

Transcript

Pioneers in Quality – Expert to Expert Annual eCQM Update Series STK Measures and PC-05 On-Demand Webinar December 2020

0:01

Thank you for joining us for our Pioneers in Quality on demand webinar series: Expert to Expert 2020 eCQM Annual Update Series for the 2021 Reporting Period.

0:13

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

0:21

This on demand webinar series will offer continuing education credit.

0:27

This webinar series addresses changes that occurred during the 2020 eCQM Annual Update Cycle for the STK and VTE Measure sets, PC05, and ED-2.

0:39

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.

0:50

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&A.

1:01

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

1:12

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 eCQMs and eCQI education page.

1:44

Today's session will focus on the eCQM annual updates for the STK and PC-05 measures. Before we start, we'd like to offer just a few tips about webinar audio.

1:54

Use your computer speakers or your headphones to listen. Feedback or dropped audio are common for streaming video; refresh your screen, if this occurs. You can pause the playback at any time.

2:05

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.

2:31

As noted in the introduction, CE credits are offered for this on-demand webinar series.

2:37

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3:07

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3:22

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3:54

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

Apply concepts learned about the logic and intent for the stroke and PC05 eQMs,

Identify common issues and questions regarding the stroke and PC05 eQMs, and

Prepare to implement the stroke and PC05 eQMs for the 2021 eQM reporting period.

4:19

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.

4:34

Susan Funk, Marc Hallez, Karen Kolbusz, Susan Yendro, Yanyan Hu, and Mia Nievera.

4:42

I'm Susan Funk, Senior Research Associate and the Lead Operations Staff for Pioneers in Quality

4:47

My name is Marc Hallez and I work at the Joint Commission as an Associate Project Director on the eQMs team.

4:53

My name is Karen Kolbusz and I'm an Associate Project Director at The Joint Commission on the clinical team and the clinical lead for the stroke measures.

Hi, I'm Susan Yendro - I'm a Project Director in the Department of Quality Measurement and I've been working with the Perinatal Quality Care Measures for a number of years now.

5:13

Hello everyone, I'm Yanyan Hu, I'm the Measure Lead for PC-05 on the eCQM team.

And I'm Mia Nievera, Project Director for the eClinical Team.

5:24

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

5:35

Thank you, Mia.

5:37

Stroke performance measures are used to evaluate the care provided to both ischemic and hemorrhagic stroke patients. The chart-based stroke measures and specifications were re-specified as electronic clinical quality measures or eCQMs and required by CMS Inpatient Quality Reporting in 2016.

5:58

Today, we will discuss STK-2, discharged on antithrombotic therapy; STK-3, anticoagulation therapy for atrial fibrillation flutter; and STK-6, statin medication prescribed at discharge.

6:14

These three measures address medications for secondary stroke prevention and have been proven to decrease the risk of another stroke in patients who have had an ischemic stroke.

6:27

We will also discuss STK 5, antithrombotic therapy administered by the end of [hospital] day 2.

6:35

The evidence supporting this measure demonstrates that early antithrombotic therapy, in particular aspirin, administered within 24 to 48 hours of stroke onset, reduces ischemic stroke morbidity and mortality. Ischemic stroke is associated with atherosclerosis, which is more common in older patients.

6:58

Recently, there have been case studies reporting large vessel strokes in an increasing number of patients younger than 50 years of age, who also tested positive for COVID-19.

7:11

Complications of the coronavirus include thrombotic and embolic conditions, such as pulmonary embolism and deep vein thrombosis, acute myocardial infarction, and ischemic stroke.

7:24

The stroke eCQMs have been and remain clinically relevant and important measures for use, especially in light of the current COVID pandemic.

Marc, take it away.

Thanks, Karen. I'll take it from here. Let's dive right into the initial population of the stroke measure set.

7:46

The initial population are patients aged 18 and older.

7:50

They must be discharged from inpatient care, that are non-elective admissions.

7:56

Their length of stay must be less than or equal to 120 days and must also end during the measurement period.

8:05

New for 2021. Due to a QDM update, the Principal Diagnosis attribute has been removed, and is now represented using the encounter diagnosis attribute, and its components of rank equals one and a code, and hemorrhagic or ischemic stroke.

8:25

The first measure we'd like to review is STK-5, antithrombotic therapy by the end of hospital day 2.

8:33

Moving on to the denominator. We're now looking for patients with a diagnosis of ischemic stroke only.

8:40

We start with encounter with principal diagnosis and age. And, as you'll note in the yellow box, they are the three definitions that make up our initial population that we just reviewed.

8:52

A change to note, for the 2021 recording year, we are utilizing the same approach with the ischemic stroke encounter that we are with all stroke encounters from the initial population.

9:04

That denominator now also utilizes rank (the rank attribute) to identify a primary diagnosis of ischemic stroke.

9:14

On to the denominator exclusions, patients who have a length of stay less than two days, patients with comfort measures documented on the day of or the day after arrival, patients that had intravenous or intra-arterial thrombolytic therapy, TPA, administered within 24 hours prior to arrival or anytime during hospitalization. The union operator allows for any one of these conditions to meet the denominator exclusions.

9:46

You may note two different colored boxes calling out the exclusions.

9:50

For the 2021 recording here, we have updated the encounter with thrombolytic therapy, given prior to arrival or during hospitalization definition.

10:01

It has been consolidated from four definitions into one. Our first exclusion is encounters less than two days. There were no changes for this definition for the 2021 reporting year.

10:15

We use ischemic stroke encounter as the qualifying encounter, that moves through our measure algorithm.

10:22

Next, we use the function called hospitalization with observation length of stay to calculate encounters that are less than two days.

10:32

Here's the next exclusion. The encounter with comfort measures during hospitalization definition. We did not make any changes to this definition for the 2021 reporting year.

10:43

As a refresher, we use the Coalesce function that is a CQL operator, that allows for if/then logic to look for two time attributes.

10:54

It first looks for the intervention performed relevant period. If that does not exist, then it looks for author date time of either intervention order, or the intervention performed, documentation.

11:09

We use the function calendar day of, or day after, which looks for concrete measures to occur, anytime the day of hospitalization and one calendar day after hospitalization.

11:23

Here are the consolidated definitions we have previously mentioned.

11:28

Let's review these definitions individually to highlight any changes for the 2021 reporting year. In the first definition, encounter with thrombolytic therapy medications or procedures, we combined the medication administration and the procedure performed of thrombolytic therapy to be a union state.

11:47

We then look for thrombolytic therapy to start 24 hours or less prior to the hospitalization, which includes Emergency Department and observation encounters, that end less than one hour prior to the inpatient encounter and the next definition criteria.

12:06

Patients that receive antithrombotic therapy prior to admission should be excluded from the denominator.

12:12

The exclusion Encounter with thrombolytic therapy prior to arrival uses the new component code from the diagnosis attribute to select status post administration of t-PA.

12:24

No changes were made to this exclusion, the exclusion uses the diagnosis data type to look for the history of the same diagnosis code, status post, administration of t-PA.

12:36

We use the author date time attribute to capture when the diagnosis was documented during the encounter.

12:43

This allows for a clinician to document that the patient received t-PA prior to arrival to the current hospitalization at any time during the hospitalization.

12:55

Moving on to the numerator, no new changes were made here. The numerator is looking for patients who had antithrombotic therapy administered, the day of or day after hospital arrival.

13:08

Next, we'll cover the denominator exceptions.

13:10

Inpatient hospitalization for patients with a documented reason for not administering antithrombotic therapy the day of, or day after, hospital arrival.

13:23

Inpatient hospitalizations for patients who receive Ticagrelor or Prasugrel as an antithrombotic therapy the day of, or day after hospital arrival, inpatient hospitalization for patients with an INR greater than 3.5.

13:42

Looking at the first exception, there are no new changes.

13:46

These definitions simply use the data types: medication not administered, and medication not ordered with negation rationale attribute to indicate the reason why the medication was not given or ordered, as either a medical reason or patient refusal.

14:05

This documentation should be completed the day of, or the day after hospitalization starts.

14:13

We have revised the denominator exception encounter with pharmacological contraindications for antithrombotic therapy given the day of, or day after hospital arrival.

14:24

For the 2021 reporting year, this exception previously only included the medication Ticagrelor, and we have now added Prasugrel to this exception. The two medications are rolled up into one value set named "pharmacological contraindications for antibiotic therapy."

14:44

We then look for administration of these medications on the day of, or day after the start of hospitalization.

14:52

Moving on to our next exception, this was previously the denominator exclusion. There are no changes to the contents of the definition.

15:00

The definition was moved to better align with clinical intent.

15:05

We use the laboratory test performed data type, and the result attribute to look for an INR result greater than 3.5. The result date time attribute is the time when the lab result populates in the EMR.

15:22

We're looking for the INR result to occur the day of, or the day after, the start of hospitalization.

15:31

Stroke 2 - Discharged on antithrombotic therapy. We reviewed the initial population previously, so we will dive right into the denominator. The denominator is the same definition from STK-5.

15:43

So we can move on to denominator exclusions. There are several denominator exclusions. No changes to the 2021 reporting year. Patients admitted for elective carotid intervention are not addressed in the exclusion definition.

15:57

The exclusion is actually addressed in the initial population by only including non-elected hospitalizations. The exclusions we're then looking for are: patients discharged to another hospital, who left against medical advice, who expired, discharged to home for hospice care, discharged to a health care facility for hospice care, or comfort measures during hospitalization.

16:26

Moving to the second expression, comfort measures during hospitalization. This is using the same logic we reviewed in STK-5. The only difference is in the timing, where here comfort measures can occur at any time during the hospitalization.

16:39

Notice the union again. So a patient can meet either one of these conditions to satisfy the denominator exclusion.

16:49

The numerator for STK-2 was not revised for 2021 either.

16:54

The definition is looking for patients prescribed or continuing to take antithrombotic therapy at hospital discharge.

17:02

The timing associated to medication discharge accounts for the time the discharge medication list, on the discharge instruction form, is authored, which should be done prior to discharge and during the encounter.

17:20

Moving along to denominator exceptions. We're looking for patients with a documented reason for not prescribing antithrombotic therapy at discharge. And new to 2021 reporting: "patients who received Ticagrelor or Prasugrel therapy during the hospitalization encounter with no anti-thrombotic therapy at discharge" looks for a reason the patient did not receive an antithrombotic at discharge, which has to be documented during the encounter.

17:51

Now for the second condition, encounter with pharmacological contraindications for antithrombotic therapy at discharge. This exception was revised for 2021, where we are looking for Ticagrelor or Prasugrel, administered at discharge, during the patient's hospitalization.

STK-3 - Anticoagulation Therapy for Atrial Fibrillation, we are utilizing the same initial population.

18:20

So let's focus on the denominator. The denominator for STK-3 is looking for patients with a principle diagnosis of ischemic stroke and a history of atrial ablation, or current, or history of, atrial fibrillation or flutter.

18:39

There have not been any changes to this definition for 2021. In the first condition, we're looking for a "procedure of atrial ablation was performed" before the start of the encounter.

18:53

In the second condition, we're looking for a "history of atrial fibrillation or flutter" using the diagnosis data type.

19:01

The "prevalence period" attribute is looking for the onset of atrial fibrillation or flutter to start on, or before, the end of the encounter.

19:12

And for the third condition, the logic is looking for atrial fibrillation as an attribute of the encounter.

19:19

So it is tied to this admission.

19:23

We have not made any changes to the exclusions for the 2021 reporting year. But what I do want to note, is that although the denominator exclusions for STK 2 and 3 are the same, there is a slight difference. Because remember, the denominator for stroke 3 is different.

19:43

In this measure, the definition denominator is pulled through the measure algorithm as the qualifying encounter as highlighted.

19:52

Which means, we can use the same data types, attributes, and value sets across the measures, and only change the qualifying encounter for each respective measure.

20:05

As we move through the stroke measures, you will see the same method applied for other definitions.

20:13

And, again, although the numerator is the same, for STK 2 and 3, we apply the same concept of using the denominator encounter to start the expression. Also note that there are no changes for 2021, there were not any changes to the exceptions for 2021.

20:30

Again, the same concept applies where the logic is unchanged, but we use the denominator and encounter to start the expression.

20:38

STK-6 - Discharged on Statin Medication, has the same initial population, and denominator as our previous measures. On to the denominator exclusions... There have not been any changes to the denominator exclusions and STK-6 with the 2021 reporting year.

20:55

This is using the same logic we reviewed as our previous measures, which takes us to the numerator. The numerator is looking for patients prescribed, or continuing to take, statin medication at hospital discharge. The statin at discharge definition also uses "medication discharge" data type.

21:15

We learned previously that this data type uses the time the discharge medication list on the DC instructions is authored at the time-stamp to satisfy this measure.

21:26

We did not make any revisions to this definition for the 2021 reporting year.

21:33

The denominator exception is looking for patients with a reason for not prescribing statin therapy at discharge or patients with a maximum LDL result of less than 70 milligrams a deciliter greater than or equal to 30 days to the arrival, or anytime during the hospital stay.

21:53

Patients with a documented statin allergy or intolerance will also satisfy the logic.

22:00

In the first expression highlighted, “statin not given at discharge,” uses the same negation rationale, as we discussed in the previous stroke measures.

22:10

There were no revisions made to this definition for 2021. This definition has remained the same for 2021, as well.

22:19

In this next definition, we use the CQL operator of “max,” which returns the maximum element of something.

22:27

In this case, the highest LDL result, and the “return” clause helps to shape that the result is a maximum LDL of less than 70.

22:37

For the timing for this logic, we're looking for the result date time, which is the time the LDL was resulted in the EHR to be 30 days or less, before the start of the encounter and anytime during the encounter until discharge.

22:53

And with that, we end the annual updates review.

22:57

Stay tuned for the Q&A, where I ask our measure leads questions from JIRA.

23:11

Karen, we've received a lot of questions regarding Lovenox and why 40 milligrams is not included in the antithrombotic value set. Can you give some clarification around that?

Lovenox 40 milligrams Sub-Q is generally given for VTE prevention. Stroke patients require antithrombotic therapy within 24 to 48 hours of stroke onset and the recommended antithrombotic medication is aspirin for early antithrombotic therapy. So, a stroke patient should receive both antithrombotic therapy and VTE prophylaxis, whether it is Lovenox 40 milligrams Sub-Q or another form of VTE prophylaxis.

24:03

Yeah. Mia, I just wanted to add that this is a really good question and one that has come up quite a bit in our Jira tickets. So from the value set perspective, the antithrombotic value set uses RX-Norm codes with the term type of SCD, which is the semantic clinical drug. The SCD refers to active ingredients, strengths, and dose formulation, not how much the patient was given, which is a very important distinction. Although the measure intent is to give a therapeutic dose, the dose is not specified in the logic and is not intended for the value set. In the upcoming annual update cycle we will be including all applicable SCD codes into the antithrombotic therapy value set, which will include the Enoxaparin 40mg code. Again, not because it meets a therapeutic dose but because it is a formulation that could be used as a therapeutic dose.

Right, so in other words, if you were looking to capture the medication dose that would be called into the logic. But since that's not the intent, the value set is really there to represent the medication concepts to meet measure intent.

Yes, that's correct.

OK. And here's our next question.

25:28

So this question is for STK-2. If an antithrombotic medication is prescribed at discharge while the patient is in observation, will that count towards the numerator?

Yeah. That's a question that comes up sometimes, Mia. Discharge data type looks for the time that the discharge medication was offered and that means not the time the medication was prescribed.

Right, OK. So it is looking for the timestamp on the medication discharge list.

Yep, that's right.

Great, thanks for the clarification. On to the next question...

26:17

For this next question, were the clinical trials excluded from the stroke measures?

So, no, the short answer is that it lies in the medical reason value set.

And there is a code called "Clinical Trial Participant" that is not discreetly called out in the logic but it is in that medical reason value set.

Makes sense.

It is evaluated in the denominator exception criteria as a documented medical reason for not prescribing or administering the medication across the stroke measures.

I see, so, it was just consolidated in one value.

Yes, that's correct.

Next question, please.

27:00

So, Marc, this question is for you, not new for 2021, but still a common question, and that's with the hospitalization with observation function. Can you go through that a little bit more in detail?

Oh yeah, Mia. You know, the best way for us to do that would be to look at the slide together. And we'll go over the logic piece-by-piece.

Great.

That'll make the most sense.

Yep, I have that right here for you.

27:29

Here's the logic of the hospitalization function.

The "let" clauses that are highlighted here, only introduce content that can be referenced within the scope of the query. So in this case, we're referencing the ObsVisit in the first section of the logic.

So if an ObsVisit exists, that will provide the most recent or last Obs using the last operator and that ends one hour or less on or before the inpatient encounter. So, we want it to be within 60 minutes.

In the "visit start" clause, that's in the next section, we're defining where and when the visit begins. We use coalesce as a CQL operator that allows for conditional logic.

So, if an observation visit occurs or exists, then the visit starts at observation. If not, then it starts at the inpatient admission.

But what about ED visits.

In the last next clause, it says it starts with ED visit.

The last ED visit has to end one hour or less on or before the visit start. In the return clause, we use the coalesce function again to determine where the hospitalization begins.

How does that relate into a real setting or a case?

Yeah, when you look at the logic, it's not readily apparent to you what kind of different scenarios might be acceptable.

So, in our next slide, we look at that in a little bit more detail. Here's an illustration of the pathways the hospitalization function can cover.

29:10

The start of the encounter depends on the pathway into the hospital. So, let's look at the admission through the ED examples.

In the first one, if a patient is admitted from the ED to inpatient, in order for the ED visit to count, the transition time between the ED end, and the inpatient start, must be equal to one hour or less, so anything less than 59 minutes will count, 60 minutes will count too.

So, in the second example, in order for the observation to count, then the transition times between the ED end and the OBS start, and the OBS end and the inpatient start must be equal to one hour or less.

The timing is very important for these hospitalization functions to work.

Right, so if I'm hearing you correctly, then, anything outside of that, those specific transition points would not be included into the hospitalization function.

That's correct.

Yeah, okay, let's take that to the next question.

30:21

This is for STK-5, and I think this is pertaining to the function of "calendar day of, day after." And the question is if a patient is admitted on 7/1 at 9 AM, what is the cutoff for when an antithrombotic medication can be given to pass the numerator?

Yeah, it does. The "calendar day of, day after" function is, again, best examined when we look at a slide. Here's an illustration of "calendar day of or day after" timeframe.

There's a short answer there. and the bottom line is, anytime that day one starts, the second day will always end at 11:59 PM.

So, if the patient was admitted at 7AM on day one, they would have until 11:59 PM on day two to meet the exclusion.

The occurrence can start anytime during day one, but it will always end on the next day at 11:59 PM.

So, if you're saying that, if a patient came in at 11:59 PM on day one, that they still only have until 11:59 PM on day two to meet the numerator. Correct.

I think this graphic does help illuminate that...

It can be a little confusing as to how do you start the day one or the day of and the day after, correct., yeah.

Thank you, Marc and Karen for participating. That concludes our Q&A.

I'll turn it over now to Susan who will introduce PC-05.

32:04

Thank you, Mia.

The intent of this [PC] measure is to increase the number of newborns who are exclusively fed breast milk during their entire hospitalization.

Evidence has shown us that breastfeeding or human milk is the recommended standard for infant feeding. This has been well-documented that short-term and long-term medical and developmental advantages exist to breastfeeding. HealthyPeople, CDC, and many other organizations actively promote this goal. We continue to see an opportunity for improvement. However, in that, the aggregate rate for organizations submitting the eCQM to The Joint Commission was 58% in 2018. Now it's important to note that it is not anticipated or expected, that measure rates will reach 100%. Our available evidence suggests that a 70% threshold may be the more reasonable target for most organizations.

And with that, we'll hand it over to Yanyan.

33:05

Thank you, Susan.

Hello, everyone. Today, we're going to talk about PC-05.

This is the initial population.

Single live term newborns who were born in the hospital that ends during the measurement period will be in PC-05 initial population.

You may note two different boxes called out here. The 2021 initial population is listed in the top of the box.

33:38

So, for 2021, we've added the birth weight condition to identify a term newborn and also remove diagnosis of galactosemia lengths of stay conditions to the denominator exclusions.

We will talk about it in the later slides.

34:00

The definition for the initial population is single live term newborn encounter during measurement period. To build the initial population by using union, either gestational age 37 weeks or more, or birth weight 3000 grams, or more, will be in the initial population.

Single live first encounter is a basic definition used in initial population.

For 2021 reporting year, we added code as a component to the attribute of "encounter diagnoses" to identify single, live born newborn, born in the hospital.

That definition, single live birth encounter with gestational age of 37 weeks or more, uses gestational age results greater than equal to 37 weeks to look for term newborns.

35:01

In 2021 version, we add a new definition, single live first encounter with birth weight 3000 grams, or more without gestational age where we are looking for a birth weight greater than equal to 3000 grams, only when that estimated gestational age is not present in the patient records.

35:29

We are using the “relevant date time” attribute to check if the actual assessment performed time is during encounter relevant period.

Because the denominator doesn't change from initial population, we can simply call it in initial population as a definition.

By doing that, we in fact carry through all the definitions from the initial population into the denominator. So then the definition single live term newborn encounter during measurement period becomes the qualifying encounter to continue moving through the measure algorithm.

36:12

Denominator Exclusions. You may note two different colored boxes here, comparing 2021 to 2020.

So for 2021, in addition to three discharge dispositions from the 2020 reporting year, we've added three more conditions of lengths of stay greater than 120 days, a diagnosis of galactosemia and subject to parental nutrition. If you recall earlier, we use single live term newborn encounter during measurement period as qualifying counter to continue moving through the measure.

We used encounter performed attributes, facility locations, and the codes, to identify a neonatal intensive care unit.

37:06

We also use the attribute discharge disposition to identify patient expired or discharged to acute care facility or other health care facility.

Any newborn's discharge to any one of these places will be excluded from a nominator, PC-05 is also excluding newborns with length of stay greater than 120 days, by using global function “length in days” to calculate inpatient encounter relevant period.

37:42

The last denominator exclusion is looking for if an encounter has “procedure performed in parental nutrition” and the procedure must start during encounter all newborns with encounter diagnoses of galactosemia. Again, here we have added code and component of encounter diagnosis in 2021 reporting year. The PC-05 numerator is looking for single live first encounter with newborns who were fed breast milk only since birth; no change is made to this definition for 2021 year.

38:27

In the first condition, the logic is looking for a qualifying encounter with “substance administered” in breast milk value set, and the substantive illustration must start during this encounter.

In the second condition, we also use “substance administered”, data type to look for dietary intake other than breast milk, and the substance was administered starts during the encounter.

So the PC-05 numerator is looking for an encounter with a substance administered by breast milk-only and without any other dietary intake.

39:13

That concludes our measure review. Stay tuned for the Q and A.

39:26

Welcome to the Q&A, So, we'll begin with the first question. Why did length of stay, a diagnosis of galactosemia, and the administration of parental nutrition move to the denominator exclusions?

Good question. The Joint Commission is currently developing a new eCQM measure, PC-06, and having a common initial population applicable for both measures will reduce the burden for hospitals.

Most changes for PC-05 in 2021 year move criteria that results in a removal of patients from the initial population to the denominator exclusions. So that's the changes for 2021, and the reason why.

Susan, did you have something to add?

And I would just add that these changes were also made in the chart-abstracted measures for PC-05 and PC-06 to keep the measures in alignment between chart-abstracted and eCQM.

Right, I see, Makes sense.

Here's our next question.

40:41

Why was 3000 grams added to the initial population?

I can answer that, Mia. We added that as a proxy in order to identify term newborns in the case that perhaps there isn't an estimated gestational age or term newborn listed in the [EMR/EHR] right.

That makes sense. If you didn't have EGA documented, this was just another way to capture a term newborn. Great. So, Yanyan, could you explain how this proxy works in the logic?

Sure, I'd love to. Here is a slide for the initial population. The highlighted text addresses how and when birth weight is evaluated on a birth weight criteria to the initial population or patient with missing estimated gestational age at birth. So, this means only when the first gestational age is missing from the EHR records, the newborn birth weight will be evaluated.

Here's our next question.

41:55

So this is an interesting question. If the newborn is given glucose gel, does that count as a feeding?

Yeah, I'll take that one Mia. So, dextrose or glucose gel at 40% is considered a medication and not a feeding. This should be reflected as such in the medical record.

Great, thanks Susan. Next question. Oh, another good question. Why were the maternal medical condition exclusions removed?

42:30

Hmm, good question.

The maternal medical condition exclusions never modeled in the eCQMs.

So Susan, do you have any additional input?

Oh, yeah, so we originally had maternal conditions modeled in the chart-based measure. And our analysis showed that it was less than 2% of the time that mothers had these maternal conditions for exclusion, and it really wasn't worth the burden of collecting data on all of those elements. And that's why we removed them from the chart-abstracted measure, and they were never modeled for the eCQM.

43:16

Makes sense. Well, thanks for that clarification and something to think about for the future.

And on to the next question.

43:34

All right. It looks like it's our last question is a specialty care unit considered an ICU location?

43:41

Yeah, so clinically, what we're really looking for, the intent is, those babies who are in a critical care unit, those units that are focused with the right people, and equipment, to take care of really sick babies, those critically ill babies.

44:00

Yanyan, you have more to add to that?

Yes, On the eCQM side that we use facility location codes, there are two value sets, one is the SNOMED value set, there's only one on neonatal intensive care unit codes, for the other value set. We have two location codes. One is the neonatal critical care Level 2 and 3. The other one is critical care, Level four.

44:37

Right. So, we really don't want to focus on just the facility location name but more so focus on the intent, which is: does that unit provide critical care services? And if so, then that would meet the intent of the measure.

Yeah, that's correct.

Yeah, I agree.

Great. Thank you, Yanyan and Susan. That concludes the Q&A.

45:04

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.

45:25

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46:32

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