Outpatient Quality Reporting Program

Support Contractor

Tracking Quality Improvement by Using Hospital OQR Data

Questions & Answers

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Question: Please address if there are any plans to revamp the Pain Management measure. Our QualityNet responses to questions around this measure have been confusing and inconsistent. I have suggested this to the QualityNet folks already, but it appears to me the leading question to this measure should be "Did the patient complain of pain upon arrival," as patients with no pain at the time of arrival should be excluded from this measure, and that is not the case currently. We have had different debates internally and in response from QualityNet submissions about pain score results and without clear direction to disregard the lack of pain at arrival. The data is going to be calculated from arrival to pain medication, when in fact, it is possible for the patient to have no pain until someone starts manipulating and then pain med is given. As the definitions are currently written, they don't clearly address lack of pain. We've been advised that even if the patient is having no pain, the MD must document "No pain" as a reason for not giving pain medication immediately in order to consider that as an exclusion. The leading question in the measure is "Was pain med given," and the examples you list doesn't really even include that the patient had no pain. Even if staff offered pain medication and the patient declined, I am not convinced documentation would reflect that. However, starting with whether pain is present at arrival would get to that point much more simply. Honestly, I initially just approached chart reviews as a straightforward look at the time lapse between arrival and earliest pain

med. The issue got confusing when a co-worker shared that she was basing her abstraction responses on the presence of a pain score and was excluding those without one to reflect pain.

Answer: If there is documentation that the patient refused initial pain medication, as stated in the Specifications Manual, "If there is physician or nursing documentation of a reason for not administering pain medication (e.g., patient unconscious, decreased respiratory rate, patient refusal), select No." This is how the patients are excluded when they do not complain of pain upon arrival. The patient has a long bone fracture, and the measure assesses if there is documentation of pain medication administration. However, you present a good point, and we will pass this along to the measure writers. We have looked at this issue before, and the outcome was, "Is the pain upon arrival being addressed?" I understand the hip fracture patient may not be in pain until moved for X-ray, and if pain med is administered an hour after arrival, this will reflect on your Hospital Compare data. The question is though, "Was the pain assessed and documented upon arrival?" As you stated, the addition of "Denies pain upon arrival" would be a good addition. Again, we can address this with the measure writers.

Question: For ED departure documentation issues, if the nurse writes a note that says "Patient discharged with instructions and left via private vehicle with family," but 30 minutes later the ED departure time is documented because the patient was removed from the tracking screen, which time should be used?

Answer: If the time that the patient is removed from the tracking board is labeled as "Departure time," then you should abstract that time as the time of ED departure. However, if that is the case, I would encourage you to address this verbiage with your EHR vendor so that the time is appropriately labeled to indicate what the ED Departure Time truly is.

Question: If mandatory reporting is not required for Critical Access Hospitals (CAHs), do some states require input from CAHs?

Answer: Yes. The MBQIP Program on a state level requires reporting for the CAHs. There may also be other requirements for individual states. Please check with the state you are in for specifics.

Question: Is there an exception if a patient is held in the ED waiting for psych evaluation?

Answer: If you are talking about OP-18b, ED-throughput, then if the patient has an ICD-10 code that is listed under the "Mental Disorders" in Appendix A of the Specifications Manual, then these patients are not included in the facility's 18b throughput numbers. OP-18c is the Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients. This is not part of the reporting measure. This means that patients with psychiatric/mental health diagnoses (and as a note, ED-transfers), are not included in your ED throughput time. OP-18 has four components as outlined in the Specifications Manual. If this is not the measure you were speaking of, then please put your question in the Q&A in QualityNet, or call the Help Desk at 866.800.8756.

Question: Is there a specific date for the posting of the OPPS/ASC proposed rule for CY 2017?

Answer: There is not a specific date for the OQR/ASC Proposed Rule yet; it is usually scheduled to be released in the month of July. Email notification will be sent when this becomes available.

Question: Are there benchmarks available for OP-29 and OP-30? If not, when will they be available?

Answer: There are not currently benchmarks established for OP-29 and OP-30. Benchmarks for all measures are evaluated on a quarterly basis and are developed using the Achievable Benchmarks of Care™ (ABC) methodology. Further information about benchmarks, as well as those that are currently available, can be found on the QualityNet website.

Question: I find a lot of my problems come with charts that come up on our sampling that are not actually ED but OB triage which is coded as ED. Why do these get included?

Answer: Evaluation of suspected labor is treated and billed as an emergency visit. The OB triage evaluation is completed by a physician/APN/PA or institutionally credentialed provider. For purposes of OP-20, it is the time of the initial contact between the patient and a credentialed provider.