Pioneers in Quality:
eCQM Expert to Expert Webinar Series: STK-2, -3, & -6 eCQMs
December 11, 2018
Q & A Document

QUESTION 1: Will there be a copy of the slides and a recording available?
A: A webinar replay link, and the slide presentations will be available on The Joint Commission website Pioneers in Quality: Expert to Expert Series within approximately 30 business days of the webinar at https://www.jointcommission.org/topics/pioneers_in_quality.aspx.

QUESTION 2: Just realized this webinar is for hospital clients. I am in private practice. Will there be a series for private practice?
A: Yes – there is a similar series for the EP/EC side. There will be a total of 5 webinars from November (CQL basics) to March. The second webinar will be held 1/15 and the registration information will be posted to the eCQI Resource Center in the next couple of weeks. All registration information for that series will be housed on the eCQI Resource Center.

QUESTION 3: Will you be covering how to translate CQL into SQL, so we don't have to translate and lose meaning of the now more complex CQL?
A: There is a framework that has some rough support for translation of ELM to SQL [Health eDecisions Tooling] (https://github.com/cqframework/healthedecisions). It is outdated (since it is based on the 1.1 version of ELM that was published with CQL 1.1), but it illustrates how such a translation process can work and would be a relatively easy lift to upgrade to the latest CQL. In terms of a webinar to cover this information, please go to the CQL Issue Tracker link below and create an issue request.
https://oncprojectracking.healthit.gov/support/projects/CQLIT

QUESTION 4: Are SNOMED codes used for elective/non-elective admissions?
A: The non-elective inpatient encounter value set contains SNOMED codes, procedure codes representing a non-elective inpatient encounter which are emergency hospital admission and hospital admission. This does not include a hospital admission elective code.

QUESTION 5: Do you have to purchase a license to access VSAC detailed information?
A: A license is required to utilize the VSAC, but it is free to the public.

QUESTION 6: The term "non-elective" is used frequently, how is it defined?
A: The Non-elective Inpatient Encounter value set intends to capture all non-scheduled hospitalizations. This value set is a subset of the Inpatient encounter value set, excluding concepts that specifically refer to elective hospital admissions. Non-elective admissions include emergency, urgent and unplanned admissions.

QUESTION 7: How would a stroke ever be an "elective"? Why would this need to be defined, if this will never be an elective encounter?
A: The rationale for defining a “non-elective encounter” is to be able to exclude an “elective” carotid intervention which is one of the denominator exclusions.

QUESTION 8: For STK-2 shouldn't you also exclude patients discharged to hospice, acute care facility, left against medical advice, expired?
A: The denominator exclusion does include discharge to another hospital, discharge to home for hospice, or health care facility for hospice care and patients who left AMA – this is on slide 36 of the webinar presentation.

QUESTION 9: Will hospitals need to capture any new/different data or enter the date in a different way into the EHR to populate the CQL version of these measures, as compared to the 2018 STK-2, STK-3, and STK-6 eCQMs?
A: No, the data would not be entered differently into the EHR, then it is currently.

QUESTION 10: With the Medication discharge date/time; what if a patient starts in observation bed and the provider orders the medication proactively for discharge while the patient is in observation bed. Then the patient becomes an inpatient. According to the measure the patient does NOT meet the numerator?
A: We use the medication discharge data type which does not look at time the medication was prescribed, but the discharge medication list date/time that is captured on the discharge instructions. To meet the measure, the patient must be an inpatient at the time of discharge with an antithrombotic listed on the discharge instructions that is timed before the patient is discharged.

QUESTION 11: At times, the physician may document in the discharge summary a reason for not ordering a medication at discharge (e.g., patient refusal). Would it be an exception, or does it need to be in a mapping field?
A: This is called a negation rationale and it does need to be in a discrete field to be able to satisfy the measure.

QUESTION 12: Can you please state again when the antithrombotic therapy at discharge is captured for STK- 2? I want to make sure I understood it correctly.
A: We use the medication discharge data type which does not look at time the medication was prescribed, but the discharge medication list date/time that is captured on the discharge instructions. To meet the measure, the patient must be an inpatient at the time of discharge with an antithrombotic listed on the discharge instructions that is timed before the patient is discharged.

QUESTION 13: Why is STK5 not included in this webinar?
A: We did not include STK-5 eCQM in this webinar session as we wanted to have adequate time to cover STK-2, -3, & -6 today. We will be presenting the STK-5 measure during the January 29 Expert to Expert webinar session and that session will also include the AMI-8A measure. Information on the Pioneers in Quality Expert to Expert series with dates and registration links is available at: https://www.jointcommission.org/piq_expert_to_expert_series/

QUESTION 14: What is the actual definition of high intensity statin?
A: High intensity statin therapy is dependent on the specific type of statin medication that is prescribed for the patient. High intensity therapy is looking for a statin at a dose that would be expected to reduce the LDL-c greater than or equal to 50%. Atorvastatin 40-80 mg every day or rosuvastatin statin 20-40 mg every day are considered high intensity statin dosages.

QUESTION 15: How can anticoagulation contraindications be captured if the patient shouldn't be starting anticoagulation therapy until confirmed by CT no evolvement of hemorrhagic transformation (i.e. patients who received alteplase)?

A: A plan to initiate or restart anticoagulation therapy after discharge once hemorrhage has been ruled out would be captured as a medical reason for not prescribing anticoagulation therapy at discharge.

QUESTION 16: If you are looking for medications dc datatype when list is authored- how does this work if the list is addended prior to discharge and updated?
A: If it is addended prior to discharge then it would take the addended timestamp. Anything after discharge would not satisfy the measure.

QUESTION 17: These changes will apply to reporting period 2019 correct?
A: Yes, that is correct, these CQL changes go into effect with 1/1/2019 discharges.

QUESTION 18: Where in the electronic record should the diagnosis codes be pulled from, specifically atrial fibrillation?
A: In the EHR, it can be in the problem list, list of encounter diagnoses, a diagnosis list, or history depending on your vendor and where it is captured. Since, it can be found in any of those locations in your EHR, we use both an attribute of the encounter or a diagnosis data type (historical diagnosis) to allow for flexibility, so it just needs to be mapped appropriately for reporting.

QUESTION 19: For STK-6 what about the denominator exclusions?
A: The Denominator Exclusions for Stroke 6 were bypassed in the interest of time since they were reviewed during Stroke 2 and are the same for both measures.

QUESTION 20: Does Union='or'?
A: Yes, Union does also mean or, but it also serves another purpose in CQL. It's also used to combine lists of different types. To be more specific, the comfort measures logic is a good example of this where we combine the 2 data types: Intervention, Order and Intervention, Performed, to identify if the comfort measures exists for the patient. But because they do not share the same time attributes of attributes of relevantPeriod and authorDatetime we use union to combine the 2.

QUESTION 21: Is the discharge disposition value set new to the exclusion criteria for STK-2?
A: No, the discharge disposition value set is not new to the exclusion criteria.

QUESTION 22: For STK-6 if there are multiple LDL values and one of them is less than 70 mg/dL will the case fail if a statin medication is not prescribed at discharge?
A. Yes, that's where we use the max operator in which we're looking for the highest LDL value in the time period. If any LDL value is greater than or equal to 70 mg/dL and a statin was not prescribed without a documented reason for not, then the case fails the numerator and does not count as a denominator exception.

QUESTION 23: Where in the electronic record should the diagnosis codes be pulled from, specifically atrial fibrillation?
A: In the EHR, it can be in the problem list, list of encounter diagnoses, a diagnosis list, or history depending on your vendor and where it is captured. Since, it can be found in any of those locations in your EHR, we use both an attribute of the encounter or a diagnosis data type (historical diagnosis) to allow for flexibility, so it just needs to be mapped appropriately for reporting.

QUESTION 24: What does and mean?
A: That would be the intersect operator.

QUESTION 25: Can you address result date/time vs. the start date/time for a laboratory result?
A: In CQL, we can get more specific with the attributes in the specific date and times we're looking for. In QDM, we only had a start or the end of a lab test performed. There were different interpretations for the start and end. Since CQL, allows for more precise timing attributes, we used resultDateTime to capture when the lab was resulted versus when the test was performed. More information on the result date and time and start date and time attributes can be found in the Quality Data Model User Guide version 5.3 on the Electronic Clinical Quality Improvement (eCQI) Resource Center at https://ecqi.healthit.gov/.

QUESTION 26: Do you have a resource that provides definitions for all Operators used in the CQL?
A: CQL operators are in the HL7 CQL Specifications Guide. The QDM is still used as the data model which can be found in the Quality Data Model User Guide version 5.3. Both links are listed on the resource slides or can be found on the eCQI Resource Center.

QUESTION 27: Some of my clinical staff are concerned about hemorrhagic stroke being included in the denominator for STK-2 because it isn't mentioned in the Joint Commission's specifications manual found here: https://manual.jointcommission.org/releases/TJC2018A1/Stroke.html
A: The hemorrhagic stroke patients are actually in the initial population for all the STK measures across the stroke measure set. In the denominator, we refine the stroke patients to only include the ischemic patients for STK-2, -3, and -6. This can be seen in slides 27-29.

QUESTION 28: How can the "documentation" of comfort measures be captured?
A: Comfort Measures can be captured as an order or as an intervention if you have specific documentation fields related to comfort measures (i.e. Comfort Measures Plan of Care)

QUESTION 29: For STK-6, *Get With The Guidelines*® (GWTG) LDL guideline says LDL can only be collected up to 48 hours after admission. Please provide information regarding the difference in the guidelines.
A: STK-6 measure specifications prior to October 1, 2015, included the data element *LDL-c Measured Within the First 48 Hours or 30 Days Prior to Hospital Arrival*. This data element was removed from the STK-6 measure logic with the 2016 annual update for 2017 reporting, and the numerator statement revised to reflect current clinical guideline recommendations for statin therapy following ischemic stroke.

QUESTION 30: I have a question about the discharge statin medication; if LDL is more than 70 mg/dl? Is there a change about the 30 days?
A: No, in the previous QDM version for 2018 reporting, the denominator exclusions included patients with an LDL-c of less than 70 mg/dL <30 days prior to arrival or any time during the hospital stay. In the 2019 reporting year, this was moved to the denominator exceptions, and we included the Max operator, to align better with the chart-abstracted measure.

QUESTION 31: Are patients greater than age 75 excluded from STK measure?
A: No, this measure includes patients 18 years and older.

QUESTION 32: Will discharge to a hospice medical facility not count as an exclusion for the denominator for STK-2?
A: No, STK-2 includes a denominator exclusion for patients discharged to a health care facility for hospice care. You can review slides 30-31 for more information.

QUESTION 33: For STK-6, does Carleton count as anticoagulation for atrial fibrillation patient?
A: We are unable to identify an anticoagulant medication named Carleton. Please check the medication name and/or spelling and submit your question to the eCQM issue tracker on JIRA. https://oncprojectracking.healthit.gov/support/projects/CQLIT

QUESTION 34: For STK-2 the initial population included hemorrhagic strokes. When are hemorrhagic strokes excluded from the STK-2 measure?
A: The hemorrhagic stroke patients are actually in the initial population for all the STK measures across the stroke measure set. In the denominator, we refine the stroke patients to only include the ischemic patients for STK-2, -3, and -6. This can be seen in slides 27-29.

QUESTION 35: Are The Joint Commission specifications following CMS, or are they modified and how much modification?
A: The same eCQM specifications are used for both the CMS HIQR program and TJC Accreditation. The eCQM specifications can be found on the eCQI Resource Center here: https://ecqi.healthit.gov/eligible-hospital/critical-access-hospital-ecqms?field_year_value=1

QUESTION 36: You said the usage of MAX is a difference in STK-6's logic between CY2018 and CY2019. Please confirm, and, are there any other differences in logic between CY2018 and CY2019? Can all the differences be documented somewhere?
A: Yes, the MAX operator is new for the 2019 reporting year, where we are looking for the highest LDL result. In the previous QDM version for 2018 reporting, the denominator exclusions included patients with an LDL-c of less than 70 mg/dL <30 days prior to arrival or any time during the hospital stay. In the 2019 reporting year, this was moved to the denominator exceptions, and we included the Max operator, to align better with the chart-abstracted measure.

You can find the changes between versions on the eCQI Resource Center in the Technical Release Notes here:
https://ecqi.healthit.gov/eligible-hospital/critical-access-hospital-ecqms?field_year_value=1

QUESTION 37: How can the reason for not prescribing a statin at discharge be captured if it is a narrative documentation in the progress notes?
A: The data must be captured in a discrete field and mapped to a code in the "Medical Reason" or "Patient Refusal" value sets in order to count. Some organizations use clinical decision support alerts or order entry to capture this type of information.

QUESTION 38: Would discharge to another acute facility within the same health system because facility 1 does not treat stroke, but is still a patient in the health system, be considered an exclusion for facility 1 that discharged to facility 2 for treatment?
A: A patient that is discharged from facility 1 to another acute care facility (facility 2) with a different Joint Commission HCO ID / CMS CCN, regardless of if it is the same health system, is considered to be discharged from facility 1 and admitted to facility 2. This would satisfy the denominator exclusion.

QUESTION 39: STK-2 please repeat the difference between [elective] encounter and non-[elective] encounter
A: The Non-elective Inpatient Encounter value set intends to capture all non-scheduled hospitalizations. This value set is a subset of the Inpatient encounter value set, excluding concepts that specifically refer to elective hospital admissions. Non-elective admissions include emergency, urgent and unplanned admissions. The rationale for defining a "non-elective encounter" is to be able to exclude an "elective" carotid intervention which is one of the denominator exclusions.

QUESTION 40: Is there a way to capture data if the physician does not document during the encounter time, but goes back and document at a later time?
A: The intent of authorDateTime is to capture the date/time of when the clinician documented something.

QUESTION 41: Does UNION includes duplicate entries?
A: Union can mean "OR", but it also serves another purpose in CQL. It's also used to combine lists of different types.

QUESTION 42: There used to be a 48-hour timeframe for LDL to be drawn from admission, is that still the case?
A: No, the eCQM specifications changed with the 2016 reporting year to include and LDL reult 30 days before or anytime during the hospital stay. You can see this on slides 58.

QUESTION 43: Do you have any suggestions for patients with larger stroke syndromes and atrial fibrillation and the provider documents that they want the anticoagulation to start a week or two after discharge because of the risk of bleeding? How do we capture this electronically?
A: A plan to initiate or restart anticoagulation therapy after discharge would be captured as a medical reason for not prescribing anticoagulation therapy at discharge. To capture electronically, the documentation would need to be in a discrete field and mapped to one of the codes in the medical reason value set.

QUESTION 44: For STK-6, could you provide insight as to why Zetia isn't considered for patients with sensitivity (not allergy and not refusal) of statins but still a treatment for blood cholesterol?
A: Zetia (ezetimibe) alone is not a statin medication, so it is not included in our Statin Grouper value set. We do include RxNorm codes for combination ezetimibe/Simvastatin medications.

QUESTION 45: Four antiplatelet drugs have been approved by the FDA for prevention of vascular events among patients with a stroke or TIA (i.e., aspirin, combination aspirin/dipyridamole, clopidogrel, and ticlopidine). The antithrombotic medications for Stroke 2 list only includes the ones on slide 11?
A: No, in order to see the list of medications, you must look at the Antithrombotic Therapy value set (2.16.840.1.113883.3.117.1.7.1.201) in the Value Set Authority Center (VSAC) or go to the eCQI Resource Center and click on the eCQM Value Sets Addendum document. This will take you to the VSAC and you can get all of the value sets and codes included in them, and sort by eCQM.

QUESTION 46: You mentioned there are 2 intensive statin medications. GWTG has 4 listed now: Lipitor 40mg or 80 mg, Crestor 20 or 40 mg, Zocor 80 mg and Vytorin 10/80. Do you accept all 4?
A: We include the semantic clinical drug RxNorm codes for all of the medications you are asking about. You can view all of the codes included in the Statin Grouper (2.16.840.1.113762.1.4.1110.19) value set in the VSAC.

QUESTION 47: Are denominator exceptions included in the numerator?

A: No, although Denominator Exceptions are processed after the Numerator, they are not included in the Numerator. Denominator Exceptions are cases that meet the Denominator, but not the Numerator because there is a specific reason why that is captured also called a negation rationale. If the patient satisfies the numerator, the denominator exceptions are not checked.

QUESTION 48: Can a list of links be emailed?
A: Links can be found on the resource slide

QUESTION 49: If our hospital was already using an ORYX vendor to submit our eCQM data to The Joint Commission and we changed our mind to submit directly via the Direct Data Submission Platform, how do we go about notifying you of the change?
A: Assuming you are referring to 2018 eCQM data related to Joint Commission ORYX requirements, changes can be made using the 2018 ORYX eCQM Selection form found here: https://www.jointcommission.org/2018_oryx_ecqm_selections_form_and_instructions/. The form was due October 31, 2018, but can still be used to make changes. To complete the form, you will need to download and save it to your computer or network. After completing the form, email it to hcooryx@jointcommission.org. Include a statement that you would like to change from vendor to direct data submission and any additional information about eCQM changes in the body of the email. Information about ORYX reporting requirements, including 2019 reporting requirements and answers to Frequently Asked Questions, can be found here https://www.jointcommission.org/performance_measurement.aspx.