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# The Process to Green Light Submissions and Beyond

Lisa Wells. R.N., Stony Brook University Hospital, Stony Brook, NY

Donna Albergo, R.N., Stony Brook University Hospital, Stony Brook, NY

Andrea Gravino, R.N., Stony Brook University Hospital, Stony Brook, NY

Michelle Iaboni, R.N., Stony Brook University Hospital, Stony Brook, NY

Paul Ventiquattro, M.S., Stony Brook University Hospital, Stony Brook, NY

Lisa Wilbert, R.N., Stony Brook University Hospital, Stony Brook, NY

**Background:** The department of Quality Measurement and Analytics (QMA) at Stony Brook University Hospital (SBUH) started submitting data to the PVI Registry™ (then CARE) in 2007. As abstraction got underway, it was evident that many of the data points required for registry submission were not included in current documentation in the legal medical record. This posed a significant problem as SBUH would not pass data completeness criteria to be included in the Quality Outcomes Report and national benchmarking.

**Methods:** Efforts began in 2007 to create a paper tool. This tool was designed by the data abstractor with the goal of capturing data elements that were often missing from the legal medical record. Some of the data elements that were problematic included carotid duplex results, pre-procedure NIH and Modified Rankin scores, aortic arch type, lesion length, minimal luminal diameter (MLD), calcification type, and diameter of distal (non-tapered) ICA. This tool, The Carotid Artery Stent (CAS) Procedure Note, was put into production, with the approval of a multidisciplinary team, in the spring of 2008. This team was compromised of a data abstractor, a data analyst, the Chief of Neurosurgery, vascular surgeons, and cardiologists. The team agreed that it was the responsibility of the interventionalists to complete the form for every carotid stent that was placed. Much education was provided and constant email reminders were sent asking the Interventionalists to use and /or complete the tool. An analyst in QMA created a report to monitor the usage of the CAS note. This report was brought to quarterly meetings to review compliance. After much persistence and determination, SBUH was able to receive a 'green light' for data submission. In 2014, the CAS note was converted into an electronic format by the Electronic Quality Data Manager and the data abstractor. Prior to the form being placed into production in the legal medical record, permission was again obtained from the multi-disciplinary team. The CAS note was the first of its kind at SBUH to be a multi-contributor form. This allowed both nurses and interventionalists to document. Ultimately, the form must be signed off by the interventionalists.

With the new CAS note in place, additional education was provided. During data abstraction, it was noted that the CAS note was not being used for all carotid stent procedures, most notably for acute stroke patients. The abstractor sent out frequent email reminders to the services asking for the CAS note to be completed. In February 2016, the CAS note was split into two sections; one for elective cases and one for acute strokes. It continued to be a struggle to achieve data completeness in Acute Stroke

patients receiving carotid stents. On March 8, 2017, the CAS note was updated making all the data elements for elective carotid stent cases mandatory. This meant that the CAS note could not be signed unless all data elements were documented. As for the acute stroke patients, specific data elements, including pre-procedure % stenosis, remain mandatory because they are Center for Medicare & Medicaid Services (CMS) requirements. An updated report was created to track the use of the new electronic CAS note.

**Results:** Stony Brook University Hospital continues to receive a 'green light' for data submission on a quarterly basis because of all of the efforts put into place. All staff involved have become more accustomed to using the note, and compliance has greatly improved. In 2016, the compliance of note usage/completeness ranged from 71% to 87% prior to any emails being sent out. With the creation of a report to monitor the usage of the electronic CAS note, the compliance has increased to 95% and 100% in 2017. The report also allows the data abstractor to find any PVI cases without the note on a more real-time basis, instead of waiting for abstraction to begin.

**Conclusions:** Complete and accurate data documented allows for cleaner data capture and submission. With the interventions put into place, this has allowed SBUH to be consistently included in NCDR's benchmark dashboard which allows us to be compared to hospitals nationwide.

Moving forward, our goal is to electronify all publically reported registries. This will free up abstractors from intense manual review. Abstractors will then be able to devote more of their time to review all outlier and noncompliant cases.