



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0372

Corresponding Measures: 0372e

De.2. Measure Title: Intensive Care Unit Venous Thromboembolism Prophylaxis

Co.1.1. Measure Steward: The Joint Commission

De.3. Brief Description of Measure: This measure assesses the number of patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer). This measure is part of a set of six prevention and treatment measures that address VTE (VTE-1: VTE Prophylaxis, VTE-3: VTE Patients with Anticoagulation Overlap Therapy, VTE-4: VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring by Protocol, VTE-5: VTE Warfarin Therapy Discharge Instructions and VTE-6: Hospital Acquired Potentially-Preventable VTE).

1b.1. Developer Rationale: VTE remains a major patient safety concern for hospitalized patients. Approximately two-thirds of all VTE events are associated with recent hospitalization. VTE has been identified as the most common preventable cause of hospital death and as many as three-quarters of all VTE-related deaths may be related to hospitalization. In a review of evidence-based patient safety practices, the Agency for Healthcare Research and Quality defined thromboprophylaxis against VTE as the "number one patient safety practice" for hospitalized patients. Updated "safe practices" published by the National Quality Forum (NQF) recommend routine evaluation of hospitalized patients for risk of VTE and use of appropriate prophylaxis. While the majority of VTE cases are associated with recent hospitalization, a substantial number of these patients develop their clinical manifestations of VTE after hospital discharge. For some conditions such as operations for total hip replacement or in those patients undergoing surgery and subsequent treatment of malignancy, the risk for development of VTE may be present for as many as six weeks after hospital discharge.

It is also well known that despite the publication and widespread dissemination of multiple guidelines for the prevention and management of VTE, clinical practices in hospitals have not changed at an acceptable pace and multiple studies that have included the audit of hospital records of medical and surgical patients continue to show underuse of VTE prophylaxis. Underuse of prophylaxis or inappropriate treatment can be associated with well-known complications of VTE. Up to 30% of patients will suffer a recurrent episode of VTE within 10 years of a first event and 28-30% of adults will develop the post-thrombotic syndrome within 20 years of their VTE diagnosis.

This measure will assist health care organizations (HCOs) to track evidence of assessment and prophylaxis administration to the target population, therefore decreasing incidence of preventable VTE formation in their ICU inpatient population.

S.4. Numerator Statement: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:

- the day of or the day after ICU admission (or transfer)
- the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)

S.6. Denominator Statement: Patients directly admitted or transferred to ICU

S.8. Denominator Exclusions: • Patients less than 18 years of age

- Patients who have a hospital length of stay (LOS) less than two days and greater than 120 days
- Patients with Comfort Measures Only documented on day of or day after hospital arrival
- Patients enrolled in clinical trials related to VTE
- Patients with ICU LOS less than one day without VTE prophylaxis administered and documentation for no VTE prophylaxis
- Patients with ICD-9-CM Principal or Other Diagnosis Code of Obstetrics or VTE as defined in Appendix A, Table 7.02, 7.03, or 7.04
- Patients with ICD-9-CM Principal Procedure Code of Surgical Care Improvement Project (SCIP) VTE selected surgeries as defined in

Appendix A, Tables 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, 5.24 that start the day of or the day after ICU admission or transfer.
De.1. Measure Type: Process S.17. Data Source: Electronic Health Data, Electronic Health Records, Other, Paper Medical Records S.20. Level of Analysis: Facility, Other
IF Endorsement Maintenance – Original Endorsement Date: May 15, 2008 Most Recent Endorsement Date: Aug 09, 2012
IF this measure is included in a composite, NQF Composite#/title: IF this measure is paired/grouped, NQF#/title: De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable

1. Evidence, Performance Gap, Priority – Importance to Measure and Report
Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.
1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 0372_Evidence_MSF5.0_Data.doc 1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission? Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.
1b. Performance Gap Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating: <ul style="list-style-type: none"> considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or Disparities in care across population groups. 1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure) <i>If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.</i> VTE remains a major patient safety concern for hospitalized patients. Approximately two-thirds of all VTE events are associated with recent hospitalization. VTE has been identified as the most common preventable cause of hospital death and as many as three-quarters of all VTE-related deaths may be related to hospitalization. In a review of evidence-based patient safety practices, the Agency for Healthcare Research and Quality defined thromboprophylaxis against VTE as the "number one patient safety practice" for hospitalized patients. Updated "safe practices" published by the National Quality Forum (NQF) recommend routine evaluation of hospitalized patients for risk of VTE and use of appropriate prophylaxis. While the majority of VTE cases are associated with recent hospitalization, a substantial number of these patients develop their clinical manifestations of VTE after hospital discharge. For some conditions such as operations for total hip replacement or in those patients undergoing surgery and subsequent treatment of malignancy, the risk for development of VTE may be present for as many as six weeks after hospital discharge. It is also well known that despite the publication and widespread dissemination of multiple guidelines for the prevention and management of VTE, clinical practices in hospitals have not changed at an acceptable pace and multiple studies that have included the audit of hospital records of medical and surgical patients continue to show underuse of VTE prophylaxis. Underuse of prophylaxis or inappropriate treatment can be associated with well-known complications of VTE. Up to 30% of patients will suffer a recurrent episode of VTE within 10 years of a first event and 28-30% of adults will develop the post-thrombotic syndrome within 20 years of their VTE diagnosis. This measure will assist health care organizations (HCOs) to track evidence of assessment and prophylaxis administration to the target population, therefore decreasing incidence of preventable VTE formation in their ICU inpatient population.
1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is

required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Despite its proven effectiveness, rates of appropriate thromboprophylaxis remain low in both medical and surgical patients. A recent analysis from the ENDORSE survey, which evaluated prophylaxis rates in 17,084 major surgery patients, found that more than one third of patients at risk for VTE (38%) did not receive prophylaxis and that rates varied by surgery type. Other studies of patients receiving thromboprophylaxis have shown that the regimens often do not follow guideline recommendations and do not continue for the recommended time. A more recent study in 33 academic medical centers demonstrated that only 48% of patients received guideline-directed prophylaxis (59% were medical and 41% were surgical patients). VTE history was more common among medical patients with guideline-directed prophylaxis. Surgical patients admitted from the emergency department and with higher illness severity were more likely to receive appropriate prophylaxis.

Based on 5 quarters of data reported to The Joint Commission, VTE-2 has an aggregate performance rate of 87.9 %, indicating a potential performance gap of 12.1 %. There is no reportable benchmark to compare the performance rate. Since this measure was introduced nationally in 2009, aggregate performance has improved. VTE-2 began with 2009 Quarter 4 reporting data at 75.1 % or a performance gap of 24.9 %, There has been consistent improvement in aggregate performance rates for the following consecutive four quarters, with the most recent 2010 Quarter 4 reportable performance at 93.7 %.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

1. Tapson VF, Hyers TM, Waldo AL, et al. Antithrombotic therapy practices in US hospitals in an era of practice guidelines. Arch Intern Med. 2005;165:1458-1464.
2. Cohen AT, Tapson VF, Bergmann JF, et al. Venous thromboembolism risk and prophylaxis in the acute hospital care setting (ENDORSE study): a multinational cross-sectional study. Lancet. 2008;371:387-394.
3. Amin A, Spyropoulos AC, Dobesh P, et al. Are hospitals delivering appropriate VTE prevention? The venous thromboembolism study to assess the rate of thromboprophylaxis (VTE start). J Thromb Thrombolysis. 2010; 29:326-339.
4. Goldhaber SZ, Tapson VF; DVT FREE Steering Committee. A prospective registry of 5,451 patients with ultrasoundconfirmed deep vein thrombosis. Am J Cardiol. 2004; 93:259-262.
5. Kakkar AK, Cohen AT, Tapson VF, et al; ENDORSE Investigators. Venous thromboembolism risk and prophylaxis in the acute care hospital setting (ENDORSE survey): findings in surgical patients. Ann Surg. 2010;251:330-338.
6. Schleyer AM, Schreuder AB, Jarman KM, et al. Adherence to guideline-directed venous thromboembolism prophylaxis among medical and surgical inpatients at 33 academic medical centers in the United States. Am J Med Qual. 2011; 26:174-80.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

There are few data published on racial differences in use of VTE prophylaxis. A single study from a University hospital in Hawaii showed that Japanese patients were less likely to receive VTE prophylaxis than other racial groups. However this is not likely representative of practice in most US hospitals and may be appropriate based on their lower risk for VTE events.

There are robust data on racial differences in rates of VTE based on race/ethnicity. In most studies African American men have higher rates of VTE than white patients, and this seems to be particularly true when exposed to a provoking risk factor such as surgery. The lowest rates of VTE are seen in patients of Asian/Pacific Islander decent.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

1. Gelber RP, Seto TB. Patient ethnicity and use of venous thromboembolism prophylaxis. Int J Qual Health Care. 2006; 18:23-9.
2. White RH, Keenan CR. Effects of race and ethnicity on the incidence of venous thromboembolism. Thromb Res. 2009; 123 suppl 4:S11-7.
3. Stein PD, Matta F. Epidemiology and incidence: the scope of the problem and risk factors for development of venous thromboembolism. Clin Chest Med. 2010; 31:611-28.

4. Heit JA, Beckman MG, Bockenstedt PL, et al. Comparison of characteristics from White- and Black-Americans with venous thromboembolism: a cross-sectional study. *Am J Hematol.* 2010; 85:467-71.
5. Tang Y, Sampson B, Pack S, et al. Ethnic differences in out-of-hospital fatal pulmonary embolism. *Circulation.* 2011; 123:2219-25.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

Primary Prevention

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk, Populations at Risk : Individuals with multiple chronic conditions

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures/

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population,

i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:

- the day of or the day after ICU admission (or transfer)
- the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Seven data elements are used to calculate the numerator:

1. Anesthesia Start Date The date the anesthesia for the procedure started.
2. ICU VTE Prophylaxis The type of venous thromboembolism (VTE) prophylaxis that was initially administered in the ICU. Allowable values: 1 - 8 or A – None of the above, not documented or UTD.
3. ICU VTE Prophylaxis Date The day, month and year that the initial VTE prophylaxis (mechanical and/or pharmacologic) option was administered after admission/transfer to the intensive care unit (ICU).
4. Reason for No VTE Prophylaxis – ICU Admission Documentation why mechanical or pharmacologic VTE prophylaxis was not administered at ICU admission/transfer. Allowable values: Yes or No
5. Reason for Oral Factor Xa Inhibitor- ICU Admission: Documentation of an Oral Factor Xa Inhibitor use for VTE Prophylaxis. Allowable Values: Yes or No
6. Surgery End Date – ICU Admission The date the surgical procedure ended after ICU admission or transfer.
7. Surgical Procedure – ICU Admission A surgical procedure was performed using general or neuraxial anesthesia the day of or the day after ICU admission or transfer. Allowable values: Yes or No/UTD.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

Patients directly admitted or transferred to ICU

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Eleven data elements are used to calculate the denominator:

1. Admission Date – The month, day and year of admission to acute inpatient care.
2. Birthdate - The month, day and year the patient was born.
3. Clinical Trial - Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied. Allowable values: Yes or No/UTD
4. Comfort Measures Only - Physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation of comfort measures only. Commonly referred to as “palliative care” in the medical community and “comfort care” by the general public. Palliative care includes attention to the psychological and spiritual needs of the patient and support for the dying patient and the patient’s family. Comfort Measures Only are not equivalent to the following: Do Not Resuscitate (DNR), living will, no code, no heroic measure. Allowable values represent the earliest physician/APN/PA documentation: Day 0 or 1, Day 2 or after, Timing unclear or Not Documented/UTD.
5. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.
6. ICD-9-CM Other Diagnosis Codes - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.
7. ICD-9-CM Principal Diagnosis Code - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.

8. ICD-9-CM Principal Procedure Code - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

9. ICU Admission or Transfer Date - The day, month and year that the order was written for the patient to be directly admitted or transferred (from a lower level of care) to the intensive care unit (ICU).

10. ICU Admission or Transfer - Documentation that the patient was admitted or transferred to the intensive care unit (ICU) at this hospital. The definition of an ICU for the purpose of the measures noted above is that used by the CDC in the NHSN Patient Safety Project. An intensive care unit can be defined as a nursing care area that provides intensive observation, diagnosis, and therapeutic procedures for adults and/or children who are critically ill. An ICU excludes nursing areas that provide step-down, intermediate care or telemetry only and specialty care areas. Allowable values: Yes, No, or UTD.

11. ICU Discharge Date - The day, month and year that the order was written to discharge the patient from the intensive care unit (ICU), left against medical advice (AMA) or expired.

Please note: The majority of general data elements that are missing data cause the EOC record to be rejected.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

- Patients less than 18 years of age
- Patients who have a hospital length of stay (LOS) less than two days and greater than 120 days
- Patients with Comfort Measures Only documented on day of or day after hospital arrival
- Patients enrolled in clinical trials related to VTE
- Patients with ICU LOS less than one day without VTE prophylaxis administered and documentation for no VTE prophylaxis
- Patients with ICD-9-CM Principal or Other Diagnosis Code of Obstetrics or VTE as defined in Appendix A, Table 7.02, 7.03, or 7.04
- Patients with ICD-9-CM Principal Procedure Code of Surgical Care Improvement Project (SCIP) VTE selected surgeries as defined in Appendix A, Tables 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, 5.24 that start the day of or the day after ICU admission or transfer.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

- The patient age in years is equal to the Admission Date minus the Birthdate. The month and day portion of the admission date and birthdate are used to yield the most accurate age. Patients less than 18 years are excluded.
- Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is greater than 120 days or equal to or less than 2 days, the patient is excluded.
- Patients with Comfort Measures Only allowable value of 1 (Day 0 or 1) are excluded.
- Patients are excluded if “Yes” is selected for Clinical Trial.
- The data element ICU Admission or Transfer is used to determine if the patient was admitted to the ICU. If “Yes” is selected, the case flows to the ICU Admission or Transfer Date and ICU Discharge Date. The ICU Admission and ICU Discharge Date are used to determine if the patient was in the ICU for one or more days. If the ICU LOS is less than one day, the patient is excluded from VTE-2.
- Patients with ICD-9-CM Principal or Other Diagnosis Codes of Obstetrics or VTE are excluded.
- Patients with ICD-9-CM Principal Procedure Code of Surgical Care Improvement Project (SCIP) VTE selected surgeries are excluded if the surgery started the day of or the day after ICU admission or transfer.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

Not Applicable, the measure is not stratified.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

1. Start processing. Run cases that are included in the VTE Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.

3. Check Length of Stay

a. If Length of Stay is less than 2 days, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

b. If Length of Stay is greater than or equal to 2 days, continue processing and proceed to ICD-9-CM Principal or Other Diagnosis Code.

4. Check ICD-9-CM Principal or Other Diagnosis Code

a. If at least one of the ICD-9-CM Principal or Other Diagnosis Code is on Table 7.02, 7.03, or 7.04, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

b. If none of the ICD-9-CM Principal or Other Diagnosis Code is on Table 7.02, 7.03, or 7.04, continue processing and proceed to Comfort Measures Only.

5. Check Comfort Measures Only

a. If Comfort Measures Only is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Comfort Measures Only equals 1, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If Comfort Measures Only equals 2, 3, or 4, continue processing and proceed to Clinical Trial.

6. Check Clinical Trial

a. If Clinical Trial is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Clinical Trial equals Yes, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If Clinical Trial equals No, continue processing and proceed to ICU Admission or Transfer.

7. Check ICU Admission or Transfer

a. If ICU Admission or Transfer is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If ICU Admission or Transfer is equal to 2 or 3, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If ICU Admission or Transfer is equal to 1, continue processing and proceed to ICU Admission or Transfer Date.

8. Check ICU Admission or Transfer Date

a. If ICU Admission or Transfer Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If ICU Admission or Transfer Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

c. If ICU Admission or Transfer Date equals a Non Unable to Determine Value, continue processing and proceed to the ICD-9-CM Principal Procedure Code.

9. Check ICD-9-CM Principal Procedure Code

a. If ICD-9-CM Principal Procedure Code is on Tables 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, or 5.24, the case will proceed to Anesthesia

Start Date.

b. If ICD-9-CM Principal Procedure Code is missing or not on Tables 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, or 5.24, the case will proceed to step 13 and check ICU Discharge Date.

10. Check Anesthesia Start Date

a. If Anesthesia Start Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Anesthesia Start Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

c. If Anesthesia Start Date equals a Non Unable to Determine Value, continue processing and proceed to the ICU Initial Surgery Day calculation.

11. Calculate ICU Initial Surgery Day. ICU Initial Surgery Day, in days, is equal to the Anesthesia Start Date minus the ICU Admission or Transfer Date.

12. Check ICU Initial Surgery Day

a. If ICU Initial Surgery Day is less than or equal to 1 day, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

b. If Initial Surgery Day is greater than or equal to 2 days, continue processing and proceed to ICU Discharge Date.

13. Check ICU Discharge Date

a. If ICU Discharge Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If ICU Discharge Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

c. If ICU Discharge Date equals a Non Unable to Determine Value, continue processing and proceed to the ICU VTE Prophylaxis.

14. Check ICU VTE Prophylaxis

a. If ICU VTE Prophylaxis is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If ICU VTE Prophylaxis is only equal to A, continue processing and proceed to Reason for No VTE Prophylaxis – ICU Admission.

c. If ICU VTE Prophylaxis is equal to 1, 2, 3, 4, 5, 6, 7 or 8, continue processing and proceed to step 18 and recheck ICU VTE Prophylaxis.

15. Check Reason for No VTE Prophylaxis – ICU Admission

a. If Reason for No VTE Prophylaxis – ICU Admission is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Reason for No VTE Prophylaxis – ICU Admission equals Yes, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.

c. If Reason for No VTE Prophylaxis – ICU Admission equals No, continue processing and proceed to the ICU LOS calculation.

16. Calculate ICU LOS. ICU LOS is equal to ICU Discharge Date minus ICU Admission or Transfer Date.

17. Check ICU LOS

a. If ICU LOS is less than zero days, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If ICU LOS is equal to zero days, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Stop processing.

c. If ICU LOS is greater than or equal to 1 day, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

18. Recheck ICU VTE Prophylaxis

a. If ICU VTE Prophylaxis is only equal to 8, continue processing and proceed to check Reason for Oral Factor Xa Inhibitor – ICU Admission.

1. If Reason for Oral Factor Xa Inhibitor – ICU Admission is missing, the case will proceed to a Measure Category Assignment of X and

will be rejected. Stop processing.

2. If Reason for Oral Factor Xa Inhibitor – ICU Admission equals No, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

3. If Reason for Oral Factor Xa Inhibitor – ICU Admission equals Yes, the case will proceed to check ICU VTE Prophylaxis Date.

b. If any ICU VTE Prophylaxis is equal to 1,2,3,4,5,6 or 7, continue processing and proceed to check ICU VTE Prophylaxis Date.

19. Check ICU VTE Prophylaxis Date

a. If ICU VTE Prophylaxis Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If ICU VTE Prophylaxis Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

c. If ICU VTE Prophylaxis Date equals a Non Unable to Determine Value, continue processing and proceed to the ICU Initial Prophylaxis Day calculation.

20. Calculate ICU Initial Prophylaxis Day. ICU Initial Prophylaxis Day, in days, is equal to ICU VTE Prophylaxis Date minus ICU Admission or Transfer Date.

21. Check ICU Initial Prophylaxis Day

a. If ICU Initial Prophylaxis Day is less than zero days, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If ICU Initial Prophylaxis Day is equal to zero days or 1 day, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.

c. If ICU Initial Prophylaxis Day is greater than or equal to 2 days, continue processing and proceed to Surgical Procedure – ICU Admission.

22. Check Surgical Procedure – ICU Admission

a. If Surgical Procedure ICU Admission is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Surgical Procedure ICU Admission equals No, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

c. If Surgical Procedure ICU Admission equals Yes, continue processing and proceed to Surgery End Date - ICU Admission.

23. Check Surgery End Date - ICU Admission

a. If Surgery End Date - ICU Admission is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

b. If Surgery End Date - ICU Admission equals Unable to Determine, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

c. If Surgery End Date - ICU Admission equals a Non Unable to Determine Value, continue processing and proceed to the ICU Initial Surgical Prophylaxis Day calculation.

24. Calculate ICU Initial Surgical Prophylaxis Day. ICU Initial Surgical Prophylaxis Day, in days, is equal to the ICU VTE Prophylaxis Date minus Surgery End Date - ICU Admission.

25. Check ICU Initial Surgical Prophylaxis Day

a. If ICU Initial Surgical Prophylaxis Day is greater than or equal to 2 days, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing.

b. If ICU Initial Surgical Prophylaxis Day is equal to zero days or 1 day, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.

c. If ICU Initial Surgical Prophylaxis Day is less than 0 days, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

The global Initial Patient Population includes patients admitted for inpatient acute care. Patients with no ICD-9-CM Principal or Other Diagnosis Code defined in Appendix A, Tables 7.02, 7.03 and 7.04, a patient age (Admission Date minus Birthdate) greater than or equal to 18 years and a length of stay less than or equal to 120 days. Hospitals that choose to sample have the option of sampling quarterly or monthly. The sample is taken randomly as follows for a monthly sample:

- Average monthly Initial Patient Population > or = 296 results in a minimum random sample size of 60
- Average monthly Initial Patient Population of 76 – 295 results in a random sample of 20% of the population size
- Average monthly Initial Patient Population 15 - 75 results in a random sample of 15
- Average monthly Initial Patient Population < 15: No sampling; 100% population required.

S.16. Survey/Patient-reported data (*If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.*)

Specify calculation of response rates to be reported with performance measure results.

S.17. Data Source (*Check ONLY the sources for which the measure is SPECIFIED AND TESTED*).

If other, please describe in S.18.

Electronic Health Data, Electronic Health Records, Other, Paper Medical Records

S.18. Data Source or Collection Instrument (*Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Each data element in the data dictionary includes suggested data sources.

The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

S.19. Data Source or Collection Instrument (*available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1*)

S.20. Level of Analysis (*Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED*)

Facility, Other

S.21. Care Setting (*Check ONLY the settings for which the measure is SPECIFIED AND TESTED*)

Inpatient/Hospital

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (*Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.*)

2. Validity – See attached Measure Testing Submission Form

[0372_MeasureTesting_MS5.0_Data.doc](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry), Other
If other: Data elements like admission date and discharge date can be generated from an administrative source.

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

ALL data elements are in defined fields in electronic health records (EHRs)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

If instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Although this measure has been specified for electronic data collection via the meaningful use of EHR program, at the present time, hospitals using this performance measure generally collect measure data via manual review of the paper medical record. Collected

data are submitted to The Joint Commission on a quarterly basis, by way of contracted performance measurement system vendors, as described previously. Specifications for this measure are freely available to anyone who wishes to use the measure. Feedback from hospitals using this measure indicates that required data elements are generally available in the medical record, and measure specifications are robust and easy to understand. As described above, as feedback from measure users has indicated the need for clarification or revision of measure specifications, this has taken place.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	
Regulatory and Accreditation Programs	
Quality Improvement (Internal to the specific organization)	

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4a2.2.2. Summarize the feedback obtained from those being measured.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

Originally, VTE prophylaxis administered at hospital or ICU admission was determined based on the date and time of administration compared to hospital or ICU admission, but we soon realized that ICU specific data elements should be added to more reliably distinguish VTE prophylaxis administered in ICU and be able to evaluate prophylaxis administration if patients were in both settings. In response, new data elements were created specifically for the ICU setting: ICU VTE Prophylaxis, ICU VTE Prophylaxis Date, Surgery End Date-ICU Admission, and Surgical Procedure-ICU Admission. In general, the Notes for Abstraction section of the data element are clarified after review of the frequent questions and repeated feedback received from various sources.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same

target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0217 : Surgery Patients with Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered

0217 : Surgery Patients with Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered

0218 : Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

0218 : Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

0239 : Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis

0239 : Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

Measures 0217, 0218, are SCIP measures (Surgical Care Improvement Project). They are part of the Centers for Medicare & Medicaid Services/The Joint Commission aligned measures related to the administration of VTE prophylaxis for hospital inpatients and are harmonized with 0372 to the extent that the measures utilize some of the same data elements. The target population for 0217 and 0218 is surgical inpatients within a select group of surgical procedures. The target population for 0372 differs in that it includes patients admitted or transferred to intensive care with the exception of those captured in measures 0217 and 0218. Measure 0239 is a physician performance measure with a targeted population of surgical patients identified through CPT codes and could extend to the outpatient setting. This measure evaluates physician practice as opposed to hospital processes.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Not Applicable

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or

methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [The Joint Commission](#)

Co.2 Point of Contact: [JohnMarc, Alban, jalban@jointcommission.org, 630-792-5304-](#)

Co.3 Measure Developer if different from Measure Steward: [The Joint Commission](#)

Co.4 Point of Contact: [Jerod M., Loeb, jloeb@jointcommission.org, 630-792-5920-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

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The technical advisory panel (TAP) members determined priority areas that could be evaluated to improve care related to prevention and treatment for VTE during the development timeframe. Public comments and hospital feedback was reviewed during the testing phases of the project to assist the TAP in making the final measure recommendations. After implementation, minor revisions, acknowledged by TAP representatives, were made to improve clarity.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2009

Ad.3 Month and Year of most recent revision: 07, 2011

Ad.4 What is your frequency for review/update of this measure? Biannual

Ad.5 When is the next scheduled review/update for this measure? 01, 2012

Ad.6 Copyright statement: The Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual) is the result of the collaborative efforts of the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission to publish a uniform set of national hospital quality measures. A primary objective of this collaborative effort is to promote and enhance the utility of these measures for all hospitals.

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: