Release Notes for the 2020B Manual

Measure Information Forms

Section	Rationale	Description
ACHFOP-04	Correct typo in the measure name.	Name **Change** from: Hosptial Outpatient New York Heart Association (NYHA Classification Assessment) **To:** Hospital Outpatient New York Heart Association (NYHA Classification Assessment)
CSTK-03	A denominator exclusion statement was revised to better align with the algorithm.	Denominator Excluded Populations (list) **Change** from: • Patients with admitting diagnosis of traumatic brain injury (TBI), unruptured arteriovenous malformation (AVM), and non-traumatic subdural hematoma *(ICD-10-CM Other Diagnosis Codes* as defined in Appendix A, Table 8.2f for ICD-10 codes) **To:** • Patients with traumatic brain injury (TBI), unruptured arteriovenous malformation (AVM), and non-traumatic subdural hematoma *(ICD-10-CM Other Diagnosis Codes* as defined in Appendix A, Table 8.2f for ICD-10 codes)
CSTK-05	Risk adjustment has been suspended as of January 1, 2020.	Risk Adjustment: **Change** from: Yes **To**: Suspended Risk Adjustment Notes: **Change** from: This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET). **To**: This section has been moved to the ORYX Risk Adjustment Guide. The guide is available to the public on the Joint Commission's website.

CSTK-08	Risk Adjustment has been suspended as of January 1, 2020.	Risk Adjustment **Change** from: Yes **To**: Suspended Risk Adjustment Notes: **Change** from: This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET). **To**: This section has been moved to the ORYX Risk Adjustment Guide. The guide is available to the public on the Joint Commission's website.
CSTK-10	Risk Adjustment has been suspended as of January 1, 2020. The measure information has been updated to provide stratified rates based on documentation of a mRS prior to the acute stroke event.	Risk Adjustment **Change** from: Yes **To**: Suspended Risk Adjustment Notes: **Change** from: This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET). **To**: This section has been moved to the ORYX Risk Adjustment Guide. The guide is available to the public on the Joint Commission's website. Changes throughout the Measure Information Form (measure description, numerator statement, numerator data elements, algorithm). Refer to the manual for complete content edits. Algorithm **Add**: Page 3 for strata CSTK-10a and CSTK-10b category assignment. If "Pre-Stroke Modified Rankin Score (mRS)" allowable value is 1 or 3, it goes to "CSTK-10a" and set Measure Category Assignment for strata measure CSTK-10a = Measure Category Assignment for measure CSTK-10. If "Pre-Stroke Modified Rankin Score (mRS)" allowable value is 2, it goes to "CSTK-10b" and set Measure Category Assignment for strata measure CSTK-10b = Measure Category Assignment for measure CSTK-10. If "Pre-Stroke Modified Rankin Score (mRS)" is missing, set Measure Category Assignment for strata measure CSTK-10a and CSTK-10b to "X".

HBIPS-1	Update MIF to reflect measure NQF endorsement status.	Adoption Status (header note) **Remove** NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE
PC-05	PC-05 and PC-06 Initial Patient Population were made the same.	**Algorithm** **Add** Table 11.21 and 11.22 Exclusions that were removed from the Initial Patient Population.
PC-06	Remove tables that are covered by Table Number 11.31: Fetal Conditions.	Denominator Exclusion **Change** from: ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for birth weight < 2500g as defined in Appendix A, Table 11.12, 11.13, 11.14, 11.15, 11.16, 11.20 OR Birth Weight < 2500g **To:** Birth Weight < 2500g
STK-4	The Measure Information Form was updated to reflect new guideline recommendations for thrombolytic therapy.	Selected References **Add**: • Powers WJ, Rabinstein AA, Ackerson T, Adeoye OM, Bambakidis NC, Becker K, Biller J, et al. Guidelines for the Early Management of Patients with Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke. A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. *Stroke*. 2019 Dec;50(12):e344-e418. Rationale **Change** from: The administration of IV alteplase to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. These included two positive randomized controlled trials in the United States: The National Institute of Neurological Disorders and Stroke (NINDS) Studies, Part I and Part II. Based on the results of these studies, the Food and Drug Administration (FDA) approved the use of intravenous alteplase for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV alteplase in patients treated within 3 hours of symptom onset. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment.

The European Cooperative Acute Stroke Study (ECASS) III trial indicated that intravenous rtPA can be given safely to, and can improve outcomes for, carefully selected patients treated 3 to 4.5 hours after stroke; however, as the NINDS investigators concluded, the earlier that IV thrombolytic therapy is initiated, the better the patient outcome. Therefore, the target for IV alteplase initiation remains within 3 hours of time last known well. The administration of IV alteplase beyond 3 hours of stroke symptom onset has not been FDA approved.

Although the benefit of IV alteplase has been well established, only a minority of patients with acute ischemic stroke actually receive this medication across the United States. Recent recommendations from the American Heart Association/American Stroke Association and FDA remove or make less specific many previous contraindications and warnings for therapy.

To:
The administration of IV alteplase to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials (Class I, Level of Evidence A, American Heart Association/American Stroke Association (AHA/ASA), 2019). These included two positive randomized controlled trials in the United States: The National Institute of Neurological Disorders and Stroke (NINDS) Studies, Part I and Part II. Based on the results of these studies, the Food and Drug Administration (FDA) approved the use of intravenous alteplase for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV alteplase in patients treated within 3 hours of symptom onset. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment.

The European Cooperative Acute Stroke Study (ECASS) III trial indicated that intravenous r-tPA (alteplase) can be given safely to, and can improve outcomes for, carefully selected patients treated 3 to 4.5 hours after stroke; however, as the NINDS investigators concluded, the earlier that IV thrombolytic therapy is initiated, the better the patient outcome. Therefore, the target for IV alteplase initiation remains within 3 hours of time last known well. The administration of IV alteplase beyond 3 hours of stroke symptom onset has not been FDA approved.

Although the benefit of IV alteplase has been well established, only a minority of patients with acute ischemic stroke actually receive this medication across the United States, despite the removal of many previous contraindications and warnings for alteplase

		therapy in recent years. Updated recommendations from the AHA/ASA in 2019 identify tenecteplase as a reasonable alternative to alteplase in acute ischemic stroke patients with minor neurological impairment and no major intracranial occlusion (0.4-mg/kg single IV bolus), or who are also eligible to undergo mechanical thrombectomy (0.25-mg/kg single IV bolus, maximum 25 mg). Clinical evidence at this time is unclear whether tenecteplase is as effective as or more effective than alteplase (Class IIb, Level of Evidence BR). The administration of IV tenecteplase for ischemic stroke within or beyond 3 hours of stroke symptom onset has not been FDA approved.
SUB-2	The algorithm is being updated to account for cases in which the patient was not screened for Alcohol Use with a validated tool within the first day of admission. This was previously captured in SUB-1 which was retired 12/31/18. Cases were previously excluded from SUB-2 because they did not pass SUB-1. These cases will no longer be excluded and therefore will not pass SUB-2.	Algorithm **Change** the flow of allowable values 3 and 6 in the data element Alcohol Use Status, from: Category Assignment B **To:** Category Assignment D **Change** the flow of allowable value 4 in the data element Alcohol Use Status, from: Going to the diamond Brief Intervention **To:** Category assignment D
THKR-IP-4	Clarify description and numerator statement.	Description **Change** from: * Percentage of patients who completed the general health and joint specific functional status assessments within 90 days prior to surgery as specified below: **To:** * Patients who completed the general health and joint specific functional status assessments within 90 days prior to surgery as specified below: Numerator Statement **Change** from:

		* Patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days prior to surgery. **To:** * Patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days prior to surgery.
THKR-OP-4	Clarify description and numerator statement.	Description **Change** from: * Percentage of patients who completed the general health and joint specific functional status assessments within 90 days prior to surgery as specified below: **To:** * Patients who completed the general health and joint specific functional status assessments within 90 days prior to surgery as specified below: Numerator Statement **Change** from: * Percentage of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days prior to surgery. **To:** * Patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days prior to surgery.
TOB-2	The algorithm is being updated to account for cases in which the patient was not screened for Tobacco Use within the past 30 days prior to the day of hospital admission. This was previously captured in TOB-1 which was retired 12/31/18. Cases were previously excluded from TOB-2	Algorithm **Change** the flow of allowable value 5 in the data element Tobacco Use Status, from: Category assignment B **To:** Category assignment D

	because they did not pass TOB-1. These cases will no longer be excluded and therefore will not pass TOB-2.	

Data Elements

Section	Rationale	Description
Arrival Date	The data element was updated to provide clarification for abstractors.	Notes for Abstraction last bullet exception **Add** STK-OP
Arrival Time	The data element was updated to provide clarification for abstractors.	Notes for Abstraction last bullet exception **Add** STK-OP
IV Alteplase Initiation	The data element was updated to reflect new guideline recommendations for thrombolytic therapy in acute ischemic stroke.	Inclusion Guidelines for Abstraction **Change** from: **Only Acceptable Thrombolytic Therapy for Stroke:** • Activase • Alteplase • IV t-PA • Recombinant t-PA Tissue plasminogen activator • t-PA Tissue plasminogen activator **To**: **Only FDA-Approved Thrombolytic Therapy for Stroke:** • Activase • Alteplase • IV t-PA • Recombinant t-PA Tissue plasminogen activator • t-PA Tissue plasminogen activator **Reasonable Alternative to Alteplase:** • Tenecteplase • TNK

		• TNKase Exclusion Guidelines for Abstraction **Add:** • Thrombolytic agents other than alteplase or tenecteplase
IV OR IA Alteplase Administered at This Hospital or Within 24 Hours Prior to Arrival	The data element was updated to reflect new guideline recommendations for thrombolytic therapy in acute ischemic stroke.	Inclusion Guidelines for Abstraction **Change** from: **Only Acceptable Thrombolytic Therapy for Stroke:** • Activase • Alteplase • IV t-PA • Recombinant t-PA Tissue plasminogen activator • t-PA Tissue plasminogen activator **To**: **Only FDA-Approved Thrombolytic Therapy for Stroke:** • Activase • Alteplase • IV t-PA • Recombinant t-PA Tissue plasminogen activator • t-PA Tissue plasminogen activator **Reasonable Alternative to Alteplase:** • Tenecteplase • TNK • TNKase Exclusion Guidelines for Abstraction **Add:** • Intra-arterial (IA) tenecteplase • Thrombolytic agents other than alteplase or tenecteplase
LVSD	Clarify removal of table 2.6.	Notes for Abstraction **Add** bullet point* * Do not use narrative descriptions that indicates uncertainty about the patient's EF. E.g. questionable EF of <36%.

		Guideline for Abstraction Section, Exclusion box. **Remove** bullet point: • Any term in Inclusion list A or B described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table
Positive Brain Image	The data element was updated to provide clarification for abstractors.	Inclusion Guidelines for Abstraction **Add:** • Small (e.g., bleed, hemorrhage)
Pre-Stroke Modified Rankin Score (mRS)	The data element was updated for measure stratification and added to the algorithm.	Changes throughout the Data Element. Refer to the manual for complete content edits.
Psychiatric Inpatient Days - Medicare Only	Removal of ORYX vendor references.	Definition: **Remove** statement: ORYX vendors can refer to the Joint Commission's ORYX Technical Implementation Guide for more information.
Psychiatric Inpatient Days-Non-Medicare Only	Removal of ORYX vendor references.	Definition: **Remove** statement: ORYX vendors can refer to the Joint Commission's ORYX Technical Implementation Guide for more information.
Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2	The data element was updated to reflect removal of Appendix H, Table 2.6 from the specifications manual.	Exclusion Guidelines for Abstraction **Remove:** • Antithrombotic medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.
Reason for Not Prescribing **Antithrombotic** Therapy at Discharge	The data element was updated to reflect removal of Appendix H, Table 2.6 from the specifications manual.	Exclusion Guidelines for Abstraction **Remove:** Antithrombotic medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.
Reason for Not Prescribing **Anticoagulation** Therapy at Discharge	The data element was updated to reflect removal of Appendix H, Table 2.6 from the specifications manual.	Exclusion Guidelines for Abstraction **Remove:** Anticoagulant medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.

Reason for Not Prescribing Statin Medication at Discharge	The data element was updated to reflect removal of Appendix H, Table 2.6 from the specifications manual.	Exclusion Guidelines for Abstraction **Remove:** Statin medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.

Supplemental Materials

Section	Rationale	Description
Appendix H - Miscellaneous Tables	To reflect the updated guidelines for treatment of VTE.	**Change** second footnote from: 2 The U.S. Food and Drug Administration has approved Xarelto (rivaroxaban) to reduce the risk of blood clots, deep vein thrombosis (DVT) and pulmonary embolism (PE) following knee or hip replacement surgery only. It is additionally approved: to reduce the risk of stroke in patients with non-valvular atrial fibrillation; for treatment of DVT or PE; to reduce the risk of recurrent DVT and PE following initial treatment. **To:** 2 The U.S. Food and Drug Administration has approved Xarelto (rivaroxaban) for the prevention of venous thromboembolism (VTE) in hospitalized acutely ill medical patients at risk for thromboembolic complications who are not at high risk of bleeding. It is additionally approved: to reduce the risk of deep vein thrombosis (DVT) and pulmonary embolism (PE) following knee or hip replacement surgery; to reduce the risk of stroke in patients with non-valvular atrial fibrillation; for treatment of DVT or PE; to reduce the risk of recurrent DVT and PE following initial treatment.
Table of Contents	Refer to new release 2020B in the pdf file links. Remove PC-03 and PC-04 measures. Rename or Remove some Transmission Sections to reflect change from Transmission of individual cases to upload of aggregate counts for Chart-based measures.	**Change** pdf links to 2020B. **Remove** PC-03 and PC-04 Measures. **Remove** Transmission Data Elements **Change** from: Transmission Data Processing Flow: Clinical **To**: The Joint Commission Clinical Data Processing Flow **Remove** Transmission Data Processing Flow: Population and Sampling

General Release Notes

Rationale	Description
Retire PC-03 (Antenatal Steroids) and PC-04 (Health Care-Associated Bloodstream Infections in Newborns).	**Remove** PC-03 and PC-04 Measures from the manual and related materials. **Remove** Appendix A tables related to the removal of PC-03 And PC-04 : 11.10, 11.10.1, 11.10.2, 11.10.3, 11.12, 11.13, 11.14, 11.15, 11.16, 11.18, 11.19, 11.20 **Remove** Appendix C tables related to the removal of PC-03 and PC-04: 11.01
Unify the Initial Patient Population for PC-05 (Exclusive Breast Milk Feeding) and PC-06 (Unexpected Complications in Term Newborns) with each other to reduce the burden of identifying the population and to align with eMeasure versions.	PC Measure Set Initial Patient Population **Change** so that PC-05 and PC-06 are the same. Move unique logic down into measure(s). **Remove** low birth weight code tables (Tables 11.12, 11.13, 11.14, 11.15, 11.16, 11.20) from Initial Patient Population for PC-06 because all of the codes are included in table 11.31 that also exclude infants from the measure. PC-05 Algorithm **Add** Exclusion from IPP: Length of Stay, Table 11.21 and Table 11.22.
Suspend Risk Adjustment for discharges January 1, 2020 onward. Hospitals will submit aggregate data rather than patient level data.	CSTK-05, CSTK-08 and CSTK-10 MIFs: **Remove** Data Elements from the Risk Adjustment section. Risk Adjustment: **Change** from: 'Yes' **To**: 'Suspended'
Starting with Calendar Year 2020	Remove references to ORYX vendors, submitting patient level data for chart-based measures and data

data, the Joint Commission no longer has contracts with ORYX chart-based vendors for certification or accreditation purposes. Beginning with Calendar Year 2020 and moving forward for chart-based measure data, all hospitals will utilize the DDS Platform for submission of ORYX Performance Measure data used for Accreditation. Hospitals participating in certification programs manually enter their aggregate numerator and denominator data on the Certification Measure Information Process (CMIP) application available on JC Connect®.	transmission throughout the manual.
Chart-based Measure results for accreditation will no longer be transmitted to the Joint Commission for individual cases but instead aggregate counts will be submitted to the Direct Data Submission Platform (DDSP). This led to changes in descriptions of how the data should be processed by the hospital before sending it to the Joint Commission.	Language around Transmission of data was changed to Processing of data for Accreditation Measures.