Outpatient Quality Reporting Program

Abstraction Tricks and Tips

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*Please be advised that an additional slide (slide 48) was inserted into the presentation slide deck after the original presentation was given. This update is not reflected in this word-for-word transcript of the original presentation.

Nina Rose:	Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Nina Rose. I'm a Project Coordinator for the Hospital OQR Program. If you have not yet downloaded today's handout, you can get them from our website at qualityreportingcenter.com. Go to the **Events** banner on the right-hand side of the page, then click on today's event. Go down to the **Event Resources** at the bottom of the page, and there will be a link that will allow you to access and print the handouts for today's webinar.
	As you can see, we have a slightly different platform we are using this time, as we are live streaming in lieu of using only phone lines. Before we begin today's program, let's highlight some important dates and announcements.
	August 1 is the next deadline for Quarter 1 population and sampling and clinical data submission. This would include encounter dates of January 1 through March 31, 2015. Remember, this is the first quarter that you will not be submitting the data for OP-6 and OP-7. The submission period for your Hospital OQR web-based measures via QualityNet will begin on July

1 and extend through November 1, 2015. We cannot stress enough how important it is to not wait until the last minute for your data submission to enter your web-based measures. The QualityNet website is very busy and slows down considerably during submission 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 the lengthy submission period; please take advantage of that.

On July 14, there will be a presentation by Yale on the dry-run results for the new measure OP-32. We will be sending out a ListServe with registration information.

On July 15, there will be a webinar introducing the Calendar Year 2016 Proposed Rule. This will be presented by Elizabeth Bainger, the CMS Program Lead for the OQR Program. Additional webinars and educational opportunities will be forthcoming. Notifications will be sent via ListServe by HSAG. ListServe notification is our primary mode of communication with regard to this program. If you are not signed up for this, please take a moment to do so. This is done on the home page of QualityNet. It is on the left-hand side of your home page, the third box down. If you click on the ListServe notification, it will take you directly to the page to sign up for this service. It takes less than five minutes. This will keep you informed of updates, educational webinars, and information about this program.

The learning objectives for this program are listed here on the slide. This program is being recorded. A transcript of today's presentation, including the question and answers received in the chat box and the audio portion of today's program, will be posted at qualityreportingcenter.com at a later date. During the presentation, as Matt stated earlier, if you have a question, please put the question in the chat box, located on the left-hand side of the page. One of our subject matter experts will respond. Again,

by having live chat, we hope to be able to accommodate your questions timely and have real time feedback. Some of the questions will be shared at the end of the presentation.

Now, let me introduce our speaker. I'm pleased to introduce today's speaker, Karen VanBourgondien. Karen joined HSAG in 2012 as the Education Coordinator. Now, I will turn the presentation over to Karen.

Karen VanBourgondien: Thank you, Nina. Hello everyone, and thank you for joining us. The presentation today is a generalized overview of the Hospital Outpatient Quality Reporting Program. This is geared towards new abstractors or those new to reporting for this program.

The OQR Program is a pay-for-reporting program and was initiated with the calendar year 2008 Final Rule. Hospitals report data for services on the quality of hospital outpatient care using standardized measures of care in order to receive full annual payment update or APU. Although the program is voluntary, a hospital is at risk for up to a two percent reduction of their total APU if they do not fulfill the requirements of the program which we will discuss here in a moment. Penalties are not applied to individual measures or elements. So, this is not a pay-for-performance program, but rather it is a pay-for-reporting, as we said a moment ago.

Proposed and Final Rule. Hopefully, you have heard these terms as it relates to the OQR Program. However, if you are new or you are just not that familiar, let's talk about these terms for just a few minutes. The Proposed Rule with Comment Period is published annually around June. This proposal session is the discussion of any changes that may occur with the OQR Program. The Hospital Outpatient providers are highly encouraged by CMS to submit comments on the proposed regulations affecting the rule-making for the current year and future years. CMS addresses each comment. This is a time when facilities can be involved in

policy-making. The process is in place to allow feedback and comments and exchange of ideas. So, please make comments. CMS provides an extended period of time for feedback and input. The comment period is open for 60 days. Once all of this information is obtained, decisions are made regarding the Proposed Rule, and this becomes the Final Rule. The Final Rule is then published annually and, by law, must be displayed in the *Federal Register*.

Your data for the OQR measures are submitted through the QualityNet Secure Portal. We will discuss this in a little more detail shortly. If your hospital chose not to publicly report, you would have to officially withdraw from the OQR Program. Remember, this is a pay-for-reporting program. So, if you chose this option, the hospital could lose up to two percent of your APU. Clinical measures are updated on *Hospital Compare* quarterly while claims-based and web-based measures are updated annually. For detailed information regarding *Hospital Compare* and public reporting, you may wish to view the webinar on this subject that was presented in March, or visit the *Hospital Compare* website. As a point of interest, all the educational webinars are always archived at qualityreportingcenter.com.

Maintaining an active Security Administrator, or SA, is a program requirement. The SA information packet can be found on the QualityNet website which is QualityNet.org. Please follow the instructions, as there will be a delay if the package is submitted incorrectly, such as sending copies instead of originals or other errors. This will allow you to enter the secure portion of the QualityNet website. Once your paperwork has been processed, you will be sent two emails from QualityNet. One will contain your user ID, then a separate email will be sent with your temporary password. These are not sent together for security reasons.

If you are new to this program, you will need to complete the OQR Online Pledge; this is your notice of participation. A pledge to participate is required. Once the hospital is pledged, you will not need to re-pledge. It is carried forward unless you officially withdraw from the program. You can find all of this information under the **How to Participate** tab on QualityNet's **Hospitals - Outpatient** tab. It can be accessed on our website, qualityreportingcenter.com, as well. You will need your secure log-in capabilities in order to enter data into the warehouse. You will enter the data by using the CMS CART tool available on QualityNet or by using a third party vendor. We will go into further detail regarding these two issues, CART and vendors, a little while later in this presentation.

Let's discuss the measures that are part of the OQR Program. This slide represents some of the chart-abstracted measures. Please keep in mind that the Chest Pain measure incorporates both OP-4 and OP-5. The criteria on how to abstract these measures can be found in the Specifications Manual. You should become extremely familiar with the Specifications Manual, also referred to as the Specs Manual, in order to have accurate abstracting. But right now, we will discuss a few things as it relates to the AMI and Chest Pain measures.

Let's briefly discuss the patient population for the cardiac measures. All patients in these measures are 18 years or older. In order to be included in the AMI cardiac measures, which are OP-1 through OP-5, there are a few things to know about the population. The only two discharge or transfer codes are short-term general acute care hospital or federal facility such as a VA Hospital. So, let's say for example, you had a patient that expired or a patient that was transferred back to jail. These patients would not be included in the AMI cardiac care population.

Let's talk about the E/M code as it relates to these measures. You will need the E/M code, as this code is used for billing the appropriate level of

care. It is also used to determine the outpatient population. So, they are important, and these codes also need to be acceptable and are listed in the appendix of the Specs Manual. Cases also must have the appropriate diagnosis codes which are also found in the Specs Manual appendix.

AMI codes must have the AMI ICD-9 or ICD-10 code as the principal diagnosis code. Chest Pain codes do not have to be primary codes. In other words, they can have other primary diagnosis codes, and can be located in any position on the billing list: primary, secondary, or tertiary.

OP-18. This is a stratified measure, meaning it is divided. Many people get confused about this measure. This measure is the median time from Emergency Department arrival to the time of departure. 18a is the overall rate, this includes all the patients that are discharged from the ED; 18b is the reported rate on *Hospital Compare*; 18c are the discharge patients with psychiatric or mental health diagnoses; and 18d are patients that are transferred to another facility.

Because patients being transferred and psychiatric patients may take longer than the uncomplicated discharge and may not represent the actual time of discharge for ED patients, they are excluded from the 18b measure set. This provides a more accurate true median time for ED discharge. This is why 18b is the reported measure. If you use just one time and included all transfers, even the complicated transfers, the times would be skewed and would not reflect a true discharge time.

OP-20 is the median time from arrival to provider contact for ED patients. The included patient population is any patient in the facility's emergency department except patients who expired in the ED. This is the time the patient first had direct personal contact or face-to-face contact with the physician/APN/PA or institutionally credentialed provider. This may include the OB nurse to initiate a medical screen exam in the OB

Department. We mention the OB aspect because your facility may send pregnant ED patients to the OB Department for evaluation.

OP-21 is the median time from Emergency Department arrival to time of initial oral or parenteral pain medication administration for ED patients with a principal diagnosis of long bone fracture. Your included population are patients that are older than two years old and have a principal diagnosis code of a long bone fracture. You will get the diagnosis from the table in the appendix of your Specifications Manual. So, you will not include patients that are less than two years old, patients that have expired, and patients that leave against medical advice.

OP-23. The rationale for this measure is to improve access to diagnostic imaging and assist clinicians in a decision-making process and treatment plan. The included populations are patients that are 18 or older with an ICD-9, ICD-10 principal diagnosis for acute ischemic stroke or hemorrhagic stroke. Again, you will reference the table in the Specifications Manual. These are patients who had a head CT or MRI scan. You will exclude expired patients or patients that left AMA.

We have talked about some of the chart-abstracted measures. Let's talk a little about the Imaging Efficiency measures. The information for these measures is obtained directly from Medicare billing claims data. Thus, they are referred to as claims-based measures. It is done strictly by Medicare claims. These measures are calculated based on a one-year window of claims data. If you want to see your facility's specific data, it can be obtained from your billing department looking at the Medicare claims.

Web-based measures. You may also hear the term "structural" measures. They are synonymous. We're going to discuss these measures over the next few slides. The web-based measures are entered into the QualityNet Secure Portal annually. As a point of interest, we did do a webinar in

February regarding all the web-based measures and how to enter them into QualityNet, and we discussed the measures themselves in detail. So, if you feel like you need more assistance, by all means, view that webinar. The web-based measures are submitted once a year, and the submission period for entering this data to the OQR Program is July 1 to November 1 of every year.

OP-12 and -17. These are entered into the QualityNet Secure Portal, and this is answered with either a "Yes" or a "No" response. OP-22, this measures the percentage rate of patients that leave the ED before being seen by a provider. This will be entered as a denominator and numerator. The denominator will be the total number of patients that presented to the ED. The numerator will be the total number of patients who left without being evaluated by a physician, APN, or PA.

OP-25. This also will be entered as a "Yes" or a "No" into the Portal. This will simply answer the question, "Does your facility use a safe surgery checklist based on accepted standards of practice?" Now, the use of this checklist includes safe surgery practices during each of the three perioperative periods: the period prior to the administration of anesthesia, the period prior to skin incision, and the period of closure of the incision and prior to the patient leaving the OR. In addition, with this measure, it would be for the entire year, so you can answer yes to this question if your facility used the checklist for the entire year for which you were reporting.

OP-26. With this measure, you are counting the number of procedures that matched the codes provided to you in the Specifications Manual. You will have to resource your Specs Manual to get these codes. They are divided into organ systems. So, let's say for example, under the organ system Skin, you total the procedure codes provided in the Specs Manual, and you enter that number into the Skin organ system. You would repeat this for

each organ system. If you have no procedures done under an organ system, you would then enter zero. Do not leave any blank organ systems.

OP-27, the healthcare personnel vaccine information. This is reported to the CDC and NHSN. This requires a completely separate registration, and this measure is not entered into QualityNet. This is the only measure not entered into that Portal. The facility obtains data for both inpatient and outpatient together. It is only reported once per facility. Please check within your facility as to who reports this data to the NHSN.

OP-29 and -30. Again, we went into great detail with regard to these measures in the February webinar, as they are new measures. However, a few points here to assist you in abstracting for these measures may be of further assistance. You will obtain your population number from the CPT codes on the Measure Information Form, otherwise known as the MIF. In the Specifications Manual version 8.0a, table 4, which is page 4-9, you will find this sample size requirement chart. If your facility does zero to 900, then your sample size is 63. If you have 901 or more, then your sample size is 96. All of the patients in the sample size must meet the denominator criteria in your final sample. Then you would determine if those patients meet numerator criteria. Please be aware that OP-29 and -30 have different inclusion criteria.

OP-31. This is a voluntary measure. What this means is if you do not report on this measure, it will not impact your APU, but be advised that if you do report data, it is subject to public reporting.

The five or fewer rule. If you have five or fewer cases per measure topic, then submission for that measure topic is voluntary. Hospitals that have five or fewer cases in a quarter for Medicare and non-Medicare for any measure set will not be required to submit patient-level data for that set for that quarter. By all means, you can do so voluntarily. AMI and Chest Pain are mentioned specifically on this slide, as they are combined as a

measure set. So, for instance, if you had one AMI and three Chest Pain patients for that cardiac set, you would not have to submit data for the quarter on those measure sets because the one and the three will only be a total of four. On the other hand, if you had four AMI and three Chest Pain cases, you would have a total of seven. You would need to report seven cases for the AMI/Chest Pain set. The same rule applies to the Pain and Stroke measures.

We mentioned using a vendor briefly earlier. If your facility uses a vendor to submit your data into the warehouse, your facility must authorize the vendors to do so. If you use a vendor on the inpatient side, you also have to authorize them for your outpatient side. So, they will need to be authorized separately. Vendor authorization is accessible to those with those assigned roles through QualityNet. To authorize them, you must put in a start date; assigning an end date is not necessary, and it would actually be beneficial that you do not put an end date. An end date can be done at any time. So if you do change vendors and you know when the new vendor contract will begin, you can put in the end date for the old and the start date for the new vendor at the same time.

Vendors do not have to be approved by CMS for the OQR Program. They can submit data via CART or their own tool, as long as that tool meets the measure-specific requirements for data transmission. Some states do require data for this program to also be reported to The Joint Commission. If this is the case for your state, you may wish to contact The Joint Commission directly with regard to that and vendor use.

We said this before, I'll say it again, if your facility does use a vendor, it is ultimately the hospital's responsibility to ensure that the data is complete, correct, and accepted into the warehouse before submission deadlines. Once the deadline has passed, the warehouse is closed for that quarter. No changes, additions, or deletions can be made, period.

There are multiple reports you can check to ensure your submission is complete. I also don't think we can say this enough; please do not wait until the last minute to submit your data. If there is a mistake, you want ample time to correct it prior to a deadline.

Now I just mentioned there are reports available to you to check on your submission. Whether they're submitted via CART or by a vendor, there are many reports available. We will discuss a few of these reports here in a minute. If you are using a vendor with regard to submitting the data timely, vendors may give your facility an earlier submission deadline than the CMS warehouse closure deadline. So again, follow up and ensure that submission is timely.

Validation, what is it? This is designed to verify that the patient-level data submitted by a hospital is accurate and consistent. For validation, 450 hospitals are randomly selected and up to 50 are targeted hospitals. The targeted hospitals are selected based on either failing the validation requirement or having outlier values in their submitted data.

The selected hospitals will be required to send in records quarterly for one year. The cases to be submitted are selected randomly. Once the selection is complete, the CDAC uses certified mail to request the supporting medical record to each selected case. Hospitals can submit the records in paper format, removable media, or QualityNet Secure File Transfer.

Hospitals must ensure a full medical record is submitted for accurate validation. The CDAC re-abstracts data for the clinical measures for the records received, comparing those results with the results that were submitted by the hospital. All data must be received within 45 days of the date of the request. If the hospital does not comply within 30 days of the initial request, the CDAC will send a second certified letter to the hospital, reminding them that the documentation must be received within 45 days from the initial request.

For the calendar year 2016, CMS began requesting medical records beginning with encounter dates of April 1, 2014, from up to 500 hospitals. The hospital may only submit a record one time. No additional information can be added to that record. Please verify for accuracy and completion prior to submitting that record.

There will be up to 12 records requested per hospital per quarter. To receive the full APU, the selected hospital must obtain at least a 75 percent validation score. If the hospital does not comply or fails to send the records in, a zero score will be assigned to each data element, and the case will fail for all measures in that same topic.

A hospital's list of selected cases for validation each quarter can be accessed in the QualityNet Secure Portal under the Case Selection Report. If you wish to access these reports, you must have the appropriate sign-in credentials. We'll discuss this further here in just a minute.

So, we mentioned the availability of reports to assist you in the reporting and submitting of data for this program. There are numerous reports, but for now we're going to talk about the three on this slide. The first two reports shown on this slide will be under the APU feedback reports category.

The Provider Participation Report, or PPR, is a tool that enables hospitals and vendors to monitor their compliance with Hospital OQR Program requirements. This report displays a summary of information of cases that were accepted into the clinical data warehouse. This can assist providers in making sure that they are meeting the program requirements.

The Submission Summary Report can be used if you made a submission and want to ensure your data has been successfully accepted into the warehouse. It will display the number of charts that were accepted and rejected, and there will be error codes.

The Case Selection Report is under the validation category. This report is when you want to view the cases that are selected for your facility for validation. This report is under a different report category than the first two we just talked about. Remember, the Provider Participation Report and the Submission Summary Report are under the APU category. The Case Selection Report is under the Validation category. For an in-depth discussion on some of the reports available to you, please review the presentation that was given on April 15 on this subject matter. This presentation went into detail on how to run and read some of the most commonly used reports for this program.

Some of the tools available to you on the QualityNet website are here on this slide. We will discuss more tools on our website in a moment. I will also show you some screenshots that will assist you in finding your way around the QualityNet website.

You heard us reference the Specifications Manual multiple times so far. This manual was developed to provide a uniform set of quality measures to be implemented in the hospital outpatient setting. The primary purpose of these measures is to promote high quality care for patients. The Specifications Manual should be your right hand as far as abstracting is concerned.

It will guide you on inclusion, exclusion, abstraction notes, etc. We're going to discuss the Specs Manual in more detail in just a minute. It is probably the most important tool for abstracting, so we really need to spend some time talking about it. Right now we are in the midst of changing from ICD-9 codes to ICD-10 codes, and this change will occur October 1.

CART. We mentioned this before. This is an application for the collection and analysis of data. This can be downloaded directly from the qualitynet.org website. You will see a screenshot of where to download

this shortly. If you have difficulty loading CART, please call the QualityNet Help Desk for assistance.

There is also a training manual specific to CART, which is also available on QualityNet. This application enables hospitals to manage their data. It is available at no charge, and it is a stand-alone, Windows-based system. A paper tool is also available on the QualityNet website.

The Q&A tool is a web-based question and answer system that can be accessed on the QualityNet website. We will talk about this a little bit more in the following slides. There are various training modules also available on QualityNet. I really encourage you to see what is available that will suit your needs.

The ListServe notification, as mentioned prior, is the primary communication tool used to keep you informed of everything going on with this program. You can sign up for ListServe notifications on QualityNet's home page. You can enter your email and check the programs that you wish to be informed about, and this whole process takes less than five minutes.

This slide is the home page of the QualityNet website. The second tab from the left; that's **Hospital Outpatient**. If you hover your cursor over this tab, you will see the drop-down box seen here on this slide. In the outlined box, you will see the resources that we mentioned on the previous slide. All you would do is go down to the subject you want to view and click. So, for the Specifications Manual, we would click on that tab.

As we mentioned on the prior slide, this is also where you would find the tab to download CART. You can see this tab here in the drop-down box selection as well. By the way, on this slide just under that red outlined box, you can see the link to join the ListServe. That box says "Join

ListServe," that you would click on, and it would direct you to the area to sign up for the ListServe notifications.

Once you click on the Specifications Manual from the drop-down box on the previous slide, you will see this. Now notice how many versions there are. The program has evolved since initiation and will continue to do so. There are two Specifications Manuals released every year. They are released on January 1 and July 1 of every year.

Notice that the data collection period on the left, as seen with the red arrow, this will indicate the time frame of the encounter dates. The various versions will be on the right-hand column. So, let's look at this slide for further explanation of this.

For the encounter dates of January 1, 2015 to September 30, 2015, you would refer to the Specifications Manual version 8.0a. For encounter dates of October 1, 2015 to December 31, 2015, you would use this version 8.1. To download or print out the Specs Manual, you would just click on the version that you want.

When you click on the version you want, this page will display. You can see it is divided into sections, or there's an option to download the entire manual. If you do choose to print it out, please be aware that this manual is several hundred pages long.

Now you will notice at the top it says "Release Notes." These are addendums, if you will, to the Specifications Manual. These release notes will have things that were updated or changed since the prior Specifications Manual and before the release of the new version.

As we look on this slide and at the different sections, we can see how it is divided. Each section has valuable information. The Specs Manual contains the Measure Information Form, or MIF, with algorithms for each measure along with their descriptions. The Data Dictionary section will

assist you with the data element descriptions. So for example, if you wanted to know about *Arrival Time*, you would look at the Data Dictionary under *Arrival Time,* and it will tell you exactly what section and page you can reference that information. Again, this manual is your guide on how and what to abstract. As you can see, information on your population and sampling specifications are in section 4. Section 5, you can resource for information pertinent to your data transmission.

The appendices. Throughout the manual, the measure criteria will refer to various tables and appendices. These tables will give you acceptable CPT codes, diagnoses, and other information related to the measure criteria.

The Specs Manual is vital, and you should be very comfortable with using it and know the information well. This is what guides you on the what, why, and where of abstracting these measures. Also, selected professional references for each measure can be found at the end of the Measure Information Form.

We mentioned a moment ago the Q&A tool. If you were to go back to the home page of QualityNet, you will find the access port for this tool. The box here in red is the Q&A tool, and the arrow is pointing to **Outpatient,** which is what you will choose to ask a question regarding this program. If you're confused about something or you just need further clarification, you can enter this tool and you can ask a question and a subject matter expert will provide you an answer to that question.

This slide represents some of the resources available on our website, qualityreportingcenter.com. This website is for Outpatient, Inpatient, and the ASC community, so you will always click on the **Outpatient** tab for information regarding this program. In a moment, we will look at this website.

There is an enormous amount of information for you to assist you. Please take the time to peruse through this site. Educational webinars are geared towards feedback we get from you. The goal is to provide information that is needed for hospitals. You can always view **Upcoming Events** to see if the subject matter is what you need. There is also an **Archived Events** page. You can go there and view previous webinars, which you missed but need information on. These webinars are also archived on the QualityNet website. We send out quarterly newsletters, and you will have access to them as well on this website, qualityreportingcenter.com.

Abstraction guidance available on this website can be found under the **Resources and Tools** tab. Some of these are listed here on this slide. These tools will provide guidance on how to instruct on measures when you feel like you just are not quite as clear as you would like to be. We will look at some examples in a moment.

Submission deadlines can also be found, as well as general program information. As a matter of fact, if you click on the **Program Information** tab, you will have a list of all the measure sets, timelines, including validation requirements. So let's take a look at what this website looks like.

This is the home page of qualityreportingcenter.com. The tabs in the center of the page will guide you to where you want to go. Remember on the last slide I said for this program, you will choose **Outpatient**. This is referring to the **Outpatient** blue tab you see here at the top center with the red arrow. If you allow your cursor to hover on this tab, a menu will open up to the right; this is where further options will appear. I will show you that on the next slide, but while we're on this slide, take note of the orange banner on the right that says **Upcoming Events**. This displays the upcoming webinars. To register for a webinar listed here, all you would do is click on that event. It will automatically take you to the registration

area. You can also view the current, past, and future months by clicking on **See the full calendar**.

I stated prior that if you place your cursor on the **Outpatient** tab, a menu bar will open on your right. You can see that menu here. Remember we talked about **Program Information**. This is what you would click on to get an overview of the list of measure sets and deadlines. You can see the other options on this slide as well. For now, let's discuss the abstraction guidance tools available to you. Again as I mentioned, this will be under the **Resources and Tools** tab circled here in red. We will not discuss all the tools available, so please take the time to discover everything that's available to you.

So right now, let's pretend you just clicked on the **Resources and Tools** tab. When you click on the **Resources and Tools**, the page that will display is shown here on this slide. What you see on this slide is only part of that page. There are many other resources of varying types, so please again take the time to look at all that's available. But for now we're going to talk about one abstraction tool, and that is the endoscopy tool for OP-29 and OP-30. We're choosing this tool, as these measures are newer and there are lots of questions regarding these measures and how to abstract them. Once you click on this tool, that's next to the red arrow, that tool will display.

This slide illustrates this abstraction tool. Section A relates to OP-29. Section B relates to OP-30. This helps guide you on whether or not you will include or exclude a case from the denominator and numerator for these measures.

As we said previously, there are numerous tools on our website, which will help you not only with these measures, but other measures as well, so please take the time to look at these. These can be very helpful, especially if you're new to abstraction or you're new to this program.

When you are abstracting, you want to make sure that your internal data sources for identifying cases is capturing the correct cases, meaning they are capturing the correct codes and that they meet all the other requirements for the program. Every facility is different. You may select your own cases or your vendor may. Either way, you may obtain your patient population using the codes provided in the Specifications Manual.

We had a pretty lengthy discussion about the Specs Manual. It is the most vital aspect of abstracting. You really need to familiarize yourself with it.

When it comes to abstracting, it's black or white, no gray. Yes, yes, yes, I know; it's easier said than done. Essentially what you see is what you abstract. If it's not documented, it is not available to you. You don't want to assume that something was done or a process was completed by using your clinical judgment or critical thinking. Even if you know that something must have been done or you know you have a process, if it isn't documented, it wasn't done, period. Also remember that the record you are abstracting is subject to validation. The person at the CDAC who is going to re-abstract the same record will not be assuming a step, a process, or event was done. They will abstract what they see documented. The record needs to be legible. If a CDAC abstractor cannot read the record, it will fail. Again, no assumptions in patient care are going to be made during the validation process.

Demographics as seen here on this slide: name, sex, date of birth, race, and ZIP code, all of those hospital identifiers will always be abstracted. Please make sure this is accurate like everything else that you will abstract.

We have mentioned several times the ICD-9 codes, as they relate to the measures and the change from ICD-9 to ICD-10, which will occur in October. The evaluation and management code, which you will hear it referred to as that E/M code, they are used to determine populations, so

they are important to the program, and once again, you will find these in the Specs Manual. You will refer to the appropriate appendix and table in the Specs Manual. If you look at the face sheet of a medical record, you can usually find the name, address, and date of birth type of information.

The patient identifier and payment source, the Medicare HIC number, is not required, but if you do use it, it needs to be correct.

When abstracting the payment source, your choice will either be Medicare, which will have the allowable value of "1," or non-Medicare, which has the allowable value of "2." Let me also add that if a patient is an undocumented alien or illegal immigrant, select "1."

For the AMI population, we are only interested in patients who transfer out. This is where you will refer to the discharge codes, which are, of course, in the Specs Manual. There are various scenarios that can occur, but the bottom line is if the patient is transferred out with the appropriate discharge code, they are in this patient population. You will not include observation patients that are not transferred, nor will you include patients that are discharged from the ED. The EKG needs to be interpreted by a credentialed provider, and it needs to be signed. You cannot interpret the EKG yourself. The EKG closest to the ED arrival is used when multiple EKGs are performed during the ED encounter.

Once again, refer to your Specifications Manual with regards to inclusion and exclusion terms to appropriately evaluate and know how to abstract this measure. Exclusion and inclusion terms can be found within the MIF that pertains to that measure.

In the event that the patient has an EKG done prior to arrival to the ED and within 60 minutes of arrival, enter the time the patient arrived at the ED. If there are two EKGs performed, one prior to arrival and one after, abstract the EKG performed prior to arrival. An example would be if a

patient had an EKG done in an ambulance at 9:17 and presented to the hospital at 9:30, the hospital then did an EKG in the ED at 9:35. Well, let's talk about this scenario. If there are two ECGs performed, one prior to arrival and one after arrival, abstract the ECG prior to arrival. Although the ECG performed after arrival was closest to the ED arrival time, the ECG performed within 60 minutes prior to ED arrival takes precedence. The ECG performed prior to arrival should be abstracted as the *ED Arrival Time*. The reason CMS collects pre-hospital ECG time as arrival time, is that this benefits the hospitals to have an ECG time of zero minutes. Also please remember that the data elements for OP-5 are *ECG Date and Time*. This is not tied to the data element called *Initial EKG Interpretation*.

In a scenario when an ECG is done prior to triage, abstract the earliest documented time of arrival from review of all applicable data sources to determine the arrival time. The ECG is an acceptable data source, as long as it was performed in the ED.

Median Time to ECG. This identifies the median time for ECG for Chest Pain in the AMI patients. This is a timing measure.

Evidence supports that reperfusion benefits patients with identified STEMI. The diagnosis and management of STEMI patients is dependent upon practices within the ED. Timely ECGs assist in identifying STEMI patients. Guidelines recommend patients have a 12-lead within a target of 10 minutes of ED arrival.

ED Arrival Time. This is the earliest documented time the patient arrived at the outpatient or ED. Now having said that, the arrival time should not be abstracted simply as the earliest time in the acceptable sources without having substantiated documentation. Every facility is different, and there may be various places arrival time is documented. Review the chart and use the time that's appropriate.

Ambulance run sheets are not part of the acceptable sources as well as other sources. So again, you will have to refer to your Specs Manual with regard to that. If the time of arrival is unable to be determined from the medical record, you will abstract UTD. Remember as always, you must take the record at face value.

With the *Departure Time* element, the intention is to capture the latest time the patient was receiving care. So the *ED Departure Time* is the documented time that patient physically left the emergency department. You can use any part of the permanent medical record for the ED. When more than one discharge time is documented, you will abstract the latest time. If you are unable to determine from the medical record what the discharge time was, you will abstract UTD. Please refer to your Specs Manual for inclusion and exclusion guidelines for this measure. Now, if the patient is admitted into observation, you'll use the time that order was written for your discharge time. The reason for that is, in the real world, the patient cannot always immediately be physically moved to a hospital bed, they are admitted and no longer under the supervision of the ED physician, but under the supervision of the admitting physician.

This does seem a little contrary to abstracting the time when the patient physically departed, but in effect, in that scenario they are no longer under the care of the ED. If the time of the physician observation order is not documented in the ED record, then you would have to abstract the time the patient physically left the ED Department.

Transfer to Another Facility. OP-3 is the Median Time from ED Arrival to Time of Transfer to Another Facility for Acute Coronary Intervention. You will notice on this slide and in your Specs Manual that there are three parts, if you will, to this measure – 3a, 3b, and 3c. So, when you look in your Specs Manual, you will notice the allowable values of 1, 2, and 3. In short, these values, decide whether the patient was transferred for an acute

coronary intervention, admitted to observation status prior to transfer, or the patient was transferred to another facility for reasons other than acute coronary intervention, or specific reason for transfer was unable to be determined.

These different categories will basically decide what bucket the case will be in, either a, b, or c. 3b is the reporting rate displayed on *Hospital Compare,* and this is the median time to transfer.

Let's talk about some tidbits to help you with the abstraction of the stroke measure. To determine the last well-known can be very confusing. Again, you will have to refer to your Specs Manual.

As usual, you will take the chart at face value. If there are multiple dates and times at the *Last Known Well*, you will refer to the hierarchy seen here on the slide, and this is also in your Specs Manual. What this means is if that there are multiple times given in the medical record, you will always use neurology's time first, then the admitting physician, and so on, according to the hierarchy seen here. As always, you will refer to any inclusions and exclusions that are listed in your Specs Manual for these measures. When you're abstracting for this measure, please note you will exclude patients that are less than two years of age. You will not include any patient that has expired or has left AMA.

For the Pain Management measure, a dilemma that comes into play a lot with this abstraction is the home medication list. If there are routine pain medications on the home medication list, it can be assumed that these medications were taken within 24 hours prior to arrival, so you will select **no** to pain medication. If the pain medication on the home list is PRN, then you do not assume they were taken in the last 24 hours. That is, unless there is documentation of administration of that time frame. If you look at the exclusion guidelines, you will also not include transdermal pain medications.

We mentioned earlier that the endoscopy measures are newer measures. With that whether you are new or not, there is some confusion with these measures simply because facilities are not yet used to them. They are written a little differently than some of the other measures. Let's first say that you will use the ICD-9 or -10 codes in the Specs Manual to determine your case eligibility.

All cases in your sample size will meet denominator criteria. You will then see if those cases fit into the numerator criteria. Again, we did quite an extensive webinar in February on all the web-based measures. In that presentation we really focused on the endoscopy measures. We highly encourage you to go that webinar if you need further assistance. And again all of our webinars are archived on our website at qualityreportingcenter.com.

I think that concludes our presentation, and I will turn it back over to Nina.

Nina Rose: Thank you, Karen, for all that wonderful information. While you are presenting, I actually saw that there are lot of questions coming in to the chat box that I think we should discuss. The first one I think is a really good one. "I'm new to the program. What is the difference between claims-based measures and clinical measures?"

Karen VanBourgondien: That's a good question, Nina. Simply put, claims-based measures for this program are measures that are extracted from billing submitted to Medicare. There is no active involvement in chart abstraction for those measures. On the other hand, the clinical measures require abstraction of information of varying degrees, based on the measure.

Here Nina, I see a question also. This is – this is a good question. The question is, "Can you please explain again about the measure 18? I know it's divided, but I'm not sure I really understand what you said."

Nina Rose: Yes, of course. This measure is divided. 18a is the overall rate; 18b is the reporting measure; 18c is the psychiatric/mental patient; 18d is the transfer patient. If you used just one time and included all transfers, even the complicated transfers, those times will be skewed and will not reflect the true discharge time. That is why 18b is the reporting measure. This is the time that's publicly reported.

Here's another one. "I think I heard that the web-based measures are only reported once a year, is that correct?"

Karen VanBourgondien: Yes, Nina, that is correct. Web-based measures for this program are answered annually, and the submission period is from July 1 to November 1 annually.

Here is a question, Nina. "Can you repeat where to find the abstraction tools you spoke about during the presentation?"

Nina Rose: Absolutely. You can find various tools on our website at www.qualityreportingcenter.com. Once there, you'll choose the **Outpatient** tab and go to the **Resources and Tools** section. From there, you will need to find the fact sheet, abstraction tools, and tons of other helpful information.

All right. I think – I think I found another one. "How will we know if our hospital was chosen for validation?"

Karen VanBourgondien: I can take that. Once the facility is chosen, the CDAC uses certified mail to request the supporting medical record to each selected case. Hospitals can submit the records -- again, as we mentioned, you can submit it on

paper format, removable media, or QualityNet secure file transfer. The hospitals must ensure, please, that a full medical record is submitted for accurate validation.

There will be only one opportunity per record to send in information. So, if there is something lacking in the medical record you send, there are no other opportunities to add on to what you originally sent. It is absolutely imperative that you check and double check what you are going to send before you send it.

Nina Rose: I think that's actually all the time we have for questions for today. So, I really hope you guys enjoyed the information that was presented. We would like to remind you that today's webinar has been approved for one continuing education credit by the boards listed on the slide. Please stay tuned until the conclusion of this presentation so you can complete the CE process.

Also, we would like to mention that if your questions did not get answered in the chat box, it will be answered and posted along with the presentation script on our website: qualityreportingcenter.com.

We now have an online CE certificate process. You can receive the CE in two different ways. If you registered for this webinar through ReadyTalk, a survey will automatically pop up when the webinar closes, and the survey will take you to the certificate. The second way is to utilize the survey link and the email that are sent to all participants within the next 48 hours. If there are others listening to these events that are not registered in ReadyTalk and these individuals were in the room and participated in the presentation, please pass the survey to them.

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If you have accessed our surveys in the past and are an existing user, this is what the **Existing User** page screen looks like. Use your complete email address as your user ID and the password you registered. You will then be directed to a link that will allow you to print your CE certificate. If you experience any difficulty with this process, please refer to our website at qualityreportingcenter.com. Under the **Continuing Education** link, there are also links for first time and existing users. There is also a link for further instructions for this process, should you need them.

This concludes our presentation today. We hope you heard useful information that will help you with reporting for the OQR Program.

Thank you guys, and have a great day.

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