

AHRQ Quality Indicators Software: v2020 ICD-10-CM/PCS
Wednesday, August 5, 2020

Transcript

>> JENNIFER: Okay, everyone -- thank you for being here. It's three o'clock, so why don't we get started. Welcome to the AHRQ Quality Indicators Software Version 2020 Release Webinar.

Before we really get into it, we have a couple of announcements. We will be recording this webinar and it will be posted to the AHRQ QI website at qualityindicators.ahrq.gov. By staying with us, you are opting into the recording.

Because we do have so many attendees, all of our participation lines will be in listen-only mode. You can ask questions at any time during the presentation, but just know that we will be answering them during the Q&A session at the end. You can ask questions by using the chat feature that appears in the zoom window. Just click chat and a window will pop out and you can enter your question there.

if you have any technical difficulties, please just go ahead and contact Megan Lee. And this is her email address.

This is our agenda for today. We have an overview of the AHRQ QIs. We'll be covering their origins, what they're used for, the different modules and a little about the downloads. We have an overview of the software and version 2020 improvements, fiscal year 2020 updates, indicator logic changes, population files, risk adjustments. We have some usability improvements, specification changes for select Qis. And then we have some software resources for you.

Today's speakers: Jennifer Newburg - that's me. I'm a project manager for Pantheon Software. We have Mia DeSoto, PhD, MHA - she is our program lead for AHRQ Quality Indicators. Alex Bohl is the Associate Director for Hospital Quality Indicators Project Director at Mathematica. Heidi Cohen is a Senior Data Scientist for IBM and Vivek Kumar is project director for the AHRQ QI project from Pantheon.

And now I'm going to turn it over to Mia DeSoto.

>>MIA: Thank you, Jennifer. Good afternoon, everybody and welcome to this QI version 2020 software release webinar. My name is Mia DeSoto and I lead the AHRQ Quality Indicators Program here at the Agency. Today I'm joined by my colleagues Rhona Limcangco and Cecilia Hahn on this webinar.

As many of you are aware, the origins of AHRQ QIs lie with HCUP. The QIs were originally developed at the request of state organizations and hospital associations as a quality

improvement tool. AHRQ used the evidence-based practice centers (EPC) methodology for the development of these indicators and they were tested using HCUP data from about 47 states.

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Since their early development, the QIs have come a long way and have evolved to become measures of healthcare quality, as they have been revised to include risk adjustment, POA, and reference population. The uses of AHRQ QIs are multiple and varied. They are used for quality improvement and monitoring. They're also used for research, needs assessment and for planning at local, state, and national levels. They're used in hospital and community quality improvement initiatives. They're used for public reporting to reward favorable outcomes and encourage changes in hospital behavior. Sometimes the QIs are also used for performance-based payment programs. However, AHRQ's focus continues to be on measurement for quality improvement, population health, and patient safety monitoring. And we continue to use the HCUP all-payer data to develop our measures. With over 60 measures, QIs have a broad applicability and can be used with readily available administrative data. QIs are actionable -- they provide real-time information. For instance, hospitals and health systems use the AHRQ QIs to monitor their performance over time, using their own data. The results can be used to motivate, guide, and evaluate performance improvement initiatives. Users can dissect the indicator results and relate them back to individual records, allowing them to distinguish data quality issues from actual quality problems.

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What are the hallmarks of AHRQ QIs? What makes AHRQ QIs unique are the two important hallmarks of our program, which are continuous quality improvement and transparency. On an annual basis, the QI program undertakes various activities to assess refinements and evaluate the scientific acceptability of the QIs. We conduct reviews of research evidence, rigorous empirical testing. We review changes to administrative data coding, and guidelines. We review measure enhancements and refinements that come to us via literature reviews and environmental scans. We also often convene technical expert panels and work groups to provide recommendations, and last, but certainly not the least, we also take into account user feedback and suggestions for refinements that we receive through our technical assistance query line. Annually, the QI program goes to great lengths to maintain transparency. We make our tech specs and associated documentation publicly available. The software is open source and is improved over time based on public and private input. For more information on the history of AHRQ QIs, as well as the origins and hallmarks, please visit our website.

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Currently the QIs represent four different areas that address inpatient care: patient safety, prevention, and pediatric care. PQIs, our prevention quality indicators, are reported at county-level. They are population-based measures rather than hospital-based measures. Our PQIs are conditions for which access to high-quality and well-coordinated ambulatory care can

potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

IQIs, our inpatient quality indicators, are for adults and cover mortality, morbidity, and utilization. The IQI measure set covers a wide range of measures and are often used in public reporting efforts. PSIs, our patient safety indicators, focus on potentially avoidable in-hospital complications and adverse events during surgeries and procedures. Some examples include measurements of avoidable complications such as pressure ulcers or post-operative sepsis. Our PDIs, the pediatric quality indicators, are hospital-based measures and area-level measures covering patients under 18. They include neonates and cover a wide range of conditions. The PDIs are similar to other modules but are adapted for a pediatric population. The PDIs highlight problems that pediatric patients experience as a result of exposure to the health care system, and that may be amenable by changes at the hospital level.

With that, I will turn it over to Jennifer.

These are some of the resources that are available for the AHRQ QIs, as mentioned.

>>JENNIFER: Yes, thank you, sorry about that. AHRQ QIs are standardized evidence-based health care quality measures that hospitals or systems can use with readily available hospital inpatient administrative data to create indicators. AHRQ offers two free software programs platforms to help users create the indicators: SAS QI and WinQI. The software input, or the quality indicator results, can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes in quality over time.

As needs and refinements are identified, the programs and technical specs are updated and posted annually. Version 2020 is also risk adjusted, just as it was in 2019. For a deeper dive, we do provide tutorial videos for both platforms: WinQI is about an hour and SAS QI is about 15 minutes. And of course, it's available at no cost to the user from AHRQ.

Both of our programs, SAS QI and WinQI, launched on July 31st. And SAS QI will have separate packages available for each module to download, or you can download the full package that contains all of the modules. WinQI is a single installer package that you can download as well.

And now I'm going to turn it over to Alex Bohl.

>>ALEX: Hi there -- can you hear me?

>> JENNIFER: Yes. Please go ahead.

>> ALEX: Okay, sorry. Thank you. I was double muted - my apologies. So, yes, every year, when we start off the software refinement process, we're very focused on fiscal year updates. The software is explicitly designed for backward compatibility, so everything -- we first try to move forward everything one year, starting with the individual measure specifications and then

making changes throughout the software for all of the value sets or diagnostic codes and procedure codes, as well as the reference population. And this is all doc-- all these changes are then documented throughout not only the software, but all the supporting specifications and documentation. So, for version 2022, after doing all this deliberation, we started to rebuild the software using the 2017 HCUP state inpatient database reference population. That serves as the backbone for the software to develop risk-adjusted rates, signal variances, population rates, and composite weights.

Please note that while we do -- this is compatible up through fiscal year 2020, due to timing we have not been able to account for COVID-19 in the software, but this is of course on our radar and we can discuss this during the FAQs, sorry, during the question and answer session, but we are developing some user guidance for those interested in adapting the software to account for COVID. So, as I mentioned, everything is based on coding so we have -- sorry for diagnostic and procedure coding, so the software will be compatible through fiscal year 16, through fiscal year 20 of ICD-10 diagnostic and procedure coding, and these changes will impact all modules.

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As a reminder, the software gives both discharge and hospital or other stratum-specific rates, but a lot of our efforts before things are released are focused on the methodology that, as it relates to risk adjustment, smoothing, and compositing, so you will be able to get out of the software these rates for all modules. You'll also be able to get the non-adjusted numerators, denominators, and observed grades. And just a note that for the PSIs and PDIs, there's now a tweak in how it accounts for the exclusion for present-day admission, where it's now solely based on denominator criteria, and no longer looking to exclude only when conditions -- sorry when certain criteria match with the numerator. So, if you're looking to understand how everything changed for version 2020, we have a link below to the software release notes that gives a high-level summary. We also have a more detailed log of changes as well available on the website.

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So looking specifically at different modules, so first one new change for this year is that across all modules, we are now creating an upfront exclusion for any discharges with ungroupable diagnostic related groups. In this case, those are DRGs coded to 999. They are excluded up front and will never be included in numerators or denominators. In the past, these had very little impact but there was, I believe, one indicator, PSI 14, that in rare cases, an ungroupable DRG could make it into the denominator.

As for the IQIs, we've now changed the methodology on how to assign the all-payer refined diagnosis-related groups. Previously it was based on the discharge information but is now only using information that is present on admission to determine the flags. For the PSI and PDI modules, as I mentioned before, they're a small number of exclusions that used to be based on whether or not the discharge qualified for the numerator, but those were changed now and

they only consider denominator criteria. And for the area-level PQIs, there are no significant changes to report in terms of the indicator logic.

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The PQIs do use population finals. As a reminder, they are area -- they do provide area-level estimates and there are a subset of the PDIs that are also area level. With this software release, in the spirit of updating everything one year as we did, we've now included -- updated the population file to include county-level estimates from the 2009 to 2019 intercensal and postcensal periods. And these will include population categories for the demographic groups listed here, and if you're interested to learn more about how the population file is created, or how that relates to the denominators of the area-level indicators, we point you to the population file methodology document at the bottom of this slide.

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So, as I mentioned, a lot of our time before the software's release is focused on risk adjustment. And the risk adjustment for the QI software is enabled by the HCUP state inpatient databases that cover all payer discharges, and these - this allows for both benchmarking of rates at the hospital level to a national benchmark, or other benchmarks, potentially, as well as offering some opportunities for internal quality improvement projects to track trends over time, adjusted for case mix. Risk adjustment, it broadly speaks to the expected rates that are calculated, that therefore feed into risk adjusted smooth and composite values, but it's very important to remember that just like with version 2019, users are expected to have defined the major diagnostic category for all discharges. This isn't a critical feature of the risk adjustment module modules and the user must define that themselves as upon input to the software.

>>VIVEK: Alex, we lost your audio.

>>ALEX: Oh sorry, I'm not sure somehow I was muted again. In terms of what to do with risk adjusted rates, um we recommend comparing, as I mentioned, a hospital's performance to a national average or a benchmark. And that and the point of risk adjustment is to account for differences in case mix by setting an expectation, but we do not recommend that risk adjusted rates are used to compare two different hospitals' performance or rank hospitals on their relative performance. Risk-adjusted rates are not designed for this.

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Compared to the version 2019, users will see some changes in rates. Some of this has to do with the methodology and some of it with the underlying data. So, the big piece here to know is that for the area level indicators, um users might see increases in rates of four to five percent, but this is because of basically a correction in the population files. There were certain areas that included in the population files previously, for which we did not have HCUP data, so therefore

the denominator was inflated -- it was too large -- it made the rates look slightly too low, so this a correction was made when preparing version 2020.

And for PSI 2, there, users will see large increases and the reason why is because a change in the methodology. We now use two years of reference population data to define the low mortality rates of conditions, as well as apply the other PSI 2 exclusions before determining those low mortality conditions. So this, of course, by virtue of it increasing, it's basically implying that we're pulling out a lot of denominator cases that no longer qualify for the measure methodology.

Okay, well, thank you for that, and my apologies for the muting and technical difficulties, and I'll now hand it over to Heidi and she'll talk about usability improvements.

>>HEIDI: Thank you, Alex. Usability improvements. Next slide.

Usability for IQI software is designed to be compatible with data from fiscal year 2016 through fiscal year 2020, which Alex already mentioned. This only covers ICD-10-CM/PCS coding. Other changes to measure logic, also described by Alex, are not expected to be backward compatible. A notable change is having options to calibrate smoothed rates and composite values using an option for the observed-to-expected ratio. The default to calibrate using the 2017 HCUP SID reference population is recommended. The alternative is to calibrate to the user's input data. There's more important - there's more information available about this in the release notes and in the empirical methods documents, which are available on the website.

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User suggestions help improve the QIs and are the result of responses to TA requests. The reviewed and expanded list of Operating Room Procedure Codes (OR PROC) include some restored codes for backward compatibility. Other changes were made based on current year coding, which is typical. The operating room procedure codes are used in a number of PDI and PSI indicators, as listed. Setname code lists are reviewed and codes are added and removed every year to improve consistency with clinical intent and to exploit uh the clarity provided by ICD-10-CM/PCS. Some examples of this--some examples from this release of setname code lists, which are used to identify exclusions, are cardiac procedure codes for PQI 07 and 08, esophageal resection procedure codes for IQI 08 and for the related indicators PSI 11 and PDI 09, thoracic surgery procedure codes for also for the related indicators, PSI 06 and PDI 05.

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The indicator name of some - excuse me - of some QIs were changed to clarify the intent of the indicator. For example, PSI 15 is now abdominopelvic accidental puncture or laceration rate. There are also some new setname code lists in this release. New denominator exclusion criteria is provided by these diagnosis code examples. Pressure ulcer stage or deep tissue injury--this is

a new distinct denominator exclusion based on a related numerator setname. It's used in PSI 03. Malignant hypothermia, which is used in related indicators PSI 11 and PDI 9, and peri-prosthetics fractures, which is used in PSI 08.

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Other changes were considered for this year, which may still be included in future releases. Following refinements were tested but not implemented: For PSI 12, exclusion for procedures occurring 7 to 14 days from admission and do not resuscitate setname DNR as an exclusion for PSI 04. If you have suggestions for future improvements, they can be sent to the AHRQ QI support team at the email address on the screen.

Next slide, please. And with that, I turn it over to Vivek.

>> VIVEK: Thank you, Heidi. So, the changes we discussed so far are also implemented in WinQI. In this slide we will discuss highlights of the updates specific to WinQI in version 2020. If you are running a prior version of the WinQI software, the app will notify you that a new version of the software is available. Once you accept and proceed to update, the update process will automatically uninstall the prior version and install the new version, which is version 2020. Please know that the SQL server database gets refreshed as well, so your prior data will be deleted as part of the update process.

We have been trying to make some process improvements uh, but the hospital PDI now are risk adjusted, so running a large input file, for example, more than three million discharges in the file can take a few hours to finish. It's advisable to, to run one module at a time, and that helps you reduce the processing time.

So as discussed before um, as Heidi uh talked about it, in version 2020, users can now switch between using the O:E ratio of the reference population or the ratio from their own population. So, this option is also added in WinQI and it's available in both hospital-level and area-level reports in the configuration screens for them. So, when you check it, it means that you're using the reference population-based O:E ratio. If you uncheck it, then it means that you're using your own population-based O:E ratio. In version 2020, in all screens, on all screens, labels where you display a provider are now updated to display hospital to represent the intent accurately. Since 2020 includes risk adjustment, both hospital- and area-level reports are risk-adjusted and include observed expected reference population risk-adjusted and smoothed rates in WinQI as well.

Based on our understanding through technical assistance, many users now use the automation feature in WinQI. We recommend you make use of this feature to create scheduled runs of the software by using command line utilities. Detailed instructions on how to use automation in WinQI are available in the software instructions document. Starting with 2020, we have added visual cues on the top right corner of the WinQI screen to improve the notifications uh for software updates, so, going forward, if AHRQ releases another update in the future a

notification will appear on the screen for you to easily review it and update the software. We also wanted to confirm that there were no changes made to the data structure of the input file so your existing formatting and mapping file, that you've been using, will work seamlessly.

Next slide, please. So, the next slides are some of the highlights of the indicator changes. So next.

In version 2020, specifications and programming changes are made across all modules. These changes go through many iterations of detail, deliberation, and assessment process with clinicians and expert coders before incorporating into AHRQ QI. These changes are updated in the change log document and are also available on the website. The location of each module is listed on the slide for your reference.

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Although the change log document provides you a full log of all indicator level changes, today we'll go through a few of them in my presentation. So PQI 5, 7, 8, 11, 12, and 16 went through the annual coding update, so you may expect to see some changes in the rate. Other than the coding update, a few setnames were removed in version 2020, as they were used in PQI 2 and 10 that retired in the prior version. Similarly, IQI 8, 21, 33 went through the annual coding update, since IQI 13 and 14 retired in the prior version. Some setnames were removed, such as head trauma diagnosis codes, partial or partial or full hip replacement procedure codes, and others. Details can be found in the change log. In IQI 21 and 33, cesarean delivery Medicare severity DRGs were removed, as the related MS-DRGs were retired, effective October 2018. Almost all PSIs went through the coding updates in version 2020, in addition to the annual coding updates. Out of all four modules, PSI indicators went through the most changes. These indicators are listed under the header "other updates" here on the slide.

I will go through a few, for example, in PSI 3. We have added a new setname to differentiate between the setname used to define the PSI numerator and the setname used for PSI exclusions. In PSI 4, for example, we added the GI hemorrhage exclusion of a secondary diagnosis code for esophageal varices with bleeding. We also added a new setname for several GI hemorrhage or acute ulcer diagnosis codes in PSI 4. There are a few other setnames added in PSI 4, such as severe pulmonary embolism or deep vein thrombosis diagnosis codes. Severe pneumonia diagnosis codes and cardiac arrest diagnosis codes were also added. There are others which you can certainly go and check out on the change log document.

Similarly, in PSI 11, some new setnames were added. One of them is a malignant hyperthermia diagnosis code, which is now used in exclusion. In PSI 12, we removed the code for skull fracture based on conceptual review of setname. Certainly, like I said, check out that the change log document for more information and learn about changes related to other indicators listed here.

In PDI, other than the annual coding update in NQI 3 and PDI 1, 5, 9, 10, 12, we added new

codes for ventilator dependence. Also, MS-DRGs to modify DRG mapping is updated. That affects PDI 1, 5, 8, 9, 10, 12. We also had a DRG 319 and 320 to surgical DRGs, which affect PDI 1, 5, 8, 9, 10, 12 as well. Also, a new alternative transfer variable is added as input to risk adjustment. This affects PDI 1, 5, 8, 10, 12 and NQI 3. We also removed codes related to PDI 3, that was retired in 2019. These codes are no longer relevant. For example, retained surgical items or unretrieved device fragments diagnosis codes were removed. We also removed code related to PDI 3, like I mentioned. These are a few examples, but please do check out the change log document for further details.

So, next slide.

Of course, you can contact AHRQ QI technical assistance any time with your question -- the support email information is on the slide. You can access the software documentation on the website. You can also go to the FAQ page to see FAQs related to version 2020 updates.

Next. Yes, so I'm going to hand it over to Jennifer and I think we are ready to start our Q&A discussion.

>>JENNIFER: Yeah. Thank you, Vivek. We are ready to take some Q&A. I see we already have a few that came in. If you'd like to add another one, you can submit your questions using the chat feature in the edge of the webinar window. Just click on chat and a window will pop out - you can enter your questions there. And as you're typing, only the moderators will be able to see it there. And just as a quick reminder, we have so many people on this webinar that everyone is listen-only mode, so questions have to be sent that way so we get them.

Okay, so our first question is for Rhona, and the question is: How is COVID-19 impacting AHRQ QI software?

>>RHONA: I'm hoping you could hear me.

>>JENNIFER: Yes.

>>RHONA: So, as Alex mentioned earlier, the version 2020 QI software did not include COVID-19 diagnosis or oracle reminding procedure codes in its algorithm, so it does not so it doesn't have any exclusion criteria for COVID or isn't included in the risk adjustment. AHRQ anticipates that COVID-19 pandemic will have a substantial impact on the QI rates because of changes in hospital case mix and hospital volume. For the case mix, as hospitals prepared for COVID-19, surgeons and as hospitals responded to federal directives, COVID-19 has shifted case mix away from elective surgery, so this may decrease the number of surgical discharges, and change the risk profile of the reference population that's used in the risk adjustment methodologies.

Now for the volume, similarly, the volume of discharges is likely to decrease, as short-stay elective surgeries are cancelled or released, whereas longer stay emergency or medical discharges become more prevalent, so this changes impact on the reliability of the individual

and composite indicators, which is primarily driven by the volume. So, in the future, AHRQ will provide updated guidance on how users might adapt their input data files to account for COVID-19 cases. So this, this will work for both WinQI and SAS QI users. AHRQ also plans to provide documentation to assist users in directly modifying the SAS QI code to exclude discharges with COVID-19. They decide to do it this way. Thank you, Jennifer.

>>JENNIFER: Thank you and Rhona, I'm afraid you're up again for question number two. Why is AHRQ QI still using 2019 formats for comorbidity programs while 2020 is already out?

>>RHONA: Oh, so the AHRQ comorbidity software is used in the PSI risk adjustment. So the development of the QI software, as you may know, takes several months. And during the time of development, specifically when on in the risk adjustment stage, the comorbidity software, the latest comorbidity software, was not available, so so we had to use the previous version. Thank you, Jen.

>>JENNIFER: Okay, thank you very much. And we have another question - this one is for Alex. The data that you use, 2017, is dated. Is there a way to bring that closer in the future to at least a year from our current year, or is the delay related to population data as well? Alex, do we have you?

>>ALEX: Sorry, for whatever reason, I keep getting muted and I cannot unmute myself, so my apologies, but yes, you have me. And the answer is that the QIs are designed for all-payer data - the HCUP data on which the QIs are based, they receive information from states and related organizations such as hospital associations that provide data to AHRQ on a periodic basis, sometimes quarterly or sometimes annually, but because the large amount of data that's required to fit risk adjustment models, as well as the goal of creating a broadly applicable software that can cover hospital- and area-level quality throughout the country, we wait until we have a sufficient number of states with data available. So, as of the time of development, the most recent data we had for a substantial number of states was 2017.

However, we should note that, as a reminder, we have the diagnosis codes in the software so that the user can use more recent data. And also, the feature that Heidi mentioned, where the user now has the option to calibrate the smoothed rates to their population is maybe another way to overcome sort of the lag in the in the reference population data. So, for example, if a user had, for example, a large set of Medicare data for a year or multiple years, the user could then calibrate the rates to that sample for better interpretability.

>>JENNIFER: Okay thank you very much. And Rhona, you're back -- this one's for you as well. We are often asked to produce the same PSIs, especially 90, that CMS reports. What do you advise?

>>RHONA: So, we would refer this user to connect directly with CMS, specifically CMS--how fast they can provide the user with the software that CMS used to produce the CMS PSIs. Thank you.

>>JENNIFER: Okay, thank you. Next we have a question for Mia. Is there a resource for organizations that have never used the software at all? We would like to consider using it now.

>>MIA: Thank you, Jennifer. Absolutely yes. On our website we have resources for people who are new to QIs and would like to talk about QIs to their senior leadership and their hospital executive team. If you connect with us via the QI support line, we can point those resources out to you and where they exist on our website. Excellent question, thank you.

>>JENNIFER: Thank you, Mia. Next I have a question for Vivek, and our questioner says: this may have been addressed and I just missed it, but are there software updates actually available to be able to put into production? We use 3M Encompass 360 for our PSI measure management and I'm wondering if they, 3M, have version 2020 available to install now.

>>VIVEK: Yeah, so this question -- we can only speak for AHRQ QIs. 3M is one of the vendors who use the updates that we publish on an annual basis so I would suggest you to directly contact 3M to get their schedule for release of the updates for 2020.

>>JENNIFER: Great, thank you, and Alex, I have another question for you. The change logs do not always contain the specific ICD-10-CM and PS codes that were added or deleted. Where can I find the specific codes that were updated?

>>ALEX: Yeah, that's a good question. Because thousands of codes are added and changed from the software each year, it's unwieldy, unfortunately, to put this in a summary file. However, probably the best way to programmatically do this would be to take two versions of the SAS QI software for the modules you're interested in, take the all formats program for each version and then using ultra edit or a similar tool, doing a comparison to point out the differences. If you're looking at a particular indicator and want to know what codes changed, probably the best, the best, method would be to go and pull out um the technical specifications related to those, and again make a comparison, given that the appendices and setnames are generally in the same order. Again, unfortunately this is just we haven't found an optimal way to provide that information with the other documentation, just given the volume of codes that change year to year.

>>JENNIFER: Okay, thank you, and Alex, this one's also for you. Did I hear that POA is going to be determined in some other way, other than abstracted by the coder?

>>ALEX: The answer is no, unless you're using a version of the software before version 4.5. In version 2020, we do not modify the POA that is coded on the discharge in any way. But just to clarify, when we were mentioning changes related to POA before, it was instead relating to how the measure specifications use that POA information to apply inclusions and exclusions to the measures, as well as how present on admission information is used to derive risk adjustment of flags such as the APR-DRGS.

>>JENNIFER: Okay, great. And one more for you, Alex. You mentioned proposed exclusion to PSI 4 as DNR status documentation. Any idea when that might be implemented?

>>ALEX: That's a good question. So, this year, we did not release DNR as an exclusion. When going through testing, um we realized that it is on the the ability to – sorry, that not all patients uniformly have a DNR on record, so next year we are hoping for version 2021 to test the use of DNR as a risk adjustment variable. However, we are just beginning that process, so we are hoping for version 2021, but we right now we do not have any firm plans to include it in version 2021, as of yet, until testing is complete.

>>JENNIFER: Okay, thank you, Alex. The next question is for Vivek. What is the release date for the tech specs and the change log? I checked for version 2020 this morning and I didn't see it.

>>VIVEK: Yes so, it was released on July 31st and it is available on the website. One possible reason I can think of why you're not seeing is that it may be cached on your machine, and you're still seeing the old content, so one thing you can try is to clear your cache and try to reload it. The technical specifications are available under measures and then you can pick the modules that you want to see the specifications for, and within that page is pretty much the first card on that page is what will take you there. So I would say try cleaning your cache, clearing your cache and reloading the website -- you should be able to see it.

>>JENNIFER: Okay, thank you, Vivek. I have yet another question for you. I believe that you said version 2020 was available in July. So when should we work with our vendors to have this implemented? As soon as possible? Please advise.

>>VIVEK: Yeah, so this, again, is a question that you would need to ask to your vendor depending upon who you deal with, you know they might have a different schedule and this is something that AHRQ may not be able to answer, as we don't have information on their release dates.

>>JENNIFER: Okay, thank you very much. This this next question is for Alex. And, a couple of updates were mentioned for PSIs that I'm unable to identify in the specs. PS 12 exclusion for procedures occurring 7 to 14 days from admission and PSI 4 exclusion for DNR. Where in the spec are these updates noted?

>>ALEX: So, my apologies that you scoured the specs for these, but these are not in the specs. These are examples of refinements that we tested during our annual process, but they were not included in version 2020. So, each year we test roughly 10 to 20 refinements. Only a subset make it into the software, but we wanted to call these out today because these stemmed from user feedback. AHRQ systematically catalogs all user inquiries, and then every multi, almost quarterly, we go through that list and identify ways that we can be responsive to user feedback, so this was just a way to indicate that we're listening and we really appreciate all the questions and feedback sent to the help desk.

>>JENNIFER: Thank you, and I have another question for you, Alex. The version 2020 software SAS uses OW ratio to adjust the expected rate. Users have the option to use the O:E ratio from the reference population or from their own data. What's the rationale behind adding the OE adjustment to the expected rate?

>>ALEX: Got it This is a great question. So this, in general, gets at, uh is derived from, the statistical concept of calibration, so observed is, of course, a rate that's observed, so it's in the data. We see that, for example, we can imagine that PSI 3 has a rate in the population of 1 over 1000 and the expected is how many we would expect based on the characteristics of the data that the user puts into the software. So, you could imagine that that prediction might be different from observed, and at times that difference is what the user wants to study, for example, and that difference between the observed to expected rate represents something, potentially quality performance or other factors, that the hospital might view as the opportunity for improvement. However, certain users, such as users with more recent data or larger data sets, they might see differences between observed to expected in their population and if they want to calibrate, you can do this by basically then taking and using this factor and adjusting the expected rate to match the observed rate, so that that the point is to calibrate to the user's population. It depends on the use -- we only recommend that calibration, that optional calibration, for users that have a clear intent of why they're using it and with a large sample size.

>>JENNIFER: Okay. thank you very much, and Alex, one more time. For version 2019 (SAS), the risk adjustment feature was optional. It came to a separate SAS program – I'm sorry, came in a separate SAS program. For version 2020, is risk adjustment also an optional feature? We are only planning on needing to execute the PQI and PDI measure modules without a denominator -- we're interested only in the numerator.

>>ALEX: Yes, so this, from from a SAS perspective, this is always possible. So, the way that the SAS program works is that there are multiple programs. One is called All Measures and the All Measures reads in discharge data, and at a discharge level, it creates flags for whether the discharge met the numerator or denominator criteria. Typically, we call that the P flags. So, for the PSI, that would be the TPPS variables -- and if it's a one, it means that you're in the numerator. If it's a zero, it meant that you qualify for the denominator. So um, so if you wanted, for this this person's purposes, if you wanted to just identify numerator cases for each module, you could just run the All Measures program. And you would get out a discharge level file that you could then feed into your analysis, just with the numerators. But then other users can continue on and execute the other programs that also do risk adjustment and provide hospital-level risk-adjusted or composite rates.

>>JENNIFER: Okay, great, thank you. This next one is for Rhona and the question is: have you heard from users having difficulty using COVID as a PDX and this impacting PSI recognition? Our PSIs do not seem to be true. Do you have any guidance for users?

>>RHONA: I'll answer shortly and then I'll also let Alex um say something about this. We have not, however, we do not have um, also we do not have any data with COVID cases yet, but as soon as we uh we have some data that we can that we can analyze, then we'll be able to provide some guidance on this. Alex?

>>ALEX: Yes. yes, thank you, Rhona. And so, and definitely the data-driven response will be more informative, and we will alert users to what we're seeing, but what this user is suggesting is not terribly surprising. First of all, many of the PSIs only consider surgical discharges, for example, PSI 13 post-operative sepsis. So, of course there are a subset of the PSIs where if someone has a COVID primary diagnosis, they would often be moved into a medical into a medical DRG and therefore they would not be included in the denominator for many of those PSIs. Of course, then there are a handful such as pressure ulcers, but oftentimes pressure ulcers, they're of course each indicator has their own inclusion exclusion, and so it's possible because of length of stay, because of transfer, and because of a variety of reasons, that users are not seeing PSI denominators being triggered for COVID primary diagnosis cases.

>>JENNIFER: Okay, great. Thank you very much. We have another question - this one is for Vivek, and the question is: I'm sorry if I missed it, but are there any indicators being retired or old retired ones being brought back in 2020?

>>VIVEK: No, so there is there is no new retirement in 2020 or none of the ones that retired in 2019 has been brought back here in 2020. So, uh what's retired in 2019 has been retired, and no further retirements for this for this release.

>>JENNIFER: Okay, thank you, and Vivek, I have another question for you. Will all cases beginning with July 2020 discharges be according to these new technical specs?

>>VIVEK: Yes, so all cases begin that are recorded in fiscal year 2020 will be using the new technical specifications, that's correct. You know, for uh certainty, they are backward compatible. So if you are running a prior year data through 2020 software, that will still work but certainly recommended to use the latest version for fiscal year 2020 data.

>>JENNIFER: Okay, great. Thank you very much. That is all the time that we have for Q&As today. If you submitted a question and we were unable to get to it, we encourage you to submit it to our QI support team at this email address. We do address all queries that are submitted and they help us because we can see what the patterns of questions are, and they help us, too, with things like frequently asked questions and future communications to users.

Thank you very much for joining us and this concludes our webinar. Have a wonderful afternoon.