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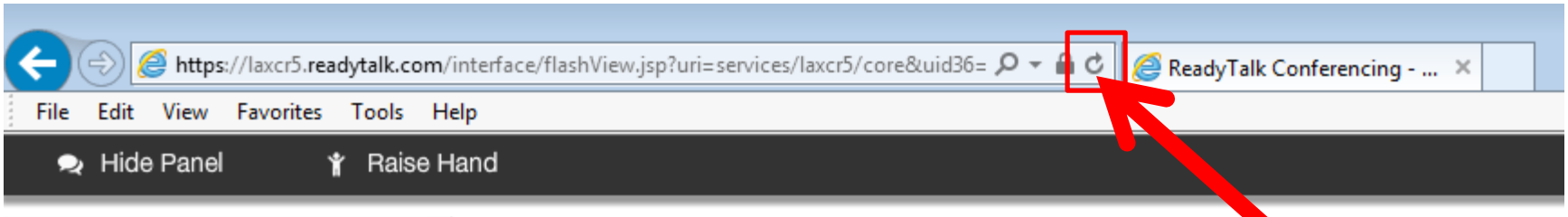
Audio from computer speakers breaking up?
Audio suddenly stops?

- Click **Refresh** icon
  or
- Click F5

F5 Key
Top row of keyboard

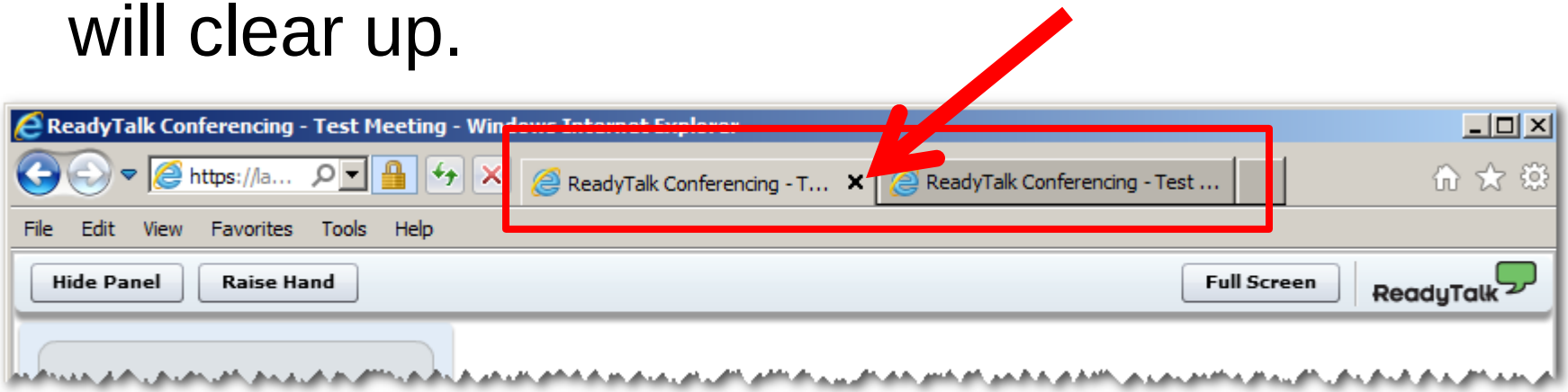


Location of buttons

Refresh

Troubleshooting Echo

- Hear a bad echo on the call?
- Echo is caused by multiple browsers/tabs open to a single event (multiple audio feeds).
- Close all but one browser/tab, and the echo will clear up.



Example of two browsers/tabs open in same event

Submitting Questions

Type questions in the “Chat with Presenter” section located on the bottom-left corner of your screen.

The Question and Answer Show

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Hospital Outpatient Quality Reporting (OQR) Program
Support Contractor

June 21, 2017

Save the Date

- Upcoming Hospital Outpatient Quality Reporting (OQR) Program educational webinar:
  - August 2, 2017: Proposed Rule
- Notifications of additional educational webinars will be sent via ListServe

Learning Objectives

At the conclusion of the presentation, attendees will be able to:

- ✓ Identify some common difficulties for chart-abstracted measures
- ✓ Describe at least five common hurdles and possible solutions when reporting measures via the online submission tools
- ✓ List resources available to help troubleshoot problems when reporting data

WHAT DO YOU WANT TO KNOW?

AMI/Chest Pain Measures

- OP-1: Median Time to Fibrinolysis
- OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
- OP-4: Aspirin at Arrival
- OP-5: Median Time to ECG

Reason for Not Receiving Fibrinolytic Therapy

Scenario

"The patient arrived to our ED from a walk-in clinic with a STEMI. The record from the clinic shows a BP of 178/120. The clinic record is now a part of our ED record. The patient was then transferred from our hospital to another hospital for the CATH lab. Can I use the BP of 178/120 (diastolic >110 on presentation) as a reason for no thrombolytic?"

Answer

Yes. A blood pressure of 178/120 aligns with the contraindication “Severe uncontrolled hypertension on presentation (SBP >180 mmHg or DBP >110 mmHg).” As the medical record from the clinic is now a part of the emergency department medical record, you can abstract a value of “1.”

Documentation a 12-lead electrocardiogram (ECG) was performed prior to emergency department arrival or in the ED prior to transfer

Question

"If there is a valid time documented when an ECG was performed but we are unable to find the actual ECG tracing in the medical record, is it acceptable to answer 'Yes' to the question, 'Was an ECG performed'?"

Answer

It is acceptable to abstract “Yes” for *ECG* if there is documentation that an ECG was performed.

- Please note that a physical ECG printout is not required to abstract *ECG.*


ED Throughput

Measures

- OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP-22: Left Without Being Seen

Arrival Time

The earliest documented time the patient arrived at the outpatient or emergency department.

Question

"We had a patient in our free-standing satellite ED transfer to our main campus. Would this patient be included in our outpatient measures?"

Answer

Yes, patients who transfer from a free-standing satellite ED to the facility's main campus would remain in the outpatient population, if they meet all other inclusion criteria. If the free-standing ED is billing using the main hospital's CCN, then think of these as one ED.

Scenario

“Upon arrival to the ED, patients complete a ‘Reason for Visit’ form that includes the date and time of arrival and remains a part of the ED record. The triage nurse documents the date and time of arrival on the triage assessment. However, if the patient's time of arrival is earlier than the triage nurse's documented time of arrival, which time would be abstracted?”

Answer

If the “Reason for Visit" form is a permanent part of the medical record, it can be used as a data source. Abstract the earliest documented time of arrival from review of all applicable data sources to determine the *Arrival Time*.

Provider Contact Time

The time represented in in hours and minutes for the first direct, personal exchange between an ambulatory patient and a physician or institutionally credentialed provider to initiate the medical screening examination in the emergency department.

Question

"If the documentation states 'Patient seen on arrival' on the ED summary, which includes the patient exam, can the arrival time be used as the *Provider Contact Time*?"

Answer

No, the arrival time cannot be accepted for the time of first provider contact. There must be a specific time documented for the initial direct encounter between the patient and the provider that is distinct from the patient's arrival in the ED.

ED Departure Time

The time represented in hours and minutes at which the patient departed from the emergency department.

Question

"If a patient is admitted to observation services, but is kept in the ED until a bed is available, what time is the *ED Departure Time*?"

Answer

For the patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*.

Scenario

The ED nurse documented in multiple places that the patient was transferred at 1237.

- The last vital signs were recorded at 1241.
- The STEMI data sheet included a line ‘Time Patient Left ED’ with the entry of 1243.

What discharge time should be abstracted?

Answer

When more than one discharge time is documented, abstract the latest time. In this case, abstract “1243.”

Discharge Code

The final place or setting to which the patient was discharged from the outpatient setting.

Question One

"The physician ordered 'Discharge home with discharge instructions.' The nursing notes reflect that the patient left before the discharge instructions could be given. What is my discharge code?"

Answer One

As there is documentation that the physician ordered the patient's discharge status as "discharged to home," you may select value "1" for home.

Question Two

"The medical record progress notes state that the patient requested to be discharged, but the discharge was medically contraindicated at that time. An AMA form was not signed. We would abstract a value of '7,' correct?"

Answer Two

Yes, you are correct. A signed AMA form is not required to select value "7," -Left Against Medical Advice/AMA. However, you must have explicit documentation that the patient left AMA.

More Measures

- OP-21: Median Time to Pain Management for Long Bone Fracture
- OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival


Pain Management:
Median Time to Pain Management for
Long Bone Fracture.

Question

"If the patient lists aspirin as a home medication and it is noted as low dose (as in a cardiac dose), would this patient be included in the measure? Should we still answer "No" to 'Was there documentation the patient received oral, intranasal, or parenteral pain medication during this emergency department visit'?"

Answer

Aspirin/ASA as a daily home medication would be considered a pain medication given prior to arrival. If there is clear evidence of any medication with pain-relieving properties received within the 24 hours prior to arrival, this would exclude the patient from the measure so as not to penalize the facility if pain medication administration in the hospital was in any way delayed due to the patient having taken or received a pain medication prior to arrival.


Stroke: Head CT or MRI Scan
Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival

Question

“The head CT report states ‘Dictated time 0941’ and has a signed time of ‘1020.’ Which is the correct time to abstract for interpretation time?”

Answer

You would abstract “0941” if the dictation time is known to be an accurate representation of when the head CT interpretation occurred.

- Remember, you may abstract the earliest head CT or MRI scan interpretation.

Scenario

“ED provider notes: ‘Today at roughly 1800 she was relaxing when she had a rather sudden and severe headache.’ Nurse documented: “Patient was last known well at 1853 on 01/18/17. Patient states today it was really bad starting at 1900. Then the headache came out of nowhere.”

“Knowing the provider stated ‘roughly,’ which is not an exact time, and the nurse wrote an exact time of ‘1853,’ but then documents that the patient said it was really bad starting at 1900, do I take the provider time of 1800?”

Answer

You may use 1800 to abstract *Time Last Known Well* because physician documentation takes precedence over nursing documentation. Furthermore, if multiple times last known well are documented by different physicians or the same provider, use the earliest time documented.

Measures Submitted Using a CMS Web-Based Tool

Selected Measures

- OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures
- OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
- OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps–Avoidance of Inappropriate Use
- OP-33: External Beam Radiotherapy for Bone Metastases

OP-26

Hospital Outpatient Volume on Selected Outpatient Surgical Procedures.

Question

"Why are the surgical procedure codes for OP-26 not in the Specifications Manual when it is released?"

Answer

CMS pulls the top 100 surgical codes. The table of categories and Healthcare Common Procedure Coding System (HCPCS) codes for Outpatient Surgical Procedures is updated in November of each year.

Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients.

Question One

"The physician performs a biopsy during the colonoscopy and is awaiting the results. Does the physician still need to document a recommendation for a 10-year follow-up, or would the documentation of 'Awaiting biopsy results; will follow-up in office' be sufficient documentation to be excluded from the measure?"

Answer One

If the patient had a biopsy, then the case is excluded from the OP-29 measure.

- To meet the criteria for the denominator, the patient should be 50 to 75 years of receiving screening colonoscopy ***without*** biopsy or polypectomy.

Question Two

"Is documentation of 'No follow-up due to age' sufficient for exclusion for OP-29?"

Answer Two

Yes. If there is documentation that a follow-up colonoscopy is not recommended due to a patient's age, the case can be excluded based on a medical reason.

Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use

Question One

"If a colonoscopy interval of less than three years can be determined from a prior colonoscopy report and the physician documents a medical reason for performing the colonoscopy (i.e., rectal bleeding), is this still acceptable for denominator exclusion purposes?"

Answer One

If the interval can be determined as less than three years, it would be acceptable to exclude the case based on a medical reason. The interval does not have to be documented by the physician if the interval can be determined.

Question Two

"For OP-30, if a physician only mentions a history of colon cancer found three years ago, does this count as a past last colonoscopy?"

Answer Two

No, the documentation does not indicate that a colonoscopy was performed.

External Beam Radiotherapy for Bone Metastases.

Question One

"A patient received EBRT, but the physician's documentation on the initial treatment plan noted this was a 're-treatment.' Should this case be excluded?"

Answer One

Yes. When the documentation states the EBRT was prescribed as “re-treatment” or “re-irradiation,” this is an indication that the patient has previously received radiation to the same anatomic site.

Question Two

“Would pelvic fractures be considered cord compression?”

Answer Two

Pelvic fractures, in the context of this measure, should not be considered spinal cord compression unless there is explicit clinical documentation linking the two.

Question Three

"A patient had two treatments to two different anatomic sites but they were captured in a single encounter (billing number). Should this be abstracted as a single case or as two cases?"

Answer Three

This should be abstracted as two cases. All encounters to separate anatomic sites should be abstracted individually even if they are within the same encounter (billing number).

We Hope This Helped!

- Support Contractor contact:
  - Helpdesk: 866.800.8756
  - www.qualityreportingcenter.com
- Have a question? Use the Questions & Answers tool:
  - https://cms-ocsq.custhelp.com/

Questions

Continuing Education Approval

This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:

- Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
- Florida Board of Nursing Home Administrators
- Florida Council of Dietetics
- Florida Board of Pharmacy
- Board of Registered Nursing (Provider #16578)
  - It is your responsibility to submit this form to your accrediting body for credit.

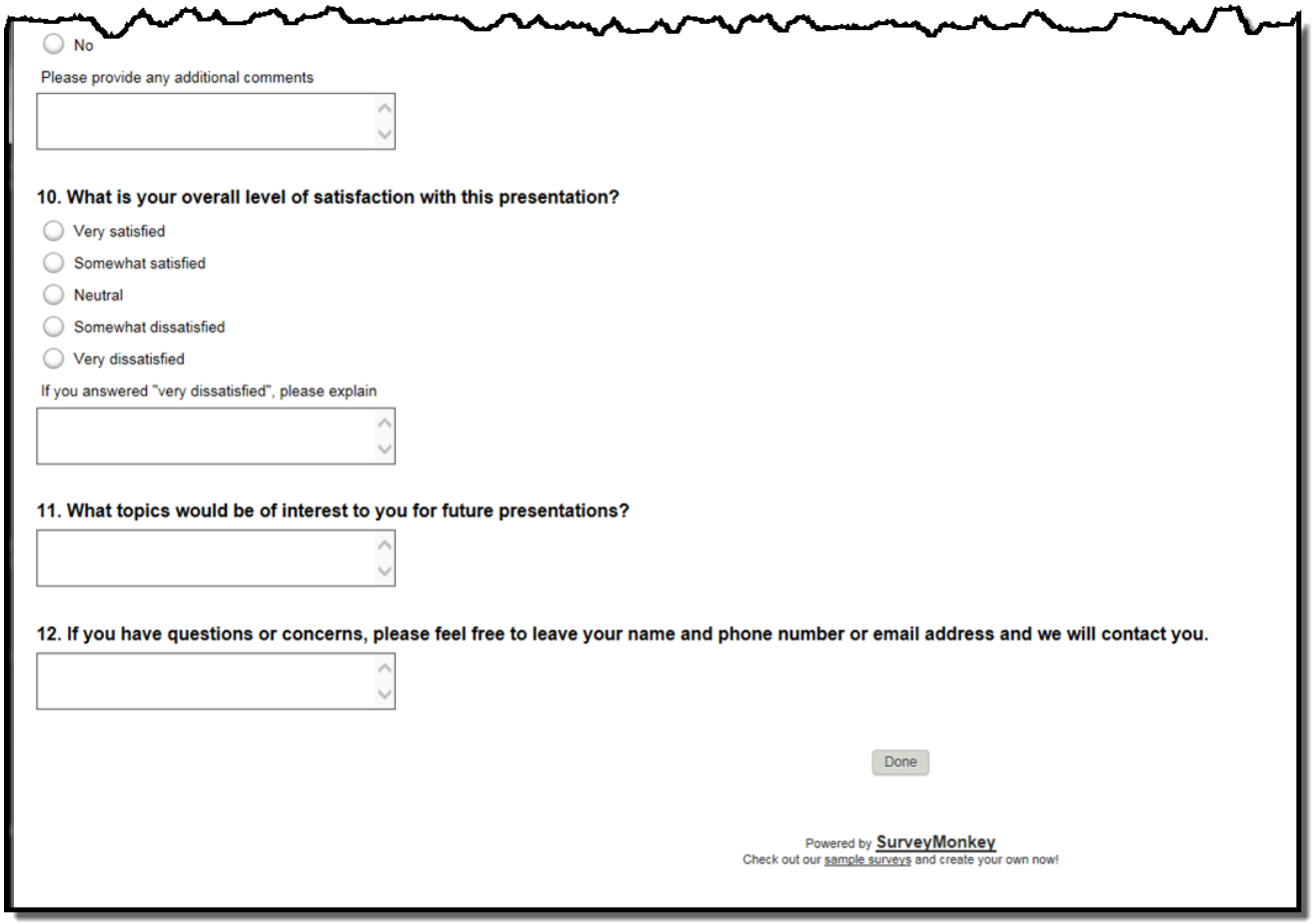
CE Credit Process

- Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click “Done” at the bottom of the screen.
- Another page will open that asks you to register in HSAG’s Learning Management Center.
  - This is separate from registering for the webinar. If you have not registered at the Learning Management Center, you will **not** receive your certificate.
  - Please use your **personal** email so you can receive your certificate.
  - Healthcare facilities have firewalls that block our certificates.

CE Certificate Problems?

- If you do not immediately receive a response to the email you used to register in the Learning Management Center, a firewall is blocking the survey link.
- Please go back to the New User link and register your personal email account.
- If you continue to have problems, please contact Deb Price at dprice@hsag.com.

CE Credit Process: Survey



No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
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If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

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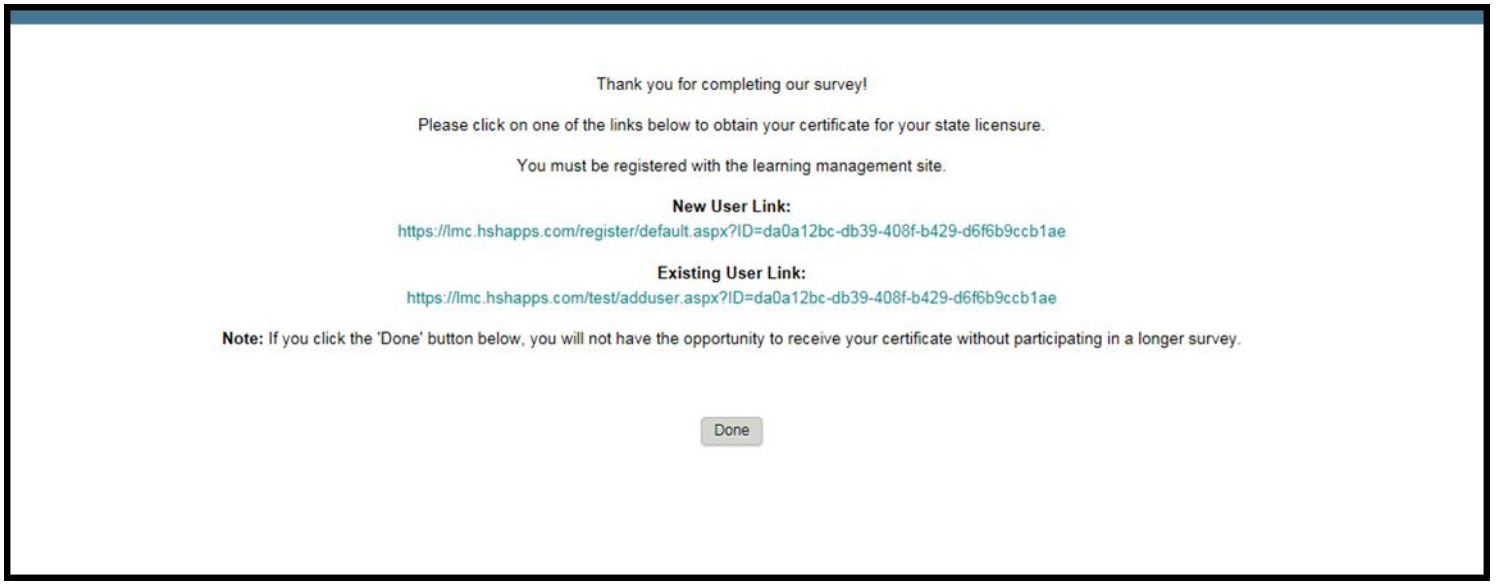
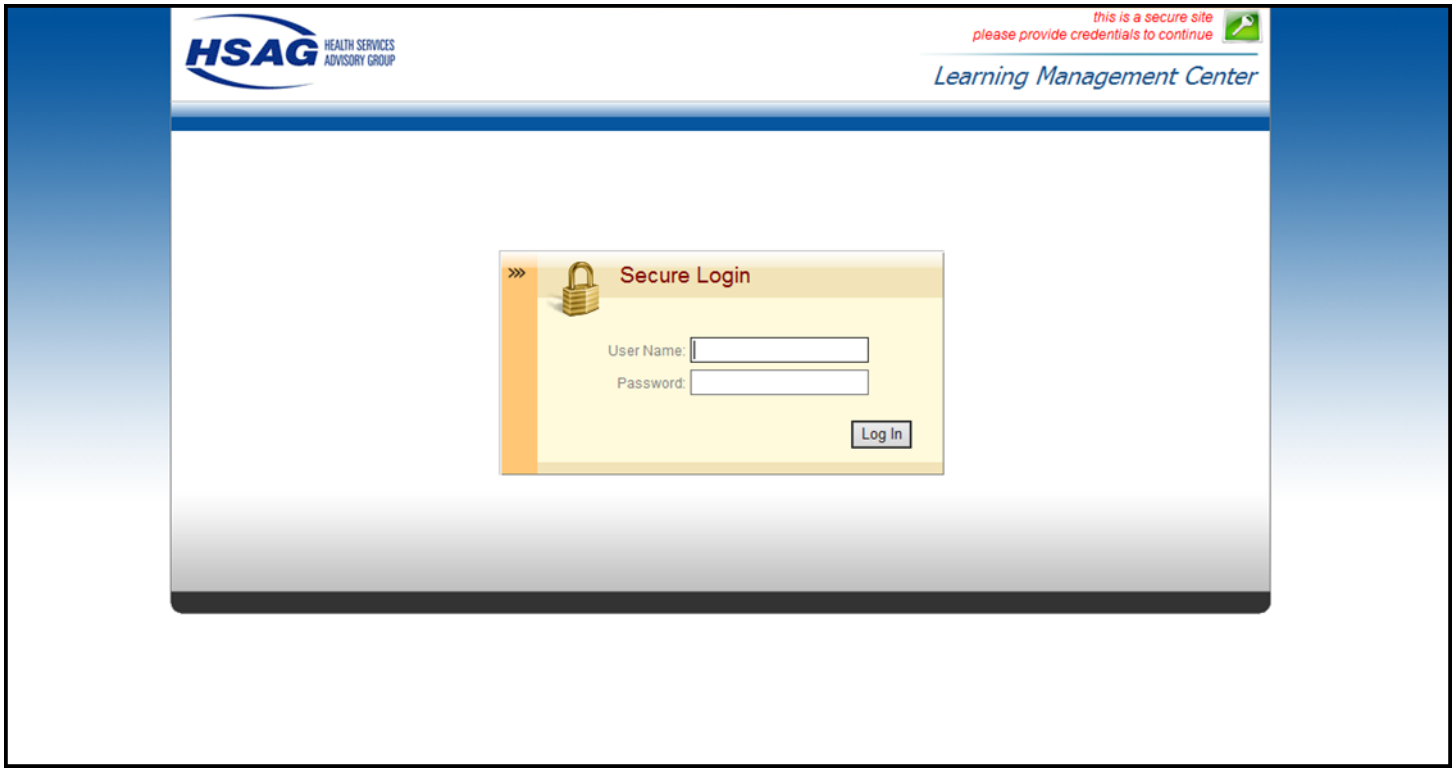
CE Credit Process



CE Credit Process: New User

CE Credit Process: Existing User



Thank You for Participating!

Please contact the Support Contractor if you have any questions:

- Submit questions online through the QualityNet Question & Answer Tool at www.qualitynet.org

Or

- Call the Support Contractor at 866.800.8756.

Acronyms

- AMA – Against Medical Advice
- APN – Advanced Practice Nurse
- ASA – Acetylsalicylic acid (aspirin)
- BP – Blood pressure
- CATH lab – Catheterization laboratory
- CCN – CMS Certification Number
- CMS – Centers for Medicare & Medicaid Services
- CT – Computerized tomography
- DBP – Diastolic blood pressure
- DC – Discharge
- EBRT – External Beam Radiotherapy
- ECG – Electrocardiogram
- ED – Emergency Department
- MRI – Magnetic resonance imaging
- PA – Physician's Assistant
- SBP – Systolic blood pressure
- STEMI – ST-elevation myocardial infarction