HOSPITAL OUTPATIENT QUALITY DATA REPORTING PROGRAM SUPPORT CONTRACTOR

HOP QDRP NEWS

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Arrival and Discharge/ Departure Times
Page 2

OP-19: Transition Record with Specified Elements Received by Discharged ED Patients
Page 3

Notes from the Project Coordinators
Page 4

QualityNet Secure File Exchange Notification
Page 5

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Proposed Diabetes Measures to Be Released

Look for the Diabetes Measures in Appendix P of the January 2012 *Specifications Manual* version 5.0 to be released July 1, 2011. Comments are welcomed and encouraged. Send your questions and comments on these Measures or the Proposed Rule (see below) to: http://cms-ocsq.custhelp.com

OPPS Proposed Rule

The OPPS Proposed Rule will be released soon. Please read the Rule and send your comments to the Centers for Medicare & Medicaid Services (CMS). It is very important that CMS hears your feedback, including any concerns, about the Rules and Measures, including the Imaging Measures and those Measures proposed for the coming year or future years. Once the Rule has been released, HOP QDRP will notify hospitals via ListServe regarding when and where the Proposed Rule may be found.

Upcoming HOP QDRP Webinars
(Subject to Change)

July 20, 2011 - Proposed Rule CY 2011

August 2011 - No Webinar Scheduled

September 21, 2011- The Future of Quality Reporting

Learn more about these webinars at http://www.hopqdrp.com/education.

Thanks to everyone who submitted comments about the imaging measures. More than 100 comments were sent in to the Lewin Group/CMS.

Arrival and Discharge/Departure Times

Arrival Time

We suggest you begin working with your Electronic Health Records (EHR) and the Emergency Department (ED) Nursing Staff and Registration Clerks to capture the arrival and departure times in the record so that they will be easily recognized by your abstractors and an outside abstractor like the Clinical Data Extraction Center (CDAC). Arrival time is the earliest time a patient enters the facility. You may know that Emergency Medical Services (EMS) always calls in before the patient arrives and you pre-register the patient, but no one else will know that. We do realize that many hospitals register (short form) patients before they are seen in triage. Ensure the wording is clear.

Please use the earliest time found, which may be the electrocardiogram (ECG), registration sheet, lab (make sure the lab is not using a time when the blood was drawn in the ambulance), triage, medical administrative record (MAR), vital signs sheet, etc. Please be careful with the vital signs sheet as you may want to have Information Technology (IT) or Informatics work on this issue. The challenge is that many hospitals use the print-out from the vital signs monitor in the record. The monitor strips frequently are blocked out in 15-minute intervals. Because of this, a patient's vital signs may have been checked at 0612, but that patient falls into the 0600 box.

In this case, the CDAC views the time of the vital signs as 0600.

	0600	0615	0630
B/P	140/80	120/70	117/70
P	80	74	70
R	18	16	16

Discharge/Departure Time

Departure time is another area where improvement is needed. This relates to the time the patient left the building. For example, the nurse writes, "patient discharged at 1500" but records a medication at 1510. We cannot give a medication when the patient has left, so we use 1510 as the departure time. Disposition time has a number of meanings, from the time the clerk closed the record and removed the patient from the tracking board to the time the physician wrote a note, for example. The Data Dictionary states to use the time the patient actually left the building. Please be sure that the record shows a discharge time or left the ED time, departure time, check-out time, or patient has left the building time.

If you can to get the Electronic Health Record (EHR) to recognize the actual arrival/discharge times electronically, that is better. Remember that **OP-18: Median Time from ED Arrival to ED Departure or Discharged ED Patients** is coming with January 2012 encounters. If your ED sees 100 patients per day (on average), you will need to abstract a minimum of **351** records per quarter.

Beginning August 1, 2011,
the Hospital Outpatient Quality Data Reporting Program (HOP QDRP)
will be renamed the **Hospital Outpatient Quality Reporting (OQR) Program**.

OP-19: Transition Record with Specified Elements Received by Discharged Patients*

START PLANNING NOW

This is scheduled to begin with encounters as of January 2012 and will apply to ***ALL*** patients leaving the ED: Observation Patients and Transfers. EDs need to begin to develop forms and in-service education to meet this requirement, commencing in 2012.

Patients or their caregivers who received a transition record at the time of ED discharge including, at a minimum, ***ALL*** of the following elements:

The transition record must contain all major procedures and tests performed during the emergency department encounter. Major procedures may include fracture management, wound repair, incision and drainage (I&D), foreign body removal, joint reduction, joint aspiration, chest tube placement, emergency endotracheal intubation, central line placement or lumbar punctures. Tests may include lab tests, scans, or x-rays that were performed. Tests with results pending should be included because they were performed during the encounter.

Principal clinical diagnosis OR the chief complaint (causing presentation to the ED) must be documented in the transition record at discharge. Patient instructions for post-discharge care must be documented in the transition record. This may include wound care or instructions about adverse reactions, signs/symptoms of infection, or instructions covering life-threatening emergencies.

Instructions for follow-up care must be included in the transition record. This may include a follow-up visit with a primary care physician or other provider, referral to another level of care or site, any needed post-discharge therapy (oxygen, physical, or occupational), and required durable medical equipment. If no follow-up care is necessary, a statement to that effect must be provided in the transition record.

A post-discharge medication list in the transition record must contain any new medications prescribed as well as changes to current or "home" medications. Instructions for any new medications must be documented. The list of current or "home" medications should contain any over-the-counter (OTC) or herbal medications that are taken. Discontinued medications should be listed along with drug interactions and allergies. The quantity prescribed/dispensed must be documented or the intended duration must be listed. If a discharge or reconciled medication list (medication reconciliation form) is used, all of the above requirements must be fulfilled with that list.

*As always, measures are subject to change per the FINAL RULE published in November 2011.

Notes from the Project Coordinators

Please be sure that someone in the Quality/Performance Improvement Department checks the validation records **BEFORE** they are sent. We have experienced a number of hospitals sending in their records to us for review because the CDAC missed the antibiotic or ECG time. When we checked with the CDAC, we were told that the document in question was not included in the record.

For those who need to plan their budgets, take into account that both **OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients** and **OP-19: Transition Record with Specified Elements Received by Discharged Patients** apply to all patients.

You will need to chart abstract a minimum number of medical records, based on population:

Population per Quarter	Quarterly Sample Size
1,001 - 2,000	323
2,001 - 3,000	341
3,001 - 4,000	351
4,001 - 5,000	357
5,001 - 10,000	370
10,001 and above	377

Do you know that there is a poster-ready copy of the **Prophylactic Antibiotic Regimen Selection for Surgery? http://www.hopqdrponline.com/tools.aspx.**

For our friends in the QIO world: To receive web conference notices, as well as other important updates related to the OQR, please sign up for the HOP QDRP ListServe at: https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register.

Structural Measures Start Next Month

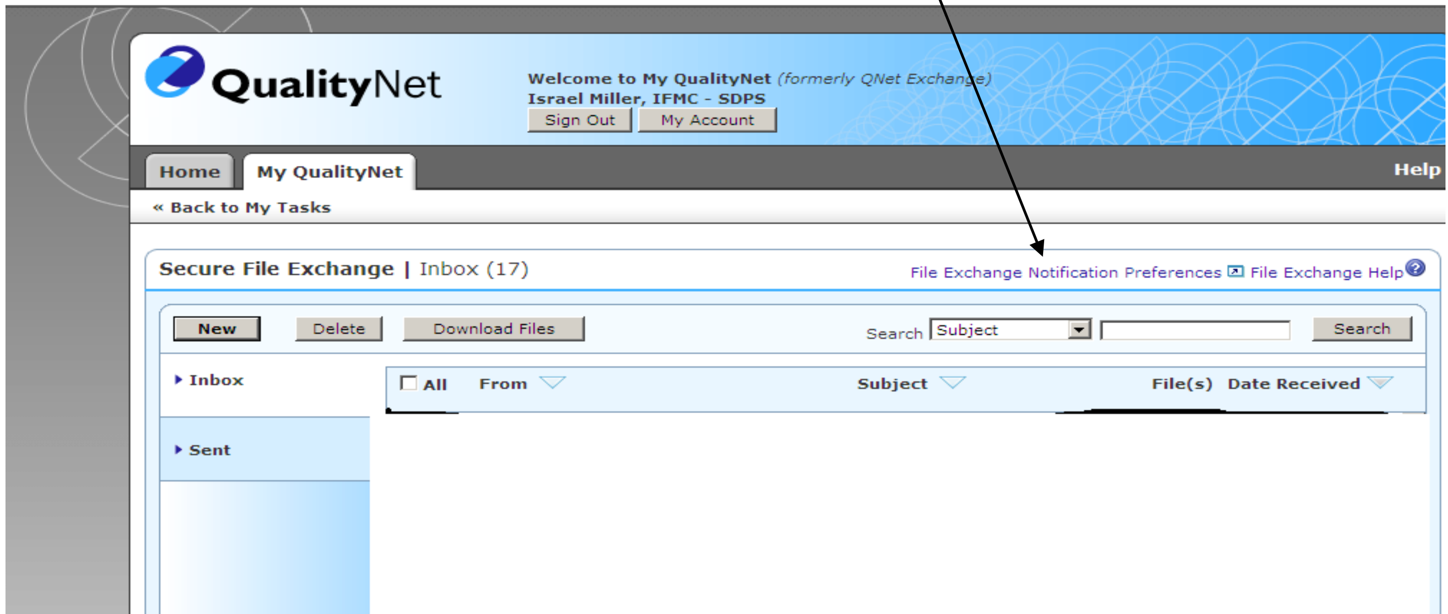
OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data—Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

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

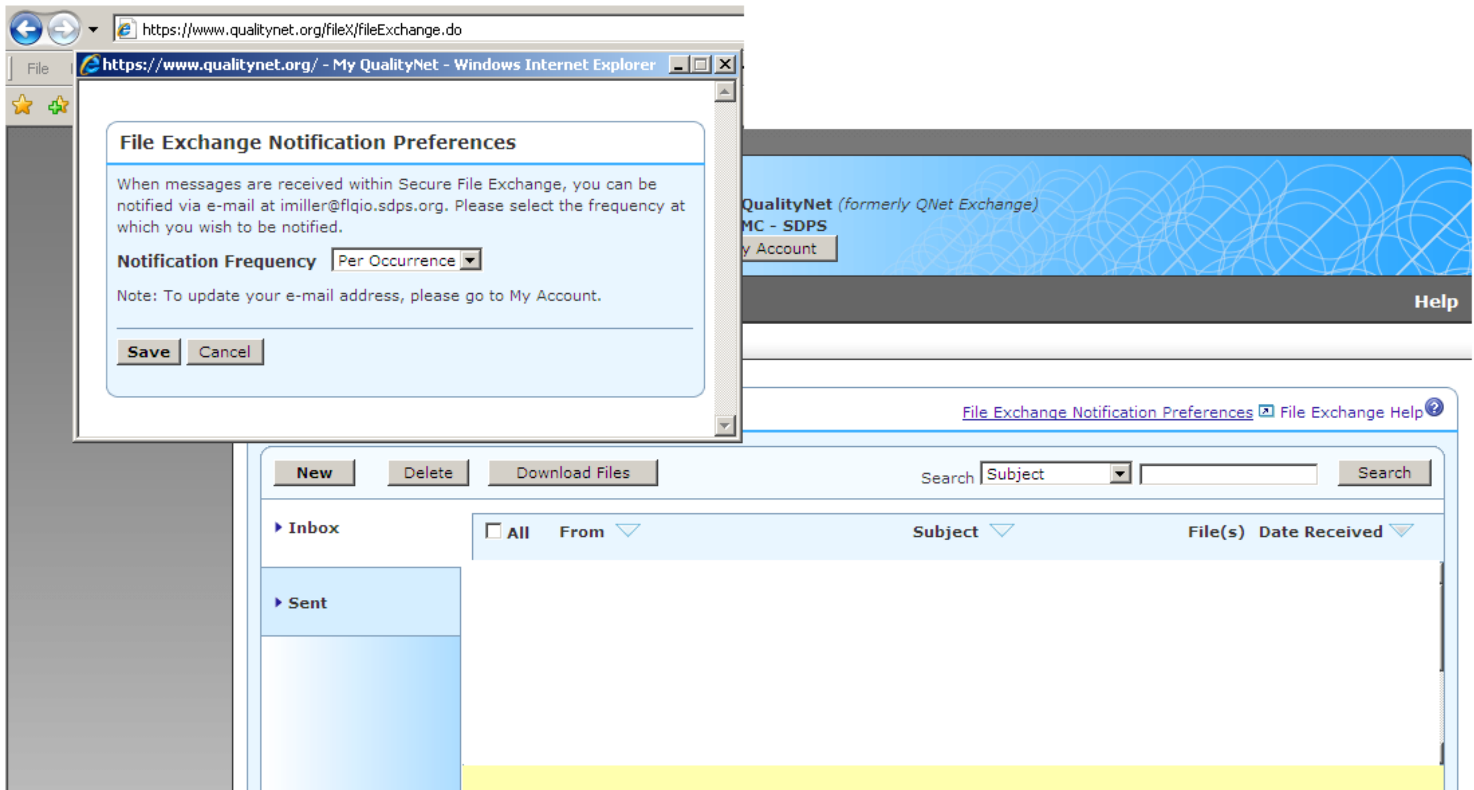
The HOP QDRP has found a website (maintained by The Commonwealth Fund) offering an accumulation of resources to assist hospitals in meeting the Outpatient Measure requirements: http://www.whynotthebest.org/.

QualityNet Secure File Exchange Notification

To be notified when you receive a secure item in QualityNet.org, click on File Exchange Notification.



Set Preference to "Per Occurrence."



This material was prepared by FMQAI, the Support Center for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). FL-9SOW-2011SS1T11-6-12286