# Hospital Outpatient Quality Reporting Program

## Support Contractor

## Improving Quality with the Hospital Outpatient Quality Reporting (OQR) Program Presentation

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Marty Ball: Hello, and welcome to the Hospital OQR webinar. Thank you for joining us today. My name is Marty Ball, and I'm the Project Manager for the OQR Program. As you can see, we have slightly different platform. We're using this time – we're live streaming in lieu of using phone lines only.

Before we begin today's program, I would like to highlight some important dates and announcements. August 1 is the next deadline for quarter one data in the voluntary population and sampling submission. This will include encounter dates of January 1 through March 31 of 2015. Remember, this is the first quarter that you will not be submitting data for OP-6 and -7. The submission period for the web-based measures will begin on July 1 and extends through November 1, 2015.

On June 17, we will be presenting a webinar geared towards new abstractors. This will give you hints and tips for abstracting. This will be directed towards those new to the program and/or abstracting.

On July 15, there will be a webinar regarding the calendar year 2016 Proposed Rule with Comment Period. This will be presented by Elizabeth Bainger, the CMS Project Lead for the OQR Program.

Additional webinars and educational opportunities will be forthcoming. Notifications will be sent by ListServe by the Support Contractor. This is the primary mode of communication for news and updates regarding the OQR Program. Please make sure you are signed up for the ListServe notification service, which can be done on the homepage of QualityNet.

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

During the presentation, as the operator stated earlier, if you have a question, please put that question in the chat box located on the left side of the screen. 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. Again, this is a change based on the feedback we are getting from you in regards to this. Some of these questions will be posted and shared towards the end of the presentation.

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

Now I will turn the presentation over to Karen.

Karen

VanBourgondien: Thank you Marty. Hello everyone, and thank you for joining us. The presentation today is the basic overview of essentially looking at information and data for your facility and using that information to discover how you can make improvements. The entire purpose of the Hospital OQR Program, at the very core, is making things better for patients.

When looking at the OQR Program and how to improve your measure data, there are resources available to assist you. There are multiple reports on the QualityNet website that will provide you with various types of data. We just presented a very comprehensive webinar on this subject matter last month. If you missed that webinar, please go back and view it, as it goes into detail on some of these reports available to you and their uses. There are some extraction tools available on QualityNet as well as our website qualityreportingcenter.com.

The ListServes and newsletters provide updates and valuable information regarding the measures as well as to inform you regarding the Specifications Manual, clarifications, updates, etc. Public recording information, which is also found in QualityNet, is seen first as a preview report. This preview report is available for 30 days. You will be sent notification when this report is available. The most current preview period ended on May 2.

Many facilities use this public reporting data as invaluable information. This is where the rubber meets the road, so to speak. Facilities aspire to have their

publicly recorded data in the top 10 percent. *Hospital Compare* is where the patients, the consumers, see this information. It represents a platform for your facility and how the public views your hospital's success.

Before we get into how you can use data generated by either the QualityNet reports or internal reports to improve quality, let's briefly discuss the data itself. The next two slides represent some of the OQR measures. We are including OP-6 and -7. However, as you are aware, May 1st was the last time you reported on these. So they are included here, as the data was collected on them and resulted in such high compliance that these two measures are now topped-out. Essentially, this means that hospitals did such a great job with compliance that CMS does not require reporting on these measures from this point moving forward. We will look at specific data in a moment.

Before we get into specifics, I do want to mention that we will not be discussing all the measures that pertain to the OQR Program. We will be focusing on the chart-abstracted measures during this particular presentation. So, you will notice that many measures, particularly the claims-based measures, will not be discussed. On this slide, you can see many of the chart-abstracted measures, the measure type and the frequency that they are reported.

This is a continuation of some of the abstracted measures. OP-19 is included on this table. We have left it in this presentation, as there are still some individuals who will inquire about this measure, and there was some earlier data collection. However, please be aware that this measure has been removed, and you do not report on this measure.

This slide represents the newer measures. As you are aware, facilities have just begun collecting data on these. You will begin reporting them in July when the submission period opens. The submission period for hospitals for the web-based measures is July 1 through November 1, 2015. Remember, the reporting of OP-31 will be voluntary. You can choose to submit data or not for that particular measure. Please be aware that if you do report on OP-31, this data will be subject to public reporting.

OK, we're going to discuss some data briefly on the next two slides. We will not go into great detail, as that is not a particular focus of this presentation. However, it is worthy of discussion to assist you in viewing your *Hospital Compare* reports, QualityNet reports, and in addition, any reports your facility may run internally. This chart represents data that HSAG has obtained through data reported by facilities under the OQR Program. We won't discuss all of these, but I do want to just point out a few things that will help you look at some of the reports and better assist you in understanding the basics. Also, this discussion will support you in understanding how data is important in determining what areas your facility may need to improve upon.

So let's talk about the information here. Again, OP-6 and -7 are included, as data been collected and utilized in the decision to retire them. These have only recently been topped-out and will no longer be reported, as we said prior. We can see here on this slide the mean and median for these two measures are very high. There is very little variance for these two measures which indicate compliance will be sustained, lending credence to why they were topped-out.

Let me draw your attention to the OP-23 measure here on this chart. We are going to use this measure to talk about mean and median first. The reason we're talking about these two is they are used quite commonly, and sometimes people assume they are the same. In general, the mean is sufficient if the data is distributed evenly. However, if data is skewed, the median will be a better measure for the center distribution point.

All right then, let's switch gears and talk about percentile. This is also very commonly used in reporting data. Let's again use the OP-23 information. You will notice that the 95th percentile, as shown here on this chart, is 100 percent. Well, what does that mean? In a nutshell, what this means is that of the 2,851 hospitals shown here, at least five percent are at 100 percent. Or another way to look at it is that 95 percent of those cases are below 100 percent, so about 142 of the 2,851 hospitals are in this percentile. Now when you are looking at percentage measures, the higher the percentage, the better. When looking at timing measures, the lower the number, the better. This distinction we will see in a moment.

For now, let's look at another percentile to review. Again, looking at the OP-23 measure data shown here for the 75th percentile, this means that 75 percent of the 2,851 hospitals are below 84.6 percent, or at least 25 percent are 84.6 percent or higher. Remember, on this slide we are looking at percentage, so higher is better. If your facility is performing at a 75th percentile, you would want to increase your quality by performing at the 95th percentile.

Now, let's look at timing measures. On this slide, these data are the timing measures. So the data displayed is in minutes, so the lower the number the better. Let's look at OP-5, circled here in red, Median Time to EKG. The number of hospitals in this calculation is 2,631. The mean is 11.9 minutes. The median time is 7.5 minutes. As we mentioned before, when there is a larger difference between the mean and the median, the median would represent a more accurate value of the center. Let's look at the 95th percentile for this measure. To interpret, we can say that five percent of the 2,631 hospitals have an EKG time of one minute or less, or 95 percent of the hospitals have an EKG in more than one minute.

Let's look at another measure just to make sure we've made it clear. OP-1, as indicated by the red arrow, Median Time to Fibrinolysis, let's look at the 95th percentile. The number displayed is 15. That means that out of 610 hospitals in this calculation, five percent of those hospitals have 15 minutes or lower, or 95 percent of the 610 hospitals achieved this measure in more than 15 minutes. For

the 75th percentile, the number displayed is 23. So 25 percent of the hospitals have a median time to fibrinolytics at 23 minutes or lower, or 75 percent of the hospitals have a median time to fibrinolytics in more than 23 minutes.

Now you have a very basic idea of how to interpret data. So you might ask, "OK, I have numbers, now what?" That's a critical question. You can have all the data in the world, but if you don't do anything with it, what's the point?

OK, we've come to a polling question. So at this time, I'll turn it over to our host to introduce the question.

Operator: Our first question for today's event is this, "Who is responsible in your facility for quality improvement initiatives?" Your four choices are, "Our designated team or department," "The OQR rep is solely responsible," "The OQR rep plays some role or has some input," or the last answer is, "I have no idea where this data goes." So please select one of those four options. Again, your response is anonymous, but you do want to select one of those four, and then click submit.

All right, Karen, we'll go ahead and we'll close this poll question. And you can see on the screen, we've shared the results with everybody, 78.9 percent of our attendees today say that their designated team or department at their facility is responsible for these quality improvement initiatives. That's out of almost 600 responses. So we do appreciate you answering and participating today. We'll be back in a little bit with another polling question. But for now, we'll turn this back over to Karen, and we'll resume our presentation. Thank you so much, and we'll get back momentarily.

Karen VanBourgondien: Quality improvement is an area entirely in itself. The scope of this presentation is to provide you with a general knowledge on why you report these measures, why it's important, and give you some idea of what you can do to improve quality within your facility. Having information on your facility and how your facility measures up, so to speak, on a state and national level is important. Just as important to having these data is making use of it. Using data, whether it's obtained from the sources we have mentioned or by your own internal data analysis, can really provide platforms for you to initiate quality improvements.

Some of the objectives you can strive for are noted here on this slide. Rather than go through each measure in the OQR Program and provide details on how to improve your facility's performance as it relates to the measures individually, it would make more sense to provide an overview on quality improvement ideas and tools.

Later in the presentation, there will be a specific example of how one facility improved upon two of the OQR measures. What that facility did to achieve improvement can be accomplished in a number of ways, and hospitals of varying sizes and capabilities have different implementation styles. The objectives noted

on this slide can be held in a view of an outline to help guide you as you proceed in whatever performance issues you are evaluating.

So let's pretend you just looked at your hospital's preview report, and there are areas in which you need to improve. What in the world to do? Where do you start? If you work in a larger facility, it is very likely you have a designated team that is focused on just this problem. If you are a smaller facility, this may fall in your lap. Either way, the focus of this presentation is an overview. The first question to ask when you look at data and it is not at the level you or your administration wants – is to ask, "What the heck is wrong? Why aren't we doing better?"

Analyzing trouble spots can be lengthy. You may also hear the term Root Cause Analysis or RCA. This is a necessary first step to get to the bottom of what the areas of improvements are. To put it in a nutshell, the purpose of the RCA is determining the underlying causes of the issues. This process is not a quick determination, and depending on the issues and the extent of the problems, it can take an extended period of time. Often, you uncover issues that you never suspected were issues.

How to fix the problem? Well, once you get to the root of the problem, you have to implement a plan to correct the issue. This will likely involve a multidisciplinary team approach. If the left hand doesn't know what the right hand is doing and why, it will not be as effective. Involving the front line staff is imperative. These are the individuals that are going to actually carry out whatever changes are deemed necessary. Getting their buy-in is critical. Nurses, techs, et cetera, often feel stretched to the limit. Sometimes, seeing the quality person coming with a clipboard for suggested changes does not always go over well initially. We will discuss that issue in a little more detail here in just a moment.

So at this point, we have just figured out what the problem and how to fix it. That's great. Sustaining the improvement is essential and not always easy. Continuous monitoring is a “must do.” Please keep in mind if you are randomly monitoring things to ensure compliance, you really need to make sure you are sampling a big enough sample size. If performance drops off, it is more effective to have an immediate reaction and correction. This will be easier to correct if performance drops off and is identified quickly.

So we have talked about some initial analysis. There are a number of issues that can cause the need for improvement. For the purposes of this presentation, we're going to talk about the three shown here on the slide. These three are extremely common issues across the board. So let's pretend for a moment that you have looked at your *Hospital Compare* report, or your facility ran internal data, and there are some areas of improvement needed with some of the measures recorded for the OQR Program. You did your analysis, and you discovered that the issues listed here on these slide are the areas of improvement.

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The next few slides will give you some ideas that may assist you in this type of scenario. Since the majority of you are abstractors, we really want to gear things towards your world. We will discuss each one of these in a little bit more detail.

Knowledgeable abstractors on staff are essential. Accurate abstracting is a vital piece of ensuring core measure compliance, as well as correct record-keeping. So dotting every “i” and crossing every “t” is a necessity. Knowing the rules and optimizing the resources available, including the Specifications Manual, updates, and other resources that we mentioned earlier, all play a key role. Having an engaged and committed team of everyone knowing their role is a key objective. Communication is vital. Developing and maintaining processes, including inter-rater reliability to maintain accuracy, will really help propel you to the next level.

As abstractors, running frequent reports and even daily reports can also improve accuracy and quality. This can identify weak spots, trends, and hot spots. This can enable a more proactive approach rather than a reactive approach in addressing the core measure standards. Sharing these results to keep everyone aware, including staff, management, and administration, will help keep everyone in the loop, so to speak. I don't think it can be said enough that communication is the vital key in everyone's success, so share the wisdom.

Documentation across the board poses numerous issues. As abstractors, you are constantly combing the record to see if this or that is documented so that you know how to abstract the chart. If it isn't written, it isn't done. Let's look at OP-29, for example. You have a patient that meets all the denominator criteria, and the physician does not document on the colonoscopy report a follow-up colonoscopy interval. You just want to scream because if he would have just charted that one thing, you would have had a case that met denominator and numerator criteria. But it did not happen that way because that piece of the puzzle was missing. And that's an area you have a denominator met but not numerator criteria. That's just a short example, and I know all of you have tons of stories just the same.

Running various reports and collecting data is key. Again, though you need to really use this data you're collecting, having a multidisciplinary team to provide support, expertise, and guidance to the entire hospital team is really what you want. Having an abstractor in attendance in the process improvement meetings will give credibility, credible knowledge on the variances, trends, and issues with documentation that you may have discovered during your analysis. This will immediately put the "what can be done to correct this question" right on the table.

Now let's talk just a minute about the third bullet on this slide. Having any software change added to your Electronic Health Record (EHR) to address consistent documentation issues can be beneficial. This can be anything from tagging on details in certain areas, adding check boxes or entire assessments, or using alerts such that the chart cannot be closed until an area is documented on. There are a multitude of situations and solutions with regards to this. Having

things changed on standardized order sets can also be very beneficial. For example, for OP-30 it is necessary to know the interval of the previous colonoscopy. Having a change such as “Date of last colonoscopy” added to the standardized H&P or order set that your facility uses may be helpful in providing the necessary information needed for helping to meet the measure criteria.

So you now that you have some issues identified, getting input from staff as to the feasibility of implementing things is also important, as we have said. When you implement any change, you would again monitor its success. It may be necessary to make additional tweaks and changes to optimize results and keep things moving in a positive direction.

As seen here on slide 19, we've previously spoken about keeping staff in the loop to help quality and performance all around. This slide demonstrates some tools used by facilities to help with staff education. Ideally, education of staff should begin with the new hire and be continuous. Engaging staff on a continuous basis can be challenging. Posters, handouts, and PowerPoint presentations can be used to provide education on the measures and/or changes. This can also be in the form of self-learning modules so staff members can view these presentations as their time allows.

Again, they are much more likely to contribute if they understand why there are changes and what it means. There's nothing worse than being told you have to do something and not having any idea why. They may already feel overworked, so this may be viewed as just another thing administration is having them do. Communication is the name of the game. Most people really do want to do the right thing. Keeping them informed and updated goes a really long way. Posting progress can be a morale booster by letting staff know that they're really doing a great job.

Staff meetings or huddles are effective and do not have to be long and complicated. You can communicate data in areas that are in need of improvement. Remember, communicating the reason why this data is being collected and why it's important is essential. As we've already said, if the staff doesn't know why they have to chart something or why there is a change in process, they are going to be much less likely to carry this out.

You may also consider a huddle notes area. This can be an electronic shared space that will allow feedback with regard to any changes that are going on. If they do have questions or disagreements, this can also be an area to get those cards on the table. How you choose to keep your staff involved and engaged is individualized based on your facility and the unique challenges that exist.

Education does not stop at the front line staff. Keeping everyone informed will increase your chances of success. Having a multidisciplinary team approach will provide a broader perspective and a broader understanding of a situation.

Physicians are hugely important. Even if we take the previous example from a few slides ago regarding OP-29 and the lack of documentation, educating that physician that they have to document a 10-year follow-up colonoscopy on the colonoscopy report. In the practical world, this may be easier said than done. Maybe providing laminated cards for them to carry or stick on arrows on the order sets, and changing order sets, are to name a few things you can do to accomplish the necessary documentation.

OK, we've come to a polling question. So at this time, I'll turn it over to our host to introduce the question.

Operator: So without further ado, let me go to our second polling question of the day. And this question is, "What primary resource do you access for information on your OQR performance?" Your choices are, "*Hospital Compare*," "QualityNet reports," "Internal reports," or "None."

We're going to go ahead and close our second poll question here, and let's take a look at our responses. It looks like more than half of you have selected QualityNet reports, 50.6 percent of you. And that is the most popular resource that is utilized for information on your OQR performance, followed secondly by 37.7 percent of you who selected internal reports.

So we do thank all of you for your responses. We appreciate your participation and your candor. But without further ado, we're going to go ahead and hand it back to our presenters to continue the event, and we'll be back with another polling question shortly. Thank you.

Karen VanBourgondien: We have talked about some ideas on quality improvement. Since there is a huge range of issues and scenarios, it may be helpful if we use an example to illustrate how these suggestions may be used to get to the bottom of what issues can be addressed and thus improve quality within your facility. Although this is an example, it will focus on two of the ED-Throughput measures. It lends to the significance of analyzing the areas where you need to improve.

The example hospital shared with us how they specifically handled issues they were having with some of the OQR measures. As demonstrated on this slide, they saw a problem, they developed a plan, they implemented this plan and monitored and maintained the success. Now, this example is specific to this hospital. Your changes and improvements may be completely different. This is an example only. Furthermore, CMS does not regulate or endorse any specific changes. This is solely at the discretion of the facility. It is your facility, you know the ins and outs better than anyone. So again, the improvements you make for your hospital are unique.

So let's look at this hospital's success story. This facility has approximately 48,000 ED visits a year. They shared with us their own analysis and how they improved

their performance for two of the OQR measures. We will discuss their findings on the next few slides.

The facility wanted to decrease their times for these two measures, OP-18b and OP-20. This slide represents the result. Essentially, they did a workflow analysis looking at all the different areas that a patient might travel from door to disposition, whether it be an admission or discharge from the ED. Conducting an analysis of your entire ED can provide information as to where your weaknesses and areas of improvement may be. They looked at both the ED front, middle, and end processes. This included the patient access and registration process as well. Staff mix and staff development within the ED was also evaluated, as well as the departments that the ED interacted with. So the laboratory and the imaging turnaround times were also reviewed. They evaluated the admission and bed management process. Finally, they looked at the patient throughput on the inpatient side, and how quickly the discharges were occurring on the floor.

So let's a look at this analysis a little bit closer. As a patient enters the door, the first order of business is usually registering that patient. This particular facility found that this first step in the process was taking too long. A registration process exceeded this facility's recommended standards. This, in turn, delayed the patients seeing the triage nurse. They found that the process was not seamless and was fragmented. Another area of delay was the use of lab and imaging such as x-ray, CAT scans, et cetera. The turnaround times were delayed and presented with an area of tremendous improvement. This particular facility was also a teaching hospital. Every service line with residents was required to present their case to their attending physician. This too was causing further delay. They also found that their admission process was too lengthy and resulted in bottlenecking of patients.

If you are at all familiar with the ED, this delay continues down the line. The next patient walks in the door, they're delayed, and the whole delay process starts over again. Hence, part of the reason for an extended length of stay was due to the initial delay.

This particular facility had a problem with the ED patients as well as the inpatient population. Looking at the inpatient discharge side, patients that were being discharged from an inpatient bed and were not being physically released in a timely manner, this again causes delay. The ED cannot move admitted patients out of the ED if the bed is not ready. They discovered that this was of particular concern if the patient was discharged late in the afternoon, as later discharges were even more delayed.

Essentially, they recognized the need to get all of the decision-makers at the table. They developed what they referred to as the ED Medicine Task Force. This task force included a multidisciplinary team. They all came together to help troubleshoot and brainstorm on the various obstacles. Based on their findings that were just summarized, they initiated changes in their protocols. Since this was a

teaching hospital, they had to reduce the time that an intern would take in discussing things with their attending physician. Further changes made in their current processes allowed their fast track area to absorb some of their "Admitted but waiting for a bed" patients.

They added a staff member who was an RN and acted as a flow coordinator. This staff member worked in conjunction with the charge nurses and helped facilitate getting the patient admitted or discharged. This individual would also attend the A.M. bed meeting. This would allow them to have updated information regarding how many beds were available or becoming available. This individual, throughout the day, would communicate with triage and admitting teams to ensure they were getting the level of care on admitting orders timely. Monitoring the waiting room and constantly communicating with the charge nurse and the primary nurses was constant to ensure an even flow. She would also communicate with the unit clerks and put in transport orders.

Although every facility and every ED department is different, some things do not vary. You are always busy, and there are always a seemingly endless flow of patients. This flow coordinator position really seems to ensure that things don't stop and prevent the patient from being seen, admitted, discharged, receiving pain medications, et cetera. Any or all of these things will affect your data and your quality.

As triage would sometimes get busy, the process was changed in that, if there was an influx of patients, the patients would be taken directly to a bed. The initial triage and registration would be done at that time, bypassing the front triage and registration process altogether.

They had difficulty getting the staff to buy-in on the changes. They had to convince the staff that triage is a process, not a place. As we noted before, it's extremely important for everybody to be on the same page. This really does improve your chances of success.

They added a new greeter position at the front entrance which would allow the patient to bypass registration if need be. The greeter is able to present the patient to the documentation system, and either go directly to registration or directly in the back if a bed was available.

The registration process had opportunities to streamline the paperwork. Instead of doing the entire registration process in the front, it was divided, and the completion was done at the bedside. This was a tremendous help in quickening the process.

So again, this facility was able to improve times on two of their OQR measures. Every facility and improvement issues are different. This again is just an example of one hospital. Your hospital and its challenges are different. Based on that comment, your needs and improvement will be different as well.

If we compare this facility to the national information of all hospitals reported, as demonstrated on this table, you can imagine why they were eager to initiate change to improve their data. As you can see here for OP-18b, the median time for facilities is 141 minutes. This hospital's was 172 to start. For OP-20, the median time on this chart is 25 minutes. This hospital's time before their changes was 40 minutes. They were able to improve both of these measures. Well, this is only a small example of how using data from the reporting you do for the OQR Program can assist you in improving quality. Again, CMS does not dictate your quality improvement initiative. This is just this facility's example on how they were able to improve their hospital's performance.

We hope you found some of this information useful in the reporting of the OQR Program.

OK, we've come to a polling question. So at this time, I'll turn it over to our host to introduce the question.

Operator: Our polling question is this. It is a simple one. Wrapping up today, this question is, "Have you evaluated your facility's outpatient data on *Hospital Compare*?" This is a simple yes or no question, so please select either yes or no, and then click that gray submit button.

All right, Karen, I'm going to go ahead, and we'll close this final poll question. And let's take a look at our responses today. From a four to one response rate, 80 percent of you, almost 80 percent, say yes, you have; 79.5 percent of our respondents today, almost 550 responses to this question, yes, you have evaluated your facility's outpatient data on *Hospital Compare*. So to all of you who've participated in all three of our poll questions today, we do thank you so much for your responses. But that is going to do it for our third and final question, so I'm going to hand it back over to our presenters to resume the presentation and our conclusion. Thank you.

Marty Ball: All right Karen, it looks like one of the first questions we had coming in is on slide 12. “It looks like the OP-4 has a high compliance. Why was this measure not topped out?”

Karen VanBourgondien: Yes. Yes, you are correct. The slide that was shown, slide 12, did demonstrate data for all hospitals. However, with further breakdown of hospital data, particularly hospitals with smaller size, the compliance was not that high. The decision was then made to maintain this measure. In addition, OP-4 is not a stand-alone measure. Basically, what that means it is part of the AMI and the Chest Pain measures.

Marty Ball: Great. I have a question. “How do you sign up for the ListServe notifications?”

You can sign up for the ListServe service on the QualityNet homepage. You do not need to sign in to a QualityNet account. This is in the public domain. There will be a blue box on the left-hand side of the screen. It is the third box down. It will say "Join ListServes, Notifications and Discussions." Just click that link, and it will take you where you can go to the sign-up page.

Karen VanBourgondien: Marty, here's a good question as it relates to this presentation. The question is, "Where can I get more information on how to do a Root Cause Analysis?" And again, that's a really great question.

Performing a Root Cause Analysis, or an RCA, is quite an extensive process. It also depends on the issues at hand, as we mentioned during the presentation. There are numerous resources available to you with regard to this. Probably the easiest and most helpful would be accessible by the Internet. If you do not have this information available to you internally, there are a few organizations that even have instruction formats, tutorials, PDFs, tables – all of that you can download. Some of these reference materials can be found at cms.gov, the World Health Organization, The Joint Commission. I would recommend you just enter into your browser one of those organizations with the phrase "Root Cause Analysis." This should direct you right to this material.

Here's another question, Marty. "Where on QualityNet can we get reports, and what information do they provide?"

Marty Ball: All right, Karen. Well, the folks in the facilities, they can access reports on the Secure Portal if they have their appropriate security credentials. There are numerous reports available. The reports can provide your hospital list submission, performance, and rejection information on your data. To gain a comprehensive overview of this material, as it is extensive, you can view the tutorial available on the QualityNet.org website, or you can view the webinar we presented in April on this subject matter. The educational webinars – we archive all of those, and they can be found on www.qualityreportingcenter.com under the archived Education tab.

Here's another question, Karen. It says, "You mentioned there are abstraction tools. What are these tools, and where can I find them?"

Karen VanBourgondien: Yes, that's a good question. There are a number of abstraction tools available on our website at www.qualityreportingcenter.com. Once on the homepage, you would select "Outpatient," and then "Resources and Tools." There, you will find fact sheets, guidelines, and other tools available with regard to some of the chart-abstracted measures.

Excuse me, here's another question. "We are a small facility. Where can we find information about quality improvement processes?" If you want further assistance in this regard, again, there are numerous resources available. You can, as

suggested prior, enter the phrase, for example "healthcare quality improvement" and one of the previous mentioned resources. In addition, there is the Health Resources and Services Administration, I believe. They have quite a bit of information on this subject matter. Their direct website is www.hrsa.gov. If you just put that in, most of that website is all geared towards healthcare quality improvement.

Marty Ball: Okay Karen, here's another question. "I understand we will be reporting OP-29 and -30 starting in July. Will these measures be reported now every year?" That's correct. These measures will be reported annually as part of the Hospital OQR Program. Again, the submission period for hospitals to enter the web-based measures is July 1, 2015, through November 1, 2015. That time period is coming right up. These measures will be entered into the Secure Portal of QualityNet. The entry will be done with data from January 1 through December 31, 2014.

And here's another question. It's a good question because we get this in our call center quite a bit. And that is, "I just want to clarify. I no longer have to submit the surgical measures, the OP-6 and -7. Are these measures still going to appear on the CART tools?" Well, that's correct. The 2015 Final Rule removed these surgical measures because they were topped out and have minimal room for improvement. So that means that any data submitted for 2015 encounters and forward will exclude the outpatient surgical measures. You still will see the surgical measures on the CART tool, but these will not be used, so you don't have to answer those questions for your data submission. If your facility inadvertently submits that data, it will be suppressed from public reporting.

Okay. I think that's going to conclude today's presentation. I'd like to thank Karen again for all of the helpful information that she provided today. We'd like to remind you that today's webinar has been approved for one continuing education unit by the boards listed on this slide. Please stay on the line until the conclusion of this presentation so you can complete the CE process.

We now have an online CE certificate process. You will receive the CE certificate in two ways. If you registered for this webinar through ReadyTalk, a survey will automatically pop up when the webinar closes. The survey will then take you to the certificate. The second way we have, we will be sending out a survey link in the email to all participants within the next 48 hours. If there are others listening to this event that did not register in ReadyTalk and these individuals are in the room with you and participated in this presentation, please pass the survey on to them. And they will be able to follow the same procedure to receive their certificates. If you complete the survey today, you can disregard the second email.

This slide displays what the survey will look like. It will pop up again at the end of this event and will be sent to all attendants within 48 hours. Once the survey is completed, click "done" at the bottom of the page when you're finished. After you hit the "done" button, as I just said, this is what will be displayed. If you have

already attended our webinars and received CEs, click the “Existing User.” If this is your first webinar for credit, then click the “New User” link. This is what the new screen looks like. So you need to register a personal email like Yahoo or Gmail, since these accounts are typically not blocked by your hospital’s firewalls. Remember your password that's going to be used for all of our events and to retrieve future CE credits.

If you have assessed our surveys in the past and are an existing user, this is what the existing user screen looks like. Using your complete email address as your user I.D. and the password that you registered, you will then be directed to a link that'll allow you to print your CE certificate. If you experience any difficulties with this process, please refer to our website at www.qualityreportingcenter.com. Under the Continuing Education link, there are lots of links for first time and existing users. There's also a link for further instructions for this process should you need them.

This concludes our program for today. I'd like to thank Karen for the valuable information that she shared with us today. We hope you have heard useful information that will help in your OQR Program. Thank you, and enjoy the rest of your day.

**END**

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