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Upcoming HOP QDRP Webinars (Subject to Change)

April 20, 2011	Imaging Efficiency Measures
May 18, 2011	TBA
June 15, 2011	<i>Specifications Manual Update</i>
July 20, 2011	Proposed Rule CY 2012

WHAT WAS THE PATIENT'S DISCHARGE TIME FROM THE ED?

The *Specifications Manual Data Dictionary* defines discharge time as “the time the patient **physically left the facility.**” The Data Dictionary also states, “When more than one discharge time is documented, abstract the latest time.” Review the medical record for the latest time, electronic or handwritten, to determine the time the patient left. Any hospital form within the patient record can be used for abstraction of the discharge time; it does not have to be an official discharge form. If the discharge order has been written but the patient is delayed in leaving the facility due to transportation delays or some other reason and the hospital requires vital signs or medications to be given to the patient while they wait, then you must use the latest entry on the chart. The rationale is that a patient cannot receive treatment after leaving the facility.

To avoid having to search through the chart for various entries, a formal educational approach in the emergency department (ED) might be more productive. Education to the ED staff to use the last encounter as the official discharge time to be charted would be appropriate and an easier way to ensure compliance with this documentation requirement.

As an increasing number of hospitals invest in electronic health records (EHRs), hospital IT departments are working with these companies to customize the systems to interact with existing medical records. It is essential that you have clinical representation on the EHR implementation committees to ensure that wording and vocabulary for the ED documentation accurately reflects patient care and times, such as the actual discharge time, that is necessary for meeting requirements.

Note: We are changing the data element Discharge Date and Time to ED Departure Data and Time starting with January 1, 2012, encounter dates.

Imaging Measure Dates for CY 2012 APU		
Imaging Efficiency Measures	Claim Date	Published on Hospital Compare
OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	January 2010-December 2010	June 2012
OP-14: Simultaneous Use of Brain CT and Sinus CT	January 2010-December 2010	June 2012
OP-15: Use of Brain CT in the ED for Atraumatic Headache	January 2010-December 2010	June 2012

Structural Measures

Measure Set: Structural Measures

Set Measure ID #: OP-12

Performance Measure Name: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their EHR System as Discrete Searchable Data.

Description: Documents the extent to which a provider uses an electronic health record (EHR) system that incorporates an electronic data interchange with one or more laboratories allowing for direct electronic transmission of laboratory data in the EHR as discrete searchable data elements.

Measure Ascertain Response to the Following Question or Questions:

- Does/did your facility have the ability to receive laboratory data electronically directly into your EHR system as discrete searchable data? Yes/No
- Did your facility use this feature during the performance period? Yes/No*

*This question would be answered only if the previous question was answered "Yes."

Annual Data Submission Period: July 1-August 15, 2011, covering the performance period January 1-June 30, 2011.

Data entry will be achieved through the secure site of QualityNet.org via an online tool available to authorized users.

Definition for Ability to Receive Data Electronically: The ability to incorporate laboratory test results into EHR technology as structured data. This includes:

1. Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format.
2. Display test report information.
3. Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record.

Note: This measure applies to all outpatient departments in the facility that bill under the Outpatient Prospective Payment System (OPPS). This may include the Emergency Department, the outpatient imaging department, the outpatient surgery department, and the facility's clinics.

Look for more definitions in next quarter's edition of *HOP QDRP NEWS!*

Overview of Validation Statistics and Results Q2 2009 - Q1 2010	
Description	Value
Statistics	
Number of Validated Cases	7,300
Number of Providers Included	2,401
Number of Provider Classes	182
Validation Results	
Average Provider Class Score	86.1%
Number and Percentage of Provider Classes with Scores of at Least 75%	181 (99.5%)*
*Note: When the upper bound of a one-tailed 95.0 percent confidence interval was applied to class scores, all of the provider classes (182 or 100.0%) passed validation.	

Data elements that commonly failed evaluation are identified in the following table to help to recognize areas for program improvement.

Top Three Data Elements That Failed Validation by Measure Set Q2 2009 - Q1 2010			
Data Element	Question	Count	Percent
AMI			
ECG Date and Time (ECGDTTM)	What was the documented date and time of the earliest ECG?	732	22.8%
Arrival Time (ARRVLTIME)	What was the earliest documented time the patient arrived at the emergency department?	612	19.0%
Initial ECG Interpretation (INITECGINT)	Is there documentation of ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to emergency department arrival?	607	18.9%
Chest Pain			
ECG Date and Time (ECGDTTM)	What was the documented date and time of the earliest ECG?	366	32.1%
Arrival Time (ARRVLTIME)	What was the earliest documented time the patient arrived at the emergency department?	281	24.7%

HOP QDRP Deadlines

Encounter Quarter	Population and Sampling Due	Data Submission Deadline
Q4 2010	May 1, 2011*	May 1, 2011
Q1 2011	August 1, 2011*	August 1, 2011
Q2 2011	November 1, 2011*	November 1, 2011
Q3 2011	February 1, 2012†	February 1, 2012

*Population and Sampling is voluntary.

†Population and Sampling submission for this quarter is subject to the Final Rule, which will be published in November 2011.

Top 10 Mismatched Data Elements Q2 2009 - Q1 2010

Rank	Data Element	Description	Mismatches
1	ECG Date and Time (ECGDTTM)	What was the documented date and time of the earliest ECG?	1,098 (23.4%)
2	Arrival Time (ARRVLTIME)	What was the earliest documented time the patient arrived at the emergency department?	893 (19.0%)
3	Initial ECG Interpretation (INITECGINT)	Is there documentation of ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to emergency department arrival?	607 (12.9%)
4	Reason for Not Administering Fibrinolytic Therapy (REASONNOFIBADMIN)	Select one of the following potential contraindications or reasons for not administering fibrinolytic therapy.	330 (7.0%)
5	Discharge Date and Time (DISCHDTTM)	What is the date and time the patient was discharged from the emergency department?	279 (5.9%)
6	Transfer for Acute Coronary Intervention (TRANSFERCORINT)	Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention?	218 (4.6%)
7	Aspirin Received (ASPIRINRCVD)	Was aspirin received within 24 hours before emergency department arrival or administered prior to transfer?	211 (4.5%)
8	Probable Cardiac Chest Pain (PROBCARDCP)	Was the patient's chest pain presumed to be cardiac in origin?	211 (4.5%)
9	Antibiotic Name (NAMEABX)	What is/are the name of the antibiotic(s)?	197 (4.2%)
10	Reason for No Aspirin on Arrival (CTRASPRN)	Select one of the following potential contraindications or reasons for not prescribing aspirin.	143 (3.0%)

HOP QDRP Validation Tip Sheet

ECG's Relation to Arrival Time

Arrival Time: This is the earliest time the patient arrived in the emergency department. The time can come from the face sheet [unless it is obviously in error (printed at 00:00)], triage note, vital sign sheet, ECG, etc.

ECG Time: You aren't required to have the ECG time for the earliest time.

ECG Time Prior to Arrival: If there was an ECG done prior to arrival (if it was done within 60 minutes of arrival), you change the time to the time the patient arrived in the ED. This gives you a median time from arrival to ECG of "0" minutes. You do not need the ECG in the record. You need documentation that a 12 lead ECG was done. If it just says "ECG," we assume it was a 12 lead. If it says ECG monitor, we assume it was a rhythm strip and not a 12 lead. Ideally, you need to get your ED manager to have the ambulance staff record that they did a **12 lead ECG**, what time they did it and leave a copy. The Clinical Data Abstraction Center (CDAC) will read the run sheets looking for a notation that an ECG was done and will use that. If the ambulance wasn't out for more than 60 minutes, they will use the notation that an ECG was done prior to arrival and use the arrival time as the ECG time. You need to do the same.

ECG Time in the ED: Make sure the time is visible on the ECG when the chart is copied. The CDAC will look for the ECG and will also look for a nurse's note for a time. If there are two different times, the Data Dictionary directs to take the time on the ECG Strip.

ECG Closest to Arrival: It must be signed. If it is the only ECG done, it can be referred to by the physician without specifically mentioning which ECG. If more than one ECG is done, the earliest ECG is the closest to arrival, and it may be the one in the ambulance, which may be used if it is signed or referred to in writing by the physician.

Remember that ECG time and interpretation are separate and have separate rules regarding timing.