the AMI initial patient population and will continue to be submitted to CMS.

Question 69: I thought there were also changes in VTE confirmed?

Answer 69: A time frame was added for VTE confirmed. The data element now asks if the VTE was confirmed within four days prior to arrival or anytime during the hospitalization.

Question 70: What is the reason for removing VTE-4? Thank you.

Answer 70: VTE-4 was deemed as a "topped-out" measure, meaning that there was no further room for improvement.

Question 71: If the SCIP measures are voluntary and we are not participating in the voluntary measures, how would this scenario work?

Answer 71: SCIP-Inf-4 is not voluntary; it is a required SCIP measure. You will still determine the Initial Patient Population for all eight SCIP strata. If there are cases in any of those strata, then you will abstract and submit SCIP-Inf-4 for those cases.

Question 72: What data elements are required in order to report on the SCIP-Inf-4 measure? We currently have to answer anesthesia begin and end times, infection prior to anesthesia, etc. Thank you.

Answer 72: If the case(s) do not have a Principal Procedure Code of cardiac surgery (Table 5.11), then you will only abstract and submit the general/demographic data elements, e.g., ICD-9-CM elements, Admission Date, Discharge Date, Race, Payment Source, etc.

Question 73: Will you update the CART forms for each measure?

Answer 73: Yes, CART and the paper tools will be updated accordingly.

Question 74: AMI-2 and AMI-10 will be removed from specification, but will they be developed for eCQMs?

Answer 74: For 2015 discharges, both AMI-2 and AMI-10 are voluntary eCQMs.

Question 75: Will there be new abstracted measures added after October 1, 2015?

Answer 75: Any new chart-abstracted measures would need to be done through rulemaking. Please refer to the proposed and final rules when they are posted.

Question 76: We do not give thrombolytics for STEMI, but instead a primary PCI site only. Why would we open all those records and abstract if it is not applicable for our institution? It is a waste of abstraction resource to do that? Am I understanding this requirement correctly?

Answer 76: You are understanding the requirement correctly. Thank you for your feedback.

Question 77: When will the measure list be posted for Calendar Year 2015 discharges on *QualityNet*?

Answer 77: The “measure list” is currently under review and should be posted in the near future.

Question 78: How will Meaningful Use measures be impacted by the removal of the selected measures?

Answer 78: Meaningful Use measures will not be impacted by the removal of selected measures. That removal will only have an impact on the IQR chart-abstracted measures.

Question 79: When will IQR questions be answered? I still have questions unanswered from August and September. Thank you

Answer 79: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 80: I was surprised that so many of the Stroke measures were deemed topped out already when they have only been required by CMS since January 2013. How do you determine "topped out" (scores too high?)? Especially STK-3 when so much clinical focus is on afib as a significant risk factor for Stroke.

Answer 80: Thank you for your feedback. Currently, a measure is considered “topped-out” when the measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. Please refer to the IPPS Final Rule for the criteria to remove measures from the Hospital IQR Program.

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