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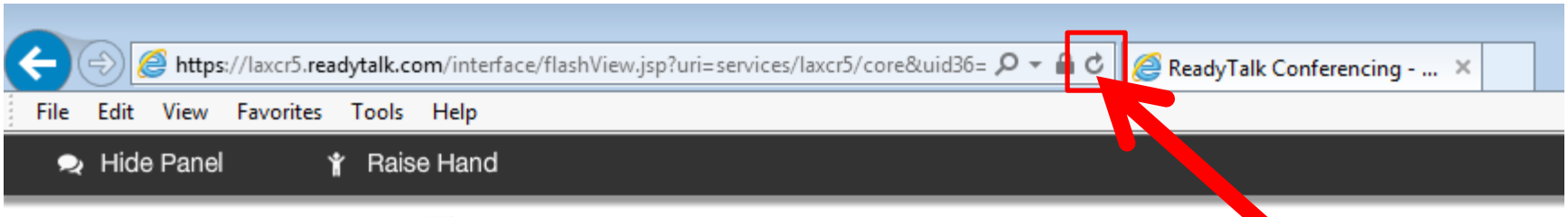
Troubleshooting Audio

Audio from computer speakers breaking up?
Audio suddenly stops?

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

F5 Key
Top row of keyboard

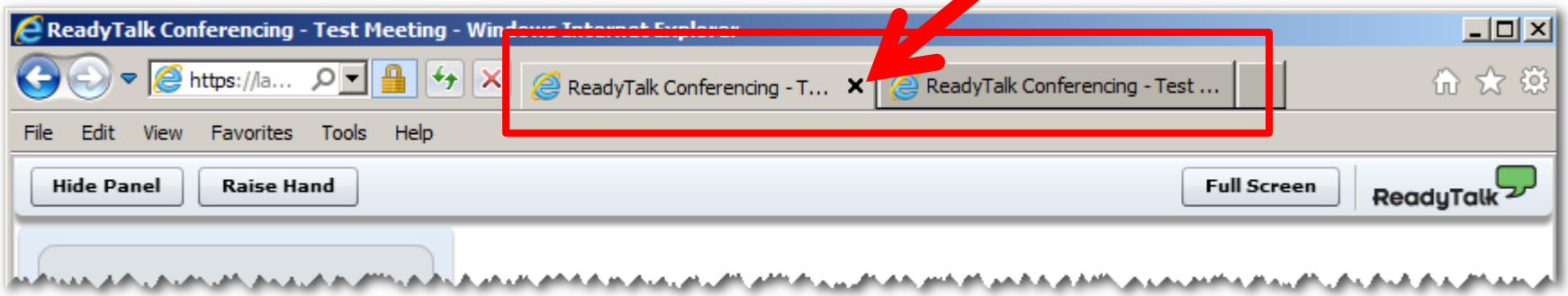


Location of buttons

Refresh

Troubleshooting Echo

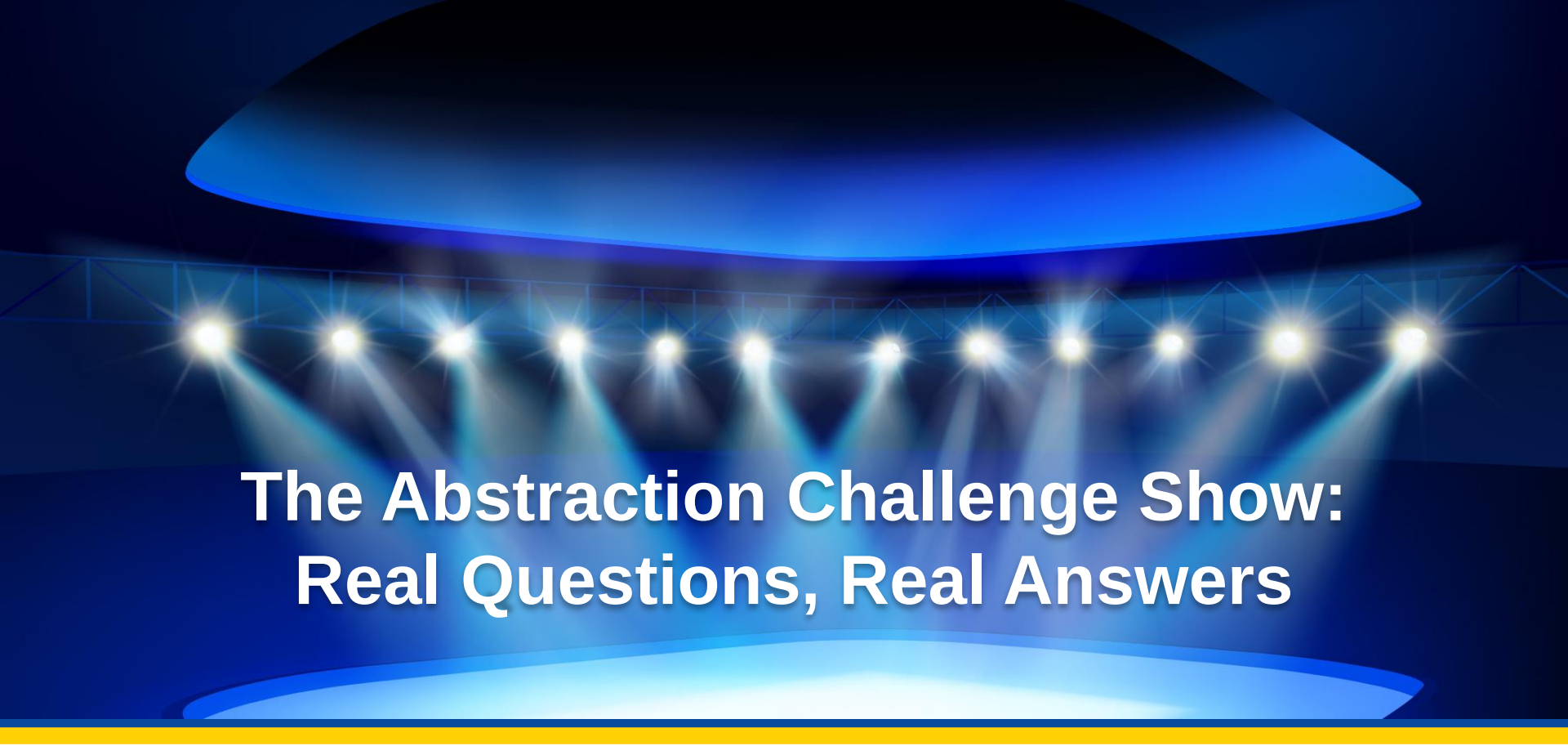
- Hear a bad echo on the call?
- Echo is caused by multiple browsers/tabs open to a single event (multiple audio feeds).
- Close all but one browser/tab, and the echo will clear up.



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 Abstraction Challenge Show: Real Questions, Real Answers

Hospital Outpatient Quality Reporting (OQR) Program Support Contractor

June 20, 2018

Learning Objectives

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

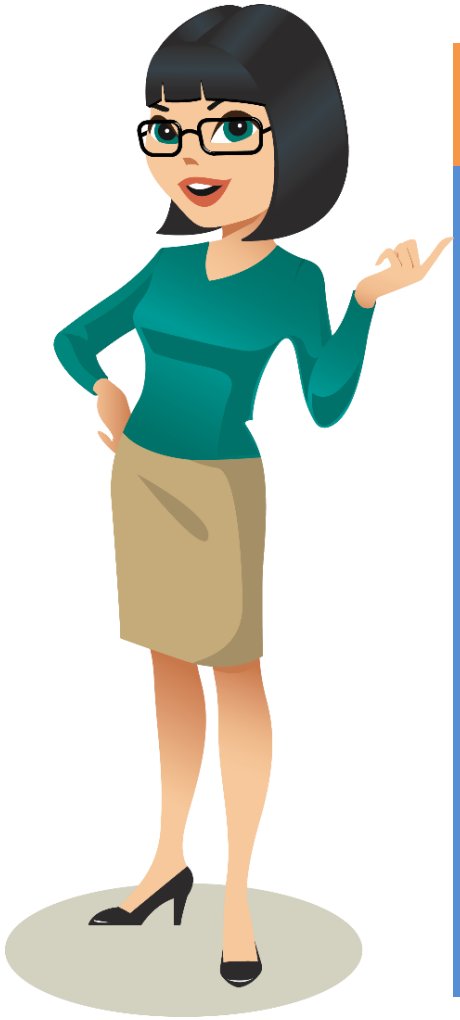
- ✓ Identify how to seek assistance for program-related questions and issues.
- ✓ Describe at least 10 common barriers when abstracting measures for this program.
- ✓ State how to contact Subject Matter Experts (SMEs) with questions.

Your Game Show Host

Game Rules

- Each contestant will choose a category.
- Each question is assigned a point value.
- If contestants are unable to answer a question, they may use 1 of 3 Lifelines.

Contestant #1



Contestant #1

Name
Marylou

Occupation
Abstractor for ABC Hospital. She has been abstracting for the Hospital OQR Program for five years.

Interests
Her favorite food is pizza, and she loves dogs.

Contestant #2

Contestant #2

Name

Spencer

Occupation

Data abstractor for XYZ Hospital. He has been abstracting for the Hospital OQR Program for one year.

Hobbies

His favorite food is sushi, and he enjoys skiing.

Categories

OP-29	ECG Time	Time Last Known Well	Discharge Code
OP-33	Program Questions	Probable Cardiac Chest Pain	OP-30
Arrival Time	Initial ECG Interpretation	ED Discharge Time	Bonus Question

OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients

Question
OP-29 for 100 Points

There is not a documented follow-up interval. The physician documented in the colonoscopy report “Recommendation for a repeat colonoscopy pending pathology results.”

Should this case be a denominator exclusion?

Answer

Yes. This case would be excluded. If the patient had a biopsy or polypectomy, they do not meet the denominator statement criteria:

- All patients aged 50-75 years of age receiving screening colonoscopy without biopsy or polypectomy

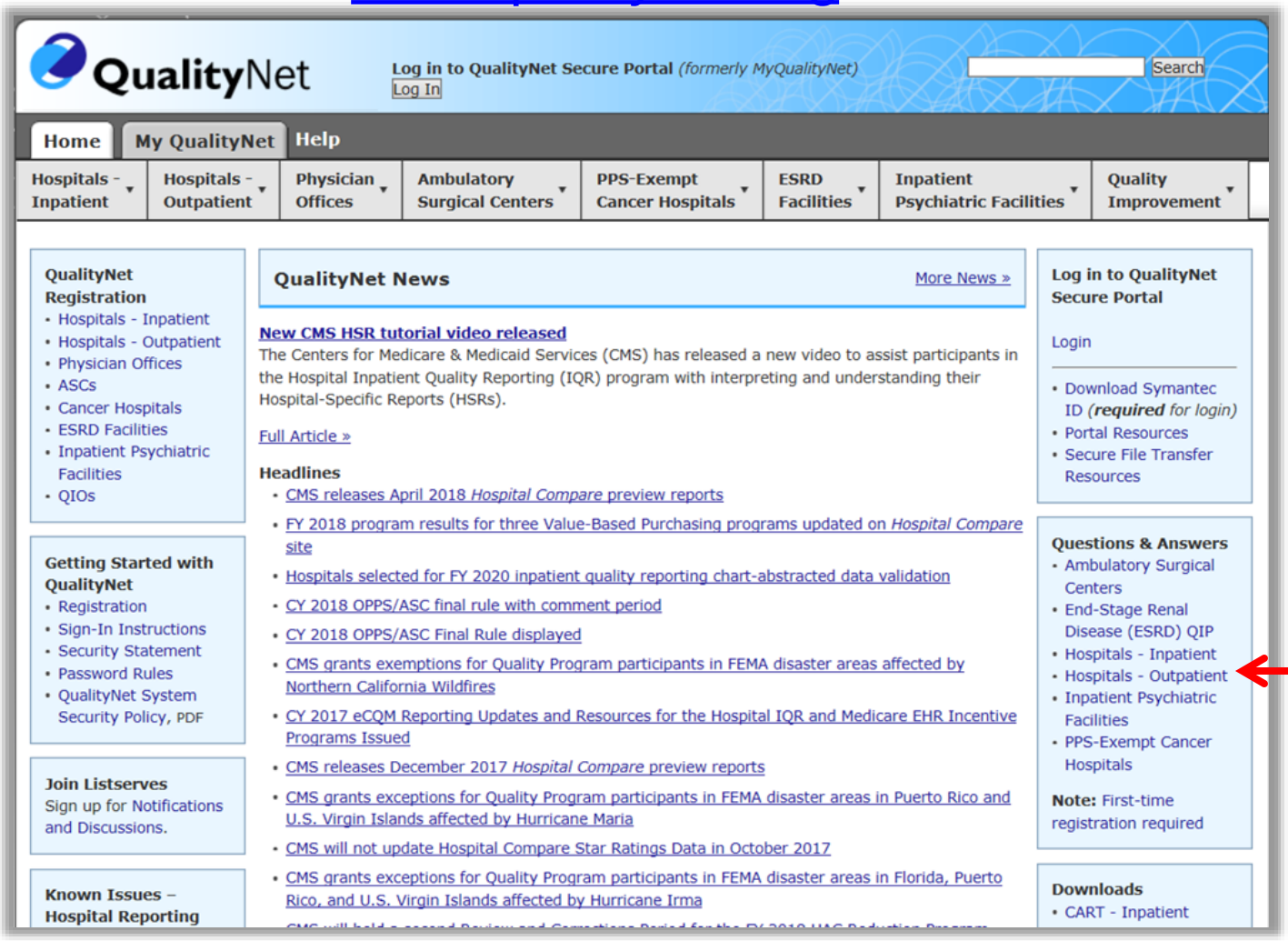
Question
OP-29: 200 Points

Can the abstractor take the Date of Birth (DOB) listed on the operative report to indicate the patient is older than 66 years of age and accept that as a medical reason for no follow-up recommendation of at least 10 years, or does the physician have to document no follow-up recommended because the patient is greater than 66 years of age?

Ask an SME

To Ask a Question

www.qualitynet.org

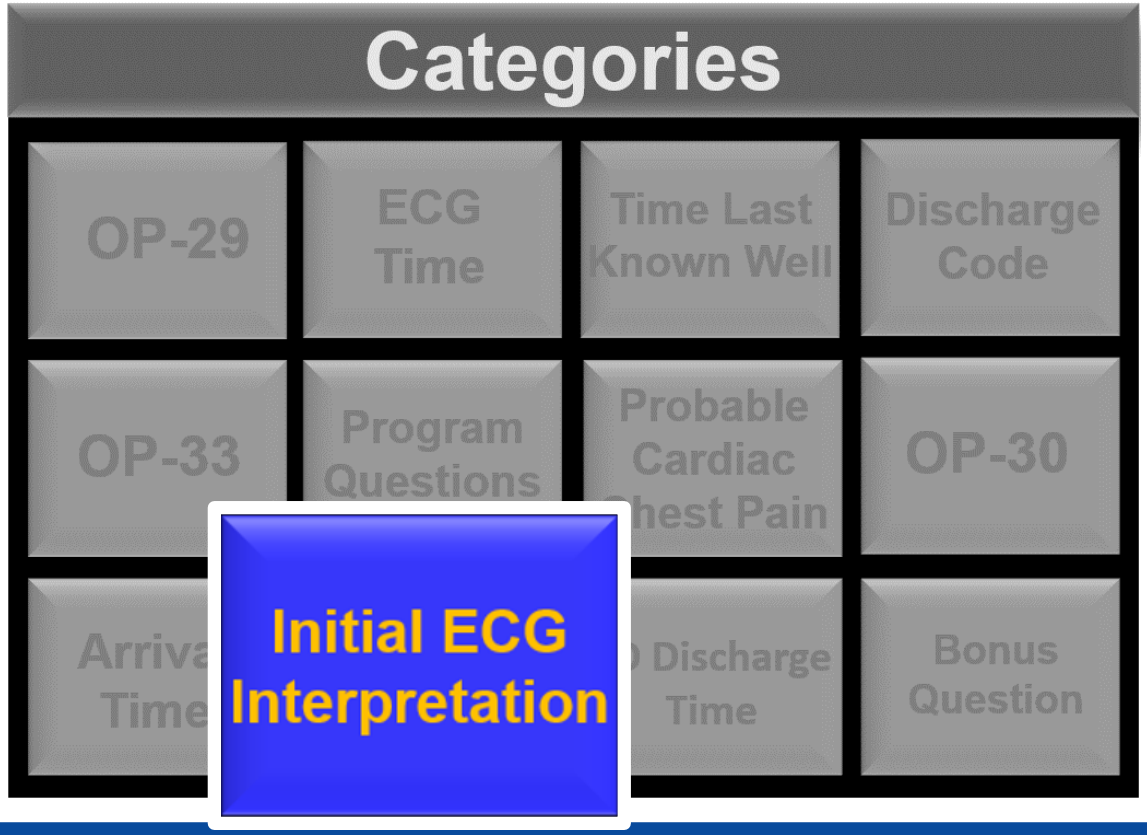


Question
OP-29: 200 Points

Can the abstractor take the DOB listed on the operative report to indicate the patient is older than 66 years of age and accept that as a medical reason for no follow-up recommendation of at least 10 years, or does the physician have to document no follow-up recommended because the patient is greater than 66 years of age?

Answer

Yes. The DOB can be taken from the operative report indicating the patient is greater than 66 years of age. If the patient's age is greater than or equal to 66, or life expectancy is less than 10 years and there is documentation for no further colonoscopy needed, it would be acceptable to exclude the case from the denominator.



Initial ECG Interpretation: ST-segment elevation based on the documentation of the electrocardiogram (ECG) performed closest to the emergency department arrival

Question
Initial ECG Interpretation: 200 Points

For the data element Initial ECG Interpretation, would the word "minimal" be considered an exclusion criterion?

Answer

Yes. In version 11.0a of the Specifications Manual it states, "All ST-elevation (ST↑, STE) in one interpretation described in one or more of the following ways…: 'Minimal' should be considered an exclusion for the *Initial ECG Interpretation* data element."

Time LKW: The time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health

Question
Time LKW: 300 Points

The arrival time was 2259. The ED physician documents: "timing/time-course: onset of symptoms was sudden, severity is moderate, duration for approximately one hour prior to arrival."

Can I use 2159 as the Time LKW?

Answer

- Yes. Based on the documentation provided, subtract one hour from the arrival time of 2259, and use that time to abstract *Time LKW.*
- Version 11.0a of the Specifications Manual defines this data element as “the time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.”
  - If the *Time LKW* is documented as being a specific number of hours prior to arrival (e.g., felt left side go numb two hours ago) rather than a specific time, subtract that number from the time of ED arrival and enter that time as the *Time LKW.*

OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps–Avoidance of Inappropriate Use

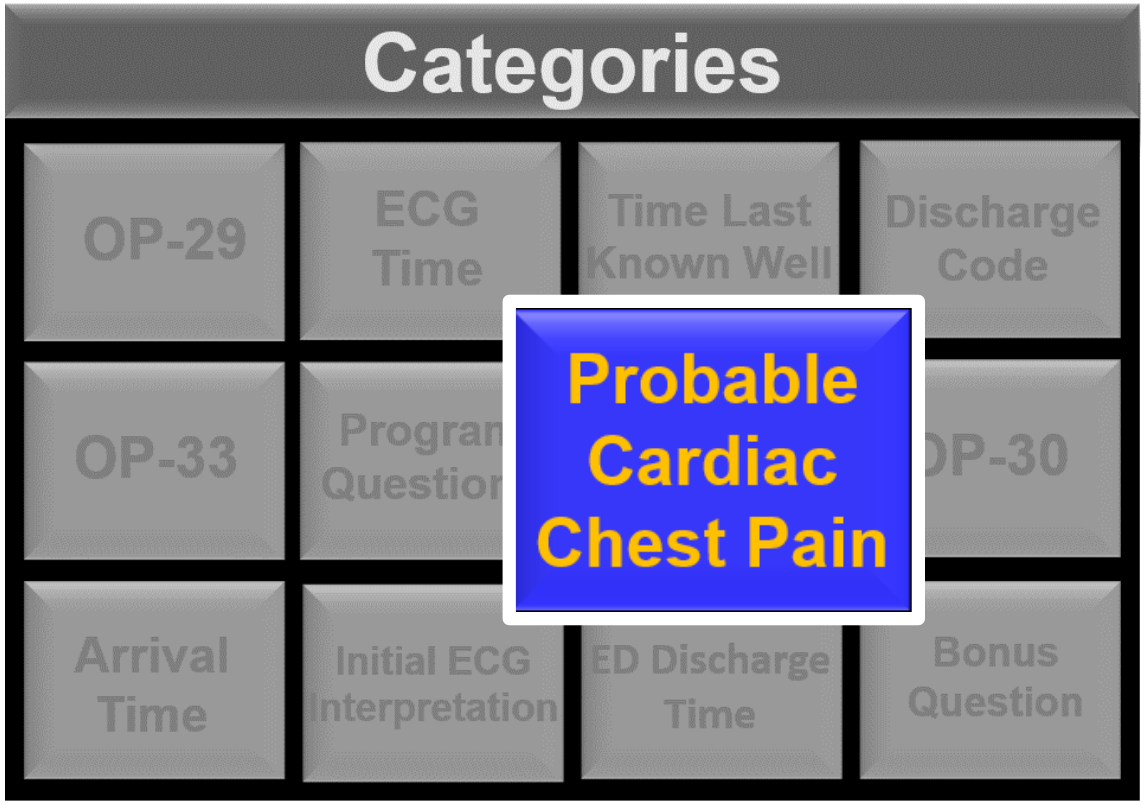
Question
OP-30: 200 Points

The physician writes on the H&P: "WM presents for colon cancer screening, he had a polyp on exam in 2008."

How do I answer documentation that the patient had an interval of three or more years since their last colonoscopy?

Answer

The documentation provided does not indicate a colonoscopy was performed and would not be used to establish the interval since the last colonoscopy.



Probable Cardiac Chest Pain: Documentation that a nurse or physician/APN/PA presumed the patient's chest pain to be cardiac in origin

Question
Probable Cardiac Chest Pain: 200 Points

A response in the QualityNet Q&A tool from 2015 contains this wording: "precordial chest pain would be considered to be clinically synonymous with 'chest wall pain' which is also an exclusion."

Please clarify if the diagnosis "Precordial Chest Pain" is an exclusion when evaluating Probable Cardiac Chest Pain.

Answer

Precordial chest pain is considered to best match exclusion or inclusion terms on a case-by-case basis. If there is surrounding documentation to indicate that “precordial chest pain” best matches the exclusion term “chest wall pain,” then a “No” may be abstracted for the *Probable Cardiac Chest Pain* data element. However, since our team does not have a full account of the patient record, please consider the entire context and differential diagnoses and use your best judgment to determine if there is a working/differential diagnosis of acute myocardial infarction or any additional documentation that clearly suggests the patient’s chest pain was presumed to be cardiac in origin.

Arrival Time: The earliest documented time (military time) the patient arrived at the outpatient or emergency department

Question
Arrival Time: 100 Points

A patient arrives to the ED by ambulance. The ambulance arrived in the parking lot of the hospital at 0651. The hospital triage note is 0659. The EMS note states arrival to the ED is 0645.

What is the Arrival Time?

Ask the Audience

Answer

You will abstract the time the patient physically arrived in the ED for the ED *Arrival Time*. In this scenario, the time would be 0659.

- Documentation outside of the Only Acceptable Sources list should not be referenced (e.g., ambulance record, physician office record, H&P).

Question
Arrival Time: 200 Points

A patient came to the radiology department at 1417 and had an outpatient ultrasound. During this ultrasound, the patient was found to have an acute DVT and was sent to the ED. The patient arrived at the ED at 1659.

Which time would I use for the patient Arrival Time for OP-18?

Answer

You would abstract the time documented of when the patient physically arrived to the ED. In this scenario that time would be 1659.

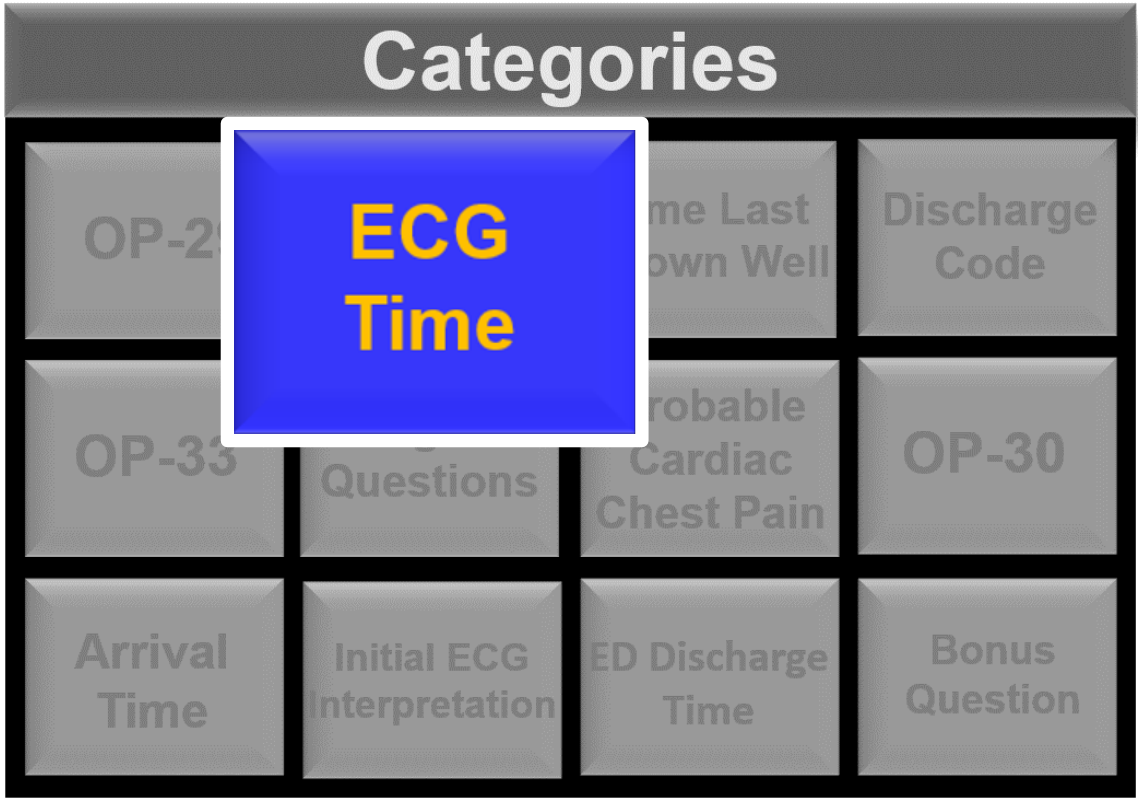
Question
OP-29: 300 Points

The reason for exam in the colonoscopy report states "routine screening, high risk" with a discharge recommendation of "repeat in five years."

Would this patient be excluded from the denominator due to the medical reason of "high risk"?

Answer

Yes. If the physician documents that the patient is high risk as the medical reason for recommending a follow-up interval of less than 10 years, then the patient would be excluded from the denominator. It is at the physician's discretion to determine the medical reason for recommending a repeat procedure in a shorter time interval.



ECG Time: The time (military time) represented in hours and minutes at which the earliest 12-lead Electrocardiogram (ECG) was performed

Question
ECG Time: 200 Points

The patient arrived to the ED via ambulance at 0523. “Pt was hooked up to 12-lead” is documented in the ambulance’s narrative documentation with no stated time. There is not a copy of an ECG in the ambulance records. In the ambulance record under Vitals, there is a column with the heading “Rhythm.” Under this “Rhythm” column, there are two entries of “Regular” at 0454 and 0510. The patient did have a 12-lead ECG at 0529 just after arrival to the hospital.

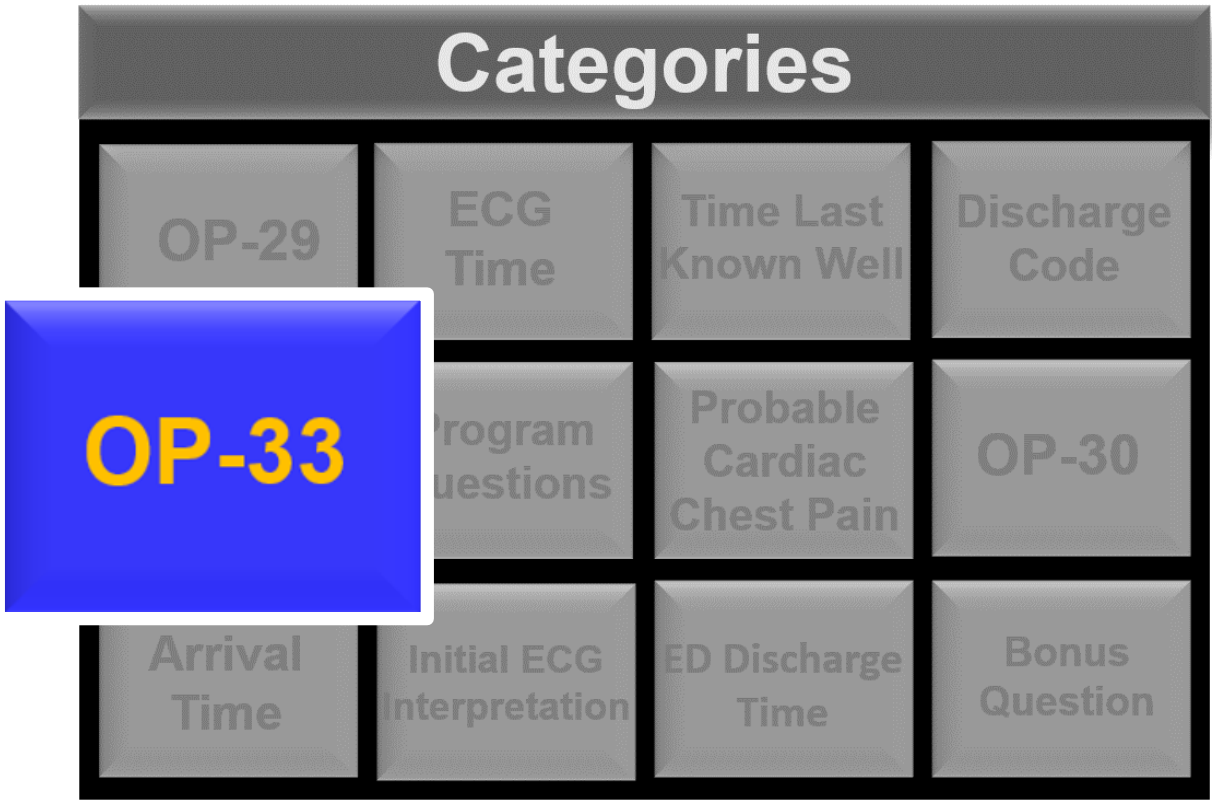
Question (cont.)
ECG Time: 200 Points

Would the ambulance record documentation be enough to prove that the patient had a 12-lead ECG performed prior to arrival?

Would my answer be 0523 or 0529 to the ECG Time question based on this questionable ambulance documentation?

Answer

- Based on the documentation, you may use *Arrival Time*, 0523, to abstract *ECG Time* because there is documentation a 12-lead ECG was performed within 60 minutes of arrival. Please note that a physical or scanned copy of the ECG is not required to abstract this data element.
- Version 11.0a of the Specifications Manual defines this data element as “the time (military time) represented in hours and minutes at which the earliest 12-lead Electrocardiogram (ECG) was performed.”
  - If there are two ECGs performed (one prior to arrival and one after arrival), abstract the ECG performed prior to arrival.
  - In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the time the patient **arrived** at the emergency department.



OP-33: External Beam Radiotherapy for Bone Metastases

Question
OP-33: 200 Points

For a patient undergoing EBRT, the documentation notes thoracic spine cord compression, and the new site is noted at T7-T12.

Based on current guidelines, this patient should be excluded from the EBRT measure for this site. Is that correct?

Answer

Cord compression only qualifies a case for exclusion if it has afflicted the same anatomical site that is now receiving EBRT treatment. Does the documented thoracic cord compression overlap with the treatment site (T7-T12)? If so, the patient should be excluded.

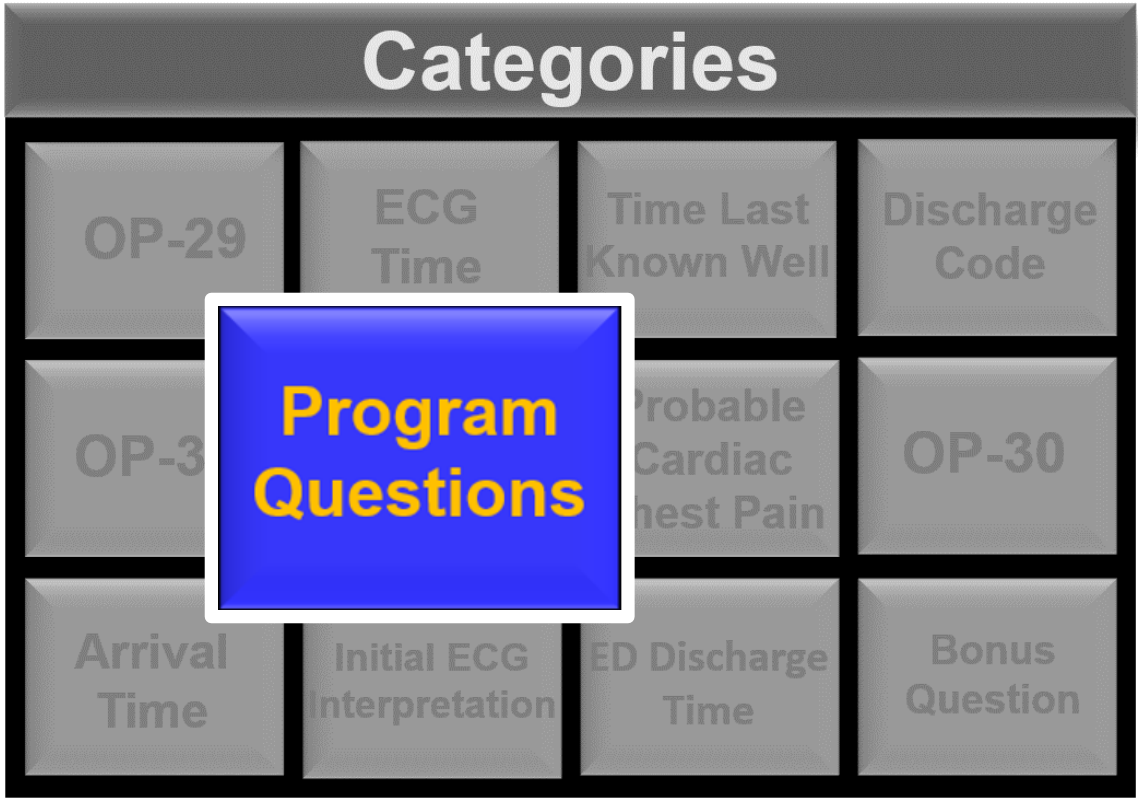
Question
Time LKW: 200 Points

The arrival time is 2229. The physician documentation at 2236 is “An 83-year-old male presents one hour after the sudden onset of right hemiparesis."

For the time of symptom onset, do I subtract an hour from the 2236 documentation (so that Time LKW/symptom onset would be 2136) or from the arrival time (so that time LKW/symptom onset would be 2129)?

Answer

- You may subtract one hour from the arrival time and use that time, 2129, to abstract *Time LKW*.
- Version 11.0a of the Specifications Manual defines this data element as “the time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.”
  - If the *Time LKW* is noted to be a range of time prior to ED arrival (e.g., felt left side go numb two to three hours ago), assume the maximum time from the range (e.g., three hours) and subtract that number of hours from the time of arrival to compute the *Time LKW.*



Program Question

Question
Program Question: 100 Points

I know when abstracting the clinical measures if I have low case volumes I do not have to report anything.

Is this true? I have heard something about five or fewer. Can you elaborate?

Phone an Expert

Submission Threshold

- What is the five or fewer rule?
  - Hospitals with five or fewer cases in a quarter are not required to submit data for that measure set.
  - Acute Myocardial Infarction (AMI) and Chest Pain (CP) measure sets are combined.
- This information can be found in the Specifications Manual in Section 5.

Question
Initial ECG Interpretation: 100 Points

I have a medical record with the following documentation: “EKG interpretation: Sinus tachycardia, probable anterior infarct, acute borderline T abnormalities, inferior leads.”

Are “T abnormalities” synonymous with “ST abnormalities”?

Answer

No. The Specifications Manual states that “ST-elevation (or ST-segment noted as greater than or equal to .10mV/1mm) described using one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for Abstraction should be considered an exclusion.” However, “T abnormalities” are not synonymous with “ST abnormalities,” and you should not consider “borderline T abnormalities” to be an exclusion in this case.

Question
Probable Cardiac Chest Pain:300 Points

The ED physician documented the impression as “acute chest pain” but did not document that this was related to a cardiac issue. The case was coded as R07.9 chest pain, unspecified. The manual indicates that this code typically best matches the exclusion term "non-specific chest pain."

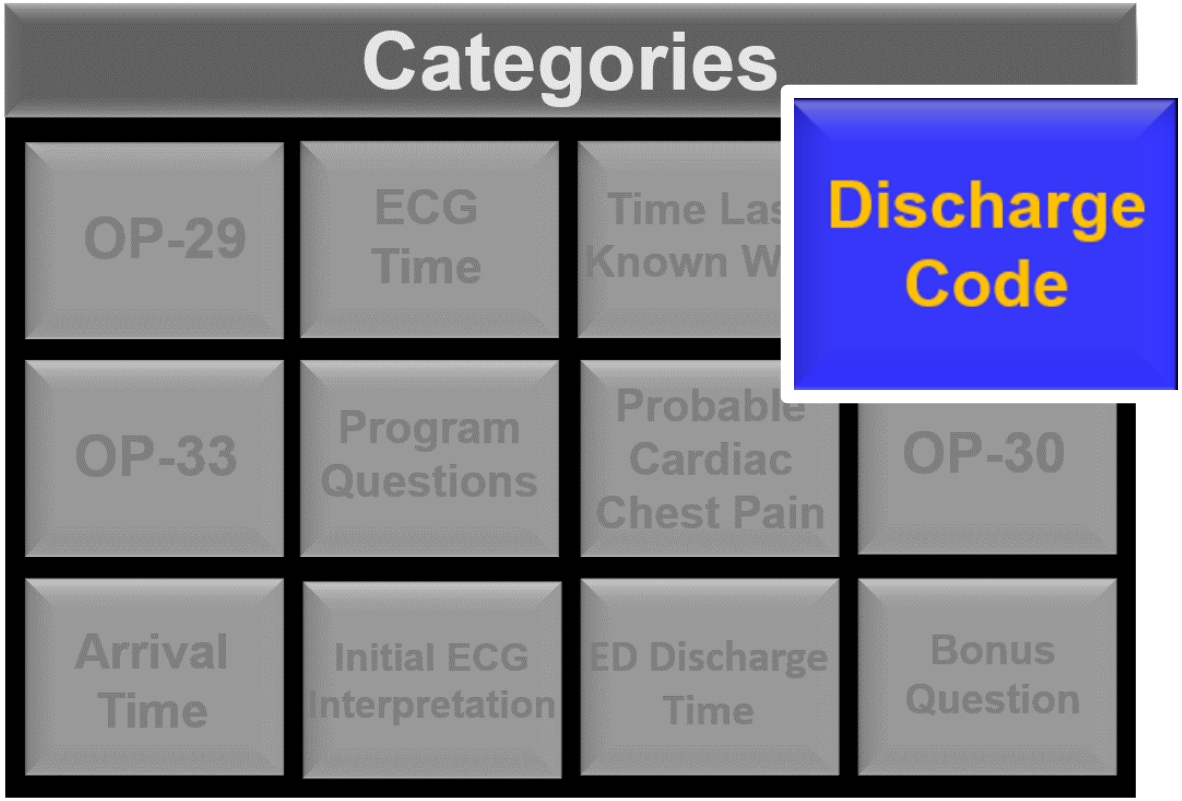
Does this mean that even if an inclusion term is used, such as acute chest pain, but with no documentation that this is related to a cardiac issue, then it would be abstracted as “No" to Probable Cardiac Chest Pain?

Answer

- Typically, “R07.9 Chest Pain, unspecified” matches the data element exclusion term “non-specific chest pain” unless surrounding documentation suggests that the “chest pain, unspecified” is clearly linked to a cardiac issue.

Answer (cont.)

- Version 11.0a of the Specifications Manual states that if there is documentation of any inclusion criteria and no exclusions are present, you should select “Yes” for the *Probable Cardiac Chest Pain* data element. However, if there is documentation of an exclusion term, select “No.” That being said, if there is documentation of a differential/working diagnosis of acute myocardial infarction, select “Yes,” even if an exclusion term is documented. The intent of this data element is to determine if the patient’s chest pain was cardiac in origin.



Discharge Code: The final place or setting to which the patient was discharged from the outpatient setting

Question
Discharge Code: 200 Points

- The ED Disposition is listed as “eloped” in the medical record. There is no specific mention of the patient leaving against medical advice (AMA) or being discharged home. The nurse documented “Patient walked out of ED. Writer was in another room. Pt will be called by writer per MD request.”

Question (cont.)
Discharge Code: 200 Points

- The physician documented “The CT results were discussed with the patient who appeared very comfortable during his ED stay. He was agreeable to follow-up with his neurologist, and if we can initiate contact with him, an outpatient MRI scan will be arranged and follow-up with the neurologist will be scheduled as well.”

Can the documented ED Disposition of “eloped" be interpreted as the patient leaving AMA without specific documentation of the patient leaving against medical advice? If not, do I select unable to determine (UTD) for the discharge code in this situation?

Answer

Although a signed AMA form is not required for this data element, the medical record must contain physician or nurse documentation that the patient left against medical advice. Since there was no documentation of the patient leaving the ED as AMA in the medical record, you would abstract the ED discharge code as UTD.

Question
OP-33: 400 Points

A patient is to have EBRT treatment to the left SI pelvis area with the CT simulation worksheet saying the body area is the pelvis, the superior border is L1, and the inferior border is mid-thigh. There is documentation on the PET scan of a metallic left hip prosthesis.

Would this documentation be enough to say "Yes" to surgical stabilization with the prosthesis being in the treatment area?

Answer

Yes. Given the hip replacement, exclude the patient from the measure as the previous surgery and insertion of the prosthetic changes the anatomy of the area and, therefore, the physical considerations.

Bonus Question
500 Points

The patient did not enter the hospital through the ED; she went directly to Labor and Delivery.

Do I select UTD for arrival time as she did not arrive to the ED, or do I add the arrival time to Labor and Delivery?

Answer

The Specifications Manual states that this data element intends to capture the earliest documented time (military time) the patient arrived at the outpatient or emergency department. In this scenario, you should abstract the earliest documented time (military time) the patient arrived to Labor and Delivery if the patient has an E/M code for emergency department encounter as defined in Appendix A, OP Table 1.0 for ED Throughput measures.

Today's Champion


Thank You for Playing

Acronym List

AMA	Against medical advice
AMI	Acute myocardial infarction
aVF	Elevation I, II, III in anterior leads
APN	Advanced practice nurse
CMS	Centers for Medicare & Medicaid Services
CT	Computerized tomography
DOB	Date of birth
DVT	Deep vein thrombosis
E/M	Evaluation & management
EBRT	External beam radiotherapy
ECG	Electrocardiogram
EMS	Emergency Medical Services
H&P	History and physical
L1	Lumbar disk 1
LKW	Last known well
MI	Myocardial infarction
NSR	Normal sinus rhythm
OQR	Outpatient Quality Reporting
PA	Physician assistant
PET	Positron emission tomography
SI	Sacroiliac
SME	Subject matter expert
STEMI	Segment Elevation Myocardial Infarction
UTD	Unable to determine
V1-4	Anterior/Septal/Lateral Infarct patterns
WM	White male

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
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- 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.
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  - 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.
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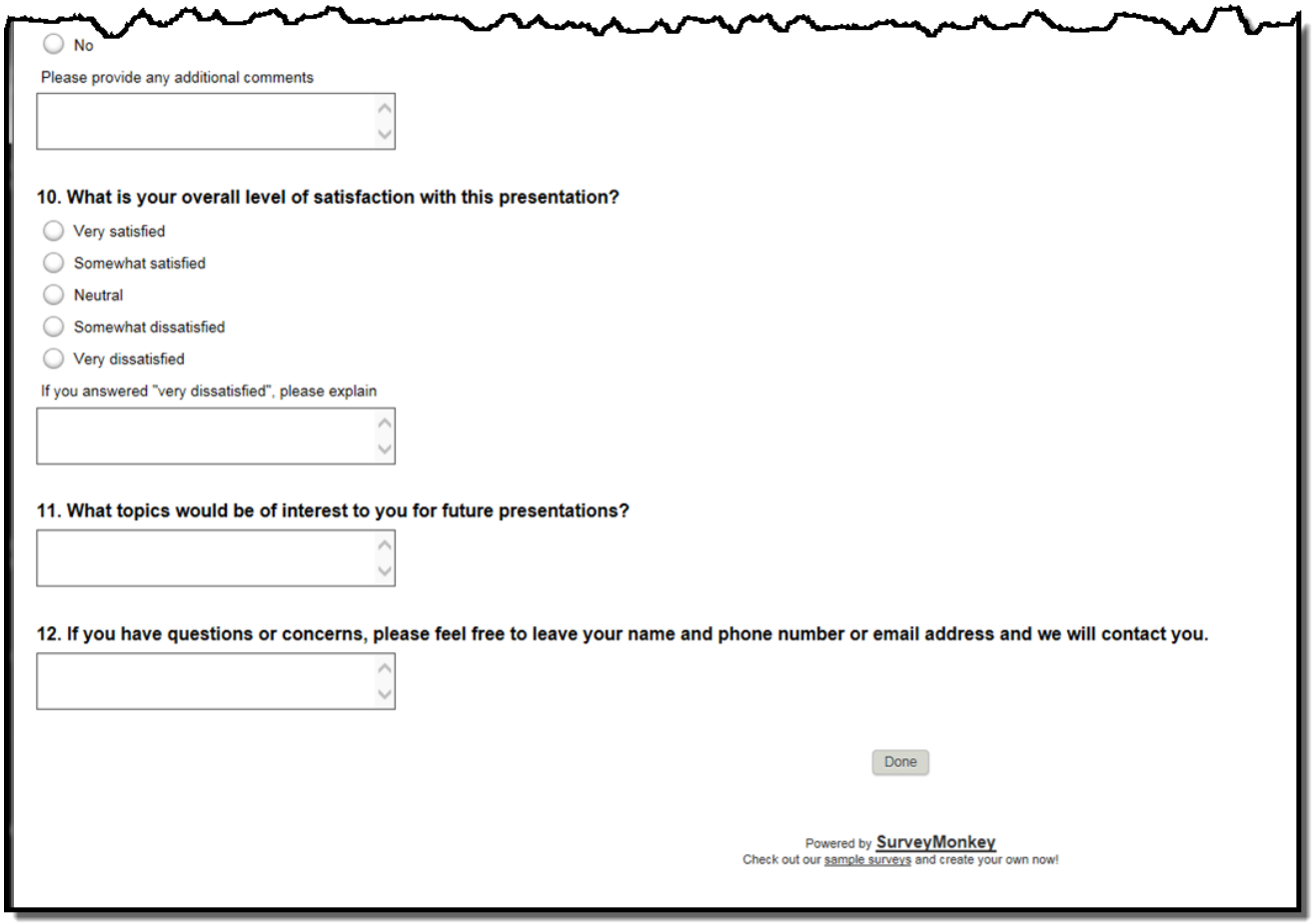

No

Please provide any additional comments

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

- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

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.

Done

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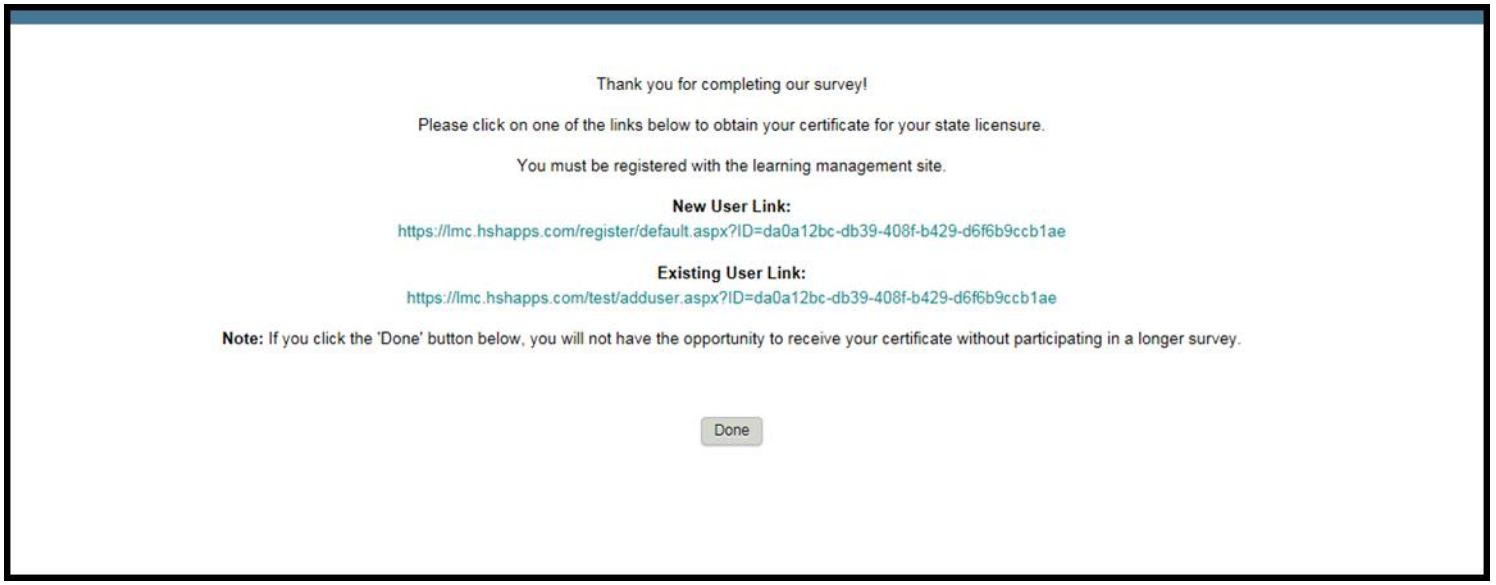
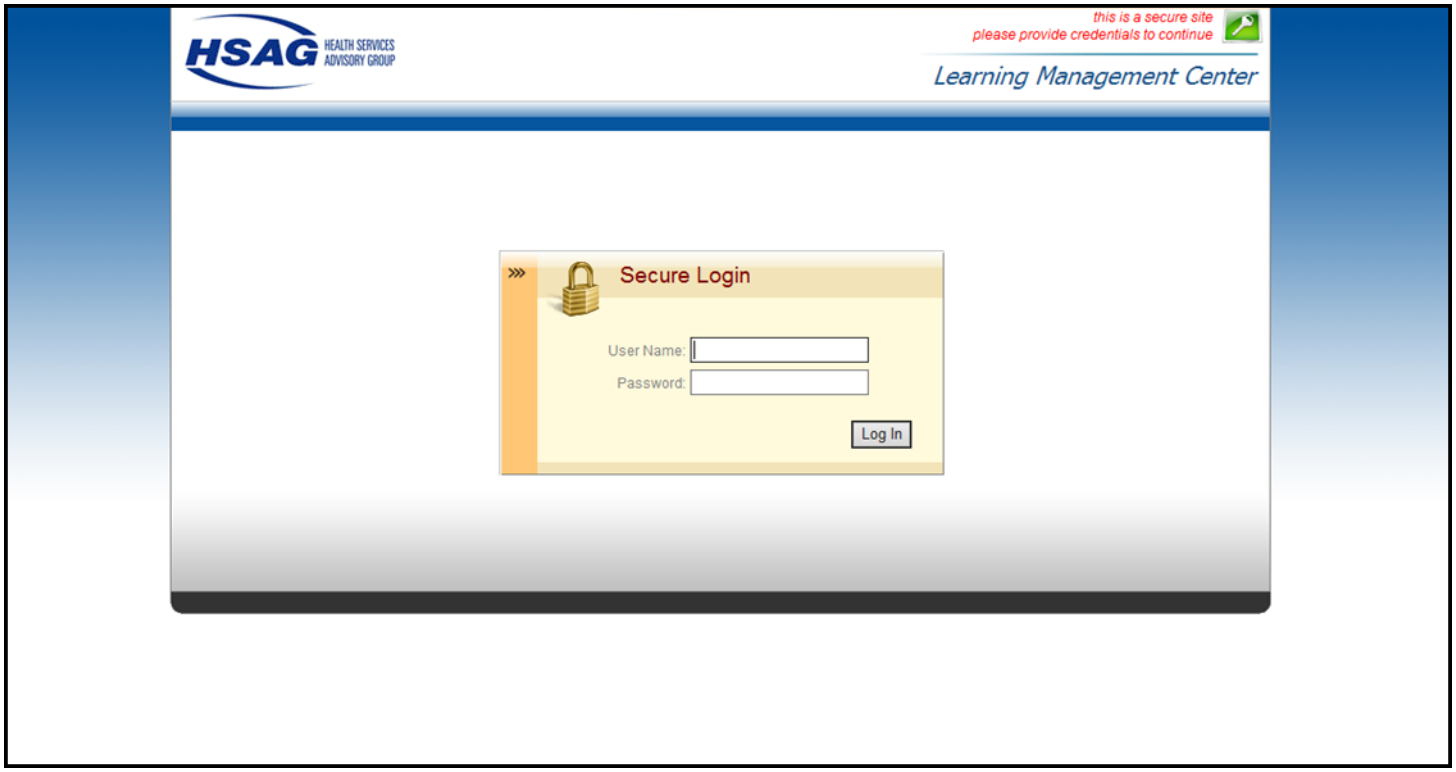


CE Credit Process: New User

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.