Welcome to MIRCal video training. By the end of this video, you should understand how to utilize the Data Distribution Report to help ensure that your data is accurate as reported. This report is referred to as the DDR.

The DDR is a summary report that displays each data element and lists the breakdown of records within each data element category, including blank and invalid data. It is a beneficial tool during the correction process to review prior to formal submission for unusual distribution of data.

Once data has been finalized, a similar summary report is available to the public on the OSHPD web site.

During data submission, use the current and historical DDRs in conjunction with Trend or Comparative Edit Summary Reports to aid in data review. Most of the outpatient data elements are the same as the inpatient elements with a few exceptions. For now, let's look at the Inpatient DDR.

Having logged in and selected the inpatient data type and desired reporting period, Select "Error Reports" under Results on the Main Menu. Then, choose 'View' on the Data Distribution Report row listed under Informational Reports.

It is important for facilities to review the Data Distribution Report to check if the summarized data appears accurate, or if a data percentage looks incorrect. It is not possible for the MIRCal validation programs to check all error possibilities.

Now let's look at some of the specific data elements on the DDR.

Type of Care is defined as Acute, Skilled Nursing/Intermediate, Psychiatric, Chemical Dependency Recovery, and Physical Rehabilitation. If the Data includes Types(s) of Care that a facility is not licensed for, these may be errors and should be corrected.

Records reported as Unknown Sex may be considered errors and should be verified. Look for the expected breakdown of male and female based on your facility.

Now let's look at Type of Admission. It should be reviewed in conjunction with Source of Admission. For instance, the combination of Urgent and Elective admissions should closely match the number of admissions through your ED. If your facility is a trauma center, review the breakdown of Type of Admission data in Emergency and Trauma.

Most ZIP Codes reported should be valid. If there are no Homeless reported, question this data. Homeless patients should be coded with the ZIP Code ZZZZZ, not the ZIP Code of the hospital or of the patient's mailing address.

A hospital's demographics should be considered when reviewing the Race/Ethnicity distribution. Race and Ethnicity must be collected separately. Therefore, you should see more than one race reported for each Ethnicity category. Also "Other" Race category should not be used as a default when reporting Hispanic. If any category has a high percentage of Unknown reported, question this data.

When reviewing the Source of Admission data element, check for reasonableness in the distribution of the data. Source of admission should be compared with both type of admission and disposition of patient.

If a facility is licensed for multiple Types of Care, there should be records reported in Source of Admission category Transfer from One Distinct Unit to another Distinct Unit of the Same Hospital. If there are records reported with a patient disposition of Skilled Nursing, confirm that there are also admissions from category Skilled Nursing.

If there are records in Court/Law Enforcement category, your facility likely should have discharges to Court/Law Enforcement.

Confirm that dispositions are distributed reasonably and are consistent with admission sources. Check that there are cases of "expired" and "against medical advice." Some specialty facilities may be an exception to this guideline.

Expected Source of Payment should be consistent with facility demographics. A high number of records in Self Pay or other payer should be questioned: For most hospitals, Medicare, Medi-Cal, and Private Coverage typically have the highest number of records of all the payer categories. Also, most facilities will have HMO contracts, so there should be records reported for HMO (Knox-Keene) on the Inpatient DDR.

When reviewing diagnoses, check for the number of other diagnoses. Generally, other diagnoses codes are typically at least twice the number of principal diagnosis codes for Types of Care Acute, Skilled Nursing and Rehabilitation. Psychiatric and Chemical Dependency facilities may have significantly fewer other diagnoses reported.

When reviewing procedures, General Acute Care and Skilled Nursing records should have some procedures reported. For Psychiatric and Chemical Dependency, procedures such as detoxification therapies are reported, as these procedures have risk. Common procedures for Skilled Nursing may include Therapeutic Radiology; Nonoperative intubation, dilation and manipulation; excision and irrigation.

There should be a portion of External Causes of Morbidity reported in the facility's data. Facilities with a trauma center or ED should have a significant number of external causes reported.

A facility may have a high or low number of DNRs depending on its patient population. If a DNR order was written within the first 24 hours of the patient's admission to each type of care, then "Yes" should be reported to OSHPD. If the DNR order was written after the first 24 hours of admission, then "No" should be reported.

Collection of the Social Security Number data element is required when it is recorded in the patient's medical record. Social Security Numbers are very important to researchers because they allow them to study healthcare trends, track the quality of care, and inform healthcare policy and research. Facilities are encouraged to stress the importance of collecting this information to their patients and staff. Review this data element to determine if the number of unknown Social Security Numbers can be reduced.

Total Charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the facility's full established rates. For inpatient data, if a patient's length of stay is more than 1 year, report total charges for the last 365 days of stay only.

You should also review this area to ensure your total discharge days, Average Length of Stay, and Adjusted Charge per Day seem reasonable for your facility and consistent with past report periods. You can view the Inpatient Reporting Manual for more information on how these are calculated.

Preferred Language Spoken is the language the patient prefers to be used in communicating with those in the health care community. An unknown Preferred Language Spoken is only reported when a patient is not able to communicate during his or her stay. In addition, most facilities will have "write in" values if the data is being collected correctly.

We hope this training has provided some helpful guidance you can use when reviewing your DDR. This concludes Video 6: Reviewing the Data Distribution Report.