



The Importance of Data Validation in Healthcare

Objectives



What is Data Validation?



Foundational Steps to Data Validation



Data Abstraction & Validation



Application

The What's and Whys of Data Validation

Data Validation

- Checking of data for accuracy and/or compliance with applicable standards, rules & conventions
- Any process used to flag inaccurate, incomplete or unreasonable data: format checks, completeness checks, check key tests, reasonableness checks and limit checks

Verification

- Are you pulling the correct report?
- Are you using the correct measurement period?

Validation

- Is your EHR pulling correct information into Numerator/Denominator?
- Are fields within your EHR tracking to give you credit?
- Is everyone on your team trained to enter data in appropriate fields?

Data Abstraction & Validation

Minimum Data Sets

Measure
Specification Sheets

Abstraction Tools and
Hints



Foundation: Reviewing Specification Sheets

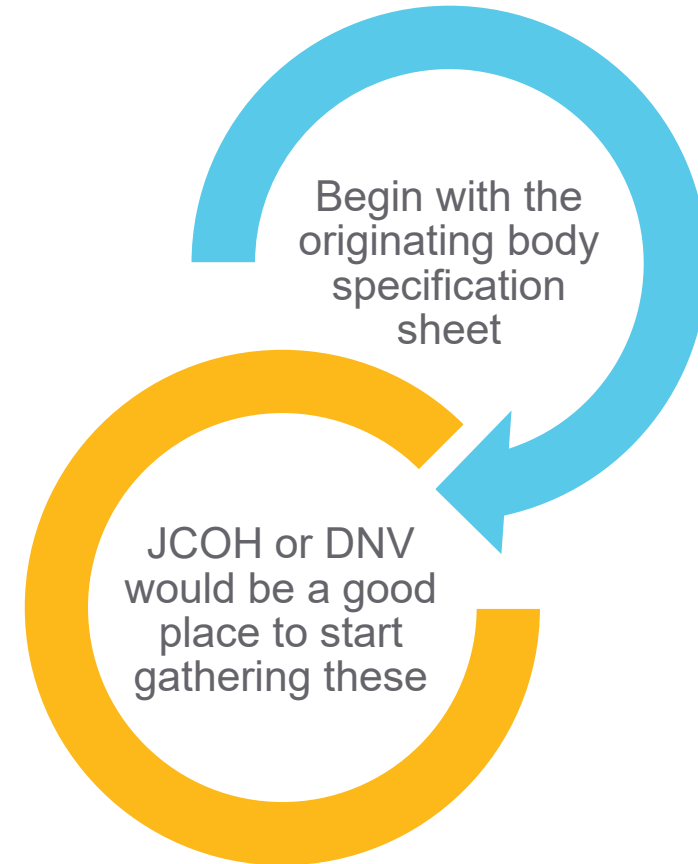


Specification Sheets are a key tool to have in your toolkit in any quality improvement project



Explain

- Patient Population
- Numerator
- Denominator
- Exclusions



Understanding the Measure



Measure Information Form

Measure Set: Stroke (STK)

Set Measure ID: STK-1

Performance Measure Name: Venous Thromboembolism (VTE Prophylaxis)

Description: Ischemic or hemorrhagic stroke patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission

Rationale: Stroke patients are at increased risk of developing venous thromboembolism (VTE). One study noted proximal deep vein thrombosis in more than a third of patients with moderately severe stroke. Reported rates of occurrence vary depending on the type of screening used. Prevention of VTE, through the use of prophylactic therapies, in at risk patients is a noted recommendation in numerous clinical practice guidelines. For acutely ill stroke patients who are confined to bed, thromboprophylaxis with low-molecular-weight heparin (LMWH), low-dose unfractionated heparin (LDUH), or fondaparinux is recommended if there are no contraindications. Aspirin alone is not recommended as an agent to prevent VTE.

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Ischemic or hemorrhagic stroke patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given on the day of or the day after hospital admission.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- [Reason for No VTE Prophylaxis – Hospital Admission](#)
- [Reason for Oral Factor Xa Inhibitor](#)
- [VTE Prophylaxis](#)
- [VTE Prophylaxis Date](#)

How to Validate Data



Run baseline data report



Systematic sample chart audit



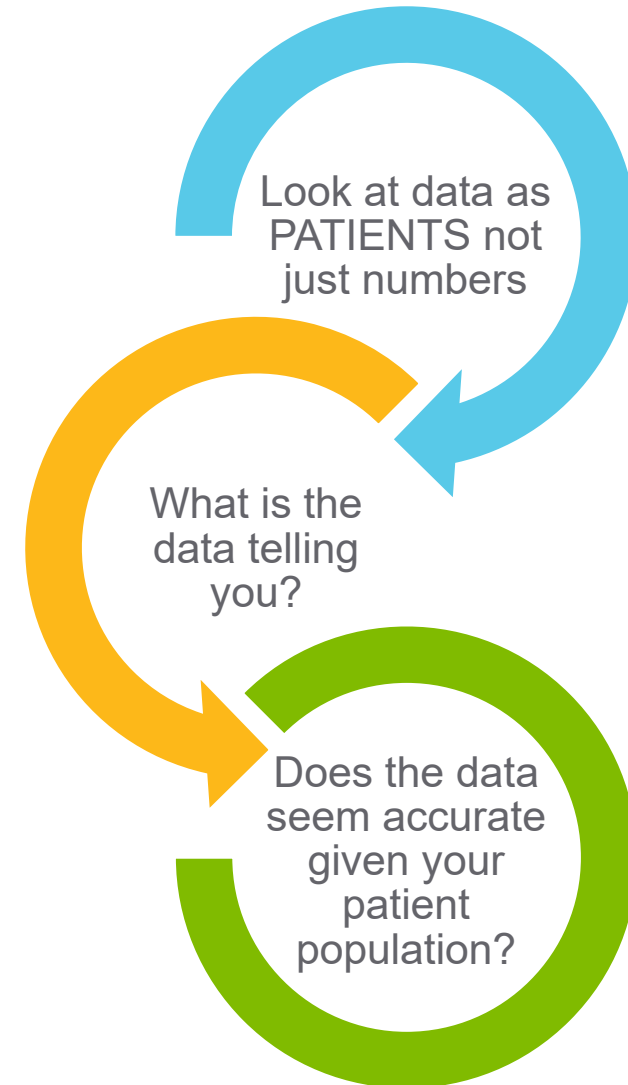
Drill down into Num/Den

- Date of Service
- Exclusions identified properly



Identify discrepancies

- Workflow
- Vendor



GWTG Data Abstraction

What was the patient's discharge disposition on the day of discharge?

Discharge Disposition

Collected For: GWTG, STK, CSTK, ASR

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Question: What was the patient's discharge disposition on the day of discharge?

Format: Drop Down

Allowable Values:

- 1 – Home
- 2 – Hospice – Home
- 3 – Hospice – Health Care Facility
- 4 – Acute Care Facility
- 5 – Other Health Care Facility
- 6 – Expired
- 7 – Left Against Medical Advice (AMA)
- 8 – Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.
Example:
 - Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5" (Other Health Care Facility).
- The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.
- If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation. Examples:
 - Discharge summary dictated 2 days after discharge states patient went "home". Physician note on day of discharge further clarifies that the patient will be going home with hospice". Select value "2" ("Hospice - Home").
 - Discharge planner note from day before discharge states "XYZ Nursing Home". Discharge order from day of discharge states "Discharge home". Contradictory documentation use latest. Select value "1" ("Home").
 - Physician order on discharge states "Discharge to ALF". Discharge instruction sheet completed after the physician order states patient discharged to "SNF". Contradictory documentation, use latest. Select value "5" ("Other Health Care Facility").
- If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
 - Acute Care Facility
 - Hospice - Health Care Facility
 - Hospice - Home

Monthly Data



Continue to use the same method each month






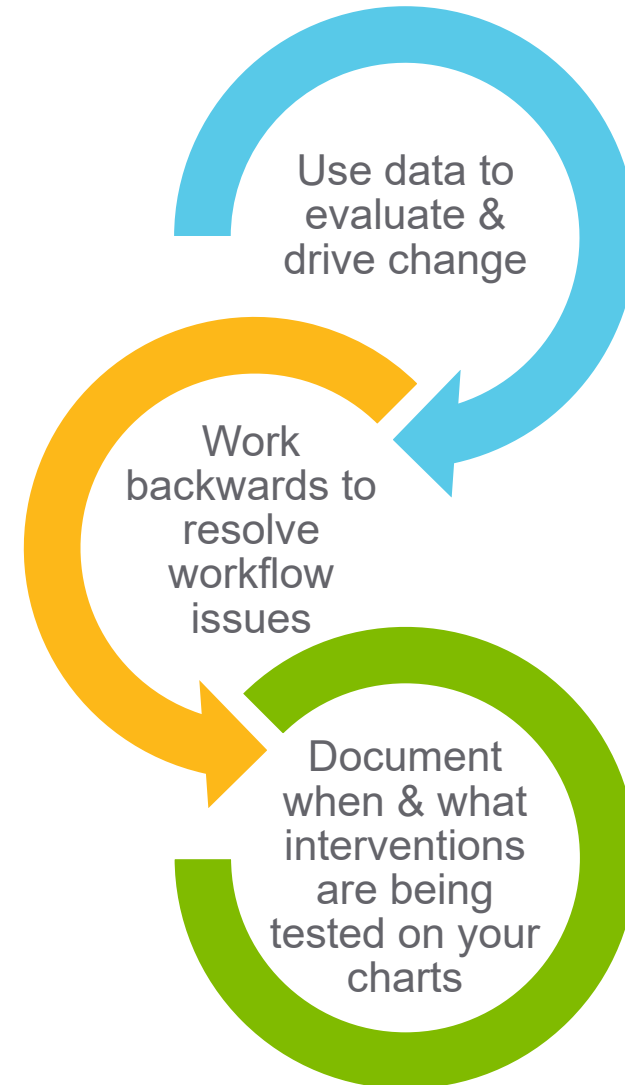
Report YTD data through the current month

- Example:
 - January report – 1/1-1/31 2024



Tools to Track Data

- **Line Charts**
 - Trend is 5 or more data points that change in either direction
- **PDSA Tracking Sheets**
 - Plan spread
- **Share Data Throughout Organization**
 - Helps team to understand the overall goal and where they stand



Questions



Please let us
know of your
questions &
concerns!