Transcript
Pioneers in Quality – Expert to Expert Series
2020 eCQM Annual Updates – ED-2
On-Demand Webinar
December 2020

0:06

Thank you for joining us for Pioneers in Quality On-Demand webinar series, Expert to Expert 2020 eCQM Annual Updates for the 2021 Reporting Period.

0:18

This series is brought to you by The Joint Commission, the Centers for Medicare & Medicaid Services, Mathematica Policy Research, and Lantana.

This On-Demand webinar series will offer Continuing Education credit.

0:32

This webinar series addresses changes that occurred during the 2020 eCQM Annual Update Cycle for the Stroke and VTE Measure sets, PC-05 and ED-2. We will also be offering a session that provides an overview for a new measure: The Centers for Medicare & Medicaid Services Safe Use of Opioids Concurrent Prescribing for the 2021 reporting period.

Each session will also include a segment during which the measure leads will respond to common questions from JIRA and other sources. So, make sure to stick around for the end of the session to hear all of the Q and A.

1:08

You can access these sessions by visiting the Joint Commission webpage and also the eCQI Resource Center under the general eCQM and eCQI page.

1:18

Also, new to this webinar series are a series of supporting educational video shorts that address the more basic components of eCQMs and CQL, most sessions are approximately two minutes in length.

These videos can be viewed anytime, so whether you're in need of a refresher, or if you're new to the eCQM landscape, it takes less than 20 minutes to watch all five video shorts.

These videos can also be accessed on the Joint Commission website as well as on CMS' under the same general eCQM and eCQI education page.

1:50

Today's session will focus on the eCQM annual updates for ED-2 Median Admit Decision Time to ED Departure Time for Admitted Patients.

2:00

Before we start, we'd like to offer just a few tips about webinar audio.

Use your computer speakers or your headphones to listen. Feedback, or dropped audio, are common for streaming videos. Refresh your screen if this occurs.

You can pause the playback at any time.

2:16

If you'd like to follow along and take notes, you can access the slides now within the viewing platform, see the left side of your navigation pane, and select the icon that looks like a document.

A new popup window will open, and you can select the name of the file. A new browser window will open, and from it, you can download and save or print the PDF of today's slides. The slides will also be posted on the Joint Commission's website at this link.

2:42

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This webinar is approved for one Continuing Education credit for the Accreditation Council for Continuing Medical Education, American Nurses Credentialing Center, American College of Healthcare Executives, the California Board of Registered Nursing, and the International Association for Continuing Education and Training.

3:08

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For more information on the Joint Commission's continuing education policies, visit the link shown on this slide.

4:04

At the end of this webinar, participants should be able to:

Apply concepts learned about the logic and intent for the ED-2 eCQMs.

Identify common issues and questions regarding ED-2 eCQMs, and

Prepare to implement the ED-2 eCQM for the 2021 eCQM reporting period.

4:25

The following staff and speakers have disclosed that neither they nor their spouses, or partners have any financial arrangements, or affiliations with corporate organizations that either provided educational grants to this program or may be referenced in this activity.

Susan Funk, Angela Flanagan, and Mia Nievera. I'm Susan Funk, Senior Research Associate and Lead Operations Staff for Pioneers in Quality

Hello.

I'm Angela Flanigan, Lantana Consulting Group, and I am the senior nurse informaticist, eCQM Lead, and I lead the ED-2 measure, and I'm Mia Nievera, Project Director for the e-Clinical Team.

5:05

During today's session, we will review the measure logic with a primary focus on what's new for 2021. Team, take it away.

5:14

Thank you, Mia.

The ED-2 measure assesses the median time in minutes from the time the decision to admit is made to the time the patient physically leaves the emergency department. Reducing the time the patient spends in the emergency department can improve the access to treatment and increase the quality of care.

We do see less time, potentially, improve access to care, specific to the patient condition, and increases the capability to provide additional treatment.

5:45

This measure is a continuous variable and is stratified by patients with and without, a principal diagnosis of mental health or psychiatric disorders.

5:57

So, you will see changes in the logic, because we did make significant changes for the 2021 reporting period based on feedback from implementers and vendors, other measure developers, and we put forward more in depth Bonnie testing. For example, logic changes made are to constrain the ED visit that is within an hour of the inpatient admission to the ED visit that contains the decision to admit and includes the data required to calculate the observation time.

6:28

We expanded options for capturing the decision to admit and revised the logic to ensure that the initial population, the denominator exclusions, and the measure observation are all calculating the same data from the same ED visit and inpatient encounter.

6:44

So let's take a look at the logic, and the clinical data that makes up the measure.

OK, so you can see we've changed the initial population from what we call long hand version to shorthand version.

7:01

Here is a long hand version for the ED encounter with the decision to admit definition.

It continues to constrain the inpatient encounter to have an ED visit, with a decision to admit to inpatient.

7:15

But we have added logic to constrain it a bit more.

So for this piece of the initial population logic, you may have seen in another measure, the global inpatient encounter, this logic accesses for inpatient encounters, where the length of stay is equal to, or less than 120 days, and ends during the measurement period.

7:38

Now this function, the last ED encounter, EncounterInpatient "Encounter Performed".

It assesses for the most recent, or last ED encounter that is within an hour of an inpatient encounter.

7:54

The Global ED Encounter function is used throughout the measure to ensure that the measure calculates the same ED encounter and the initial population denominator exclusions, and for the measure observation.

8:09

So this function was created to provide another option for capturing a decision to admit prior to departing the ED.

Stakeholders informed us that the encounter order many times occurs after the patient leaves the ED.

8:25

So if we consider the workflow, say, the provider sees the patient, and they assess or evaluate the need for the patient to be admitted.

8:35

So to better align the measure with the workflow, it was determined to include an assessment that demonstrates the provider performing an evaluation that results in the need to admit the patient.

This led to capture the most recent assessment performed with an ED Evaluation.

And that ED Evaluation is a new value set that includes things like an ED note, and a consult note, a triage note, an evaluation note, and even an admission note.

9:05

So, with this ED Evaluation, resulted in the decision to admit the patient.

And this includes documentation that the patient is listed for admission to the hospital or requires hospitalization.

9:21

These are just a couple of the concepts in the new value set.

And these need to be performed during the last or most recent ED visit, and prior to the patient physically leaving the ED.

9:35

Please note that the departure and discharge are two completely different times.

9:42

As stated, the departure is the time the patient physically leaves the ED, and discharge is when the patient is no longer a patient in that department.

The patient discharge time from the ED and admission time to the hospital inpatient may be the same time as the ED department relinquishes the responsibility for the patient, and the inpatient accepts responsibility for the patient.

10:11

However, the patient may not have physically left the ED until sometime later.

So maybe when a bed is available.

10:21

Note that this logic uses the last ED encounter. The logic we spoke about on the last slide, and you will see this logic, again and again.

10:32

Some of you may be familiar with the encounter order for the decision to admit to hospital inpatient.

10:38

This logic has been around for a while.

10:41

The logic continues to assess for the most recent ED, where there was an encounter order of the decision to admit the patient's, hospital inpatient, during the last ED visit.

10:52

An observation department is considered outpatient, and, therefore, not included in the measure, as intent is to capture those patients who are admitted inpatient.

11:04

Therefore, the hospital admission for observation code that has been part of the value set, is no longer part of the value set, seems to cause quite a bit of confusion.

So, it has been removed from the decision to admit the hospital inpatient value set.

11:26

One more thing, you may be wondering why the encounter order and assessment performed are not using the same value set.

That's a great question. Have you heard of the CMS Blueprint?

11:39

Well, it is a guide put out by CMS to inform of recommendations and best practices for measure development and maintenance.

In the blueprint there is a section dealing with terminologies and value sets, which includes an appendix with recommended clinical vocabularies for the use with data types.

In this section, the Blueprint recommends the use of SNOMED CT procedure hierarchy codes for encounter order, and findings or disorders hierarchy for assessment performed.

12:11

So, two different types of data, the data type requires different types of hierarchies.

12:20

So, and this is the final piece of the initial population logic.

So, we have an inpatient encounter within an hour of an ED encounter that has an assessment result, or an encounter order to admit the patient.

12:39

Now, we want to make sure that the ED encounter includes necessary timings to calculate the measure observation, because it defeats the purpose to include encounters where the measure observation cannot be calculated.

12:52

The revised logic includes facility location, location period, and location code for the Emergency Department to ensure other locations are not inadvertently captured.

The end operator returns the ending point of the interval, in this case, the location period, which is the interval between start and stop time.

The exclamation mark, followed by the equal sign, identifies the inequality comparison operator.

13:23

Basically, what this is saying, is that, if the end date and time is a null, then the way CQL works is, if the stop time is null, the logic will return the latest possible date for that time.

So, as long as the ED location end period is not known, not the maximum end date, then the criteria will be met.

13:50

So the measure population is used only in continuous variable measures.

It is similar to the denominator in ratio and proportion measures.

For the ED-2 measure, this is the same as last year where a measure population is the same as the initial population that we just covered.

The measure population exclusion, excludes emergency department encounters with an admission source in hospital settings.

14:19

That's in any different facility by location or CCN that results in an inpatient stay.

The change here is to ensure that the Initial population and exclusions are assessing the same last ED encounter.

So exclude the most recent ED encounter, the last ED encounter, that occurred within an hour of the inpatient admission, within the ED admission source hospital setting any different facility, by location or CCN.

15:03

The Global Inpatient Encounter and last ED encounter functions are the same as the last ED encounter and Global Inpatient encounter used in Initial population.

This should ensure that the same inpatient and ED encounters are used throughout the measure.

15:22

The Hospital setting value set did undergo considerable change.

We reduced it to make it lean, and to reduce the burden of upkeep for all those involved; only the primary settings were maintained.

15:40

For the measure observations, the primary intent of the measure is to assess the time the patient physically departed the ED to inpatient hospitalization.

The revised logic includes newly added Assessment result for decision to admit inpatient and ensures the use of the same, inpatient and ED logic to capture the same encounters throughout.

16:06

The duration from the Decision to Admit Assessment to the Departure from the Emergency Department last ED that also had an inpatient encounter.

The logic assesses the duration from the Decision to Admit encounter order to the Departure from the Emergency Department that also had an inpatient encounter.

16:29

The coalesce that you could see in the blue, returns the first non-null expression among these two functions - between the assessment and the encounter order - that has an ED departure time and an inpatient encounter associated.

The ED time function calculates the time the patient physically departed the Emergency Department.

The last ED encounter function is the same last ED encounter used in initial population and the measure population exclusion to determine that the most recent or last ED encounter that is within an hour of the inpatient encounter.

17:13

This measure evaluates patients with and without mental health diagnosis. So there's two stratifications.

So, Stratification 1, are all patients seen in the ED and admitted as an inpatient without a principal diagnosis of psychiatric mental health diagnosis. A principal diagnosis, is indicated by rank equals one.

So, we're looking for those patients that do not have a rank one, consistent with the psychiatric mental health disorders.

17:50

And Stratification 2, evaluates those patients with a mental health diagnosis.

A principal diagnosis is indicated by rank equals one.

That concludes our measure review.

18:25

Please stick around for the Q&A. Questions for this segment were obtained from common questions submitted to JIRA and other sources.

18:27

Hi, Angela. Thanks for joining us for the Q&A today. I'm going to go ahead and dive right in.

And for our first question, if a system is trying to map the admission order start time, but they find that there is an earlier time, should that timestamp be used?

18:50

That's a great question. And I'd actually need to know what version the person is referring to.

Because in 2019, the answer would have been an earlier time.

However, in '20 and '21, we updated this to align with the logic of catching that most recent ED visit.

So the decision to admit, now, is that most recent, or the last one made in that most recent last ED encounter.

So that is the documentation of the decision to admit the patient to ED is closest to the inpatient encounter. And since admission processes vary, we do have some variation in what's accepted for an order for the Decision to Admit.

So we have the admission order. This would be an operational order rather than a hospital admission to inpatient status order.

We also accept the disposition order, it must explicitly state that it is to admit, a documented bed request, a documented acceptance from the admitting physician.

20:07

These do not include a bed assignment; we're also frequently asked that.

And then just most recently, to the 2021 version, we added an option for an assessment.

So, that decision to admit could also be the ED evaluation that results in a Decision to Admit. And that would also be the latest or most recent.

20:29

Great, so, it sounds like there may be a few variations depending on hospital workflow.

So, thank you for going through those, let's go to the next question.

Alright, so for our next question, there are two values sets that are used for the decision to admit inpatient assessment, the Emergency Department Evaluation Value set, and the Admit Inpatient Value Set. Can you clarify the difference between the two as they are both using an Assessment data type, and one is LOINC and one is SNOMED.

21:20

OK, yes, good question, so if a concept is a question, we use LOINC codes,

And if a concept is an answer, we use SNOMED codes.

The SNOMED codes are used for the Emergency Department evaluation.

And the LOINC codes are used for the assessment performed.

That make sense. So, could you share a little bit about how we would find this information?

OK, the CMS Measures Management Blueprint that can be found on the eCQI Resource Center or eCQIhealthit.com.

21:53

Yes, pretty close, it's eCQI.healthit.gov.

We also added it to the resource slide at the end of the presentation so our audience can link through the Blueprint from that page.

All right. So let's take it to the next question.

22:21

OK, Angela, this one is a doozy for me as well, so can you clarify what the ! = maximum date time means in the ED encounter with Decision to Admit logic?

22:39

Basically, what this is saying is if the end date, that departure time from the ED, if it is unknown or null, the logic will return the system end date time which is infinity. Therefore the criteria is not met because we cannot calculate the median time from decision to admit to the inpatient hospital setting to the ED departure without ED departure time. I hope that helps.

23:10

So, I think I'm tracking.

So, therefore, if the ED location, is not null, so not the maximum end date time, then the criteria will be met.

That's true.

See, I am paying attention. On to the next question.

23:46

OK, so for this next question, it's a two-part question.

So first, for the ED evaluation.relevantdatetime during last ED visit, that relevant period, do we need to consider the relevant period of the ED encounter?

24:07

Mia, if you want, the short and sweet answer, it would be yes.

We need to consider the relevant period of the ED encounter, that is admission start and discharge end times for the encounter performed to be able to evaluate, if the evaluation was performed during the ED encounter.

We also consider the ED relevant period to determine if the ED encounter ended within an hour of the inpatient admission.

Right, that makes sense. So you mentioned the ED department time, so, if the ED evaluation relevant date time is before or on the ED departure time so that last ED visit, do we need to validate the location attribute of the encounter performed?

24:58

Yes, there again, we need to ensure that the location is the emergency department location and that the evaluation was performed prior to the patient physically leaving that ED location.

25:12

Okay. Makes sense. Great, thank you for answering that question.

Onto the next.

25:36

OK, Angela, for this next question, if there are multiple timestamps for the decision to admit, which time should be used?

OK, if there are multiple times for the ED Decision to Admit, use the last or the most recent time that occurred during the ED encounter that preceded the inpatient admission.

26:02

OK, so to piggyback on that question, is there a source that would be used first when there are multiple times on different sources, some sort of source hierarchy?

26:14

Mia, if you recall, we discussed the coalesce operator.

And the coalesce returns the first non-null expression among those two functions: the one about the Admit Decision using the assessment during the last ED before the departure, and Admit Decision using the encounter order, last ED, and before the departure.

So if the assessment is present, then the logic would not execute the part about the encounter order.

So whichever one has the non-null expression. So between these two functions, and then also look for which one of these functions also has the ED departure time and an inpatient encounter. And then again, it takes the first one that has a non-null value. Hope that helps.

27:10

All right. Let's take it to the next question.

So for this next question, can an ADT-1 Documentation of a Bed Request be used over an ADT-9 Decision to Admit for admitted patients?

27:37

Well, there is no hierarchy for the acceptable concepts for the encounter order of the decision to admit. So those acceptable items are for an order are the admission order, physician order, documented bed request, or the documented acceptance from an admitting Physician. So there's not a hierarchy there. Now, regarding the assessment performed, we talked about that coalesce so, in that coalesce, the first one is assessment performed.

So, if there is an evaluation, assessment performed evaluation, that one would be considered first before the encounter order. But just based on the encounter order, there's not a hierarchy for those four options.

28:27

All right, let's take it to the next question.

For this next question, if there are multiple ED visits and multiple facility locations, which one should be used?

29:00

Well, prior to 2021, the logic may have selected an ED visit for the initial population. And a different ED visit in the measure observation.

But for the 2021 version, this will calculate the ED visit that is used in the initial population. That is an ED within an hour of the inpatient admission, where there is a Decision to Admit that was during the ED encounter and prior to the departure from the ED, and not include ED visits that did not have a departure time.

So therefore, the measure observation will use the same most recent, or the last ED visit that qualified for the IP. So, because it has to meet all of this criteria now, it should only be selecting one ED visit. I hope that helps.

30:04

Yeah, Angela it does, I think I'm tracking,

So, basically, if I may, if the specifications are met, then that last qualifying ED visit should be used by the measure observation function to do the calculations for the duration.

And let's take it to the next question.

30:43

OK, so for our next question, if a patient comes to the ED and a Decision to Admit to observation is ordered, but then at that 23rd hour the patient is transferred to inpatient, is that patient included in the initial population?

Great question.

So the data for this measure is actually assessed after the inpatient hospitalization ends, for an encounter that was equal to or less than 120 days.

So, in retrospect review of this encounter, does the chart reflect an inpatient admission to follow an ED visit within an hour, with a Decision to Admit to inpatient.

If that is the case, then the patient encounter, would be considered an initial population.

However, if in this retrospective review, it does not indicate that the inpatient admission followed the ED visit with a Decision to Admit, that it would not be considered part of the initial population.

31:53

Right. So, in part, there seems to be some variation pending on hospital workflow that would need to be accounted for.

32:04

That's true, Mia, it makes it impossible for us to be able to give a definitive answer, because it's all about when assessing the chart, after the patient was discharged from an inpatient stay, does the chart reflect that decision to admit an inpatient stay that occurred within an hour of the ED discharge time?

32:26

So, in some places, I understand that observation is part of the ED, so then that ED time would be reflected so that they went from ED or ED/observation to an inpatient encounter.

But some facilities, their observation is not part of their ED, and they may leave that as observation.

And so, it may look like this huge gap from the ED to observation to inpatient.

It would appear to be hours before that patient left the ED, and went to inpatient, and, therefore, it would be longer than that... not within that one hour. So, then it would not be included.

So, those processes do vary from hospital to hospital. We just didn't give a definitive response.

Yeah, I definitely hear that. That same situation occurs within the hospitalization functions across the other EH measures. So I've seen those questions that come through that vary with hospital workflow.

33:30

Sure. Yeah. I bet.

All right so let's go ahead and take it to the next question.

34:10

OK, last question. If a patient arrives and was discharged from an emergency department in CCN 1, and is admitted as an inpatient in CCN 2, how would that impact the initial population?

Do you need to match the CCN of the Emergency Department and the inpatient encounter?

And how will this patient qualify for the initial population?

34:48

Another question we have received a few times. So if the CCN is not shared by the ED and this hospital, the patient should not be included in the ED-2 measure. The measure intends to assess the time the Decision to Admit was made to the time patients physically left.

You know, departed the hospital ED.

If the hospital has an offsite ED with the same CCN as the hospital the patient is being admitted to, then that patient may be included in the initial population. But if the CCN is not shared by the ED and this hospital then these would not be accessible to include an initial population for ED-2.

35:38

Well, Angela, that looks like it's our last question. Thank you so much, again, for participating.

Thank you, Mia, it's been great to be here.

That concludes our Q&A.

35:49

There are two more questions with answers we are providing on-screen. Please read them at your own pace. After this segment you'll be given instructions on how to obtain CE credit.

39:27

Measure specifications and other eCQM resources can be accessed through the eCQI Resource Center. For eCQM related questions, submit a ticket through the ONC JIRA platform. The CMS Blueprint provides additional guidance for eCQMs.

39:52

All current and previous Expert to Expert Webinars can be accessed on the Joint Commission's webpage via these links shown on the screen.

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This will launch the PDF that includes a table that has links to all of our previous webinar recordings, slides, transcripts, and Q&A documents. For more information, visit the Pioneers in Quality landing page for information on our Expert to Expert and other Pioneers in Quality programs.

40:25

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41:00

Thank you to our presenters and thank you for participating in this webinar.

[41:05-45:00 references and addendum slides provided on screen]