Outpatient Quality Program Systems and Stakeholder Support Team

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

Speakers

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July 21, 2021
2 p.m. Eastern Time (ET)

Karen VanBourgondien: Hello everyone, and welcome to today's webinar. Thank you for joining us. my name is Karen VanBourgondien, and I have Pam Rutherford with me. Today, we are going to be covering some frequently asked questions for the chart-abstracted measures for this program. We are presenting this information with a theme of an escape room, which is very fun. Hopefully, you have had the opportunity to experience one. Although we have this theme to make it a little fun, we have picked some pretty challenging scenarios. We are going to try to get to as many scenarios as we can in our time with you today. We will also be involving you directly with some of these abstracting dilemmas, so put your thinking caps on!

To help us answer your questions, we are fortunate today to have the measure writers here with us. We have the Lewin group, Mathematica-MPR, Yale, Lantana, and Telligen. These contractors all work to improve quality by bringing these measures together. We are lucky to have them here today to share their expertise. They were also very instrumental in the creation of this event. We could not have brought this to you without their collaboration. So, we thank them for their time.

Today, we will be using a lot of acronyms in our scenarios and we realize you most likely know these. However, we have provided a list here for reference, should you need them.

The learning objectives for this presentation are listed here on the slide.

Although we will have some interactive scenarios with you, you can also ask questions directly. So, during the presentation, if you have a question, please put that question in the chat box located on your screen and one of the subject matter experts I mentioned earlier will respond directly to you.

Before we get started, let me make just a few program announcements. The quarter one data, using encounters from January 1 through March 31, 2021, are due August 2, 2021. They are due the second as the first falls on a Sunday this year.

The calendar year (CY) 2022 proposed rule will be published soon, likely sometime next month. Of course, we will be presenting a webinar discussing the proposals that relate to this program shortly after the publication of the rule. So, don't miss that.

If you have not yet downloaded today's slides you can get them from our website: QualityReportingCenter.com. Okay, enough of that, let's get started.

Let's begin in our escape room and start figuring out some scenarios. Pam? What do you think?

Pam Rutherford: Yes, we are ready to go. Karen and I will be going over scenarios today. In order to advance through the rooms, we will need to successfully conquer these scenarios. So, let's begin...

Karen VanBourgondien: In this first section of our first escape room, we will present scenarios that relate to the ED throughput measure set. This measure set includes OP-18 and OP-22.

Included on the slide are the OP-18 measure-specific data elements. Both measures have general data elements to determine inclusion in the population. However, OP-22 does not have any measure-specific data elements. Also, in this section we will be covering OP-29, a web-based measure.

The web-based measures for this program are OP-29 and OP-31.

We just talked about OP-22, which is an ED-throughput measure, but it is submitted annually via a web-based tool with the OP-29 and OP-31 measures. Let's get to the first scenario.

Our first scenario includes data element *Arrival Time*. The situation is as follows: The medical record shows the following documented events: RN documentation on 10/01/20: Door Time 2359, start triage at one minute after midnight. The ED event log on 10/01/20: 0000 Patient arrived in ED.

The question is, "What would be the earliest arrival time?" So, let's review a bit before we discuss the answer.

Pam Rutherford: Okay, yes. In the specifications manual, the definition for the *Arrival Time* data element is "the earliest documented time (military time) the patient arrived at the outpatient or emergency department."

In this scenario, you would abstract the Door Time of 2359, as that is the earliest documented time the patient arrived at the ED.

Karen VanBourgondien: Well, we are starting off a little easy. So, let's move on.

Here's our next scenario for the data element *ED Departure Time*.

A patient has an ED checkout time of 1518 and then has an event for transfer to the next department at 1525. The patient also had an order for observation written at 1131 the following day. There is no documentation in the ED provider notes after 1405.

What time would be acceptable for *ED Departure Time*?

Pam Rutherford: Well, Karen, there are a few things to consider in this scenario. Under Notes for Abstraction in the specification manual for the data element *ED Departure Time*, 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 or care."

Now another statement to consider is, "*ED Departure Time* is the documented time the patient physically left the emergency department;" "When more than one emergency department departure/discharge time is documented, abstract the latest time."

Now, considering what we just discussed under Notes for Abstraction, in this scenario, there are two times that may reflect when the patient physically left the ED, the ED checkout time of 1518 and the Event for Transfer at 1525.

Now, as we just discussed, when more than one emergency department departure or discharge time is documented, you would abstract the latest time. So, in this scenario, you would abstract the later time of 1525 for the *ED Departure Time*.

Karen VanBourgondien: All right, great job. Our next scenario involves OP-29. The scenario is this: A 70-year-old patient had a colonoscopy done at our hospital. Other than "return PRN," there is no documentation of a recommended follow-up colonoscopy.

So, this abstractor is asking the question, "Would this case be excluded from the denominator?"

Pam Rutherford: To address this scenario, we would consider the denominator exclusions in the manual, which reads, in part, "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."

Now, this case would be excluded from the denominator because of the patient's age and guidance that specifies documentation indicating no follow-up colonoscopy is needed or recommended is acceptable if the patient's age is greater than or equal to 66 years old.

Karen VanBourgondien: Well, great job, you got the key to go into the next room.

Okay, for our new room, our next group of scenarios is related to OP-23. Again, we have the data elements related to this measure. These elements can be tricky, so we have quite a few scenarios to consider these data elements as they relate to OP-23.

Okay then, our first scenario in this room is for the data element *Time Last Known Well*.

The scenario is the patient arrived at 0724. The notes state, "Patient woke up at four in the morning and developed a posterior headache with dizziness, general neck pain, no nuchal rigidity, and nausea and vomiting." The ED physician note states, "The patient presented with sudden severe headache this morning." Additional documentation states, "The patient arrived within one hour of sudden severe headache."

So, the abstractor wants to know, having read all of this, how to abstract *Time Last Known Well*.

Pam Rutherford: Okay, let's go back and review the manual; and the definition for this data element is, "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."

Now, there are exceptions listed in the manual, and one of these exceptions, as seen on the slide, states, "If the only time documented is time of symptom onset without mention of when the patient was last known well, use the time of symptom onset for the *Time Last Known Well*."

Now the two other exceptions that we should consider with this scenario are, "If there are multiple times of 'last known well' documented in the absence of the *Time Last Known Well* explicitly documented on a Code Stroke Form, use physician documentation first before other sources; and, if the time is noted to be 'less than' a period of time prior to arrival, assume the maximum range." So, all right, for example, if *Time Last Known Well* was less than one hour ago, you would subtract one hour from the time of arrival to compute the *Time Last Known Well*.

Now, in this scenario, because there is no documentation of last known well or symptom onset in a Code Stroke Form but there is physician documentation upon which symptom onset can be derived, you would abstract 0624 as the *Time Last Known Well*.

Karen VanBourgondien: Wow, thank you, Pam. Getting into little bit more difficult scenarios. Our next scenario is also concerning the data element *Time Last Known Well*. In this scenario, the patient arrived to the ED at 1802. The ED physician documents the "time last known well" as one hour prior to arrival. EMS documents a specific time of last known well as 1700.

So, the question being asked is, "Which documentation do you use for the *Time Last Known Well*?"

Pam Rutherford: Okay, a few minutes ago, we discussed the definition and some of the exceptions for this data element. One of the data elements we mentioned a few slides back is seen here, and it applies to this situation that, if there are multiple times of last known well" documented in the absence of the *Time Last Known Well* explicitly documented on a Code Stroke Form, use physician documentation in first before other sources. The other sources would mean nursing or EMS documentation, for example.

So, given all of that information, let's talk about the answer. If time last known well is not documented on a Code Stroke Form, then look for documentation of last known well in other sources of the record, with physician documentation taking priority over other sources like nursing or EMS documentation. If the time last known well is documented as being a specific number of hours prior to arrival instead of specific time, you can subtract that from the arrival time to determine the time last known well.

Since the ED physician documented time last know well was one hour prior to arrival, you can subtract one hour from the arrival time of 1802 and abstract 1702 as the *Time Last Known Well*.

Karen VanBourgondien: Okay, great job. Moving on to the next scenario for the data element *Last Known Well*. The abstractor writes: The nurse documents a last known well date and time of 1/17/21 at 1700 and the ED physician documents both last known well as yesterday and reason tPA not ordered was secondary to unknown onset.

The abstractor wants to know: Does the nurse's documentation of the last known well date and time take precedence over the physician's documentation of "unknown onset"? Additionally, they are asking if there can be clarification in the guidance in the *Last Known Well* data element about *Time Last Known Well.* Are onset of signs and symptoms being unknown, uncertain, or unclear?

Pam Rutherford: So, to get to the answer here, let's first look at a few things. Okay, the definition for this data element is "the date and time prior to hospital arrival at which it was witnessed or reported that 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." The allowable values are [the following]: Y (Yes) There is documentation that the date and time of *Last Known Well* was witnessed or reported; N (No) There is no documentation that the date and time of *Last Known Well* was witnessed or reported; and Unable to Determine from medical record documentation.

Also, something we need to consider. Under the Notes for Abstraction for this element it states, "Documentation must explicitly state that the *Time Last Known Well* is unknown/uncertain/unclear."

So, when abstracting the *Last Known Well* data element, there must be documentation that the date and time are witnessed or reported or unknown, uncertain, or unclear. If a nurse documents last known well, but the physician notes last known well is unknown, you would abstract the allowable value of No.

Karen VanBourgondien: Wow, thank you, Pam. Okay, our next scenario involves the data element *Head CT or MRI Scan Order*. The documentation indicates the patient arrived at the ED at 1249 and the physician ordered an MRI during the ED visit at 1300. However, the documentation indicates the MRI scan order was cancelled at 1431 given the patient is transferred to another facility at 1450.

So, the abstractor asks, "Do I abstract Yes or No?"

Pam Rutherford: Okay, in review, the definition for this data element, as stated in the manual, is "documentation in the medical record that a CT or MRI scan of the head was ordered during an emergency department visit." The Allowable Values are [the following]: Yes, there is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit; and No, there is no documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.

Under the Notes for Abstraction section of the manual it says, "If there is documentation a head CT or MRI scan is ordered during the emergency department visit but is cancelled and there are no other head CT or MRI scans ordered during the emergency department visit, abstract No."

Now, considering these points of discussion, the answer to the question is, since the MRI or CT was cancelled, you would abstract No for the *Head CT or MRI Scan Order* data element.

Karen VanBourgondien: So, Pam, this is our last scenario in the stroke-related portion of the escape room, and it refers to the data element *Head CT or MRI Scan Interpretation Time*. The scenario is as follows: A patient was admitted to one of our other hospitals at 0934 and was transferred to our hospital at 1306 with the same identifier and medical record numbers. A CT scan was done at the first hospital at 1055 and interpreted at 1105. There was a CAT scan ordered at the second hospital at 1356 but was cancelled.

The abstractor wants to know what time should be abstracted for *Arrival Time*, and which CT scan should be used?

Pam Rutherford: Patients visiting the ED twice in one day is a fairly common event. It happens. So, to address this, you would review the manual, of course. The General Abstraction Guidelines section includes Abstraction Recommendations for Multiple Same-Day Encounters, and it says, if two ED visits on the same day are rolled into one claim, abstract the first chronological encounter that meets the inclusion criteria for the population.

If two ED visits on the same encounter date meet the inclusion criteria and are billed as two separate claims, both cases may be eligible for abstraction according to sampling requirements. Because the data element *Arrival Time* is used to differentiate between two cases that occur on the same encounter date, if both cases are submitted with UTD, Unable To Determine, for *Arrival Time*, the case submitted last will override the previous case.

So, if the first situation we just spoke about applies to your situation, meaning the two same-day ED visits are rolled into one claim, you would use the arrival time at the first hospital and the CT scan from the first hospital. If the second scenario applies to your situation and the two ED visits are billed as two separate claims, then you would treat each facility as two separate cases to be abstracted. So, in this situation if the second ED visit is abstracted there will not have been a CT ordered while the patient was in the ED, due to the fact it was ordered and then cancelled.

Karen VanBorugondien: Karen: Okay, great job. We have the key to move on into the final room.

Okay, now we are going to move to the AMI measure set. This set includes OP-2 and OP-3. You can also see the AMI-specific data elements for this measure set. We will address a few of these data elements.

Okay, so our first scenario will address the data element *Fibrinolytic Administration* and the abstractor writes, "Many cardiologists are asking us to start heparin before we ship, this means before we transfer, which is the recommendation we follow? Please clarify what medications count toward being a fibrinolytic for the OP-2 measure." Can we use heparin as a fibrinolytic being started?

Pam Rutherford: Well, let's go back to the specifications manual. You would first refer to Appendix C, Table 1.3 for a listing of acceptable fibrinolytic agents for purposes of abstracting the *Fibrinolytic Administration* data element, which you can see here on this slide, and you can also see that heparin is not included in this table.

In addition to referring to the table we just discussed, there are allowable values for this data element: Yes, if fibrinolytic therapy was initiated at this emergency department; No, if there is no documentation fibrinolytic therapy was initiated at this emergency department; or Unable to Determine from medical record documentation.

Since heparin is not an included fibrinolytic agent in this scenario, you would select No, as there is no documentation that fibrinolytic therapy was initiated at your emergency department. Selecting No removes the case from the OP-2 measure population and abstraction ends.

Karen VanBourgondien: Next, let's discuss a scenario for the data element *Reason for Delay in Fibrinolytic Therapy*. The situation is the patient arrived at the ED, and there was a 15-minute delay in getting the initial ECG and its interpretation. TNKase (Tenecteplase) was given within 33 minutes. Is this an acceptable reason for delay in fibrinolytic therapy?

Pam Rutherford: Okay, again, to answer this question, we will review what the specifications manual says and the definition for this data element is "documentation of a reason for a delay in initiating fibrinolytic therapy after hospital arrival by a physician/advanced practice nurse/physician assistant (physician/APN/PA). System reasons for delay are not acceptable."

So, the allowable values are: Yes, Reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival; No, No reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival; or Unable to Determine from medical record documentation.

Under the Notes for Abstraction, it states that system reasons for delay are not acceptable, regardless of any linkage to the delay in fibrinolysis or reperfusion. Considering this information, in the scenario, the abstractor would select No for the *Reason for Delay in Fibrinolytic Therapy* data element. Waiting on ECG results is considered a system reason and, as we just discussed, system reasons for delay are not acceptable.

Karen VanBourgondien: Okay, thank you. Next, we will resource the data element *Initial ECG Interpretation*. Here is the scenario. The ECG interpretation reads: Normal sinus rhythm, left axis deviation, right bundle branch block, inferior infarct, age undetermined. Abnormal ECG." Will this be abstracted as a "Yes" for the *Initial ECG Interpretation* data element because of the inferior infarct? Great question. Pam?

Pam Rutherford: Let's review. The definition for this data element is seen here on the slide: ST-segment elevation based on the documentation of the electrocardiogram (ECG) performed closest to emergency department arrival. The normal ECG is composed of a P wave (atrial depolarization), Q, R, and S waves (QRS complex, ventricular depolarization), and a T wave (ventricular repolarization). The ST-segment, the segment between the QRS complex and the T wave, may be elevated when myocardial injury (AMI) occurs. The allowable values are: Yes, ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival; No, no ST-elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival, no interpretation or report available for the ECG performed closest to emergency department arrival; or unable to determine from medical record documentation.

For further consider in this scenario, we would want to look at the inclusion guidelines for abstraction for this data element, which are seen here as they are in the manual, and of course, we will also have to consider the exclusion guidelines for abstraction. When looking at the inclusion and exclusion guidelines, it can be confusing. So, just take it one at a time.

In considering all of this for this scenario, the Inclusion Guidelines for Abstraction indicate that if there is documentation of an MI, there must also be mention of a location or combination of locations and it must be described as acute or evolving. In this scenario, infarct and location are documented but the "inferior infarct" is not described as acute or evolving. So, it is not considered an inclusion term and no exclusion terms are noted in the ECG interpretation.

This would be abstracted as a No value for the *Initial ECG Interpretation* data element because the ECG does not contain any inclusion terms.

Karen VanBourgondien: That was a lot of information Pam. All right. Well, let's move on.

We are almost there. Okay we should do another scenario for this same data element, *Initial ECG Interpretation*, because you did just go over a lot of information there, Pam, and we would reference the same information from the specifications manual that you just discussed to figure out the next scenario. So, the abstractor states that the initial signed ECG reads line by line: Sinus Rhythm, Borderline Left Axis Deviation, ST elevation VI and AVL. ED MD interpretation of initial ECG: "normal sinus rhythm, no ectopy, normal PR & QRS intervals, EP Interpretation of initial ECG: There are minimal ST depressions in V1 and aVL measuring less than a millimeter. There is slight ST depression in V3 and aVF and less than 1 mm. The precordial leads are normal. Minimal degree of the EKG changes, but we have contacted cardiology early in this case."

The question is, how do you abstract initial ECG interpretation?

Pam Rutherford: Again, we are going to access the information in the manual we discussed in the last scenario. You will start by reviewing the signed tracing. The initial signed ECG contains an inclusion term, ST elevation, and no exclusion terms are noted.

Next proceed to review other interpretations that clearly refer to the ECG done closest to arrival. There are no inclusion or exclusion terms noted in the ED MD documentation. The EP documentation indicates the presence of ST depression, which is not mentioned in the manual. Only ST elevation is mentioned in the manual and is therefore neither an inclusion nor an exclusion. In this scenario, you will select Yes for this case, since there is an inclusion in the initial signed tracing and no exclusions in any interpretations of the initial ECG.

Karen VanBourgondien: Wow, great job everybody! The next scenario relates to the data element *Transfer for Acute Coronary Intervention* and the abstractor presents this scenario: A patient arrived in our ED and the physician documented the reason for transfer was for higher level of care.

The question the abstractor is asking is, is this enough to answer 1 for this question?

Pam Rutherford: Okay. The definition for this data element is "documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention." The allowable values are: There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention; There was documentation the patient was admitted to observation status prior to transfer; There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.

So again, based on this information, you should not select value 1 in this case because the documentation states the transfer was for a "higher level of care" but does not specifically define the reason for transfer is for an acute coronary intervention.

This would be abstracted as value 3, which we just discussed. Now, remember allowable value 3 states: The reason for transfer must be a defined Acute Coronary Intervention. As such, if implicit reasons for transfer, such as "Patient has STEMI" or "Transferred for cardiology consult to discuss possible cath lab" are listed, then select Value 3.

Karen VanBourgondien: All right and again we are almost there and everyone's done a great job. Let's do another scenario for the data element *Transfer for Acute Coronary Intervention.*

Here's the situation: The ED provider documents the following: "Hospital interventional cardiology attending physician will see patient in the emergency department for likely cath lab. Patient has been accepted to the hospital emergency department by physician. Disposition: Transfer to Another Facility." In the Non-Emergency Ambulance Transportation documentation completed by the nurse, the "Reason for Transport" is documented as "Tx for cardiac cath," and the transport location is defined as "Hospital Cath Lab."

Would we select value 1 or value 3 for *Transfer for Acute Coronary Intervention* in this case?

Pam Rutherford: Remember the *Transfer for Acute Coronary Intervention* data element is defined as "documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention."

Now, the manual does not specify the documentation source. According to the information provided, there is documentation in the emergency department record of transfer for cardiac cath. Because cardiac catheterization is an inclusion term for this data element, you can select a value of 1 in this scenario.

Karen VanBourgondien: Okay, great job everyone. You made it through. You made it out of the escape room to conclude the scenario-based information, and that was a lot of information. Thankfully, we have the measure writers here to answer all of your questions.

So, just like any good escape room we go over some clues. Before we wind up today's event, we do want to hit a few more pieces of information that are important and that we do receive a lot of correspondence about.

Outcome measures: We did not review these today but listed here are the outcome measures for this program. These are claims-based and do not require manual abstraction on the part of the hospital. Data are collected via paid Medicare Fee-For-Service claims that meet the measure criteria. The outcome measures for this program are OP-32, OP-35 and OP-36.

Additionally, we did not cover the imaging efficiency measures. So, like the outcome measures, these measures do not require manual abstraction. So, that is part of the reason we didn't include these measures in the scenario-based portion. So, the imaging measures currently for this program are OP-8, OP-10, and OP-13 .

So, let just address some reports that are related to these measures. A common question asked is, "What is the difference between my Facility-Specific Report, or FSR, and the Claims Detail Report, or the CDR?"

The answer is the FSRs and CDRs for the Outpatient Imaging Efficiency measures contain similar information. Both include patient-level information, for example, qualifying cases for the measure cohort, applied exclusion criteria, and outcome information, those sorts of things, patient-level data from claims used to calculate results for public reporting.

Now the FSRs include the following additional information: facility-level measure results; state and national results, where applicable; Medicare claims data for the entire reporting period used to calculate measure results; measure performance information, including whether a facility performed better than the national rate; and a summary of each facility's case mix.

Additionally, the FSRs and CDRs released in 2021 cover different payment periods. The FSRs released in spring 2021 covered public reporting period 2021 and used claims data from July 1, 2019 through December 31, 2019. Conversely, the CDRs released in 2021 will include a portion of preliminary data for public reporting period 2022. The first CDR was released in spring 2021 and included claims data from July 1, 2020 to November 30, 2020, and the second CDR will be released in fall, this year, 2021, and that will include claims data from July 1, 2020 to May 31, 2021.

So, we all know COVID has brought with it many issues. So, another question commonly asked is, "How is data collection for the imaging measures impacted by COVID-19?"

In response to the COVID-19 pandemic, as a relief to facilities and providers, CMS will not use the data from January 1, 2020 through June 30, 2020 for performance calculation, and that is including for the identification of cases for exclusion. Therefore, the data collection period for values to be reported on the public reporting site in summer 2021 ran from July 1, 2019 through December 31, 2019. Additional information can be found at the web address we provide here on this slide.

So, okay, I think that's all we have time to cover today.

Of course, here we have some resources available to you. Again, the slides are available to you at QualityReportingCenter.com.

If you are abstracting and have measure-specific questions, please use the QualityNet Question and Answer Tool found on QualityNet. Your email will go to the subject-matter experts, and they will respond directly back to you by email.

As always, with any program related questions, always give us a call, we are happy to hear from you. Our number is 866.800.8756.

Pam, I think that's about it. I can hand the closing off to you. Pam.

Pam Rutherford: Thank you, Karen. We did have fun. I think that's all the time we have. Thank you for joining us today. We hope this was a little fun for you and very helpful. We would also like to again thank Lewin Group, Mathematica-MPR, Yale, Lantana, and Telligen again for their collaboration and time. We really appreciate it and thank you everyone. Have a wonderful day.