Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital IQR Program Requirements for CY 2019 Reporting (FY 2021 Payment Determination)

Presentation Transcript

Speaker/Moderator

Candace Jackson, ADN
Project Lead, Hospital IQR Program
Hospital Inpatient Values, Incentive, and Quality Reporting (VIQR)
Outreach and Education Support Contractor

Speaker

Artrina Sturges, EdD
Alignment of Electronic Clinical Quality Measures (eCQM) Lead
Hospital Inpatient VIQR Outreach and Education Support Contractor

April 29, 2019
2 p.m. ET

Candace Jackson: I would like to welcome everyone to today's IQR presentation, titled *Hospital IQR Program Requirements for CY 2019 Reporting (FY 2021 Payment Determination)*. I am Candace Jackson, the [Hospital] IQR [Program] Project Lead at the CMS Hospital Inpatient VIQR Outreach and Education Support Contractor. I will be the moderator for today's event and will also be a speaker along with my colleague, Dr. Artrina Sturges, who is the [Hospital Inpatient] VIQR Outreach and Education Support Contractor lead for the Alignment of Electronic Clinical Quality Measures. We also have with us today Veronica Dunlap who will be assisting with the polling questions and the live Q&A session later in this presentation. Before we begin, I'd like to make our first view regular announcements. This program is being recorded. A transcript of the presentation along with the answers to the questions asked today will be posted to the inpatient website *www.QualityReportingCenter.com* at a later date. If you registered for this event, a reminder email and a copy of today's slides were sent out to your email about a few hours ago. If you did not receive that email, you can download the slides at our inpatient website and, again, that is *www.QualityReportingCenter.com*. If you have a question as we move through the webinar, please type your question into the chat window and we will answer questions as time allows at the end of the webinar. For the presenters to best answer your questions, we request at the beginning of your question, please type the slide number associated in the chat window.

This event will provide insight into the calendar year 2019 Hospital Inpatient Quality Reporting Program requirement, as well as a review of the calendar year 2019 Hospital Inpatient Quality Reporting Program and Medicare Promoting Interoperability Program areas of alignment.

At the conclusion of today's event, participants will be able to identify the quarterly and annual requirements for the Hospital Inpatient Quality Reporting Program, be familiar with the areas of alignment between the [Hospital] Inpatient Quality Reporting and Medicare Promoting Interoperability Program requirements and locate resources that are

available for both the Hospital Inpatient Quality Reporting and the Medicare Promoting Interoperability Programs.

Here's just a list of the acronyms that we use throughout the presentation.

In today's presentation, I will be covering the quarterly and annual Hospital Inpatient Quality Reporting Program requirement for calendar year 2019, except for the electronic clinical quality measures requirement. After addressing these requirements, I will turn the presentation over to Dr. Artrina Sturges to cover the calendar year 2019 electronic clinical quality measures reporting requirement for the Hospital IQR Program and the Medicare and Medicaid Electronic Health Record Incentive Program requirements.

So, let's start the review of the [Hospital] IQR Program requirements with our first polling question. Veronica, can you go over the question?

Veronica Dunlap: Thank you, Candace, and hello everyone. Again, we appreciate your time today on today's webinar, and we would like to get started with our first polling question regarding the Hospital IQR Program requirement.

The first question is, "Which of the following Hospital IQR Program requirements are submitted on a quarterly basis? (A) Clinical process of care measures, which also refer to the core measures or the chart-abstracted measures; (B) Aggregate population and sampling; (C) the HCAHPS Survey data which is the Hospital Consumer Assessment of Healthcare Providers and Systems; or (D) All of the above.

I would like to give everyone a few moments to go ahead and select the proper answer. Okay, we'd like to just give another second or two here. Okay, great. Rachel, let's go ahead and close our poll and review the answer.

For all of those who answered (D) all of the above, you are correct. All of these requirements are submitted on a quarterly basis for the [Hospital] IQR Program. Now, I would like to hand it back over to Candace to continue with the webinar.

Candace Jackson: Thank you, Veronica. We'll begin by going over the quarterly requirements. On a quarterly basis, IQR-eligible hospitals are required to submit their Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS, Survey data; their aggregate population and sampling count for the chart-abstracted measures or sets of measures; the clinical process of care measures, which are the chart-abstracted measures; the National Healthcare Safety Network, or NHSN, Healthcare-Associated Infection measures; and the web-based perinatal care elective delivery measure. Additionally, those that are selected for validation will need to submit their medical record. We will go through each of those requirements in a little more detail in the upcoming slides.

Hospitals must submit aggregate population and sample size counts for Medicare and non-Medicare discharges for the chart-abstracted measures only. So, this would include the counts for the Global and Severe Sepsis and Septic Shock initial patient population. The aggregate counts can be submitted either by accessing the population and sampling application within the *QualityNet Secure Portal* or by submitting an extensible markup language, or XML, file to the CMS Clinical Data Warehouse. Hospitals are required to submit the aggregate population and sample size counts even if the population is zero. Leaving the field blank does not fulfill the requirement. A zero must be submitted even when there are no discharges for a particular measure set. Additionally, if you do not have an emergency department and you have submitted an IPPS Measure Exception Form or waiver, you will still need to submit your global population count. As a note, the Perinatal Care Elective Delivery, or PC-01, aggregate population and sample size are not broken down by Medicare and non-Medicare discharges, and the data for this measure set are collected through the web-based tool located within the *QualityNet Secure Portal*.

There are three chart-abstracted clinical process of care measures that will be required for the [Hospital] Inpatient Quality Reporting Program for calendar year 2019, beginning with January 1, 2019 discharges. Hospitals must chart abstract and submit complete patient-level data for the ED-2

and the SEP-1 measures. The measures specifications and abstraction guidelines can be found within the *Specifications Manual for National Hospital Inpatient Quality Measures*, located on the *QualityNet* website. Please note that, for calendar year 2019, there are two applicable specification manuals: Version 5.5a which covers January 1 through June 30 discharges and Version 5.6 which covers July 1 through December 31 discharges. So, as you are abstracting for the different quarters, you will want to make sure that you are using the correct specifications manual. The patient-level data for these measures are submitted via an XLM file through the *QualityNet Secure Portal* and, although it is considered a chart-abstracted measure, only the exit data, not patient-level data, for PC-01 [are] submitted manually via the *QualityNet Secure Portal* online tool. Data for PC-01 cannot be submitted via an XML file. The measure specifications and abstraction guidelines for the PC-01 measure can be found within the *Specifications Manual for Joint Commission National Quality Measures* located on The Joint Commission website.

There are no changes in the Healthcare-Associated Infection, or HAI, measures that are required for the [Hospital] IQR Program. Hospitals will continue to submit the CAUTI, CLABSI, CDI, SSI, and MRSA Bacteremia measures to the National Healthcare Safety Network.

Although not a quarterly requirement, I would just like to take a few moments and address the Influenza Vaccination Coverage Among Healthcare Personnel measure. Hospitals must collect and submit annually to the Centers for Disease Control and Prevention through NHSN the HCP Influenza Vaccination Coverage Among Healthcare Personnel measure. The submission period corresponds to the typical flu season, which is October 1 through March 3,1 and the data for this measure are due annually by May 15 each year. So, for calendar year 2019, which would be the flu season from fourth quarter of 2018 through first quarter 2019, the data will need to be entered by May 15 of 2019.

For calendar year 2019, there were several changes to the claims-based measures. The Centers for Medicare & Medicaid Services, or CMS, uses a variety of data sources to determine the quality of care that Medicare

beneficiaries receive. For the quality of care claims-based measures, CMS uses Medicare enrollment data and Part A and Part B claims data submitted by the hospitals for Medicare fee-for-service patients. No additional hospital data submission is required to calculate the measure rate. Each measure set is calculated using a separate, distinct methodology and, in some cases, separate discharge period. Hospital-Specific Reports, or HSRs, for the claims-based measures are made available for hospitals via the *QualityNet Secure Portal*. The HSRs contain discharge-level data, hospital-specific results, and state and national results for the Hospital IQR Program. Hospitals will find their HSRs within the *QualityNet Secure Portal* in the Auto Route Inbox of Secure File Transfer. To be able to access the reports, you must be a registered *QualityNet* user and have been assigned both the Hospital Reporting Feedback Inpatient role and the File Exchange and Search role.

This slide just outlines the reporting periods and submission deadlines for the calendar year 2019 data. Please note that the deadlines for second, third, and fourth quarter 2019 population and sampling, clinical, HAI, and PC-01 data has been extended due to the original deadlines falling on a Saturday [or weekend or holiday].

Data accuracy is a vital component of the [Hospital] IQR Program. CMS assesses the accuracy of chart-abstracted and HAI data that [are] submitted through the validation process. CMS verifies on a quarterly basis that the chart-abstracted and HAI data can be reproduced by a trained abstractor using a standardized protocol. For chart-abstracted data validation, CMS performs a random and targeted selection of inpatient prospective payment system hospitals once a year. The random selection of 400 hospitals for fiscal year 2021 occurred in January 2019, and that list of hospitals can be found in the Data Validation section on *QualityNet*. In April or May of this year, an additional targeted provider sample of up to 200 hospitals will be selected for validation. The quarters included for fiscal year 2021 validation are third and fourth quarter 2018 and first and second quarter of 2019.

Support Contractor

All chart-abstracted measures included in the Hospital IQR Program, with the exception of PC-01, are included in the validation process. As PC-01 is recorded as aggregate data and not patient-level data, it is not included in the validation process. CMS will validate up to eight cases for clinical process of care measures per quarter, per hospital. Cases are randomly selected from data submitted to the CMS Clinical Data Warehouse by the hospital. For HAI, CMS will validate up to ten candidate cases per quarter, per hospital. The determination of a validation pass or fail status involves CMS calculating a total score across all quarters included in the validation fiscal year. If the calculated confidence interval or total score is 75 percent or higher, the hospital will pass the validation requirement. As in past years, a confidence interval document explaining the scoring and calculation will be provided on *QualityNet* at a later date.

As it is our goal to have all hospitals meet their [Hospital] Inpatient Quality Reporting Program requirement, we do have a few best practices or helpful tips to help you meet those requirements. The first best practice is to submit data early and not wait until the submission deadline. Hospitals can update and/or correct their submitted clinical data until the CMS submission deadline which immediately after the CMS Clinical Data Warehouse will be locked. No updates can be made after the submission deadline and will not be reflected in the data CMS uses. This also includes data submitted to NHSN. Data that are modified in NHSN after the submission deadline are not sent to CMS and will not be used in any CMS program. It is highly recommended that hospitals designate at least two *QualityNet* Security Administrators, one to serve as the primary security administrator and the other to serve as a backup. On the same line, it is also recommended that you have more the one person who's able to do your chart abstractions and submit that data to the CMS Clinical Data Warehouse. We went over this earlier, but we just want to reiterate that hospitals are required to submit that aggregate population and sample size counts even if the population is zero. Leaving the fields blank does not fulfill the requirement. A zero must be submitted even when there are no discharges for a particular measure set. And lastly, hospitals with five or fewer discharges, both Medicare and non-Medicare, combined in a

measure set in a quarter are not required to submit patient-level data for that measure set for that quarter. So, for the quarter, if you look at your Provider Participation Report and your population size and your Medicare claims count is five or less for any of the measure sets, you are not required to submit patient-level data for that measure set. However, even though you are not required to submit the data, CMS still encourages a submission of that data. If you do choose to submit the data, then one to five cases of the Initial Patient Population may be submitted. So, for example, if your sepsis population size is five, you would not be required to submit the sepsis patient-level data but, if you choose to submit it, you could submit just one case or two cases or up to all five of the cases.

There are some circumstances in which a hospital may be exempt from submitting data for a few of the required measures. If the hospital meets the criteria for any of these measures, then they can submit an [IPPS] Measure Exception Form. The [IPPS] Measure Exception Form may be used for the PC-01, ED-2, the SSI colon and abdominal hysterectomy, and the CAUTI and CLABSI measures. If your hospital has no emergency department and does not provide emergency care, you can submit the [IPPS] Measure Exception Form for ED-2. Otherwise, hospitals that do not have an emergency department and they do not submit a [IPPS] Measure Exception Form, you must abstract and submit patient-level ED files for each discharge quarter. If your hospital has no obstetrics department and does not deliver babies, you can submit the [IPPS] Measure Exception Form for PC-01. Otherwise, hospitals that do not deliver babies and do not submit an [IPPS] Measure Exception Form, must enter zero for each of the data entry fields in the PC-01 web-based data entry tool for each discharge quarter. Hospitals that performed nine or fewer of any of the specified colon and abdominal hysterectomy SSI procedures combined in the calendar year prior to the reporting year can request an exception from submitting SSI measures to fulfill the IQR HAI reporting requirement. And lastly, hospitals that have no units mapped as medical, surgical, medical-surgical, or ICU can request an exception from submitting CAUTI and CLABSI measures to fulfill the IQR HAI reporting requirement. Please remember that, if you do submit the [IPPS] Measure

Exception Form, that it must be renewed at least annually. The IPPS Measure Exception Form can be found on *QualityNet* under the Hospital Inpatient tab and then under the Hospital Inpatient Quality Reporting Program link.

So, let's just summarize what we have gone over so far. On a quarterly basis, hospitals are required to submit their HCAHPs survey data, the chart-abstracted population and sampling count, the clinical process of care measures, the HAI measures, aggregate PC-01 data, and validation records if they have been selected for validation.

Now Veronica, can you please go over our next polling question?

Veronica Dunlap: Sure, Candace. Hello, again, everyone. We'd like to take a few moments here and ask our audience our second polling question. So, let's get started. Which of the following Hospital IQR Program requirements are submitted annually or once a year? (A) the Data Accuracy and Completeness Acknowledgment, also referred to as the DACA; (B) two active *QualityNet* Security Administrators; (C) electronic clinical quality measures, or eCQMs; (D), which includes the DACA and eCQMs, (A) and (C); or (E) all of the options above.

So, let's go ahead and take a moment and please record your answer and we'll give the poll a couple of seconds here for everyone to submit their response. Okay, let's give it another few seconds here. Okay, Rachel, it looks like we can go ahead and close our second poll.

Great. For all of those who selected (D), which includes the DACA and eCQMs, you are correct. Those two requirements are submitted once a year and they're not quarterly. For all of those who selected the two active *QualityNet* Security Administrators, please keep in mind that the [Hospital] IQR Program only does require one. However two, at least two, is highly recommended as a backup. Okay and that concludes our polling question, and I would like to hand it back over to Candace.

Candace Jackson: Thank you, Veronica. The only change to the IQR requirements that are due on an annual basis was the removal of the structural measures and

we'll briefly go over the annual requirements. As Veronica noted, hospitals are required to maintain an active *QualityNet* Security Administrator at all times. As I stated earlier, it is highly recommended that hospitals designate at least two Security Administrators. It is also recommended that the Security Administrator log into their account at least once a month to maintain an active account. Any accounts that have been inactive for 120 days will be disabled. The Data Accuracy and Completeness Acknowledgment, or DACA, must be completed and signed on an annual basis. The DACA is done via the *QualityNet Secure Portal* and it electronically acknowledges that the data submitted for the Hospital IQR Program [are] accurate and complete to the best of the hospital's knowledge. The open period for signing and completing the DACA is April 1 through May 15, with respect to the reporting period of January 1 through December 31 of the preceding year. Additionally, hospitals must submit the electronic clinical quality measures annually which Artrina will cover later on in this presentation.

Just to reiterate, hospitals are required to complete the DACA on an annual basis via the *QualityNet Secure Portal*. As noted before, the data submission period is between April 1 and May 15 with respect to the reporting period of January 1 through December 31 of the preceding year. However, for calendar year 2019, the submission deadline for the DACA will be extended until May 18, 2020, due to the original deadline falling on a Friday.

So, just to summarize again, the annual IQR requirements are to have at least one active *QualityNet* Security Administrator, sign the DACA, submit the HCP measure, and submit the required eCQMs.

This slide just provides you with some resources that are available to you for assistance with the [Hospital] Inpatient Quality Reporting Program.

And this slide provides you with some tools, resources, reference and training materials that are available to assist you in meeting the Hospital IQR Program requirements.

I would now like to turn the presentation over to Dr. Artrina Sturges to cover the calendar year 2019 eCQM reporting requirements for the Hospital IQR Program. Artrina, the floor is yours.

Dr. Artrina Sturges: Thank you, Candace, and good afternoon everyone. Now, at this time Veronica is going to join us to start off with a polling question, Veronica?

Veronica Dunlap: Thank you, Artrina, and hello everyone. We'd like to get started with our last polling question. For calendar year 2019 reporting, hospitals are required to submit all 15 available electronic clinical quality measures for all four quarters: (A) True or (B) False.

Please take a few seconds and select the correct response. Okay, we'd like to just give it another second or two here. All righty, Rachel, if you wouldn't mind, go ahead and close the poll and we'll take a look at the answer.

Thank you. Yes, the answer is (B) False, and I will go ahead and hand it back over to Artrina to further review the eCQM portion.

Dr. Artrina Sturges: Thank you, Veronica. We'll start by reviewing the calendar year 2019 eCQM reporting requirements. Hospitals participating in the Hospital IQR Program are required to report on four of the 15 available eCQMs for one self-selected quarter of calendar year 2019 data for the March 2, 2020 submission deadline.

We provided a chart of the available eCQMs. A similar chart is available for download under the eCQM Measure Information tab on the *QualityNet* website, as well as the eCQM Resources tab for IQR on the *Quality Reporting Center* website.

Hospitals are also required to use the EHR technology certified to the 2015 Edition of ONC standards and certified to all available eCQMs. The eCQMs specifications required for reporting were published in the 2018 annual update for calendar year 2019 reporting. This also includes all applicable addenda. The specifications information and the *2019 CMS*

QRDA Category I Implementation Guide for Hospital Quality Reporting are posted on the eCQI Resource Center. The links are provided on this slide.

The definition for successful submission of eCQMs is a combination of accepted QRDA Category I files for patients meeting the initial patient population of the applicable measures, zero denominator declarations, and case threshold exemptions.

So, we'll provide a quick summary of the last few slides. Hospitals participating in Hospital IQR Program are required to report on four of the 15 available eCQMs for one self-selected quarter of calendar year 2019 data by the March 2, 2020 submission deadline. Hospitals are also required to use EHR technology certified to the 2015 Edition of ONC Standards and certified to report on all available eCQMs. The eCQM specifications required for reporting were published in the 2018 annual update for calendar year 2019 reporting. Again, this also includes all applicable addenda. The specifications information and all supporting documentation such as the eCQM value sets addendum, measure logic guidance, and, as we mentioned earlier, the *2019 CMS QRDA Category 1 Implementation Guide for Hospital Quality Reporting* are posted on the eCQI Resource Center. Just a quick refresher that the definition for successful submission for eCQMs is a combination of accepted QRDA I files for patients meeting the initial patient population of the applicable measures, zero denominator declarations, and case threshold exemption.

With regard to how data [are] reported via QRDA Category I, the expectation is one file per patient, per quarter. The QRDA I files should contain all episodes of care and the measures associated with the patient file in that self-selected reporting period. The maximum QRDA file size if 10 megabytes. Files are uploaded by zip file before submission to the *QualityNet Secure Portal*. The maximum number of QRDA files within that zip file should be 15,000. And, if a hospital finds that they have more than 15,000 files to report, feel free to submit the number of zip files needed to represent your patient population for the quarter. If you have any questions, please contact the *QualityNet* help desk.

Just a quick reminder, as in prior years with eCQM reporting, public display of eCQM data on *Hospital Compare* is delayed. Public display of eCQM data will be addressed in a future IPPS rule.

The eCQM validation process is unchanged from last year. Following the close of the calendar year 2019 eCQM submission period, up to 200 hospitals will be randomly selected for eCQM validation of calendar year 2018 data. The slide lists the exclusion criteria for greater details. So, please keep in mind that the exclusion criteria will be applied before hospitals are randomly selected.

We'll quickly review the number of cases required for submission and scoring. Hospitals selected for eCQM data validation will be required to submit eight cases for one quarter of calendar year 2018 eCQM data for the fiscal year 2021 payment determination. The accuracy of eCQM data submitted for validation will not affect a hospital's validation score. Hospitals will pass or fail validation based on the timing and complete submission of at least 75 percent of the records requested by CMS.

To review this and other information, we encourage you to visit the Data Validation - Chart Abstracted and eCQM page on the *QualityNet.org* website. The link is provided on this slide.

And now we'll take a few moments to review the calendar year 2019 eCQM reporting requirements for the Medicare Promoting Interoperability Program. For the Promoting Interoperability Program, eligible hospitals and critical access hospitals who are electronically reporting are asked to report on at least four self-selected measures for one quarter of clinical quality measures or CQMs. The quarter to report on is the hospital's choice as well and, just a quick reminder, the submission deadline is March 2, 2020.

The information listed here is the same as what we reviewed earlier in the webinar. One additional note that I'd like to add is that the requirements that have the EHR technology certified to the 2015 Edition do not require recertification each time the EHR technology was updated to the most

recent version of clinical quality measures if it continues to meet the 2015 Edition certification criteria. Any questions regarding this information should be directed to the *QualityNet* help desk.

Hospitals that choose to fulfill the Medicare Promoting Interoperability Program using attestation are permitted to report for the full calendar year which equates to four quarterly data reporting periods on all 16 available CQMs. The submission deadline is March 2, 2020, and again, any questions regarding Promoting Interoperability Program should be submitted to the *QualityNet* help desk.

State Medicaid Programs for the Promoting Interoperability Program will continue to determine whether or how electronic reporting of CQMs would occur or if they wish to allow reporting through attestation. We provided the link to the Promoting Interoperability Program Medicaid State Information page to assist you to obtain additional details.

Oftentimes, submitters have questions regarding the attestation process. We encourage you to visit the Eligible Hospital Information page on CMS.gov to obtain additional details regarding updated reference guides and posted webinar materials. And once again, the *QualityNet* help desk is the primary resource for assistance.

I'd like to take a few moments to review the key points regarding clinical quality measure reporting and the PI Program. Hospitals have two ways to meet the Promoting Interoperability Medicare clinical quality measure reporting requirement: either through successful electronic reporting of CQMs which fulfills the Hospital IQR and the PI requirement with one submission or hospitals have the option to attest if the hospital is only participating in the Promoting Interoperability Program. So, for example, this would be applicable to critical access hospitals. It's important to remember that if the hospital attests for the PI Program, they're required to attest to all 16 measures for all four calendar quarters by the deadline, March 2, 2020. The eCQI Resource Center is your source of truth to locate all educational materials regarding eCQM reporting. Another quick reminder that the CMS.gov Promoting Interoperability webpage is your

resource for all materials associated with attestation. And one last comment, state Medicaid PI Program details are available on the CMS.gov Medicaid State Information page.

We have provided a table of resources categorized based on the topic, who to contact for assistance, and the method for reaching out or locating information.

Now at this time, Veronica Dunlap will join us again to begin addressing questions that are entered into the chat box. Please continue to enter your questions and we will do our best to address your questions during the webinar. Veronica, the floor is yours.

Veronica Dunlap: Great, thank you, Artrina and hello everyone. Let's get started with our first question. In regards to the Healthcare-Associated Infection measures, or HAI measures, does CMS plan on removing them in the future?

Candace Jackson: Thank you, Veronica. This is Candace. Yes, the HAI measures will be removed from the [Hospital] IQR Program with fiscal year 2022. However, please note that you will continue to submit the HAI measures as the measures will remain in the Hospital-Acquired Condition, or the HAC, Reduction Program. So, just because they go away from IQR does not mean that they're being removed completely, and you will still be required to submit those measures for the HAC [Reduction] Program.

Veronica Dunlap: Great, thank you, Candace. Rachel, if we could maybe move to Slide 18. It looks like we have a question there.

Okay, here on Slide 18, the question is, "What are the criteria for the targeted provider sample?"

Candace Jackson: Okay, this is Candace again. And actually I think that's going to be 20.

Veronica Dunlap: Yes, thank you.

Candace Jackson: Right, 20. Right off the top of my head, I cannot list off all of the different criteria that are under the targeted sample. You can find that information in the fiscal year 2014 IPPS Final Rule which is 78FR, pages 50833 to

50834. If you have additional questions about the targeted or the random sample, you can go to *QualityNet* and that information is there. I would also recommend that you go to some of the chart-abstracted webinars for validated, both the targeted and random that are out on the *QualityReportingCenter.com* website. There was a webinar in February of this year that went over the random selection and what you need to do for validation for that. And there will be a targeted validation webinar coming up later next month May-early June. So, you'll want to watch for that. And also again, if you have specific questions, if your hospital has been selected as the targeted hospital, you can always contact the validation support contractor with your questions at validation@hcqis.org. Thank you, Veronica.

Veronica Dunlap: Thank you, Candace. Okay, looks like our next question is regarding the healthcare personnel influenza vaccination coverage measure, the HCP measure. Where do we enter this information? Is this information entered in *QualityNet*?

Candace Jackson: Good question, thank you, Veronica. No, the HCP influenza vaccination measure data [are] entered into the CDC's National Healthcare Safety Network, the NHSN. And then the CDC will supply CMS with the data that have been entered in there. So, you do not enter it directly into *QualityNet*. You'll need to enter it into NHSN.

Veronica Dunlap: Great, thank you. Rachel, if we could to Slide 32. It looks like there's a question on the stroke measures. All right, are we able to get the Slide 32 on the requirements?

Candace Jackson: Try slide 38, Veronica.

Veronica Dunlap: Oh thank you. And the question is, "We currently report on all six of the stroke measures. Are we required to report any of the other measures?"

Dr. Artrina Sturges: Hi, Veronica. This is Artrina. In terms of the measures that are reported, CMS just asks that you report on whichever measures are represented by your population. So, if you have patients who, you know, fit specific categories, if you have certain types of care, we know for some folks it's a

little bit different. But, if you find that in your case that reporting on the six stroke measures represents your population or if it turns out you're submitting QDRA I files for your patients and it turns out that the majority of what you're reporting on are stroke measures then that's sufficient. Just make sure that whatever measures you're reporting because, again the focus is on patient files not specifically on the measures themselves, so you want to make sure that any patients that you're reporting on, whatever measures are represented by that care, that's what you should be reporting on to CMS.

Veronica Dunlap: Okay, thank you, Artrina. Our next question: "For a hospital that is changing their electronic health record system in late November 2019, is it possible to submit data from November and December for quarter four but does not represent the full quarter?"

Dr. Artrina Sturges: Very good question, thank you, Veronica. So, in this particular case, CMS is going to encourage you to report any data that you have, even in the midst of a transition in EHR. But what you can also do, since it's not fully representative of what you would be able to report due to that transition, we encourage you to submit that Extraordinary Circumstances Exception application. All that information is available on the *QualityNet.org* website. But we encourage you to do that if it turns out that for some reason a hospital can't fully represent their data for a quarter.

Veronica Dunlap: Thank you. Next question: "When will the PSVA tool be updated for calendar year 2019 reporting?"

Dr. Artrina Sturges: Hi, this is Artrina. PSVA, as soon as that is updated to receive 2019 to test that file format, CMS will send a ListServe out to the community. You'll see the ListServe come out. There will probably be an update to the *QualityNet* website. And of course, we'll make any updates during any webinars or any other calls where we're able to communicate that information out to you.

Veronica Dunlap: Great. Next question: "Where do I go to see if my hospital was selected for the eCQM validation?"

Dr. Artrina Sturges: Thanks, Veronica. This is Artrina. Notification actually happens a couple of ways. You have a news article that's typically posted on *QualityNet* along with the list of selected hospitals. The ListServe will also be released to notify the community that selection has occurred. An email communication from the validation support contractor is typically sent directly to the hospitals that are selected. The other thing that kind of happens with this is that if you want to visit the *QualityNet.org* website, once it's communicated that this is active, if you hover over the Hospital Inpatient dropdown, you can select Data Validation. And you'll see that it's for chart-abstracted eCQMs. And there's a link there. And then it's followed by selecting eCQM Data Validation Program. There'll be a list and it's typically on the upper right-hand side of the screen. And within the box it will say, hospitals selected for inpatient eCQM data validation.

Veronica Dunlap: Thank you. Next question: "Is there an issue if the population and sampling counts are one or two patients off from the total inpatient admissions?"

Candace Jackson: Hi. This is Candace. No, there is no penalty for that. When you enter your population and sampling, it is the counts at the best of your knowledge at that time. So, if you had determined your population count was 25 at the time of the submission deadline and you entered that and that was the count to the best of your knowledge, if it later turned out to be 26, there will be no repercussions due to that.

Veronica Dunlap: Thank you. Next question: "Does a hospital have to submit 100 percent of the eCQM patients that were included in a hospital's quarter or just submit a sample of those patients?" I think they're referring to the 100 percent of the patient population for eCQMs.

Dr. Artrina Sturges: Thank you; this is Artrina. Yes, just to continually clarify; it needs to be 100 percent representative of your patient population for the self-selected quarter.

Veronica Dunlap: Next question: "Has the IMM measure been removed for reporting?"

Candace Jackson: For the [Hospital] IQR Program, the immunization IMM-2 measure was removed beginning first quarter 2019. So, that was beginning January 1,

2019 discharges. It is no longer being collected. So, the last time you would have been able to abstract and submit an IMM-2 case would have been December 31, 2018.

Veronica Dunlap: Great, thank you. Next question: "If you do not have an emergency department and less than five patients with sepsis, are you required to do any of the chart-abstracted measures?"

Candace Jackson: If all you had was five sepsis cases, the five and fewer rule would apply. And you would not be required to submit the patient-level data for the sepsis measure. Now, please remember for if you have no emergency department, you will want to make sure you fill out the [IPPS] Measure Exception Form for ED because, even if you don't have an ED and you don't have any patients, if you do not submit that form then you would be required to submit cases for the ED measure since it falls under the global population.

Veronica Dunlap: Great, okay, thank you, Candace and Artrina. I'm going to go ahead and hand it over to Dr. Price to review the continuing education process. And again we thank you for your time today. Deb?

Dr. Deb Price: Well, thank you. And I'd like to talk to everyone for a moment about continuing education credit.

This presentation has been approved for continuing education credit by the boards listed on this slide. If your board is not listed, you can forward your certificate to your own board and see if they accept this certificate across state lines.

There are three easy ways to get your credit. Number one: Complete the survey at the end of the event. Number two: Register as a New User or an Existing User on HSAG's Learning Management Center. Number three: Printout your certificate from the Learning Management Center website. I have a couple of caveats, however, and let me just go over those real quick. The first one is this is a separate registration from the one that you used with ReadyTalk. So ,please if you are a new user, use your personal

email and that's because healthcare facilities have blocks on our automatic link. So, sometimes they don't work.

This is what the survey will look like when you see it. It will pop-up at the end of our slide. And will also be sent to you within 48 hours, so you'll have a second one. When you're done, click on the Done button down in the bottom right-hand corner.

And this is the page that pops up after you click that Done button. You'll notice that there are two green links in the middle. The first one is if you have never attended or never received credit. Click that New User link. The second one is, if you have been attending our events and you have not had any problems so far, then you click the existing user link.

And depending on which link you clicked on, you will be taken to one of these two pages. For the New User link on the left, use your personal email and your personal phone number. If you had any problems getting credit before, I'm asking that you go back and register as a New User with your personal email and personal phone number. If you are an Existing User, the right-hand side of the screen is what pops up. You're going to use your entire email address as your user name and that's including what's after the @ sign.

And now I'd like to thank everyone for attending today's event. If we didn't get to your question, all submitted questions related to the webinar will be posted to the *QualityReportingCenter.com* website at a later date.

We hope you learned something today. Thanks and enjoy the rest of your day. Goodbye.