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Audio from computer speakers breaking up?
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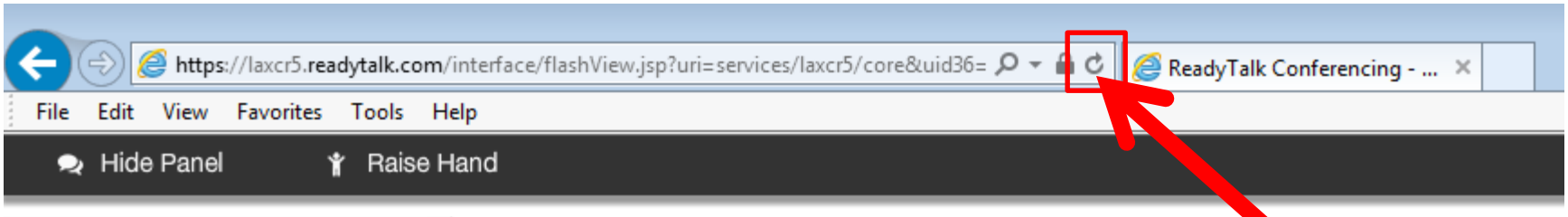
F5 Key
Top row of keyboard



Location of buttons

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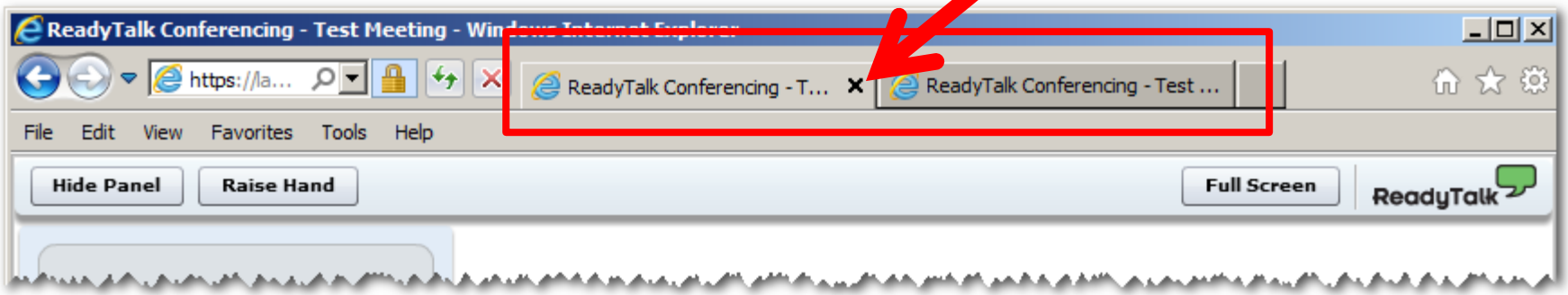

Example of two browsers/tabs open in same event

Submitting Questions

Type questions in the “Chat with Presenter” section located on the bottom-left corner of your screen.

Hospital Outpatient Quality Reporting (OQR) Program 2017 Specifications Manual Update

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The Lewin Group

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Telligen

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December 12, 2016

Announcements

- January 1, 2017: Submission period begins for measures submitted using a Centers for Medicare & Medicaid Services (CMS) web-based tool via the Q*ualityNet* website
- February 1, 2017: Clinical Data and Population and Sampling deadline for Q3 (July 1–September 30, 2016)
- Please be sure to access the National Healthcare Safety Network (NHSN) and QualityNet Secure Portal every 60 days to keep your password active

Save the Date

- Upcoming Hospital Outpatient Quality Reporting (OQR) Program educational webinars:
  - January 18, 2017: Help I'm New: What Do I Do?
  - February 15, 2017: Go CART: What Is It, and How Do I Use It?
- Notifications of additional educational webinars will be sent via ListServe

Learning Objectives

At the conclusion of the presentation, attendees will be able to:

- ✓ Identify changes to the Specifications Manual through version 10.0a and list changes in the measure information forms.
- ✓ Describe how these changes will impact abstracting and reporting for this program.

Appendix A

Appendix A: 9.0a and 9.1

In versions **9.0a** and **9.1** Appendix A, the following changes were made:

- Removal of dots/decimals in the ICD-10 codes to align the Hospital Outpatient and Inpatient Quality Reporting Program format requirements
- Links to the master code table and the data elements for *ICD-10-CM Other Diagnosis Codes* and *ICD-10-CM Principal Diagnosis Code* were updated to reflect this change

Appendix A: 9.1

- In version **9.1** for Quarter 4 encounters only, revisions were made to the ICD-10 codes used to identify the patient populations for OP-18, OP-21, and OP-23.
  - Table 7.01: Mental Disorders
  - Table 8.0: Ischemic and Hemorrhagic Stroke
  - Table 9.0: Long Bone Fracture
- A total of 128 new codes were added; seven were deleted.

OP-1, OP-2, OP-3, OP-4, OP-5

Acute Myocardial Infarction and Chest Pain Measures

OP-1, OP-2, OP-3, OP-4, OP-5

- OP-1: Median Time to Fibrinolysis (**no changes**)
- OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (**no changes**)
- OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-4: Aspirin at Arrival
- OP-5: Median Time to ECG

Reason for Not Administering Fibrinolytic Therapy (1 of 2)

- Collected for OP-3
- In version **10.0**, the following change was made:
  - The Notes for Abstraction were updated to clarify the type of documentation sufficient for selecting allowable value 1. One bullet was removed, and two bullets were added.

Reason for Not Administering Fibrinolytic Therapy (2 of 2)

- **Remove:** Only use reasons and contraindications listed in the data element.
- **Add:** Two bullet points which further explain the documentation necessary to select 1.

Transfer for Acute Coronary Intervention

- Collected for OP-3
- In version **10.0**, the following change was made:
  - The Notes for Abstraction were updated to clarify the type of documentation that is allowable to abstract a 1.
  - **Add**: “The Inclusion Guidelines for Abstraction is not an all-inclusive list. If the acute coronary intervention is not listed in the Inclusion Guidelines for Abstraction, but it is a defined reason for transfer, this is sufficient to abstract a 1.”

Aspirin Received (1 of 2)

- Collected for OP-4
- In version **10.0**, the following change was made:
  - The Notes for Abstraction were updated to clarify the type of documentation that is allowable to abstract a value of Yes.
  - This change addresses input received from stakeholder inquiries and aims to decrease abstractor burden.

Aspirin Received (2 of 2)

- **Add**: “Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications, referred to in the Inclusion Guidelines for Abstraction, is not all-inclusive. If there is documentation the patient received an aspirin/aspirin-containing medication that is not in Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications, you may abstract a Yes for this data element.”

ECG

- Collected for OP-5
- In version **10.0**, the following change was made:
  - The Notes for Abstraction were updated to address common stakeholder inquiries about pre-hospital electrocardiograms (ECGs).
  - **Add: "**If a pre-hospital ECG (i.e., ECG performed prior to ED arrival) cannot be confirmed as a 12-lead ECG based on documentation or the ECG strip, then abstract No for *ECG*. In contrast, if there is documentation of an ECG performed in the ED (i.e., ECG performed after ED arrival) that is not specified as a 12-lead ECG, then abstract Yes for *ECG*."

Probable Cardiac Chest Pain

- Collected for OP-4 and OP-5
- In version **10.0a**, the following changes were made:
  - **Add:** “If there is documentation of a differential/working diagnosis of AMI **and** an exclusion term, continue to select Yes.”
  - **After: “**If there is documentation of a differential/working diagnosis of acute myocardial infarction, select Yes.”
  - **Change:** “If there is documentation by the nurse or physician of an exclusion term, select No; if there is a working/differential diagnosis of AMI, continue to select Yes.”
  - **To: “**If there is nurse or physician documentation of an exclusion term, or a term that aligns with an exclusion term, select No.”

OP-8, OP-9, OP-10, OP-11, OP-13, OP-14

Outpatient Imaging Efficiency Measures

Imaging Efficiency Measures (1 of 3)

- OP-8: MRI Lumbar Spine for Low Back Pain
- OP-9: Mammography Follow-up Rates
- OP-10: Abdomen CT–Use of Contrast Material
- OP-11: Thorax CT–Use of Contrast Material
- OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
- OP-14: Simultaneous Use of Brain CT and Sinus CT

Imaging Efficiency Measures (2 of 3)

- In version **10.0**, each measure information form for the six Outpatient Imaging Efficiency (OIE) measures includes the measure name and description.
- Additional details on the OIE measures can be found on *QualityNet*: https://www.qualitynet.org/dcs/ContentServer?cid=1228695266120&pagename=QnetPublic%2FPage%2FQnetTier3& c=Page

Imaging Efficiency Measures (3 of 3)

- Updates to OIE measures:
  - **Added** non-traumatic aortic disease to the list of measure exclusions for OP-10 and OP-11
  - **Added** cardiac CT angiography (CCTA) to the list of imaging procedures included in the measure denominator for OP-13
- These changes will affect public reporting beginning in July 2017.

OP-18, OP-20, OP-22

ED-THROUGHPUT

OP-18, OP-20, OP-22

In version **10.0** and **10.0a**, no changes were made for the ED-Throughput measures:

- OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP-22: Left Without Being Seen

OP-21

Pain Management

OP-21

In version **10.0** and **10.0a**, no changes were made to the Pain Management measure:

- OP-21: Median Time to Pain Management for Long Bone Fracture

OP-23

Stroke

OP-23

- OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival

Measure Information Form (MIF)

In version **10.0a**, the following change was made:

- **Change:** “Because of the therapeutic time window for treatment possibilities, timely completion and results of the CT or MRI scan are imperative and will directly impact the quality of care a patient receives.”
- **To:** “Because of the therapeutic time window for treatment possibilities, timely completion and interpretation of the CT or MRI scan are imperative and play a role in determining the quality of care a patient receives. Clinical consensus indicates that stroke treatment is most effective when administered rapidly based on interpretation of real-time intracranial imaging.”

Last Known Well (1 of 3)

- Collected for OP-23
- In version **10.0**, the following changes were made:
  - One bullet was added to the Notes for Abstraction to clarify guidance for documentation of unknown/uncertain/unclear *Last Known Well*.
  - One bullet was revised to clarify guidance for in-house strokes that occur after hospital arrival.

Last Known Well (2 of 3)

- **Add**: “Documentation must explicitly state that the *Time Last Known Well* is unknown/uncertain/unclear. Documentation that time of symptom onset is unknown/uncertain/unclear is also acceptable when *Time Last Known Well* is not documented. If *Last Known Well* is not explicitly documented as ‘unknown,’ do not make inferences (e.g., do not assume that patient awoke with stroke so *Last Known Well* is unknown, unless explicitly documented).”

Last Known Well (3 of 3)

- **Change**: “Documentation of *Last Known Well* or stroke symptoms that occurred at a date or time following hospital arrival (e.g., in-house stroke), select No.”
- **To**: “If there is no documentation that *Last Known Well* or stroke signs/symptoms occurred prior to hospital arrival but there is documentation that *Last Known Well* first occurred after *Arrival Time* (e.g., in-house stroke), select No.”

Date Last Known Well (1 of 4)

- Collected for OP-23
- In version **10.0**, the following changes were made:
  - Three bullets were added to the Notes for Abstraction to clarify guidance for documentation of unknown/uncertain/unclear *Date Last Known Well* and to add information about Code Stroke Forms.
  - Seven examples of Code Stroke Forms were added to the Inclusion Guidelines for Abstraction; two examples were also added to the Exclusion Guidelines for Abstraction.

Date Last Known Well (2 of 4)

- **Add: “**A Code Stroke Form is used by the stroke team or ED staff to document the acute stroke process. See the inclusion list for acceptable terms used for a Code Stroke Form. The list is not all-inclusive.”
- **Add**: *“Date Last Known Well* on a Code Stroke Form may be documented by a nurse or other member of the care team authorized to serve as a scribe.”

Date Last Known Well (3 of 4)

In version **10.0**, the following changes were made to the inclusion guidelines.

Add: *Code Stroke Form*

- Stroke Activation Form
- Stroke Alert Form
- Stroke Assessment Form
- Stroke Intervention Form
- Stroke Rapid Response Form
- Thrombolysis Checklist
- tPA Eligibility Form

Date Last Known Well (4 of 4)

In version **10.0**, the following changes were made to the Exclusion Guidelines.

Add: *Code Stroke Form*

- Stroke Education Form
- Core Measure Form

Time Last Known Well (1 of 3)

- Collected for OP-23
- In version **10.0**, the following changes were made:
  - A series of exceptions were added to the Notes for Abstraction to clarify guidance for documentation of unknown/uncertain/unclear *Time Last Known Well*.
  - Three bullets were added to provide more information about Code Stroke Forms and to estimate a value for *Time Last Known Well* if there is no documentation of a specific time.
  - Seven examples of Code Stroke Forms were added to the Inclusion Guidelines for Abstraction; two examples were also added to the Exclusion Guidelines for Abstraction.

Time Last Known Well (2 of 3)

Add:

- "Any physician/APN/PA documentation that *Last Known Well* or onset of signs/symptoms is unknown/uncertain/unclear takes precedence over specific time on a Code Stroke Form."
- "Crossing out of a specific time on a Code Stroke Form and a specific time documented on the same or different Code Stroke Form, use the specific time that is not crossed out."
- "A specific time on a Code Stroke Form and another time reference documented (e.g., '8 hours' on the same or different Code Stroke Forms), use the specific time."
- "Multiple specific times on the same or different Code Stroke Forms, use abstraction guidelines for multiple times *Last Known Well*."
- "If unable to determine if a form is a Code Stroke Form, continue to review the medical record for *Time Last Known Well* documentation in other sources."

Time Last Known Well (3 of 3)

Add:

- "A Code Stroke Form is used by the stroke team or ED staff to document the acute stroke process. See the inclusion list for acceptable terms used for a Code Stroke Form. The list is not all-inclusive."
- *"Time Last Known Well* on a Code Stroke Form may be documented by a nurse or other member of the care team authorized to serve as a scribe."
- "If the time is noted to be 'less than' a period of time prior to ED arrival, assume the maximum range. Example: '*Time Last Known Well* less than one hour ago.' Subtract one hour from the time of arrival to compute *Time Last Known Well*."

OP-12, OP-17, OP-25, OP-26, OP-27, OP-29, OP-30, OP-31

Measures Submitted Using a Web-Based Tool

OP-12, OP-17, OP-25

No changes were made to these measures in version **10.0** and version **10.0a**.

- OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
- OP-17: Tracking Clinical Results between Visits
- OP-25: Safe Surgery Checklist Use

OP-26

OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures

- The table of categories and Healthcare Common Procedure Coding System (HCPCS) codes for Outpatient Surgical Procedures is updated in November of each year.

OP-27

- OP-27: Influenza Vaccination Coverage among Healthcare Personnel
- The fourth *optional* category of healthcare personnel will now be addressed on the MIF.
  - Definition for Healthcare Personnel (HCP)

    Add: “Reporting data on the optional, other contract personnel category is not required at this time.”

OP-29

- OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
- Changes made in version **10.0**:
  - Denominator Exclusions

    "Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as the reason."

OP-30

- OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps–Avoidance of Inappropriate Use
- Changes made in version **10.0a**:
  - Denominator Criteria (Eligible Cases)

    The following ICD-10 code has been removed:

    Z85.038, history of colonic polyps

OP-31

- OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
- No changes for this measure

Version 9.0a and Subsequent

OP-32 Measure Updates

OP-32: 9.0a and 9.1

- OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- In version **9.0a** and **9.1**:
  - **Add:** NQF #2539* for OP-32
  - **Add:** Links to the 2015 Measure Specifications Report and the 2016 Measure Updates and Specifications Report

*National Quality Forum

OP-32: 9.0a (1 of 6)

In **9.0a** and subsequent versions, the following changes were made:

- Summary of updates
  - Denominator Statement
  - Included Populations
  - Cohort Exclusions (excluded colonoscopies)

OP-32: 9.0a (2 of 6)

In **9.0a** and subsequent versions, the following change to the Denominator Statement was made:

- **Change**: "The target population for this measure includes colonoscopies performed at hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) for Medicare FFS patients aged 65 years and older."
- **To:** "The target population for this measure includes *low-risk* colonoscopies performed in the outpatient setting for Medicare FFS patients aged 65 years and older. *For implementation in the OQR Program, the measure will be calculated among hospital outpatient departments (HOPDs).*"

OP-32: 9.0a (3 of 6)

In **9.0a** and subsequent versions, the following change to Included Populations was made:

- **Updated second paragraph**:
  "*The measure is focused on low-risk colonoscopies.* The measure did not include colonoscopy CPT procedure codes that reflected fundamentally higher-risk or different procedures. Qualifying *colonoscopies billed with a concurrent* high-risk colonoscopy procedure code were not included in the measure; *the 2016 Measure Updates and Specifications Report at the link above contains the complete listing of all high-risk procedure codes*."

  - The link to the 2016 Measures Updates and Specifications Report is located in the **Introduction** section of the measure information form.

OP-32: 9.0a (4 of 6)

In version **9.0a**, the following change to Cohort Exclusions (excluded colonoscopies) was made:

- **Change**: “colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at the time of index colonoscopy”
- **To: “**colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at the time of index colonoscopy *or on a subsequent hospital visit outcome claim*”

OP-32: 9.0a (5 of 6)

In **9.0a** and subsequent versions, the following change to Cohort Exclusions was made:

- **Change:** “Colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis at time of index colonoscopy”
- **To:** “Colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis at time of index colonoscopy *or on a subsequent hospital outcome claim*”

OP-32: 9.0a (6 of 6)

In **9.0a** and subsequent versions, the following changes for Cohort Exclusions were made:

- **Change:** “Colonoscopies that occur on the same hospital outpatient claim as an ED visit.”
- **To:** “Colonoscopies that *are billed* on the same hospital outpatient claim as an ED visit.”
- **Add: “**Colonoscopies that are billed on a separate claim on the same day and at the same facility as an ED visit.”
- **Change: “**Colonoscopies that occur on the same hospital outpatient claim as an observation stay.”
- **To: “**Colonoscopies that *are billed* on the same hospital outpatient claim as an observation stay.”
- **Add: “**The 2016 Measure Updates and Specifications Report contains complete coding for all exclusions.”

OP-32: 10.0 (1 of 4)

In **10.0** and subsequent versions, the following changes were made:

- Summary of updates
  - Cohort Exclusions (excluded colonoscopies)
  - Risk Adjustment

OP-32: 10.0 (2 of 4)

In **10.0** and subsequent versions, the following changes to Cohort Exclusions (excluded colonoscopies) were made:

- Table 1 updates
  - "ICD-9-CM Code" and "ICD-9-CM Code Description" columns removed, table updated to ICD-10-CM diagnoses only
  - Table 1 name updated to "Inflammatory Bowel Disease (IBD) ICD-10-CM Diagnosis Codes"
  - Note added to refer readers to v9.1 of the OQR Specifications Manual for ICD-9-CM diagnosis codes listing

OP-32: 10.0 (3 of 4)

In **10.0** and subsequent versions, the following changes to Cohort Exclusions were made:

- Table 2 updates
  - "ICD-9-CM Code" and "ICD-9-CM Code Description" columns removed, table updated to ICD-10-CM diagnoses only
  - Table 2 name updated to "Diverticulitis ICD-10-CM Diagnosis Codes"
  - Note added to refer readers to v9.1 of the OQR Specifications Manual for ICD-9-CM diagnosis codes listing

OP-32: 10.0 (4 of 4)

In **10.0** and subsequent versions, the following changes to Risk Adjustment were made:

- Language updated to reference ICD-10-CM diagnosis codes
- Narrative updated to “The measure defines comorbidity variables using condition categories (CCs), which are clinically meaningful groupings of the many thousands of ICD-10-CM diagnosis codes.”

OP-32: 10.0a

In version **10.0a**, the following changes to Cohort Exclusions (excluded colonoscopies) were made:

- Table 1 updates
  - Changes the use of the ‘X’ at end of ICD-10-CM diagnosis codes to ‘*’
  - Removed ‘without complications’ from some of the ICD-10 codes descriptions
  - Removed duplicate rows for codes 51.8* and 51.80*

Version 9.0a and subsequent

OP-33 Measure Updates

OP-33

- OP-33: External Beam Radiotherapy for Bone Metastases
- Changes to Denominator Criteria and Denominator Exclusions

Denominator Criteria

Denominator Criteria (Eligible Cases):

- **Change**: CPT codes 77261, 77262, 77263
- **To:** 77402, 77407, 77412

Denominator Exclusions

Denominator Exclusions:

- **Add:**
  - "Patients treated with radiosurgery or SBRT"
  - "Patients who are part of a prospective clinical protocol or registry study"
  - ICD-10-CM codes that identify the exclusion criteria "Spinal Cord Compression," "Cauda Equina," and "Radicular Pain"

Version 10.0a and subsequent

OP-33 Measure Updates

OP-33

In version **10.0a**, the following changes were made:

- Description, Numerator, and Denominator Statements:
  - **Remove**: the term “painful” from the measure description, numerator, and denominator
  - **Add**: “for the treatment of bone metastases” to the numerator and denominator

Denominator Exclusions (1 of 6)

Documentation of Medical Reasons:

- **Add**: “The EBRT is used to treat anything other than bone metastases.”
- **Clarification:** “Previous radiation treatment to the same anatomic site *(i.e., retreatment)”*

Denominator Exclusions (2 of 6)

Documentation of Medical Reasons:

- **Change:** “Patients treated with radiosurgery or SBRT” and “Patients who are part of a prospective clinical protocol or registry study”
- **To:** “Patients who are part of a prospective clinical protocol or registry study involving the administration of radiation therapy, especially stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT)”

Denominator Exclusions (3 of 6)

Documentation of Medical Reasons:

- **Change**: “Patients with femoral axis cortical involvement greater than 3 cm in length”
- **To**: “Patients with femoral axis cortical involvement greater than 3 cm in length *if the current EBRT is to that femur*”

Denominator Exclusions (4 of 6)

Documentation of Medical Reasons:

- **Change:** “Patients who have undergone a surgical stabilization procedure”
- **To:** “Patients who have undergone a surgical stabilization procedure if at the site of the current EBRT treatment”

Denominator Exclusions (5 of 6)

Documentation of Medical Reasons:

- **Change: “**Patients with spinal cord compression, (ICD-10-CM G95.20 or G95.29), cauda equina compression, (ICD-10-CM G83.4), or radicular pain (ICD-10-CM M54.10 through M54.18) NOTE: Only the ICD-10 codes listed above can be used to identify denominator exclusions”
- **To**: “Patients with spinal cord compression, cauda equina compression, or radicular pain documented in the chart as related to the bone metastases being treated with EBRT”

Denominator Exclusions (6 of 6)

Documentation of Patient Reasons:

- **Remove**: Documentation of patient's reason(s) including patient declines treatment; economic, social, or religious reasons

Additional Instructions (1 of 2)

Add: Additional Instructions

- "All encounters that result from a single treatment plan should be considered one case with the case being attributed to the first date of administration of EBRT."
- "Consider the administration of EBRT to different anatomic sites as separate cases."

Additional Instructions (2 of 2)

Additional Instructions:

- “If any portion of the EBRT treatment course is billed as part of the outpatient bill, the case should be included.”
- “If the EBRT treatment course is initiated but not completed, the case should still be included.”

Resources

- To locate the Specifications Manual: www.qualitynet.org
- Have a question? Use the Questions & Answers tool: https://cms-ocsq.custhelp.com/
- Contact the support contractor: 866.800.8756

Continuing Education Approval

This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:

- Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
- Florida Board of Nursing Home Administrators
- Florida Council of Dietetics
- Florida Board of Pharmacy
- Board of Registered Nursing (Provider #16578)
  - It is your responsibility to submit this form to your accrediting body for credit.

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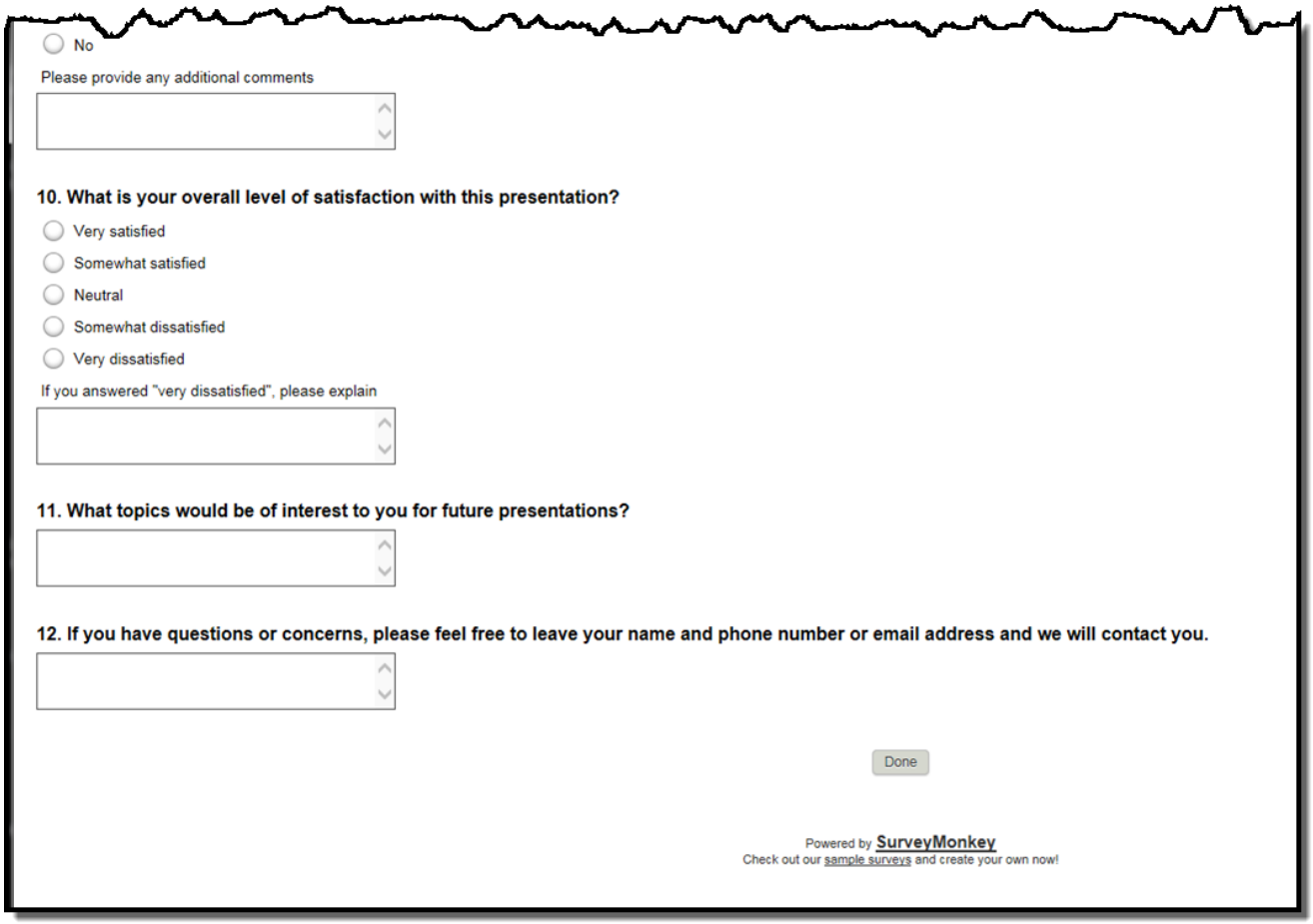
CE Credit Process: Survey



No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
- Neutral
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If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

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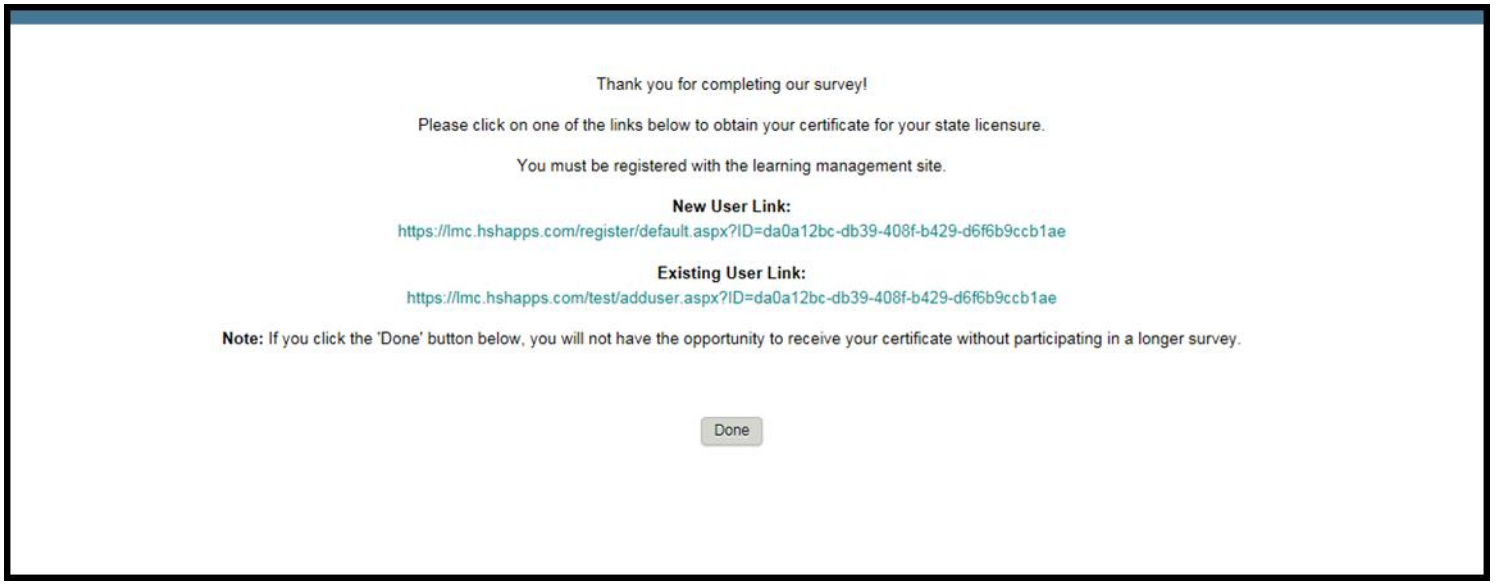
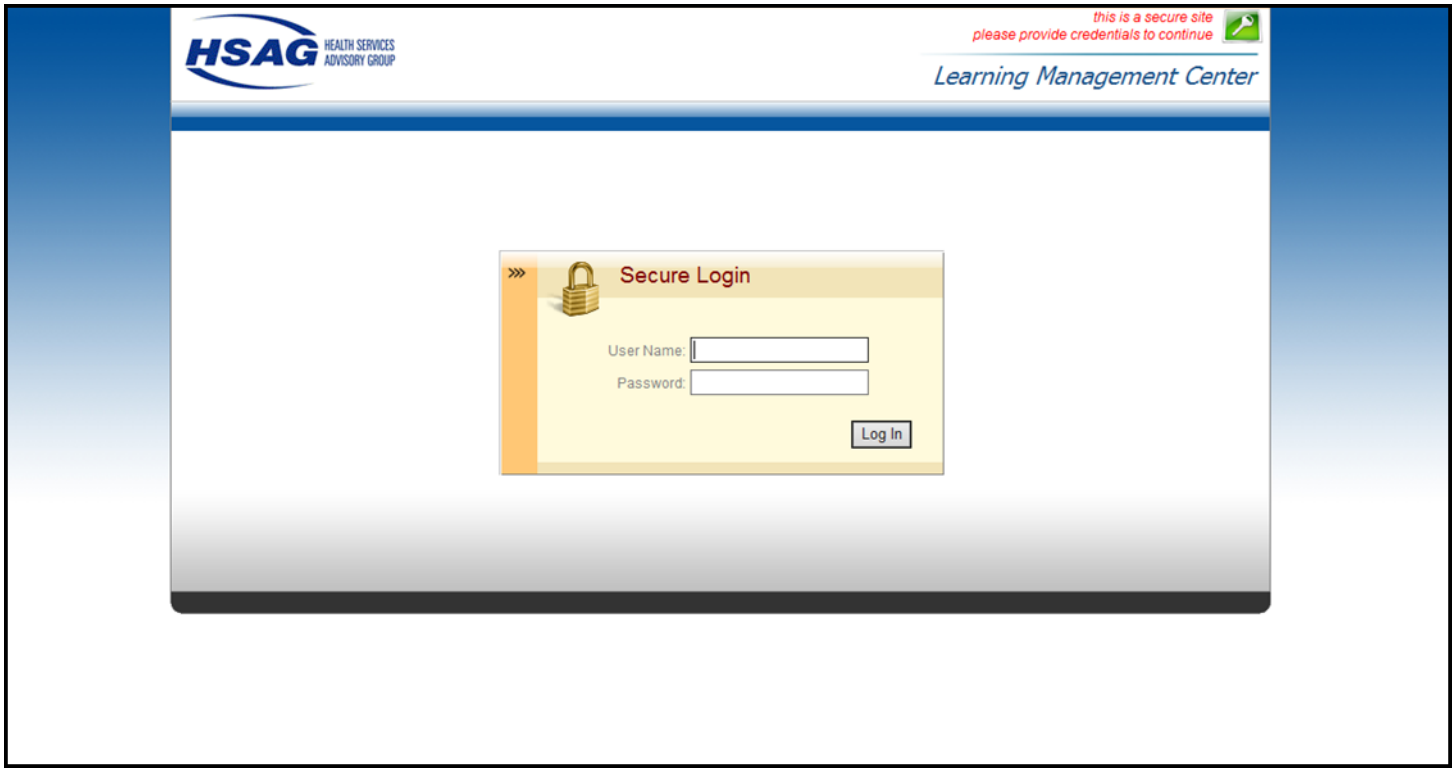


CE Credit Process: New User

CE Credit Process: Existing User



Thank You for Participating!

Please contact the Support Contractor if you have any questions:

- Submit questions online through the QualityNet Question & Answer Tool at www.qualitynet.org

Or

- Call the Support Contractor at 866.800.8756.

Biographies

- **Jennifer Witt, RN**

  Jennifer Witt is a Sr. Health Informatics Solutions Coordinator with the Measures Development and Maintenance team at Telligen. Most recently, Jennifer has been supporting CMS with the development and maintenance of hospital clinical quality measures. This includes responding to questions from hospital personnel regarding quality measures, using end user feedback and information from literature reviews in the revision of existing quality measures, and helping develop the specifications for new measures.

- **Marianna Gorbaty, MHSc, MSc (Coll.)**

  Marianna Gorbaty is a Lead Program Analyst at Mathematica Policy Research. Prior to joining Mathematica in 2013, she held a number of leadership healthcare informatics positions, focusing on the application of information technology solutions to advance healthcare delivery and applied research in Canada and in the United States. Mrs. Gorbaty's programs portfolio at Mathematica includes the implementation of the Value-Based Payment Modifier Program, analytic support for the Advanced Alternative Payment Models track of the Quality Payment Program, and clinical quality measures implementation and maintenance for CMS Quality Reporting Programs.

- **Colleen McKiernan, MSPH**

  Ms. McKiernan is a senior consultant at the Lewin Group. She joined Lewin in June 2012; she has significant experience in clinical quality measure development, including in the development, testing, implementation, and maintenance of chart-abstracted, claims-based, and EHR measures. Colleen received her bachelor's degree in psychology and public health from the University of Massachusetts and her master's degree in health policy from the Johns Hopkins Bloomberg School of Public Health.

- **Jacqueline Hudson, BSN, CPHQ**

  Jackie Hudson joined Health Services Advisory Group, HSAG, in 2015 and is a Project Coordinator and Project Lead for the Specifications Manual. Additionally, Jackie works with the Quality Improvement Network in the development of innovative strategies for improving outcomes in hospital outpatient environments. Her background includes extensive clinical, administrative, and Quality Improvement experience in a wide array of healthcare settings.