Meaningful Use Criteria - Ambulatory
Michael Andraychak | Product Mgr
Agenda

Terminology

ARRA/HITECH

Meaningful Use Defined / Health Outcomes Policies

Stages / Rollout of ARRA Program

Demonstrating Meaningful Use for Eligible Providers
  • Core Objectives
  • Menu Set Objectives
  • Clinical Quality Measures (min 6/max 9)

Security Requirements
Terminology / Acronyms

ONC HIT - Office of the National Coordinator for Health Information Technology

CMS – Centers for Medicare & Medicaid Services

HITECH Act - Health Information Technology for Economic and Clinical Health Act

PQRI – Physician Quality Reporting Initiative

EP/EH – Eligible Provider / Eligible Hospital

ONC ATCB – ONC Authorized Testing & Certification Body

HITSP – Health Information Technology Standards Panel

NIST – National Institute of Standards & Technology

NQM – National Quality Forum
ARRA/HITECH

ARRA

*Overall program*

American Recovery and Reinvestment Act of 2009

Economic Stimulus Program

Multiple program components

HITECH Act

*EHR component of ARRA*

Intended to promote adoption of electronic health records

Provides for financial incentives to eligible hospitals and providers using electronic health records

Final Rule outlines initial set of standards, implementation, specifications and certification criteria for EHRs

Separate final rule establishes certification programs for health information technology

ONC/CMS/HHS
Meaningful Use Defined

An EP /EH shall be considered a meaningful user of EHR technology if they meet the following 3 requirements:

1. Demonstrate use of certified EHR technology in a meaningful manner (core objectives and menu set objectives)

2. Demonstrate that EHR technology is connected in a manner that provides for the electronic exchange of health information

3. Using certified EHR technology, submit information on clinical quality measures (CQM)
Meaningful Use Health Outcomes Policies

Improve quality, safety, efficiency [of healthcare], and reduce health disparities

Engage patients and families in their care

Improve care coordination

Improving population and public health

Ensure adequate privacy and security protections for PHI
Meaningful Use Stages / Program Rollout

Stage 1
2011
- Electronic capture of health information in a structured format
- Implement clinical decision support tools
- Engage patients & families in their care
- Reporting of quality measures and public health information

Stage 2
2013
- Expand on Stage 1 requirements
  - CPOE – transmission (likely EBOS)
  - Continuous quality improvement
- Information exchange

Stage 3
2015
- Improved health outcomes
- Decision support for national priorities
- Patient self-management
- Population health
## Demonstrating Meaningful Use

<table>
<thead>
<tr>
<th>Core Objectives</th>
<th>Menu Set</th>
<th>CQMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>5 / 10</td>
<td>Total 44 CQMs</td>
</tr>
<tr>
<td>All are required</td>
<td></td>
<td>- 3 core measures – required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 3 alternate measures – conditional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 3/38 additional measures</td>
</tr>
</tbody>
</table>

- Flexibility
- More difficult to attain
### Demonstrating Meaningful Use

<table>
<thead>
<tr>
<th>Numerator</th>
<th># Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total population</td>
</tr>
<tr>
<td>Threshold</td>
<td>Expected minimum compliance rate</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Excluded encounters</td>
</tr>
<tr>
<td>Self attestation</td>
<td>Some measures are Y/N</td>
</tr>
</tbody>
</table>
Demonstrating Meaningful Use

Unique Patient

“To further describe the concept of ‘unique patient’ we mean that if a patient is seen by an EP more than once during the EHR reporting period then for purposes of measurement they only count once in the denominator for the measure.

All the measures relying on the term ‘unique patient’ relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.”
Core Objectives
All 10 are required
Core Objectives

Subject: **CPOE – Computerized Provider Order Entry**

Description: Use 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.

Denominator: The number of unique patients with at least one medication in their medication list who were seen by the EP during the reporting period.

Numerator: The number of patients in the denominator that have at least one medication order entered using CPOE.

Threshold: >30%

Exclusions: None for EH.
Core Objectives

Subject: **Implement drug-drug and drug-allergy interaction checks**

Description: The EP has enabled this functionality for the entire EHR reporting period (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Core Objectives

Subject: Generate and transmit permissible prescriptions electronically (eRx)

Description: Permissible prescriptions written by the EP are transmitted electronically using certified EHR technology

Denominator: # prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the reporting period

Numerator: The number of prescriptions in the denominator generated and transmitted electronically

Threshold: >40%

Exclusions: EP writes fewer than 100 prescriptions during EHR reporting period
Core Objectives

Subject: Record demographics

Description: Record demographics, including preferred language, gender, race, ethnicity, date of birth

Denominator: Number of unique patients seen by the EP during the EHR reporting period

Numerator: The number of patients in the denominator who have all the elements of demographics recorded as structured data

Threshold: >50%

Exclusions: None
Core Objectives

**Subject:** Problem List

**Description:** Maintain an up-to-date problem list of current and active diagnoses

**Denominator:** The number of unique patients seen by the EP during reporting period

**Numerator:** The number of patients in the denominator who have at least one entry (or “no known”) recorded as structured data in their problem list

**Threshold:** >80%

**Exclusions:** None
Core Objectives

Subject: **Medication List**

Description: Maintain an active medication list

Denominator: Number of unique patients seen by the EP during the EHR reporting period

Numerator: The number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data

Threshold: >80%

Exclusions: None
Core Objectives

Subject: **Allergies**

Description: Maintain an active medication allergy list

Denominator: Number of unique patients seen by the EP during the EHR reporting period

Numerator: The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

Threshold: >80%

Exclusions: None
Core Objectives

Subject: **Vital Signs**

Description: Record and chart changes in vital signs, including height, weight, BP; calculate and display BMI; plot and display growth charts for children 2-20 years, including BMI

Denominator: Number of unique patients age 2 or over seen by the EP during the EHR reporting period

Numerator: The number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structure data

Threshold: >50%

Exclusions: An EP who sees no patients 2 years old or younger; EP who believes that all three vitals have no relevance to their scope of practice
Core Objectives

Subject: **Smoking status**

Description: Record smoking status for patients 13 years old or older

Denominator: Number of unique patients age 13 or older seen by the EP during the EHR reporting period

Numerator: The number of patients in the denominator with smoking status recorded as structured data

Threshold: > 50%

Exclusions: EP who sees no patients age 13 years or older
Core Objectives

Subject: **Clinical Decision Support**

Description: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Core Objectives

Subject: **Quality Measures**

Description: Report ambulatory clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the States.

For 2011, an EP would provide the aggregate level data for the numerator, denominator, and exclusions through attestation (Y/N).

For 2012, an EP would electronically submit the measures.

Denominator: n/a
Numerator: n/a
Threshold: n/a
Exclusions: None
Core Objectives

Subject: **Electronic Copy of Health Information**

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

Denominator: The number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

Numerator: The number of patients in the denominator who receive an electronic copy of their electronic health information within **three business days**.

Threshold: > 50%

Exclusions: EP has no such requests from patients.
Core Objectives

Subject: Clinical Summaries

Description: Provide clinical summaries for patients for each office visit

Denominator: # of unique patients seen by the EP for an office during the EHR reporting period

Numerator: Number of patients in the denominator who are provided a clinical summary of their visit within three business days

Threshold: >50%

Exclusions: EP has no office visits during the EHR reporting period
Core Objectives

Subject: **Exchange Key Clinical Information Electronically**

Description: Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically; perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Core Objectives

Subject: **Privacy and Security Protections**

Description: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities; conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of its risk management process (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Menu Set Objectives
5 of 10 required
Menu Set Objectives

Subject: **Drug Formulary Checks**

Description: The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire reporting period (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Menu Set Objectives

Subject: **Lab Results**

Description: Incorporate clinical lab test results into certified EHR technology as structured data

Denominator: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number

Numerator: The number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data

Threshold: >40%

Exclusions: EP orders no lab tests (positive/negative or numeric)
Menu Set Objectives

Subject: Patient Lists

Description: Generate at least one report listing patients of the EP with a specific condition (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: None
Menu Set Objectives

Subject: **Send Patient Reminders**

Description: Send reminders to patients per patient preference for preventive/follow-up care

Denominator: Number of unique patients 65 years old or older or 5 years older or younger

Numerator: The number of patients in the denominator who were sent the appropriate reminder

Threshold: >20%

Exclusions: EP has no patients age 65 years or older, or 5 years or younger
Menu Set Objectives

Subject: **Timely Electronic Access to Health Information (patient portal)**

Description: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, allergies) upon request.

Denominator: # of unique patients seen by the EP during the EHR reporting period.

Numerator: # of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information **online**.

Threshold: 10%

Exclusions: EP neither orders nor creates any of the information listed.
Menu Set Objectives

Subject: **Patient-Specific Education Resources**

**Description:** Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate

**Denominator:** Number of unique patients seen by the EP during the EHR reporting period

**Numerator:** The number of patients in the denominator who are provided patient education specific resources

**Threshold:** >10%

**Exclusions:** None
Menu Set Objectives

Subject: Medication Reconciliation

Description: The EP, eligible hospital, or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.

Threshold: >50%

Exclusions: None
Menu Set Objectives

Subject: **Summary Care Record**

Description: 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 of care record for each transition of care or referral

Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided

Threshold: >50%

Exclusions: None for EH
Menu Set Objectives

Subject: **Immunization Registries**

Description: Perform at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: none of the immunization registries to which the EP, EH, or CAH submits such information have the capacity to receive the information electronically; no immunizations administered during reporting period
Menu Set Objectives

Subject: **Syndromic Surveillance**

Description: Perform at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies (Y/N)

Denominator: n/a

Numerator: n/a

Threshold: n/a

Exclusions: none of the public health agencies to which the EP, EH, or CAH submits such information have the capacity to receive the information electronically
Clinical Quality Measures

Total 44 CQMs (min 6/max 9 reported)

- 3 core measures – required
  - 3 alternate measures – conditional – if core denominator equals zero
- 3/38 additional measures
**Core Clinical Quality Measures (EP)**

**NQF 0013**

**AMA**

**Hypertension: Blood Pressure Management**

Description: Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients aged > 18 years with diagnosed hypertension

**Inclusions**

- Encounter outpatient
- Principal diagnosis hypertension
- Age > 18 years

**Exclusions**

No exclusions
Preventive Care and Screening Measure Pair

a. **Tobacco use assessment** (% patients $\geq 18$ years of age queried for tobacco use)

b. **Tobacco cessation intervention** (% patients $\geq 18$ years ID’d as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention)

Multiple variations of encounter types

Tobacco user or non-tobacco user

Age $\geq 18$ years

No exclusions
### Core Clinical Quality Measures (EP)

**NQF 0421/PQRI 128**

#### NQF/PQRI

**Inclusions**

- **Adult Weight Screening and Follow-Up**
  - Percentage of patients aged 18 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 outside parameters, a follow-up plan is documented
  - Age $\geq 18$ years and $\leq 65$ years
  - Encounter outpatient

#### Exclusions

- Terminal illness
- Pregnant
- Valid reason for not being done
# Preventative Care and Screening:

**Influenza Immunization for Patients ≥50 Years Old**

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

<table>
<thead>
<tr>
<th>NQF 0041/PQRI 110</th>
<th>Inclusions</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMA</strong></td>
<td>Age ≥50 Years Old</td>
<td>Contraindication to the medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient refused</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient reason for medication not done</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical reason</td>
</tr>
<tr>
<td></td>
<td></td>
<td>System reason</td>
</tr>
</tbody>
</table>
### Alternate Clinical Quality Measures (EP)

<table>
<thead>
<tr>
<th>NQF 0024</th>
<th>Inclusions</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NQF</strong></td>
<td><strong>Age 2-17 years</strong></td>
<td><strong>None</strong></td>
</tr>
<tr>
<td><strong>Weight Assessment and Counseling for Children and Adolescents</strong></td>
<td><strong>Encounter PCD/OB GYN</strong></td>
<td></td>
</tr>
<tr>
<td>The percentage of patients 2-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NQF 0038

**Childhood Immunization Status**

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

### Inclusions

Age \( \geq 1 \) year and \(< 2\) years to capture all patients who will reach 2 years during the measurement period.

### Exclusions

- Allergy to medication(s)
- Diagnosis active: cancer of lymphoreticular or histiocytic tissue
- Diagnosis inactive: cancer of lymphoreticular or histiocytic tissue
- Diagnosis active: asymptomatic HIV
- Diagnosis active: multiple myeloma
- Diagnosis active: leukemia
- Diagnosis active: immunodeficiency
### Additional Clinical Quality Measures (EP)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Developer</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td>AMA</td>
<td>Asthma Assessment</td>
<td>Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.</td>
</tr>
<tr>
<td>0002</td>
<td>NCQA</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>The percentage of children 2–18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.</td>
</tr>
<tr>
<td>0004</td>
<td>NCQA</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement</td>
<td>The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.</td>
</tr>
</tbody>
</table>
## Additional Clinical Quality Measures (EP)

<table>
<thead>
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<th>Measure</th>
<th>Developer</th>
<th>Title</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0012</td>
<td>AMA</td>
<td>Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)</td>
<td>Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit.</td>
</tr>
<tr>
<td>0014</td>
<td>AMA</td>
<td>Prenatal Care: Anti-D Immune Globulin</td>
<td>Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.</td>
</tr>
<tr>
<td>0018</td>
<td>NCQA</td>
<td>Controlling High Blood Pressure</td>
<td>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.</td>
</tr>
</tbody>
</table>

Source: CMS Final Rule
### Additional Clinical Quality Measures (EP)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Developer</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
</table>
| 0027    | NCQA      | Smoking and Tobacco Use Cessation, Medical assistance:  
  a. Advising Smokers and Tobacco Users to Quit,  
  b. Discussing Smoking and Tobacco Use Cessation Medications,  
  c. Discussing Smoking and Tobacco Use Cessation Strategies | 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. |
| 0031    | NCQA      | Breast Cancer Screening | The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer. |
| 0032    | NCQA      | Cervical Cancer Screening | The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer. |
| 0033    | NCQA      | Chlamydia Screening for Women | 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. |

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## Additional Clinical Quality Measures (EP)

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<tr>
<td>0034</td>
<td>NCQA</td>
<td>Colorectal Cancer Screening</td>
<td>The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.</td>
</tr>
<tr>
<td>0036</td>
<td>NCQA</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).</td>
</tr>
<tr>
<td>0043</td>
<td>NCQA</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>The percentage of patients 65 years of age and older as of January 1 of the measurement year who have ever received a pneumococcal vaccine.</td>
</tr>
<tr>
<td>0047</td>
<td>AMA</td>
<td>Asthma Pharmacologic Therapy</td>
<td>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.</td>
</tr>
<tr>
<td>0052</td>
<td>NCQA</td>
<td>Low Back Pain: Use of Imaging Studies</td>
<td>The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.</td>
</tr>
</tbody>
</table>

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## Additional Clinical Quality Measures (EP)

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<tr>
<td>0055</td>
<td>NCQA</td>
<td>Diabetes: Eye Exam</td>
<td>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.</td>
</tr>
<tr>
<td>0056</td>
<td>NCQA</td>
<td>Diabetes: Foot Exam</td>
<td>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).</td>
</tr>
<tr>
<td>0059</td>
<td>NCQA</td>
<td>Diabetes: HbA1c Poor Control</td>
<td>The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c &gt;9.0%.</td>
</tr>
<tr>
<td>0062</td>
<td>NCQA</td>
<td>Diabetes: Urine Screening</td>
<td>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.</td>
</tr>
<tr>
<td>0064</td>
<td>NCQA</td>
<td>Diabetes: LDL Management &amp; Control</td>
<td>The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C &lt;100mg/dL.</td>
</tr>
<tr>
<td>0067</td>
<td>AMA</td>
<td>Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.</td>
</tr>
</tbody>
</table>

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## Additional Clinical Quality Measures (EP)

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<tr>
<td>0068</td>
<td>NCQA</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic</td>
<td>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.</td>
</tr>
<tr>
<td>0070</td>
<td>AMA</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.</td>
</tr>
</tbody>
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<tr>
<td>0073</td>
<td>NCQA</td>
<td>Ischemic Vascular Disease (IVD): Blood Pressure Management</td>
<td>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 whose most recent blood pressure is in control (&lt;140/90 mmHg).</td>
</tr>
<tr>
<td>0074</td>
<td>AMA</td>
<td>Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).</td>
</tr>
</tbody>
</table>

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### Additional Clinical Quality Measures (EP)

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<thead>
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<th>Measure</th>
<th>Developer</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0075</td>
<td>NCQA</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control</td>
<td>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 a complete lipid profile performed during the measurement year and whose LDL-C was &lt;100 mg/dL.</td>
</tr>
<tr>
<td>0081</td>
<td>AMA</td>
<td>Heart Failure (HF) : Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF &lt; 40%) who were prescribed ACE inhibitor or ARB therapy.</td>
</tr>
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</table>
## Additional Clinical Quality Measures (EP)

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<tr>
<td>0083</td>
<td>AMA</td>
<td>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF &lt; 40%) and who were prescribed beta-blocker therapy.</td>
</tr>
<tr>
<td>0084</td>
<td>AMA</td>
<td>Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation</td>
<td>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.</td>
</tr>
<tr>
<td>0086</td>
<td>AMA</td>
<td>Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.</td>
</tr>
<tr>
<td>0088</td>
<td>AMA</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.</td>
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<td>0089</td>
<td>AMA</td>
<td>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.</td>
</tr>
<tr>
<td>0105</td>
<td>NCQA</td>
<td>Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment</td>
<td>The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.</td>
</tr>
<tr>
<td>0385</td>
<td>AMA</td>
<td>Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients</td>
<td>Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.</td>
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<td>0387</td>
<td>AMA</td>
<td>Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer</td>
<td>Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.</td>
</tr>
<tr>
<td>0389</td>
<td>AMA</td>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer</td>
</tr>
<tr>
<td>0575</td>
<td>NCQA</td>
<td>Diabetes: HbA1c Control (&lt;8%)</td>
<td>The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c &lt;8.0%.</td>
</tr>
</tbody>
</table>
Security Requirements

All are required
No data submission
Security Requirements

Access Control
• Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.

Emergency Access
• Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.

Automatic Log-Off
• Terminate an electronic session after a predetermined time of inactivity.
Security Requirements

Audit Log
• (1) Record actions. Record actions related to electronic health information in accordance with the standard.
• (2) Generate audit log. Enable a user to generate an audit log for a specific time period and to sort entries in the audit log according to any of the elements specified in the standard.

Authentication
• Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
Security Requirements

Integrity
• (1) Create a message digest in accordance with the standard specified in 170.210(c).
• (2) Verify in accordance with the standard specified in 170.210(c) upon receipt of electronically exchanged health information that such information has not been altered.
• (3) Detection. Detect the alteration of audit logs.

(Optional) Accounting of Disclosures
• Record disclosures made for treatment, payment, and healthcare operations in accordance with the standards
Security Requirements

§170.302 (t) Authentication
• Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.

§170.302 (u) General encryption
• Encrypt and decrypt electronic health information in accordance with the standard.

§170.302 (v) Encryption When Exchanging Electronic Health Information
• Encrypt and decrypt electronic health information when exchanged in accordance with the standard.
Continuing Education Requirements - Presentations

In order to qualify for contact hours you must:

• Register your attendance by signing in and signing out of each of your selected courses. A sign in and sign out sheet will be available in each class.

• Complete a course evaluation form prior to leaving the class. Forms will be provided at the start of each session and must be left with the instructor prior to leaving.

• Within two weeks of the conclusion of Connect 10, you will receive verification of successful completion.
Thank you for attending
Meaningful Use Criteria - Ambulatory