Inpatient Quality Reporting Program

Support Contractor

Venous Thromboembolism 2015 Abstraction Guidance

Presentation Transcript

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Mike Seckman: This is Conference # 98848731.

Good day. I hope everybody is having a great Monday. Welcome to the Venous Thromboembolism 2015 Abstraction Guidance presentation. My name is Mike Seckman and I'll be your virtual host for today.

Again, audio for this event is available via Internet streaming, so please connect your computer speakers or your headphone, whatever you prefer to listen to, to your computer, and no telephone is required. No telephone line required. We do not have the ability to unmute our attendees today, so please don't raise your hand asking a question. Instead, what we're going to be doing, is we're going to be sending any comments or questions that you may have via the Chat panel. The Chat panel is located down on the lower left-hand corner of your screen – and please send it to all panelists so that everybody can see your question, and we can help you if you're having a problem or if you have a question about the presentation. We can go ahead and answer that, as well. So we'll be using the Chat panel to answer any questions that may come in today.

Again, this is the Venous Thromboembolism 2015 Abstraction Guidance and your virtual host today will be Candace Jackson. Candace, the floor is yours.

Candace Jackson: Thank you, Mike. Hello and welcome to our IQR monthly webinar. My name is Candace Jackson, and I will be your host for today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the Qs&As, will be posted to our Inpatient Web site at www.qualityreportingcenter.com within two days and will posted to *QualityNet* at a later date. If you are registered for this event, a reminder email, as well as the slides, were sent out to your email approximately one hour ago. If you did not receive the email, you can download the slides at our Inpatient website, again, at www.qualityreportingcenter – all one word – dot com.

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The purpose of today's webinar is to provide information and update regarding changes to the extraction of the data elements, Reason for Discontinuation of Parenteral Therapy, Warfarin Administration, VTE Present at Admission, and VTE Confirmed. Abstraction guidance for new data element, Reason for No Administration of VTE Prophylaxis will also be discussed. Additionally, information regarding the measures that are required for the Inpatient Quality Reporting program and the VTE sub-populations will be provided.

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At the end of today's presentation, you will be able to explain and understand the rationale behind the changes and updates for the VTE data elements, apply abstraction guidance, and identify and understand the VTE sub-population.

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I would now like to introduce our guest speaker, Denise Krusenoski. Denise is an Associate Project Director in the Quality Measurement Department at the Joint Commission, and is a subject matter expert for the Venous Thromboembolism (measure set). Denise, the floor is yours.

Denise Krusenoski: Thank you, Candace. Thank you for having me here today.

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As Candace alluded, the objectives for today's presentation are to assist the audience with data abstraction for the Venous Thromboembolism Data element, to explain to the audience the rationale behind the changes and updates in the data element, and to provide answers to questions regarding the changes and updates in the data element.

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The data elements that will be covered today are Reasons for Discontinuation of Parenteral Therapy, VTE Confirmed, Reason for No Administration of VTE Prophylaxis, Warfarin Administration, VTE Present at Admission, and Reason for No VTE Prophylaxis. These are data elements that had changes in the manual or [have been] seen to elicit questions.

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The data element Reason for Discontinuation of Parenteral Anticoagulation Therapy – This data element is from VTE-3 Overlap Therapy. There were a few changes in this data element to better match the ACCP (American College of Chest Physicians) Guidelines. First of all, the intention of this data element is to account for the rare occasion in which five days of overlap therapy could not occur, and the risk of bleeding outweighs the benefit of coagulation. The data element begins with "There must be a reason documented for the discontinuation of the Parenteral Anticoagulation Therapy." It must be documented by a physician, APN (Advanced Practice Nurse), PA (Physician Assistant), or pharmacist and it must be documented on the same day or the day before the order for the discontinuation. This means that the documentation must be written prior to the order for the discontinuation of the Parenteral Therapy or on the same day. Any documentation dated or timed after the discharge is not included. Addendums are not included.

So what kind of explicit documentation is allowed? Any kind of explicit documentation that was a link to the discontinuation of the Parenteral Therapy or link to one of the inclusion guidelines is allowed. So, an example would be Discontinue Heparin: GI (Gastrointestinal) bleed; Discontinue Heparin: Fall Risk; Discontinue Heparin: Head Injury; or Discontinue Heparin: a Procedure or Surgery.

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For this example, we have, on the day before the order, the discontinuation of the heparin drip. The physician indicates "D/C (discontinue) heparin drip – has recent falls." You may select "Yes." This patient is not a candidate for anticoagulation. The order was written on the day before the discontinuation. The data element indicates the timeframe for the documentation is the same day or the day before the order for the discontinuation. Also, this example indicates explicit documentation of recent fall.

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The data element, Reason for Discontinuation of parenteral Anticoagulation Therapy continues. On this slide, we examined that for patients who have less than five days of overlap therapy, additional documentation is needed to support the reason for discontinuation of Parenteral Anticoagulation Therapy. Our example is, the patient is bleeding. Additional documentation must be explicit and be linked to the discontinuation.

Example again includes D/C Lovenox rectal bleed, so there are six types of patient scenarios that pass this measure. One is *overlap therapy that's lasting for greater than five days, the patient is discharged home*. The second is *overlap therapy that's lasting less than five days, the patient is discharged home with parenteral therapy*. A third is o*verlap therapy that lasted less than five days, INR (International Normalized Ratio) is greater than 3.0, the patient is discharged home*. Another is *overlap therapy is greater than – is greater than five days, INR is 2.0 to 3.0, the patient is discharged home with parenteral therapy*. Another is *overlap therapy that's less than five days, INR is less than 2.0, the patient is discharged home with parenteral therapy*. And the last one is *overlap therapy is less than five days, INR is less than 2.0, the patient is discharged home without parenteral therapy but with a reason for the discontinuation of the anticoagulation*.

Now, there are two scenarios that fail this measure. Number one, overlap therapy is less than five days, the INR is less than 3.0, and there is no parenteral anticoagulation upon discharge, and the second one is, overlap therapy is less than five days, the INR is less than 3.0, and there is no reason documented for the discontinuation of the parenteral therapy.

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The second example here is when the patient has had three days of overlap therapy. Under the assessment and planning, on the day that the Parenteral Therapy was discontinued, the M.D. writes, “acute hypoxic respiratory failure secondary to multiple PEs (Pulmonary Embolisms) resolved, recent intracranial hemorrhage, CT here no change. INR is noted. D/C Lovenox, hold Coumadin. Follow up INR in a.m.” Select “Yes, recent intracranial hemorrhage.” This example indicates recent intracranial hemorrhage so the Lovenox is discontinued.

There are also a lot of questions of having an INR value of 1.8 or 1.9. An example is date of discharge. Physician documents “INR of 1.9. Patient should be therapeutic after last dose. Discontinue Parenteral Therapy and have patient follow up INR with physician.” In this example, you would select “No.” You do not have five days’ worth of therapy and you do not have a reason for discontinuation of Parenteral Therapy at discharge. The last INR was less than two and you were not even therapeutic yet.

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Reason for Discontinuation of Parenteral Anticoagulation Therapy continued – On this slide, for a patient who has less than five days of overlap therapy and documentation of the therapeutic INR or an INR with a value equal to 2.0 to 3.0 with a target range of 2.5, additional documentation is needed to support the reason to select “Yes.” There is no acceptable documentation of D/C Lovenox, INR 2.0. If the therapeutic INR is noted as this reason for the discontinuation, another explicit reason must be documented. [This is] therapeutic INR. INR greater than 3.0 can be used as an acceptable reason for discontinuation. This bullet is quoted several times in our question and answer form. It is clear that documentation is needed to indicate why parenteral Therapy was discontinued prematurely.

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In this example, the patient was admitted for a PE. The patient was started on Lovenox subcu (subcutaneous) and Warfarin with three days of overlap therapy. On the day of discharge, the physician documents “INR of 2.5. The patient is therapeutic. Discharge on Warfarin. Follow-up in clinic.” For this example, you would select “No.” This patient was not on overlap therapy for five days. The record moves to the data element “Reason for Discontinuation of Parenteral Therapy.” The only documentation

indicating why the patient was discontinued is the words, “Patient therapeutic.” We know from the bullet in the last slide that this is not acceptable documentation.

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In this example, the patient was admitted for PE/DVT (Deep Vein Thrombosis). The patient was started on Lovenox subcu and on it for three days and had overlap therapy with Warfarin for three days. Xarelto was also administered on the day of discharge. Warfarin and Lovenox were not prescribed at discharge. For this example, you will select “Yes. Reason for Discontinuation of Parenteral Therapy, administration of Xarelto or Eliquis.” These are standalone reasons. If the patient is switched from overlap therapy to Xarelto or Eliquis, it is administered. Then you can select “Yes” for the Reason for Discontinuation of Parenteral Therapy.

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By the way, you have here the ACCP Guidelines 9th Edition under the Section Anti-Thrombotic Therapy for VTE Disease Section 2.4: “In patients with acute DVT of the leg, we recommend early initiation of VKA (Vitamin K Antogonists), example, same day as parenteral therapy is started, over delayed initiation and continuation of parenteral anticoagulation for a minimum of five days **and** until the international normalized ratio, INR, is 2.0 or above for at least 24 hours. This is a Grade 1B recommendation.” I did bold the “**and**” word. This guideline provides us evidence of the measure. It clearly indicates the recommended five days of overlap therapy, and until the INR is 2.0 or above or at least 24 hours, there are still clotting abilities in the blood. Even when the INR first reaches 2.0, the patient continues to need Parenteral Therapy for protection.

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This is a new data element, Reason for No Administration of VTE Prophylaxis. This data element is from VTE-6, Hospital Acquired VTE. It accounts for patients who already acquired a case in the hospital and demands a reason why they were not prophylaxed. This data element used to be Allowable Value 3 in the data element VTE Prophylaxis Status. It was broken away and made into a new data element to define some reasons why VTE

prophylaxis could not be given. It specifies, in detail now, what is and is not acceptable documentation. The slide indicates there must be physician, APN, [or] PA documentation of why VTE prophylaxis was not administered, and it must be dated between arrival and the VTE diagnostic test performed. At first, you would review the records that the VTE diagnostic test that confirms the VTE. Then, review if any documentation of a reason why VTE prophylaxis was not administered anytime between arrival and the VTE diagnostic test performed. If, on the same day, the diagnostic test was performed on the day of or the day after arrival, you may select "Yes." The assumption is that there was not time to prophylax. The same exception is made in the data element, VTE Prophylaxis Status. If you did not have time to prophylax because the testing [was] done the same day or the day after admission, you may select "Yes" to the data element and pass the measure.

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The example here is "The patient was admitted on October 2nd with bilateral lower extremity burn. No SCDs (Sequential Compression Devices) documented in the E.R. Patient with a history of recent rectal bleeding. No pharmacoprophylaxis documented on 10/03. No SCDs were ever placed. No pharmacoprophylaxis was administered. A CT with contrast of the chest was ordered on October 7th. CT findings were positive for a PE." Select "Yes." Review the CT of the chest with contrast then evaluate if it was one that confirmed the VTE test. If so, review the chart to see if the VTE prophylaxis was administered. If there's no VTE prophylaxis administered, review the chart for a reason for no VTE prophylaxis. Again, this is for (admission) to the diagnostic test.

These are helpful brief explanation. To select "Yes," to do the documentation of bilateral lower extremity burns and no SCDs documented. You have documentation of a contraindication to pharmacoprophylaxis with a history of rectal bleeding and mechanical prophylaxis with bilateral lower extremity burn.

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Reason for No Administration of VTE Prophylaxis Continued. The following notes for instruction indicated that "There is no low risk assessment acceptable, no IV Heparin is acceptable, ambulation of the patient is acceptable, patient refusal is acceptable, and

comfort measures only are – is acceptable." The rationale behind this – that the technical advisory panel felt that the patient was originally evaluated as low-risk the acquired a clot during the hospital stay. They should have been reassessed for VTE risk assessment. At some point, they became a high-risk. Therefore, the data element does not allow for documentation regarding "low-risk IV Heparin is not acceptable" because those patients should have already have their anticoagulants managed and should not have acquired a VTE. These are not acceptable automatic reasons why the patient should not have been prophylaxed.

Next slide please.

The next data element is Warfarin Administration. This data element is used in VTE-3 and VTE-5. This is used to determine if Warfarin was administered after the VTE diagnostic test. When reviewing this data, first locate the acceptable VTE diagnostic test completed. Then review the chart to ascertain if Warfarin was administered any time after the test. The acceptable test is the earliest test that confirmed the VTE. If the answer is "Yes," the record moves to the data element overlap therapy. If the answer is "No," such as when Xarelto was used instead of overlap therapy, then the record is excluded from the measure.

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This example is a patient admitted with bilateral DVTs on December 1st, confirmed with venous Doppler of the lower extremity on December 1st. Lovenox was given from December 1st to December 6. MRI of the pelvis is done on December 6. Warfarin was administered on December 6 and the patient was discharged on December 6. You may select "Yes."

First, you review the diagnostic test that confirms the VTE, just the Doppler of the lower extremities. Then you review if the Warfarin was administered. Warfarin was administered on December 6, which is after both the Doppler and the MRI of the pelvis.

Next slide please.

This data element is VTE Present at Admission. If any VTE is present or suspected in the record, it could be used to select

"Yes" to the data element VTE Present at Admission. It must be documented from time of arrival to the day after admission. This VTE can be found anywhere in the body. The purpose of this data element is to exclude cases that come to the emergency room or hospital for treatment. Patients with only a history of VTE are to select "No." If a patient had only a history of VTE, they could still acquire a new VTE at the facility. That is why history VTE is left out. Patients with the current VTE anywhere in the body documented between arrival to the day after admission are to select "Yes."

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In this example, if a patient is transferred with a known clot in her arm and SVC (Superior Vena Cava), this is diagnosed by a CT done at the transferring facility and has a CT with contrast in the emergency room that indicates positive PE. The question is, should it be answered "Yes" or "No?" Please select "Yes." The patient has documentation of a CT with contrast that indicates a positive PE and this is done in the ER. This is present at admission, please select "Yes."

Next slide, please.

The data element is VTE Confirmed. This data element is used in VTE-3, 4, 5, and 6. It is use to assure the patient had a clot in the defined location to ensure the proper treatment is done. To this data element, first you must review the chart for physician/APN/PA documentation that the patient had a VTE Diagnostic Test. Then review if the VTE was confirmed in one of the defined locations. Be sure this is documented within four days prior to arrival, or any time during the hospitalization. To this data element, you must have both the VTE Diagnostic Test and the VTE Confirmed in one of the defined locations, and this can be four days older than the day of the arrival date or any time during the hospitalization.

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In this example, the patient arrives to the emergency room with pneumonia on January 2nd. A CT chest is ordered on January 2nd. The results are negative. On January 4th, the patient complains of shortness of breath. [A] VQ (Ventilation/perfusion scan) scan indicates a high probability of PE. MD documents PE

on January 5th, select “Yes.” Select the VTE test that was from the acceptable sources in the data element VTE Diagnostic Test. Then review the documentation to see if it indicates a positive finding. Then review the documentation to determine if the location is acceptable.

Next slide.

VTE Confirmed Continued – If more than one test is performed, first review all the VTE diagnostic tests and make sure that they are all acceptable. Only look at those that are acceptable. Then review the chart for the earliest acceptable VTE Diagnostic Test that confirmed the VTE, and be sure the VTE is in one of the defined locations. So, you begin with review of the chart for all the acceptable VTE Diagnostic Tests. Those noted in the data element VTE Diagnostic Test. Find the earliest test that confirmed the VTE, review the record to be sure it’s in one of the defined locations.

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VTE Confirmed is recurrent chronic, sub-acute or history of VTE is acceptable only if there is documentation of an acute or new VTE. Our example is if a patient had a history of lower extremity DVT, but vascular ultrasound found a new DVT in the proximal vein of the right lower extremity, you would select “Yes.” Acute and chronic VTE is acceptable. Documentation must indicate the vessel of the VTE in one of the defined locations.

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I’m going to pass over these two next slides for the interest – best interest of time.

Next slide, please. And next slide, please.

Okay, now, we’re on the slide with VTE Confirmed on the top, and this is for patients with “low probability” or “inconclusive” test results on any of the acceptable VTE Diagnostic Tests, select :No.” If the radiology test is all you have, and the test is inconclusive, please select “No.” However –

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If there is questionable physician/APN/PA documentation regarding whether the patient had a VTE, now you are to select yes. In the example, is if the radiologist interpretation of the exam did not confirm the DVT, but there is documentation of a DVT in the physician's progress notes, please select yes. Again, if you have more than one provider and one of them documents a positive result, please select yes. If you have complete the documentation and once physician said yes to VTE Confirmed, please select yes, but note there must be a vein location.

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Patient had a VQ scan which shows intermediate probability of pulmonary embolism. The patient also had a venous duplex of the lower extremity which shows acute DVT of the right gastrocnemius vein. On the progress note, the physician states under assessment: acute PE and the patient was treated for PE, you would select yes.

The patient had a positive VQ scan, but it is intermediate, which is questionable. There is another VTE, but it is not a deep vein. It is superficial. However, the MD documents PE, so select "Yes" based on the slide before.

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If the record indicates that only a radiology report – if the record indicates only a radiology report and that report is questionable regarding whether the patient had a VTE, you would select "No." But here are some helpful hints that might clear things up. If the radiology report is questionable, but the MD confirmed the VTE and the documentation, select "Yes." If the MD documentation is questionable, and that's all you have, select "Yes." If the MD confirmed the test, select "Yes." And if there is no radiology report and the MD confirmed the test, select "Yes."

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Finally, the last data element for review is VTE-1 – Reason for No VTE Prophylaxis – Hospital Admission. And this notes, for abstraction, a new history of "Warfarin used" is an automatic "Yes." We now allow for all pre-admission Warfarin.

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The Reason for No VTE Prophylaxis – Hospital Admission. Again, for patient with reason for no pharmacological or no mechanical prophylaxis and an order for any prophylaxis that was not administered without a reason, please select no. So, if any VTE prophylaxis is ordered and is not administered and you have reason – you have a reason for no pharmacological or reason for no mechanical, you still select no.

Last slide, please.

In this example, the patient has an MD risk assessment stating low-risk with an order for SCDs. There is no documentation that the SCDs were applied if the patient – and the patient received no other VTE prophylaxis. In this example, you would select "No."

Questions can be submitted in the queue as the operator has indicated, or they can be submitted in *QualityNet* at https://www.qualitynet.org.

Candace, you may please take over the slides.

Candace Jackson: Thank you, Denise, and I would like to thank Denise for the information that she has shared with us today. For the next portion of our presentation, we will be going over the VTE Population and Measures.

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Beginning with January 1st 2015 discharges, the following VTE measures will be required for the hospital inpatient quality reporting program:

- VTE-1 – Venous Thromboembolism Prophylaxis
- VTE-2 – Intensive Care Unit Venous Thromboembolism Prophylaxis
- VTE-3 – Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
- VTE-5 – Venous Thromboembolism Warfarin Therapy Discharge Instructions and VTE-6 – Hospital-acquired Potentially Preventable Venous Thromboembolism
- VTE-4 – Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram
    - Can be submitted to CMS voluntarily. It is not required for the IQR Program.

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The VTE measure set is unique in that there are three distinct initial patient populations or sub-populations within the measure set, each identified by a specific group of diagnosis codes or lack thereof. All three VTE sub-populations utilize the same three data elements: admission date, birth date, and discharge date to determine the patient age and length of stay. To be included in any one of the three sub-populations, the patient must be greater than or equal to 18 years of age and have a length of stay less than or equal to 120 days. A modified sampling procedure is required for hospitals performing sampling for VTE. As the measure set contains three independent sub-populations, each of these populations must be sampled independently from each other.

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We are now on the slide titled VTE Sub-population. Sub-population 1, or the No VTE sub-population, consists of patients with no principal or other diagnosis code as defined in Appendix A Table 7.02, 7.03, and 7.04; a patient age greater than or equal to 18 years of age; and a length of stay less than or equal to 120 days. As such, this population contains patients with any diagnoses or any ICD-9-CM principal or other diagnosis code, except for those patients that have a diagnosis of VTE or Obstetrics. The principal VTE sub-population or sub-population 2 is all patients with a principal diagnosis of VTE as per Table 7.03 and 7.04; a patient age of greater than or equal to 18 years of age; and a length of stay less than or equal to 120 days.

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The other VTE Only sub-population or subpopulation 3 consists of patients with an “other” diagnosis code of VTE, as defined again in Appendix A Table 7.03 and 7.04; a patient age of greater than or equal to 18 years of age; and a length of stay less than or equal to 120 days. For this sub-population, the patient cannot have a principal diagnosis of VTE.

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As stated earlier, each of the three distinct populations must be determined and sampled independent of each other. So, if you

look at sub-population 1, if you are sampling quarterly, if your population is 100, then you would need to sample and submit 45 cases at a minimum. You can always decide to submit more than the required sample size, but to meet IQR requirement, you must submit the required sample size at a minimum. You will abstract and submit all of the required VTE measures for this sub-population. However, this population will be evaluated and determined if they received the VTE prophylaxis, which is VTE-1 and VTE-2. You will then do the same thing for sub-population 2. You would determine your population size, again, which is all patients with a principal diagnosis of VTE, and your sample size. You will abstract and submit all of the required VTE measures for this population also. However, this population is going to evaluate whether or not the patient received the appropriate thrombolytics and discharge instructions, which is VTE-3, VTE-4, and VTE-5.

It is important to know that the sampling for sub-population 3 is different. For this sub-population, sampling is not allowed. You must submit 100 percent of the initial patient population. Again, you will abstract and submit all the required measures. As in sub-population 2, this sub-population evaluates if the patient received the appropriate thrombolytics and discharge instructions. However, it also evaluates if the VTE was preventable. As such, this population utilizes VTE-3, VTE-4, VTE-5, and VTE-6.

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As discussed in the last slide, whether or not a case is included in the measure denominator is dependent upon the sub-population that the case is included in. For subpopulation 1, as we are looking to see if the patient received VTE prophylaxis, these cases will automatically be excluded or result in a measure outcome of “B” for VTE-3, VTE-4, VTE-5, and VTE-6. Again, however, you will still submit these cases for all of the required VTE measures. A case could be – also be excluded from VTE-1 and VTE-2 depending on how the case flows through the measure algorithm and if it meets any of the other measure exclusion criteria.

The cases for subpopulation 2 will automatically be excluded or result in a measure outcome of “B” for VTE-1, VTE-2, and VTE-6, since this population determined if the patient received the appropriate thrombolytics and discharge instructions. As sub-population 3, is looking to see if the patient received the appropriate thrombolytics and discharge instructions and also

looks to see if the VTE was preventable, these cases will automatically be excluded from VTE-1 and VTE-2.

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For assistance and guidance for questions related to the abstraction of the data element and measure sets, please submit your questions to the Q&A Tool. Questions or assistance for the IQR Program can be submitted through the Q&A Tool, site email, or through the phone support helpline. We would also encourage you to attend the monthly Web conferences that are provided and to visit the Quality Reporting Center website.

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The next slide is titled, Continuing Education Approval. Today's Webinar has been approved for 1.0 continuing education credit by the boards listed on this slide.

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This is what pops up after you click "Done" on the survey. If you have already attended our webinars and received CEs, click "Existing User." If this is your first webinar for credit, click "New User."

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This is what the New User screen looks like. Please register a personal email like Yahoo! or Gmail, since those accounts are typically not blocked by hospital firewalls. Remember your passwords since you will use it for all of our events.

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And this is what the Existing User screen looks like. Use your complete email address as your user ID and the password you registered.

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And now, we will open up the phone lines to our subject matter expert for the Q&A, as time allows. And we do have some questions that happen [to have] made it to the queue for – to be addressed. So, we will start going over those questions at this time.

First question, Denise, "If a patient has SCDs placed on day one of admission and has Lovenox administered later that day, which prophylaxis should I abstract?"

Denise Krusenoski: Great question, Candace. You should abstract both prophylaxes. Note: When abstracting from the data element VTE prophylaxis states abstract all VTE prophylaxes that was administered on the day of or the day after hospital admission, for the day of and the day after, if you have surgery, for surgeries that only start on the day over the day after hospital admission.

If no prophylaxis was administered, of course, you would select "A."

Candace Jackson: Thank you, Denise. And next question, "If the patient has aspirin administered on the day of admission but then has SCDs placed later on that day, do I abstract aspirin?"

Denise Krusenoski: Well, that's a very common question because aspirin can be very confusing in this measure, but it's actually very straightforward. Yes, you would abstract all VTE prophylaxes again, just like I noted in the above data element, VTE prophylaxis. You do abstract aspirin. In the algorithm, any acceptable allowable value used with aspirin will move to the measure.

Candace Jackson: And my next question, "What if my patient has only aspirin administered?"

Denise Krusenoski: Well, then you would abstract Allowable Value 9, which is aspirin. The algorithm will move the record to the data element, Reason for No VTE Prophylaxis. Then, the abstract will have to determine if there was a reason indicated in the chart. So, aspirin is essentially not viewed as prophylaxis in the measure.

Candace Jackson: "And can I use VTE prophylaxis that was administered in the ER?"

Denise Krusenoski: No, you can't. In the data element, VTE Prophylaxis Date, suggested data questions state that what date was the VTE Prophylaxis Administered after Hospital Admission. So, you really only have to look at after hospital admission. Only abstract prophylaxis administered or applied after that hospital admission.

Candace Jackson: And Denise, we got quite a few questions in the queue related to slide 19. "Is it correct, ambulation counts as a reason for no VTE prophylaxis?"

Denise Krusenoski: Yes, in the data element, Reason for No VTE Prophylaxis, ambulation must be tied to the wording VTE prophylaxis, or Reason for No VTE Prophylaxis for that ambulation, is an acceptable reason for no VTE prophylaxis.

Candace Jackson: Okay, and we have quite a few more questions that we will try to address as many as we can. "If the VTE scoring is done by our hospital is high, for example, eight, and the physician says low-risk, which would you use?"

Denise Krusenoski: You would use the physician documentation, low-risk.

Candace Jackson: Okay,and this is for Reason for Discontinuation of Parental Anticoagulant Therapy. "If [a] patient received only three or four days of overlap therapy and the INR is 2.5 and [the] patient does not have any risk of bleeding or any reason listed in the manual, where are acceptable reasons – what are acceptable reasons for discontinuing parental anticoagulant?"

Denise Krusenoski: Well, I did allude in one of my slides that explicit documentation must be in there. There is no set list of acceptable reasons

because we would want to leave that open to physician preference. However, it must be linked with the discontinuation of the parental therapy.

Candace Jackson: All right. Next question, "If a patient has a CT of the abdomen and pelvis with IV contrast, and the result was that findings were suspicious for acute pulmonary embolism involving segmental branch of the right lower lobe, does that constitute a reason?"

Denise Krusenoski: In my slide, see, it's 28 for me which might not be – might be a little different for you since we have different number of the slides, if the record indicates only a radiology report and that report is questionable regarding whether the patient had the VTE, you would select "No." So, in the example provided, it sounds like all they have is a CT of contrast, and it's questionable, so you would select "No."

Candace Jackson: Okay, and "Did you say an addendum is not acceptable for a reason for discontinuation of anticoagulation therapy?"

Denise Krusenoski: Yes, that is correct. An addendum is not acceptable.

Candace Jackson: "Is it acceptable for the doctor to document Discontinue Heparin: Patient is Therapeutic?"

Denise Krusenoski: No, that is no longer acceptable. Therapeutic INR or an INR of 2.0 to 3.0 requires additional documentation.

Candace Jackson: Next question, "Reason for – and this is for Reason for Discontinuation of Parental Therapy is another example – another example of acceptable documentation that the patient is changed to another form of oral therapy, for example, Xarelto?

Denise Krusenoski: Xarelto would have to be administered prior to discharge. Xarelto and Eliquis need to be administered. Plan for switching the patient to other anticoagulation therapy is not acceptable.

Candace Jackson: **"**And in this scenario, you gave of the INR 3, is this in an automatic reason, for reason for Parental Therapy discontinuation?"

Denise Krusenoski: Yes, if an INR is greater than three and is documented by the physician, it is automatically acceptable.

Candace Jackson: Next question, "For overlap therapy, if the INR is greater than 3.0, is Discontinuation of Parental Therapy okay?"

Denise Krusenoski: Yes, similar to the last question, yes. Discontinuation is acceptable.

Candace Jackson: And up for a follow up, "Did the INR level change to 3.0? We thought it was 2.0."

Denise Krusenoski: Well, the ACCP Guideline dictates that 3.0 is the threshold for supratherapeutic INR and so – and has not changed. That follows the ACCP Guideline.

Candace Jackson: "Does Xarelto have to be administered during the encounter or can it simply be prescribed at discharge?"

Denise Krusenoski: No, Xarelto and Eliquis both have to be administered during the encounter.

Candace Jackson: "Is Xarelto, Eliquis administration required or needed to pass or in clarification to that, is – has no link required?"

Denise Krusenoski: No link is required. Just administration of the drug is sufficient.

Candace Jackson: "Please clarify, do we need explicit documentation if patient is discharged on Xarelto as long as it is part of the discharge medication?"

Denise Krusenoski: To me that sounds like if it's part of the discharge medication, it's not present on INR form or medication administration record. So, I would say that that would not be sufficient. It needs – there needs to be evidence that the medication was administered.

Candace Jackson: Thank you. And the next question, "Can you give an example of an acceptable documentation to discontinue parental discontinuation for patients with less than five days, even if MD documented INR 2.5, patient therapeutic and discharge discontinue Lovenox?"

Denise Krusenoski: Well, as I stated in the slide, if the INR is only 2.5, that patient is still at risk for clotting and still requires protection for the recommended five days by the ACCP Guideline. So, unless the patient – risk of bleeding – outweighs the benefits of

anticoagulation, would be the really only acceptable discontinuation. So, I would say an example would be I put in the slide, intracranial hemorrhage, any kind of rectal bleeding, GI bleeding, those would all be reasons, acceptable reasons why you would discontinue Parental Therapy when you have a therapeutic INR, but you don't have five days of overlap therapy yet.

Candace Jackson: And I just want to remind people that all of the Qa&As will be responded to and posted on the Quality Reporting Center website and eventually, to *QualityNet*. So, if we do not get to your question today, it will be answered in the near future.

Next question, "Does the refusal of one prophylaxis by a patient or family member cover all prophylaxes?"

Denise Krusenoski: Yes, refusal of one prophylaxis covers all prophylaxes and the data element, Reason for No VTE Prophylaxis.

Candace Jackson: Okay, "Is Heparin flush given within 24 hours of arrival an acceptable reason for – is this acceptable for VTE prophylaxis?"

Denise Krusenoski: No, Heparin is only given subcutaneously and that is found in Appendix H Table 2.1.

Candace Jackson: "When (stating to) the day after admission, does that mean through the end of the day after admission, for example, midnight, or does it mean the day, the actual day after admission?"

Denise Krusenoski: That means the day after admission, the calendar day after admission.

Candace Jackson: Next question, "If DVT was diagnosis – was diagnosed, but age of the clot cannot be defined, how would we answer VTE Confirmed?"

Denise Krusenoski: That's a difficult one, because you know if it's sub-acute or chronic, we don't want to accept it into the measure. We would select "No." So, with age undetermined, I would still say that that's a questionable report. So, I would say going back to, again, slide number 28, if it's a questionable report, then you would select "No" and the radiology report is all you have.

Candace Jackson: And this one is related to slide 15, I'm not sure. Can we go to slide 15? And the question, "Is overlap, if it's less than five days with no reason for no overlap, Lovenox at discharge – how is this a 'Yes?' If overlap is less than five days with no reason for no Lovenox at discharge, how is this a 'yes?'"

Denise Krusenoski: Because the Xarelto was administered on the day of discharge. So, if Xarelto was administered, you may select "Yes" to automatic reason.

Candace Jackson: Okay, and this next question is in relation to slide 23. We'll let them get to slide 23. Okay, the example on slide 23 explains the Present on Admission of a VTE. "That isn't part of overlap therapy, right?"

Denise Krusenoski: That's correct. This is the explanation of VTE Present on Admission, [a] separate data element.

Candace Jackson: And a next question, "If VTE prophylaxis is not given, if the patient is combative, is that an allowable reason as the same as if the patient refused?"

Denise Krusenoski: It has to be documented as patient refusal.

Candace Jackson: And we have time for just a couple of more questions here – And the next question is, "If the patient refuses pharmacological, then that is a reason for no prophylaxis. The physician doesn't need then to order mechanical, is that correct?"

Denise Krusenoski: That is correct. Any refusal of any of the VTE prophylaxis medication counts for a yes in the data element Reason for No VTE Prophylaxis.

Candace Jackson: And on the ambulation question that we covered earlier, "Is it acceptable for the nurse to document if the patient is ambulating? Can you take the nurse's documentation?"

Denise Krusenoski: No, you must take physician documentation, provider documentation, physician/APN/PA, pharmacist –

Candace Jackson: And next question, "Can we start inferring the reason the VTE prophylaxis was not given if the patient is a bilateral amputee?"

Denise Krusenoski: No, that still must be documented.

Candace Jackson: Okay, and we have time for one more question. "Many times you have referred to an automatic reason. Does that mean a link is not required?"

Denise Krusenoski: I'm sorry, yes, that's what I mean for an automatic reason, meaning that specific explicit documentation does not need to be noted in the chart. An example would have been the Xarelto. If the Xarelto is administered, it's an automatic reason. The physician does not need to document reason for discontinuation, administration of Xarelto.

Candace Jackson: Okay, and Denise, we thank you again for your expertise. You've provided much valuable information today. And we would now like to thank everyone for participating in our webinar and hope that you have learned something beneficial from this webinar. We hope that you enjoy the rest of your day. Thank you very much.

Denise Krusenoski: Thank you, Candace.

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