Hospital Outpatient Quality Reporting Program

Support Contractor

Understanding Web-Based Measures for the Outpatient Quality Reporting Program (OQR) Presentation

Moderator:
Marty Ball,
Hospital OQR Project Manager
HSAG

Speaker:
Karen VanBourgondien, BSN, RN
Hospital OQR Education Coordinator
HSAG

February 18, 2015

Marty Ball: Hello and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Marty Ball, and I'm a Project Manager for the Hospital OQR Program. If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. On the right side of the page, there is a banner which reads “Upcoming Events.” Click on this event, and this will take you to the webinar event. You can choose either to load the slides at one-per-page or three-per-page.

Before we begin today's program, I would like to highlight some important dates and announcements. The data submission deadline for Quarter 4, which is for encounter dates of October 1st through December 31st of 2014, this must be completed by May 1st. We cannot stress enough how important it is to not wait until the last minute. The QualityNet website gets very busy and slows down considerably during submission deadline times. We do not want to see anyone not be able to have a timely submission due to technical difficulties. Again, do not wait until the last minute. CMS provides a lengthy submission period. Please take advantage of that.

As a reminder, this will be the last quarter OP-6 and OP-7 will be publicly reported. As you recall, these measures have been topped out. The CDAC is expected to mail requests for Quarter 3 charts if you're being validated. Please look for this notice; this will be in March.

We will be presenting a webinar on Hospital Compare on March 18th. This will be a general overview of Hospital Compare: how to read the reports, how to decipher the Hospital Compare website, and how this information can be used to improve quality within your institution. ListServe announcements will be sent for future webinars as we get closer to these dates, as well as other valuable information regarding the OQR Program.

The learning objectives for this program are listed here on slide 4. This program is being recorded. A transcript of today's presentation and the audio portion of today's program will be posted at www.qualityreportingcenter.com at a later date.

During today's webinar please do not use the chat feature on the WebEx screen, as we do not monitor this function during the program. We will follow today's presentation with a question-and-answer session until the top of the hour.

We have a special guest today joining us for the Q&A session, Bob Dickerson. Bob is with the Measures Contractor. He's a Registered Respiratory Therapist with a master's degree in Health Service Administration from the University of St. Francis. Bob has numerous years of hospital and healthcare-based experience analyzing and incorporating quality measures as well as evidence-based care in the healthcare quality process improvement initiatives. These initiatives result in better patient care outcomes and increased compliance with quality measures. So again, he will be joining us for the Q&A period after the presentation.

Now I'm pleased to announce today's speaker, Karen VanBourgondien. Karen joined HSAG/FMQAI in 2012 and began working on the OQR team last year. Karen earned her bachelor's degree in nursing from the University of South Florida. She has extensive clinical experience in ICU, CCU, PACU, pre-op, and the emergency department. She also has clinical education experience as well as data collection, clinical extraction, and clinical quality improvement.

Now I will turn the presentation over to Karen.

Karen VanBourgondien: Thank you, Marty. Hello everyone. Thanks for joining us. Today we are going to talk about all of the web-based measures, but we're really going to focus on the OP-29 and -30. We've received numerous calls and emails regarding these two measures, so it warrants trying to provide some additional information so that, hopefully, we can make your life as abstractors a little easier.

As we move forward in the presentation, you will notice that we will be spending significant time discussing and analyzing these two measures in particular. However, we are going to first start with the simpler web-based measures.

On this slide you can see some of the web-based measures. We will discuss these particular measures briefly as they are really relatively straightforward.

OP-12. This measure establishes whether your facility has the ability for providers with health information technology, otherwise known as HIT, to receive lab data electronically directly into their ONC-certified EHR system. ONC refers to the Office of the National Coordinator for Health Information Technology. This measure applies to all outpatient departments associated with your facility that bill under the OPPS. This will be entered as a “yes” or “no” into the QualityNet Secure Portal.

OP-17. Essentially this measure evaluates the extent to which a provider uses an ONC-certified EHR system to track pending lab tests, diagnostics, and patient referrals. When you enter this data, it will be either “yes” or “no.”

OP-22. This measure is the number of patients that left the ED before being seen by a provider. This data will be entered as a numerator and denominator, so the denominator will be the total number of patients who presented to the ED, and the numerator is the total number of patients who left without being evaluated by a physician, PA, or APN.

OP-25. This measure wants to know if your facility used a Safe Surgery Checklist during the entire year of 2014. Again, this will simply be answered with “yes” or “no.”

OP-26 is the aggregate count of surgical procedures that match the HCPCS codes found in the Specifications Manual. Please be advised that these codes are updated annually by CMS. An addendum to the Specifications Manual will be released when the codes are finalized by CMS.

OP-27 measures healthcare vaccination information. The facility must report vaccination data for the individuals that fall into the categories and are employed one day or more from October 1, 2014, through March 31, 2015. Please be advised that the deadline for this information is May 15, 2015. This measure is reported through the CDC and NHSN. If you have not started the registration process, we cannot stress enough how important it is to get started. It is a rather lengthy process, and we do not want to see anybody unable to enter their data because they're not registered.

Please check within your facility to verify who will be reporting the measure. There will only be one number entered per facility, which would include both the inpatient and outpatient populations. We have found that, in the majority of cases, an Inpatient Quality Reporting contact reports this data for the facility. There is not a phone number to give you direct access to NHSN. As there is no phone number provided, you will have to use the email address. The helpdesk email for this measure is nhsn@cdc.gov. Please write this down and keep it handy so you have it available.

Okay, now we're going to switch gears a little and discuss the next couple of measures in detail. OP-29, as you can see from this slide, is measuring the appropriate follow-up interval. So first, we're going to go over the standard language here, and then we're going to take a few minutes to discuss it in detail.

To begin, this measure is looking at a patient population of individuals that are 50 years and older who are receiving a screening colonoscopy with no biopsy or polypectomy and no history of biopsy or polypectomy, and with a recommendation of a repeat colonoscopy of at least 10 years documented on the colonoscopy report.

Now let's talk about the denominator. As you can see on this slide, the patients that are going to be in your denominator are, again, 50 or older that are receiving a screening colonoscopy without biopsy or polypectomy. So let's say, for example, a patient named John comes in for a screening colonoscopy. He is 57 years old. He has no polyps during his colonoscopy, and he had no biopsies. Boom, he is in your denominator. Conversely, if that same patient came in but did have a polyp removed, then he is not in the denominator. If the patient does not fit into the denominator, you are done.

Okay, so now the numerator. For the numerator, this measure is looking for documentation by the physician on the colonoscopy report that there is a time interval of at least 10 years for a repeat colonoscopy. So if the previously mentioned patient, John, who was in the denominator because he's 57 and he did not have a polyp removed and he did not have a biopsy, then there needs to be documentation on the colonoscopy report that a follow-up colonoscopy is recommended for at least 10 years.

So with this patient, if the physician documents something like follow-up in five to 10 years, then this patient would not be in the numerator. Again, the measure is looking for a recommendation for follow-up colonoscopy of at least 10 years. A range of less than that does not meet that criteria.

All right now, denominator exclusions. Let's talk a while about exclusions to this measure in a little more detail. On – one exclusion for OP-29 is in the form of documentation of a medical reason for not recommending at least a 10-year follow-up interval. As you will recall on the previous slide, there had to be a recommendation of at least 10 years. So if there is documentation of a medical reason for not recommending this interval, then this completely excludes these patients from the measure.

Well, what does this mean exactly? If there is documentation of a medical reason - which can be a diagnosis, reason, symptom, complaint, or a condition documented in the medical record - right now CMS does not have an inclusive list of medical reasons. Additionally, a medical reason could be inadequate prep. For example, the physician felt he could not properly view the colon, so he recommended a shorter follow-up. In this case the physician just needs to document that as the reason for a shorter follow-up interval. The important issue here is there must be documentation of a medical reason if the follow-up interval is less than 10 years. Remember, the intent of the measure is not to justify the current colonoscopy but to avoid inappropriate use.

Frequently asked questions. Although we get various questions with a very wide range of scenarios, we have sort of categorized them into three general themes here on this slide. Some of these have been touched on briefly but warrant some further discussion. We're going to discuss each one of these individually in greater detail.

Medical reason. Now we briefly have discussed medical reason for exclusion, but again, let's go into a little bit more detail regarding this topic. This slide includes a medical reason for exclusion. If the physician documents in the medical record that the patient is above-average risk and therefore recommends a shorter interval than 10 years, this would be criteria for exclusion from the measure.

So let's say, for example, the physician documents high risk screening and then recommends follow up in five years. This would be reason to exclude the patient from the measure, as the physician has documented the medical reason for a less than 10-year interval because the patient is high risk. Again, CMS does not have an inclusive list of medical reasons. This is up to the discretion of the physician. It can be a symptom, condition, reason, or diagnosis that a physician feels warrants the patient having less than a 10-year follow-up interval for repeat colonoscopy. So if the physician documents a medical reason for a follow-up interval of less than 10 years, then that patient would be excluded from this measure.

Inadequate prep is also a reason for exclusion. If a patient had a colonoscopy and a physician was unable to properly view the colon and this was documented in the medical record, then this is also reason for medical exclusion.

Remember, it is up to the physician's discretion to determine if there is a medical reason for recommending a shorter interval of at least 10 years. It is worth mentioning that you should not use a medical reason for exclusion if the recommendation of at least 10 years for follow-up has been made. If that recommendation has been made, you want to keep that in your population. It would meet the denominator and numerator criteria, so it's a positive. It's like a gold star example. You wouldn't want to exclude that - what is being done correctly. You want to get credit, so to speak, for meeting the measure criteria. So you would only use a medical reason as an exclusion from the denominator if a recommendation of less than 10 years follow-up is made.

Age and lack of documentation. Now, on this slide there is a question of age and does this really matter with the recommendation of the follow-up interval. In order to exclude a patient based on age, the physician should clearly state in the documentation that age is the medical reason for not recommending a follow-up interval of at least 10 years. An example would be “I am not recommending follow-up at this time based on age.” The physician has to make clear that the medical reason is age. Now, as stated prior, the decision to continue screening is made by the physician based on clinical judgment.

Guidelines from the U.S. Preventative Services Task Force recommend that screenings should be continued – I'm sorry, should not be continued after the age of 85 because the risk of the procedure could exceed the potential benefit. For patients that will be between the ages of 75 and 84 at the time of their next colonoscopy, the physician should document the age-related reason for not scheduling the next colonoscopy for at least 10 years.

Now next, we're going to talk about the documentation of at least 10 years. On this slide the question is: what if there is a range? So if there is documentation of say five to 10 years, how is this answered? This is a very relatively common question, and we have already discussed this briefly. But to answer this, let's just talk about a few things.

First, on the measure information form, otherwise known as the MIF, the numerator of this measure are all the patients who have a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. So if you have a range of anything less than 10 years, then it does not meet this criteria. The measure is looking for a recommendation of at least 10 years for

follow-up colonoscopy. Remember, the measure is concerned with appropriate follow-up. If you have a patient that meets all the denominator criteria but the physician did not document the 10-year follow-up, then the patient will be in the denominator but excluded from the numerator.

So now, let's put this information into practice with some patient scenarios. Our fictitious patient number one is a 58-year-old male with no previous colonoscopy. The colonoscopy report states a normal exam, and it's documented a follow-up interval of 10 years. So this is a very straightforward example.

So let's first decide if the patient belongs in the denominator. To fit in the denominator, the patient has to be 50 or older and receiving a screening colonoscopy without a biopsy or polypectomy. This patient fits that criteria, so the patient is in the denominator.

Now let's see if they fit in the numerator. To fit in the numerator, again look at the MIF. The patients that are going to be counted in the numerator are patients that have a recommended follow-up interval of at least 10 years for a repeat colonoscopy documented on the colonoscopy report. This patient would fit into the numerator as well. So this first fictitious patient fits into the denominator and the numerator.

If you look at this same patient and the physician documented in the colonoscopy report that the follow-up would be five to 10 years, then the patient would be in the denominator but not in the numerator.

Patient number two. A 68-year-old female receiving a screening colonoscopy. No previous colonoscopy. Colonoscopy report says no polyps, no biopsy, and the physician documents that this is a high risk patient and recommends follow-up in five years.

Okay, so in this particular scenario, the patient is excluded from the denominator because there is a medical reason documented by the physician. This excludes the patient from the measure. If the physician did not document that the patient was a high-risk patient and did not document any other medical reason for recommending a follow-up interval of less than 10 years, then this patient would be in the denominator but not in the numerator.

Patient number three. A 62-year-old male receiving a screening colonoscopy. Physician performs a biopsy during the colonoscopy and is awaiting results. The physician documents “Awaiting biopsy results will follow-up in office.” Well, with this situation the patient had a biopsy. This case would be excluded from the OP-29 measure all together. To meet the criteria for the denominator, the patient has to be 50 years of age or older, which this patient is, without biopsy or

polypectomy. So if the patient had a polypectomy or a biopsy, they are not in the measure.

When you're abstracting, first see if they fit in the denominator. If they do not fit in the denominator, then they are excluded from the measure. You're done. There's no reason to evaluate numerator criteria. Move to the next chart.

There are numerous scenarios and situations, as you very well know. We're just trying to incorporate a few examples to assist you in deciding how to analyze this information and hopefully make your abstraction easier.

Now we're going to switch gears a little, and we're going to talk about OP-30 in a little bit more detail. On this slide we have the description, numerator, and denominator. We're once again going to go over these.

The description as it reads in the Specifications Manual is on this slide, but let's just talk about it. The description outlines the measure. It is the percentage of patients 18 years and older receiving a surveillance colonoscopy who have a prior history of polyps in a previous colonoscopy and it has been 3 or more years since the last colonoscopy. Right away, we can see differences between the OP-29 and -30.

The denominator is all patients that are 18 or older with a history of polyps on a previous colonoscopy. The numerator is all the patients who had an interval of three or more years since the last colonoscopy. Remember, this measure is interested in avoidance of inappropriate use. Various task force and statistical data show that, in patients with a history of polyps, it is not beneficial to have a repeat colonoscopy in less than three years. That's really the bottom line of what this measure is all about.

Okay, so denominator exclusions. Again, let's just break this down step by step. You can see on this slide the denominator exclusions as written in the MIF. As we stated before, if the physician has a medical reason for doing this repeat colonoscopy in a shorter interval than three years, it must be documented. In OP-30 we are looking at the interval since the last colonoscopy and ensuring it's been at least three years. With OP-29 we are looking for the physician to document in the current colonoscopy report to be a recommendation of at least a 10-year follow-up. Don't get those two confused.

System reason. What does that mean? Well, let's say the previous report cannot be located. Maybe the patient is out of state, you can't find the medical records, you can't obtain a report, whatever the situation is. In this case, there must be documentation in the present

medical record event stating that. Essentially, the physician needs to document that there has been an interval of less than three years and the system reason. If this is documented, then the case would be excluded from the measure as a system reason.

Frequently asked questions. Now on this slide we have once again sort of lumped together the categories of the most frequently asked questions. As you know, sometimes when you're abstracting, things are not always black and white, and there are any number of variances that can occur, and we definitely understand that. But for simplicity's sake, we're going to use broad examples to hopefully appeal to the situations that arise most frequently. So let's discuss each one in a little more detail.

Medical reason. We discussed medical reasons for exclusion in detail when discussing OP-29. The principle is really the same. The physician must document a reason as to why they are repeating a colonoscopy in less than three years.

On this slide you will see some examples of medical reasons, and again, there is no inclusive list for medical reason. It is up to the discretion of the physician. With regard to the last colonoscopy being incomplete, well, there are many reasons why a previous colonoscopy was not completed, such as an inadequate prep, adverse reaction of the patient, among many others. The important point here is, again, there must be documentation.

Now regarding acute symptoms, there are situations when a colonoscopy may be necessary in shorter time intervals due to acute symptoms. In these cases the patient will be excluded from the sample. They are excluded from your denominator. This is a medical reason. Remember, the intent of the measure is to avoid inappropriate use.

Date of last colonoscopy. With regard to the first issue noted on this slide, what do we do if we do not know the exact date of the last colonoscopy? Okay, if you do not know when the date is and the patient meets the denominator inclusion criteria, meaning they are at least 18 years or older with a prior history of colon polyps, then they would be in the denominator but not in the numerator since the numerator states that there has to have been three or more years since their last colonoscopy. You cannot say they meet that objective if you do not know when that was.

Okay, date of last colonoscopy, and this really can get very confusing for people. The specifics of the date of the previous colonoscopy must match, in short. If you have only the year of the last colonoscopy, you can use the year. In the situation where there is a month and a year,

then the date of that has to be at least three years. If you have the month, the day, and the year, then the repeat colonoscopy has to be at least three years from that exact month, day, and year.

So let's say, for example, a patient had a colonoscopy in December of 2011, and he is back for his repeat colonoscopy in November of 2014, then he would not meet the numerator criteria.

The issue regarding office notes and colonoscopy dates. If this information is not noted anywhere in the current medical episode, it cannot be used. You cannot go retrospectively and look into the physician office notes. However, if there is documentation in the current episode of care regarding the office note and the date, then it can be utilized. However, please note that this documentation must also be current, meaning within 30 days of the colonoscopy, in order to be utilized. This information regarding the interval between the previous and current colonoscopy can be documented anywhere in the current encounter medical date.

So let's put this information into practice again with some imaginary patients. This first patient is 30 years old with a history of polypectomy. The patient is not sure when the last colonoscopy was, and that report is unavailable. In this example the patient does not know the exact date of the last colonoscopy, and the previous report is not available. This will exclude the patient from the denominator due to system reasons if there is appropriate documentation of this by the physician. Remember, to use a system reason as a denominator exclusion, there should be documentation of an interval of less than three years and the system reason. Without this documentation the case would be counted in the denominator but not in the numerator.

Now if this scenario was slightly different and the patient was able to state the date of the last colonoscopy, then the situation is different. If you do not have the previous colonoscopy report, the information regarding the history of colonic polyps and the date of the last colonoscopy may be obtained from the patient or another facility. If the year of the previous colonoscopy is known and documented in the current record, this will establish the interval between the colonoscopies. The previous colonoscopy report does not need to be placed in the current record.

Patient number two is a 58-year-old female who had a previous polypectomy and biopsy with previous colonoscopy two years prior, but she presents with symptoms of abdominal pain and sluggish digestion, and this is documented in the current episode of care. With this particular patient, this patient would be excluded from the measure. Again, remember if there is a medical reason documented in the

medical record, then the patient is excluded from the denominator. In this case there is documentation of abdominal pain and sluggish digestion. As stated before, there is no inclusive list of medical reasons. This is left up to the discretion of the physician.

Patient number three. A 62-year-old male who had a previous colonoscopy on January 29, 2012. During the last colonoscopy the patient had multiple polyps removed with biopsy. So let's assume that today is the day the patient returns for this next colonoscopy. The date of the last colonoscopy was January 29, 2012. This puts it just over three years because, remember, we have a month, a day, and a year in this scenario, so that is what we have to use for the prior colonoscopy interval date. This patient would be in the denominator and in the numerator. Now the month, day, and year is not required, but the interval will be based on whatever is provided.

So let's review this just for a minute. The patient meets the denominator criteria because the patient is 18 or older, is receiving a surveillance colonoscopy, and has a history of polyps. The patient also meets the numerator criteria because there is an interval of three or more years since their last colonoscopy. Again, the measure is capturing avoidance of inappropriate use. In this case the interval for the colonoscopy has been three or more years. This is appropriate use of follow-up colonoscopy.

That concludes our practice patients, so let's talk about some other issues. We know that patient charts and abstracting them are not always easy and they're not black and white. We do have some tools that are beneficial when trying to figure out who fits in the denominator, who fits in the numerator. If you go to our website at qualityreportingcenter.com as noted on this slide, choose Resources and Tools. This will open a page with various tool selections. Go down to endoscopy tools, and you will find fact sheets, endoscopy tools, and denominator codes regarding both OP-29 and 30.

The fact sheets go over each measure, the denominator, and numerator, and has helpful hints to assist in abstraction. The tool sheets provide a step-by-step evaluation of what the criteria is to fit in both the numerator and denominator. Please take the time later to go to the website and take a look at these. You may find them to be very helpful.

The measure tools. This is a tool for data collection, again, for both OP-29 and 30, and the tool is designed to determine whether colonoscopy patients fall into the measures indicated, keeping in mind that OP-29 looks at recommendations for future care, so that's forward looking. OP-30 looks at previous care, so you're backward looking. It may be

useful for you to print these out or have an electronic copy to refer to while you're abstracting. Remember OP-29 looks into the future; OP-30 looks at the past.

Flow chart for OP-29. This is a tool containing the same information I've presented on the previous too, but it is in a slightly different format. There's also a flow chart for OP-30 and, again, it's containing the same information as presented on slide 26 for OP-30. But again, this flow chart may be a better resource for those of you who are a little bit more visual.

So let's talk about our last web-based measure, OP-31. This measure is interested in patients that have had a cataract surgery and have improvement in visual function after 90 days. The patients that are going to be in the denominator are all patients that are 18 or older that had a pre and post visual function instrument and had cataract surgery. Patients that are in the numerator are going to be the patients that achieved improvement in visual function within 90 days after surgery. And this is based on the completion of that pre and post visual function instrument.

So let's talk about this visual function instrument. As we have already talked about, the patient must have a pre and post visual function done to be in the measure. The same tool must be used for the pre and post evaluation. You can't use different tools. Sometimes people will ask if they can develop their own function tool. Well, in short, the answer is no. The visual function tool should be a data collection instrument that has been appropriately validated for this patient population. The visual function assessment recommendation is the VFQ, the VF-14, and the modified VF-8. You will find this information in the Specifications Manual as well.

As most of you should be aware, the final rule stated that this measure will be reported voluntarily. Be aware though, that if you do submit this data, it is subject to public reporting.

Well, that completes the measure-specific information, so let's just talk about a few other topics. Sample size. We're going to discuss sample size here, as we do get quite a lot of questions regarding this issue as well.

Hospitals have the option to sample from their population or submit their entire population. Hospitals that choose to sample for these measures should use a simple sample approach selecting a population from cases that meet the requirements to be included in the denominator. Once the population has been determined, the sample

size will be determined at either 63 or 96 cases for a year. This is an annual total population of the colonoscopies performed.

Again, you can see from the chart on this slide the number of abstractions required. But let's say, for example, that your facility does 1,000 colonoscopies. Your sample size should be 96 for each measure. So if you pulled 96 charts, and out of those 96 charts, 76 were in your denominator, then you would have to find 20 more charts to meet that 96 sample size. All of the charts in your sample size are the charts that meet denominator criteria. This information is also in the Specifications Manual.

Now we've talked about the web-based measures, so let's talk about how we're going to enter them into the Secure Portal. As you know, web-based measures are submitted once a year. On this slide, as you can see, it demonstrates the encounter dates and submission period for the calendar year 2016, which is the period you will report starting on July 1st of this year. This is all measures except for OP-27. As we discussed earlier, this measure is reported to the CDC and NHSN with a due date of May 15, 2015. The encounter dates on this slide for 29, 30, and 31 are from April 1st to December 31st, 2014. Next year the encounter dates will be for the entire year of 2015, so the encounter dates will be from January 1, 2015, to December 31, 2015, and subsequent years moving forward.

As you can see, CMS does provide a lengthy submission period. We cannot stress enough - do not wait until the end of October to submit your data. As you can imagine, there are a high volume of facilities submitting data, and we don't want to see anyone not be able to successfully submit their information due to technical issues. Please, please, submit early.

Again, please notice on this slide that OP-31 is voluntary.

So now let's briefly discuss how we're going to put this information into the QualityNet Secure Portal. The first thing you are going to do is, you're going to log in using your secure information, and the log-in is either on the top of the page or on the right of the screen, as you can see here.

You will choose your program, which will be the Outpatient Hospital Quality Program. You're going to log in to the QualityNet Secure Portal. If you're a new user and have not completed the identity proofing, then select the Start/Complete New User Enrollment on this screen. Sign in as you regularly would into the Portal, using your Symantec VIP Access.

Select from the Quality Programs drop-down, select the Hospital Outpatient Quality Reporting Program. And as you can see on this slide, it is the first one in the drop-down choices. From the My Task screen, select Manage Measures. It will say Manage Measures, View/Edit/Web-Based Measures/Data Acknowledgement. Please note that on this slide there is an error. Manage Security is circled. It should be the box to the right saying Manage Measures. That should be circled. Manage Measures is what you want to click to enter this data.

The next screen you will see is what is shown here on this slide, and you are going to select Outpatient Structural Web-Based Measures. Select the payment year from the drop-down box. You will be answering the web-based measures July 1st through November 1st in 2015 for payment year 2016, so select 2016.

This page is the View/Edit Structural Measures Summary. You will notice that the payment year on this slide does say 2015. That is because the upcoming submission period has not opened yet. QualityNet does not give the payment year 2016 as an option as of yet. You will find all the required measures that need to be answered for payment year 2016. On this slide, however, you will notice that 20, 30, and 31 – I'm sorry, 29, 30, and 31 are not on this screen. Again, that is because this snapshot is not what it'll look like with the upcoming submission period.

Data is saved when you submit – when submit is selected and only when it is selected. Once it's selected this pop-up box will appear each time, Return to Summary, if selected. If information was changed or needs to be changed after Submit was selected, then select Cancel in the pop-up to return to the submission screen, and select Submit to save the changed information. If you have submitted all the information and no changes have been made, then select Okay and move to the next measure.

After answering the pop-up box Okay question, you will be returned to the summary screen. Confirm that all of your web-based measures have been answered. This is so important. We have had instances where one measure was not completed. If you fail to answer all questions, you will be at risk for losing up to two percent of your facility’s APU. We strongly recommend that you save a screenshot of this screen showing that all your measures were successfully answered. Again, all of the measures you will be reporting this upcoming submission period are not on this screen, as this has not been opened on QualityNet yet. Once you have submitted all your data and it reads complete across the page, we recommend you take a screenshot.

We hope this has clarified the web-based measures, particularly OP-29 and 30. Please take the time to look at the various tools which we mentioned earlier in the presentation that are available to you. Hopefully they will assist you with the abstraction of these measures. That concludes the presentation on the OQR web-based measures, and we hope it's been very helpful to you. And now I will turn it back over to Marty.

Marty Ball: While we wait for the first question, I'd like to remind you that this webinar has been approved for one continuing education unit credit by the boards listed on slide 41. And we have an online CE certificate process. There are three methods for receiving your CEs: two through WebEx, and one through the phone only.

If you registered for this webinar through WebEx you will receive a survey from WebEx within 48 hours. It will not arrive today. Once you have completed the survey – once you have completed the survey you will be sent to a site to download your CE certificate. This is where you want to print your certificate.

If you are listening to this webinar with a colleague who logged on to WebEx, ask them to forward the survey from WebEx to you. And if you're listening to the webinar by phone only since you did not register with WebEx, you will not receive the survey with the link to the CEs. In a few weeks an online version of the webinar will be posted on our qualityreportingcenter.com website for you to get your CE certificate.

END

This material was prepared by the Outpatient Quality Reporting Outreach and Education Support Contractor under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS).
FL-OQR/ASC-Ch8-03102015-06