

Report from 13-May-2011 NCAD Meeting

2011-12 Changes

- See **Item 7a_DAD NACRS 2011-2012 Change Summary_March 7 2011_EN.xls** on DQC SharePoint site for more details.
- There is a new CACS grouper for NACRS and DAD day surgery. No more DPG! Data regrouped to the 2010 grouper will be available for one year only to help with the transition.
- Unknown birth date value 99990901. Please continue to estimate unless you have absolutely no idea of the birth date. Responsibility for payment 01 (SK Health) records will fail HSN edits if a birth date of 99990901 is entered.
- Unknown postal code 99. Please continue to use province mini-codes SK, AB etc. if you know the province.
- Alpha characters are now possible with the second digit of institution numbers.
- Amended edit generating error number 11 06 54 - Provider and Service Missing - to allow for blanks when Intervention Pre-Admit Flag is Y.

2012-13 Proposed Changes

- See **Item 7b_DAD NACRS FY 2012-13 Annual Change Cycle_Final_May 1 2011_EN.docx** on DQC SharePoint site for more details.
- **Definition of stillbirth** in DAD and NACRS will change to be consistent with ICD10CA, so will no longer match Vital Statistics definition. Stillbirth abstract should reflect the capture of data specific to the intrauterine death or the termination of pregnancy equal to or greater than 20 weeks gestation. Abstracting guidelines also need to emphasize that a missed abortion is not a stillbirth. (Row 2)
- **Feedback Required:** ON has requested a new Intervention Location in DAD and NACRS called Interventional Radiology to be separate from the generic Diagnostic Imaging intervention location (06). (Row 8)
- Clarification of definition of **Unplanned Return to Intervention Location** (Row 36).
- Modification of the requirement/edit for Day Surgery length of stay to be less than or equal to 24 hours. (Row 40)
- Data element **Died in OR** to be **Renamed Died During Intervention** along with removal of two existing edits. (Row 41)
- Project 925 (**surgeries in private clinics**) will get a permanent project number of 225 and will get all of the edits currently applied to BC. (Row 43)
- There will be a new baseline calculation for HSMR including data from Quebec. (Row 45)
- New edits for post-admit comorbidities prefix 5 (before first intervention) and 6 (after first intervention) (Rows 46-50)
- New edit for prefix 8 (palliative care) (Row 51)
- New edits for diagnosis clusters so that they can only be applied to complications of medical and surgical care and drug resistant organisms. Currently, analysts are having trouble picking up the information properly. (Rows 52-54)

- **Feedback required:** New DAD and NACRS data element: Loss of Consciousness (Row 61). Also see **Item 7b_Row 66_Loss of Consciousness_NCAD Feedback Form_May 1 2011.docx**.
- **CMG+:** Diagnosis List and methodology will to be revised to introduce comorbidity adjustment (multiplicative instead of simply additive). (Row 62)
- **Feedback required:** Proposed new Program Area (Geriatric Assessment) in NACRS. (Row 66) Also see **Item 7b_Row 61_Program Area new value of Geriatric Assessment - NCAD Feedback Form_April 1 2011.doc**.

Other News

- Canadian Collaborative for Excellence in Healthcare Quality: http://www.acen.ca/documents/presentations/Think_Tank_Chantal_Backman_Canadian_CEHQ.pdf (Saskatoon is a participant.)
- Nova Scotia is going to submit day surgery data via NACRS.
- British Columbia is going to be the first province to submit NACRS Level 2 data.
- Version 2012 of ICD-10-CA/CCI will be available for download rather than being distributed by CD. It will allow import of the 2009 shadow file.
- The ED diagnosis short list from NACRS has been mapped to SNOMED.
- MB Health will not be purchasing the CACS grouper module for DAD day surgery from Med2020.

Question from NL Regarding Tracking of Coding of Incomplete Charts (*feedback required*)

1) Does your province utilize a feature within the abstracting software application (e.g. 3M) to track incomplete charts?

MB: No, there is no provincial process. We have one vendor in Manitoba and the software does provide a “chart complete when abstracted” check box; however, each region determines the collection process for this data element.

If yes,

What are the advantages and disadvantages?

MB: Some regions monitor how many abstracts are incomplete at the time of coding and run this report prior to the submission. This means some will go back into the abstract and change the No to Yes if the chart becomes complete prior to the submission of the file. Some regions have added a drop down list in the “is the chart complete” area to identify what was missing from the chart (discharge summary, path etc). This allows the coder/management to go back to any incomplete chart to justify (incorrect coding, missed coding etc.)

Where on the abstract is this data collected?

Are all facilities within your province collecting this data? MB: No

2) Does your province use the Ontario Project 100 to track incomplete charts?

MB: No

NS: Yes, but called project 700.

If yes,

What are the advantages and disadvantages?

NS: Can be used as evidence of incomplete charts when inconsistencies found in CIHI re-abstractation studies, can be used as an answer to questions about coding quality. The disadvantage is that not all hospitals go back and complete the fields that ask when the chart was reviewed.

Are all facilities within your province collecting this data?

The NS Provincial Data Quality Committee has made it mandatory for all inpatient discharges.

3) Does your province utilize another process(es) to track incomplete charts?

MB: No

If so, please provide further details re the process, advantages/disadvantages, level of usage, etc.

NS Project 700



Microsoft Office
Excel Worksheet