	2011 Measures	NQF Endorsed Measures	QDS Datatypes (HITEP)	Recommend
1	% diabetics with A1c under control [EP]	Title: Comprehensive Diabetes Care: HbA1c control (<8.0%) Description: The percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). Numerator: Use automated laboratory data to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is <8.0%. The member is not numerator compliant if the automated result for the most recent HbA1c test is = 8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Denominator: Members 18 – 75 years of age with diabetes. There are two methods to identify members with diabetes: pharmacy data and claims/encounter data. The organization must use both to identify the eligible population, but a member only needs to be identified in one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Method 1: Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis Method 2: Claim/encounter data. Members who had two face-to-face encounters with a diagnosis of diabetes on different dates of service in an outpatient setting or nonacute inpatient setting, or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Exclusions: – Members with a diagnosis of polycystic ovaries who did not have any face-to-face encounters with a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year. Diagnosis can occur at any time in the member's history, but must have occurred by December 31 of the measurement year. – Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year. Diagnosis can occur at any time in the member's history, but must have occurred by December 31 of the measurement year. Time Window: The measurement year or year prior to the measurement year. Note: Should capture HbA1c value to enable stratification as well as broad adherence to all individuals <8.0% [OP] Steward: NCQA Endorsed: Under review 11/21/2008	– patient age – active diabetes diagnosis – active gestational diabetes diagnosis – active polycystic ovarian disease diagnosis – steroid induced diabetes active diagnosis – insulin prescription – hypoglycemic medication prescription – antihyperglycemic medication prescription – HbA1c result	Endorsement expected within the next month. For retooling, diabetes on the Problem List (ICD-9 or SNOMED), or Medication List with appropriate medication.
2	% of hypertensive patients with BP under control [EP]	Title Controlling High Blood Pressure* Description: Percentage of patients with last BP < 140/80 mm Hg. Numerator: Patients with last blood pressure measurement adequately controlled to systolic blood pressure < 140 mm Hg and diastolic blood pressure < 80 mm Hg during the measurement year. Denominator: All patients > 18 years of age with a diagnosis of hypertension in the first six months of the measurement year or any time prior. Patient Selection: ICD-9-CM codes for Hypertension: 401.0, 401.1, 401.9, 402.xx, 403.xx, 404.xx A patient is considered to be hypertensive if there is at least one outpatient encounter (outpatient or other outpatient services – 99201-99205, 99211-99215, 99241, 99245) with a diagnosis of hypertension (applicable ICD-9 codes) during the first six months of the measurement year. To confirm the diagnosis of hypertension, notation of the following must be found in the medical record on or before June 30 of the measurement year: • HTN • high blood pressure (HBP) • elevated blood pressure • borderline HTN • intermittent HTN • history of HTN. The notation of hypertension may appear anytime on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded on any of the following documents: • a problem list • office note, • subjective, objective, assessment, plan (SOAP) note, • encounter form, • telephone call record, • diagnostic report, and/or • hospital discharge summary. Statements such as "rule out hypertension," "possible hypertension," "white-coat hypertension,"	– age – hypertension diagnosis – elevated blood pressure diagnosis – borderline hypertension diagnosis – intermittent hypertension diagnosis – history of hypertension – ambulatory encounter – systolic blood pressure result – diastolic blood pressure result	History of hypertension currently from ICD code list. For retooling 'notation' should indicate presence on the Problem List.
3	% of patients with LDL under control [EP]	Title: IVD: Complete Lipid Profile and LDL Control <100 Description: Percentage of patients with a full lipid profile completed during the 12-month measurement period with date of each component of the profile documented; LDL-C<100. Numerator 1: Number of patients with a full lipid profile completed during the 12-month measurement period with date of each component of the profile documented. • Identify the most recent visit to the doctor's office or clinic that occurred during the measurement year (but after the diagnosis of IVD was made) in which a full lipid profile was documented. • Each component of the lipid profile must be noted with the date of the laboratory test and results. Numerator 2: Number of patients with a LDL completed during the 12-month abstraction period with date and LDL less than 100 mg/dl documented. CPT II codes for compliance: 3048F CPT II codes for non-compliance: 3049F, 3050F Denominator A systematic sample of patients, age 18 years and older with a diagnosis of ischemic vascular disease (IVD) for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months.) Codes to Identify a Patient with a Diagnosis of Ischemic Vascular Disease:- ICD-9: 411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445 DRG: 140, 559 If using health plan administrative claims to identify the eligible population and then attributing to physicians, use the following denominator specifications: Discharged alive for AMI, CABG or PTCA on or between 1/1-11/1 of the year prior to the measurement year or at on+C5e outpatient or acute inpatient during the measurement year and year prior to the measurement year. AMI: ICD-9: 410.x1, DRG: 121, 122, 516 PTCA: CPT: 33140, 92980-92982, 92984, 92995, 92996, ICD-9:00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09, DRG: 516, 517, 526, 527, 555-558 CABG: CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572, HCPCS: S2205-S2209, ICD-9:36.1, 36.2, DRG: 106, 107, 109, 547-550 Codes to Identify a Patient with a Diagnosis of Ischemic Vascular Disease:- ICD-9: 411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445 DRG: 140, 559 Outpatient Codes: CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499, UB-92: 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983 Acute inpatient: CPT: 99221-99223, 99231-99233, 99238, 99239, 99251, 99255, 99261-99263, 99291, UB-92: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 0987 Presentation of Codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x" which represents a required digit. For example ICD-9 CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual. Exclusions Exclude patient self-report or self-monitoring, LDL to HDL ratio and findings reported on progress notes or other non-laboratory documentation. [OP] Steward: NCQA	– age – active ischemic vascular disease diagnosis – ambulatory care encounter – lipid profile result – LDL result – LDL to HDL ratio – non-laboratory documentation of LDL – hospital discharge diagnosis AMI – hospital discharge diagnosis CABG – PTCA procedure – discharge status alive	For retooling, compliance requires presence of LDL result during the measurement year. Diagnosis in the ambulatory record requires entry on the Problem List with ICD-9 or SNOMED coding.
4	% of smokers offered smoking cessation counseling [EP, IP]	Title: Measure pair – a. Tobacco use prevention for infants, children and adolescents, b. Tobacco use cessation for infants, children and adolescents* Description: Percentage of patients' charts showing either that there is no tobacco use/exposure or (if a user) that the current use was documented at the most recent clinic visit Percentage of patients with documented tobacco use or exposure at the latest visit who also have documentation that their cessation interest was assessed or that they received advice to quit Numerator: a: Number of patients' charts audited whose current tobacco status is documented in the medical record b: Number of tobacco users advised to quit or whose readiness to quit was assessed at the latest visit. Denominator a: Total number of patients' charts audited b: Total number of tobacco users audited Exclusions a: inclusions: total number of patient charts audited exclusions: none. The measures applies to all patients visiting the practice, regardless of age, who have any indication on their charts that they are or may be users of tobacco, or in the case of children that they are regularly exposed to tobacco smoke b: inclusions: total number of patient charts audited exclusions: none The measures applies to all patients visiting the practice, regardless of age, who have any indication on their charts that they are or may be users of tobacco, or in the case of children that they are regularly exposed to tobacco smoke [OP] Steward: Institute for Clinical Systems Improvement	– outpatient encounter – smoking history – smoking cessation counseling / advice – smoking readiness to quit assessment	Requires that smoking is addressed at every visit. May need to use CPT II attestation for 2011.
4a	% of patients with recorded BMI [EP]	Title: Body Mass Index (BMI) 2 through 18 years of age* Description: Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender Numerator: Number of children 2 through 18 years of age who came in for a well child visit in the measurement period month and who were classified based on BMI percentile for age and gender. Denominator: Number children 2 through 18 years of age, with a well child visit in the measurement period month. Exclusions: None [OP] National Initiative for Children's Healthcare Quality	– age – ambulatory encounter – BMI – gender	Limited to Pediatrics BMI present in Vital Signs
4b		Title: Adult weight screening and follow up Description: Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented. Parameters: age 65 and older BMI > or = 30 or < 22; age 18-64 BMI > or = 25 or< 18.5 Numerator: Patients with BMI calculated in the past six months and a follow-up plan documented if the BMI is outside of parameters Denominator Patients 18 years and older Exclusions: Patients can be considered not eligible in the following situations: – There is documentation in the medical record that the patient is over or under weight and is being managed by another provider – If the patient has a terminal illness – If the patient refuses BMI measurement – If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate – Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status. [OP] CMS	– age – BMI – terminal illness – patient refusal – medical exclusion – urgent / emergent medical situation	BMI present in Vital Signs Exclusion (i.e., "terminal illness," and "urgent/emergent medical situation") may be complex and may be relaxed for 2011.
5	% eligible surgical patients who received VTE prophylaxis [IP]	Title: Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time* Description: Percentage of surgery patients who received appropriate Venous Thromboembolism (VTE) Prophylaxis within 24 hours prior to surgery to 24 hours after surgery Surgery patients with recommended VTE prophylaxis ordered during the admission Denominator: All selected surgery patients (i.e., patients receiving general or neuraxial anesthesia) Exclusions: – Patients who are less than 18 years of age. Patients with procedures performed entirely by laparoscope. Patients whose total surgery time is less than or equal to 30 minutes – Patients who stayed less than or equal to 24 hours postoperatively. Burn patients (refer to Specifications Manual, National Healthcare Quality Measures, Appendix A, Table 5.14 for ICD-9-CM codes). – Patients who are on warfarin prior to admission. – Patients with contraindications to both mechanical and pharmacological prophylaxis. Patients whose ICD-9-CM – Prinicpal Procedure occurred prior to the date of admission end time [IP] CMS	– age – neuraxial anesthesia administered – general anesthesia administered – laparoscopic procedure performed – VTE prophylaxis medication administered – VTE prophylaxis medication intolerance – Antithrombotic device applied – Antithrombotic device intolerance – Surgical incision time – anesthesia end time – hospital admission – hospital discharge – burn diagnosis – warfarin administered – Antithrombotic device refused – comfort measures only – clinical trials for VTE	Exclusions may need to be relaxed for 2011 ("antithrombotic device refused," "comfort measures only," clinical trials for VTE," "Antithrombotic device intolerance"). Consider a single field for "contraindication" to cover exclusions. Most complex is identification of "antithrombotic device" and "antithrombotic device applied." These two items are gaps in standards. Recommend this measure not be used and substitute, instead, the Stroke measure for anticoagulation with atrial fibrillation.
6	% of orders (for medications, lab tests, procedures, radiology, and referrals) entered directly by physicians through CPOE	No current measures	NA	
7	Use of high-risk medications (Re: Beers criteria) in the elderly	Title: Drugs to be avoided in the elderly: a. Patients who receive at least one drug to be avoided, b. Patients who receive at least two different drugs to be avoided.* Description: Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly in the measurement year. Percentage of patients 65 years of age and older who received at least two different drugs to be avoided in the elderly in the measurement year. Numerator: a: at least one prescription for any drug to be avoided in the elderly in the measurement year. b: At least two different drugs to be avoided in the elderly in the measurement year. Denominator: All patients ages 65 years and older as of December 31 of the measurement year. Exclusions: None [OP] NCQA [IP] none	– age – high risk medication for elderly prescribed	Use existing list of high risk medications for the elderly. The committee challenged the measure in that a single prescription for one high risk medication may be appropriate and adversely affect the physician's score. Consideration for modification requested.
8	% of patients over 50 with annual colorectal cancer screenings [EP]	PQRI 113: Preventive Care and Screening: Colorectal Cancer Screening Title: Colorectal Cancer Screening* Description: Percentage of adults 50–80 years of age who had appropriate screening for colorectal cancer (CRC) including fecal occult blood test during the measurement year or, flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year or, double contrast barium enema during the measurement year or the four years prior to the measurement year or, colonoscopy during the measurement year or the nine years prior to the measurement year [OP] NCQA [IP] – none	– age – history of colorectal cancer diagnosis – history of colectomy procedure – fecal occult blood test performed – flexible sigmoidoscopy performed – double contrast barium enema performed – colonoscopy performed (CAT Scan imaged colonoscopy Is in the code set for colonoscopy)	Colorectal cancer diagnosis is expected on the Problem List.
9	% of females over 50 receiving annual mammogram [EP]	PQRI 112: Preventive Care and Screening: Screening Mammography [PQRI age range 40-69] Title: Breast Cancer Screening* Description: Percentage of eligible women 50-69 who receive a mammogram in a two year period Numerator: One or more mammograms during the measurement year or the year prior to the measurement year. Denominator: Women 52–69 years as of December 31 of the measurement year. Note: Given the measurement look back period, women 50–69 will be captured in this measure. Exclusions: Exclude women who had a bilateral mastectomy and for whom administrative data does not indicate that a mammogram was performed. Look for evidence of bilateral mastectomy as far back as possible in the patient's history, through either administrative data of medical record review (exclusionary evidence in the medical record must include a note indicating a bilateral mastectomy.) If there is evidence of two separate mastectomies, this patient may be excluded from the measure. The bilateral mastectomy must have occurred by December 31st of the measurement year. [OP] NCQA	– age – mammogram performed – history of mastectomy procedure – history of bilateral mastectomy procedure	No specific comments
10	% patients at high-risk for cardiac events on aspirin prophylaxis [EP]	Title: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic.* Description: Percentage of patients who have documentation of use of aspirin or another antithrombotic during the 12-month measurement period. Numerator: The number of patients who have documentation of use of aspirin or another antithrombotic during the 12-month measurement period. Documentation in the medical record must include, at a minimum, a note indicating the date on which aspirin or another antithrombotic was prescribed or documentation of prescription from another treating physician. Denominator: A systematic sample of patients, age 18 years and older with a diagnosis of ischemic vascular disease (IVD) for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months.) Codes to Identify: Patient with a Diagnosis of Ischemic Vascular Disease If using health plan administrative claims to identify the eligible population and then attributing to physicians, use the following denominator specifications: Discharged alive for AMI, CABG or PTCA on or between 1/1–11/1 of the year prior to the measurement year or at one outpatient or acute inpatient during the measurement year and year prior to the measurement year. AMI: ICD-9 PTCA: CPT CABG: CPT Codes to Identify a Patient with a Diagnosis of Ischemic Vascular Disease:- ICD-9 DRG Outpatient Codes: CPT Acute inpatient: CPT Presentation of Codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x" which represents a required digit. For example ICD-9 CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual. Exclusions: Exclude patient self-report. [OP] Steward: NCQA Endorsed: 12/01/2006 Contraindications?	– age – active diagnosis ischemic vascular disease – ambulatory care encounter – aspirin medication order – Antithrombotic medication order – patient self-reported diagnosis	Diagnosis of "ischemic vascular diasease" is on the Problem List. "Patient self-reported diagnosis" may be problematic and should be modified for 2011.
11a	% eligible patients who received flu vaccine [EP]	PQRI – 110: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Title: Influenza Vaccination* Description: Percentage of patients who received an influenza vaccination Numerator: Patients who received influenza vaccination from September through February of the year prior to the measurement period ICD-9-CM codes for need vaccine: V04.81 Or CPT procedure codes for adult influenza vaccine: 90656, 90657, 90658, 90660 Or HCDCS code: G0008 Or Medical record includes documentation of patient report of having received the vaccination Denominator: All patients => 50 years of age at the beginning of the one-year measurement period Patient Selection: CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99386-99387, 99396-99397, 99401-99404, 90471-90474 And Patient's age is > 50 years at the beginning of the one-year measurement period Exclusions: – Egg allergy (ICD-9-CM codes: 693.1, V15.03, 995.68) – Adverse reaction to influenza vaccine (995.0 and E949.6, 995.1 and E949.6, 995.2 and E949.6) – Other medical reason(s) documented by the practitioner for not receiving an influenza vaccination – Patient reason(s) (eg, economic, social, religious) [OP] AMA	– age – influenza vaccination administered – influenza vaccination documented – influenza vaccination refused – medical reason for not administering influenza vaccine – patient reason for not receiving influenza vaccine – egg allergy – influenza vaccine intolerance	History of influenza vaccine should be documented; EHR will need to be configured for this item as a searchable field (many ambulatory systems have already done so). Allergy should be present on an Allergy List but intolerance may be more difficult to find. Patient and medical reason will require some form of 'attestation;' consider 'contraindication' field.
11b		Title: Influenza Vaccination of Nursing Home/ Skilled Nursing Facility Residents Description: Percent of nursing home/ skilled nursing facility residents given the influenza vaccination during the flu season.	– influenza vaccine admistered – influenza vaccine offered – influenza vaccine history – influenza vaccine allergy – nursing home risk category assessment – admission to long term care – discharge from long term care – bone marrow transplant history – chemotherapy history – radiation therapy history	History of influenza vaccine should be documented; EHR will need to be configured for this item as a searchable field (many ambulatory systems have already done so). Allergy should be present on an Allergy List but intolerance may be more difficult to find. Patient and medical reason will require some form of 'attestation;' consider 'contraindication' field.
12	% lab results incorporated into EHR in coded format [EP,IP]	Title Medical Home System Survey Description: Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions Measure by attestation Attest by quartile – for 2011 Steward(s) National Committee for Quality Assurance Project(s) Health Information Technology Structural Measures Endorsed 2008-08-29	Attestation – Survey	Single annual survey
13	Stratify reports by gender, insurance type, primary language, race, ethnicity [EP, IP]	NQF has identified quality measurement criteria for which there are known disparities. CMS can use these criteria for stratification.	– gender – insurance type – primary language – race – ethnicity	Not a specific measure
14	% of all medications, entered into EHR as generic, when generic options exist in the relevant drug class [EP, IP]	No current measures	NA	Develop attestation measure
15	% of orders for high-cost imaging services with specific structured indications recorded [EP, IP]	No current measures	NA	Develop attestation measure
16	% claims submitted electronically to all payers [EP, IP]	No current measures	NA	Develop attestation measure
17	% patient encounters with insurance eligibility confirmed [EP, IP]	No current measures	NA	Develop attestation measure
18	% of all patients with access to personal health information electronically [EP, IP]	No current measures	NA	Develop attestation measure
19	% of all patients with access to patient specific educational resources [EP, IP]	No current measures	NA	Develop attestation measure
20	% of encounters for which clinical summaries were provided [EP]	No current measures	NA	Develop attestation measure
21	Report 30-day readmission rate [IP]	Title: All-Cause Readmission Index (risk adjusted)* Title: All-Cause Readmission Index (risk adjusted)* Description: Overall inpatient 30-day hospital readmission rate. Numerator: Measured outcome: 30-day all-cause readmissions for patients discharged from the hospital with a principal diagnosis of HF, as measured from the date of discharge of the index HF admission Denominator: Included population: Index admissions for Medicare fee-for-service beneficiaries age 65 or over admitted to the hospital with a principal ICD-9-CM discharge diagnosis of heart failure and discharged alive Exclusions: Age <65 In-hospital deaths Incomplete data (without FFS Part A, without 12 mo enrollment prior to discharge, without 1 month enrollment post discharge) Transfers out Additional HF admissions within 30 days [IP] Steward: United Health Group	– age – hospital admission – hospital discharge – maternity diagnosis – transfer to acute care hospital – death	Providers will be able to report only for discharges from their own facilities without HIE support. Address: 2011 – readmissions to same hospital 2013 – readmissions to hospitals within the same enterprise 2015 – readmissions to any other hospital +E30
22a	% of encounters where med reconciliation was performed [EP, IP]	Title: Medication Reconciliation * Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented. [OP] NCQA	– age – hospital discharge – outpatient visit encounter – medication reconciliation completed	While attestation required, there is no method to identify a cognitive process without attestation.
22b		Care for Older Adults – Medication Review (COA) IP Owner: National Committee for Quality Assurance At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record A medication review is a review of a member's medications including prescription medications, over the counter medications (OTC) or herbal therapies. A medication list is a list of member's medications in the medical record which may include prescriptions, over the counter medications and herbal therapies or supplements. Documentation must come from the same medical record and must include the following: •A medication list in the medical record, and •Evidence of a medication review and the date on which it was performed At a minimum, medication review is documentation that a practitioner has reviewed all medications that the member is taking (including prescriptions, OTCs and herbal or supplemental therapies). A review of side effects for a single medication at the time of prescription alone is not sufficient. If the member is not taking any medications, notation of this fact and the date on which it was noted is also considered numerator compliant. Codes to indentify medication review: Medication review (CPT 90862, 99605, 99606), (HCPCS G8427, G8428, G8530), (CPT-II 1160F) Medication List (CPT-II 1159F) Denominator: All patients 66 and older as of December 31 of the measurement year	`– birthdate	While attestation required, there is no method to identify a cognitive process without attestation.
22c		Measure#MM-028-08 Title: Medication Reconciliation Post-Discharge (MRP) Medication reconciliation on or within 30 days after discharge. Documentation in the medical record must include evidence of medication reconciliation, and the date on which it was performed. The following evidence meets criteria: •A list of medications that were prescribed or ordered upon discharge, or •Notation that no medications were prescribed or ordered upon discharge Codes to identify medication reconciliation: CPT-II 1111F Denominator: All patients 66 and older as of December 31 of the measurement year All patients 66 years and older as of December 31 of the measurement year. IP Owner: National Committee for Quality Assurance		While attestation required, there is no method to identify a cognitive process without attestation.
23	Implemented ability to exchange health information with external clinical entity (specifically labs, care summary and medication lists) [EP, IP]	Title Medical Home System Survey Description: Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions Measure by attestation Steward(s) National Committee for Quality Assurance Project(s) Health Information Technology Structural Measures Endorsed 2008-08-29	Attestation – Survey	Annual survey
24	% of transitions in care for which summary care record is shared (e.g., electronic, paper, e-Fax) [EP, IP]	No current measures	NA	Develop attestation measure
25	Report up-to-date status for childhood immunizations [EP]	Title: Childhood Immunization Status * Description: Percentage of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates Numerator: For all antigens, count any of the following: •evidence of the antigen or combination vaccine, or •documented history of the illness, or •a seropositive test result. For combination vaccinations that require more than one antigen (i.e., MMR), find evidence of all of the antigens. For immunization information obtained from the medical record, count patients where there is evidence that the antigen was rendered from: •a note indicating the name of the specific antigen and the date of the immunization, or •a certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. For documented history of illness or a seropositive test result, find a note indicating the date of the event. The event must have occurred by the patient's second birthday. Notes in the medical record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "patient is up-to-date" with all immunizations that does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for this measure. Denominator: A systematic sample drawn from children who turn two years of age during the measurement year. Exclusions: None [OP] Steward: NCQA	– age – DtaP/Dt administered – IPV administered – MMR administered – Hib administered – Hepatitis b vaccine administered – VZV administered – pneumococcal conjugate vaccine administered – varicella history – active Hepatitis b – Hepatitis b immunity	Patient and medical reason for exclusion will require some form of 'attestation;' consider 'contraindication' field.
26	% reportable lab results submitted electronically [IP]	No current measures	NA	Develop attestation measure
27	Full compliance with HIPAA Privacy and Security Rules	No current measures	NA	Defer to Privacy and Security Workgroup
28	Conduct or update a security risk assessment and implement security updates as necessary	No current measures	NA	Defer to Privacy and Security Workgroup
29	Other Measures Under Consideration (In addition to initial Policy Measure 2001 Grid)	PQRI 7: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)* Title: CAD: Beta-Blocker Therapy–Prior myocardial infarction (MI) Description: Percentage of patients with prior MI at any time who were prescribed beta-blocker therapy. Numerator: Patients who were prescribed beta blocker therapy (drug list available at www.ama-assn.org/ama/pub/category/4837.html) OR CPT-II code: 4006F Beta-blocker therapy prescribed Denominator: All patients with CAD who also have prior MI at any time > 18 years of age Patient Selection: ICD-9-CM codes for CAD, OR CPT codes, AND ICD-9-CM codes for MI, AND Patient's age is > 18 years Exclusions: Documentation of medical reason(s) for not prescribing beta-blocker therapy: •Documentation of bradycardia < 50 bpm (without beta-blocker therapy) on two consecutive readings, history of Class IV (congestive) heart failure, history of second- or third-degree atrioventricular (AV) block without permanent pacemaker. ICD-9-CM exclusion codes, OR •Other medical reason(s) documented by the practitioner for not prescribing beta blocker therapy; OR •CPT-II code with modifier: 4006F 1P Documentation of patient reason(s) (e.g., economic, social, religious), OR CPT-II code with modifier: 4006F 2P Documentation of system reason(s) for not prescribing beta-blocker therapy; OR CPT II w/modifier 4006F 3P [OP] Steward: AMA Endorsed: 7/01/2006	– age – active diagnosis coronary artery disease – past history myocardial infarction – heart rate < 50 (bradycardia) physical finding – beta blocker prescription	Expect diagnosis on the Problem List using ICD-9 or SNOMED. Expect presence of medications on the Medication List (and do not accept CPT-II codes). Patient and medical reason for exclusion will require some form of 'attestation;' consider 'contraindication' field.
30	Other Measures Under Consideration (In addition to initial Policy Measure 2001 Grid)	PQRI 5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)* Title: Heart Failure (HF) : ACEI/ ARB Therapy Description: Percentage of patients with HF who also have left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy. Numerator: Patients who were prescribed ACEI or ARB therapy (drug list available at www.ama-assn.org/ama/pub/category/4837.html), OR CPT-II code: 4009F Angiotensin Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker therapy prescribed Denominator: All HF patients > 18 years of age with LVEF < 40% or with moderately or severely depressed left ventricular systolic function Patient Selection: ICD-9-CM codes for HF, AND CPT procedure codes for LVF assessment testing, AND Additional individual medical record review must be completed to identify for those patients who were tested had documentation of an ejection fraction < 40% (use most recent value) or moderately or severely depressed left ventricular systolic function, OR [CPT-II codes: 3021F Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function; 3022F Left ventricular ejection fraction (LVEF) = 40% or documentation as normal or mildly depressed left ventricular systolic function], AND Patient's age is > 18 years Exclusions: Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy: •Allergy or intolerance to ACE inhibitor or ARB; OR •ACE inhibitor contraindications including angioedema, anuric renal failure, moderate or severe aörtic stenosis or pregnancy ICD-9-CM exclusion codes, OR •Other medical reason documented by the practitioner for not prescribing ACE inhibitor or ARB therapy; Or •CPT-II code w/modifier: 4009F 1P Patient reason (e.g., economic, social, religious), OR CPT-II code w/modifier: 4009F 2P Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy, OR CPT II code 4009F 3P [OP] Steward: AMA	– age – active diagnosis congestive heart failure – left ventricular function diagnostic study order – left ventricular function diagnostic study result – active diagnosis left ventricular systolic dysfunction – left ventricular systolic ejection fraction – angiotensin converting enzyme inhibitor prescription – angiotensin receptor blocker prescription – angiotensin converting enzyme inhibitor allergy – angiotensin converting enzyme intolerance – angiotensin receptor blocker allergy – antiotensin receptor blocker intolerance – active diagnosis of anuric renal failure – past history angioedema – active pregnancy – moderate to severe aortic stenosis diagnosis – medical reasons for avoiding ACEI, ARB – patient refusal – system reasons for avoiding ACEI, ARB	Expect diagnosis on the Problem List using ICD-9 or SNOMED. Expect presence of medications on the Medication List (and do not accept CPT-II codes). Patient and medical reason for exclusion will require some form of 'attestation;' consider 'contraindication' field.
31	Other Measures Under Consideration (In addition to initial Policy Measure 2001 Grid)	Title: Use of appropriate medications for people with asthma Description: Percentage of patients who were identified as having persistent asthma during the measurement year and the year prior to the measurement year and who were dispensed a prescription for either an inhaled corticosteroid or acceptable alternative medication during the measurement year Numerator: Documentation in the medical record must include, at a minimum, a note indicating the patient received a t least one written prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylxanthines during the measurement year. Denominator: All patients ages 5-56 years as of December 31 of the measurement year with persistent asthma reported in three age stratifications (5-9, 10-17, 18-56) and as a combined rate. Exclusions: Exclude from the eligible population all patients diagnosed with emphysema and chronic obstructive pulmonary disease (COPD) anytime on or prior to December 31 of the measurement year as identified by the following codes, or for medical record collection, as documented within the chart: EmphysemaICD-9 codes (492, 506.4, 518.1, 518.2)COPD ICD-9 codes: (491.2, 493.2, 496, 506.4) [OP] Steward: NCQA	– age – active diagnosis persistent asthma – active diagnosis emphysema – active diagnosis chronic obstructive pulmonary disease – inhaled corticosteroid prescription – leukotriene modifier prescription – methylxanthine prescription – nedocromil prescription – cromolyn sodium prescription	Stage this measure – use of appropriate medications for asthma in 2011. Expect appropriate medication by asthma stage (e.g., chronic persistent asthma) in 2013. Asthma staging requires further analysis at this time.
32	Other Measures Under Consideration (In addition to initial Policy Measure 2001 Grid)	Title: Patients with Atrial Fibrillation Receiving Anticoagulation Therapy Description: Patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy. Numerator: Patients discharged on anticoagulation therapy. Denominator: Patients with a diagnosis of ischemic stroke with documented atrial fibrillation. Exclusions: • Patients discharged/transferred to another short term general hospital for inpatient care • Patients who expire • Patients who left against medical advice • Patients discharged to hospice • Patients receiving comfort measures only • Patients admitted for the performance of elective carotid endarterectomy [IP] Steward(s) The Joint Commission Project(s) NVCS for the Prevention and Management of Stroke Across the Continuum of Care Endorsed 2008-07-31	-active diagnosis ischemic stroke - active diagnosis atrial fibrillation - elective carotid endarterectomy performed - death - signed out against medical advice - transfer to inpatient facility - transfer to short-term hospital - discharge to hospice - comfort measures only - anticoagulation therapy administered	Patient and medical reason for exclusion will require some form of 'attestation;' consider 'contraindication' field.