Quality Reporting Program

Support Contractor

Measure by Measure: Data for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Presentation Transcript

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Dianne Glymph: Hello, and welcome to the Ambulatory Surgical Center Quality Reporting Program webinar. Thank you for joining us today. My name is Dianne Glymph; I'm a Project Coordinator for the ASC Quality Reporting Program. If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. Just click on the events calendar, then on today's event, and then you'll be able to download the handouts from that page. They're also attached to the invitation you received for this webinar. Our speaker today is Pam Harris. She's a Project Coordinator for the ASCQR Program Support Contractor, and she will be discussing some various data reported for this program, along with some reports available to you and how these reports can assist you in quality improvement. Before I hand things over to Pam, let me make just a few announcements.

Before we get started, let me just point out a few reminders here. The first one is that May 15 is the submission due date for all web-based measures. This is the first year for ASCs where all of your web-based measures are due in May. You will no longer be submitting measure data to QualityNet in August; all those data need to be submitted by May 15, so please don't let that trip you up. If you need any help with submitting your data, just give us a call. We're always glad to help. We can even do screen-sharing to make sure you're submitting data correctly. So, measures submitted using a web-based tool to QualityNet and to the NHSN are

due in May. We recommend submitting early so that you don't encounter any technical issues that can't be solved by the deadline.

Please keep your passwords for both your QualityNet and NHSN accounts current and active. These are two separate systems, and each account has to be kept active to be able to access the system. The easiest way to do this is to log in every 90 days or so. This consistent log-in will prevent password problems and will keep your account from being locked. You don't want to get close to that May 15 deadline, find you have an inactive account, and not be able to enter your data. If you don't log in within 365 days, your account will be deactivated, and you'll have to go through the entire application process again.

Additionally, we recommend that you have two active Security Administrators for QualityNet and at least two people who have current and active access to NHSN. Also, please make sure you are signed up for the ListServe. It's an automated email service which allows you to receive program updates and other important information. It's a very simple way to stay informed about what's going on with the program. If you're not signed up for this free service, you can do so from the homepage of QualityNet – that's www.qualitynet.org.

There's an important announcement from the NHSN that we'd like you to take special notice of. They sent emails at the end of January to Facility Administrators and Primary Contacts for each facility registered in the NHSN to make them aware that an updated NHSN Agreement to Participate and Consent form is available. This form must be signed by your facility's Primary Contact or Facility Administrator by April 14. If the form isn't signed by then, you will risk losing access to the NHSN, and then you won't be able to enter your data for the Influenza Vaccination Coverage among Healthcare Personnel measure, that's ASC-8, by the May 15 deadline. They're allowing electronic signatures, so please ensure that your facility has signed the form by April 14. They have now added a document with screenshots to assist you in this process, should you need it. We have the direct link to that document right there on the slide.

And here's the date for our next event. March 28, 2018: Identifying and overcoming the most common hurdles when reporting for this program. We will review current deadlines for all the measures, how to stay on top of your NHSN data, and how to ensure that your QDCs are being credited correctly, which will also include evaluating such resources as the Claims Detail Report, Remittance Advice, and others. We'll also review the encounter periods and reporting periods for all the measures. That webinar will sure to have all of the information you need to assist you in timely and successful reporting for this program. As always, we'll send ListServe notifications prior to this webinar.

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The learning objectives for this program are listed here 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 your screen. One of our subject matter experts will respond. By having live chat, we hope to accommodate your questions as soon as possible and provide real-time feedback. And now it's time to hand things over to Pam. Pam?

Pam Harris: Thank you, Dianne. For many of us, the word "measure" has a double meaning. It can represent patient care standards that we uphold for the 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 a great deal of preparation. So, before we can analyze data and use data to create a superior performance, so let's see how we can compose 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 transform our processes and promote, disseminate, and utilize best practices to optimize patient quality of care.

Now, improving quality of care is a big part of CMS in general, and reviewing data that you, the ASCs, have reported for this program will enable you to set goals for quality improvement initiatives within your organization. On this slide are the claims-based measures for this program. ASC-1 through ASC-4 are QDCs, or Quality Data Codes, that are placed on your Medicare Fee-for-Service claims. ASCs submit information on these measures using QDCs entered on their claim via the CMS 1500 paper form or the equivalent electronic form. But remember, in the Calendar Year 2018 Final Rule, ASC-5 was removed from this program. The last measure on this slide, ASC-12, is an outcome measure, so data is collected

from administrative claims. Now, the facility does not have to actively report or manually abstract data for this measure.

Okay, let's view the web-based measures. Now the measures on this slide are the web-based measures that are entered into QualityNet. Now, remember that ASC-6 and -7 were removed from this program in the Calendar Year 2018 Final Rule. So, for ASCs, you will not report on these measures anymore. As a matter of fact, they will not even be an option in QualityNet when you go to enter your data. Now, the measures you are currently reporting for are: ASC-9: Now, this measure looks at the recommended follow-up documentation by the physician for patients who have a screening colonoscopy. And to meet this measure, the physician must document a recommended follow-up of 10 years on the colonoscopy report.

Then we have ASC-10: This measure looks at the interval since the last surveillance colonoscopy. ASC-10 is a measure designed to look at inappropriate use of the colonoscopy procedure. ASC-11: Now, this measure monitors a patient's visual improvement post-cataract surgery through a visual assessment tool. Now, this measure remains a voluntary measure. If you do not report on this measure, it will not impact your annual payment update at all. However, if you do report data, this data is subject to public reporting. Then we come to ASC-13 and -14. These are web-based measures and will be submitted into QualityNet in 2019 using 2018 patient encounters. There is one more web-based measure but this last one, you do not enter into QualityNet.

ASC-8, the Influenza Vaccination Coverage among Healthcare Personnel measure, is entered annually. For this measure, facilities report vaccination data for three categories of the ASC personnel. This is the only web-based measure for this program that is not entered into QualityNet. This data is entered into the NHSN platform. By the way, NHSN and QualityNet are completely different systems that do not speak to one another. So, these two systems require separate websites, passwords, and security access. And while we're on the subject of the security access, let's talk the SAMS grid card. Now, the SAMS grid card is the security access for NHSN, but this is your SAMS grid card. This card goes with you and can be used at other facilities if needed.

Now, let's talk about some data. Starting with ASC-8, the Influenza Vaccination Coverage among Healthcare Personnel or the flu measure, as stated, for this measure facilities report vaccination data for three categories of employees. Now, this data is from the 2014-2015 flu season, which was reported in 2015. Now notice there is a key at the bottom of each slide. Red represents less than 60%. Orange is 60 to 69.99%, light green is 70-79.99%, medium green is 80-89.99%, and dark green is equal to or greater than 90%. Yay, dark green! And on

this slide, we can see only one state with a dark green, meaning equal to or greater than 90% and an overall performance nationally of 74.62%. Now, we know that ASCs have experienced some hurdles with this particular measure, and we are going to be talking about that in just a few minutes. But before we do, let's look at the same measure but for the following year. This would be for the 2015-2016 flu season which was reported, of course, in 2016. Here we can see some improvement, with the rate nationally at 76.13%--seeing some improvement over the previous year. But there are only two states with that dark green of equal to or better than 90%.

Here we're viewing the most updated flu data available. Now, this is the 2016-2017 flu season reported last May. A few more states with that dark green and an overall national rate of 77.54%. Now, we spoke previously of some hurdles ASCs had with respect to the flu measure. We won't get into details, as we've covered this in-depth in previous webinars, but it's worth hitting a few highlights again.

There are several common reasons why facilities fail to complete submission of their data. One is the enrollment process for new facilities; it's a lengthy one. If you do not start well in advance of the submission deadline, it's possible that you will not have completed the process in time to report the measure. We strongly encourage facilities to begin enrolling as soon as possible to allow ample time for the process to be completed well before the reporting deadline. Now, we frequently hear from facilities that they were unable to report the measure because their authorized user left and they did not get another authorized user in time to report. So, don't get caught in this situation! It's easily avoidable. Facilities are permitted to have multiple users and we strongly encourage you to do so.

During enrollment, facilities are allowed to use their NHSN facility number if they don't know or don't have their Medicare Certification Number, or their CCN number. If you do that, you have to go back and edit your entry with the correct CCN number, or you will not receive credit for reporting your data. And, if you don't know your CCN but have your NPI, number you can access the Lookup Tool on the qualityreportingcenter.com website to find the correct CCN number for your facility, or you can simply give us a call.

Another stumbling point for facilities in reporting their data is that they don't add a new reporting plan for the new flu season. As a result, while they're thinking they're being compliant by entering their data, it's being attributed to the wrong flu season, which means they won't receive credit for submitting their data for the current flu season. Each new flu season you will need to add a new reporting plan in order for your data to be correctly associated to the flu season for which you're entering the data. Again, if you find entering your data difficult or you just

can't get the hang of it, give us a call, and we'll walk you through the process. And don't forget we have the screen share option as well.

Let's move on to ASC-9, Appropriate Follow-Up Interval for the Normal Colonoscopy in Average Risk Patients. This measure is the percentage of patients aged 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. Now, this is also a web-based measure, and it's entered annually into the QualityNet system. So, let's take a look on how ASCs across the nation did with the reporting of this measure.

For this colonoscopy measure, we are once again going to start with the data reported in 2014. We're using the same color key as prior. Some of you may remember submitting this data back then. We can see some red and orange going on. However, we also see quite a few states with the dark green demonstrating equal to or better than 90%. So, for the data in 2014, there was a national rate of 78.38% for the ASCs reporting this measure. So, remember that as we move forward. Now we move forward a year, and we are looking at data for the year 2015. We see improvement over the previous year with a national rate of almost 81%. Yay! Getting better.

Now for the year 2016, we actually see a drop over the previous years' performance with a national rate of 77.78%. This is actually a lower national rate than in 2014. Remember a couple of slides back I asked you to remember that rate? Well, here's why. In 2014, the rate was 78.38%; we saw improvement, and now in 2016 the national rate is 77.78%. In summary, what this means is that 77.78% 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. Well, we know there are some common issues when abstracting for this measure, so let's take some time and see what a few of these are.

When abstracting for ASC-9, there are a lot of questions that come up. For the sake of today's discussion, we're going to discuss the range of the three issues listed here on our slide: Appropriate documentation of a medical reason for exclusion, Exclusion regarding the age of the patient, and A lack of documentation regarding the follow-up interval These are just some examples of some of the most common general areas of concern for abstractors when looking at this measure. Now there were some changes 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."

Now, 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 life expectancy less than 10 years. So now let's move on to ASC-10.

ASC-10: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use. This measure is the percentage of patients aged 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. Now, this measure is also entered annually through the QualityNet system. So, let's take a look at the performance of ASCs nationally on ASC-10.

Again, we refer to the percentage key, with the dark green correlating to greater than or equal to 90%, and the red being below 60%. Now, for ASCs reporting this measure, we can see that for this year, for the 2014, there was just over an 80% rate – starting off pretty good. The national rate for 2015 is 79.9%, and is just slightly lower than the 2014 national rate we just talked about.

Now let's look at the data for ASC-10 in 2016. This is the most current data which you submitted last August. The national rate reported by ASCs are 73.21%. And it's interesting, ASCs started off in 2014 with a national rate of 80.38% and ended up in 2016 with 73.21%. On that note, let's take a look at some common questions and issues abstractors have when abstracting for this measure.

There are a menagerie of issues and questions that can come up when you are abstracting a chart for data. The three most common themes, if you will, with respect to ASC-10 are: Confusion about documentation of the last colonoscopy, Documentation of medical reasons, and Acute symptoms relating to the time interval of the present colonoscopy. If you ever have questions, we encourage you to enter your question in the QA tool through QualityNet and the measure writers will respond directly back to you.

ASC-11: Cataracts: Improvement in the Patient's Visual Function within 90 Days Following Cataract Surgery. Now, this measure is the percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following cataract surgery. And like the others, data is entered annually in QualityNet, and, remember, ASC-11 is a voluntary

measure. You can elect to submit this data or not; either way, it will not affect your payment. Please know that if you do report data, it will be publicly displayed. But let's look at a couple of years of data for this measure.

Now, we're looking at the same rate scale as we used for the colonoscopy measures, and we can see visually there is little variance, and with a national rate of 96.4% for ASCs that reported this measure in 2015. Because this is a voluntary measure, not all facilities reporting for the ASC program report data on this measure.

The following year, 2016, we see a slight decrease in the rate from the 2015 data. Displayed here for 2016, there is a national rate of 95.82%. Again, this is a voluntary measure, but there are some common issues in abstracting this measure.

Some of the frequent points of clarification for the ASC-11 measure are confusion on how many cases to submit and the use of the visual assessment tool. Now, with regard to the population and sampling issue, you will 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 for that measure of 0-900 cases, you will submit at least 63 cases. And if you have 901 or more, you would submit 96 cases. Now, let's talk about claims-based measure ASC-12.

ASC-12: 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 seven days of an outpatient colonoscopy among Medicare fee-for-service patients aged 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 seven days of the outpatient colonoscopy. The number of unplanned visits is then risk-adjusted based on the previous year's data. Now, this measure is an outcome measure, and the data is collected through the administrative claims data that meet the measure criteria; there is no manual abstraction necessary on the part of the facility.

And ASC-12 is calculated different than the previous measures we just talked about. In this graph, ASCs show a nationwide risk-adjusted rate of 12.5 unplanned hospital visits within seven days of an outpatient colonoscopy. Now, the 12.5 displayed here is per 1,000 colonoscopies. It is displayed this way instead of percent, so it's important to note that a lower rate indicates better performance for this measure. The goal of this measure is to reduce 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's always room for improving your performance.

Although this is a claims-based measure and there are not abstracting issues, there are a few questions that people have that are somewhat common, which are listed on the slide. As I previously said, data for this measure is gathered through paid Medicare claims that meet the measure criteria. This information is sent to facilities in various forms by that measure contractor, and we're going to discuss those reports in just a few minutes.

You report data for this program and off it goes, so how do 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.

Now, we've looked at data which is always helpful in improving quality within your own facility, and there are reports available to ASCs which will provide you data and assist you in improvement and comparison. We are going to be talking about these in a little more detail on the next slide. But essentially, utilizing the availability of this data assists you in improving performance and quality which is unique to your ASC setting.

Please be aware of the reports you can run in QualityNet. There are two that ASCs have access to: the Claims Detail Report and the Provider Participation Report. You can run these reports yourself on the Secure Portal of QualityNet, and I'll show you an example of each of these in just a moment. There are also what are referred to as auto-routed reports. That means the report is generated and sent to you through the Secure File Transfer in your QualityNet Inbox. The ASC-12 Reports are auto-routed through QualityNet from the measure contractor. And you'll receive data for the measures that are specific to your facility. For our example, let's start with the reports you can run yourself in QualityNet. First up, Claims Detail Report.

Now I want to remind you – all patient information displayed here is fictitious. Now, this is an excellent auditing tool when used in conjunction with the remittance advice. This report allows you to see what QDCs are being applied to the claims, or if there are claims that were without QDCs, either because they were absent from the claim or because they were not accepted into the warehouse. And those are the claims that you will want to research because if a claim goes into the warehouse without associated QDCs, your facility is not getting credit for reporting those QDCs. And remember, in order to meet the program requirements and receive the full annual payment update, your facility must meet or exceed the 50% QDC submission threshold set by CMS. So, let's move on to the discussion of the Participation Report.

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Now, this is an example of the Provider Participation Report, or PPR. This is for the Payment Year 2018, so this would contain everything you reported last year. Now, this is a very useful report with information about how your facility is performing related to the program requirements. On the upper left side of the report, you will see the state in which the facility is located, the facility's NPI number, its name, and the city in which it resides. Below that you will see the total number of claims with QDCs, the total claims volume, and the QDC reporting percentage, or the Data Completeness rate. Because this is payment year 2018 we are viewing, ASC-5 is included in this report. The Calendar Year 2018 Final Rule has removed ASC-5 from the program, so you will no longer be applying QDCs as they relate to that measure. So, let's take a look at the last page of this report.

Again, this is payment year 2018, so this is data that you submitted in 2017 and using patient encounters 2016, and you can see ASC-6 and -7. These two measures have also been removed from this program. Under ASC-6 and -7, you will see data for ASC-9, -10, and -11. This facility did not submit data for ASC-11, but remember, ASC-11 is voluntary, so that's okay. And below this information, towards the bottom, you will see ASC-8. Now that's the flu data, and you can see that this facility submitted their data for this measure.

Now, the individual reports for the ASC-12 measure are sent by the measure contractor. You can see here the first report has the same name as the report we just talked about earlier that you can run yourself in QualityNet, the Claims Detail Report. Same name, completely different reports, alright? The Claims-Detail Report will provide facilities information on their colonoscopy cases that will be included in the measure's calculation. This will allow facilities to observe and correct coding errors in the claims used to calculate the measure and provide facilities with opportunities to improve the quality of care. The Facility-Specific Report includes: state and national measure results, facility-level distribution of measure risk-factors, and the facility-level measure rate and the performance category.

You can access more detailed information on QualityNet by following the pathway shown on the slide. You can also put a question in the QualityNet Q&A tool, and the measure contractor will respond directly back to you. So, now let's talk about the Preview Report.

An email notification is always sent when the preview period opens. Another notification will be sent again when this preview period closes. This preview period is available for approximately 30 days. Please make sure you access this report in the 30-day period. This report is sent through the Secure File Transfer through QualityNet. And, of course, you must have an active QualityNet Security

Administrator to access the Secure File Transfer box and obtain this report. So please download them so you can have them available to review. Also note, and this is very important, this preview period is not a correction period. This data is based on the data you reported. CMS allows a long period for data submission in which you can change, edit, modify, and add any information. But once that deadline has passed and the warehouse closes, you cannot make changes. Additionally, if you make errors on the application of QDCs, you cannot resubmit a claim for the sole purpose of reporting QDCs after it has been adjudicated. The preview report data is refreshed, or updated, annually in December. So, know that any data you report will be publicly reported.

Now, here is a fictitious preview report. This would be a view that you would have had with the last report in December of 2017, but realize it will not look like this moving forward due to the changes put forth in the Final Rule. Notice that there are footnotes seen at the bottom of the report and that helps explain your data that is not displayed. And you'll have this report sent again prior to the December 2018 refresh, and that's usually in September or October.

Now, I think of this diagram as the full orchestra – each instrument blending together for one objective. 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 the family through engagement as partners in their own care, Promoting effective communications and coordination of care, Promoting effective prevention and treatment of chronic disease, and Working with communities to promote best practices and healthy living. Yes, we can make beautiful music together by using data to improve quality. I hope this webinar has provided everyone something. That's all for me today. Let me hand things back over to Dianne. Dianne?

Dianne Glymph: Pam, thank you so much for that overview. It's really helpful information; we appreciate it. While we have a few minutes, why don't we look at some questions from the chat box? You know, we've been getting a lot of questions about reporting Quality Data Codes now that ASC-5 has been removed. Would you mind summarizing again how many codes they are to report moving forward?

Pam Harris: Yes, of course. First, let me say that if you do continue to report ASC-5, it will not harm you. For some ASCs it's going to take time to remedy their systems accordingly. Now back to what you asked me, Dianne. If you have no incidents — and we're referring to no fall, no burn, no transfer, and no wrong side — you will still report the one QDC of G8907. However, if you do have an incident, then each code is reported separately. So, let's say for example, you have a patient that fell. You will then report the G8910, as that is the code to place on your claim in the

event of a fall. But since you are no longer in the situation where you can report the single code G8907 for No Event, you will also have to report for each of the other measures as well, so you will be reporting all four codes. In short, you will report one code if there is no event and four codes if there was an event. Alright, Dianne, my turn to pick a question. Ah, let's see. Now, another person wants to know what measures are in QualityNet. The question specifically is "what measures am I entering into QualityNet this time around?"

Dianne Glymph: Ah, yeah, let's clarify that. Due to the changes to the program put forth in the Final Rule, and as we discussed in the presentation, ASCs will be reporting ASC-9, -10, and -11, now -11 is voluntary. That's what you'll see displayed in QualityNet when you go to submit the web-based measures. You'll use version 6.0a of the Specifications Manual for the submission of these data which are for encounter dates of January 1, 2017 through December 31, 2017. Um, you know, I think it would be a good idea to mention here, since we're talking about the web-based measures, that the submission deadline for all of the web-based measures is May 15.

Pam Harris: Ooh, great point, Dianne. Yes! Previously, the ASC-8 measure was the only measure that was due May 15. The remaining web-based measures were due August 15. Now, this submission period and moving forward, they are all due on May 15. We certainly do not want anyone missing this deadline.

Dianne Glymph: Thanks, Pam. Um, oh, and also, we highly recommend that each facility have at least two active Security Administrators. Now, I know you're tired of us saying this, but every year we receive calls from ASCs that had one Security Administrator, and then that person left the facility for whatever reason, and then there's no one else authorized to enter the data. So, you don't want to find yourself in that situation three days before the submission deadline. Please be pro-active and ensure that you have more than one Security Administrator and that they have active passwords. This goes for both QualityNet and NHSN. And always, please feel free to call our Help Desk with any questions. Well, as a reminder, a recording of today's event, as well as the transcripts for the presentation, and all of the Q&As in the chat box will be posted on our website at qualityreportingcenter.com. That's all the time we have today. We know that your time is valuable, and we thank you for sharing it with us.