Appropriate Treatment for STEMI Patients in the Emergency Department (ED)

Presentation Transcript

Speakers

Amanda Audette, MPH
Research Associate IV, Yale/YNHH Center for Outcomes Research and Evaluation (CORE)

Moderators

Karen VanBourgondien, RN, BSN
Outpatient Quality Program Systems and Stakeholder Support Team

Danielle Leffler, MS
Outpatient Quality Program Systems and Stakeholder Support Team

Karen VanBourgondien: Hello everyone. My name is Karen VanBourgondien. I am with the Outpatient Quality Program Systems and Stakeholder Support team. Thank you for joining us today for our discussion on the new eCQM for this program. As you now, OP-40 is the first eCQM for the Hospital OQR Program and we are excited to bring you information and we have the measure writers from Yale CORE here with us today to discuss this measure. We are also going to be addressing your questions. We do have quite a large audience today so if we do not get to your question either in the chat box, or verbally, please put your question in the QualityNet Q&A tool and we will put that direct link to that in the chat box.

Our speaker today is Amanda Audette, she is with Yale/CORE. So, without any further delay let me turn things over to Amanda.

Amanda Audette: Thank you, Karen. To orient you to today's webinar, we list the agenda here. Today, we will review objectives, background, measure specifications, the reporting timeline – from voluntary to mandatory reporting, resources, including measure-specific resources, educational resources, and the JIRA Q&A submission process. We will also be answering questions from attendees.

Here, we overview objectives for this webinar. By the end of the presentation, participants will be able to state the 2024 mandatory reporting of the appropriate treatment for STEMI Patients in the ED eCQM, identify calendar year 2024 eCQM reporting requirements for the Hospital Outpatient Quality Reporting Program, or OQR, and locate resources to ensure successful submission of STEMI eCQM measure data, including measure methodology and educational support.

A brief overview of the history of this measure. Hospitals have been reporting eCQMs in the Inpatient Quality Reporting and Promoting Interoperability programs since calendar year 2016. The STEMI eCQM was finalized in the calendar year 2022 Hospital Outpatient Prospective

Payment System, or OPPS, Final Rule as the first eCQM in the program. The measure ID is OP-40; and the eCQM measure ID is CMS996e.

The STEMI eCQM measure replaces two chart-abstracted measures: OP-2: *Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department (or ED) Arrival*, and OP-3: *Median Time to Transfer to Another Facility for Acute Coronary Intervention*. These two measures were finalized for removal from the OQR Program beginning with calendar year 2023 reporting period or calendar year 2025 payment determination.

The STEMI eCQM is a process measure, calculated via Electronic Health Record, or EHR, data. The measure score is the percentage of ED encounters for patients with a diagnosis of STEMI, who received appropriate treatment. Improvement is noted as an increase in rate, measured at the facility level.

The denominator of this measure includes all ED encounters for patients 18 years of age and older with a diagnosis of STEMI, who should have received appropriate treatment for STEMI. The numerator includes ED encounters for STEMI patients, who received appropriate treatment via one of three scenarios. The first is whose time from ED arrival to fibrinolytic therapy is 30 minutes or less; the second is for non-transfer ED STEMI patients who received percutaneous coronary intervention, or PCI, within 90 minutes of ED arrival; and the third is for ED STEMI patients who were transferred to a PCI-capable hospital within 45 minutes of ED arrival at a non-PCI-capable hospital.

There are several denominator exclusions to this measure, for which we will overview by time frame. Within 24 hours before the start of ED encounter or during the ED encounter, patients are excluded from the denominator with: aortic dissection or ruptured aortic aneurysm; severe neurologic impairment; mechanical circulatory assist device placement, including aortic balloon pump, biventricular assist device, intra-aortic balloon, intra-aortic balloon counterpulsation, intra-aortic counterpulsation

balloon pump, left ventricular device, percutaneous ventricular assist device, or ventricular assist device. Additionally, intubation, including endotracheal intubation, mechanical ventilation, nasotracheal intubation, or orotracheal intubation; and cardiopulmonary arrest (including cardiac arrest), CPR, defibrillation, respiratory arrest, or ventricular fibrillation (or V-fib), ventricular tachycardia (or VT), pulseless electrical activity (or PEA); or, traumatic or prolonged CPR lasting greater than 10 minutes.

Other denominator exclusion include: during the ED encounter, patients who had an allergic reaction to alteplase, streptokinase, anistreplase, tenecteplase, or reteplase; patients who expired in the ED: within 90 days before start of ED encounter, patients who underwent intracranial or intraspinal surgery; and within 90 days before start of or at the start of ED encounter, patients who had ischemic stroke, significant facial and/or closed head trauma, or peptic ulcer.

The measure also excludes from the denominator: within 21 days before the start of, or starts during ED encounter, patients who underwent major surgery; and, at the start of ED encounter, patients who have bleeding or bleeding diathesis (excluding menses), known malignant intracranial neoplasm (primary or metastatic), known structural cerebral vascular lesion, or AVM, advanced dementia, pregnancy, or are on active oral anticoagulant therapy.

Here, we present the reporting timeline for the STEMI eCQM. For the calendar year 2023 reporting period, hospitals may submit any quarter or quarters of data by the May 15, 2024, submission period deadline. Please note this period if for voluntary reporting, and thus, does not impact payment determination. For the calendar year 2024 reporting period, hospitals must submit one quarter of data that they may self-select, by the May 15, 2025, submission period deadline. This will impact calendar year 2026 payment determination. For the calendar year 2025 reporting period, hospitals must submit two quarters of self-selected data, by the May 15, 2026, submission period deadline, which will impact calendar year 2027 payment determination. For the calendar year 2026 reporting period,

hospitals must submit three quarters of self-selected data, by the May 17 2027, submission period deadline, which will impact calendar year 2028 payment determination. And lastly, for calendar year 2027 reporting, hospitals must submit four quarters, or one full calendar year of data, by the May 15, 2028, submission period deadline, which will impact calendar year 2029 payment determination.

Here, we provide a reporting timeline example. While voluntary reporting begins with calendar year 2023, we use the calendar year 2024 reporting period, the first round of mandatory reporting, for calendar year 2026 payment determination, as this example. So, in this scenario, calendar year 2026 payment determination is calculated based on admissions from January 1st to December 31st, 2024, in which data must be submitted by hospitals for the May 15, 2025, submission deadline. Confidential reports will be distributed to hospitals in the summer of 2025. Please note that while a measured entity with no qualifying denominator population in the measurement period will be able to submit a zero-denominator declaration for the measure to meet reporting requirements for that period. Please also note that hospitals must use Health Information Technology certified by the Office of the National Coordinator for Health IT, or ONC to the 2015 Edition Cures Update criteria.

For additional resources, hospitals may access I eCQI Resource Center at ecqi.healthit.gov. There, you will find measure specifications, definitions, value sets, and flowsheets; the ONC Project Tracking System, which is available at oncprojectracking.healthit.gov. From there, you can create an account, search for an issue, create an issue, and submit technical and implementation questions in the ONC Project Tracking System, otherwise known as JIRA. For hospital outpatient reporting guidance, you may visit *QualityNet* and the Quality Reporting Center for specific program reporting education. And all the links I just mentioned are available on this slide.

Now, we will overview the eCQI Resource Center.

Here, you can see the eCQI Resource Center homepage.

From the homepage, hover your cursor over eCQMs. From the drop-down box, select Outpatient Quality Reporting eCQMs.

This will take you to the measure information page. From there, you can filter by period from the *Select Period* drop-down box. Select the "STEMI eCQM" option.

On the STEMI eCQM measure-specific page, you can find Measure Information Specifications and Data Elements, as well as Technical Release Notes for the corresponding update cycle.

On the eCQI Resource Center, you will also find resources related to the QRDA (Quality Reporting Document Architecture). From the homepage, hover your cursor over "Resources." Then select "QRDA" (Quality Reporting Document Architecture) from the drop-down box.

On the QRDA page, you can select "Education" from the available resources tabs.

Some features of the QRDA education page include informational slides and videos, available in each category. Please note, a detailed reporting webinar on the QRDA will be upcoming.

Here we will overview the ONC Project Tracking System. In other words, how to submit a JIRA inquiry.

To create a ticket, first, go to oncprojectracking.healthit.gov. From the homepage, select "Create an Issue Ticket." If you do not have an account, select the "Create an Account" option, where you will create a username and password.

Enter your username and password, and select "Log In."

Once you are logged in, select "eCQM Issue Tracker" from the *Project* drop-down menu, select "OQR eCQMs" from the *Issue Type* drop-down menu and click "Next." From there you can draft and submit your inquiry for a response. That includes the end of the informational part of this.

Karen VanBourgondien: Thank you, Amanda. We appreciate you sharing that with us. We do have some time, so I think it would be good if we just went over some questions if that is okay with you.

Amanda Audette: Absolutely**.**

Karen VanBourgondien: Okay, I am also going to bring in Danielle Leffler. She is an education specialist for our team as well because I see there are some program related questions as well. So, Danielle, if you don't mind if you can unmute. Are you there?

Danielle Leffler: I'm here.

Karen VanBourgondien: Okay, perfect. So, Amanda, the first question is *"How do we identify PCI start and stop times?"*

Amanda Audette: Sure. So, PCI start time should be the moment the balloon is deployed, not simply the start time of the procedure. The goal of treatment is reperfusion, so it is acceptable for hospitals to use the time of balloon inflation. So, for example, device deployment time, time the catheter crosses the blockage, or the time the procedure was performed – in other words, when the "wire crossed the lesion."

Karen VanBourgondien: Okay, perfect. Thank you. Amanda, the next question for you is *"Would you mind defining what the "measure period" and "ED encounter period" are in context of the measure?"*

Amanda Audette: Sure. The measurement period refers to the time period for which outcomes are measure8orfor example, this time period could be one quarter of calendar year for calendar year 2023. The initial population for this measure only includes ED encounters with a diagnosis of STEMI. The ED encounter is from start of the ED encounter, or admission to ED, until the end of ED encounter, or discharge from the ED, whether to home or another level of care at the same hospital. We have these definitions listed in the measure specifications on the eCQI Resource Center.

Karen VanBourgondien: Thank you, Amanda. And we will put that direct link into the chat box. So, the next question is for Danielle. Danielle, the question is, and I know you went over this Amanda, but I think it needs to be clarified a little bit, so, Danielle, *"When will hospitals start submitting data for OP-40?"*

Danielle Leffler: Yes, the voluntary reporting for the OP-40 STEMI eCQM measure begins with the voluntary reporting period for the calendar year 2023 reporting with a May 15, 2024, submission deadline. Mandatory reporting begins with the calendar year 2024 reporting period for the calendar year 2026 payment year. For the first mandatory reporting period, submission of one self-selected quarter of data is mandatory. Your hospital will gradually work up to submitting a full calendar year of data by the calendar year 2027 reporting period for the calendar year 2029 payment year.

Karen VanBourgondien: Thank you, Danielle. I know that is summarized as well on slide 13. Amanda, question for you. *"What happens if a patient is admitted with a suspected STEMI, but after examination, clinicians determine there is no STEMI?"* Can you respond to that? That's a good question.

Amanda Audette: Sure. So, according to current specifications, if STEMI is included in the diagnosis list during the ED encounter, even if it was only suspected, the patient would be included in the measure.

Karen VanBourgondien: Okay, thank you. We have some good questions here. Okay, Amanda, I have another question for you. This person, it looks like they put in a question in the Q&A tool on *QualityNet* because they're saying "*I recently received a response that an issue would be considered in the next annual update. How and when will I know what that outcome is?*"

Amanda Audette: Sure. So, final specifications applicable for the next reporting year following the Annual Update cycle, they are typically posted on the eCQI Resource Center in May, along with Technical Release Notes. That document categorizes all the changes made to the measure for that cycle with rationale.

Karen VanBourgondien: Okay, thank you. And I know you have made that comment a couple of times, so thank you for clarifying that. Danielle, I think maybe I am going to send this question to you. The question is *"Will we submit the OP-40 measure via a Quality Reporting Document Architecture, or QRDA, Category I or Category III file?"* It seems like a lot of people have similar questions. Can you respond to that, Danielle?

Danielle Leffler: Yes. Data for this measure will be submitted via QRDA Category I files. You can find additional information and specifications for this measure on the eCQI Resource Center website under the OQR Measures. Amanda did go over that during her presentation and we will also place the direct link to that resource center in the chat box. Additionally, we will be bringing you a separate webinar discussing data submission specifically. So, stay tuned for that.

Karen VanBourgondien: Thank you, Danielle. And, of course, if you're signed up for ListServs you will get a notification when we are going to be presenting that webinar that Danielle just mentioned. Amanda, back to you. Question. *"How does the measure handle STEMI patients transferred between satellite and main EDs within the same hospital system?"* Great question. There are a lot of stand-alone EDs these days. Amanda?

Amanda Audette: Sure. The measure does not distinguish between satellite and main EDs within a health system with the same CCN where the same account number or encounter number is used for the patient at both locations. So, the outcome would be attributed to the initial ED, where patients should receive appropriate treatment within the measure's suggested time frames.

Karen VanBourgondien: Okay, thank you Amanda. Let's see. Danielle, here's a question for you. This is a good question. *"Can a hospital's HQR security official or other authorized hospital personnel upload the final data, or do we have to go through a vendor?"* Great question. Danielle?

Danielle Leffler: Yes, great question. Hospitals have the option to submit their own eCQM data or authorize a vendor to submit data on the hospital's behalf. Hospitals choosing to use a vendor must log into the HQR Secure Portal and select Vendor Management to confirm the vendor's permission.

Karen VanBourgondien: Okay, great. Thank you, Danielle. I am going to give you another, Danielle, because it seems like the QRDA is a common theme here. So, Danielle, the next question is "Do we still need a certified vendor…" this is sort of along the same lines *"Do we still need a certified vendor to submit for our hospital if our electronic health recoIsystem provides certified scripts to create QRDA Category I files?"* Wow, that's a great question. Danielle?

Danielle Leffler: Yes, if your hospIl's EHR is certified according to the applicable calendar year reporting requirements, then you can submit the files yourself. Hospitals are required to use the most current specifications, standards,

and technical versions according to the CMS Annual Update. CMS requires that data must be reported using Health Information Technology, or Health IT, certified by the Office of the National Coordinator for Health IT, or ONC, to the 2015 Edition Cures Update criteria beginning with the calendar year 2023 reporting period.

Karen VanBourgondien: Okay. Thank you, Danielle. So, Amanda, here's a question. *"What if the patient is excluded from the denominator due to a PCI counted as a major surgery within 21 days prior to the ED encounter and/or STEMI diagnosis?"* Can you respond to that?

Amanda Audette: Sure. So, the voluntary reporting using version four of the measure, we are aware of seven SNOMED CT codes in the Major Surgical Procedure grouping value set used to define the denominator exclusion, and that exc"usion is "Major Surgical Procedure 21 Days or Less Before End of ED Encounter." These seven codes were also included in the numerator value set. And that is "Percutaneous Coronary Intervention." This led to patients being excluded from the denominator if they had one of the overlapping procedures performed within 21 days or less before the end of the ED encounter even if they meet the numerator criterion. We made an update during the 2024 Annual Update cycle for version five of this measure. That is going to be used for the first round of mandatory reporting in calendar year 2024. So, the overlapping codes were removed from the Major Surgical Procedure value set, to ensure that they are captured in the numerator only. The updated measure specifications with this change in the Major Surgical Procedure value set are going to be posted on the eCQI Resource Center in May, and this issue will be documented in a "Known Issues Ticket" through JIRA.

Karen VanBourgondien: Okay, perfect. So, Amanda, I have another one. "*What if STEMI is not the primary diagnosis on the ED encounter?"*

Amanda Audette: The measure currently includes any ED encounter with a diagnosis of STEMI. If STEMI is listed as a diagnosis code during that encounter regardless of other diagnosis codes in the ED claim, that patient will be

included in the measure denominator. So, it doesn't matter if it is the primary, or secondary, or twenty-seventh code.

Karen VanBourgondien: Okay. I know that is a pretty common question. So, thank you for that. Danielle, here is a question for you. *"What is the difference between a case threshold exemption and a zero-denominator declaration?"*

Danielle Leffler: Great question. A case threshold exemption may be applied when there are five or fewer discharges applicable to an eCQM within the same discharge quarter. In this instance, hospitals have the option to either submit these data via QRDA Category I files or manually enter the case threshold exemption. A zero-denominator declaration is used when the hospital does not have any patients that meet the denominator criteria of that particular eCQM. In both cases, a hospital is required to report the selected measure, or measures, using certified EHR technology to the 2015 Edition Cures Update criteria.

Karen VanBourgondien: Ok, so, with that, Danielle, because we have had to answer quite a few things about the EHR technology. *"How does a hospital know if their EHR is certified?"*

Danielle Leffler: Yes. To check whether a Health IT product has been certified, you can check the Certified Health IT Product List and we will put that direct link to the website in the chat box. This list provides the comprehensive listing of Health IT certified through the ONC Health IT Certification Program. CHPL generates the CMS EHR Certification Identification Number after the product has been passed as certified. This CEHRT ID should be used for CMS reporting. A CMS EHR Certification Identification Number can represent a single Health IT product that could have relied upon software or a combination of EHR products that a hospital uses to meet the CEHRT definition.

Karen VanBourgondien: Wow! Thank you, Danielle.

Danielle Leffler: You're welcome!

Karen VanBourgondien: I put that direct link to that product list in the chat box. Alright. Amanda, back to you. *"If a patient received Fibrinolytics at an initial hospital, but the patient is later transferred to another PCI-capable hospital through the ED for treatment, will this patient be included in the measure denominator at the transfer hospital?"*

Amanda Audette: That's a good question, Karen. For version five of the measure, this is going to be the version that's used for the first round of mandatory reporting, we have included a direct reference code (ICD-10 code Z92.82 Status post administration of TPA) and this identifies and excludes patients who have received fibrinolytics at a previous hospital within 24 hours prior to transfer and admission to the current facility from the denominator. So, this code will be used for the measure for that first round of mandatory reporting to exclude those patients from the denominator.

Karen VanBourgondien: Okay, thank you. Amanda, another question for you. *"What is the timing for the anticoagulants denominator exclusion?"*

Amanda Audette: The measure excludes patients from the denominator who are on oral anticoagulants at the start of the ED encounter.

Karen VanBourgondien: Okay, thank you. And one more question for you Amanda. *"How does the measure handle patients that have a STEMI after an inpatient admission?"* And boy is that a great question.

Amanda Audette: Absolutely. So, the aim of this measure it to capture appropriate treatment for patients with STEMI that are admitted to the ED. It's an outpatient measure. The logic unions the ED encounter with a STEMI diagnosis, so that only STEMI diagnoses documented during the ED encounter are captured. This measure does not include any patients with STEMI diagnosis that was documented during the inpatient admission.

Karen VanBourgondien: Okay, thank you. Danielle, this question is for you. ***"****Is it acceptable to submit each quarter's data at a separate time, or do we have to submit all the quarters of data all at once?"*

Danielle Leffler: Great question. Submitters can choose to upload a batch of QRDA Category I files that represent data for one quarter or a combination of quarters upon availability of the HQR system; however, submitters are expected to report one QRDA Category I file, per patient, per quarter. Each QRDA Category I file must represent a single quarter of data; however, files from different quarters may be uploaded within the same batch at the same time. CMS encourages hospitals and vendors to access the portal as often as necessary to upload and troubleshoot. You must have all of your data uploaded by the submission deadline.

Karen VanBourgondien: Thank you, Danielle. Appreciate it.

Danielle Leffler: You're welcome.

Karen VanBourgondien: I do want to mention quite a few important reminders. Please remember that for your clinical data beginning with the July 1, 2023, encounters, the *Sex* data element has the following Allowable Values: 1 – Male, 2 – Assigned or Designated Male at Birth, 3 – Female, 4 – Assigned or

Designated Female at Birth, 5 – LGBTQ, and 6 – Unknown. However, for clinical data beginning with July 1, 2024, encounters, the *Sex* data element will be replaced by the *Sex assigned at birth* data element. And the Allowable Values would be: 1 – Female, 2 – Male, 3 – Intersex, 4 – None of the Above, Other,–or Unable to Determine, 5 - Preferred Not to Answer. So, all of that is in the specification's manual. If you have any questions, certainly give us a shout out. The definition for the *Sex assigned at birth* data element is the patient's biological sex assigned at birth and collecting the sex that is assigned at birth is useful as basic demographic information when used with the *Gender Identity* data element.

Okay, so that's the first reminder. Let me just mention important submission deadlines because we are coming up in May for a lot of deadlines. The submission deadline for your Quarter 4 2023, that's October 1st through December 31st, 2023, that clinical data is due on May 1st, 2024, no later than 11:59 p.m. Pacific Time. And the clinical data, the measures for that includes *Median Time from ED Arrival to ED Departure for Discharged ED Patients*, the *Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT* or *MRI Scan Interpretation Within 45 Minutes of ED Arrival*. These are all submitted into the Hospital Quality Reporting, or HQR, system. And please remember for our program, for the OQR program, Population and Sampling is voluntary.

The next submission deadline is for your web-based measures and that is for the reporting period for calendar year 2023 and that would be encounters January 1st through December 31st, 2023. That data needs to be entered by May 15, 2024, in a couple - a few weeks. Again, no later than 11:59 p.m. Pacific Time. And the web-based measures, those are for OP-22, which is *Left Without Being Seen,* OP-29, which is *Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients,* the OP-31 measure - that's the *Cataracts* (measure)*: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*. And yes, OP-31 is still voluntary. All your web-based measures should also be submitted through HQR.

And as we have talked about throughout today's presentation, the voluntary reporting for the *eCQM*, the OP-40 measure, that data is due also by May 15th. And that would be for the reporting period calendar year 2023. That would be January 1st through December 31st, 2023, and that is, again, any quarter for that year. And it's voluntary this go-around. If you choose to report that data, it is voluntary.

Lastly, the submission deadline for the OP-38 measure, that is the *COVID-19 Vaccination Coverage Among Healthcare Personnel* data, that is submitted through NHSN, and that deadline is also May 15th, no later than 11:59 p.m. The Quarter 4 is for the encounter period of October 1st through December 31st, 2023.

So, in summary, May has a lot of deadlines. May 1st and May 15th, the two big days. Please get your data in early. Better to be early than late. You don't want to be troubleshooting on the day of submission. And boy do we have that happen. Please don't let that happen to you.

Danielle Leffler: Hey Karen, this is Danielle. Can you hear me?

Karen VanBourgondien: Yes, I can.

Danielle Leffler: Oh, great. Before we take a few more questions from the audience, we have said a few times throughout this presentation that we have a detailed webinar on OP-40 coming soon. This webinar will include details on QRDA files and data submission, but what do you think about getting some feedback from the audience today on any topics or additional details they would like for us to discuss during that webinar?

Karen VanBourgondien: I think it's a great idea. Thank you for bringing that up, Danielle. So, today we really just wanted some subject matter experts, Yale/CORE and also, we have subject matter experts from Tantus Technology and Bellese, to respond to some of your system-related questions today. So, some of

the questions that you guys are asking are great questions. They do take a little bit to answer, so they are all trying to feverishly get to your questions in the chat boxes as quickly as they can. And we will cover some more. So, because we're responding mostly to questions today, we do, as Danielle said, want some feedback from you about what specifically maybe you're having trouble with, you need clarification on, and this helps us present information that's valuable to you. We are asking for your feedback on the eCQM measure specifically, but you can also just pop in the chat box what you need clarification on or education on; and this is for the Hospital Outpatient Quality Reporting Program, not IQR or some of the other programs. So, include information that is related to the measures for the OQR Program. Just pop in a quick message in chat and we will collect those at the end of – the conclusion and we'll be able to bring you valuable information. So, again, thank you to Yale/CORE, Bellese, and Tantus Technology for helping us respond to all these questions. So, with that, Danielle, I think we maybe have time for a few more questions. Do you want to pick out a question?

Danielle Leffler: Yes. There is one that has come through from a lot of our participants today. This particular question is from Susanne. *"Is there a way to account for the first positive EKG for STEMI being a subsequent EKG? Many of our patients do not have a STEMI diagnosis upon registration."*

This is a great question and I think it will answer a lot of the lingering questions for our participants and that is EKG timing specifically is not integrated into the logic of this measure as long as STEMI diagnosis is listed in the diagnosis list at any point during the ED encounter, the patient will be included in the measure denominator. And, I think Amanda said specifically, it doesn't matter if the primary code, secondary code, or the twenty-seventh code, if it is listed then they will be included in the measure denominator.

Karen VanBourgondien: Yes. Thank you, Danielle. I saw Susanne put that question in early, so, that was a great question Susanne, thank you. Before we go to the next question, I do want to mention that our slides are always posted prior to

any event I did put the direct link to the slides in the general chat box. We will put it in again. And, also, a few of you asked if there is a recording. Yes, this event is being recorded as we speak, and we will have that posted within 48 hours for review. And I will plug in that direct link – actually, I will do it right now – we'll put that direct link in the chat box as well.

So, next question – we got a great question from Christopher – and his question was *"Our EMR partner is currently capturing the ED encounter end-time, rather than the time that the patient departs from the ED, as a transfer. This is often due to acuity and staff being unable to fully document in real time. What is the intended time meant to be captured as the ED end date and time?"*

So, great question Christopher. And the answer was the measure currently uses the timing of ED departure with transfer to acute care facility within 45 minutes of arrival as the numerator. So, this is collected in the measure logic via hospital departure time with a discharge disposition of discharge to acute facility. This status should be recorded from the EHR, from the discharging facility rather than the EMR record. That's a great question, Christopher. Thank you. Danielle, do you have another question?

Danielle Leffler: I do. And this one has come through a few times as well. *"This measure is voluntary, correct? Does it become mandatory and if so, when?"*

And the answer for that one is voluntary reporting for this measure begins with calendar year 2023 reporting with a May 15, 2024, submission deadline. Mandatory reporting begins with calendar year 2024 reporting period for the calendar year 2026 payment year. For the first mandatory reporting period remember submission of one quarter of data is mandatory and your hospital will gradually work up to submitting a full calendar year of data by the calendar year 2027 reporting period which is for the calendar year 2029 payment year.

Karen VanBourgondien: Okay. Super. I have a question here from Peggy. And Peggy wanted to know – her question was "*I had a patient show up as an OP-40 that*

presented with a NSTEMI prior to taking them to the cath lab and after their ER visit, they converted to a STEMI while in observation status. How is it determined that the patient would be in the OP-40 denominator?"

And, basically, the answer is, according to current specification if STEMI is included in the diagnosis list during that ED encounter even if only suspect that the patient will be included in the measure. So, your patient would be included.

Another great question from Emily. *"I do not see consideration for patients diagnosed in the ED based on a subsequent EKG. How should this be managed?"*

And the subject matter experts responded, "If the STEMI was diagnosed during the ED encounter, from arrival to discharge from ED, the patient will be in the initial population. The measure will not exclude the patient if a STEMI was diagnosed during the ED encounter. Whether from first or fourth EKG, as long as it was diagnosed during the ED encounter. The STEMI measure is not based on EKG, timing or frequency but on diagnosis of STEMI during that encounter." Great questions!

Oh, I have another question here – this is a good one. Even though this is an OQR metric, it appears to incorporate both outpatient and inpatient since it includes everyone with a STEMI diagnosis during the ED encounter. *"Is it ok to have an inpatient and outpatient in the denominator for the OQR metric?"*

Okay. So, that's a really great question. And the SME's responded that, *"The denominator includes all emergency encounters for patients 18 years and older at the start of the emergency encounter with a diagnosis of STEMI during the measurement period as found in the specifications. The intent is to capture patients in the outpatient setting. So, only patients with an ED visit are captured. Also, if they are an inpatient admission, they are not going to be included in the OQR measure set."*

So, Danielle, do you see anything else? The team has done a great job at answering all these questions and we're going to have to wrap it up here pretty soon. Yeah, I have one more question here. So, the question is: *"We do not have a cath lab and all STEMIs are transferred out by the facility so will this measure apply to our facility?"*

That's a great question. And the answer is case threshold exemption may be applied when there are five or fewer discharges applicable to an eCQM within the discharge quarter. So, in this instance, for your hospital, your hospital has the option to either submit these data via QRDA category 1 files or manually enter the case threshold exemption. A zero-denominator declaration is used when the hospital does not have any patients that meet the denominator criteria or the particular for this measure, the OP-40 measure. So, in both cases the hospital is required to report the selected measure using the certified EHR technology. And I know that you sort of discussed that earlier in the Q&A session.

So, there is one more here about **voluntarily reporting**. Did you want to go over that again, Danielle? It seems like we've had quite a few of those.

Danielle Leffler: Yes. So voluntary reporting is going to be for this calendar year 2023, which is due May 15, 2024. Mandatory reporting begins with this year, calendar year 2024 reporting period. And for this first mandatory reporting period you're only going to submit one self-selected quarter of data and then you will gradually work up to submitting a full calendar year of data by calendar year 2027 reporting period for 2029 payment year.

Karen VanBourgondien: Okay. Great, thank you. I think that we've responded either verbally or in the chat box to everybody's questions. If not, if we somehow missed you, please put your question in the QualityNet Q&A tool. We're also going to insert a link to the survey. Danielle, if you don't mind putting that in the chat box? Please take our survey – we're very interested in your feedback, and it does have a blank area where you can free text where you can tell us what you want in the future, what you like, what you don't like, those

kinds of things. We really read every single comment and we do appreciate your feedback.

So, Rachel, I think we're going to wrap things up. So, if you could go to the next slide.

Karen VanBourgondien: So, as always, we do have some important resources here on the slide. If you have and issues with data submission, what have you, please give us a call. Our support team phone number is right there at the top and as I mentioned earlier if we did not get to your question today either in the chat box or verbally, we do apologize. We have many team members on, and we try to get to as many as possible. But we do have a large crowd here today, so if we didn't get to you today, please put your question in the QualityNet Q&A tool. Again, we will put that link in the chat box and the direct link is on the slide, as well. We will have all the questions that were asked with the answers posted to our website alongside this event in the coming weeks. We do thank you for joining us today. We hope it was helpful and we will see you next time.