Pioneers in Quality Expert to Expert Series: 2025 Annual Updates for Stroke eCQMs

Broadcast date: December 5, 2024

(00:00:04):

Welcome to our Expert to Expert webinar, 2025 Reporting Year Annual Updates for Stroke-2, 3, and 5 eCQMs. I'm Susan Funk, an Associate Project Director with The Joint Commission's Engagement and Quality Improvement team. And today I'll be serving us this webinar's facilitator. Thank you for joining us.

Before we start, just a few comments about today's webinar platform. Use your computer speakers or headphones to listen. There are no dial-in lines. Participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events. Refresh your screen or rejoin the event if this occurs.

We will not be recognizing the Raise a Hand or the Chat features. To ask a question, click on the Question Mark Icon in the audience toolbar on the left side of your screen. A panel will open for you to type your question and submit. The slides are designed to follow Americans with Disability Act rules.

Before we get started covering today's electronic Clinical Quality Measure content, we do want to explain that this webinar is highly technical and requires a baseline understanding of eCQM logic and concepts. Participant feedback from previous webinars indicated that the content is often too technical for individuals that are new to eCQMs to comprehend.

We recommend that anyone new to eCQMs visit the eCQI Resource Center at the hyperlink provided on this slide. You'll find a collection of resources to help you get started with eCQMs.

The slides are available now within the viewing platform. On the left side of your navigation pane, select the document icon. A new pop-up window will open and you can select the name of the file. A new browser window will open, and from it, you can download or print the PDF of the slides. The slides will be posted at the link at the bottom of this screen within two weeks following this broadcast.

One last note about the slides. The links are not clickable on screen within this viewing platform. However, if you download the slides, all the links provided during the webinar are functional.

This webinar is approved for one continuing education credit or qualifying education hour for the following organizations: Accreditation Council for Continuing Medical Education, American Nurses Credentialing Center, American College of Healthcare Executives, and the California Board of Registered Nursing.

Participants receive a certificate after completing the webinar and survey. Although we've listed organizations that accredit Joint Commission to provide CEs, many other professional societies and state boards that are not listed accept credits or will match credit from Joint Commission's educational courses.

To earn CE credit, participants must individually register for this broadcast, participate for the entire webinar, and complete a post-program evaluation and attestation survey.

For more information on The Joint Commission's continuing education policies, visit the link included at the bottom of this slide.

Just a few words about how to navigate to the CE survey and obtain your CE certificate. You will receive the CE survey link in two ways.

On the last slide, we've included a QR code that is accessible via most mobile devices. If you miss the QR code, you will also receive an automated email within 24 hours that includes the survey link.

After you access and submit the online evaluation survey, you'll be redirected to a link from which you can print or download and save a CE certificate. In case you miss the pop-up screen with the certificate, an automated email will also deliver the certificate link. Complete the certificate by adding your own name and credentials.

The participant learning objectives for this webinar are: Locate measure specifications, value sets, measure flow diagrams, and technical release notes on the eCQI Resource Center. Facilitate your organization's implementation of the STK-2, 3, and 5 eCQM annual updates for the 2025 calendar year, and utilize answers regarding common issues and questions regarding the STK-2, 3, and 5 eCQMs to inform 2025 eCQM use and implementation.

This webinar does not cover these topics, basic eCQM concepts, topics related to chart-abstracted measures, process improvement efforts related to this measure, and eCQM validation.

These staff and speakers have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content.

Myself, Susan Funk, Melissa Breath, Raquel Belarmino, Kelly Franklin, Sheila Aguilar, Karen Kolbusz, and Susan Yendro.

(00:05:32):

The agenda for today's discussion follows, highlight how to access eCQM resources on the eCQI Resource Center, review the measure flow and algorithm, review the STK-2, 3, and 5 eCQM annual updates for reporting year 2025, review frequently asked questions, and then we'll do a live facilitated audience Q&A segment where our experts will be responding to your questions and typing in responses.

The team will now highlight some of the resources available on the CMS eCQI Resource Center. The eCQI Resource Center provides a centralized location for news, information, tools, and standards related to eCQMs. The majority of tools and resources referenced within the eCQI Resource Center are openly available for stakeholder use and provide a foundation for the development, testing, certification, implementation, reporting, and continuous evaluation of eCQMs.

Melissa, whenever you're ready, please feel free to start your part of the presentation.

Hello, I am Melissa Breth, Associate Project Director for Clinical Quality Informatics. For the measure specifications and other helpful documents, navigate to the eCQI Resource Center website at ecqi.healthit.gov.

Click on the second orange rectangle labeled Eligible Hospital/Critical Access Hospital eCQMs, which leads to a new webpage where you can download specifications or click on the hyperlinked title of the desired measure to access and readily view specifications and data elements.

Available documents include the HTML version of the Human Readable measure specifications, value sets, data elements, the eCQM flow, technical release notes of all changes for this year, and even link out to view Jira tickets submitted for the selected measure. The eCQM flow document depicts the flow process diagrams that some may refer to as algorithms. They walk through the steps to calculate an eCQM. Value sets links out to the Value Set Authority Center, or VSAC, where one will find all the terms and associated codes contained within each value set. Note that a login is required, but anyone can request a UMLS account and it's free. For details, view the eCQI Resource Center navigation video short.

Hello, I am Raquel Belarmino, Associate Project Director for Clinical Quality Informatics. Now we will provide some background information for the stroke measure set.

The Stroke measure set consists of three measures, STK-2, Discharged on Antithrombotic Therapy, STK-3, Anticoagulation Therapy for Atrial Fibrillation or Flutter, STK-5, Antithrombotic Therapy by End of Hospital Day Two. STK-2 and STK-3 focus on medications that should be taken after discharge to prevent a second stroke.

These measures capture the percentage of Ischemic Stroke patients prescribed the appropriate medication at discharge. The clinical practice guidelines for secondary stroke prevention supporting these measures were updated in 2021. There is strong evidence for the recommendation supporting these three measures with recommendations graded class I, level of evidence A by the American Heart Association and American Stroke Association. STK-5 is also supported by a Class I, Level of Evidence A recommendation. This measure captures the percentage of Ischemic Stroke patients who are administered Antithrombotic therapy on the day of or day after hospital arrival as recommended for the early treatment for acute Ischemic Stroke. 2023 national averages for all hospitals in the CMS dataset that reported 25 or more cases were STK-2, 95.34%, STK-3, 75.16%, and STK-5, 92.78%.

(00:10:18):

Let's take a moment to review a Frequently Asked Question. Where can I find a list of approved medications for the stroke measures? Answer. The Human Readable has a terminology section where the value sets are listed. You'll find the medications are listed in the value sets in the VSAC searched by the value set name or OID.

Quick question. Can I ask what is an OID?

Oh, good question, Melissa. OID stands for Object Identifier, which is a unique code that each value set gets assigned. I have an example up here from STK-3. The OID is the group of numbers in the parentheses next to the value set name.

Okay, thanks. That's helpful to see.

Great. For more information, access the What Is A Value Set video short, and you can visit the VSAC at the URL listed to find all of the terms included in the value sets. Here is a table of the changes that impact all the stroke measures for 2025.

Please note throughout this presentation that the star in a circle icon will denote changes for this reporting year.

Next, before reviewing each individual measure, Melissa will review the Initial Population since it is the same across the measure set.

Thanks, Raquel. There were several changes to the IP to combine components of the logic to reduce the burden of data collection. Let's get into the details.

This slide is for reference only, which denotes the removal of definitions TJC, Encounter with Principal Diagnosis and Age, and TJC, All Stroke Encounter, since they were combined with other logic to reduce the complexity, as well as remove the Hemorrhagic Stroke to reduce the burden of data collection. We have a star in a circle icon here which denotes changes, with new content as underlined text, while stricken text denotes removed content.

The Initial Population starts off by calling the definition, Non Elective Encounter with Age. This definition was updated to combine logic noted in the previous slide and is looking for all nonelective encounters. Nonelective encounters include emergency, urgent, and/or unplanned admissions. The length of stay less than or equal to 120 days criteria was removed to align with other program measures. The age criteria of greater than or equal to 18 was added and the encounter ends during a day in the measurement period.

Now, to further define this population using the definition, Ischemic Stroke Encounter, this definition was updated to remove... Oh. I lost my place. One moment. Raquel. There we go. To further define the population using the definition, Ischemic Stroke Encounter, this definition was updated to remove encounter with age logic since this is now included in the definition we just reviewed, and calls in Non-Elective Encounter with Age, and is looking for the principal diagnosis of Ischemic Stroke.

Please note that the Initial Population is no longer looking for a diagnosis of Hemorrhagic Stroke. This change was made to reduce the burden of data collection since the current program measures are not evaluating this population. Sorry about that. Raquel will now review the measure rationale for CMS104 STK-2 discharged on Antithrombotic therapy.

(00:15:14):

Thanks, Melissa. The STK-2 measure focuses on long-term Antithrombotic therapy. Multiple clinical studies have demonstrated that Antithrombotic medications help improve patient outcomes after an Ischemic Stroke by thinning the blood and reducing the possible clot formation that can result in another stroke. Although both antiplatelet and anticoagulant medications are included in the Antithrombotic drug category, antiplatelet agents are preferred for Ischemic Stroke patients that do not have NVAF, Nonvalvular Atrial Fibrillation.

Aspirin, clopidogrel and aspirin/ER dipyridamole are frequently prescribed Antithrombotic medications for long-term Antithrombotic therapy. Dual antiplatelet therapy are not generally recommended after an Ischemic Stroke. However, short-term administration of clopidogrel and aspirin or ticagrelor and aspirin may be appropriate for some patients. THALES trial concluded that in patients with mild to moderate acute non-cardioembolic Ischemic Stroke defined as a NIHSS score less than or equal to five who were not candidates for IV tPA or mechanical thrombectomy. The risk of stroke or death within 30 days was lower with ticagrelor-aspirin than with aspirin alone. Severe bleeding was more frequent with ticagrelor. Ticagrelor alone without aspirin is not recommended. Other trials such as POINT and INSPIRES also suggest lower stroke risk for similar groups with mild Ischemic Stroke when clopidogrel and aspirin are administered for a limited period after discharge. Melissa will now review the measure flow for STK-2.

Let's start with the Initial Population. This is defined using definition, Ischemic Stroke Encounter. The right-hand side of the diagram shows the definitions and logic called to meet the Initial Population. The patient must have a nonelective inpatient encounter, be 18 years of age or older, and a principal diagnosis of Ischemic Stroke. If Initial Population criteria is not met, processing ends. If Initial Population is met, the encounter is in the Initial Population.

Now we check Denominator criteria which is the same as the Initial Population. This means that if a case met the Initial Population, then it will pass for the Denominator as well and processing will continue. The Denominator Exclusion is looking for either an encounter with Ischemic Stroke and qualifying discharge disposition criteria or the intervention comfort measures during the hospitalization. If either of these criteria are met, then the patient is excluded from the Denominator and processing ends. If they are not met, processing continues to the Numerator.

The Numerator looks to see if an Antithrombotic was prescribed at discharge. If there was, this meets the Numerator. If processing continues to look for the Denominator Exception if not.

The Denominator Exceptions look for documented reason for not providing treatment or patient refusal or a pharmacological contraindication for not prescribing an Antithrombotic. If either of these Exceptions are met, the case meets the Denominator Exception and processing ends. A sample calculation is provided to show how the performance rate is calculated. The Numerator is divided by the Denominator minus Denominator Exclusions minus Denominator Exceptions. The letter values in the formula are indicated on the previous slides and represent the various populations.

Let's review the measure logic detail, as well as the changes for STK-2. Here is a table of the changes to STK-2 for 2025. Let's move on to the Denominator. Since the Initial Population was updated to only include Ischemic Stroke patients, the definition, Encounter with Principal Diagnosis and Age, was removed and the STK-2 Denominator has been updated to Initial Population. The Denominator Exclusions definitions are Ischemic Stroke Encounters with Discharge Disposition, union, and the union operator in CQL acts like an OR, Encounter with Comfort Measures during Hospitalization. If either definition occurs, then it is true. No changes have been made to the Denominator Exclusions.

(00:20:39):

Let's take a closer look at the first library definition, TJC, Ischemic Stroke Encounters with Discharge Disposition. An encounter is excluded from the Denominator if one of the following is true, the discharge disposition is to an acute care facility, left against medical advice, patient expired, discharged to home for hospice care, or a healthcare facility for hospice care.

Now, let's look at the second definition that qualifies for Denominator Exclusions. TJC, Encounter with Comfort Measures during Hospitalization first selects encounters that have a principal diagnosis of Ischemic Stroke, then it checks to see if there was a comfort measure intervention. Let's take a look at the Intervention Comfort Measure definition. This gathers all comfort measure interventions ordered or performed. The Coalesce logic and Global.NormalizeInterval ensure that the available data is used in a consistent manner. Lastly, the comfort measure intervention timing must be during the hospitalization.

The Numerator calls the Initial Population, Ischemic Stroke Encounter, and looks for the QDM data element of medication, discharge, Antithrombotic therapy for Ischemic Stroke, that is authored during the encounter. No changes were made to the Numerator.

If the Numerator does not pass, the Denominator Exceptions are checked. And there are two definitions that could qualify, Encounter with Documented Reason for No Antithrombotic At Discharge and Encounter with Pharmacological Contraindications for Antithrombotic Therapy at Discharge. No changes were made to the Denominator Exceptions.

The first Denominator Exception definition is Encounter with Documented Reason for No Antithrombotic At Discharge, which checks to see if there was a documented reason for not giving Antithrombotic therapy that is authored during the encounter.

The second definition, Reason for Not Giving Antithrombotic at Discharge, checks for negation rationale that matches criteria within the value sets, Medical Reason For Not Providing Treatment or Patient Refusal. The second definition that could qualify an encounter for STK-2 Denominator Exceptions is Encounter with Pharmacological Contraindications for Antithrombotic Therapy at Discharge. This definition checks to see if a contraindication was authored during the encounter of one of the medications in the Antithrombotic therapy value sets.

At this point, let's take a look at some Frequently Asked Questions or FAQs.

Question. "If a stroke patient is discharged to an acute rehab facility, is this considered a discharge to another hospital?"

Answer. The measure utilizes the value set, Discharge To Acute Care Facility, for the discharge disposition Denominator Exclusion, inpatient hospitalizations for patients discharged to another hospital. The value set includes concepts that represent encounter with a discharge to a short-term acute care hospital, including a specialty hospital. Patients discharged to a rehabilitation hospital or a rehabilitation unit of an acute care hospital are not excluded, and therefore, included in the measure population.

Can I ask a question to clarify?

Sure, Raquel, what's your question?

"So, an acute rehab facility on hospital grounds is not excluded from the measure, even though we discharge and readmit the patient to our acute rehab unit?" Yes. Rehabilitation facility includes but is not limited to inpatient rehab facility or hospital rehabilitation unit of a hospital and chemical dependency, alcohol rehab facility.

(00:25:22):

Next we have question. "The discharge summary and discharge medication lists include one aspirin 81-milligram chewable tablet to be taken two days after discharge, followed by apixaban five-milligram tablet twice daily, starting on day three post discharge. Will this meet Antithrombotic therapy at discharge since aspirin was prescribed for only two days?"

Answer. Aspirin prescribed at discharge for two days will meet STK-2. Aspirin is in the Antithrombotic therapy value set. Clopidogrel prescribed as a discharge medication is also in the Antithrombotic therapy value set. And as long as it is prescribed as a discharge medication and authored during the Ischemic Stroke encounter, the case will be included in the Numerator.

Now Raquel will review the measure rationale for STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter.

Thanks, Melissa. In Ischemic Stroke patients that have NVAF, Anticoagulation therapy is preferred over Antithrombotic therapy. These patients are at significantly increased risk of stroke due to an embolic event. Stroke risk for this group has been estimated to be five times higher. For this reason, more potent blood thinners are recommended for them.

Updated American Heart Association and American Stroke Association clinical guideline recommendations from Kleindorfer and colleagues last year now suggest that DOACs should be considered for most of these patients. Ischemic Stroke patients with moderate or severe mitral stenosis or mechanical heart valve would be the Exception. Although these medications are more costly than warfarin, they may be taken once or twice a day and do not require the routine INR monitoring and drug dosage adjustments needed with warfarin therapy, so there may be advantages in terms of long-term patient compliance.

Several large clinical trials have demonstrated the safety and efficacy of DOACs. For example, the RE-LY trial, ROCKET AF, ARISTOTLE, and ENGAGE AF-TIMI trials. DOACs includes several different FDA-approved medications, specifically apixaban, edoxaban, and rivaroxaban, which are all oral factor Xa inhibitors, and one direct thrombin inhibitor, dabigatran. The updated CBGs also recommend maintaining an INR between 2.0 and 3.0 if warfarin is selected for Anticoagulation therapy. This range is acceptable for most Ischemic Stroke patients with Atrial Fib/Flutter. Patients with mitral stenosis or a mechanical heart valve may require higher INR values greater than 3.0. Melissa will now review the measure flow for STK-3.

Let's start with the Initial Population. This is defined using the definition, Ischemic Stroke Encounter. The right-hand side of the diagram shows the definitions and logic called to meet the Initial Population. The patient must have a nonelective inpatient encounter, be 18 years of age or older, and have a principal diagnosis of Ischemic Stroke. If Initial Population criteria is not met, processing ends. If Initial Population is met, the encounter is in the Initial Population.

Now we check the Denominator criteria. The Denominator is checking for an encounter with a history of Atrial Ablation and a principal diagnosis of Ischemic Stroke, or a prior or present diagnosis of atrial fibrillation or flutter and a principal diagnosis of Ischemic Stroke. If the encounter meets either criteria, it is in the Denominator population and processing continues to look for any Denominator Exclusions.

The Denominator Exclusion is looking for either an encounter with Ischemic Stroke and a qualifying discharge disposition criteria or comfort measures intervention during the hospitalization. If any of these criteria are met, then the patient is excluded from the Denominator and processing ends. If they are not met, processing continues to the Numerator.

(00:31:21):

The Numerator looks to see if an anticoagulant was prescribed at discharge. If an anticoagulant was prescribed, the case will meet the Numerator. If not, processing will continue to look for a Denominator Exception. The Denominator Exceptions look for a documented reason for a medical reason for not providing treatment or patient refusal for not prescribing an anticoagulant at discharge.

A sample calculation is provided to show the performance rate is calculated. The Numerator is divided by the Denominator minus Denominator Exclusions minus Denominator Exceptions. The letter values in the formula are indicated on previous slides and represent the various populations.

Let's review the measure logic detail, as well as changes for STK-3. Here is a table of the changes to STK-3 for 2025. The Denominator definitions are, Encounter with a History of Atrial Ablation, union, which remember, that means or, Encounter with Prior or Present Diagnosis of Atrial Fibrillation or Flutter. If neither definition occurs, then it is true. No changes have been made to the Denominator.

Let's review the first definition of the Denominator, Encounter with a History of Atrial Ablation. It looks to see if there was an Atrial Ablation procedure that started before the Ischemic Stroke encounter or a diagnosis indicative of a history of Atrial Ablation, or clinical documentation using the assessment, performed data type, noting a history of Atrial Ablation.

Let's look at the second definition called by the Denominator, Encounter with Prior or Present Diagnosis of Atrial Fibrillation or Flutter. This definition calls in all TJC Ischemic Stroke Encounter and uses prevalence period to call for a diagnosis of atrial fibrillation or flutter prior to or during the current encounter, or the definition will look for an encounter diagnosis of atrial fibrillation or flutter using the diagnosis attribute on the encounter data type to capture patients with a current diagnosis of AFib or flutter.

The Denominator Exclusions definitions capture the Denominator encounter where the discharge disposition is to an acute care facility left against medical advice, patient expired, discharged to home for hospice care, or to a healthcare facility for hospice care, union, Encounter with Comfort Measures during Hospitalization. If either definition occurs, then it is true. No changes have been made to the Denominator Exclusions.

Now let's take a look closer at the second definition that qualifies for the Denominator Exclusions, Encounter with Comfort Measures during Hospitalization for Patients with Documented Atrial Fibrillation or Flutter. This definition first selects encounters that meet the Denominator, then it checks to see if there was a comfort measure intervention.

Let's take a look at the Intervention Comfort Measures definition. This gathers all comfort measure interventions ordered or performed. The Coalesce logic and Global.NormalizeInterval ensure that the available data is used in a consistent manner and the comfort measure intervention timing must be during the hospitalization.

The Numerator calls the Denominator with the data type medication, discharge to check any medications from the Anticoagulation therapy value set or prescribed at discharge and using authorDatetime to ensure that it was authored during the encounter. No changes were made to the Numerator.

The Denominator Exceptions call in the Denominator and the definition, Documented Reason for Not Giving Anticoagulant at Discharge, that needs to be authored during the encounter. Taking a closer look at the definition, Documented Reason for Not Giving Anticoagulant at Discharge, this definition is using the data type, medication, not discharged, to review the anticoagulant therapy medication was not prescribed, and there is documentation of a medical reason for not providing treatment or patient refusal that was authored during the encounter. No changes were made to the Denominator Exceptions.

(00:35:49):

Let's review another FAQ.

"Would atrial fibrillation documented from a previous visit be considered applicable to the current encounter?"

Answer. Yes. A history of atrial fibrillation documented on a previous visit is considered applicable to the current encounter. The logic checks whether the Atrial Fibrillation or Flutter diagnosis start time occurred on or before the Ischemic Stroke encounter. Once a patient has AF or Atrial Fibrillation or Flutter, they are always at risk. The nature of the Arrhythmia is that it comes and goes or Paroxysmal.

It can also be persistent or permanent. Even with patients that have ablation procedures, it is not uncommon for AF to return.

And now we'll review STK-5 Antithrombotic Therapy by End of Hospital Day Two. Raquel will discuss this measure rationale.

Early Antithrombotic therapy is recommended to reduce morbidity and mortality following an acute Ischemic Stroke event. Aspirin is the recommended drug. Two large clinical trials established the safety and benefit of aspirin administered within the first 48 hours of stroke onset and doses between 160 milligram and 300 milligram. Limited data exists on the use of alternative antiplatelet agents in the treatment of AIS. However, in patients with a contraindication to aspirin, administrating alternative antiplatelet agents may be reasonable.

Aspirin interrupts platelet aggregation and thereby reduces the risk of blood clot formation. Aspirin is not recommended as substitute treatment for acute Ischemic Stroke in patients who are eligible for IV thrombolytic therapy, however, has aspirin administration may be delayed up to 24 hours to reduce the risk of bleeding in patients who receive thrombolytic therapy. For this reason, patients who receive IV tPA at the hospital or within 24 hours prior to hospital arrival are excluded from STK-5. Aspirin is usually given orally, but may also be administered via an NG tube or rectal suppository for patients who are NPO or have difficulty swelling, Melissa will now review the measure flow for STK-3.

Let's start with the Initial Population. This is defined using the definition, Ischemic Stroke Encounter. The right-hand side of the diagram shows the definitions and logic called to meet the Initial Population. The patient must have a Nonelective Inpatient Encounter, be 18 years of age or older, and have a principal diagnosis of Ischemic Stroke. If Initial Population criteria is not met, processing ends. If Initial Population is met, the encounter is in the Initial Population.

Now we check the Denominator criteria, which is the same as the Initial Population. This means that if the case met the Initial Population, then it will pass for the Denominator as well and processing will continue.

The Denominator Exclusion looks for an encounter with Ischemic Stroke and a length of stay less than two days or an order for comfort measures on the day of or day after the start of hospitalization. And one more condition found on the next slide. Thrombolytic therapy is given during the hospitalization, or thrombolytic therapy is given prior to arrival at the hospital, or thrombolytic therapy is documented as already given prior to the arrival at the hospital. If any of these criteria are met, the patient is excluded from the Denominator. If they are not met, processing continues to the Numerator.

(00:40:12):

The Numerator looks to see if an Antithrombotic was given the day of or day after the start of the hospital encounter. If it was, the case meets the Numerator. If not, processing continues to look for a Denominator Exception.

The Denominator Exceptions look for an occurrence on the day of or day after hospitalization for not ordering or administering an Antithrombotic with documentation of a medical reason for not providing treatment or patient refusal or a pharmacological contraindication to an Antithrombotic or an INR result greater than 3.5. If any of these Exceptions are met, the case meets the Denominator Exception and processing ends. A sample calculation is provided to show how the performance rate is calculated. The Numerator is divided by the Denominator minus Denominator Exclusions minus Denominator Exceptions. The letter values in the formula are indicated on the previous slides and represent the various populations.

At last, we will review the logic detail for STK-5 Antithrombotic Therapy at the End of Hospital Day Two. Here is a table of the measure changes for STK-5 for 2025. Let's begin with the STK-5 Denominator. Since the Initial Population was updated to only include the Ischemic Stroke patients, the definition, Encounter with Principal Diagnosis and Age, was removed and has been updated to Initial Population. The Denominator Exclusions call three definitions, Encounters that are Less Than Two Days or Encounters with Comfort Measures or Encounters with Thrombolytic Therapy Given Prior to Arrival or During Hospitalization. There are no changes to the Denominator Exclusions.

The first definition, Encounter Less Than Two Days, simply checks whether the hospitalization is less than two days using the HospitalizationWithObservationLengthofStay function. This function returns total interval from the start of any immediately prior emergency department or observation visit to the discharge of the given encounter.

Now let's look at the second definition, TJC Encounter with Comfort Measures during Day of or Day After Arrival. First selects encounters that have a principal diagnosis of Ischemic Stroke, then it checks to see if there was a comfort measures intervention. Let's take a look at the Intervention Comfort Measures definition. This gathers all comfort measure interventions ordered or performed. The Coalesce logic and Global.Normal. The Coalesce logic and Global.NormalizeInterval ensure that the available data is used in a consistent manner.

Lastly, the comfort measure intervention timing must be the day of or day after the hospitalization.

The third definition is named Encounter with Thrombolytic Therapy Given Prior To Arrival Or During Hospitalization. This is a nested definition that calls three sub-criteria, Encounter with Thrombolytic Therapy Medication or Procedures or Encounter with Thrombolytic Therapy Prior to Arrival or Encounter with Thrombolytic Therapy Documented As Already Given.

The first definition in Encounter with Thrombolytic Therapy Given Prior To Arrival Or During Hospitalization is named Encounter with Thrombolytic Therapy Medication or Procedures. It looks for Ischemic Stroke encounters with thrombolytic therapy medication or procedures. The definition named Thrombolytic Therapy Medication or Procedures checks medication, administered against thrombolytic tPA therapy value set and checks procedure, performed against intravenous or intra-atrial thrombolytic tPA therapy value set. And the timing of these therapies must be during the 24 hours before the hospitalization through the end of the hospitalization.

(00:45:11):
The second definition called by Encounter with Thrombolytic Therapy Given Prior To Arrival Or During Hospitalization is named Encounter with Thrombolytic Therapy Prior to Arrival. It checks the Ischemic Stroke encounter diagnosis against the value set, Intravenous or tPA Therapy Prior to Arrival.

The third definition called by Encounter with Thrombolytic Therapy Given Prior To Arrival Or During Hospitalization is named Encounter with Thrombolytic Therapy Documented As Already Given. It checks for diagnoses of IV or IA tPA prior to arrival. Note that slight change in value set name, the space was removed in the word intraarterial. And authored during this hospitalization. The STK-5 Numerator looks for Antithrombotic therapy medications administered the day of or day after the start of the hospitalization.

The Denominator Exceptions for STK-5 includes three definitions of Encounter with Documented Reason for No Antithrombotic Ordered or Administered Day Of or Day After Hospital Arrival, Encounter with Pharmacological Contraindications for Antithrombotic Therapy Given Day Of or Day After Hospital Arrival, or Encounter with An INR Greater Than 3.5. If any of these definitions are true, then the encounter qualifies for the Denominator Exceptions.

The first definition of the Denominator Exceptions is Encounter with Documented Reason for No Antithrombotic Ordered or Administered Day Of or Day After Hospital Arrival. The logic checks for a reason for not ordering or not administering an Antithrombotic that was authored on the day of or day after the start of the hospitalization. This definition calls documented reason for no Antithrombotic ordered or administered. Let's take a closer look at this definition on the next slide.

Documented reason for no Antithrombotic Ordered or Administered calls in the two definitions, Reason for Not Ordering Antithrombotic and Reason for Not Administering Antithrombotic to check when no Antithrombotic therapy is ordered or administered that there was a medical reason for not providing treatment or patient refusal documented.

Now we will look at the second definition called by STK-5 Denominator Exceptions, Encounter with Pharmacological Contraindications for Antithrombotic Therapy Given Day Of or Day After Hospital Arrival. It checks to see if any of the medications in the value set, Pharmacological Contraindications For Antithrombotic Therapy, were given during the day of or day after start of the hospitalization.

The third definition called STK-5 Denominator Exceptions is Encounter with An INR Greater Than 3.5, checks if there were any INR laboratory tests resulted the day of or day after start of the hospitalization and the INR results were greater than 3.5.

Let's review our last FAQ.

Question. "If patient arrives to the hospital at 23:00 and aspirin is ordered the following day, but not given to the patient for two days, will the case meet the measure?"

Answer. Antithrombotic therapy must be administered on the day of or day after arrival to include the case in the Numerator. The logic specifically calls out CalendarDayOrDayAfter with one day, whoops, with day one being the date of arrival. So no, does not meet the measure. That concludes our review of the stroke measure set. Back to you, Susan.

Wow, Melissa and Raquel, so much information you guys just presented. Thanks for advancing to the next slide. So we've included additional resource slides and provided links to direct you to the following resources, the eCQI Resource Center, CMS Eligible Hospital Measures page, and the Get Started with eCQM links, as well as the Teach Me Clinical Quality Language Video Series, including video shorts on hospitalization with observation and what is a value set.

Continuing on with the next slide with additional resources, we included on links to the Value Set Authority Center or the VSAC support, Pioneers In Quality landing page on The Joint Commission's website, the Expert to Expert webinar series landing page, and finally, the ASTP ONC Issue Tracking System, and this is where the clinical and technical questions about these eCQMs should be submitted. Next slide. Okay, we're going to open up the live Q&A in just a moment.

(00:50:51):

You've all been typing in questions as we've been progressing through the presentation, so we do have a number to start with. As a reminder, please submit questions via the question pane. Click the question mark icon in the audience toolbar and a panel will open for you to type and submit your question. Indicate which eCQM your question concerns. And all questions that are not answered during the live event will be addressed in a written follow-up Q&A document. The follow-up Q&A document will be posted to The Joint Commission website several weeks after the live event. And Raquel, I believe we're going to have you kick off the facilitation for the Q&A, so when you're ready, please jump right in. While you are doing that, I will take over the screen sharing. Thanks.

Great, thank you, Susan.

Our first question here is, "If a stroke is diagnosed on the third day, and aspirin is administered the same day, would this be considered a fallout?" The answer.

If a principal diagnosis code for Ischemic Stroke is assigned at discharge, then the case is included in the STK-5 Denominator population. The time frame for measurement is the day of or day after hospital arrival, regardless of the date of the clinical stroke diagnosis. There was a question about where can I find the slides. All the slides are available now. To access the slides, in the viewer toolbar, click the icon that looks like a document, select the file name, and the document will open in a new window. You can print or download and save these slides.

Okay. Thanks, Melissa.

Our next question here. "If the stroke occurs following admission, does the Antithrombotic need to be administered by hospital day two following the stroke?"

We do have a similar response from the first question. If a principal diagnosis code for Ischemic Stroke is assigned at discharge, then the case is included in the STK-5 Denominator population. And the time frame for measurement is the day of or day after hospital arrival, regardless of the date of the clinical stroke diagnosis.

Okay, next question, STK-3. "If an ED physician interprets the EKG as AFib, but it is signed as normal, is that considered a diagnosis?"

Any physician documentation of atrial fibrillation or flutter, remote, persistent, paroxysmal, in the medical record abstracts as a yes for this data element.

Okay, next question. "Can a secondary code of Hemorrhagic Stroke, primary code Ischemic Stroke exclude be an auto-contraindication to anticoag meds?"

The answer is a principal diagnosis code for Ischemic Stroke is required to include the case in the STK-5 Denominator population. Other or secondary diagnosis of ischemic or Hemorrhagic Stroke without a principal diagnosis code for Ischemic Stroke will exclude the case.

Okay. Next question. "Will Heparin injects count this year as discharge STK-3 acceptable medication?" Answer. Heparin at lower subcutaneous or SQ doses are administered for VTE prophylaxis. Lower doses of subQ heparin do not meet the clinical intent of Anticoagulation therapy for STK-3.

(00:55:07):

Next question is, "Is there any recommendation for maintenance meds Anticoagulation as prevention standard? Answer. Clinical practice guideline recommendations from the American Heart Association prefer the use of DOACs, e.g., apixaban, rivaroxaban, unless contraindicated for Ischemic Stroke patients with a current diagnosis or history of atrial fibrillation or flutter. Okay. "What about ED observation patients transferred for a higher level of care?"

Answer. The patient must be admitted for acute inpatient care to be included in the inpatient population for STK-3, STK-2, and STK-5. An admission date, discharge date, birth date, and primary diagnosis for Ischemic Stroke is needed.

Okay. And to clarify, "Will patients in observation status be included in the Initial Population?"

The stroke measures are inpatient measures and an inpatient encounter must end during the measurement period in order to be included in any of the stroke measures. If the patient is not admitted to inpatient status, they are not included in the measure.

Okay. "For STK-2 CMO Exclusion, will case meet criteria for Exclusion if CMO on day one or day two or any day during the encounter?"

I believe these are comfort measures, so comfort measure documented at any time during the hospital stay will exclude the case from STK-2 and STK-3. For STK-5, CMO must be documented on the day of or day after arrival to exclude the case.

Okay. "Does the medical reason for not providing the Antithrombotic need to be specified?"

The reason for not administrating or prescribing Antithrombotic therapy should be specified.

"For STK-2, if the patient has an Ischemic Stroke principal and Hemorrhagic Stroke within the codes as well, then does the doctor need to chart a contraindication since the patient had a bleed, or does the mapping pick up the Hemorrhagic Stroke as well?"

The primary diagnosis of Ischemic Stroke puts the patient or the case in the measure population. The secondary diagnosis of Hemorrhagic Stroke will not exclude the case. Reasons for not prescribing Antithrombotic therapy at discharge should be specified.

Okay. "For STK-3, we have issues with diagnosis of AFib/AFlutter from years prior, but not currently being captured. When it says prior to current encounter, how far back is prior?"

And the answer is a documented diagnosis, current finding, or history of atrial fibrillation/flutter needs to be documented in the medical record for the episode of care being reviewed.

Real quick, Melissa, before you start on the next question, I just wanted to send a quick reminder to the audience that this webinar was scheduled to conclude at 3:15, so we're going to continue with the Q&A until we get closer to the end time. Thanks.

Thanks, Susan. And I apologize, I lost my place. I will.

I can read off the next question, Melissa. Okay, thanks. Yeah, no problem.

"Does a specific reason for the medical reason need to be given or just medical reason being selected is good enough?"

All medical reasons should be specifically documented in the medical record. Thanks, Raquel.

"What is Atrial Ablation?" Wait. Was done in an, oh, "What if an Atrial Ablation was done in an infant or child STK-3?"

Answer. A history of Atrial Ablation will not exclude the case from STK-3. Atrial Ablation as a medical reason for not prescribing Anticoagulation therapy at discharge should be documented in the current medical record. Okay.

(01:00:13):

"Is Watchman or other left atrial appendage device on appropriate contraindications for STK-3 if performed prior to stroke incident?"

An atrial appendage closure device may be a medical reason for not prescribing Anticoagulation therapy at discharge depending on when the closure device was placed. It should be documented in the medical record as the medical reason if the basis for not prescribing Anticoagulation therapy at discharge.

Okay. "In the presentation, aspirin 81 milligrams was mentioned, and the question is, aspirin 81 milligrams, not 325 milligrams?"

And the answer. Either dosage of aspirin will meet the clinical intent of the measure.

Okay, and this question is for STK-3. "If patient had Watchman, can it be a reason for not prescribing the anticoagulant?"

So, a closure device may be a medical reason for not prescribing Anticoagulation therapy at discharge and should be documented as a reason in the medical records.

Okay. "If a patient was admitted as observation on day one and was transitioned to inpatient on day two at 13:00 when MRI showed positive results, if a patient received aspirin on day one during and day two at 9:00 AM, does this count towards compliance with Antithrombotic therapy within the first two days, even though the patient was technically in observation status?"

STK-5 timing starts when the patient arrives to the hospital. If aspirin or another Antithrombotic medication is administered on the day of or day after arrival, then the case will be captured in the Numerator population.

Okay. This question here about the STK-2, 3, 4, and 5 measures have not changed and if this was only a deep review of the measures. There was no major changes made to the STK-2 and 3 and 5 for the annual update. The most significant change was the update to the Initial Population to better align with the remaining measure populations and reduce the abstraction burden.

Okay, I think we're winding down on the answered questions. And we will be posting the questions and their answers in the next few weeks. So, all these questions and the additional ones that we have not necessarily gotten back to will be included.

So, here's the last one. "Regarding the stroke diagnosed on the third day and aspirin administered that day, the manual says that a delay in stroke diagnosis is an Exclusion. Is this still the case?"

Answer. A delay in stroke diagnosis does not count as a reason for not administering Antithrombotic therapy by the end of hospital day two, data element Exclusion guideline. It is not an Exclusion from the Denominator population for STK-5.

And so, with that, thank you all for your questions, and I send back to you, Susan.

Excellent.

Thanks, Michelle, I'm sorry, Melissa and Raquel, for facilitating all of those questions. It was so many of them. And thanks to the team in the background for typing the responses to them.

Let's get through the last of the operations pieces so everyone can get the rest of their day back.

All of the Expert to Expert webinar recording links, slides, transcripts, and when available, Q&A documents, can be currently accessed on The Joint Commission's webpage. The captioned recording and materials will be available via the link we've provided on this slide within several weeks of the webinar.

In today's handouts, we've included a PDF that includes the registration links for all of the Expert to Expert webinars that are currently open for registration. The link on this slide leads to the Expert to Expert landing page on The Joint Commission's website, which will also be updated to include links to the additional webinars as the registration's open for them.

(01:05:03):

Just one last thing before the webinar concludes, a reminder about the CE survey. We use your feedback to determine education gaps and your organization's needs, inform future content, and assess the quality of our educational programs. As we explained earlier, a QR code is provided on the next slide. If you prefer to take the CE survey later, an automated email will also deliver the survey link.

At the end of the survey when you click Submit, you'll be redirected to a page where you can print or download your certificate, and you'll complete that by adding your name and credentials. If you log off without downloading or printing that PDF, an automated email will also deliver a link to that PDF. And we are at the end of the webinar now. We will pause on this slide for several moments to permit those that wish to use the QR code to scan it with your mobile device.

Thank you to Melissa, Raquel, Sheila, and Karen for developing and presenting the content, Melissa and Raquel for facilitating the Q&A segment, and to our team in the background that were typing responses as you submitted your questions.

Finally, thanks to everyone that attended today's webinar. Have a great day.