Outpatient Quality Reporting Program

Support Contractor

Tracking Quality Improvement by Using Hospital OQR Data

Presentation

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Karen VanBourgondien: Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the Education Coordinator for the OQR Program.

Before we begin today's program, I'd like to highlight some important dates and announcements.

The Quarter 4 data deadline has been extended until June 1st of Quarter 4 2015. Now remember, these encounters are from October 1st through December 31st, 2015. In light of this extension, please do not wait until the last minute. If you can get your data in early, we recommend you do so. We don't want you to miss the deadline because you're having technical difficulties at the last minute.

A communication was sent out last month letting hospitals know that the preview period for the July 2016 Hospital Compare release was available May 6th, rather than the original due date of the 22nd of April. Hospitals will still have 30 days to review their data prior to the public release of information in July 2016.

As always, please remember to keep your QualityNet passwords current. The easiest way to accomplish this is to sign in to your account every 60 days or so.

On July 20th, we will be presenting a webinar on the 2017 proposed rule. This will be presented by Elizabeth Bainger, the OQR Program Lead from CMS, and Vinitha Meyyur, the OQR Measures Lead from CMS. Please join us for that webinar so you can be aware of all the changes that will be forthcoming with regard to this program. Any other additional webinars will be sent via ListServe by the support contractor.

The learning objectives for this program are listed here on this slide. This program is being recorded. A transcript of today's presentation, including the question and answers received in the chat box, and the audio portion of today's program will be posted on 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 side of your screen. One of our subject matter experts will respond. Some of the questions that are entered into that chat box will be shared at the end of the presentation. So let me introduce our speakers for the day.

Our first speaker is Pam Harris. Pam has diverse clinical experience as well as experience in education, utilization, management, and quality. Pam is a project coordinator for the OQR program.

Our second speaker will be Kristy Swanson. Kristy provides expertise in analytic project management for various federal and state clients, including the Centers for Medicare & Medicaid Services. As an analytic manager in informatics, Ms. Swanson is responsible for monitoring data submission compliance, analyzing hospital reported data, and providing analysis to support the outreach activities associated with CMS' Hospital Outpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contract. She holds a bachelor's of interdisciplinary studies with an emphasis in business and communications from Arizona State University. So now, I'm going to turn things over to our first speaker, Pam Harris. Pam?

Pam Harris: Hi, everyone. Thanks for joining us today. Today, we're going to discuss some data as it relates to the OQR Program. We will discuss some benefits to having this data and ultimately how it can benefit your facility and promote quality improvement within your organization.

Before I hand things over to Kristy for the actual data and the analysis of the data, let me just briefly review payment update. Sometimes there's a little confusion on encounter dates, reporting times, and payment year. Let's review this before we get started. On this slide, we have summarized things for the 2017 payment year. For the Outpatient Quality Reporting Program, the 2017 APU is made up of 2016 reporting with the 2015 data. Briefly, when talking about payment year – and here we're using payment year 2017

because that is what we're dealing with right now – every year there are quarterly submissions and there are also annual submissions of web-based measures.

The data are collected one year and reported the next for payment the following year. Essentially, you can look at it this way: you have an encounter period of 2015. This is when the patient is receiving the services and those are the charts you are looking at. You enter that information into the submission tool in the year 2016 to get paid for 2017.

Now, for the sake of simplicity and consistency, we will refer to the data presented as APU payment years throughout this presentation. Right now, let me hand things over to Kristy to go over the data. Kristy?

Kristy Swanson: Thank you, Pam. Today we will present an overview of some of the data trends we've seen through the OQR Program from APU payment year 2015, 2016, and from the data we've received to date for 2017.

This slide presents an overview of the Hospital Outpatient Quality Reporting Program participation for APU payment year 2015, 2016, and for the first quarter of 2017, which was the third quarter of 2015 encounters. As seen on this table, the number of participating hospitals has remained relatively stable at approximately 4,500 hospitals each quarter. These providers include hospitals that are eligible for the OQR Program, critical access hospitals, and other voluntary reporting providers.

Of the hospitals submitting data for the 2015, 2016, and 2017 APU payment years, approximately 70 percent of the providers were OQR-eligible hospitals. Approximately 29 percent of the providers were CAHs, or critical access hospitals, and approximately one percent was other voluntarily reporting hospitals such as the Maryland hospitals.

The total number of submitted cases and the average number of cases submitted per provider have consistently increased. This is most likely due to the addition of new measures such as OP-18, which is the median time from emergency department arrival to emergency department departure, and also OP-20, door-to-diagnostic evaluation.

Just to remind everyone, at the time this presentation was developed, the data available for calendar year 2017 APU only included one quarter, which was the third quarter 2015 clinical data. It also did not include the calendar year 2017 web-based measures data. Due to this, please exercise caution when interpreting the results for calendar year 2017 as we still have a few more quarters of data to go.

Over the course of the next three slides, I will present national rates for cardiac care, ED-throughput, pain management, stroke, and web-based measures. Each table provides an overview of the current national benchmark that's posted on QualityNet, the individual calendar year overall rates or median times per measure, as well as the difference in results between each calendar year; for example, the difference in results between calendar year 2015 and calendar year 2016.

The measures presented on slide 12 are from the cardiac care, pain management, and stroke measure sets. The national measure benchmarks presented in the first column represent rates for the top 10 percent of hospitals in the second quarter of 2015 as posted on QualityNet.

During the presentation, we will focus on the two "Difference in Results" columns which are shaded in light blue. As seen on slide 12, between calendar year 2015 and calendar year 2016, a majority of the measures remain stable in performance or improved in performance between the two years.

Specifically, OP-3 improved by one minute between calendar year 2015 and calendar year 2016. Similarly, OP-23 improved between calendar year 2015 and calendar year 2016 by 4.5 percent. Between calendar year 2016 and the first quarter of calendar year 2017, most measures remained stable or improved. OP-21 improved by three minutes, and OP-23 improved by 1.8 percent. Again, the only data available for calendar year 2017 is one quarter, Quarter 3 2015; thus, these results may change as more data become available.

The measures presented on slide 13 are the web-based measures. These measures ask providers to attest whether they have the ability to receive laboratory data electronically directly through their EHR system, whether they track clinical results between visits, or whether they use a safe surgery checklist.

The rates presented in this table are the providers responding "yes." National benchmarks are not published on QualityNet for these measures, so we will focus on the difference in results between calendar year 2015 and calendar year 2017, the columns shaded in light blue. Between those two years, all three measures showed an increase in the number of "yes" responses, with OP-17 having the largest increase at 5.5 percent between the two years. Calendar year 2017 data were unavailable at the time this presentation was developed, so they're not included in this table.

The measures presented in slide 14 are the ED-throughput and the new web-based measures OP-29 and OP-30. As with the previous slides, we'll focus on the two "Differences in Results" columns. National performance between calendar year 2015 and calendar year 2016 declined for OP-18 by six minutes

and then again by another minute between calendar year 2016 and the first quarter of 2017. I believe Pam will talk a little about that later.

However, the median time for OP-20 appears to show the promise of improvement with a reduction of two minutes in the median time to diagnostic evaluation in the first quarter of APU payment year of 2017. Again, only Quarter 3 2015 data are available for the calendar year 2017 APU column; thus, these rates also may change as more data become available.

The following five slides provide an overview of the 2016 APU payment year state-level performance in relation to the national percentile for the ED-throughput and the two new web-based measures – OP-29 and OP-30.

Slide 15 presents the state-level performance for OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients. One thing to remember with time-based measures is that shorter times indicate better performance, as can be demonstrated by the dark green states which are in the 90th percentile for this measure. States with median time from ED arrival to ED departure of 117 minutes or less are among the best performing states in the country. One thing to keep in mind is that these results include all participating providers, eligible and voluntary.

Slide 16 presents the state-level performance for OP-20, door to diagnostic evaluation. Again, lower times are better here. Therefore, states with a median time to diagnostic evaluation of 18 minutes or less are among the best performing states in the country, shaded in dark green to indicate their position in the 90th percentile.

Slide 17 presents the state-level performance for OP-22: Left Without Being Seen. In this measure, lower rates are better. Therefore, as indicated by the dark green color, states with 1.1 percent or less of patients leaving the emergency room before being seen are among the best performing states in the country.

Slide 18 presents the state level performance for OP-29, appropriate follow-up for normal colonoscopy. For this measure, higher rates are better, as indicated by the dark green color. States with rates at or above 87.1 percent are among the best performing states in the country.

Slide 19 presents rates for OP-30, colonoscopy interval for patients with a history of polyps. States with rates at or above 92 percent are among the best performing states.

Now, I want to turn our attention to providers demonstrating improvement over time. This table shows the percentage of providers that improved their

performance between APU payment year 2015 and 2016, and also providers that improved their performance between APU payment year 2016 and the first quarter of APU payment year 2017.

The number of providers, indicated by the "n" in parentheses below the rate, demonstrates the number of providers that reported the measure in both years. For example, for OP-3b, 1,463 providers reported data for calendar year 2015 and 2016. Of those providers, 52.1 percent demonstrated improvement in their performance for the measure from one year to the next. Then between APU payment year 2016 and APU payment year 2017, 1,008 providers reported data for OP-3B, with 50.2 percent of those providers demonstrating improvement in their performance for the measure from one year to the next.

As seen on this table, between calendar year 2015 and 2016, 50 percent of providers improved their performance on OP-21, and 50.7 percent of providers demonstrated any improvement in their performance on OP-23. Further, according to the first quarter of 2017, it appears as though more than 50 percent of providers are demonstrating any improvement in their performance over calendar year 2016 for the measures OP-1, OP-3b, OP-20, and OP-21.

Thank you again for the opportunity to present some of the data trends for the OQR Program. Now, I'll turn it back over to Pam.

Pam Harris: Thanks, Kristy, for all that wonderful information. It's great to see the data and the updates on the state to national numbers. That's great. Now that we've talked about the data comparison in different ways, let's talk about what we can do with all this data.

Quality improvement is an entire area in itself. The scope of this presentation is to provide you with general knowledge on why you report these measures – why it's important – and give you some idea of what you do with it to improve quality within your facility.

Having information on your facility and how your facility measures up, so to speak, on the state and national level is important. Just as important as having the data is making use of it. Using data, whether it's obtained by the sources we've mentioned or by your own internal data analysis, can really provide a platform for you to initiate quality improvement.

Some of the objectives you would strive for are noted 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 sense to provide an overview on quality improvement ideas and tools.

For those of us for whom just the mention of data gives us heartburn, take a deep breath, and let me point out some of the ways data can be your friend. Your data lets you know what is really happening versus what you thought was happening. Have you ever had that jaw-dropping moment when a problem is brought to your attention and you have no idea how it happened because, all along, you thought there was a process being followed, but you found out real quick that not only is there not a process, but everyone's kind of doing their own thing? Or you do have a process, but it turns out the process is not effective? Well, monitoring your process will give you data to let you know there is a problem before the problem is laid at your feet. Data can show if you are getting it right or if you need to go back a step and reevaluate some things. Data is your compass. It shows you the way.

One of the biggest things data can do for you is provide administrative support for implementing change. Hospitals operate on a streamlined budget. Data will let you prove that the changes made – like redesigns or changes of the EHR record – were worth it.

So you have the data, now what? In order to make sense of the data, you have to use that data to make improvements. This should not be just taking a shot in the dark to come up with a quick fix. You should use some evidence-based continuous quality improvement processes.

For the sake of discussion today, we're using the PDSA model. You can use whatever evidence-based tool best suits your facility. There are many well-established CQI programs, strategies, and tools to achieve your improvement goal. The PDSA model is a scientific method used for action-oriented learning, which is Plan, Do, Study, and Act. Plan ahead for change, analyze, and predict the results. Do is execute the plan, taking small steps in controlled circumstances. Study is checking the study results. And then act is you take action to standardize or improve the process.

Some other continuous quality improvement processes are Lean; that is a great one to help organizationalize the change to create workflows, hand-offs, and processes that work over the long term. Then there is the Six Sigma process. But what all of these and other evidence-based continuous quality improvement processes have is that they have the science of improvement, which means it's been researched and proven to give results. You can find several wonderful sites that I've listed on the resource slide at the end of the presentation.

As we have talked about on the previous slide, you will ultimately need to figure out what's going on in your facility. Every institution is different. The problems are different. The reasons are different, so the solutions may also be

different. For the sake of simplicity, we will discuss some of the most common issues hospitals seem to run into.

We've talked about some of the initial analysis. There are a number of issues that cause the need for improvement. For the purposes of this presentation, we're going to talk about the three shown here. These three are extremely common issues across the board. Let's pretend for a moment that you looked at your Hospital Compare report for your facility or ran internal data, and there were some areas of improvement needed with some of the measures reported for the OQR Program. You did your analysis and discovered that the issues listed on this slide are the areas of improvement. 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 want to gear things toward your world. We will discuss each one in a little 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 which we've mentioned earlier – all play a key role. Having an engaged and committed team of everyone knowing their role is the key objective. Communication is vital for developing and maintaining processes.

As an abstractor, 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 keep everyone involved in the loop, so to speak. I don't think it can be said enough that communication is a vital key in everyone's success, so share the wisdom.

Documentation across the board poses numerous issues. As abstractors, you're consistently 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.

Running various reports and collecting data are key. Again though, you need to really use the data that you're collecting. Having a multidisciplinary team to provide support, expertise, and guidance to the entire hospital team is really what you want.

Now, let me talk just a minute about the third bullet point on this slide. Having a software change added to your electronic health record to address consistent documentation issues can be beneficial. This can be anything from

tagging on details in certain areas, adding checkboxes or entire assessments using alerts such that the chart can't be closed until that area is documented on. There are a multitude of situations and solutions with this in regard. Having things changed on standardized order sets can also be 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 for your facilities may be helpful and provide the necessary information for helping meet this measure.

We previously spoke 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, PowerPoint presentations – all can be used providing education on the measures and the changes. This can also be in the form of self learning modules. Those staff members can view these presentations as time allows. 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 have no idea why. They may already feel overworked, so this may be viewed as just another thing administration is having us do. Communication is the name of the game. Most people want to do the right thing. Keeping them informed and updated goes a very long way. Posting progress can be a morale booster by letting staff know they're doing a great job.

Staff meeting or huddles are effective. They don't have to be long and complicated. You can communicate data and areas 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 the changes going on. If they have questions or disagreements, this can also be a platform to get these 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.

But education does not stop with the frontline 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 the situation. Phyicians are hugely important.

So, we've talked about identifying some problems. Let's talk about how we go about fixing some of those problems.

We're going to look at the measure 18b for a minute. We saw earlier when we were discussing the data that this measure continues to have variance in performance. Remember, there is a six minute difference between the 2015 and the 2016 calendar year APU. Conducting an analysis of your entire ED can provide information as to where your weaknesses and areas of improvement may be. Since your facility is unique, the problems you have may be completely different than another facility, the point being that reporting measures for this program and keeping an eye on your own data, benchmarks, and even comparing your performance can be very helpful.

Let's look at a couple of example hospitals who found that their performance was not where they wanted it to be. Let's see what some of the problems they found were.

In our first hospital, they analyzed their data, performed the root cause analysis, and discovered some issues. They found that they were holding patients in the ED for too long, waiting for hospitalist evaluation. A patient sitting in a bed waiting for admission orders is eating away at your time. They also found that there were times when the beds were available, but stayed empty too long, as the triage nurse was too busy and unaware that the rooms were available. Documentation was an issue. Honestly, being a nurse myself, that was almost always on top of the list. As you know, we are concerned with ED discharge times with this measure. At this point, this facility has looked at the data, identified a need for improvement, involved multidisciplinary areas, and initiated change.

To resolve the areas and the issue, the administration directed that patients would not be held in the ED awaiting their admission or consultation. They were finding that oftentimes there were hours of delay. They developed a process in which the charge nurse would update the empty bed status to the triage nurse so patients could be placed in a more timely manner. They modified their tracking system which assisted in this area as well. This particular facility involved all their ED staff to decide what would work most efficiently. When staff understand why there is a need for change, they are more likely to comply. You would get their buy-in end, so to speak.

As the patient enters the ER doors and after the nurse's quick look, 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. The registration process exceeded this facility's recommended standards. This, in turn, delayed the patient seeing the triage nurse to complete their assessment.

They found that their admission process was too lengthy and resulted in bottlenecking the patients. If you are at all familiar with the ED, this just continues down the line. The next patient walks in the door, their wait time is

delayed, and the whole delay process starts all over again. Hence, part of the reasons the length of stay was lengthy was due to the initial delay. This particular facility had a problem with the ED patients as well as the inpatient population. Looking on the inpatient discharge side, patients that were being discharged from an inpatient bed had a lengthy delay before they were actually physically released. This again causes delay. The ED cannot transfer admitted patients out of the department 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.

This facility changed their registration process and removed paperwork that was repetitive. They added a greeter position which would assist in the paperwork and getting it initiated. They added a staff member who is an RN and acted as a flow coordinator. The staff member worked in conjunction with the charge nurses and helped facilitate getting the patients admitted or discharged. This individual would also attend the a.m. bed meetings. 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 the triage and admitting team to ensure that they are putting the level of care on admitting orders timely. On the inpatient side, the new process set guidelines on length of time for the discharge process to be complete; this would be from the discharge nurse, to housekeeping turning the room.

Now at this point, we've talked about identifying your internal issues, developing a plan to improve, and now you have accomplished the improvement that you were looking for. Now it is important to keep your success going. So let's look at some suggestions on how just to do that.

Well, this far, we've talked about the data: what to do with it, why, and how. If you've identified some issues, made changes, and monitored your success, you're on the road to success. In addition to what we talked about, please reference the reports available on QualityNet. This can really enable you to have a continuous insight to your own performance. Keeping up with benchmarks -- and so, if you're not aware, these are updated on the QualityNet website as they relate to this program. Compare your performance with other like facilities. Hospital Compare is another avenue to utilize for comparison. The public will do so, so you might as well. As we have talked about throughout this presentation, also use continuous internal monitoring incorporating all of these avenues.

When looking at the OQR Program and how to improve your measure data, there are resources available to assist you with this.

There are multiple reports from the QualityNet website that will provide you with various types of data, as we've just mentioned. The ListServe and newsletters provide updates and valuable information regarding the measures, as well as to inform you regarding the Specifications Manual, clarifications, updates, and others. Public reporting information is also found on QualityNet, first as a preview report. This preview report is available for 30 days. You will be sent notification that this report is available. 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 reported data in the top 10 percent. Hospital Compare is where the patients, your consumers, see this information. It represents a platform for your facility and how the public views your hospital's success.

The support contractor's website at qualityreportingcenter.com has an enormous amount of information to help in your success, not only for the reporting for the program but also for improving quality and performance within your facility. And at the end of the day, that's what it's all about. We did just do a webinar a couple of months ago, outlining resources available that pertain to this program. You can always access past webinars on the qualityreportingcenter.com website under the Archived Events tab.

We've discussed a lot of information today. In summary, please utilize all of the tools available to you and evaluate your own performance. Don't be afraid to compare your performance with other more successful facilities. Implement changes where there is a dip in performance and a need for improvement. When you do initiate change, make sure you keep tabs on those changes to ensure they're headed in the right direction and continue on the road to success.

That is all I've got today, Karen. Back to you.

Karen Vanbourgondien: Thank you, Pam. I'd like to thank our speakers, Pam and Kristy; we really appreciate all the great information you provided today. We do have a little bit of time to go over some of the questions, and I have some here that came in while the discussion was going on. So right off, Kristy, I have a question that I believe you can answer, and the question is: "Calendar year 2017 OP-18b data is missing for several measures. When will that data be available?"

Kristy Swanson: Good question, thank you. Yes, so the measures for which calendar year 2017 data are missing in the presentation mostly are the web-based measures. The data submission deadline for these measures was May 15 of 2016. We realize that was a few days ago; unfortunately, the data were not available in enough time to be analyzed and documented as part of our presentation.

Additionally, for those measures where calendar year 2017 data are presented, those are the clinical measures, and only Quarter 3 2015 data are included at

this time. A second quarter of data, Quarter 4 of 2015, will be available after the data submission deadline which was extended to June 1st of 2016.

Karen VanBourgondien: Thank you, Kristy. Great, thank you. I do have another question for you, Kristy. This is a common question, so this individual wants to know where they can find information for the measure benchmarks.

Kristy Swanson: Great question. Yes, the measure benchmarks are calculated quarterly. They can be found on the QualityNet website, so at qualitynet.org. The benchmarks used for this presentation are the ones that are the most current for the Outpatient benchmark document labeled Q2 2014 to Q1 2015. There are benchmarks for Outpatient and Inpatient.

Karen VanBourgondien: Thank you, Kristy. Pam, here is a question for you. "What measures are mandatory for critical access hospitals?" Can you answer that?

Pam Harris: Sure Karen. For critical access hospitals, their participation is voluntary for the Hospital OQR Program. That means that there are no mandatory measures required for the critical access hospitals. All data submitted by your facility is voluntary. CMS encourages hospitals to submit their data, but again, any data submitted is completely voluntary.

Karen VanBourgondien: Thank you, Pam. Kristy, I have another question for you. The question is: "Can you explain what a percentile is?"

Kristy Swanson: A percentile is the value below which a percentage of the data falls. In this presentation, it represents where each hospital stands compared to the rest of the reporting hospitals. I'll give you an example. If General Hospital's median time to diagnostic evaluation by a qualified medical professional was, let's say, 18 minutes, or within the 90th percentile, then you can say that 90 percent of the reporting hospitals have a longer median time to diagnostic evaluation than General Hospital. In other words, General Hospital had a lower time, which means better performing, than 90 percent of the reporting hospitals.

Karen VanBourgondien: Thank you Kristy, I appreciate that. I did pull this question because it's a very common question, so I wanted to address it. I can go ahead and answer it. The question is: "How do I sign up for ListServe notifications?" The answer is that you can sign up for the ListServe on the qualitynet.org website on their home page. Once you're on the home page, you will go to the third blue box on the left-hand side of the screen, and it will say Join ListServes. You will just click on that link. It takes less than five minutes; you can sign up with whatever email you desire. Any communications would go directly to the email that you signed up with.

And Kristy, not to pick on you, but this is a great question. The question is: "When looking at the Improving Performance table, why are there approximately 4,500 submitting providers, but the number of providers for each measure is so low?"

Kristy Swanson: Right. That is definitely something we see in this presentation and something we know is part of the Outpatient Quality Reporting Program. So, in the Improving Performance table, the number of providers, or hospitals, includes those that reported that measure for both of the APU payment years being present. Generally, the reason for the large difference in the number of hospitals reporting each measure is related to the included population for that measure.

I'll give you a couple of examples. The AMI measure set excludes patients under the age of 18, and it also only includes patients with an ST segment elevation on the ECG performed closest to ED arrival and patients for whom fibrinolytic administration was administered as defined by the data dictionary. That's a pretty small eligible population for that measure where you'll see much smaller numbers of hospitals reporting that measure with eligible patient for that population.

Alternatively, the ED-throughput measures are more inclusive, such as patients seen in hospital emergency departments with the appropriate EM codes, that's OP-18 and OP-20, or all patients that signed in to be evaluated for ermergency services, OP-22. So, as you can see, that includes a much broader population set for inclusion into that measure, hence a lot more providers reporting that measure.

Karen VanBourgondien: Wow, thank you very much, Kristy. We have a lot of data questions, so this is going to come to you again. "Can you explain how to interpret the Difference in Results column?"

Kristy Swanson: Sure, no problem. The Difference in Results column in the tables shows the improvement or the decline in performance that a measure has made between two payment years. And so for the purposes of ease of reference, numbers in red indicate that the measure results worsened between the two years. One thing to keep in mind as you're attempting to look between the two years for improvement or decline in performance is knowing for which measures higher rates are better and for which measures lower times or lower rates are better. It's easy to get confused.

Karen VanBourgondien: Thank you, Kristy. I think we have time just for one more question. I'm going to direct that to you. "Some of the maps present time-based measures where lower rates are better. How should I interpret my state performance on each of those maps?"

Kristy Swanson: Right. Another good question. So for ease of reference, we made it consistent across the board. Each of the maps display the state performance of individual measures as a percentile, and states with rates or times in the 90th percentile or above demonstrated the highest performance compared to other states. So, for measures where lower rates are better, the best performance is still represented as having rates in the 90th percentile or above, and also presented in that dark green color. For the maps we presented today, the dark green color will always represent the highest performing states.

Karen VanBourgondien: Thank you, Kristy. I appreciate it. I think that's all the time we're going to have today. I really appreciate our speakers, their time, and their information. And that's going to conclude our presentation for today.

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