



Hospital Inpatient Quality Reporting IQR Program

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Navigating Hospital IQR Program Reports Tips to Access, Run, and Review

Presentation Transcript

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Candace Jackson: Thank you, everyone, for joining today's presentation titled, *Navigating Hospital IQR Program Reports Tips to Access, Run, and Review*.

I am Candace Jackson, the Project Lead for the Hospital Inpatient Quality Reporting Program with the Hospital Inpatient Values, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the speaker for today's event. Before we begin, I would like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers, will be posted to the inpatient website -- www.QualityReportingCenter.com -- and to the *QualityNet* site at a later date. If you are registered for this event, a reminder email, as well as the slides, were sent out about a few hours ago. If you did not receive that email, you can download the slides at our inpatient website. Again, that is www.QualityReportingCenter.com. If you have questions as we move through the webinar, please type your question into the chat window. We will not be using a raised-hand feature for today's webinar. To best answer your questions, we request that, at the beginning of your question, please type the slide number into the chat window with it. As time allows, we will have a question-and-answer [Q&A] session at the conclusion of the webinar. Applicable questions that are not answered during the question-and-answer session at the end of today's webinar will be posted to the www.QualityReportingCenter.com website at a later date.

Today's presentation will be geared more to those participants that are new to the *QualityNet Secure Portal* reports or those who may just need a refresher. and will focus on the reports that are relevant to the chart-abstracted measure submissions. This presentation will provide information regarding the types of reports that are available, the purpose of each report, how to access and run reports, and how to interpret the report data.

By the end of this presentation, you will be able to identify reports that are available to you, what their purpose is, and how to locate the reports on the *QualityNet Secure Portal*. In addition, you will be able to select the appropriate report and interpret the data provided.

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This slide just provides you with a list of the acronyms and abbreviations that will be used throughout the presentation.

Prior to being able to run or view reports, a provider, facility, health care system, or vendor must have a *QualityNet* account with the appropriate rights and roles. The roles can be assigned by your *QualityNet* Security Administrator. To log in to the *QualityNet Secure Portal* for access to reports, users must have a *QualityNet* user ID and password provided by their security administrator and must complete the New User Enrollment process that included identity-proofing and multi-factor credential enrollment. Please see the *QualityNet Secure Portal* User Guide on the *QualityNet* website for detailed information on completing this process. To access the reports, once you have logged in to the *Secure Portal*, select My Reports, and select either Run [Reports], Search [Reports], or Analytics Report. In the event that a user is experiencing problems accessing reports, they should contact their security administrator and/or the *QualityNet* Help Desk to verify that they have the appropriate system access rights and roles set up. The *QualityNet* Help Desk can be reached from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday, by email at qnetsupport@hcqis.org or by phone at (866) 288-8912.

On the Start Reports page, click Run Report(s) to produce a new report. On the Run Report(s) tab, select the appropriate program from the Report Program dropdown menu. After the program is selected, select the Report Category you need. Options displayed in the Report Program and Report Category menu will vary and will depend on the roles that you have been assigned as the user. You must first select a program before the corresponding Report Category is displayed and is available for selection. Once the selections are made, select View Report.

Once you select View Report, the list of applicable reports for the Report Category will display. Click on the line with Report Name to run a report. Once you have selected a report, the report parameters page will be populated. Various parameter options appear on the Report Parameter page depending upon the report. Select your choices from the fields and dropdown controls. Required parameters are marked with a red asterisk.

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To generate a report with the parameters you have assigned, you will then click Run Report.

To view the report that you have run, click the Search Report(s) tab and the reporting application.

The Search Report(s) screen lists reports that you have run in chronological order with the most recent report being on top of the list. The status icons on the left indicate that the report execution is in progress and this will display with a counterclockwise blue circular arrow icon. If it has completed, it will be displayed with a green checkmark icon. You can use the Search features to find a specific report in the list by searching on the report name or specify a date range. You can also specify which reports to search based on status. The table also shows the last time specific reports were downloaded, along with their size. The column on the right of the table contains icons for the actions you can take with reports. They are View, Download, Save as Favorite, and Delete. Click the magnifying glass icon to view the report. The green down arrow icon is used to download a report which you may then save. The red circle icon is used to delete a report.

For today's presentation, we will be going over the Claims Detail and Provider Participation Report under the Annual Payment Update Reports category and several of the feedback reports that have been listed here in this slide.

The Claims Detail Report will provide users with the ability to monitor claims submitted in final action status. The report includes only Medicare fee-for-service claims, which is Medicare Part A claims that have been finalized. Claims related to the Inpatient Quality Reporting, Global, and venous thromboembolism (the no VTE sub-population) are excluded from this report as there are so many claims that it would make the report not feasible to use as it would be so long. As mentioned earlier, the parameters that are displayed are based on your access role. For the Claims Detail Report, the parameters include state and, as I mentioned earlier, the parameters that are displayed, again, are based on your state access. So,

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not all providers are going to see the state parameter. If the state parameter is displayed, you can select one, several, or all states from the dropdown. Provider displays all providers associated with the user signed on to *QualityNet*. You will then select a discharge quarter, which is a required field. You are then able to select one, several, or all of the desired measure sets within the Measure Set field dropdown list. If nothing is selected, it will default to “All.” The report format for this report includes both PDF and CSV. When the report is generated, the report headers contain the report title, report run date, and retrieval criteria entered by the user.

The information included on the Claims Detail Report includes the Date As Of, which displays the last time claims data was loaded for the provider; the Medicare beneficiary identifier for the episode of care or record which would assist in trying to locate the claim; the claim start and end date; and the measure set associated with the claim. The claims data is updated monthly, usually at the beginning of the month, until approximately 15 days prior to the submission deadline for that quarter. This is a cumulative report. So, if there was a claim that did not show up last month, but you have since submitted that claim, by the time the next claim count is run, that claim should show up on the report at that time.

The next report that we will go over is the Provider Participation Report, or the PPR. The Provider Participation Report summarizes the provider’s data submission. Inpatient Quality Reporting providers can use this report to monitor their data submission to make sure they have submitted all information necessary to comply with the IQR annual payment update requirement. When the report is generated, it will contain the report title, report run date, and retrieval criteria entered by the user. Please keep in mind, though, that the report does not guarantee a provider received their full annual payment update. The parameters for the Provider Participation Report include State, Provider (if applicable for the user roles), and Calendar Year. If you are running a report for second quarter 2018 discharges, you would then select Calendar Year 2018. The Discharge Quarter displays available discharge timeframes for selection. Click on the Discharge Quarter dropdown to display available quarters for the selected

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calendar year. This parameter is optional and, if you do not select a specific quarter, it will default to all quarters for that calendar year. Although the report format has an arrow to denote a dropdown, this option is only available to those that have the Hospital Reporting Vendor Feedback Report role. For those that have that role, the report is available in either a PDF or CSV format. Otherwise, the report format field is not available, and the PDF formatted report is generated by default. The PDF-formatted reports are available for all years. In the CSV format, the report is generated only for the current and prior calendar year.

The Provider Participation Report is updated nightly with the data that was successfully submitted or processed from the previous day. So, that means if you submitted your data today, it would not display on the Provider Participation Report until tomorrow. For the clinical measures, you are going to want to pay attention to the Total Patient Population, the Total Medicare Claims, and the Total Cases Accepted columns. The Total Patient Population column displays the providers, self-reported, and Medicare and non-Medicare combined population. Totals are by clinical measure set, measure set strata, and sub-populations as applicable. In instances where no population size is reported “No” is displayed. The Total Medicare Claims displays, on a quarterly basis, the total number of Medicare claims submitted for the provider. Totals are by clinical measure steps, measure set strata, and sub-populations. The column remains blank until quarterly summarized Medicare claims counts are available. The Total Medicare Claims column will be updated monthly with a cumulative total until approximately 15 days prior to the submission deadline for that quarter. One thing to note is that it is unlikely that the number that displays in the Total Medicare Claims count and on the Claims Detail Report will match the number of Medicare cases that you submit for your population and sampling -- Medicare population size -- as the criteria that is used to determine these counts are different. For the Provider Participation Report Total Medicare Claims count [column], only finalized pure Medicare Part A claims are pulled. The population and sampling initial patient population size -- Medicare only -- includes all patients that are billed under Medicare or Title XVIII. For this, it includes all types of Medicare

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from Medicare Part A, Part B, and/or Part D. Medicare can be the primary, secondary, tertiary, or lower on the payment sources for the patient. In addition, it also includes Medicare HMO, Medicare Advantage, Medicare secondary payer, railroad retirement, black lung, etc. The Total Cases Accepted displays the count of unique clinical cases, both Medicare and non-Medicare combined together, that successfully met all clinical status submission requirements and were accepted into the CMS Clinical Warehouse. If a zero displays, then no cases have been accepted into the warehouse. I'd like to take a moment here and talk about those hospitals that did not have an emergency department. Hospitals that do not have an emergency department may opt out of the reporting ED measures for the Hospital IQR Program by submitting an IPPS Quality Reporting Program Measure Exception Form. This is also known as a waiver. The form is available on the *QualityNet* website under Hospitals Inpatient, then Hospital Inpatient Quality Reporting Program, and IPPS Measure Exception Form. Hospitals that do not have an ED, must submit ED files prior to each quarterly data submission deadline unless they submit this form. If you have submitted an ED waiver, the Provider Participation Report will continue to show zero for the total cases accepted. As a reminder, hospitals can't update or correct their submitted clinical data until the CMS submission deadline. CMS gives approximately a four and one-half month's review and correction period from the time the discharge period ended until the submission deadline. It is highly recommended the hospital submit their data early so that they have ample time to review their data, make any corrections, and resubmit it. The CMS Clinical Warehouse will be locked immediately after the submission deadline. Once the Warehouse is locked, no changes can be made. Okay. So, moving on with the report, the Discharge Quarter Sample Frequency displays the providers identified, population sampling frequency, which are monthly, quarterly, not sampled, and submission not required. In situations where no sampling frequency has been reported, "No" is displayed. So, when you see "No" displayed in any of the columns, that means you have not met that IQR requirement.

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For the determination of whether or not a provider has submitted data or under-submitted, CMS uses both the Total Patient Population and the Total Medicare Claims count. Whichever is the greatest of the two is then used to determine if the hospital has met the minimum sample-size requirement for the specific measure set, measure set strata, or sub-population. So, for example, in this slide, the provider has a total patient population that's 577 for sepsis and has a Medicare claims count of 299. Since the population size is greater than the Medicare claims count, the population size will be used to determine how many cases the provider must have accepted into the CMS Clinical Warehouse. In this case, since their sepsis population is 577, they would be expected to have, at the minimum, 60 cases accepted into the warehouse. In regard to the sampling frequency, if the sampling frequency is monthly, then CMS uses the monthly sampling tables to determine if the hospital has met this minimum sample-size requirement. If the sampling frequency is quarterly, not sampled, or submission not required, then CMS uses the quarterly sample tables to determine submission and/or under-submission. As a note, when you are referencing the sample tables for each of the measure sets, you want to make sure you go into the Measure Information Form for that specific measure set within the specifications manual and use the tables in that section and not use the sampling examples that are provided in Section IV of the specifications manual under population and sampling. Section IV is only examples of the different types of sampling and how the population and sampling is determined. So, again, you want to make sure you access the appropriate tables for the appropriate measure set.

On the second page of the Provider Participation Report, you will find the data submission information for PC-01, which is the web-based measure, and for the hospital-associated infection, or HAI, measures. For PC-01, the report displays the Total Numerator, which is the count of patients with an elective delivery. Please remember this is an inverse measure. So, you want the numerator to be low. You want it to be as close to zero as possible. The Total Denominator displays the count of patients delivering newborns you would warrant with greater than or equal to 37 and less than 39 weeks of gestation completed.

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The Total Mother Population is the count of the number of cases that met the mother population criteria. Quite frequently we do see people submitting the global population as the Total Mother Population for PC. So, just remember, this is just the count of the mother total patient population as described in the specifications manual on The Joint Commission's website. The Total Exclusions [Count] is the combined total, or count, of patients that met any of the exclusion criteria. For PC-01, if a zero is entered, the report will display zero. If no data exist, then the report will display "No." As with ED, hospitals that do not deliver babies may opt out of reporting PC-01 measure data by submitting an IPPS Quality Reporting Programs Measure Exception Form or waiver. Hospitals that do not deliver babies must enter a zero for each of the PC-01 data entry fields prior to each quarterly data submission deadline unless they submit this form. If your hospital submitted a waiver or exception form for PC-01, your Provider Participation Report will continue to display "No" for submission of this measure. Additionally, this page displays the IQR-HAI data that were successfully submitted to the CDC's National Healthcare Safety Network, referred to as NHSN. Hospitals must collect HAI data monthly and submit data at least quarterly prior to each quarterly submission deadline. The only exception is the healthcare personnel influenza vaccination measure, which is submitted annually. The report displays the value "Yes" when the provider has successfully submitted data to NHSN and CMS has received that data; otherwise, "No" is displayed. The Last NHSN File Update to CMS column displays the date the NHSN file was last updated for the discharge quarter. HAI data is updated monthly until the submission deadline for the respective quarter. An important note here is that you need to make sure to allow ample time before the deadline to review and, if necessary, correct your HAI healthcare personnel data. NHSN does allow modification to the data after the submission deadline. However, data that are modified in NHSN after the submission deadline are not sent to CMS and will not be used for the IQR Program or any other CMS pay-for-performance programs, including the Hospital Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program. As with ED and PC-01, there is the opportunity to submit waivers for the SSI and CAUTI/CLABSI measures.

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For SSI, hospitals that have performed nine or fewer of any of the specified colon and abdominal hysterectomy SSI procedures, combined in the calendar year prior to the reporting year, can request an exception or waiver from submitting SSI measures. If a waiver is not requested, the SSI data must be reported. For CAUTI and CLABSI, hospitals that do not have an ICU, neonatal ICU, or one of the six designated CDC wards must submit an IPPS Measure Exception Form. One last helpful hint here for HAI data is it's highly recommended that hospitals have at least two active NHSN users who have the ability to enter HAI and healthcare personnel data. This practice may help hospitals meet some data submission deadlines in the event one of the NHSN users becomes unavailable. Just a note, if you are a critical access hospital or a non-eligible IQR hospital, you will be able to run the Provider Participation Report; however, no data will be displayed since these hospitals are not part of the IQR program.

The Hospital Reporting Case Status Summary Report is a total of unique cases submitted to the CMS Clinical Warehouse. The report parameter fields are State and Provider, depending upon the user role; the Discharge Quarter, which limits the report generation to a specific discharge date range; the Submitter, which is an optional field. This provides a list of valid submitter IDs and the submitter name associated with each ID returned by a query of the submitters for that provider discharge date range. The measure set allows the users to select one or more measure sets for the report and, if not selected, the report defaults to "All" in the report format. The available formats for this report are PDF and CSV. When the report is generated in the PDF format, the report contains the report title, report run date, and retrieval criteria entered by the user. This information will not be included in the reports generated in a CSV format.

The Case Status Summary Report includes the number of cases submitted, accepted, and rejected. If you look, submissions of the same case are counted only once. If multiple submissions have been made of the same case, the status of the most recently submitted case within the designated discharge period will be displayed. The report is grouped by provider and then measure. For a case to be included in the Cases Accepted column, it

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must have met the acceptance criteria and was successfully submitted and stored in the CMS Clinical Warehouse. Rejected cases do not count towards successful submissions. Rejected cases do not count towards successful submissions. For cases that are rejected, it is recommended that you review the Submission Detail Report to ascertain why the case was rejected so that you can correct the errors and resubmit the case. The expectation is that cases that are rejected from the right warehouse will be corrected and resubmitted. Additionally, related cases and test cases are removed from all case counts.

So, moving on to the Facility, State and National Report. The Facility, State and National Report displays the number of hospital records abstracted for a provider and summarizes and compares, by quarter, the data for the measure chosen at the facility, state, and national level. This report can also be used to verify that you have submitted your data for the applicable discharge quarter. Your report parameters include the ability to filter by state and provider, if you have the appropriate user role. For hospitals, the Provider field will display the organization. If more than one organization is displayed, select the desired organization. You will then select the Discharge Quarter. This parameter limits the report generated to a specific calendar year. Select the Measure Set by clicking on one or more of the desired measure sets within the Measure Set fields dropdown list, and then select the Report Format. The available options for this report are PDF and CSV, depending upon the user role that you have. For providers, the report is available only in the PDF format. When the report is generated in the PDF format, the report contains report title, report run date, and the retrieval criteria entered by the user.

For the Facility, State and National Report, all data and calculations are obtained from cases that have been successfully accepted into the CMS Clinical Warehouse. The Medical Records Abstracted, which is for clinical chart-abstracted measures only, displays the total number of successfully accepted cases for the measure set for the selected timeframe. A zero appears if no data are available. Each measure set has associated measure rows. Rows contain values in Numerator, Denominator, and % of Total

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columns. Values are provided in each of these columns at the facility, state, and national levels. Facility data are available in real-time; however, the state and national columns will display blank until approximately 30 days after the submission deadline for the quarter. Looking at each of the Facility columns, the facility-level numerator values are either the number of cases that satisfy the conditions of the performance measure or, for time-based measures such as ED, a value and minute. The facility-level denominator values are either the number of cases in the measure population successfully accepted or a forward slash for time-based measures. A dash will display if there are no cases eligible for inclusion within the denominator and the facility-level percent of total values are either the percent of cases included in the denominator that satisfy the performance measure, or the numerator, or a forward slash for time-based measures. If an N/A displays on the report for the clinical measures only, then that indicates that no data are available or the data are not applicable.

The perinatal care measure information for the facility, state, and national level will contain the following columns: Exclusion, which is the name of the exclusion as per the Measure Information Form and algorithm for PC-01; the Numerator and Denominator, which are the number of cases of elective delivery and the number of cases of newborns delivered with greater than or equal to 37, and less than 39 weeks, gestation completed; the % of Total, which is the percentage of the population included in the denominator that is also included in the numerator; and the Exclusion Count which is the count of patients that meet the specific exclusion criteria for each exclusion. Again, that is per the Measure Information Form and algorithm for PC-01. The HAI measure rows contain the following columns: Number of Observed Infections or Numerator, which is the number of observed HAI occurrences for the applicable HAI measure; the Number of Predicted Infections, or Denominator, which is the number of predicted infection occurrences for the applicable HAI measure; the Standardized Infection Ratio, or SIR, for the applicable measure; and the Locations, which indicates the data source as either ICU or combined for CAUTI and CLABSI and all for C. difficile, MRSA, and SSI. The report also displays Device Days/Patient Days and/or Procedures

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performed for the applicable HAI measure. This column is reported only for the facility level. The Device Days/Patient Days/Procedures field displays exceptions if the provider has an HAI waiver on file for the SSI measures. This report, as with Provider Participation Report, can be used to verify and ensure that all required data have been submitted to the CMS Clinical Warehouse to meet IQR requirements.

The Hospital Reporting Measure Designation Summary Report allows the user to view a summary of measures and their data submission designation status by provider and reporting period. The report is available for the IQR Program only. The report displays a designation status; most recent designation date and time; and the user responsible for the most recent designation. The report parameter fields include State and Provider, as applicable for the user role; the Discharge Quarter, which limits the report generation to a specific discharge timeframe; a Measure Set allows the user to select one or more measure sets that are available from the dropdown list to be included in their report; the Designation Status, is an optional field that allows the user to designate whether to include the status of selected, or deselected, or both, from the report; and the Report Format allows the user to select either PDF or CSV format. When the report is generated in the PDF format, the report contains a report title, report run date, and retrieval criteria entered by the user.

The information displayed in the Hospital Reporting Measure Designation Summary Report includes the current warehouse designation status for the indicated measure, and the valid values for this field are selected and deselected. If you are an eligible IQR-participating hospital, the measures that are required for the IQR Program cannot be deselected. So, at this time, the required IQR measures are ED-1 and 2, IMM-2, SEP-1, and VTE-6. There are no voluntary measures included in the IQR Program. As such, the eligible IQR-participating hospitals would not be able to deselect any of these measures.

If you are a critical access hospital or a non-participating IQR hospital, you would have the ability to deselect, or select, any of the measures that you are planning to submit. The report also displays the date and time that

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the most recent designation was saved for the indicated measure and the individual, or system, responsible for the most recently saved designation for the indicated measure.

The Hospital Reporting Measure Status by Case Report is a detailed report that has an option to display detailed information of individual cases which include measure inclusion status and Reason for Exclusion. For each case, the report provides detailed information on the population eligibility, or denominator; whether the case was included in the numerator or excluded from the measure calculation; and, if excluded, the reason for the exclusion. For the parameters, you will select the discharge quarter from the dropdown pick list; select the submitter desired, as this is an optional field; and select the measure set as applicable. The Measure Set field should display the measure set for the associated submitter and provider. The user has the ability to select multiple measure sets and then select the report format. The available options for this report include PDF and CSV. When the report is generated in the PDF format, the report contains the report title, report run date, and retrieval criteria entered by the user.

The report displays population eligibility and will display a “Y” if the case was included in the measure denominator. The allowable values for the numerator, or Passed the Measure column, includes “Y” if the case was included in the measure numerator; an “N” if the case was included in the denominator, but failed or did not meet the intents of the measure; or an asterisk, in the CSV format only, if a time element was present. This field will remain blank if a time element is present in the Continuous Variable columns in the PDF version. If a case was excluded from the measure calculation or was not included in the denominator of the measure, the report will display a “Y” in the Excluded from the Measure Calculation column. Lastly, if the case was excluded from the denominator of the measure, the report will display the reason why the case was excluded under the Reason for Exclusion column. As a note, rejected cases are not included in this report.

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The Hospital Reporting Population and Sampling Summary Report displays summary information on population and sampling data from Medicare and non-Medicare by quarter, measure set, and provider. Data may be submitted by XML file or through the population and sampling application within the *QualityNet Secure Portal*. As with the other reports, the State and Provider parameters may or may not be available depending on your user role. For this report, you will select the Discharge Quarter, which limits the report generation to a specific discharge quarter; the Population Type, in which the user may select one or multiple population types; and then the Report Format. The available report formats for this report include PDF and CSV. When the report is generated in the PDF format, the report contains a report tile, report run date, and retrieval criteria selected by the user. The report will display the sampling frequency selected by the provider. The values include monthly, quarterly, not sampled, and N/A, submission of clinical patient data is not required. The report displays the breakdown of the population and sample sizes by Medicare and non-Medicare and then provides the total population and sample sizes which is the Medicare and non-Medicare counts combined. An N/A in any of the data cells indicates that the population and sampling size data have not been submitted for this quarter or this specific measure set, strata, or sub-population.

The Hospital Reporting Potential Duplicate Report identifies potential duplicate records submitted to the CMS Clinical Warehouse. To run the Potential Duplicate Report, you will select the appropriate discharge quarter and then the report format. Only a PDF format is available for this report.

Multiple records submitted for the same patient stay are considered potential duplicates. This can mean that they match on one or several of the key submission elements. The key elements used to identify potential duplicates are the CMS Certification Number, or CCN; the measure set; the admission and discharge data; and the patient identifier. In some instances, the birth date is also used to identify potential duplicates. For example, if you submit a case with the same CCN, measure set, patient

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identifier, and admit date, but the two cases have different discharge dates, as in the example on this slide, those cases will be identified as a potential duplicate. Please remember that this identifies potential duplicates only. So, they may or may not be an actual duplicate and it's up to the facility to determine if it is a duplicate or not. The list of potential duplicates should be reviewed to determine if each record is a valid record or if it is an actual duplicate. Duplicate records can cause incorrect data to be reported to the IQR Program and can potentially adversely affect the facility's outcome if the provider is selected for validation. As a result, it is important that any duplicate records be deleted prior to the submission deadline. The important areas of the report that you will want to review in determining if a record is a duplicate or not are the admit and discharge date, which is the month, day, and year that the patient was admitted and discharged from the hospital; the patient identifier, which is the unique number that is used by the hospital to identify the case; and the first and last name, if available. The first and last name will only display if those data fields were submitted in the patient-level XML file. If they were not submitted, as though they're optional data elements, then those fields will be blank. Then you will also want to check the birth date.

The Hospital Reporting Submission Detail Report is a detailed report of cases submitted to the CMS Clinical Warehouse. The report includes all submissions for a particular case rather than just the most recent submission. So, if the case was submitted multiple times, then it's going to show up multiple times on the report. After selecting the appropriate discharge quarter, the remainder of the parameters are optional and will assist you in drilling down the information that is included in the report. The optional parameters include the ability to select the submitter, the dropdown provides a list of valid submitter IDs; the submitter's names associated with each ID; the file status, which allows the user to designate whether to include accepted, rejected, or both statuses for the report (The measure set dropdown displays the typical measure sets for the program type.); the action code field, allowing the user to designate whether to include added data, deleted data, or both in the report; and the message type field, allowing the user to select the type of message to display. A

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user may select one or more message types. The message types include critical and/or informational edits. As a note, critical edits are those that cause a case to be rejected from the Clinical Warehouse, whereas informational messages are just asking the user to verify that the information submitted is correct. The informational messages will not reject a case from the warehouse, whether the case was excluded, failed, included, passed the measure, or if the measure calculation was unable to be determined.

The Submission Detail Report displays the following pertinent information for each case: the dates that the patient was admitted and discharged from the hospital; the date the case was submitted to the CMS Clinical Warehouse; the warehouse submission status of the file for the selected measure, which is known as the Action Code (Again, the Action Code is either “Add,” meaning the case is being added to the warehouse, or “Delete,” which means the case is being deleted from the warehouse.); the status of the case that was submitted, or otherwise known as the File Status, which will display either “Accepted,” “Rejected,” or “Unknown”; and the message. The message will either state if the case passed the measure, failed the measure, was excluded from the measure, or if there was a critical error that occurred resulting in the file not being accepted into the warehouse. Additionally, the message will provide the reason why the case was excluded, passed, or failed.

These next four slides just list all the reports that are available for the IQR Program and a brief description of what the report entails. I won't be going over all of these slides and you can review them at your leisure.

This slide will just focus on the EHR, HCAHPS, and Data Validation Reports that are available.

This slide focuses on the available value-based purchasing and public reporting slides available.

This last slide covers the Hospital-Specific Reports that are available for the Hospital IQR Program.

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This slide just provides you with some resources that are available to you for assistance with the Inpatient Quality Reporting Program. If you have questions related to the Measure Information Forms or the individual measures or how to abstract the data elements for the individual measures, we ask that you submit those questions to the Q&A tool, so that they can be routed to the appropriate measure developers. If you have questions in relation to the IQR Program or requirements, submission deadlines, or other aspects of the program, then there is the email support, phone support, and inpatient live chat this is available to you. Additionally, we encourage you to visit our website at www.QualityReportingCenter.com for additional information and resources.

Lastly, this slide provides you with some tools, resources, references, and training materials that are available to assist you in meeting the Hospital Inpatient Quality Reporting Program requirements. One other resource that is not listed on this slide, but I would like to point out, is the Known Issues Document. If you find things that do not look appropriate on the report, the first thing you want to do is look at the Known Issues Document. This document tells you, or explains, any issues that are currently occurring within any of the reports and what the workaround is. You can find the Known Issues Document on the home page of *QualityNet* on the bottom left-hand side of the page.

We'd like to thank you for joining our webinar today. I hope the information was useful to you. At this time, unfortunately, we will not have a live Q&A session due to time constraints. Again, we will be looking at all the questions that were submitted through the chat box, during the webinar, and those will be responded to and posted to the *QualityReportingCenter.com* website at a later date. So, at this time, I'd like to turn the presentation over to Dr. Debra Price to do a brief synopsis of our CE process. Again, we thank you for joining us today and, Deb, the floor is yours.

Dr. Debra Price: Hi, everyone. Thanks for attending today's event. The presentation has been approved for continuing education credits by the boards listed on this slide. If your board is not one of those boards listed, you can forward the

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certificate to your own board and see if they accept this certificate across state lines. Now, you can always reach out to me if you have issues.

There are three easy steps for completing your credits. The first step, complete the survey at the end of this event. It'll automatically pop up. The second step, register either as a New User or an Existing User on our HSAG Learning Management Center website. The third step: print out your certificate from the website. One precaution for everyone is that this is a separate registration than the one you used to get into the ReadyTalk and the webinar. Also, we prefer that you use your personal email because your healthcare emails have blocks that seem to be blocking our automatic links.

Okay. This is what will pop up at the end of our slides. It's the bottom of the survey and what you do is you finish the survey and click that greyed button on the right-hand bottom that says "Done," and...

This page will pop up. You note that there are two green links. The first one is the New User link and please use that if you have had any kind of issues before or if you are a new user. The second link is the Existing User link. Use that if you haven't had any issues before.

Depending on the link that you clicked on, you'll be taken to one of these screens. For the New User screen on the left, use your personal email and a personal phone number. If you've had any problems getting your credit, please go back and use this New User screen. The Existing User screen on the right is for you to complete if you haven't had any problems with past events. Your complete email is your user name and that includes whatever is after the @ sign.

Finally, we would like to thank everyone for attending today's event. If we didn't get to your question, all submitted questions relating to this webinar will be posted to our *QualityReportingCenter.com* website at a later date.

Now, we hope you learned something today. Thank you and enjoy the rest of your day. Good bye everyone.