Volume 1, Issue 5

Hospital Outpatient Quality Reporting Program Support Contractor News

DECEMBER 2011

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Hospital OQR News

Provider Webinars

- **November 16** – Final Rule
- **December 21** – Happy Holidays – No webinar
- **January 18** – Specifications Manual Changes – New Measures

Information for Critical Access Hospitals and Others Wishing to Sign a Pledge for Hospital Outpatient Quality Reporting (Hospital OQR)

Hospitals that wish to pledge must do so for CY 2013. You can no longer pledge for CY 2012 as there was a March 31, 2011, deadline. If you pledge before February 1, 2012, you will be able to submit data for the third quarter of 2011. The OPPS Warehouse will begin accepting data for the third quarter of 2011 at the end of November 2011. If you pledge between Feb 2, 2012, and March 31, 2012, you will be able to begin submission with fourth quarter 2011 data. If you pledge after March 31, 2012, you will not be able to sign up for CY 2013.

Top 3 Validation Mismatches

QUESTION NAME	DESCRIPTION	COUNT	%
Antibiotic Name	What is the name of the antibiotic(s)?	1701	20.6
ECG Date and Time	What was the documented date and time of the earliest ECG?	1384	16.8
ED Arrival Time	What was the earliest documented time the patient arrived at the emergency department?	1223	14.8

A few suggestions for some of the mismatches that we have come across:

Antibiotic Name

- Anesthesia charts the antibiotic but no route. Consider adding “All Non-Inhalation Medication Given IV Unless Otherwise Noted” to the anesthesia sheet.
- EHR has the name of the medication but either no route, or no signature or initials.
- EHR has medication on more than one sheet in the record, all without a route or a signature.

Suggestions:

- Consider antibiotics initiated via an appropriate route (PO, IV, or UTD) to answer this data element.
- Either a signature or initials signifying administration of the antibiotic is required to abstract that antibiotics were given.
- Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic. If the antibiotic name and route are not contained in a single source for that specific antibiotic, utilize “UTD” for the missing information.

ECG Date and Time

- Nurse charts ECG at 10:00. The ECG is time-stamped 09:00, or the reverse occurs (the chart time is earlier than the time stamp).
    - Abstractor must take the earliest time, but it is perfectly acceptable for the ED nurse or tech to cross out the ECG time and put in the correct time if the clocks were shifted to Standard or Daylight Savings Time, and the ECG time was not adjusted.
- Abstractor uses the time on the ECG done in the ambulance. Abstractor is required to use the actual ED arrival time.
- Synch all the clocks in the ED, including the ECG machine and monitors.

ED Arrival Time

The registration sheet uses arrival time, but the clerks get a call from the ambulance with the patient information, and they register the patient using a time 10 minutes prior to arrival. The abstractor cannot tell which patient was pre-registered and which one was not. The hospital knows, but CDAC will not.

What to do?

- Take the word “arrival” or “admit” off the registration sheet.
- Do not print the record until you see the patient enter the ED.
- Take the time off the registration sheet.

Clean up the language on the EHR to actually use the language of all the data collection being done. Arrival time is the earliest time the patients arrive in the department.

A few other suggestions:

Antibiotic Timing

- Anesthesia charts the antibiotic but no time.

Consider adding a line on the anesthesia sheet:

"Antibiotic___________IV at _________am/pm"

Infection Prior to Anesthesia

The anesthesia record has a list of illnesses that anesthesia circles. The record does not note whether the illness is "history" or "present," and anesthesia circles "bronchitis." The patient had bronchitis 8 years ago, but the chart seems to show they have it now. The hospital abstractor misses it because the rest of the record indicates that the patient had bronchitis 8 years ago. What to do?

- Consider changing the anesthesia sheet to differentiate between present and past illnesses.
- Many of the validation mismatches are errors in documentation. We suggest that someone from QI meet with the facility's informatics group to "fix" the language. There are many upcoming new measures that rely on arrival and discharge time.

OP-1 and OP-2: Median Time to Fibrinolysis and Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival

The medical system goal is to facilitate rapid recognition and treatment of patients with STEMI so that either door-to-needle (or medical contact-to-needle) for initiation of fibrinolytic therapy can be achieved within 30 minutes or door-to-balloon (or medical contact-to-balloon) for PCI can be achieved within 90 minutes. **These goals should not be understood as "ideal" times but rather as the longest times that should be considered acceptable for a given system.** Systems that are able to achieve even more rapid times for treatment of patients with STEMI should be encouraged. †

A door-in to door-out time (DIDO) of 30 minutes or less for patients with ST-elevation myocardial infarction, transferred for primary percutaneous coronary intervention (PCI), is associated with shorter reperfusion delays and reduced in-hospital mortality, according to a study published online June 22/29 in the *Journal of the American Medical Association*. Wang and colleagues found that patients with a DIDO time of **30 minutes** or less had a significantly higher likelihood of having an overall Door to Balloon (D2B) time of 90 minutes or less compared to those with a DIDO time above 30 minutes. A DIDO time of 30 minutes or less was observed in only a small proportion of patients transferred for primary PCI, but was associated with shorter reperfusion delays and lower in-hospital mortality. †

The 2010 Median time to transfer was 68 minutes, and the 90th percentile was only 39 minutes. Your goal should be to lower those times to 30 minutes or less to transfer patients to PCI hospitals or consider using a fibrinolytic if you cannot meet the time constraints. As the door to balloon times for inpatients dropped, there were lessons learned and a number of procedures changed to lower that time.

The first change was that the decision to reperfuse should be made by the ED physician, not by the on call cardiologist or even the interventionalist. Activation of the cath lab occurred with a single phone call. Chest pain patients were seen immediately, and ECGs were performed quickly (under 10 minutes) and read quickly by the physician.

The challenge to reduce the reperfusion times is now on the non-PCI hospitals to either transfer the patient in 30 minutes or less or strongly consider the use of a fibrinolytic. If you are a non-PCI hospital and do not have an agreed upon protocol with the receiving hospital, a protocol should be considered. If transportation is going to be delayed or if the weather is a factor, it has to be agreed that reperfusion will be done using a fibrinolytic and the patient transferred at a later time.

If you are more than one hour away from a PCI hospital, it will be virtually impossible to make a D2B time of 90 minutes or less. You must consider using a fibrinolytic as suggested in the AHA/ACC Guidelines.

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

For patients sent to observation status on an inpatient unit:

The E/M requirement (E/M code from table 1.0 in Appendix A of the *Specifications Manual 5.0*) includes patients sent from the ED to observation and then transferred or discharged home. This group consists of patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:

- Major procedures and tests performed during ED visit, AND
- Principal diagnosis at discharge OR chief complaint, AND
- Patient instructions, AND
- Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND
- List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each.

Included Populations:

An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0. **This excludes patients admitted as inpatients because those patients will not have the ED E/M code on their bill but does include patients sent from the ED to observation and then transferred or discharged home.**

The transition record must contain all of the major procedures and tests performed during the emergency department encounter. The 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 that have results pending should be included, since they were performed during the encounter. The principal clinical diagnosis OR the chief complaint (causing presentation to the emergency department) at discharge must be documented in the transition record.
Patients seen in the ED and discharged home/transferred=Transition Record at Discharge/Transfer
Patients seen in the ED and sent to Observation without formal ED Discharge= Transition Record at time of discharge from Observation (includes all information throughout stay)
Patients seen in the ED and sent to Observation with a "formal ED Discharge"=Transition Record at time of ED departure (includes all information up to ED departure)

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 post-discharge therapy (oxygen therapy, physical or occupational therapy) that might be needed, and durable medical equipment required. If no follow-up care is necessary, a statement to that effect must be provided in the transition record. **For the observation patient the floor instructions given to discharged patients may meet the requirements for OP-19.**

The 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 the 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.

(Endnotes)†

1 Antman, E.M., et al. (2007). 2007 Focused Update of the ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction. *Circulation*, 117, 296-329. doi: 10.1161/circulationaha.107.188209

2 Wang, T.Y., Nallamothu, B.K., Krumholz, H.M., Shuang-Li, Roe, M.T., Jollis, J.G. … Ting, H.H. (2011). Association of Door-In to Door-Out Time With Reperfusion Delays and Outcomes Among Patients Transferred for Primary Percutaneous Coronary Intervention. *JAMA*, 305 (24), 2540-2547. doi: 10.1001/jama.2011.862

This material was prepared by FMQAI, the Support Center for the Hospital Outpatient Quality Reporting (OQR) Program, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS).
FL-10SOW-2011FST211-8-12385