



# Hospital Outpatient Quality Reporting Program

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## Support Contractor

### Measuring Up: Benchmarks and Quality Improvement

#### Presentation Transcript

**Moderator:**

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**Speaker(s):**

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**October 21, 2015**

**Nina Rose:**

Hello and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Nina; I am a project coordinator for the Hospital OQR Program. If you have not yet downloaded today's handouts, you can get them from our website at [qualityreportingcenter.com](http://qualityreportingcenter.com). Go to the **Events** banner on the right-hand side of the page, and click on today's event. Go down to the '**Events Resource**' tab at the bottom of the page; there will be a link that will allow you to access and print the handouts for today's webinar.

As you can see, we are live streaming in lieu of using only phone lines. However, phone lines are available if needed.

Before we begin today's program, I would like to highlight some important dates and announcements. November 1, is the next deadline for the quarter one Population and Sampling, and Clinical Data Submission. This would include encounter dates of April 1 through June 30, 2015.

The submission period for the web-based measures via QualityNet began on July 1 and extends through November 1, 2015. So you'll have both of these submissions due by November 1, 2015. We cannot stress how important it is not to wait until the last minute for your data submission. The QualityNet website gets very busy and slows down considerably during submission time. We do not want to see anyone not have a timely

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submission due to technical difficulties. CMS provides a lengthy submission period, so please take advantage of that.

Please login to QualityNet consistently to avoid your password being locked. If you do not access it, you will be sent an email via QualityNet. If you continue to not access your account, your password will become locked. To avoid this, we recommend that you access and login routinely every 60 days.

On November 18th, there will be a webinar introducing the calendar year of 2016 Final Rule. This will be presented by Elizabeth Bainger, the CMS Program Lead for the OQR Program. There was a presentation on the proposed rule that was presented on July 15. An archived recording is available on our website at [qualityreportingcenter.com](http://qualityreportingcenter.com).

On December 16, Elizabeth Bainger will also present a webinar on the Measure Development Process, and how facilities and the public influence these measures – their development and implementation. Be sure to join us for that.

Additional webinars and educational opportunities will be forthcoming. Notifications will be sent via ListServe by the support contractor. ListServe notifications are our primary mode of communication with regard to this program.

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 questions and answers received in the chat box and the audio portion of today's program will be posted at [qualityreportingcenter.com](http://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 the left-hand side of the screen. One of our subject matter experts will respond. Again, by having a live chat, we hope to accommodate your questions timely, and have real time feedback. Some of the questions that are entered during the presentation will be shared at the end of the presentation.

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Now, let me introduce our speaker.

I am pleased to introduce today's speaker, Karen VanBourgondien. Karen has a diverse clinical nursing experience, as well as experience in quality and education. She joined the support contractor in 2012 as an education coordinator. Now, I will turn the presentation over to Karen.

**Karen**

**VanBourgondien:**

Thanks, Nina. Hello everyone, and thank you for joining us today. The presentation today is a brief overview of benchmarks and how this can improve quality within your organization. The benchmarks assist facilities in identifying the best performance. Benchmarks for this program can be found on the QualityNet website. We will briefly discuss *Hospital Compare*. That data is different, but allows an avenue to compare your performance to others. This can also assist you to improve quality within your facility. The website links are seen here on this slide.

So just what is a benchmark? It is a measurement that serves as a standard. These standards can be utilized by facilities internally to motivate and promote improvement in quality and practice standards. When looking at the OQR Program specifically, we are identifying the performance of the top 10 percent of the hospitals in the reporting of the OQR data. These benchmarks are produced to allow providers like yourselves the understanding of the high standards at which the top facilities are performing. This allows you the ability to strive toward a replicable goal.

Benchmarks are calculated quarterly, and the ABC methodology is utilized for some of the data elements. We will go into some discussion of this methodology here in a minute. The benchmarks are based on the performance of the facilities from data reported. They strive to identify and represent a measurable level of excellence, which is above the average, again, driven by the data.

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Let me just introduce the two terms here on the slide if you are not familiar. Basically, non-continuous variables answer yes or no questions. Continuous variables relate to time interval questions. You can see on this slide the OQR measures that relate to each type of variable. With the analysis of data for the benchmarks, these two variables are calculated in different ways. This will become clearer as we move forward in the presentation, and we discuss analysis and the calculating methods. But for right now, keep these two terms in mind as we move forward.

We mentioned the ABC methodology on the previous slide. Under this methodology, a benchmark should represent excellence, be attainable, and identify high performance with reliable data. This methodology is used to incorporate providers of varying sizes. Well, what exactly does this mean? What is this methodology, and how is it used with all the differences and provider sizes? This methodology is applied to the non-continuous variables, which are the yes and no variables. So let's discuss this ABC methodology a little further.

Here on this slide are the steps involved for this methodology. We don't want to get into a statistics class here, but rather give you an idea of where these benchmarks come from and how they are calculated as they relate to the Hospital OQR Program.

A particular problem faced in calculating this data, is from low numbers of eligible patients indicated for a given measure. The ABC methodology recognizes this problem and uses this calculation to reduce the impact of providers with small numbers of eligible patients. So, let's break these steps down.

Now, as we just said, this ABC methodology is used to compensate for providers who may have large and small numbers. This is particularly important for facilities with small patient populations. Let's say, for example, there is a provider who has one patient, and that one patient met the measure criteria. This would be 100 percent in performance. Conversely, another provider has 10 patients, but only seven met the measure criteria. This would be a 70 percent performance.

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Well, common sense would say 100 percent is better. However, the denominator was so small in the first example, and in that scenario the performance would artificially inflate the benchmark level. The ABC methodology recognizes this problem and uses a calculation to reduce the impact of providers with small numbers of eligible patients.

Let's put the concept to use in how this relates to the ABC methodology. The denominator for these variables is the total number of patients. The numerator is the number of patients that met the measure criteria. The method takes the numerator and denominator. An equation is then applied to get an adjusted rate. So the raw rate is not used, only the adjusted rate.

Now, remember back to our example, we don't want the benchmark to be artificially inflated due to small numbers. Therefore, the equation is used to accommodate for differences in population size. Now, we have the adjusted rate. This adjusted rate is then used to rank the providers in descending order. The denominator is counted until 10 percent of the total population is reached. That gives you the top providers. At that point, the aggregate rate of the top providers is used to obtain the benchmark rate.

So looking at the continuous variables, these are not calculated using the ABC methodology. You will remember – we stated before that continuous variables are for time interval data elements. So, to obtain the benchmark for these, median is used. For the calculation of these variables, the population size is not considered. The median of the data elements are counted until the top 10 percent is reached. And you can see that this is a much simpler calculation than the ABC methodology, albeit this is a simplified explanation.

The benchmarks for this program are found on the QualityNet website. Let's take a look at some of these benchmarks and where to find them.

To locate the benchmarks on QualityNet, you first start on the home page of the QualityNet website. Select **Hospitals – Outpatient** outlined here in red.

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In the drop-down menu, you will see the selection of **Benchmarks of Care**, select this link.

This is the Benchmarks of Care page. This is the page that will open when you click on that '**Benchmarks of Care**' tab. This page does incorporate both the inpatient and outpatient benchmarks. Here at the bottom of the slide, you can see the inpatient benchmarks. To view the outpatient benchmark tables, you will just continue to scroll down on this page. You would then click on the quarter you want to view. You can see here the quarter you can choose on the left, and the file type is on the right. The view of the outpatient benchmarks is set-up the same way.

Let's say you scrolled down to the outpatient benchmarks and you clicked on Outpatient 2014 fourth quarter data.

On this slide, you can see one of the OQR benchmarks that are posted on the QualityNet website. This is the fourth quarter 2014 data using the ABC technique. The left of the dark line is the benchmark rate. To the right of that line is the national rate. Let's briefly discuss this to make sure that we're all on the same page.

Again, the benchmark rate is calculated using the top 10 percent sample. For the first data element listed in the red outline box, OP-2, the benchmark is 99 percent. The numerator was 95; the denominator was 96. The number of hospitals was 18. Well, all right, what does this mean?

Now, remember we discussed that for non-continuous variables, the yes or no questions, the ABC methodology is used. As a matter of fact, this is stated at the top of this page. So, the denominator is the number of patients which is 96. The numerator is the number of patients that met the criteria which is 95. These are the top providers representing 10 percent of the patient population. These patients were found in a total of 18 hospitals.

Now let's look at the right side of this dark line. This is the national percentage, and it's calculated using all of the eligible samples. For the same measure, you can see the national percent is 60.4 percent. This

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calculation includes everyone. The denominator is a national number of 939 patients. The numerator is 567 that met measure criteria. These patients were found in a total of 492 hospitals.

So now we are moving on to continuous variables which are the time elements. As we discussed earlier, these are calculated using median, the smaller the value, the better the performance. Let's look at the first data element on the chart here, which is OP-1. Again, the left of the dark line is the benchmark. To the right of that line is national performance. The top 10 percentile, or benchmark for this measure, is 15 minutes. The national hospital median is 28 minutes. And the total number of hospitals is 489.

There are additional graphs on QualityNet, which allow you to compare over quarters. Hopefully, this has aided your understanding of the benchmarks just a little, and will assist you in further evaluating and improving quality within your organization.

Let's pause here for a moment. I'm going to turn things over to our host for a polling question.

**Matt McDonough:** Thank you very much, Karen. And then we have come to the part of our presentation where we'd like to have a little interactivity with our audience and this is via a polling question.

And the question is this, what is the primary purpose of the OQR benchmarks for your facility? What is the primary way that you use these benchmarks at your facility? Is it quality improvement opportunities? Is it comparison to other providers? Is it creating standards of practice? Or the last option is, I don't know if we use them. And that's fine. If that's an honest answer, then that's fine.

And we'll show you what the results look like here. Two-thirds of you – pretty much exactly two-thirds of you – said quality improvement opportunities is the primary reason that these are used. And then we've got comparison to other providers; second, standards of practice; third, and

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7 percent of you don't know if you use them. And that's fine, we appreciate that feedback as well.

So that is our first polling question. We thank you all for your feedback. But I'm going to go ahead and turn things back over to Karen to continue this morning's presentation. So, Karen, we'll turn it back to you.

**Karen**

**VanBourgondien:**

Thank you. Thank you everyone for your input. We really appreciate you giving your input with regard to the polling question.

*Hospital Compare* is a public display of hospital performance.

The link here on this slide can be used to access this information. The public can utilize this in their medical decision making. *Hospital Compare* data is released quarterly, but the imaging efficiency measures and web-based measures are updated annually and are released in July.

We did a comprehensive webinar several months ago on *Hospital Compare*. If you feel like you need additional information, you can always access that on the '**Archived Events**' tab on our website at [qualityreportingcenter.com](http://qualityreportingcenter.com).

We are mentioning *Hospital Compare* here because we really want to point out that in addition to the public use of this website, you as a provider can compare yourself to other facilities.

In order to view the *Hospital Compare* data, you must find your hospital. To begin your search, select your location either through your ZIP code, city and state, or just the state. You can see this area just under the red arrow. *Hospital Compare* also shows state and national averages.

Let me stop here a minute and mention something. Customer testing found that *Hospital Compare* customers did not know what the term median meant, so, on this site you would see the word "average" used. Median was actually used in the calculation, but due to public interpretation, the term "average" is utilized on that website.



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So, back to finding your hospital. Let's suppose you've just entered your hospital ZIP code or state. You will then click on the green **'Search'** button.

This slide demonstrates the next page you will see. The page will automatically populate a listing of all the hospitals within 25 miles of your initial search of ZIP code, city and state, or just state. If you notice, on the right-hand side of the page outlined here in red, you can alter the search parameters to larger distances. You must select at least one facility in order to activate the **'Compare Now'** button circled here in red.

Let's suppose you've just selected three hospitals. After you have selected the three hospitals that you want to compare, and in our case, this slide demonstrates the three fictitious hospitals we chose, you can now select and click on the green **'Compare Now'** button.

This page shows the results of our search. You would need to scroll down the page to view all the information that is available.

Now, let's look at the *Hospital Compare* 90th percentile page. You can access this by clicking on the **'Timely and Effective Care'** tab seen here under the red arrow.

Once you select the **'Timely and Effective Care'** tab, this page will display. This is only a partial image of all the categories that you can select. To view the graphs, you will need to select one of these categories. So let's suppose we select **'Heart Attack Care.'**

Once you've made your category selection, which in this case is **Heart Attack Care** page, you would then click on the green **'Show Graphs'** button which you can see here at the bottom of this slide.

This slide shows you the bar graph for the fictitious hospitals we selected. You may choose to compare your facility to others in your area for process or quality improvement objectives. These are just a few brief examples of what you can view on the *Hospital Compare* website. If

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you're not familiar with this site or the information it provides, please take the time to examine these possibilities.

Let me just briefly mention here the five star rating; you may or may not be familiar with this. This star rating allows consumers to more easily compare hospitals using a five star scale, with more stars indicating a better quality of care. The five star rating provides a snapshot of 11 measures of the patient experience. However, other information that may be important to the consumer, like timely and efficient care, and results or outcomes of care measures, are not included in the five star ratings. The comment period for this ended on September 14th. Stay tuned for the outcomes of this rating system.

We've discussed the benchmarks and *Hospital Compare* for the OQR program. Let's talk about some of the barriers that are encountered when abstracting this data.

The data elements listed on this slide are the elements that pose the most difficulty and mismatches based on data collection and analysis. Now, each of these elements affects multiple measures. Instead of looking at every OQR data element individually, the easiest thing to do would be to talk about some of the common abstraction errors. We will also address some frequently asked questions, when abstracting these data elements.

Provider Contact Date and Time is an element that presents frequent issues in abstraction. This data element is collected for OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional, which is in the ED –throughput measure set. In abstracting this element, ask yourself, at what time and day did the provider and the patient have their first direct personal contact?

Here you can see some of the most common hurdles in abstracting for this element. No documentation of face-to-face encounter between the provider and the patient is in the record, or there's no documentation of a substantiating exam. Do not use physician-generated sheets that do not

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indicate direct contact between the provider and the patient at the source for documentation of this data element.

Use of “T” sheets is a very common method of documentation in the ED. Unfortunately, oftentimes, they are not dated or timed. There must be documentation of the date and time that the provider and the patient have their initial direct contact. If the documented date of initial provider contact is invalid or an obvious error, select UTD when abstracting. If the date of the initial provider-patient contact is not documented but you are able to determine the date from other documentation, then that is acceptable.

So let’s talk about some frequently asked questions about this data element. These questions here are generalized but capture some of the difficulties when abstracting this element. The first data element says that if the physician documents “Patient seen immediately upon arrival,” can the time of the admission be used for a Provider Contact Time?

The second question is, if there is not explicit documentation of the time that the ED physician first directly contacted the patient, can the documented time of a test that was performed by the provider, be used to abstract the provider contact time?

These questions are different, but speak to the same essential issue. When abstracting the chart, it is sometimes difficult to determine when and if the physician had personally interacted with the patient.

Before moving on, let me also mention something regarding the credentialed provider. This may include the OB nurse to initiate a medical screening exam in the OB department. When mentioning the OB aspect, your facility may send pregnant ED patients to the OB department for an initial exam.

All of you are aware that things are not always black and white when abstracting. So let’s talk about this answer in a little bit more detail. So with respect to the question, can I use arrival time because the physician documented “seen on arrival”? This can be muddy when you’re

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abstracting. The time of arrival cannot be accepted for the time of first provider contact, because there must be a specific time documented for the initial direct encounter between the patient and the provider that is distinct from the patient's arrival in the ED.

If there is not exact documentation of a specific time of direct contact between the patient and the provider in the medical record, the abstracter should abstract UTD. Now, if the provider documents "seen on arrival" and has other substantiating evidence of direct contact such as a physical exam, then you can use that documentation for the contact time.

What if the patient had a test? So let's say, for example, the record contains evidence that a skin culture was performed directly by the physician. The main abstractor may abstract the time of this encounter as the value for the *Provider Contact Data Element*. That being said, if the abstracter does not have evidence that there was direct provider contact during the skin culture, the abstractor must select UDT for this data element.

Before we talk about our next data element, which is ED Departure Time, let's look at a fictitious patient. We're going to go through a scenario and then ask a question based on that scenario. This will give us an opportunity to discuss a scenario, and what is involved in these data elements.

So let's imagine what you see on this slide is what is represented in the patient's medical record. The medical record has the following documentation: 11:50, the nurse documented the patient was transferred to Happy Hospital. At 11:56, there was documentation of "Care was turned over to EMS." At 12:02, there's a set of vital signs documented.

So think about this for a minute, and decide what time would be most appropriate as the ED departure time.

Right now, let me turn things over to our host to present this interactive question.

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**Karen**

**VanBourgondien:** Thanks everyone, for your input on that. It's great to see everyone's response.

Let's talk about the answer to the question. The correct answer in abstracting for ED Departure Time for this fictitious patient is 11:56. Although the nurse documented that the patient was transferred at 11:50, there was also later documentation that care was transferred to EMS at 11:56.

Notes for abstraction with regard to this issue are here on this slide. And as you will recall, this chart also had vital signs that were documented after this 11:56 time. However, vital signs alone cannot be used as ED departure time. If there is no documentation to support the patient within the ED after 11:56, you would abstract that 11:56 time, not the vital signs time.

So let's continue our discussion of the ED Departure Time element. This element is collected for OP-3, Median Time To Transfer To Another Facility For Acute Coronary Intervention, and OP-18, Median Time For ED Arrival To ED Departure. So ask yourself, "when did that the patient depart the ED."

If the Department Time is documented in the record but it is clear that the patient was receiving services after the time and there is not another documented time of departure, select UTD. Discharge orders and discharge instructions do not specify the time the patient left the ED. When more than one ED departure time is documented, abstract the latest time.

Disposition time is an exclusion, but a disposition sheet containing the discharge date and time is acceptable. When an order for observation is written, this order can be used as the discharge date and time. The problem abstractors have is that often this order is without a date or time.

Let's talk about a couple of questions with regard to the ED Departure Time. The first question is; the "physician documented an order for

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observation, but did not time the order. The time the patient was transferred to the floor is clearly charted. What should be abstracted for ED departure time?”

The second question wants to know; “if the patient leaves the ED, but stops in another department on the way to the room, is the time the patient left the ED for CAT scan, or the time he was transported from the CT scan to his observation room abstracted?”

Well, let’s go over these answers.

The answer would apply to both questions asked on the previous slide. You will abstract the time the patient physically left the ED. If the order for observation was written while the patient is still in the ED, then the time the order was written would be abstracted as the ED Departure Time. However, in this case, the order was not timed. You should then abstract the patient physically left the ED.

In the second question, given that the patient went to the observation unit from the CT scan, abstract the time the patient left the ED.

The next data element to be discussed is Pain Medication, which is abstracted for OP-21; Median Time To Pain Management For Long Bone Fracture. “When abstracting this element, you should ask, what is the earliest time that pain medication was administered?”

An order for pain medication is not sufficient documentation that the patient actually received the pain medication. There must be documentation in the medical record of administration of the medication in order to abstract yes to this data element. If the time of administration is not documented, you should select UTD for this data element. If multiple administration times are documented, always choose the earliest time of medication administration.

Let me also add here that for patient’s 2 to less than 18, if oral intranasal or parenteral pain medication is administered, answer yes. For patients 18 or greater, if intranasal or parenteral medication is administered, you

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would answer yes. If there is documentation of routine pain medication on the home medication list, it should be assumed that medication was taken, and you would abstract no to this data element. If the medication was ordered PRN, then it must be documented that the patient received the medication to assume it was given.

On this slide are two questions that are asked quite commonly, and there seems to be some confusion. They both have to do with medication given before the patient arrives at the ED. And the first question says, “If the ED physician documents that the patient received pain medication prior to arrival, does the route have to be included to answer no to Pain Medication?”

The second question is: “if a patient’s home medication list includes acetaminophen, would we have to infer that it was taken prior to arrival and answer no to Pain Medication? Or would we need more explicit documentation that the patient actually took acetaminophen before answering yes to Pain Medication?”

Documentation requirements for pain medication administered prior to arrival and home medications differ from the requirements for pain medications in the ED. If there is evidence of any medication with pain relieving factors received within 24 hours prior to their arrival at the ED, this excludes the patient from the measure, and you should abstract a value of no. This is in line with guidance from Version 8.0A of the Specifications Manual that states, “If there is documentation in the medical record the patient received pain medication, self-administration by physician’s office, or ambulance prior to arrival, you will select no.”

Let’s stop here for a minute, and talk about the home medication list. Hopefully we can clarify some confusion with regard to this. If there are routine pain medications on a home medications list, it will be assumed these medications were taken within 24 hours prior to arrival. So, you would select no to Pain Medication. If the pain medication on the home list is PRN, then you do not assume that they were taken in the last 24 hours unless there is documentation of administration in that time frame.

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As some added information let me also mention, that if there is documentation of a reason for not administering pain medication, for example, if the patient refused, then you would also select no.

Arrival time also has a high percentage of errors. As this slide indicates, this element is collected for multiple measures. When abstracting this element, ask what is the earliest time documented that the patient arrived at the outpatient or ED department. Look for the earliest time that the patient is known to be in the ED. You can use a face sheet or registration form as the source of abstraction, as long as the time is specified and not nondescript.

*Arrival Time* should be abstracted from acceptable sources such as ED record, observation record, et cetera. Documentation outside the accepted sources would be reference. Examples of this would be ambulance records or physician office notes. Always refer to your Specifications Manual. CMS allows the CDAC to accept a five-minute variance. If the arrival time abstracted by the hospital is within five minutes on either side of the time abstracted by the CDAC, the element will not mismatch during validation.

So let's talk about the two questions here on the slide. The first question: "can the time recorded on the EKG printouts be abstracted as the ED *Arrival Time*?" The second question; "Upon arrival to the outpatient department, the outpatient encounter is recorded as Service Date and Time." Will the terminology "service time" be acceptable for Arrival Time?

Well, on the first question here, the individual wants to know if ED staff gets an EKG first before any other admission process, so, the EKG printout shows a time of one to three minutes faster than any nursing documentation of ED arrival or face sheet admission Arrival Time. The EKG is being performed inside the ED by the ED staff and the EKG printout has the hospital name and printed on it along with the date and time of that EKG. Should the time recorded on the EKG printouts be abstracted as the ED arrival time?



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The second question is related to the term “service date and time,” and if this particular terminology is an issue with the abstraction of this time.

So let’s apply these two questions to what we see here on the slide.

Abstract the earlier documented time of arrival from review of all applicable data sources to determine the ED Arrival Time. The EKG is an acceptable source, therefore, abstract that time as the ED Arrival Time if it is the earliest documented time.

Also, the Specifications Manual does state that documentation outside of the acceptable sources should not be referenced. And, again, that’s the ambulance records, physician records, things of that nature. But with regard to this question here in the EKG, that EKG was performed by the hospital in the ED. Again, for this data element, you will abstract the earliest time the patient arrived at the outpatient or emergency department. If the service time is the earliest time in the record, then that can be used.

To summarize today’s discussion, we talked about the benchmarks and *Hospital Compare*. You can use this resources to improve quality within your organization. We also discussed some common barriers when abstracting. You will always refer to your Specifications Manual for guidance. However, abstracting is very rarely cut and dried. For situations you find confusing, we do encourage you to utilize the Q&A tool on the QualityNet website.

In addition, there are numerous abstraction tools found on our website [qualityreportingcenter.com](http://qualityreportingcenter.com) under the ‘**Video Resources and Tools**’ tab for Hospital Outpatient. I hope this information has assisted you in some way.

Please stay tuned and complete the survey. We read every survey, and we value your thoughts and your input.

Nina, back to you.

**Nina Rose:**

Thank you Karen, for all the information. Again, we hope this has been informative. Now, we would like to share some of the questions that have

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been coming in to the chat box during the presentation, and we'd like to share them with all of the participants.

So here's the first question, "Why are the 2015 benchmarks not available?" Well, this question came in very early in the presentation, but we pulled it because we get this question asked a lot. Benchmarks for 2015 and beyond are not posted yet, because, as we discussed during the presentation, the benchmarks are based on data that is collected. The data is collected, analyzed, and then posted. So in other words, it takes time for the entire process. So the data you're looking at is the prior data collected for previous encounter dates.

Now remember, on the QualityNet website, you will see the quarters that are available, and the timeframe they encompass.

Here's another good question, Karen, I think that you would be great to answer. "Can you explain again what the ABC methodology is about?"

**Karen**

**VanBourgondien:**

Yes. Well, again, to explain briefly, a calculation is utilized in this method to account for variances in the number so that the data is not artificially inflated. This provides an adjusted rate. The raw data is not used, only the adjusted data. There are several resources available to you for more information and specifics on that. As a matter of fact, there is a link to an article on the QualityNet website with regard to this information and there are others as well.

Here's a question, Nina. "For OP-21, how would we abstract the scenario?" OK, so this is a scenario they're giving. "A patient receives pain medication in the setting prior to arrival at the emergency department. The patient then receives additional pain medication in the ED subsequent to arrival. How do we abstract when the patient received pain medication prior to arrival in the ED?"

I'll go ahead and I'll answer that Nina, if you don't mind. In the Specifications Manual, it says if there is documentation in the medical

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record that the patient received pain medication – for example, self-administration, again, physician office, ambulance, what have you – prior to arrival, you will select no. Therefore, if there is any documentation that the patient received pain medication prior to arrival, or any documentation of a reason for not administering a pain medication, you would abstract a value of no, regardless as to whether the patient received medication later during their ED visit.

**Nina Rose:**

We would like to discuss the CE process so please stay tuned until the end as the survey will display at the conclusion and it will direct you to receive your CE.

I would like to remind you that today's webinar has been approved for one continuing education credit by the boards listed on this slide. Please stay online until the conclusion of this presentation, so you can complete the CE process.

Also, we would like to mention that if your question did not get answered in the chat box, it will be answered and posted along with the presentation transcript on our website at [qualityreportingcenter.com](http://qualityreportingcenter.com).

We are now a nationally accredited nursing provider. And as such, all nurses report their own credits to their boards using our National Provider number 578. Please be aware that the CEUs are only available one week after the presentation.

We have an online CE certification process. You can receive your certificate two ways. If you register for this webinar through ReadyTalk, a survey will automatically pop-up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out a survey link and an email to all participants within the next 48 hours. If there are others listening to this event that are not registered in ReadyTalk, pass the survey on to them.

They will then be able to follow the same process to receive their certificate. If you complete the survey today, you can disregard the second email survey.

# Hospital Outpatient Quality Reporting Program

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## Support Contractor

If you did not receive a response to the email you signed up with immediately, you may have firewall issues, and the email may have been blocked. Go back to the **New User** link and register with a personal email. I know we mentioned this prior, but we continue to have issues with this as people are not using a personal email account after problems receiving their certificate.

This slide displays what the survey will look like. It will pop-up again at the end of the event, and will be sent to all attendees within 48 hours. Once the survey is completed, click **'Done'** at the bottom of the page when you are finished.

This is what pops up after you click **'Done'** on the survey. If you have already attended our webinars and received CEs, click **'Existing User.'** If this is your first webinar for credit, click **'New User.'**

Please register a personal email like Yahoo or Gmail, since those accounts are typically not blocked by hospital firewalls. Remember your passwords since you will use it for all of our events.

If you have accessed our surveys in the past and an existing user, this is what the Existing User's 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 difficulties with this process, please refer to our website at [qualityreportingcenter.com](http://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 everything for today, so I hope you enjoyed the webinar. And enjoy the rest of your day.

**END**