

Hospital Outpatient Quality Reporting Program

Support Contractor

News

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Hospital OQR
<http://www.hospitaloqr.com>

QualityNet
<http://www.qualitynet.org>

Hospital OQR Program

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Hospital Outpatient Quality Reporting (Hospital OQR) News (Formerly known as HOP QDRP News)

On August 1, 2011, the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) became the Hospital Outpatient Quality Reporting Program or Hospital OQR. In addition, consistent with the 10th Scope of Work, the QIOs are now responsible for outpatient reporting; you may now begin to call your contacts at the QIO for questions and assistance. The Question and Answer database (found on the <http://www.hospitaloqr.com> or on *QualityNet* in the lower right-hand corner of the home page) will continue to be the place to go to have your questions answered.

Upcoming Provider Webinars

- October 19 – Future of Hospital Reporting, presented by:
Jim Poyer, Director
Division of Quality Improvement for Acute Care
Quality Improvement Group
Office of Clinical Standards and Quality
Centers for Medicare & Medicaid Services
- November 16 – Final Rule
- December 21 – Happy Holidays – No webinar
- January 18 – Specifications Manual Changes – New Measures

Measure Notes from the Hospital OQR SC

Please be reminded that **OP 22: Patient Left Before Being Seen** is to be answered **NEXT** July 1, 2012, through August 15, 2012, and asks for the percent of patients who left from **January 1, 2011, through December 31, 2011.**

The following measures do not include patients who have been admitted as inpatients:

- **OP-16:** Troponin Results for ED AMI/CP Patients (with Probable Cardiac Chest Pain) Received Within 60 Minutes of Arrival **and**
- **OP-20:** Door to Diagnostic Evaluation by a Qualified Medical Professional **and**
- **OP-21:** ED – Median Time to Pain Management for Long Bone Fracture **and**

- **OP-23:** Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT Scan Interpretation Within 45 Minutes of Arrival.

Emergency Department Arrival and Departure Times

On July 13, 2011, the Emergency Nurses Association issued a Consensus Statement regarding Definitions for Consistent Emergency Department Metrics at

http://www.ena.org/media/PressReleases/Documents/07-13-11_DefinitionsED_Metrics.pdf.

In the statement, ED Arrival and Departure Times are defined as follows:

- **Emergency Department Arrival Time**

The time that the patient first arrives at the institution for the purpose of requesting emergency care should be recorded as the arrival time. This is the first contact, not necessarily the registration time or the triage time.

- Emergency Medical Services (EMS): The time the EMS vehicle arrives at emergency department door.
- Ambulatory: The time a patient requests care or is asked by ED staff if he/she is here to receive emergency care.

- **Emergency Department Departure Time**

This time is the physical departure of a patient from the ED treatment space and is the time most closely represented by being out of the department and no longer the ED's responsibility.



This statement was signed by the following organizations: American Academy of Emergency Medicine, American Academy of Pediatrics, American Association of Critical-Care Nurses, American College of Emergency Physicians, American Nurses Association, Association of periOperative Registered Nurses, Emergency Department Practice Management Association, Emergency Nurses Association, and National Association of EMS Physicians.

Hospital OQR Benchmarks (May be found on QualityNet)

The following screen shots show the location of the Hospital OQR Benchmarks of Care located on *QualityNet* under Hospitals - Outpatient/HOP QDRP Benchmarks of Care.

The screenshot shows the QualityNet homepage. At the top left is the QualityNet logo and a 'Sign in to My QualityNet' button. Below the logo is a navigation bar with 'Home' and 'My QualityNet' tabs. A main menu contains several categories: 'Hospitals - Inpatient', 'Hospitals - Outpatient', 'Physician Offices', 'Nursing Homes', 'ESRD', and 'Quality Improvement'. Under 'Hospitals - Outpatient', a dropdown menu is open, listing various links. A red arrow points to the 'Hospital Outpatient Quality Data Reporting Program (HOP QDRP)' link. Other links in the dropdown include 'E-mail Notifications', 'Registration', 'Specifications Manual', 'Imaging Efficiency Measures', 'Data Collection (& CART)', 'Data Submission', 'Data Validation', 'Resources - Program', 'Resources - Vendor', 'Support Contact', and 'Training'. To the right of the dropdown is a 'More News >' link. Further right are three boxes: 'Downloads' (with links for CART Downloads & Info and Specifications Manual), 'Training' (with links for CART Training and QualityNet Training), and 'Frequently Asked Questions' (with a link for QNet Quest).

The screenshot shows the 'HOP QDRP Overview' page. The header is identical to the previous screenshot. The main content area is titled 'HOP QDRP Overview' and 'Hospital Outpatient Quality Data Reporting Program (HOP QDRP)'. On the left side, there is a vertical navigation menu with links: 'How to Participate', 'Benchmarks of Care', 'Measures', 'Deadlines', 'APU Reconsideration', 'APU Determinations', 'Support Contact', and 'Extraordinary Circumstance Form'. A red arrow points to the 'Benchmarks of Care' link. The main content area contains sections for 'Background and Purpose', 'Provider Support', and 'Summary of HOP QDRP Requirements'. To the right of the main content are three boxes: 'About HOP QDRP' (with links for Questions/Answers, Quick Start Guides, and Quarterly Events Calendars), 'Hospitals Selected - CY 2012 Validation' (with links for List, PDF, and List, XLS), and 'Measures and Timelines' (with a link for For CY 2012 Payment Determination, PDF).

Hospital OQR Questions/Answers For New and Preview Measures

OP-16: Troponin Results for ED AMI Patients or Chest Pain Patients Received Within 60 Minutes of Arrival

1. Is the “received time” the time the physician or nurse documented receipt of the results, or is it the time the results are time-stamped by the lab?

Answer: Either is acceptable; however, you would want to use the earliest of these times. The goal is to determine how quickly the troponin result was available for review and use in making a clinical determination. It likely will be found most often in the lab section with a results time.

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

1. What cases are publicly reported on *Hospital Compare*?

Answer: OP-18b is the reporting rate. OP-18b excludes cases that received observation services within the emergency department, had a psychiatric or mental disorder diagnosis from Table 7.01, or were transferred (discharge status codes 02, 20, 41, 43 or 66).

2. My emergency department (ED) sees 60,000 patients a year. How many cases do I need to abstract?

Answer: Sampling is based on the quarterly number of cases. If an ED has more than 10,000 cases per quarter, the maximum number of cases required for abstraction is 377.

3. If a patient is admitted to Observation services but is kept in the ED until a bed is available, what time is the departure time?

Answer: The departure time is the time the patient physically left the ED. In this situation, the time would be when the patient left the ED for the nursing unit.

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

1. What defines a major procedure or test?

Answer: 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, and lumbar punctures. Tests may include lab tests, scans, and x-rays that were performed. Tests that have results pending should be included since they were performed during the encounter.

2. Do test results need to be included in the Transition Record?

Answer: No, the test results do not need to be included; only the list of the major procedures and tests that were performed during the outpatient encounter needs to be included.

3. If the ED physician was not the ordering physician for all the medications prescribed, do these medications have to be listed?

Answer: Yes, all medications should be listed, including new medications and changes to continued medications that patients should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each. This includes any over-the-counter or herbal medications that are taken.

4. Are patients discharged with discharge status code 07 (Left Against Medical Advice) included in the measure population?

Answer: Discharge status codes 07, 09, 20, and 41 are not included in the measure population for OP-19.

5. Why do patients who are transferred require a transition record since copies of the records are sent with the patient?

Answer: By definition, the records that are sent with the patient at the time of transfer are considered a transition record, but make sure that **all** the required elements are included:

- Major procedures and tests performed during ED visit
- Principal diagnosis at discharge OR chief complaint
- Patient instructions
- Plan for follow-up care (OR statement that none required), including primary physician, other healthcare professional, or site designated for follow-up care
- 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

If any one of the required components listed above is missing from the transition record, select “No.”

6. Why are patients who are transferred included in the measure population?

Answer: These patients have the greatest need for a complete and accurate record.

7. Does the copy of the ED medical record count as a transition record for patients who are transferred to another facility?

Answer: Only if the copy of the ED medical record contains **all** of the required elements as listed after question number five above. If any one of the required components is missing from the transition record, select “No.”

8. If a patient is incapable of signing the transition record (e.g., confused), and there is no caregiver to sign the form, is this a “Yes” or a “No”? Does the form have to be signed?

Answer: A signed form is not necessary if a copy of the transition record is in the medical record and the documentation clearly conveys the patient or caregiver was given a copy of the material.

OP-21: ED – Median Time to Pain Management for Long Bone Fracture

1. What ages are included in the measure population for OP-21?

Answer: The Patient Age criteria for OP-21 is 2 years and older.

2. What are considered acceptable pain medications for OP-21?

Answer: Documentation of administration of any medication that is listed in Appendix C, OP Table 9.1 (Analgesic Medications) is acceptable, as well as documentation of one of the anesthesia or analgesia forms listed in the data element Pain Medication. The notes for abstraction state:

- Patients aged 2 to less than 18 years are eligible if administered oral or parenteral pain medication, including local or regional anesthesia.
- Patients aged 18 years or greater are eligible if administered parenteral pain medication, including local or regional anesthesia (e.g., if initial medication administration is oral, select “No”).

3. Do I have to give a pain medication to an elderly patient with a fracture who is not complaining of pain?

Answer: If there is a physician/APN/PA documentation of a reason for not administering pain medication, select “No” (e.g., patient unconscious, decreased respiratory rate, patient refusal).

DM-1 through DM-5 – Outpatient Diabetes Measures (Proposed)

1. How can I find the cases that are in the Diabetes Measures population?

Answer: The cases must meet the inclusion criteria stated in the Hospital OQR *Specifications Manual*, including: Evaluation & Management code for an outpatient clinic encounter on Appendix A, Table 11.4, Principal or Other ICD-9-CM code on Appendix A, Table 15.0 & 15.1, and age >18 and <75 years of age.

2. What defines a hospital-based outpatient clinic, and how do I identify them?

Answer: A hospital-based outpatient clinic will use the same CCN on the OPSS claim as the hospital. Additional information will be provided before these measures are implemented.

3. If a patient is seen multiple times in a month, with multiple encounters billed on the same claim, how am I to abstract this?

Answer: A single claim with multiple encounters should be treated as one visit for the purposes of abstraction. Additional information will be provided before these measures are implemented.

4. If a patient is seen in a hospital-based outpatient clinic (e.g., wound care clinic) for wound care and the patient has a diabetes ICD-9 code on the claim, am I to include this for abstraction?

Answer: These measures are intended for primary care clinics, not specialties. Additional information will be provided before these measures are implemented.

5. Is the clinic physician/specialist (who is not the primary physician) responsible for the patient’s diabetic care as defined in DM-1 through DM-5 (e.g., urine screening, dilated eye exam)? If this physician documents these as reported by the patient, is this acceptable?

Answer: Each data element requires documentation specific to the measure. As long as there is physician documentation of the test being completed, it will be sufficient. Additional information will be provided before these measures are implemented.

6. For the Diabetes Measures, what does “most recent” mean when referring to testing (e.g., Low-density lipoprotein and Hemoglobin A1c)? Can this information be taken from any results in the patient’s history?

Answer: The most recent test results available in the medical record may be used for this measure. A physician documentation of the most recent result is acceptable. Additional information will be provided before these measures are implemented.