

DATA MANAGER BREAKOUT SESSION

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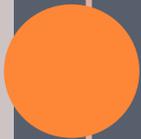
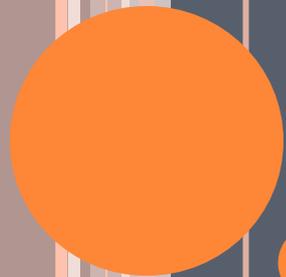
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AGENDA

- General VQI Questions
- How to Develop a Data Management System Based on Your Medical Center: Data Entry Methods
- Data Abstraction from Operative Notes
- Best Follow-Up Practices
- Data Management Techniques





GENERAL VQI QUESTIONS

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- Is it mandatory for institutions and surgeons to participate in a vascular registry to receive Medicare/Medicaid reimbursement?
 - Not currently



GENERAL VQI QUESTIONS

- Does the VQI-PQRS host Registry Site Manager Calls (RSM) for data abstractors/ administrators?
 - M2S often hosts webinars for VQI data managers and abstractors when significant changes are made or new functionality is provided in the VQI. Currently, there is no schedule for regular data managers/abstractors conference calls. Individual centers and regional groups are encouraged to address their questions to PATHWAYSsupport@m2s.com.
- If not, do they plan to host RSM calls in the future like the STS, and NCDR databases do to provide their participants an overview of updates?
 - M2S provides PQRS services to VQI participants for an additional fee. This service is separate from the VQI registry. Information about PQRS is sent to VQI hospital managers annually, and interested participants will be invited to participate in a webinar about the PQRS service provided by M2S.



GENERAL VQI QUESTIONS

- Is the Frequently Asked Questions (FAQ's) a tool to help clarify the data definitions per each institutions case scenario? If so, on the V1.19 FAQ, Infra-Inguinal demographic section asks for smoking status (line#196). The FAQ considers the nicotine patch a form of current smoking, but the electronic and paper V1.19 definition field does not read this way. Is this the data definition for Infra cases only or is this the data definition for smoking history on all abstraction forms? Additionally, how is the FAQ's generated and how often is it updated?
 - The FAQ's are provided as a tool to help clarify VQI data definitions. The smoking variable appears in the demographics section of all VQI procedure modules and should be responded to consistently. Thus, the use of a nicotine patch should be captured as current smoking on all forms.
 - The FAQs are updated as needed based on questions received at PATHWAYSsupport@m2s.com, usually monthly.



GENERAL VQI QUESTIONS

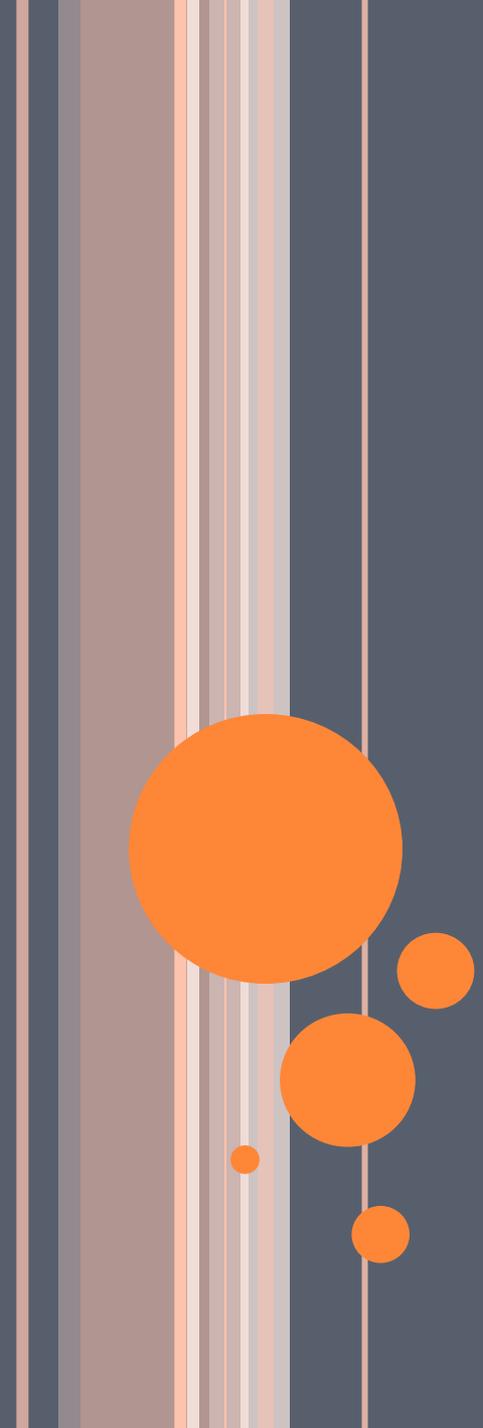
- When printing one blank follow-up patient form, the last four digits of the SS# appear only in the demographics section. When printing a whole month (select all option) the entire SS# prints out. Is there an option to hide the SS# when printing? If a “hide option” is not available do you have plans to display only the last four digits of SS# for all print options?
 - All follow-up forms should print with only the last 4 digits of the SSN displayed. This is a known bug and will be corrected in a future release.



GENERAL VQI QUESTIONS

- M2S Follow-up data collection is 9-15 and 16-21 months. Some National Registry follow-up databases set the follow-up date range of months with an acceptable number of days prior or after the data collection date range. Does M2S follow-up have this option and/or plan to have in the future?
 - The goal of the VQI is to collect a one year (12 month) follow-up for every procedure captured in the registry. The SVS PSO defines the allowable time frame for the one year follow-up to include any follow-up with a date of contact between 9 and 21 months post procedure date. There is no additional time allowance.
 - Centers capturing Hemodialysis Access procedures also need to collect an “early” follow-up for those cases. The allowable time frame for the early follow-up for Hemodialysis Access procedures is between 0 and 6 months post procedure date.



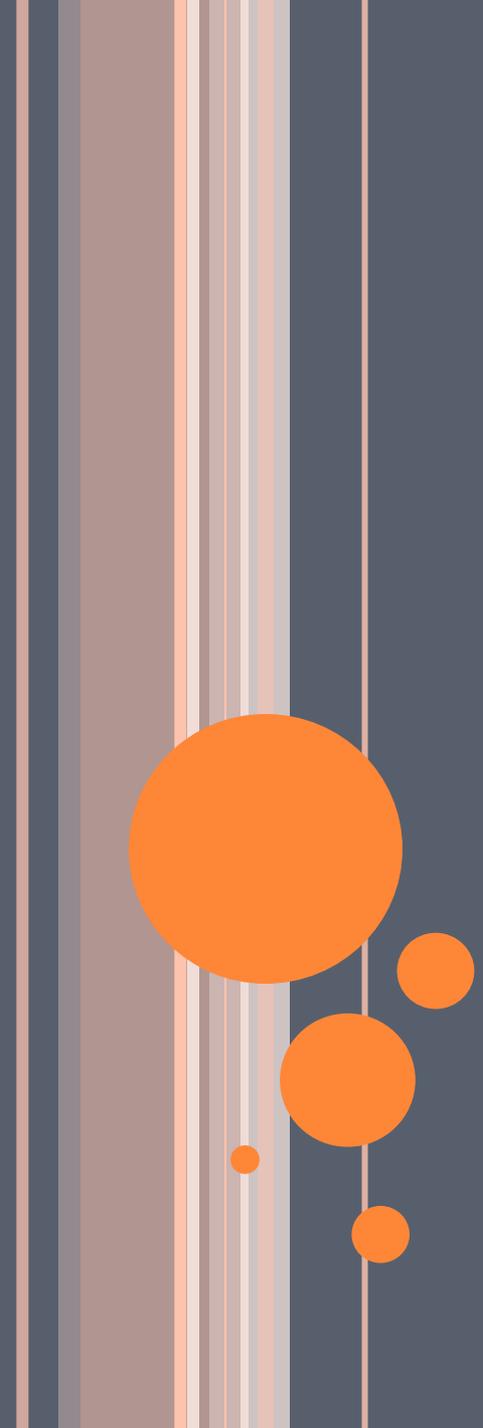


HOW TO DEVELOP A DATA MANAGEMENT SYSTEM BASED ON YOUR MEDICAL CENTER

QUESTIONS TO ASK

- How does your medical center operate?
 - Academic research center or private practice?
 - Who is funding VQI participation?
- How many modules do you participate in?
 - What is the weekly caseload for each procedure?
- What is the background of the DM?
 - How many registries is the DM responsible for?
 - How much time per week can the DM spend on VQI?
- How involved are the participating physicians?
- Are their mid-level practitioners and schedulers to help?





DATA ABSTRACTION FROM OPERATIVE NOTES

USE YOUR RESOURCES

- Resources tab in M2S has all data field definitions
- All data fields have a hyperlink to definitions
- Meet with your surgeons and ask them to go over abstraction techniques with you
- Know your medical records system
- Know what devices your hospital carries
- Don't be afraid to ask when you don't know or if a case is complicated: data integrity comes first!



CAROTID ENDARTERECTOMY

- Skin Prep: if not in op note, check intraoperative checklists, or ask OR staff to record for you
- Type: Conventional or Eversion
 - Surgeon will dictate that the ICA was “everted” or an “eversion endarterectomy” was performed. Usually the CCA is transected before eversion.
 - Be careful: sometimes ECA is everted during a conventional endarterectomy. Make sure the case isn’t documented as an eversion if this happens.
 - Shunts usually aren’t used in eversion endarterectomies, but can be with difficulty



CAROTID ENDARTERECTOMY

- Shunts: more of a practice pattern than something that is dictated
 - Some surgeons shunt all patients (we do)
 - Some shunt selectively because the patient is high risk (i.e. a patient with contralateral carotid occlusion)
 - Some shunt intraoperatively for indication
 - Some do this while the patient is awake with local anesthesia and shunt if the patient demonstrates a neurologic change intraoperatively (patient is instructed to follow commands during surgery)
 - Some check a pressure after clamping the CCA by sticking a needle into the artery and seeing if the patient has enough flow from the contralateral side to not warrant a shunt. If the pressure is low, a shunt is needed (each surgeon has a different threshold).
 - Some use EEG monitoring intraoperatively, and shunt only if the patient demonstrates concerning EEG changes once the carotid is clamped



OPEN AAA

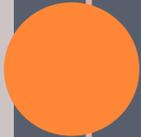
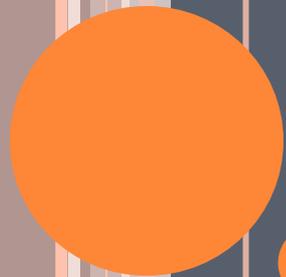
- Proximal clamp position: the most proximal location of the clamp during the aortic reconstruction
- Conversion: early = within 30 days, late >30 days
- Graft type: hint: may not be on op note
 - Check the records of all implanted devices, or ask an OR nurse for a list of devices in stock (this will differ depending on your medical record system)



PERIPHERAL VASCULAR INTERVENTION

- Occlusion length and number of lesions: not normally dictated in the op note unless the surgeon started adding it specifically for VQI
 - Consider paper forms that you keep in the OR
 - Make sure they're filled out ASAP; it's easy to forget these variables and they may not be documented elsewhere
- Fluoro and Contrast: Ask OR staff to record this for you if not in op note or anesthesia record
- Go through the variables with your surgeon and OR staff and make a plan that works for both of you





BEST FOLLOW-UP PRACTICES

UF FOLLOW-UP PRACTICE

- On the day before clinic, check schedule for FGVSG patients
 - Vascular and TCV clinics
- Print follow-up forms
- Paperclip forms to patient's FACE sheets so providers know to fill out form during visit
- Database manager receives forms after clinic and enters into M2S
- Other methods?



BARRIERS TO LONG-TERM FOLLOW-UPS

○ Geography

- VSGNE v. FGVSG
- Transportation

○ Hospital clinical standard of care differ from M2S requirements

- Open AAA
- HD Access

○ Patients say they feel fine and refuse medical care



BARRIERS TO LONG-TERM FOLLOW-UPS

- Patients lose insurance and are unable to pay
 - CT scans are expensive
- Patients refuse imaging after EVAR/TEVAR because they don't want another surgery
- Chronically ill patients already have enough medical appointments
 - Especially true for patients on dialysis



BARRIERS TO LONG-TERM FOLLOW-UPS

- Patients are difficult to contact
- Outside medical records aren't always comprehensive
- Patients can be poor historians
- Older patients may not be able to understand or hear you over the phone
- Cancellations and No-Shows



FOLLOW-UP RATES TODAY

- The median of LTF rate of regional 75%-2011 (range 62%-77%) and 14%-2012 (range 4%-50%)
- The median of LTF rate of national 75%-2011 (range 1%-100%) and 25.5%-2012 (range 0%-69%)
- Data pulled 10/14/2013



ASK FOR HELP

- Run your long-term follow-up report
- Who can help?
 - Schedulers, database managers, other clinical staff, medical students, interns, etc.



HOW UF INCREASED LONG-TERM FOLLOW-UP COMPLIANCE

- Look at patient's chart for clinic visits that aren't entered
- Complete easy follow-up modules first
 - Open AAA: you only need medications and related surgeries
 - HD Access: if you can't get in touch with them, call dialysis center



PHONE FOLLOW-UPS

- They only work for certain modules
- Chronically ill patients may not be able to remember timelines of all their procedures
- Patients may be difficult to understand
- Use phone visits to get information on PCP, local specialists, imaging locations, ER visits and hospital location if not in chart



OUTSIDE MEDICAL RECORDS

- Be specific when asking for information
 - Ask medical records to pre-screen information
 - Not uncommon to get a 50 page fax and not have enough information to enter follow-up form
 - Ask medical records if they have any other hospital visits, other specialists, or imaging reports on file
 - PCPs aren't always aware of hospitalizations – it can take time to get all the information you need



WHAT WE LEARNED

- Each month, run the long-term follow-up for that month last year and check SSDI
 - This avoids playing “catch up”
- Make a plan to get support staff on-board
- When patients are in pre-op, make your clinical standard of care follow-up clear

