Taking the “Mis” Out of Mismatch: Top 10 Mismatched Data Elements from Q2 2011 through Q1 2012

April 17, 2013

Announcements

Upcoming Report Dates

- Hospitals are responsible for ensuring that their Hospital OQR requirements are met.
- The next clinical data submission and population sampling deadline is May 1, 2013, for Q4 2012 (October – December) encounters.
- Structural (web-based) measures must be reported from July 1, 2013 – November 1, 2013.
CDAC Validation

• Q2 2012 validation results are expected to be published in late May.
• Q3 2012 hospital records were due to CDAC on April 15, or 45 days from when your hospital received the CDAC request.
• Q4 2012 record requests are anticipated to be sent in late May.

QualityNet Updates

• Hospital Compare Preview Reports are expected to be updated in mid-April and will cover the reporting period of Q4 2011 through Q2 2012. The report can be located at My QualityNet.
• Facilities must maintain at least one active Security Administrator.
• CMS strongly urges facilities to maintain at least two active Security Administrators.

Save the Date

• The next Hospital Outpatient Quality Reporting Program webinar will be held on May 15 and will review using CART, the CMS Abstraction & Reporting Tool.
Learning Objectives

At the conclusion of this program, attendees will be able to:

• Identify the top ten mismatched data elements for Q2 2011 – Q1 2012;
• Discuss common abstraction errors; and
• Describe opportunities to correct mismatched data elements for the Hospital Outpatient Quality Reporting Program.

Taking the “Mis” Out of Mismatch: Top 10 Mismatched Data Elements from Q2 2011 through Q1 2012

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April 17, 2013
Top 10 Mismatched Data Elements Q2 2011 – Q1 2012 (QualityNet Oracle Validation Tables)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Data Element</th>
<th>Description</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Antibiotic Name</td>
<td>What is the name of the antibiotic(s)?</td>
<td>1,388</td>
<td>15.1%</td>
</tr>
<tr>
<td>2</td>
<td>Provider Contact Time</td>
<td>What is the time the patient first had direct contact with the physician/NP/N in the emergency department?</td>
<td>5,386</td>
<td>15.3%</td>
</tr>
<tr>
<td>3</td>
<td>ECG Date and Time</td>
<td>What was the documented date and time of the earliest ECG?</td>
<td>709</td>
<td>8.7%</td>
</tr>
<tr>
<td>4</td>
<td>ED Arrival Time</td>
<td>What was the earliest documented time the patient arrived at the emergency department?</td>
<td>733</td>
<td>9.5%</td>
</tr>
<tr>
<td>5</td>
<td>ED Departure Time</td>
<td>What is the time the patient departed from the emergency department?</td>
<td>439</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Top 10 Mismatched Data Elements Q2 2011 – Q1 2012 (QualityNet Oracle Validation Tables)

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<tbody>
<tr>
<td>6</td>
<td>Antibiotic Timing</td>
<td>Was an antibiotic initiated (started) after the procedure (30 minutes for vancomycin or quinolones) prior to surgical incision?</td>
<td>426</td>
<td>5.5%</td>
</tr>
<tr>
<td>7</td>
<td>Initial ECG Interpretation</td>
<td>Is there documentation of ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to emergency department arrival?</td>
<td>339</td>
<td>4.4%</td>
</tr>
<tr>
<td>8</td>
<td>Probable Cardiac Chest Pain</td>
<td>Was the patient's chest pain presumed to be cardiac in origin?</td>
<td>338</td>
<td>4.4%</td>
</tr>
<tr>
<td>9</td>
<td>E/M Code</td>
<td>What was the E/M Code documented for this outpatient encounter?</td>
<td>269</td>
<td>3.3%</td>
</tr>
<tr>
<td>10</td>
<td>Antibiotic</td>
<td>Did the patient receive an antibiotic during this outpatient encounter?</td>
<td>245</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Mismatches and Scoring

- One measure set includes multiple measures.
- Within each measure are multiple data elements.
- Missing one data element will not cause you to mismatch the entire measure.
- The number of measures divided by the number of mismatches equals the percentage (# of measures/# of mismatches = %).
- The percentage must be ≥ 75% for a full annual payment update.
Multiple Data Elements Per Measure: Example 1

Measure OP-6: Timing of Antibiotic Prophylaxis
• Data Elements:
  - Antibiotic
  - Antibiotic name
  - Antibiotic route
  - Birth date
  - Case cancelled
  - Clinical Trial
  - CPT code
  - Infection prior to anesthesia
  - Outpatient encounter date
  - Replacement

Multiple Data Elements Per Measure: Example 2

Measure OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
• Data Elements:
  - Arrival time
  - Discharge code
  - E/M code
  - Outpatient encounter date
  - Provider contact date
  - Provider contact time

Measure Set and Data Elements That Mismatched
• Mismatched elements in surgical measure set = 25%
• Mismatched elements in ED Throughput = 31%
• Mismatched elements in Chest Pain/AMI measure set = 18%
Mismatch #1: Antibiotic Name

“What is the name of the antibiotic(s)?”

- Incomplete record submitted to the CDAC
- No antibiotic name given, just a blanket statement such as “antibiotic given as ordered”
- No route indicated
- Antibiotic named but no route noted, no time given, and no signature documented
- Abstraction from excluded narrative documentation

Antibiotic Name:

Improvement Suggestions

- Standardize your hospital’s OR record.
  - For electronic records utilize drop down boxes.
  - For paper records use check boxes with antibiotic names.
- Quality Improvement needs to review all records (copied charts) prior to the submission to CDAC.
- If records are handwritten, make certain the writing is legible, especially Anesthesia and Operating Room Flow Sheets.
- Remember to abstract drug, dose, time, route, and patient all from one source.

Mismatch #2: Provider Contact Time

“What is the time the patient first had direct personal contact with the physician/APN/PA to initiate the screening exam in the ED?”

- Verbiage does not imply direct contact – for example, “physician assigned”
- Time abstracted from physician orders, history and physical, history of present illness, note time, review of system, or other physician-generated sheet that does not imply face-to-face contact
- No documentation of exam found in record
Provider Contact Time:
Improvement Suggestions

- Include verbiage that implies direct contact such as “MD in room,” “MD at bedside,” “MD with patient,” etc.
- “MD saw patient on arrival” requires documentation of an exam on arrival associated with the encounter.
- If possible, modify ED forms to include a field labeled “Initial Provider Contact Time.”

Abstracting from a T-Sheet

- The time labeled on an ED T-sheet is an acceptable source if there is an exam documented.
- If the T-sheet time specifies initial provider contact, no documentation of exam is required.

Sample T-Sheet
Mismatch #3: ECG Date and Time

“What was the documented date and time of the earliest ECG?”
• Missing or overlooked earliest ECG time
• Most common mismatch – missing the earliest ECG if done by EMS

ECG Date and Time: Improvement Suggestions

• If EMS did ECG prior to arrival, abstract arrival time as time of ECG (abstract the ECG as zero minutes)
• This will report on Hospital Compare as zero time to ECG

Mismatch #4: ED Arrival Time

“What was the earliest documented time the patient arrived at the outpatient or emergency department?”
• Incomplete charts submitted to CDAC
• Earliest time not abstracted
• Using an excluded source
ED Arrival Time:
Improvement Suggestions

- Copy the complete record to send to CDAC.
- Abstract the earliest time that the patient was in the ED or Outpatient Department.
- Do not use face/registration sheet with unspecified “Time” as Arrival Time.
- Arrival time is not validated for surgical patients.

Mismatch #5: ED Departure Time

“What is the time the patient departed from the ED?”

- “Discharge instructions given” does not indicate the patient physically left the ED
- Abstractors may not be familiar with accepted verbiage from the Specifications Manual
- Patient still receiving services after the abstracted Departure Time
- Using Discharge Summary without noted Departure Time
- Abstractor missing the latest time documented
- Disposition is an exclusion term

ED Departure Time:
Improvement Suggestions

- Submit complete record.
- Know acceptable verbiage (“Release Time,” “Gone Time,” “Out Time,” etc.).
- Review charts to be sure patient physically left the ED and did not continue to receive services.
- If two discharge times are documented, choose the latest of two acceptable times.
Mismatch #6: Antibiotic Timing

“Was an antibiotic initiated (started) within 60 minutes (120 minutes for vancomycin or quinolones) prior to surgical incision?”

- Incision time not clearly documented
- IV route not documented
- Antibiotic name not found
- Antibiotic not within allowable time frame

Antibiotic Timing: Improvement Suggestions

- Use documentation verbiage that adheres to the priority of synonyms
- Add “All medications administered IV unless otherwise noted” to all sources demonstrating actual administration, such as anesthesia record, nurse’s notes and MAR, etc.
- Standardize paperwork

Mismatch #7: Initial ECG Interpretation

“Is there documentation of ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to emergency department arrival?”

- Missed initial ECG interpretation (other elements of abstraction, such as fibrinolytic administration, were not enabled, resulting in mismatches)
- Use of EMS documentation for interpretation
- Use of documentation not specifically related to initial ECG
Initial ECG Interpretation: Improvement Suggestions

Documentation from physician must match initial ECG done closest to arrival.

Mismatch #8: Probable Cardiac Chest Pain

“Was the patient's Chest Pain presumed to be cardiac in origin?”
• Abstraction of exclusion terms (atypical, musculoskeletal, and non-specific)
• Use of inclusive term when exclusion terms are present

Probable Cardiac Chest Pain: Improvement Suggestions

• Be aware of exclusionary terms
  o Atypical Chest Pain
  o Chest Pain musculoskeletal
  o Chest Pain qualified by a non-cardiac cause
  o Chest wall pain
  o Non-Cardiac Chest Pain
  o Traumatic Chest Pain
  o Trauma
  o MVA
• Clearly document Chest Pain
• Inclusion – angina used with atypical Chest Pain (exclusion)
Mismatch #9: E/M Code

“What was the E/M Code documented for this outpatient encounter?”
• Indicates a process problem vs. a mismatch
• Not abstracted by the CDAC for validation

Mismatch #10: Antibiotic

“Did the patient receive an antibiotic during this outpatient encounter?”
• MAR not included in the chart submitted to CDAC
• No administration time documented

Antibiotic:
Improvement Suggestions

• Send only complete medical records to CDAC
• Include MAR with medical record
• Be sure there is a single source documentation that includes drug name, dose, route, time administered, name, or initial of person administering medication
Resources Available Online

Specifications Manual with Release Notes and Timelines:
www.qualitynet.org

Observation Services Guidelines:

Door to Evaluation Time Guidelines:

Arrival Time Guidelines:
http://hospitaloq.com/media/Arrival_Time_Fact_Sheet-final_508.pdf

Resources Available Online (continued)

Departure Time Guidelines:

Standardized Gynecological and Urological Preoperative Orders:

Anesthesia Record:

Antibiotic Table and more:
www.oqsupport.com/hospitaloq/tools

We Will Now Open the Phone Lines for Q&A

• This program is approved for a 1.0 continuing education hour.
• Please send your name, state, license number, and profession to theron@fmqai.com following the program.
  o Professionals that are licensed by approved Florida Boards will have their CE credit submitted to CE Broker.
  o Professionals licensed in other states will receive a Certificate of Completion to submit to their Boards.
Thank You!

Please contact the Hospital OQR Support Contractor if you have questions.

Submit questions online through the Question & Answer Tool: Hospitals-Outpatient Question/Answer.

OR

Call the Hospital OQR Support Contractor at 866-800-8756.