Quality Reporting Program

Support Contractor

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

Presentation Transcript

Speaker:
The Hospital Outpatient Quality Reporting Program Support Contractor Team

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Host: Hello and welcome to the Hospital OQR Webinar. Thank you for joining us today.

We are going to cover some of the most commonly asked questions, today. Now, these are real questions, asked by all of you. They will be scenario-based with a follow-up answer and rationale. This is part one in a two-part series. We are very fortunate, today, to have the measure writers, not only here with us today to answer your questions directly in the chat box, but they were very instrumental in the development of this presentation. We really can't thank them enough for lending their expertise to assist all of you in dealing with your abstraction dilemmas. If you have a question, please utilize the chat box. The experts will respond directly to you.

Additionally, if you have not yet downloaded the slides for this presentation, you can get them from our website at qualityreportingcenter.com. Just click on today's event and you should be able to download the slides. These slides are attached to the invite you were sent for this presentation.

So, without any further ado, let's get started.

Announcer: Angela and Betty have decided to get away from it all and go to an Escape Room for some fun. Their only chance to escape is to answer challenging abstraction scenarios correctly. They will be given clues to assist them. They can also ask for clues if they are stuck and cannot figure out the answer. They can even ask you for help.

We are joining them as they have just entered the Escape Room.

One their way into the room, they were given a series of scenarios regarding discharge codes to answer. They were told they would need the correct numbers to move forward.

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Angela: Okay, Betty, let me open up this first scenario. Here it is. The record indicates the patient is a private vehicle transfer to an acute care hospital. He left the transferring ED with his father who was driving him to the acute care hospital. Which of these two is the correct discharge code, “1” for home, or, “4a” for acute care facility general inpatient care? Well, he is not going home, he is going to another facility. So, it’s not home.

Betty: Yes, but he is not being transported by an ambulance.

Angela: So, he is still being transferred to another facility. If the patient was discharged to an Acute Care facility, regardless of mode of transportation, you would select discharge code 4a: Acute Care Facility-General Inpatient Care.

Betty: Hm, that makes sense. So that’s great Angela. We have the first number to the code, 4.

Angela: The next scenario is: A patient did not discuss leaving with the physician, who had performed the evaluation, he just left. The patient left before there was a discharge order written by the physician.

What discharge code should be used? Well, I guess he went home. So, I would select the value 1—Home.

Betty: Well, you can’t really select 1 for home because there was no discharge order written. He left before his care was complete, but we definitely can’t choose 7—Left Against Medical Advice, or AMA, because there doesn’t appear to be any specific documentation stating the patient left AMA.

Angela: Oh, I think you are right Betty. So, then the answer would be value 8-Not Documented or Unable to Determine.

Betty: Yes. With the scenario provided, the abstractor would select value 8: Not Documented or Unable to Determine (UTD).

Angela: Okay, Betty, our final scenario for discharge code is as follows: A patient from the ED was discharged from the unit to home after documentation of multiple attempts to get the patient to be admitted to the hospital or to be transferred to another facility. In the ED record, it states "patient refused admission." The physician dictation states "I did as well as I could to convince him he needs to be admitted...explained the risks...at this point, my hands are tied. I cannot get him to be admitted." There is no AMA form or no word-for-word exact verbiage stating: "against medical advice.” The abstractor asks, can I imply that the verbiage stated both in the dictation and in the chart are the medical advice from the physician that the patient would not accept and, therefore, left “AMA”?

Betty: Angela, I think this is straight forward. It really appears the patient left AMA to me. I mean, the physician was giving the advice that the patient should stay. In his/her opinion that is what was medically necessary, and the patient did not heed this advice and just left.

Angela: I totally agree. I think the correct value is 7: Left Against Medical Advice.

Reviewer: Correct. With the information provided, there is explicit documentation that the patient left against medical advice to select value 7: AMA.

In the Specifications Manual, under Notes for Abstraction, when determining whether to select value 7 Left Against Medical Advice. It states: A signed AMA form is not required for this data element, but in the absence of a signed form, the medical record must contain physician or nurse documentation that the patient left against medical advice or AMA.

In this scenario, there was explicit documentation that the patient left AMA.

Betty: Okay, we have answered all of these scenarios and we have three numbers 4, 8, and 7. What we doing with them? We were told we would have to gain the correct numbers in order to move on.

Angela: Betty, look! There is a safe behind this picture. Let's enter the code into the safe. Let's see; we answered with the values 4, 8, and 7. Let me put that combination into the safe.

Betty: It opened! Look Angela, a scroll. Oh, it's a long scroll. It says, answer the following scenarios correctly. Okay, here we go again. Now, here's our first scenario: This is a question about OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients. The physician documented in the procedure note, "The colonoscopy was technically difficult and complex due to significant looping and a tortuous colon. Successful completion of the procedure was aided by applying abdominal pressure." The recommendation states "Repeat colonoscopy in 5 years for screening purposes."

Would this be enough documentation of a medical reason for not recommending at least 10-year follow-up interval?

Betty: Huh, I am not really good at colonoscopy measures, Angela. What do you think?

Angela: I think it appears there is a medical reason for an interval of less than 10 years. This would then exclude the case from the measure.

Reviewer: This is correct. Let's review this question about OP-29. In this scenario, there is documentation of a medical reason for an interval of less than 10 years.

Under Denominator Exclusions in the Specifications Manual it states:

Medical reason(s) are at the discretion of the physician. It also states that documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the documented recommended follow-up interval is less than 10 years.

As this case is excluded from the denominator, this case would not be included for your abstraction for OP-29.

Angela: Great! Ok, here is the second scenario and this is about the data element Arrival Time. The medical record shows the following documentation: The RN Documents said on 10/01/18 at 0001. The Door Time is: 2359. The Start Triage start was at: 0001. But the ED Event Log has 10/01/18 at 0000 "Patient arrived in ED." What would be the earliest arrival time?

Betty: Well, there is documentation that the patient entered the ED, or arrived at the ED, at 2359. That's what the Door Time is.

Angela: Yes, but the RN does not start documenting until one minute after midnight.

Betty: So, that doesn't matter. The definition of Arrival Time is the earliest document time the patient arrived at the outpatient or emergency room department. So, it would be 2359. There is no substantial documentation to support otherwise.

Angela: Hm, okay, so we are going with the Door Time of 2359.

Reviewer: Correct. For the data element Arrival Time, the Specifications Manual's definition is: The earliest documented time (military time) the patient arrived at the outpatient or emergency department. In this scenario, Door Time of 2359 is the earliest documented time the patient arrived to the ED.

Angela: Okay Betty, here is our last scenario which is about the data element ED Departure Time. The medical record shows: 08:38 Report given, ambulance at bedside for transport; 08:40 Patient discharged; 08:55 Medication administration documented; 08:58 Vital signs recorded. What time should the abstractor use for *ED Departure Time*? So, Betty the record says the patient was discharged at 0840, but the patient had medication documented and vital signs recorded after that time.

Betty: Yes, that is true. However, in the Specifications Manual there is a Tools and Resources section. The guidelines in that section say not to use medication or vital signs if they are later than the documented ED Departure Time. So, the abstractor would use the 8:40 time as the *ED Departure Time*.

Reviewer: Correct. With the information provided, you would abstract the documented discharge time of 8:40. Under Notes for Abstraction, in the Specifications Manual, it states: "The intention is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to service/care."

Additionally, in Section 6 of the Specifications Manual, there are Tools and Resources to assist you in abstracting. The Departure Time Guidelines state: "Do not use Medication or Vital Signs if they are later than the ED Departure Time."

Announcer: You have successfully solved these three scenarios and will now being given a clue to find your next set of scenarios. This clue is: "Turn the stone to find the key."

Betty: Turn the stone?

Angela: Look on this desk, here, Betty. Here is a stone being used as a paperweight. Ha! There is a key under it!

Betty: Let's see if it opens the drawer here on the desk. How convenient!

Angela: It does! There is a new set of scenarios in here. Okay, here is our new scenario: and this is about OP-33: External Beam Radiotherapy for Bone Metastases. Stereotactic body radiation therapy (SBRT) is no longer listed as an exclusion for this measure but may be given as a curative treatment as opposed to palliative. Would SBRT be included in the population for OP-33? Oh, wow. I don't know about this one, Betty.

Betty: Yeah, me either. Let's ask for a clue.

Angela: We need some assistance in figuring this OP-33 question out. Can we have a clue?

Announcer: To assist you in any abstraction dilemma, there is a Tools and Resources section in the Specifications Manual. When accessing the Specifications Manual on the QualityNet.org website, you will see Section 6 is for Tools and Resources. By clicking on the Section 6 link, you will have access to tools, algorithms, fact sheets, and more. These tools are available for OP-29, -31, and -33. To assist you in answering your given scenario, consider the OP-33 Fact Sheet.

Betty: Angela read this portion of the fact sheet. It says: "Do not include patients who are part of a prospective clinical protocol involving the administration of radiation, especially stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT)."

Angela: Well, that's the answer then. This patient would not be included in this measure.

Reviewer: You got it! Let's review this OP-33 measure. Since SBRT is considered radiation therapy, any anatomic site that has previously been treated with SBRT (or any other radiation therapy) should be excluded from the denominator.

In the Specifications Manual, under Denominator Exclusions, it states "Patients who are part of a prospective clinical protocol or registry study involving the administration of radiation therapy, especially stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT)."

Betty: Okay, we have got that settled, let's move on to our next scenario. And this one is also about OP-33: A patient is receiving external beam radiation to two separate bony areas. One area is a retreatment of radiation to the same site.

The question here is: When answering the question "Is there a history of previous radiation to the same anatomic site?" do I answer the question with repeated therapy, and it falls out of the measure? Or do I answer it for the therapy to the non-repeated site and it stays in the measure?

Angela: Huh, well, let me see, wait a minute. There are two separate sites but only one of them is a retreatment, right?

Betty: Yes, that's what it says. But the abstractor wants to know what to do with the case for this encounter.

Angela: If one of the sites is a retreatment, it will be excluded. But the other one wouldn't, right?

Betty: They would be abstracted independently then.

Reviewer: Correct. In cases such as these, you would abstract each site separately and apply the exclusion criteria to each site independently. In this case, only one site would be excluded due to previous radiation.

The Specifications Manual references the Denominator Exclusion previous radiation treatment to the same anatomic site. For example, retreatment; and the Additional Instructions section states: "Consider the administration of EBRT to different anatomic sites as separate cases."

Betty: Okay, here we go with the next scenario involving OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients.

The patient's age is 66 years old. The physician documents on the colonoscopy report: "Repeat colonoscopy PRN for screening purposes;" is this acceptable documentation?

Angela: Well, I know the manual states that documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as ≥66 years old, or life expectancy <10 years. This fits the scenario provided here, so it appears to me that the documentation provided appears to be consistent with the information.

Betty: I think that is correct, too.

Reviewer: That is correct. Under the Denominator Exclusions for this measure, it is stated: "Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as ≥66 years old, or life expectancy <10 years." This case would be excluded from the OP-29 measure.

Angela: Okay, Betty. Here's the next scenario about the data element: ED Departure Time. A patient was admitted to Inpatient on 7/9 at 2255 and then a change was made 7/9 at 2305 to hospital observation status. Should the abstractor take the order for observation at 2305 as ED Departure Time? Or should the initial order for Inpatient time of 2255 be used?

Betty: Now, wait a minute. Since this is for the Hospital Outpatient Quality Reporting Program, why would they consider Inpatient orders?

Angela: I don't think we should. I think we should go with the time that the status was changed from Inpatient to Hospital Observation Status.

Betty: I totally agree. So, we would tell the abstractor not to abstract orders for Inpatient for the OQR program. You can abstract the time for an Observation Order if the patient was physically in the ED when the order was written. If the patient departed the ED prior to the Observation Order, then they would abstract the time the patient physically departed the ED for your ED Departure Time.

Reviewer: Ladies, you are correct. For patients who are placed into observation services, you will use the time of the order for observation for ED Departure Time. This is in the Specifications Manual under Observation Status.

Angela: Yay, I think we got all of those right.

Announcer: You have once again answered the scenarios correctly. Your next clue is: look under your feet.

Angela: Woah! I am standing on a rug.

Betty: Well, pull it up!

Angela: Betty there is a small trap door here.

Betty: And there's a pad of paper with our next set of scenarios. Here is the first of our next series of questions and it looks like we are starting with another question about OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients.

There is an After Visit Summary (AVS) report under discharge instructions with the recommendation for a ten-year follow up. I saw in a fact sheet, if your facility utilizes another report that is equivalent or contains the OR report, it can be used. The After Visit Summary report does not contain the OR report. For the recommended follow-up interval of ten years, does it only have to be on the OR report?

Angela: It doesn't seem to me that they can use these documents. The recommended follow-up interval should be documented in the colonoscopy report. Based on the information in the scenario, it appears that the interval in the After Visit Summary would not be sufficient.

Reviewer: That is correct, Angela. Based on the information provided, it appears that the interval in the After Visit Summary would not be sufficient. For OP-29, the follow-up interval must be documented in the colonoscopy report. The numerator statement for this measure states: "Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report."

Betty: Oh, thank goodness, a new type of question here. This question is about the data element Head CT or MRI Scan Order. So, here it goes, Angela.

A patient presented to the ED on 7/2. The ED record notes: "Pt had an outpatient MRI on 6/30. Dr. called patient today after MRI on 6/30/18 showed a possible acute ischemic infarct left cerebellum and told him to come to the ER for evaluation." During this ED visit on 7/2, the patient had an MRA of the head done. How should I answer the question, "Was a CT or MRI scan ordered by the physician during the ED visit?"

Angela: I have to tell you, this is a difficult data element for me. It's the earliest head CT or MRI scan interpretation was completed or reported.

Betty: Yes, Angela. That's true but the patient did not have a CT or an MRI ordered during the ED. I think the abstractor should abstract, "No," for Head CT or MRI Scan Order.

Angela: You are absolutely right, Betty. Based on the documentation provided, you would abstract, "No," for the data element Head CT or MRI Scan Order if there is no documentation of a head CT or MRI scan ordered during the emergency department visit.

Review: Based on the documentation the abstractor has provided, you may abstract, "No," for the data element Head CT or MRI Scan Order if there is no documentation of a head CT or MRI scan ordered during the emergency department visit. In this case, the patient had an MRI on June 30th. The patient arrived to the ED on July 2nd. During the ED visit, the patient had an MRA not a CT or MRI.

The Specification Manual provides guidance under the Allowable Values section; it states: You would Select, "Y" or "Yes,": There is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit. Or, "No," if there is no documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit?

Angela: Okay Betty, next situation and this is about Head CT or MRI Scan Interpretation Time.

The patient had a last known well 30 minutes before to arrival but needed to be stabilized before going to CT. He needed to be intubated and sedated before going to CT; therefore, his time from arrival to CT read is over the 45 minutes for the measure. The question at hand is: Is there a way to exclude the patient due to need to stabilize on arrival?

What do you think here Betty?

Betty: Well, they had to stabilize the patient, there's nothing you can do about that. They had to protect his airway and intubate him before getting a CT scan. However, that is not going to be a reason because to exclude him from the measure, right?

Angela: This is tricky. Let's ask for help. Hello? We need some help again.

Announcer: How can I help you?

Betty: Hi**,** yes, we are not sure how to answer the question. Can we get some assistance with this?

Announcer: Yes, would you like to ask the people participating on the outside to offer their assistance?

Angela: Yes! That would be great.

Reviewer: Thank you, everyone. Let's review some information about Head CT or MRI Scan Interpretation Time. Based on the documentation provided, you may abstract the interpretation time closest to arrival for Head CT or MRI Scan Interpretation Time.

The Specifications Manual defines this data element as, "the time (military time) represented in hours and minutes at which the earliest head CT or MRI scan interpretation was completed or reported." The manual provides the following guidance under Notes for Abstraction: Abstract the result of the earliest head CT or MRI scan interpretation (closest to arrival). Please take note of that, currently, there are no exclusions for the situation described in this scenario.

Betty: Okay, that makes sense. I'm glad we were able to get some help with that. Let's move on to our last scenario here. Here we go. This question looks like this is about Initial ECG Interpretation. "The first and only printed ECG, signed by the cardiologist has Anterior Infarct 'Age Indeterminate.' We do not see this as either an inclusion or exclusion term."

The abstractor asks: How do we treat this phrase? Do we ignore it and just utilize Anterior Infarct?

Angela: Okay, "Age Indeterminate" is neither an Inclusion or Exclusion term. So, it seems the abstractor should only consider "Anterior Infarct."

Betty: Yes, I agree with you. The only term to be used is Anterior MI, I think the abstractor should abstract a value of Yes for the Initial ECG Interpretation data element.

Reviewer: Well done! Great job! Let's review Initial ECG Interpretation.

In Version 12.0a of the Specifications Manual, it states: "Notations which describe ST-elevation as old, chronic, age unknown, recent, or previously seen, or which state ST-elevation and 'no new changes,' 'unchanged,' 'no acute changes,' or 'no significant changes,' when compared to a prior ECG, should be disregarded. Other documentation of ST-elevation within the same interpretation or a different interpretation may still count as an Inclusion or Exclusion." And that aligns with the "Age Unknown" descriptor, you just disregard the entire line.

Therefore, the only Inclusion or Exclusion term is "Anterior MI," so you should abstract a value of "Yes" for this data element.

Announcer: You have successfully answered that set of scenarios. Now, follow this clue to find your next set. The Specifications Manual is a book of knowledge.

Angela: Huh, short clue. Hmm, well we have all of these books here on the bookcase.

Betty: Yes, but, uhh let's see, Angela, Angela, look! There is only one red book, towards the top here on the left.

Angela: Pull it out.

Betty: Ok, great we found our next set of scenarios. Surprise!

Angela: Yes, okay. We are going to start out with OP-33: External Beam Radiotherapy for Bone Metastases. Here's the question: "The medical record has the following documented 'Pain is in the lumbar spine with radiation to the legs.'"

Would this documentation be able to be used to say, "Yes," to radicular pain?

Betty: Okay, so when we are abstracting for OP-33, if a patient has radicular pain, they would be excluded from the measure based on that. But I don't see this as being specific to radicular pain.

Angela: I agree. So, to answer the abstractor's question: No, this documentation could not be used to answer Yes to radicular pain.

Reviewer: Correct again! For OP-33, in order to meet the exclusion for radicular pain, the documentation must reflect a clear and explicit diagnosis of radicular pain. In this case, the documentation is not definitive in the diagnosis of radicular pain and should not be excluded on this basis.

Betty: Ok, here's our next scenario, Angela and this question is about the data element Reason for Not Administering Fibrinolytic Therapy. "The documentation by the provider states that 'cardiologist does not want fibrinolytic at this time, transfer to cardiac cath.' Is this sufficient to choose 'documented reason for not administering fibrinolytic?'"

Angela: I think so. I think this is a pretty clear documented reason for not administering the fibrinolytic.

Betty: I think so, too, I agree. The answer is, "Yes."

Reviewer: Based on the information provided, 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 administered fibrinolytics.

To review some information about this data element. The Allowable value "1" Documented contraindication or reason in the Specifications Manual indicates that if there is documentation of a contraindication or other reason by a physician/APN/PA or pharmacist that is explicitly listed in the data element as a

contraindication for administering fibrinolytic therapy, then you should select or abstract a value of "1." Additionally, under Notes for Abstraction in the manual, it states that if there is a contraindication/reason not listed under the Inclusion Guidelines for Abstraction, but there is clearly physician/APN/PA or pharmacist documentation linking this contraindication/reason to the decision to not administer fibrinolytic therapy, you may also abstract a value of "1."

Angela: Here we go, Betty. This next question is about Head CT or MRI Scan Order. The patient arrived at 1518, was admitted to observation, and departed the ED at 1846. A CT was ordered after the patient left the ED but during the OP encounter. Is it acceptable to use the CT from outside the ED? Okay, Betty. I think the answer here is no. The CT scan was not ordered at the time the patient was in the ED. The patient had already left the ED when it was ordered.

Betty: Yes, but it was still during the same encounter.

Angela: But that's not what the manual says. The manual says you abstract, "Yes," if the CT was ordered during the emergency department visit. The patient was departed from the ED and CT was ordered after that. So, the abstractor would choose, "No."

Reviewer: That is correct regarding Head CT or MRI Scan Order. Based on the documentation provided, the abstractor would select No for Head CT or MRI Scan Order. Although a CT was ordered during the outpatient encounter, because it was not ordered while the patient was in the emergency department, you would abstract, "No."

The Specifications Manual defines this data element as "documentation in the medical record that a Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) scan of the head was ordered during an emergency department visit." The manual also provides guidance under Allowable Values that states: "Select Yes if there is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit. Select 'No' if there is no documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit."

Angela: Okay, Betty, what's the next scenario?

Betty: Okay Angela. Here is our last scenario in this book and it is with regard to the data element Time Last Known Well. Now, the ED physician documents the last known well time is 30 minutes prior to arrival. The ED nurse's note says the last known well time is 20 minutes prior to arrival.

Is there a hierarchy rule regarding physician's notes before nurse's notes?

I have to tell you, Angela, I always get confused with this issue.

Angela: Oh no. I do too! I always get confused when there are multiple times of last know well documented.

Announcer: Will Angela and Betty escape the room? Stayed tuned. Join us for the conclusion. We will bring you a new set of scenarios to work through in Part II.

Host: Thank you everyone for joining us today. Have a great day!