QUESTION 1: Is there a dial in number for this presentation? I cannot hear the presenters, what should I do?

A. This session is broadcast over the web and audio for this session is by Computer audio (VoIP - Voice over Internet Protocol) only; there are no participant phone dial in lines.

Tips: To best experience the audio and have the highest sound quality, we encourage participants to:
• Check your computer to ensure you have a sound card
• Check your computer's speakers to ensure they are not set to mute and you can control the volume
• If you are joining with a group, you may wish to connect the audio through an external speaker
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QUESTION 2: Are there issues with the audio/presenter line? We are hearing an echo.

A.: There may be issues with VOIP (Voice over Internet Protocol) that are inherent to live streaming events offered over the internet. The GoToWebCast platform recommends that any viewer using Internet Explorer 11 and Windows 7 use an alternate browser to view the presentation in order to avoid any potential streaming issues. You can test that your system meets both audio and system requirements by running this diagnostic offered by GoToWebCast before you join then next webinar session: **https://event.webcasts.com/test/**

Should you experience an echo during the live session, which is common with VOIP live streaming sessions, you can try to disconnect and rejoin the session using the join link (URL).

QUESTION 3: Are slides available for download?

A: The slides are available for all the GoToWebCast Expert to Expert Sessions during the live session under the Event Resources section. Click the triangle and you can either download or print the PDF file. Within a few weeks of the session, the PDF of the slides will also be posted to the Joint Commission Expert to Expert series landing page at https://www.jointcommission.org/piq_expert_to_expert_series/ and the CMS eCQI Resource Center.

QUESTION 4: How can I view the slides and look at closed captioning at the same time?

A: You can access a PDF of the slides via the Event Resources section of the dashboard. You can print the slides, and then watch the Closed Captioning to determine what the presenters are saying within the audio feed.

QUESTION 5: Will you be sending a recording out after the presentation?

A: A recording will be available on the Expert to Expert landing page at: https://www.jointcommission.org/piq_expert_to_expert_series/ in March.

QUESTION 6: Can we use the same QRDA I file we are sending to CMS as we did last year to The Joint Commission?

A: The Joint Commission Direct Data Submission Platform has been implemented to accept the same QRDA I documents that are submitted to CMS.   For submission of eCQM data thru a Joint Commission ORYX vendor for CY 2018, a QRDA I file formatted to meet the Joint Commissions' ORYX eCQM Vendor requirements, among other changes, restricts the submission of certain protected information.

QUESTION 7: How do you define the library?

A: The library is defined in the measure authoring tool (MAT). It is a home for definitions or functions we may want to re-use for multiple measures to allow for greater harmonization across measures.

QUESTION 8: Are the slides lagging behind?

A: Inherent to live streaming an event offered via the internet, there might be a slight delay between what the presenters say and the participants hear and see. This is a characteristic of webcast presentation platforms. The presenters will be asked to pause between slides to allow the audio and presentation to synch better.

QUESTION 9: Have other participants lost audio? We could hear, but now the speakers cannot be heard.

A: Due to the nature of live streaming events, there can be intermittent sound and technical issues. These can usually be resolved if the participant refreshes their screen/feed or leaves and rejoins the session.

QUESTION 10: Is this the same language being used to submit eCQMS to the CMS Secure Portal?

A: Yes, Clinical Quality Language (CQL) is the new expression language for eCQMs. Both The Joint Commission and CMS use the same measure specifications. All eCQMs for the 2019 reporting year use CQL.

QUESTION 11: Relevant Period is used frequently in CQL and is very confusing. Does it apply to a single encounter?

A: Yes, it can apply to a single encounter, an intervention, procedure or other datatype. The Relevant Period is the time between the start and end of an event. For example, patient is admitted to inpatient 2/10/2019 and was discharged on 2/13/2019. The relevant period is from 2/10/2019 to 2/13/2019. The ED measure assesses if this time is less than 120 days – yes, it is because this stay was for 3 days. The measure also assesses if the inpatient relevant period ends during the measurement period- yes, the measurement period is 2019 and the inpatient relevant period ended before the end of the year.

QUESTION 12: Will retired ED measure be an option for reporting to The Joint Commission?

A: ED-1 and ED-2 are included as eCQMs available for reporting to The Joint Commission and CMS. CMS is removing 7 eCQMs for the CY 2020 reporting period, including ED-1. The Joint Commission will determine the CY 2020 ORYX performance measurement reporting requirements in 2019 following the release of the CMS' FY 2020 IPPS final rule.

QUESTION 13: We have Epic as our EHR and wanted to know if they will be updating their system to use CQL.

A: Yes, EHR vendors will update to the new expression language.

QUESTION 14: Can you include the definitions just given for relevant period etc. in the Q&A document? I didn't catch all of that.

A: Supplemental timing attributes added to most datatypes in Quality Data Model (QDM) 5.3 to facilitate accurate retrieval of time related information within CQL logic. Timing attributes now include time intervals, such as prevalence period or relevant period, and actual time of documentation with Author Datetime. Prevalence period is used with the datatype's diagnosis, allergy and symptom to more accurately define onset and abatement times. Relevant period is the general/default method to describe start and stop times. It is used with about 13 datatypes such as encounter performed, procedure performed, medication active. You can access this document here:
https://ecqi.healthit.gov/system/files/QDM_5_3_ANNOTATED_2017August_508.pdf

QUESTION 15: Could you please repeat from slide 21 what is included in the prevalence period?

A: Prevalence period is used with the datatype's diagnosis, allergy and symptom to more accurately define onset and abatement times.

QUESTION 16: Why is Median time versus Average time used in the ED Measures?

A: Average time could be significantly skewed by times that are extremely high or extremely low. For example, suppose a hospital had the following ED visit times (in minutes): 45, 50, 60, 60, 70, 90, 120, 120, 300, 500, and 500. In this example, the average ED stay is 174 minutes and the median is 90. The median is less affected by outliers.

QUESTION 17: Are the ED measures only looking at inpatient visits where the emergency department depart to inpatient admit is less than one hour? Doesn't that defeat the purpose of showing the high wait times, since this measure only looks at visits that have a short time between emergency department depart to inpatient admit?

A: ED visits have been assessed in a variety reporting programs:

ED – 1 assesses the time from the ED arrival to ED departure for patients admitted inpatient

ED – 2 assess the time from the decision to admit to ED departure for patients admitted inpatient

ED - 3 (an outpatient measure) assessed the time from ED arrival to ED departure for patients discharged from ED

QUESTION 18: Where is the Measurement period defined in CQL logic?

A: The Health Quality Measure Format (HQMF) defines the Measurement Period control variable that is made available to CQL libraries.

QUESTION 19: If we have a freestanding ED that is part of our health system, and the patient is seen there and then transferred to our hospital setting ED, will these patients be excluded?

A: ED – 1 & 2 considers those patients who are admitted inpatient status directly from the ED for the initial population.

QUESTION 20: Will you be showing how to look up value sets in the VSAC library?

A: Today's webinar will not cover how to use the VSAC to access value sets. For assistance, here is a link to a tutorial on the VSAC: https://www.nlm.nih.gov/vsac/support/usingvsac/searchvsac.html

QUESTION 21: How do we use CQL in our database's, so we don't have to re-write this logic? Our analysts are telling us, we have to re-write everything in SQL and things are lost in translation

A: To assist you here is a link to a presentation from MITRE regarding technical implementation from HIMSS 2018. https://health.mitre.org/blog/getting-started-with-cql-technical-implementation-for-vendors/

For additional questions, please submit a JIRA ticket:
https://oncprojectracking.healthit.gov/support/projects/CQLIT

QUESTION 22: Are both of the ED-1 & ED-2 measures remaining on the list of eCQMs to select for CY 2019 eCQM reporting?

A: Both ED-1 and ED-2 are available for selection and reporting for CY 2019.

QUESTION 23: Are we required to submit for all strata for ED-1 & ED-2?

A: Yes, when a measure definition includes stratification, each population in the measure definition should be reported both without stratification and by each stratification criteria.

QUESTION 24: Our CMS upload to QNet calculated a smaller median time than the Joint Commission. Is this to be expected or do we need to review our data for accuracy?

A: The Joint Commission Direct Data (DDS) Submission Platform provides the ability to analyze how the data was processed. In the case of the DDS Platform calculating a larger median, one should start with the Data Accuracy page to ensure the files did not generate a Warning message that could assist in explaining the difference. Then, proceed to the Quality Improvement page and utilize the Source Viewer and Patient Results list to assist in identifying the cases that need to be further analyzed. After performing their analysis, the hospital believes that the DDS Platform has incorrectly calculated the Median, they should open a Support Ticket from within the DDSP and provide several of the QRDA I documents (XML file names) and their expected Observation Value. This will assist Joint Commission staff in providing support for the issue.

QUESTION 25: How do you define ED departure? We have a workflow that when the patient is ready to transfer to the unit, in the system the patient is placed in an Off the Floor placeholder while waiting for transport. Will that be considered as ED departure? Or when patient arrived in the Inpatient unit?

A: Departure is defined as the time the patient physically leaves the ED department.

QUESTION 26: Does the ED admit order represent the ED decision to admit order, or the actual admission order?

A: The ED – 2 admit order represents the actual order to admit the patient to inpatient status.

QUESTION 27: If a patient is admitted but placed in a hold status due to waiting for an available bed, does the time in hold count as ED time?

A: If the patient has physically left the ED and is admitted to inpatient status, the patient will be considered in the initial population of ED 1 and 2.

QUESTION 28: Are observation patients excluded from the ED visit with admit order?

A: Only those patients who are admitted to inpatient status are considered in the initial population for the ED measures. Inpatient status is constrained by the value set 'Encounter Inpatient (2.16.840.1.113883.3.666.5.307: 183452005, 32485007, 8715000)'. Therefore, Observation patients are not considered in the initial population because Observation status is an outpatient status.

QUESTION 29: For ED-2 when they note "last" or most recent, does that mean to use the earliest mapped field for decision to admit like for the chart abstracted metric or the "last" one. Example: Bed Request Order at 17:40, Admit Order at 18:40, ED departure 19:00. In chart abstraction we would use 17:40 which to me is more valid, but this isn't the "last" decision to admit.

A: For the eCQM, the measure is assessing for the most recent/last decision to admit that is during the ED visit that occurred within an hour of the inpatient admission.

QUESTION 30: For the population, it appears that patients are excluded if the time they become Inpatient status is before the ED discharge time. That would be a negative number, which would be less than 1 hour. So the logic should allow it, but our experience has been that those negative values result in the patient being excluded. So, do we have to invent the time that the patient became an Inpatient, instead of using what is in our EHR. This doesn't seem right to me.

A: You are correct, negative numbers are not considered.

QUESTION 31: Can you please provide a list of the psychiatric mental health diagnosis set?

A: The value set contains almost 2,000 codes. Access to value sets are provided by the Value Set Authority Center to those who have a UMLS account. https://vsac.nlm.nih.gov/welcome https://uts.nlm.nih.gov/home.html

QUESTION 32: Does stratification pull only encounters with that diagnosis?? Psychiatric/mental health diagnosis? Or does it exclude those encounters? I am confused on what the stratification does exactly.

A: For the ED measures, the number of encounters that fall into the initial and measure population are reported without stratification and then reported according to defined stratification. Stratification is where the measure population is further divided into specific groups. Stratification 1 identifies patients without a principal diagnosis in the "Psychiatric/Mental Health Diagnosis." Stratification 2 identifies Patients with a principal diagnosis that is in the "Psychiatric/Mental Health Diagnosis."

QUESTION 33: Some patients may be inpatient but are changed to outpatient. For those patients, do you have any recommendations on logic on status (if take first it will be inpatient, last would be outpatient)?

A: ED – 1 and ED –2 are only assessing patients who were admitted to inpatient status from the ED. Once the patient is no longer inpatient status, the inpatient encounter would be assessed for being within 1 hour of the ED and if the inpatient encounter was less than 120 days.

QUESTION 34: Is CQL language required in order to be able to submit 2019 eCQM data?

A: Yes.

QUESTION 35: Time stamps need to be consistent across all measures, what is an operational admission order?

A: An operational admission order is your hospitals routine activity for an admission order.

QUESTION 36: For decision to admit, all data elements have to be discreet fields, correct? Not able to pull from ED doc notes?

A: For eCQMs, documentation should be in a structured/discrete form; meaning that the data is stored in a database table then the individual pieces can be processed making it measurable and reportable. If the ED provider notes are not in discrete data fields, these will not meet the intent of the eCQM.

QUESTION 37: We submitted our 2018 eCQM to CMS directly through the PSVA tool and used a vendor to submit to the Joint Commission. How do we submit our data for 2019 eCQM to TJC?

A: For The Joint Commission, all hospitals will be transitioned to the Direct Data Submission Platform for CY 2019 eCQM data. Hospitals can expect additional communication and instruction from The Joint Commission in spring 2019 regarding the transition to the DDS Platform.

QUESTION 38: On Question 28 I am not clear; did you say that observation would or would not meet this criteria?

A: Only those patients who are admitted to inpatient status are considered in the initial population for the ED measures. Observation patients are considered to be outpatient.

QUESTION 39: Do I include Observation days in the Admission Days? I ask this because of the VTE core measure.

A: Only those patients who are admitted to inpatient status are considered in the initial population for the ED measures. Inpatient status is constrained by the value set 'Encounter Inpatient (2.16.840.1.113883.3.666.5.307: 183452005, 32485007, 8715000)'. Therefore, Observation patients are not considered in the initial population because Observation status is an outpatient status.

QUESTION 40: In our hospital's EMR we have an "Event Summary" for ED that includes "Disposition Set to Admit", which is often prior to admit order. Would this time be used for decision to admit, or the admit order which is later?

A.: Decision to Admit: documentation of the decision to admit the patient from the ED. Specification: as admission processes vary at different hospitals, this can use the documented time of any of the following: 1) admission order (this may be an operational order rather than the hospital admission to inpatient status order), 2) disposition order (must explicitly state to admit), 3) documented bed request, or 4) documented acceptance from admitting physician. This is not the "bed assignment time" or "report called time."

QUESTION 41: What if a patient is initially admitted and then changed to observation...would the logic pick up the last change?

A: The logic will assess the relevant period of the inpatient encounter.

QUESTION 42: It is not helpful to have a webinar without a live Q&A. I would recommend that you time your webinars to include time for Q&A - very important

A: During this 60-minute webinar, we went over with the time needed to cover the presentation content for the ED-1 and ED-2 measures. We will answer all questions asked in the Live Session Questions panel via the Q&A document that is prepared following the session. Based on participant feedback, we are extending the duration of the remaining sessions to 90 minutes. This will permit adequate time to cover presentation content in the first hour and Q&A at the end of each session for the additional 30 minutes.