Outpatient Quality Reporting Program

Support Contractor

The Escape Room: The Search for Clues in Your Data Abstraction

Questions & Answers

Speakers:

Hospital Outpatient Quality Reporting (OQR) Program Support Contractor

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Question: Are CEUs available for this presentation?

Answer: Yes. Instructions to obtain your CEU will be on the slides following the presentation.

Question: How does the scenario on slide 5 differ from the previous scenario that they said no to against medical advice (AMA)? The previous scenario had documentation that the patient left before treatment was complete. If that is not against medical advice, then I am not sure what is.

Answer: A signed AMA form is not required to list AMA value 7, but the medical record must contain physician or nurse documentation that the patient left against medical advice, or AMA. You can find this information in the Specifications Manual 12.0a, page 2-102.

Question: For OP-29, what if the physician documents a time range of follow-up from 5–10 years?

Answer: A documented interval of 5–10 years would not be considered an interval of "at least 10 years."

Question: Is the time of 2359 at 9/30/18 on slide 10 correct?

Answer: Yes, it is correct.

Question: What if medication or vital sign times are prior to arrival, i.e., Walk-In Clinic info is pulled into the ED Note with no mention that the patient just came from a Walk-In Clinic? Are those times not to be used for arrival times?

Answer: Vital signs graphic records are considered an acceptable data source for abstracting ED *Arrival Time*. However, ED *Arrival Time* should not be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. Please review the entire ED record to determine if the vital sign time or ED arrival time was documented in error. Additional information on the specifications for the Hospital OQR Program measures can be accessed at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244.

Question: What if the discharge instructions are timed after the departure time?

Answer: Discharge Instruction time is an exclusion for this data element.

Question: With regard to slide 23, often the only order for an outpatient ED patient is an inpatient (IP) order. The status may be changed post-discharge. Would we use the IP order time or the ED disposition time?

Answer: If the inpatient order is changed to observation status after the patient has already departed the ED, then please use the time that the patient physically departed the ED to abstract *ED Departure Time*.

Question: For outpatient Stroke, if the patient comes to the ED with a Urinary Tract Infection (UTI) at 0800 and has signs and symptoms of a stroke while in the ED at 1030, when would the last known well time be?

Answer: Based on the documentation that you provided, you may abstract unable to determine (UTD) for *Time Last Known Well* because the *Time Last Known Well* cannot take place after arrival to the emergency department.

Question: In reference to slide 23, what if the nurse documents “patient left ED” 12 hours after the observation order was written? Should we still take the earlier time of the order even though the patient was still receiving care in the ED?

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

Question: On slides 26 and 27, what is the *Time Last Known Well*? Would this exclude this patient before needing the computed tomography (CT)/magnetic resonance imaging (MRI) time?

Answer: Based on the scenario given in the presentation, you may abstract No for *Head CT or MRI Scan Order*. The *Time Last Known Well* was not

mentioned in this example and thus would not impact how we respond to CT or MRI Scan.

Question: For outpatient *ED Departure Time*, if the patient status is changed to observation at 1300 but the patient doesn't leave the ED until 1500, which time do we use for the *ED Departure Time*? I'm a little confused based on the answer you all gave with the scenario that was provided during the call.

Answer: If the observation order was written while the patient was in the ED, then please use the time of the physician/APN/PA order for observation for *ED Departure Time*. If the status was changed to observation after the patient had already departed the ED, please use the time that the patient physically departed the ED.

Question: The interval follow-up colonoscopy is in five years. Although there is documentation of a large amount of semi-liquid stool, a lavage was performed resulting in adequate visualization. Is there a medical reason for shortened interval between colonoscopies?

Answer: Yes. The documentation of a large amount of semi-liquid stool can be used as a medical reason for a follow-up interval of less than 10 years.

Question: For the electrocardiogram (ECG) example, it doesn't say it was acute or evolving, but we say Yes just because it indicates a location?

Answer: According to Version 12.0a of the Specifications Manual, you should disregard the qualifier "age indeterminate," but not necessarily the entire line.

Question: For the measure OP-29, if a patient's age is 66 years and the physician documents in the colonoscopy report "repeat colonoscopy in 5 to 10 years," will this be an exclusion or no because they used 5 to 10 years?

Answer: It doesn't appear there is a medical reason documented for the follow-up interval of less than 10 years.

Question: Can you clarify the correct answer on slides 31 and 32?

Answer: For the scenario on slides 31 and 32, the abstractor would choose the value Yes.

Question: For slide 23, which outpatient measure is this the answer for?

Answer: This is for the data element of *ED Departure Time*. This would apply for OP-3 and OP-18.

Question: On slide 31, *Initial ECG interpretation*, the first and only printed ECG signed by the cardiologist has anterior infarct "age indeterminate." The answer states to exclude "age indeterminate"; that part I understand. Then it states to look at only "anterior infarct" and abstract Yes to initial ECG interpretation. Can you please clarify why you would abstract Yes to anterior infarct when it is not described as "acute or evolving"?

Answer: Version 12.0a of the Specifications Manual considers "Myocardial infarction (MI), with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination), if described as acute/evolving (e.g., "posterior AMI")" to be an Inclusion term. If the initial signed ECG interpretation says, "anterior infarct age indeterminate" and is clearly referring to the ECG performed closest to arrival, you may abstract a value of No for this data.

Question: For OP-33, I'm still unsure how to "abstract separately" two different sites if under one account? How are we to abstract them?

Answer: OP-33 is a web-based measure. You will report a numerator and a denominator. You will consider all encounters that result from a single treatment plan as one case, with the case being attributed to the first date of administration of External Beam Radiotherapy (EBRT).

Question: Regarding your example for not giving fibrinolytics because the cardiologist doesn't want it prior to transfer, that is not how we have been told to answer this in the past. So, we just change now?

Answer: For the scenario presented, the documentation of "cardiologist does not want fibrinolytics at this time," is sufficient to abstract a "1" for this data element, as this is a clearly documented reason for not administering fibrinolytics. The Specifications Manual states under the Notes for Abstraction that "if a contraindication/reason listed under the Inclusion Guidelines for Abstraction is clearly documented in the content of the Emergency Department record, then this is sufficient to abstract value 1 for this data element. There does not need to be explicit documentation of a rationale by a provider linking the documented contraindication/reason and the decision to not administer fibrinolytic therapy if the contraindication/reason is listed under the Inclusion Guidelines for Abstraction."

Question: If there is physician documentation that states fibrinolytics not indicated, would you use Value 1?

Answer: If the ED record states, “fibrinolytics not indicated,” that is not documentation of a patient-centered reason for not administering fibrinolytic therapy. Therefore, you may abstract a value of “3” for this data element.

Question: I am confused by this answer for the *ED Departure Time*. I thought the manual states that if the patient has an order for observation and they are still in the ED, we have to use the time the patient left the ED if they are admitted under observation.

Answer: Version 12.0a of the Specifications Manual states that “For patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*. The intent of this guidance is to abstract the time that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time.”

Question: On the ECG interpretation you disregarded the documentation of “age indeterminate,” but there is also no documentation of an evolving or acute MI, so wouldn't that entire line be disregarded since the inclusion guidelines say that it has to be acute/evolving?

Answer: Version 12.0a of the Specifications Manual considers "Myocardial infarction (MI) with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination), if described as acute/evolving (e.g., “posterior AMI”),” to be an Inclusion term. If the initial signed ECG interpretation says “anterior infarct age indeterminate” and is clearly referring to the ECG performed closest to arrival, you may abstract a value of No for this data.

Question: Another question related to *ED Departure Time*, you note the Specifications Manual has that the observation order *may* be used. Does this mean we don't have to use it if documentation supports a later time the patient physically left the ER?

Answer: Version 12.0a of the Specifications Manual does state that providers may use the time at which a patient physically left the ED, despite an order being entered for observation.

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Question: On the slide 8 scenario and documentation of "repeat colonoscopy in 5 years," I would have chosen that there was not a medical reason for exclusion because the scope was completed successfully. The physician did not note that he could not visualize, or state repeat in 5 years due to tortuous colon.

Answer: Any medical reason, such as a diagnosis, symptom, or condition that is documented in the medical record can be used to exclude a case from the denominator population when the recommended follow-up interval is less than 10 years. The medical reason does not need to be explicitly stated as a reason within the follow-up interval documentation. It can be found anywhere in the record for the current encounter and implied as the medical reason if the follow-up interval is documented as less than 10 years.