Ambulatory Surgical Center Quality Reporting Program

Support Contractor

Racing to the Finish Line: Tracking Data to Improve Quality

Presentation

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Pam Harris: Hello, and welcome to the Ambulatory Surgical Center Quality Reporting Program Webinar. Thank you for joining us today. My name is Pam Harris, a project coordinator for the ASCQR Program.

Before we begin today's program, I would like to highlight some important dates and announcements. January 1st began the submission period for the web-based measures that are entered through QualityNet. The submission deadline is August 15, 2016. Hopefully, you did meet the May 15th deadline for the submission of ASC-8, the flu measure.

Please be sure to keep your QualityNet and your NHSN passwords active by logging into your accounts on a regular basis. If you do not routinely access these accounts, they can become locked. The easiest way to avoid these issues is to log in every 60 days. If you have any problems with your log-in capabilities on QualityNet, please call their Help Desk directly at the number you see here on the slide. For problems with your NHSN account, please contact the NHSN directly at the email address you see here.

Please join us on July 27 for the discussion of the 2017 Proposed Rule webinar. This will be presented by Anita Bhatia from CMS. We will continue to send notifications and upcoming educational webinars by ListServe. As a reminder, if you are not signed up for the ListServe notifications, please do so. You can access the sign-up link on the home page of QualityNet.

The learning objectives for this program are listed here on the 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.

Now let me introduce our speaker. I am pleased to introduce today's speaker, Karen VanBourgondien. Karen is the Education Coordinator for the ASC and OQR Programs. She has diverse clinical experience in data abstraction, quality improvement, and education. Karen?

Karen VanBourgondien: Hello, everyone. I appreciate you joining us today. We hope to cover quite a bit of information regarding data reporting for this program.

During the presentation, we will discuss some overall data as it relates to this program. We'll talk about the trends, patterns, and even errors that occur when entering data. The data will incorporate both claims-based and web-based measures. Then we will talk about why data is important and how it can be used to improve quality and performance within your facility.

On the next two slides, we will discuss all the measures for the ASCQR Program. If you are not familiar with some of these, it may very well be worth it to you to review this information. For now though, let's briefly review the measures for this program.

ASC-1 through ASC-5, listed here on this slide are known as claims-based measures. ASC-12 is also a claims-based measure but a different type, and we will talk about that in just a moment. ASC-1 through ASC-4 are outcome measures that assess outcomes that occur in your facility.

ASC-5 is a process measure which pertains to pre-op IV antibiotics. These measures are reported through the application of Quality Data Codes, or QDCs, which are applied to Medicare Fee-for-Service billing claims. We just did a two-part webinar series on QDCs. If you need more information on these measures specifically, please review that webinar.

ASC-12, which is the Facility Seven-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy, is also a claims-based measure but different than the ASC-1 through ASC-5. As I just mentioned, this information is extracted automatically from paid Medicare claims that meet the criteria and CPT codes that are specific to this measure.

ASC-6 answers the question as to whether or not your facility uses a safe surgery checklist. ASC-7 collects the aggregate count of selected surgical procedures. ASC-9 is a colonoscopy measure which, in general terms, answers the question, "Did the physician recommend a follow-up interval of at least 10 years for a repeat colonoscopy on the colonoscopy report for patients without biopsy or polypectomy?" ASC-10 is also a colonoscopy measure which deals with patients that do have a history of colonic polyps and there has been at least a three-year interval since their last colonoscopy.

ASC-11 has to do with cataract surgery and assessing improvement within 90 days following cataract surgery. This is a voluntary measure for this program, so you may report data on this or not. Either decision will not impact your payment, but be aware that if you do enter data for this measure, it will be publicly displayed.

ASC-8 is the flu vaccination measure, which is reported to the NHSN and the CDC. This is the only measure that is not entered into the QualityNet online submission tool. It is entered through the NHSN online submission tool. This does require separate registration and enrollment. And, as Pam said, hopefully everyone met that May 15th data submission deadline that just passed for this measure.

Now we've briefly discussed all the measures that pertain to this program. Let's talk about quite a few of these and break down some data as they relate to specific measures.

We're going to start with the quality data codes ASC-1 through ASC-5. To review, if your facility bills 240 or more Medicare patients annually, you should be participating in this program. Now, if you find yourself in the position where you are under that but you may hit that 240 threshold or go over, we recommend you go ahead and apply QDCs. Better to be safe.

In order to meet the requirements, you should be applying QDCs on a minimum of 50 percent of your claims. If you have 500 Medicare Fee-for-Service claims, you need to have QDCs on at least half of those in other to meet the minimum requirement for this program. You will have at least two QDCs if all goes well on each claim, or a maximum of five QDCs if there was an event that took place during that patient encounter. By placing these codes on your billing forms, information is collected for the ASCQR Program. Applying those codes correctly is one part of the program's requirements.

Now we're going to take a closer look at the reporting of QDCs in general. Here on this slide we can see the representation by state as to the reporting

of QDCs. You can see at the top that this is for the year 2014. The percentages relate to all of the Medicare Fee-for-Service claims for that state. The key at the bottom of this slide will let you know what percentages are associated with what color.

Let's look at a few states specifically here. For informational purposes, we're going to go ahead and look at North Dakota. North Dakota has 93 percent. What that means is 93 percent of all Medicare claims paid in that state had QDCs applied. Alaska had 73.4 percent. Again, this is for the year 2014.

Notice here the distribution of color. We have one state that is below 79.9 percent represented by the gray color. We have three states that are 80 percent to 89.9 percent as represented by that dark orange color. We have 11 states that have the yellow, which is 90 percent to 92.9 percent. The rest are 93 percent or greater. In a nutshell, we have 16 states that are performing below 93 percent in applying QDCs on their claims. That was for the year 2014.

Let's take a look at the year 2015. Here is the same type of information, and it is set up the same way, only this slide represents the year 2015. And you will notice that nationally, there is an overall improvement in the reporting of the QDC measures. Ultimately, we would like to see 100 percent in the reporting of QDCs. That would be the goal.

We just discussed the changes in the reporting of the QDC measures between 2014 and 2015. If we look back, 2012 was the beginning of this program. The following year in 2013, people were still getting used to entering this data, as it was fairly new. There has been steady improvement since. We were just able to see that on the previous slide. CMS, as you will recall, did allow facilities to suppress their data for 2013 and/or 2014 on Hospital Compare for the first release only. You can use this information on Hospital Compare to compare your own performance with other facilities.

Let's talk about these measures individually for a minute. Again, we have color representation for corresponding rates. On this slide we are looking at the year 2014 for the measure ASC-1, Patient Burn. In this visual depiction, the rate is per 1,000. So for the dark orange, that represents .51 or more per 1,000. Let me point out here that you would want your rate to be low. This would represent a lower incidence of patient burns. The dark orange and yellow represent a higher incidence. On that note, the dark green would be the most desirable goal, as this represents the lowest number of patient burns.

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On this slide, still with the same colors and same key, we see 2015 data for ASC-1. This measure demonstrates the most variance of all the QDC measures. This may be related to the QDC number that is applied on the claim form. So, ask yourself why some states are improving: is it because they are, in fact, having less burns? Or is it that there are less coding errors? Well, we'll talk about common errors in just a little bit.

Now, we move on to ASC-2, Patient Fall. Sometimes we assume there should be a higher incidence of falls, and this would be the most common incidence of these measures. That's why data can really illuminate things. Sometimes data does not validate what we initially predicted. Here we are viewing the year 2014. Again, we will point out that yellow, which notes the higher rate of occurrence is present in several states for the year 2014.

This is the same measure, ASC-2, a year later in 2015. There are two states with the yellow, and no dark orange seen here at all.

On this slide for ASC-3, which is Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, or Wrong Implant, I want you to notice the key at the bottom; the rates are different than on the previous slide. This is because a smaller percentage range is needed to interpret the difference. It's sort of like using the same type of scale to weigh an elephant as you would a bar of gold. If you use the same scale you used for an elephant for the bar of gold, the needle wouldn't move. So that's a bit of an exaggerated example, but you get the point. Again, the rates used are much smaller so we are able to establish the variance.

Now this is 2015. In comparison, steady improvement is noted in the rates for this measure. Where is your state? How are you doing in all of this?

Now we're going to look at some percentages for ASC-4, Hospital Transfer/Admission. Again, please note the percentage key to understand the value in relation to the color. Wow, there is a lot of yellow here, a higher incidence of transfers for the year 2014.

For this same measure we now look at the following year, 2015. The overall percent of transfers is lower for this year. As always, when you are looking at data, you will want to know answers. Why were there less transfers? This would be a question you may need to ask within your facility. Or if your facility percentage went up, you would want to know that as well; why was that? The bottom line here is when you are evaluating data, you are doing so to see what is happening, why, and what you can do about it.

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Let's take a break from looking at data for just a minute and talk about ASC-1 through ASC-4 and some common issues that can occur when dealing with these outcome measures. Let's review a few things first. For each of the four measures, ASC-1 through ASC-4, there are two assigned G-codes, the first one of which indicates the event occurred. The second one indicates the event did not occur. There is also a third G-code option available to be used to report that your patient did not experience any of these events. The single aggregate G-code is G8907. That code can be used if no events occurred.

As far as these codes go, there are some things that can go wrong. Look at what is on this slide here a minute. I have here you may have entered G8908 when you really meant to put G8907. I also have here that maybe you put G8909 instead of G8908. Well, if you're not familiar with these measures or these codes, this may be contradictory or confusing to you.

Let's stop and talk about this for just a minute. If a patient enters an ASC and no adverse event occurred – no burn, no fall, no wrong event, no transfer – then you can apply that QDC code G8907. This is the aggregate code when everything goes well, which we've just talked about on the previous slide. Now if there is an event, then you cannot use that code.

Let's suppose your patient fell. Well, in that case, you would have to answer each of the ASC-1 through ASC-4 measures individually. Of course, you will have to enter the appropriate code that this patient fell, which is G8910. So you did that, but what if when you were addressing the other measures you entered the code G8908? Well, that code really means that the patient received a burn, but what you meant to put was G8909, which means they did not receive a burn. So now you have incorrectly reported that a patient in your facility received a burn when they didn't. Coding errors are a huge cause for issues with these measures. Often facilities are not aware that these errors were even made until it's too late.

Now we will turn our attention to ASC-5, Prophylactic IV Antibiotic Timing. We talked about ASC-1 through ASC-4 together because they are outcome measures, so they are sort of grouped together, if you will. But you still have to address ASC-5. The information on this slide is for ASC-5 for the year 2014. Once again, we will refer to the key to determine what these colors mean. For the gray color, you have a range of 740 to 943 per 1,000. The green is 989 to 1,000 per 1,000.

Now we are looking at ASC-5 in the year 2015. Let me just mention something here. Your data depends on your universe. If you're in a state with 100 ASCs and another state has a thousand ASCs, this will affect

your data. So, you also need to keep little things like that in mind as well when you're evaluating your data and comparing yourself to other facilities.

ASC-5 and the appropriate reporting seems to be confusing to some, so let's talk about this confusion a little more and clarify this measure and what's expected. These three codes represent the codes for the ASC-5 IV antibiotic timing measure. Now essentially, CMS wants to know for those patients who were ordered an antibiotic: did they receive it on time or was it given late? If your patient was ordered an antibiotic, you need to look at the first two options here on this slide. G8916 is patient with preoperative order for IV antibiotic surgical site infection, prophylaxis, antibiotic initiated on time. G8917 is essentially the same but the antibiotic was not initiated on time. If your patient did not have an order for pre-operative IV antibiotic for SSI, you would then choose the third option of G8918. One of these three codes will be chosen and will be placed on the CMS Form-1500 along with the appropriate G-codes relating to ASC-1 through ASC-4.

We have found that there is some confusion with facilities that leads to some common errors. You have to address ASC-1 through ASC-4. Remember, that if there was no "event," then you can use that aggregate code of G8907. That one code addresses all four of those measures. But then you still have to deal with ASC-5. In a situation where there is no event for ASC-1 through ASC-4, then you have that one code and the code that deals with ASC-5, for a total of two codes.

Now if there is an "event," then you have to deal with ASC-1 through ASC-4 individually. So you will have those four codes, plus the one for ASC-5, for a total of five codes. There have been facilities that think that using the G89097 code means "no event" and can be used for all five measures. Therefore, they never address the ASC-5 measure at all. As I just explained, this is not the case. Please be aware of that.

There are situations when a patient does not have an order for a prophylactic IV antibiotic. In that case, you use the code G8918. We just went over that in the previous slide as well. The bottom line is you have to report on each of these measures. You want to meet your 50 percent threshold necessary to meet the program requirement.

We talked about the QDCs, which is one component of this program, and now let's talk about another component, the reporting of the web-based measures. First up is ASC-8, reporting healthcare flu vaccination data.

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This slide compares results from urban facilities to rural facilities. There were 3,763 urban and 495 rural ASCs that reported on the ASC-8 measure. The percentage rates seen here reflect the number of healthcare personnel that received a flu vaccine. And then in urban settings, 73.98 percent of the healthcare personnel received the flu vaccine, as opposed to rural, which had a higher percentage at 77.26 percent.

When we break this information down by specialty, we get the percentage rates as seen here on this slide. The total number of facilities included in this are for Eye, 799; Multi-Specialty Facilities, 1,852; Nervous, 279; GI Facilities, there were 898; and facilities that are considered "Other" were 431. It is interesting to see the difference in the percentage rates among specialties.

Now we're going to look at the rates over the U.S. for flu vaccination information. We have a different color scheme as we're now discussing the web-based measures. Earlier we were speaking about claims-based QDC measures. Again, we will look at the key at the bottom. This percentage rate represents the percent of employees that received flu vaccination. This is for the year 2014. That was the first year that ASCs had to report this measure. Many of you are aware that this posed some challenges, and facilities are really doing a great job, as this will be an annual submission for this program moving forward. So, let's discuss some of the challenges that some of you have had experience with.

ASC-8 is the healthcare personnel vaccination information and is reported through the NHSN/CDC. This is not entered into the QualityNet Secure Portal. You will need to register and enter your data through the NHSN secure online submission tool. The most current reporting period deadline was May 15. As we've said, this is an annual submission as are all of the web-based measures. We highly recommend your facility have at least two people with appropriate access and capability to report this measure in the NHSN database.

Having just passed the deadline, we've heard from many facilities that did not meet that deadline because they didn't have anyone to enter the data. Maybe the person who had the appropriate credentials left for whatever reason. That's why we highly recommend there's at least two people at all times that are able to enter this information. On top of that, if you can, have at least one of these individuals in a position where this is what they're going to do; their job performance is not going to change, so that person is going to be available to enter this data. We really want you to be able to make these submissions timely.

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Also keep in mind that you must keep your account active. You do not want to risk your account being deactivated. If your account becomes deactivated, you will need to go through the registration process all over again. If you do have any difficulties with your NHSN log-in, you will need to contact the NHSN directly at the email address on this slide.

As a matter of review, when you enter your data into the NHSN, please make sure you use your facility's CCN when you enroll your facility. Do not use an enrollment number or leave that section blank. If you do not enter your facility's CCN, the system will not correlate the data you entered with your facility. You do not want to risk failing this measure. There are several webinars with step-by-step instructions on the NHSN website, and we also have some available on our website at qualityreportingcenter.com. Now after you enter your data, we highly recommend you take a screenshot of that completed data summary page. Keep that for your records.

We've talked about this twice now in this webinar, but unfortunately, I don't think we can mention this too many times. Please make sure you have somebody with an active SAMS grid card to enter this data. I don't think we can say this enough. Please do not wait until the last minute to submit your data. If there is an issue with your SAMS card or password lock-outs or what have you, you want to make sure you have enough time to work through this situation. Unfortunately, again, there were a number of facilities that did not make that deadline, and some of their issues could have been resolved if they would have started this process a little bit sooner.

Switching to the ASC-9 measure, here is an analysis of that measure, appropriate follow-up interval for colonoscopy. This slide represents data from 2014. We do not have 2015 yet, as that submission period for this measure is not over until August 15th. But on this slide, what you are seeing is that the states with the designated orange color have 70 percent or lower. And what that means is zero to 70 percent have documentation of a recommendation for at least a 10-year follow-up for repeat colonoscopy on the colonoscopy report. So, there are 17 states that fall into this category, and eight that are in the 90 percent or greater.

Now we get this question a lot. What happens to our payment if we do not have a good percentage? Well, the answer is nothing at this point. The ASCQR Program is a pay for reporting program, not a pay for performance program. You will obviously want to improve your percentage, but your payment will not be affected by a lower percentage rate. Knowing your data and where you stand will let you know how much you need to improve.

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Some of the most common problems we hear abstractors have are noted here on this slide. Rummaging through a chart to find documentation that you need can be frustrating. Having incomplete documentation does pose a problem. Oftentimes there is no documentation of a recommendation of at least a 10-year follow-up. Another issue is physicians' documentation of a range. They may say something to the effect of "we will repeat the colonoscopy in five to 10 years." While documentation of this sort will not meet the measure criteria, having a range does not mean at least 10 years.

You can see here that we are looking at data for ASC-10. The percentages are posed in the same way as it was for the ASC-9 slide. The data on this slide is evaluating the percent of patients that have at least three years since their last colonoscopy. We are speaking of patients with a history of polyps or biopsy. There are 15 states that fall into the lower percentage group of zero to 70 percent. So, these 15 states do not have documentation that for people with a history of polyps it has been at least three years since their last colonoscopy. You can see here there are only five states with a 90 percent or greater percent for this measure.

There could be many reasons for difficulty in abstracting for this measure. Some of the reasons are noted here on this slide. Oftentimes, the date of the last colonoscopy is not documented or it cannot be found in the medical record. Please remember that in order to use a medical reason for exclusion, there has to be a medical reason documented. In order to use a system reason as a denominator exclusion, you have to have the appropriate exclusion criteria as defined in your Specifications Manual.

Up to this point, we've talked about the data for this program. So, what can we do with it, and why? Having information on your facility and how your facility measures up, so to speak, on a state and national level is important. Just as important as having the data is making use of it. Using data, whether it's obtained by the sources we've mentioned or by your own internal data analysis, can really provide a platform for use to initiate quality improvement. Some of the objectives you would strive for are noted here on the slide. At the end of the day, it's about making things better for the patients you care for and receive services.

So, how can we use data to improve quality? Well, the good thing about that is that it lets you know what is really happening, not what you thought was happening. Have you ever had a situation when you thought there was a process in place that dealt with a given situation? Or you do have a process, but it turns out that process may not be very effective?

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Well, monitoring your process will give you data to let you know there is a problem before the problem is laid down at your feet. Data can show if you are getting things right or if you need to take a step back and reevaluate some things. Data is your compass, so to speak. It will show you the way. When you have things working great and your data reflects this, it will also be displayed on Hospital Compare.

At this point, we have talked about analyzing your data, identifying your internal issues, developing a plan to improve, and you have accomplished the improvement you're looking for. Now it's important to keep your success. Let's look at some suggestions on how to do just that.

One way to stay on top of your game is to always continue to check on yourself. You can run reports on QualityNet. There are two reports, one called the Claims Detail Report and one called the Provider Participation Report. These reports allow you to monitor your success. The two offer slightly different perspectives of your performance, but both are extremely important. I don't think I can emphasize enough that you should be running these reports routinely. If something were to happen, for example, with your QDCs, you think you're submitting them and everything's hunky-dory, then one day you get an email or a phone call from us saying, "hey, you're not applying your QDCs," the better scenario is for you to catch yourself and correct it early rather than be told after the fact. Unfortunately, it may be too late for you to catch up at that point.

With regard to the QDCs, you should be looking also at your EOB and your RA codes. They will let you know if your codes are crossing over into the warehouse. Analyzing data will also assist you in keeping on track with your web-based measures as well.

Analyzing your data can gauge the progress of the measures that you report. You might want to ask yourself what makes your facility different than others. What do better performing facilities do to obtain higher performance levels? Ask yourself some of these questions. It can evaluate your weak points and improve your overall performance and attention to quality improvement. Compare your facility with others and set goals for what you want to achieve. Understanding variations will assist you in achieving these goals.

All of your hard work is displayed on Hospital Compare. The public can see this and may use this to make decisions about where they will or will not go for services. You can also use this yourself to compare your facility's performance with others. This will assist you in developing your goals and initiate quality and improvements in performance. The direct link for the Hospital Compare site for ASCs is on this slide.

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When looking at the ASCQR Program and how to improve your data, there are resources available to assist you with this. As we talked about, there are reports on the QualityNet website that will provide you with data to help keep your performance in check. Remember, we talked earlier about knowing about a problem early so that you have time to correct it. Public reporting information, which is also found on QualityNet, first as a preview report -- the preview report is available for 30 days. You will be sent notification when this report is available.

ListServes and newsletters provide updates and valuable information regarding the program. If you're not on this list, sign up right now after the presentation. It takes all of about five minutes. You can sign up from the home page of QualityNet.

The support contractors' website at qualityreportingcenter.com has an enormous amount of information to help you in the success not only for the reporting of this program, but improving quality and performance within your facility. At the end of the day, that's what it is all about.

We did just do a webinar a couple of months ago outlining resources available as they pertain to this program on our website. You can always access past webinars on qualityreportingcenter.com under the Archived Events tab.

We discussed a lot of information today. In summary, please utilize all the tools that are available to help you evaluate your own performance. Don't be afraid to compare your performance with the more successful facilities. Implement changes when there is a dip in performance and you need improvement. When you do initiate changes, make sure that you keep tabs on these changes to ensure they're heading in the right direction and continue on to the road to success.

That's all I have today. Pam, back to you.

Pam Harris: Thank you, Karen. That was great information. I think we now have time to go over some questions. Karen, I've got one here and it says: "For ASC-1 through ASC-5, did she say we must submit at least 50 percent of claims?"

Karen VanBourgondien: Okay, I can take that, Pam. Yes, I think I understand what you're asking. In order to meet the program requirements for the ASCQR Program, you must report QDCs on a minimum of 50 percent of your Medicare Fee-for-Service claims that are submitted to Medicare for payment. So – and we discussed this – on 50 percent of your Medicare Fee-for-Service, 50

percent of them have to have the QDCs applied on the claim forms, the 1500 claim form.

Karen VanBourgondien: Pam here, I have a question. "If a patient received antibiotics after the procedure, however, there was no pre-op order in place, is it still correct to report the G8918 code?"

Pam Harris: Yes, I can answer that. Yes, that's correct. If the patient did not have a pre-op order for antibiotics in place, you apply the G8918. That's great.

Okay, Karen, I've got one for you. "How does the public access the reporting information?"

Karen VanBourgondien: That's a good question. We did allude to that during the presentation. Data reported by the facility will be posted on the Hospital Compare website. This website has full access to the public, and they can see the results of all the measures that are reported. And, Pam, that's on the Hospital Compare website.

Pam Harris: Thank you, Karen. I think that's all we've got time for today. Thank you so much. We appreciate all the information that you have given us. Thanks again.

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