Pioneers in Quality Electronic Clinical Quality Measure (eCQM) EtoE Webinar Series

STK-2, -3, -6 eCQMs

December 11, 2018

Lisa Anderson: Hello, everyone. I'm Lisa Anderson, Project Director, eClinical, in the Department of Quality Measurement at the Joint Commission. I would like to thank you for joining us for our Pioneers in Quality 2018 through 2019 Expert to Expert series. Today, we will be focusing on the Stroke-2, -3, and -6 eCQMs.

For those participating that would like to use the Closed Captioning Service, please see the link on this slide for information on how to access the service. We have also pasted this information into the Chat box.

In 2016, as part of the Joint Commission Pioneers in Quality program, we offered a technical series to drill deep into the measure specifications and rationale for each electronic clinical quality measure. With the transition to Clinical Quality Language, CQL, for eCQMs starting with January 1, 2019 data collection and 2020 data submission, we heard many requests from hospitals and health systems for in-depth sessions for each eCQM as pertains to the CQL Expression Language.

The Joint Commission and the Centers for Medicaid and Medicare Services, CMS, are committed to supporting hospitals on their journey towards electronic clinical quality measure adoption and transition to the new clinical quality language, logic expression language. So we have brought back the Pioneers in Quality Expert to Expert series to accommodate this learning need.

We introduced this series with a November 29th Pioneers in Quality electronic clinical quality measure, clinical quality language basics webinar for hospitals. There will be a total of six sessions, with each session focusing specifically on two to three eCQMs.

At the end of this session, participants will be able to apply concepts learned about the new Clinical Quality Language expression language for the Stroke-2, -3, and -6 eCQMs; identify common issues and questions regarding Stroke-2, -3, and -6 eCQMs; and prepare to implement the CQL expression language for the 2019 eCQM reporting year, which is the 2020 data submission.

Good news...we have the PDF of the slides available under the "Handouts" section of the "Go To Webinar" panel. Click the triangle next to handouts, and you can find the PDF there.

This session is designed to be interactive. Participants can ask questions through the "Question" function in the dashboard. We will be handling questions during a Q&A session after the presentation. Please note you can also visit links or resources noted in the slides. We will not be recognizing the raised hand functionality.

Please note, a recording of today's webinar, along with the slide presentation, will be available on the Joint Commission website in January. An e-mail that includes the link to the Landing Page where the recording slides and Q&A will be posted will be set to "All Registered Participants" in January. We hope that you find this information helpful and that you can share it with interested colleagues.

As an added feature, we also are providing CE credits for all our primary and quality webinars. This webinar is approved for 1.0 Continuing Education Credit from the Accreditation Council for Continuing Medical Education, ACCME; AMA PRA Category 1 Credit; the American Nurses Credentialing Center, ANCC; the

American College of Healthcare Executives, ACHE; the California Board of Registered Nursing; the International Association for Continuing Education and Training, IACET; CE, CME, CEU credits are available for the live audience only. Credits will *not* be available for webinar replays.

To claim credits, you must have individually registered for the webinar; listened to the webinar in its entirety, only those listening live during the session will be eligible to receive credit; completed a post-program evaluation/attestation, the program evaluation attestation link will be set to your registered e-mail after the webinar. Printable certificates will be sent via e-mail two weeks after the session. All participant CE certificates will be sent at the same time.

If you are listening with colleagues and did not use your own link/phone line to join, you can still claim CE credit if you meet these three criteria. An automated e-mail after this session will provide information on how to access the survey.

The following staff and speakers have disclosed that neither they nor their spouses or partners have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity:

Lisa Anderson, MSN, RN, Project Director, eClinical, Department of Quality Measurement

Mia Nievera, RN, MSN, Associate Project Director, eClinical, Department of Quality Measurement

Karen Kolbusz, MBA, BSN, RN, Associate Project Director, Department of Quality Measurement

I am now going to turn over the webinar to Mia and Karen for their presentations regarding the Stroke-22, -3, and -6.

Take it away, Karen.

Karen Kolbusz: Thank you, Lisa.

Good morning, everyone. To start, I'd like to provide a brief clinical introduction of the measure, Stroke-2, Discharged on Antithrombotic Therapy. Stroke-2 captures the percentage of ischemic stroke patients prescribed antithrombotic therapy at hospitals discharge. Several therapies are recommended for the prevention of another stroke and patients who have experienced stroke or transient ischemic attack, one of which is long-term antithrombotic therapy.

Clinical studies have demonstrated that long-term antithrombotic therapy reduces risk of stroke, MI, or deaths post stroke by approximately 22% for patients prescribed antithrombotic therapy at discharge. Aspirin, combination aspirin/dipyridamole, clopidogrel, and ticlopidine have all been approved by the FDA for prevention of vascular events among patients with a stroke or TIA. Of these four agents, aspirin and clopidogrel are most commonly prescribed.

Clopidogrel was compared with aspirin alone in the CAPRIE trial, which stands for Clopidogrel versus Aspirin in Patients at Risk for Ischemic Events. The annual rate of stroke, MI, or vascular death was 7.5% in the clopidogrel group compared

to 7.71% in the aspirin group. Overall, the safety of clopidogrel is comparable to that of aspirin. Data suggests that antithrombotic therapy should be prescribed at discharge following acute ischemic stroke to reduce stroke mortality and morbidity as long as no contraindications exist.

I will now turn it over to Mia to continue the discussion of the measure logic.

Mia?

Mia Nievera: Thank you, Karen.

Good morning, everyone. Before we dive into the measure specifications, we'll take a few minutes to do a high-level overview on the new Clinical Quality Language, otherwise known as CQL. This may be a repeat for some of you who attended the CQL Basics webinar, but it will help level set for this presentation.

This diagram is one of the ways we represent the evolution of the current standards when creating the specifications for eCQM. The HQMF, the Health Quality Measure Format, is the basic electronic specification for the measure which is the metadata and the population structure. The QDM, the Quality Data Model, provides information to help finalize the HQMF; and it's divided into two parts, the data model and the logic. As you can see, in the new specifications when we transition to the new standards in 2019, only the logic changes from QDM to QCQL. And that change to CQL is really to make the logic more readable, computable, and sharable.

This is a screenshot of the human readable for Stroke-2. This may look relatively to you where you have the population criteria here at the top...so the initial population, the denominator, and numerator; however, there are two things here to notice. First, if you look under the initial population, it's only referring to a single definition; but it does have a meaningful name. So you'll see "Encounter with Principal Diagnosis and Age." With CQL, we use definitions to build the population criteria and title the definitions with more of a natural language to capture the meaning of the logic that they represent.

Secondly, I've bracketed the middle and lower sections of the definitions and functions together. These definitions serve like building blocks and are used to build the population criteria. So what do I mean by that?

Here CQL uses definitions like building blocks, using one definition to build upon another and another until you come to a final definition. Using very simple terms, this diagram depicts a visual representation of a generic patient population definition and its structure. Each block represents the definition, and each definition addresses a specific population parameter.

At the base of the diagram is the largest block with the largest population, as is indicated by those little people icons. So then "A" represents the title of the definition, and "Encounters" represents the logic in this definition. So in this piece of logic, what we're looking for is a specific encounter type; so for example, an inpatient encounter or an ED encounter.

Keeping that in mind and moving up to block "B", rather than repeating the previous encounter logic, we simply call out the definition of title "A" and add logic for "Diagnosis." So then by definition, "B" equals "A" plus "Diagnosis."

Using that same pattern in block "C," we'll call in definition "B" and add age criteria. So we've built off each definition by adding additional criteria at every level; and therefore, each successive definition helps to further constrain the logic and thereby narrowing down the patient population. Then you'll see "C" at the top level encompasses all criteria through definitions "A" *and* "B" and becomes the initial population definition. We use this methodology of building blocks because it's cleaner to read, and it does allow us to reuse or share the definitions throughout the measure specifications. It's much easier.

Looking at this concept in more concrete terms, here in Stroke-2 we have three definitions to build the initial population. We'll with the "Non-Elective Inpatient Encounter" at the base and then add diagnosis criteria in the "All Stroke Encounter" definition and then age criteria in the "Encounter with Principal Diagnosis and Age." And as we can see in the population criteria here at the top, "Encounter with Principal Diagnosis and Age" is used directly as the initial population. So using real terms, you can see how complex a definition can be if we try and sweep all that logic into one statement.

Now, there are a lot more terms used in CQL; but these are just some of the basics. Definitions in CQL have a name, as we saw before, and an identifier that is unique within the library. Libraries are created and used so we can easily share those definitions across measures. The Library Alias, as indicated here in the prefix are highlighted yellow. Some definitions though may not come from a specific library, so you will not see that enotation.

The "Expression" refers to the content of the definition. As we've seen, these expressions can reference other definitions to build up more complete expressions. Expressions use a datatype to describe a part of the clinical care process which refers to a specific category in QDM. For instance, the "Encounter Performed" datatype used in this example is in the "Encounter" category. "Medication Administered" datatype would then belong to the "Medication" category. Each datatype has a specific list of attributes associated to it which provides more specific details about that datatype. So in the example, "relevantPeriod" is an attribute of the "Encounter Performed" datatype.

Next we have a value set, which specifies the kinds of data or codes that we're looking for relative to the QDM category. Ultimately, these are the codes the logic is looking for in the EHR. So let's say, for instance, the value set consists of a hospital emergency admission SNOMED code. To satisfy the logic, we would expect to see that SNOMED code in the patient's records.

Finally, we use aliases in expressions. These are to give a source a name so that bit of logic can be referred to easily within the expression to avoid restating. We try to be very concise and meaningful when creating an alias so it makes sense to the reader.

Just briefly, there is a "Terminology" section in the human readables where you can see all the values used in the measure. The Value Set Authority Center, or the VSAC, is where you would go to verify the codes listed in each value set. Each value set has a unique object identifier, also known as an OID number, which is the quickest way to search in the VSAC.

That wraps up our CQL 101 crash course. Let's transition back to Stroke-2, CMS 104 Version 7. The version is important to note since that will be the version in the upcoming reporting year beginning January 1, 2019. The initial population reads: "Patients aged 18 and older discharged from inpatient care, non-elective admission with a principal diagnosis of ischemic or hemorrhagic stroke, and a length of stay less than or equal to 120 days that ends during the measurement period."

The definition for "initial population" is: "Encounter with Principal Diagnosis and Age." For clarity, throughout the presentation I will not be referencing the library alias when calling out the definition names.

Starting at the base of the definition, the logic is looking for a non-elective inpatient encounter that is less than or equal to 120 days. So a patient must have one of the encounter codes listed in the value set to satisfy this expression. Now, going back to the "relevantPeriod" attribute I mentioned earlier, this is used to define the start and end of a given time frame. In this instance, the relevant period defines the duration of the encounter to be 120 days or less *and* it must also occur during the measurement period.

To achieve the 120-day parameter, we use a CQL function called "Length in Days," which calculates the difference between the start and end of a value.

Moving on to the next block, so to speak, we pull in the non-elective inpatient encounter, since it is the base for the overall definition; and we give it an alas, "Non-elective encounter," so that we can refer back to it throughout the expression. The logic then states that the non-elective encounter should have a principal diagnosis or a code within the hemorrhagic or ischemic stroke value set...again, noting the attribute is represented by the ".PrincipalDiagnosis."

Moving on to the "Encounter with Principal Diagnosis and Age," again, here we pull in the previous definition, the "All-Stroke" encounter to continue building that expression; and we add an age parameter using the patient's birth date. We use assumption called "Calendar Age in Years At" to calculate that patient's age at the time of the start of the encounter. In other words, the patient needs to be 18 or older by the start of the admission. Now that we've defined all the criteria to meet the initial population, "Encounter with Principal Diagnosis and Age" becomes the single definition for the initial population.

Once the patient qualifies into the initial population, the process moves to the denominator. The denominator is looking for patients with a principal diagnosis of ischemic stroke. The definition for the denominator is "Ischemic Stroke Encounter." You'll notice in the logic that we reuse the "Encounter with Principal Diagnosis" because that is a qualifying encounter to continue moving forward. We, in effect, carry through all the definitions from the initial population into the denominator...as it's been noted here in that yellow text box. Like before, an alias is given..."Encounter with Age"...and we add a new parameter to meet the "Next Population" criteria, where we narrow the scope to *only* a principal diagnosis of ischemic stroke.

Moving on to the denominator exclusions, the patients admitted for elective carotid intervention is actually not addressed in the exclusion definition; it's addressed in the initial population by only including non-elective hospitalizations

in the value set. So then the exclusions that we're looking for are patients discharged to another hospital who left against medical advice, who expired, who are discharged to home for hospice care, discharged to health care facility for hospice care, or patients with comfort measures documented during hospitalization.

So our definition for our denominator exclusions rolls up to being: "Ischemic stroke encounters with discharge status union comfort measures during hospitalization." To note, "union" in this instance means "or." So a patient can meet either one of these definitions to satisfy the denominator exclusion.

Looking at the first expression here, "Ischemic Stroke Encounters with Discharge Status," the logic is pretty straightforward here. It's looking for the ischemic encounter with a discharge disposition code of "discharged to acute care facility," or "left against medical advice," or "patient expired." I'm not going to read the rest of the status of the dispositions here, but it follows that same pattern throughout the logic.

Moving to the second expression, "Comfort Measures During Hospitalization"...with this, we've received several questions about the definition regarding coalesce. So let's break it down by first defining all the working pieces of these two expressions: "Comfort Measures During Hospitalization" and "Intervention Comfort Measures."

The first, COALESCE, is a CQL operator that allows for if/then logic. We apply that condition to the intervention order or the intervention performed datatype, as you see highlighted here, where either one would meet the condition. "Union," as I mentioned before, means "or." It also has another function where it's used to combine two lists of different types. In this instance, we're combining the attributes of the two types..."Intervention Order" and "Intervention Performed."

Author/date/time is a common attribute for both "Intervention Order" and "Intervention Performed." However, "relevantPeriod" is the only attributed associated to the "Intervention Performed" datatype. So this is where COALESCE is used...to look for those time attributes. "relevantPeriod" is listed first because "relevantPeriod" is a timestamp when the comfort measures occurred. If a timestamp does not exist, then the logic would look for "Author/date/time," which is a timestamp when the comfort measure order or documentation was entered.

Moving to the new numerator...the numerator is looking for patients prescribed or continuing to take antithrombotic therapy at hospital discharge. Following the pattern, we start with ischemic stroke encounter and add logic for antithrombotic therapy to occur by discharge...which is indicated by that yellow highlighted expression "Discharge Antithrombotic.AuthorDate/Time during IschemicStroke Encounter.relevantPeriod."

Now let's talk about the "Medication Discharge" datatype because this is what the "Author/Date/Time" is referring to. The timing associated to "Medication Discharge" accounts for the time the discharge medication list...not the medications individually, but the list on the discharge instruction form is authored. So depending on your organizational workflow, you may be using the timestamp

of the discharge med rec or the discharge instruction, which should be done prior to discharge and during the encounter to satisfy the measure.

As an aside, we also get a lot of questions regarding the medications listed in the antithrombotic value set. As a general rule, we explicitly exclude brand name drugs and only use the semantic clinical drug names. So when mapping your local medication codes, they need to be mapped to the NDC RXNorm codes. We've also started including the generic packs, the G-packs; so those would be your dose packs to the value set, as they are identified. You can find more information on this by reviewing the CMS Blueprint that is located on the resource slide.

With a denominator exception, it is important to note the difference between an exclusion and an exception. Simply put, it differentiates in the way that it processes. An exclusion is processed before the numerator, so a patient is excluded and never in the numerator. An exception is processed after the numerator. In this case, we have a patient that has a principal diagnosis of ischemic stroke who does not receive a medication at discharge...which means they do *not* meet the numerator. So the process flows to the denominator exceptions and checks for a reason why the medication was not prescribed at discharge. This is also called a "negation rationale." This logic is looking for a medical reason or a patient refusal to satisfy the reason for not being prescribed.

I'd like to turn it back over to Karen to introduce us to the next measure.

Karen Kolbusz: Thank you, Mia.

Our next measure is Stroke-3 Anticoagulation Therapy for Atrial Fibrillation Flutter, which captures the percentage of ischemic stroke patients with documented a-fib flutter or prescribed anticoagulation therapy at hospital discharge. Atrial fib affects over 2.7 million Americans and becomes more prevalent with age, ranking as the leading cardiac arrhythmia in the elderly. The principal adverse consequence of atrial fib is ischemic stroke. In the United States, this arrhythmia is estimated to be responsible for more than 70,000 ischemic strokes each year. Therefore, the treatment of atrial fib among patients with prior ischemic strokes is a major focus of preventative stroke error.

Multiple clinical trials have demonstrated the effectiveness of warfarin versus placebo in the prevention of thrombotic events in patients with non-valvular atrial fibrillation. An analysis of pooled data from five primary prevention trials demonstrated a relative risk reduction of 68% and an absolute reduction in annual stroke rates from 4.5% for controlled patients to 1.4% in patients assigned to adjusted-dose warfarin. In other words, 32 ischemic strokes will be prevented each year for every 1,000 patients treated.

European atrial fibrillation trials confirmed the effectiveness of warfarin for secondary prevention, demonstrating the annual risks of stroke was reduced from 12% to 4%, with an annual rate of major bleeding of 1.3% compared to 1% for patients given placebo or aspirin.

In more recent years, the RELY, ROCKET-AF and ARISTOTLE clinical trials have demonstrated the safety and effectiveness of alternative anticoagulant agents for stroke prevention in patients with non-valvular atrial fibrillation.

Dabigatran was the first direct thrombin inhibitor approved for this indication. Three Factor 10a inhibitors...rivaroxaban, apixaban, and edoxaban...have also been FDA-approved for use in the United States. Clinical practice guideline recommendations have been updated to recognize the role of these newer oral anticoagulation medications for secondary stroke prevention in patients with non-valvular atrial fibrillation. For most patients with acute ischemic stroke and AF, it is reasonable to initiate oral anticoagulation within 4 to 14 days of stroke aspect.

Mia, back to you.

Mia Nievera: Thanks, Karen.

In the interest of time, since the initial population is the same for Stroke-2, we will move on to the denominator.

The denominator is looking for patients with a principal diagnosis of ischemic stroke *and* a history of atrial ablation or current or a history of atrial fibrillation or flutter. Since an initial population is the same, we call in the same ischemic stroke encounter; but we're also looking for a procedure of atrial ablation that occurred before the start of the encounter.

This definition is looking for a history of atrial fibrillation or flutter, so this is using a diagnosis datatype which confers historical diagnosis. The prevalent period attribute is looking for the onset of atrial fibrillation flutter to start on or before the end of the encounter, which means the diagnosis can occur any time before the end of the ischemic stroke admission.

In this definition, the logic is looking for atrial fibrillation flutter as an attribute of the encounter, as indicated by the ".diagnoses." And as an attribute, there is no timing needed because it's a diagnosis that's tied to this admission.

Although the denominator exclusions for Stroke-2 and -3 are the same, there is a slight difference because the denominator is different. Therefore, rather than using the ischemic stroke encounter definition, we'll begin to use the denominator encounter to start each expression. Again, although the numerator is the same for Stroke-2 and -3, we apply that same concept of using the denominator encounter to start the expression. Again, the same concept applies to the denominator exceptions where the logic remains unchanged; but we use the denominator encounter to start the expression.

I'd like to turn it back over to Karen to introduce us to our final measure.

Karen Kolbusz: Thanks, Mia.

From 2006, the Stroke Prevention by Aggressive Reduction of Cholesterol Levels, otherwise known as the SPARCL trial, was a pivotal trial which concluded that patients with stroke or TIA experienced a reduced overall incidence of another stroke and other cardiovascular events when 80 milligrams of atorvastatin was administered orally each day.

In 2013, the American College of Cardiology and the American Heart Association updated the guidelines on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults and strongly recommended high-

intensity statin therapy for secondary prevention in patients with clinical atherosclerotic cardiovascular disease unless it's contraindicated.

Patients with ischemic stroke due to atherosclerosis are included in the first of four statin benefit groups. High-intensity statin therapy should be initiated or continued as first-line therapy in both women and men less than 75 years of age. When high-intensity statin therapy is contraindicated, or for those patients unable to tolerate high-intensity statin therapy, moderate intensity statin therapy should be used as a second option. High-intensity therapy may also be reasonable for ischemic stroke patients who are older than 75 years if risk-reduction benefits outweigh the risk of adverse events and the patient can also tolerate the treatment.

AHA and ASA Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attacks from Kernan in 2014 were revised to follow the ACC and AHA recommendations. Statin therapy was recommended to reduce the risk of stroke in cardiovascular events for patients with ischemic stroke or TIAs presumed to be of atherosclerotic origin.

Mia?

Mia Nievera: Thanks again, Karen, for that introduction.

Since the initial population is the same for all the stroke measures, we will continue forward and bypass this definition. Again, the denominator is the same as Stroke-2, where we pull in the same definitions; so we'll continue pushing forward.

The denominator exclusions...same here, no change...we will continue moving forward.

Which takes us to the numerator...the numerator is looking for patients prescribed or continuing to take statin medication at hospital discharge. Going back to the initial population, we call in the ischemic stroke encounter with a statin medication. The statin at discharge definition also uses the medication discharge datatype; so again, it's using the time the discharge medication list on the discharge instructions is authored as a timestamp to satisfy the measure.

The denominator exceptions is looking for patients with a reason for not prescribing a statin medication at discharge or patients with a maximum LDL result of less than 70 milligrams per deciliter, less than or equal to 30 days prior to arrival or any time during the hospital stay.

In the first expression highlighted here, statin not given at discharge uses the same negation rationale as we discussed in Stroke-3, where if a medical reason or refusal is captured as a reason for not prescribing, that will satisfy the measure. Patients with a documented statin allergy or intolerance will also satisfy the measure.

In this next definition, "Encounter with Max LDL Less than 70 Milligrams per Deciliter," this was moved from being a denominator exclusion to a denominator exception. Now the patient is no longer automatically excluded based on their LDL. Remember, a denominator exception is processed *after* the numerator.

We move to the definition below. We use a CQL operator of "MAX," which returns the maximum element of something. This is a new operator included in the measure this reporting year, where we are looking for the highest LDL result. The return clause here helps to shape the result we're looking for, which is turn is a maximum LDL of less than seven days.

The timing for this logic uses an interval. An interval specifies a start and end time. In this definition, the interval is 30 days or less before the start of the encounter and any time during the encounter until discharge. Putting it all together, the maximum LDL results can occur any time during the interval time frame.

With that, I'd like to end with a list of resources already at your disposal. This is included in the slide deck available to you, so I do highly encourage you to take a look. At least peruse the eCQI Resource Center, which is our one-stop shop for all eCQM-related information. I want to thank you all for your time today.

Lisa, I'll turn it over to you.

Lisa Anderson: Great, thank you, Mia and Karen for your excellent presentations.

We will now open up the Q&A segment for questions about this content. To ask a question, please type your name, organization, and lastly your question and which measure you are talking about in the Question box provided in the "Go To Webinar" user dashboard. We are not using the raised hand feature or Chat box for these sessions. Due to the large number of participants listening to this presentation, we ask that you limit yourself to one question.

Okay, we have a few questions regarding the slides. Just a reminder, if you click on the triangle next to the "Handouts" section in the "Go To Webinar," there is a link to the handouts there.

We have a question for Mia regarding the elective/non-elective and does this have a SNOMAN code? Then an additional question asking: "How is the term 'non-elective' defined?"

Mia Nievera: The non-elective inpatient encounter value set contains SNOMAN codes, procedure codes, representing a non-elective inpatient encounter. You have the emergency hospital admission, a hospital admission. This does not include hospital admission elective codes.

Lisa Anderson: Great, thank you, ma'am.

The next question: "Do you have to purchase a license to access the VSAC detailed information?"

Mia Nievera: No, you do have to have a licensure; but it is free to the public.

Lisa Anderson: The next question is regarding Stroke-2: "Shouldn't you also exclude patients discharged to hospice, acute care facilities, left against medical advice, and expired?"

Mia Nievera: Yes, so the denominator exclusion does discharge to another hospital, acute care facilities. It does discharge to home for hospice or health care facility for hospice. You can see that on slide 36.

Lisa Anderson: Next question: "Will hospitals need to capture any new or different data or enter the date in a different way into the EHR to populate the CQL version of the measure as compared to the 2018 Stroke-2, -3, or -6 measures?

Mia Nievera: No, you would not have to populate the date differently.

Lisa Anderson: Oh, and I'm sorry; it was a question of the data, but the answer is the same.

The next question is: "With the medication discharge date/time, what if a patient starts in an observation bed and the provider orders the medication proactively for discharge while the patient is in the observation bed. Then the patient goes to inpatient. According to the measure, the patient does not meet the numerator. Thoughts?

Mia Nievera: It is a good thought, but we use a medication discharge datatype; and that is not speaking to the specific time that the medication was prescribed. So long as the patient is in inpatient status and that medication is listed as a discharge medication on the discharge instruction sheets, as long as you're mapping to that discharge time on the discharge sheet you should meet the measure.

Lisa Anderson: At the time the MD would document in the discharge summary reason for not ordering the medication at discharge...for example, patient refusal...would it be an exception; or does it need to be in a mapping field?

Mia Nievera: I'm sorry, could you repeat the question?

Lisa Anderson: Sure: " At the time the MD would document in the DC summary reason for not ordering the medication at discharge...for example, patient refusal...would it be an exception; or does it need to be in a mapping field?"

Mia Nievera: That would be a negation rationale, and it would need to be in a discreet field to be able to satisfy the measure.

Lisa Anderson: Great, thank you.

"Can you please state again when the antithrombotic therapy at discharge is captured for Stroke-2? I want to make sure I understood correctly."

Mia Nievera: The antithrombotic...I'm sorry, what was that?

Lisa Anderson: The antithrombotic therapy at discharge is captured for Stroke-2...when does that need to occur?

Mia Nievera: The timing?

Lisa Anderson: Mm-hm.

Mia Nievera: The timing of the antithrombotic...so, again, the discharge datatype...the author/date/time would need to occur during the encounter and before discharge.

Again, the timestamp that we're looking for, for the medication discharge medication type, is prior to discharge.

Lisa Anderson: Thank you.

The next question is: "Why is the eStroke-5 not included?"

I can answer that. We did not include the Stroke-5 measure today because we did want to allow for enough time to present on these three measures. We will be presenting on Stroke-5 on January 29th, along with the AMI measure; so please join us then.

This next question is for Karen: "For Stroke-6, what is the actual definition of 'high intensity statin'?"

Karen Kolbusz: That's a great question, and it is really dependent on the specific type of statin medication that is prescribed for the patient. Basically, high-intensity therapy is looking for a statin at a dose that would be expected to reduce the LDLC by greater than or equal to 50%. Generally, the high-intensity therapy dosages of statin would be atorvastatin, 40 milligrams to 80 milligrams every day, or rosuvastatin, 20 milligrams to 40 milligrams every day.

Lisa Anderson: Great, thank you.

This next question is regarding the author, date, and time again: "For the medications discharge type when the list is authored, how does this work if the list is addended prior to the discharge and updated?"

Mia Nievera: If it's addended prior to the discharge, then it would take the addended time frame. As long as it's done prior to discharge, it would take that timestamp. Anything that happens after discharge would not satisfy the measure.

Lisa Anderson: The next question: "These changes will apply to reporting period 2019, correct?"

Mia Nievera: Correct.

Lisa Anderson: Thank you.

The next question is: "Where in the electronic record should the diagnosis codes be pulled from; specifically a-fib??

Mia Nievera: Well, that depends on how your organization is mapping and your vendor has created it; but it's captured in both ways, as a datatype and an attribute. So we capture it historically using the diagnosis datatype; or, if it's listed as part of this admission, it would be captured as an attribute of the encounter.

So in the EHR, it could be coming from your problem list; it could be coming from a list of encounter diagnoses if you have another field in there that's capturing diagnoses or a history. That's where that would be found in your EHR, and it just needs to be mapped appropriately for reporting.

Lisa Anderson: The next question...I think this means does "union" equal "or"?

Mia Nievera: Yes, "union" does also mean "or." But again, as I mentioned in the "Comfort Measures" definition, there is another function to it; and that is to combine lists of different types that don't share the same attribute. So I can provide more detailed information in the FAQ for that.

Lisa Anderson: Thank you.

The next question: "Are the discharge dispositions value set new to the exclusions criteria for Stroke-2?"

Mia Nievera: No, they are not.

Lisa Anderson: "Stroke-6...if there are multiple LDLs and one is less than 80, will it fail if they do not discharge on statins?

Mia Nievera: That's where we use the MAX operator, where we're looking at the highest value taken, LDL, in that time period.

Lisa Anderson: Then the next question is, "And equals what?"

Mia Nievera: I'm assuming you're asking what the CQL operator is for "and," and that would be the intersect operator.

Lisa Anderson: This next question is for Stroke-6: "Can you address the result date and time versus the start date and time for a laboratory result?"

Karen Kolbusz: Thank you, I can answer that. In CQL, we can get more specific with the attributes and the specific date and times that we're looking for, which is a difference from what we were doing in QDM. In QDM, we only had the start or the end of a lab test performed; and so there were different interpretations about what the start and end meant.

In CQL, we are actually looking for when the result is actually on the patient's chart; and that's the result date and time that we're looking for, where the start date/time is when the lab test is actually collected or started the collection. You can find more information on the attributes for the result date and time and the start date and time in the Quality Data Model User Guide, Version 5.3, that is on the eCQI Resource Center.

Lisa Anderson: And I think that actually answers the next question: "Do you have a resource that provides definitions for all the operators using CQL?"

Karen Kolbusz: Yes, so the CQL operators are contained in the HL7 CQL Specifications Guide. I believe that was a resource link on our resources page. And then the Quality Data Model...that is still kept for the information on the datatypes and the attributes that are used for the logical model. Those are in that guide, which you can access through the eCQI Resource Center; and we have a link to that on our resources slide as well.

Lisa Anderson: Next question: "Some of my clinical folks are concerned about hemorrhagic stroke being included in the denominator for Stroke-2 because it isn't mentioned in TJC specs.

Mia Nievera: I can answer that. The hemorrhagic stroke patients are actually in the initial population for all of the stroke measures because that goes across all of the stroke sets. In the denominator, we refine the stroke patients to only include the ischemic stroke patients for Stroke-2, -3, and -6.

Lisa Anderson: Our next question I'm going to send to Sharon: "If our hospital was already using a vendor to submit our eCQMs and we changed our mind to submit directly via the DVP, how do we go about notifying you of the change?"

Sharon Sprenger: Thank you, Lisa.

This is Sharon. I'm assuming they're referring to your 2018 eCQM data. So I would just highlight actually for everyone on the phone related to Joint Commission or ORYX requirements, if you go to the Joint Commission main webpage, at the top of the page there's a "Measurement" tab. Click on the "Measurement" tab, and you'll see that we do have a 2018 ORYX eCQM selection form. That form was due October 31st.

But if you want to make the change for '18, open that form. Be sure to save it to your desktop, and then complete it and tell us in that form that you want to do direct data submission. Then the form will go back to the HCL ORYX and Joint Commission.org e-mail box. You might want to put in the e-mail that you want to change from a vendor to direct data submission, and then we'll follow up with you.

But I would highlight too any other information that you want regarding ORYX requirements, and in particular for 2019, you can find under that "Measurement" tab.

Lisa Anderson: Thank you.

We are running close to the session end time. So just a reminder that the handouts are available in that "Handouts" section on the screen. It shows you where to click to get those. Please download those today; otherwise, they will be posted on our website.

Any questions unanswered today will be addressed in a follow-up question-and-answer document, which we will include on the Expert to Expert series Landing Page.

Before we close this session, a few follow-up items:

Please visit the Expert to Expert series Landing Page at https://www.JointCommision.org/piq_experts_to_expert_series. This page includes registration links for all future sessions.

Also, this webinar was recorded; and the link to the replay, along with the slide presentation and Q&A, will be posted in January on this page. An e-mail that contains the link to the Landing Page will be sent to all registered participants in January when the items are available. Registration is open for all five remaining Expert to Expert series sessions.

Our next session addresses Stroke-5 and AIM I8A. Please join us on January 29th for that session.

Additional general information about Pioneers in Quality improvement practices can be found at this link.

If you qualify for CE credits, please click on the "Survey" link provided as you exit "Go To Webinar" or in the automated e-mail you will receive tomorrow. You will be redirected to the CE Evaluation Survey. The evaluation will close approximately two weeks from today. All participants that complete the survey will receive an e-mail at that time with a printable certificate available for download.

Thank you to everyone who took the time to present at today's webinar, and thanks to all of you who listened in. Have a good day.