

FAX



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Pages (including cover) :	

Re: Abstraction Assistance Conference Call (Open Forum-General Discussion)

Please respond to each comment by placing an "X" in the applicable box:

Comment	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Did you find value in this call?					
Did the topics discussed in the call meet your needs?					
Can your facility drive patient centered care with the information learned today?					
Did you have the opportunity to share information or ask questions?					
Was the format of the call appropriate?					

Please answer the following questions: On a scale of 1-10 (1 being the lowest and 10 the highest)

Please rank knowledge of abstraction prior to call: 1 2 3 4 5 6 7 8 9 10

Please rank knowledge of abstraction after the call: 1 2 3 4 5 6 7 8 9 10

Please rank overall satisfaction of this call: 1 2 3 4 5 6 7 8 9 10

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Open Forum Abstraction Assistance Call – 11/01/07
Q & A Document

During the call it was reported that the Point of Origin change would not be effective until 01/01/08 but that is incorrect the change is effective with 10/01/07 discharges. The Point of Origin can be found in the Specification Manual Version 2.3b for discharges beginning 10/01/07 on QNet Exchange. The Data Abstraction tools are now with the Specification Manual. CART 4.3 is now ready to upload.

In the CART Program for Pneumonia:

The question regarding "antibiotic taken within 24 hours prior to arrival"... when one answers this question with "antibiotic taken before and during this hospitalization" the grid pops up to enter the antibiotics.

Q: Are we to enter the antibiotic taken before arrival as well as the antibiotics given after admission? I have just run across one where the patient has had antibiotic before arrival and I did enter it into the grid as the first antibiotic followed by the two IV antibiotics given after admission in the order they were initiated. Is this correct? I cannot find any direction in the abstraction guidelines for the antibiotic taken prior to admission.

A: You would answer the question yes to antibiotics prior to arrival and during hospital stay, however you only put the antibiotics received during the hospital stay in the grid. When you look at the data dictionary for antibiotic name, time, etc, it tells you to only enter the antibiotics from arrival to 36 hours.

Q: Blood cultures: A patient presents for admission from physicians office:
Admission time is 10:43

Blood cultures x 2 are drawn: 1st draw @10:30 and 2nd at 11:55.

How do you answer the question of initial blood cultures drawn?

Before arrival? At 10:30?

After arrival? At 11:55?

What times do you use? Do you ignore the first draw and just use the after arrival draw @ 11:55 as the initial time?

A: You would answer the question yes to blood cultures drawn prior to arrival, however for the blood culture time question you only enter the blood cultures drawn after arrival. You would put the 11:55 time in for that answer.

Q: It was suggested to us to help pass validation that we "enable all questions" in the CART program for abstractions to help with validation and the parent /child questions. Some of the questions do not make sense, and are difficult to answer i.e. when no blood cultures were obtained the "child" questions come up with the date and time of the draws.... Do I just answer with the "UTD" option? Or in HF- when a patient is d/c to a swing bed in our facility... there are no discharge instructions... so I have to answer no to all those discharge instruction questions that would otherwise drop off/ not highlight to be answered.

A: You would answer UTD for the blood cultures and no for the discharge instructions. You will not fail the measure since the algorithm will have already excluded that element when you answered no to blood cultures being obtained and when the discharge status for the HF patient shows that discharge instructions were not required.

Q: Finally I was trying to "add a new abstraction to a patient already in CART and the program gave me a error message that said basically that I could not abstract HF/PNE together? I could not even enter the patient as a new patient and abstract it that way. Did this come up because I changed the preferences to match our Program management preferences on QNet?

A: You do not need to add the patient again. You should be able to search for the patient, pull that patient up and double click on the name. You then would go ahead and enter the new admission date. If the HF and PN occurred during the same admission you cannot abstract both diagnosis.

Q: I recently received the below response from QNET. I don't understand the answer "no" when the doctor uses the specific inclusion terms included in the abstraction manual and gives his clinical reason for not giving the abx. 3rd Qtr 2007-Reference to 123400. The data dictionary does not specify that there has to be included documentation that the diagnosis was delayed only that clinical circumstances were identified delaying the diagnosis. Doctor writes: "Antibiotics not initially ordered

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as there was no overt signs of pneumonia (no fever, sputum) with history of lung cancer and cough times months, mass recurrence of lung cancer is much more likely. Antibiotics ordered only at admitting physician request." Yes or No to diagnostic uncertainty.

- A: According to Quest, this is the answer I got: 4/1/2007 discharges. As noted in the first note for abstraction, "The primary intent of this data element is to determine if the physician/PAN/PA identified clinical circumstances that would delay the diagnosis of pneumonia." The above would be a "no" to the data element, Diagnostic Uncertainty.

This question to be able to answer yes needs to have documentation for three different areas. Please see explanation below.

Refer to QUEST ID# 125436, which has taken the information in the data element and identified the necessary documentation to be able to answer "yes" for this data element: 4/1/2007 Discharges For the data element Diagnostic Uncertainty this would abstract to No. Here is our general guidance: For the data element, Diagnostic uncertainty we will accept only explicit documentation of the following terms found in the guidelines for abstraction or something VERY close:

- Clinical picture not clear
- Diagnostic picture unclear
- Not suggestive of pneumonia
- No obvious signs of pneumonia
- No overt evidence of pneumonia
- Atypical presentation
- Poor patient cooperation because of impaired mental status

- Q: As stated in the Notes for abstraction: Physician/APN/PA must specifically document the diagnostic picture was questionable or unclear and not suggestive of pneumonia, etc. and that the diagnosis of pneumonia was delayed as a result. With the Point of Origin, if the patient's source was "patient seen in the office this morning" (for example). Would this be a physician or clinic referral? The physicians usually use the terminology "the office" for their clinic. Please advise which I would choose. Thanks!!
- A: The CDAC will see that as a physician referral since they do not know that the their "office" is really a clinic.
- Q: If there are conflicting times for antibiotics being given for the SCIP project, how do I abstract my doses and do they need to be only taken from one source.
- A: If the anesthesiologist documents the name, dose, date, route and time and the nurses documentation has all the same information that matches exactly, you would only abstract this particular antibiotic one time. If the documentation has all the same information except the time is off by minutes, you would abstract the antibiotics using the 3-dose abstraction method. If the nurse documents the dose was given at 0703, collect this dose as the first dose administered. If the anesthesiologist documents the dose was given at 0705 and the incision was at 0730, this dose would be the one prior and closest to incision. Both would be entered into the grid. Beginning with 10/01/07 discharges the antibiotic information needs to be abstracted from one source. For example, if the anesthesiologist record has the name and dose and the nurse documents the name, dose, date, time and route you would abstract the nurse's documentation.
- Q: For the PN question relating to multiple entries for the same medication- which one do you use? Also, looking at only using one source for antibiotics.
- A: For PN cases you need to enter all medications from admission through 36 hours. So even though you know that those doses were not all given you are abstracting the documentation so you do need to enter each one.

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For the one source – it just means that your antibiotic name, route, dose and time must come from the same source but different meds, doses can come from different sources. Example: you have Ancef 500mg given at 10 am by po – you need to use the same source for all of that information but if you have levoquin given at 8 am you can use another source for that documentation.

- Q: For 10/01/07 discharges – adult smoking history has “only acceptable sources” - ED record, H&P and nursing admission note. What about RT forms that have history and counseling documented.
- A: The history can only come from the accepted sources. The counseling can come from other sources including RT progress notes.
- Q: Can you use physician orders and discharge summary documentation for comfort measures only on the day the patient expires?
- A: Starting with 10/01/07 discharges, the only source you can use for comfort measures only on the day of discharge is the discharge summary.
- Q: Pneumonia diagnosis: ED/Direct Admit --- the Pulmonologist saw a patient in the ED but the only documentation was by nursing on the ED form. The pulmonologist wrote an admit order and admission orders not documenting pneumonia as a diagnosis. Neither was timed. He dictated an H & P, which is timed and has a diagnosis of pneumonia. Can you use the H& P for the admit diagnosis of PN?
- A: If there is an ED form that has the final impression or diagnosis left blank you can look to the admission orders, admit note or H & P for documentation of an admission diagnosis of pneumonia. You need to look for the first timed documentation and use that. If none of the sources are timed you may use any of them for the diagnosis. For this example, because the admit note and admission order are not timed and the H&P are you would use the documentation of the H&P to answer the question.
- Q: We have 3-4 different places on the record that list discharge medications including a medication reconciliation form. Do all of the medications need to match for discharge?
- A: You need to take all of the different lists and combine them to make one list for the patient at discharge. The key to be able to answer “yes” to medications addressed at discharge, is the list that is given to the patient needs to address all medications prescribed at discharge. You do not have to have over the counter medications on the list, however if the physician orders “continue home medications”, these medication names need to be written out on the discharge instructions given to the patient. This answer was verified with the Hospital Reporting QIOSC.
- Q: If the surgery end time on the anesthesia record is not legible, can you move on to the next priority source?
- A: Yes, you can move on to the next priority source. The CDAC will not accept answers that are not legible.
- Q: If a patient was admitted from prompt care, what point of origin would you use?
- A: You would use the point of origin stating the patient was admitted from a clinic.
- Q: For the pneumonia positive pathogen question, do the results need to be within 24 hours?
- A: Yes, the results identifying a positive pneumonia pathogen need to be within 24 hours of admission. You may use a preliminary report for your findings.
- Q: If the physician ordered aspirin now, then placed it on hold and switched to Plavix, can we use this as a contraindication?
- A: No, the physician has to document a reason on why he is not giving it along with the discontinuation of the aspirin to count as a contraindication.