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**Abstracting for Accuracy**

Presented by [Robyn Carlson] (85-minute Webinar) [02-20-2014]

Mary Montury: Hi everyone, welcome to another blizzardy day in Minnesota. Welcome to the Abstracting for Accuracy call, abstraction changes to the in-patient specifications manual 4.3a for discharges January 01, 2014 to September 30, 2014.

I’m pleased to introduce today’s speaker, Robyn Carlson. Robyn has a broad background in medical record abstraction, review and training. She has supervised medical records staff in acute care settings, as well as provided client support, consulting for MediQual Systems, Inc.

In her current role of data quality specialist at Stratis Health, Robyn answers data abstraction questions, assists hospitals using the CMS clinical abstraction and reporting tool, the card tool and coordinates the validation process for data submitted to the QIO clinical warehouse.

Robyn Carlson: Thanks Mary. Hi everyone. I just want to let you know that this is something a little different, Mary and I aren’t in the office due to the weather, so we’ll both be online as the speakers and hopefully you can hear everything okay. We’ll do questions at the end.

This is the call for abstraction changes for the specifications manual. You’ll note that last year we only had that one manual for the entire year and this year again they’re starting with two different manuals, although this one is just for three quarters. I don’t know that it was specifically stated anywhere that it could be because of the changes to ICD 10 that may be occurring in October. So, this is the manual for the first three quarters of 2014.

Just as a disclaimer I do on these, remember that for each new version of the specs manual and any additional addendums, you need to review the release notes for a detailed description of the changes that were made. If you remember we talked about this before, but there’s no longer any type of highlighting, so there’s no way by just looking at the manual would you know exactly what was changed.

The release notes is where it tells you word-for-word and comma by comma, because there were actually some changes that were in there just because a comma was removed.

I’m going to go over the major abstraction changes and changes to the data elements. Again, you need to check for everything. I’ll only hit the major things that I think pertain to most abstractions for everyone because our call time is limited. I’m going to review by clinical topic. Last time I believe I did it somewhat alphabetical like how the data dictionary is setup, but this time I was thinking it may be easier to go by topic, especially because there are hospitals that don’t do the stroke or VTE and those will be at the end in case those want to hang up.
When you do it by topic I believe you get more of a feel for what’s going on for that clinical topic, rather than if I just do alphabetical. As always, let me know what worked and what didn’t because that’s how we change things.

I just want to say that this time there are more measures that are now voluntary. If you decide to stop submitting on the voluntary measures, be sure to check and see that they’re not required for the joint commission or hospital and you’re seeking their certification make sure you see that those measures aren’t required for them. Voluntary, they’re still in the manual. So if you still want to abstract them you can, the warehouse will still accept them.

I just want to take a minute, because I wasn’t sure exactly... when CMS calls them voluntary measures, what is their definition of voluntary? I got this little blurb that I want to read about the voluntary measures. It says in the 2015 rule, CMS removed AMI 210, heart failure 1, 3; pneumonia 3b and skip 10 from the IQR program, beginning with the 1/1/2014 discharges.

Typically that means they would be retired and they would be removed from the specifications manual. However, as you are well aware they are still in the manual and still labeled as voluntary. Part of the reason for this is due to when the final rule was released, system resources and the alignment of these measures with the joint commission, as some of these are still being classified as part of their accountability measures, the decision was made by CMS to not remove these measures from the specifications manual and make them voluntary.

This way it’s to align with the rule of them being removed from the IQR program and not being required. They say these measures will be removed from the manual beginning with the 10/1/2014 discharges. So basically they’re still there because there wasn’t alignment yet with what the joint commission might require and because the specs manual gets released so far in advance it was out months before the final rule was, that the final rule changes weren’t able to be in there and instead of going back and making a whole new manual, they decided to make those voluntary. Hopefully that explains a little about what the voluntary means.

Now I want to go over the first couple of things, which are part of the intro to the data dictionary. It’s not really any changes. The page I’m referring to is 1-4, which talks about medical record documentation. There has been a lot of questions regarding addendums or corrections or delayed entries, so CMS added this to the manual saying, documents containing amendments, corrections or delayed entries must employ the following, why be accepted record keeping principles.

Clearly and permanently identify any amendments, corrections or addenda.
Clearly indicate the date and author of any amendments, corrections or addenda.
Clearly identify all original content.

It’s still in there, the late entries or addendums can be used for abstraction purposes, as long as it’s been added within 30 days of discharge. Now they’re saying they need to be identified. We need to know who made the amendments and you need to still know the original content. As always, it’s not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

On page 1-8, it’s addressing the act of hospitals using the pre-printed and electronic standing orders. For everyone, we’re moving towards the EHR if you don’t have it yet and a lot of times the guides here weren’t addressing that information, so they added a bullet on this page, mid-center that says hospitals may use preprinted and electronic standing orders, order sets and protocols for patient orders. If such orders and protocols are dated, timed and authenticated promptly in the patients medical record, by the ordering practitioner responsible for the care of the patient.
I don’t know that this is anything we didn’t know before or if you asked you were told this but it’s been added.

The first couple abstraction changes apply to some of the general abstraction data elements, so they apply to several measures so I’ll talk about those first.

The first one is **admission date**.

If you’re flipping pages it’s 1-19 of the data dictionary. On page 20 the first bullet there is to clarify. The admission date should not be abstracted from the early said mission order without regards to substantiating documentation. They were always telling us the admission date is the order to admit. Now they’re saying don’t use the earliest admission order without regards to any substantiating documentation. If documentation suggests the earliest admission order doesn’t reflect the date the patient was admitted to in-patient care this date shouldn’t be used.

Then they provide an example. I think it’s like one of those common sense sort of things, but they didn’t have it in there specifically and now they’re saying yes, this is the date we want you to use from the physician’s order, but if it doesn’t make sense and the physician did a pre-op order and said this is something about the order to admit. You know that patient isn’t there yet, so it’s stating the obvious but they had to include it.

I want to talk a little about **arrival date and time**.

These are on page 75 through 80. They revised some of the guidelines so you want to go through the notes for abstraction. What they really did was to say that any sources and this is a data element where there are only acceptable sources. It tells you that this is where you can find this information. So what they did to some of the notes for abstraction, some of the guidelines is they revised them to say sources outside of the only acceptable sources are no longer usable in abstraction to verify a date or time of arrival.

Your sources before were always emergency department record and they’re now saying not to go outside that record to determine if this time is acceptable. You’re only supposed to use certain acceptable sources. It says if you have a date or time but can’t tell if it was located on an only acceptable source than it should be disregarded. Again, they’re pressing that they only want certain sources.

I guess an example of that would be one of the only acceptable sources is a vital signs graphic, but if you couldn’t tell the time on there, they don’t want you looking at something else to verify. Don’t use the earliest date and time found on an only acceptable source if it’s an obvious error. That’s the deal we always get into when they tell us to take things at face value. If you’re looking at an only acceptable source and it says patient was admitted on 2/10/2014 and you know from other acceptable sources that it was really 2/14, use that, and don’t use the 2/10 because it was the earliest date, when you know that’s wrong.

These are just common sense things, but they needed to put that in writing.

I don’t think there’s anything in there that people aren’t already doing, but I wanted to let you know that it’s officially added now.

Next is something that applies to more than one measure and that is **discharge disposition**, which is on page 125. They added the first bullet that clarifies how to use post discharge dated material. Only use documentation written on the day prior to discharge, through 30 days after discharge, when abstracting this data element. Again, I believe that goes back to our timeframe about addendums and how you can only do it within 30 days. Now they have it here for the discharge disposition.
The only other change to that was on page 127. For the value other healthcare facility, they added veterans homes beneath that, because I think some people weren’t sure where to put that so they wanted to clarify. That’s now considered an, other healthcare facility.

That’s the only general changes for all the measures.

Now we’ll go by the specific topic.

Heart failure— the change in this is making some of the measures voluntary.

Heart failure 1, the discharge instruction measure and heart failure 3, which is the Acer Arb for left ventricular systolic dysfunction measure, they too are now voluntary. When I was trying to think about how to give this presentation I wondered if I should list all the data elements that pertains to those measures? When I started to do that the problem that came up is that you have data elements that pertain to more than one measure, so I would be saying this pertains to this measure but not to that one.

I thought it was getting confusing so I’m saying that heart failure 1 and 3 are now voluntary measures. You guys abstract, so I guess if you decide not to do these measures since they’re voluntary, the way your vendor tool is set up or if you’re using the cart tool, you would indicate that you are not collecting on these measures. Then the questions for that tool in that topic would be grade out for you.

We aren’t going to talk about all the data elements that are voluntary, but I wanted to let you know that these measures are voluntary. As always, if you have questions just contact me.

There are no changes to the heart failure data elements that we collect. If you’re still going to collect for the voluntary measures there are no changes and there are no changes to the heart failure measures. The only thing then would be two measures that are required anymore.

For AMI, the AMI measures aren’t required anymore. These are AMI 2 which is aspirin prescribed at discharge. AMI 7 which is median time to fibrinolysis, but it’s just 7 not 7a which is fibrinolytic therapy received within 30 minutes of hospital arrival, because that’s still a requirement. AMI 8, which is the median time to primary PCI is voluntary but AMI 8a, which is a primary PCI received within 90 minutes of hospital arrival, that’s still required. AMI 10 is also voluntary, statin prescribed at discharge.

The reason I wanted you to know that 7a and 8a are still required is because I had some questions about some critical access hospitals thinking they weren’t going to do AMI measure anymore, but these are still required for the state, so you have to do the AMI population. There are no new changes to the data elements, however, so how you’ve abstracted, no new changes. Whether you’re going to do the voluntary or not, that’s the change.

The only thing that I want to know regarding the AMI is for aspirin. On any of the data elements where aspirin is prescribed at discharge or aspirin on admission, they added equinox which was added as an exclusion and that’s not counted as aspirin. I believe people had asked that question before so some knew it but now it’s listed as an exclusion on any of the data elements involving the prescribing of aspirin.

That just leads me to a reminder. With every change of the specs manual, be sure to check out the medication tables. They are found in Appendix C. When you’re doing the data elements it will tell you about looking at what table in Appendix C if need be, but you want to make sure you look because new medications might be added and some that are discontinued could be removed. That’s always changing. We don’t get to list all the different medications that may change during this call.
For Pneumonia there is now a voluntary measure, 3b the blood cultures. Blood cultures performed in the emergency department prior to initial antibiotic received in the hospital. Both of those measures regarding the blood cultures 3a and b are now voluntary. Those data elements are basically the blood culture collected ones.

The changes for pneumonia on page 103 in looking at the chest x-ray, has one little change which is on page 104 for the inclusions. It used to say bronchogram, but now it’s air bronchogram, because apparently that’s a more specific finding. That’s an abnormality usually caught by an infiltrator of consolidation. That surrounds the bronchi. So the bronchogram is gone it needs to be the air bronchogram now. No big changes here.

The pneumonia diagnosis ED and direct admit are on page 295 and that’s the printout pages of the specs manual. There’s a small change, but there must have been enough people that picked this up incorrectly, but on page 296, when they’re talking about aspiration pneumonia it’s the second bullet down where it says, if there is any documentation of a diagnosis of aspiration pneumonia on an only acceptable source, select value two. That phrase was there before, but they added diagnosis. So what they’re saying here is that they want to see aspiration pneumonia listed as a final diagnosis or an impression to select the value that there is no documentation that pneumonia was a diagnosis on direct admit or through the ED. They don’t want to see it in a narrative. They’re looking for that as a diagnosis of aspiration pneumonia down an impression or on final diagnosis. Maybe most of you were doing that anyway, but I think sometimes you were seeing aspiration pneumonia in narrative and weren’t sure how to pick that up.

The other thing, on page 298, under inclusion guidelines they added lower respiratory tract infection. This doesn’t seem like a big deal but when you say this list is all inclusive and you were seeing lower respiratory tract infection that wasn’t there. Most people if you’re totally following guidelines would have picked that up so they added the lower respiratory tract infection.

Also for pneumonia now and maybe you have if you’re already started abstracting because I know we’re like a month and a half in to the year. The data element compromised and healthcare associated pneumonia have been removed. They are gone in name only, because they’re combined into the new data element which is on page 313. Reasons for alternatives and peri-antibiotic therapy. It’s a new data element, but everything that was in compromise and everything that was in healthcare associated pneumonia are in this data element.

The rationale for making it a new element and renaming it is rather than continuing to add antibiotic regimens to address rare conditions, this new data element was created to exclude such patients from the measure population. There are certain people you don’t want to include in your measure. There are reasons for them getting different kinds of antibiotics.

This new data element allows for additions of other exclusions, so rather than just the ones that were in compromise or healthcare associated pneumonia, those are still here but in the future this is the data element where they could add other exclusions as the need arises and to keep the pneumonia six antibiotic regimen evidenced based according to guidelines.

So really it’s just in case new things come up, new exclusions it would fit in this data element rather than trying to make another data element besides compromise and healthcare associated pneumonia.

I won’t read through this because once you look at it you will see that everything should be familiar to you because it was in other two data elements. That’s it for pneumonia, nothing big or different about that.
Talking about skip now and on page 101 it’s catheter removal. What they did was to add some instructions to address how to abstract the data element if the patient expires before the end of post op day two. On page 101 that would be bullet three. If the patient expires before the end of post op day two, prior to catheter removal select value one. This might be something everyone is already doing but there must have been questions about it or maybe it didn’t get in here so they created the bullet.

Bullets 4, 5 & 6 are the clarifications that were added to address how to abstract when catheters are re-inserted after removal. What happens if it was discontinued or unintentionally removed and then reinserted on this or that date, there are further explanations here on how to make this one easier to abstract?

On page 188, it’s a new data element, glucose. What they removed data elements, glucose post-op day one and two. Now there’s glucose and the definition is a little different than before. The blood glucose levels collected between 18 and 24 hours after anesthesia end time. That’s what they’re looking for. If no blood glucose levels were collected during this timeframe, blood glucose levels collected between 12 and 18 hours after anesthesia end time are to be used. So it wants you to look for levels between 18 and 24 hours after, but if there isn’t anything than look at anything blood glucose levels between 12 and 18 hours after anesthesia end time.

This is a different thought process and a different way of collecting the glucose, so you really need to read through the values and the notes for abstraction, because this is a new measure. People were asking me why they changed and concerns about it being less than or equal to 180, they thought that was low. Here’s what I was able to find out about this. I sent a question to our support contactor and they received an answer from Dr. Brassier and for some of you who have been doing this for a while or been on call, you know he’s a physician who’s involved with these measures and on the different committees for making these measures.

This was his response. I’ll read it but if you want a copy for yourselves in order to pass on to your physicians, contact us and we’ll make sure you get a copy. He said the performance measure is based on current guidelines from the society of thoracic surgeons to keep the blood sugar for cardiac surgery patients at 180 milligrams dl or less. The measure explicitly does not target intense glucose control as was done in studies such as ‘nice sugar’. Working with the National Quality Forum and representatives of the STS, the measure was designed to give the hospital 18 hours after the end of surgery to get the blood sugars under control. Typically, this will include the use of a continuous glucose infusion.

We would certainly agree that a target blood sugar of 140 to 180 ml dl is an appropriate goal. The performance measure allows the hospital to intervene when one blood sugar is greater than 180 ml dl after the 18th hour and it was not felt likely that intervention for a single blood sugar would result in cases developing hypoglycemia. We will discuss the issue with the technical expert panel in a future meeting.

I think there have been several questions around this new measure and the value. So, for people who have been asking, this was the response. It’s being looked at and again, if you feel like you want to share this with your physicians or other staff let me know and I can shoot you off this little paragraph.

Again, I won’t read through this, but we’re at a different data element so find out how you need to collect it.

On page 224, infection prior to anesthesia.
A lot of people have trouble with this and there are questions about what’s considered an infection, is it still an infection? What they did was to add an instruction to clarify what’s considered a current infection and what’s needed for documentation to make it be a current infection. Hopefully the bullets will help; the last one is on this page and says if there are two or more histories use the most current. To select yet an agency consult pre-op clearance or chest x-ray or other form that’s dated prior to admission that includes documentation of an infection, must be updated after admission and prior to surgery.

It must be noted that there have been no changes since the form was fill out previously. I think, for everybody who’s always asked this, this is what we said but I don’t know if it was worded clearly or at all in the other manual. Any time you have any kind of documentation and mostly it’s H&Ps, that were done prior to admission, you need to know at the time of admission and prior to surgery that there were no changes.

So, if it says a physician writes a note, H&Ps no changes or looked at H&P no changes or H&P same, anything like that which indicates they’ve looked at this again and there are no changes to what was there before. If you don’t have that, you can’t say just because they had whatever kind of infection, they had a UTI or whatever, if there’s nothing saying that patient still doesn’t have it at the time they come in than we don’t want to pick it up as a current infection. It’s not an infection prior to anesthesia.

Also on page 224, preoperative information such as an active list or other assessment form listing infections must be supported with documentation to reflect that the infection is current. There’s also an example, saying the example is not sufficient to abstract as a current infection, so they have a patient admitted on 4/10 with the following active problem list… diverticulitis dated noted 1-4… so there’s nothing stating it’s still an issue. They are saying that’s not acceptable. Even though it’s saying active problem list it says the diverticulitis date was 1-4 and they’re taking that to mean we don’t know if it’s still an active problem on 4/10.

On page 225, if an infection is documented as chronic or recent, there must be additional documentation that the infection is current or still present preoperatively. So really, this isn’t anything different from what you’ve been doing but I think if you’ve been asked about it and maybe the response wasn’t clear, so I wanted to clarify that.

The other thing is they did an addition to inclusion guidelines also on page 225, by adding COPD (chronic obstructive pulmonary disease), but it does say acute exacerbation, so you need to see that it was just that. If it doesn’t say exacerbation but it says acute, that’s fine, but if it just says COPD that isn’t going to work.

On page 226, also for the inclusions they added systemic inflammatory response syndrome (SIRS) isn’t included, so that could be considered an infection if it’s current. For the exclusions they’ve added two, fistulas without documentation of abscess or fecal contamination. You can’t just fistula alone you have to see the other documentation. The second to the last bullet under exclusions is orders for pre-op tests or screens without documentation of an infection or suspected infection.

On page 367, is reasons for not administering VTE prophylaxis. This is for the skip measures and if you do the VTE and stroke measures there are all these reasons for not administering or VTE prophylaxis, but the measure on this page is just collected for the skin. These are instructions for the skip VTE2. They updated the whole data element to try to make it easier for abstraction. You’ll note that the first difference is it’s just like a yes or a no question now.

You don’t have the choices of 1-4 like before. The definition is: the reason for not administering both mechanical and pharmacological VTE prophylaxis, so it’s not an and or anymore. Now there has to be a reason for not giving both.
That is the first bullet on page 367, to select yes there must be physicians, a PN, PA or pharmacist documentation of reasons for not administering both mechanical and pharmacological. I think this is one you might want to read through, because again it's not an and/or it's both. They've changed the wording. Instead of this and this it's both.

The one thing I want to point out is, on page 369, under the inclusion guidelines for abstraction, the reasons for not administering mechanical prophylaxis is that they added arterial insufficiency of the lower extremities and that wasn't there before as reason for not administering the mechanical under inclusions, so now there's physician documentation that the patient has arterial insufficiency of the lower extremities that would be a reason for not giving mechanical.

This would be good to read through, in order for you to understand all the changes.

On page 391, reasons to extend antibiotics. This one they've added two values under physician documentation of any reasons under the last value #3. The third bullet on the page says an antibiotic was administered post-operatively for the treatment of pulmonary fibrosis. That could be a reason to extend and the last one there an antibiotic was administered post-operatively for the treatment of acne or rosacea. They've added two reasons, but again for a physician documentation it's only these reasons that are acceptable to extend antibiotics, other than if you have like value 1 or 2.

On page 393, the inclusion guidelines for value 1 and we're still talking about reasons to extend antibiotics. Value 1 is documentation that the patient has an infection post-operatively following the principle procedure, so valuable 1, the inclusion guidelines for infections they added COPD. It's just like how it was added to the other infection this is now considered with this documentation to be an infection as well. They also added SIRS.

On page 394, the exclusions as what wouldn't be considered an infection they added the fistula's without documentation of abscess or fecal contamination and then the orders for tests or screens without documentation of an infection or suspected infection. It's like what we consider to be infections when we add it there we change here to what would be considered an infection or would be excluded.

On page 409 – 413, is the surgical incision date and time. What they did here was to clarify in both sections where it tells you what to do if you have a cystoscopy or if you have a laparoscope goes to open or multiple procedures. They changed that to clarify and help you understand what times you should be taking if you've had one of those exceptions.

They also added a bullet on page 412 under surgical incision time, if the incision time is obviously an erroneous time and there is additional documentation and the correct time associated with this same priority term, the correct time should be abstracted. This is another one of those things where there's always in the back of your mind, to take it at face value, but if you have a time that’s obviously an error and you can tell it is, than put the correct time.

If you have like, our priority source, you’re looking for surgical incision time and if you have one that says it was at 1300 and one that says 1410, but everything else on the page clearly indicates that the 1410 was the correct time, then that’s what you take. That’s what it's trying to say. It's hard, because sometimes they'll throw that, take it at face value to us and then you do that and you know sometimes it just doesn't make any sense, so here is where they sometimes have to stick in these bullets saying when we're looking for times and dates, if they're clearly wrong and on the same form you're looking at you can tell that it is, than it's acceptable to take the correct value as opposed to going at face value.
On page 439, they made a slight correction to the vancomycin. They changed value 2. They removed the requirement for pre-op physician or pharmacist documentation of Merca. So, value 2 now read, documentation of colonization with Merca, a positive Merca screen a Merca infection or a history of Merca. So they took off the physician or pharmacist documentation of and the rationale regarding that is a positive Merca test result, either a screen or a culture, shouldn’t require physician or pharmacist documentation to suffice as the reasons for the use of vancomycin. This makes it easier to pick up that value.

On page 448, the VTE prophylaxis, this is a data element that you collect for a skip VTE 2, for a stroke and for the VTE measures. So this data element is part of three different measures. Since we’re just talking about the skip right now, I want to point out that on this page they added aspirin as an allowable value. So aspirin is now #9 for what type of VTE prophylaxis was documented.

On page 449, the first group of bullets regards skip and the last one talks about, to select value #9, which is the aspirin there must be an order for aspirin for VTE prophylaxis. So just because a patient is taking aspirin, you aren’t going to say yes here because you have to know there’s an order for aspirin being for VTE prophylaxis. So, for hip and knee arthroplasty’s, aspirin must be received in the timeframe specified for the VTE time rate.

So it’s for those two surgeries where aspirin is now acceptable for VTE prophylaxis, but it still needs to be done in the VTE timeframe. This is to let you know that aspirin is added as a value but it’s only for the skip and we’ll go over that when we get to stroke and VTE.

For the immunization measures, there are only two.

Immunization one was the pneumococcal
Immunization two was the influenza

Immunization one, the pneumococcal is now voluntary. You don’t have to record that anymore if you choose not to, and there were no changes made to how to pick up the influenza data element. No changes made to the notes or guidelines there.

For ED, this is in-patient ED data elements. The big change to this is really about observation. Observation as a data element is now removed, so there isn’t that data element anymore, asking if the patient was in observation. There were tons of questions about this, it was really hard knowing what to do if the patient was in ED, than they went to observation and then they were admitted or if they went directly to observation and they were admitted.

There were many questions around that, so they got rid of observation. Some of the rationale around that again is that there was confusion on how to determine if a patient was admitted to in-patient status or placed in observation. The focus should be centered on whether or not the physician decides to keep the patient in the hospital instead of the status to which the patient is admitted.

Basically now, patients placed into observation are going to be included in the reporting group. It’s more about when they were admitted to the hospital rather than for the ED measures. So, whether they were admitted to the hospital as opposed to in-patient.

On page 117, the data elements where this comes into play is the decision to admit date and time. You want to read through this because they’ve made a lot of changes to the notes in abstraction, because of the fact that it’s no longer going into observation. The definition now is changed for the decision to admit, so I’ll read through it.
The documented date, decision to admit to observation or in-patient status occurred. So it's the date the decision was made to admit to observation or in-patient status. This is the date the physician APN, PA makes a decision to admit the patient from the emergency department to the hospital for continued care in the facility. That was the definition for admit date.

The definition for admit time is the same, just sticking time in there. The documented time, the decision to admit to observation or in-patient status occurred. That's the first bullet on the page. It's admit to observation to in-patient, decision to admit, it doesn't have to just be a decision to admit to in-patient any longer.

I know I've had tons of questions and that that's not what we've been doing, so this is a change when you start doing January discharges. Remember, this pertains to everything, if you're doing fourth quarter, don't pay any attention to anything you're hearing now because this doesn't apply. If there was a big change from the 2013 to the 2014, it doesn't apply until you start doing the January 2014 discharges.

I'm going to let you read the bullets for the notes for abstraction, but I wanted to point out some of the changes to this one. Basically, now you can select earliest documented date or time of any decision to keep the patient in the hospital, rather than determining a particular admission status. It doesn't matter if they're admitted to observation anymore, that would be fine and that's the decision to admit to the hospital.

Data sources are limited to physicians, APN, PA documentation only, because you're really looking for their orders to have that happen. One thing I want, when you read through the notes for abstraction, they tried to give some guidelines for what to do using the EHR, because I think people are finding that it's not as easy to find some of these dates or times, so one of the bullets say, if you have an EHR which has an event log or an ADT form, which is admit decision transfer form, they can be used if they're part of the permanent medical record.

And the data fields are easily understood, to mean the physician decision to admit, which means, if I came to your facility I would need to be able to look at that form, whatever you're using, and know right away that means that's when the decision was made to admit. Remember, we're all supposed to be doing it the same way and if you're chosen for validation and you're using something on the EHR and it's not clear that this is what the space means... it means that was a decision to admit... if I don't know and can't tell that then you don't want to use it.

It needs to be easily and clearly understood that it's the physician decision to admit the date or time. I would read thoroughly through those notes in particular so that you understand the changes with not making it a difference if they're in observation.

On page 152, is the ED departure date and time, whereas I think there were questions regarding this as well. They add some clarifications to the notes for abstraction. I don’t think it’s any change, but things were clarified before and again, they did that to help with our EHR. It’s the same kind of instruction as they gave you in the decision to admit date or time. If you have an event or an ADT log from your EHR, they are acceptable to use for the ED departure date and time, as long as they're part of the permanent medical record and it's easily understood to mean the patient's departure from the ED.

So, if you're using different phraseology for that, it needs to be something everyone clearly knows and I don't mean just in your hospital, I mean anybody that might look at your records, that they know this means the patient departed from your ED.

The last part on the page where it says exclusion, there is none.
Disposition used to be there but I believe they found that many people who were using that phrase or terminology, so disposition has been removed from the exclusion list, and it says you are only to use disposition if there is specific documentation of the patient’s ED departure date and time. I don’t have anything to explain that further, because I haven’t seen a record myself where they’ve used disposition so I can’t give you an example.

I’m hoping that for people who do see that term that removing the disposition from the exclusion will help them, because I think there have been a lot of questions around that. So if you see that phrase or your facility uses that term then this will be helpful for you in how to pick that up.

I only have a few more to cover. That was it for the ED. Hopefully this will help to make it easier to figure out those decision times and when they exited the ED.

The last two will be stroke and VTE measures.

For the stroke measure, page 241, for the IV or IA thrombolytic therapy administered at this hospital or within 24 hours prior to arrival. They added exclusions regarding the heparin and I don’t believe there were exclusions there before, so heparin flush, or lock, thrombolytic administration to flush open or maintain patency of a central line. Those are the exclusions.

On page 252, the LDLC greater than or equal to 100 milligrams DL. On this they revised the notes for abstraction to help clarify the timeframe. I think it wasn’t clear what they were talking about when they were talking about the timeframe for looking at this data element, so it’s within the first 48 hours after hospital arrival or within 30 days prior to arrival.

Some of the notes for abstraction they’ve tried to make clearer. For the measurement on this page, talking about bullet one, for this measurement look for the highest level from testing done within the first 48 hours after hospital arrival or within 30 days prior to hospital arrival. The third bullet below that, fasting and non-fasting LDL values are both acceptable.

Another change was, if values are reported as not calculated, if all LDL values from testing done within the first 48 hours after hospital arrival or within 30 days prior to hospital arrival are reported as not calculated, then you select no. They are trying to help with abstraction there.

On page 351, this is reasons for no VTE prophylaxis hospital admission. They changed this measure, so you want to read through this thoroughly. There are many notes for abstraction in this. They made it an and rather than an and/or or, or. So, documentation why mechanical and pharmacological VTE prophylaxis was not administered at hospital admission.

Reasons for administering both must be documented to say yes here, because this used to be values instead where the values were 1, 2 and 3, now it’s just a yes or a no. Reason why VTE prophylaxis was not administered at hospital admission yes or there was no documentation why VTE prophylaxis was not administered. The first bullet then to select yes, documentation of a reason for not administering mechanical and pharmacological VTE prophylaxis must be dated from arrival to the day after hospital admission or surgery end date.

You want to read through all the bullets as I stated, because they had to change things, because before it was like this, this and this if it was mechanical and the same if it was pharmacological. Now it’s like, it has to be and, so both have to be documented. I won’t read all the notes you can do that, but that’s the main thing to know and understand is that it has to be documentation on both.
The other thing I want to note is that the 4th bullet on page 351 states they’ve revised the notes for abstraction. What they’re saying here is if there’s no documentation that they’re at low risk than they are considered to be at risk.

So again, be sure to read through those because it’s telling you what to do. There are instructions for if it says at low risk, what you need to see and if it doesn’t say at low risk, what you need to say. If it doesn’t say at low risk than they are at risk.

The only other thing I would like to note is on page 353, under the exclusions, aspirin is added. Aspirin is not a reason for no VTE prophylaxis, that’s what that exclusion means.

There are three measures that you need to make sure you look at.

Reasons for not administering anti-thrombolytic therapy by end of hospital day two.
Reason for not prescribing anti-coagulation therapy at discharge.
Reason for not prescribing anti-thrombolytic therapy at discharge.

I want to tell you there are no changes in how you abstract, so if you’ve been abstracting those there isn’t any change to what you do, but I think people were having difficulty with how to answer that, so they gave you more examples of acceptable reasons to help us out in how to abstract. I don’t want to take the time to go through those data elements, to let you know there really aren’t any changes, but that there are a few additional examples of when you should record this or that. Look at those in your own time and see if that’s helpful when you’re trying to abstract.

On page 448, this is VTE prophylaxis and we were at this measure before when talking about the skip, but now we’re talking about the stroke. Same data element with different rules, because if you look on page 450 at the last bullet, because if you remember they added aspirin as one of the values, the last bullet says aspirin is not an approved medication for prophylaxis in the VTE and stroke population.

So if aspirin is the only source of prophylaxis found in the record, if you’re doing a stroke case or a VTE case, and all they were given was aspirin, you aren’t going to record 9 you’ll record A and then you’ll look for a reason for no VTE prophylaxis. It’s where aspirin would be considered that none was given if you’re doing a stroke or a VTE case.

This is a different data element because it’s for three different measures, but when you read through you need to look for the instructions. These are my skip instructions, then the VTE instructions or these are my stroke instructions. For stroke, aspirin isn’t going to cut it.

As a reminder, with the stroke data elements there are many different medications so you want to review your appendix C which is the medication tables and then you have appendix H which is the VTE prophylaxis inclusion table for any medications they may have added or removed. So when you’re doing these cases and all of a sudden maybe a medication has come up that you haven’t seen before or maybe even it’s a medication that wasn’t acceptable before, when you’re starting a new manual you go to see if that’s there now.

It might be something they decided to add after more study or if it’s a new medication or something to that effect, so don’t just think when you’re starting a new manual, if we couldn’t pick up this medication before, that maybe we still can’t pick it up, because you may be able to now.

On page 276, VTE changes, there is the overlap therapy data elements. This one has changed. It doesn’t look long, maybe a couple pages, but there were multiple changes made to help clarify the appropriate documentation needed to inquire if overlap therapy did occur.
Now it's a yes or no question. Where parenteral anticoagulation therapy and warfarin are both administered on the same day, any time during the hospitalization. What they did was to remove from this data element the reasons why overlap therapy didn't occur. That used to be part of this element. The question was; were they both administered or were there reasons for it not. They took off were there reasons for it not and they made that a data element by itself.

So here it's a yes or no question, in that, was it documented and administered the same day. There are different values now, either yes or no. Read through the notes for abstraction and on page 345, is the new data element which would be the reasons for no overlap therapy. They simply made another data element instead of sticking it all in one.

On page 345 also is the reasons for no overlap therapy. So either a physician or pharmacists documentation of a reason why parenteral anticoagulation therapy and warfarin were not administered. Yes they were as a reason or no. As a new data element I'm not going to read through the notes for abstraction, you can look that over. So they took that out of the overlap therapy and put it here.

On page 323, reasons for discontinuation of parenteral therapy. They changed some of the notes for abstraction here to see if they could help us on the timeframes on how to collect this information, but on this page, bullets 5-6, they gave a defined timeframe which requires specific documentation for patients who didn’t receive five days of overlap therapy or had an INR of less than two. So they gave us more instructions on how to record what happens and what we do with those patients.

They also clarified that reasons for discontinuing overlap therapy must be documented by a physician or pharmacist within the same day the parenteral therapy was discontinued. So you have your bullets under the notes for abstraction, making both changes.

There were also some changes to the inclusion guidelines and again, it's only physician, APN, PA or pharmacist documentation of a reason and then they're saying acceptable terms synonymous with and they're listing what's there.

On page 351, reasons for no VTE prophylaxis, we talked about this earlier. On this page is hospital admission and 354 is the reasons for no VTE prophylaxis ICU admission. On page 351, reason for no VTE prophylaxis hospital admission, this is for the stroke measure and VTE, so what we talked about for the stroke, it's the same here. This measure has now been changed to be an and. You have to know why both were not given, not one or the other.

It's the same when you're doing it for the VTE. On page 354, the reason for no VTE prophylaxis ICU admission, this is just a VTE measure, but it's been the same changes. It's and… you have to know why both were not given. The first bullet clarifies the timeframe on this page. To select yes for this data element, documentation of a reason for not administering mechanical and pharmacological VTE prophylaxis must be dated from arrival to the day after ICU admission or transfer or surgery end date for those surgeries that start the day of or the day after ICU admission transfer.

I think when I read it, it seems confusing but I think if I was doing a chart it would be more easily understood. I’m trying not to confuse you. Just know that the first bullet is trying to help explain the timeframe.

On page 448, is VTE prophylaxis which we’ve talked about. That’s the data element where you could do it for skip VTE or stroke and VTE and again, the added value is aspirin, but the same as I read for the stroke, for the VTE population when doing your VTE charts, aspirin is not an approved medication for prophylaxis for the VTE population.
So if aspirin is the only source of prophylaxis select value A not aspirin, which is none of the above or not documented or unable to determine from medical record documentation. You're going to select value A and then you're going to check for a reason for no VTE prophylaxis.

On page 453, VTE prophylaxis status, the only thing I want to note here is that they added a bullet on page 454. For patients receiving anticoagulant therapy other than warfarin, for atrial fibrillation or other conditions, select value 3. It's telling you what to do in this situation.

That's all I have to go over. Let's open it up for questions.

Sandy Alender: Hi. I have a question regarding the catheter removal on page 101. I'm looking at the notes where it says if the catheter was removed and reinserted prior to the end of post-op day two, due to inability to void or urinary retention select value one. Then the next bullet says if it was removed and replaced or exchanged with a catheter that remained in place beyond post-op day two select value two.

My question is… if it's reinserted prior to the end of day two but remains in place longer than post-op day two, which value would I select? The second part of that question is… do you abstract for a reinsertion beyond post-op day two?

Robyn Carlson: You want to know if it was removed on post-op day 022 you're putting one and if it's not removed you're putting two. So your situation, I would be putting value two because it wasn't on the line, but then I think if it's removed and put back in, we wouldn't want to say that it was removed, that we would have to put value two. What you're trying to get at was if it was removed they don't want it to be in after post-op day two but you have it reinserted, so I think you would put value two. Does that make sense?

Sandy Alender: It does. I just wanted to clarify for that being reinserted due to retention.

Robyn Carlson: So you have, if the catheter was removed and remains prior to the end of day two due to the inability… it's still prior to the end of day two, I think if it's still in there than it would have to be two. Sandy, I should check that out, so can you email me the question again so I can make sure to get you the correct answer and then I can have Mary give the answer back to everyone on the call.

Sandy Alender: It only talks about post-op day two, so if it's removed and hasn't been reinserted by the end of post-op day two are you good selecting one, you don't have to look to see if it's reinserted on post-op day three?

Robyn Carlson: So you’re saying if there was one in and it was removed within the timeframe you don’t have to worry about anything being admitted after that. Yes. We wouldn’t keep having to look at it every time it might be put in or taken out.

Sandy Alender: If this comes up in the future what do I do?

Robyn Carlson: Email me and I’ll get back to you.

Jeanette Hash: I have two questions. First, Robyn will you send the answer to the last question out to all of us because there are a number of us who would like the answer to that.

Robyn Carlson: Yes. I'll make sure Mary sends it to everyone.

Jeanette Hash: My next question is regarding the immunization abstractions. If the immunization measure one is a voluntary abstraction now, that just leaves the influenza abstraction for that measure set, so during the summer months or two quarters out of the year they don't want that anyway.
Do we have to abstract those patients during the months that we aren't looking at influenza? What do we do during the 2nd and 3rd quarters?

Robyn Carlson: That's a good question. This is one that's complicated and will be another one that I'll have to check on and get the answer to, in order to get back to you on.

Jeanette Hash: Thank you.

Robyn Carlson: What would I do without all of you to think of these things for me? Like right when you pull your population those patients don't apply so that question doesn't pop up in your tool. Let me get feedback on that and get back to you. Be sure to email the questions to us.

Marilyn: Our clinical team has a question. They're verifying the VTE prophylaxis for the skip population, in that that has gone to an either or situation right, either mechanical or pharmacological and they don't have to have a reason for when they don't give one or the other. Is that right?

Robyn Carlson: I have to know which data element you're talking about.

Marilyn: VTE prophylaxis for surgery, not sure of the number. I'm looking at an appendix A listing of all the skip populations.

Robyn Carlson: Do you mean of all the surgeries?

Marilyn: Yes. They are saying, like in the regular VTE population or the stroke population do you have to have a reason for not giving, but they're asking is that now in just exclusive to the skip population you don't have to give a reason for say, not giving pharmacological when you're only giving mechanical. I'm looking at appendix A.

Robyn Carlson: Send me that and I will answer that back in an email to go out to everyone. I just don't want to answer it wrong off the top of my head.

Marilyn: I understand. Thank you.

Julie Stephenson: Hi. I have a question about reason for no VTE prophylaxis for stroke or VTE. I know before, in order to select the no VTE prophylaxis needed they had to have a VTE risk assessment done and I'm not seeing that now on page 352 for this. Has that changed where they don't have to have a VTE risk assessment, do you know if that's changed?

Robyn Carlson: I do know that they had to have one before but they were saying if you did have one that depending upon what that said you could use that, but I think they took that out because of where they're saying now, unless your physician is saying patient is at low risk, than everyone is at risk. So I think they took that out about having to have or using the risk factors.

Julie Stephenson: So if the doctor just says low risk no VTE prophylaxis needed than that's acceptable, right?

Robyn Carlson: Yes. I think that having the risk assessment is great but I think they took that out because they didn't want to say you had to have one, but it didn't make it seem like it before and now it's just where if the physician documents that the patient is at low risk, than yes.

Just remember, sometimes you don't think of these questions until after you're doing it or you aren't going to be doing these until fourth quarter, so remember again that this is recorded so you can always go back and listen if you want. If you don't like
answering questions or talking on the phone, always know that you can email me and we'll find the answer and get back to you.

Mary Montury: My email is out there to everyone in case they don't have yours. I can forward questions to you.

Robyn Carlson: Mary, everyone gets an evaluation right?

Mary Montury: Yes, I'll send a link to everyone on the webinar upon completion. Then the certificates of participation will then be sent as well.

Robyn Carlson: Thank you everyone for listening in and as always, you know how to reach us if you need anything. I guess we can wrap up.

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