Transcript – Expert to Expert Webinar: Annual Updates for STK and VTE eCQMs for 2026 Reporting Year

Broadcast March 5, 2026

Slide 1 –

[00:00:01] Welcome and thank you for joining us for this Joint Commission Expert to Expert webinar addressing the 2026 annual updates for the Stroke and VTE electronic clinical quality measures -- STK-2, 3, and 5 and VTE-1 and 2. The Expert to Expert webinar series is offered in partnership with the Centers for Medicare and Medicaid Services and eCQM stewards. CE credit is available for this webinar for the live broadcast attendance only. I'm Susan Funk, Associate Project Director for Engagement on Quality Improvement Programs at Joint Commission, and today, I'll be serving as this webinar's moderator. Next slide please.

Slide 2 –

[00:00:47] Before we begin the webinar content, we would like to offer just a few tips about webinar platform functionality. Audio is by voice over internet protocol only – 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; if you experience such audio or streaming issues, refresh your screen, or leave and rejoin the session. We will not be recognizing the Raise a Hand or Chat features. To ask a question, click on the Question Mark icon in the audience toolbar. A panel will open for you to type your question and submit. The slides are designed to follow Americans with Disabilities Act rules. Next slide.

Slide 3 –

[00:01:40] Speaking of the slides, they are available now. There are many links provided throughout this webinar, but they are not clickable on screen. By downloading the slides, you'll be able to access the links and also take notes. To access the slides now, within the participant navigation pane, select the icon that represents a document. 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. Slides will also be available within 2 weeks of the webinar on Joint Commission's website at the link included at the bottom of this slide and they will also be available on the eCQI Resource Center. Next slide please.

Slide 4 –

[00:02:30] I'm sure that many of you attending today's webinar will wish to receive continuing education credit or qualifying education hours. All relevant information about continuing education credit is available within a handout we've included within the webinar resources and has also been communicated on the webinar registration page. The attachment includes the list of entities that will provide credit, the requirements for participants to earn credit, and information about how to complete the survey and obtain a certificate. So -- be sure to download that attachment to learn more.

Credit is available for attendance during this live webinar broadcast only. For information on Joint Commission's continuing education policies, visit the link provided on the bottom of this slide. Next slide please.

Slide 5 –

[00:03:20] The participant learning objectives are:

Locate eCQM resources on the eCQI Resource Center. Facilitate your organization's implementation of the STK and VTE eCQM annual updates for the 2026 reporting year. And, utilize answers to common issues and questions regarding the STK and VTE eCQMs to inform 2026 use and implementation. Next slide.

Slide 6 –
[00:03:53] This webinar does not cover these topics: Basic eCQM concepts, Topics related to chart abstracted measures, and process improvement efforts related to these measures. While we will not address how to validate eCQM data during this webinar, before submitting eCQM data to CMS or Joint Commission, please ensure your data is validated. Specifically, please ensure that extreme outlier results are verified. For example, extreme outliers may include reporting 0% or 100%. Next slide.

Slide 7 –
[00:04:38] All staff and subject matter experts 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. Next slide.

Slide 8 –
[00:05:01] During this webinar, we'll have three segments – one focused on the annual updates for the STK eCQMs and then the VTE eCQMs. During each segment we'll include a review of the annual updates for the eCQMs for the 2026 Reporting Year, then provide an overview of the measure flows and algorithms, and we'll end each segment with Frequently asked questions or FAQs. Finally, the third segment will be a live Q&A during which we'll share answers to questions submitted by the audience throughout the webinar. Next slide please.

Slide 9 –
[00:05:41] Before we transition to the discussion about the changes for the 2026 reporting year, we wanted to point you to a PDF handout that includes directions to locate and access eCQM specifications, value sets, measure flow diagrams, and technical release notes. The link to the eCQI Resource Center landing page is provided on this slide. Be sure to download the PDF Handout that has additional links. You can locate that PDF within the Resource Section of the audience navigation pane. Next slide please.

Slide 10 –
[00:06:19] I will now turn the webinar over to our first speaker for today, Raquel Belarmino with the Informatics team at Joint Commission. Raquel, please introduce yourself and when you're ready, start your presentation!

Slide 11 –
[01:03:06] [Raquel Belarmino] Thank you, Susan. Hi, I'm Raquel Belarmino, Associate Project Director at the Joint Commission. The stroke measure set consists of 3 measures: STK-2 Discharged on Antithrombotic Therapy, STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter, STK-5 Antithrombotic Therapy by End of Hospital Day 2.

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 recommendations supporting these three measures with recommendations graded Class I - Level of Evidence A by the American Heart Association/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 data set that reported 25 or more cases were STK-2 95.9%, STK-3 73.3%, STK-5 92.9%.

Slide 12 –
[01:04:20] Here is a table of the changes that impact all the STK measures for 2026 Reporting Year. The Logic definitions were updated from title case to initial case to align with CQL style guide. The measures now reflect the exact dates for the reporting period instead of a generic period. The Improvement Notation field was updated to read 'Increased score indicates improvement' based on a tooling update. The Value set Nonelective Inpatient Encounter Added 1 SNOMED CT code based on terminology update. The Value set Patient Refusal Added 1 SNOMED CT code and Deleted 1 SNOMED CT code based on terminology update.

Slide 13 –
[01:04:35] As part of our ongoing review of feedback from the public and updates to the webinar series for improvement we have combined reviewing the measure flow and logic together. If changes are made to the measure specifications or additional clarification on a definition is needed, we will take a closer at the specific definition logic in a continuation slide.

Now let's continue with the review of the Initial Population; this is the same across the measure set so we will not review again at the specific measure level.

Slide 14 –
[01:16:51] For the slides in this presentation that address the measure flow, we know the flow is very small on screen. We encourage you to download the slides and you can enlarge the zoom within the PDF.

The initial patient population is captured by the definition of "Ischemic Stroke Encounter." To meet this definition the logic looks for a non-elective inpatient encounter (non-elective encounters include emergency, urgent and/or unplanned admissions), age criteria of 18 years or older with an encounter ending during the Measurement Period, and a principal diagnosis of ischemic stroke.

No changes were made to the Initial Population for reporting year 2026.

Slide 15 –
[01:16:53] Now we will review STK-2 Discharged on Antithrombotic Therapy Measure Rationale and updates. I will turn things over to my colleague Karen Kolbusz to present the next segment.

Slide 16 –
[01:16:58] My name is Karen Kolbusz, and I'm the Clinical Lead for the Joint Commission stroke measures. I want to just start off giving some information regarding the clinical intent of the STK-2 measure. 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 (non-valvular 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. The THALES trial concluded that in patients with mild-to-moderate acute non-cardioembolic ischemic stroke - defined as a NIH Stroke Scale/Score (NIHSS) score ≤ 5 - 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 (Johnston, et al., 2020). 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.

Slide 17 –
[01:17:00] Here is a table of the changes that impact STK-2 for 2026 reporting year. The Value set Antithrombotic Therapy for Ischemic Stroke Added 2 RxNorm codes based on terminology update and Deleted 1 RxNorm code based on review by technical experts, SMEs, and/or public feedback. Deleted 1 RxNorm code (198473) based on terminology update.

The logic was updated within the denominator exception "Encounter With Pharmacological Contraindications For Antithrombotic Therapy At Discharge" to change the name of the alias from "Pharmacological" to "PharmacologicalContraindications" for clarification and to align with the CQL Style Guide.

For more details of all the technical changes you can follow the link on the slide to download the technical release notes for STK-2.

Slide 18 –
[00:23:02] Now we will review the detail of STK-2 measure flow and logic.

Slide 19 –
[00:30:11] We will start with the Denominator Criteria since the initial population was previously reviewed. The denominator 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.

No Changes were made to the Denominator for reporting year 2026.

Slide 20 –
[00:14:56] There are two criteria that qualify for the Denominator Exclusions.

The first definition is an "Ischemic Stroke Encounters With Qualifying Discharge Disposition" which looks for an "Ischemic Stroke Encounter" with a qualifying discharge disposition of "Discharge to an Acute Care Facility", "Left Against Medical Advice", "Patient Expired", "Discharged to Home For Hospice Care", OR "Discharged To a Health Care Facility for Hospice Care".

The second definition is an "Encounter With Comfort Measures During Hospitalization" which looks for an "Ischemic Stroke Encounter" with "Intervention Comfort Measures" which is defined as the intervention comfort measures is either ordered or performed anytime 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.

No Changes were made to the Denominator exclusions for reporting year 2026.

Slide 21 –
[00:32:44] The numerator evaluates whether an antithrombotic was prescribed or continuing to take at hospital discharge. The logic looks for an "Ischemic Stroke Encounter" with the QDM data element of "Medication, Discharge" and a discharge medication within the value set "Antithrombotic Therapy for Ischemic Stroke" that is, authored, during the Encounter. If the criteria is met the case meets the numerator and processing ends. If not, the case will continue processing to the denominator exceptions.

No Changes were made to the numerator for reporting year 2026.

Slide 22 –
[00:23:12] There are two criteria that can meet the denominator exceptions.

For the first exception the definition is “Encounter with a Documented Reason For No Antithrombotic At Discharge”, this includes an Ischemic Stroke Encounter with “Reason for not giving Antithrombotic At Discharge” where no discharge medication is provided and a “medical reason for not providing treatment” or “patient refusal” is documented during the encounter.

The second exception calls the definition “Encounter With Pharmacological Contraindications For Not prescribing Antithrombotic Therapy At Discharge” during the encounter. This includes an Ischemic Stroke Encounter with documentation of a discharge medication documented within “pharmacological contraindications for antithrombotic therapy” during the encounter.

If either of these exceptions are met, the case meets the denominator exception and processing ends.

There was an alias change for the denominator exception “Encounter With Pharmacological Contraindications For Antithrombotic Therapy At Discharge”, let’s take a closer look at that change.

Slide 23 –
[00:18:07] Taking a closer look at the logic “Encounter With Pharmacological Contraindications For Antithrombotic Therapy At Discharge”. The alias Pharmacological was updated to PharmacologicalContraindications, this change aligns more with the intent of the definition.

Please note throughout this presentation, new content will be underlined, while stricken text denotes removed content.

Slide 24 –
[00:18:41] Let’s review a frequently asked question. The Question is: 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” (2.16.840.1.113883.3.117.1.7.1.87) for the discharge disposition denominator exclusion 'Inpatient hospitalizations for patients discharged to another hospital'. The value set includes concepts that represent an 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.

Patients discharged to a rehabilitation hospital or unit are not excluded. This is to ensure they are still treated unless contraindicated and should receive secondary stroke prevention therapies (antithrombotic/ anticoagulation/statin) after discharge from the hospital.

Slide 25 –
[00:10:42] Now we will review STK-3 measure Rationale and updates.

Slide 26 –
[00:19:59] In ischemic stroke patients that have Nonvalvular Atrial Fibrillation (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 5 times higher. For this reason, more potent blood thinners are recommended for them.

Updated American Heart Association/American Stroke Association clinical guideline recommendations from Kleindorfer and colleagues last year now suggest that Direct oral anticoagulant (DOACs) should be considered for most of these patients. Ischemic stroke patients with moderate or severe mitral stenosis or a 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 include 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 Clinical Practice Guidelines (CPGs) 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.

Slide 27 –
[00:08:21] Here is a table of the changes that impact STK-3 for 2026. The Value set Anticoagulant Therapy Deleted 1 RxNorm code based on review by technical experts, SMEs, and/or public feedback. The Value set Atrial Ablation Added 1 SNOMED CT code and 1 ICD-10-PCS code based on terminology update. The Value set Atrial Fibrillation or Flutter Deleted 1 SNOMED CT code based on terminology update. For more details of all the technical changes you can follow the link on the slide to download the technical release notes for STK-3.

Slide 28 –
[00:23:02] Now we will review the detail of STK-3 measure flow and logic.

Slide 29 –
[00:23:09] We will start with the Denominator Criteria; there are two criteria that can pass the denominator logic.

The first criteria is checking for an “Encounter With A History Of Atrial Ablation” which is an “Ischemic Stroke Encounter” with procedure of an “atrial ablation” or documented diagnosis of “History of Atrial Ablation” prior to the encounter or an assessment documentation of a “history of Atrial Ablation” during or prior to the encounter.

The second criteria is checking for an “Encounter With Prior Or Present Diagnosis OF Atrial Fibrillation Or Flutter” which is an “Ischemic Stroke Encounter” with a prior diagnosis of “Atrial Fibrillation or Flutter” or present diagnosis of “Atrial Fibrillation or Flutter”.

If the encounter meets either criterion, it is in the Denominator Population and processing continues to look for any denominator exclusions.

No Changes were made to the Denominator for reporting year 2026.

Slide 30 –
[00:14:56] There are two criteria that qualify for the Denominator Exclusions.

The first is the “denominator” which looks for a qualifying discharge disposition of “Discharge to an Acute Care Facility”, “Left Against Medical Advice”, “Patient Expired”, “Discharged to Home For Hospice Care”, OR “Discharged To a Health Care Facility for Hospice Care”.

The second definition is an “Encounter With Comfort Measures During Hospitalization For Patients With Documented Atrial Fibrillation or Flutter” which looks for the “Denominator” Encounter with “Intervention Comfort Measures” which is defined as the intervention comfort measures is either ordered or performed anytime 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.

No Changes were made to the Denominator Exclusions for reporting year 2026.

Slide 31 –
[00:25:18] The numerator evaluates whether an anticoagulant was prescribed or continuing to take at hospital discharge. The logic looks for the “Denominator” Encounter with the QDM data element of “Medication, Discharge” and a discharge medication within the value set “Anticoagulant Therapy” that is, authored, during the Encounter.

If the criteria is met, the case meets the numerator and processing ends. If not, the case will continue processing to the denominator exceptions.

No Changes were made to the numerator for reporting year 2026.

Slide 32 –
[00:25:56] The denominator exception looks at the “Denominator” encounter with the definition "Documented Reason for Not Giving Anticoagulant at Discharge” where no discharge medication is provided and a “medical reason for not providing treatment” or “patient refusal” is documented during the encounter.

If the criteria is met, the case meets the denominator exceptions and processing ends. If the case does not meet the denominator exceptions processing ends and is still considered for the denominator.

No changes were made to the denominator exceptions for reporting year 2026.

Slide 33 –
[00:18:41] Let’s review a frequently asked question. The Question is: 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/Flutter (AF) diagnosis start time occurred on or before the Ischemic Stroke encounter. Once a patient has AF they are always at risk. The nature of the arrhythmia is that it comes and goes, i.e., “paroxysmal”. It can also be persistent/permanent. Even with patients that have ablation procedures, it is not uncommon for AF to return.

Slide 34 –
[00:10:42] Now we will review STK-3 measure Rationale and updates.

Slide 35 –
[00:27:45] 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 in doses between 160 mg and 300 mg. Limited data exists on the use of alternative antiplatelet agents in the treatment of AIS. However, in patients with a contraindication to aspirin, administering 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, 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 a NG tube or rectal suppository for patients who are NPO or have difficulty swallowing.

Slide 36 –
[00:08:21] Here is a table of the changes that impact STK-5 for 2026 reporting year. The Value set Antithrombotic Therapy for Ischemic Stroke Added 2 RxNorm codes based on terminology update and Deleted 1 RxNorm code based on review by technical experts, SMEs, and/or public feedback. Deleted 1 RxNorm code (198473) based on terminology update. For more details of all the technical changes you can follow the link on the slide to download the technical release notes for STK-5.

Slide 37 –
[00:23:02] Now we will review the detail of STK-5 measure flow and logic.

Slide 38 –
[00:30:11] We will start with the Denominator Criteria since the initial population was previously reviewed. The denominator 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.

No Changes were made to the Denominator for reporting year 2026.

Slide 39 –
[00:30:40] There are three criteria that qualify for the Denominator Exclusions. Let's review the first two.

The first criteria definition is an "Encounter Less Than Two Days" which looks for an "ischemic stroke encounter" with a qualifying hospitalization with observation with a length of stay less than two days.

The second criteria definition is an "Encounter With Comfort Measures During Day Of Or Day After Arrival" which looks for an "Ischemic Stroke Encounter" with "Intervention Comfort Measures" which is defined as the intervention comfort measures is either ordered or performed anytime during the day of or day after hospitalization.

Slide 40 –
[00:31:23] The third criteria is an "Encounter With Thrombolytic Therapy Given Prior To Arrival Or During Hospitalization" for which three definition criteria will meet this definition within the "Ischemic Stroke Encounter". The first looks at an "Encounter With Thrombolytic Therapy Medication Or Procedures" with the medication administration of intra-venous or intra-arterial Thrombolytic (t-PA) Therapy administered within 24 hours prior to arrival or anytime during hospitalization. The second criteria looks for an "Encounter with Thrombolytic Therapy Prior to Arrival" with an encounter diagnosis "Intravenous OR Intraarterial Thrombolytic tPA Therapy Prior to arrival". The third criteria to meet this is an "Encounter with Thrombolytic Therapy Documented as already given" with documentation of "Intravenous or Intraarterial Thrombolytic tPA Therapy prior to arrival" during the hospitalization.

If any of the exclusions are not met, processing continues to the numerator.

No Changes were made to the Denominator exclusions for reporting year 2026.

Slide 41 –
[00:32:44] The numerator evaluates whether an Antithrombotic Medication was administered the day or day after hospital arrival. The numerator “Encounter with Antithrombotic Therapy” calls the Initial Population “Ischemic Stroke Encounter” and looks for the QDM data element of “Medication, Administered” “Antithrombotic Therapy for Ischemic Stroke” that starts during the day of or day after hospitalization with encounter. If there was, the case meets the numerator. If not processing continues to look for a denominator exception.

If the criteria is met, the case meets the numerator and processing ends. If not, the case will continue processing to the denominator exceptions.

No Changes were made to the numerator for reporting year 2026.

Slide 42 –
[00:30:40] There are three criteria definitions that can meet the denominator exceptions.

The first criteria exception the logic looks for is an “Encounter With Documented Reason For NO Antithrombotic Ordered or Administered” within the “Ischemic Stroke Encounter”. This looks for a “Reason for Not Ordering Antithrombotic” or “Reason for not Administering Antithrombotic” when no medication is ordered or administered it looks for a “Medical Reason for Not Providing Treatment” or “Patient Refusal” the documentation must occur during the day of or day after hospitalization.

The second criteria looks for an “Encounter with Pharmacological Contraindications for antithrombotic Therapy Given Day of or Day after Hospital Arrival” within the “Ischemic Stroke Encounter” with a medication administration calling the “Pharmacological Contraindications For Antithrombotic Therapy” value set and is administered the day of or day after hospitalization.

The third criteria looks for an “Encounter With an INR Greater than 3.5” within the “Ischemic stroke Encounter” that looks for a laboratory test performed with a result of >3.5 during the day of or day after hospitalization.

If any of these exceptions are met, the case meets the denominator exception and processing ends. If they are not met, processing ends and the case still qualifies for the denominator.

No Changes were made to the Denominator exceptions for reporting year 2026.

Slide 43 –
[00:35:20] Let’s review our last FAQ. Question: If the 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 the day after arrival to include the case in the numerator, the logic specifically calls out CalendarDayOfOrDayAfter with day one being the date of arrival.

Slide 44 –

[00:36:01] [Susan Funk] Thanks, Raquel, and Karen, for your segments describing the annual updates for the stroke eCQMs. Why don't you guys catch your breath for just a second, and then we'll proceed with the overview of the VTE measure set. Karen, I think you are up next, so I'll turn things over to you to present the rationale for the VTE eCQMs.

Slide 45 –
[00:36:23] [Karen Kolbusz] Thank you, Susan. Before we get into the technical details, we want to briefly review the clinical rationale for the VTE measures. "VTE" is an umbrella term that refers to blood clots that can develop in the

pulmonary artery or a deep proximal leg vein. Most VTE are related to a recent hospitalization or surgery. Immobilization following these events increases the risk of developing a DVT or PE. ICU admission is a particularly significant risk factor not only due to immobilization, but other co-morbidities found in this patient population.

Slide 46 –
[00:36:33] VTE is a leading cause of preventable hospital death in the United States and a top patient safety priority. Sudden death is often the first symptom of PE even before the diagnosis is suspected. The rate of hospital acquired VTE is higher in the ICU than general medical and surgical units. Many of these events are preventable through prophylactic interventions such as the use of anticoagulants or mechanical compression devices, yet many hospitalized patients do not receive these measures.

Slide 47 –
[00:37:47] Clinical practice guidelines from the American College of Chest Physicians, American Society of Hematology, and other professional groups recommend VTE prophylaxis for most hospitalized patients. The intent of the VTE –1 and VTE-2 measures is VTE prevention through the promotion of anticoagulant medications or mechanical prophylaxis, such as sequential compression devices or compression stockings, administered soon after the patient's admission to the hospital. Patients who receive pharmacological or mechanical VTE prophylaxis are included in the numerator population. Also included in the numerator are patients with a reason why VTE prophylaxis was not given and patients not at risk or low risk of developing VTE during the hospitalization.

2023 national averages for all hospitals in the CMS data set that reported 25 or more cases were at 82.2% for VTE-1, and 93.5% for VTE-2.

Slide 48 –
[00:08:21] Here is a table of the changes that impact VTE measures for 2026 Reporting year. Please note throughout this presentation, new content will be underlined, while stricken text denotes removed content.

Measure library Name change is a global update based on recommendation by technical experts. All Measure CQL library names have been updated with a CMSID plus measure short name, with a version number. So VTE-1 CQL library name is now 'CMS108VTEProphylaxis-14.2.000", and VTE-2 is 'CMS190VTEProphylaxisICU-14.2.000."

Another global change is that the measures now reflect the exact dates for the reporting period 2026 instead of a generic period. In the Guidance field, we added new guidance clarifying when Oral Factor Xa medications are acceptable to count toward the Numerator for better alignment with logic. It states that "Patient administered apixaban or edoxaban, medications included in the "Oral Factor Xa Inhibitor for VTE Prophylaxis or VTE Treatment" value set, would be counted in the numerator population only when the patients also have either a prior or present diagnosis of atrial fibrillation, a prior diagnosis of VTE, or a prior or present procedure of hip/knee replacement surgery".

Slide 49 –
[00:40:52] We also Removed reference to the 'Surgical Care Improvement Project (SCIP)' in the guidance field, when describing selected surgery types qualifying for the Denominator Exclusions and added guidance to clarify the specific surgeries included in 'Selected Surgery' logic definition as "Patients with a principal procedure of selected surgeries are excluded from the measure's denominator. Selected surgeries include general surgery, gynecological surgery, hip fracture surgery, hip/knee replacement surgery, intracranial neurosurgery, and urological surgery." In the Guidance field, new guidance was added noting that there is not a specific risk assessment model or tool that is required to determine VTE risk for this measure. It's a frequently asked question. We hope this addition clarifies the intent.

The last new guidance added to this version, is to clarify that patient refusal is the only reason for no pharmacological and no mechanical VTE prophylaxis that may be documented by a nurse. It states that "The only exception is patient refusal may be documented by a nurse." Other reasons for no pharmacological and no mechanical VTE prophylaxis must be explicitly documented by the medical doctor, advanced practice registered nurse, physician assistant, or pharmacist.

Slide 50 –
[00:08:23] For 2026 Reporting year, the new Value Set Federal Administrative Sex" replaced the value set used for Sex Supplemental Data Element "ONC Administrative Sex". This change applied to all measures.

In addition, Based on terminology expert review, we added the new ICD-10 procedure codes to the value set Hip Fracture Surgery to improve the list, besides the terminology annual updates. VTE measures updated all logic definitions from title case to initial case. This is a global change across all measures.

In the measure specifications, we updated the definition names and alias to better align with the removal of 'Surgical Care Improvement Project" 'SCIP' in the Denominator Exclusions narrative section.

Relocated the timing condition function, VTE.FromDayOfStartOfHospitalizationToDayAfterAdmission, from shared VTE Library directly to the measure logic because this function is only used by the VTE-1 measure.

There were multiple value sets with code additions/deletions due to terminology updates. Review the Technical Release Notes in the eCQI Resource Center and value sets in the VSAC for more details.

Slide 51 –
[00:23:02] Now we will review the detail of VTE-1 Venous Thromboembolism Prophylaxis measure flow and logic.

Slide 52 –
[00:44:08] For these next few slides where we're going through the measure flow, we know the flow is very small on screen. We encourage you to download the slides and you can enlarge the view within the PDF.

As part of our ongoing review of participant feedback and to improve the webinar content, we have combined reviewing the measure flow and logic together. If changes are made to the measure specifications or additional clarification on a definition is needed, we will conduct a more detailed review of the specific definition logic in a continuation slide.

Both VTE-1 and VTE-2 share the same Initial Population. The main definition is "Encounter with Age Range and without VTE Diagnosis or Obstetrical Conditions". Three conditions must be met to qualify for this definition.

1. An inpatient encounter must be present and ends during the day of measurement period, which is year of 2026.
2. without VTE Diagnosis or Obstetrical Conditions
3. the patient must be >=18.

So, the initial population is looking for an inpatient encounter that does not have an encounter diagnoses of Obstetrical or Pregnancy Related Conditions, VTE or Obstetrics VTE and patient age is 18 year or older.
If the criteria is met, the patient is in the initial population and processing continues.
If not, the patient is not in the initial population and processing ends..

Slide 53 –
[00:52:39] A frequently asked question relates to the logic just presented. Question: Does a prior history of DVT and/or Pulmonary Embolism exclude the patient from the initial population of VTE1 and VTE2?

Answer: There is no exclusion for patients with a history of DVT or PE. In fact, past history of DVT or PE increases the risk for developing VTE during the hospitalization and is even more reason to make sure that VTE prophylaxis is administered in a timely fashion.

Slide 54 –
[00:46:09] Another frequently asked question relates to the swing bed Question: Swing bed patients receiving skilled nursing facility (SNF) services in our Critical Access Hospital. Are swing bed patients supposed to be considered as inpatients?

Answer: The "swing bed" designation relates to the type of care, not the hospital bed location. Patients admitted to the hospital Skilled Nursing Facility but awaiting transport or an available room should be considered admitted to the SNF, not as Hospital Acute Inpatient Care.

Please note that swing bed encounters should not be included in episode-based hospital - inpatient eCQMs. Therefore, implementers must work with their electronic health record (EHR) vendors to remove swing bed encounters from measures.

Slide 55 –
[00:47:14] Here is the VTE-1 denominator measure flow. The denominator is equal to the Initial Population, which means that encounters satisfying the initial population will also meet VTE-1 denominator. Note the notation in the small diamond. We will refer back to this when we get to the sample calculation.

Slide 56 –
[00:56:32] There are 6 criteria included in the VTE-1 denominator exclusions. An encounter satisfying any one of them will exclude the patient from the denominator population. The first is if there is an encounter with LOS < 2 days.
Second is if an Encounter is with ICU Location Stay >= 1 day. This looks for patients transferred / admitted to ICU and stayed 1 day or more, where the ICU Location starts the day of or day after the encounter starts, will be excluded from the denominator. Third criterion is if there is an Encounter with Principal Diagnosis of Mental Disorder or Stroke. We use the EncounterDiagnoses attributes of rank and code to identify a Principal Diagnosis of Mental Health Diagnosis or Hemorrhagic Stroke or Ischemic Stroke.

Note the b1, b2 and b3 in the small diamonds to be used later in the sample calculation.

Slide 57 –
[00:48:12] 4th criterion is if there is an encounter with Principal Procedure of Selected Surgery.
5th criterion is if there is an encounter with Intervention Comfort Measures From Day of Start of Hospitalization To Day After Admission.
6th criterion is if there is an encounter with Intervention Comfort Measures on Day of or Day After Procedure.
Ff any of criteria is met, the patient meets the denominator exclusion. If not met, the patient continues on through the algorithm to be considered if the numerator is met.
Again, note the b4, b5 and b6 in the small diamonds to be used later in the sample calculation.

Slide 58 –
[00:49:25] Next, we will discuss one of the updated denominator exclusions more in detail. Please note throughout this presentation, that the star in a circle icon on the left side of the slide will denote changes for this reporting year where new content will be underlined, while stricken text denotes removed content.

“Encounter With Principal Procedure of Selected Surgery”. A couple of key changes for this year.

First, as we mentioned earlier, we've updated all logic definitions from title case to initial case across all measures in an effort to harmonize. This definition name is following the guidance to be updated in "initial' case format.

Second, 'Surgical Care Improvement Project (SCIP)' has been removed from the measure specification because the Surgical Care Improvement Project is a discontinued measure set. So "SCIP VTE" is removed from the definition and aliases. This logic excludes any principal procedure defined as a selected surgery specified in the "Selected Surgery" definition.

As a refresher, we use Global."NormalizeInterval" function to access whichever timing element is available in the patient data submission file for the time comparison.
The "SCIP VTE Selected Surgery" definition that is called, simply collects patients with procedures in any of these value sets.

Slide 59 –
[00:50:58] There are 2 main category conditions in the VTE-1 Numerator. One is patient who received VTE prophylaxis, and another is patients who have a documented reason why no VTE prophylaxis was given.

Under the first category, either of the 2 conditions will suffice: a. Encounter with VTE Prophylaxis Received From Day of Start of Hospitalization To Day After Admission or Procedure OR b. Encounter with Medication Oral Factor Xa Inhibitor Administered on Day of or Day After Admission or Procedure" with either Prior or Present Diagnosis of Atrial Fibrillation or Prior Diagnosis of VTE or with Prior or Present Procedure of Hip or Knee Replacement Surgery.

Under the 2nd category, any of 3 conditions are considered - Encounter with Low Risk for VTE or Anticoagulant Administered OR No VTE Prophylaxis Due to Medical Reason OR with No VTE Prophylaxis Due to Patient Refusal"

If any of these criteria are met, the patient is in the numerator. If not met, the patient is not in the numerator.
Again, note the c1 trough c5 in the small diamonds to be used later in the sample calculation.

Slide 60 –
[00:52:21] Now that the numerator, denominator, and denominator exclusions are defined, we can plug the quantities into the calculation formula. .Here you see the diamond notations referenced from the previous slides.

Slide 61 –
[00:52:39] A frequently asked question relates to the logic just presented. Question: Is a Caprini VTE Risk Score assessment documentation considered Reason for no VTE prophylaxis?
Answer: This measure does not require the use of a specific risk assessment model or tool (e.g., Caprini, Padua, and IMPROVE) to determine VTE risk. Using the Caprini Risk Score Assessment does not count as a documented "Reason for No VTE Prophylaxis." Checking these boxes on the scoring tool adds 1 to 3 points to the total Caprini Score and indicates that the patient is at risk for developing VTE. Such patients should receive VTE prophylaxis on the day of or day after admission or surgery end date, unless there is a reason for no pharmacological AND a reason for no mechanical prophylaxis documented within the same time frame.

Slide 62 –
[00:53:41] So, this brings us to another frequently asked question. Why is Apixaban NOT listed in the value set as a medication for VTE prophylaxis?
Answer: At this time, there is no approved indication to use Apixaban for venous thromboembolism (VTE) prophylaxis and treatment with an exemption of Hip/knee replacement surgery. We continuously monitor FDA approved indications for medications to determine which ones are appropriate for inclusion in the value set. Once Apixaban is approved, we will

add it to the list. If the FDA-approved indications for apixaban should be changed in the future to include a VTE prophylaxis indication for all hospitalized medical and surgical patients, then we will update the measure specifications. Meanwhile, if you have a new announcement, please forward it to us.

Slide 63 –
[00:54:40] Question: Are apixaban and rivaroxaban the only available DOACs for Atrial Fibrillation?
Answer: Edoxaban is another FDA-approved DOAC for ischemic stroke patients with Atrial Fibrillation. It is also an oral factor Xa inhibitor anticoagulant along with apixaban and rivaroxaban.

Currently, several large clinical trials (e.g., OCEANIC-AF, AZALEA-TIMI-71, LILAC-TIMI 76) are underway to evaluate the safety and effectiveness of factor XI/XIa inhibitors. Several new anticoagulant drugs are being studied at various oral and parenteral doses. These medications will be considered for addition to the anticoagulant value set should any receive FDA approval.

Slide 64 –
[00:23:02] Now we will review the detail of VTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis measure flow and logic.

Slide 65 –
[00:55:49] As noted with the other measure flows in this presentation, we know that the fonts are small. We encourage you to download the PDF of the slides which enables enlarging the zoom. Starting with the measure flow diagram. Both VTE-1 and VTE-2 share the same Initial Population which we already covered so we will move to the denominator.

Slide 66 –
[00:56:16] The denominator population condition is Encounter with ICU Location. If yes, the denominator is met and the flow continues on the next page. If not, processing ends.

Slide 67 –
[00:56:32] There are 4 criteria included in the VTE-2 denominator exclusions. An encounter satisfying any one of them will exclude the case from the denominator population.

The first is if there is an encounter with an overall LOS < 2 days. Second is if an Encounter with First ICU Stay with Principal Procedure of Selected Surgery. Note the b1 and b2 in the small diamonds to be used later in the sample calculation.

Slide 68 –
[00:48:12] 3rd criterion is if there is an encounter with Intervention Comfort Measures From Day of Start of Hospitalization To Day After First ICU Stay.
4th criterion is if there is an encounter with Intervention Comfort Measures on Day of or Day After Procedure.

If any of criteria is met, the patient meets the denominator exclusion. If not met, the patient continues on through the algorithm to be considered if the numerator is met.

Again, note the b3 and b4 the small diamonds to be used later in the sample calculation.

Slide 69 –
[00:59:40] Moving on to the numerator. Recall the comparison of VTE-1 to VTE-2 we looked at earlier. We use the same clinical concepts, however, VTE 2 uses the First ICU admission or transfer for timing constraints where VTE-1 uses the hospital admission.

Slide 70 –
[00:58:09] Similar to VTE-1, there are 2 main category conditions in the VTE-2 Numerator. One is patient who received VTE prophylaxis, and another is patients who have a documented reason why no VTE prophylaxis was given
Under the first category, any of 2 conditions are considered for satisfaction. One is Encounter with VTE Prophylaxis Received Day of or Day After First ICU Stay or Procedure. The other is Encounter with Medication Oral Factor Xa Inhibitor Administered on Day of or Day After First ICU Stay or Procedure with either Prior or Present Diagnosis of Atrial Fibrillation or Prior Diagnosis of VTE or with Prior or Present Procedure of Hip or Knee Replacement Surgery. Under the 2nd documentation category, any of 3 conditions are considered - Encounter with Low Risk for VTE or Anticoagulant Administered OR No VTE Prophylaxis Due to Medical Reason OR with No VTE Prophylaxis Due to Patient Refusal". If any of criteria are met, the patient is in the numerator. If not met, the patient continues on through the algorithm to be considered if the denominator exception is met. Note the c1 though c5 in the small diamonds to be used later in the sample calculation.

Slide 71 –
[00:59:40] Moving on to VTE-2's Denominator Exception. It's important to note the difference between an exclusion and exception. Simply put, it differentiates in the way it processes. A denominator exclusion is processed before the numerator, so a patient is excluded and never in the numerator. An exception is processed after the numerator. So, if a case fails the numerator and meets the Denominator Exception, it will be excluded from the measure.

So, in this instance, the denominator exception condition is if an Encounter with First Intensive Care Unit length of stay < 1 day. If yes, the patient meets Denominator Exception to be excluded from the measure. If not, the patient is not in Denominator Exceptions. Note the d in the small diamonds to be used later in the sample calculation.

Slide 72 –
[01:00:39] Now that the numerator, denominator, denominator exclusions, and denominator exceptions are defined, we can plug the quantities in to the calculation formula. Here you see the diamond notations referenced from the previous slides.

Slide 73 –
[01:01:03] [Susan Funk] Excellent. Thanks so much, Raquel and Karen, for presenting today. So much information. So, we've got a couple additional slides here that are resource slides. We'll present these, and then we'll move into the Q&A segment. So, we've included this additional resource slide that has the links to the eCQI Resource Center, CMS Eligible Hospitals Measures page, and the Get Started with eCQM links, the Teach Me Clinical Quality Language video series, as well as the video shorts on Hospitalization with Observation and What is a Value Set. Next slide.

Slide 74 –
[01:01:41] Continuing on with the resource links, we've included a link to direct you to the Value Set Authority Center, or the VSAC support, the Expert to Expert Webinar Series on Joint Commission's website, and finally the ASTP/ONC Issue Tracking System, where the clinical and technical questions about these eCQMs should be submitted following this webinar. Next slide, please.

Slide 75 –
[01:02:10] So, we're now going to move into the live Q&A segment. Just a quick reminder how to submit questions. 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. All of the questions not answered during the live event will be addressed in a written follow-up Q&A document, and that follow-up document will be posted to the Joint Commission's website within several weeks after the live event, and that's after CMS reviews and approves the document.

Our subject matter experts have been very busy during the presentation responding to as many questions as they could, as they've been submitted. We will now share some of those questions and answers. Raquel, I will take over the screen sharing now, and Karen Kolbusz will be facilitating the Q&A segment. Karen, whenever you're ready, please proceed with the first question while I get the screen sharing taken care of.

[Karen] Well, thank you, Susan. Yeah, it looks like we have quite a few questions in our queue. So, let's start with number one here. Our first question asks, "Can a secondary code of hemorrhagic stroke be an exclusion or automatic contraindication to anticoagulation medications?" And the answer is, a principal diagnosis of ischemic stroke is required for a case to be included in the Initial Population. Patients with a principal diagnosis of hemorrhagic stroke are not part of the Initial Population. Patients with a secondary diagnosis of hemorrhagic stroke will be excluded from the eCQMs unless a principal diagnosis of ischemic stroke was assigned at discharge. If the principal diagnosis is ischemic and the hemorrhage recent, additional documentation is needed to exclude the case as a medical reason for the measure.

Our next question. Our next question here is about RxNorm codes. And the question asks, "The value sets only have generic RxNorms. Can brand names be used? Our cases are dropping out of the measure if our providers prescribe Eliquis instead of apixaban." And the answer is, the medication value sets developed for the program contain Semantic Clinical Drugs, SCDs, RxNorm codes that are generic and prescribable. SCD RxNorm codes are generalizable drug concepts, providing information about ingredient, strength, and dose form. Brand name medication codes can be mapped to the SCD RxNorm codes found in the value set. Please consult with your EHR vendor and clinical partners for more information about mapping. If mapping is conducted, you should maintain documentation in case of a CMS audit.

Okay. Some of these look like they are operational, so I'm going to skip through some of these operational questions and get to the clinical questions. Okay, our next question pertains to STK-2 in particular. and this question asks, "Will the case meet criteria for exclusion from STK-2 if comfort measures only, CMO, is documented any day during the encounter or does it need to be documented on day one or two?" And the answer is, inpatient hospitalizations for patients with comfort measures documented at any time during the encounter will meet Denominator Exclusion criteria for STK-2.

Our next question asks, "Is a history of DVT not included in CMS 190 V12 value set? If not, why not?" The answer is, Z codes, Z86.718 and Z79.01 specifically are situational status codes that denote a personal history of a condition. They are not diagnostic codes and therefore are not included in the venous thromboembolism value set. The measure's Numerator logic looks for a history of other venous thromboembolism diagnoses and coded in SNOMED CT and ICD-10-CM codes that start prior to the encounter using diagnosis prevalence period as an indicator of history of diagnosis.

Our next question asks, "Can a patient be in both the VTE-1 and VTE-2 measures?" And the answer is yes, a patient could be in both VTE-1 and VTE-2, depending on when admission to the hospital and transfer to the ICU happens. Only when the patient is admitted to the hospital and transferred to the intensive care unit on the day of or the day after the hospital admission, and with VTE prophylaxis given during those two days, will the patient be in both measures.

Our next question here is about a CE certificate for nursing. Actually, it's specific to one state. So, I'll just read this answer. It does say the CE entities are listed on the handout labeled CE information in the participant resource panel. While we list entities that offer CE credit for Joint Commission courses, many other state boards and professional associations also recognize Joint Commission educational content.

Our next question asks, "What is the last calendar year that the stroke measures will be able to be reported?" And the answer is, this webinar, we'll be reviewing the 2026 reporting period for the electronic stroke measures STK-2, 3, and 5. So we are talking here about calendar year 2026.

Our next question is about benchmarks. "Where to get an electronic CQM national benchmark or average?" And the answer from our staff states, "Hospital data sets containing national averages for eCQMs are located at https://data.cms.gov/providerdata/archiveddata/hospitals.

Moving down the list here... And looking for another clinical question. Now this one is about ORYX changes. The question is, "Will Joint Commission continue to support these measures with the 2026 ORYX changes? These measures are not required or listed as optional measures to submit." The answer is, "Please reference the 2026 ORYX performance measurement reporting requirements via the Joint Commission website that's listed here in the response.

Okay, the next one seems to be related to Get with the Guidelines, and the inquirer asks, "I believe AHA's Get with the Guidelines does not count aspirin on discharge to meet the discharge on antithrombotic therapy. Does CMS count aspirin on discharge to meet this measure, which would be STK-2?" And the answer is, for the discharge measures STK-2 Discharged on Antithrombotic Therapy, aspirin does qualify, while STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter does not qualify. For detailed information about acceptable medications included in the value sets, please visit the Value Set Authority Center at https.vsac.nlm.nih.gov. For STK-2...

Yes? [Susan]- Oh, sorry, sorry, Karen. We'll have time for about one more question after this one. I just wanted to to let you know that we are coming close on the end of the time. But please finish this question and, if you can, one more.

- [Karen] Okay. I will do that, Susan. Thank you. Yeah, there was a little bit more response to that last question about, after the VSAC value center. It says basically that, for STK-2 and STK-5 measures, refer to the value set Antithrombotic Therapy for ischemic stroke. That would be for STK-2. And then for STK-3... Well, STK-2 and STK-5 use the Antithrombotic Therapy for ischemic stroke value set. And then for STK-3, the AFib measure, use the Anticoagulant Therapy value set. Let's see here, one more.

Okay, our last question asks, "For STK-3, a history of atrial fib if not documented during the encounter but documented years ago in the diagnosis from other facilities, or the same facility, but documented once. Does it still count or the atrial fibrillation documentation is only related to the actual encounter?" And the answer, documentation of AFib in the record will still count for STK-3 even if the documentation does not occur within the encounter. And that's the last question. I'll turn it back to you, Susan.

[Susan] All right, thank you so much, Karen. I'm sorry I broke in there. Thanks, everyone, who's stuck it out with us for the last few minutes here. I'll close out the webinar with a little bit of information about getting to the survey. But first, we wanted to reiterate that all of these questions will be put into a written Q&A document that will be in posted on Joint Commission's website within several weeks of this event. We need to wait for CMS' approval, but we will get those posted for all of you. And if we didn't get to your question today, it will be included in that document.

Slide 76 –
[01:14:45] All of the Expert to Expert Webinar recording, links, slides, and transcripts will be available on Joint Commission's website at the link displayed on this slide. Scroll down and use the checkbox to sort for Expert to Expert Webinars. Within a couple weeks, the captioned recording and materials will be posted on that site. We will also share with CMS to put on the eCQI Resource Center. If you have any questions following this webinar about the continuing education credit or about our operations details, you can send them to tjcwebinarnotifications@jointcommission.org. And finally, for those that wish to attend any of our future webinars in this series, we've included a handout that has the registration links for all of the scheduled webinars through April. So please make sure you download that and share it with any of your colleagues that weren't able to join us today.

Slide 77 –

[01:15:39] As this webinar concludes, a few words about the survey. We use your feedback to inform future content, determine education gaps, and assess the quality of our educational programs. A QR code will appear on the next slide. You can use your mobile device to scan and access the survey. If you would prefer to take the survey later. An automated email also delivers the link to the survey. After you complete and submit your survey responses, you will be redirected to a page from which you can print or download a blank certificate that you complete by adding your own name and credentials. In case you miss that opportunity to download, an automated email also provides the link to that certificate.

Slide 78 –

[01:16:22] So, with that, thank you to everyone for attending. We will leave this slide up for a few moments so participants can access the survey QR code. Thank you, Raquel, and Karen, for presenting today regarding the changes to these eCQMs. And Karen, thank you so much for facilitating the Q&A segment. Many thanks as well to the team that was responding to all of those questions in the queue and to the operations staff that supported the webinar. Finally, thanks to everyone in the audience that joined today. This concludes our presentation. As I noted, I will just leave this slide up for a few more moments for anyone that wants to access the survey. Have a great day.