Outpatient Quality Reporting Program

Help, I'm New: What Do I Do?

Presentation

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Karen VanBourgondien: Hello, and welcome to the Hospital OQR webinar. Thank you for joining us today. My name is Karen VanBourgondien, an education coordinator for the Hospital OQR Program. Today's webinar will be outlining this particular program. It will be a great tool for those of you that are new to the reporting of this program.

If you have not yet downloaded today's handout, you can get it from our website at www.qualityreportingcenter.com. Just click on today's event, and that should allow you to download the slides. In addition, these slides are always attached to the invite that you received for this presentation. Our speaker today is Pam Harris, a project coordinator for the OQR Program. Pam has vast clinical knowledge and experience, and we look forward to what she will provide for us today.

But before we begin today's program, let me just highlight a few announcements. February 1st, 2017 is the submission deadline for Clinical Data and Population and Sampling for Quarter 3 2016 [Editor's note: This deadline was extended to February 15, 2017.], and this will be for encounter dates from July 1st, 2016 through September 30th, 2016.

And always, please be sure to keep your NHSN and QualityNet access active. The easiest way you can do this is just by logging in to both of these secure portals at least every 60 days. As a reminder, these are two different platforms, and they do not speak to one another. They're completely separate with separate registration and separate password processes.

Please join us on February 15th. The validation contractor will be presenting a comprehensive webinar on the validation process: what it is, what you need to know, what it's all about. They will be sharing information that will assist you in the validation process.

On March 15th, we will be presenting a webinar on the steps for meeting program requirements, and we'll also be discussing the many resources available to ensure your success in the reporting for this program. Any information regarding program updates or educational opportunities will be sent via ListServe. If you are not signed up for this automatic email service, you can do so on the QualityNet home page.

The learning objectives for this program are listed here on this slide. This program is being recorded. A transcript of today's presentation including the question and answers received in the chat box, as well as the audio portion of today's program, will all be posted at www.qualityreportingcenter.com at a later date.

During the presentation, as stated earlier, if you have a question, please put that question in the chat box located on left side of the screen. One of our subject matter experts will respond. If your question does not get answered for some reason, please know that all of these questions and the answers will be posted on qualityreportingcenter.com.

So let me just turn things over to our speaker today, Pam Harris. Pam?

Pam Harris: Hello, everyone. I'm glad you could join us today. Welcome to the Hospital Outpatient Quality Reporting Program. This is a voluntary data reporting program. While this is voluntary, eligible hospitals must meet administrative

data collection, submission, and validation requirements or receive a two percentage point reduction in their annual payment update under the Outpatient Prospective Payment System or the OPPS.

Now, if an eligible hospital did not meet the program requirements, that facility stands to lose up to two percent in payment for the upcoming calendar year. If this happens, facilities always have the option of filing a request for reconsideration. This is a process set forth that provides facilities the opportunity to demonstrate to CMS why they should receive their full payment update. CMS will communicate their decision in writing within 90 days following the deadline for submitting reconsiderations.

The goal for CMS is to promote higher quality and more efficient healthcare for Medicare beneficiaries. In pursuit of these goals, CMS implemented quality reporting programs for multiple care settings, including the quality reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Reporting, or the OQR. So, in implementing the Hospital OQR Program, and of course the other quality reporting programs, CMS has focused on measures that have high impact, support national priorities for improved quality, and efficiency of care for Medicare beneficiaries. All data reported will be displayed publicly. On that note, let's take a little closer look at public reporting.

Hospital Compare is the CMS website that lets consumers compare the quality of hospital outpatient services by comparing their quality data. This also leads to transparency, which is very important to CMS. The data reported is updated quarterly, and by "updated," that means that the new data will be added or replaced on that quarter, while other data will stay the same. Different measures are reported and updated at various times. Some data is updated annually. This will become more clear as we proceed and discuss the measures themselves. This display allows the public access and freedom to evaluate and compare facilities.

But before your data is displayed publicly, CMS will send hospitals a Preview Report of the data that will be posted on Hospital Compare. Preview Reports

will be sent via your QualityNet Secure File Transfer, and the reports are available for approximately 30 days. Please make sure that you print or copy this report from your secure file inbox because after 30 days, this report will be removed from your Secure File Transfer, and you will not be able to retrieve it. You will have to have appropriate secure access on QualityNet to receive this report. So hang tight though, we'll discuss that in a minute.

Since initially implementing the Outpatient Prospective Payment System, or the OPPS, CMS has published proposed rules in July, and that is when CMS encourages public comment about the measures. CMS reads and takes every comment under consideration. This is everyone's opportunity to become involved and contribute to the program. Then in November of the same year, CMS publishes the final rule in the *Federal Register*. This is done annually to implement statutory requirements and changes that were accepted from the proposed rule. I've listed the website of the *Federal Register*, but this is a vast number of documents.

So, the next link is for the 2017 Department of Health and Human Services, Centers for Medicare & Medicaid Services section of the final rule. Once you use your "Find" feature and put the page number 79753, it will take you to the Hospital Outpatient Quality Reporting Program final rule.

So now we have reviewed the CMS goal of the program and the rules and where to find it in the *Federal Register*. How do we get started?

To begin reporting data, there are some essential steps for Hospital OQR Program participation. One, identify and maintain a QualityNet Security Administrator, or SA, which we will discuss in detail. Two, if you are a new facility, you must complete and submit the Hospital Outpatient Quality Reporting Program Notice of Participation through the secure portal of QualityNet, and new facilities are required to pledge 180 days from your Medicare acceptance date. And lastly, collect and submit data. We'll discuss data collection and reporting later in the presentation, so hang on to that thought.

So, let's talk about step number one: secure access. This is the first thing you need to begin participation in this program, and you do attain secure access by becoming registered in QualityNet.

But before we walk you through becoming a Security Administrator, or SA, let's talk about the two types of QualityNet registration available to you: Security Administrator and Basic User. The Security Administrator facilitates the data submission and registration process for other users at the organization, doing creating, editing, terminating, and viewing user accounts as well as resetting basic users' passwords. Another important role is the ability to access the Secure File Transfer file on QualityNet. Reports specific to your facility will be sent to this file. You will also, on occasion, upload files in certain circumstances. As the role of the Security Administrator is so important, it is highly recommended that hospitals designate at least two people as QualityNet Security Administrators. One is to serve as the primary QualityNet Security Administrator, and the other to serve as back-up or designee. CMS highly encourages there be the second Security Administrator for back-up. You do not ever want to find yourself in a situation where you're trying to submit data or obtain a report and there's no one available to do so. So please, have at least two active Security Administrators at all times.

So what is a Basic User? That's someone that has limited access to the QualityNet secure website, and that access is determined by the Security Administrator. It could be that you just want somebody to run a report in QualityNet, so the Security Administrator would then assign this Basic User only the right to download the report. There's a registration process for the Basic User, and you can find that registration form and information on the same QualityNet registration page.   Okay, so how do you become a Security Administrator?

To register on QualityNet, you would first go to the website at www.qualitynet.org. This is pointed out by the red arrow at the very top. Then look at the first blue square on the left-hand side. See where it says "QualityNet Registration" circled in red? And right below that is "Hospitals-Outpatient"; it's got like a thin red arrow to it. Click on **Hospitals-**

Outpatient. It takes you to the QualityNet Security Administrator Registration site. Click on the **Security Administrator** link, seen here in the red outline.

It then takes you to the steps to become a QualityNet Security Administrator Registration page. To get to the actual registration packet, click on that tab within the large red circle. Download the form, follow the instructions, and mail it to the address in here on the QualityNet page. So, let's go ahead and click on the blue link of the **QualityNet Security Administrator Registration** packet.

You will see five pages of information. The first three pages are instructions. Please read them. It will save you time in the long run. What you see here on the slide is the top of page 4, and this is for the person requesting to be the Security Administrator to fill out and sign. So, page 5 is for the person at the facility that is authorizing you to become the Security Administrator to fill out and sign. Please make a copy for your files, but you must submit the originals then mail the original, two signed forms. And yes, I would send this through trackable mail.

Once your paperwork is complete, you will receive two emails from QualityNet. The first is a welcome and your user name, and the second will be your temporary password. You would then follow the directions in QualityNet on how to download the VIP access, or the Symantec ID is another name for it. A cautionary note though, these emails are only valid for a short period of time. If you missed that window, you will have to call QualityNet, and they will have to resend them to you. If you have any difficulties, please call the QualityNet Help Desk number. This is on the form and on the QualityNet home page.

So, now you're registered. Now complete the online Hospital OQR Notice of Participation available on the QualityNet Secure Portal. In order to complete this form, you must be a registered QualityNet Secure Portal user and have been assigned the OPledge update role by your active Security Administrator.

We just covered that information. So that is why it is the first reason to gain secure access onto QualityNet.

Any hospital that has a Medicare acceptance date on or after January 1st, including a new hospital and hospitals that have merged, must complete the Notice of Participation no later than 180 days from the date identified as the Medicare acceptance date. The Medicare acceptance date is the earliest date that a hospital can receive Medicare payments for services that it furnishes. These hospitals must begin data submission for the first full quarter following the submission of a completed Hospital OQR online pledge.

Hospitals with Medicare acceptance dates before January 1st that wish to participate must submit a Hospital OQR Notice of Participation by July 31st in order to submit data for the next calendar period. Data submission must begin with the first quarter of the services. So, for example, your hospital has an acceptance date of December 2016, you would have to submit your Notice of Participation by July 31, 2017, and you must begin with the first quarter 2017 services using the calendar year 2018 measures. Okay. So, let's go on to our next step.

You will be reporting quality measures. Okay, so what will you be collecting and submitting data for the measures themselves? Well, let's look.

Although there are three categories listed on this slide, as we proceed we will break these down further and attempt to clarify the verbiage and their place in the program. For now, we're just making references to the three categories. We will first discuss the patient-level chart-abstraction measures.

Now, your patient-level chart-abstracted measures, or clinical data measures as they're also referred to sometimes, are the measures reported quarterly through QualityNet using CART or through your vendor. You will notice that I have the measures listed by their numeric name only. For those of you that are new, hang tight, we will discuss the measures and their names in a little more detail in just a few minutes. Dates and deadlines for submissions are found on QualityNet and qualityreportingcenter.com, and we'll talk more

about that in a minute. But for right now, hospitals must submit complete data regarding the measures in accordance with the sampling requirements, and those are located in the Specifications Manual.

Essentially, these requirements specify that hospitals must submit a sample or a complete population of cases for each of the outpatient populations. Reporting aggregate population and sampling size counts is voluntary. If a hospital chooses to report aggregate population and sample size counts, this data must be submitted accordingly. Hospitals that have five or fewer in a quarter for both Medicare and non-Medicare for any measure will not be required to submit patient-level data for that measure set for that quarter. However, Chest Pain and AMI are combined. Say, for example, you have four AMIs and two Chest Pains – that's a total of six – so that would require you to report both measures. Again, this data can be submitted using the CART tool or by a vendor. CART is a free download application that allows you to submit your data into the CMS warehouse. This download application is available on the QualityNet website, and Security Administrators can access the online authorization process from the secure portal of QualityNet to authorize a third-party vendor to submit data on the hospital's behalf. Vendor authorizations remain in effect until the hospital modifies the authorization. Hospitals using CART do not need to complete a vendor authorization to report data. These measures are also subject to chart audit validation, so it may be a good idea to talk a little bit more about that aspect before we discuss the individual measures. So, let's talk validation.

Validation is intended to provide assurance of accuracy of the hospital's chart-abstracted data. CMS selects hospitals from a list of hospitals participating in the Hospital OQR Program that year. CMS randomly selects approximately 450 hospitals from the list of participating hospitals and an additional 50 hospitals on a targeted basis, for an estimated total of about 500 hospitals selected for validation annually.

Hospitals that meet all of the following criteria in November of the previous year are eligible to be one of the 450 hospitals selected. They must have an open status, be paid under the OPPS, have an active Notice of Participation

form to participate in the Hospital OQR Program, and have submitted at least 12 cases to the OPPS clinical warehouse during the quarter containing the most recently available data. The additional 50 hospitals are selected based on having failed validation requirements that applied to the applicable year's payment determination, or there was an outlier value for a measure based on the data that was submitted. Selected hospitals are required to supply the requested medical documentation to the CMS Clinical Data Abstraction Center, or CDAC, for validation purposes within 45 days from the date on the CDAC's request letter. To receive a full OPPS payment update, hospitals must obtain at least a 75 percent validation score for the designated time periods based upon this validation process. We won't go into further details here, as we will be presenting a webinar next month on the validation process. The validation contractor will be presenting an in-depth presentation covering the ifs and the whys and the hows of validation, so please join us for that.

For cardiac care measures – we're putting these measures together as they are referred to as the AMI and Chest Pain measure sets at times – and they are the Median Time to Fibrinolysis, the Fibrinolytic Therapy Received Within 30 Minutes of Arrival, Median Time to Transfer to Another Facility for Acute Coronary Intervention, Aspirin at Arrival, and Median Time to the ECG. Other chart-abstracted measures are OP-18, Median Time from ED Arrival to ED Departure for Discharged Patients; OP-20, Door to Diagnostic; pain management for long bone fractures; and strokes, the MRI and CT scan interpretation within 45 minutes. Now, we're not going to be discussing the measures in detail, as that is a webinar in itself, rather than the point of this particular presentation is to just familiarize you with the program and the measures in general terms.

However, I do want to make just a couple of points with regards to abstracting and validation. We mentioned a couple of slides back that hospitals must receive a 75 percent validation score. And let me just kind of pause here real briefly and discuss the top 10 mismatches, and then we will focus on the top two mismatches that comprise over 50 percent of errors during validation.

This slide is displaying the top 10 mismatched data elements that were validated by the CDAC for Quarters 2 2015 through Quarter 1 2016. This is a summary of the four quarters, including payment year 2017 and Quarter 1 of payment year 2018. There is a sizeable differential from the top two elements, which made just over 50 percent of the mismatch elements for these combined quarters. You can see on the slide that the very first line referring to the *Provider Contact Time* that the count is 366. This number reflects the number of charts that were analyzed with mismatched data elements for the ED-Throughput measure. Out of all the charts evaluated, 1,441 were the ED-Throughput measure; 366 charts, or 25.4 percent, had a mismatch for this data. Thus, this is the top mismatch. To further explain, the counts are reflective of the 500 validated facilities submitting 12 charts per quarter. Facilities are randomly selected and the number of charts per measure like Pain Management, Stroke, and ED-Throughput are randomly selected as well.

So, let's look a little harder at the two top mismatches to see what you can do while abstracting to avoid some of the common pitfalls. *Provider Contact Time* is the number one mismatch. This is abstracted for the OP-20 measure, Door to Diagnostic Evaluation by a Qualified Medical Professional. This measure wants to know what time the patient first had a direct, face-to-face exchange with a credentialed provider. Some of the common errors while abstracting are listed here on the slide. If you were going to summarize these, it would come down to documentation. Rummaging through the chart as an abstractor, trying to find an exam or any substantiating documentation that a provider was physically with the patient can be very challenging. Some EDs use T-sheets. For those who are not familiar with these, they're simply paper tools the provider documents on. They are simply a documentation tool used by the provider to document the assessment, evaluation, and plan of care for the patient. Sounds all fine and good, but if the provider does not date and time the initial assessment or it's not filled out correctly, you, the abstractor, will not get the information you need.

Another issue is with Electronic Health Records, or EHRs. There are some times the programming is not specific to certain details which you, as the abstractor, are looking for, for example, if there is no explicit documentation

of this *Provider Contact Time*. Having this window updated can also alleviate some of the abstraction headaches.

ED Departure Time is the second on the list of mismatches. This is collected for OP-3, Median Time to Transfer to Another Facility for Acute Coronary Intervention, and OP-18, Median Time from ED Arrival to ED Departure for Discharged ED Patients. So, again, we can see the most common errors while abstracting. You can see here that the "use of an exclusion term being used while abstracting." So, what does that mean? An example of this would be the date and time that discharge instructions were given. Yes, in some cases, the patient may have left at the same time the discharge instructions were given, but not always. There are many things that go on potentially with the patient after they receive the discharge instruction and before they actually physically leave. For that reason, you cannot use discharge instruction times alone as the *ED Departure Time*. Abstracting a chart is time-consuming, and missing the latest time is high on the list of mismatches. Somewhere, there is a later time the patient was discharged, and this is missed while abstracting.

With the above two situations, you have the documentation that the patient received some care or treatment after the discharge time was documented. Well, you cannot use the discharge time if the patient is still in the department. The bottom line here is abstraction is difficult enough. Knowing some of the pitfalls to avoid will be very helpful while you abstract these measures. Again, be sure to join us next month for the validation webinar. I'm sure you'll be able to pick up on some things you can utilize to improve your success.

Next, we will discuss the claims-based measures for the program. Let me just distinguish something here for a minute. Claims-based measures are measures collected from the claims that you submit to Medicare for payment. There is nothing you or your facility has to collect or submit or otherwise abstract for these measures. All the measures on the slide are claims-based – the imaging measures related to radiographic studies, and OP-32 is an outcome measure which is the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.

The measures listed on the slide are some of the measures that are submitted using the online submission tool through QualityNet. We're talking OP-12, -17, -22, -25, and -26. Now OP-22 is in the ED-Throughput measure set, but it's placed here because the measure is not a patient-level, chart-abstracted measure, but rather a measure submitted using a CMS web-based tool. So, you'll find information regarding this measure in the Specifications Manual under ED-Throughput.

All right, continuing on – OP-29 is the appropriate follow-up for normal colonoscopy, OP-30 is also a colonoscopy measure, OP-31 is cataract improvement within 90 days, and OP-33 is EBRT for bone metastases. Now, please note that OP-31 is a voluntary measure. This means at this point in time, you can report data or not. Either decision will not impact your meeting program requirements. However, any data reported will be publicly displayed.

OP-27, now this measure is presented separately, as this is a measure using the NHSN web-based tool. This is completely separate from the QualityNet reporting tool. It requires a separate registration, password, et cetera. The encounter dates follow the flu season. For the current reporting period, the encounter dates are October 1st, 2016 through March 31st, 2017. In the hospital setting on the inpatient side, there are numerous measures reported through NHSN. We find that, typically, the individual capturing data – say for example, the HAI measures – also report data with respect to the flu vaccine coverage. If, however, you have been designated to enter this data, let me just briefly give you an idea on where to go to register on the CDC NHSN website.

Now, if you have an NHSN inpatient registration, you are also, therefore, outpatient. You can access this website by the address link seen here on the top of the slide. When you enter that address and scroll down just a little bit, you'll have this view. If you are new, you will access the **New to NHSN** box seen here next to the red arrow. Please be aware that the process to gain secure access through CDC or NHSN takes up to six to eight weeks. You will be given a SAMS grid card that will allow you to access this platform. This

website also has several tutorial videos on the sign-up process. In addition, there are some webinars available to you on our website which we'll look at in a little bit.

So, we've talked about the measures and the reporting data. As you will recall, some measures are reported quarterly, and this you will see under the clinical data submission. The measures using a web-based tool have different encounter dates but the same submission date.

This slide gives you kind of a snapshot of all your submission due dates. This can also be found on QualityNet and the support contractor's website at qualityreportingcenter.com.

So, at this point, you may be saying, "but how do I know what I'm abstracting?" You will always refer to the Specifications Manual to guide you through. This manual was developed to provide a uniform set of quality measures that reflect the final rule. The Specifications Manual is your guide to the Outpatient Quality Reporting measures. So, let's take a quick look at how to find the Specifications Manual.

Your first stop, again, is going to be going to the QualityNet website at qualitynet.org. From the home page of QualityNet, when you hover your cursor over the **Hospitals-Outpatient** tab circled there in red. A drop-down menu will appear, and you will simply click on **Specifications Manual**. Now you can see on the right-hand side of this page, the heading **Specifications Manual.** See the blue arrow? And you can see there are quite a few different versions of the Specifications Manual. So, how do you know which one to pick? To answer that, look at the patient encounter, or when the patient was seen in your facility. Then you use the Specifications Manual version that corresponds to those dates. For details on the Specifications Manual and its recent updates, you can look at our webinar from last month. It's in the archived area at qualityreportingcenter.com.

So, one last point, let's imagine you just clicked on **Version 10.0a**, right there, that's the first choice circled in red. You will see this page, and you will

notice that the electronic copy of this manual is divided into sections. These divisions make it easier to find and view what you're looking for. This is a document that you should be very familiar with. If you want, you could print this off. If you decide to do that, be advised that it is several hundred pages long. That is why most people just keep a copy of this electronically.

There is another resource that is incredibly helpful to individuals new to this program, and that is the support contractor's website which I mentioned prior. This website is full of resources and tools that are available to assist you in the successful reporting of this program. Let's imagine you've just entered this website seen here on the slide in your browser. If you hover your cursor over the **Outpatient** tab, a menu will open up to your right, as seen here. There are lots of tabs filled with information. We won't go over all of the tabs today; the point we want to make is that there is an enormous amount of information here to assist you. I do want to mention one specific tab here, though. That tab is the **HOQR 101** tab circled here in red. This tab will take you to some very important resources for those of you who are new. So, let's go ahead and take a look at that tab.

So, if when you click on the **HOQR 101** tab, this is the page that would open up next. On the top, you can see all of the videos available. These are short six to eight minute videos on the subjects you see here. They will walk you through the subjects quickly and efficiently. It's a very handy tool when you're new or you just want to refresh your memory. Next, under the **Resources** section, there are valuable informational documents to assist you in starting out in the right direction. I highly recommend you access and print out the "Step-By-Step Guide for New Facilities" document seen here with the red arrow. This is a great starting point in getting yourself immersed in the program. Save it to your desktop for a quick reference. It is a great book.

Okay. We have time to look at one more tab. Once again from the home page, and viewing that same drop-down box, if you were to choose the **Archived Events** tab, you would be directed to a page that stores years of informational webinars. I mentioned this specifically here for a couple of reasons. One, I referenced previous webinars several times during the

presentation. Two, there is so much information there on many different subjects. You can also choose the **Upcoming Events** right above the **Archived Events** to view what's coming your way.

Now we've talked about the QualityNet and the Quality Reporting Center websites. I do want to mention one more thing which is important for your success in reporting for this program. That is the ListServe, or the email notifications. This is an automated email service which is free and available. You can sign up for this on the home page of QualityNet. It only takes a few minutes. Updates and important information about this program is sent directly to the email you signed up with. It is a great and easy way to stay informed about the program.

Once you get going, you'll find that you have questions. Feel free to call our help line listed here on the slide, or you can enter your question into the question and answer tool. Your answer will be sent via email. This tool can be accessed through QualityNet. As a matter of fact, we did a whole webinar on this tool in September, so check it out. And, that's going do it for me today. Let me hand things back over to Karen.

Karen VanBourgondien: Thank you, Pam, for all that great information. We really appreciate it. Typically, we like to go over some questions and answers that have come through the chat box. We really are kind of a little low on time, but we are going to respond to a few questions that seem to be kind of common. So, Pam I have a question here that maybe you can answer. And this is a very common question, so we're going to ask this one. "When are the measures submitted in QualityNet – when are they due?"

Pam Harris: Okay. Thanks, Karen. That's a great question. The current data submission deadline for the measures submitted via the web-based tools is May 15, 2017. Now the submission period is from January 1st, 2017 through May 15th, 2017, so, you can enter them at any time up until May the 15th. Now remember that OP-31 is voluntary, but if you're reporting this measure, it also has a May 15th deadline.

Karen VanBourgondien: Okay. Thank you, Pam. Thanks a lot. Here's another great question, and I know you touched on this. The question is: "I was just looking at the Specifications Manual on QualityNet. If the codes on the tables in Appendix A are highlighted in yellow, are these new codes that were added?"

Pam Harris: Thanks, Karen. Yes, that is absolutely correct. Yellow highlighted text corresponds to the updates in the manual, and it makes it so much easier to see the new changes.

Karen VanBourgondien: Thank you, Pam. Here's another question, and we get this a lot, and I'll go ahead and ask it and answer it too, Pam. "You mentioned in the webinar that all of these webinars would be on a website. When can we access this webinar?" Okay, so the answer is yes. As Pam said, all the webinars are always posted on the support contractor website, and that is www.qualityreportingcenter.com. If it is a webinar that is coming up, it will be on **Upcoming Events.** Once that presentation date has passed, all of those webinars are placed under the **Archived Events** tab on the qualityreportingcenter.com website. As Pam mentioned, there are years of webinars there on all different types of subjects. So, you can also find that on our website, and **qualitynet.org** also stores webinars.

So, that's all the time we have for questions today. We really appreciate everybody joining us today. Pam, thank you for all the great information. I'm going to hand things back over to our host to go over the CE process. Thanks again, everybody, and have a great day.

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