

Follow-up Q&A

"In the Know" Reporting, Abstraction and Validation Webinars 01/20/2010 and 01/21/2010

Answers to the questions submitted regarding either the FL 01/20/2010 or the CA 01-21-2010 "In the Know" webinar are based on information found in the *Specifications Manuals for National Hospital Inpatient Quality Measures* for abstraction of data elements. *The answers DO NOT necessarily reflect what the CMS "Conditions of Participation" may, or may not, require for documentation in the medical record; nor do they necessarily reflect what each hospital may choose to require in a hospital specific medical record policy.

Topic: ALL (AMI, HF, PN, SCIP)

Slide Retractions:

FL Slide #35 – “New” Record Selection and Validation Scoring Methods for 2012 Payment Determination

Please DISREGARD the fourth (4th) bullet. We have received clarification of some of the details of the process and this is not an accurate statement.

FL Slide #36 – “New” Record Selection and Validation Scoring Methods for 2012 Payment Determination

Please DISREGARD the first (1st) bullet. We now understand that this is not a good example to provide.

Slide Clarification:

FL & CA Slide #55 – Documentation of Conflicting Information

The PowerPoint version that was posted for your download stated, “Wording is now consistent for all measures”. After further review of the changes to the manual, the slide was corrected and the PowerPoint version used for the live presentation stated, “Wording is now consistent for all AMI & HF medication measures. In the live presentation we said, “With the addition of this clarification to the AMI & HF medication measures, the way conflicting documentation regarding whether there is a reason for not prescribing a medication is now consistent across all topics. When there is conflicting documentation, answer “yes” to “Is there a reason for not prescribing xyz medication.”

Additional Clarification: Conflicting documentation is treated differently for different data elements and/or measure sets. For the purpose of the information in slide #55, the directive to abstract conflicting documentation as “yes” applies only to those data elements that address documentation of a reason for not prescribing a particular medication. **Do Not arbitrarily apply this abstraction rule to all “conflicting documentation.”**

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TOPIC: SCIP

Anesthesia End Time

Q 1: RE: Anesthesia end time/abstraction terms-Would anesthesia "stop" time on the Nursing OR Record supersede anesthesia "finish" time in the Anesthesia Record based on abstracting terms?

A 1: If found within the record, an Inclusion Term from the Specifications Manual will supersede another term that is synonymous to an Inclusion term.

Anesthesia Start/End Time

- Necessary for passing several measures.
- If you have a Table 10 coded procedure that was done without anesthesia (conscious sedation may have been used) and there is no anesthesia record present, find a time in the record that would be most comparable to anesthesia start/end.
- Follow Manual guidelines! **The guidelines change between Manual 3.0c (1Q 2010) and Manual 3.1 (2Q 2010-3Q 2010).**
 - Manual 3.0c (1Q 2010): Look for the inclusion terms given in the Manual, review ALL the Suggested Data Sources. If no inclusion terms are found at all then look for terms that are synonymous to the Inclusion Terms, or reflect when the anesthesia time period would be. Important! When reviewing ALL the Suggested Data Sources if more than one inclusion term is found in the record for *Anesthesia Start Time* take the earliest time; *Anesthesia End Time* take the latest time.
 - Manual 3.1 (2Q 2010- 3Q 2010): The anesthesia record is now the **PRIORITY** source, if an inclusion term is found here take this term and move on. If there are more than one inclusion terms on the anesthesia record for *Anesthesia Start Time* take the earliest; *Anesthesia End Time* take the latest.

SCIP Inf-9: Tips For Understanding the Values and Abstraction

Reasons to Continue Catheter is a "select only 1" answer; however, Value "1" and Value "2" will each pass the Measure. Neither Value supersedes the other. There will not be a mismatch for the data element as long as the information is found in the record and abstracted according to the Manual. It may be in your best interest, if you have both Value "1" and Value "2," select Value "1" first. There are fewer restrictions for Value 1, and this could decrease the potential for a mismatch. Value 2 may have been documented on the wrong day or an unacceptable reason may have been given.

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SCIP Inf-9: Tips For Understanding the Values and Abstraction (cont)

Urinary Catheter:

Value "1": The only answer that requires 2 separate pieces of documentation, that of "was placed" (**inserted**) during the defined intra-op period **AND** documentation that this same catheter was still "in place" (**present**) immediately post-op.

2nd Bullet in Notes for Abstraction addresses Value "1":

- For Value 1, to determine whether an indwelling catheter was still **in place (present)** immediately postoperatively, there must be documentation within 24 hours after *Anesthesia End Time* that a catheter was **in place(present)**

Due to the potential of not finding documentation of the removal of a catheter that was placed intra-operatively, or that one was present upon arrival to PACU, documentation that a catheter was in place within 24 hours after *Anesthesia End Time* is acceptable to show that the **intra-op** catheter is still in place.

Value "2": If documentation is found after the immediate post-op period of foley **insertion** Value "2" is used because the measure is not looking for **insertion** after intra-op period, only during intra-op period. Documentation of a catheter prior to the intra-op period would possibly be a Value "3" or "4".

1st Bullet in Notes for Abstraction addresses Value "2":

- Occasionally a urinary catheter is placed intraoperatively but removed prior to leaving the operating room. If there is documentation that a urinary catheter was placed intraoperatively, but there is **NO** documentation that it was still in place (**present**) upon leaving the operating room, select "2."

Value "2" assists in excluding patients from the measure. One is to exclude the foleys that were documented as being inserted during surgery and documentation of the removal during the intra-op period was not found in the record. If the **only** documentation of a foley found in the record is insertion during the intra-op period then more than likely this foley was removed during the intra-op period.

Another is by excluding foleys placed after the intra-op period. If documentation of foley **insertion** is found after the immediate post-op period Value "2" should be selected because the measure is not looking for **insertion after intra-op period**, only during intra- op period. Documentation of a catheter prior to the intra-op period would possibly be a Value "3" or "4" answer.

- Example: There is **no** documentation of a foley "in place" (**present**) upon arrival, "was placed" (**inserted**) pre-op, or during the intra-op period, however there is documentation of **foley insertion"was placed"** in PACU or later on the floor/ICU, you would answer Value "2", No documentation that a foley was **in place (present)** immediately post-op. Value "2" is confirming that if a foley was not in place when the patient came out of the OR.

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SCIP Inf-9: Tips For Understanding the Values and Abstraction (cont)

Value “3”: Self explanatory.

Value “4”: Self explanatory.

Value “5”: “Unable to determine whether a patient had a catheter **in place (present)** from medical record documentation.” This data element centers on finding placement (insertion) of a foley during the intra-op period. With this in mind if documentation is found that a foley was **in place (present)** after the immediate post-op period, however there is no documentation in the record of when this foley was placed (**inserted**) or if it was already present prior to surgery, you would answer Value “5” UTD.

If there is no documentation of a catheter at all in the record Value “5” is the designated answer because it can’t be determined from the documentation present in the record if foley insertion was accidentally left out of the record.

Here are the Value Answers from the *Specifications* Manual to review with the above:

1. There is documentation that an indwelling catheter **was placed (inserted)** intraoperatively and was still **in place (present)** immediately postoperatively.
2. There is no documentation that an indwelling catheter was **in place (present)** immediately postoperatively.
3. There is documentation that the patient had an indwelling (urethral or suprapubic) catheter prior to admission or prior to surgery.
4. There is documentation that the patient was being intermittently catheterized prior to admission or preoperatively.
5. Unable to determine whether a patient had a catheter **in place (present)** from medical record documentation.

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TOPIC: AMI

Non-STEMI echo

Q1: The next one is a AMI (non-STEMI), she never had an echo so I put no and it came out not in measure population. She was d/c to a SNF.

A1: It is difficult to determine the exact question; however, for a STEMI, or non-STEMI, AMI case, the LV assessment is necessary documentation in order to determine if there is LVSD; and therefore, if the case is in the denominator for AMI-3 ACEI or ARB at Discharge. Evaluation of LV S function is not an AMI measure like it is for HF. For AMI "measure"3 and HF "measure" 3, if the answer to LVSD is 'NO', and your abstraction tool has scip logic activated, the question for ACEI or ARB at Discharge will be grayed out.

The discharge status comes into play even earlier in the algorithms. If the Discharge Status is 2, 7, 20, 43, 50, 51, or 66, then the case is excluded from the denominator for AMI-3, and HF-3 as well. The algorithms for each measure are very helpful in sorting out why a data element within a measure abstraction tool may not come up to be answered.

Reason for Delay in Fibrinolytic Therapy

Q2: There is physician documentation of "Will need CT angio to eval aorta prior to thrombolytics." Please advise if this is a "System" reason for delay, or an acceptable reason.

A2: **(Per the QIOSC)** For 7/1/09+ discharges: The key to understanding how to abstract this data element is to recognize that the guideline places the words "**delay**", "**hold**", or "**wait**" in quotations marks. This means that the physician/APN/PA must literally state that a **hold, wait, or delay** in fibrinolytics occurred. He/she must use one of those words, or a form of that word (e.g., holding, **held, waited, delaying, etc.**) in order for it to count as an acceptable reason for delay for the purposes of this measure.

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TOPIC: HF

Discharge Instructions address Medications

- Q1:** November 2009, quarter 4. CHF, the d/c orders and medication reconciliation match, but the MD on his d/c summary wrote no medications. Is this a no to medications?
- A1:** In the Notes for Abstraction for *Discharge Instructions Address Medications*, item #2, second open bullet under the first solid bullet states: **If documentation is contradictory (e.g., physician noted “d/c ASA” or “Hold ASA” in the discharge orders, but it is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances , context, timing, etc. documentation raises enough questions about what medications are being prescribed at discharge, the case should be deemed “unable to determine” (select “No”), regardless of whether the medication in question is included in the written discharge instructions.** Per the abstraction directive, you would abstract this data element as “No”.
- Q2:** All my questions are from November 2009 quarter 4. The first one is a CHF: The d/c orders and d/c medication reconciliation matched, but when the MD did his d/c summary, he wrote, patient will continue his usual meds and inhalers. Is this a NO for medications?
- A2:** In order to make a list from which to compare the written d/c instructions given to the patient, the abstractor would have to find a list of the patient’s “usual meds/home meds” in the record and use that along with the meds listed in the d/c orders and the d/c med rec form. If there is no home med list, or any other documentation that clarifies what the patient’s “usual meds are”, and after careful consideration the abstractor cannot determine if the written list given to the patient or caregiver is complete, then answer “No”. After following the Two Step process of compiling a list from which to compare the written d/c instructions given to the patient, if all meds that are on your comparison list are on the written discharge instructions provided to the patient or caregiver, then answer “Yes”; or, if they do not match, answer “No”

HF Discharge Instruction & addendum notes

- Q3:** In the past for HF patients if the Discharge instructions were missing we never had the luxury to do the addendum to dc summary for any of the 6 elements of DC instruction, send copy to the patient and save it from being an outlier.
Recently for Dec 2009 discharges i have been hearing from one of my colleagues that the rules have been changed so that if there is any instruction from any of the six elements and any medication is missing, to be compliant we can have a physician do the addendum in 30 days of the discharge.
Please verify this info. I really need help with this.
- A3:** ABSOLUTELY NOTHING has changed regarding the CMS specifications relative to the abstraction of the data elements that pertain to HF discharge instruction. Hospitals have never been able to meet HF Discharge Instructions Measure by using information that is provided to the HF patient, either by mail or phone, after they were discharged.

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For abstraction of documentation that is submitted to the CMS Clinical Data Warehouse for the HF discharge instructions, the specifications manual only mentions the use of documentation entered within 30 days of discharge in the first open bullet under #1 of the Notes for Abstraction for Discharge Instructions Address Medications. The directive states: **"Discharge medication information included in a discharge summary dated after discharge should be used as long as it was added within 30 days after discharge."** **This means** that documentation entered in the discharge summary by the physician as an addendum within 30 days of discharge should be used when abstracting the HF discharge medications, i.e., documentation found in the discharge summary regarding d/c meds should be used to compile the list to which you compare the written discharge instructions given to the patient/caregiver...even if the meds in the d/c summary (including an addendum) gives medications that were not in the medical record at the time the nurse compiled the written discharge instructions that were given to the patient.

CMS has in the past and continues to state that only the written instructions that count are those with which the patient leaves the hospital. While the practice of following up with these patients is good patient care, for abstraction purposes, information provided to the patient AFTER discharge cannot be used for abstraction of any of the Discharge Instructions.

Q4: Also has this guideline changed for AMI patients?

A4: There are no Discharge Instruction Measures for AMI.

Determination of LVSF

Q5: D/C Q2 2009. When the d/c summary includes documentation of the following three comments about the LVSF, which one takes priority? "EF of 53% on ECHO done 6/2008 in XYZ hospital. Admitted with bilateral PN and later found to have mild CHF. Discharge Dx: Acute on chronic combined systolic and diastolic heart failure." In the H&P, there is one reference to LVSF documented by MD – "The patient had an ECHO in XYZ hospital on 06/25/08 upon my request and it had shown EF of 53%, normal LV systolic function.

A5: (Per the QIOSC) For 7/1/09+ discharges: Answer "No" due to EF 53%. When there is conflicting documentation within ANY ONE STEP in Methodology A, the conflicting documentation guidelines state that a numeric EF has a higher priority than a narrative description of LVSF.

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TOPIC: PN

Antibiotics (grid)

- Q 1:** We are somewhat confused regarding what to do about antibiotics for Pneumonia on several of our cases. I understand from the California "In the Know" web conference from Oct 29, 2009 that we would not be penalized for additional antibiotic doses on the antibiotic grid for pneumonia. I just wanted to make sure that I understand this clearly.
- A 1:** This is correct. When the CDAC abstracts during validation, they are supposed to only enter the mandatory responses. If they enter a specific antibiotic combination into the grid, the validation programming will look to see if you came up with the same entry. It doesn't "care" if you have additional entries in the grid, because it isn't looking for them.
- Q 2a:** There was a short period of time when the date was being left off of the stamp for our ED patients. Some of the forms have the date hand written in by staff. Others have no date. If the date is unclear, unreadable or not documented, we should abstract unknown.
- A 2a:** This is correct. If you don't have the date on that page, you have to enter UTD in the date field in the grid. Be sure you read the bullet in the Notes for Abstraction to understand the instructions for using an ED stamp that has a date on it.
- Q 2b:** What if the antibiotic is documented in several places?
- A 2b:** If the same antibiotic dose is documented in several places, you definitely have to be careful. If the information is exactly the same (same antibiotic – even if one is the trade name and one is the generic name – same route, same date, and same time), you can abstract that dose into the grid on one row. If you find the same dose documented in more than one place and any one or more pieces of information is different, abstract each "dose" on a separate row in the grid (enter NOS if it just says that an "antibiotic" started, enter UTD if the route, date, or time is different), EVEN IF YOU KNOW THAT THEY ARE ONE AND THE SAME DOSE.
- Q3:** The guidelines state "antibiotic administration should be abstracted from a single source that demonstrates actual administration of the specific antibiotics." What exactly does this mean?
- A 3:** This means that you can't use documentation about the same antibiotic dose, written in two or more places, to come up with one entry (entered into one row) in the antibiotic grid. The most common example of this that we see is with SCIP when Anesthesia documents something like "Cefazolin given at 0800" on an anesthesia form dated 1/5/10. In addition to this, you might also see on a pre-op order form, "Cefazolin X mg IV for preoperative prophylaxis." In this case, you would have to abstract the anesthesia documentation as "Cefazolin – 1/5/10 – 0800 – UTD." You wouldn't be able to abstract the "route" from the pre-op order because it doesn't document *actual administration* of the antibiotic in addition to being another "source." You also can't "assume" that all meds given in the OR are given IV unless this is documented. (Some hospitals fix this by printing on their Anesthesia Record, "All meds

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given IV unless otherwise noted.”)

Q 4: In the ED, we have a place for the RN's to document administration of medications. Also, on the MD orders, there is a place for them to initial and time when orders have been completed. If either of these are missing an element (ie: date), do we need to abstract both even though they represent the same antibiotic administration?

A 4: If the nurse has initialed and timed the MD antibiotic order (preferable saying “given” or somehow signifying that they are documenting the time started versus the time the order was first noted), the Data Dictionary allows you to abstract that antibiotic dose information. If the same dose was also documented on the ED MAR and all information was identical, you only have to enter it once. If any one part is different in any way (such as the time being 0800 on the orders and 0805 on the MAR), abstract both “doses” on separate rows in the antibiotic grid. If you can ever eliminate having to document the same thing on multiple pages, it’s probably a good thing to do. The more places one event is documented, the greater the chance of discrepancies between the different entries. This can cause problems with abstraction, but can also cause problems from a legal perspective such as with lawsuits

Q 5: Is there any time when we would be penalized for abstracting antibiotics for Pneumonia? For instance, if we abstract more than one dose of an antibiotic because we are not sure if CDAC will agree with us or if we abstract doses that were given greater than 24 hrs after arrival because of “unknown” doses in ED, would we be penalized?

A 5: You won’t be penalized for entering these additional doses. As mentioned above, any “unnecessary” dosed entered into the grid aren’t used in the validation process. If you have to take a significant amount of time to try to figure out if something is a “mandatory” dose to abstract or not, you might be better off to go ahead and enter it into the grid. Just remember that, if the individual entry doesn’t show the exact day or time it was given, always enter what you have with “UTD” in the unknown fields, and then move on to the next question.

Timeliness of Antibiotics

Q 6: Patient's family refused treatment for hours and by the time they agreed it was past the 6 hours. Is this exclusion?

A 6: No. This is one of those times that a case fails the measure not because somebody did something wrong, but because the abstraction guidelines can’t be specific enough to exclude every case that should be excluded. This is why no one expects you to have a rate of 100% all of the time for these measures.

PN-3b [Blood cultures performed in the ED prior to initial antibiotic received in the hospital]: Is it going to be retired?

Q 7: Could you shed some light on when the element PN 3b (obtaining blood cultures) is going to be retired? One of our ER docs is questioning this and states that many other hospitals are not doing blood cultures at all.

A 7: We have not received any information pertaining to this measure being retired. Blood cultures are recommended for all inpatients who meet specific criteria, one criteria being Intensive Care Unit

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admission. You can read more about this in the 2007 *IDSA/ATS Consensus Guidelines on the Management of CAP*.

MISCELLANEOUS QUESTIONS

FY 2011 Data Submission Requirements

- Q1:** For FY 2011 APU, the changes indicate two [structural measures] have been added.
- 1) Will this be a yes or no participation question similar to the cardiac structure question of last year?
 - 2) What are the approved data base sources for Nursing Sensitive Care?
- A1:**
- 1) Yes. The Final Rule for payment determination for FY2011 APU states that two new structural measures will be required, Participation in a Clinical Database Registry for Stroke Care and Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care. Once CMS identifies the timeframe for submitting this information, hospitals will be notified. The final rule also indicates that the data submission process for all three structural measures for FY2011 Full APU will be the same as for the one structural measure that was required for FY 2010 Full APU. That is, it will be a Web-based tool that will be made available on the QualityNet web site.
 - 2) There are no "approved" data bases identified in the final rule. The questions are do you participate, yes or no; and, if you do which one. CMS is trying to identify how many hospitals participate in a data base whereby data for future FY measure requirements might be collected in order to increase the number of measures without increasing the burden of abstraction. Collecting if a hospital participates in a data registry and which ones is merely an assessment phase at this point.

Final Rule Outline Download Site

- Q 2:** Where is the outline they spoke about during the presentation today that has to do with the Federal register update?
- A2:** The document is posted to each state's QIO website in the Helpful Documents file for the 01/2010 webinars. The pdf file title is "Final Rule Outline." The actual document is titled:

FEDERAL REGISTER
CMS Final Rule 2010
RHQDAPU

This two page document is a cross reference to the pages in the 2011 Federal Register that pertain to RHQDAPU participation.

Changes Beginning April 2010

- Q3:** There are quite a few changes coming for April 2010, will there be another chance to talk about them?
- A3:** We have another Webinar scheduled for April. If you have questions; however, you may always email any of your QIO RHQDAPU coordinators.

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New Validation

Q4: We had several questions about the new process for selection for participation in validation and the new scoring methodology that will be introduced starting with validation of Q1 2010 clinical data. This will be the validation that applies to payment determination for FY2012. Hopefully the following will address some of your concerns. As we receive further information and clarification we will pass it along to you.

A4: There are three (3) requirements to be in the pool from which 800 hospitals will be selected.

1. Facility is open (this means not closed in PRS)
2. Pledged to participate in RHQDAPU
3. 100 cases in the warehouse for CY2009 from all payers and across all CMS topics for which you submit data

It is anticipated that the first 800 hospitals that are randomly selected to participate in validation of Q1 2010, Q2 2010 and Q3 2010 data (for 2012 RHQDAPU requirements) will be released in June of 2010.

For the 800 hospitals randomly selected from the 100 case threshold pool, for each applicable quarter, up to twelve records will be randomly selected from the cases uploaded to the CMS Clinical Data Warehouse across the four clinical topics. At least one case, but not more than three (3) cases will be randomly selected from each topic for which there were cases uploaded. That means that the first year of the new validation process, only three quarters of data will make up the final overall validation score for FY2012 payment determination.

If your hospital is one of the 800 randomly selected hospitals, you will participate in the validation as one of the requirements to receive your FULL payment update.

If you are NOT one of the 800 randomly selected hospitals, you will not have a validation requirement for FY 2012 APU determination.

For those NOT selected for validation, there will be a document compiled by the RHQDAPU – QIOSC each quarter to educate all hospitals about validation mis-matches. More details about this document and how/where it will be available are under discussion with CMS.

The 2010 Final Rule specifies under the new validation scoring methodology that the quarterly passing score, and the FY Overall Passing score will be 75% or greater.

Each quarter hospitals participating in the validation process will be required to prepare and submit up to 12 records for re-abstraction by CDAC. Remember, it may not be necessary to match 100% of the elements abstracted to actually match the measure outcome. The new process still looks at the accuracy of abstraction of elements, but moves to look at how that accuracy, or lack of accuracy, affects the measure outcomes. In other words, does CDAC end up at the same place as you did on the algorithm (MIF) for that measure.

It will still be critical for the information in the record to be abstracted according to the CMS abstraction specifications.

Just as in past years, **all IPPS hospitals that participate in the RHQDAPU program for Full APU will still be expected to meet all of the "other" RHQDAPU requirements.** Therefore, **all IPPS RHQDAPU participating hospitals will be expected to submit their Population and Sampling**

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Data and abstract and submit clinical data as they have in the past. *The only difference is that not all IPPS hospitals will have a validated requirement each year.*

- Q5:** I had hoped that some discussion regarding the use of Category Assignment Agreement Rate for validation would be addressed. I have information from my vendor, but would appreciate the perspective of the QIO.
- A5:** At this time, QIOs do not have any specific information regarding Category Assignment Agreement Rate for Validation. This might possibly be the way your vendor labels the measure outcome, pass, fail, excluded, etc.
- Q6:** If a data element allows multiple answers and CDAC does not agree with an answer provided--or determines additional answers to one(s) abstracted are required, we will fail the measure? i.e. for SCIP temp measure: if both active warming & compliant temperature are abstracted [either of which will pass the metric], but CDAC determines that only compliant temperature is correct, this will result in a measure failure? [similar scenario for new postop abx question---if CDAC does not agree with all answers abstracted, this will count as a failure?]
- A6:** It is possible that CDAC and the hospital could have a different answer, but both the CDAC's and the hospital's answers take the same path in the algorithm. This will result in a measure outcome match even though the element answers were different. **What is important is did the hospital's measure outcome match the measure outcome of the CDAC abstraction.**

Location of Slides to Download

- Q7:** Can you pls tell me where I might find the slides to print? The survey kicked me out of the Webinar site so I was not able to print. Plus, they were never posted on the fmqai.com site, as in previous Webinars.
- A7:** The links for the two sites where the slides and the recording of the live presentation are:
Florida, please use this link:
<http://www.fmqai.com/HQDR-Inpatient-ED.aspx>
California, please use this link:
<http://www.hsag.com/caproviders/events.aspx>.

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Future Webinars

- Q8:** There were several comments and questions from both states regarding the length of the event. Some requested that we extend the time to two hours; however, most requested that it be broken into two one-hour events. Some comments about going to two one-hour presentations included that separating the agenda into the review of the upcoming changes in the *Specifications Manual* and then all of the RHQDAPU “administrative” agenda items. One response was about covering changes that will not be implemented until April during the January Webinar.
- A8:** Our team continues to seek ways we can best meet your needs in an efficient and timely way. We are exploring several options and will take all of your comments and concerns into consideration. One thought that we are considering for the April Webinar is for us to make and post two recordings for your review. One of any updates to the *Specifications Manual*, and one of all of the other RHQDAPU updates and reminders that are relevant to the upcoming few months. We would then accept questions over a given period of time and then post the Q&A for everyone’s review.

Live Q&A’s are difficult to manage for several reasons. Some questions are very unique to a provider’s processes and are not pertinent to many other listeners, so we risk losing the interest of many. Some participants are just not good at asking their question in a way that allows us to quickly understand the details and provide an accurate answer; and, sometimes we need to verify what we think the answer should be based on the particular details of the question. Also, if there are numerous questions, some may not have an opportunity to ask their question. For all of these reasons, we prefer to have you submit your questions to us in writing. We would then compile a Q&A document and distribute it via our HQA Listserve and also post it as a document to the respective web sites. We anticipate that we would allow questions to be submitted for one week following the release of the recorded presentation.

After the Q&A is posted, anyone requiring further clarification and discussion may contact us directly.

Regarding the timing of when we post the slides and helpful documents, because we want to make certain we are disseminating the most recently released information, we prefer to hold the slides until 24 hours of the live presentations. Anyone signed up for the lists serve will receive notice of when things like this are posted.

We apologize for any confusion or difficulty locating our documents on the respective web sites; however, we are confined to work within the product that is provided to us. In the future we will do our best to make the location as easily accessible as possible.