Complete and detailed information is available in the Specifications Manual located on QualityNet (www.QualityNet.org) under the Hospital Outpatient tab.

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Outpatient Quality Measures
Why are they important?

- Improves the quality of care
- Hospitals that do not meet CMS Hospital OQR Program requirements may receive a 2% reduction in payment
- Becomes the standard of care—set benchmarks

Timing Is Everything
Timing is a major factor in CMS outpatient quality measures. Timing is important to the patient and to the provision of quality care.

Documentation of time by the MD, PA, NP, and CRNA is paramount to exceptional performance.

General Documentation Guidelines

Arrival Date & Time: Document the arrival date & time (patient physically present) for measures.

Discharge/Departure Date & Time: Document the departure date & time (patient physically left) for measures.

Discharge Status: Document the patient’s discharge disposition from the ED.

Nursing Staff: Time and document a discharge note.

Medication Administration: Document medications administered—time, name, route, and administrator. All items must be documented to answer “yes” to administration questions.

Non-Administration of Indicated Medications: Reasons for non-administration of indicated medications must be documented. Reason for delays must also be documented.

- System delays are not acceptable such as equipment, waiting for medication from pharmacy, etc.

Imaging Measures

OP-8: MRI Lumbar Spine for Low Back Pain
Percentage of MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim and for which the patient did not have prior claims-based evidence of antecedent conservative therapy

OP-9: Mammography Follow-up Rates
Percentage of patients with mammography screening studies that are followed by a diagnostic mammography or ultrasound of the breast study in an outpatient or office setting within 45 days

OP-10: Abdomen CT Use of Contrast Material
Percentage of abdomen studies that are performed with and without contrast of all abdomen studies performed (those with contrast, those without contrast, and those with both)

OP-11: Thorax CT Use of Contrast Material
Percentage of thorax studies that are performed with and without contrast of all thorax studies performed (those with contrast, those without contrast, and those with both)

OP-13: Cardiac Imaging for Perioperative Risk Assessment for Non-Cardiac Low-Risk Surgery
Percentage of Stress Echocardiography, SPECT MPI or Stress MRI studies performed at a hospital outpatient facility in the 30 days prior to an ambulatory low-risk, non-cardiac surgery performed anywhere

OP-14: Simultaneous Use of Brain Computed Tomography and Sinus CT
Percentage of Brain CT studies with a simultaneous Sinus CT—performed on the same day

OP-15: Use of Brain CT in Emergency Department for Atraumatic Headache (Under Revision)
Percentage of Emergency Department visits for atraumatic headache with a coincident brain CT study

Structural Measures: Submitted by Administration

OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
ONC—Office of the National Coordinator for Health Information Technology

OP-17: Tracking Clinical Results Between Visits
Outpatient Prophylactic Antibiotic Regimen Selection for Surgery
(Continued)

<table>
<thead>
<tr>
<th>Surgical Procedures</th>
<th>Approved Antibiotics</th>
<th>Approved Antibiotics If β-lactam Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecological Laparoscopically-assisted Hysterectomy, Vaginal Hysterectomy</td>
<td>Cefazolin or Cefuroxime Cefoxitin or Cefotetan or Ampicillin/Sulbactam</td>
<td>Metronidazole + Aminoglycoside OR Metronidazole + Quinolone OR Clindamycin + Aminoglycoside OR Clindamycin + Aztreonam OR Clindamycin + Quinolone OR Vancomycin + Aminoglycoside OR Vancomycin + Aztreonam OR Vancomycin + Quinolone</td>
</tr>
<tr>
<td>Gynecological Pubovaginal Sling</td>
<td>1st Generation cephalosporin OR 2nd Generation cephalosporin OR Ampicillin/Sulbactam OR Quinolone† OR Aminoglycoside + Clindamycin OR Aminoglycoside + Metronidazole OR Aztreonam + Clindamycin OR Aztreonam + Metronidazole</td>
<td></td>
</tr>
<tr>
<td>Head and Neck</td>
<td>Cefazolin or Cefuroxime OR Ampicillin/Sulbactam OR Clindamycin ± Aminoglycoside OR Vancomycin*</td>
<td></td>
</tr>
</tbody>
</table>

* Vancomycin is acceptable with a physician/APN/PA/Pharmacist documented justification for its use. Documentation by an infection control practitioner is acceptable if it is specifically designated as “infection control” documentation.
† The only operations for which oral antibiotics alone are acceptable are the prostate biopsy and pubovaginal sling procedures.
†† The only operations for which intramuscular antibiotics alone are acceptable are the prostate biopsy procedures.

Imaging Departments
Imaging should evaluate patterns/techniques to assure alignment with measures specifications.
Imaging must communicate measure specifications to ordering clinicians.

Cardiac Care (AMI & Chest Pain) Measures

**OP-1: Median Time to Fibrinolysis**
Median time from emergency department arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation or left bundle branch block (LBBB) on ECG performed closest to ED arrival and prior to transfer.

**OP-2: Fibrinolytic Therapy Received with 30 Minutes of ED Arrival**
ED acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes of ED arrival.

Reasons for not administering fibrinolytic therapy:
- Prior ICH—cerebral vascular lesion—intracranial neoplasm—ischemic stroke within 3 months—acute ischemic stroke within 3 hours—aortic dissection—active bleeding or bleeding diathesis—closed head trauma or facial trauma with 3 months—uncontrolled HTN (SBP > 180 or DBP > 110)—traumatic or prolonged CPR (> 10 min) - major surgery < 3 mos.—recent internal bleeding within 2-4 weeks—noncompressible vascular punctures—streptokinase/anistreplase expose with 5 days or prior allergic reaction—pregnancy—active peptic ulcer.

Current use of any of the following anticoagulant prior to arrival:
**Best Practice Tips—STEMI Documentation**

- Clear documentation of ECG used for diagnosing STEMI is imperative, especially in cases when the initial ECG is non-diagnostic. Timing is critical.
- The following terms would exclude from STEMI abstraction—borderline, rule out, questionable, subtle, suspicious, cannot rule out, could be, suspect, may indicate, etc.
- ECG described as LBBB is abstracted as STEMI unless documented as chronic, old, or previously seen.
- Important for ER physician to link any reason for delay to the cause of the delay.
  - Acceptable delays are those related to the patient’s condition/interventions – control of blood pressure, needed consults, testing, etc.

**OP-3: Median Time To Transfer to Another Facility for Acute Coronary Intervention**
Median time from emergency department arrival to transfer to another facility for acute coronary intervention.

**OP-4: Aspirin at Arrival**
Aspirin received within 24 hours before emergency department arrival or administered prior to transfer

**Reasons for no aspirin on arrival:**
- Aspirin allergy/sensitivity
- Current use of any of the following prior to arrival:
  - Apixaban—Coumadin—Dabigatran—Eliquis—Jantovan—Pradaxa—Rivaroxaban—Warfarin—Warfarin Sodium—Xarelto

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**Outpatient Prophylactic Antibiotic Regimen Selection for Surgery**

<table>
<thead>
<tr>
<th>Surgical Procedure</th>
<th>Approved Antibiotics</th>
<th>Approved Antibiotics if β-lactam Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac (Pacemakers or AICDs) or Vascular</td>
<td>Cefazolin or Cefuroxime or Vancomycin*</td>
<td>Vancomycin or Clindamycin</td>
</tr>
<tr>
<td>Orthopedic/Podiatry</td>
<td>Cefazolin or Cefuroxime or Vancomycin*</td>
<td>Vancomycin or Clindamycin</td>
</tr>
<tr>
<td>Genitourinary Prostate Biopsy††</td>
<td>Quinolone† OR Sulfamethoxazole/Trimethoprim OR 1st Generation cephalosporin OR 2nd Generation cephalosporin OR 3rd Generation cephalosporin OR Aminoglycoside OR Aztreonam</td>
<td></td>
</tr>
<tr>
<td>Genitourinary Penile Prosthesis Insertion, Removal, Revision</td>
<td>Ampicillin/Sulbactam or Ticarcillin/Clavulanate or Piperacillin/Tazobactam OR Aminoglycoside + 1st Generation cephalosporin OR Aminoglycoside + 2nd Generation cephalosporin OR Aminoglycoside + Vancomycin OR Aminoglycoside + Clindamycin OR Aztreonam + 1st Generation cephalosporin OR Aztreonam + 2nd Generation cephalosporin OR Aztreonam + Vancomycin OR Aztreonam + Clindamycin</td>
<td></td>
</tr>
<tr>
<td>Gastric/Biliary PEG Placement</td>
<td>Cefazolin OR Cefuroxime OR Cefoxitin OR Cefotetan OR Ampicillin/Sulbactam OR Cefazolin + Metronidazole OR Cefuroxime + Metronidazole OR Vancomycin*</td>
<td>Clindamycin ± Aminoglycoside OR Clindamycin ± Quinolone OR Vancomycin ± Aminoglycoside OR Vancomycin ± Quinolone</td>
</tr>
<tr>
<td>Neurological</td>
<td>Cefazolin or Cefuroxime or Vancomycin* or Clindamycin</td>
<td></td>
</tr>
</tbody>
</table>
Outpatient Surgery

**OP-6:** Timing of Antibiotic Prophylaxis
Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision time or within two hours prior to incision time for vancomycin or fluoroquinolone due to longer infusion time requirement.

**OP-7:** Prophylactic Antibiotic Selection
Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific for each type of surgical procedure).

**OP-29:** Endoscopy/Polyph Surveillance—Appropriate Follow-Up *(New for 2014)*
Percentage of patients > 50 yrs. receiving a screening colonoscopy or polypectomy who have a recommended follow-up of > 10 yrs.

**OP-30:** Endoscopy/Polyph Surveillance—Colonoscopy Interval for patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use *(New for 2014)*
Percentage of patients > 18 yrs. receiving a surveillance colonoscopy with history of prior colonic polpy(s) who had a follow-up interval of > 3 yrs. since last colonoscopy.

**OP-31:** Cataracts—Improvement in Visual Function within 90 days Following Cataract Surgery *(New for 2014)*
Percentage of patients > 18 yrs. who had cataract surgery and had improvement in visual function achieved within 90 days.

**Best Practice Recommendations—Surgery**
- Document the name, time, route, and administrators initials or signature.
- Urologic and pubo-vaginal sling procedures: Oral antibiotics taken prior to arrival are acceptable.
- Make sure the incision time is documented.
- Document if case is canceled.
- Document the arrival time—patient physically present.

**OP-5:** Median Time to ECG
12 Lead ECG performed within one hour of arrival to ED. May use the ECG from EMS if within one hour of arrival.
- Make sure time printed by ECG machine is correct and readable. If incorrect time is present, note correct time with explanation and sign.

**ED—Throughput Measures**

**OP-18:** Median Time from ED Arrival to ED Departure For Discharged ED Patients

**OP-19:** Transition Record with Specified Elements Received by Discharged Patients—Measure Continues to be Suspended.

**OP-20:** Door to Diagnostic Evaluation By a Qualified Medical Professional
Time in minutes from ED arrival to Provider Contact for patients discharged for the emergency room. Providers are classified as:
- MD—PA—NP—CRNA—CNM—CNS
- Providers must document time of first direct personal exchange with the patient.
- Time must be specific such as exam time, evaluation time, at the bedside, etc.
- Documentation of initial evaluation/assess times as recorded by the nurse is acceptable.
- Times that have these names should not be used—admission, arrival, presentation, provider assigned time, or triage—to indicate first direct contact.

**OP-22:** ED Patient Left Without Being Seen
Percent of patients who leave the Emergency Department without being seen by a physician/advance practice nurse/physician’s assistant.
- Number of patients who left without being seen/Total number of patients who presented to the ED
- Implement a process to capture the patients that leave without being seen. Review each month to assure accuracy.

**Pain Management Measures**

**OP-21: Median Time to Pain Management for Long Bone Fracture**
Median time from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).

**Stroke Measures**

**OP-23: ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 Minutes of Arrival**
Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients who arrive at the ED within two hours of the onset of symptoms who have a head CT or MRI scan performed during the stay and having a time of ED arrival to interpretation of the Head CT or MRI scan within 45 minutes of arrival

- This measure assesses radiology report turnaround time.
- Document the date at which the patient was last known to be well or at his or her baseline state of health.

**Best Practice Recommendations—ED**

- Educate all clinical staff on requirements.
- Synchronize time clocks in ED—staff clocks and equipment.

- Institute fast track process for chest pain, AMI, & stroke.
- Make sure all providers document times for interventions, medication administration, testing, etc.
- As a double check, nursing staff should document initial assessment/evaluation time of qualified professionals—MD, PA, NP, etc.

**Performance Targets**

The following table below indicates the national performance results for CY2010 on selected measures.

- Set the 90th percentile or better as your goal.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Median</th>
<th>90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-1: Median Time to Fibrinolysis</td>
<td>29 min</td>
<td>13 min</td>
</tr>
<tr>
<td>OP-2: Fibrinolytic Therapy Received with 30 Minutes of ED Arrival</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>OP-3: Median Time To Transfer to Another Facility for Acute Coronary Intervention</td>
<td>60 min</td>
<td>29 min</td>
</tr>
<tr>
<td>OP-4: Aspirin on Arrival</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>OP-5: Median Time to ECG</td>
<td>8 min</td>
<td>0 min</td>
</tr>
<tr>
<td>OP-6: Timing of Antibiotic</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>OP-7: Prophylactic Antibiotic Selection for Surgical Patients</td>
<td>96%</td>
<td>100%</td>
</tr>
</tbody>
</table>