Society of Thoracic Surgeons

Adult Cardiac Surgery Database: Monthly Webinar

November 3, 2021

Agenda

- Welcome and Introductions
- STS Important Dates
- STS Updates
- IQVIA Update
- STS Education: AQO Edition
- Q & A

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Important Dates for Adult Cardiac

3 Nov.

- ACSD Monthly Webinar @ 2pmCT

17 Nov.

- ACSD User Group Call @ 2pmCT

1 Dec.

- ACSD Monthly Webinar @ 2pmCT

15 Dec.

- ACSD User Group Call @ 2pmCT

17 Dec. (moved from 11/12)

- Harvest 4 Closes (OR Dates through 9/30/2021)

21 Dec.

- Harvest 4 Opt-Out Ends

Harvest 2022 Dates

ACSD					
Harvest	Close	Opt-Out	Includes procedures performed through	Report Posting	Comments
H1 2022	February 25	March 1	December 31, 2021	Spring 2021	Star Rating
H2 2022	May 27	June 1	March 31, 2022	Summer 2022	
H3 2022	August 26	August 30	June 30, 2022	Fall 2022	Star Rating
H4 2022	November 18	November 22	September 30, 2022	Winter 2022	

STS Updates

- AQO is available in the STS Learning Center
- Harvest 3 data back from analysis – IQVIA preparing for release
- November Training Manual Posted

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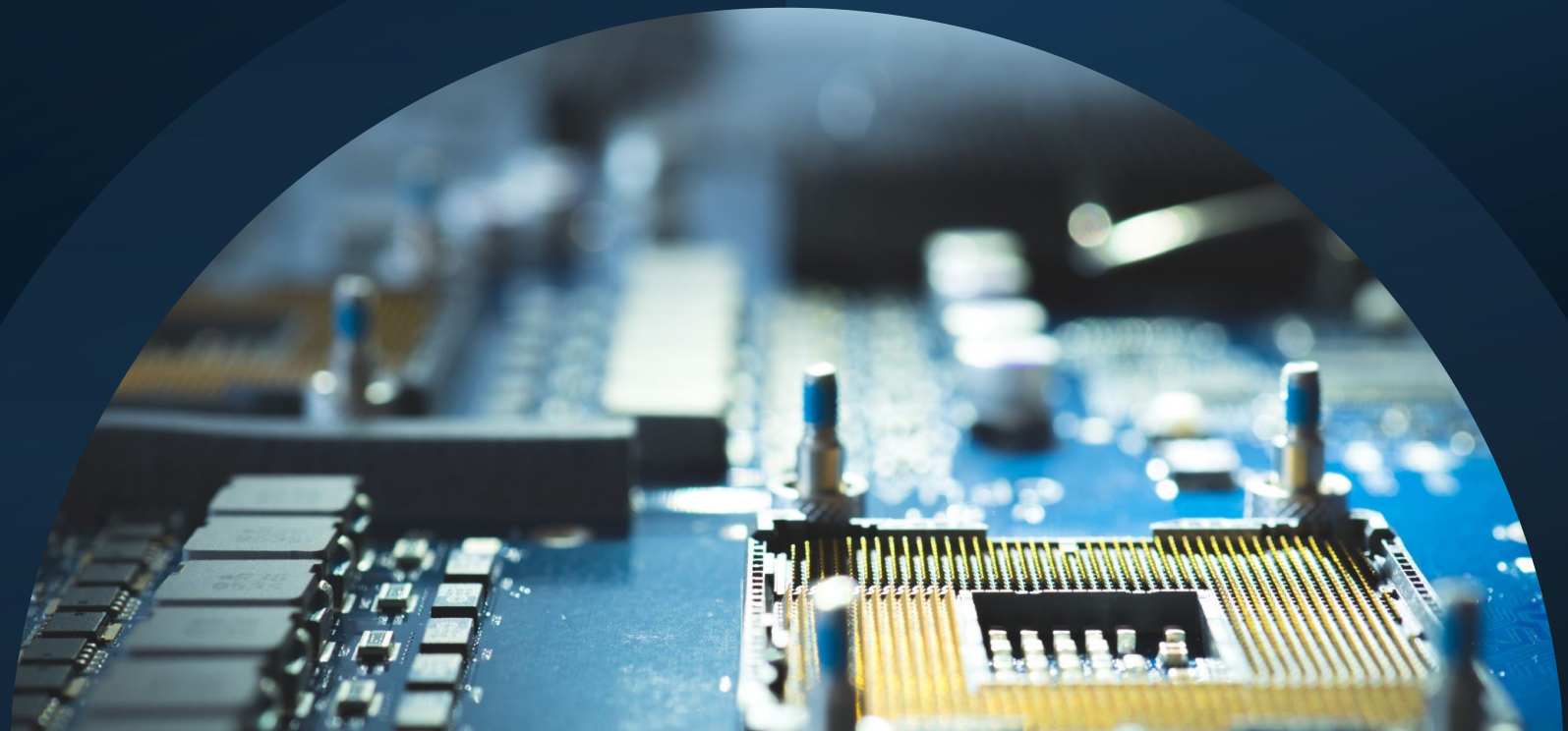
IQVIA Update
Joe Brower



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IQVIA Updates Oct 2021

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The below items are resolved and released to production the weekend of Oct. 30

Reports

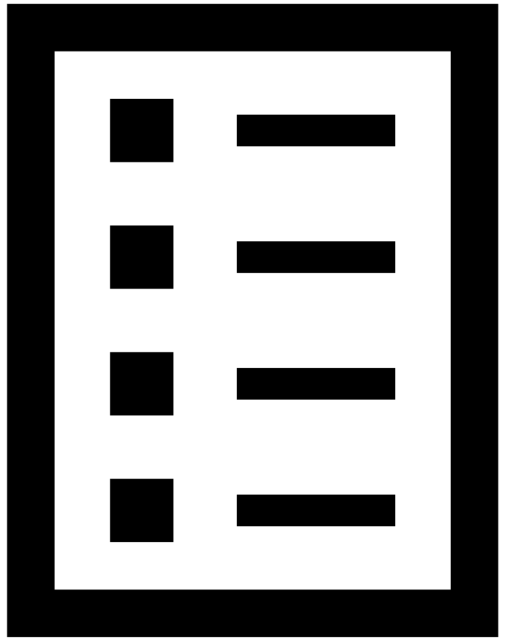
- **Participant Dashboard Report (non-analyzed)**
  - **STS-7193 -** Total Postoperative Ventilation Hours (VentHrsTot) displaying as missing when Extubated in OR is answered as N/A, should not calculate as missing
  - **STS-7152 –** Dashboard does no display the counts for patients marked as ExpiredInOR within the MtOpD+Died In Hospital + Died in OR

- **Missing Variable Report**
  - **STS-7045 –** MVR displayed Died in OR, Intra-Op post procedure TEE as missing and the Organization Participates in Adult Anesthesia Section variable was entered as No
  - **STS-7194** – MVR does not display surgical site infection as missing when it is left blank on the form

- **Risk Adjusted Report (analyzed)**
  - **STS-6785 –** NQF Outcomes measures are displayed as a percentage and should display as a ratio
  - **STS-7236** – The Rating Trend years are displaying out of order when exported or printed
  - **STS-7335** – Error stating “Page Not Found” when trying to print/export the Risk Adjusted Dashboard Report

ACSD Known Issues and Enhancement Items

IQVIA will post an updated version of the full list of known issues and enhancements to the Library for user reference this week.



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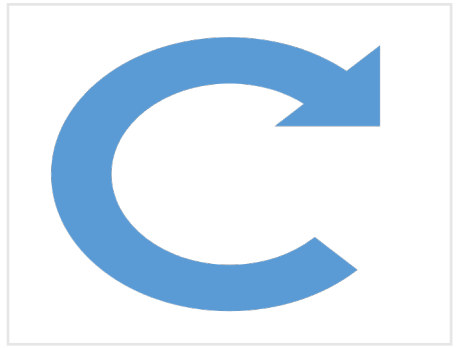
IQVIA Update

Please note: Submitted tickets are currently under review and the IQVIA support team will follow up on resolution and/or target release confirmation.



The IQVIA Team is currently reviewing items that will be released in an upcoming release. Those items will be posted to the Notifications section.

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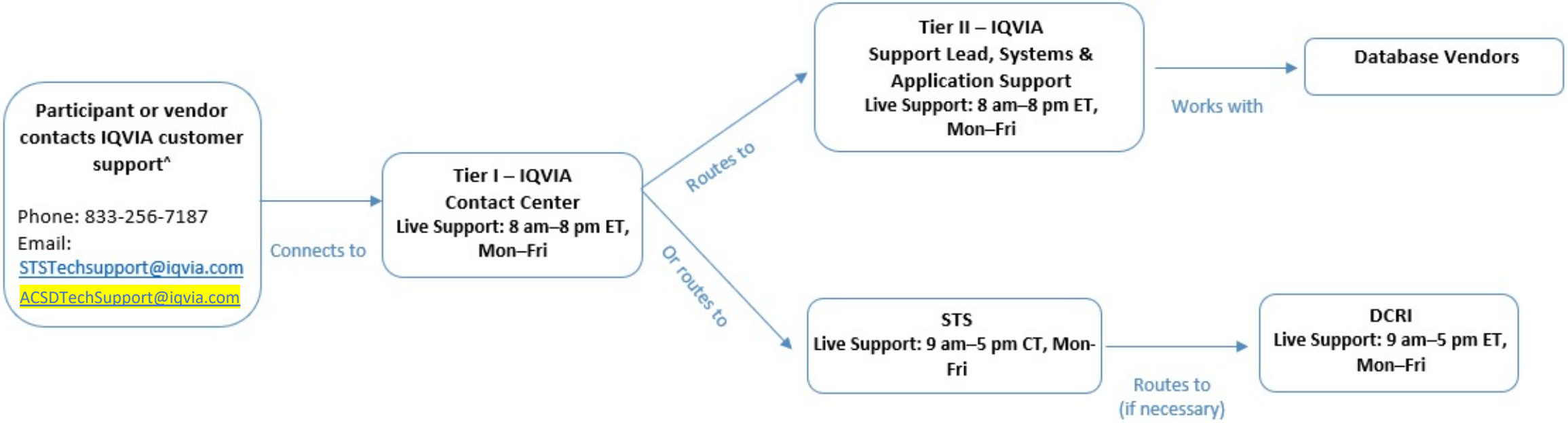
IQVIA's Support Plan

Please include your Participant ID (PID) in all communications with STS and IQVIA



^ Inquiries received outside live support hours will require a 24-hour turnaround window (i.e., one business day) for responses.

STS Education for November 2021: AQO Edition

SEQ 405 ChrLungD

Question

What if our pulmonologist classifies our patient as mild to severe obstructive or restrictive. Do I use the pulmonologist or with the manual?

Answer

Code severity based on criteria in Training manual not MD documentation

Code the most severe category if there is a discordance between the FEV1, DLCO, ABG, and inhaler criteria

SEQ 405 ChrLungD

Question

If CTA states emphysema and it is not documented anywhere else, we can choose severity unknown?

Answer

In this scenario you do have documentation of emphysema, but no criteria to determine the severity

Code as CLD Severity Unknown

SEQ 405 ChrLungD

Question

Does the use of "as needed inhaler" account for the use of inhaler for the severity classification?

Answer

Yes, chronic prn inhalers that are used to treat lung disease can be used

SEQ 405 ChrLungD

Question

With Covid resources in house and surgeon office is stretched head of pulmonary wants to stop spirometry what do you recommend?

Answer

It is important that your Hospital's Leadership know the "Severity of CLD" is a variable in the Risk Model

SEQ 405 ChrLungD

Question

With someone who is an acute heart failure and has a preop PFT, their value seems to be falsely low. Should we still be using the PFT or in those cases should they be ignored?

Answer

You can use the PFT result unless there was documentation in the medical record that the test was invalid

SEQ 915 - ClassNYH

Question

Can the NYHA class be documented by an APP (PA/NP)?

Answer

Yes, APP documentation is acceptable.

There must be physician/ provider documentation in the medical record indicating the NYHA class.

SEQ 915 - ClassNYH

Question

Is it ok to consider and code the NYHA class if it is only documented by anesthesiologists in the anesthesia record?

Answer

It depends on when the documentation by Anesthesia occurred.

Select the highest level NYHA Class documented within the two weeks prior to entry to OR for index procedure.

SEQ 1030 - MedBeta (1030)

Question

How would I respond to a surgeon who states there are studies that do not support a pre-op BB for isolated CAB?

Answer

I understand that there are some studies out there suggesting this, however, this is a NQF Endorsed Measure - Part of the medication bundle in the STS Composite Quality Rating (Star Rating).

SEQ 1030 - MedBeta (1030)

Question

In the past we always had to have a date/time documented to say yes to BB when did this change?

Answer

It is not necessarily a change.

You must be able to prove that the beta blocker was given within 24 hr. of incision, to do so you need to have a date and time of last beta blocker given, unless you have documentation such as "patient took beta blocker this am at home with sip of water as instructed prior to coming for surgery this am“

SEQ 1030 - MedBeta (1030)

Question

Patient has history of RBBB, is this a contraindication to beta blockade therapy?

Answer

There is no automatic contraindication for medications.

You will have to have documented contraindication for No Beta Blocker

SEQ 1970 - Incidence

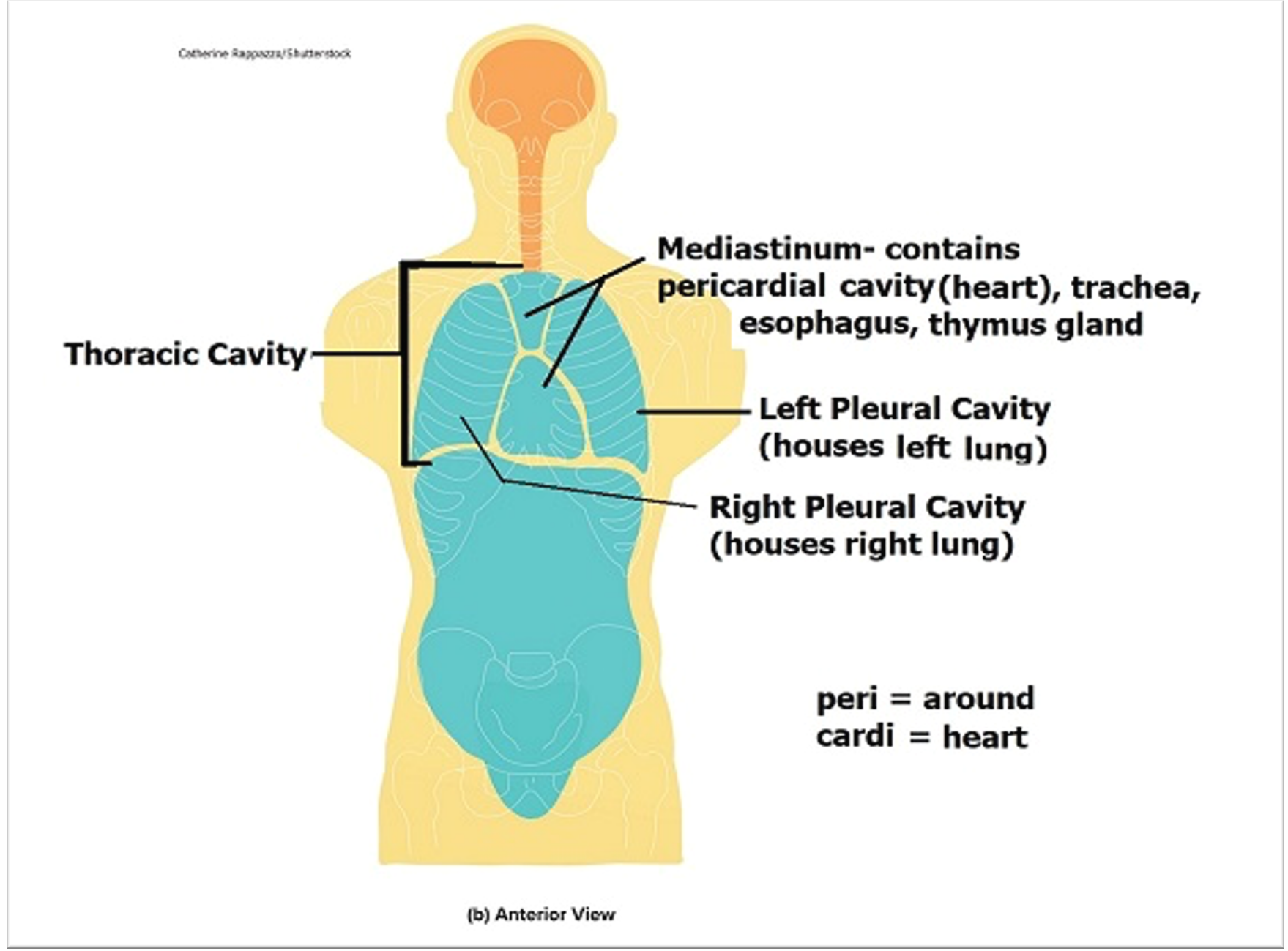
Question

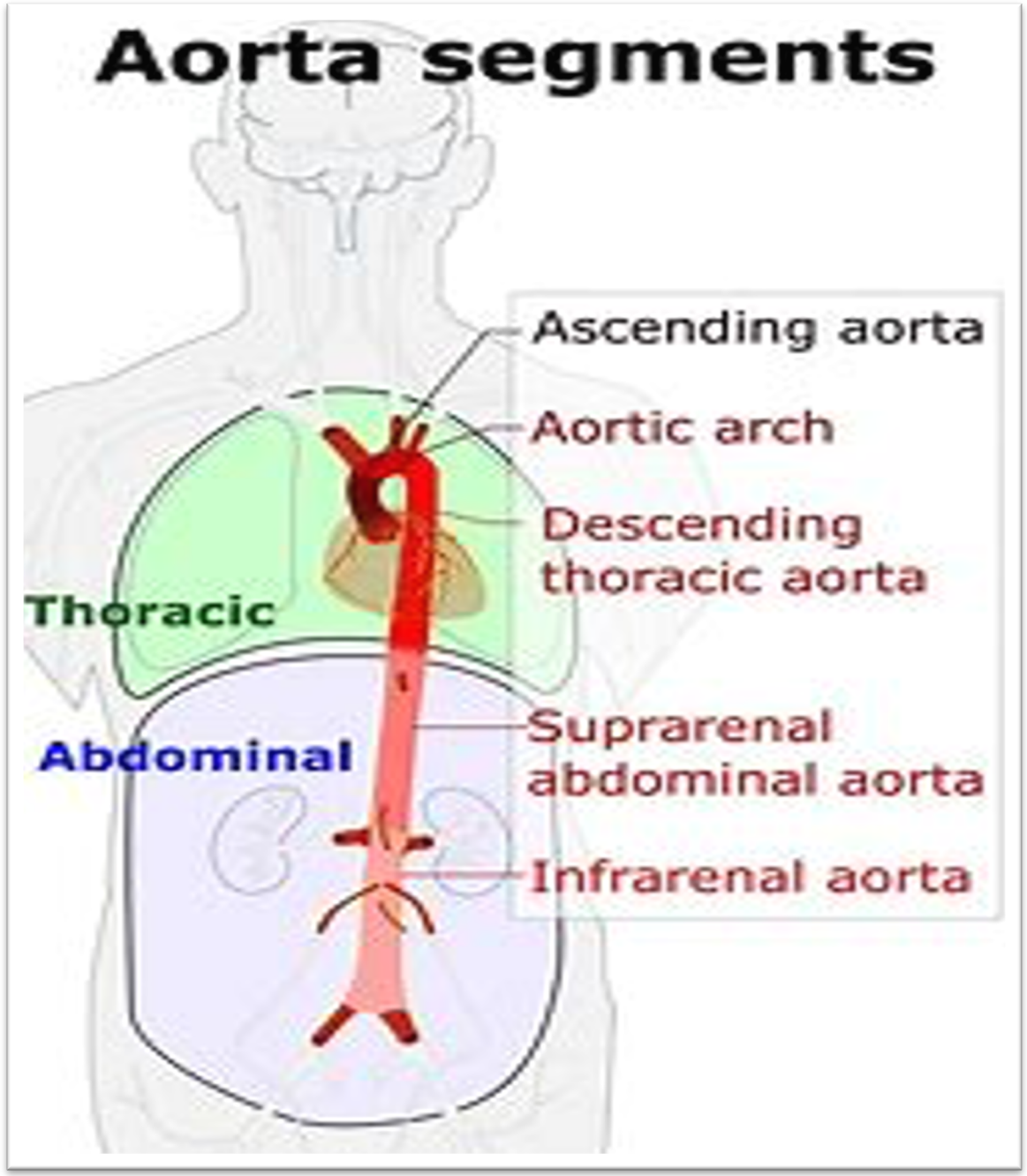
Is incidence just entry into the pericardial space?

Answer

It is not just entry in the pericardial space

It can include the pleural space such as an open distal aortic arch/descending procedure and may even involve the abdominal space if performing an open thoracoabdominal aorta procedure





SEQ 1970 - Incidence

Question

Would it be a redo CV surgery if a valve in valve TAVR is performed 2 years after a TAVR?

Answer

Previous TAVR that needs TAVR valve-in-valve procedure, code as NA not a CV surgery.

SEQ 1970 - Incidence

Question

If the patient had an open mitral commissurotomy and then presents for an MVR is that a first re-op?

Answer

Yes, Code as First- Reop

Prior entry into pericardial space

SEQ 1970 - Incidence

Question

If a patient had a prior open thoracic aneurysm repair and now is going in for a TEVAR, is the TEVAR the first re-op?

Answer

No, TEVAR is a catheter-based procedure and will be coded as NA – not a CV surgery

SEQ 2131 – Aortic Valve Procedure

Question

Do we need to enter a TAVR case that converted to a SAVR case while in the OR into the STS Adult registry, since this case would be entered into the TVT registry?

Answer

If the site usually enters TAVRs into the STS database and the patient ends up converting to SAVR (surgical AVR) then the TAVR should not be captured as the index procedure, the SAVR (surgical AVR) should be entered as the index procedure and the preoperative risk of the failed TAVR should be captured.

SEQ 2140 – Other Cardiac Procedure

Question

I just completed an AVR with reconstruction of the annulus with a patch due to endocarditis. Is this coded as AVR with other cardiac procedure?

Answer

Update Oct 2021 For Endocarditis patients

An aortic or mitral valve replacement which requires the use of patch reconstruction of any part of the aortic and/or mitral valve annulus increases the inherent risk of this procedure, justifying the coding of Seq 4135 "Other Cardiac Other".

SEQ 2195 – CPT Codes

Question

How relevant are the CPT codes in data analysis? We currently do not include them.

Answer

CPT codes are optional to enter and are not analyzed

Sites can choose to enter them if the site finds it helpful for internal tracking

SEQ 2123 – Aorta Procedure

Question

If CTS involvement is only the initial incision in a TEVAR, do we still include the procedure in ACSD?

Answer

If there was an op note done by the CTS, then yes this should be included.

TEVAR are included as endovascular aorta cases if a CT surgeon on the participant agreement participated in the TEVAR.

EVARs are not included in the STS Database

SEQ 6749 - Is there evidence that the patient had a deep sternal wound infection within 90 days of the procedure

Question	Answer
Now that SSI within 90 days is an optional question, do you see this being an analyzed metric in the future used towards ratings?	There are no plans to have this as an analyzed metric This field was added for sites who want to align with the CDC definition of the DSWI timeframe

SEQ 7003 – Transferred to Another Acute Care Hospital

Question

When a patient is transferred to another acute care hospital how are we supposed to get the information from the hospital the patient was transferred that is not in our healthcare system?

Answer

Reach out to your Medical Record Department to contact the other hospital's Medical Record Department to obtain the records.

SEQ 7011 - Extended Care/Transitional Care Unit/Rehab - Type

Question	Answer
Is LTACH considered short term or long-term rehab?	Long-term rehab Long-term Rehab - Long-Term Acute Care (LTACH, LTAC, LTCH) treat higher acuity patients (i.e., prolonged ventilation) where the goal is medical recovery with return to a residence such as home, nursing home, or with family.

SEQ 7124 – Operative Mortality

Question

Discharge to hospice but are still alive 30 days post discharge. Is this still an operative mortality?

Answer

Yes, this is an operative mortality.

Operative Mortality includes: All patients discharged to Hospice

Discharged to Hospice – Includes patients who are discharged to inpatient or outpatient hospice and home hospice.

SEQ 7124 – Operative Mortality

Question

Patients may have DC to hospice or palliative care and not expire. If occurs, can we submit evidence for STS review?

Answer

A discharge to palliative care is equivalent to a discharge to hospice and should be regarded as a mortality unless the participant group provides proof otherwise.

Reach out to STS if the patient is discharged from hospice for review.

STS Audit

Question	Answer
During audits, is the surgeon's note the primary proof of risk factor documentation, even if other providers have different documentation?	The TM definition and intent clarification statement is the main guide for the Auditor In the Risk Factor section, there is no direction in the TM to prioritize surgeon documentation over documentation of other Providers When conflicts occur, please reach out to Provider for clarification

STS Audit

Question	Answer
Can STS data collection forms that are filled out by surgeon and anesthesiologist be put in EMR so it can be assessed if audited?	Yes, please follow your Hospital's Medical Record Department policy to add documents to the Medical Record

QUESTIONS

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Three-Year CABG Composite

- Starting with Harvest 3 2021 – ACSD CABG Composite and its component domains will
  - Change from 12 months to a rolling 36-months
    - H3 will include OR Dates - July 1, 2018 to June 30, 2021
  - Increase Confidence Interval from 98% to 95%
  - Number of required cases: 50 isolated CABGs in 36-months
  - Mortality Thresholds stay the same at 2% or less
    - Example for H3 2021: 7/1/2018-6/30/2021.
      - **7/1/2018-6/30/2019** Participant must have 2% or less missing/unknown for mortality fields
      - **7/1/2019-6/30/2020** Participant must have 2% or less missing/unknown for mortality fields
      - **7/1/2020-6/30/2021** Participant must have 2% or less missing/unknown for mortality fields
  - NQF Thresholds stay the same at 5% or less, rolling 12-months
    - Preoperative Beta Blockers
    - Discharge Antiplatelet Meds
    - Discharge Beta Blockers
    - Discharge Lipid Lowering Meds
    - IMA Usage

Other Volume Requirements for STAR Ratings

10 isolated AVR or AVR+CABG or MVRR, or MVRR+CABG

MVRR results are only reported for participants with at least 36 procedures for the time period

MVRR+CABG are only reported for participants with at least 25 procedures.

When looking at mortality for the combination procedures (MVRR, MVRR+CAB, AVR+CAB, etc…) – look at the total missingness together.

Resources

- STS National Database Webpage
- ACSDTechSupport@IQVIA.com (Uploader, DQR, Missing Variable, Dashboard, Password and Login)
- Phone Support: 1-833-256-7187
- STS National Database Feedback Form
- Resource Documents
  - Contact Information
  - Webinar Information
  - FAQ Document
  - Go-Live Checklist
  - Tiered-level Support Document
  - *Training Videos*
  - *Link to IQVIA*
  - ckrohn@sts.org

Contact Information

- Carole Krohn, Sr. Clinical Manager, STS National Database
  - CKrohn@sts.org
  - 312-202-5847
- Database Operational Questions
  - STSDB@sts.org

Open Discussion

Please use the raise-hand function.

Please use the Q&A Function.

We will answer as many questions as possible.

We encourage your feedback and want to hear from you!