GE Healthcare

Using Centricity Electronic Medical Record Meaningful Use Reports

Version 9.5
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Centricity Electronic Medical Record
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Revision History

Date	Description
April 2011	Centricity Electronic Medical Record 9.5 - Rev 3 - Released version
June 2011	Centricity Electronic Medical Record 9.5 - Rev 4 - Added new report templates, corrected defects, expanded and revised report descriptions.
July 2011	Centricity Electronic Medical Record 9.5 - Rev 5 - Added new report templates, corrected defects, expanded and revised report descriptions.
August 2011	Centricity Electronic Medical Record 9.5 - Rev 6- Updated description for Core Functional Measures *13 Clinical (Visit) Summaries* and *14 Exchange Key Clinical Information Electronically among Providers of Care.*
September 2011	Centricity Electronic Medical Record 9.5 - Rev 7- Updated description for Core Functional Measures *05-Active Medication List*, *06-Active Medication Allergy List, 07-Active Problem List, 08-Record Vital Signs*, and Quality measures *NQF 0421a Weight Management 65 or older, NQF 0421b Weight Management 18-64,and NQF 0024a-i; Weight Assessment and Counseling for Children and Adolescents* (9 reports); corrected miscellaneous description errors.
November 2011	Centricity Electronic Medical Record 9.5 - Rev 8- Revised descriptions for 01 CPOE for Medication Orders - ALL Active Medications,04 e-Prescribing (eRx), 09 Smoking Status, 07 Record Demographics, 08 Record Vital Signs, 12 Electronic Copy of Health Information, 13 Clinical Visit Summary, 02 Structured Lab Results,04 Patient Reminders, 05 Patient Electronic Access, 06 Patient Specific Education Resources,07 Medication Reconciliation, 08 Transition of Care Summary.
	Added new reports 01 CPOE for Medication Orders - Prescribed Medications Only and 01 CPOE for Medication Orders - Qualification Report.
	Removed 07 Med Reconciliation All Visits.
January 2012	Centricity Electronic Medical Record 9.5 - Rev 9 - Corrected miscellaneous formatting and textual errors. Reformatted chapter 3 quality report descriptions to be consistent with chapter 2 functional measures report format.
January 2013	Centricity Electronic Medical Record 9.5 - Rev 13 - Revised descriptions for 01 CPOE for Medication Orders - All Active Medications, 01 CPOE for Medication Orders - Prescribed Medications Only, 03 Maintain Problem List, 04 e-Prescribing (eRx), 05 Active Medication List, 06 Medication Allergy List, 07 Record Demographics, 08 Record Vital Signs, 12 Provide Electronic Copy of Health Information, 13 Clinical (Visit) Summaries; 04 Patient Reminders, 08 Transition of Care Summary; NQF 0001 Asthma Assessment, NQF 0013 Hypertension: Blood Pressure Measurement, NQF 0028a Smoking Status, NQF 0028b Smoking Cessation Counseling, NQF 0031 Breast Cancer Screening, NQF 0038a-l Immunizations, NQF 0041 Fluvax, NQF 0047 Asthma Pharmacologic Therapy, NQF 0055 Diabetic Patients Eye Exam, NQF 0056 Diabetic Patients Foot Exam, NQF 0059 Hgba1c Poor Control (>9), NQF 0061 Diabetes: BP Management < 140/90, NQF 0062 Diabetic Patients Urine Screening, NQF 0064 Diabetic Patients with LDL / LDL <100, NQF 0067 CAD and Antiplatelet Therapy, NQF 0074 CAD and Lipid-Lowering Therapy, NQF 0084 Heart Failure and Warfarin Therapy, NQF 0421 Weight Management, NQF 0575 HbA1c Control (<8%).
	Corrected links for 10 Test Capacity to Submit Electronic Data to Public Health Agencies. Added a table of Obs terms for CMS Quality Measures.

Introduction

Centricity EMR includes functional and quality measure reports based on final ONC (Office of the National Coordinator for Health Information Technology) criteria as well as National Quality Forum (NQF) reports. The release is ONC-ATCB certified and includes features and functionality designed to successfully demonstrate meaningful use as specified in the CMS Electronic Health Records (EHR) Incentive Program.

For a high-level summary of functional measures linked to new features in this release and supporting reports, see *What's New in Centricity EMR* version 9.5 in your documentation library. This guide highlights those product features that support reporting for Meaningful Use measures.

Achieving Meaningful Use

There are two parts to achieving Meaningful Use: Part 1 involves certified EHR technology in a "meaningful way" as defined in both the functional and quality measure specifications. Part 2 requires organizations to apply to participate in the EHR Incentive Program and to attest to (and report on) using certified EHR technology within a defined period of time.

GE Healthcare offers Web-based reporting and data submission services designed to assist your organization in achieving Meaningful Use. For details, see "Quality Reporting Services and Quality Submission Services" on page 2.

> Quality Reporting Services are hosted by the Medical Quality Improvement Consortium (MQIC).
>
> Membership in MQIC is not required to use these services, however as an MQIC member you receive Quality Reporting Services at no extra charge and your data are prepopulated in the reporting templates.

GE also provides optional Crystal Reports templates described in this guide that you can use within the application. The templates provide basic reporting for Meaningful Use functional and quality measures, however some may need to be customized by a qualified Crystal Reports designer to meet your organization's reporting needs.

Quality Reporting Services and Quality Submission Services

Quality Reporting Services provides reports and services to assist you in evaluating your organization's ability to meet quality measurements, including all required and optional Meaningful Use reporting requirements.

GE Healthcare processes data you collect for quality measures so you can avoid costly data and report design. Your de-identified data are processed by a secure data warehouse and made available in reports via a Web portal your quality administrators and providers can access. They can also drill down from the enterprise to clinic and provider levels and customize reports. As part of these services, GE Healthcare also provides clinical analysts who can help you understand quality measures and how to improve the data your clinicians collect.

Quality Submission Services (not available yet) will submit data to third parties such as CMS on behalf of your organization, for programs such as Meaningful Use, PQRI, or the eRx Incentive. When used in conjunction with Quality Reporting Services, data are automatically generated in the required format for clinical functional and quality measures. Currently this service is not available because the EHR Incentive Program cannot receive attestation submissions electronically yet.

Quality Submission Services is part of our certified EHR solution. You only pay for this service after electronic submission, beginning in 2012 for Meaningful Use.

> Your organization is solely responsible for determining whether your Eligible Professionals meet the requirements for Meaningful Use and ensuring the accuracy of any Meaningful Use attestation. Ensure you understand the measure requirements, reporting functionality and that you monitor the quality of the data entered into the application.

To schedule a demo of Quality Reporting Services, Performance Reporting, or the MQIC program, or for more information on how to enroll, contact Centricity Services or your Value-Added Reseller or send email to mqic@ge.com.

Crystal Reports templates for Meaningful Use reporting

GE offers basic Crystal Reports templates with Crystal Parameters to gather data meeting Meaningful Use measures within the Reports module.

> **!!!** These are report templates only. They search your data with commonly used observation terms and document types. You may need to modify the reports if you use custom observation terms or documents.
>
> Due to significant changes in the database to support report ease of use and reporting performance, these reports cannot be used in earlier versions of the application.

Crystal Reports for Meaningful Use are not recommended for all customers.

> Your organization is solely responsible for determining whether your Eligible Professionals meet the requirements for Meaningful Use and ensuring the accuracy of any Meaningful Use attestation. Ensure you understand the measure requirements, reporting functionality and that you monitor the quality of the data entered into the application.

Depending on the database size and the amount of data that is being searched, certain reports take a very long time to run, which may not be workable within your environment.

To test whether your database size is consistent with using Crystal Reports templates for Meaningful Use measurements, use the following database scripts and the algorithm.

Find database size

Four factors determine database size: users, documents, observations, and audit events. Run the following four database queries using a SQL database query tool:

Users

```
select count(*) from usr where isrespprov = 1
```

Documents

```
select count(*) from document
```

Observations

```
select count(*) from obs
```

Audit Events

```
select count(*) from audit_event
```

Add queries output and divide by 10 million (10,000,000):

Users + Documents + Observations + Audit Events ÷ 10,000,000 = DB size

Check table below to see whether your database size will work with Crystal Reports Templates for Meaningful Use:

Database size	1 - 7	8	9 - 16	17 - 18	19 - 25	25 30	30+
# reports running over 2 hrs	0	1	2	3	4	5	9
#reports running less than 2 hrs	18	17	16	15	14	13	9

If your database size is in the yellow or red zones, Quality Reporting Services will be your best option based on run time performance of the Crystal Reports.

All customers will benefit from using Quality Reporting Services. Reporting is easy and flexible.

Accessing and running reports

Installation instructions are located in the Meaningful Use Reports Release Notes available at
http://support.centricityservices.com/logician/mu/index.html

All reports are located in the **Centricity EMR 95/crwpt** folder and run from the Reports Print window. You can customize report parameters in **Setup | Settings > Reports > Reports**.The reports can also be modified outside the application in Crystal Reports.

> **Important**. If reports will be accessed from multiple locations of care, copy the folder to a central user-accessible location on your network. If you customize reports, GE recommends you rename these reports or move them to a different folder so that your customizations are preserved if you import a later version of the reports clinical kit.

Report template features

This section describes the basic Report template features. Quality Reporting Services reports have similar features and settings that are accessed on the Quality Report Services Web site. Some items, such as file name, only apply to Crystal Reports.

Configuration

In each report you specify a reporting period with start and end dates. You can also select Locations of Care. To add other custom parameters go to **Setup | Settings > Reports > Reports**.

When running reports, remember that eligible providers may have relevant data in more than one authorized location.

Display format

Most reports display measured data for users (by user) with a description of the measure and how it was calculated. Each report includes three sections:

■ **Header** - Includes measure title, reporting period, and CMS-specified measure description

■ **Details** - Lists users associated with measured data, numerator and denominator counts, calculated percentage, and an indication when a user has not met the measure threshold. For measures with an exclusion, the report includes the exclusion count and an indication when the user meets the exclusion.

■ **Footer** - Includes (at a minimum) when the report was printed and a report version number on the first page of the report.

When you attest, remember to save and archive all reports in PDF format for future reference.

Eligible Provider (EP)

Meaningful Use is based on attestation by eligible providers, so the reports return data grouped by provider. For encounter- and patient-based reports, the provider is the user who is the responsible provider for a document or its appends.

Eligible providers serving as preceptors

Reports link eligible providers to measured activities when they are the responsible provider for a document or its appends. You can include encounters documented in a residency workflow where a preceptor is signing off on a resident's document.

Quality Reporting Services reports look for both the responsible provider of the document and the first signing provider on the document.

Crystal Reports templates only looks for responsible providers.

GE recommends that eligible providers serving as preceptors either be the responsible provider for the resident's document or, for Crystal Reports, the responsible provider for an append to the document.

> Reports may include individuals who are not eligible providers, if the eligible provider's name is on an append to the document.

Seen by

Most reports are based on the term "seen by" used in many Meaningful Use measures. In the application, this might be an encounter or other direct interaction with a patient that you bill E&M codes for, including those with standard document types of office visit or procedure, or where applicable, home care or psychiatric visits.

Seen by in Quality Reporting Services reports

In addition to the standard document types of Office Visit, Office Procedure, Home Care, or Psychiatric Visits, MQIC considers custom document types that can map to the standard types.

In some cases, more than one Eligible Provider can include the same encounter in their counts. The reports look for:

- Responsible Provider for a qualifying document within the measure reporting period.
- First Signing Provider for a qualifying document within the measure reporting period.

Appended documents are not considered part of the Meaningful Use "seen by" criteria.

Seen by in Crystal Reports

In Crystal Reports, a patient is "seen" when a document type that represents an office visit, office procedure, or home care report, is signed in her chart. The date of the visit is the date of the document. This is the date that must be within the measure reporting period, not the signed date.

To include documents capturing this array of encounters, the reports use the database view MU_PATIENT_PROVIDER, that automatically returns information for documents and their appends based on a global chart document view called **Patient Encounter (MU)**.

Modifying the Patient Encounter (MU) document view

This global chart document view is hidden by default but can be modified in **Setup > Settings > Chart > Document Views**. The view includes the document types *Office Procedure, Office Visit*, and *Home Care Report*. If you have other custom document types that capture patient encounters you can add them here, as shown in the following illustration.
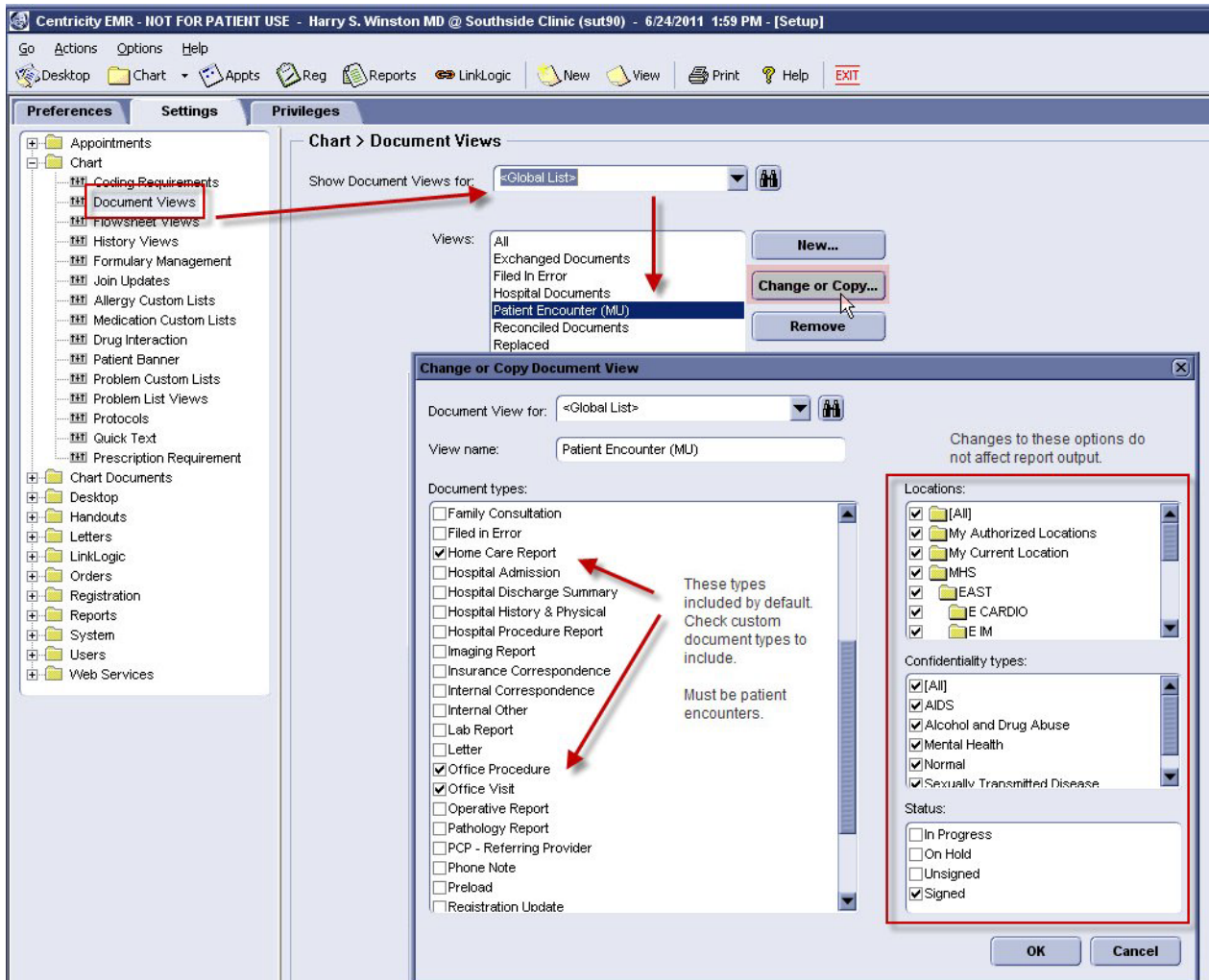
Users need not include the view in their preferred views for their data to be counted.

DO NOT check "All" types option to include all document types

Important. If you check this option to add all document types—

your reports will not return useful data. This option overrides system settings reports rely on to gather data. If you manually include document types that

are not "patient encounters," report data returned for providers is not calculated correctly.

Filed in Error or Replaced document types cannot be included

Filed in Error or Replaced document types cannot be added to the Patient Encounter (MU) view. Checking the options does not add them to the report.

One or more providers can determine "seen by"

Users who fulfill certain conditions in relation to a patient encounter determine whether a document for a patient is counted for a provider. In some cases, more than one provider can include the same encounter in their counts.

The reports look for the Responsible provider for a qualifying document within the measurement period.

Organization of reports

Meaningful Use reports are located in the CRWRPTS folder in the client application program files. However, they are accessed from two folders in the Reports module.

- **CMS Functional Measures** - reports are organized into sub-folders for required (Core) and optional (Menu) functional measures.

- **CMS Quality Measures** - reports are organized into sub-folders for required (Core, Alternate Core) and optional (Menu) quality measures.

> Report names in the user interface include the measure number and descriptive name. File names are designed to make them easy to identify by measure number, category, and short name. There are no reports for measures that require self-attestation.

Crystal report data definitions

- **Title** - This is the printed report title which differs from the report label in Report Print screen. The CMS regulation that governs this measure is displayed below.

- **Objective** - CMS definition of what it is to be achieved by using certified EHR technology.

- **Measure** - CMS definition of how the objective is measured, including the minimum threshold to qualify for the Meaningful Use incentive.

- **Exclusion** - CMS definition of when eligible providers are exempt from meeting the minimum threshold.

CMS Functional Measures

The CMS has defined required Core and optional Menu functional measures to demonstrate Meaningful Use:

- Core Set - 15 required objectives and corresponding measures. See below.
- Menu Set - 10 optional objectives and measures. See page 44

Most functional measures require a calculation based on a numerator and a denominator, a few require only Yes/No attestation.

!!! Your organization is solely responsible for determining whether your Eligible Professionals meet the requirements for Meaningful Use and ensuring the accuracy of any Meaningful Use attestation.

Ensure you understand the measure requirements, reporting functionality and that you monitor the quality of the data entered into the application.

CMS Functional Measures - Core

Core Set of required measures includes:

- 01 CPOE for Medication Orders - All Active Medications (Core)
- 01 CPOE for Medication Orders - Prescribed Medications Only (Core)
- 01 CPOE for Medication Orders - Qualification Report (Core)
- 02 Use Drug-drug / Drug-allergy Interaction-checking (Core)
- 03 Maintain Problem List (Core)
- 04 e-Prescribing (eRx) (Core)
- 05 Active Medication List (Core)
- 06 Medication Allergy List (Core)
- 07 Record Demographics (Core)
- 08 Record Vital Signs (Core)
- 09 Record Smoking Status (Core)
- 10 Report Clinical Quality Measures to CMS or State (Core)
- 11 Implement One Clinical Decision Support Rule (Core)
- 12 Provide Electronic Copy of Health Information (Core)
- 13 Clinical (Visit) Summaries (Core)
- 14 Exchange Key Clinical Information Electronically among Providers of Care (Core)
- 15 Protect Electronic Health Information (Core)

Menu Set optional objectives and measures includes:

- 01 Implement Drug Formulary Checks (Menu)
- 02 Clinical Lab Test Results (Menu)
- 03 Generate Patient Lists by Specific Condition (Menu) (attestation only)
- 04 Patient Reminders (Menu)
- 05 Patient Electronic Access (Menu)
- 06 Patient-specific Education Resources (Menu)
- 07 Medication Reconciliation (Menu)
- 08 Transition of Care Summary (Menu)
- 09 Test Capacity to Send Electronic Data to Immunization Registry (Menu)
- 10 Test Capacity to Submit Electronic Data to Public Health Agencies (Menu)

You must report on 5 measures including one population and public health measure.

01 CPOE for Medication Orders - All Active Medications (Core)

Requirements

SOURCE   42 CFR 495.6(d)(1)

OBJECTIVE   Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

MEASURE   More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.

EXCLUSION   Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/downloads/1CPOEforMedicationOrders.pdf

Calculation

DESCRIPTION   Percentage of patients seen in the reporting period who had at least one active medication on their medication list and for whom a licensed healthcare professional used CPOE to generate a prescription at least once during the reporting period.

FILE NAME   MU_Stg1_01_FC_CPOEMedOrders.rpt

DENOMINATOR   Count 1 for every patient *seen by* the eligible provider and where the patient's chart has at least one *active medication*.

> **seen by** - see , for QRS and Crystal Reports.

> **active medication** - Any medication recorded in the chart that is a coded drug (and not DME). The onset date must either be blank or on or before the last day of the measure reporting period; if there is an end date, it must be on or after the first day of the measure reporting period.

> **QRS report** - Uncoded medications may be converted to coded medications if a free text medication entry can be mapped to a coded medication.

NUMERATOR   Of the patients in the denominator, count 1 for every patient where the patient's chart has at least one prescription that was a *CPOE medication order*, signed by a *qualifying user* within the measurement period.

> **CPOE medication order** - A prescription for a coded medication (and not a DME) entered into the chart during the reporting period using one of the following Prescribing Methods available within the application: Electronic, Fax to pharmacy, Print then fax to pharmacy, Print then give to patient, Print then mail to patient, Print then mail to pharmacy, Telephone.

> **qualifying user** - Equivalent to the CMS term "licensed healthcare professional." In the application, this is indicated by the user's assigned *Job Title*.

> **licensed healthcare professional -** The signed by user's *Job Title* in the application must contain one of the following words at the time the measure report is printed: "License", "Physician", "Resident", "Medical Director," or "Nurse".

> **QRS report** - Whether a provider is considered a "licensed healthcare professional" is assessed on the last extract date during the reporting period, which is at the end of the reporting period by default.

EXCLUSION   Count 1 for every prescription for a coded medication (not DME) that was entered as a *medication order* and *written by* the eligible provider during the measurement period.

> ***written by*** - Eligible provider is the user selected as *Authorized By* for the prescription.

> ***medication order*** - A prescription for a coded medication (and not a DME) entered into the chart using one of the following Prescribing Methods available within the application: Electronic, Fax to pharmacy, Print then fax to pharmacy, Print then give to patient, Print then mail to patient, Print then mail to pharmacy, Telephone or Handwritten.

Note: If the exclusion count is less than 100, the status column in the report will say "excluded."

Setup, workflows, and best practices

SETUP   1   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

2   **Confirm or modify user Job Titles**. If necessary, you can create new or modify existing *Job Titles* and assign them to providers to capture all licensed providers in your organization. Go to **Setup > Settings > System > Users > Job Titles**.

3   **Customize report template**. If necessary, modify user job title selection criteria to include custom job titles or search for additional strings.

WORKFLOW   **Prescribe medication**, **Refill medication**, **Remove medication**

This measure focuses on patients who came into the office for a visit and were *seen by* a provider. The measure considers prescriptions produced for a patient during their visit.

> Since most application workflows related to a patient office visit include the provider signing prescriptions and refills for that patient, those workflows support this measure.
>
> This measure does not consider refill requests that come in by fax or phone or electronically if the patient has not been seen during the reporting period.

Note that—

- User who enters the prescription record **does not** have to be a licensed healthcare professional

- User who signs the prescription **must be** a licensed healthcare professional

- To receive MU credit, an eligible provider **must be** the Authorizing Provider on the prescription

- These prescribing methods do not qualify as CPOE-defined prescribing methods: Handwritten, Samples Given, Refax, Reprint, Historical.

BEST PRACTICE   While many organizations have standard policies regarding refilling medications and producing prescriptions, this Meaningful Use measure identifies the "licensed healthcare professional" as someone who can sign/send/print the order/prescription.

01 CPOE for Medication Orders - Prescribed Medications Only (Core)

Requirements

SOURCE   42 CFR 495.6(d)(1)

OBJECTIVE   Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

MEASURE   More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.

Note: This alternate report may be used only by eligible providers who—under the following circumstances—are both unable to meet the measure and unable to qualify for the exclusion. A qualifying eligible provider—

- Prescribes more than 100 medications during the EHR reporting period

- Maintains medication lists that include medications that they did not order

- Orders medications for less than 30 percent of patients with a medication in their medication list during the EHR reporting period

For additional details, see CMS FAQ 1063 at https://questions.cms.hhs.gov/app/answers/detail/a_id/10639/kw/cpoe.

Providers meeting all three criteria

…may limit their denominator to only those patients for whom the eligible provider has previously ordered medication, if they so choose.

Eligible providers who do not meet the three criteria listed above must still base their calculation on the number of unique patients with at least one medication in their medication list seen by the eligible provider during the EHR reporting period regardless of who ordered the medication or medications in the patient's medication list.

EXCLUSION   Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

REFERENCES   EHR Incentive Program Specification: http://www.cms.gov/EHRIncentivePrograms/downloads/1CPOEforMedicationOrders.pdf

Calculation

DESCRIPTION   Percentage of patients seen in the reporting period who had at least one active medication on their medication list that the eligible provider prescribed at least once on or before the last day of the reporting period and for whom a licensed healthcare professional used CPOE to generate a prescription at least once during the reporting period.

This report may be used only by those eligible providers who meet the three (3) conditions set forth in CMS FAQ 10639.

FILE NAME   MU_Stg1_01_FC_CPOEMedOrders_DenomCalc2.rpt

DENOMINATOR   Count 1 for every patient *seen by* the eligible provider and where the patient's chart has at least one *active medication* authorized by the eligible provider and entered as a *medication order* prior to the end of the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

active medication - Any medication recorded in the chart that is a coded drug (and not DME). The onset date must either be blank or on or before the last day of the measure reporting period; if there is an end date, it must be on or after the first day of the measure reporting period.

Quality Reporting Services - Uncoded medications may be converted to coded medications if a free text medication entry can be mapped to a coded medication.

medication order - A prescription for a coded medication (and not a DME) entered into the chart on or before the last day of the reporting period using one of the following Prescribing Methods available within the application: Electronic, Fax to pharmacy, Print then fax to pharmacy, Print then give to patient, Print then mail to patient, Print then mail to pharmacy, Telephone, Handwritten.

NUMERATOR Of the patients in the denominator, count 1 for every patient where the patient's chart has at least one prescription that was a *CPOE medication order*, signed by a *qualifying user* within the measurement period.

CPOE medication order - A prescription for a coded medication (and not a DME) entered into the chart during the reporting period using one of the following Prescribing Methods available within the application: Electronic, Fax to pharmacy, Print then fax to pharmacy, Print then give to patient, Print then mail to patient, Print then mail to pharmacy, Telephone.

qualifying user - Equivalent to the CMS term "licensed healthcare professional." In the application, this is indicated by the user's assigned *Job Title*.

licensed healthcare professional - The signed by user's *Job Title* in the application must contain one of the following words at the time the measure report is printed: "License", "Physician", "Resident", "Medical Director," or "Nurse".

QRS report - Whether a provider is considered a "licensed healthcare professional" is assessed on the last extract date during the reporting period, which is at the end of the reporting period by default.

EXCLUSION Count 1 for every prescription for a coded medication (not DME) that was entered as a *medication order* and *written by* the eligible provider during the measurement period.

written by - Eligible provider is the user selected as *Authorized By* for the prescription.

medication order - A prescription for a coded medication (and not a DME) entered into the chart using one of the following Prescribing Methods available within the application: Electronic, Fax to pharmacy, Print then fax to pharmacy, Print then give to patient, Print then mail to patient, Print then mail to pharmacy, Telephone or Handwritten.

Note: If the exclusion count is less than 100, the status column in the report will say "excluded."

Setup, workflows, and best practices

SETUP 1 **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See .

2 **Confirm or modify user Job Titles**. If necessary, you can create new or modify existing *Job Titles* and assign them to providers to capture all licensed providers in your organization. Go to **Setup > Settings > System > Users > Job Titles**.

3 **Customize report template**. If necessary, modify user job title selection criteria to include custom job titles or search for additional strings.

WORKFLOWS **Prescribe Medication**, **Refill Medication**, **Remove Medication**

Note that—

- User who enters the prescription record **does not** have to be a licensed healthcare professional
- User who signs the prescription **must be** a licensed healthcare professional
- To receive MU credit, an eligible provider **must b**e the Authorizing Provider on the prescription
- These prescribing methods do not qualify as CPOE-defined prescribing methods: Handwritten, Samples Given, Refax, Reprint, Historical.

01 CPOE for Medication Orders - Qualification Report (Core)

Requirements

SOURCE   42 CFR 495.6(d)(1)

OBJECTIVE   CMS FAQ 10639 requires that to use the alternate calculation, eligible providers must meet this criteria: "Orders medications for less than 30 percent of patients with a medication in their medication list during the EHR reporting period."

Use this report to determine if an eligible provider qualifies to use the alternate denominator calculation (01 CPOE for Medication Orders - Prescribed Medications Only).

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/downloads/1CPOEforMedicationOrders.pdf

Calculation

DESCRIPTION   Percentage of patients seen in the reporting period who had at least one active medication on their medication list for which the eligible provider prescribed at least once during the reporting period.

This report is used to determine if an eligible provider qualifies to use the revised denominator calculation described in CMS FAQ 10639.

FILE NAME   MU_Stg1_01_FC_CPOEMedOrders_DenomCalc2_Qualification.rpt

DENOMINATOR   Count 1 for every patient *seen by* the eligible provider and where the patient's chart has at least one *active medication*.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **active medication** - Any medication recorded in the chart that is a coded drug (and not DME). The onset date must either be blank or on or before the last day of the measure reporting period; if there is an end date, it must be on or after the first day of the measure reporting period.
>
> **QRS report -** Uncoded medications may be converted to coded medications if a free text medication entry can be mapped to a coded medication.

NUMERATOR   Count 1 for every patient in the denominator who had at least one *medication order written by* the eligible provider during the reporting period.

> **written by** - Eligible provider is the user selected as *Authorized By* for the prescription.
>
> **medication order** - A prescription for a coded medication (and not a DME) entered into the chart using one of the following Prescribing Methods available within the application: Electronic, Fax to pharmacy, Print then fax to pharmacy, Print then give to patient, Print then mail to patient, Print then mail to pharmacy, Telephone, Handwritten.

EXCLUSION   Count 1 for every prescription for a coded medication (not DME) that was entered as a *medication order* and *written by* the eligible provider and signed in the chart during the measurement period.

> **written by** - Eligible provider is the user selected as *Authorized By* for the prescription.
>
> **medication order** - A prescription for a coded medication (and not a DME) entered into the chart using one of the following Prescribing Methods available within the application: Electronic, Fax to pharmacy, Print then fax to pharmacy, Print then give to patient, Print then mail to patient, Print then mail to pharmacy, Telephone, Handwritten.

Note: If the exclusion count is less than 100, the status column in the report will say "excluded."

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

WORKFLOWS **Prescribe Medication**, **Refill Medication**, **Remove Medication**

Note that—

- User who enters the prescription record **does not** have to be a licensed healthcare professional

- To receive MU credit, an eligible provider **must be** the Authorizing Provider on the prescription

02 Use Drug-drug / Drug-allergy Interaction-checking (Core)

Requirements

SOURCE   42 CFR 495.6(d)(2)
Yes/No Attestation Only

OBJECTIVE   Implement drug-drug and drug-allergy interaction checks.

MEASURE   The eligible provider has enabled this functionality for the entire EHR reporting period.

EXCLUSION   None

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/2_Drug_Interaction_ChecksEP.pdf

Setup, workflows, and best practices

SETUP   Interaction checking is always enabled and active in the product; it cannot be disabled and requires no special configuration.

WORKFLOWS   **Prescribe Medication**, **Refill Medication**, **Change/Remove Medication**

While the application is able to check interactions between medications, medication allergies, and medications with diagnosis/age/gender, this measure only considers its ability to display interaction checking between two medications or a medication and an active medication allergy.

BEST PRACTICES   Centricity EMR permits the organization to set an enterprise-wide level of severity for an interaction that requires the user to manually acknowledge and override the interaction to produce a prescription for a medication. This feature complies with the requirements for meeting this measure.

GE recommends providers routinely review and acknowledge when an indicated medication/medication, allergy/medication interaction occurs.

03 Maintain Problem List (Core)

Requirements

SOURCE 42 CFR 495.6(d)(3)

OBJECTIVE Maintain an up-to-date problem list of current and active diagnoses.

MEASURE More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.

EXCLUSION None

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/3MaintainProblemList.pdf

Calculation

DESCRIPTION Percentage of patients seen in the reporting period whose problem list was maintained before or during the reporting period.

FILE NAME MU_Stg1_03_FC_ProblemList.rpt

DENOMINATOR Count 1 for every patient *seen by* the eligible provider.

> ***seen by*** - see for QRS and Crystal Reports.

NUMERATOR Of the patients in the denominator, count 1 for every patient where the patient's chart has at least one *active problem* or an indication of *No Known Problem* (*NKPROB*).

> ***active problem*** - A problem recorded in the chart of any problem type (except *Status Post*), where the problem code begins with 'ICD-'. The onset date must either be blank or on or before the last day of the measure reporting period; if there is an end date, it must be on or after the first day of the measure reporting period.
>
> The problem code field must start with 'ICD-'. SNOMED codes are not considered.
>
> ***No Known Problem*** - Indicated in the application when the latest recorded *NKPROB* observation in the patient's chart has a value of 'T' at any time on or before the last day of the reporting period.
>
> ***QRS report*** - Does not explicitly exclude problems with type *Status Post*. Custom Procedures with a code starting with 'ICD-' (where *Status Post* typically applies) are accepted. Additional values for *NKPROB* indicating no known problems are accepted. GE recommends you use 'T', the default value when *This patient has no known problems (NKPROB)* is checked in the application.

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See .

WORKFLOWS **Maintain Problem list**

- **Add / Change Problems** (any problem type except *Status Post;* must include 'ICD-' code)
- Check **No Known Problems**

Generate Orders

- Under **Potential Diagnoses** list, select or add a new Problem to associate with the order.
- Check **Add to Patient Problem List** to ensure problems associated with orders are counted.

For every patient seen, one of these conditions must be present to count for the eligible provider:

- **At least one problem on the Problem List** with either no start date, or a start date before the end of the reporting period.
- **This Patient Has No Known Problems (NKPROB)** is checked before the end of the reporting period.

BEST PRACTICES

- Review and update all patients active problems each visit to assure the accuracy and currency of the Active Problem list. All problems must have 'ICD-' codes.

   Problems with onset dates prior to the end of the reporting period (or no start date) are counted as active problems. It does not matter who added the problem(s) to the list.

   Measure calculation is not affected when **Problem List Reviewed During This Update** is checked.

- If all the patient's problems are resolved, check **This Patient Has No Known Problems (NKPROB)** when the last problem is removed.

04 e-Prescribing (eRx) (Core)

Requirements

SOURCE 42 CFR 495.6(d)(4)

OBJECTIVE Generate and transmit permissible prescriptions electronically (eRx).

MEASURE More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

EXCLUSION Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/4PermissiblePrescriptions.pdf

Calculation

DESCRIPTION Percentage of permissible prescriptions that were transmitted electronically during the reporting period.

FILE NAME MU_Stg1_04_FC_eRX.rpt

DENOMINATOR Count 1 for every *permissible prescription written by* the eligible provider during the measure reporting period.

written by - The eligible provider is the user selected in the application as *Authorized By* for the prescription.

permissible prescription - A prescription for a prescription-only (not OTC - over the counter) coded medication (and not DME) entered into the chart using one of the following prescribing methods available within the application:

- Electronic
- Fax to pharmacy
- Print then fax to pharmacy
- Print then give to patient
- Print then mail to patient
- Print then mail to pharmacy
- Telephone
- Handwritten

Note: Controlled substances class code 1-5 are not included.

QRS report - Uncoded medications may be converted to coded medications if a free text medication entry can be mapped to a coded medication.

NUMERATOR Of the prescriptions in the denominator, count 1 for each where prescribing method is Electronic.

EXCLUSION Count 1 for every prescription for a coded drug medication (and not DME) *written by* the eligible provider as a *medication order* and signed in the chart during the measure reporting period.

written by - The eligible provider is the user selected as *Authorized By* for the prescription.

medication order - A prescription for a coded medication (and not a DME) entered into the chart using one of the following Prescribing Methods available within the application:

- Electronic
- Fax to pharmacy
- Print then fax to pharmacy
- Print then give to patient
- Print then mail to patient
- Print then mail to pharmacy
- Telephone

- Handwritten

Setup, workflows, and best practices

SETUP   1   **Implement Centricity Advanced ePrescribing** - configure application and users for ePrescribing.

2   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

WORKFLOWS   (With ePrescribing enabled) **Prescribe medication**, **Refill medication**

- **Set the eligible provider as 'Authorized By'** when producing a prescription for medications permitted to be transmitted electronically. The measure does not assume that all medications can be electronically prescribed.

- **Use prescribing method of 'Electronic'** for prescriptions that are not for

  - Controlled substances

  - Over the counter (OTC) medications

  - Over the counter supplies

The product meets all requirements with Centricity Advanced ePrescribing. For details, see *What's New in Centricity EMR*.

BEST PRACTICES   Always set the eligible provider as "Authorized By" when completing a prescription request. Use the "Electronic" prescribing method whenever possible for medications permitted to be transmitted electronically.

05 Active Medication List (Core)

Requirements

SOURCE 42 CFR 495.6(d)(5)

OBJECTIVE Maintain active medication list.

MEASURE More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

EXCLUSION None

REFERENCES EHR Incentive Program Specification: http://www.cms.gov/EHRIncentivePrograms/Downloads/5ActiveMedicationList.pdf

Calculation

DESCRIPTION Percentage of patients seen in the reporting period whose medication list was maintained before or during the reporting period

FILE NAME MU_Stg1_05_FC_MedList.rpt

DENOMINATOR Count 1 for every patients seen by the eligible provider.

> ***seen by*** - see , for QRS and Crystal Reports.

NUMERATOR Of the patients in the denominator, count 1 for every patient where the patient's chart has at least one a*ctive medication* or an indication of *No Known Medication (NKMED)*.

> ***active medication*** - Any medication recorded in the chart, coded or uncoded, drug or DME, and so on. The onset date must either be blank or on or before the last day of the measure reporting period; if there is an end date, it must be on or after the first day of the measure reporting period.
>
> ***No Known Medication*** - Indicated in the application when the latest recorded *NKMED* observation in the patient's chart has a value of 'T' at any time on or before the last day of the reporting period.
>
> **QRS report**: Additional values for *NKMED* indicating no known medications are accepted. GE recommends you use 'T', the default value when *This Patient Takes No Known Medications (NKMED)* is checked in the application.

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See .

WORKFLOWS **Maintain Medication list**, **Add / Change Medication**, **Record No Known Medication**

For every patient seen, one of these conditions must be present to count for the eligible provider:

- **At least one medication on the Medication list** with either no start date, or a start date before the end of the reporting period.

- **This Patient Takes No Known Medications (NKMED)** is checked before the end of the reporting period.

BEST PRACTICES
- Review and update all patients active medications each visit to assure the accuracy and currency of the Medication list.

- Medications with onset dates prior to the end of the reporting period (or no start date) are counted as active medications. It does not matter who added the medication(s) to the list.

Measure calculation is not affected when **Medications List Reviewed During This Update** is checked.

- If all patient's medications are discontinued or ceased, check **This Patient Takes No Known Medications (NKMED)** when the last medications is removed.

06 Medication Allergy List (Core)

Requirements

SOURCE | 42 CFR 495.6(d)(6)

OBJECTIVE | Maintain active medication allergy list.

MEASURE | More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

EXCLUSION | None

REFERENCES | EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/6_Medication_Allergy_List.pdf

Calculation

DESCRIPTION | Percentage of patients seen in the reporting period whose allergy list was maintained before or during the reporting period.

FILE NAME | MU_Stg1_06_FC_MedAllergyList.rpt

DENOMINATOR | Count 1 for every patient seen by the eligible provider.

> ***seen by*** - see "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR | Of the patients in the denominator, count 1 for every patient where the patient's chart has at least one *active medication allergy or other allergy* or an indication of *No Known Allergy* (NKA).

> ***active allergy*** - Any allergy recorded in the chart, including food allergies, environmental allergies, uncoded (custom) allergies, and medication allergies. The onset date must either be blank or on or before the last day of the measure reporting period; if there is an end date, it must be on or after the first day of the measure reporting period.

> ***No Known Allergy*** - Indicated in the application when the latest recorded NKA observation in the patient's chart has a value of 'T' at any time on or before the last day of the reporting period. In determining *No Known Allergy*, the system does not distinguish between types of allergies. Therefore, it cannot report only No Known Medication Allergies if other allergies are indicated in the system.

> **QRS report**: Additional values for *NKA* indicating no known allergies are accepted. GE recommends you use 'T', the default value when *This Patient Has No Known Allergies or Adverse Reactions (NKA)* is checked in the application.

> Currently, the active status of an allergy is assessed at the date of the last MQIC data extract. For 3-month reporting periods the last extract date is synonymous with the last day of the reporting period.

Setup, workflows, and best practices

SETUP | **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

WORKFLOWS | **Maintain Allergies list**, **Add / Change Allergy**, **Record No Known Allergy**

For every patient seen, one of these conditions must be present to count for the eligible provider:

- **At least one allergy (medication or non-medication)** on the Allergies and Adverse Reactions list with either no start date, or a start date before the end of the reporting period.

- **This Patient has No Known Allergies or Adverse Reactions (NKA)** is checked before the end of the reporting period.

▪ Review and update all patients active allergies each visit to assure the accuracy and currency of the Allergies and Adverse Reactions list.

▪ Allergies with onset dates prior to the end of the reporting period (or no start date) are counted as active allergies. It does not matter who added the allerg(ies) to the list.

Measure calculation is not affected when **Allergies and Adverse Reactions List Reviewed During This Update** is checked.

▪ If all patient's allergies are resolved, check **This Patient has No Known Allergies or Adverse Reactions (NKA)** when the last allergy is removed.

07 Record Demographics (Core)

Requirements

SOURCE   42 CFR 495.6(d)(7)

OBJECTIVE   Record all of the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth

MEASURE   More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.

EXCLUSION   None

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/7RecordDemographics.pdf

Calculation

DESCRIPTION   Percentage of patients seen in the reporting period for whom the required demographics (preferred language, gender, race, ethnicity, and date of birth) were recorded in patient registration before or during the reporting period.

FILE NAME   MU_Stg1_07_FC_Demographics.rpt

DENOMINATOR   Count 1 for every patient *seen by* the eligible provider.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   Of the patients in the denominator, count 1 for every patient for whom all *required demographics* are *recorded with OMB specific values*.

required demographics - Include the following attributes: Date of Birth, Gender, Preferred Language, Race, Ethnicity.

Race:

Any custom value or default system values except: Hispanic, Other, and Multiracial.

The OMB values include:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Ethnicity:

The following default and custom values are the only acceptable values.

Default system values:

- Hispanic or Latino
- Non Hispanic or Latino
- Other or Undetermined

Custom values:

- Declined
- Not Hispanic or Latino
- Non-hispanic or Latino

- Nonhispanic or Latino

recorded - at the time the measure report is printed.

QRS report: GE recommends you record demographics in the application Registration module. Otherwise, enter values using observation terms in the observation groups *RACE MU*, *ETHNICITY MU*, and *LANGUAGE*. Values for race, ethnicity, preferred language, gender, and date of birth from the application registration module are assessed on the last extract date for the reporting period, which is at the end of the reporting period by default. Obs groups and demographic data can only be obtained through the chart module and not the billing system.

Setup, workflows, and best practices

SETUP 1 **Configure Race/Ethnicity values**. Set up, add or change Race and Ethnicity values in Setup | Settings > Registration > Ethnicity and Setup | Settings > Registration > Race.

2 **Avoid using default Race values "Hispanic", "Other", "Multiracial"**. These default values are not compliant with OMB. To record Multiracial, create a custom value containing the component OMB races (for example, "Asian/White").

3 **Modify your Check-In /Registration workflow** to capture *Ethnicity* value where needed.

4 **Set up LinkLogic**. LinkLogic automatically imports both values.

5 **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

WORKFLOWS **Register/Schedule patient**, **New /Change patient**

BEST PRACTICES The system is pre-populated with values that meet EHR Incentive Specification guidelines: "Race and ethnicity codes should follow current federal standards published by the Office of Management and Budget (http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr). "

- Document Date of Birth, Gender, Preferred Language, Race, Ethnicity values for patient in Registration manually or through electronic interface exchange of demographics data.

- Modify Check-in/Registration workflows to require staff to ask about race, ethnicity, and language preference in a professional and sensitive manner.

- If patient declines to provide Race or Ethnicity or if collection of this information is prohibited by law, select list option *Undetermined* for Race and *Other or Undetermined* for Ethnicity. These values meet the goal of structured data.

  Note. Historic information is not counted.

Caution. Your system may include default values that do not map to OMB categories and are not counted to meet Meaningful Use criteria.

- **New installations** - Default values not mapped to OMB categories can be removed.

- **Existing installations** - If a value has been used for a patient, it cannot be removed from the system until all instances of its use have been removed from Registration.

Recommended. If a patient wants to record more than one race, OMB requires that each race value be indicated separately. If necessary, set up custom race values, so the Registration list includes all races that might apply to a patient of more than one race. For example: Black/White or White/Asian or Asian/Hawaiian/White.

Data exchange. Additional interface data may need to be added to the producing system file to assist with capturing data in the application. If manually updating the registration items, appropriate privileges must be enabled to complete this task. If the patient refuses to answer questions about race and ethnicity documenting "undetermined" qualifies for meeting this measure. Any value means you are in compliance with the measure.

08 Record Vital Signs (Core)

Requirements

SOURCE   42 CFR 495.6(d)(8)

OBJECTIVE   Record and chart changes in the following vital signs:

- Height
- Weight
- Blood pressure
- Calculate and display body mass index (BMI)
- Plot and display growth charts for children 2 - 20 years, including BMI

MEASURE   More than 50 percent of all unique patients age 2 and over seen by the eligible provider, height, weight and blood pressure are recorded as structured data.

EXCLUSION   Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/8RecordVitalSigns.pdf

Calculation

DESCRIPTION   Percentage of patients seen in the reporting period for whom the required vital signs (height, weight, and blood pressure) were recorded in their chart before or during the reporting period.

FILE NAME   MU_Stg1_08_FC_VitalSigns.rpt

DENOMINATOR   Count 1 for every patient that meets the *qualifying age* and is *seen by* the eligible provider.

> *seen by* - see "Seen by" on page 7, for QRS and Crystal Reports.

> *qualifying age* - Includes any patient 2 years old or older at the time the patient is seen by the eligible provider.

NUMERATOR   Of the patients in the denominator, count 1 for every patient for whom all *required vitals* are *recorded* at least once in the patient's chart

> *recorded* - The required vitals entry date must be on or before the last day of the measure reporting period.

> *required vitals* - Includes height, weight, and blood pressure only as specified in the CMS measure.

> **Crystal Report**: - Searches for the observations HEIGHT, Height (cm), WEIGHT, Weight (kg), BP DIASTOLIC, BP SYSTOLIC. BP SYS STAND, BP SYS LYING, BP DIA STAND, BP DIA LYING.

> **QRS report** - Searches for additional observations in these observation groups: BP DIASTOLIC, BP SYSTOLIC, HEIGHT, WEIGHT (multiple terms in each group). Data is de-identified, with only the patient month and year of birth available. This may affect which patients meet the age criteria for a particular reporting period.

EXCLUSION   The eligible provider is not listed in the report if the eligible provider's denominator value is 0 (zero), which indicates that the eligible provider may meet the exclusion criteria.

Setup, workflows, and best practices

SETUP   1   **Confirm supported clinical content**. Import latest clinical kits and confirm supported encounter forms are associated with your encounter types/documents.

2 **Confirm custom forms** use observation terms noted above.

3 **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

4 The *Patient Encounter (MU)* document view is hidden by default but can be modified in **Go > Setup > Settings > Chart > Document Views**. Make sure you import the upgrade.ckt clinical kit before attempting to modify this view.

5 **Customize report template**. Modify report template in Crystal Reports to include custom observation term if needed, or consider using Quality Reporting Services (QRS) which includes many additional terms.

WORKFLOWS **Update Chart**

■ **Use encounter forms** (any GE or CCC vital signs encounter form that uses supported observations).

■ **Growth charts/BMI calculation**: Only height, weight, and blood pressure are required. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.

Note: Required vitals need not be updated at every patient encounter. According to the EHR Incentive Program Specification: "Height, weight, and blood pressure do not have to be updated by the eligible provider at every patient encounter. The eligible provider can make the determination based on the patient's individual circumstances as to whether height, weight, and blood pressure need to be updated."

BEST PRACTICES When clinically appropriate, record required height, weight, and blood pressure vitals as part of a patient visit. All standard vital signs encounter forms assist in documenting and recording these vitals.

This measure references BMI (Body Mass Index) and growth cart data available for patients between the ages of 2 and 20 years. BMI is automatically calculated using entered weight and height. The Growth Chart uses BMI plotted on the chart/graph. This functionality available for patients between 2 and 20 years old meets current requirements for this measure.

If creating custom content or editing a vital signs form, store the data using the Observation terms: HEIGHT, Height (cm), WEIGHT, Weight (kg), BP DIASTOLIC, BP SYSTOLIC.

Note: BP supine and BP standing do not store data in the BP SYSTOLIC and BP DIASTOLIC observation terms. Ensure that your users are using the BP sitting vital signs or modify the form to change the observation terms for these values.

09 Record Smoking Status (Core)

Requirements

SOURCE   42 CFR 495.6(d)(9)

OBJECTIVE   Record smoking status for patients 13 years old or older.

MEASURE   More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

EXCLUSION   Any EP who sees no patients 13 years or older.

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/9RecordSmokingStatus.pdf

Calculation

DESCRIPTION   Percentage of patients seen in the reporting period for whom smoking status was recorded in their chart before or during the reporting period.

FILE NAME   MU_Stg1_09_FC_SmokingStatus.rpt

DENOMINATOR   Count 1 for every patient that meets the *qualifying age* and is *seen by* the eligible provider.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.

> **qualifying age** - Includes any patient 13 years old or older at the time the patient is seen by the eligible provider.

NUMERATOR   Of the patients in the denominator, count 1 for every patient for whom a *smoke status* was *recorded* and signed in the patient's chart using smoke status observation terms with *ONC-specified values*.

> **recorded** - the smoking status entry date is on or before the last day of the measure reporting period.

> **smoke status** - searches for the observations Cigaret smkg, SMOK STATUS, smokes, smoking hx, HX CIGARETTE, SMKSTATOVR13.

> **ONC-specified values**
>
> - *current every day smoker*
> - *current some day smoker*
> - *former smoker*
> - *never smoker*
> - *unknown if ever smoked*
> - *smoker, current status unknown*
>
> Accepted variations (custom values):
>
> - *smoker - current status unknown*
> - *smoker current status unknown*
> - *smoker-current status unknown*
> - *smoker- current status unknown*
> - *smoker,current status unknown*
> - *smoker, current status unknown*
> - *smoker:current status unknown*
> - *smoker: current status unknown*
>
> **QRS report**: Text strings for smoking status that begin with one of the values listed above are accepted. Additional text following one of these strings will not exclude the term. Data is de-identified, with only the patient month and year of birth available. This may affect which patients meet the age criteria for a particular reporting period.

EXCLUSION   The eligible provider is not listed in the report if the eligible provider's denominator value is 0 (zero), which indicates that the eligible provider may meet the exclusion criteria.

Setup, workflows, and best practices

<small>SETUP</small>
1. **Confirm supported clinical content**. Import latest clinical kits and confirm supported encounter forms are associated with your encounter types/documents.

2. **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

3. The *Patient Encounter (MU)* document view is hidden by default but can be modified in **Go > Setup > Settings > Chart > Document Views**. Make sure you import the upgrade.ckt clinical kit before attempting to modify this view.

4. **Customize report template**. Modify report template in Crystal Reports to include custom observation term if needed, or consider using Quality Reporting Services (QRS) which includes many additional terms.

<small>WORKFLOWS</small>
Current product captures smoking status on the Risk Factors form. In FH-SH-CCC form, the smoking status field includes more detailed values specified in the final ARRA regulation 45CFR 170.302(f).

Update Chart - Only use encounter forms that include supported observations and observation values.

<small>BEST PRACTICES</small>
Smoking Status must be recorded before the end of the measure reporting period but can occur before the beginning of the period. This design is based on the EHR Incentive Program specification: "If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community."

During routine patient visits, clinical interaction regarding smoking, and smoking cessation can be documented by any clinician working with the patient.

The report does not count how often the patient is asked about smoking status. If a patient over 13 has been asked this question and the answer is recorded using a valid observation term, the patient counts toward meeting the measure if they are seen within the reporting period regardless of whether they were asked during the reporting period.

Use the Social History or Risk Factor Form during the interaction with the patient to record their response to smoking status and smoking questions. You can use the form for patients of any age, but only patients over the age of 13 are counted for this measure.

If using alternative content or editing the FH-SH form component, use the observation term SMOK STATUS.

10 Report Clinical Quality Measures to CMS or State (Core)

Requirements

SOURCE   42 CFR 495.6(d)(10)
          Yes/No Attestation Only

OBJECTIVE   Report ambulatory clinical quality measures to CMS, or in the case of Medicaid eligible providers, to the states.

MEASURE   Successfully report to CMS or the States ambulatory clinical quality measures selected by CMS in the manner specified by CMS or states.

EXCLUSION   None

REFERENCES   EHR Incentive Program Specification:
          http://www.cms.gov/EHRIncentivePrograms/Downloads/10ClinicalQualityMeasures-CQMs.pdf

          Refer to "CMS Quality Measures" on page 55.

Setup, workflows, and best practices

SETUP   Varies.

WORKFLOWS   New web-based Quality Submission Services permit organizations to enter data and generate and send formatted reports.

          Application workflows vary depending on clinical measure.

11 Implement One Clinical Decision Support Rule (Core)

Requirements

SOURCE   42 CFR 495.6(d)(11)
Yes/No Attestation Only

OBJECTIVE   Implement one clinical decision support rules relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

MEASURE   Implement one clinical decision support rule.

Providers have considerable flexibility in meeting this measure. They need only attest they are using a clinical decision support rule. For example, anything that provides a notification will be counted, including a pop-up alert that requires a response or an indicator on a form showing an immunization, exam, or test due.

EXCLUSION   None

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/11ClinicalDecisionSupportRule.pdf

Setup, workflows, and best practices

SETUP   **Optionally log decision support user actions**. Although not required for attestation, to see how user decision support actions are captured by the system, go to **Setup > Settings > System > Auditing** and confirm that *MEL Decision Support* is in the Log Audit Events column.

WORKFLOWS   Various workflows support this measure including:

- **Using Pop Up Alerts** on charts that have been designated as needing a clinical intervention based on a treatment deficiency.

- **Using Protocols** for USPS or Treatment/Diagnostic related treatment interventions.

- **Using content that alerts or interacts with the provider** based on clinical treatment needs or deficiencies.

BEST PRACTICES   You do not need to track these actions to fulfill this measure requirement.

The application provides MEL functions *UserYesNo* and *UserOK* in encounter forms, document templates, and patient banners to support decision support rules.

System auditing automatically logs user responses to alerts and care suggestions created with MEL decision support functions. You can optionally track, record, and generate reports on the number of alerts responded to by a user.

12 Provide Electronic Copy of Health Information (Core)

Requirements

SOURCE   42 CFR 495.6(d)(12)

OBJECTIVE   Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.

MEASURE   More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.

EXCLUSION   Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/12ElectronicCopyofHealthInformation.pdf

Calculation

DESCRIPTION   Percentage of patient requests for an electronic copy of their health information that were provided within 3 business days of the request.

FILE NAME   MU_Stg1_12_FC_eCopyHealhInfo.rpt

DENOMINATOR   Count 1 for each *recorded qualifying request* to which the eligible provider is *linked*.

> **linked provider**
>
> **Crystal Reports** – login name (ROI AUTH LN) of the user selected from the *Authorized By* (ROI AUTH) field on the Patient Authorization Form. (Entering the user name manually to match DOES NOT push required ROI AUTH LN term to the chart.)
>
> **QRS** – MQIC is not able to utilize the 'authorizing provider' field. The responsible provider and first signer on the document containing the required obs terms are given credit for the patient. No specific document type is necessary.
>
> **qualifying request**
>
> - *Date Request Received* (ROI DTE RCVD) must be within the measure reporting period up to 4 business days prior to the last day of the reporting period
>
> - *Purpose of Disclosure* (ROI REASON) must be **copy for patient**.
>
> - *Sent Via* (ROI METHOD) must be **electronic**.
>
> *recorded* - Linked provider and qualifying request observation terms must be on the same document.
>
> **Note**: Appends do not count as same document.

NUMERATOR   Of the qualifying requests in the denominator, count 1 for each request that was *fulfilled* in the *required time frame*.

> *fulfilled* - *Date Sent* must be specified on the same document as the request for one or more disclosed information types (ROI AL SD DT, ROI CR SD DT, ROI DA SD DT, ROI DD SD DT, ROI DTE SENT, ROI EN SD DT, ROI ER SD DT, ROI GT SD DT, ROI HA SD DT, ROI IR SD DT, ROI LR SD DT, ROI MH SD DT, ROI ML SD DT, ROI OR SD DT, ROI OT SD DT, ROI PL SD DT, ROI RR SD DT, ROI XR SD DT).
>
> **QRS report**: Currently MQIC only recognizes one observation term for the date the health information was delivered (ROI ER SD DT).
>
> *required time frame* - Within 3 business days of the request.

EXCLUSION   The eligible provider is not listed in the report if the eligible provider's denominator value is 0 (zero), which may indicate that the eligible provider may meet the exclusion criteria.

Setup, workflows, and best practices

SETUP **Confirm and use Patient Authorization** (release of information) form to capture information about requests that can be reported

WORKFLOWS **Important**: the following information describes how to use the application for Meaningful Use reporting only. It does not address usage and process to be in compliance with HIPAA rules for releasing PHI.

This authorization form is located in Clinkits/BasicPr/Items/FormComp /AuthForm/AUTHFORM.CKT

This authorization form is enhanced so you can also use it to capture a patient's request for an electronic copy of their health information and the date of fulfillment. The form can also be used for its intended purpose in other contexts. Entries required for calculation include:

- *Information Disclosed* - if you are using QRS reports, select **Entire Record**. If you are using Crystal Reports, you can select one or more options.
- *Date Sent* - must be selected
- *Purpose of Disclosure* - select **Copy for patient**
- *Authorized By* - always select the eligible provider for the measure from the Authorized By list. (Typing the name manually to match does not push the required observation term ROI AUTH LN to the chart.)
- *Sent Via* - select **Electronic**
- *Date Request Received* - must be selected

Note: Always use the calendar utility by each date field to select and enter the date. Or if entering manually, use required slash delimiters to format as a date value, for example, 12/13/2011. If you enter an unformatted date (12312011 or 12-31-2011), the form does not correct the error.

Delivery mechanisms:

- **Generate Chart Summary** in **CCD format** (from Actions menu) and save it to electronic media (portable storage device, CD)

- **Send CCD Chart Summary** to patient via Secure Messaging

These options meet the EHR Incentive Program Specification requirements that data be structured to CCD standards and human readable.

BEST PRACTICES Generate and send clinical summary in CCD format to other systems via Secure Messaging, SMIM secure email, or HIE. You may send by regular email ONLY if the CCD file is

password-protected at the time you generate the CCD. DO NOT include the password in the same email.

GE recommends using Secure Messaging which lets the application user send a CCD generated from the patient chart to another provider or to the patient. For security reasons, this method is preferable to generating a CCD to an external, portable storage device.

13 Clinical (Visit) Summaries (Core)

Requirements

SOURCE 42 CFR 495.6(d)(13)

OBJECTIVE Provide clinical summaries for patients for each office visit.

MEASURE Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.

EXCLUSION Any EP who has no office visits during the EHR reporting period.

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/13ClinicalSummaries.pdf

Calculation

DESCRIPTION Percentage of patient visits for which a clinical (visit) summary was provided within 3 business days of the visit.

FILE NAME MU_Stg1_13_FC_ClinicalVisitSummaries.rpt

DENOMINATOR Count 1 for every *qualifying office visit linked* to the eligible provider.

Note that for this measure the *Patient Encounter (MU)* document view is not used to filter documents because it includes more document types than those used for an office visit.

For the document to be counted in the denominator, the document needs to be signed AFTER the Clinical Summary has been printed and BEFORE the end of the reporting period.

> **qualifying office visit**
>
> > **Crystal Report** - Includes documents with a clinical date in the measure reporting period where the document type starts with the word "Office".
> >
> > **QRS report** - Includes documents with a clinical date in the measure reporting period and one of these document types: *Office Visit* or *Office Procedure*. It also includes any custom document types you have mapped to these types. Once mapped, all prior instances of the custom document type are counted.
>
> **linked** - See "Eligible Provider (EP)" on page 6.

NUMERATOR For qualifying office visits in the denominator, count 1 where at least one q*ualifying visit summary audit event* is logged or if a patient has the qualifying portal access during the *required time frame.*

> **qualifying visit summary** - One of the following handouts: *Clinical Visit Summary* or **Patient Instructions-CCC* form or a Chart Summary CCD for a patient generated (exported) from the application. These formats meet the CMS definition of a "clinical summary" for this measure.
>
> **audit event** - Refers to the *Print Report* and *Fax Report* audit events created when a qualifying visit summary is printed/faxed. Also refers to audit events generated when a user exports a chart summary from the application or when a patient accesses a CCD via Patient Portal. Audit events generated by Kryptiq's ACM product are also included.
>
> **QRS report**: MQIC considers audit events regardless of a value in the OUTCOME field in the event log. Audit events generated by Kryptiq's ACM product are not considered.
>
> **qualifying portal access** - The portal to which the patient has access must be configured to use the Chart Summary CCD. This ensures a qualifying visit summary is provided.
>
> Portal access is determined by the existence of the observation term PATPORTALPIN. The observation date cannot be later than the third day after the visit.

> **Note**: In order to use this part of the calculation, you must select "Yes" in the report prompt: "Include patients with portal access in the numerator?".
>
> *required time frame* - Within 3 business days of the visit.

Setup, workflows, and best practices

SETUP Go to **Setup > Settings > System > Auditing** and confirm that *Print Report* is in the Log Audit Events column.

WORKFLOWS **Print Handout**

> **Important**. The handout must be printed BEFORE the chart document is signed, otherwise visit-specific content is not included. The handout must be printed from an IN-PROGRESS update. If you attempt to print the handout outside an update, you cannot include visit information, and you will see MEL errors for some sections.

1   In the application, start an update of any type and document the patient encounter, but do not SIGN the update document. (Clinical List updates, including Problems and Medications, can be signed prior to printing.)

2   In the Chart menu, click **Handouts**.

3   Find and select the **Clinical Visit Summary** handout (or ****Patient Instructions** handout associated with the Patient Instructions-CCC form), and then click **Print**.

> **Important**: The asterisk (*) must precede **Patient Instructions** in the name of the handout.

4   On the Print Patient Education Handout window, select **Record handout printing in Chart** before clicking **Print**. This workflow can be simplified when using handout custom lists and placing the Clinical Visit Summary in the appropriate handout custom list.

5   Give the handout to the patient or mail within 3 business days.

Generate CCD

1   In the application, go the patient's chart and in the main menu click **Actions > Generate Chart Summary**.

2   Set export, security, and clinical list options.

3   Export to preferred destination.

BEST PRACTICES This report does not use the *MU Document View* to determine which patients were seen by the eligible provider. For this measure, the report considers document types starting with the word "office".

It is standard practice to provide patients with information at the end of their visit, typically a list of their medications and instructions. Generating either handout for the patient during the visit meets this measure.

You can also meet the measure by printing a letter to send to the patient with the same name (and content) as the handout. The report looks for the print event as recorded in the Print Audit Logs, titled Patient Instructions or Clinical Visit Summary. It does not look for a document in the chart.

Important: Your practice is responsible for assuring that handout and letter content meets measure criteria.

14 Exchange Key Clinical Information Electronically among Providers of Care (Core)

Requirements

SOURCE 42 CFR 495.6(d)(14)
Yes/No Attestation Only

OBJECTIVE Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results) among providers of care and patient authorized entities electronically.

MEASURE Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

EXCLUSION None

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/14ElectronicExchangeofClinicalInformation.pdf

Setup, workflows, and best practices

SETUP Varies

WORKFLOWS Generate and send clinical summary in CCD format to other systems via Secure Messaging, SMIM secure email, or HIE. You may send by regular email ONLY if the CCD is password-protected at the time you generate the CCD.

15 Protect Electronic Health Information (Core)

Requirements

SOURCE	42 CFR 495.6(d)(15)
	Yes/No Attestation Only
OBJECTIVE	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
MEASURE	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
EXCLUSION	Any EP who has no office visits during the EHR reporting period.
REFERENCES	EHR Incentive Program Specification: http://www.cms.gov/EHRIncentivePrograms/Downloads/15ProtectElectronicHealthInformation.pdf

Setup, workflows, and best practices

SETUP	N/A
WORKFLOWS	N/A
BEST PRACTICES	Your organization must implement and maintain an internal security risk analysis or contract with another third party to analyze and maintain the security of your Centricity EMR network, clients and database.

CMS Functional Measures - Menu

Menu Set of 10 optional objectives and measures includes:

- 01 Implement Drug Formulary Checks (Menu)
- 02 Clinical Lab Test Results (Menu)
- 03 Generate Patient Lists by Specific Condition (Menu) (attestation only)
- 04 Patient Reminders (Menu)
- 05 Patient Electronic Access (Menu)
- 06 Patient-specific Education Resources (Menu)
- 07 Medication Reconciliation (Menu)
- 08 Transition of Care Summary (Menu)
- 09 Test Capacity to Send Electronic Data to Immunization Registry (Menu)
- 10 Test Capacity to Submit Electronic Data to Public Health Agencies (Menu)

You must report on 5 measures including one population and public health measure.

01 Implement Drug Formulary Checks (Menu)

Requirements

SOURCE	42 CFR 495.6(e)(1)) Yes/No Attestation Only
OBJECTIVE	Implement drug formulary checks.
MEASURE	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
EXCLUSION	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
REFERENCES	EHR Incentive Program Specification: http://www.cms.gov/EHRIncentivePrograms/Downloads/1DrugFormularyChecks.pdf

Setup, workflows, and best practices

SETUP	N/A
WORKFLOWS	**Prescribe Medications**

Centricity Advanced ePrescribing supports electronic formulary checking.

The system flags any prescription with a medication selected from the formulary alternatives list and removes the flag when the medication is replaced with one selected from the reference list. The value is FMYALTSELECTED in the MEDICATE table. You can run a query on this value to view formulary alternative use.

02 Clinical Lab Test Results (Menu)

Requirements

SOURCE 42 CFR 495.6(e)(2))

OBJECTIVE Incorporate clinical lab-test results into EHR as structured data.

MEASURE More than 40 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive (pos)/negative (neg) or numerical format are incorporated in certified EHR technology as structured data.

EXCLUSION An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/2ClinicalLabTestResults.pdf

FILE NAME MU_Stg1_02_FM_LabResults.rpt

QRS report: This measure has not yet been released by MQIC.

Calculation

DESCRIPTION Percentage of lab result observations terms ordered, received and stored as structured data during the reporting period.

Important: This report only counts lab results that have been entered into the application via HL7 interface or manually into observation terms. The application cannot calculate the number of lab results received that were not entered into the system as observation terms, for example, items scanned as attachments, or entered as free text into notes. Be sure to add any of these types of un-structured results to the report denominator and re-calculate the percentage before attesting.

DENOMINATOR Count 1 for every *recorded* structured or unstructured lab result observation *linked* to the eligible provider for which *results* are *expressed* in *a positive or negative affirmation* or as a *number.*

linked - The eligible provider is the responsible provider or first signer of the document that records the lab result whether entered manually or imported via the LinkLogic interface.

recorded - The clinical date and signed date of the document that records the lab result must both be within the reporting period. This ensures the lab result being measured is both ordered and received during the reporting period. (CMS FAQ 10642)

structured - Observation terms are filed in the lab folder or its subfolders (visible when adding or updating a flowsheet), including Lab, Chemistry, Coagulation, Hematology, Serology, Toxicology, Urinalysis, Genetics/fertility, Challenge tests, Blood bank, Newborn Screen, Microbiology. In the database, these include observation terms where OBSHEAD.GROUPID is one of the following: 1103, 1234, 1235, 1238, 1245, 1248, 1249, 1251, 1253, 1254, 1504,1241

unstructured - When lab results are imported through the LinkLogic interface with an invalid cross-reference, they appear in the document with an exclamation mark (!) and are not visible in the flowsheet. In the database, these values are stored in the observation term with OBSHEAD.HDID of -1 (ZZ-GE-unk).

results expression - The value of the lab result determines whether or not it can be expressed in a positive or negative affirmation or as a number:

Positive or negative expression

The structured lab result value must equal one of the following case-insensitive strings: Positive, negative, pos, neg, y, n, yes, no, true, false, T, F.

Number

The observation term value is computable based on standard accounting rules:

- Can contain numbers
- Cannot contain alpha characters
- Cannot contain any special characters except:
  - A decimal point (.) anywhere in the string, occurring only once
  - One or more commas (,) adjacent to a character in the string or as the first or last characters
  - A minus sign (-) or dollar sign ($) as the first character in the string
  - A set of parentheses enclosing a string, where an open parenthesis '(' is the first character and a close parenthesis ')' is the last character

NUMERATOR For every structured observation in the denominator, count 1.

EXCLUSION If the eligible provider is not listed in the report, it does not necessarily indicate the eligible provider meets the exclusion criteria. See the **Calculation** for details.

Setup, workflows, and best practices

SETUP Set up a LinkLogic Lab Results Import relationship to receive lab results data from external labs. You must also configure a cross-reference file to translate laboratory information system (LIS) result codes to application observation terms. You might also need a cross-reference file to map application user IDs to external system user initials. See "Cross-referencing field values" in *Managing Interfaces with Centricity Electronic Medical Record*.

For all workflows, consider creating a custom document type for lab results such as pathology that do not have numeric or positive/negative value. This prevents them from being counted in the denominator.

WORKFLOWS **LinkLogic Lab Results import** - Import and sign lab results to update the patient flowsheet and make them part of the chart.

Scanned file attachments - Use this workflow if you scan paper lab reports and attach files to the chart using File Attachment (from the Desktop) or if you use Centricity Document Management to create and manage remotely stored Lab Report file attachments.

For any value that is numeric, negative or positive, append and manually add observation values to the flowsheet or enter them in an encounter form designed for that purpose, such as *Urinalysis* or *Lipids.* Always use *Append* or *Lab Report* document types when you attach or append documents.

03 Generate Patient Lists by Specific Condition (Menu)

Requirements

SOURCE	42 CFR 495.6(e)(3))
	Yes/No Attestation Only
OBJECTIVE	Generate lists of patients by *specific conditions* to use for quality improvement, reduction of disparities, research, or outreach.
	specific conditions - Conditions in the patient Problem list.
MEASURE	Generate at least one report listing patients of the EP with a specific condition.
EXCLUSION	None
REFERENCES	EHR Incentive Program Specification: http://www.cms.gov/EHRIncentivePrograms/Downloads/3PatientLists.pdf

Setup, workflows, and best practices

SETUP	Varies
WORKFLOWS	In Reports > Inquiries, run an inquiry for patients with a specific condition.

04 Patient Reminders (Menu)

Source: 42 CFR 495.6(e)(4)

Requirements

SOURCE 42 CFR 495.6(e)(4))

OBJECTIVE Send reminders to patients per patient preference for preventive/followup care.

MEASURE More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.

EXCLUSION An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/4PatientReminders.pdf

Calculation

DESCRIPTION Percentage of patients 65 years old or older or 5 years or younger at the beginning of the reporting period who were provided a patient reminder during the reporting period.

FILE NAME MU_Stg1_04_FM_PatientReminders.rpt

DENOMINATOR Count 1 for every active patient who meets the qualifying age and who is a patient of the provider.

> *Patient of Provider -* Patient is seen by the eligible provider in the last 3 years prior to the start of the reporting period. The 3 years is based on the standard CMS new patient definition. Patients who have not been seen within the 3 years are not considered to be active patients of the provider.
>
> *seen by*- see the **Seen by** sections for QRS and Crystal Reports starting on .
>
> *active* - The patient has the Status *Active* in Registration at the time the measure report is printed.
>
> **QRS report**: An active patient registration status is assessed at the last data extract in the reporting period. MQIC defaults to the end of the reporting period.
>
> *qualifying age* - Includes patients aged 5 or younger or 65 or older at the start of the measure reporting period. If a patient is not 6 years old at the start of the reporting period, then the patient is considered to be 5 years old. Example: 5 years and 8 months is included n the definition of 5 years old or younger.

NUMERATOR For patients in the denominator, count 1 where at least one indication is found that an appropriate reminder was sent during the measure reporting period.

> *indication* - Includes a print report or Kryptiq ACM audit event, or document if **Save to Chart** is selected when printing, generated from printing a letter that contains "Reminder," "Recall," "appointment", "due", "follow", "next", "recall", or "remind" in the title at the time the letter is printed. The contained words are case insensitive. The document must be one of these types: External correspondence, External other, Letter, or Phone Note. Phone Notes do not have to be printed to be counted in the numerator. The document summary must contain one of the listed strings.
>
> **QRS report**: Reminders recorded as documents in the patient chart and Kryptiq ACM audit events are not considered.

EXCLUSION The eligible provider will not print on the report if the eligible provider's denominator value is 0 (zero), which indicates that the eligible provider may meet the exclusion criteria.

Setup, workflows, and best practices

SETUP Go to **Setup > Settings > System > Auditing** and confirm that *Print Report* is in the Log Audit Events column.

To add or change letters, go to **Setup > Settings > System > Letters > Letter Templates**.

WORKFLOWS Current product supports reminders through inquiries, reports, and letter templates; enhanced support for immunizations due reporting and letters.

Note: You may need to modify titles of existing letters to use for this purpose. Changes do not retroactively apply to past audit events.

Print Letter - This report tracks letters, but your clinic may use other mechanisms for reminders. If running this report does not meet the measure requirement, run additional inquiries or reports to collect data on other methods you have used and then combine the numbers when you report.

BEST PRACTICES If bulk printing from an inquiry, you must have **Save to Chart** turned on for events to be counted in this report.

05 Patient Electronic Access (Menu)

Source: 42 CFR 495.6(e)(5)

Requirements

SOURCE	42 CFR 495.6(e)(5))
OBJECTIVE	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
MEASURE	At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the eligible provider's discretion to withhold certain information.
EXCLUSION	Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR measure reporting period.
REFERENCES	EHR Incentive Program Specification: http://www.cms.gov/EHRIncentivePrograms/Downloads/5_Patient_Electronic_Access.pdf

Calculation

DESCRIPTION	Percentage of patients seen in the reporting period for whom electronic access was provided either before the patient's last visit in the reporting period or within 4 days of either the patient's last visit during the reporting period or the end of the reporting period, whichever came first.
FILE NAME	MU_Stg1_05_FM_eAccessForPatient.rpt
DENOMINATOR	Count 1 for every patient seen by the eligible provider.
	seen by - see "Seen by" on page 7, for QRS and Crystal Reports.
NUMERATOR	For patients in the denominator, count 1 where there is at least one *indication* that electronic access has been provided to the patient.
	indication - The patient chart includes a value for PATPORTALPIN observation dated no later than 4 business days after the last encounter in the reporting period or by the end of the reporting period, whichever comes first.
	PATPORTALPIN is an observation term used to indicate in the chart that a patient has been configured for access to Centricity Patient Portal.
EXCLUSION	The eligible provider is not listed in the report if the eligible provider's denominator value is 0 (zero), which indicates that the eligible provider may meet the exclusion criteria.

Setup, workflows, and best practices

SETUP	To create a quick text entry to add the PATPORTALPIN observation term, go to **Setup > Settings > Chart > Quick Text**.
WORKFLOWS	**Register patients** - Add a step to your registration workflow (for example, quick text) to note a value for PATPORTALPIN in the chart when you grant portal access to a patient.

06 Patient-specific Education Resources (Menu)

Requirements

SOURCE   42 CFR 495.6(e)(6))

OBJECTIVE   Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

MEASURE   More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.

EXCLUSION   None

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/6Patient-specificEducationResources.pdf

Calculation

DESCRIPTION   Percentage of patients seen in the reporting period who were provided at least one medication handout when a prescription was recorded in the patients chart during the reporting period.

FILE NAME   MU_Stg1_06_FM_PatientEducation.rpt

DENOMINATOR   Count 1 for every patient *seen by* the eligible provider.

> ***seen by*** - see "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   For patients in the denominator, count 1 for every patient who was provided a medication handout at the time a prescription was generated and the handout exists in the database at the time the report is printed.

Setup, workflows, and best practices

SETUP   N/A

WORKFLOWS   At this time, the only reportable option for an application-suggested handout based on patient clinical information is the medication handout available when a prescription is recorded in the patient's chart.

1   Create a prescription for a medication using any prescribing method (if "Historical," quantity and refill must have a value).

2   Check **Print Handout**. The system records prescribe record with value of "Y" in PRESCRIB.PRINTINFO.

3   Sign the prescription. The system generates the handout.

4   Give the handout to the patient.

Note: The following related workflows cannot be measured in accordance with the meaningful use criteria and should not be used to meet meaningful use:

■   Manually select a handout not "recommended" by the application

■   Generate medication handouts from the **Find Medication** window

■   Generate a handout for other than medications

BEST PRACTICES   If you customize the system to prompt a user to provide patient education based on elements of the patient's chart, GE recommends you create a custom report to capture this workflow for attestation. Currently, there are too many customizable options for GE to accurately report this functionality.

07 Medication Reconciliation (Menu)

Requirements

SOURCE   42 CFR 495.6(e)(7))

OBJECTIVE   The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

MEASURE   The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

EXCLUSION   An EP who was not the recipient of any transitions of care during the EHR reporting period.

REFERENCES   EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/7MedicationReconciliation.pdf

Calculation

DESCRIPTION   Percentage of transitions of care (in) during the reporting period for which medication reconciliation was performed.

FILE NAME   MU_Stg1_07_FM_MedReconciliation.rpt

DENOMINATOR   Count 1 for each *transition of care indication linked* to the eligible provider.

> ***transition of care indication*** - Each CARETRANSIN observation recorded in a patient chart or any document during the measure reporting period.
>
> **QRS report**: Values not mapped to '**no**' are considered acceptable for CARETRANSIN.
>
> ***linked*** - The eligible provider is the responsible provider for at least one document associated with the transition of care indication.

NUMERATOR   Count 1 for each *transition of care indicatio*n in the denominator where *documented medication reconciliation* occurred in the same document as the transition of care (not including appends).

> ***documented medication reconciliation*** - includes the following observation terms: MEDS REVIEW, MEDS REVIEWD, MLSTPRINREV, REW MED, NCHG, and MEDRECON where the value is not "not done" or "no" (not case sensitive).
>
> **QRS report**: Values not mapping to '**not done**' in an obs term in the MED REVIEW obs group is acceptable.

EXCLUSION   The eligible provider is not listed in the report if the eligible provider's denominator value is 0 (zero), which indicates that the eligible provider may meet the exclusion criteria.

Setup, workflows, and best practices

SETUP   To create a quick text entry to add the CARETRANSIN observation term, go to **Setup > Settings > Chart > Quick Text**.

WORKFLOWS   **Update Medications** - This report filters visits that include medication reconciliation to also indicate a transition of care occurred. To implement this filter, add a step to your update workflow that pushes CARETRANSIN observation term to the document (for example using quick text).

Note: In Centricity Advanced ePrescribing, you can add historical medications to the medications list during medication reconciliation, however you must check **Meds Reviewed** to get credit in this report.

08 Transition of Care Summary (Menu)

Requirements

SOURCE 42 CFR 495.6(e)(8))

OBJECTIVE The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

MEASURE The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.

EXCLUSION An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/8TransitionofCareSummary.pdf

Calculation

DESCRIPTION Percentage of transitions of care (out) or referrals during the reporting period for which a clinical visit summary was provided within 90 days of transition of care or before the end of the reporting period, whichever came first.

FILE NAME MU_Stg1_08_FM_TransCareSummary.rpt

DENOMINATOR Count 1 for each *transition of care indication linked* to the eligible provider.

> ***transition of care indication*** - CARETRANSOUT may be included in any document type.

> **QRS report**: Each CARETRANSOUT observation recorded in a patient chart during the measure reporting period that does not have a value of '**no**' (case insensitive).

> ***linked*** - The responsible provider of the document associated with the transition of care indication.

NUMERATOR For each transition of care indication in the denominator, count 1 where at least one *qualifying audit event* occurred within the *required time frame*.

> ***qualifying audit event*** - Includes audit events generated when printing or faxing a report or letter that contains "Chart Summary" in the title (case insensitive), or audit events generated when the user exports a chart summary (CCD).

> **QRS report**: MQIC considers audit events regardless of a value in the OUTCOME field in the event log.

> ***required time frame*** - Up to 90 days after the transition of care OR the end of the reporting period, whichever comes first.

EXCLUSION The eligible provider is not listed in the report if the eligible provider's denominator value is 0 (zero), which indicates that the eligible provider may meet the exclusion criteria.

Setup, workflows, and best practices

SETUP To create a quick text entry to add the CARETRANSOUT observation term, go to **Setup > Settings > Chart > Quick Text**.

WORKFLOWS **Update Chart -** The observation term CARETRANSOUT must be entered in the chart, otherwise printing or faxing a chart summary in support of a transition of care doesn't count. To make sure all qualifying care transitions are counted, add a step to your update workflow (for example, quick text) that pushes CARETRANSOUT to the document when a transition of care occurs.

09 Test Capacity to Send Electronic Data to Immunization Registry (Menu)

Requirements

SOURCE 42 CFR 495.6(e)(1))
Yes/No Attestation Only

OBJECTIVE Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

MEASURE Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).

EXCLUSION An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

REFERENCES EHR Incentive Program Specification:
http://www.cms.gov/EHRIncentivePrograms/Downloads/9ImmunizationRegistriesDataSubmission.pdf

Setup, workflows, and best practices

SETUP N/A

WORKFLOWS GE offers certified content exchange standards and implementation specifications for exchanging electronic health information using LinkLogic HL7 interfaces and Centricity Clinical Gateway interface engine. EHR applications support HL7 2.3.1 specifications for immunizations messaging. GE also meets required standards for representing electronic health information (HL7 Standard Code Set CVX -Vaccines Administered). See *Managing Interfaces with Centricity EMR* for information about the immunization registry interface.

If you choose to demonstrate sending immunizations data, you must use GE's certified methodology or, another methodology that is certified with ONC. You may be excluded if the registry you want to send information to cannot accept the information electronically as defined by the Meaningful Use certification requirements.

- Submission of actual patient data is not required

- A single test satisfies the objective where multiple providers use the same EHR technology at a single location.

The test does not have to be successful to satisfy the objective.

10 Test Capacity to Submit Electronic Data to Public Health Agencies (Menu)

Requirements

SOURCE	42 CFR 495.6(e)(1))
	Yes/No Attestation Only
OBJECTIVE	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.
MEASURE	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).
EXCLUSION	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.
REFERENCES	EHR Incentive Program Specification:
	http://www.cms.gov/EHRIncentivePrograms/Downloads/10_Syndromic_Surveillance_Data_SubmissionEP.pdf

Setup, workflows, and best practices

SETUP	Varies. Contact your Centricity Services technical consultant or Value-Added Reseller for help planning and implementing data exchange with public health agencies.
WORKFLOWS	Current product certified for data submission in HL7 2.3.1 message format.

CMS Quality Measures

Clinical quality measures reporting is one of the 15 Meaningful Use Core objectives. Organizations are required to report on six clinical quality measures:

- 3 Core or Alternate Core measures
- 3 additional Menu measures

> Your organization is solely responsible for determining whether your Eligible Professionals meet the requirements for Meaningful Use and ensuring the accuracy of any Meaningful Use attestation. Ensure you understand the measure requirements, reporting functionality and that you monitor the quality of the data entered into the application.

Core quality measures

- Hypertension: Blood Pressure Measurement
- Preventative Care and Screening

  Measure Pair:

  - Tobacco Use Assessment
  - Tobacco Cessation Intervention
- Adult Weight Screening and Follow-up

Alternative Core measures

- Weight Assessment and Counseling for Children and Adolescents
- Preventative Care and Screening: Influenza Immunization for Patients 50 Years Old
- Childhood Immunization Status

> In this chapter report templates that have been modified or newly added since initial release have more extensive documentation.

Zero Denominators in Quality Measure Reports

Eligible Professionals (EP) should first reference the CMS guidance on selecting Clinical Quality Measures (CQMs) with zero denominators, which can be found on CMS.gov FAQ ID 2773. In the CQM reports, there are two ways that a zero denominator may be handled:

- If a provider has no patients who meet ANY of the inclusion criteria, the provider is not listed on the measure report.

- If a provider has one or more patients who each meets SOME BUT NOT ALL of the inclusion criteria, the provider is listed on the measure report with a 0 denominator and a 0 numerator. For example, for a measure where the denominator requires more than one criterion but all of the EP's patients met only a subset of the criteria, the report will display the EP with a 0 denominator and a 0 numerator.

For audit purposes, it is recommended that when the EP is not listed on the report that is used for attestation, the user annotate the report with the EP's name, referencing this user guide.

CMS Quality Measures - Core

- "NQF 0013 Hypertension: Blood Pressure Measurement"
- "NQF 0028a Smoking Status"
- "NQF 0028b Smoking Cessation Counseling"
- "NQF 0421a Weight Management 65 or over"
- "NQF 0421b Weight Management 18-64"

NQF 0013 Hypertension: Blood Pressure Measurement

Requirements

MEASURE
This report calculates % of Encounters where blood pressure was evaluated for Hypertensive patients who were seen 2 or more times within the specified date range. Counts observation terms BP SYSTOLIC, BP DIASTOLIC.

VERSION
CMS Original Publication

Calculation

DESCRIPTION
Hypertension with BP Measurement (NQF 0013)

Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded at each office visit

FILE NAME
MU_Stg1_nqf0013-bpmgmt.rpt

DENOMINATOR
Count 1 for every visit associated with the qualifying patient *seen by* the eligible provider who meets the *qualifying age* and *number of encounters*, whose chart includes an active diagnosis of *hypertension* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients who were 18 years old or older before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.
>
> **hypertension** - includes these ICD-9 codes: ICD-401.0, ICD-401.1, ICD-401.9, ICD-402.00, ICD-402.01, ICD-402.10, ICD-402.11, ICD-402.90, ICD-402.91, ICD-403.00, ICD-403.01, ICD-403.10, ICD-403.11, ICD-403.90, ICD-403.91, ICD-404.00, ICD-404.01, ICD-404.0, ICD-404.03, ICD-404.10, ICD-404.11, ICD-404.12, ICD-404.13, ICD-404.90, ICD-404.91, ICD-404.92, ICD-404.93

NUMERATOR
Count 1 for each visit associated with the qualifying patient in the denominator with *BP SYSTOLIC* and *BP DIASTOLIC* observation terms entered for two or more encounters.

> **BP Systolic** - Observation term *BP systolic*, *BP SYS STAND*, or *BP SYS LYING*.
>
> **BP Diastolic** - Observation term *BP diastolic*, *BP DIA STAND*, or *BP DIA LYING*

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

WORKFLOWS
Record Vitals

A blood pressure reading must be taken for hypertensive patients at each encounter.

NQF 0028a Smoking Status

Requirements

MEASURE The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

VERSION 1

Calculation

DESCRIPTION Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment (NQF 0028a)

Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.

FILE NAME mu_stg1_nqf0028a-smokstatus.rpt

DENOMINATOR Count 1 for every patient *seen by* the eligible provider who meets the *qualifying age* and *number of encounters*.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients 18 years old or older before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has an indication of tobacco use during the last 2 years starting from (and including) the last day of the reporting period.

> **tobacco use screening** - Observation terms *SMOK STATUS* or *Tobacco Use* were entered in the application within 2 years from the last day of the reporting period.
>
> **QRS report -** Looks for terms in Observation Group *SMOKING STATUS*

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0028b Smoking Cessation Counseling

Requirements

MEASURE
The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

VERSION
1

Calculation

DESCRIPTION
Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention (NQF 0028b)

Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

FILE NAME
mu_stg1_nqf0028b-smokstatus.rpt

DENOMINATOR
Count 1 for every patient *seen by* the eligible provider who meets the qualifying age and number of encounters and was screened for tobacco use.

> **seen by** - see , for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients 18 years old or older before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.
>
> **tobacco use screening** - Observation terms *SMOK STATUS* or *Tobacco Use* were entered in the application within 2 years from the last day of the reporting period. For *Tobacco Use*, one of these specific values must be entered: *Y, y, Yes*, or *YES*.
>
> **QRS report -** Looks for terms in Observation Group *SMOKING STATUS*

NUMERATOR
Of the patients in the denominator, count 1 for every patient whose chart has an indication of tobacco cessation counseling.

> **tobacco cessation counseling** - Observation terms *Adv to quit* or *SMOK ADVICE* were entered in the application within the reporting period.
>
> **QRS report** - Observation Group *SMOKING CESSATION COUNSELING*

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See .

NQF 0421a Weight Management 65 or over

Requirements

MEASURE   This report calculates % of patients 65 and older who have had a BMI within the previous 6 months of their visit date, and if BMI was out of range, a follow-up plan was documented. Provides the first numerator for NQF 0421.

VERSION   1

Calculation

DESCRIPTION   Adult Weight Screening and Follow-Up (NQF 0421) - Population 1

Percentage of patients aged 65 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is out of range, a follow up plan is documented.

FILE NAME   MU_Stg1_nqf0421A-AdultWeightManagement.rpt

DENOMINATOR   Count 1 for every patient *seen by* the eligible provider who meets the *qualifying age* and *number of encounters*.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age - Includes patients 65 years old or older before the first day of the reporting period.

number of encounters - Includes patients with one or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition regardless of responsible provider for the encounter(s).

NUMERATOR   Of the patients in the denominator, count 1 for every patient who has an indication of an in range BMI or an out of range BMI with an indication of a follow-up plan.

In Range BMI - observation term BMI with a value equal to or greater than 22 or less than 30 recorded within the past 6 months up to and including the day of the seen by encounter. No follow up plan needs to be recorded if the BMI is in range.

Out of Range BMI - observation term BMI with a value less than 22 or equal to or greater than 30 recorded within the past 6 months up to and including the day of the seen by encounter. A follow up plan needs to be recorded if the BMI is out of range.

follow up plan - one or more observation term of *DIET COUNSEL, DIET PLAN, WEIGHT EDUC, BCDD, DIET CMPLIANT, WGTMGMTREF, WGTMGMTCOUNS, NUTRITIONIVN* recorded during the reporting period.

EXCLUSION   A patient is not counted in the denominator if—

■   Diagnosed as terminally ill within 6 months before the encounter. Includes patient with an active diagnosis with an ICD-9 code of V66.7, Encounter for palliative care (including End-of-life care, Hospice care, and Terminal care).

■   Diagnosed as pregnant

Note. The regulatory exclusion also includes a patient with a justifiable reason for not having the exam done including patient choice, medical reasons. or other system reasons. However, there is currently no mechanism to capture this information.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0421b Weight Management 18-64

Requirements

MEASURE
This report calculates % of patients 18 to 64 years old who have had a BMI within the previous 6 months of their visit date, and if BMI was out of range, a follow-up plan is documented. Provides the second numerator for NQF 0421.

VERSION
1

Calculation

DESCRIPTION
Adult Weight Screening and Follow-Up (NQF 0421) - Population 2

Percentage of patients aged 18-64 years old with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is out of range, a follow up plan is documented.

FILE NAME
MU_Stg1_nqf0421B-AdultWeightManagement.rpt

DENOMINATOR
Count 1 for every patient *seen by* the eligible provider who meets the *qualifying age* and *number of encounters*.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.

> **qualifying age** - Includes patients between the ages of 18 to 64 years old before the first day of the reporting period.

> **number of encounters** - Includes patients with one or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition regardless of responsible provider for the encounter(s).

NUMERATOR
Of the patients in the denominator, count 1 for every patient who has an indication of an in range BMI or an out of range BMI with an indication of a follow-up plan.

> **In Range BMI -** observation term BMI with a value equal to or greater than 18.5 or less than 25 recorded within the past 6 months up to and including the day of the seen by encounter. No follow up plan needs to be recorded if the BMI is in range.

> **Out of Range BMI -** observation term BMI with a value less than 18.5 or equal to or greater than 25 recorded within the past 6 months up to and including the day of the seen by encounter. A follow up plan needs to be recorded if the BMI is out of range.

> > **follow up plan** - one or more observation term of *DIET COUNSEL*, *DIET PLAN*, *WEIGHT EDUC*, *BCDD*, *DIET CMPLIANT*, *WGTMGMTREF*, *WGTMGMTCOUNS*, *NUTRITIONIVN* recorded during the reporting period.

EXCLUSION
A patient is not counted in the denominator if—

- Diagnosed as terminally ill within 6 months before the encounter. Includes patient with an active diagnosis with an ICD-9 code of V66.7, Encounter for palliative care (including End-of-life care, Hospice care, and Terminal care).

- Diagnosed as pregnant

Note. The regulatory exclusion also includes a patient with a justifiable reason for not having the exam done including patient choice, medical reasons. or other system reasons. However, there is currently no mechanism to capture this information.

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

CMS Quality Measures - Alternate Core

Weight Management

- "NQF 0024a Weight Management 2-17 with BMI calc"
- "NQF 0024b Weight Management 2-17 Nutrition Counseling"
- "NQF 0024c Weight Management 2-17 Physical Activity"
- "NQF 0024d Weight Management 2-10 with BMI calc"
- "NQF 0024e Weight Management 2-10 Nutrition Counseling"
- "NQF 0024f Weight Management 2-10 Physical Activity"
- "NQF 0024g Weight Management 11-17 BMI calc"
- "NQF 0024h Weight Management 11-17 Nutrition Counseling"
- "NQF 0024i Weight Management 11-17 Physical Activity"

NQF 0024a Weight Management 2-17 with BMI calc

Requirements

MEASURE	This report calculates % of patients aged 2 - 16 who have had a BMI documented during the measurement period. Counts observation term *BMI*.
	Provides the first numerator for population 1 for NQF 0024.
VERSION	1

Calculation

DESCRIPTION	Weight Assessment and Counseling for Children and Adolescents, BMI (Ages 2-16)
FILE NAME	MU_Stg1_nqf0024a1-pediatricweightmanagement.rpt
DENOMINATOR	Number of patients aged 2-16 at time of visit with at least one patient encounter within the measurement period.
	Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.
NUMERATOR	Number of patients with a documented *BMI* (Body Mass Index observation); BMI is within the measurement period.

Setup, workflows, and best practices

SETUP	**Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024b Weight Management 2-17 Nutrition Counseling

Requirements

MEASURE
This report calculates % of patients 2 - 16 who have had nutrition counseling documented during the measurement period.

Provides the second numerator for population 1 for NQF 0024.

VERSION
1

Calculation

DESCRIPTION
Weight Assessment and Counseling for Children and Adolescents, Nutrition (Ages 2-16)

FILE NAME
MU_Stg1_nqf0024a2-pediatricweightmanagement.rp

DENOMINATOR
Number of patients aged 2-16 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR
Number of patients with a documented nutrition counseling observation within measurement period, including *DIET COUNSEL*, *DIET PLAN*, *NUTRITNL GL*, *NUTRITN GUID*, *BCDD*, *DIET CMPLIANT*, *NUTRITIONIVN*.

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024c Weight Management 2-17 Physical Activity

Requirements

MEASURE
This report calculates % of patients 2 - 16 who have had physical activity counseling documented during the measurement period.

Provides the third numerator for population 1 for NQF 0024.

VERSION
1

Calculation

DESCRIPTION
Weight Assessment and Counseling for Children and Adolescents, Physical Activity (Ages 2-16)

FILE NAME
MU_Stg1_nqf0024a3-pediatricweightmanagement.rp

DENOMINATOR
Number of patients aged 2-16 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR
Number of patients with a documented physical activity counseling observation within measurement period, including *WMEXRGOAL*, *EXERPRG REF*.

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024d Weight Management 2-10 with BMI calc

Requirements

MEASURE   This report calculates % of patients 2 - 10 who have had a BMI documented during the measurement period. Counts observation term *BMI*.

Provides the first numerator for population 2 for NQF 0024.

VERSION   1

Calculation

DESCRIPTION   Weight Assessment and Counseling for Children and Adolescents, BMI (Ages 2-10)

FILE NAME   MU_Stg1_nqf0024b1-pediatricweightmanagement.rp

DENOMINATOR   Number of patients aged 2-10 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   Number of patients with a documented *BMI* (Body Mass Index observation); BMI is within the measurement period.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024e Weight Management 2-10 Nutrition Counseling

Requirements

MEASURE   This report calculates % of patients 2 - 10 who have had nutrition counseling documented during the measurement period.

Provides the second numerator for population 2 for NQF 0024.

VERSION   1

Calculation

DESCRIPTION   Weight Assessment and Counseling for Children and Adolescents, Nutrition (Ages 2-10)

FILE NAME   MU_Stg1_nqf0024b2-pediatricweightmanagement.rp

DENOMINATOR   Number of patients aged 2-10 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   Number of patients with a documented nutrition counseling observation within measurement period, including *DIET COUNSEL*, *DIET PLAN*, *NUTRITNL GL*, *NUTRITN GUID*, *BCDD*, *DIET CMPLIANT*, *NUTRITIONIVN*.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024f Weight Management 2-10 Physical Activity

Requirements

MEASURE — This report calculates % of patients 2 - 10 who have had physical activity counseling documented during the measurement period.

Provides the third numerator for population 2 for NQF 0024.

VERSION — 1

Calculation

DESCRIPTION — Weight Assessment and Counseling for Children and Adolescents, Physical Activity (Ages 2-10)

FILE NAME — MU_Stg1_nqf0024b3-pediatricweightmanagement.rp

DENOMINATOR — Number of patients aged 2-10 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR — Number of patients with a documented physical activity counseling observation within measurement period, including *WMEXRGOAL*, *EXERPRG REF*.

Setup, workflows, and best practices

SETUP — **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024g Weight Management 11-17 BMI calc

Requirements

MEASURE   This report calculates % of patients 11- 16 who have had a BMI documented during the measurement period. Counts observation term *BMI*.

Provides the first numerator for population 3 for NQF 0024.

VERSION   1

Calculation

DESCRIPTION   Weight Assessment and Counseling for Children and Adolescents, BMI (Ages 11-16)

FILE NAME   MU_Stg1_nqf0024c1-pediatricweightmanagement.rp

DENOMINATOR   Number of patients aged 11-16 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   Number of patients with a documented *BMI* (Body Mass Index observation); BMI is within the measurement period.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024h Weight Management 11-17 Nutrition Counseling

Requirements

MEASURE
This report calculates % of patients 11- 16 who have had nutrition counseling documented during the measurement period.

Provides the second numerator for population 3 for NQF 0024.

VERSION
1

Calculation

DESCRIPTION
Weight Assessment and Counseling for Children and Adolescents, Nutrition (Ages 11-16)

FILE NAME
MU_Stg1_nqf0024c2-pediatricweightmanagement.rp

DENOMINATOR
Number of patients aged 2-10 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR
Number of patients with a documented nutrition counseling observation within measurement period, including *DIET COUNSE*L, *DIET PLAN*, *NUTRITNL GL*, *NUTRITN GUID*, *BCDD*, *DIET CMPLIAN*T, *NUTRITIONIVN*.

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0024i Weight Management 11-17 Physical Activity

Requirements

MEASURE
This report calculates % of patients 11- 16 who have had physical activity counseling documented during the measurement period.

Provides the third numerator for population 3 for NQF 0024.

VERSION
1

Calculation

DESCRIPTION
Weight Assessment and Counseling for Children and Adolescents, Physical Activity (Ages 11-16)

FILE NAME
MU_Stg1_nqf0024c3-pediatricweightmanagement.rp

DENOMINATOR
Number of patients aged 2-10 at time of visit with at least one patient encounter.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR
Number of patients with a documented physical activity counseling observation within measurement period, including *WMEXRGOAL*, *EXERPRG REF*.

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

Immunizations

- "NQF 0038a DTAP"
- "NQF 0038b IPV"
- "NQF 0038c MMR"
- "NQF 0038d HIB"
- "NQF 0038e HEP B"
- "NQF 0038f VZV"
- "NQF 0038g Pneumovax"
- "NQF 0038h HEP A"
- "NQF 0038i Rotavirus"
- "NQF 0038j FLU"
- "NQF 0038k Combined Vaccines 1"
- "NQF 0038l Combined Vaccines 2"
- "NQF 0041 Fluvax"

NQF 0038a DTAP

Requirements

MEASURE
This report calculates % of patients age 1 to 2 years who received 4 or more DTAP Vaccines prior to their second birth date.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the first numerator for NQF0038.

VERSION
1

Calculation

DESCRIPTION
DTAP Vaccine

FILE NAME
MU_Stg1_nqf0038a-DTAP.rpt

DENOMINATOR
Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR
Four or more *DTAP* observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038b IPV

Requirements

MEASURE	This report calculates % of patients age 1 to 2 years who received 3 or more IPV Vaccines prior to their second birth date.
	See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.
	Provides the second numerator for NQF0038.
VERSION	1

Calculation

DESCRIPTION	IPV Vaccine
FILE NAME	MU_Stg1_nqf0038b-IPV.rpt
DENOMINATOR	Number of patients age 1 to 2 years seen during the selected date range.
	Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.
NUMERATOR	Three or more *IPV* observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP	**Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038c MMR

Requirements

MEASURE	This report calculates % of patients age 1 to 2 years who received 1 or more MMR Vaccines prior to their second birth date.
	See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.
	Provides the third numerator for NQF0038.
VERSION	1

Calculation

DESCRIPTION	MMR Vaccine
FILE NAME	MU_Stg1_nqf0038c-MMR.rpt
DENOMINATOR	Number of patients age 1 to 2 years seen during the selected date range.
	Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.
NUMERATOR	One or more MMR observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP	**Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038d HIB

Requirements

MEASURE   This report calculates % of patients age 1 to 2 years who received 2 or more HIB Vaccines prior to their second birth date. Counts *HEMINFB*, *COMVAX* and *HIB* observation terms.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the fourth numerator for NQF0038.

VERSION   1

Calculation

DESCRIPTION   HIB Vaccine

FILE NAME   MU_Stg1_nqf0038d-HIB.rpt

DENOMINATOR   Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   Two or more HIB observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8 .

NQF 0038e HEP B

Requirements

MEASURE   This report calculates % of patients age 1 to 2 years who received 3 or more Hepatitis B Vaccines prior to their second birth date.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the fifth numerator for NQF0038.

VERSION   1

Calculation

DESCRIPTION   Hepatitis Vaccine

FILE NAME   MU_Stg1_nqf0038e-HEPB.rpt

DENOMINATOR   Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   Three or more HEPB observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP | **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038f VZV

Requirements

MEASURE | This report calculates % of patients age 1 to 2 years who received 1 or more Varicella Vaccines prior to their second birth date.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the sixth numerator for NQF0038.

VERSION | 1

Calculation

DESCRIPTION | Varicella Vaccine

FILE NAME | MU_Stg1_nqf0038f-VZV.rpt

DENOMINATOR | Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR | One or more Varicella observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP | **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038g Pneumovax

Requirements

MEASURE | This report calculates % of patients age 1 to 2 years who received 4 or more Pneumococcal Vaccines prior to their second birth date.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the seventh numerator for NQF0038.

VERSION | 1

Calculation

DESCRIPTION | Pneumococcal Vaccine

FILE NAME | MU_Stg1_nqf0038g-Pneumovax.rpt

DENOMINATOR | Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR | Four or more Pneumococcal observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038h HEP A

Requirements

MEASURE This report calculates % of patients age 1 to 2 years who received 2 or more Hepatitis A Vaccines prior to their second birth date. Counts *HEPA VAX* and *HEPAVAX* observation terms.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the eighth numerator for NQF0038.

VERSION 1

Calculation

DESCRIPTION Hepatitis A Vaccine

FILE NAME MU_Stg1_nqf0038h-HepA.rpt

DENOMINATOR Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR Two or more Hepatitis A observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038i Rotavirus

Requirements

MEASURE This report calculates % of patients age 1 to 2 years who received 2 or more Rotavirus Vaccines prior to their second birth date. Counts *ROTATEQ* and *ROTAVIR* observation terms.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the ninth numerator for NQF0038.

VERSION 1

Calculation

DESCRIPTION Rotavirus Vaccine

FILE NAME MU_Stg1_nqf0038i-Rotavirus.rpt

DENOMINATOR Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR Two or more Rotavirus observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038j FLU

Requirements

MEASURE This report calculates % of patients age 1 to 2 years who received 2 or more Flu Vaccines prior to their second birth date. Counts *FLU VAX* and *FLUMIST* observation terms.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the tenth numerator for NQF0038.

VERSION 1

Calculation

DESCRIPTION Flu Vaccine

FILE NAME MU_Stg1_nqf0038j-FLU.rpt

DENOMINATOR Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR Two or more Flu observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038k Combined Vaccines 1

Requirements

MEASURE This report calculates % of patients age 1 to 2 years who received 4 or more DTAP Vaccines, 3 or more IPV Vaccines, 1 or more MMR Vaccines, 1 or more Varicella Vaccines, and 3 or more Hepatitis B Vaccines prior to their second birth date.

QRS report - Looks for terms in Observation Groups *DTAP VAX, IPV, MMR, MEASLESVAX, MUMPSVAX, RUBELLAVAX, HIB VAX, HEP B VACCINE, and VARICELLAVAX*.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the eleventh numerator for NQF0038.

VERSION 1

Calculation

DESCRIPTION Multiple Vaccines 1

FILE NAME   MU_Stg1_nqf0038k-CombinedVaccines1.rpt

DENOMINATOR   Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   All observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0038l Combined Vaccines 2

Requirements

MEASURE   This report calculates % of patients age 1 to 2 years who received 4 or more DTAP Vaccines, 3 or more IPV Vaccines, 1 or more MMR Vaccines, 1 or more Varicella Vaccines, 3 or more Hepatitis B Vaccines, and 4 or more Pneumococcal Vaccines prior to their second birth date.

QRS report - Looks for terms in Observation Groups *DTAP VAX, IPV, MMR, MEASLESVAX, MUMPSVAX, RUBELLAVAX, HIB VAX, HEP B VACCINE, VARICELLAVAX*, *PCV, and PNEUMONIA VACCINE*.

See the table "CMS Quality Measures: Observation terms - by measure" in the Appendix to determine which observation terms are counted for this measure.

Provides the twelfth numerator for NQF0038.

VERSION   1

Calculation

DESCRIPTION   Multiple Vaccines 2

FILE NAME   MU_Stg1_nqf0038l-CombinedVaccines2.rpt

DENOMINATOR   Number of patients age 1 to 2 years seen during the selected date range.

Includes documents based on the "seen by" definition. See "Seen by" on page 7, for QRS and Crystal Reports.

NUMERATOR   All observation terms with unique dates populated before the patient's 2nd birthday.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0041 Fluvax

Requirements

MEASURE   Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)

VERSION   1

Calculation

DESCRIPTION   Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old (NQF 0041)

Percentage of patients aged 50 years and older who received an influenza immunization during the measurement period's flu season

Note: Measurement period's flu season starts the September of the previous year and ends the February of the current year based on the reporting period start date entered to run this report.

FILE NAME   MU_Stg1_nqf0041-fluvax.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider during the measurement period's flu season who meets the qualifying age.

> *seen by* - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> *measurement period's flu season* - starts the September of the previous year and ends the February of the current year based on the reporting period start date entered to run this report.
>
> *qualifying age* - Includes patients 50 years or older at the time the patient was seen.

NUMERATOR   Of the patients in the denominator, count 1 for every patient patient whose chart has one or more indications of FluVax Given.

> *FluVax Given Indication*- Observation terms entered in the application during the measurement period's flu season: *FLU VAX, FLU VAX#1, FLUMIST, CVX141B, CVX140B, CVX144B, TIV_HIGHDOSE, H1N1 VAX*.

EXCLUSION   Of the patients in the denominator, count 1 for every patient not in the numerator whose chart has one or more indications of a qualified exclusion.

> *active diagnosis* - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out*, and *Status Post*) where the onset date is on or before the last day of the measurement's flu season and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measurement's flu season.
>
> *Indication of reason not given* - Observation terms entered in the application during the measurement period's flu season: *RSNFLUNTGVN, CVX141BRNG, CVX140BRNG, CVX144BRNG, FLUMISTRNG, H1N1RSNNTGVN*.

Setup, workflows, and best practices

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

CMS Quality Measures - Menu

- "NQF 0001 Asthma Assessment"
- "NQF 0018 Controlling High BP"
- "NQF 0027 Tobacco Use and Cessation"
- "NQF 0031 Breast Cancer Screening"
- "NQF 0032 Cervical Cancer Screening"
- "NQF 0033 Chlamydia Screen 15-24"
- "NQF 0033 Chlamydia Screen 15-20"
- "NQF 0033 Chlamydia Screen 21-24"
- "NQF 0034 Colorectal Cancer Screening"
- "NQF 0043 Pneumonia Vaccination Older Adults"
- "NQF 0047 Asthma Pharmacologic Therapy"
- "NQF 0055 Diabetic Patients Eye Exam"
- "NQF 0056 Diabetic Patients Foot Exam"
- "NQF 0059 Hgba1c Poor Control (>9)"
- "NQF 0061 Diabetes: BP Management < 140/90"
- "NQF 0062 Diabetic Patients Urine Screening"
- "NQF 0064 Diabetic Patients with LDL / LDL <100"
- "NQF 0067 CAD and Antiplatelet Therapy"
- "NQF 0068 IVD Patients and Oral Antiplatelet Therapy"
- "NQF 0073 IVD and Blood Pressure"
- "NQF 0074 CAD and Lipid-Lowering Therapy"
- "NQF 0075 IVD Patients with LDL / LDL <100"
- "NQF 0084 Heart Failure and Warfarin Therapy"
- "NQF 0575 HbA1c Control (<8%)"

NQF 0001 Asthma Assessment

Requirements

MEASURE   Percentage of patients aged 5 through 40 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

VERSION   1

Calculation

DESCRIPTION   Asthma Assessment (NQF 0001)

Percentage of patients aged 5 through 40 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

FILE NAME   MU_Stg1_nqf0001-AsthmaAssessment.rp

DENOMINATOR   Count 1 for every patient *seen by* the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *asthma* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients between the ages of 5 and 40 years old before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.
>
> **asthma** - Includes patients with one or more active diagnoses of the following ICD-9 codes: 493.00. 493.01, 493.02, 493.10. 493.11, 493.12, 493.20, 493.21, 493.22,493.81, 493.82, 493.90, 493.91, 493.92
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient whose chart has one or more indications of *Asthma Assessment Daytime* or *Asthma Assessment Nighttime* before or during the reporting period.

> **Asthma Assessment Daytime, Asthma Assessment Nighttime** - Observation terms *ASTHSEV1* or *ASTHSEV2* were entered in the application within the reporting period.

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0018 Controlling High BP

Requirements

MEASURE The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

VERSION 1

Calculation

DESCRIPTION Controlling High Blood Pressure (NQF 0018)

The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

FILE NAME MU_Stg1_nqf0018-bpcontrol.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters*, whose chart includes an *active diagnosis* of *hypertension* in the first 6 months of the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients who were 17 years old or older or 84 years or younger before the first day of the reporting period.
>
> **number of encounters** - Includes patients with one or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition regardless of responsible provider for the encounter(s).
>
> **hypertension** - Includes patients with one or more active diagnoses of the following ICD-9 codes: 401, 401.0, 401.1, 401.9.
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.
>
> If the reporting period is less than 6 months, then the diagnosis must be active within the reporting period, otherwise it must be active up to the first six months of the reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient for who has a *qualifying blood pressure reading* recorded in the patient's chart during the reporting period.

> **qualifying BP reading** - Most recent recording in the reporting period is <140/90.
>
> **BP Systolic** - Observation term *BP systolic, BP SYS STAND,* or *BP SYS LYING*.
>
> **BP Diastolic** - Observation term *BP diastolic, BP DIA STAND,* or *BP DIA LYING*

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0027 Tobacco Use and Cessation

Requirements

MEASURE The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

VERSION 1

Calculation

DESCRIPTION Smoking and Tobacco User (NQF 0027) - Numerator 1

The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year

FILE NAME MU_Stg1_nqf0027a-TobaccoUserandCessation.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and was *screened for tobacco use* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients 17 years old or older on the first day of the reporting period.
>
> **tobacco use screening** - Observation terms *SMOK STATUS* or *Tobacco Use* were entered in the application within 2 years from the last day of the reporting period.
>
> **Quality Reporting Services** - Observation Group *SMOKING STATUS*

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has an indication of tobacco use.

> **tobacco user** - Observation terms *SMOK STATUS* or *Tobacco Us*e were entered in the application within the reporting period. SMOK STATUS should contain the word "current" or equal "Y" or "Yes".
>
> **Quality Reporting Services** - Observation Group *SMOKING STATUS*

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0031 Breast Cancer Screening

Requirements

MEASURE
The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

VERSION
1

Calculation

DESCRIPTION
Breast Cancer Screening (NQF 0031)

The percentage of women 42-69 years of age who had a mammogram to screen for breast cancer.

Note: The age range is changed from the source requirement.

The NQF specification population criteria starts at age 42 because a 40 year old woman has up to 2 years to get the mammogram. (See Measure Description note above.)

FILE NAME
MU_Stg1_nqf0031-BreastCancerScreen.rpt

DENOMINATOR
Count 1 for every patient seen by the eligible provider once or more during the last 2 years starting from (and including) the last day of the reporting period, who meets the *qualifying age and gender* and whose chart does not include an indication of *bilateral mastectomy* diagnosis.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age and gender - Includes female patients between the ages of 42 and 69 before the first day of the reporting period. Note that the age range in the calculation is different than the range in the report description, because the population criteria in the measure specifications starts at age 42. See the original NQF specification for more information.

bilateral mastectomy - Excludes patients with an indication of ICD-9 diagnosis code V45.71.

ICD-9 code must exist in the patient's chart on the problem list. The Crystal Reports template does not look in the Orders module.

NUMERATOR
Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Mammogram Screening* during the last 2 years starting from (and including) the last day of the reporting period.

Mammogram Screening - includes observation terms *Last mam dat* or *Mammogram*

SETUP
Set up Document Types. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

PERFORMANCE
Performance - Due to the nature of the measure calculation, this report may take longer to generate than other reports. It should not to be included in the report count in the section "Find database size" on page 4.

NQF 0032 Cervical Cancer Screening

Requirements

MEASURE The percentage of women 21-63 years of age who received one or more Pap tests to screen for cervical cancer.

VERSION 1

Calculation

DESCRIPTION Cervical Cancer Screening (NQF 0032)

The percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer.

FILE NAME MU_Stg1_nqf0032-PapTest.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider once or more during the last 2 years starting from (and including) the last day of the reporting period, who meets the *qualifying age and gender* and whose chart does not include any indication of *hysterectomy* procedure.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age and gender** - Includes female patients between the ages of 23 and 63 before the first day of the reporting period. Note that the age range in the calculation is different than the range in the report description, because the population criteria in the measure specifications starts at age 23. See the original NQF specification for more information.
>
> **hysterectomy** - Excludes patients with one or more indications of these CPT procedure codes: 51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58951, 58953, 58954, 58956, 59135
>
> CPT codes must exist in the patient's chart on the problem list. The Crystal Reports template does not look in the Orders module.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Cervical Cancer Screening* during the last 3 years starting from (and including) the last day of the reporting period.

> **Cervical Cancer Screening** - includes observation terms *Last PAP dat*, *PAP SURVEY*, or *Pap smear*.
>
> **Mammogram Screening** - includes observation terms *Last mam dat* or *Mammogram*

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

PERFORMANCE **Performance** - Due to the nature of the measure calculation, this report may take longer to generate than other reports. It should not to be included in the report count in the section "Find database size" on page 4.

NQF 0033 Chlamydia Screen 15-24

Requirements

MEASURE The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

VERSION 1

Calculation

DESCRIPTION Chlamydia Screening for Women (NQF 0033) - Population 1

The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

FILE NAME MU_Stg1_nqf0033-ChlamydiaScreen_Pop1.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider once or more during the last 2 years starting from (and including) the last day of the reporting period, who meets the *qualifying age and gender* and whose chart includes one or more observations of *Sexually Active* before or during the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age and gender - Includes female patients between ages of 14 and 23 before the first day of the reporting period.

Sexually Active - Includes observation terms *SEXUAL ACTIV* or *SEXUALLYACT* with a value of "Y" or "Yes."

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Chlamydia Screening* during the reporting period.

Chlamydia Screening - includes observation terms *CHLAMYD CULT*, *CHLAMYD AMPL*, or *CHLAMYD DNA*.

EXCLUSION Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0033 Chlamydia Screen 15-20

Requirements

MEASURE The percentage of women 15-20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

VERSION 1

Calculation

DESCRIPTION Chlamydia Screening for Women (NQF 0033) - Population 2

The percentage of women 15-20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

FILE NAME MU_Stg1_nqf0033-ChlamydiaScreen_Pop2.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider once or more during the last 2 years starting from (and including) the last day of the reporting period, who meets the *qualifying age and gender* and whose chart includes one or more observations of *Sexually Active* before or during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.

> **qualifying age and gender** - Includes female patients between ages of 14 and 19 before the first day of the reporting period.

> **Sexually Active** - Includes observation terms *SEXUAL ACTIV* or *SEXUALLYACT* with a value of "Y" or "Yes."

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Chlamydia Screening* during the reporting period.

> **Chlamydia Screening** - includes observation terms *CHLAMYD CULT*, *CHLAMYD AMPL*, or *CHLAMYD DNA*.

EXCLUSION Of the patients in the denominator, count 0 (zero) for each patient.

> **Note**: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0033 Chlamydia Screen 21-24

Requirements

MEASURE The percentage of women 21-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

VERSION 1

Calculation

DESCRIPTION Chlamydia Screening for Women (NQF 0033) - Population 3

The percentage of women 21-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

FILE NAME MU_Stg1_nqf0033-ChlamydiaScreen_Pop3.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider once or more during the last 2 years starting from (and including) the last day of the reporting period, who meets the *qualifying age and gender* and whose chart includes one or more observations of *Sexually Active* before or during the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age and gender - Includes female patients between ages of 20 and 23 before the first day of the reporting period.

Sexually Active - Includes observation terms *SEXUAL ACTIV* or *SEXUALLYACT* with a value of "Y" or "Yes".

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Chlamydia Screening* during the reporting period.

Chlamydia Screening - includes observation terms *CHLAMYD CULT*, *CHLAMYD AMPL*, or *CHLAMYD DNA*.

EXCLUSION Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0034 Colorectal Cancer Screening

Requirements

MEASURE The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

VERSION 1

Calculation

DESCRIPTION Colorectal Cancer Screening (NQF 0034)

The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

FILE NAME MU_Stg1_nqf0034-ColorectalCancerScreen.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider once or more during the last 2 years starting from (and including) the last day of the reporting period, who meets the *qualifying age* and whose chart does not include one or more indications of *Total Colectomy* procedure.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients between ages of 50 and 74 before the first day of the reporting period.
>
> **Total Colectomy** - Excludes patients with one or more indications of these CPT procedure codes: 44150, 44151, 44152, 44153, 44155, 44156, 44157, 44158, 44210, 44211, 44212.

Note. CPT codes must exist in the patient's chart on the problem list. The Crystal Reports template does not look in the Orders module.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart includes at least one of the following observations:

- *colonoscopy* - one or more during the last 10 years starting from (and including) the last day of the reporting period
- *flexible sigmoidoscopy* - one or more during the last 5 years starting from (and including) the last day of the reporting period
- *FOTB* - during the measurement period

> **colonoscopy** - includes the observation term *colonoscopy*.
>
> **flexible sigmoidoscopy** - includes the observation term *flex sigmoid*.
>
> **FOTB** - includes the observation term *Hemoccult*.

EXCLUSION Of the patients in the denominator, count 1 for every patient not in the numerator whose chart has one or more indications of a *qualifying diagnosis* active at one time during the reporting period.

> **qualifying diagnosis** - colorectal cancer

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

PERFORMANCE **Performance** - Due to the nature of the measure calculation, this report may take longer to generate than other reports. It should not to be included in the report count in the section "Find database size" on page 4.

NQF 0043 Pneumonia Vaccination Older Adults

Requirements

MEASURE   The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

VERSION   1

Calculation

DESCRIPTION   Pneumonia Vaccination Status for Older Adults (NQF 0043)

The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

FILE NAME   MU_Stg1_nqf0043-PneumoVax.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* during the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age - Includes patients 64 years old or older before the first day of the reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient whose chart has one or more indications that *pneumonia vaccine* was administered on or before the last day of the reporting period.

pneumonia vaccine - Observation term *Pneumovax* was entered in the application within the reporting period.

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

WORKFLOW   If the observation is entered in error and subsequently deleted from a patient's chart (during or after the reporting period), the report will still count the patient in the numerator.

NQF 0047 Asthma Pharmacologic Therapy

Requirements

MEASURE Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

VERSION 1

Calculation

DESCRIPTION Asthma Pharmacologic Therapy (NQF 0047)

Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

FILE NAME MU_Stg1_nqf0047-AsthmaPharma.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *asthma* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients between the ages of 5 and 40 years old before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.
>
> **asthma** - Includes patients with one or more active diagnoses of the following ICD-9 codes: 493.00. 493.01, 493.02, 493.10. 493.11, 493.12, 493.20, 493.21, 493.22,493.81, 493.82, 493.90, 493.91, 493.92
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more *qualifying active medications* during the reporting period.

> **qualifying medication** - asthma therapy

EXCLUSION Of the patients in the denominator, count 1 for every patient not in the numerator whose chart has one or more indications of a *qualifying medication allergy* active at one time during the reporting period.

> **qualifying medication allergy** - asthma therapy

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0055 Diabetic Patients Eye Exam

Requirements

MEASURE   The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.

VERSION   CMS Supplemental Publication

Calculation

DESCRIPTION   Diabetes: Eye Exam (NQF 0055)

The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.

FILE NAME   MU_Stg1_nqf0055-eyeexam.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.
>
> **diabetes** - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Eye Exam* during the reporting period.

> **Eye Exam** - Observation terms *diab eye ex* or *dilateyeexam* were entered in the application within the reporting period.

EXCLUSION   Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0056 Diabetic Patients Foot Exam

Requirements

MEASURE   The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).

VERSION   1

Calculation

DESCRIPTION   Diabetes: Foot Exam (NQF 0056)

The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).

FILE NAME   MU_Stg1_nqf0056-footexam.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

> **seen by** - see , for QRS and Crystal Reports.

> **qualifying age** - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.

> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

> **diabetes** - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".

> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Foot Exam* during the reporting period.

> **Foot Exam** - Observation terms *DIAB FOOT CK* or *CARVILLEEXAM* were entered in the application within the reporting period.

EXCLUSION   Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See .

NQF 0059 Hgba1c Poor Control (>9)

Requirements

MEASURE The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c > 9.0%.

VERSION 1

Calculation

DESCRIPTION Diabetes: HbA1c Poor Control >9% (NQF 0059)

The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c > 9.0%.

FILE NAME MU_Stg1_nqf0059-hgbA1c90.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.

> **qualifying age** - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.

> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

> **diabetes** - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".

> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *HbA1c Control* during the reporting period and where the most recent value within the reporting period is >9.

> **HbA1c Control** - Observation term *HgbA1C* was entered in the application within the reporting period.

EXCLUSION Of the patients in the denominator, count 0 (zero) for each patient.

> **Note**: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0061 Diabetes: BP Management < 140/90

Requirements

MEASURE   The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP < 140/90 mmHg.

VERSION   1

Calculation

DESCRIPTION   Diabetes: Blood Pressure Management (NQF 0061)

The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP < 140/90 mmHg.

FILE NAME   MU_Stg1_nqf0061-bpcontrol.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.
>
> **diabetes** - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient for who has a qualifying blood pressure reading recorded in the patient's chart during the reporting period.

> **qualifying BP reading** - Most recent recording in the reporting period is <140/90.
>
> **BP Systolic** - Observation term *BP systolic*, *BP SYS STAND*, or *BP SYS LYING*.
>
> **BP Diastolic** - Observation term *BP diastolic*, *BP DIA STAND*, or *BP DIA LYING*

EXCLUSION   Of the patients in the denominator, count 0 (zero) for each patient.

> **Note**: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0062 Diabetic Patients Urine Screening

Requirements

MEASURE The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.

VERSION 1

Calculation

DESCRIPTION Diabetes: Urine Screening (NQF 0062)

The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.

FILE NAME MU_Stg1_nqf0062-urineprotein.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.

number of encounters - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

diabetes - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".

active diagnosis - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *Urine Screening* during the reporting period.

Urine Screening - Observation terms *PROTEIN*, *URN PROT*, *24H URN*, *PROTEIN UR*, *TOT PROT UR*, *PROT 24H UR* were entered in the application within the reporting period.

QRS report: Looks for terms in Observation Groups *URINE MICROALBUMIN* and *DIALYSIS*.

EXCLUSION Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0064 Diabetic Patients with LDL / LDL <100

Requirements

MEASURE   The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.

VERSION   CMS Original Published Specification

NQF 0064a - Numerator 1

Calculation

DESCRIPTION   Diabetes: LDL Management & Control (NQF 0064) - Numerator 1

The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL lab test result.

FILE NAME   MU_Stg1_nqf0064a-ldl.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

seen by - see , for QRS and Crystal Reports.

qualifying age - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.

number of encounters - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

diabetes - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".

active diagnosis - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *LDL Test Result* during the reporting period.

LDL Test Result- Observation terms *LDL*, *LDL (CALCUL)*, or *LDL dir* were entered in the application within the reporting period.

EXCLUSION   Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

NQF 0064b - Numerator 2

DESCRIPTION Diabetes: LDL Management & Control (NQF 0064) - Numerator 2

The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.

FILE NAME MU_Stg1_nqf0064b-ldl100.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.

number of encounters - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

diabetes - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".

active diagnosis - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *LDL Test Result* during the reporting period and the most recent value within the reporting period is <100.

LDL Test Result- Observation terms *LDL*, *LDL (CALCUL)*, or *LDL dir* were entered in the application within the reporting period.

EXCLUSION Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0067 CAD and Antiplatelet Therapy

Requirements

MEASURE Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.

VERSION 1

Calculation

DESCRIPTION Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD (NQF 0067)

Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.

FILE NAME MU_Stg1_nqf0067-CADAntiplateletTherapy.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *Coronary Artery Disease* Includes MI during the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age - Includes patients 18 year es or older before the first day of the reporting period.

number of encounters - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

Coronary Artery Disease Includes MI - Includes patients with one or more active diagnoses of ICD-9 codes 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 45.81, V45.82.

active diagnosis - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more qualifying active medications during the reporting period.

qualifying medication - oral anti-platelet

EXCLUSION Of the patients in the denominator, count 1 for every patient not in the numerator whose chart has one or more indications of a *qualifying diagnosis* active at one time during the reporting period.

qualifying diagnosis - bleeding coagulation disorder

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0068 IVD Patients and Oral Antiplatelet Therapy

Requirements

MEASURE   The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1 - November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.

VERSION   1

Calculation

DESCRIPTION   Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic (NQF 0068)

The percentage of patients 18 years of age and older who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.

FILE NAME   MU_Stg1_nqf0068-IVDAsprin.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *IVD* during the reporting period that started within 2 years prior to the last day of the reporting period.

> **seen by** - see , for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients 17 years old or older before the first day of the reporting period.
>
> **number of encounters** - Includes patients with one or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition regardless of responsible provider for the encounter(s).
>
> **IVD** - Includes patients with one or more active diagnoses of ICD-9 codes starting with: 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433, 434, 440.1, 440.2, 440.4, 444, 445.
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient whose chart has one or more qualifying active medications during the reporting period

> **qualifying medication** - oral anti-platelet

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See .

NQF 0073 IVD and Blood Pressure

Requirements

MEASURE   The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1st to November 1st of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).

VERSION   1

Calculation

DESCRIPTION   Ischemic Vascular Disease (IVD): Blood Pressure Management (NQF 0073)

The percentage of patients 18 years of age and older who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).

FILE NAME   MU_Stg1_nqf0073-bpcontrol.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *IVD* during the reporting period that started within 2 years prior to the last day of the reporting period.

seen by - see , for QRS and Crystal Reports.

qualifying age - Includes patients 17 years old or older before the first day of the reporting period.

number of encounters - Includes patients with one or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition regardless of responsible provider for the encounter(s).

IVD - Includes patients with one or more active diagnoses of ICD-9 codes starting with: 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433, 434, 440.1, 440.2, 440.4, 444, 445.

active diagnosis - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient for who has a qualifying blood pressure reading recorded in the patient's chart during the reporting period.

qualifying BP reading - Most recent recording in the reporting period is <140/90.

BP Systolic - Observation term *BP systolic, BP SYS STAND*, or *BP SYS LYING*.

BP Diastolic - Observation term *BP diastolic*, *BP DIA STAND*, or *BP DIA LYING*

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See .

NQF 0074 CAD and Lipid-Lowering Therapy

Requirements

MEASURE Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy.

VERSION 1

Calculation

DESCRIPTION Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol (NQF 0074)

Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy.

FILE NAME MU_Stg1_nqf0074-CADLipidLoweringTherapy.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *Coronary Artery Disease Includes MI* during the reporting period.

seen by - see "Seen by" on page 7, for QRS and Crystal Reports.

qualifying age - Includes patients 18 years or older before the first day of the reporting period.

number of encounters - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

Coronary Artery Disease Includes MI - Includes patients with one or more active diagnoses of ICD-9 codes 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, ICD-V45.81, V45.82.

active diagnosis - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out*, and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more qualifying active medications during the reporting period

qualifying medication - lipid-lowering

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0075 IVD Patients with LDL / LDL <100

Requirements

MEASURE The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1st to November 1st of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was < 100 mg/dL.

VERSION CMS Original Published Specification

NQF 0075a - Numerator 1

Calculation

DESCRIPTION Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (NQF 0075) - Numerator 1

The percentage of patients 18 years of age and older who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had an LDL lab test during the measurement year.

FILE NAME MU_Stg1_nqf0075a-ldl.rppt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *IVD* during the reporting period that started within 2 years prior to the last day of the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients 17 years old or older before the first day of the reporting period.
>
> **number of encounters** - Includes patients with one or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition regardless of responsible provider for the encounter(s).
>
> **IVD** - Includes patients with one or more active diagnoses of ICD-9 codes starting with: 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433, 434, 440.1, 440.2, 440.4, 444, 445.
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *LDL Test Result* during the reporting period.

> **LDL Test Result**- Observation terms *LDL*, *LDL (CALCUL)*, or *LDL dir* were entered in the application within the reporting period.

NQF 0075b - Numerator 2

DESCRIPTION Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (NQF 0075) - Numerator 2

The percentage of patients 18 years of age and older who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had an LDL lab test during the measurement year and whose LDL-C was < 100 mg/dL.

FILE NAME MU_Stg1_nqf0075b-ldl.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *IVD* during the reporting period that started within 2 years prior to the last day of the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients 17 years old or older before the first day of the reporting period.
>
> **number of encounters** - Includes patients with one or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition regardless of responsible provider for the encounter(s).
>
> **IVD** - Includes patients with one or more active diagnoses of ICD-9 codes starting with: 411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433, 434, 440.1, 440.2, 440.4, 444, 445.
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *LDL Test Result* during the reporting period and the most recent value within the reporting period is <100.

> **LDL Test Result**- Observation terms *LDL*, *LDL (CALCUL)*, or *LDL dir* were entered in the application within the reporting period.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0084 Heart Failure and Warfarin Therapy

Requirements

MEASURE   Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.

VERSION   1

Calculation

DESCRIPTION   Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation (NQF 0084)

Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who [were candidates for warfarin therapy and] were prescribed warfarin therapy.

FILE NAME   MU_Stg1_nqf0084-HeartFailureWarfarinTherapy.rpt

DENOMINATOR   Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *Heart Failure* on or before the encounter date and *Atrial Fibrillation* before or during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.
>
> **qualifying age** - Includes patients 18 years old or older before the first day of the reporting period.
>
> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.
>
> **Heart Failure** - Includes patients with one or more active diagnoses of the following ICD-9 codes: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11. 404.13, 404.91,404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9.
>
> **Atrial Fibrillation** - Includes patients with one or more active diagnoses of 427.31.
>
> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out,* and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR   Of the patients in the denominator, count 1 for every patient whose chart has an active medication *Warfarin* at least once during the reporting period.

> **Warfarin** - Includes patients with one or more active medications with GPI code "832000%".

SETUP   **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

NQF 0575 HbA1c Control (<8%)

Requirements

MEASURE The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.

VERSION 1

Calculation

DESCRIPTION Diabetes: HbA1c Control (<8%) (NQF 0575)

The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.

FILE NAME MU_Stg1_nqf0575-HbA1c8.rpt

DENOMINATOR Count 1 for every patient seen by the eligible provider who meets the *qualifying age* and *number of encounters* and whose chart includes an *active diagnosis* of *diabetes* during the reporting period.

> **seen by** - see "Seen by" on page 7, for QRS and Crystal Reports.

> **qualifying age** - Includes patients between the ages of 17 and 74 years old before the first day of the reporting period.

> **number of encounters** - Includes patients with 2 or more encounters during the reporting period. Encounters are based on the document type in the *seen by* definition.

> **diabetes** - Includes patients with one or more active diagnoses of ICD-9 codes that start with "250". "357.2", "362.0", 366.41", or "648.0".

> **active diagnosis** - A problem recorded in the chart of any type (except *Family History Of*, *Rule Out*, and *Status Post*) where the onset date is on or before the last day of the measure reporting period and the problem has either no end date when the measure report is printed or an end date on or after the first day of the measure reporting period.

NUMERATOR Of the patients in the denominator, count 1 for every patient whose chart has one or more observations of *HbA1c Control* during the reporting period and the most recent value within the reporting period is <8.

> **HbA1c Control** - Observation term *HgbA1C* was entered in the application within the reporting period.

EXCLUSION Of the patients in the denominator, count 0 (zero) for each patient.

Note: Due to the fact that the exclusion logic only applies to denominator logic that is *not* implemented in this report, the exclusion will always be zero.

SETUP **Set up Document Types**. Add any custom encounter documents to *Patient Encounter (MU)* global chart document view. See "Modifying the Patient Encounter (MU) document view" on page 8.

Observation Terms

CMS Functional Measures: Observation terms - by name

OBS Name	QRS OBS Group	HDID	Measure	QRS	Crystal
AFCETHNICITY	ETHNICITY	193138	FC 07	✓	
AFCETHNICITY	RACE	193138	FC 07	✓	
AOMS#2 36	ETHNICITY	14172	FC 07	✓	
AOMS#2 36	RACE	14172	FC 07	✓	
BP baseli sy	BP SYSTOLIC	2777	FC 08	✓	
BP basli dia	BP DIASTOLIC	2778	FC 08	✓	
BP dia #2	BP DIASTOLIC	5248	FC 08	✓	
BP dia #3	BP DIASTOLIC	5250	FC 08	✓	
BP dia #4	BP DIASTOLIC	21679	FC 08	✓	
BP dia #5	BP DIASTOLIC	21680	FC 08	✓	
BP dia #6	BP DIASTOLIC	21681	FC 08	✓	
BP dia #7	BP DIASTOLIC	26155	FC 08	✓	
BP dia #8	BP DIASTOLIC	51993	FC 08	✓	
BP dia AM	BP DIASTOLIC	50478	FC 08	✓	
BP dia l arm	BP DIASTOLIC	2880	FC 08	✓	
BP dia L leg	BP DIASTOLIC	6869	FC 08	✓	
BP dia lying	BP DIASTOLIC	2886	FC 08	✓	✓
BP dia PM	BP DIASTOLIC	50480	FC 08	✓	

OBS Name	QRS OBS Group	HDID	Measure	QRS	Crystal
BP dia r arm	BP DIASTOLIC	2878	FC 08	✓	
BP dia R leg	BP DIASTOLIC	6870	FC 08	✓	
BP dia sit	BP DIASTOLIC	2882	FC 08	✓	
bp dia sit l	BP DIASTOLIC	5912	FC 08	✓	
bp dia sit r	BP DIASTOLIC	26967	FC 08	✓	
BP DIA SIT#2	BP DIASTOLIC	92416	FC 08	✓	
BP dia stand	BP DIASTOLIC	2884	FC 08	✓	✓
BP DIAS REP	BP DIASTOLIC	300065	FC 08	✓	
BP diastolic	BP DIASTOLIC	53	FC 08	✓	✓
BP sys #2	BP SYSTOLIC	5247	FC 08	✓	
BP sys #3	BP SYSTOLIC	5249	FC 08	✓	
BP sys #4	BP SYSTOLIC	21682	FC 08	✓	
BP sys #5	BP SYSTOLIC	21683	FC 08	✓	
BP sys #6	BP SYSTOLIC	21684	FC 08	✓	
BP sys #7	BP SYSTOLIC	26151	FC 08	✓	
BP sys #8	BP SYSTOLIC	52001	FC 08	✓	
BP sys l arm	BP SYSTOLIC	2879	FC 08	✓	
BP sys L leg	BP SYSTOLIC	6871	FC 08	✓	
BP sys lying	BP SYSTOLIC	2885	FC 08	✓	✓
BP sys r arm	BP SYSTOLIC	2877	FC 08	✓	
BP sys R leg	BP SYSTOLIC	6872	FC 08	✓	
BP SYS REP	BP SYSTOLIC	300064	FC 08	✓	
BP sys sit	BP SYSTOLIC	2881	FC 08	✓	
bp sys sit l	BP SYSTOLIC	5909	FC 08	✓	
bp sys sit r	BP SYSTOLIC	26607	FC 08	✓	
BP SYS SIT#2	BP SYSTOLIC	92415	FC 08	✓	
BP sys stand	BP SYSTOLIC	2883	FC 08	✓	✓
BP systolic	BP SYSTOLIC	54	FC 08	✓	✓

OBS Name	QRS OBS Group	HDID	Measure	QRS	Crystal
CareTransIn	CARETRANSIN	261261	FM 07	✓	✓
CareTransOut	CARETRANSOUT	261263	FM 08	✓	✓
Cigaret smkg	SMOKING STATUS MU	130	FC 09	✓	✓
EH LANGUAGE	LANGUAGE	130661	FC 07	✓	
ethnicity	ETHNICITY	11404	FC 07	✓	
ethnicity	RACE	11404	FC 07	✓	
GPRAQOLRACE	ETHNICITY	128590	FC 07	✓	
GPRAQOLRACE	RACE	128590	FC 07	✓	
Height	HEIGHT	55	FC 08	✓	✓
Height (cm)	HEIGHT	3094	FC 08	✓	✓
HOI/1.193.1	HEIGHT	1628	FC 08	✓	
HX CIGARETTE	SMOKING STATUS MU	16025	FC 09	✓	✓
Languag Home	LANGUAGE	97796	FC 07	✓	
languag pref	LANGUAGE	9861	FC 07	✓	
max height	HEIGHT	73266	FC 08	✓	
medicat educ	MED REVIEW	5892	FM 07	✓	✓
medicat list	MED REVIEW	10065	FM 07	✓	✓
MEDLISTPRTD	MED REVIEW	111471	FM 07	✓	✓
MedRecon	MED REVIEW	96264	FM 07	✓	✓
Meds review	MED REVIEW	2540	FM 07	✓	✓
meds reviewd	MED REVIEW	9528	FM 07	✓	✓
MEDSAFTREC	MED REVIEW	167161	FM 07	✓	✓
MLSTPRINREV	MED REVIEW	138975	FM 07	✓	✓
NKA	NO KNOWN ALLERGY	2779	FC 06	✓	✓
nkmed	NO KNOWN MEDICATION	6459	FC 05	✓	✓
nkprob	NO KNOWN PROBLEM	6460	FC 03	✓	✓
PQRI MEAS130	MED REVIEW	150143	FM 07	✓	✓
race	ETHNICITY	45034	FC 07	✓	

OBS Name	QRS OBS Group	HDID	Measure	QRS	Crystal
race	RACE	45034	FC 07	✓	
REW MED NCHG	MED REVIEW	192206	FM 07	✓	✓
ROI AL SD DT		43803	FC 12		✓
ROI AUTH LN	ROI AUTH LN	261401	FC 12		✓
ROI CR SD DT		43798	FC 12		✓
ROI DA SD DT		43790	FC 12		✓
ROI DD SD DT		43793	FC 12		✓
ROI dte rcvd	ROI DTE RCVD	22291	FC 12	✓	✓
ROI DTE SENT		22292	FC 12		✓
ROI EN SD DT		43794	FC 12		✓
ROI ER sd dt	ROI ER SD DT	43799	FC 12	✓	✓
ROI GT SD DT		43792	FC 12		✓
ROI HA SD DT		43791	FC 12		✓
ROI IR SD DT		43804	FC 12		✓
ROI LR SD DT		43795	FC 12		✓
ROI method	ROI METHOD	62091	FC 12	✓	✓
ROI MH SD DT		43789	FC 12		✓
ROI ML SD DT		43802	FC 12		✓
ROI OR SD DT		43797	FC 12		✓
ROI OT SD DT		43805	FC 12		✓
ROI PL SD DT		43801	FC 12		✓
ROI reason	ROI REASON	22297	FC 12	✓	✓
ROI RR SD DT		43800	FC 12		✓
ROI XR SD DT		43796	FC 12		✓
SMKSTATORVR13	SMOKING STATUS MU	303701	FC 09	✓	✓
SMOK STATUS	SMOKING STATUS MU	300015	FC 09	✓	✓
smokes	SMOKING STATUS MU	43476	FC 09	✓	✓

OBS Name	QRS OBS Group	HDID	Measure	QRS	Crystal
smoking hx	SMOKING STATUS MU	9407	FC 09	✓	✓
Weight	WEIGHT	61	FC 08	✓	✓
Weight (Kg)	WEIGHT	3095	FC 08	✓	✓

CMS Functional Measures: Observation terms - by measure

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
FC 03	NO KNOWN PROBLEM	nkprob	6460	✓	✓
FC 05	NO KNOWN MEDICATION	nkmed	6459	✓	✓
FC 06	NO KNOWN ALLERGY	NKA	2779	✓	✓
FC 07	ETHNICITY	AFCETHNICITY	193138	✓	
FC 07	ETHNICITY	AOMS#2 36	14172	✓	
FC 07	ETHNICITY	GPRAQOLRACE	128590	✓	
FC 07	ETHNICITY	ethnicity	11404	✓	
FC 07	ETHNICITY	race	45034	✓	
FC 07	LANGUAGE	EH LANGUAGE	130661	✓	
FC 07	LANGUAGE	Languag Home	97796	✓	
FC 07	LANGUAGE	languag pref	9861	✓	
FC 07	RACE	AFCETHNICITY	193138	✓	
FC 07	RACE	AOMS#2 36	14172	✓	
FC 07	RACE	GPRAQOLRACE	128590	✓	
FC 07	RACE	ethnicity	11404	✓	
FC 07	RACE	race	45034	✓	
FC 08	BP DIASTOLIC	BP DIA SIT#2	92416	✓	
FC 08	BP DIASTOLIC	BP DIAS REP	300065	✓	
FC 08	BP DIASTOLIC	BP basli dia	2778	✓	
FC 08	BP DIASTOLIC	BP dia #2	5248	✓	
FC 08	BP DIASTOLIC	BP dia #3	5250	✓	
FC 08	BP DIASTOLIC	BP dia #4	21679	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
FC 08	BP DIASTOLIC	BP dia #5	21680	✓	
FC 08	BP DIASTOLIC	BP dia #6	21681	✓	
FC 08	BP DIASTOLIC	BP dia #7	26155	✓	
FC 08	BP DIASTOLIC	BP dia #8	51993	✓	
FC 08	BP DIASTOLIC	BP dia AM	50478	✓	
FC 08	BP DIASTOLIC	BP dia L leg	6869	✓	
FC 08	BP DIASTOLIC	BP dia PM	50480	✓	
FC 08	BP DIASTOLIC	BP dia R leg	6870	✓	
FC 08	BP DIASTOLIC	BP dia l arm	2880	✓	
FC 08	BP DIASTOLIC	BP dia lying	2886	✓	✓
FC 08	BP DIASTOLIC	BP dia r arm	2878	✓	
FC 08	BP DIASTOLIC	BP dia sit	2882	✓	
FC 08	BP DIASTOLIC	BP dia stand	2884	✓	✓
FC 08	BP DIASTOLIC	BP diastolic	53	✓	✓
FC 08	BP DIASTOLIC	bp dia sit l	5912	✓	
FC 08	BP DIASTOLIC	bp dia sit r	26967	✓	
FC 08	BP SYSTOLIC	BP SYS REP	300064	✓	
FC 08	BP SYSTOLIC	BP SYS SIT#2	92415	✓	
FC 08	BP SYSTOLIC	BP baseli sy	2777	✓	
FC 08	BP SYSTOLIC	BP sys #2	5247	✓	
FC 08	BP SYSTOLIC	BP sys #3	5249	✓	
FC 08	BP SYSTOLIC	BP sys #4	21682	✓	
FC 08	BP SYSTOLIC	BP sys #5	21683	✓	
FC 08	BP SYSTOLIC	BP sys #6	21684	✓	
FC 08	BP SYSTOLIC	BP sys #7	26151	✓	
FC 08	BP SYSTOLIC	BP sys #8	52001	✓	
FC 08	BP SYSTOLIC	BP sys L leg	6871	✓	
FC 08	BP SYSTOLIC	BP sys R leg	6872	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
FC 08	BP SYSTOLIC	BP sys l arm	2879	✓	
FC 08	BP SYSTOLIC	BP sys lying	2885	✓	✓
FC 08	BP SYSTOLIC	BP sys r arm	2877	✓	
FC 08	BP SYSTOLIC	BP sys sit	2881	✓	
FC 08	BP SYSTOLIC	BP sys stand	2883	✓	✓
FC 08	BP SYSTOLIC	BP systolic	54	✓	✓
FC 08	BP SYSTOLIC	bp sys sit l	5909	✓	
FC 08	BP SYSTOLIC	bp sys sit r	26607	✓	
FC 08	HEIGHT	HOI/1.193.1	1628	✓	
FC 08	HEIGHT	Height	55	✓	✓
FC 08	HEIGHT	Height (cm)	3094	✓	✓
FC 08	HEIGHT	max height	73266	✓	
FC 08	WEIGHT	Weight	61	✓	✓
FC 08	WEIGHT	Weight (Kg)	3095	✓	✓
FC 09	SMOKING STATUS MU	Cigaret smkg	130	✓	✓
FC 09	SMOKING STATUS MU	SMOK STATUS	300015	✓	✓
FC 09	SMOKING STATUS MU	HX CIGARETTE	16025	✓	✓
FC 09	SMOKING STATUS MU	SMKSTATORVR13	303701	✓	✓
FC 09	SMOKING STATUS MU	smokes	43476	✓	✓
FC 09	SMOKING STATUS MU	smoking hx	9407	✓	✓
FM 07	CARETRANSIN	CareTransIn	261261	✓	✓
FM 07	MED REVIEW	MEDLISTPRTD	111471	✓	✓
FM 07	MED REVIEW	MEDSAFTREC	167161	✓	✓
FM 07	MED REVIEW	MLSTPRINREV	138975	✓	✓
FM 07	MED REVIEW	MedRecon	96264	✓	✓
FM 07	MED REVIEW	Meds review	2540	✓	✓
FM 07	MED REVIEW	PQRI MEAS130	150143	✓	✓
FM 07	MED REVIEW	REW MED NCHG	192206	✓	✓

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
FM 07	MED REVIEW	medicat educ	5892	✓	✓
FM 07	MED REVIEW	medicat list	10065	✓	✓
FM 07	MED REVIEW	meds reviewd	9528	✓	✓
FM 08	CARETRANSOUT	CareTransOut	261263	✓	✓
FC 12	ROI AUTH LN	ROI AUTH LN	261401		✓
FC 12	ROI DTE RCVD	ROI dte rcvd	22291	✓	✓
FC 12	ROI METHOD	ROI method	62091	✓	✓
FC 12	ROI REASON	ROI reason	22297	✓	✓
FC 12		ROI MH SD DT	43789		✓
FC 12	ROI ER SD DT	ROI ER sd dt	43799	✓	✓
FC 12		ROI EN SD DT	43794		✓
FC 12		ROI LR SD DT	43795		✓
FC 12		ROI XR SD DT	43796		✓
FC 12		ROI OR SD DT	43797		✓
FC 12		ROI CR SD DT	43798		✓
FC 12		ROI RR SD DT	43800		✓
FC 12		ROI PL SD DT	43801		✓
FC 12		ROI ML SD DT	43802		✓
FC 12		ROI AL SD DT	43803		✓
FC 12		ROI IR SD DT	43804		✓
FC 12		ROI DA SD DT	43790		✓
FC 12		ROI HA SD DT	43791		✓
FC 12		ROI GT SD DT	43792		✓
FC 12		ROI DD SD DT	43793		✓
FC 12		ROI OT SD DT	43805		✓
FC 12		ROI DTE SENT	22292		✓

CMS Quality Measures: Observation terms - by measure

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0001	ASTHMA Assess	ASTHSEV1	30785	✓	✓
NQF 0001	ASTHMA Assess	ASTHSEV2	30786	✓	✓
NQF 0001	ASTHMA Assess	AOMS 19	14159	✓	
NQF 0001	ASTHMA Assess	ASTHCTRLASSE	164810	✓	
NQF 0001	ASTHMA Assess	AsthSxAEany	36229	✓	
NQF 0001	ASTHMA Assess	AsthSx_Day	101217	✓	
NQF 0001	ASTHMA Assess	AsthSx_Night	101218	✓	
NQF 0001	ASTHMA Assess	Asthma day	96051	✓	
NQF 0001	ASTHMA Assess	asth msd dys	19152	✓	
NQF 0001	ASTHMA Assess	asthma hx01c	16130	✓	
NQF 0001	ASTHMA Assess	asthma hx01f	16133	✓	
NQF 0013	BP DIASTOLIC	BP DIA SIT#2	92416	✓	
NQF 0013	BP DIASTOLIC	BP DIAS REP	300065	✓	
NQF 0013	BP DIASTOLIC	BP basli dia	2778	✓	
NQF 0013	BP DIASTOLIC	BP dia #2	5248	✓	
NQF 0013	BP DIASTOLIC	BP dia #3	5250	✓	
NQF 0013	BP DIASTOLIC	BP dia #4	21679	✓	
NQF 0013	BP DIASTOLIC	BP dia #5	21680	✓	
NQF 0013	BP DIASTOLIC	BP dia #6	21681	✓	
NQF 0013	BP DIASTOLIC	BP dia #7	26155	✓	
NQF 0013	BP DIASTOLIC	BP dia #8	51993	✓	
NQF 0013	BP DIASTOLIC	BP dia AM	50478	✓	
NQF 0013	BP DIASTOLIC	BP dia L leg	6869	✓	
NQF 0013	BP DIASTOLIC	BP dia PM	50480	✓	
NQF 0013	BP DIASTOLIC	BP dia R leg	6870	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0013	BP DIASTOLIC	BP dia l arm	2880	✓	
NQF 0013	BP DIASTOLIC	BP dia lying	2886	✓	✓
NQF 0013	BP DIASTOLIC	BP dia r arm	2878	✓	
NQF 0013	BP DIASTOLIC	BP dia sit	2882	✓	
NQF 0013	BP DIASTOLIC	BP dia stand	2884	✓	✓
NQF 0013	BP DIASTOLIC	BP diastolic	53	✓	✓
NQF 0013	BP DIASTOLIC	bp dia sit l	5912	✓	
NQF 0013	BP DIASTOLIC	bp dia sit r	26967	✓	
NQF 0013	BP SYSTOLIC	BP SYS REP	300064	✓	
NQF 0013	BP SYSTOLIC	BP SYS SIT#2	92415	✓	
NQF 0013	BP SYSTOLIC	BP baseli sy	2777	✓	
NQF 0013	BP SYSTOLIC	BP sys #2	5247	✓	
NQF 0013	BP SYSTOLIC	BP sys #3	5249	✓	
NQF 0013	BP SYSTOLIC	BP sys #4	21682	✓	
NQF 0013	BP SYSTOLIC	BP sys #5	21683	✓	
NQF 0013	BP SYSTOLIC	BP sys #6	21684	✓	
NQF 0013	BP SYSTOLIC	BP sys #7	26151	✓	
NQF 0013	BP SYSTOLIC	BP sys #8	52001	✓	
NQF 0013	BP SYSTOLIC	BP sys L leg	6871	✓	
NQF 0013	BP SYSTOLIC	BP sys R leg	6872	✓	
NQF 0013	BP SYSTOLIC	BP sys l arm	2879	✓	
NQF 0013	BP SYSTOLIC	BP sys lying	2885	✓	✓
NQF 0013	BP SYSTOLIC	BP sys r arm	2877	✓	
NQF 0013	BP SYSTOLIC	BP sys sit	2881	✓	
NQF 0013	BP SYSTOLIC	BP sys stand	2883	✓	✓
NQF 0013	BP SYSTOLIC	BP systolic	54	✓	✓
NQF 0013	BP SYSTOLIC	bp sys sit l	5909	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0013	BP SYSTOLIC	bp sys sit r	26607	✓	
NQF 0018	BP DIASTOLIC	BP DIA SIT#2	92416	✓	
NQF 0018	BP DIASTOLIC	BP DIAS REP	300065	✓	
NQF 0018	BP DIASTOLIC	BP basli dia	2778	✓	
NQF 0018	BP DIASTOLIC	BP dia #2	5248	✓	
NQF 0018	BP DIASTOLIC	BP dia #3	5250	✓	
NQF 0018	BP DIASTOLIC	BP dia #4	21679	✓	
NQF 0018	BP DIASTOLIC	BP dia #5	21680	✓	
NQF 0018	BP DIASTOLIC	BP dia #6	21681	✓	
NQF 0018	BP DIASTOLIC	BP dia #7	26155	✓	
NQF 0018	BP DIASTOLIC	BP dia #8	51993	✓	
NQF 0018	BP DIASTOLIC	BP dia AM	50478	✓	
NQF 0018	BP DIASTOLIC	BP dia L leg	6869	✓	
NQF 0018	BP DIASTOLIC	BP dia PM	50480	✓	
NQF 0018	BP DIASTOLIC	BP dia R leg	6870	✓	
NQF 0018	BP DIASTOLIC	BP dia l arm	2880	✓	
NQF 0018	BP DIASTOLIC	BP dia lying	2886	✓	✓
NQF 0018	BP DIASTOLIC	BP dia r arm	2878	✓	
NQF 0018	BP DIASTOLIC	BP dia sit	2882	✓	
NQF 0018	BP DIASTOLIC	BP dia stand	2884	✓	✓
NQF 0018	BP DIASTOLIC	BP diastolic	53	✓	✓
NQF 0018	BP DIASTOLIC	bp dia sit l	5912	✓	
NQF 0018	BP DIASTOLIC	bp dia sit r	26967	✓	
NQF 0018	BP SYSTOLIC	BP SYS REP	300064	✓	
NQF 0018	BP SYSTOLIC	BP SYS SIT#2	92415	✓	
NQF 0018	BP SYSTOLIC	BP baseli sy	2777	✓	
NQF 0018	BP SYSTOLIC	BP sys #2	5247	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0018	BP SYSTOLIC	BP sys #3	5249	✓	
NQF 0018	BP SYSTOLIC	BP sys #4	21682	✓	
NQF 0018	BP SYSTOLIC	BP sys #5	21683	✓	
NQF 0018	BP SYSTOLIC	BP sys #6	21684	✓	
NQF 0018	BP SYSTOLIC	BP sys #7	26151	✓	
NQF 0018	BP SYSTOLIC	BP sys #8	52001	✓	
NQF 0018	BP SYSTOLIC	BP sys L leg	6871	✓	
NQF 0018	BP SYSTOLIC	BP sys R leg	6872	✓	
NQF 0018	BP SYSTOLIC	BP sys l arm	2879	✓	
NQF 0018	BP SYSTOLIC	BP sys lying	2885	✓	✓
NQF 0018	BP SYSTOLIC	BP sys r arm	2877	✓	
NQF 0018	BP SYSTOLIC	BP sys sit	2881	✓	
NQF 0018	BP SYSTOLIC	BP sys stand	2883	✓	✓
NQF 0018	BP SYSTOLIC	BP systolic	54	✓	✓
NQF 0018	BP SYSTOLIC	bp sys sit l	5909	✓	
NQF 0018	BP SYSTOLIC	bp sys sit r	26607	✓	
NQF 0024a	BMI	BMI	2788	✓	✓
NQF 0024a	BMI	BMI MQIC	35805	✓	
NQF 0024b	JUVENILE NUTRITION COUNSELING	BCDD	30400	✓	✓
NQF 0024b	JUVENILE NUTRITION COUNSELING	Diet Counsel	2487	✓	✓
NQF 0024b	JUVENILE NUTRITION COUNSELING	Diet plan	2832	✓	✓
NQF 0024b	JUVENILE NUTRITION COUNSELING	DietCmpliant	30801	✓	✓
NQF 0024b	JUVENILE NUTRITION COUNSELING	WGTMGMTCOUNS	156251	✓	
NQF 0024b	JUVENILE NUTRITION COUNSELING	nutritionivn	241375	✓	✓

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0024b	JUVENILE NUTRITION COUNSELING	nutritn guid	18297	✓	✓
NQF 0024b	JUVENILE NUTRITION COUNSELING	nutritnl gl	14496	✓	✓
NQF 0024c	JUVENILE FITNESS COUNSELING	EXERPRG REF	156247	✓	✓
NQF 0024c	JUVENILE FITNESS COUNSELING	WGTMGMTCOUNS	156251	✓	✓
NQF 0024c	JUVENILE FITNESS COUNSELING	wmexrgoal	113578	✓	✓
NQF 0024d	BMI	BMI	2788	✓	✓
NQF 0024d	BMI	BMI MQIC	35805	✓	
NQF 0024e	JUVENILE NUTRITION COUNSELING	BCDD	30400	✓	✓
NQF 0024e	JUVENILE NUTRITION COUNSELING	Diet Counsel	2487	✓	✓
NQF 0024e	JUVENILE NUTRITION COUNSELING	Diet plan	2832	✓	✓
NQF 0024e	JUVENILE NUTRITION COUNSELING	DietCmpliant	30801	✓	✓
NQF 0024e	JUVENILE NUTRITION COUNSELING	WGTMGMTCOUNS	156251	✓	
NQF 0024e	JUVENILE NUTRITION COUNSELING	nutritionivn	241375	✓	✓
NQF 0024e	JUVENILE NUTRITION COUNSELING	nutritn guid	18297	✓	✓
NQF 0024e	JUVENILE NUTRITION COUNSELING	nutritnl gl	14496	✓	✓
NQF 0024f	JUVENILE FITNESS COUNSELING	EXERPRG REF	156247	✓	✓
NQF 0024f	JUVENILE FITNESS COUNSELING	WGTMGMTCOUNS	156251	✓	
NQF 0024f	JUVENILE FITNESS COUNSELING	wmexrgoal	113578	✓	✓
NQF 0024g	BMI	BMI	2788	✓	✓
NQF 0024g	BMI	BMI MQIC	35805	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0024h	JUVENILE NUTRITION COUNSELING	BCDD	30400	✓	✓
NQF 0024h	JUVENILE NUTRITION COUNSELING	Diet Counsel	2487	✓	✓
NQF 0024h	JUVENILE NUTRITION COUNSELING	Diet plan	2832	✓	✓
NQF 0024h	JUVENILE NUTRITION COUNSELING	DietCmpliant	30801	✓	✓
NQF 0024h	JUVENILE NUTRITION COUNSELING	WGTMGMTCOUNS	156251	✓	
NQF 0024h	JUVENILE NUTRITION COUNSELING	nutritionivn	241375	✓	✓
NQF 0024h	JUVENILE NUTRITION COUNSELING	nutritn guid	18297	✓	✓
NQF 0024h	JUVENILE NUTRITION COUNSELING	nutritnl gl	14496	✓	✓
NQF 0024i	JUVENILE FITNESS COUNSELING	EXERPRG REF	156247	✓	✓
NQF 0024i	JUVENILE FITNESS COUNSELING	WGTMGMTCOUNS	156251	✓	
NQF 0024i	JUVENILE FITNESS COUNSELING	wmexrgoal	113578	✓	✓
NQF 0027	SMOKING STATUS	Adv to quit	500017	✓	
NQF 0027	SMOKING STATUS	BTS1	77789	✓	
NQF 0027	SMOKING STATUS	BTS2	77790	✓	
NQF 0027	SMOKING STATUS	BTS3	77791	✓	
NQF 0027	SMOKING STATUS	Cigar use	3028	✓	
NQF 0027	SMOKING STATUS	Cigaret smkg	130	✓	
NQF 0027	SMOKING STATUS	CrTobaccoUse	100418	✓	
NQF 0027	SMOKING STATUS	HOV1.237.1	1618	✓	
NQF 0027	SMOKING STATUS	PQRIMEAS114	150127	✓	
NQF 0027	SMOKING STATUS	SMOK ADVICE	300019	✓	
NQF 0027	SMOKING STATUS	SMOK STATUS	300015	✓	✓

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0027	SMOKING STATUS	SMOK YR Q	300016	✓	
NQF 0027	SMOKING STATUS	SMOKSTATODAY	79699	✓	
NQF 0027	SMOKING STATUS	Smok Hx tota	2621	✓	
NQF 0027	SMOKING STATUS	Smok hx PPD	2622	✓	
NQF 0027	SMOKING STATUS	SmokCessGoal	20745	✓	
NQF 0027	SMOKING STATUS	TobaccAmtDay	39285	✓	
NQF 0027	SMOKING STATUS	Tobacco Use	2200004	✓	✓
NQF 0027	SMOKING STATUS	TobaccoType	32621	✓	
NQF 0027	SMOKING STATUS	cigarette/d	16028	✓	
NQF 0027	SMOKING STATUS	quit smk stg	17386	✓	
NQF 0027	SMOKING STATUS	smokes	43476	✓	
NQF 0027	SMOKING STATUS	smoking hx	9407	✓	
NQF 0027	SMOKING STATUS	when quit	17300087	✓	
NQF 0028a	SMOKING STATUS	Adv to quit	500017	✓	
NQF 0028a	SMOKING STATUS	BTS1	77789	✓	
NQF 0028a	SMOKING STATUS	BTS2	77790	✓	
NQF 0028a	SMOKING STATUS	BTS3	77791	✓	
NQF 0028a	SMOKING STATUS	Cigar use	3028	✓	
NQF 0028a	SMOKING STATUS	Cigaret smkg	130	✓	
NQF 0028a	SMOKING STATUS	CrTobaccoUse	100418	✓	
NQF 0028a	SMOKING STATUS	HOV1.237.1	1618	✓	
NQF 0028a	SMOKING STATUS	PQRIMEAS114	150127	✓	
NQF 0028a	SMOKING STATUS	SMOK ADVICE	300019	✓	
NQF 0028a	SMOKING STATUS	SMOK STATUS	300015	✓	✓
NQF 0028a	SMOKING STATUS	SMOK YR Q	300016	✓	
NQF 0028a	SMOKING STATUS	SMOKSTATODAY	79699	✓	
NQF 0028a	SMOKING STATUS	Smok Hx tota	2621	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0028a	SMOKING STATUS	Smok hx PPD	2622	✓	
NQF 0028a	SMOKING STATUS	SmokCessGoal	20745	✓	
NQF 0028a	SMOKING STATUS	TobaccAmtDay	39285	✓	
NQF 0028a	SMOKING STATUS	Tobacco Use	2200004	✓	✓
NQF 0028a	SMOKING STATUS	TobaccoType	32621	✓	
NQF 0028a	SMOKING STATUS	cigarette/d	16028	✓	
NQF 0028a	SMOKING STATUS	quit smk stg	17386	✓	
NQF 0028a	SMOKING STATUS	smokes	43476	✓	
NQF 0028a	SMOKING STATUS	smoking hx	9407	✓	
NQF 0028a	SMOKING STATUS	when quit	17300087	✓	
NQF 0028b	SMOKING STATUS	Adv to quit	500017	✓	
NQF 0028b	SMOKING STATUS	BTS1	77789	✓	
NQF 0028b	SMOKING STATUS	BTS2	77790	✓	
NQF 0028b	SMOKING STATUS	BTS3	77791	✓	
NQF 0028b	SMOKING STATUS	Cigar use	3028	✓	
NQF 0028b	SMOKING STATUS	Cigaret smkg	130	✓	
NQF 0028b	SMOKING STATUS	CrTobaccoUse	100418	✓	
NQF 0028b	SMOKING STATUS	HOV1.237.1	1618	✓	
NQF 0028b	SMOKING STATUS	PQRIMEAS114	150127	✓	
NQF 0028b	SMOKING STATUS	SMOK ADVICE	300019	✓	
NQF 0028b	SMOKING STATUS	SMOK STATUS	300015	✓	✓
NQF 0028b	SMOKING STATUS	SMOK YR Q	300016	✓	
NQF 0028b	SMOKING STATUS	SMOKSTATODAY	79699	✓	
NQF 0028b	SMOKING STATUS	Smok Hx tota	2621	✓	
NQF 0028b	SMOKING STATUS	Smok hx PPD	2622	✓	
NQF 0028b	SMOKING STATUS	SmokCessGoal	20745	✓	
NQF 0028b	SMOKING STATUS	TobaccAmtDay	39285	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0028b	SMOKING STATUS	Tobacco Use	2200004	✓	✓
NQF 0028b	SMOKING STATUS	TobaccoType	32621	✓	
NQF 0028b	SMOKING STATUS	cigarette/d	16028	✓	
NQF 0028b	SMOKING STATUS	quit smk stg	17386	✓	
NQF 0028b	SMOKING STATUS	smokes	43476	✓	
NQF 0028b	SMOKING STATUS	smoking hx	9407	✓	
NQF 0028b	SMOKING STATUS	when quit	17300087	✓	
NQF 0028b	SMOKING CESSATION COUNSELING	AA1	77795	✓	
NQF 0028b	SMOKING CESSATION COUNSELING	Adv to quit	500017	✓	✓
NQF 0028b	SMOKING CESSATION COUNSELING	Motivtn Prov	90486	✓	
NQF 0028b	SMOKING CESSATION COUNSELING	Relapse Prov	90487	✓	
NQF 0028b	SMOKING CESSATION COUNSELING	SMOK ADVICE	300019	✓	✓
NQF 0028b	SMOKING CESSATION COUNSELING	SMOKADVDATE	132954	✓	
NQF 0028b	SMOKING CESSATION COUNSELING	SMOKASSTPROV	79697	✓	
NQF 0028b	SMOKING CESSATION COUNSELING	SmokCessMeds	72362	✓	
NQF 0031	MAMMOGRAM	Abn Mam Dat	26412	✓	
NQF 0031	MAMMOGRAM	Last mam dat	2682	✓	✓
NQF 0031	MAMMOGRAM	MAMM SURVEY	300008	✓	
NQF 0031	MAMMOGRAM	MammRecAct	40095	✓	
NQF 0031	MAMMOGRAM	MammoBIRADS1	50594	✓	
NQF 0031	MAMMOGRAM	MammoBIRADS2	50595	✓	
NQF 0031	MAMMOGRAM	MammoBIRADS3	50596	✓	
NQF 0031	MAMMOGRAM	MammoBIRADS4	50597	✓	
NQF 0031	MAMMOGRAM	MammoScreeng	34678	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0031	MAMMOGRAM	Mammogram	71	✓	✓
NQF 0031	MAMMOGRAM	MgmResults	48855	✓	
NQF 0031	MAMMOGRAM	PQRIMEAS112	150125	✓	
NQF 0031	MAMMOGRAM	mammo left	9935	✓	
NQF 0031	MAMMOGRAM	mammo right	9936	✓	
NQF 0031	MAMMOGRAM	mammogr ord	7004	✓	
NQF 0038a	DTAP VAX	DTAP #1	1035	✓	✓
NQF 0038a	DTAP VAX	DTAP #1By	2166	✓	
NQF 0038a	DTAP VAX	DTAP #2	1034	✓	✓
NQF 0038a	DTAP VAX	DTAP #2By	2167	✓	
NQF 0038a	DTAP VAX	DTAP #3	1033	✓	✓
NQF 0038a	DTAP VAX	DTAP #3By	2168	✓	
NQF 0038a	DTAP VAX	DTAP #4	141	✓	✓
NQF 0038a	DTAP VAX	DTAP #4By	2169	✓	
NQF 0038a		DTAP #5	190		✓
NQF 0038a	DTAP VAX	Kinrix	171824	✓	
NQF 0038a	DTAP VAX	PEDIARIX1	42614	✓	✓
NQF 0038a	DTAP VAX	PEDIARIX2	42617	✓	✓
NQF 0038a	DTAP VAX	PEDIARIX3	42620	✓	✓
NQF 0038a	DTAP VAX	PENT#1	169564	✓	✓
NQF 0038a	DTAP VAX	PENT#2	169572	✓	✓
NQF 0038a	DTAP VAX	PENT#3	169580	✓	✓
NQF 0038a	DTAP VAX	PENT#4	169588	✓	✓
NQF 0038a		DPT #1	84		✓
NQF 0038a		DPT #2	97		✓
NQF 0038a		DPT #3	98		✓
NQF 0038a		DPT #4	99		✓

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038a		DPT #5	100		✓
NQF 0038a		DTP/HIB #1	131		✓
NQF 0038a		DTP/HIB #2	132		✓
NQF 0038a		DTP/HIB #3	133		✓
NQF 0038a		DTP/HIB #2	134		✓
NQF 0038a		DTP/HIB #5	135		✓
NQF 0038a		DTAP/HIB#1	3892		✓
NQF 0038a		DTAP/HIB#2	3897		✓
NQF 0038a		DTAP/HIB#3	3902		✓
NQF 0038a		DTAP/HIB#4	3907		✓
NQF 0038a		DTAP/HIB#5	3912		✓
NQF 0038a		DPT #6	17397		✓
NQF 0038a		DT #1	24738		✓
NQF 0038a		DT #2	24744		✓
NQF 0038a		DT #3	24750		✓
NQF 0038a		DT #4	24756		✓
NQF 0038a		DT #5	24762		✓
NQF 0038a		DTAP #6	70664		✓
NQF 0038a		DTAPHBIPV4	109587		✓
NQF 0038a		DT #6	152625		✓
NQF 0038a		TRIHIBIT	157339		✓
NQF 0038a		DTAPHIBIPV1	174774		✓
NQF 0038a		DTAPHIBIPV2	174782		✓
NQF 0038a		DTAPHIBIPV3	174790		✓
NQF 0038a		CVX106#1	287758		✓
NQF 0038a		CVX106#2	287774		✓
NQF 0038a		CVX106#3	287790		✓

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038a		CVX106#4	287806		✓
NQF 0038a		CVX106#5	287822		✓
NQF 0038a		CVX106#6	287838		✓
NQF 0038b	IPV	IPV	95636	✓	
NQF 0038b	IPV	IPV #1	86	✓	✓
NQF 0038b	IPV	IPV #1By	2139	✓	
NQF 0038b	IPV	IPV #2	191	✓	✓
NQF 0038b	IPV	IPV #2By	2140	✓	
NQF 0038b	IPV	IPV #3	192	✓	✓
NQF 0038b	IPV	IPV #3By	2141	✓	
NQF 0038b	IPV	PEDIARIX1	42614	✓	✓
NQF 0038b	IPV	PEDIARIX2	42617	✓	✓
NQF 0038b	IPV	PEDIARIX3	42620	✓	✓
NQF 0038b	IPV	PENT#1	169564	✓	✓
NQF 0038b	IPV	PENT#2	169572	✓	✓
NQF 0038b	IPV	PENT#3	169580	✓	✓
NQF 0038b	IPV	PENT#4	169588	✓	✓
NQF 0038b		OPV #1	85		✓
NQF 0038b		OPV #2	101		✓
NQF 0038b		OPV #3	102		✓
NQF 0038b		OPV #4	103		✓
NQF 0038b		IPV #4	2741		✓
NQF 0038b		OPV #5	2978		✓
NQF 0038b		IPV #5	11243		✓
NQF 0038b		DTAPHBIPV1	40645		✓
NQF 0038b		DTAPHBIPV2	40653		✓
NQF 0038b		DTAPHBIPV3	40661		✓

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038b		IPV #6	95043		✓
NQF 0038b		DTAPHIBIPV1	174774		✓
NQF 0038b		DTAPHIBIPV2	174782		✓
NQF 0038b		DTAPHIBIPV3	174790		✓
NQF 0038c	MMR	MMR	183316	✓	
NQF 0038c	MMR	MMR #1	87	✓	✓
NQF 0038c	MMR	MMR #1By	2142	✓	
NQF 0038c	MMR	MMR #2	104	✓	✓
NQF 0038c	MMR	MMR #2By	2143	✓	
NQF 0038c	MMR	MMR #3	5168	✓	✓
NQF 0038c	MMR	MMR #3By	5169	✓	
NQF 0038c	MEASLESVAX	MEASVACSER	130626	✓	
NQF 0038c	MEASLESVAX	MeaslesVax	89	✓	
NQF 0038c	MEASLESVAX	MeaslesVaxBy	2149	✓	
NQF 0038c	MEASLESVAX	measle vax#2	5733	✓	
NQF 0038c	MEASLESVAX	measlvax#2by	5734	✓	
NQF 0038c	MUMPSVAX	MUMPBOOSTBY	245579	✓	
NQF 0038c	MUMPSVAX	MUMPSBOOSTER	245577	✓	
NQF 0038c	MUMPSVAX	MumpsVax	2955	✓	
NQF 0038c	MUMPSVAX	MumpsVaxBy	2959	✓	
NQF 0038c	MUMPSVAX	mumps vax #2	5738	✓	
NQF 0038c	MUMPSVAX	mumpvax#2by	5739	✓	
NQF 0038c	RUBELLAVAX	RUBBOOST BY	245376	✓	
NQF 0038c	RUBELLAVAX	RUBELLABOOST	245374	✓	
NQF 0038c	RUBELLAVAX	RubellaVax	2960	✓	
NQF 0038c	RUBELLAVAX	RubellaVaxBy	2964	✓	
NQF 0038c	RUBELLAVAX	rubellavax#2	5743	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038c	RUBELLAVAX	rubellvax2by	5744	✓	
NQF 0038c		MMR VAR#1	94580		✓
NQF 0038c		MMR VAR#2	94581		✓
NQF 0038c		MMR VAR#3	94582		✓
NQF 0038c		CVX06#1	287902		✓
NQF 0038c		CVX06#2	287918		✓
NQF 0038c		CVX06#3	287934		✓
NQF 0038c		CVX04#1	287998		✓
NQF 0038c		CVX04#2	288014		✓
NQF 0038c		CVX04#3	288030		✓
NQF 0038c		CVX07#1	288178		✓
NQF 0038c		CVX07#2	288194		✓
NQF 0038c		CVX07#3	288210		✓
NQF 0038c		CVX05#1	289270		✓
NQF 0038c		CVX05#2	289286		✓
NQF 0038c		CVX05#3	289302		✓
NQF 0038d	HIB VAX	Comvax	12174	✓	
NQF 0038d	HIB VAX	Comvax#1	17848	✓	
NQF 0038d	HIB VAX	Comvax#2	12212	✓	
NQF 0038d	HIB VAX	Comvax#3	12219	✓	
NQF 0038d	HIB VAX	HIB4 IM	281429	✓	
NQF 0038d	HIB VAX	HemInfB#1	88	✓	
NQF 0038d	HIB VAX	HemInfB#1By	2144	✓	
NQF 0038d	HIB VAX	HemInfB#2	105	✓	
NQF 0038d	HIB VAX	HemInfB#2By	2145	✓	
NQF 0038d	HIB VAX	HemInfB#3	106	✓	
NQF 0038d	HIB VAX	HemInfB#3By	2146	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038d	HIB VAX	HemInfB#4	107	✓	
NQF 0038d	HIB VAX	HemInfB#4By	2147	✓	
NQF 0038d	HIB VAX	Hib	95638	✓	
NQF 0038d	HIB VAX	PdvaxHIB1Vax	67612	✓	
NQF 0038d	HIB VAX	PdvaxHIB2Vax	67621	✓	
NQF 0038d	HIB VAX	Pent#1	169564	✓	
NQF 0038d	HIB VAX	Pent#2	169572	✓	
NQF 0038d	HIB VAX	Pent#3	169580	✓	
NQF 0038e	HEP B VACCINE	COMVAX	12174	✓	✓
NQF 0038e	HEP B VACCINE	COMVAX#1	17848	✓	✓
NQF 0038e	HEP B VACCINE	COMVAX#2	12212	✓	✓
NQF 0038e	HEP B VACCINE	COMVAX#3	12219	✓	✓
NQF 0038e	HEP B VACCINE	HEP B IMM	183277	✓	
NQF 0038e	HEP B VACCINE	Hep B IgHx	143777	✓	
NQF 0038e	HEP B VACCINE	HepBseries	17654	✓	
NQF 0038e	HEP B VACCINE	HepBvax#1	93	✓	✓
NQF 0038e	HEP B VACCINE	HepBvax#1By	2153	✓	
NQF 0038e	HEP B VACCINE	HepBvax#2	109	✓	✓
NQF 0038e	HEP B VACCINE	HepBvax#2By	2154	✓	
NQF 0038e	HEP B VACCINE	HepBvax#3	110	✓	✓
NQF 0038e	HEP B VACCINE	HepBvax#3By	2155	✓	
NQF 0038e	HEP B VACCINE	Pediarix1	42614	✓	✓
NQF 0038e	HEP B VACCINE	Pediarix2	42617	✓	✓
NQF 0038e	HEP B VACCINE	Pediarix3	42620	✓	✓
NQF 0038e	HEP B VACCINE	vac_hepB_d	91081	✓	
NQF 0038e		HEPBVAX#4	2939		✓
NQF 0038e		HEPBVAX#5	2940		✓

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038e		HIBHEPB#1	4259		✓
NQF 0038e		HIBHEPB#2	4264		✓
NQF 0038e		HIBHEPB#3	4269		✓
NQF 0038e		HEPB BOOSTER	5210		✓
NQF 0038e		COMVAX#4	12226		✓
NQF 0038e		HEPBVAX#6	13317		✓
NQF 0038e		TWINRIX1GIVN	24877		✓
NQF 0038e		TWINRIX2GIVN	26474		✓
NQF 0038e		TWINRIX3GIVN	26477		✓
NQF 0038e		DTAPHBIPV1	40645		✓
NQF 0038e		DTAPHBIPV2	40653		✓
NQF 0038e		DTAPHBIPV3	40661		✓
NQF 0038e		HEPBVAXNB	74737		✓
NQF 0038e		HEP B	95637		✓
NQF 0038e		HIB-HEP B	95639		✓
NQF 0038e		DTAPHBIPV4	109587		✓
NQF 0038e		HIBHEPB#4	109595		✓
NQF 0038e		HEPBVAX#7	114724		✓
NQF 0038e		CVX08#1	287690		✓
NQF 0038e		CVX08#2	287706		✓
NQF 0038e		CVX08#3	287722		✓
NQF 0038e		CVX08#4	291217		✓
NQF 0038e		TWINRIX4	292058		✓
NQF 0038f	VARICELLAVAX	Varicella#1	305	✓	✓
NQF 0038f	VARICELLAVAX	Varicella#1B	2171	✓	
NQF 0038f	VARICELLAVAX	Varicella#2	306	✓	✓
NQF 0038f	VARICELLAVAX	Varicella#2B	2172	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038f	VARICELLAVAX	Varivax #2	36713	✓	
NQF 0038f	VARICELLAVAX	Varivax inj	26507	✓	
NQF 0038f	VARICELLAVAX	immun 12e	16191	✓	
NQF 0038f		VARICELLA	18329		✓
NQF 0038f		VARICELLA#3	80523		✓
NQF 0038f		MMR VAR#1	94580		✓
NQF 0038f		MMR VAR#2	94581		✓
NQF 0038f		MMR VAR#3	94582		✓
NQF 0038f		CVX21#1	289076		✓
NQF 0038f		CVX21#2	289092		✓
NQF 0038f		CVX21#3	291455		✓
NQF 0038g	PCV	PCV7 #1	23752	✓	✓
NQF 0038g	PCV	PCV7 #2	23753	✓	✓
NQF 0038g	PCV	PCV7 #3	23754	✓	✓
NQF 0038g	PCV	PCV7#1 By	14098	✓	
NQF 0038g	PCV	PCV7#2 By	14105	✓	
NQF 0038g	PCV	PCV7#3 By	14112	✓	
NQF 0038g	PCV	PREVNAR	183341	✓	
NQF 0038g	PCV	pneuped#1	13916	✓	✓
NQF 0038g	PCV	pneuped#1by	13917	✓	
NQF 0038g	PCV	pneuped#2	13923	✓	✓
NQF 0038g	PCV	pneuped#2by	13924	✓	
NQF 0038g	PCV	pneuped#3	13930	✓	✓
NQF 0038g	PCV	pneuped#3by	13931	✓	
NQF 0038g	PCV	pneuped#4	13937	✓	✓
NQF 0038g	PCV	pneuped#4by	13938	✓	
NQF 0038g	PNEUMONIA VACCINE	LastPneumVax	31298	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038g	PNEUMONIA VACCINE	PQRI MEAS111	150124	✓	
NQF 0038g	PNEUMONIA VACCINE	Pneumovax	91	✓	✓
NQF 0038g	PNEUMONIA VACCINE	immun 12b	16188	✓	
NQF 0038g	PNEUMONIA VACCINE	lstpneuvx dt	19106	✓	
NQF 0038g		PCV7 #4	23755		✓
NQF 0038g		PNEUPED#5	43150		✓
NQF 0038g		PNEUPED#6	83129		✓
NQF 0038g		PNEUPED#7	83138		✓
NQF 0038g		PCV7 #5	177821		✓
NQF 0038g		PNEUMPED1	243291		✓
NQF 0038g		PNEUMPED2	243309		✓
NQF 0038g		PNEUMPED3	243327		✓
NQF 0038g		PNEUMPED4	243345		✓
NQF 0038g		PNEUMPED5	243363		✓
NQF 0038h	HEP A VACCINE	HepA vax	2576	✓	
NQF 0038h	HEP A VACCINE	HepAseries	17650	✓	
NQF 0038h	HEP A VACCINE	HepAvax #1	2860	✓	
NQF 0038h	HEP A VACCINE	HepAvax #2	2861	✓	
NQF 0038h	HEP A VACCINE	HepAvax#1 By	2950	✓	
NQF 0038h	HEP A VACCINE	HepAvax#2By	2954	✓	
NQF 0038h	HEP A VACCINE	vac_hepA	91078	✓	
NQF 0038h	HEP A VACCINE EXCLUSION	HEP A EXCL	189743	✓	
NQF 0038h	HEP A VACCINE EXCLUSION	HEP A IGRNG	189026	✓	
NQF 0038h	HEP A VACCINE EXCLUSION	HEPASERRNG	189029	✓	
NQF 0038i	RV	ROTAVIR2 IM	214356	✓	
NQF 0038i	RV	ROTAVIRUS IM	183350	✓	
NQF 0038i	RV	RotaTeq #1	109287	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038i	RV	RotaTeq #2	109288	✓	
NQF 0038i	RV	RotaTeq #3	109289	✓	
NQF 0038i	RV	rotavir#1	6647	✓	
NQF 0038i	RV	rotavir#1by	6648	✓	
NQF 0038i	RV	rotavir#2	6652	✓	
NQF 0038i	RV	rotavir#2by	6653	✓	
NQF 0038i	RV	rotavir#3	6657	✓	
NQF 0038i	RV	rotavir#3by	6658	✓	
NQF 0038i	RV	rotrix1	184853	✓	
NQF 0038i	RV	rotrix1by	184854	✓	
NQF 0038i	RV	rotrix2	184860	✓	
NQF 0038i	RV	rotrix2by	184861	✓	
NQF 0038j	FLU VACCINE	FLU MIST BY	95408	✓	
NQF 0038j	FLU VACCINE	FLU VAX#1	138441	✓	
NQF 0038j	FLU VACCINE	FLUVXNAS DAT	90582	✓	
NQF 0038j	FLU VACCINE	Flu vaccine	70639	✓	
NQF 0038j	FLU VACCINE	Flu vax	92	✓	
NQF 0038j	FLU VACCINE	Flu vaxAD	208573	✓	
NQF 0038j	FLU VACCINE	Flu vaxBy	2152	✓	
NQF 0038j	FLU VACCINE	FluVaxDate	37605	✓	
NQF 0038j	FLU VACCINE	LstFluvaxDat	46180	✓	
NQF 0038j	FLU VACCINE	PQRI MEAS110	150123	✓	
NQF 0038j	FLU VACCINE	flu vax #2	5728	✓	
NQF 0038j	FLU VACCINE	flu vax #2by	5729	✓	
NQF 0038j	FLU VACCINE	flu vax #3	23290	✓	

Measure	QRS OBS Group	OBS Name	HDID	QRS	Crystal
NQF 0038j	FLU VACCINE	flu vax #4	23291	✓	
NQF 0038j	FLU VACCINE	flumist	82775	✓	
NQF 0038j	FLU VACCINE	lstfluvax dt	19107	✓	