Inpatient Quality Reporting Program

Support Contractor

Introduction to Inpatient Quality Reporting Program
AM Questions and Answers

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Question 1: I thought PO Sepsis had been suspended?

Answer 1: That is correct. The chart-abstracted Sepsis Measure has been suspended at this time.

Question 2: But I also thought the PSI-13 was not included either in the AHRQ PSI-90 Composite?

Answer 2: PSI-13, Post-operative Sepsis Rate, is one of eight of the underlying indicators for the PSI-90 Composite.

Question 3: I ran our facility Provider Participation Report for the 2nd quarter and noticed that there is a “NO” to the IQR-HAI CAUTI measure. We

have CAUTI cases and [they] were submitted via NHSN. Why is [it] still showing “NO?” Is this a known issue? Thanks.

Answer 3: You will need to go into NHSN and check your alerts for possible missing data. You should also check your summary data and your events. If you have any months with no events, you will need to be sure you check “No Events.” You can also run new data sets. You may also run the Facility, State, and National Report to verify that your CAUTI data is complete if it is not showing up on the Provider Participation Report.

Question 4: Also, does the three minimum mean that three patients meet the denominator criteria, or the numerator criteria? Sorry for so many questions.

Answer 4: Thank you for your inquiry. The three-case minimum on any one underlying indicator is for denominator criteria.

Question 5: Does that mean if from State and National reports it displays “Yes,” that we have submitted CAUTI cases, it should be fine even if we don't see it in [the] Provider Participation Report?

Answer 5: Correct.

Question 6: I asked this question to *QualityNet* in August and still haven't heard from them, maybe you can answer it for me, or tell me how I can get it answered. Thank you. Our ED record says “Disposition: Admit to Hospital at 1600”; under assessment it says “Adm.”

Answer 6: Abstraction questions cannot be responded to during this presentation. Please re-submit your question to the Q & A tool on *QualityNet*.

Question 7: Regarding Slide 10, in reference to minimum eligible cases, I assume you are referring to denominator cases?

Answer 7: Thank you for your inquiry. The three-case minimum on any one underlying indicator is for denominator criteria.

Question 8: "Admit to Hospital at 1530” ... Which time should I use, the earliest or the one under disposition for ED thru Decision to Admit.

Answer 8: Please re-submit to the Q & A tool.

Question 9: I have, to no avail.

Answer 9: Be sure you submit questions on the "Admission Date" data element to the HIP - Data Collection topic, and select "Admission Date" as the sub-topic. The question will be answered from that topic area.

Question 10: Kathleen, how did you roll out [the] Good Catch Award, and what criteria are used to determine "best" Good Catch?

Answer 10: When we rolled it out, it was basically just a lot of marketing among staff. In fact, it was slow going at first. Staff was not anxious to report near-misses. However, after we did it, and we started out awarding very simple ones, because that's basically all we got. And as people saw the recognition and the people who were winning prizes (we put their pictures in newsletters), slowly but surely we've gotten more meaty events reported to us. So, it was a slow, gradual process, but a lot of marketing, a lot of pushing the managers to push their staff to report things. It did take some time, though. It probably took close to a year before people started feeling comfortable.

Question 11: For Delta Regional, what data did you provide to surgeons? Did you get push-back from surgeons who were not performing as well?

Answer 11: Very good question, and you know quite well we received a lot of pushback from those physicians that felt our data did not readily support what they were doing. In the end, we provided them with data that we had pulled and mined manually after we had started with running a list of sepsis patients that had been seen in the last 12 months.

So, we ran the list. We looked at those that were post-operative sepsis patients. Then we really dug into those and looked at the treatment: did it align with a standard treatment? We used our pharmacokineticist a lot in reviewing these records, as well as our ID doctor, so that we could rely back to them for peer information.

Once we had what we felt were the actual facts of the record, we would present them with the surgeon. Of course, initially the remark that we would get is, "Well, no, I handled that patient because …" and then they would give us a reason. So it was really a very interactive process where we provided the data, then they provided the excuse, and then we gave the rationale as to why that excuse was not valid.

There were a couple of cases where the patient may have had some little piece of medical history or some little indicator that indicated that they would be treated differently. But, ultimately, we just reasserted the information within and the evidence behind it. And once they became accustomed with our process of just providing them evidence of why it should have been handled differently, they kind of all accepted the information. And, on occasion, they will ask. But now it's kind of a routine conversation. They understand that we're going to provide them the evidence of why it should have been done a little differently, or why we had an opportunity for improvement. I hope that answered your question.

Question 12: Angela, do you do concurrent coding at your facility?

Answer 12: This is Angie. I'll start with that one. We do review concurrent coding. We do that using our EMR based on the diagnosis entered for "Reason for Admission" or "Reason for Visit." We also are fortunate enough within our EMR to have very quick or concurrent coding completed.

So our abstractors look daily at the census and look at the reasons for the patients being admitted from their diagnoses. They cast a very large net. And then, over the next 24 to 48 hours, if those patients may be coded by the nurse coders or they may be discharged and coded, they go back and start to clean up their process there and really deleting those patients that maybe don't meet our needs.

Question 13: Delta Hospital, was a particular surgery associated with more of your PSI-12 events? If so, were you already using best practices or did you need to identify and encourage use of best practices?

Answer 13: That's a very good question. Thank you. We did identify one surgery procedure that was more prevalent in our post-operative sepsis patients. We did go back to that physician that was performing the procedures and really reviewed his processes and how he was practicing and performing the procedure. What we found is that there were some opportunities for best practices to be implemented. But we also found that there were a few miscommunications in the steps of who was doing what, when.

So, once we were able to really walk it out, everyone looking at the same path, and put it all on paper so everyone could see where they were in the process, we were able to really solve the problem very quickly, and we've had no more incidents since then.

Question 14: Do you employ your physicians, including surgeons, or are they all independent from [the] hospital?

Answer 14: We employ the majority of our physicians. Of all surgical providers, we employ roughly 60% of them.

Question 15: I would like to contact those who stated that they have "Nurse Coders." I am interested in when a Nurse Coder would code a record versus when a patient would be discharged and coded. What criteria is used to determine the method to use?

Answer 15: We do use "Nurse Coders" at our facility. Our Nurse Coders review the majority of non-surgical inpatient records. Their coding is not final coding, but decreases the work burden of final coding. The Nurse Coders have a concurrent review process, as well.

The following questions will continue to be researched, and we hope to have a reply shortly.

Question 1: For the FY 2015 Hospital VBP Program, why does CMS only take nine Diagnosis codes and six Procedure codes? For the majority of CMS programs, they take the full 25 Diagnosis codes and 25 Procedure codes that are allowed to be transmitted on the UB-04.

Answer 1: Thank you for your inquiry. CMS has not discussed this topic in relation to the Hospital VBP Program in the IPPS Rules. We recommend that you submit a formal comment to the FY 2016 IPPS Proposed Rule.

Question 2: How does Mathematica work with [The] Joint Commission on FAQs and Measures Spec inquiries to make sure they are consistent?

Answer 2: The Joint Commission is a subcontractor to Mathematica under their Measures Maintenance contract. We work closely together to ensure consistency in response.

Questions 3: I just wanted to make sure I understand how the PSI-90 Composite is compiled: is it based on submitted coded charts of traditional Medicare patients?

Answer 3: The PSI-90 Composite measure is claims-based, meaning the data used for the calculations are derived from eligible Medicare claims and are not chart abstracted by a member or representative of the hospital. The AHRQ PSI-90 Composite utilizes Medicare Fee-for-Service patients with complete Present on Admission or POA data, excluding data from patients in Medicare Advantage plans.

Question 4: For Angela, are you planning on changing your core measure review process with the decrease in measures and the weighted change in Value-Based Purchasing? We are concerned about [a] drop in compliance in care with measures being dropped.

Answer 4a: **[Angie]** We have restructured our reporting. However, we are not planning to restructure our data abstraction. We, too, feel that if we really allow that to fall by the wayside, we'll see an impact to the care delivered to the patient there. So, for the next six to 12 months, we'll keep our original abstractions and add to it, paying more focus to those things that are going to be restructured and calculated in the Value-Based Purchasing. However, we're not quite ready to let go of those other measures just yet, until we really know for sure and feel confident that the staff and the physicians have a grasp on that.

Answer 4b: **[Kathleen]** Yes, and at Bergen we're also continuing to collect that data. We saw a little falloff in our core measures when we moved to an electronic medical record. So, we very much have to continue to pursue those that are going away, so to speak.

Question 5: Question to Angela: Who are the members/attendees of your Patient Safety Committee?

Answer 5: Our Patient Safety Committee is made up of an interdisciplinary group that contains our front line, some front line staff, director staff is involved, quality, nursing administration, senior administration, and then the information from there is rolled to our Quality Committee which has physician participation at that level. We also share a staff with laboratory, radiology and several other therapies involved in that committee.

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