Outpatient Quality Reporting Program

Support Contractor

Measure by Measure: Data for the Hospital Outpatient Quality Reporting (OQR) Program

Presentation Transcript

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Pam Harris: Good day to everyone, and welcome to the Outpatient Quality Reporting Program webinar. Thanks for joining us today. My name is Pam Harris, a Project Coordinator for the Hospital OQR Program.

If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. So, just click on today's event, and you should be able to download the handouts. They're also attached to the invite that you received for this webinar.

Our speaker today is Dianne Glymph, a Project Coordinator for the Hospital OQR Program. Dianne will be discussing with you today some of the data reported for this program, and we're not going to have time to discuss the data for all of the measures, but as many as we can. She will also briefly discuss some reports available to you and how these reports can assist you in quality improvement.

But, before I hand things over to Dianne, let me make a few announcements.

May 1, 2018 is the submission deadline for Clinical Data and Population and Sampling for Quarter 4, 2017; now this will be for encounter dates October 1–December 31, 2017. And on May 15 is the submission due date for your web-based measures, so please don't miss that.

And as always, please be sure to keep your NHSN and your QualityNet access active. The easiest way you can do this by logging in to the NHSN and QualityNet Secure Portal at least every 60 days.

And if you want the most up-to-date information about the OQR Program, then make sure you are signed up for ListServe, as this is our main area for communicating information about the OQR Program. You can sign up or you can check what listserves you are signed up for on the QualityNet home page.

Now, there's an important announcement by the NHSN that we would like you to take special notice of. NHSN has sent emails to Facility Administrators and Primary Contacts for each facility registered in the NHSN to make them aware of an updated NHSN Agreement to Participate and Consent form is available. So, please pay attention to this email because this form must be signed by your facility's Primary Contact or Facility Administrator by April 14. Now, if the form isn't signed by then, you can risk losing your access to the NHSN, and then you will not be able to enter your data for the Influenza Vaccination Coverage among Healthcare Personnel measure by the May 15 deadline.

They're allowing signatures electronically, so please ensure that your facility has signed the form by April 14. NHSN has now added a document with screenshots to assist you in this process should you need it, and we have the direct link to that document on this slide.

And, of course, if you have questions or need to contact the NHSN regarding this reconsent form, you would email the NHSN help desk at NHSN@cdc.gov, and please use the phrase "NHSN Reconsent" in your subject line if you wish to contact them with questions about the process, or, you know, who got it, and they'll be able to help you get that answer back faster if you put that in the subject line.

Alright, now, our next webinar will be on March 21 where we will be presenting a webinar on what are some of the most common questions, hurdles, and obstacles for the Hospital OQR Program and how to deal with them. We'll review quarterly submission, how to know how many cases to report, reports you can run to check your status. We'll be addressing submitting your web-based measures, sampling requirements, and common issues when submitting, along with timelines, deadlines, and resources available, and review the changes that were done by the Final Rule as well as any administrative issues that came up. So, don't miss the excitement!

The learning objectives for this program are listed on this slide. This program is being recorded. A transcript of today's presentation including the questions and answers received in the chat box, and the audio portion of today's program will be posted at www.qualityreportingcenter.com at a later date.

During the presentation, as stated earlier, if you have a question, please put that question in the chat box located on the left side of the screen. One of our subject matter experts will respond. Again, by having live chat we hope to accommodate

your questions timely and have real-time feedback. If your question does not get answered, please know that all questions and answers will be posted on the qualityreportingcenter.com website. In addition, always call our help desk if you need assistance, and we are always happy to help.

So now, let me turn the presentation over to Dianne. Dianne?

Dianne Glymph: Thank you, Pam. For many of us, the word "measure" has a double meaning. It can represent the patient care standards that we uphold for quality reporting programs such as ours, and it can mean the metrical basis for a musical composition. So whether you're wondering "claims-based or web-based" or whether you're thinking "¾ or 6/8" before any great performance there must come an awful lot of preparation. So, before we can analyze and use data to create a superior performance, we have to report it. With its mission for quality reporting programs, CMS sets the stage for composing meaningful measures.

CMS' vision for this program is reducing the burden of reporting, adopting meaningful measures that align with other programs, and providing useful information that can lead to better patient outcomes and improved quality of care. CMS is always looking to make the changes necessary to regulations, policies, practices, and procedures to better achieve transparency.

CMS' programs and initiatives will help transform healthcare and support the CMS goals and objectives, making sure that people and families are engaged, informed, and empowered partners in care to complete the framework for better patient care. In addition, improving communication, care coordination, and satisfaction with care, in conjunction with reducing causes of mortality, can help us to transform our processes and promote, disseminate, and utilize best practices to optimize patient quality of care.

When you're putting together a musical composition, one huge decision you have to make is what instruments you will use to create the best performance possible. With the tools available through CMS, the instruments you need to improve the quality of care at your facility are gathered for you. Gathering data is a big part of CMS in general and a big part of this program. Reviewing data that you and other hospitals across the country have reported for this program will enable you to set goals for quality improvement initiatives within your organization.

Here on this slide are the measures for this program. Recall that OP-1, -4, -20, and -21 listed here under the Clinical Data section were removed from the program; that's why we've bolded those measure numbers. However, you will still collect data for those clinical measures through Quarter 1 of 2018 which has encounter dates of January 1 through March 31. These data are due August 1.

The imaging measures are listed here; these are claims-based measures. We won't be discussing data for the Imaging Efficiency Measures today. The web-based measures are here as well. However, in the Calendar Year 2018 Final Rule, OP-25 and OP-26 were removed from this program. You will report your 2017 data for these measures by the May 15 deadline, as you have in the past. But after this submission, you will no longer submit data for those two measures. Since they've been removed, we won't be discussing data for OP-25 or OP-26.

Last but not least, we have the Outcome Measures — OP-32, OP-35, and OP-36. OP-32 is fairly new, and we'll be sharing the data that we have available for that measure. OP-35 and -36 are also new and were finalized in the Calendar Year 2017 Final Rule, but the performance period just began last month. As such, we will not have data for those two measures to share with you today. So, today we'll be discussing some of the chart-abstracted web-based measures and OP-32.

Since we won't be discussing the clinical data, we wanted to refer you to a resource that has information regarding some of these measures. You can find these benchmarks and trends on the QualityNet website. Simply click on the "benchmarks" link in the drop-down menu under the Hospitals - Outpatient tab. Or you can utilize this direct link you see here on the slide. The most current information posted at the moment is for Quarter 1 2016 through Quarter 1 2017.

So, we'll begin our data overview with OP-27, the Influenza Vaccination Coverage among Healthcare Personnel measure, that's entered annually. For this measure, facilities report vaccination data for three categories of hospital personnel. This is the only web-based measure for this program that is not entered into QualityNet. The data for this measure are entered into the NHSN platform. By the way, QualityNet and NHSN are completely different systems that do not speak to one another, so these two systems require separate access, separate passwords, and so on.

Another note worth mentioning is there are numerous programs within CMS for hospitals. Data entered for this particular measure is per facility, not per program. So there is one entry per hospital for this measure. Alright, let's look at some numbers. All the data we're reviewing will be the data that were reported by hospitals for this program for OP-27.

OP-27: the flu vaccination measure. Here we're looking at the 2014-2015 flu season. Again, these data are self-reported by hospitals for this measure. The color of each state represents the various rates. The rate key will always be displayed at the bottom of each map that we discuss, but, generally, the dark green color represents a rate greater than or equal to 90% and higher. The medium green shade notes a rate of 80 to 89.99%, light green is 70 to 79.99%, orange represents 60 to 69.99%, and red is less than 60%.

We can see some orange and red here on this map. The national rate for this measure for the 2014-2015 flu season was 84%, meaning that 84% of these hospitals' healthcare personnel were vaccinated for this flu season in this first year of reported data.

Let's move forward a year; same measure, but for the following year, the 2015-16 flu season. And right away you can see an improvement over the previous year with a national rate of 86%, compared to 84% for the previous year.

For the most current reporting right here, and that was last year's flu season, the 2016-2017 flu season, hospitals experienced continued improvement in the reporting for this measure with a national rate of 88% of healthcare personnel receiving their flu vaccination.

Okay, so let's move on to OP-29, Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients. This measure is the percentage of patients 50-75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least ten years for repeat colonoscopy documented in their colonoscopy report. This is also a web-based measure, and it's entered annually into the QualityNet system. Let's take a look at how hospitals across the nation did with the reporting of this measure. Looking at OP-29 data for 2014, we'll use the same color representation as we did for the previous measure, and, again, the key is right there at the bottom of the screen. For 2014, we're seeing quite a bit of orange and red, which represents a rate of 69.99% or less. So, in summary, we have 13 states with 69.99% or less of hospitals that reported the appropriate follow-up times. There were only two states represented that have greater than or equal to a rate of 90%. The national rate for this measure in 2014, as you can see, is 74%.

Now, for the same measure for the following year, 2015, we do see some improvement. We still see some red and orange, but we've gone from 13 states of red and orange to only four, and the number of states with a rate of 80 to 89.99% are more prevalent. And, we see a national rate that has climbed to 80%.

So, here we are at the last year we have data for the OP-29 measure. Wow, there's a definite increase in that dark green color, demonstrating a rate of equal to or greater than 90%. That national rate has now climbed to 85%, so we went from 74% in 2014 to 85% in 2016.

In summary, what this means is 85% of the patients that had a colonoscopy screening and did not have a biopsy or polypectomy, had a recommended follow-up colonoscopy of at least ten years documented in their colonoscopy report. So, why 85%? What are some of the hurdles that you can encounter when you're abstracting for OP-29?

The most common areas of concern for abstractors when looking at this measure are: Appropriate documentation of a medical reason for exclusion, Exclusion regarding the age of the patient, and A lack of documentation for the follow-up interval. Now there were some changes to version 11.0 of the Specifications Manual to deal with some of these common issues and provide clarification with respect to the denominator exclusions. For example, there was a clarification from "Documentation of medical reasons for not recommending at least a 10-year follow-up interval (for example, above average risk or inadequate prep)" to "inadequate prep, familial or personal history of colonic polyps, patient had no adenoma, and age is equal to or greater than 66 years old, or life expectancy is less than 10 years, or other medical reasons." There was an additional change that essentially indicated that if the reason for exclusion is due to age, then the age needs to be documented as equal to or greater than 66 years old, or the life expectancy is less than 10 years.

OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use. This measure is the percentage of patients 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings, who had a follow-up interval of three or more years since their last colonoscopy. Just like OP-29, this measure is entered annually through the QualityNet system. So, let's move forward and take a look at the performance of hospitals nationally on this particular measure. Again, we're using the same color key for rates as we did earlier. For the OP-30 measure in the year 2014, there was a national rate of 80%. As with OP-29, there is some red and orange in this year, but the overall rate of 80% is higher than the rate for 2014 we discussed with OP-29 in its first year.

Now, moving ahead one year for OP-30, hospitals improved by 7%. Additionally, we see no red or orange at all. In 2015, there was a national rate of 87% - a general rising tide. Looking at the last data set for this measure for 2016, we again see improvement, with a national rate of 89%. Essentially, this means that in the cases reported for this measure for the Hospital OQR Program, 89% reported at least a three year interval since the last colonoscopy in patients with a history of colonic polyps. So, what are some stumbling blocks when you're abstracting for this measure?

There are a wealth of issues and questions that can come up when you're abstracting a chart. The three most common themes, if you will, with respect to OP-30 are: Confusion about documentation of the last colonoscopy -that's been a trouble spot, Documentation of medical reasons, and Acute symptoms relating to the time interval of the present colonoscopy. There are some helpful fact sheets and guidelines on our website – qualityreportingcenter.com – that may assist you if you have questions. You can also enter your question in the Q&A tool through QualityNet, and the measure writers will respond to you directly with the answer. OP-31, Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. This measure is the percentage of patients 18 years

and older who had cataract surgery and had improvement in visual function achieved within 90 days following cataract surgery. The data are entered annually in QualityNet, and it's a voluntary measure. You can elect to submit this data or not; either way will not affect your payment. Please know, however, that if you do report data, it will be publicly displayed.

So, let's look at a couple of years of data for this measure. For OP-31 data for 2015, the national rate is 87%. As I stated on the previous slide, this measure is voluntary, so the data relate to the facilities that decided to report for this measure. A few states are performing in the "red" (which of course is less than 60%). Wow, look at this: for 2016 the national rate for OP-31 is 96% — that's a big jump. Although this is reported voluntarily, there are still some common questions that abstractors encounter with respect to this measure.

Some of the abstraction issues for the OP-31 measure are confusion on how many cases to submit and the use of the visual function assessment. The Specifications Manual comes to the rescue for this issue, too. With regard to population and sampling, you can refer to Table 4 in the Specifications Manual under the Population and Sampling tab to obtain the sample size requirement, but, in short, if you have a yearly population of 0-900 cases, you submit 63 cases. If you have 901 cases or more, you will submit 96 cases.

OP-33: External Beam Radiotherapy for Bone Metastases. This measure is the percentage of patients, regardless of age, with a diagnosis of bone metastases and no history of previous radiation who receive external beam radiation therapy, or EBRT, with an acceptable fractionation scheme. And it's also entered annually through QualityNet. Now, this is a newer measure and has undergone some changes since it was first adopted. Accordingly, we can only show you the first year of data.

So, we're using the same colors for reference and looking at the data submitted by hospitals for this program. We can see a few states with a rate of less than 60% - they're shaded in red. Only two states are shaded dark green. And there you see a national rate of 82%. A new measure can be challenging, so let's talk about some of those challenges.

As we said, OP-33 is new; it's had some tweaks since you began abstracting for this measure. Some of the common questions that have arisen when abstracting are: Clarification of what the "initial encounter" is, Confusion related to the separate anatomical sites, and How to abstract for patients that did not receive the treatments as ordered for various reasons. Luckily, I can sing the same refrain and send you back to the Specifications Manual. There were some modifications to version 11.0, with the addition of some denominator exclusions. We presented a comprehensive webinar on the changes to the Specifications Manual in January. If you missed that and need to know more information, you can access that on our website, qualityreportingcenter.com, under the Archived Events tab.

We've talked about some web-based measures; let's talk about the outcome measure OP-32. OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. This measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare fee-for-service patients 65 years and older. CMS inpatient and outpatient claims are used to determine whether a beneficiary has had an unplanned hospital visit to any acute care hospital within 7 days of an outpatient colonoscopy. The number of unplanned visits is then risk-adjusted based on the previous year's data. Since this measure is an outcome measure and the data are collected through administrative claims that meet the measure criteria, there is no manual abstraction necessary on your part. However, we do have some data to show you.

In this graph, hospitals show a nationwide risk-adjusted rate of 16.4. Unlike the previous measures we discussed, please note that a lower rate indicates a better performance. The goal of this measure is to reduce the adverse patient outcomes associated with preparation for colonoscopy, the procedure itself, and follow-up care by capturing all unplanned hospital visits following an outpatient colonoscopy. So in this instance, lower is better. However, there is always room for improving your performance. Although this is a claims-based measure and there are no abstracting issues, there are a few questions that keep bubbling up, and they're listed here on this slide. As I previously said, data for this measure are gathered through paid Medicare claims that meet the measure criteria. The information for this measure is sent to facilities in various forms by that measure contractor.

Now, let's move along and look at utilizing your data. You report data for this program and off it goes. How can you keep up with it? How can you stay on top of it? Ultimately, it can be used for quality improvement, which is the intent of all of this – tuning the instruments, if you will. Having the state and national data we discussed is always helpful in improving quality within your own facility, and there are data reports available to hospitals that can assist you in improvement and comparison. We'll discuss these next.

There are many data reports available to you to run in QualityNet; we're only mentioning a few here. You can see them on this slide. We won't be going into detail on these reports. We'll just be touching on them as a reminder that running some of these reports is helpful to you, particularly from a quality improvement standpoint. Pam presented an entire webinar last October that gives you a step-by-step guide on how to run and download QualityNet reports. If you need more information on reports, please access that webinar. It is available in the Archived Events section of the Hospital OQR division of qualityreportingcenter.com. It is well worth your time.

Other reports are auto-generated and sent through Secure File Transfer via QualityNet for the outcome measures OP-32, OP-35, and OP-36 in the form of a Claims Detail Report or a Facility-Specific Report. Let's talk a little bit about some of these reports. First up: the Claims Detail Report. This is a report that you can run yourself in QualityNet.The Claims Detail Report provides hospitals with the ability to monitor the claims submitted to Medicare during a specified quarter, and it includes only Medicare fee-for-service, or Medicare Part A, claims that are in final status. Please note that the ED-Throughput claims are not included in this report due to the very high volume of claims submitted each quarter. If you are a high volume facility seeing 60,000 patients or more a year in your ED, you can imagine how large this report would be if it included that patient population, so that's the reason ED-Throughput is not included in this report.

As a reminder, QualityNet is experiencing some technical issues with this particular report, so when you're attempting to run it, don't fill in the measure box, just leave it blank. If you leave the measure box blank, the report will run. If you attempt to assign a measure, the report will return blank. QualityNet is aware of this and is working to resolve the issue.

Now the next report is the Provider Participation Report, and this report is a tool that enables hospitals and vendors to monitor their compliance with Hospital OQR Program requirements. This report displays a summary of information of cases that were accepted into the Clinical Data Warehouse. So, if you have a vendor and you want to verify that they submitted the data on your behalf or if you just want to make sure there are enough cases submitted each quarter, you can use this report. This can assist you in making sure that your hospital is meeting the requirements of the program.

The Case Detail Report, not to be confused with the Claims Detail Report. We talked earlier about some of the common problems with abstracting some of the cases. Well, what this report demonstrates is a comparison of the hospital's abstraction against what the CDAC's re-abstraction result was for the same record. It will also provide a list of all of the data elements that were abstracted on each case.

Moving on to one of those reports that puts your data in perspective – the Facility, State and National Report. This report displays the number of cases abstracted for your hospital and summarizes and compares the chosen data by quarter, to state and national levels. Now this report will not be displayed until approximately 30 days after the submission deadline for the quarter. Hospitals can run a preview report prior to public display of the data on Hospital Compare. Just as with these other reports, your facility must have an active Security Administrator to obtain the preview reports. Hospitals have approximately a 30-day period in which to run and download their preview reports. After this 30-day period, the report will no longer be available.

The most recent preview report was made available to hospitals on February 1. We sent a ListServe on the first about the opening of this preview period. The preview reports will be available for you to run and download through March 2 and are for the April release on Hospital Compare. You will run this report through QualityNet, so if you have not yet accessed this report, please do so, as it is only available for this time period.

Now, let's turn our attention to the reports that are sent via Secure File Transfer. The data reports for the outcome measures aren't run on demand in QualityNet; they're sent by the measure contractor through Secure File Transfer. This first report has the same name as the report we talked about earlier that you can run yourself in QualityNet. Same name, different reports.

This Claims Detail Report will provide facilities information about their colonoscopy cases that will be included in the measure calculation. This will allow hospitals to observe and correct coding errors in the claims used to calculate the measure and provide you with the opportunity to improve the quality of care at your hospital. Both the Claims Detail and Facility-Specific Reports include patient-level data, or included and excluded colonoscopy cases.

Only the Facility-Specific Report, or FSR, contains measure performance information. The FSR includes: state and national measure results, facility-level distribution of measure risk factors, and the facility-level measure rate and performance category. You can access much more information on these reports on QualityNet by following the pathway shown here on this slide. You can also put a question into the QualityNet Q&A tool, and the measure contractor will respond to you directly.

I think of this diagram as the conductor's score – here's the entire score with all the parts before us – the goals of CMS, the really big picture. The ultimate objective of reporting measures is to improve quality. Through reporting, CMS aims to achieve: Safer care – making care safer by reducing harm caused in the delivery of care; Family Engagement – strengthening the person and family through engagement as partners in their own care; Promoting effective communication and coordination of care; Promoting effective prevention and treatment of chronic disease; Working with communities to promote best practices and healthy living. Yes, we can make beautiful music together by using data to improve quality. That's all for me today. Let me hand things back over to Pam.

Pam Harris: Thank you Dianne, we appreciate all the great information. And just as a reminder, a transcript of today's presentation, and all the questions and answers that were in the chat box, will be posted on our website, qualityreportingcenter.com, at a later date. Now, that's all the time we have today. We appreciate you joining us.