



**Pioneers in Quality:
eCQM Expert to Expert Webinar Series: VTE-1 & VTE-2 eCQMs
February 26, 2019
Q & A Document**

QUESTION 1: How can I download the slides?

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 2: Where will this recording be posted? Will we be alerted once it is posted?
Apologies but I have been pulled off of this webinar several times to service my organization

A: A recording of today's presentation, the slide deck and Q&A documents will be available on The Joint Commission website in April at https://www.jointcommission.org/piq_expert_to_expert_series/ and the CMS eCQI Resource Center at approximately the same time.

QUESTION 3:

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QUESTION 5: If a patient was admitted as outpatient, observation ordered by MD. Then patient transition to inpatient, will the observation order stand or will the case become a negative numerator?

A: The outpatient and observation are not considered in the inpatient hospitalization calculation - so no.

QUESTION 6: Based on the webinar, if a patient is in ICU less than a day, and no VTE prophylaxis is documented, will it be excluded from the measure? For example, a patient is transferred to ICU, and then transferred to another facility 5 hours later for a higher level of care. Does that exclude the requirement for VTE prophylaxis during that 5 hours (if Sequential Compression Device (SCDs) were ordered)?

A: For the VTE 2, yes, if ICU length of stay less than 1 day and no VTE prophylaxis is documented, the patient will be excluded from VTE 2 denominator exception evaluation (see slide #107). And for the VTE 1, a patient with ICU stay 1 day or more will be excluded from Denominator. Therefore, a patient with ICU stay less than 1 day will be evaluated in VTE 1 measure accordingly (see slide #40-42).

QUESTION 7: When you refer to "union", it's basically the exclusions or what would be excluded from the numerator, correct?

A: No, the union operator can be used in multiple areas of the measure logic. It's not limited to the numerator or the exclusion. It's used to combine 2 or more lists together so any element in any of those lists will satisfy the condition (see slide #21 Or CQL Standards: <http://cql.hl7.org/STU2/index.html>).

QUESTION 8: If a patient has devices ordered, but the nurse doesn't document application, are they noncompliant?

A: A device applied for VTE prophylaxis must be documented in order to pass the measure. A device ordered without a reason will fail the measure.

QUESTION 9: So can a VTE assessment of low risk be done in ED or day of/day after admission? Same as refusal? As long as the ED encounter ends no more than 1 hr before an encounter?

A: VTE assessment of low risk is part of the reason for no VTE prophylaxis. If Low Risk for VTE is done during ED that ED must end 1 hour or less on or before admission, or Low Risk for VTE

is done on day of or day after Admission, will satisfy the numerator (see slides #66 – #69). Yes, same timing conditions are applicable for No VTE Prophylaxis Due to Medical Reason and No VTE Prophylaxis Due to Patient Refusal.

QUESTION 10: If patient received SCD prior to procedure, after a procedure does Day 0/Day 1 repeat and they need another documentation to satisfy this measure.

A: We need more information to be able to answer the question correctly. In general, if a patient received SCD prior to a procedure or a day after procedure will satisfy the numerator, ONLY when this procedure ends 1 day after Admission date (for VTE-1) or ends 1 day after first ICU admission date (for VTE-2).

QUESTION 11: For VTE-1, if a patient is admitted 2/24 (day 1), and has a procedure 2/25 (day 2); Does VTE prophylaxis start over as of the procedure date on 2/25?

A: If the VTE prophylaxis is on 25th, it counts. For this patient have the procedure on Feb. 25 with VTE prophylaxis administered on 26th, it will still count. It is because it satisfies the condition that VTE prophylaxis was administered the day of the day after procedure. That procedure ends the day after admission (see slide#59).

QUESTION 12: How is 2 days calculated, is it a 48 hour count or Admission date plus 2 days?

A: Both measures are using 'day' as a calculation unit. So a 'day' refers to a calendar day not a 24 hour count. For example, Day 1 ends at 1159pm on the same day and Day 2 begins at midnight until 1159pm.

QUESTION 13: For patients that are an Inpatient Direct Admit and do not have an ED encounter, they would still be in the VTE population correct?

A: Yes, that is correct.

QUESTION 14: Does Aspirin fulfill the measure?

A: No. Aspirin is not considered a VTE prophylaxis medication. The qualifying medications for VTE prophylaxis value sets are stated in the measures (see slide #57). You can also go to the Value Set Authority Center (VSAC) <https://vsac.nlm.nih.gov/> to find the medications in the value sets by using the OID or object identifier for each value set. You will need to obtain a license to access the VSAC, but is free with registration on the site.

QUESTION 15: Does a patient refusal of either mechanical or pharmacological prophylaxis count as a refusal for both?

A: For patient refusal, both measures are looking for either mechanical or pharmacological prophylaxis not done. Since it uses UNION(), either one will pass the numerator unlike the medical reason which requires both. See slide #83.

QUESTION 16: Where does the data logic look for documentation of low risk, no VTE, no prophylaxis needed?

A: The data must be in a discrete field, but could be captured in a few places in your EHR depending on how your system is set up. Some organization capture this information as a response to a decision alert, within an order set, or in a discrete field within in a progress note.

QUESTION 17: You mentioned Observation time does not get included for VTE, but does the same apply for the ED measures?

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 18: Given that many EHR's still have not put the new CQM and PI Objectives in place in their production systems- do you see the reporting timeframe changing? Or perhaps the attestation timeframe?

A: At this time we are not aware of any future changes to the reporting period. We recommend that you review the CMS annual proposed rule regarding the Inpatient Prospective Payment System (IPPS), released in the spring and includes the Hospital Inpatient Quality Reporting (HIQR) Program. This would provide the opportunity to review proposed changes and provide public comments.

The Joint Commission will determine for example, the CY 2020 ORYX performance measurement reporting requirements following the release of the CMS' FY 2020 IPPS final rule.

QUESTION 19: For the contraindication of no VTE, does it have to be documented in a certain spot or is it ok in the MD notes?

A: The medical reason has to be documented in the discrete field that is coded and mapped. There is no one correct place to capture this information. The information could be captured in a few places in your EMR depending on how your system is set up. Some organization capture this information as a response to a decision alert, within an order set, or in a discrete field within in a progress note.

QUESTION 20: If the inpatient admit order is during the ED visit (prior to ED depart) is the ED information/interventions included for the encounter/VTE measure?

A: Yes. Any interventions that are tied to that hospitalization function, will count if they were done in the ED. So you'll need to look at the logic to see which criteria match, because it's mostly in the denominator exclusions that we use that function.

QUESTION 21: Is a standardized risk assessment required in order to use the low risk exclusion?

A: We do not use a standardized risk assessment tool for VTE 1 or VTE 2. There are multiple tools available, often referred to as risk assessment models (RAMs). Some of the validated tools which can be found in the literature include the Caprini, the Padua, and IMPROVE. We do not require the use of one specific tool for VTE 1 or VTE 2.

QUESTION 22: Slide 40. Does the start of encounter mean the Arrival time to the hospital, or the Admission to the unit time, in order to calculate day of and day after?

A: The Slide #40 is about “Encounter ICU location Stay is 1 day or more.” The start of Encounter means start of inpatient encounter, which is admission datetime.

QUESTION 23: Could you clarify the "patient ambulating" as reason for no prophylaxis process.

A: Reasons for no pharmacological and no mechanical VTE prophylaxis must be explicitly documented and linked with VTE prophylaxis like the example below:

"No VTE prophylaxis. Patient ambulating" is acceptable.

"Patient ambulating" alone without linkage is not acceptable.

Question 24: What happens if a patient is placed in observation before they are changed to an Inpatient Status? Are they excluded in the measures? Or does the "hospitalization" not start until the date that they change to Inpatient Status?

A: Slide 30 illustrates the hospitalization time frame. Observation is NOT considered a part of the hospitalization time frame calculation.

QUESTION 25: Can you provide the full articles that are referenced in the two referenced articles below?

System-wide alerts (computer or human alerts) increase the rate of VTE prophylaxis administration (Kahn, et al, 2018).

The majority of fatal events occur as sudden or abrupt death, underscoring the importance of prevention as the most critical action step for reducing death from PE (Geerts, et al, 2008).

A: We are not able to provide the full articles, however, you should be able to access the articles through Google or library services.

QUESTION 26: Is there any more specific guidance as to what Medical Reasons are acceptable?

A: We reuse the medical reasons value set for multiple measures, so it is fairly generic, including concepts such as medical contraindications, etc. You can find out all eligible medical reason from the value set authority center by entering OID “2.16.840.1.113883.3.117.1.7.1.473”.

QUESTION 27: What about Atrial Flutter Dx as intersection for Oral Factor Xa?

A: The value set includes the diagnosis of atrial flutter as well as atrial fibrillation. Atrial Flutter Diagnosis as intersection for Oral Factor Xa means a patient who had prior or present diagnosis of Atrial Fibrillation AND was given Oral Factor Xa Inhibitor within the required timeframe will satisfy the numerator.

QUESTION 28: Does comfort measure documentation meet the requirement or does it have to be an order from a provider for CMO?

A: It could be either Comfort Measures was documented or Comfort Measures was ordered. Either one will meet the measure intent.

QUESTION 29: Can a patient be in the denominator population for both VTE 1 & VTE 2 if they were admitted to Med-Surg then transferred to ICU during the encounter?

A: Yes.

QUESTION 30: Does the venous thromboembolism diagnosis make a difference for Present on Admission (POA) or NOT POA?

A: Both VTE-1 and VTE-2 measures do not look for Present on Admission as part of diagnosis.

QUESTION 31: Does documentation from provider qualify for CMO or does there have to be a provider order?

A: It could be either Comfort Measures was documented or Comfort Measures was ordered. Either one will meet the measure intent.

QUESTION 32: Where we can [sic] find a list of vendors for eCQM Submissions and Deadline on Dates for selecting measures.

A: For The Joint Commission, from our website select the Measurement Tab and you will find a list of ORYX vendors or use this link:

https://www.jointcommission.org/performance_measurement.aspx . For purposes of The Joint Commission CY 2018 eCQM data is due March 15, 2019 and for CMS the CY 2018 eCQM deadline submission has been extended from February 28, 2019 to March 1, 2019.

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 33: Can you please define LOS 2 days? Is day one considered the day of arrival until midnight or a 24 hour period?

A: In slide 38, it states that Encounter Length of Stay is less than 2 days. The calculation is to find the difference in days between 2 dates; thus, it is calculated by day not hour. For example, February 24th 11am and February 26th 8am is considered as 2 'days' apart, although they are less than 48 hours apart.

QUESTION 34: So the intervention has more time now than under the prior specification, before it was within 24 hours of admission. Day of and day after is technically longer, is this correct?

A: In slide 46, "Day of" is a CQL operator that refers to a calendar day when calculating day of or day after. So the logic is looking for an intervention to occur the day of hospitalization start until 1159pm the following day.

QUESTION 35: Can you clarify how INTERSECT works?

A: Intersect is a CQL operator which looks for the common elements between List A and List B. In this example, in order to exclude Admission Without VTE or Obstetrical Conditions, we use intersect along with operator NOT. See an example in slide 21. Or CQL Standards:

<http://cql.hl7.org/STU2/index.html>.

QUESTION 36: Does mechanical prophylaxis alone count?

A: Mechanical prophylaxis alone will meet the measures.

QUESTION 37: So if our electronic health record provides a means to document either 'patient refusal' or 'reason why prophylaxis not implemented [med or device]' those entries would have to be entered 'day of or day after' admission and can't be entered later by like an HIM professional based on provider documentation?

A: Correct, the documentation of No VTE Prophylaxis Due to Patient Refusal cannot be back entered by HIM. The logic uses the author date time so, it must be documented during any of these 3 timeframes – during ED Visit, or on Day of or Day After Admission, or on Day of or Day After Procedure that procedure ends 1 day after hospital admission.

QUESTION 38: Are reasons for no VTE Prophylaxis that are documented while the patient is an Observation status counted?

A: No, a reason for no VTE Prophylaxis that were documented in Observation will not be counted.

QUESTION 39: I have a question about what is needed for to make the numerator if there is a medical reason. I know you need the medical reason code for mechanical and pharmacologic but do you also need the OID for the device and/or medication that was not ordered/performed?

A: Not done is a negation for all required Medications and devices. It Is not tied to a specific medication or device. The Medical Reason value set contains generic reason for no VTE prophylaxis. And a code from Medical Reason values set is needed in order to satisfy the condition.

QUESTION 40: Clarification on question about SCD'd ordered and not applied by nurse the patient fails the measure correct?

A: Correct. If SCDs were ordered but not applied, then a reason for no mechanical prophylaxis as well as no pharmacological prophylaxis is needed.

QUESTION 41: When a patient is considered low risk and is up and ambulating, where is this documented? We have an order that identifies the patient as low risk with a group response of patient ambulating, it sounds like this may not be sufficient now. Can we modify the response to "patient ambulating in room & halls" or something like that? Slide 78, 79

A: Reasons for no pharmacological and no mechanical VTE prophylaxis must be explicitly documented and linked with VTE prophylaxis like the followings -
"No VTE prophylaxis. Patient ambulating" is acceptable.
"Patient ambulating" alone without linkage is not acceptable.

QUESTION 42: I note that the timing definitions all state 'DAY of or DAY after'. Our vendor's logic also looks at the time the patient was admitted to IP or transferred to ICU. If the anticoagulant or reason for not was documented 1 minute prior to the date/time of admit to IP or ICU, we fail the measure. Is this correct?

A: Yes, for VTE Prophylaxis Received. It will fail the measure if an anticoagulant was given 1 minute prior to admission / ICU admission datetime. However, for a reason for No VTE prophylaxis, VTE-1 allows a reason was documented in ED that ED ends 1 hour or less before inpatient admission. In VTE-2, the reason documentation timeframe is from Start of ED to a day after First ICU.

QUESTION 43: We currently have Reason for No VTE Prophylaxis available for physicians to order. One of the drop down selection options is "Other" and physicians can then enter a free text reason. Currently we have nothing mapped to the selection of "Other" to satisfy the measure. Could we map to "Other" since a physician is documenting a medical reason they did not order it, or should we leave our mapping as is and consider eliminating the "Other" option?

A: The Medical Reason value sets contain generic reason for no VTE prophylaxis. And a code from Medical Reason values set is needed in order to satisfy the condition. The reason of "other" is ambiguous and is not specifying a generic reason such as "Treatment not indicated", "Medical contraindication", etc. It will cause a problem for mapping. You can find out all eligible medical reason from the value set authority center by entering OID "2.16.840.1.113883.3.117.1.7.1.473".

QUESTION 44: Since CMS is no longer utilizing the SCIP surgery measures, why do the SCIP inclusions need to be included?

A: Both VTE measures are excluding patients with a principal procedure of SCIP VTE selected surgeries due to the clinical intent. This is nothing to do with SCIP surgery measures.

QUESTION 45: Can you answer the question in regards to the SCD's being ordered but the nurse did not document that they were applied. According to the eCQM specs you have to see that the device was not only ordered but also administered. Without the nurse documenting the application of SCD's that would not pass the measure.

A: SCDs must be applied in order to pass the measure. If SCDs were ordered but not applied, then a reason for no mechanical prophylaxis as well as no pharmacological prophylaxis is needed.

QUESTION 46: If "hold for surgical procedure" is documented on the MAR does that satisfy the "Hold for medical reason" criterion?

A: "Hold VTE prophylaxis" or "No VTE prophylaxis" would be an acceptable reason on the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission.

QUESTION 47: Aspirin is used primarily in Total Knee and Hip Replacement surgery based on current research and literature.

A: Aspirin was removed as an acceptable form of VTE prophylaxis as it is no longer an FDA-approved medication for VTE prophylaxis. Oral Factor X Inhibitor is a qualifying medication for eligible Hip or Knee Replacement surgeries in both VTE measures.

QUESTION 48: Unrelated measures--but for ED-2 are patients admitted from ED to Observation status supposed to be in the measure? If they have admission orders from ED to

OBS, then later (greater than 1 hour later) are admitted to Inpatient, should they be included in the measure?

A: If the observation unit is part of the ED the patient would be assessed like any other ED patient. If the patient is not considered part of the ED then the patient would not be considered for inclusion in the initial population as the measure is assessing those patients from ED to inpatient status within an hour of one another.