Inpatient Quality Reporting Program

Support Contractor

QualityNet Security Administrator: Roles and Responsibilities
eCQM Validation Pilot Project

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Question 1: Can you clarify for me. I have always had two security admins at each of my sites. My question is, can I have three if I would like to? I was not sure if you were limited to only two security admins.

Answer 1: Yes, you can have three security administrators at your facility if you wish.

Question 2: If we have been a Security Administrator, are we being asked to apply again, or is this just information for anyone who has not been a security administrator?

Answer 2: You are not being asked to register again. This was just a review/refresher of the process.

Question 3: Can a System Admin edit their own email address?

Answer 3: Yes, an SA can change their own email address. It's actually preferred that they change it themselves. When you log into *QualityNet*, you would choose the "My Account" option to modify your own settings (change password, answer security questions, etc.).

Question 4: If we already have two SAs that are active, is there anything else we need to do now?

Answer 4: No, if you have two active SAs, there's nothing additional to do.

Question 5: Can we change a regular user to an SA? How would we do that?

Answer 5: Yes, you can upgrade a Basic User to Security Administrator. Complete the *QNet* Security Admin forms and submit them to the Help Desk. The account will be updated by the Identity Management Team and the user will receive an email notification when [the change has been] completed.

Question 6: So, we would have to have the forms redone by the notary, etc.? Basically like the person is a new user?

Answer 6: Yes, that is correct.

Question 7: If we need to change SAs, we used to do that through our QIO (for us it was CFMC), and they would ensure that all went through properly. What is the address/contact info we would send to now that we no longer have CFMC?

Answer 7: Contact the *QualityNet* Help Desk.

Question 8: We already have an SA, but how do we find out who else in our facility is an SA?

Answer 8: Contact the *QualityNet* Help Desk, and an agent can look up your facility and provide that information for you.

Question 9: What is an ASC?

Answer 9: An ASC is a type of facility that is supported by the *QualityNet* help desk and the *QualityNet Secure Portal*.

Question 10: Does the Security Administrator have to log in occasionally in order to maintain Security Administrator rights?

Answer 10: Yes, you will need to log in to make sure your account does not expire due to inactivity.

Question 11: How long does it usually take to get the credentials for an SA? All my information was sent in on 12/10/14, and I have not received anything yet. What should I do at this point? I have reports that need to be done thru *QualityNet* by 2/1/15.

Answer 11: Contact the *QualityNet* help desk at 866.288.8912.

Question 12: What if someone already has an account with a previous employer? Do they use the same information or do we need to set up a new account?

Answer 12: You will need to re-register under your new provider.

Question 13: How do we know if we have already done this and who the SA is?

Answer 13: You can contact the *QualityNet* help desk and they will be able to look up your facility.

Question 14: Will *QNet* assign all of the roles for the SA for acute facilities? The slide noted to send our notarized PPW straight to *QNet*, instead of HSAG/FMQAI.

Answer 14: Yes, *QNet* will assign roles for the Admins at the facilities.

Question 15: If a hospital will not be able to attest for Stage II until after September 2015, is the hospital still eligible to participate in the program if they can demonstrate that they meet Stage II prior to the attestation deadline?

Answer 15: So, it's not about the attestation deadline, but if the hospital is able. If the hospital has all of the functionalities that we need them to have by July 1, 2015, then we would be happy to work with them.

Question 16: What types of hospital resources are required for the eCQM Pilot, and how many hours will be needed for preparation and follow up?

Answer 16: So, we have an answer to that on our Frequently Asked Questions. We expect that it will be about 16 hours total, including some time for setup. There may be some time involved in getting your hospital consent, permission to work with us, and I don't have a feel for how much time it may take an individual hospital to go through a process of reaching agreement among itself that they would like to participate, but the process with us should take 16 hours.

Question 17: Have hospitals volunteered for the eCQM Pilot? How many are participating?

Answer 17: Hospitals have volunteered and are participating. The number changes almost every day. I don't have a good number now, so sorry. We hope we'll get to a hundred, but we're, you know, we're still, we're not there yet. So, by any – all means, please volunteer.

Question 18: Are Critical Access Hospitals included in the eCQM Pilot?

Answer 18: Well, this actually was an IPPS pilot, so our focus is on IPPS hospitals.

Question 19: Where can I find feedback in regard to last year's CQM validation findings?

Answer 19: Last year's feasibility study was entirely about logistics. It answered questions such as, "How long did it take CDAC to review an EHR record?" and "What data sources were used to identify data?" We have an internal report but have no plans to publish it because we do not believe that it is of general interest.

Question 20: Does the validation only include the IQR program, or does the validation include Meaningful Use?

Answer 20: Hospitals must be able to produce QRDA Category 1 Revision 2 (April 2014 version) extracted data (individual patient date) based on April 2014 specifications for at least 6 of the 16 measures in STK, VTE, ED, and PC topic areas by July 1, 2015. These measures are used both in the IQR Program and for Meaningful Use.

Question 21: Will there be a list of participating hospitals?

Answer 21: To the extent that participating hospitals want to be acknowledged, we will acknowledge them. If they would like to remain anonymous, we will not publicize their names.

Question 22: Will the results of the validation be communicated to the measure stewards for measure improvement?

Answer 22: Yes, this is an important component of our plans.

Question 23: When do you expect the eCQM Pilot project will be completed?

Answer 23: We plan to complete data collection by September 2015. A final report should be available in early 2016.

Question 24: If you are part of a network, will your enrollment include all member hospitals or do you have to enroll individual hospitals?

Answer 24: This depends on the specifics of your situation, including hospital and network corporate policy. Each participating hospital needs to agree to participate. However, CMS would be delighted to enroll a network of hospitals and to work with contact staff at more than one hospital within that network.

Question 25: On earlier webinars about eCQM, we have initially been told there would be no validation once this became mandatory. When did this change? Thank you.

Answer 25: The policy has not changed. There is no required validation process at this time. However, CMS fully recognizes that we need a validation policy in the future, and as finalized in the FY 2015 IPPS Rule (79 FR 50269-50273).

Question 26: Not long ago *QNet* required two Administrators. What happened to the alternate Administrators? Does *QNet* still recognize them?

Answer 26: It is strongly recommended that each provider have at least two Security Administrators. All registered Security Administrators are recognized.

Question 27: How can 12 cases from 100 hospitals that volunteer represent the national situation?

Answer 27: This pilot project will test *procedures* for conducting validation of eCQM data. For example, logging in remotely to hospital systems, time spent reviewing records, etc. For this purpose, a volunteer sample of 100 hospitals is more than sufficient to evaluate the likely burden and acceptability of the processes in which we are engaged. However, a sample of volunteer hospitals is clearly not representative of all hospitals in the nation. Instead, it provides us with a general impression as to whether hospitals are able to produce accurate data for one or more measures. If most volunteer hospitals are unable to do this, the nation is probably not ready. If many hospitals within this volunteer sample are able to produce accurate data for one or more measures, this would indicate that achieving accurate reporting *is possible*. To confirm that hospitals, as a whole, are submitting accurate data, CMS will develop a more formal validation policy through future rule making.

Question 28: If a hospital opts to submit IMM as eCQM and ED as an abstracted measure, do these samples/populations need to match?

Answer 28: No, the populations and sample sizes would not need to match.

Question 29: When will [hospitals] be required to report all IQR measures electronically, 2016 or 2017?

Answer 29: At this time there has been no direction from CMS as to when the IQR measures will be required to be submitted electronically.

Question 30: Is there a date that eCQM submission is mandatory?

Answer 30: At this time there has been no direction from CMS as to when the IQR measures will be required to be submitted electronically.

Question 31: Does [the] highest level executive on the *Qnet* SA form mean CEO, or can a Chief Medical Officer or Administrative Director sign off as well?

Answer 31: It is the highest level of authority at your location. So, if your CEO is located in another site and your Medical Director is there at the facility that you are at, yes, you can have that person sign. It needs to be the highest level of authority at your facility.

Question 32: Where do we direct providers with abstraction questions?

Answer 32: Abstraction questions should be submitted through the Inpatient Q&A tool that is located on *QualityNet*.

Question 33: Do we need to have our vendor involved in order to submit data on our behalf?

Answer 33: No, you do not have to have a vendor involved.

Question 34: Does our Vendor need to be involved? They currently electronically submit our data.

Answer 34: No, the vendor does not have to be involved. The pilot project has been setup to support hospitals, but we are very interested in partnering with vendors and welcome vendor suggestions on which of their hospitals might be ready to participate. However, it would be up to the hospital itself to decide to participate.

Question 35: Is there a deadline when hospitals will be required to submit *e*measures instead of chart abstracted?

Answer 35: At this time there has been no direction from CMS as to when the IQR measures will be required to be submitted electronically.

Question 36: Can an SA reactivate or update another SA? We have multiple facilities, and the SA at one is retiring soon.

Answer 36: An SA can reset the password for another SA, as long as their account is active. If the account has become inactive, the active SA would need to submit a request to the *QualityNet* Help Desk to have the inactive SAs account reactivated. Once the ticket has been closed and the SA has been notified that the account has been activated, they should log into *QualityNet* to request a temporary password be sent for the reactivated account. At that time the other SA should be able to log back in.

Question 37: Have you had anyone sign up yet? If so, how many?

Answer 37: Hospitals have volunteered and are participating. The number changes almost every day. We hope we'll get a hundred, but we are not there yet. So, by all means, please volunteer.

Question 38: Who is recommended to be a Basic User?

Answer 38: The difference between a Security Administrator and a Basic User is that the Security Administrator, once they have their account, can create accounts for other users. Other than that, a Basic User,

depending upon which roles their Security Administrator gives them, could basically have the same roles as the Security Administrator, except that extra piece where you create and edit and maintain your user accounts.

Question 39: You mention "conflicting data" will be reported. How do you determine "conflicting data?"

Answer 39: When measure results, based on a manual abstraction of data elements from an EHR system do not agree with measure results calculated from an extracted QRDA-1 file, this represents a conflict. CMS intends to look for patterns of data elements that are more likely to differ when the manually abstracted and system extracted data do not agree.

Question 40: When will the eCQM submissions become mandatory?

Answer 40: At this time there has been no direction from CMS as to when the IQR measures will be required to be submitted electronically.

Question 41: The slides or information that she is speaking from, can we get a copy of the financial reimbursement that she spoke of?

Answer 41: Information regarding the reimbursement can be found in the "EHR Validation Pilot FAQs" located on *QualityNet*.

Question 42: I heard (unintelligible) medical record, but missed how much an hour or total number of hours will be reimbursed.

Answer 42: We will reimburse your hospital at a rate of $26 per hour for up to 16 hours of labor associated with your participation. The CDAC will request two QRDA Category 1 files from the Electronic Health Record system and digital images of the entire medical records for 12 patient records meeting specific criteria. Hospitals will be reimbursed for providing this information at $3 per medical record.

Question 43: If we use Vendor MIDAS to submit eCQM, will we still be required to submit to CMS directly?

Answer 43: Either you or the vendor would be required to submit to CMS. It is ultimately the hospital that is participating.

Question 44: If we need to change SAs, we used to do that through our QIO (for us it was CFMC), and they would ensure that all went through properly. What is the address/contact info we would send to now that we no longer have CFMC? Thank you.

Answer 44: The address that you would now send it to would be the *QualityNet* Help Desk at 1401 50th Street, Suite 200, West Des Moines, IA 50266.

Question 45: If our facility is back at square one of finding a new EHR vendor, will the eCQM project be extended into CY 2016 for testing?

Answer 45: This is a discreet project and hopefully it will just be the first of many projects that we work on together. So, if you have a strong interest in participating but you cannot at this time because you don't meet the requirements that we have, my recommendation would be to let the Clinical Data Abstraction Center know that you would be interested in participating, at some later time, in whatever it is that we are testing at that time.

Question 46: Would this participation have any impact on the individual facilities' actual IQR reporting?

Answer 46: No, as this is a pilot project, it will have no impact on the IQR reporting.

Question 47: Can the ROLE of each *QNet* user be placed beside their NAME in the report section? This would keep everyone on board with everyone's access level.

Answer 47: This application functionality does not currently exist. However, to see if a user has Security Administrator privileges, an existing SA can go to the "Edit User" page, select the user, and click on "View Selected User Summary." If the user summary shows the OARS Final Approval role, the user is a Security Administrator.

Question 48: What is the typical turnaround time for setup after the form is received by the help desk?

Answer 48: It depends on the amount of volume that the help desk is getting. Typically they are processed within 10 business days.

Question 49: When will electronic reporting be mandatory?

Answer 49: At this time there has been no direction from CMS as to when the IQR measures will be required to be submitted electronically.

Question 50: What is the turnaround time on gaining *QNet* Security Administrator access once the proper paperwork has been sent to our QIO?

Answer 50: Registration forms should no longer be sent to the QIOs. All registration forms (except for ASCs) should be sent to: *QualityNet* Help Desk, 1401 50th Street, Suite 200, West Des Moines, IA 50266. The instructions on the *QualityNet* web page are currently under review and should be updated soon. Forms are processed in the order they are received.

Forms should be sent by traceable mail. If you have not received your login credentials 10 business days from the date the forms are **received at the *QualityNet* help desk**, please contact the help desk to submit an inquiry.

Question 51: For Security Administrator access, will *QNet* assign all roles available? This used to be a function of HSAG for acute facilities.

Answer 51: Yes, all roles are assigned when creating Security Administrator accounts.

Question 52: Will this pilot take the measure logic differences into account, as well as the data element differences, i.e., data dictionary vs. data sets?

Answer 52: To calculate measure rates, CMS will use the measure logic included in the HR 7.0 measures engine for both QRDA-1 data-extracted and manually-abstracted data. Once the individual data elements are abstracted/ extracted, the same measure logic will be applied to both manually-abstracted and EHR-extracted data. Therefore, there should be no logic errors to check at the measure calculation stage.

CMS will not be able to assess what errors may have occurred in the extraction logic that resulted in the creation of an erroneous QRDA-1 file. The checking will only check to confirm that data elements in the QRDA-1 file agree with the information manually abstracted from the EHR system. This is because CMS was informed by the vendor community that the ability to obtain source information for the extract files is not easily available.

We will be able to identify situations where structured fields used to support the QRDA-1 file conflict with enhanced information available in unstructured fields. In those situations, we may be able to rule-out measure logic errors. Where differences are identified between the data elements extracted and those manually abstracted, and the reason cannot be attributed to the storage of key information in an unstructured field, this might indicate an error in measure extraction logic. By publishing common patterns of errors at the data element level, we hope to provide the hospital, vendor communities, and measure stewards with clues to how errors arose.

Question 53: I am currently the SA for the IQR for a campus but received an email stating we don't have an active SA for the OQR. Is there something I need to do differently?

Answer 53: Please contact the *QualityNet* Help Desk to have a ticket submitted. If OQR roles are available to your group, they may need to be added to your account.

Question 54: Is this different from your existing logon if you already have access to the portal?

Answer 54: No, the process that was presented during the 1/26/2015 National Provider Call was just a review for existing users.

Question 55: Does the validation only include the IQR program, or does the validation include Meaningful Use?

Answer 55: Hospitals must be able to produce QRDA Category 1 Revision 2 (April 2014 version) extracted data (individual patient data) based on April 2014 specifications for at least six of the 16 measures in STK, VTE, ED, and PC topic areas by July 1, 2015. These measures are used both in the IQR Program and for Meaningful Use.

Question 56: How will you connect remotely to provide assistance?

Answer 56: We use a software application known as Bomgar. More information about Bomgar can be found at: www.bomgar.com.

CMS security personnel have reviewed and approved the Bomgar appliance to be used for remote support sessions between the CDAC and hospital staff computer systems. This remote session would be fully supervised by a member of each hospital's staff, who could discontinue the session at any time. The administrative settings in Bomgar have allowed CMS to restrict CDAC staff access to read-only. Therefore, the medical records staff will have total control of all applications and information being displayed to the CDAC.

Question 57: Please provide the remote connection website information site … unsure of spelling.

Answer 57: For more information on Bomgar, please visit their website at www.bomgar.com.

Question 58: Can you clarify the six measure requirement? Is it six measures in total, and can they cross the different topics?

Answer 58: Hospitals must be able to produce QRDA Category 1 Revision 2 (April 2014 version) extracted data (individual patient data) based on April 2014 specifications for at least six of the 16 measures in STK, VTE, ED, and PC topic areas by July 1, 2015.

Question 59: You mentioned "conflicting data" will be reported. How do you determine conflicting data?

Answer 59: When measure results based on a manual abstraction of data elements from an EHR system do not agree with measure results calculated from

an extracted QRDA-1 file, this represents a conflict. CMS intends to look for patterns of data elements that are more likely to differ when the manually abstracted and system extracted data do not agree.

Question 60: I am very unclear about what the Validation Pilot entails. How will you assess a hospital's true system readiness?

Answer 60: CDAC will use a secure technology allowing an abstractor to view a hospital's medical records remotely, while a member of the hospital's staff navigates from screen to screen. While CDAC is viewing the hospital's computer, the hospital will be asked to:

Generate separate lists of patients eligible for measures to be validated.

Show up to 12 selected records for the measures to be validated.

Information such as laboratory records and patient medical history will be viewed while the hospital navigates through the medical record, as directed by CDAC. During this session, the CDAC will follow the specifications for the measure to abstract relevant information related to each data element from up to 10 different sources, such as medication administration records, laboratory reports, and patient hisotry, including structured and unstructured fields within each medical record. After concluding the real-time session with a hospital, CDAC will use the abstracted data to create a pseudo-QRDA Category 1 file. The "pseudo" file will contain all the information that a QRDA Category-1 file contains, and in the same format, but the information will be constructed from abstracted data (both structured and unstructured fields) instead of the extracted EHR system. The measure calculation from the two different sources for the same medical record would then be compared.

System readiness will be determined based on comparing the measure results from the EHR system produced QRDA – I file to the measure results from the file created using data manually abstracted from the EHR screens. If the measure results align, it would allow for agreement that the data elements necessary for measure calculations are being captured in the system and exported to a QRDA – I file for reporting correctly. If the measure results do not align, it would indicate a gap that would warrant further review between data elements capture to exporting of the file for reporting. The mismatches will be reported and emphasis placed on where and why those errors are occurring.

Question 61: Do we need to do all ED, VTE, STK, and PC measures to participate in the eCQM Pilot?

Answer 61: Hospitals must be able to produce QRDA Category 1 Revision 2 (April 2014 version) extracted data (individual patient data) based on April

2014 specifications for at least six of the 16 measures in STK, VTE, ED, and PC topic areas by July 1, 2015.

Question 62: What would qualify a hospital to be ready to volunteer?

Answer 62: Hospitals that volunteer to participate must be able to:

Meet Medicare EHR Incentive Program Stage 2 criteria by July 1, 2015

Produce QRDA Category 1 Revision 2 (April 2014 version) extracted data (individual patient data) based on April 2014 specifications for at least six of the 16 measures in STK, VTE, ED, and PC topic areas by July 1, 2015

Produce a list of patients eligible for each of these measures

Provide any or all of this information directly, or authorize a vendor to provide this information on its behalf. Hospitals working through a vendor will be asked to provide the name of the vendor, a point of contact, and must state in writing what information the vendor may provide on its behalf

Hospitals are also strongly encouraged to submit electronic clinical quality measure data for the voluntary option in the Hospital IQR program.

Question 63: I expect that IT Security Systems at the hospital level will have issues granting access to the EHR; or it may take an extensive time frame to have this approved …. Thoughts?

Answer 63: The CDAC facility and operational processes have been audited and reviewed by CMS security personnel. CMS is compliant with all standards within the *QualityNet* Security Manual for protecting health data. The Bomgar software, used for the eCQM Remote Validation Pilot, is installed on a secure CMS-owned system that has safeguards in place in accordance with the HIPAA Security Rule, to protect sensitive patient data. The Bomgar software is configured to transmit all information exchanged during the medical record review through CMS-owned hardware at a secure facility. All information needed to access hospital systems remotely is guarded by a strong HTTPS secure socket layer (SSL) encryption, which protects the information as it is transmitted from the hospital to the CDAC. This hardware and software, which CDAC will use to access medical records remotely, will not store any information about the medical records themselves. Only a limited number of CDAC personnel, authorized by CMS, will have access to the Bomgar device.

The process we are using is analogous to reviewing an EHR system on site with a hospital staff person watching. Our process has been reviewed and approved by Privacy and Security Officers both at CMS and at CDAC. The documentation regarding our procedures can be found at: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1140537256076. We encourage you to review it.

We understand that each individual hospital may wish to review the approach with its own security team prior to volunteering to participate and that for some hospitals this may take a few weeks or months. We are advertising now in the hope that you will be able to participate by July 1.

Question 64: How do we know if our hospital is going to participate in the eCQM pilot project (when preparations for *e*Measures are contracted out)?

Answer 64: The pilot is a voluntary project. Therefore, if your hospital does not volunteer, it cannot be a participant. A third party agent interested in participating would have to work through specific hospitals to enroll them. We are interested in reviewing the information that a hospital sees when it pulls up data from a patient medical record. We are not auditing back-end databases, except to the extent that QRDA extracts from such databases produce the same answer as the medical record viewed remotely. If a hospital does volunteer, it should be aware of its participation status.

Question 65: Where do I go to get CE credit for this webinar?

Answer 65: A survey is sent to attendees after the event. After completing the survey, attendees are sent the CE link.

END

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