

**Clinical Quality Measures for CMS's 2014
EHR Incentive Program for Eligible Hospitals:
Release Notes**

10/11/2012

**CLINICAL QUALITY MEASURES FOR CMS'S 2014 EHR INCENTIVE PROGRAM
FOR ELIGIBLE HOSPITALS
RELEASE NOTES**

In August 2012, the Centers for Medicare & Medicaid Services (CMS) finalized the clinical quality measures (CQMs) for the 2014 Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Hospitals, also known as Meaningful Use Stage 2 (MU2) for Eligible Hospitals.¹ This list of CQMs for MU2 includes measures retained from Meaningful Use Stage 1 (MU1) for use in MU2. All retained MU1 measures have been updated based on advances in technology and tools for eMeasure development, comments from stakeholders, changes initiated by measure developers, and CMS's standards as defined in the agency's Measures Management System Blueprint, Version 8 (Blueprint).²

CMS recognizes the importance of providing support, training, and information to MU stakeholders, particularly as the EHR Incentive Programs transition to MU2. The purpose of this document is to inform eligible hospitals and the vendor community about updated program requirements related to the CQMs. This update includes information about global changes incorporated across all measures as well as specific changes to the measures retained in MU2. Global changes are listed first and include structural modifications; updates to value sets; and data elements and standards revised in accordance with the Blueprint. Specific changes to measures include changes to measure components, such as initial patient populations, denominators, numerators, exclusions, and exceptions, as well as logic changes that affect how data elements interrelate during the measurement period.

This document is intended for readers who are familiar with eMeasure components and the current standards for construction an eMeasure. For more information on eMeasures, please visit the CMS website (<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html>)

¹ CMS. "Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2." 2012. Available at [[http://www.ofr.gov/\(X\(1\)S\(uzclbwrX5fwqm2w2mipkysrh\)\)/OFRUpload/OFRData/2012-21050_PI.pdf](http://www.ofr.gov/(X(1)S(uzclbwrX5fwqm2w2mipkysrh))/OFRUpload/OFRData/2012-21050_PI.pdf)]. Accessed August 28, 2012.

² CMS. "CMS Measure Management System Blueprint, ." Available at [<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MeasuresManagementSystemBlueprint.html>]. Accessed August 28, 2012. Since the completion of MU2 CQM's the latest Blueprint version is 9.0.

Global Edits

- Introduced a new measure-identification scheme that combines the eMeasure identifier, National Quality Forum (NQF) number (if applicable), and eMeasure version number.
- Updated the rationale, clinical recommendation statements, and references to include the latest clinical guidance related to the measures.
- Provided additional guidance to help implementers interpret the calculation requirements for the measures as well as instructional and clarifying notes.
- Updated the eMeasure header to reflect Blueprint requirements (such as using the initial patient population to define the denominator and including stratification variables in the header) and modified other fields, such as population criteria, to reflect these changes.
- Changed the standardization of the measurement period from “year” to “period.”
- Updated the measure logic to reflect the changes to the Quality Data Model (QDM), to reflect consistent use of relative timing across measures (including age calculation), occurring, and denominator exclusions.
- Assigned data elements based on version 2.1.1.1 of the QDM³ to each clinical concept, adding attributes as needed to precisely define QDM elements.
- For measures using the QDM of “Medication, Active,” added the AND / AND NOT construct to compensate for varying interpretations of the relative timing “during.” The “Medication, Active” period can start at any time but cannot end before “Occurrence A of Encounter, Performed.”
- Incorporated supplemental data elements (race, ethnicity, sex, and payer) as required by the Blueprint.
- Reorganized and retitled the encounter value sets to standardize them across developers. Also incorporated encounter value sets using SNOMED-CT to align with the Health Information Technology Standards Committee (HITSC) vocabulary recommendation for the QDM data type “Encounter.”
- Updated existing value sets and added new value sets to align with the transitional and final vocabularies, based on the HITSC recommendations and required by the Blueprint.
- Value sets include fully-specified ICD-9-CM and ICD-10-CM codes.
- Provided grouping object identifiers for each data element.
- Added copyright information for vocabularies.

³ For more on the Quality Data Model, visit the NQF website at <http://www.qualityforum.org/QualityDataModel.aspx>

NQF 0495 Median time from ED arrival to ED departure for admitted ED patients

- Added length of stay check for initial patient population of <=120 days
- Observation services no longer used for stratification
- ED visit must end within one hour of the inpatient encounter to associate the ED encounter with the inpatient encounter.

NQF 0497 Median admit decision time to ED departure time for admitted patients

- Added length of stay check for initial patient population of <=120 days
- Observation services no longer use for stratification
- ED visit must end within one hour of the inpatient encounter to associate the ED encounter with the inpatient encounter.

NQF 0435 Ischemic stroke – Discharged on anti-thrombotic therapy

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Specified that a medication order for antithrombotic therapy could be present within one day prior to discharge.

NQF 0436 Ischemic stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Created the Atrial Ablation procedure value set to only include procedures specifically done for atrial fibrillation/flutter.

NQF 0437 Ischemic stroke – Thrombolytic Therapy

- Revised “Last Known Well” data element to create value sets for neurologic symptoms of stroke or baseline state symptom documented within 120 minutes of ED arrival.
- ED visit must end within one hour of the inpatient encounter to associate the ED encounter with the inpatient encounter.
- Added denominator exclusion if Thrombolytic Therapy (t-PA) was administered within two days prior to inpatient encounter.
- Added denominator exclusion for risk category of National Institute of Health Stroke Scale = 0.

NQF 0438 Ischemic stroke – Antithrombotic therapy by end of hospital day two

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added logic to denominator exclusion to identify patients with Thrombolytic Therapy (t-PA) administered during their ED encounter for ED encounters within one hour of the inpatient encounter.

NQF 0439 Ischemic stroke – Discharged on Statin Medication

- Added logic to denominator to evaluate timing of LDL-c laboratory results or Lipid-Lowering medication in relation to the ED encounter for ED encounters within one hour of the inpatient encounter.
- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Specified that a medication order for statin could be present within one day prior to discharge.
- Removed denominator exclusion for patients without evidence of atherosclerosis.

NQF 0440 Ischemic or hemorrhagic stroke – Stroke education

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.

NQF 0441 Ischemic or hemorrhagic stroke – Assessed for Rehabilitation

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added numerator statement to include patients transferred to a rehabilitation facility.

NQF 0371 Venous Thromboembolism Prophylaxis

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added denominator exclusion for patients with palliative care (comfort measures only) orders within one day of a procedure using general or neuraxial anesthesia occurring the day of or the day after the inpatient encounter.
- VTE prophylaxis medication and VTE prophylaxis mechanical device value sets separated into individual value sets based on type of medication and device.
- Added numerator statement for patient assessment of low risk for VTE.

NQF 0372 Intensive Care Unit (ICU) Venous Thromboembolism Prophylaxis

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added denominator exclusion for patients with palliative care (comfort measures only) orders within one day of a procedure using general or neuraxial anesthesia occurring the day of or the day after the ICU admission or transfer.
- VTE prophylaxis medication and VTE prophylaxis mechanical device value sets separated into individual value sets based on type of medication and device.
- Added numerator statement for patient assessment of low risk for VTE.

NQF 0373 Venous Thromboembolism Patients with Anticoagulation Overlap Therapy

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Removed denominator exclusion for patients not discharged on warfarin.
- Added denominator exclusions for the following discharge status values:
 - Discharge to Another Hospital
 - Discharge to Home for Hospice Care
 - Discharge to Health Care Facility for Hospice Care
 - Patient expired
 - Left against advice
- Added denominator statement to include patients with warfarin administration starting within one day prior to inpatient encounter.
- Clarified calculation method for determining patients who were on 5 or more days of overlap therapy.
- Added numerator statements to include patients with documented reason for no overlap or discontinuation of overlap therapy.
- Added numerator statements to check for the administration of parenteral anticoagulant during the ED encounter for ED encounters within one hour of the inpatient encounter.

NQF 0374 Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added denominator exclusions for the following discharge status values:
 - Discharge to Another Hospital
 - Discharge to Home for Hospice Care
 - Discharge to Health Care Facility for Hospice Care
 - Patient expired
 - Left against advice
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to inpatient encounter.
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to ED encounter for ED encounters within one hour of the inpatient encounter.

NQF 0375 Venous Thromboembolism Discharge Instructions

- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to inpatient encounter.
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to ED encounter for ED encounters within one hour of the inpatient encounter.
- Revised description and updated denominator statement to include patients discharged to court/law enforcement.
- Added denominator statement to include patients with warfarin administration starting within one day prior to inpatient encounter
- Added numerator statement to include patients who refused discharge instructions.

NQF 0376 Incidence of potentially preventable Venous Thromboembolism

- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to inpatient encounter.
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to ED encounter for ED encounters within one hour of the inpatient encounter.
- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- VTE prophylaxis medication and VTE prophylaxis mechanical device value sets separated into individual value sets based on type of medication and device.