AHRQ Quality Indicators Software: Transition to ICD-10
Tuesday, July 19, 2016

Transctipt

>>FEMALE: Welcome to today's webinar on the AHRQ QI software,the transition to ICD-10. Thank you so much for joining us. At this time, I'd like to introduce our moderator, Diane Stollenwerk.

>>DIANE: Well, thank you. And thank you, everyone today, for joining us. I'm Diane Stollenwerk, and I'll be your moderator. And we know that some folks are still joining, so we're going to take a quick moment while folks are still logging in to do a couple of quick polls. If you take a look at your screen, there should be a poll question that appears, and if you would answer the question, that would be great. The question says, "Does your organization use the free AHRQ SAS QI or WinQI software?" And please select one of the following: "My organization doesn't plan to use the free QI software," "My organization is considering using the free QI software," "My organization uses the SAS QI software," "My organization uses the WinQI software," "My organization uses different software with the AHRQ QIs." So if you would answer -- just click on the answer that makes most sense for your organization. We should be able to see the poll results. So it looks like we've got some folks who are answering, which is great. Looks like it's, so far, spread nicely across --you know, pretty evenly across organizations that are already using the SAS QI software. Some are using -- about a third are using the WinQI software. And it looks like roughly 25 percent are considering using the AHRQ QI software. This is helpful. This gives us a good sense of the perspectives of various folks that are on the webinar today.

So I think we're going to do one more quick poll, again, as we give folks a minute or so to log in. And if we could put up the next poll question, which is, "Which, if any, of the AHRQ QI modules" -- these are the software modules -- "Which, if any, of the AHRQ QI modules does your organization use? Please check all that apply." And you can see they're listed down here. Patient Safety Indicators, also called PSIs, the Inpatient Quality Indicators, which are called IQIs, the Prevention Quality Indicators, which is the PQIs, the Pediatric Quality Indicators, or the PDIs, or, "My organization does not currently use the AHRQ QIs." So again, if you would click on one or more of the modules or the response that makes most sense for your organization, that would be great. And it looks like at this point, of the organizations that are using the modules, it looks like almost 90 percent are using the Patient Safety Indicators. About 50 percent are using the Inpatient Quality Indicators. Roughly 40 percent are using the Prevention Quality Indicators. About 30 percent say that they're using the Pediatric Quality Indicators. And about 10 to 15 percent are saying that their organization does not currently use the QIs. So again, very, very helpful.

For those of you who are just joining us, this is the webinar on the AHRQ QI software, the transition to ICD-10. We're taking a moment to hear from all of you before we jump into the content, and we'll get started in about a minute. So it looks like we've gotten the responses on the poll that we've shared. Okay, so again, thank you, everyone, for that. And we're going to get started. So we need to go ahead and move to the first slide.

I do want to share that we have a number of announcements. This webinar will be recorded, and so it will be available on the AHRQ QI website, and there's the URL, for those of you who would like to get to the recording later. Because we've got so many people we expect and we know are attending this webinar, all of the participant lines are in listen-only mode. Although, even though we would very much like to hear your questions. So if you notice that there is a chat box where you can submit questions -- and we'd really like you to use the question feature at any time. We are going to use that list of questions when we get to the Q&A session, and we'll be able to then draw from those questions during

the question-and-answer section of this webinar. If you have several people from the same organization dialing in from the same building or location, it would be wonderful if you could use only one line. That allows for more space for additional attendees. If you have any technical difficulties through this process, Erin Johnson is available, and we'd appreciate it if you would email Erin at EJohnson@AIR.org, and she's available to help. So with that, if we could go to the next slide, that would be great.

So this webinar -- we are intending to cover a variety of things. We want to make sure that the folks who are attending the webinar are able to learn about the changes to the AHRQ QI software because of the ICD-10 transition. We know it's been a big change throughout the healthcare industry, and so we know that folks have been anxiously awaiting this transition. So we want to make sure that you have the information that you need. This also is a great opportunity to highlight the enhancements and the changes that allow you to more easily select the AHRQ QIs, and then we'll have a discussion about ways that the software, the Version 6.0 ICD-10 software, has been improved to make it easier for you to use, and then to make sure that you're able to find the various AHRQ QI resources that have been developed to help support you and your hospital or other organization in using the AHRQ QI software. So I would appreciate it, though, if everybody notes that this webinar is not intended to address questions about PSI-90. For additional information about changes to PSI-90, for the ICD-9-CM/PCS, it'll be in the upcoming Version 6 software, so in the meantime, we'd really appreciate it if you would refer to the PSI fact sheet that's available on the AHRQ QI homepage. If you just look under the section that's called "News and Announcements," you'll find information about that, about the ICD-9 version of the software and specific to PSI-90. So go ahead and go to the next slide, please.

So I'm Diane Stollenwerk, as I mentioned. I am with a small firm called StollenWerks. I am a member of the AHRQ QI support contractor team that's led by Pantheon Software. Others on today's session, today's webinar, are Pam Owens, who is the scientific lead for the AHRQ Quality Indicators program. She is with the Agency for Healthcare Research and Quality, or AHRQ. We also have Vivek Kumar, who's the senior project manager of Pantheon Software, which leads the AHRQ QI software development. He leads the software development team. He also manages the AHRQ QI technical support team, so, as you might guess, Vivek has deep expertise in project management, technology development, and extensive and specific experience in healthcare-related projects and products. So we go to the next slide.

So today we're going to be covering the changes in the AHRQ QI software that are related to the ICD-10 transition. We'll also be talking about the improvements that have been made to the Version 6 ICD-10 software, and then again we'll talk about some of the resources and share links and such to make sure that you know where to go to get information to support your hospital or organization's use of the AHRQ QI software. So we're going to do that. And with that, before we turn to the panel, we want to provide a brief update on the Version 6.0 software releases. So the SAS QI software -- we expect -- both that release and the WinQI software have been released. They are available on the AHRQ QI website. They were released in July, so they are ready and good to go. And you can then, throughout the remainder of 2016 -- the SAS and the WinQI ICD-9 CM version of the software for each of the AHRQ QI modules -- they'll be released at various points through the rest of this year. So please keep an eye out for additional announcements from the AHRQ QI team in order to find out the details about these ICD-9 releases. You can get the software at the URL that you see at the bottom of your screen, which is QualityIndicators.AHRQ.gov/Softw are/Default, where you can download the SAS and the WinQI versions of the ICD-10-compatible software. So with that, I would like to turn it over to Pam Owens from AHRQ, who is going to be covering the main content around the AHRQ QI software. So we're very excited to turn it over to you, Pam. Welcome.

>>PAM: Thank you very much, Diane. I thought I'd start this presentation by sharing some background about ICD-9 and ICD-10 coding so that we're all on the same page and then talk about how that relates to the AHRQ Quality Indicators. So this slide basically talks about the differences between ICD-9 codes and ICD-10 codes. What you can see is that there are five times as many ICD-10 diagnosis codes as there are ICD-9 codes and 19 times the number of ICD-10 procedure codes as there are ICD-9 procedure codes. Procedure codes in ICD-10 are differentiated by body parts, by procedure type, by surgical approach and by the device used. Moreover, the reason that the procedure performed is no longer done within ICD-10 -- it was done periodically within ICD-9. So you can see we're going to have some differences between the ICD-9 codes and the ICD-10 codes. Next slide, please.

As I was suggesting, you can begin to see the complexity of the conversion already just looking at the number of codes. Despite the increase in the number of codes from ICD-9 to ICD-10, there is actually sometimes a one-to-one map between an ICD-9 code and an ICD-10 code. However, more often, there is one ICD-9 code that maps to many ICD-10 codes, and occasionally we get several ICD-9 codes that map to one ICD-10 code. Because of this complexity, AHRQ really needed a starting point about how to convert the set names or the list of codes that operationalize the AHRQ QI from ICD-9 to ICD-10. And we did this starting with the CMS general equivalence mapping, or GEM files. We took the GEM files and created a tool -- we call it the Map It tool -- to automate the conversion of the codes using forward mapping, backward mapping and then reverse mapping to double-check our work. So we had all of the codes within the QIs and their set names. We had those maps reviewed by over 80 clinical and coding experts. We also made the decision to capitalize on the increased specificity of the ICD-10 codes, and you can see when I talked about the difference between ICD-9 and ICD-10 that we're going to have more specificity under ICD-10. That increased specificity allowed us to create specifications that aligned most closely with the intended clinical construct. In most cases, this means the cases identified using ICD-9 codes would also be identified using ICD-10 codes, but not always.

The ICD-9 specifications of the QIs include logic that takes into account ICD-9 coding practices, the availability of data and information -- for instance, Present on Admission -- and the lack of specificity in ICD-9 descriptions. We had to include additional exclusions to work around the fact that an ICD-9 code may not be as specific as the QI really clinically intended. These exclusions, though, are not necessary when using ICD-10 coding system. Moreover, the conversion of the AHRQ QIs into ICD-10 involves coordination with others throughout the Department of Health and Human Services. Some of the ICD-9 codes actually do not have an ICD-10 equivalent. At least, that's what we found out as we were trying to do the mapping. Or that they require additional clarification in terms of what is meant by that code. And some coding practices still need to be refined. AHRQ coordinates with the ICD-10 Coordination and Maintenance Committee. We also coordinate with others in the department, so, for instance, with Centers for Medicare and Medicaid Services and the MS-DRG, which is the Medicare Severity Diagnostic-Related Group classification system that has, in Appendix E, a list of operating room procedures. This list of operating room procedures is critical to our denominator on the Patient Safety Indicators, so it's really important that we understand what that list says and what's happening to the list over time, because CMS similarly converted their list of operating room procedures in ICD-9 to ICD-10. Additionally, the AHRQ QI software embeds classification systems, and these are actually within AHRQ, including the Elixhauser Comorbidity Software and the Clinical Classification Software. So it's really important you can see that in this conversion, we need to coordinate across the department. Next slide, please.

I wanted to let you know that the conversion of the AHRQ QIs has actually been an ongoing process for quite some time. We began mapping clinical concepts prior to 2011. We created an automated mapping tool, which I mentioned before, and had experts review those maps of the code sets in 2011 and 2012. We posted draft specifications of numerators and denominators in the Federal Register for

Public Comment in 2013. Last year, we released alpha versions of the ICD-10 software for the QIs in Version 4.5 and in Version 5.0. We also conducted some preliminary testing with some state data that we were able to obtain that coded the records in both I-9 and I-10. It was a very small set, but it was a starting place. And then, as you know, last week, we released Version 6.0 of the ICD-10 AHRQ QI software. Next year, in 2017, we are planning to obtain nationally representative reference population data. This is one year of ICD-10-coded data, and I'll talk about that in just a moment. Once we have the reference population data, we will be able to release all components of the all-payer ICD-10 software, which includes risk adjustments and smoothing. Next slide, please.

So this is actually one of the most -- places in terms of concerns and what people are most interested about, is risk adjustments and smoothing in the ICD-10 software. Risk adjustments and smoothing are not part of the ICD-10 software that was released last week. I know this is of great concern to you, especially as the indicators are used in public recording and comparisons of hospitals. But I want to provide an explanation and try to alleviate some of your concerns. I think once you understand why it's not provided, it would help you to be able to explain to your users when it would be available and why. Risk adjustments and smoothing require the use of a reference population or the general population, a standard population, that is based on one year of nationally representative ICD-10-coded data. This reference population is used for indirect standardization. It is used to derive risk models and parameter estimates that get embedded in the software. It is used for variance estimates, and it's used in the calculation of smoothed rates. So you can see that having reference population data is critical to the creation of risk-adjusted software. As you know, however, a full year of ICD-10-coded data is not yet available, and in fact, the first year of data being collected for ICD-10 will not actually finish being collected until September 30th, 2016. The data will need to be processed, which takes additional time. The data will need to be assessed to determine if coding is complete across all types of hospitals and across all types of patients or discharges that have different expected payers. Some of this assessment is already being undertaken at AHRQ with preliminary quarterly billing data, but the testing does take additional time. All that to be said, we do expect a full year of complete all-payer data, ICD-10-coded data, by mid-2017. Taking into account development time for the software, we expect to be able to provide risk-adjusted ICD-10 software in 2018.

We know that not having the ability to risk-adjust is a burden to you. We have, in fact, explored numerous other options, such as using six months of data or six months of ICD-10-coded data. Our assessment has said that we believe that these estimates would not be reliable, so we are not using six months of ICD-10-coded data as a reference population. We've thought about using ICD-9 parameter estimates, but, given the specificity of ICD-10 codes, we expect the risk models to change enough and with the exclusions that no longer have to be embedded within the algorithms that the parameter estimates from ICD-9 could not possibly be applied to ICD-10. We are also exploring other options to see if we could get a subset of all-payer data sooner. For instance, maybe Medicare fee-for-service claims data. Although, in reality, even this type of data, a full year of this type of data, would not be available until early 2017. As I noted, the data won't finish being collected until September 30th of this year.

Now, to assure you. Our discussions about risk adjustment and smoothing actually have been coordinated across the Department. The Department is aware of the time frame for the development, of the need for reference population data and the development of risk-adjusted software. Nobody has ICD-10 risk-adjusted software for the AHRQ QIs. Next slide, please. So, what can you use the ICD-10 software for? What are you able to calculate? Numerators, denominators and observed rates can be calculated with Version 6 ICD-10 AHRQ QI software. You can use the software to track within-hospital performance over time, such as looking across quarters. You could look across units within the hospital for those indicators that have higher prevalence. We do not recommend using the observed rates to compare hospitals, because there is no risk adjustment. That is, you're not able to level the

playing field such that the rates of hospitals take into account the case mix of the hospital. You can, in this software, calculate observed rates for individual indicators and for area-level composites, which are included in the Prevention Quality Indicator and the Pediatric Quality Indicator modules. Next slide, please.

However, you cannot calculate the scores for provider-level composites. These composites are based on risk and reliability-adjusted component indicator estimates. Since we do not have such estimates in the software, the composite scores cannot be calculated. There are four provider-level composites within the AHRQ QI software: IQI-90, IQI-91, PSI-90, and PDI-19. Of course, as Diane mentioned at the beginning, we are under the assumption that the provider-level composite of most interest to you is the revised version of the PSI-90. As she noted and I have now noted, it is not available in this software. However, it is scheduled to be released in the ICD-9 version in August of 2016. As she noted, we will not be addressing questions regarding the updated PSI-90 composite during this webinar, but there is a fact sheet on our website that you are free to download. You can see the URL listed here, or you can find the fact sheet under "News and Announcements." Next slide, please.

Now I will take some time to discuss the enhancements to specific indicators, including updates across the indicators, refinements to select indicators, the addition of a new composite indicator and the retirement of one indicator. Refinements actually are the hallmark of the AHRQ QI project as we try to continually improve the indicators as we get new evidence, information and feedback. So we have updated some of the specifications across several of the indicators in Version 6.0, and some of these apply to both I-9 and I-10, but I'm going to speak from it from the I-10 perspective. We have removed the option to omit the Present on Admission indicator, and we feel that this data element is critical to accurately operationalizing the clinical constructs of the indicators. And this is based on the rationale that PoA coding has improved over time. We have updated the denominator specifications for the PSIs and the PDIs, so the Patient Safety Indicators and the Pediatric Quality Indicators, by taking a closer look at the operating room procedure list produced by CMS. We have omitted certain procedures that we do not feel fit within the QI definition of surgical procedures. For example, percutaneous insertion of a catheter device in an upper artery for blood pressure monitoring, at one time, was on the CMS procedure list, operating room procedure list. We have excluded it from our definition of this version of the ICD-10 software. In fact, we have an FAQ about this particular procedure, as many of you highlighted for us that this ICD-10 code ended up on the operating room procedure list and hence in our denominator for the PSIs. It is of note that the operating room procedure list produced by CMS will be updated, with codes removed or added over time, and we will continue to monitor how that impacts the QI specifications. This is really where coordination with other departmental programs is an important component of the AHRQ QI program. In addition, we have revised the delivery code specifications to use ICD-10 codes instead of surgical MS-DRGs. We believe we're able to get more specificity with the ICD-10 codes over the MS-DRG codes. This is really where understanding the codes and coding practices becomes important. We continue to monitor information from the coding clinic to best determine how to operationalize the clinical concepts of the indicators. Next slide, please.

We have also updated the specifications of specific indicators, based in part on the increased specificity of ICD-10, but also in part on the input from clinical experts, reviewers and users like you. We very much appreciate your feedback and welcome and encourage it. I just want to take a moment to thank you for all of your input. I will be discussing a few examples of refinements that actually apply to both I-9 and I-10. I thought it would be important to show you that with each version, we actually improve our indicators. There is a change log that will be posted on the AHRQ QI website so that you can see Dear justice of the peacethe specific changes for any indicators not mentioned here. I just took a sample of them. And because, well, 90 percent of the people that called in are using the PSIs, I focused on the PSIs. In addition, we also created a new composite in Version 6.0, and this

applies to the ICD-10 version released last week, as well as the upcoming ICD-9 version, and that's the Prevention Quality Diabetes Composite. Next slide, please. So turning to the pressure ulcer rate -- it was refined to remove the exclusion of the Major Diagnostic Category 09 and added focused exclusion of major skin disorders that are associated with higher risk of pressure injuries to the denominator. The rationale is that some skin disorders put patients at greater risk for skin breakdown. Next slide, please.

Again, just another example -- the in-hospital fall with hip fracture rate. Sorry. I've got a typo in there. We changed the denominator to include the medical MS-DRGs. The rationale was that it applies equally to both surgical and medical patients, and we're able to do that because of consistent Present on Admission coding. Next slide, please. For PSI-10, postoperative acute kidney injury requiring dialysis, we removed cases with a principal diagnosis of urinary tract obstruction and cases with dialysis access before or on the same day as the first operating procedure from the denominator. In ICD-10 only, we dropped the cardiac arrhythmia diagnosis codes from the denominator. The rationale for this last component to be able to do it in ICD-10 is that the specificity of the ICD-10 codes allowed us to actually drop that component and still get the clinical concept well-defined in ICD-10. We believe these changes increase the validity of the indicator. And, as I mentioned before regarding ICD-10, the other component was the consistency of POA coding. Next slide, please.

For PSI-12, perioperative pulmonary embolism or deep vein thrombosis rate, we removed cases with acute brain or spinal injury from the denominator specification, and we removed cases with isolated calf vein DVT from the numerator specification. These patients may be patients with acute brain or spinal injury, may be less preventable because of safety concerns with the prophylaxis in hyper-acute periods. DVT is an isolated cath vein that's not as clinically meaningful. So we found that to refine this indicator would be appropriate. And then the last example that I have -- next slide please -- is PSI-15, with the unrecognized abdominal pelvic accidental puncture or laceration rate. We limited the denominator to abdominal and pelvic surgery only. We limited the numerator to accidental punctures and lacerations that require a return to the operating room at least one day after the index procedure. This allowed us to focus on the most serious interoperative injuries caused by an accidental puncture or laceration. And these patients, we felt, were at the most risk for a reoperation. Next slide, please.

The other point that I mentioned is the creation of a new composite called the Prevention Quality Diabetes Composite. This creates a composite of the four components, diabetes-related indicators, including PQI-1, diabetes with short-term complications, diabetes with long-term complications, PQI-3, PQI-14, uncontrolled diabetes admission rate and PQI-16, lower extremity amputation among patients with diabetes. We feel that combining these components actually increases the reliability of estimates in counties with small populations. Next slide, please.

So with the update, we actually ended up omitting some estimates that continue to undergo changes. I'll speak about the pediatric indicators in a moment. But we did not include population prevalence estimates for diabetes. This will be forthcoming. We, as I mentioned before, did not include risk-adjusted rates or smoothed rates or provider-level composites because we do not have a reference population yet. In addition, we removed a few things. We removed PQI-13, angina without procedure admission rate. We noted in the previous version that we would be removing this, and we followed through. And we also removed codes that seemed to have been holdovers from previous versions that we never continued to refine. They were considered exploratory (inaudible) such as complications from anesthesia. Next slide, please.

So as I mentioned, we do not include the Pediatric Heart Surgery Mortality Indicators. We will be revisiting this in the future. But the necessary ICD-10 diagnosis and procedure codes to calculate these indicators are not available, and they are actually under consideration at the ICD-10

Coordination and Maintenance Committee. So you can see the importance, again, of us coordinating across the department. Next slide, please. PQI-13 was retired. New evidence has raised some concerns about its current utility. There's changes in coding practices relating to angina. There's a shift in where care is provided. More of it's being provided in an observation space than in an inpatient setting. And we may be inadvertently incentivizing unnecessary procedures. Therefore, we removed it from the software. We also removed it from the PQI composites for the prevention quality overall composites and the prevention quality climate composites. That's all that I have for now. So I'll be on the phone to answer questions for you during the Q&A period. Now I'm going to turn it over to Vivek, who will describe some of the enhancements to the SAS and WinQI Version 6.0 software. Thank you.

>>VIVEK: Thanks, Pam. So Version 6.0 is one of the significant releases in terms of improvements around usability of the software in both SAS QI and WinQI software. I'll go through some of the high-level SAS QI program structure changes first, and then touch upon the WinQI changes. Next slide.

In Version 6.0 of the SAS program, organization has changed to make it more manageable and usable. For example, the files requiring user's input are separated out from the support files. Additionally, the default values in the control program allow fewer inputs from the user while providing capabilities to add additional information in the output. For example, adding the version number to the output is now possible. You will notice that the program names are revised to align with operations being performed. For example, the program that computes measures rate is called All Measures. The program that creates provider level observed rate is called PROVIDER_OBBSERVED.CAS, and so forth. Additionally, in the control file, the introductory comments clearly describe the order in which the programs should run. With the assumption that all ICD-10-coded discharges will have associated Present on Admission indicator, the support for input files missing PoA is removed in 6.0, and discharge missing PoA -- that will be defaulted to not PoA. This was also noted by Pam in her previous slides. Next slide, please.

So while the slide is loading, so with WinQI, 6.0 is the first deployment of the next-generation redesigned software. Those who have already installed the new version will see many changes in terms of user interface and additional functions. So the redesign is a result of feedback that we have received from WinQI users. You will notice that we have tried to reorganize the user interface to better utilize the screen real estate. So we have introduced the concept of a dashboard to keep the key information and function at a central location. Improved horizontal progress bars provide you a better sense of progress on a process. We have also added context-sensitive help at this screen, and it has been added in some cases at the field level. In the past, the data import and indicator compilation process were integrated. In the new version, these processes are now decoupled, providing the flexibility to run each process a different time. And that definitely saves you time if you're running a larger data set. The data mapping function in the data input process expanded with a couple of search and filter capabilities, and this makes your mapping process a little bit more efficient. The error report is expanded to show the impact of a warning at the indicator level. So in the past there were warnings added, but you would not have a sense of what indicator may get impacted. That information (inaudible) every report. Next slide, please.

So in addition to decoupling the import process, from calculation, features are added to generate indicators rate selectively for each module, making it efficient and faster to process. And there are an overall improvement in the calculation processing time, so you will see some significant improvement there if you're running a very large input file. One of the most sought-after features is automation of the indicator generation process. The automation feature was present in the previous versions, but it's now expanded in the new version. Users will be able to generate their own automation script using interfaces that we have created, and then they can run it through a schedule -- a batch process, and I hope this feature will come handy to you. Next slide.

The improvements to the reporting feature include quick report data, load summary and error reports. One of the most useful improvements for you will be for you to be able to go back from one of the aggregated provider-level or error-level reports to the patient-level reports. So there are links now available from the aggregated report back to the individual patient-level report, which was one of the requests from a lot of WinQI users. There are videos available to learn on SAS and WinQI products on the AHRQ QI channel, so certainly make use of that. So that's all for now, and I will turn it back to Diane.

>>DIANE: Well, thank you. Thank you very much for that. Before we wrap up and start taking questions, we wanted to do one more poll. So please take a look at your screen, and you should see a poll that appears that says, "For what purpose does your organization use the AHRQ QI?" So if you would check all that apply, that would be great. The options are for public reporting, pay for performance, clinical quality improvement or improvement of patient care, which is listed as quality performance improvement, population health, public health initiatives or noting that your organization does not currently use the AHRQ QIs. So if you would go ahead and click on any of the responses that resonate with you as far as what you know your organization is doing. It looks like about 80 to 85 percent of the people on this webinar say that the primary reason for using the AHRQ QIs is around the quality, performance improvement, improving patient care. About 50 percent are for public reporting. About 40 percent say they're using the AHRQ QIs for pay for performance. And around 20 percent are using it to support a public health initiative. And then about 10 percent of folks are saying that their organization does not currently use the AHRQ QIs. Very interesting. Thank you very much for doing that. We really appreciate that.

So I want to share with you just very quickly some of the resources that are available to support your work in using the AHRQ Quality Indicators. So on your screen you see a few links. One is to the AHRQ QI technical assistance. It's a link to the FAQs that are on the QI website, which is QualityIndicators.AHRQ.gov/faqs_ support. Or you can also email to QISupport@AHRQ.HHS.gov in order to interact with somebody on the technical assistance team to get some support for your use of the AHRQ QI software. And then you can find the software and documentation for the AHRQ QI ICD-10 software by using the link that is at the bottom of your screen, which is the QualityIndicators.AHRQ.gov/software/default.aspx. Go ahead and go to the next slide.

So we're also pleased to share with you -- and this goes back to the coordination that Pam was mentioning -- a team has just finished and AHRQ has now made available a new and enhanced version of the AHRQ QI Toolkit. You can access it using the link that you see on your screen. It's essentially a general how-to guide about using the AHRQ QIs, and it's to support your organization's or hospital's use of the software. It's just been released. It's got new resources to help you implement the AHRQ QIs. You can find it by going to the resources section of the AHRQ QI website, and you can see a list of the various updates, which cover a wide range of things, including a new presentation template for engaging your staff in improvement efforts, case studies, guidance for how to improve on pediatric quality using the PDIs and other quality measures -- so on and so forth. So that's the AHRQ QI Toolkit. To learn more about the Toolkit -- before I jump into that, specifically around the pediatric toolkit for using the AHRQ QIs -- that is a more specific toolkit that you can find also on the AHRQ website, and it's focused on the PDIs or the Pediatric Quality Indicators and other measures of inpatient pediatric quality. It includes the materials that can support your use of the PDIs. It's a standalone version. It's also now available. And it includes a concise set of tools to facilitate your efforts to improve clinical quality. It includes tools for the same six steps as the overall AHRQ QI Toolkit, including materials that your improvement teams can use to identify and catalog quality and patient safety concerns; also to educate your clinical leaders and staff and then hone in on priorities that really need your focus. It also includes 13 indicator-specific best practices to help you improve performance on the

AHRQ QI Pediatric Quality Indicators, plus a case study of a toolkit user in the pediatric setting. This new toolkit can be used to improve your performance on the PDIs, as well as other measures of inpatient pediatric quality. So to learn more about the Toolkit, there's a couple of options for you. There will be two webinars held during the month of August, and you can register now for either one of them. Space is limited, so if you're interested, this is something you might want to jump on right away. So the first webinar is on Monday, August 1st, from 1:00 to 2:30 PM Eastern Standard Time. The other is at the end of August. There are a couple of different dates offered, because we know this will be a very popular webinar. The content is the same, so if you attend one, you don't need to attend the other. But you'll get a deeper dive into the new and enhanced version of the Toolkit and then the inventory of customizable resources. So wanted to make sure you were aware of that.

So with that, we are going to switch now into the Q&A. Please remember that you can submit your questions using the question feature in the webinar menu. There should be a drop-down that says "Question." You can submit your question there. We do have a large number of attendees, so everyone is going to remain in listen-only mode, but we are tracking the questions that are submitted through the question box. We know we won't have time to answer all of the questions, but please know that we closely review all of the questions that are submitted. It informs our future communication around the AHRQ QIs. So if you have a burning question, please, please, please put it in the question box, and we'll try to get to it on this webinar or certainly in future communications.

So let's start with this question. "Can the AHRQ QI software accept a data set with mixed coding? That is, part of the year's coded using ICD-9, and part of the year is coded using ICD-10." So Pam, do you want to go ahead and answer that question?

>>PAM: Right. So, no, you can't actually use the data set. You can truncate the data set so that three-quarters of the year is ICD-9 and run ICD-9 software, Version 6.0, when it's available, or use a prior version. You could use one-quarter of ICD-10 or do it quarterly thereafter. But no, the software itself does not accept both I-9 and I-10 codes.

>>DIANE: All right, thank you, Pam. So the next question -- this is probably also best for Pam -- "Is there an effective date when we should start using the ICD-10 version of the 6.0 software?"

>>PAM: You can start using the ICD-10 version now. The coding is as accurate as is currently available. And so I mentioned that everybody is continually reviewing the codes and the classification system, so you will see changes, but it is as current as it could possibly be today for the codes that you're collecting today.

>>DIANE: Okay, thank you. Here's a question for Vivek: "If I download the WinQI software for ICD-10, will the WinQI for ICD-9 be automatically overridden?"

>>VIVEK: That is correct. We recommend you uninstall ICD-9 before you install the new version. You may go to an upgrade where it kind of installs into the top of the existing one, but it will override your ICD-9 version and install the new version.

>>DIANE: Okay, thank you. So Pam, here's question for you. "You mentioned that facility comparison is really not recommended for PSI. Can you say why? Could you give a little bit more about that, please?"

>>PAM: So in ICD-10, we do not have risk adjustment. And risk adjustment is the way in which we level the playing field to make Hospital A comparable on everything else except what we're evaluating to Hospital B. And since we don't have risk adjustment in ICD-10, we're recommending that

you not use it for hospital comparisons. Now, you don't have to do that risk adjustment when you're looking within your hospital, because your case mix within your hospital is your case mix, right? It's the same case mix over time, unless there's been some drastic differences. And that's why we say you can compare observed rates over time within the same hospital. So when I talked about comparing the facility-level or hospital-level PSIs, you certainly can do this under ICD-9. The ICD-9 software has risk adjustment and takes care of that case mix piece. Under ICD-10, we do not yet have risk adjustment. I hope that makes sense.

>>DIANE: Well, thank you. And those of you who've asked that question, if you want to follow on, you can type an additional question in the question box. So in previous versions, there seems to be additional software for APR-DRG grouping, but I don't see it in Version 6.0. Could you speak to this?

>>PAM: Yes. So APR-DRGs is what we use for risk adjustment, and we don't have risk adjustment in ICD-10 software. Therefore, we did not provide the limited license for APR-DRG calculations. It will be in future versions when we have risk adjustment for the AHRQ QIs.

>>DIANE: Okay, thank you. So here's a question for Vivek. "Can the SAS QI software be deployed in Enterprise Guide environments?"

>>VIVEK: I believe it is, because I'm going to refer it to David Douglas, who is our SAS expert and has a deep understanding of AHRQ QI software. So David, if you can answer that question?

>>DAVID: Certainly, Vivek. We did not specifically test the software with the Enterprise Guide, but we have successfully managed on an ad hoc basis. So yes, you should be able to do it in Enterprise Guide.

>>DIANE: Thank you. Thank you very much. So here's a question for Pam. "What recommendations do you have for comparing my hospital's performance based on the rates calculated using the previous version of the AHRQ QI software, which specifically was Version 5.0 using ICD-9, comparing that to performance rates calculated using the new version of the AHRQ QI software, that is, Version 6.0 using ICD-10?"

>>PAM: So we are not recommending making any comparisons between I-9 and I-10 rates until we actually see what's going on with ICD-10. As I mentioned, there's going to be quite a bit of testing. For some indicators, the rates actually might be quite comparable, because there is the one-to-one mapping that I talked about before. For other indicators, the identification of a case under I-9 and the identification of a case under I-10 may not be comparable, in which case comparisons of those rates would be very difficult to do. I hope that as soon as we can get more quarterly data, we could give you some information about expectations, about the changes of rates. At the moment, I can't give that to you.

>>DIANE: So thank you for that. So another one for Pam. "Can you speak to how much difference there is between the alpha ICD-10 specifications previous release and this Version 6.0 release?"

>>PAM: So there are quite a few cosmetic changes, and Vivek mentioned some of them. There's changes within the comments and that kind of thing. I think what you're really asking is regarding the coding specifications. There's been more updates in terms of refinements of the indicators around the PSIs, particularly because it went through review. The PSI-90 composite went through review at the Patient Safety Committee. And as part of that review, the reviewers in the committee asked for specific updates to some of the Patient Safety Indicators, and that's what I was reflecting on when I gave my presentation. So you'll see more changes there. And then you'll see some additional change in terms of, the operating room procedure list has been updated with more exclusions now that we understand -

- there's something -- I forget how many codes are on the operating room procedure list. But at any rate, we went through and did some more exclusions to better align it by what we mean by surgical patients. So you will see some changes, and I would expect more changes under the PSIs than the other indicators. And the change log, I should say -- Diane, sorry -- the change log -- we will try to have that up in August so that you can make a decision as to whether or not it's worth it to rerun it.

>>DIANE: That's very helpful. Thank you. And that would be on the AHRQ QI website in August, correct?

>>PAM: Mm-hmm.

>>DIANE: So someone's asking for a quick clarification regarding PSI-90. Pam, you stated that the revised PSI-90 is not included in the new software. Can you clarify: Are you referring to the Modified PSI-90?

>>PAM: Correct. The Modified PSI-90 is what it is officially called, at least within rulemaking documents, and I colloquially call it "revised," and I apologize for the distinction. They're the same thing.

>>DIANE: Okay. That's helpful, just to make sure everybody understands what we're referring to here. So thank you. Vivek, will you be able to have this Version 6.0 of ICD-10 and Version 6.0 ICD-9 when it's available installed at the same time?

>>VIVEK: No, because of some architectural limitation, it is not possible to have two versions of the software installed at the same time on the same machine. We are looking into making some improvements in the future so it can be installed together, but at this point with Version 6.0 as well, you can only have one software on your machine at a time.

>>DIANE: So thank you. Pam, what should small hospitals do if they want to use the AHRQ QIs but have very small denominators, especially during this first ICD-10 transition year?

>>PAM: Yes, that's problematic. The rates are what they are. There's no smoothing component within ICD-10, which would actually take into account the estimates that you're getting from the small hospitals, and I understand that. So I think you have to know that you have a small hospital, and one or two events -- it makes a huge difference percentage-wise. But without having enough data to know, in the grand scheme of things, what that should be a from smoothing perspective, I'm not sure you can say much, other than to always caveat it as that you have a small hospital, and that you can only at the moment provide observed rates.

>>DIANE: Thank you. And related to management of data, a question about the transition: "How should I calculate the QI results for the 2015 calendar year when part of the year is coded in ICD-9 and part is coded in ICD-10?"

>>PAM: So our recommendation is that you use nine months of ICD-9 to calculate the rates and three months of ICD-10 to calculate the rates. Alternatively, it has been suggested that you could convert to fiscal year so that you have a full year of ICD-9, if that is what you choose to do.

>>DIANE: So Vivek, do you want to add to that? It's all right.

>>VIVEK: Okay, yeah.

>>DIANE: That's all right. Sounds like Pam covered it. Thank you.

>>PAM: The other thing I would say is, as we look at trends across the Department -- and this is not unique. This question actually is not unique to the Quality Indicators, and you should be aware of it -- it's consistent as we look at utilization of any hospitalization or any visits that are impacted by the ICD-10 coding change. And the recommendation across the Department is that we sort of have this break point. And until we have a full year of ICD-10 data, we don't know whether that break point needs to remain -- in other words, this was data and rates and utilization collected under I-9, and this is what's going on under I-10. And until we have that data to know if we can say, "Well, the trends are actually consistent, and there's a one-to-one map, and so it's no problem looking from prior to the conversion to after the conversion in comparisons," or if we need to keep that as a break that basically,unfortunately, we just have to stop and start again.

>>DIANE: Okay. A final question for Pam:"What do you anticipate is the biggest impact of the AHRQ QI transition to ICD-10 on the indicator rates?"

>>PAM: You know, unfortunately, I cannot tell you until we have a full year of ICD-10-coded data. You know, our testing thus far has been on a very small dual-coded database. We are beginning to get quarterly data, and we will begin to assess that to see how much difference we see in the quarterly rates. We've been doing some assessments of the ICD-10 data in an all-pair version, and we are seeing differences in the types of hospitals and how they compare from before and after I-9 and before and after the transition, and also by payer, quite frankly. And so all of these things come into play in our testing.

>>DIANE: Well, thank you. We will learn more over time. So looks like we're at time, so unfortunately that's all the time we have for Q&A today. Again, if you have questions or if you've submitted questions that we didn't get to, we are noting those questions, and it will inform the communications from AHRQ about the AHRQ QIs. We encourage you to submit your questions to the AHRQ QI support team using the email that you see on the slide. We definitely are here to address your submitted questions, and they also help us plan future communications such as adding to the Frequently Asked Questions that are on the AHRQ QI website. Thank you so much for joining us. We appreciate your continued interest in improving clinical quality and patient care. This concludes our webinar for today. Thank you very much.