Summary of Findings for DSRIP Category 3

Prepared by Myers and Stauffer LC

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Summary of Findings for IT-1.7: Controlling High Blood Pressure

Prepared by Myers and Stauffer LC

9/17/2015

1) **Incorrect Age Limitations:**
    a. Calculating patient age as of the date of encounter or the reporting date instead of the end of the measurement period.
    b. Rounding up when calculating the age which causes patients to be included before they are actually 18 years of age.
    c. Not using the compendium's age requirements of patients 18-85 in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
    a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
    b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
    c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
    d. Supporting data contains clerical errors which allows for patients to be counted more than once.

3) **Incorrectly Reporting Patient Eligibility for Numerator:**
    a. Including patients whose blood pressure readings are equal to 140/90mm Hg.
    b. Including patients whose blood pressure reading was done after the end of the measurement period.
    c. Including patients when only one of their diastolic or systolic BP readings meets the criteria of being less than 140/90mm Hg..
    d. Including blood pressure results of each test the patient had instead of the results of the most recent testing during the measurement period for each patient.
    e. Counting patients whose most recent blood pressure reading and date of diagnosis are on the same date.
    f. Including patients in the numerator that are not included in the denominator.
    g. Stating that the patients met the numerator criteria without providing blood pressure results and test dates.

4) **Support Missing Patient Diagnosis Codes:**
    a. Not providing diagnosis codes in the support to define what type of HTN patients were diagnosed with.

b. Not providing the date of diagnosis for HTN, high blood pressure, elevated blood pressure, borderline HTN, Intermittent HTN, history of HTN, hypertensive vascular disease, hyperpiesia, or hyperpiesis.
c. Not demonstrating that the exclusions for the denominator (end-stage renal disease, pregnancy, non-acute inpatient setting) were not included in the denominator due to lack of diagnosis codes in the supporting documents.

5) Incorrect Calculations and Data Manipulation:

a. Manually manipulating data for analysis which caused errors in the data when reported for the baseline.
b. Age calculation for the patient did not align with the patient's date of birth as provided in the supporting documentation.

6) Exclusions and Inclusions Incorrectly Applied:

a. Not reporting at least one outpatient encounter date that falls within the measurement period.
b. Not clearly reporting that patients included in the denominator had an encounter with a diagnosis of HTN during the first 6 months of the measurement period.
c. Not including dates of diagnosis for patients who had an encounter in the prior twelve months of the measurement period.
d. Providing a list of patients who were excluded without provided diagnosis codes, dates or clinical judgments to demonstrate why they were excluded.

7) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

8) Data Management and Record Retention:

a. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a "live" data system.
b. Provider's report using terminology that is not easily recognizable and not including a list of definitions.
c. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
d. Provider should support all HHSC subset approvals with supporting documentation.

Summary of Findings for IT-1.10: Diabetes Care: HbA1c Poor Control (> 9.0%)

Prepared by Myers and Stauffer LC
09/29/2015

1) **Incorrect Age Limitations:**
   a. Calculating patient age as of the date of encounter or the reporting date instead of the end of the measurement period.
   b. Not using the compendium's age requirements of patients 18-75 in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
   a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
   b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
   c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
   d. Supporting documentation contains clerical errors which allows patients to be counted more than once.

3) **Support Missing Patient Diagnosis Codes:**
   a. Not providing diagnosis codes in the support to define what type of diabetes patients were diagnosed with.
   b. Not demonstrating that the exclusions for the denominator (polycystic ovaries, etc.) were not included in the denominator due to lack of diagnosis codes in the supporting documents.

4) **Incorrect Calculations and Data Manipulation:**
   a. Manually manipulating data for analysis, such as the use of VLOOKUP formulas or Pivot Tables, caused errors in the data when reported for the baseline.
   b. Age calculation for the patient did not align with the patient's date of birth as provided in the supporting documentation.

5) **Incorrectly Reporting Patient Eligibility for Baseline:**
   a. Not counting patients who lack an HbA1c test during the period as a part of the numerator.

b. Patients were being included/ excluded based on HbA1c test results that were from outside of the baseline measurement period.
c. Counting the HbA1c results of each test instead of the results of the most recent testing during the measurement period for each patient.
d. Including patients in the numerator that are not included in the denominator.
e. Excluding patients from the numerator due to technical error in reporting date (i.e. 7/4/214 instead of 7/4/2014) that should have been included.
f. Supporting documentation not including date of HbA1c test results and/or encounter dates.
g. Supporting documentation not specifying if encounter date relates to date of diabetes diagnosis or date of HbA1c test result.
h. Including patients in the numerator who have an HbA1c of >9% or a missing HbA1c test result for the baseline measurement period. All patients with HbA1c equal to 9% should be excluded from the numerator.
i. Not providing a detailed description of the provider's use of clinical judgment in excluding patients from the baseline for reasons other than those outlined in the compendium.
j. Apply non-approved subsets including payor types and educational classes which did not have prior approval from HHSC.

6) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

7) Data Management and Record Retention:

a. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a “live” data system.
b. Provider’s report using terminology that is not easily recognizable and not including a list of definitions.
c. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
d. Provider should support all HHSC subset approvals with supporting documentation.

8) Misinterpretation of the Compendium:

a. Including only patients with encounters in the year prior to the measurement year in their denominator but had patients with test results in the measurement period as their numerator. HHSC clarified the compendium which states, “Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2)

during the measurement year <u>or the year prior to the measurement year.</u>" HHSC stated that the provider could choose an inclusion of the year prior as well as the baseline measurement year, not solely the use of the year prior by itself.

Summary of Findings for IT-1.11: Diabetes Care: BP Control (< 140/90mm Hg)

Prepared by Myers and Stauffer LC
09/29/2015

1) **Incorrect Age Limitations:**
    a. Calculating patient age as of the date of encounter or the reporting date instead of the end of the measurement period.
    b. Rounding up when calculating the age which causes patients to be included or excluded before they are actually 18 years of age.
    c. Not using the compendium's age requirements of patients 18-75 in order to determine a patient's eligibility for the baseline

2) **Duplicate Patients Counted Towards Baseline:**
    a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
    b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
    c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
    d. Supporting documentation contains clerical errors which allow patients to be counted more than once.

3) **Incorrectly Reporting Patient Eligibility for Numerator:**
    a. Including patients whose blood pressure readings are equal to 140/90mm Hg, not less than 140/90mm Hg.
    b. Including patients whose blood pressure reading was done after the end of the measurement period.
    c. Including patients when only one, not both, of their diastolic or systolic BP readings meets the criteria.
    d. Including blood pressure results of each test instead of the results of the most recent testing during the measurement period for each patient.
    e. Including patients in the numerator that are not included in the denominator.
    f. Reporting the numerator by grouping them by clinic or healthcare professional instead of individually.
    g. Stating that the patients met the numerator criteria without providing blood pressure results and test dates.

4) **Support Missing Patient Diagnosis Codes:**
    a. Not providing diagnosis codes in the support to define what type of diabetes patients were diagnosed with.

b. Stating that all included are diabetic without any diagnosis codes to support the claim.
c. Not demonstrating that the exclusions for the denominator (polycystic ovaries, etc.) were not included in the denominator due to lack of diagnosis codes in the supporting documents.

5) Incorrect Calculations and Data Manipulation:

a. Manually manipulating data for analysis, such as the use of VLOOKUP formulas or Pivot Tables, caused errors in the data when reported for the baseline.
b. Age calculation for the patient did not align with the patient's date of birth as provided in the supporting documentation.

6) Exclusions and Inclusions Incorrectly Applied:

a. Not reporting at least one outpatient encounter date that falls within the measurement period.
b. Excluding patients who had a type 1 or 2 diabetes diagnosis as well as polycystic ovaries, gestational diabetes or steroid induced diabetes.
c. Providing a list of patients who were excluded without provided diagnosis codes, dates or clinical judgments as to demonstrate why they were excluded.

7) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

8) Data Management and Record Retention:

a. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a "live" data system.
b. Provider's report using terminology that is not easily recognizable and not including a list of definitions.
c. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
d. Provider should support all HHSC subset approvals with supporting documentation.

Summary of Findings for IT-1.13: Diabetes Care: Foot Exam

Prepared by Myers and Stauffer LC

09/29/2015

1) **Incorrect Age Limitations:**
   a. Calculating patient age as of the date of encounter or the reporting date instead of the end of the measurement period.
   b. Not using the compendium's age requirements of patients 18-75 in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
   a. Not excluding all duplicate patients from the denominator.
   b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
   c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
   d. Supporting documentation contains clerical errors which allows patients to be counted more than once.

3) **Incorrect Calculations and Data Manipulation:**
   a. Manually manipulating data for analysis, such as the use of VLOOKUP formulas or Pivot Tables, caused errors in the data when reported for the baseline.
   b. Age calculation for the patient did not align with the patient's date of birth as provided in the supporting documentation.

4) **Incorrectly Reporting Patient Eligibility for Baseline:**
   a. Including patients who had the foot exam outside the baseline measurement year.
   b. Listing patients excluded from the numerator and denominator that were still included in the numerator and denominator patient list.

5) **Support Missing Patient Diagnosis Codes:**
   a. Not providing diagnosis codes in the support to define what type of diabetes patients were diagnosed with.
   b. Labeling patients as "Criteria Met" instead of providing the information necessary in order to verify that the criteria was actually met for each patient.
   c. Not demonstrating that the exclusions for the denominator (polycystic ovaries, etc.) were not included in the denominator due to lack of diagnosis codes in the supporting documents.

6) Misinterpretation of the Compendium:

a. Including only a partial amount of patients with encounters from the prior year with their reporting of the patients with encounters during the measurement year. HHSC clarified the compendium which states, "Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year." HHSC stated that the provider could choose an inclusion of the year prior as well as the baseline measurement year, not solely the use of the year prior by itself. However, it is not clear if a partial inclusion of the prior year is acceptable.

7) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

8) Data Management and Record Retention:

e. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a "live" data system.
f. Provider's report using terminology that is not easily recognizable and not including a list of definitions.
g. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
h. Provider should support all HHSC subset approvals with supporting documentation.

Summary of Findings for IT-1.18: Follow – Up after Hospitalization for Mental Illness

Prepared by Myers and Stauffer LC

9/17/15

1) **Incorrect Age Limitations:**
   a. Calculating patient age as of the date of encounter or the reporting date instead of the date of discharge.
   b. Not using the compendium's age requirements of patients 6 years and older in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
   a. Not excluding all duplicate patients from the denominator.
   b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
   c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
   d. Supporting data contains clerical errors which allows for patients to be counted more than once.

3) **Incorrectly Reporting Patient Eligibility for Baseline:**
   a. Not excluding both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first eleven months of the measurement year.
   b. Not excluding patients that were readmitted within 30 days after discharge.
   c. Not ensuring that there are incorrect or misleading admission or discharge dates listed in support, such as a readmission taking place before the discharge date or a follow-up date taking place during a time when the patient had been readmitted.
   d. Not including dates of birth for all patients included in the baseline to verify ages are within the appropriate limitations.
   e. Not indicating if patients were readmitted during the baseline measurement period.

4) **Support Missing Patient Diagnosis Codes:**
   a. Not providing diagnosis codes to support reason patients are excluded from baseline.
   b. Not demonstrating a principal diagnosis of mental health.
   c. Not indicating if the patient was discharged alive.

5) **Misinterpretation of the Compendium:**
   a. Including patients with a readmission/direct transfer in the first eleven months of the measurement year and patients that were readmitted within 30 days after discharge as discussed in the exclusion criteria in the compendium."

6) Data Management and Record Retention:

e. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a “live” data system.
f. Provider’s report using terminology that is not easily recognizable and not including a list of definitions.
g. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
h. Provider should support all HHSC subset approvals with supporting documentation.

Summary of Findings for IT-1.21: Adult Body Mass Index (BMI) Assessment

Prepared by Myers and Stauffer LC

09/29/2015

1) **Incorrect Age Limitations:**
    a. Not using the compendium's age requirements of patient's age being 18 years old as of the first day of the 12 month period prior to the measurement period to 74 years old as of the last day of the measurement period for eligibility in the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
    a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
    b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
    c. Counting the number of encounters instead of the number of patients towards the baseline calculation.

3) **Incorrectly Reporting Patient Eligibility for Baseline:**
    a. Including patients in the numerator that are not included in the denominator.
    b. Excluding patients from the numerator due to technical error in reporting date (i.e. 7/4/214 instead of 7/4/2014) that should have been included.
    c. Not demonstrating that patients had at least 1 encounter in the prior 12 month period prior to the measurement year.
    d. Numerator and denominator totals should count the number of patients and not the number of encounters.
    e. Not providing a detailed description of the provider's use of clinical judgment in excluding patients from the baseline for reasons other than those outlined in the compendium.
    f. Supporting documentation should include all data elements to show proper inclusion in the baseline. Example: Date of encounter, patient date of birth, patient name, and unique patient identifier.

4) **Support Missing Patient Diagnosis Codes:**
    a. Not demonstrating that the exclusions for the denominator were not included in the denominator due to lack of diagnosis codes in the baseline support.

5) **Incorrect Calculations and Data Manipulation:**
    a. Manually manipulating data for analysis, such as the use of VLOOKUP formulas or Pivot Tables, caused errors in the data when reported for the baseline.

b. Age calculation for the patient did not align with the patient’s date of birth as provided in the supporting documentation.

6) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

7) Data Management and Record Retention:

i. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a “live” data system.
j. Provider’s report using terminology that is not easily recognizable and not including a list of definitions.
k. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
l. Provider should support all HHSC subset approvals with supporting documentation.

Summary of Findings for IT-3.22 Risk-Adjusted All-Cause Readmissions Rate

Prepared by Myers and Stauffer LC

7/22/2015

1) **Measurement Periods:**
   a. All providers are using a defined 12 month measurement period to measure both index admission discharges and readmissions. This does not allow for a 30 day measurement of subsequent readmissions within the baseline measurement period. As a result, providers may have included a readmission without a corresponding index admission.

      MSLC Recommendation: When developing a corrective action plan, MSLC will advise providers to start the measurement of index admission discharges 30 days prior to the beginning of the baseline measurement period.

   b. Providers end the measurement of index admission discharges in the final month of the baseline measurement period. This has resulted in either a) providers including readmissions that occur in the month following the end of the baseline period or b) providers including index admission discharges in the count of total discharges but not allowing for a 30 day count of readmissions based on these index admissions.

      MSLC Recommendation: When developing a corrective action plan, MSLC will advise providers to end the measurement of index admission discharges 30 days prior to the end of the baseline measurement period to allow for a 30 day count of readmissions.

2) **Count of Index Admission Discharges and Readmissions:**
   a. See attached worksheet for summary of the count of index admissions by provider. For providers that include readmissions as eligible index admissions, the result has been index admission discharges counted in the final month of measurement that are not allowed the 30 day span to count a subsequent readmission.

   b. The criteria applied to a qualifying index admission do not necessarily apply to a readmission. For example, patients with a discharge status of EXPIRED are excluded as an index admission. However, a readmission with a status of expired is still a valid readmission, regardless of the resulting discharge.

      MSLC Recommendation: When developing a corrective action plan, MSLC will advise providers to exclude readmissions in the count of index admissions.

   c. See attached sheet for summary of readmission counts by provider. Providers vary in terms of the method used to count readmissions. Some providers are totaling the number of readmissions, regardless if more than one readmission occurs within an index admission chain. Other providers are only counting one readmission per index admission chain.

d. HHSC clarified that the numerator should be calculated by identifying the number of index admission discharges that result in a readmission within 30 days and that multiple readmissions should be assigned a value of “1”.

    MSLC Recommendation: When developing a corrective action plan, MSLC will advise providers to calculate the number of index admissions that resulted in a readmission within 30 days, regardless of the actual number of readmissions within 30 days of an index admission. As a result, providers will need to recalculate normative values or reassign PPR norms based on the revised list of index admissions.

3) Exclusions and Inclusions of the following vary among providers:

a. Inclusion of newborns and patients under 18 years of age, patients who left against medical advice, and expired patients in the list of index admissions.
b. Readmissions related to surgery, pregnancy, and rehabilitation.
c. “Planned” vs. unplanned readmissions and/or substance abuse /psychiatric treatment.
d. Same-day readmissions (may be included or excluded based on readmission diagnosis)

    MSLC Recommendation: When developing a corrective action plan, MSLC will advise providers to include all patients in the list of index admissions except for patients who expired while in the hospital, were transferred to a higher level of care, or left AMA. Readmissions within 30 days should also be excluded. Providers including additional exclusionary criteria outside of the global criteria should maintain a written methodology.

4) Data Management and Record Retention:

a. Some providers do not have an effective way to count index admissions and readmissions. The template developed by HHSC to assist a provider in the identification of the counts does not account for length of stay. As a result, readmissions were included in an identified chain that occurred outside the 30 day span of the index admission and therefore subsequent readmissions were not properly identified.
b. If using a query, providers need to ensure that index admission and readmissions are identified based on the relevant date (discharge date for index admission and admission date for readmission).

    MSLC Recommendation: If HHSC agrees to MSLC’s proposed criteria and as long as the provider can identify all admissions, a simple Macro in Visual Basic can be developed that would identify index admission discharges and readmission chains. Parkland Hospital has also developed a formula that can be used to identify readmissions chains based on the corresponding index admission discharge date.

c. When requesting baseline data, not all providers submitted the data related to the calculation and risk-adjusted value of each index admission, including all source data (historical index admissions and identified readmission chains, Texas Medical PPR norms and case-mix factors, HEDIS table coefficients, etc.).

d. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a “live” data system.

   MSLC Recommendation: When developing a corrective action plan, MSLC will advise providers that all data used to support baselines and performance should be run and archived as of the date of reporting.

Summary of Findings for IT-10.1.a.iv: Assessment of Quality of Life (AQoL-8D)

Prepared by Myers and Stauffer LC
09/29/2015

1) **Incorrect Age Limitations:**
    a. Support should include DOB to determine if all patients were at least 16 years old when the survey was administered.

2) **Incorrect Calculations:**
    a. Age calculation for the patient did not align with the patient's date of birth as provided in the supporting documentation.

3) **Incorrectly Reporting Patient Eligibility for Baseline:**
    a. Not including formulas to show how the survey score was calculated.
    b. Not including individual question test answers to determine how 0-4 scale was applied to report total quality of life score.
    c. Not including category description of questions to ensure all questions were assigned the same scores and no weighted averages were used in totals.
    d. Not including survey date to verify if all surveys were administered during measurement year.
    e. Provider's description of the survey administration methodology and the survey data provided not clearly indicating the methodology used is in line with the description of metric 10.1.a.iv as noted in the compendium.
    f. Rounding the mean score used in the calculation of the score boundary.
    g. Not including detailed description of the methodology used to administer surveys to demonstrate compliance with survey instructions.

4) **Unknown Discrepancies in Reporting:**
    a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
    b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

5) **Data Management and Record Retention:**
    a. Provider should support all HHSC subset approvals with supporting documentation.

Summary of Findings for IT-10.1.a.v: Pediatric Quality of Life (PedsQL)

Prepared by Myers and Stauffer LC
09/29/2015

6) Incorrect Age Limitations:

a. Support should include DOB to determine if all patients were under the age of 18 years old when the survey was administered.

7) Incorrect Calculations:

a. Age calculation for the patient did not align with the patient's date of birth as provided in the supporting documentation.

8) Incorrectly Reporting Patient Eligibility for Baseline:

a. Not including formulas to show how the survey score was calculated.
b. Not including individual question test answers to determine how 0-4 scale was applied to report total quality of life score.
c. Not including category description of questions to ensure all questions were assigned the same scores and no weighted averages were used in totals.
d. Not including survey date to verify if all surveys were administered during measurement year.
e. Provider's description of the survey administration methodology and the survey data provided not clearly indicating that the methodology used is in line with the description of metric 10.1.a.v as noted in the compendium.
f. Rounding the mean score used in the calculation of the score boundary.
g. Not including detailed description of the methodology used to administer surveys to demonstrate compliance with survey instructions.

9) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

10) Data Management and Record Retention:

a. Provider should support all HHSC subset approvals with supporting documentation.

Summary of Findings for IT-11.25: Daily Living Activities

Prepared by Myers and Stauffer LC

09/24/2015

1) **Incorrectly Reporting Patient Eligibility for Baseline:**
    a. Not providing the patient date of birth in order to verify that the patient was within the appropriate age range for the administration of the survey.

2) **Support Missing Survey Scores:**
    a. Not providing the calculations used make the scoring determination for the numerator.
    b. Including surveys in the denominator which do not have all questions answered.
    c. Indicating that some patients have "interim" surveys but do not have a clear pre-test and post-test identified.

3) **Incorrect Calculations and Data Manipulation:**
    a. Manually manipulating data for analysis, such as the use of Excel Spreadsheets, or manually calculating data in surveys which caused errors in the data when reported for the baseline.

4) **Duplicate Patients Counted Towards the Baseline:**
    a. Supporting data contains clerical errors which allow patients to be counted more than once.

5) **Misinterpretation of the Compendium:**
    a. Provider reports including the additional questions triggered by the main survey questions in their calculation of dimension scores to be used in the calculation of the numerator. HHSC clarified that these additional questions should not be included in the calculation of each dimension score.

Summary of Findings for IT-11.26c: Adults Needs and Strengths Assessment

Prepared by Myers and Stauffer LC
09/18/2015

1) **Incorrectly Reporting Patient Eligibility for Baseline:**
    a. Including surveys administered outside of the baseline period.
    b. Not including all eligible patients in the baseline.
    c. Not clearly stating the date that the survey was administered.
    d. Not indicating whether a different version of the survey is being used than what is noted in the compendium.
    e. Including the discharge date and referral date instead of the test date.

2) **Support Missing Survey Scores:**
    a. Not providing all raw survey scores and calculations used to determine overall scores.
    b. Not including data from all clinics or requesting the use of a facility subset.

3) **Incorrect Calculations and Data Manipulation:**
    a. Manually manipulating data for analysis, such as the use of VLOOKUP formulas or Pivot Tables, caused errors in the data when reported for the baseline.

4) **Duplicate Patients Counted Towards the Baseline:**
    a. Review of data for any clerical errors prior to submission that allows for patients to be counted twice.

5) **Misinterpretation of the Compendium:**
    a. Provider reports including the additional questions triggered by the main survey questions in their calculation of dimension scores to be used in the calculation of the numerator. HHSC clarified that these additional questions should not be included in the calculation of each dimension score.

Summary of Findings for IT-11.26.e.iv: Patient Health Questionnaire

Prepared by Myers and Stauffer LC

09/21/2015

1) **Incorrectly Reporting Patient Eligibility for Baseline:**
   a. Including surveys administered outside of the baseline period.
   b. Not including all eligible patients in the baseline.
   c. Not clearly stating the date that the survey was administered.
   d. Not indicating if a different version of the survey is being used than is noted in the compendium.
   e. Including the discharge date and referral date instead of the test date.

2) **Support Missing Survey Scores:**
   a. Not providing all raw survey scores and calculations used to determine overall scores.
   b. Not including data from all clinics or requesting the use of a facility subset.

3) **Incorrect Calculations and Data Manipulation:**
   a. Manually manipulating data for analysis, such as the use of excel formulas, caused errors in the data when reported for the baseline.
   b. Incorrectly calculating the total survey scores by hand.

4) **Duplicate Patients Counted Towards the Baseline:**
   a. Data included clerical errors prior to submission that allowed for patients to be counted twice.
   b. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.

5) **Misinterpretation of the Compendium:**
   a. Provider reports including the additional non-numbered question in the calculation of overall scores to be included in the numerator. The PHQ-9 survey instructions clarified that these additional questions should not be included in the calculation of each patient score.

Summary of Findings for IT-12.1: Breast Cancer Screening

Prepared by Myers and Stauffer LC

09/29/2015

1) **Incorrect Age Limitations:**
    a. Not using the compendium's age requirements of patients 50-74 in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
    a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
    b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
    c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
    d. Not including patients name and date of birth to allow for unique patient identifiers.

3) **Support Missing Patient Diagnosis Codes:**
    a. Not demonstrating that the exclusions for the denominator (bilateral mastectomy) were not included in the denominator due to lack of diagnosis codes in the supporting documents.

4) **Incorrectly Reporting Patient Eligibility for Numerator:**
    a. Including patients in the numerator that are not included in the denominator.
    b. Not including date of last mammogram to determine if test was done in the measurement year or 18 months prior.

5) **Incorrectly Reporting Patient Eligibility for Denominator:**
    a. Not including date of encounter to verify if patient was seen in the prior 12 month period.
    b. Reporting patient's age but not including DOB to verify calculation of age.

6) **Misinterpretation of the Compendium:**
    a. Including only a partial amount of patients with mammogram tests from the prior 18 months with their reporting of the patients with mammogram tests during the measurement year. HHSC clarified the compendium which states, "Women who had

mammogram during the measurement year or the 18 months prior to the measurement year."

7) Data Management and Record Retention:

e. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a "live" data system.
f. Provider's report using terminology that is not easily recognizable and not including a list of definitions.
g. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
h. Provider should support all HHSC subset approvals with supporting documentation.

8) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

Summary of Findings for IT-12.2: Cervical Cancer Screening

Prepared by Myers and Stauffer LC
09/29/2015

1) **Incorrect Age Limitations:**
    a. Not using the compendium's age requirements of patients 24-64 in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
    a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
    b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
    c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
    d. Not including patients name and date of birth to allow for unique patient identifiers.

3) **Support Missing Patient Diagnosis Codes:**
    a. Not demonstrating that the exclusions for the denominator (hysterectomy with no residual cervix any time during the medical history) were not included in the denominator due to lack of diagnosis codes in the supporting documents.
    b. Support should include codes from Table CCS-A to demonstrate what cervical cancer screening was performed.

4) **Incorrectly Reporting Patient Eligibility for Numerator:**
    a. Including patients in the numerator that are not included in the denominator.
    b. Not including which cervical cancer screening method (Pap or Pap+ HPV) has been done for each patient.
    c. Including in the numerator patients who did not had cervical cancer testing performed during the baseline measurement period

5) **Incorrectly Reporting Patient Eligibility for Denominator:**
    a. Not including date of encounter to verify if patient was seen in the prior 12 month period.
    b. Reporting patient's age but not including DOB to verify calculation of age.
    c. Including male patients in the baseline population

6) **Misinterpretation of the Compendium:**
    a. Including partial patients as provider is including Pap Tests from measurement period and not including Pap tests from 2 years prior to the measurement period. HHSC

clarified the compendium which states, “Women who were screened for cervical cancer during the measurement year or the two years prior to the measurement year.”

7) Data Management and Record Retention:

i. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a “live” data system.
j. Provider’s report using terminology that is not easily recognizable and not including a list of definitions.
k. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
l. Provider should support all HHSC subset approvals with supporting documentation.

8) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

Summary of Findings for IT-12.3: Colorectal Cancer Screening

Prepared by Myers and Stauffer LC

09/29/2015

1) **Incorrect Age Limitations:**
    a. Not using the compendium's age requirements of patients 51-75 in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
    a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
    b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
    c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
    d. Not providing enough information to determine if the patients are unique patients or duplicates.

3) **Support Missing Patient Diagnosis Codes:**
    a. Not demonstrating that the exclusions for the denominator (diagnosis of colorectal cancer or total colectomy) were not included in the denominator due to lack of diagnosis codes in the supporting documents.

4) **Incorrectly Reporting Patient Eligibility for Numerator:**
    a. Including patients in the numerator that are not included in the denominator.
    b. Not including adequate support demonstrating that patients met at least one of the criteria for numerator such as: FOBT during the measurement year, flexible sigmoidoscopy during the measurement period or for year prior to the measurement year, or colonoscopy during the measurement period or 9 years prior to the measurement period.

5) **Incorrectly Reporting Patient Eligibility for Denominator:**
    a. Not including date of encounter to verify if patient was seen in the prior 12 month period.
    b. Reporting patient's age but not including DOB to verify calculation of age.

6) **Data Management and Record Retention:**
    m. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a "live" data system.

n. Provider's report using terminology that is not easily recognizable and not including a list of definitions.
o. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.
p. Provider should support all HHSC subset approvals with supporting documentation.

7) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

Summary of Findings for IT-12.4: Pneumonia Vaccination Status for Older Adults

Prepared by Myers and Stauffer LC
09/29/2015

1) **Incorrect Age Limitations:**
   a. Not using the compendium's age requirements of patients 65 years and older as of the first day of the measurement year in order to determine a patient's eligibility for the baseline, which HHSC has clarified to MSLC that is the proper interpretation of the compendium.

2) **Duplicate Patients Counted Towards Baseline:**
   a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
   b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
   c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
   d. Not including enough information to determine if the patient s are unique patients or duplicates.

3) **Support Missing Patient Diagnosis Codes:**
   a. Not demonstrating that the exclusions for the denominator (medical reason) were not included in the denominator due to lack of diagnosis codes in the supporting documents.

4) **Incorrectly Reporting Patient Eligibility for Numerator:**
   a. Including patients in the numerator that are not included in the denominator.
   b. Indicating what patients are included in the numerator but not specifically stating the answer to the vaccine question.

5) **Incorrectly Reporting Patient Eligibility for Denominator:**
   a. Not including date of encounter to verify if patient was seen in the prior 12 month period.
   b. Reporting patient's age but not including DOB to verify calculation of age.

6) Data Management and Record Retention:

q. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a “live” data system.

r. Provider’s report using terminology that is not easily recognizable and not including a list of definitions.

s. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.

t. Provider should support all HHSC subset approvals with supporting documentation.

7) Unknown Discrepancies in Reporting:

a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.

b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.

Summary of Findings for IT-12.6: Ambulatory Influenza Immunization

Prepared by Myers and Stauffer LC

09/29/2015

1) **Incorrect Age Limitations:**
   a. Not using the compendium's age requirements of patients 6 months and older in order to determine a patient's eligibility for the baseline.

2) **Duplicate Patients Counted Towards Baseline:**
   a. Assigning patient IDs to patients using a methodology that allows patients to be counted more than once.
   b. Recording patient names with slight variations on different visits resulting in the patient being assigned multiple patient numbers even though it is the same person.
   c. Counting the number of encounters instead of the number of patients towards the baseline calculation.
   d. Not including patients name and date of birth to allow for unique patient identifiers.

3) **Not Supporting Exclusions:**
   a. Not demonstrating that the exclusions for the denominator (patient allergy, patient declined, vaccine not available, other medical /patient /system reason) were not included in the supporting documentation.
   b. Not indicating the reasoning patients were excluded from the baseline calculation.

4) **Incorrectly Reporting Patient Eligibility for Numerator:**
   a. Including patients with a reported date of immunization prior to August 1, 2013.

5) **Data Management and Record Retention:**
   u. Some providers ran data in response to our request which resulted in an alternate baseline calculation due to a "live" data system.
   v. Provider's report using terminology that is not easily recognizable and not including a list of definitions.
   w. If patient level detail for exclusions is unavailable, provider should clearly state how the exclusions were removed from the baseline calculations.

6) **Unknown Discrepancies in Reporting:**
   a. Advising Myers and Stauffer that supporting documentation will result in a different baseline than reported to HHSC without providing a cause for changes.
   b. Submitting supporting documentation to Myers and Stauffer that does not demonstrate the same numerator and denominator as reported to HHSC without advising Myers and Stauffer ahead of time.