Hospital Outpatient Quality Reporting Program

Support Contractor

Measuring Up: Benchmarks and Quality Improvement

Questions & Answers

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Question 1: QNet responses have indicated that "MD at bedside" is acceptable documentation for Initial Provider Contact. Do you agree?

Answer 1: Yes, documentation of "MD at bedside" is acceptable verbiage for Provider Contact Time.

Question 2: If a physician documents a date and time immediately upon arrival, can you use the date and time noted?

Answer 2: With the date and time, there should be documentation of direct contact with the patient. But also remember your guideline exclusions are: *Admission Time, Arrival Time Presentation Time, Triage Time, Provider Assigned Time*. If there is substantiating evidence that the provider had direct contact with the patient, such as a physical exam, then that time can be used. Arrival time alone cannot be used.

Question 3: We have an events section at the end of our ED encounter that documents "seen by Dr. X at whatever time." Will that suffice?

Answer 3: Yes. The events section is acceptable as long it clearly states "seen by doctor," and there is no conflicting time noted anywhere else in the record.

Question 4: Is this being recorded for future viewing?

Answer 4: Yes, you may review this presentation on qualityreportingcenter.com in about two weeks. You can access the archived events at the following: http://www.qualityreportingcenter.com/hospitaloqr/events/.

Question 5: The terms listed under inclusion guidelines: ED Leave Time, ED Discharge Time, ED Departure Time, ED Check Out Time- do these terms have to be used?

Answer 5: Related to *Departure Times,* these terms can be used for abstraction.

Question 6 Many patients have "Admit to Inpatient Services" and go to a room or unit. Due to various billing reasons/rules, the patient may be billed as an OP. Would the date/time for "admit to IP svcs," be the correct ED *Departure Time* (in place of OBS order).

Answer 6: What I think you are asking is that if a patient is in the ED and is admitted as Inpatient, then later in the hospital stay the admission order changes to OBS, then for departure time from the ED, you would use the time the patient physically left the ED.

Question 7: On provider contact, how would a provider do a skin culture without direct contact?

Answer 7: There needs to be documentation of direct initial provider contact, whether it is a skin culture, exam, etc. For *Provider Contact Time*, the intent is to capture the earliest time at which the patient had direct contact with the credentialed provider.

Question 8: I was instructed in a recent QNet response that I could NOT use *Provider Contact* as *Arrival Time*. I just wanted to verify that--so if the earliest time is the "*Provider Contact Time*"--followed by a documented exam--I must answer UTD for *Arrival Time*?

Answer 8: For the *Provider Contact Time*- the time of arrival alone cannot be used for *Provider Contact Time*. *Arrival Time* is an exclusion on this element. If there is substantiating documentation, such as a physical exam, that the physician had direct personal contact upon arrival, then that time can be used.

Question 9: *Ed Departure Date*: If the patient is admitted to observation status but a bed is not available on the unit so the patient stays in the ED until a bed is ready, what date/time should be abstracted?

Answer 9: For the Hospital OQR Program, the guidelines state that the time of the order for observation should be abstracted as the *ED Departure Time*. The order time should be abstracted regardless, that the patient stays in the ED for a period of time thereafter.

Question 10: I thought you were to use the time the patient physically left the ED for the *ED Departure Date and Time*.

Answer 10: For patients that are admitted to observation, the Specification Manual states "use the time of the physician/APN/PA order for observation for *ED Departure Time."*

Question 11: Could you please explain again when to use the observation order for discharge from the ED?

Answer 11: When a patient is admitted to observation services, the date/time of the observation order is abstracted as the *ED Departure Time* per the guidelines for this element.

Question 12: Which would be the *ED Departure Time*: MD order for observation was 7/10/2015 at 10:10 a.m. ED RN documented patient "left the ED at 7/10/2015 10:21 a.m.?"

Answer 12: Your ED Departure Time would be 10:10 am.

Question 13: For patient's 18 and up, if the patient receives a PO pain medication prior to arrival, answer no despite the requirement of intra nasal & IM/IV medications for this age range of patients when they are in the ED?

Answer 13: If there is documentation in the medical record that the patient received pain medication prior to arrival, select no.

Question 14: So, if the patient has just "Tylenol" on home med list, no frequency---how would this be abstracted? It doesn't say "daily" or "prn."

Answer 14: If the pain medication is ordered PRN, then the dose must be documented and timed. If the home medication is ordered as a routine dose, then it is assumed the medication was taken in the 24 hours prior to arrival. If there is no other documentation of pain medication given, then you would answer no, unless parental medication was given after arrival.

Question 15: OB RN contact can be used for first provider contact? I thought it had to be a MLP or physician.

Answer 15: You are correct, but for OB, you can use OB nurse, who has been approved by the facility as an institutionally credentialed provider. 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.