Hospital Outpatient Quality Reporting Program

Support Contractor

Measuring Up: Benchmarks and Quality Improvement

Questions & Answers

Moderator:
Nina Rose, MA
Project Coordinator, Hospital OQR Support Contractor

Speaker:
Karen VanBourgondien, RN, BSN
Education Coordinator, Hospital OQR Support Contractor

October 21, 2015
10:00 a.m. ET

Question 1: Are the benchmarks the same as the HQMR data?

Answer 1: No, the benchmarks are not the same as the HQMR data. Our presentation today is only related to Hospital OQR benchmark data, and relates to the data reported for the OQR Program.

Question 2: Does the ABC methodology dilute the impact of a singular case in a measure that fails: giving a 0% passing rate as it dilutes the impact of one case that passes giving a 100% passing rate?

Answer 2: We are not sure what you mean by "dilute." Generally speaking, the ABC methodology is used to accommodate population size, particularly with smaller population sizes.

Question 3: We have a timeline that the providers' document on for the face-to-face contact; however, this does not always list their credentials, but you can find that in the notes portion. Can we use the documentation in the timeline if you have to find the provider credentials elsewhere?

Answer 3: Yes, the timeline can be used as a source for abstraction of Provider Contact Time. The physician's credentials do not have to be located on the same source document.

Question 4: You said vital signs times cannot ever be used for abstraction?

Answer 4: For *ED Departure Time*, vital signs alone should not be used for abstraction.

Question 5: Would the triage nurse seen on arrival be the contact time?

Answer 5: No, the Triage Nurse seen on arrival time cannot be used for *Provider Contact Time*. This element requires face-to-face contact with the patient by the physician/PA/APN, or institutionally credentialed provider, excluding the triage nurse.

Question 6 Are there any kind of benchmarks regarding OP-29 and OP-30?

Answer 6: Since this will be the initial submission of data for OP-29 and OP-30 there are no benchmarks for these measures at this time. The data will first be collected, and then put forth into benchmarks.

Question 7: So, even if the patient remains in the ED 30 minutes after the order was written for Observation, should we use the time the order was written for the *ED Departure Time*?

Answer 7: That is correct. The time that the order for observation was written is to be abstracted as *ED Departure Time*.

Question 8: Our ED uses “Left AMA” when the patient leaves the ED after triage, but before contact with provider and no AMA forms completed. I abstract this UTD?

Answer 8: To select "7," there must be explicit documentation that the patient left against medical advice, and there must be signed AMA papers in the record. A patient cannot be considered AMA without having been seen by a physician/APN/PA.

Question 9: "*Provider Contact Time*" field not entered, but nurse notes "Dr. in to discuss lab results," but this is at D/C, so we know it's not the INITIAL visit, but do we still have to abstract because it's the only time documented, or use UTD?

Answer 9: Based on the information you have given, and if this is the only documentation of the physician having direct personal exchange between his/herself, then, yes, you would use this time. There must be documentation of direct contact between the ambulatory patient and the provider.

Question 10: If nurse documents time Dr. in to see patient and Dr. does too, but they don't match, do we abstract the earlier of the 2?

Answer 10: Based on the information you have provided, then yes, you can use the earliest time provided that meets the measure.

Question 11: Does this mean that we can take the MD order time for admit for observation of *ED Departure Time* even if that is not the time that the patient physically left the ED?

Answer 11: That's correct. The time that the order for observation was written is to be abstracted as the *ED Departure Time*.

Question 12: What was the answer to the culture performed by the ED physician as *Provider Contact Time*?

Answer 12: If there is evidence that there was direct provider contact during the skin culture, this can be used. If the abstractor cannot determine if the provider was present and cannot determine a date/time of contact, then abstract UTD.

Question 13: Can I use the order for observation (dated and timed) as the *ED Departure Time* even if the patient did not leave the ED at that time? It could be hours before the patient leaves the ED.

Answer 13: Yes. The order for observation should be used as the *ED Departure Time* regardless of the time the patient physically leaves the ED.

Question 14: Is this recorded to listen to later?

Answer 14: Yes, the presentation is being recorded and will be available at www.qualityreportingcenter.com in approximately 3-4 weeks.

Question 15: How could 11:56 be used as the time the pt. left the ED, if they have documented V/S at 12:02?

Answer 15: Vital signs alone cannot be used as *ED Departure Time*. If there is no documentation, other than vital signs to support the patient continued within the ED after 11:56, you would abstract the 11:56 time, not the vital signs time.

Question 16: What type of information can we find on Qualityreportingcenter.com?

Answer 16 All program information, such as archived webinars and various tools, can found on this website.

Question 17: If a patient leaves AMA prior to being seen by the physician, do we abstract time seen by physician UTD?

Answer 17: In order to select AMA, there must be signed paperwork in the chart. A patient cannot be considered as AMA without having been seen by the physician/APN/PA. Patients who leave without being seen by a provider should not be considered AMA. They are, however, considered left without being seen.

Question 18: You said we could use OB nurse, our patients are sent directly to the OB, not in the ED. Patients may only be in ED 5-10 minutes and transferred. How should we collect *Provider Contact Time?*

Answer 18: You should use the contact time indicated by the provider in OB who saw the patient. This provider may be an OB nurse who has been approved by the facility as an institutionally credentialed provider. Your hospital has decided that the OB department (for patients who believe they are in labor but are not) is an extension of the ED because OB uses the E/M codes, meaning that those codes are to be included in the ED – Throughput measures.

Question 19: For capturing immediately upon arrival (slide 37), can physician documentation of 'immediately upon arrival' be accepted when there is evidence of when the physician checked in to see the patient? Can we abstract the physician's check in time when this is how we've trained the physicians to document when they've first seen the patient? Otherwise, can we abstract from a 'time seen stamp' on a physician's note?

Answer 19: If the provider documents seen on arrival and there is other substantiating evidence of direct contact, such as a physical exam, then you can use that documentation for the contact time.

Question 20: How do you abstract departure time to OBS, if the OBS bed (separate unit) is part of the ED service line? Bed is called OBS, but in EMR patient notes looks like ED.

Answer 20: You would abstract *ED Departure Time* when the observation order is written. If this is not an ED patient, (as they go directly to an observation unit), then this chart would not be abstracted as ED Departure Time.

Question 21: What if the patient goes to inpatient status instead of observation; how should this measure be abstracted?

Answer 21: Patients who are admitted to inpatient status, fall out of the ED measures. Such cases are ineligible for OP abstraction.

Question 22: What if our documentation in the chart states "last dose taken as last year, February 2014?"

Answer 22: If you are talking about OP-21 Pain Medication, and the last dose of pain medication taken was not within 24 hours prior to arrival and there is no other documentation of pain medication given, then you would answer "No," unless parenteral medication was given after arrival.

Question 23: If the initial pain score is 0, then later the patient complained of pain, is that considered an acceptable reason for not administering pain medications?

Answer 23: Based on the information given, if the only documentation found is a "0" pain scale, then no, this would not be considered an acceptable reason for not administering pain medication. If the nurse/physician/APN/PA documented that pain medication was not ordered due to patient's pain level, then that would be considered an acceptable reason for not administering pain medication.

Question 25: If an adult patient received both po and parenteral medication at the same time, i.e., 10 a.m., which one should be abstracted?

Answer 25: If this is an adult patient 18 years or greater, then you would abstract parenteral, and answer yes.

Question 26: On ED physician notes, the Dr. has documented the time they saw the patient but it is earlier than the time of arrival on the ED triage sheets. Would this be UTD, or do we take that time for ED–throughput?

Answer 26: If the *Provider Contact Time* is documented prior to arrival or after departure/discharge from the ED, abstract UTD.

Question 27: Going back to the OP-20; If the record has a time stamp used and the physician pulls that in to his designated FC, can we use it?

Answer 27: The event log or time stamp may be abstracted, provided that there is supporting documentation in the medical record that substantiates the patient was evaluated face-to-face by the provider. The data element specifies that there must be documentation of direct contact between the patient and the physician/APN/PA or institutionally credentialed provider.

Question 28: Do you have any suggestions for OP-21 Pain management QI initiatives?

Answer 28: Our suggestion would be to review your processes and documents, to see where opportunities for improvement present.

Question 29: We use an ED tracking board that gives us the time a patient departs the ED. You said we need to use the Observation admit order as the time the patient departed the ED. Is this because some hospitals house observation in the ED?

Answer 29: The reason that the order for observation services is used as the *ED Departure Time* is to reduce ED –Throughput time for patients who remain in the ED after the order for observation is written.

Question 30: My vendor manual says to use the arrival time for the ECG time, if the ECG time is before the *Arrival Time*. Which is correct? You said to use ECG time as *Arrival Time*.

Answer 30: In the event the patient had an ECG performed within 60 minutes prior to arrival at the ED, enter the time the patient arrived at the ED, as the ECG time. This is for data element ECG, not data element *Arrival Time*.

Question 31: Are the Benchmarks of Care the same as the benchmarks on the *Hospital Compare* Preview Reports?

Answer 31: The Benchmarks of Care on QualityNet are calculated quarterly, utilizing data reported by the facilities. The benchmarks are calculated using the top 10% sample. *Hospital Compare* is reflective of all of the data reported by facilities. The information displayed on the benchmark tables discussed in this presentation illustrates the difference.

Question 32: An adult patient with hx CAD has Aspirin 80 mg po listed as routine home medication. Could this be abstracted as Pain Medication and assumed taken within the 24 hour time frame. How will this be abstracted? Would this be considered pain meds or cardiac meds?

Answer 32: If there is documentation of routine pain medication on the home medication list, it can be assumed that these medications were taken within 24 hours prior to arrival. Select no to Pain Medication.

Question 33: If patient received IV pain med in ED, but has list of home meds that includes Toradol po, is the answer still "no"?

Answer 33: For patients aged 18 or older, if the Toradol is a PRN (as needed) basis, then the date and time of last dose must be documented and taken within 24 hours prior to arrival, then the Toradol is not considered. If the Toradol was scheduled, or there is documentation that the medication was taken within 24 hours prior to arrival, then you would answer no. Use the Pain Medication time as the initial intranasal or parenteral pain medication.

Question 34: Is a pain scale score of zero, assigned by the nurse, sufficient documentation of a reason to not administer pain medication, even if several minutes later she/or someone else in the ED, administers pain medication?

Answer 34: Based on the information given, if the only documentation found is a 0 pain scale, then no, this would not be considered an acceptable reason for not administering pain medication. If the nurse/physician/APN/PA documented that pain medication was not ordered due to patient's pain level, then that would be considered an acceptable reason for not administering pain medication. As pain medication was ordered and given, then abstract this documentation.

Question 35: ED Throughput- If the *Provider Contact Date* is missing, can we use the date the patient was in the ED if the patient arrived and discharged on the same date? There would be no other day.

Answer 35: If the date of provider contact is not documented, but you are able to determine the date from other documentation, then this is acceptable.