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PRESENTATION  
Operator: Good morning, ladies and gentlemen, and thank you for waiting. Welcome to the Hospital Outpatient Quality Data Reporting Program educational webinar. All lines have been placed on listen-only mode. And the floor will be open for your questions and comments following the presentation. As a reminder, if you have muted your telephone, please unmute it as your line is automatically muted. 

Without further adieu, it is my pleasure to turn the floor over to your host, Mrs. Tami Gendreau. Mrs. Gendreau, the floor is yours.  

Tami Gendreau: Thank you, Brittany. Hello, everybody. Welcome, and thank you for joining us today for the February educational webinar for the HOP QDRP. My name is Tami Gendreau, and I am one of the project coordinators for the HOP QDRP Support Contractor team. And I'm located here in Tampa, Florida, at FMQAI.
Today we will present Part II of the validation results. You can access Part I via the QualityNet or our website at www.hopqdrponline.com.

Just a few quick announcements before we begin. Excuse me. The next HOP QDRP deadline for submitting Quarter 4 2010 clinical data and population and sampling is May 1st, 2011, at 11:59 p.m. Central Time. Please remember to monitor your OPPS Clinical Warehouse feedback reports and your HOP QDRP provider participation reports. These are available through your secure QualityNet accounts. These reports enable you to verify whether the data you or your vendor submitted was accepted into the OPPS Clinical Warehouse. Please remember that hospitals are responsible for ensuring that their HOP QDRP requirements are met. So please check these reports I mentioned in addition to any reports your vendors may give you at the end of the quarter.

Also, please make sure you have at least one active security administrator. Although you are required to have one, we strongly recommend that you have at least two active security administrators in the event something were to happen.

If you are not signed up for our ListServe notifications, we encourage you to do so. Please give us a call or email us. We'll provide that information on the last slide of the presentation. And we'll be happy to assist you in signing up on that notification list.

The next educational program will be the Outpatient Imaging Efficiency Measures that will be on April 20th and presented by
the Lewin Group. We will not be holding an educational presentation for the month of March, and May will be announced later on.

So please do not use the chat feature that you see on your screen. We do not monitor that area for questions. And then at the end of the program, we will send out a short program satisfaction evaluation that will come via email. So please take a moment to provide us with your valuable feedback.

Okay. For today, our speakers are going to be Ryan Fair and Marty Ball. Mr. Fair is the Director of Informatics for Health Services Advisory Group and has been with -- we call them HSAG -- since March of 2007. He is responsible for the day-to-day oversight of data management and analysis functions for the HOP QDRP Support Contractor. Marty Ball is a Project Coordinator at FMQAI. He's on the HOP QDRP Support Contractor team. Mr. Ball is a registered nurse with an extensive clinical background in emergency care. And he will be -- whoo. Excuse me. He will be presenting the second half of today's program.

So without further adieu, I would like to welcome Ryan and turn the program over to him at this point in time. Go ahead, Ryan.

Ryan Fair: All right. Thanks, Tami. Today, I'll briefly be discussing the methodology and results from the validation analysis that was performed an data submitted to the ops warehouse.
First, some brief background. For the validation process, a random sample of 7,300 cases from approximately 2,400 providers was selected from cases submitted for encounters that occurred between April and March of 2010. The hospitals selected for validation submitted medical record documentation for each sample case to the Clinical Data Extraction Center, or the CDAC. And once the CDAC completed validation activities in the fall of 2010, HSAG and FMQAI were then able to perform an analysis of the data validated by the CDAC. And the original abstracted results were compared to the CDAC's validated results for each data element.

The next slide. As was just noted, 7,300 cases were sampled for validation. And almost half of these were chosen from the AMI population, and the remaining cases were split between chest pain and the surgery populations. AMI cases were oversampled because there was a smaller percentage of AMI cases that met denominator criteria as compared to the chest pain and surgery measures. So therefore, a higher sample was needed in order to obtain an adequate number in the denominator for future evaluations.

So this slide shows the distribution of cases by provider that were selected for validation. So what we can see from this slide is that over half of the providers included in the validation had just one or two cases selected for validation. So there was minimal burden on each provider for this first iteration of validation. We can see that only six providers had to submit 15 or more cases to the CDAC.
So this slide presents some provider characteristics or demographics for those providers who were randomly chosen. So whenever a random sample is chosen, one important thing is to ensure that the chosen sample is representative of the entire population. And based on prior analyses of the provider characteristics, we know that the validation sample is consistent with the provider characteristics of the provider population as a whole. For example, 90% of the hospitals are using a vendor, 67% are located in urban settings, and approximately 60% of the hospitals included in the validation have bedsides -- or have less than 200 beds.

So for the validation analysis, the CDAC evaluated each data element using the clinical documentation or medical records submitted for each case selected in the sample. In the analysis of the data, the original abstracted results were compared to the CDAC's validated results for each data element. So out of the 7,300 cases, there was a total of 62,808 elements used in the validation scoring. The original abstractor and CDAC found different results or came to different results for only 4,700 of those data elements. So what this means is approximately 93% of the data elements were considered a match.

So many of the following slides present a point estimate or a validation score which is simply the percent agreement between the original abstraction and the CDAC validation as well as the upper bound of a confidence interval. So since the actual validation score is based on a sample of all the cases, a
confidence interval is calculated to address potential sampling variations. And a confidence interval is the range around a statistic, in this case, our validation score, obtained from a sample within which the actual value for the population is likely to fall. So for all the validation scores we'll subsequently present, the upper bound of a one-tailed 95% confidence interval is applied.

So next we'll discuss some of the validation scores by measurement, and we also present the upper confidence interval bound for each measure. For each measure population, we present a large end and a small end. The large end simply represents the number of cases submitted to the warehouse, and the small end represents the number of cases randomly chosen for validation. And you'll see that the small ends match a previous slide that selected the number of cases from each measure population used for validation.

So for AMI, the highest score for the AMI we measured was OP-4, aspirin arrival, where -- the validation score of 96.4%. So this means that the CDAC and original abstraction agreed on 96.4% of the measures -- for the measure. The lowest score for OP-3, was median time to transfer. The validation score for this was 72.2%, and the upper bound was 73.4%. So a little variation between the actual validation score and the upper bounds. When we look at it by measures, there's a large number of cases selected for validation.

Next slide. Thanks. So this slide presents the same scores for chest pain and surgical measures. The total number of chest pain
cases for Quarter 2 through 2009 through Quarter 1 of 2010 was 109,000. And the number of chest pain cases selected for validation was 1,887. The total number of surgical cases for the same time period was 597,340. And the number of surgical cases selected for validation was 1,888. For chest pain, the measure with the lowest score was OP-5, median time to ECG with a 68.3% validation score and a 70% upper bound score. And both surgical measures had validation scores above 93% and upper bound scores above 94%.

Next slide. Thank you. So as was discussed earlier, most providers just submitted one or two cases to the CDAC. When such a small sample is used, the validation and the confidence interval scores for the providers will likely have a large variation and little reliability. So this means that there is often a large gap between the two values, the validation score and the confidence interval.

And because there were so few cases for most providers, what we wanted to do is we created pseudo providers or provider classes by grouping cases based on similar provider characteristics using urban and rural status and CMS regions. We then looked at the validation scores using those provider classes to approximate the performance of hospitals in future years when the sample size will be higher for each chosen provider. So for future validation years, providers could have approximately up to 48 cases. So the overall rate was calculated for each class represented the aggregate of individual case rates.
So the next two slides will present some basic information on those -- on those pseudo providers. So there were 182 pseudo providers created. And the average number of cases per pseudo provider was 40. And the average number of providers per class was 13. So we didn't want a single provider class to contain more than 40 cases. So therefore, classes with more than 40 cases were broken out into multiple pseudo providers.

So again, what we're trying to do here is just approximate. Once providers are going to submit more cases than just one or two, we wanted to see what the impact that would have on the validation scores. And here are some validation results on those provider classes. Next slide, please. So the score for pseudo providers ranged from 70.7% to 96.4%. The average score was 86.1%. And what's important to note is that there was only one provider that fell below the 75% threshold validation score.

So this slide simply presents a graphical representation of the distribution of scores that were present on the pseudo providers. So here again we can see that only one provider, one pseudo provider, fell under the 75% threshold, while all other pseudo providers had greater than or equal to a 75% validation score.

So on the next slide, what we have done here is, once we've applied the upper bound of the confidence interval, we can see that no pseudo provider would fall under the 75% threshold. So
there's only six providers who even had a validation score between 80 and 89.9%.

Next we'll briefly discuss the most commonly mismatched data elements by measure. So these are the data elements that the abstractor, the original abstractor, and the CDAC reviewer most commonly disagreed on for each measure. So knowing the data elements that have the highest percent disagreement between the original abstractor and the CDAC is important because it can help providers and/or vendors focus on documentation and abstraction activities.

For the AMI measures, we found that of the 224 cases that failed OP-1, 44% were due to a mismatch on arrival time. For OP-2, initial ECG interpretation was the most mismatched data element as well as for OP-3. And OP-4, the most mismatched data element was aspirin received. And for OP-5, it was ECG date and time. So we do the same thing for chest pain as well. So for chest pain, the most mismatched data element for OP-4 was probable cardiac chest pain. And for OP-5, it was ECG date and time. And finally, for surgeries, the most mismatched data element for OP-6 was antibiotic timing. And for OP-7, it was antibiotic name.

So in summary -- this is the key takeaway. We presented lots of metrics here. The key takeaway from this presentation is that little to no providers should have an issue with meeting the 75% threshold for purposes of APU in the future. So with that, now I'll turn the presentation over to Marty for Part II.
Marty Ball: Thank you, Ryan. Hello. My name is Marty Ball. I'm a Project Coordinator at Hospital Outpatient Quality Data Reporting Program Support Contract. Today I will be presenting Hospital Outpatient Data Validation Part II. Topics that I will be covering today include validation, the new mock case detail report and the educational review process.

The hospital selected for validation can be found on the QualityNet website under the "HOP QDRP" dropdown. If selected, you will have received an initial letter from the CDAC, and you would have received a second letter if your records were not sent -- were not received by CDAC by the deadline. There will be no hospitals added to the validation list if any hospitals drop off because they chose to withdraw from the program. The list was final with its inception.

The data obtained from validation previously presented by Ryan was used for educational purposes and to provide the hospitals with experience with validation prior to validation results being used in payment determination. The validation results are not used for Hospital Compare website. 800 hospitals have been selected for this validation. 12 records will be selected for the validation process, and that is if the hospital has 12 cases. This should total approximately 9,600 charts per quarter for validation.

The mock case detail report, and the letters are used in reference to measure category assignments are calculated measure results used to summarize the outcome for the record that is processed.
through a specific measurement algorithm as in the specification manual. The letters B, E, X, Y and D are referred to as "buckets."

This is the new mock case detail report. This is presented as a handout in the material that you can download. Areas that are highlighted are changes from the last case detail report. And some of the notable changes are, they've added the display for the numerator and denominator to the overall measure outcome reliability rate, added the display for the numerator and denominator to the individual case measure outcome reliability rate. They've added the word "minutes" to the display of continuous variable measure outcomes and added the description of the buckets assignments to the original and validated outcome columns, such as B is not in the measure, E is in the measure population.

Continued variable measures will display minutes and bucket assignments descriptions. Scoring of continuous variable measures will require minutes and bucket assignments in the match rate, and add a column to display match or mismatch descriptions. Mismatches will be displayed in red text, and matches will be displayed in black text.

Okay. This slide represents a snapshot for the specification manual displaying the various buckets. In this example of OP-3, median time to transfer to another facility for acute coronary intervention, it's a continuous variable statement, time and minutes from emergency department arrival to the transfer to another facility.
So when answering the question, was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention, if reasons one, there was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention, or, two, there was documentation that the patient was admitted to observation status prior to transfer, the measure falls into the D-2 bucket, all patients that meet reasons one and two.

For this internal quality control called OP-3C, quality improvement rate, this should mean there are going to be limited exclusions for not receiving fibrinolytic therapy. This would be something your hospital would want to investigate if you have a lot of contraindications and cardiogenic shock.

If the reason for not administering fibrinolytic therapy was there was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention or the specific reason for transfer was unable to be determined from the medical record documentation, then the measure falls to the D bucket, OP-3B, the reporting rate. This rate reports on Hospital Compare.

The educational review process, 800 hospitals are randomly selected for validation. All selected hospitals are welcome to submit charts to the HOP QDRP for educational review if there is a CDAC mismatch. The charts sent in for review must be identical
to the charts requested by and sent to CDAC. Upon the case
detailed report, hospitals have 30 days to return the charts to HOP QDRP for an educational review. The review will be done, and the hospital is to be notified of the results. With the educational review, there will be no changes in the results in the warehouse, meaning that if HOP QDRP’s decision differs from CDAC, no changes will take place in the warehouse.

If the hospital loses APU payment at the end of four quarters because they fail validation, they will have an opportunity to apply for reconsideration and will then review -- we will then review the mismatches, and you will need to complete the form found on QualityNet under "Reconsideration."

Thank you very much. And I'm going to turn it back to Tami.

Tami Gendreau: Hi. Thank you, Marty and Ryan. Great explanations of the data and the processes. What we're going to do is open the line for questioning. But I just want to -- just want to say that we do have to limit our time to the top of the hour. However, if you don't have the opportunity to ask a question, you may email the HOP QDRP Support Contractor via the QualityNet home page. And that information is on the slide that you see up there now. Or you can give us a call at the 1-866 number listed up there.

Operator, we can go ahead and begin taking questions from our participants on the line.
Hospital Outpatient Quality Data Reporting Program

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This material was prepared by FMQAI, the Support Center for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). FL-9SOW-2011S1T11-2-12144