The Joint Commission recognizes that many call participants had questions regarding Joint Commission ORYX measurement requirements for calendar year 2017. To address these questions, we plan to offer a follow-up webinar on Tuesday, February 14th. Your questions will be answered at that time, along with additional time for Q&A. Follow this link to register: https://www.jointcommission.org/webinar_piq_2017_oryx_ecqm_requirements_reporting/

Questions Regarding CMS ICD-10 Addendum Presentation

QUESTION #1: How often do you anticipate these value sets changing? At least once with the federal fiscal year each October?

Answer: CMS is currently investigating the possibility a yearly addendum, but no decisions have been made at this time. Value sets will continue to be updated as part of the annual update to the measure specifications.

QUESTION #2: looking at the TRN now, is there a way to determine which codes were added or deleted? Or do you just get to review the new OID?

Answer: The TRNs provide information on which OIDs have been updated as part of the addendum, including an overview of the number of codes added and deleted. For more details, please visit the National Library of Medicine’s Value Set Authority Center (https://vsac.nlm.nih.gov) which provides all the eCQM value sets as a complete set, as well as value sets per measure.

QUESTION #3: Looking for OID/mapping implementation on the CMS website?

Answer: More information on implementing and mapping of ICD-10 codes can be found on the CMS website at: https://www.cms.gov/Medicare/Coding/ICD10/Frequently-Asked-Questions.html

QUESTION #4: What is the effective date, 01/01/2017?

Answer: The ICD-10 update is effective 10/1/2016, however the effective date for value sets in the ICD-10 addendum released by CMS is 1/1/2017.
QUESTION #5: There were significant implementation concerns raised in the Value Set Impact Committee and other forums about any code changes that would be retroactively effective. Were these concerns considered in the decision to release value set changes after Jan 1 and if so, why were they ignored?

Answer: CMS appreciates the feedback from the Value Set Impact Committee and other forums. In making the decision to proceed with the ICD-10 addendum, CMS considered all the feedback from stakeholders, but determined that updating the ICD-10 addendum would benefit hospitals in their 2017 reporting. CMS is reviewing the possibility of future addendums and will continue to consider the effect on implementation.

QUESTION #6: Due to CMS re-evaluating the eCQM requirements, is Joint Commission planning on making any adjustments with their requirements?

Answer: The Joint Commission will continue to closely monitor CMS activities surrounding this issue to include review of the release of the FY 2018 IPPS proposed rule that we anticipate will be released in late spring followed by the final rule, anticipated to be released late July/early August 2017. Following release of the FY 2018 IPPS final rule the Joint Commission will determine if any modifications should be considered regarding the reporting of eCQMs to The Joint Commission for 2017.

QUESTION #7: If ICD10 is automatically mapped from the billing side of the EMR, we don’t rely need to remap any of these ICD10 removals/additions do we? We just need to be aware in case it impacts workflows, internal reporting, etc.?

Answer: If ICD10 is mapped from your billing system and your billing system implemented the October 1, 2016 ICD-10 Addendum, you are likely already using the additional codes. You should confirm this with your EHR and/or reporting vendor.

QUESTION #8: Will the mapping [for The Joint Commission] be the same as what CMS is requiring for mapped requirements?

Answer: The Joint Commission uses the same measure specifications and value sets as CMS, so your mapping would be the same.

QUESTION #9: We have a question regarding the eCQM VTE-1 specifications. It is suggested by the specifications that the OB patients are excluded from the measure. After reviewing the list of OB codes that are excluded, there are other OB codes that are not listed! The below normal “OB” codes are not listed as any of the OB exclusion codes for VTE1. Could you please confirm these OB codes are included or excluded from this measure? [followed by list of codes]

Answer: Questions about the technical implementation and clinical workflows of eCQMs, inclusions/exclusions should be sent to JIRA.
Questions or issues with eCQMs are reported via JIRA. JIRA is the Office of the National Coordinator’s (ONC) tracking system that is a collaboration platform that supports the implementation of health information technology by providing a space in which internal and external users can transparently log, prioritize, and discuss issues with appropriate subject matter experts on a host of topics. In order to submit an issue, you will select the CQM Issue Tracker project.

Click here for the CQM Issue Tracker

**QUESTION #10:** if we have a vendor who submits our data now will they submit our eCQM for us?

**Answer:** Hospitals may continue to use a third party, i.e., ORYX vendor, to submit QRDA Category I files on their behalf. A hospital may utilize a different listed ORYX vendor for chart abstracted and/or eCQMs. However, the vendor must support all of the measures in a topic area with multiple measures. For example, a hospital may use one vendor that supports the two chart-abstracted ED measures and a different vendor that supports the two ED eCQMs, or a single vendor that supports both. The Joint Commission eCQM Vendor List can be found here: https://www.jointcommission.org/core.emeasure_pilot_project_systems_list/

**QUESTION #11:** We found out that the RXNORM codes on medications that we have are not the same as that listed on the UMLS website. Who do we communicate it with? This is for Stroke measures.

**Answer:** Please report issues with measures to the ONC JIRA Clinical Quality Measures (CQM) project, located here: https://oncprojecttracking.healthit.gov/support/projects/CQM

**QUESTION #12:** We are changing EMR vendors in October 2017, can we submit from 2 separate vendors within that one-time reporting period for the Joint Commission requirement?

**Answer:** If your hospital believes it has an extenuating circumstance beyond its’ control (e.g., EHR implementation issues, natural disaster) that may impact the ability to report 2017 ORYX measure data to The Joint Commission for a defined period of time, please request the Extenuating Circumstance Form. Note: In making the request for the form, please indicate whether this is for an individual hospital or a healthcare system that has multiple facilities with a common mitigating situation. Send an email to hcooryx@jointcommission.org and include in the e-mail subject line: Request for Extenuating Circumstance Form – Individual Hospital (include HCO ID) or Healthcare System (Include Healthcare System Name). The forms are due February 10, 2017.

**QUESTION #13:** Is TJC going to require a different format for submission?
**Answer:** The Joint Commission and CMS use the same format. eCQM data must be reported using Quality Reporting Document Architecture (QRDA) Category I files.

**QUESTION #14:** What is the update on having a Joint Commission secure portal available for testing of file transmissions?

**Answer:** The Joint Commission is looking at all our options for eCQM direct submission to select the right technology solution and we plan to have a solution in place for 2017 eCQM data submission.

*Questions Regarding eCQM Updates for 2017.*

**QUESTION #1:** I’m having trouble wrapping my brain around the difference in results between the eCQM submitted results and the chart abstracted results. Shouldn’t the chart abstracted and eCQM measure results match? Are the manual chart abstraction data elements guidelines the same for the eCQM measures?

**Answer:** We do not expect eCQM submitted results and chart abstracted results to be identical. For a further discussion of the reasons for differences, we suggest you review our eCQM 101 webinar, slides, and Q&A documents, located here: https://www.jointcommission.org/time_to_get_back_to_ecqm_101_-_a_breakdown_of_the BASICS

**QUESTION #2:** Does TJC have a list of vendors that can submit these data on behalf of the providers or will individual hospitals be given access to some secure server space? If so, does it match the CMS list of vendors?

**Answer:** The Joint Commission eCQM Vendor List can be found here: https://www.jointcommission.org/core_emeasure_pilot_project_systems_list

**QUESTION #3:** Are all these measure changes aligned for both CMS and TJC?

**Answer:** Yes. The Joint Commission and CMS accept 2017 eCQM discharge data that are consistent with the April 2016 annual update eCQM specifications posted on the CMS website for the 2017 Reporting Year. See eCQMs for Eligible Hospitals and Critical Access Hospitals, eCQMs for eReporting for the 2017 Reporting Period (as of April 2016): https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

**QUESTION #4:** How will all these measures get submitted to you?
**Answer:** eCQM data must be reported using Quality Reporting Document Architecture (QRDA) Category I files.

The Joint Commission is looking at all our options for eCQM direct submission to select the right technology solution and we plan to have a solution in place for 2017 eCQM data submission.

For organizations choosing to submit measures through a vendor, the Joint Commission eCQM Vendor List can be found here: [https://www.jointcommission.org/core_emeasure_pilot_project_systems_list](https://www.jointcommission.org/core_emeasure_pilot_project_systems_list)

**QUESTION #5:** What is your recommendation for those non-IT clinical folks to understand all of the measures clearly and what has to be done?

**Answer:** We acknowledge the technical nature of the topics presented today. eCQMs are a new measure format that will require non-technical quality staff to develop some understanding of eCQM logic, value sets, and standard terminologies. There are a number of “101” presentations available for your review. We suggest the following:

**Joint Commission Webinars**

Available on the Pioneers in Quality portal, the following links will take you to a webinar recording, downloadable slides, and a Q&A transcript:

- Pioneers in Quality: Time to get back to eCQM 101
- Pioneers in Quality: ABCs of eCQMs: Acronyms and Resources You Need to Know
- Pioneer in Quality; eCQM Implementation and Submission Insights (presented by Cerner and Nebraska Methodist Health System)

**Other Resources**

- [eCQI Resource Center:](https://ecqi.healthit.gov) [https://ecqi.healthit.gov](https://ecqi.healthit.gov)
- [Guide to Reading eCQMs](https://ecqi.healthit.gov)

**QUESTION #6:** Can I get a copy of the PowerPoint?

**Answer:** Yes, the slides along with the webinar replay will be posted to our site in the next 7-10 business days.

**QUESTION #7:** Where can I find ED 1 and 2 benchmarks for 2017?

**Answer:** To date, there are no benchmarks for the ED 1 and ED 2 in the eCQM format.

**QUESTION #8:** Will there come a time were TJC and CMS will receive the same eCQMs?
**Answer:** The Joint Commission and CMS receive the same eCQMs, with the exception that The Joint Commission is not accepting eSTK-8 or eSTK-10.

**QUESTION #9:** Only patients prescribed lovenox in the 100mg/ml or 120 mg/ml will qualify for the measure? What for patients with creatinine clearance < 30 who received a modified dose?

**Answer:** The codes included in medication value sets are RXNORM codes of the semantic clinical drug term type. These codes include the generic medication name, form, and either dose or concentration and volume, as applicable. In the case of enoxaparin, the medication is available in concentrations of 100MG/ML and 150MG/ML. For doses <100mg, the codes include the packaged volume. For example: 0.6 ML Enoxaparin sodium 100 MG/ML Prefilled Syringe.

If your question is in regard to the codes included in a particular value set, we encourage you to submit your question, along with the value set OID, to JIRA.

**QUESTION #10:** Will TJC require a different format for submission?

**Answer:** eCQM data must be reported using Quality Reporting Document Architecture (QRDA) Category I files. This is the same format as CMS.

**QUESTION #11:** What if your facility doesn’t have the population to submit 6 ECQMs? What needs to happen?

**Answer:** The hospital should make its best efforts to identify a minimum of six eCQMs for which it has a related patient population. Hospitals unable to identify six eCQMs will be required to select and report on all those eCQMs as appropriate. Hospitals unable to identify six eCQMs will be required to attest to the lack of the relevant services/patient populations as part of the measure selection process.

**QUESTION #12:** When does the Inpatient encounter start? Is it from the time that the "admit order" was received from the Admitting MD or is it from the time that the patient arrived on the in-patient floor?

**Answer:** This depends on the mapping in your system. Please discuss the timestamps selected with your IT team and/or vendor. The intent is to determine the date and time that the patient was actually admitted to acute inpatient care. The admission order is the priority data source for this data element. The time the patient arrives on the floor is captured using a separate attribute, "facility location arrival datetime"

**QUESTION #13:** What were the changes in the ED measures intended to address? Did you change the requirement for the time of Inpatient admit to come after the patient physically leaves the ED? Currently this requirement excludes almost all of our patients.
The Joint Commission

Answer: The changes for the 2017 reporting period were made to more accurately capture the intent of the measure and align with the chart abstracted measure where possible. The initial population logic continues to align with other eligible hospital measures.

QUESTION #14: Will hospitals be able to submit in 2017?

Answer: The Joint Commission is looking at all our options for eCQM direct submission to select the right technology solution and we plan to have a solution in place for 2017 eCQM data submission.

QUESTION #15: If we change our mind about which measures we want to submit to TJC, can we change the selection after 2/10/2017?

Answer: Hospitals are encouraged to carefully consider their eCQM selections for 2017 in an effort to avoid the need to request a change in their selection of eCQMs. However, The Joint Commission will take such requests under consideration on an individual, as needed basis.

QUESTION #16: Do ED1/ED2 still require that end of the ED visit take place <= 60min before start of an INP visit?

Answer: The changes for the 2017 reporting period were made to more accurately capture the intent of the measure and align with the chart abstracted measure where possible. The initial population logic continues to align with other eligible hospital measures, using the <= 60 minutes ends before start temporal operator.

QUESTION #17: If the eCQM data and abstracted data do not match, which data outcomes will be reported to the public domain and when?

Answer: Hospitals reporting on chart-abstracted measures to The Joint Commission will continue to have their data and performance on the chart-abstracted measures reported on Quality Check. The Joint Commission will not publicly report the 2017 eCQM data on Quality Check.

QUESTION #18: When a patient is admitted as observation and latter changed to inpatient, the data shows the patient is still in ER during the observation time. Is there a way to get this logic included so the patient does not show in the ER?
Answer: The issue of capturing Observation status was discussed at length as part of the multistakeholder Change Review Process (CRP) in 2015. To date, the Quality Data Model and the HQMF standard limit our ability to accurately represent multiple encounters within an Episode of Care, which is most evident when attempting to represent Observation. For a complete discussion, please visit: https://oncprojecttracking.healthit.gov/support/browse/CQM-1608

QUESTION #19: Can I expect that there may be a difference in the number of patients in my ED-1 eCQM versus my total number of Chart abstracted ED-1? Would the answer apply to any measure eCQM vs chart abstracted?

Answer: We do not expect eCQM submitted results and chart abstracted results to be identical. For a further discussion of the reasons for differences, we suggest you review our eCQM 101 webinar, slides, and Q&A documents, located here: https://www.jointcommission.org/time_to_get_back_to_ecqm_101_-_a_breakdown_of_the_basics/

QUESTION #20: Can you explain the intent of the new ED data element "transfer from"? We've been getting questions on this as the value set contains non-hospital settings such as "outpatient environment". I'm assuming you wouldn't expect all outpatient environments (doctors' offices) to be excluded?

Answer: The "Transfer from" exclusion was added to align more closely with the intent of the measure and the chart abstracted measure. This includes Emergency department encounters being transferred from another hospital setting (any different facility, even if part of the same hospital system).

QUESTION #21: For version 4 2016, if our satellite hospital shares the same CCN# should both our main campus and our satellite campus be included in the ED-1 and ED-2 eCQM measure population?

Answer: If the satellite hospital shares the same CCN (CMS Certification Number), then report them both under that single CCN. If the EDs are identified under separate CCN numbers, then they would be reported separately. This response is available on JIRA, here: https://oncprojecttracking.healthit.gov/support/browse/CQM-2187

QUESTION #22: STROKE CARE: for reasons as to why no Anticoagulant given at discharge, for STK-3 (CMS71v6) for the very new procedures such as Watchmen and Convergent, that truly treat Afib, and therefore anticoag is truly Not suggested to be given to patient right after this procedure, what is direction to get this mapped as an acceptable reason, to meet STK-3,
Anticoag at discharge? Do we simply just need to obtain the procedure codes for these surgeries that treat this afib diagnosis in order to add the procedure code and map it to a mapping code, in order for it to be an acceptable reason why a patient SHOULDN'T have anticoag at discharge? Thank you.

**Answer:** At this time, the Watchman procedure is not a stand-alone reason for not giving an oral anticoagulant at discharge. In other words, patients undergoing the Watchman procedure should have a documented medical reason for not receiving an anticoagulant and discharge, and the Watchman procedure should not be mapped to one of the existing exclusion codes.

**QUESTION #23:** From our review of the eCQM specs, it doesn't appear that there are any exclusions for delays related to stabilizing the patient or informed consent. These currently are not listed as exclusions. Will this be considered in the future?

**Answer:** At this time, AMI-8a does not contain logic to capture reason for delay in PCI, but measure developers are discussing this concept with the measure steward for the 2017 Annual Update.

**QUESTION #24:** All these measures changes today are for eCQM only?

**Answer:** Yes. This webinar addressed changes in the April 2016 eCQM annual update, for Reporting Year 2017.