eSTK-5

QUESTION #1: When will slides be available?

ANSWER: The slides will be available within 7-10 business days on our Pioneers In Quality website.

QUESTION #2: You mentioned ASA 325 is considered for STK 5. How about baby aspirin?

ANSWER: Baby aspirin will also be acceptable to meet the measure, but the recommended dosage is 325mg per the clinical practice guidelines from AHA and ASA.

QUESTION #3: Is there any way to receive the slides before the webinar for note taking in the future?

ANSWER: Thank you for this suggestion.

QUESTION #4: How do you suggest we capture TPA prior to arrival when the procedure code would not be entered by our hospital?

ANSWER: Right. So, that’s a good question. There would have to be transcription of information from another hospital that would take place in a discrete field in your EHR that you could map to. So, depending on your work flow and how your organization wants to handle that, that's a good discussion.

QUESTION #5: How are contraindications to eMeasures captured to avoid fallouts?

ANSWER: Thank you for your question, and I think you're talking about the reasons for not, to capture things that are not done. We have heard a few good practices that hospitals are doing. One is to have orders that capture the reasons for not ordering something in an order set.
We’ve also heard of people using best practice alerts, to say why they are not doing something, you know maybe the medications or the procedure is contraindicated, and it’s captured discretely using best practice alerts. Again, it would go back to your organization and how your work flow is, and working with your EHR vendor to support your work flow and your needs.

QUESTION #6: To exclude patient due to t-PA can this be pulled with a smart data element or can this only be pulled with a communication order?

ANSWER: The exclusion for t-PA administration done uses the data types of Medication, Administered or Procedure, Performed. We would expect the data source to be the actual administration of t-PA on the medication administration record for that datatype. Or, if you capture t-PA as a procedure, then that data source would be the procedure note, which would need to be structured with discrete fields that you could then map to the appropriate code. This exclusion does not use an order datatype.

QUESTION #7: I noticed that the specifications shown on the slides do not match the specifications exactly on the eCQM library site. Are there other specifications?

ANSWER: Thank you for raising this issue. You are correct, there is an error on slide 10, STK-5: Denominator Exclusions continued. The narrative reads “Patients with intra-venous or intra-arterial thrombolytic (t-PA) administered the day of or day after hospital arrival.” This is incorrect, and should read: “Patients with intra-venous or intra-arterial Thrombolytic (t-PA) Therapy administered within 24 hours prior to arrival or anytime during hospitalization.”

QUESTION #8: If there is an order for comfort measures and that order is marked completed, can that be used for performed?

ANSWERED: This measure is looking for the comfort measures order or the intervention. If you have an order for comfort measures, you would want to map that order and use that.

QUESTION #9: Regarding exclusion for comfort measures, how would the intervention be documented?

ANSWER: If you are documenting interventions that relate to the comfort measures which is the end of life care that’s in the definition of the value set, you would have to have a discrete field in your EHR that you could map to the appropriate SNOMED code for that.

QUESTION #10: Does Heparin 5,000 units Sub-Q meet STK-5?
**ANSWER:** Heparin 5,000 units SQ does not meet STK-5 Antithrombotic Therapy by End of Day 2. Heparin IV qualifies, but not SQ doses. SQ doses of heparin are generally given for VTE prophylaxis. Ischemic stroke patients are to receive both VTE prophylaxis on the day of or day after hospital admission AND antithrombotic therapy on the day of or day after arrival. Aspirin is the recommended form of antithrombotic therapy by end of day 2.

The Antithrombotic Therapy (2.16.840.1.113883.3.117.1.7.1.201) value set includes the RxNorm code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1361615</td>
<td>heparin sodium, porcine 5000 UNT/ML Injectable Solution</td>
</tr>
</tbody>
</table>

You can always review the contents of the value sets at the [Value Set Authority Center](#).

**QUESTION #11:** Is ASA ever accepted if given PTA (EMS or home)?

**ANSWER:** Aspirin prior to admission at the hospital is not accepted for STK-5. The aspirin needs to be administered at the hospital on the day of or day after of arrival to count for this measure.

**QUESTION #12:** Are you saying rectal suppository for ASA is now acceptable?

**ANSWER:** Rectal suppository aspirin (ASA) is acceptable beginning January 1, 2017, using CMS72v5 for the electronic quality measure. The previous version, CMS72v4, which was for the 2016 reporting year, does not include the rectal forms for aspirin in the Antithrombotic Therapy value set.

**QUESTION #13:** How do you account for ASA allergy?

**ANSWER:** Antithrombotic medications for stroke include both antiplatelet and anticoagulant medications. Since this is a broad drug category with many possible options available to meet the measure, an allergy to aspirin alone will not exclude the case from the STK-5 denominator population. An antithrombotic medication that does not contain aspirin may be administered to the patient,

**QUESTION #14:** Could you walk through the explanation of the meaning of “Union” again, and then walk through an example using Union in the standard again, please?
ANSWER: The “union” operator is like an OR statement. With a union, if any of the conditions indented beneath the union is present on the record, it evaluates to TRUE, and the case is included. For this measure, patients with either a principal diagnosis of ischemic stroke OR hemorrhagic stroke starting during the encounter will be included in the Initial Patient Population, if they also meet the Age >= 18 criteria.

- **Initial Population =**
  - AND: Age >= 18 year(s) at: Occurrence A of $EncounterInpatientNonElective
  - AND: Union of:
    - "Diagnosis, Active: Ischemic Stroke (ordinality: Principal)"
    - "Diagnosis, Active: Hemorrhagic Stroke (ordinality: Principal)"
    - starts during Occurrence A of $EncounterInpatientNonElective

**QUESTION #15:** Please re-explain the logic error you mentioned on Slide 12?

**ANSWERED:** In the Denominator Exclusions for comfort measures, there is an error of omission on the Occurring of encounter as highlighted here:

```
- OR:
  - AND: "Occurrence A of Encounter, Performed: Emergency Department Visit" <= 1 hour(s) ends before or concurrent with start of Occurrence A of $EncounterInpatientNonElective
  - AND: $InterventionComfortMeasures <= 1 day(s) starts after start of "Occurrence A of $EncounterInpatientNonElective"
  - OR: $InterventionComfortMeasures <= 1 day(s) starts after start of $EncounterInpatientNonElective
```

The statement should read:

OR: $InterventionComfortMeasures <= 1 day(s) starts after start of “Occurrence A of $EncounterInpatientElective"

This measure will be updated during the 2017 Annual Updates cycle, for the 2018 reporting year. For more information on this issue, please see CQM-2266

**QUESTION #16:** When hospice is considered and the only documentation is from case management but the doctor documents case management notes reviewed and agreed with.

**ANSWERED:** The measure is not only looking that hospice has been considered for the Comfort Measures exclusion, but that there is discrete documentation that Comfort Measures have been implemented or ordered. This can either be an order or interventions.
QUESTION #17: When can we expect information regarding the process for sites who want to direct submit ORYX eCQMs?

ANSWER: The Joint Commission is in the process of identifying the right technology solution for direct submission of eCQM data that will allow hospitals to directly submit their QRDA Category I file in 2018. Further information will be shared when available.

QUESTION #18: Our understanding was that orders could not be substituted for discrete documentation for “reasons for not.” Is that inaccurate?

ANSWER: Yes, this is inaccurate. We understand that when mapping codes to represent negation (a reason for not) the datatype negated, such as Procedure, Performed, may not represent the best data source for capturing the reason for not completing the procedure within the EHR. We acknowledge vendors represent medical reasons for not performing procedures or interventions with the "order" QDM datatypes when a procedure or intervention is not clinically indicated and find this an acceptable way to capture the information.

eSTK-2

QUESTION #1: Will the capture of comfort measures be pulled from order or nursing documentation?

ANSWER: Thank you for your question. You can do it from either or for this measure. Since we’re using the two different data types either the order or the intervention, you can map either or, or both if you want. I would suggest working with your vendor, or whoever helps you do that mapping.

QUESTION #2: How are comfort measures captured for exclusion?

ANSWER: Thank you for your question. I’m not sure if you’re asking about the data types, but you can have an order for comfort measures on the chart that you can map, or you have interventions specific to comfort measures, those can also be mapped to the appropriate SNOMED codes. So again, I would suggest working with your vendor or whoever helps you with that mapping.

QUESTION #3: What are acceptable terms to be included in comfort measures? (i.e. Palliative Care, Hospice, etc.)

ANSWER: Thank you. All those things sound like appropriate things that you to map for your comfort measures. Again, you would want to look at the value set associated with the comfort
measures in the value set authority center, and look at the codes that are in there and choose the appropriate codes to map.

QUESTION #4: Does inpatient documentation of patient refusal or medical reason for no antithrombotic account for no antithrombotic at discharge STK-2?

ANSWER: Yes. When we were talking about the denominator exceptions, we have the allowable, denominator exceptions are patient refusal or medical reason for not prescribing antithrombotic therapy at discharge. So again, you would just need to make sure that those are mapped appropriately, so that you are getting those refusals accounted for.

QUESTION #5: Where should contraindications to antithrombotic on discharge be documented to capture in eMeasure?

ANSWER: It would depend on your work flow in your EHR. Some facilities, we have been seeing, they’re putting it into the orders, in the discharge orders when they’re doing that medication reconciliation. It does have to be in a discrete field to map to it. If you have other discrete fields available in your EHR, it can be done there as well.

QUESTION #6: Do you have a table listing the acceptable antiplatelet medications?

ANSWER: We have a value set, Antithrombotic Therapy (2.16.840.1.113883.3.117.1.7.1.201) that contains all the RxNorm codes that are acceptable in there. I would suggest you look in the Value Set Authority Center at that value set to see the contents.

QUESTION #7: Where do we find sufficient dosing for medications that are specified?

ANSWER: That’s a good question. The codes that we use to represent medications in eCQMs are RxNorm codes. If you ever looked at that coding system, the drug name, as well as dosage is included in them. What it doesn’t account for, is that if you have to give two pills of something to get a specific dose. We do try to, you know, take out codes that we know that would never be of sufficient dosages without getting many, many of those, either as pills or injections. But in that value set, the code has the dosages in there.

QUESTION #8: What is considered a sufficient dose for enoxaparin?

ANSWER: SQ enoxaparin (Lovenox) and SQ heparin are pharmacological forms of prophylaxis recommended unless contraindicated for VTE prevention in stroke patients. Enoxaparin SQ 40 mg once daily and enoxaparin SQ 30 mg Q12 hours are dosages prescribed for VTE prophylaxis. Higher dosages of enoxaparin would need to be administered on the day of or day
after hospital arrival in order to meet Antithrombotic Therapy By End of Hospital Day 2, since ischemic stroke patients are to receive both VTE prophylaxis and early antithrombotic therapy.

**QUESTION #9:** Is the discussion and all answers to the questions included at a later time or just the slides?

**ANSWER:** The slides and the questions and their answers will be posted to the web portal. The slides will be there within 7-10 business days. Sometimes it does take a little bit longer to get the actual questions and their answers loaded onto the portal, but generally within a month after the webinar.

**QUESTION #10:** Will I be able to print the slides if I wish?

**ANSWER:** Yes.

**QUESTION #11:** Can discharge disposition be used for the comfort care exclusion?

**ANSWER:** For the Comfort Measures exclusion, we are looking for either an Order or Interventions. However, if you look at the Denominator Exclusions, we do allow exclusion for patients discharged to home for hospice care or discharged to a health care facility for hospice care. You would need to work with your vendor to assist you with that mapping.

**QUESTION #12:** I am sorry, I may have miss this, how can I print the slides please?

**ANSWER:** The slides are posted on the Pioneers in Quality web portal within 7-10 business days after the presentation.

**QUESTION #13:** If antithrombotic is discontinued during stay, is that acceptable for medical reason for not ordering on discharge?

**ANSWER:** Discontinuation of an acceptable antithrombotic medication would be a reason for not prescribing antithrombotic at discharge provided that another antithrombotic was not then ordered or the dosage of antithrombotic discontinued, and that same antithrombotic medication ordered at a different dosage.

**QUESTION #14:** What about medication ingredient value set RxNorm codes?

**ANSWER:** When we currently specify the value sets for things that are not done in negation using ingredients specific value sets instead of the actual semantic clinical drugs (SCD) that are used in value sets to represent medications. This may be going away with the next update of the value sets for 2017, just because of the way that negation can be represented going forward.
in the future, you don’t need a specific code. You just need to reference the object identifier (OID). But for now, it’s there. So, they are codes that are just more specific to the ingredients, instead of a specific medication code.

QUESTION #15: Where should contraindications to antithrombotic on discharge be documented to capture in eMeasures?

ANSWER: So, that’s a good question. It would depend on your work flow in your EHR. Some facilities, we have been seeing, they’re putting it into the orders, in the discharge orders when they’re doing that medication reconciliation. It does have to be in a discrete field in order to map to it. If you have other discrete fields available in your EHR, it can be done there as well.

QUESTION #16: Where can we go to listen for a replay of this presentation at a later date, and will the slides and Q&A be available to non-Joint Commission hospitals?

ANSWER: Yes. The replay and the slides are all publicly available, and they will be posted on our Pioneers and Quality web page in about 7-10 business days.

Website to go and print slides at a later date –
https://www.jointcommission.org/piq_expert_to_expert_series/

QUESTION #19: How do we access the “value sets” that are being mentioned as resources?

ANSWER: Yes. The eCQMs specifications include all the value sets in their OID, which is the object identifier in the specification. You would have to go to the Value Set Authority Center to access those value sets. We do have more information on how to access the Value Set Authority Center on our Pioneers and Quality web portal if you’re not familiar with that.

Value sets website: https://vsac.nlm.nih.gov/

eSTK-3 and General

QUESTION #1: Would diagnosis, inactive be similar to patient history of a condition?

ANSWER: Yes. The current way to diagnosis is represented today in the eCQMs, it is defined as diagnosis active, or diagnosis inactive. So, the diagnosis inactive is similar to a patient history of the condition. Where there is a diagnosis on the chart with an end date, it’s considered an inactive diagnosis. When we move forward in the next version, we no longer have the diagnosis inactive or active as we discussed in the general changes.
QUESTION #2: Is there a reference document to help in the “reading” of the standards?

ANSWER: Yes. There are quite a few documents that make up the reading of the standards. The QDM is a document that describes what the quality data model is. For more information, visit the eCQI Resource Center: https://ecqi.healthit.gov/

QUESTION #3: Is discharge home with End of Life Care acceptable for an exclusion?

ANSWER: Yes. So, we have a denominator exclusion for discharge to home for hospice care, discharge to healthcare facility for hospice care. So again, I would use one of those codes to map to that concept in your EHR.

QUESTION #4: Do I understand correctly that if stroke is not an initial encounter diagnosis, but is found later during hospital stay, then it will not be included in the measure?

ANSWER: I believe the question was so if the patient does not have a stroke, or it gets ruled out at some point or whatever, but then they do have a stroke if they are included - the answer is that it depends on what gets documented in the problem list, or in the final coded diagnosis and how your EHR vendor has mapped it. It could be any of those things dependent on the workflow and mapping. So, you should look, but the eCQMs are picking up codes. If it finds that code, it’s going to put it into the population.

QUESTION #5: Is JIRA a specific web site? Sorry if this has been addressed in the past.

ANSWER: Yes, JIRA is an ONC sponsored website, that’s kind of like an issue tracker. It’s open to the public. You can find more information on the JIRA website as well as a PowerPoint on how to navigate JIRA on our Pioneers and Quality portal on the Joint Commission website.

CMS JIRA website:
https://oncprojecttracking.healthit.gov/support/login.jsp?os_destination=%2Fsecure%2FDashboard.jspa

QUESTION #6: Does a Data Dictionary exist for eCQMs? (like chart abstraction measures)

ANSWER: No, we currently do not have a Data Dictionary. There have been discussions on how something like that could be promulgated and published, but it does not exist today.
QUESTION #7: Most CAH will send patients with stroke to a higher level of care. What is your suggestion to CAH hospitals to meet these measures?

ANSWER: In the denominator exclusions, you will see an exclusion for patients discharged to another hospital, which is synonymous with discharge to an acute care hospital, so if the CAH transfers patients out to an acute care hospital, you will meet that exclusion.

QUESTION #8: If a patient experiences transient Afib during the encounter, but then returns to baseline NSR without intervention, would that count as an exclusion for STK-3?

ANSWER: If the patient has any documentation of Afib, a current finding during the hospital stay, or has documentation of a past history in the value set, then that patient will be included in the measure and continue through the measure logic.

QUESTION #9: JIRA is the eCQM issue tracking site?

ANSWER: Yes.

QUESTION #10: So an inpatient rehab hospital is not considered an acute hospital?

ANSWER: Inpatient rehabilitation facility would be considered another type of hospital under the discharge disposition value set.

QUESTION #11: I don’t mean to be difficult, but where are contraindications for antithrombotic to be documented for discharge to meet eMeasure requirement?

ANSWER: It would depend on your work flow in your EHR. Some facilities, we have been seeing, they're putting it into the orders, in the discharge orders when they're doing that medication reconciliation. It does have to be in a discrete field in order to map to it. If you have other discrete fields available in your EHR, it can be done there as well.

QUESTION #12: The diagnosis of active vs inactive are in reference to what is found in the problem only? Or does data source include what is found in MD History and Physical?

ANSWER: That would depend on how your EHR maps that information to the codes that are used. Generally, it's found in the problem list, but if you have discrete fields in your history and physical that can be mapped to those codes, then it could be that as well. I would suggest following up with your vendor to see the capabilities of your EHR and how the mapping takes place.
QUESTION #13: When will all Stroke measures be required to be e-submitted? Do we know a timeframe on that yet?

ANSWER: No, there’s no timeframe on that yet. Some of the eSTK measures are included in the list of measures that can be submitted for the 2017 ORYX requirements, and all that information is on the Joint Commission website under the Performance Measurement portal.

QUESTION #14: If a stroke occurs on day three (ischemic) how can the patient be given antiplatelet by the second day? Is this an outlier?

ANSWER: Only those patients assigned an ICD-10-CM Principal Diagnosis Code for ischemic stroke at discharge are included in the denominator. The ICD-10-CM Principal Diagnosis Code is the code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization. Patients with an ICD-10-CM Other Diagnosis Code for ischemic stroke (secondary diagnosis) are not included in the measure population. If ischemic stroke was not the reason for the patient’s admission to the hospital, then stroke should be a secondary diagnosis rather than the primary diagnosis. However, if ischemic stroke was not diagnosed until after day 2 but is determined to be the reason for the patient’s hospitalization and assigned as the principal diagnosis, then the case fails STK-5. (end of story)

QUESTION #15: Most critical access hospitals will send patients with stroke to a higher level of care. What is your suggestion to CAH hospitals to meet these measures?

ANSWER: In the denominator exclusions, you will see an exclusion for patients discharged to another hospital, which is synonymous with discharge to an acute care hospital, so if the CAH transfers patients out to an acute care hospital, you will meet that exclusion.

QUESTION #16: We have patients who have the Watchman procedure performed for Afib. They are then subsequently taken off all anticoags. How do we remove these patients from falling into this measure as the anticoag is no longer necessary?

ANSWER: The Watchman procedure, the anticoagulation was not being prescribed for that reason. It would have to be picked up under that value set for medical reason. There would have to be some kind of indication in the record that the patient did not need anticoagulation therapy.