Digging Deeper Into the Data: How to Access and Interpret QualityNet Reports

Presentation

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April 15, 2015

Marty Ball: Hello, and welcome to the Hospital Outpatient Quality Reporting Program webinar. Thank you for joining us today. My name is Marty Ball, and I am the project manager for the OQR Program. If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. On the right side of the page, there is a banner which says “Upcoming Events.” Click on the **Digging Deeper into the Data** event. This will take you to the webinar event, and you can choose the presenter’s slides: one per page or three per page.

Before we begin today's program, I would like to highlight some important dates and announcements. The submission deadline for quarter four, which is encounter dates of October 1 through December 31 of 2014, this must be completed by May 1. We cannot stress enough how important it is to not wait until the last minute. The QualityNet website gets very busy and slows down considerably during submission times. We do not want to see anyone not be able to have a timely submission due to technical difficulties. Again, do not wait until the last minute. CMS provides a lengthy submission period. Please take advantage of that.

As a reminder, this will be the last submission for OP-6 and 7. As you will recall, these measures have been topped-out. If your facility inadvertently submits the surgical measures with encounter dates after January 1 into the warehouse, the data will be accepted in the warehouse; however, the data will

be suppressed and will not be publicly reported. We encourage facilities to not submit any outpatient surgical data into the warehouse with encounter dates of January 1, 2015, and forward.

On May 20 we'll be presenting a webinar discussing data you report for the OQR Program on how to use this data for quality improvement initiatives for your facility. The presentation will have suggestions and ideas in this area. Be sure to join us for that. As always, we'll send out a ListServe once the date gets closer.

The learning objectives for this program are listed here on slide 4. This program is being recorded, and a transcript of today's presentation and the audio portion of today's program will be posted at qualityreportingcenter.com at a later date. During today's webinar, please do not use the chat feature on the WebEx screen since we do not monitor that function of the program for questions. However, we will follow this presentation with a question and answer session until the top of the hour.

I'm pleased to introduce today's speaker, Karen VanBourgondien. Karen joined HSAG in 2012, and has been working on the OQR team since last year. Karen earned her bachelor's degree in nursing from the University of South Florida. She has extensive clinical experience in ICU, CCU, PACU, pre-op, and the emergency department. She also has clinical education experience as well as data collection, clinical abstraction, and clinical quality improvement. Now I'll turn the presentation over to Karen.

Karen VanBourgondien: Thank you, Marty. Hello everyone. Thank you for joining us. Today we'll be discussing frequently accessed reports available on QualityNet for this program–not only what they are, but how you can use them, and why you would want to use them. We will not have time to discuss all the reports available, but we will discuss the reports that are most frequently utilized. You can refer to the QualityNet User Guide for an in-depth tutorial of all the reports provided for this program.

When obtaining reports on QualityNet, there are four report categories you can choose from, which are displayed here on this slide. However, within these categories there are numerous individual reports. In the interest of simplicity, we will discuss the most popular selections within each category. First, let's talk about how to access the reports on QualityNet, and then we will discuss the reports and view examples.

This is the home page of QualityNet, which I'm sure most of you are very aware. You can log in at the top or on the right-hand side of the page, as you see here circled in red. After clicking the log-in button that was circled in red on the previous slide, this page will then display. On this page you will choose your destination, which will be the **Outpatient Hospital Quality Reporting Program**. This is the log-in page where you will use your secure log-in

credentials. If you do not have these credentials, you will not be able to access the Secure Portal.

Once you log in to the Secure Portal, you will see this page. As you can see in the thin yellow banner going across the page, there are numerous options to choose from. To run a report, you select the **My Reports** option on the yellow banner, and the first drop-down box will be **Run Reports**. Click on this **Run Reports** option as shown here on this slide. After you choose the **Run Reports** option, this page will display, and once again you're going to choose **Run Reports**, as circled in red. As a point of interest, if you run a report and you get distracted and you come back later to view the report, that is when you would choose the **Search Report** option, which you can also see on this slide under the **Run Reports** option that is circled that we just spoke about. But for now, let's continue with our **Run Reports** option.

Once you choose **Run Report**, you will see this page. Under the **Report Program**, it will be **OQR**. To view the reports for this program, you will always choose **OQR** under the **Report Program**. Then under **Report Category**, which is also circled in red, you will click on the down arrow key. This is where you will choose your report category. We will discuss the various categories one at a time. Again, within each category we will discuss the most common individual reports.

The first category we are going to talk about is under the **Annual Payment Update Reports,** as shown here under the Report category. So once again, as circled in red on this slide, is the **Report Category**. You will click on **View Reports**, which is the blue box next to the **Report Category**. Once you choose the category and click on **View Reports**, as we said just a moment ago, you will then see this page. Here you will see all the reports that are available under this category. This is the page where you will select the individual report you want to run under this category. As I mentioned before, there are different report categories. Once you choose a category and click on **Reports**, you will then be given the various report names and descriptions of the reports available under that category. On this slide the category selected was **Annual Payment Update Reports**. So let's talk about these just for a minute.

This slide demonstrates the three reports you can run under the category. The reports under the APU Category are the Claims Detail Report, Confidence Interval Report, and Provider Participation Report. The Claims Detail Report and Provider Participation Report, also known as PPR, are the most common reports used in this category. So let's discuss these individually in a little more detail. We're going to begin with the Claims Detail Report.

The Claims Detail Report provides hospitals with the ability to monitor the claims submitted to Medicare during a specified quarter. It includes only Medicare Fee-for-Service or Medicare Part A claims that are in final status. No Medicare Advantage, Medicare Part B, or Medicare Secondary Payment

claims are included. ED-Throughput claims are not included in the 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 the ED, you can imagine how large this report would be if it included that patient population. So that's the reason why ED-Throughput is not included on this report.

This report is released three times per quarter. It is a tool for providers to use to identify the number of cases for abstraction for that given quarter. On this slide is a sample report. At the top of the page you will have your provider number, encounter quarter, and you can see on this sample report that the encounter quarter is October through December 2014. On the left-hand side above the dark grey line is the date **As Of**. This is the date the last time claims data was loaded for the provider.

On the left in the first column, the **Beneficiary Claim Number,** which has been redacted, is the Medicare number. Moving to the right you will see the **Start** and **End Dates** which are used for billing purposes, the **Measure Set** this bill falls under, and the **Name, Birth Date** and **Gender** of the patient. The measure sets included on this report are AMI, Pain, and Surgery. Remember the Claims Detail Report is a tool to be used by hospitals in identifying the number of cases to abstract for each measure set and reflects the claims submitted to CMS for payment.

If a patient shows up on this report that you cannot find in your outpatient population, their admitting status may have changed. An example of this may be when utilization review finds the patient was an inpatient admission and their initial bill was resubmitted. It does take time for this billing process, hence, the report is used as a tool only. This gives the providers an idea of the number of charts to abstract, not necessarily the exact patients to abstract. As we stated, this report will only have Medicare Fee-for-Service claims; however, data that is submitted to the warehouse by your facility is a combination of Medicare and non-Medicare patients.

As noted on this slide, we're going to talk a little bit about the PPR report. This is a tool that enables hospitals and vendors to monitor their compliance with the Hospital OQR Program requirements. This report displays a summary of information of cases that are accepted into the clinical data warehouse. This can assist providers in making sure that they are meeting the requirements of the program.

This is a sample of a PPR report, and at the top of the page you will see your facility-specific information. But also note that within that information will be the active QualityNet administrator status, whether you have completed your web-based measures, and if you are being validated. All of that information is at the top of the report. The second section of the report is measure and population information. Starting at the left-hand side, you will notice the measures that are reported. Moving to the right, the next heading is

Outpatient Population. This is the number of Medicare and non-Medicare encounters for each measure that was submitted to the warehouse. If you see a zero here, no population was submitted.

Next, the sample heading. This displays the population that will be sampled for the program. In this sample report you will notice that the outpatient population for the stroke measure is four, but the sample entered by the facility was zero. That is because they have five or fewer, and thus are not required to submit for that quarter data submission.

Okay, continuing on to the right of the slide, **Total Cases Accepted by Submission Deadline**. This is the sum of the total number of cases, by measure set and discharge quarter, that were successfully submitted and accepted into the warehouse by the submission deadline. This column would be blank for any measure set that has no data accepted. On this report this column is blank because it was run before the submission deadline and the data had not yet been entered.

The **Total Medicare Claims** column displays the total number of Medicare claims by measure for the quarter. This is updated monthly. This column is locked down for respective quarters about 15 days prior to the submission deadline for that quarter. The **Maximum Encounter Date from Claims** column displays the most recent data of claims pulled. Again, this will be blank if no claims have been submitted for that measure set.

Now we're going to move to the next report category. This is the **Validation** category. So once again, your **Report Program** will be **OQR** and **Report Category** will be **Data Validation Report.** You will then click on **View Reports**, which is the blue box next to the **Report Category**. When you click on **View Reports**, you will be taken to the page, as we discussed prior. The reports available under the category that you chose, which is again the **Validation** category, will display. As you can see on this slide, there are four reports under this category. So let's look at the reports available under **Validation**.

The reports shown on this slide are the reports you can choose from under the category of **Data Validation**, and a description of their function. Again, we will discuss the most frequently used reports utilized under the **Data Validation Reports** individually and in a little more detail, but let's talk about the Case Detail Report.

Now, you will recall we just talked about the Claims Detail Report. That was under the **APU** category. Now we're going to discuss the Case Detail Report under the **Validation** category. Similar name under different categories, so be careful. Lots of people get confused because of the similar names. So to backtrack just for a second, under the **APU** category we discussed the Claims Detail Report. Under the **Validation** category, as you can see here, it is the Case Detail Report.

In short, what this report demonstrates is a comparison of the hospital's abstractions against CDAC's reabstraction result for the same record. It will also provide a list of all the elements that were abstracted on each case. So let's take a look at what one of these reports looks like so we can better understand exactly what that means.

Okay, starting again at the top, there is the **Report Run Date**, which -- that's the date you run the report. **Validation Report Posted** – that is the first business day that the validation results become available to view through QualityNet Validation Reports. It is also the date the email notification was sent to the provider. Normally, in the thick black line you would see your facility's name and CCN number. In that same line is the **Overall Measure Outcome Reliability Rate**. The numerator is divided by the denominator to get this percentage. The numerator is the number of scored measures which matched measure outcome results between the original and the adjudicated result. The denominator is all scored measures associated with validated cases.

In this example, there's 100 percent, 26 over 26. So once again, starting at the left-hand, under that black line you will see the **Abstraction Control Number**: this is a unique number used by CDAC, the **Patient ID** number, and the **Measure Set** and **Encounter Date**. Under that, towards the middle of the page, you will see **Individual Case Measure Outcome Reliability Rate**. To get this percentage, the numerator is the number of scored measures within a measure set which match measure outcome results. The denominator is the number of all scored measures within a measure set. Underneath the reliability rate is a breakdown of this percentage.

Starting again at the left-hand side, you will see the measure itself, and then moving to the right you will see **Original Outcome**. This is the original measure outcome bucket results from submitted cases prior to validation. The potential values are B, not in the measure population, D, in the measure population, D2 in measure population/QI rate, E, in the numerator population, Y, included in the measure (UTD). These descriptions will be found at the bottom of this report, and you can see these demonstrated on the slide.

As we move to the right, you will see **Validated Outcome**. This is the validated measure outcome bucket assignment results for the same case. The **Result** column will display the outcome of the case validation which will display **Match** or **Mismatch**. Under this information will be the number of matched and the number of measures validated. **Educational comments –** Under this column, comments are provided by CDAC regarding the adjudicated value.

Here is another example of the same report; however, this example report shows a mismatch. Notice the reliability rate that is circled on this slide. This is displayed here as 86.4. The numerator is 19; the denominator is 22. So remember what we said earlier: the numerator is the number of scored

measures which match measure outcome results between the original and the adjudicated result. The denominator is all scored measures associated with the validated cases. So really another way to look at this is if there were 22 measures validated, 19 of those matched the validated results.

The Case Selection Report is a good report for hospitals undergoing validation. This report provides a list of the cases selected for submission to the CDAC for a particular quarter. The data is dependent on CDAC entry of medical record events into the clinical abstraction tracking system. This is also known as the CAT system. When the CDAC uploads the appropriate medical record events into the CAT system, noting that records are received, the report is immediately updated. A facility can always run this report to view the records being requested for validation.

A reminder, as we've said this many times, when you are being validated, CDAC will only accept one submission of validated cases. Please make sure you check your records for completeness before you send them to validation. You will only have one opportunity.

Okay, again, we will notice the facility-specific information is at the top of this sample report. Normally, in the grey line you will also find the facility name and CCN number. As you can see, under the grey line to the far left, the Patient's Name and hospital Patient Identifier number, the Encounter Date, and Arrival Time of the record. This particular record has Measure Sets reporting ED-Throughput and Pain Management. The Measure Sets could also include AMI, Chest Pain, and Surgery, but for this report, only ED-Throughput and Pain Management are indicated.

Remember – the Surgery measure is topped out and will no longer be abstracted for encounter dates of January 1, 2015, and moving forward. The Abstraction Control Number is a unique number created for each sample record selected. The Medical Record Request Date is the date that the validation record was requested. The Due Date is the deadline for submitting the record. This is 45 days from the record request. When a record is received, there will be a Y. Until the record is received it will be indicated by an N.

Feedback Reports. So once again, we're going to choose another category. As you can see on this slide, the next category we're going to look at is the **Feedback Reports** category. When you choose this category and click on **View Reports**, you will see all the reports available under this category. As you can see on this slide, there are 10 different reports that can be run under the report category. We will briefly discuss each one; however, we will be discussing the reports that are most commonly used in more detail.

Before we discuss the individual reports, let's discuss the general purpose of Feedback Reports. As we said, there are 10 reports available in this category. Most of the reports in this category are geared towards the provider, while the

others are directed to the vendor community. So now let's discuss the individual reports that fall under this report category.

Over the next few slides you will see what each report does, and some of these will be discussed in a little more detail than the others as they are more frequently used. The Case Status Summary Report is a summary report of information submitted to the warehouse. We will discuss this report in more detail in just a minute. The Facility, State And National Report summarizes and compares by quarter the facility to state and national participants for the clinical measure sets. Just to let you know, there are some functionality issues with this report, and it only displays partial information.

Measure Status by Case Report. This is a detailed report of individual cases. This also provides detailed information of the population eligibility, the denominator, and whether each case was included in the numerator or excluded from the measure calculation. If it was excluded, the reason for exclusion will be given.

The first report on this slide is Measure Status by Category. We just discussed Measure Status by Case. The previous report mentioned was by individual case. The Measure Status by Category is a summary of measure status, both included or excluded from measure calculation, and the measure category assigned for cases that are accepted into the warehouse.

The Population Submission Report provides information regarding the submission of your population and sampling data. It includes whether the data was successfully accepted, and if not, indicates any errors related to the rejection. The Population and Sampling Summary Report displays summary information of the population and sampling data entered by the facility for Medicare and non-Medicare cases by quarter, measure set, and provider. So this report will provide greater detail than the Population Submission Report.

The Potential Duplicate Report identifies potential duplicates, and we will also discuss this further in a moment.

The Submission Detail Report provides information on the data submitted through QualityNet to the warehouse. The report displays detailed information of selected uploaded data grouped by provider. It will also display error codes associated with each file that was submitted and the total counts of the number of files and error codes. The Submission Summary Report provides information on the data submitted through QualityNet into the warehouse. The report displays counts of accepted and rejected cases and counts of error codes. It will have a report that displays Unknown, and it is likely that an invalid XML file was received if you get that error code.

Vendors Authorized to Upload Data Report. This provides a list of hospitals that have approved a vendor to submit hospital outpatient data on their behalf. The report allows organizations to view the authorized vendors for a facility's

organization. It is a quick reference tool to view if a provider has authorized a vendor to view their Feedback Reports.

Now we're going to discuss the more frequently used reports in this category in a little more detail. Let's start with the Case Status Summary Report. On this slide you can see the purpose of this report. Essentially, it is a total of cases submitted to the warehouse by measure set for a specific encounter period. It will display the number of cases submitted, accepted, and rejected. If the record was submitted multiple times by you or your vendor, the status of the most recently submitted case will be displayed within the designated encounter period. For example, several cases were rejected with your data upload, then the cases were resubmitted. The rejections would disappear from the report, and the most recent case would be retained in the warehouse. Remember, once the data submission deadline is passed, no further submissions or changes would be allowed.

This report can be very handy when you have submitted data and you want to check to make sure all of your cases were accepted. There's nothing worse than thinking you've submitted data and, come to find out, that the cases you thought you submitted were rejected. This is an example of the Case Status Summary Report. In this example, the Surgery measure set is displayed. This facility submitted 192 cases, and 192 were accepted. So of course, there were no cases rejected.

Potential Duplicate Records Report. This report identifies potential duplicate records that were submitted to the warehouse. Multiple records submitted for the same patient encounter are considered potential duplicates. The list of potential duplicates should be reviewed to determine if each record is a valid record or if it is actually a duplicate. Duplicates can cause incorrect data to be reported for the OQR Program and will adversely affect the facility's outcome for data validation. There is an automated duplicate checking process, and during this process deletion requests will be completed, and the system will identify any new potential duplicates. Once the duplicate record issue is corrected, no records will display in the generated report. However, it is possible the same record may be requested for two different measures, for example, ED-Throughput and Pain Management. This report is provided in CSV format only.

So let's talk about this sample report for potential duplicates, and keep in mind that some of the information had to be redacted, but on the top portion you will have the Provider Number and Encounter Quarter. Below the black line you will see the Potential Duplicate Records in the various categories. As you move from left to right, you will notice the Encounter Date, Arrival Time, Measure Set, Patient ID, Name, Gender, Date of Birth, and Postal Code. Then there is the Upload Date, which is the date the data was uploaded to the warehouse. You can see that these are not the same, referring to the Upload Date. One is listed as 1/20, the other as 1/28. Next is the File Name, which is

the name of the XML file that was submitted, and again, these are not the same. But you're going to use all of this information to decide if this is a duplicate record. Moving on, the Upload User Name is the QualityNet user name of the individual that uploaded the XML file.

Let's move on to the Submission Detail Report. This is one of our more frequently used reports. This report provides information about the data that was submitted to the warehouse. It displays detailed information of selected uploaded data grouped by provider. It displays the error codes associated with each file that was submitted. Total counts of the number of files and error codes will also display.

Here's an example of a Submission Detail Report. Provider information is at the top, as well as the report criteria. You will notice at the top the Measure Set, File Status, Action Code, and Message Type. When we select -- when we ran this report, we selected All for these options. Starting at the left, again, you will have the Patient ID, the Encounter Date and Time, the Upload Date, which is the date it was uploaded to the warehouse, then you will see the Action Code. This code displays the action performed by the warehouse for the submission of the cases, and this will display as either Add or Delete. The Error Code displays the warehouse Error Codes, Message Type, and Message for each error in the batch. The Measure Type values are Critical, Informational, Measures Passed, Measures Failed, Measures Excluded, Measures Included, and Measures UTD. The two Measure Type values on this report are Excluded and Critical. Now again, this is a detailed submission. Notice at the top right-hand corner of this report it is 181 pages long. Keep that in mind for a minute as we talk about the next report.

This is the Submission Summary Report. If you have made a submission and you want to ensure that your data has been successfully accepted into the warehouse, this is a good report to run. The report is based on the data submitted to the warehouse. It will display the number of charts that were accepted and rejected and will have error codes. If an invalid XML file is received, the report will display Unknown.

Once again, on this sample report, the provider-oriented information is on the top of the report. The information is divided into Measure Set, Provider, File Status, and File Count. The File Status will state whether it is Accepted or Rejected. In this example, all were accepted. The File Count is the total number of uploaded, both accepted and rejected, for each measure set. Now in real life, you're really most likely to run this report versus the previous one that was 181 pages, which was the Submission Detail Report. But there are situations where you may need or want to view that detailed version.

Moving on to our last category, the Public Reporting category. Under this report category the Public Reporting Preview Report is available. This preview report reflects the data entered by your facility. The preview period is

available for 30 days prior to the release on Hospital Compare. If you access this report outside the preview period, it will state "No Reports Available." This is only available for the 30 days. We presented a webinar last month on this information.

That concludes today's presentation. I hope this has provided you with some assistance with regard to the reports available. And now I will turn it back over to Marty.

Marty Ball: Thank you, Karen. The information that you shared today is very valuable. We now have time available to answer questions until the top of the hour. While we wait for the first question, I'll just review our CE process that we have online now. There's three methods for receiving your CE. Two are through the WebEx and one is through the phone only. If you registered for today's WebEx, you will receive a survey from WebEx within 48 hours. It will not arrive today. Once you've completed the survey, you will be sent to a site to download your CE certificate. If you are listening to this webinar with a colleague who has logged on to WebEx, ask them to forward the survey from WebEx to you. If you are listening to the webinar by phone only, since you did not register with WebEx, you will not receive this survey with the links for the CEs. In a few weeks an online version of the webinar will be posted to our qualityreportingcenter.com website for you to get your CE certificate.

This material was prepared by the Outpatient Quality Reporting Outreach and Education Support Contractor under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). FL-OQR/ASC-CH8-05042015-03