Society of Thoracic Surgeons

Adult Cardiac Surgery Database: User Group Call

July 20, 2022

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Agenda

- Welcome and Introductions
- STS Important Dates
- STS Updates
- IQVIA Updates
- STS Education: Operative Mortality
- Q & A

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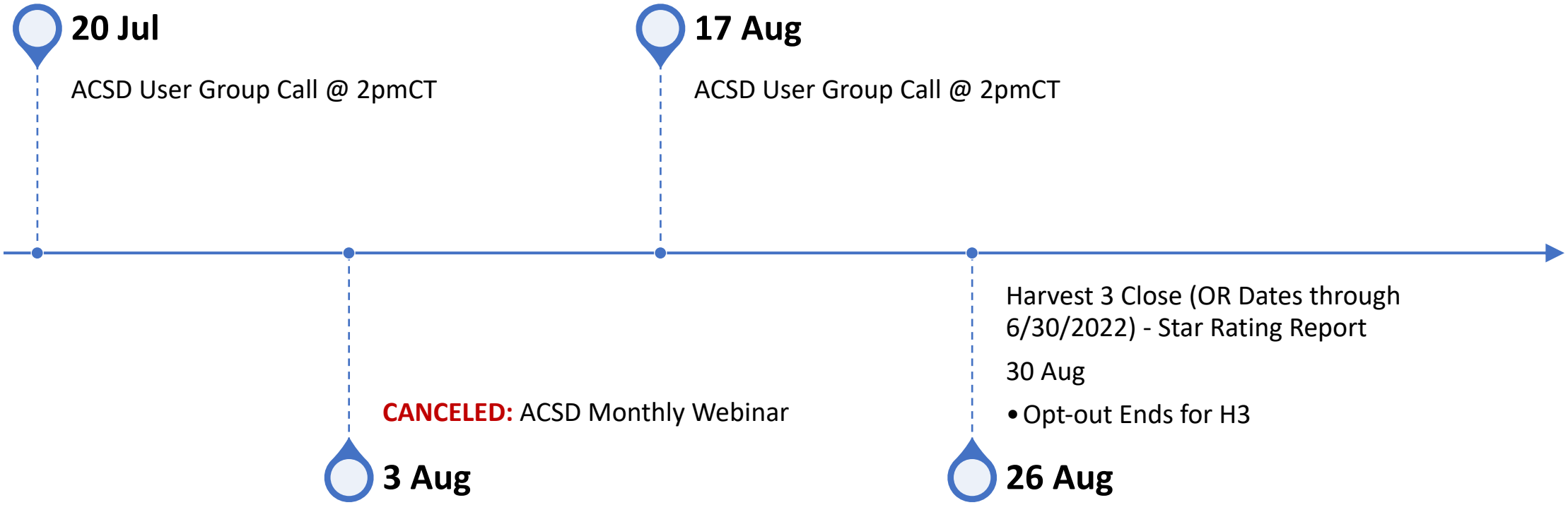
Important Dates



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

- Harvest 2 data back from analysis – to be posted soon
- July Training Manual Posted
- Email STSDB@sts.org for contact updates
- AQO Registration OPEN!!!

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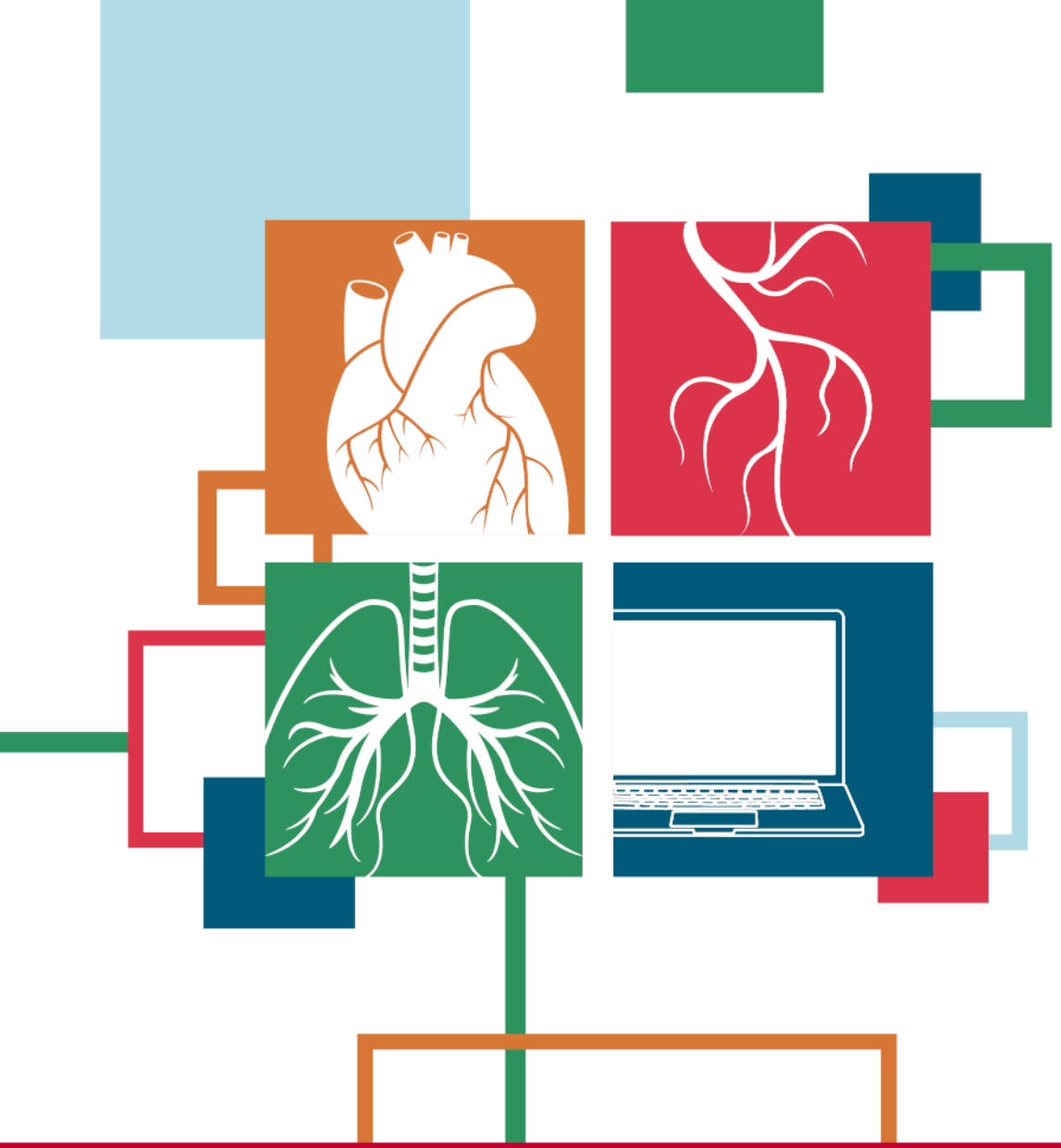

ADVANCES IN QUALITY & OUTCOMES:
A Data Managers Meeting

October 26–28, 2022 ▪ PROVIDENCE, RHODE ISLAND

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Thursday, October 27, 2022 – Adult Cardiac In-Person Option

- In-person sessions for the track(s) you choose with opportunity for live Q&A
- Breakfast, lunch, and refreshment breaks
- Networking Reception with speakers, vendors, and colleagues
- Face-to-face time with Exhibitors
- Opportunity to view and vote on your favorite E-Poster
- All on-demand content available on virtual meeting platform in mid-October
- All recorded in-person sessions available for additional viewing in **mid-November**
- Post-AQO Webinar “Hot Topics” in **January**
- Access to digital conference materials such as: PowerPoint slides and case scenarios
- CE/CEU Credit

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ADVANCES IN QUALITY & OUTCOMES:
A Data Managers Meeting
October 26–28, 2022 ▪ PROVIDENCE, RHODE ISLAND

AQO Registration is OPEN.

Receive Early Bird Registration Pricing through Friday, August 26.

STS MEMBER	Early Bird (August 26, 2022)	Standard
One Track	$550	$650
Two Tracks	$900	$1,100
Multi-Day (Three Tracks)	$1,150	$1,450
Virtual Pass	$300	$300

NON-MEMBER	Early Bird (August 26, 2022)	Standard
One Track	$650	$750
Two Tracks	$1,100	$1,300
Multi-Day (Three Tracks)	$1,450	$1,750
Virtual Pass	$400	$400

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- Educational sessions and social events will take place at the Rhode Island Convention Center (1 Sabin St, Providence, RI 02903).

- A block of rooms have been reserved at the Omni Providence Hotel (1 West Exchange St., Providence, RI 02903). The special AQO group rate of $259, plus state and local taxes, is guaranteed through **Tuesday, October 4,** or until the group block is sold out.
- Reserve online
- Call 401-598-8000. Be sure to reference “AQO” or “Advances in Quality and Outcomes.”

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Preliminary Program Topics

- Aorta/Arch/Debranching
- AVR with Annular Enlargements
- MV Procedures
- CABG Anastomoses
- Devices: VAD, ECMO, Impellas
- Databases in Value Based Care
- TVT Registry
- Cath/Echo

- Submit your questions or case scenarios **by Friday, August 16.**

- **AQO is going GREEN in 2022!**

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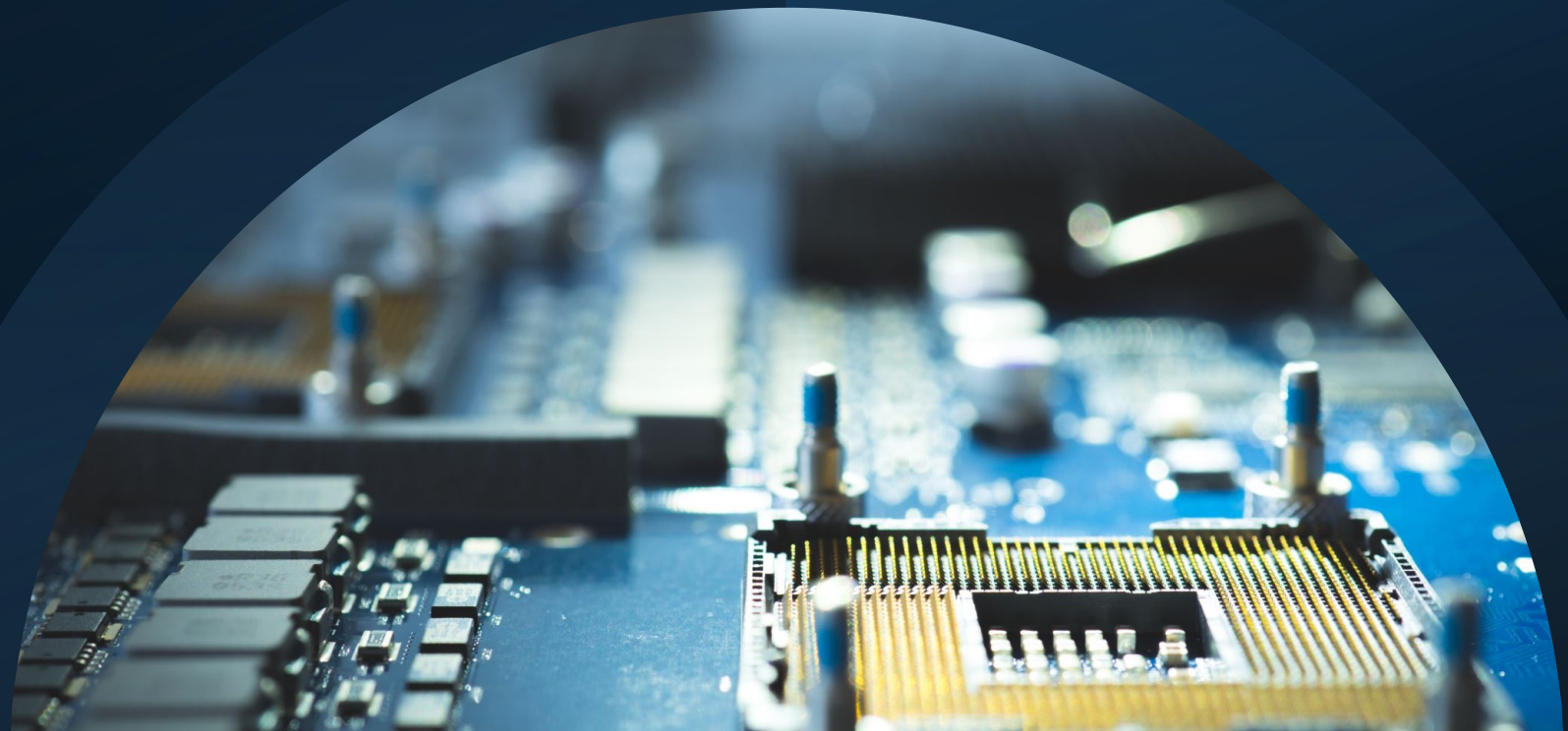
IQVIA Update
Joe Brower



IQVIA Release July 2022

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The below items were deployed to production the weekend of July 9

Risk Adjusted Report

STS-8056 – Risk Adjust and Regional Outcomes Report – Isolated Mitral Valve Replacement + CABG Report – The Renal Failure calculation was updated and now display the same results between the benchmark results and Regional Outcomes Isolated Mitral Valve Replacement + CABG Report - Renal Failure.

STS-8446 – The Harvest 1 2022 AVR + CABG Star Rating did not display the correct number of stars for the Absence of Morbidity quality rating per the designated score has been corrected. Minimum (~2) sites impacted.

Participant Dashboard Report Updates

STS-8426 – Incorrect percentages were identified for the Rhythm Disturbance Required Permanent Pacemaker results due to the change in the variable for the 4.20.2 data version. The logic was updated to correct this issue.

IQVIA Known Issues July 2022

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Risk Adjusted Report

New Item

STS-8582 – Benchmark Reports - The IMA Used results are displaying cases where if the LEFT and RIGHT are selected on the form, those cases are displayed in each individual category - LEFT, RIGHT and BOTH. This will be corrected to only display those cases in the BOTH category.

The July 2022 Known Issues List is posted to the Library for reference.

IQVIA Update

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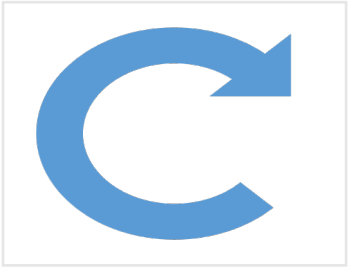
Please note:

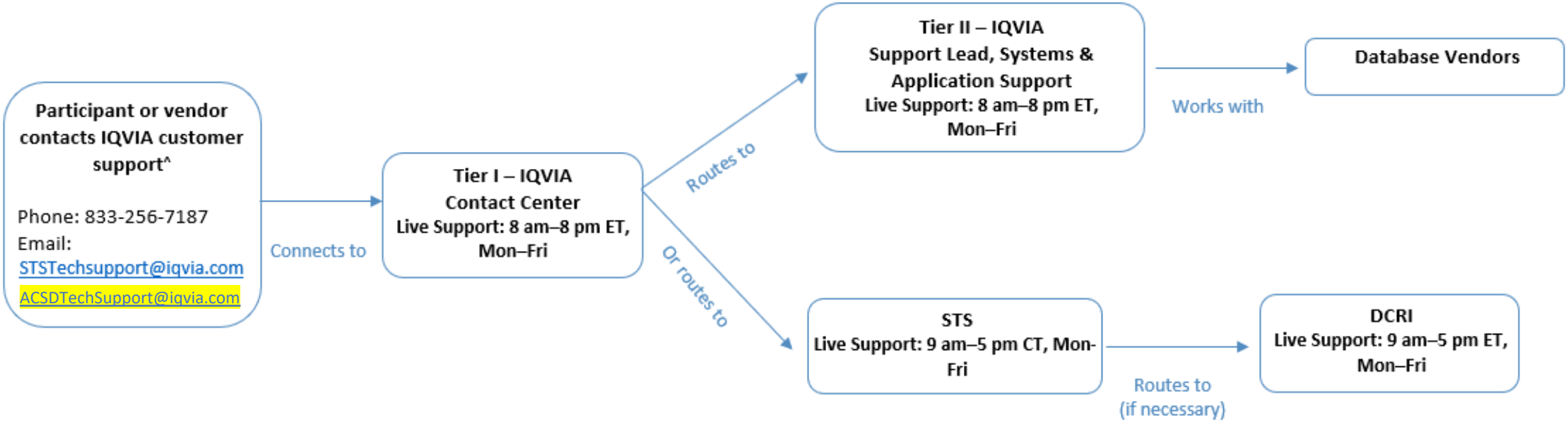
Submitted tickets are currently under review and the IQVIA support team will follow up on resolution and/or target release confirmation.



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

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 July: Operative Mortality

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SEQ 7124 Operative Mortality

SEQ. #: 7124

Long Name: Mort-Operative Mortality

Short Name: MtOpD

Operative Mortality includes:

- all deaths, regardless of cause, occurring during the hospitalization in which the operation was performed, even if after 30 days (including patients transferred to other acute care facilities)

- all deaths, regardless of cause, occurring after discharge from the hospital, but before the end of the thirtieth postoperative day.

- all patients discharged to Hospice. Update August 2020 - A discharge to palliative care is an acknowledgement that the patient is not expected to survive. Therefore, 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.

Question #1

Date of surgery 11-24-21. Date of discharge 1-17-22. Discharged LTAC. Died in LTAC facility on 1-28-22. Is this considered an Operative Mortality?

A. Yes
B. No
C. What is LTAC?

Answer #1

Date of surgery 11-24-21. Date of discharge 1-17-22. Discharged to LTAC. Died in that facility on 1-28-22. Is this considered an Operative Mortality?

A. Yes

B. No

C. What is LTAC?

This is not a mortality since patient was discharged to LTAC which is a long-term acute rehab facility > 30 days post-op and died there.

Question #2

Surgery on 1/15, discharged to a hospice on 3/25 and later died. What should we code for 7124 MtOpD?

A. Yes
B. No
C. I don’t have a clue!

Answer #2

Surgery on 1/15, discharged to a hospice on 3/25 and later died. What should we code for 7124 MtOpD?

A. Yes
B. No
C. I don't have a clue!

Operative Mortality includes - All patients discharged to Hospice. Update August 2020 - A discharge to palliative care is an acknowledgement that the patient is not expected to survive. Therefore, 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.

Question #3

Pt was in at home hospice prior to admit; came to ED with Type B dissection and had successful TEVAR for Type B dissection; no issues or post op events; patient was discharged back to home hospice. Patient died 3 days after discharge; since the patient was on hospice prior to arrival and discharged back to hospice; do I still capture this as an operative mortality. (Sequence 7124 "yes")?

A. Yes
B. No
C. Help me!

Answer #3

Pt was in at home hospice prior to admit; came to ED with Type B dissection and had successful TEVAR for Type B dissection; no issues or post op events; patient was discharged back to home hospice. Patient died 3 days after discharge; since the patient was on hospice prior to arrival and discharged back to hospice; do I still capture this as an operative mortality. (Sequence 7124 "yes")?

A. Yes
B. No
C. Help me!

Operative Mortality includes all patients discharged to Hospice.

Question #4

Patient surgery date is 1/2/2022, discharge date is 1/9/2022 , she is readmitted 1/22/2022 and dies during that admission on 2/4/2022. Is this an operative mortality?

A. Yes
B. No
C. Send in a FAQ

Answer #4

Patient surgery date is 1/2/2022, discharge date is 1/9/2022 , she is readmitted 1/22/2022 and dies during that admission on 2/4/2022. Is this an operative mortality?

A. Yes

B. No

C. Send in a FAQ

Died greater than 30 days post procedure and was discharged from the index operation acute care stay.

Question #5

I have a patient who developed a wound infection/septicimia > 30 days post surgery. She never left the hospital after the surgery and ultimately died 48 days after surgery. Do I code this as an operative death?

A. Yes
B. No
C. Call a friend

Answer #5

I have a patient who developed a wound infection/septicimia > 30 days post surgery. She never left the hospital after the surgery and ultimately died 48 days after surgery. Do I code this as an operative death?

A. Yes
B. No
C. Call a friend

Operative Mortality includes: (1) all deaths, regardless of cause, occurring during the hospitalization in which the operation was performed, even if after 30 days (including patients transferred to other acute care facilities)

Question #6

OR date 11-8-21 and D/C on 12-24-21 to home hospice. Death date was 12-24-21. So alive at 30 days post OR. D/C'd alive to hospice but died in hospice? Is this an operative mortality?

A. Yes
B. No
C. I need to look this up in the Training Manual

Answer #6

OR date 11-8-21 and D/C on 12-24-21 to home hospice. Death date was 12-24-21. So alive at 30 days post OR. D/C'd alive to hospice but died in hospice? Is this an operative mortality?

A. Yes
B. No
C. I need to look this up in the Training Manual

Operative Mortality includes all patients discharged to Hospice

Question #7

A patient committed suicide w/in the 30-day window of his surgery - will this be an Operative Death.

A. Yes
B. No
C. Not sure how to answer this one

Answer #7

A patient committed suicide w/in the 30-day window of his surgery - will this be an Operative Death.

A. Yes
B. No
C. Not sure how to answer this one

Operative Mortality includes all deaths, regardless of cause, occurring after discharge from the hospital, but before the end of the thirtieth postoperative day

Question #8

I wanted to confirm for our surgeon that a patient discharged to hospice who dies six months later, he is considered an operative mortality, correct?

A. Yes
B. No
C. I don’t have any idea

Answer #8

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A. Yes
B. No
C. I don't have any idea

Operative Mortality includes all patients discharged to Hospice. Update August 2020 - A discharge to palliative care is an acknowledgement that the patient is not expected to survive. Therefore, 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.

Question #9

In the past I have used the Social Security Death Index (SSDI) to see if there was a death listed but never used it to prove that the patient was alive at 30 days. Can we use the Social Security Death Index (SSDI) as a source to prove that the patient is still alive at 30 days post op?

A. Yes
B. No
C. What is the SSDI?

Answer #9

In the past I have used the Social Security Death Index (SSDI) to see if there was a death listed but never used it to prove that the patient was alive at 30 days. Can we use the Social Security Death Index (SSDI) as a source to prove that the patient is still alive at 30 days post op?

A. Yes
B. No
C. What is the SSDI?

The SSDI is **not** a source of life.

Use information from the SSDI, obituary listings, or National Death Index as proof of death; however, absence of names in these sources is not considered proof of life.

Question #10

I have a patient who was discharged to home, readmitted 1 week later. The patient was eventually discharged to hospice, still < 30 days post-op. However, the actual expiration date was > 60 days postop. Do I code this as an operative mortality?

A. Yes
B. No
C. I am clueless

Answer #10

I have a patient who was discharged to home, readmitted 1 week later. The patient was eventually discharged to hospice, still < 30 days post-op. However, the actual expiration date was > 60 days postop. Do I code this as an operative mortality?

A. Yes

B. No

C. I am clueless

This patient was discharged **home** and died after discharge.

This is not an operative mortality since death > 30 days post-op.

Question # 11

Are cases that are emergent or emergent salvage excluded from the Risk-
Adjusted Operative Mortality for CABG and Aortic Valve Replacement cases?

A. Yes
B. No
C. What is the Risk-Adjusted Operative Mortality?

Answer # 11

Are cases that are emergent or emergent salvage excluded from the Risk-
Adjusted Operative Mortality for CABG and Aortic Valve Replacement cases?

A. Yes
B. No
C. What is Risk Adjusted Operative Mortality?

No, emergent or emergent-salvage are not excluded for operative mortality risk model.

The more emergent the status the higher the Risk co-efficient added to the Risk Model.

Question #12

My patient had surgery on 1/1 and died on 1/31. As you know, a 30-day period is thirty 24-hour blocks of time, which equates to a period of 720 hours. Our patient expired 730 hours postoperatively, so do I code this as an operative mortality?

A. Yes
B. No
C. No clue! Who has time to calculate hours from surgery to death!!

Answer #12

My patient had surgery on 1/1 and died on 1/31. As you know, a 30-day period is thirty 24-hour blocks of time, which equates to a period of 720 hours. Our patient expired 730 hours postoperatively, so do I code this as an operative mortality?

A. Yes

B. No

C. No clue! Who has time to calculate hours from surgery to death!!

Per the STS Training Manual, mortality is counted by days, not hours as follows:

Using this instruction, the patient expired on Day 30 which is an operative mortality.

The time of OR exit or the time of death is not used for counting days for mortality. Mortality is counted by days, not hours as follows:

- Day of surgery = Day 0. (for this case – Jan 1.)
- First post-op day = Day 1, (for this case – Jan 2.)
- Second post-op day = Day 2

For this case patient expired on day 30 (Jan. 31)

- Data Completeness Requirement: **Participants were excluded from the analysis if they had fewer than 10 isolated CABG procedures in the patient population** and if they had more **than 5% missing data on any of the following 5 NQF-endorsed process measures: use of IMA, preoperative beta blockade therapy, discharge beta blockade therapy; discharge anti-platelet medication; and discharge anti-lipid medication.**

- There are also thresholds that must be met for mortality fields. Mortality fields: Mortality is counted as missing for a record if any of the fields below are missing. **A value of unknown counts as missing**.

- If the percent missing is higher than 2% for year 2017 or after you are at risk of not receiving a star rating.

- **It is <2% missing per year** - so each year in the 3-year period has to have <2% missing.

Tips for Collecting 30-Day Follow-Up Data

- Maintain a spreadsheet.
- Use the electronic health record to look for proof of life (e.g., readmission, lab results, other diagnostic testing).
- Coordinate with other departments in your organization (e.g., Cardiac Rehabilitation, Coumadin Clinic, Cancer Registry) to determine contacts made on or after 30 days post-surgery.
- Contact home care provider for patients receiving home care services.
- Contact the surgeon's office.
- In the case of transfers, contact the facility to which the patient was transferred.
- Contact the patient's primary care or referring physician office.
- Call the patient/family on or after 30 days post-surgery.
- Capture the patient's e-mail address upon admission and send a note to the patient at 30 days post-surgery.
- Use information from the Social Security Death Master File, obituary listings, or National Death Index as proof of death; however, absence of names in these sources is not considered proof of life.

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!