Q. What is the HITECH Act?

A. The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American recovery & Reinvestment Act of 2009 (ARRA), provides payments through the EHR Incentive Program to Eligible Hospitals and Eligible Professionals that demonstrate Meaningful Use of certified EHR technology.

Q. What does it mean to be a "meaningful user" of certified EHR technology?

A. On July 28, 2010 the final rule for Stage 1 was issued by CMS, establishing the definition of meaningful use and the criteria required for Eligible Professionals, Eligible Hospitals and Critical Access Hospitals to demonstrate meaningful use of certified electronic health record (EHR) technology.

According to the final rule, in order to be a meaningful user, an eligible provider must be using EHR technology that has been certified by an ONC Authorized Testing & Certification Body (ONC-ATCB); and that an eligible provider must be using EHR technology in a meaningful manner. To demonstrate meaningful use an eligible provider must be able to meet the criteria set forth in the rules for Core Set Objectives, Menu Set Objectives and report data Clinical Quality Measures (CQMs).

See Appendix A for Stage I Criteria

Q. Who will certify EHR technology under ARRA?

A. On June 24, 2010 the ONC published the final rule to establish the criteria for certification of electronic health record technology for Stage 1 (2011-2012). The final rule established the standards and authorization process for temporary testing and certification bodies.

Private sector organizations that can demonstrate to the ONC that they have the ability to both test and certify electronic health record technology will be known as ONC-ATCBs (Office of the National Coordinator of Health Information Technology - Authorized Testing & Certification Body).

The Certification Commission for Health Information Technology (CCHIT) is recognized by the Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services (HHS) as an Authorized Testing and Certification Body (ONC-ATCB). More information about CCHIT, CCHIT Certified® products and ONC-ATCB certified electronic health record technology is available at http://www.cchit.org.

Q. Has Healthland been certified by an ONC-ATCB?

A. The Healthland Inpatient EHR was certified as a Complete EHR for Stage 1 Meaningful Use on December 15, 2010, by the CCHIT®. In addition, Healthland Centriq EHR was certified as a Complete EHR for Stage 1 Meaningful Use on June 10, 2011, by the CCHIT®. ONC-ATCB 2011/2012 certification from CCHIT confirms that the Healthland EHR meets all requirements necessary to achieve Stage 1 Meaningful Use compliance.

Q. When must an eligible hospital demonstrate meaningful use standards for Stage 1, Stage 2 and Stage3?

A. See chart below.

First Payment Year	Payment Year				
	2011	**2012**	**2013**	**2014**	**2015+**
2011	Stage 1	Stage 1	Stage 1	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD
2015+					TBD

Q. How many stages of Meaningful Use are there?

A. There will be a minimum of three Meaningful Use stages. However, the language in the Final Rule for Stage 1 indicated that CMS will have the option to implement additional stages beyond Stage 3. The design for each stage is listed below.

- **Stage 1** – Electronic capture of health information in a coded format; tracking key clinical conditions and communicating outcomes for care coordinating; implementing clinical decision support tools to facilitate disease and medication management; and reporting outcomes for public health purposes.
- **Stage 2** – Expands on Stage 1. Encourages the use of health IT to enhance computerized provider order entry; transitions in care; electronic transmission of diagnostic test results; and, research.
- **Stage 3** – Expands on Stage 2. Promotes improvements to quality and safety; focuses on clinical decision support at a national level by encouraging patient access and involvement; and, improved population health data.

Q. How long do we have to implement EHR technology and demonstrate "meaningful use"?

A. Medicare incentive payments will be paid out at a decreasing rate over a four year period according to the reimbursement formulas described in the Act. Full incentive payments will paid to Eligible Hospitals that can demonstrate meaningful use of EHR technology in fiscal years 2011, 2012 or 2013. These bonus amounts decrease beginning in 2014, with further reductions in 2015. Critical access hospitals must meet meaningful use by FY 2012 to receive all four incentive payments. By 2015, all hospitals who are not yet meaningful users will incur penalties. Hospitals must initiate participation in the Medicaid program no later than FY 2016 to receive payments. Medicare incentive payments for Eligible Professionals will be maximized when Eligible Professionals demonstrate Meaningful Use no later than CY 2012. Professionals must initiate participation in the Medicaid program no later than CY 2016 to receive payments.

Q. What is the EHR Reporting Period (required length of meaningful use period) for eligible hospitals and CAHs?

A. The EHR reporting period is a designated length of time that a hospital must demonstrate meaningful use prior to a submission for ARRA incentive payments.

- For the first payment year, any continuous 90-day period within the Federal fiscal year
- For the second, third, and fourth payment year, the entire Federal fiscal year
- ***Explanation*** – for year one, the hospital must show meaningful use of a continuous period of 90 days prior to the submission for incentives. In the following years, the hospital must show meaningful use of a continuous period of one year prior to the submission for incentives.

Q. What if we are not able to implement EHR technology and demonstrate "meaningful use" prior to FY 2015?

A. By 2015, those who are not yet meaningful users will incur penalties. These penalties will be assessed through reduced Medicare reimbursements.

PPS Hospital Penalties:

For fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital that is not a meaningful EHR user for the reporting period for such fiscal year; three quarters of the applicable Market Basket Adjustment percentage increase otherwise applicable for such fiscal year shall be reduced by: 33.3% reduction (FY 2015); 66.67% reduction (FY 2016); and 100% reduction (FY 2017 and each subsequent fiscal year).

Critical Access Hospital Penalties:

The legislation includes a separate formula for a Critical Access hospital that is not a meaningful EHR user by fiscal year 2015 and each subsequent fiscal year. Specifically, the penalty is a 0.33% annual reduction in Medicare cost reimbursements.

Without meaningful EHR use, a Critical Access hospital would receive reimbursement at the following reduced levels: 100.66 percent (FY 2015); 100.33 percent (FY 2016); and 100 percent (FY 2017 and each subsequent year).

Q. How can we determine what our Medicare incentive payments will be?

A. To estimate what your incentive payments will be, utilize Healthland's Medicare Incentive Payment Calculator. For further considerations, consider the following determinations of incentive payments.

Medicare Incentive:

Eligible Hospitals (IPPS Hospitals)

Initial amount *times* Medicare Share *times* Transition Factor

- Initial Amount = $2 million *plus*
    - o $200 per discharge between the 1,150th and 23,000th discharge in a 12 month period
    - o $0 for the first 1,149 discharges and $0 for each discharge after 23,000
- Medicare Share
    - o Numerator = Inpatient-bed days attributable to Part A *plus* Inpatient-bed days attributable to Part C
    - o Denominator = Total Inpatient Days *times* (non-charity care charges *divided by* total amount of charges)

- Transition Factor

	Adopt FY 2011	Adopt FY 2012	Adopt FY 2013	Adopt FY 2014	Adopt FY 2015	Adopt FY 2016+
FY 2011	1.0	--	--	--	--	--
FY 2012	.75	1.0	--	--	--	--
FY 2013	.5	.75	1.0	--	--	--
FY 2014	.25	.5	.75	.75	--	--
FY 2015	0	.25	.5	.5	.5	--
FY 2016	0	0	.25	.25	.25	0
FY 2017	0	0	0	0	0	0

Medicaid Incentive:

Eligible Hospitals (IPPS Hospitals)

Medicaid incentives are calculated similar to how Medicare calculates the incentive for PPS hospitals, but without the scale-down of the transition factor and assuming an annualized growth rate.

- In any year, the total amount shall not exceed 50% of the Medicaid Incentive and in any 2 year period, the total amount shall not exceed 90% of the Medicaid Incentive
- Determined as if the Transition Factor were 1
- Assumes that discharge rates will increase each year at the average annual rate of growth based upon the past 3 years
- Medicaid Share shall be calculated in the same manner as the Medicare Share except using the number of inpatient-bed days attributable to individuals who are receiving medical assistance instead of Medicare

Medicare Incentive:

Critical Access Hospitals

EHR Costs *times* (Medicare Share *plus* 20%) – *not to exceed 100% Medicare Share*

- May receive no more than 4 payment years
  - No payments after FY 2015
- Payment Year 1 EHR Costs = EHR costs in first year of "meaningful use" ***plus*** any non-depreciated EHR costs from previous years
- Payment Year 2-4 EHR Costs = EHR costs in that year
- For Critical Access hospitals to obtain the full incentive of four payment years, they must demonstrate meaningful use no later than FY 2012.
  - Payment years for CAHs

First Year Meaningful Use	Number of Payments
FY 2011 & 2012	**4**
FY 2013	**3**
FY 2014	**2**
FY 2015	**1**
FY 2016+	**0**

Q. For Critical Access hospitals, what is considered reasonable EHR costs when computing incentive payments?

A. Reasonable costs for the purchase of certified EHR technology mean the reasonable acquisition costs, excluding any depreciation and interest expenses associated with the acquisition, incurred for the purchase of depreciable assets as described at part 413 subpart G, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined" in this rule.

- For details on what qualifies as a reasonable EHR cost for the incentive payment calculation refer to the *EHR Incentive Payments for Critical Access Hospitals* whitepaper.

Medicaid Incentive:

Critical Access Hospitals

Medicaid incentives are calculated similar to how Medicare calculates the incentive for PPS hospitals, but without the scale-down of the transition factor and assuming an annualized growth rate.

- In any year, the total amount shall not exceed 50% of the Medicaid Incentive and in any 2 year period, the total amount shall not exceed 90% of the Medicaid Incentive
- Determined as if the Transition Factor were 1
- Assumes that discharge rates will increase each year at the average annual rate of growth based upon the past 3 years
- Medicaid Share shall be calculated in the same manner as the Medicare Share except using the number of inpatient-bed days attributable to individuals who are receiving medical assistance instead of Medicare

Medicare Incentive:

Eligible Professionals (EP)

HITECH EHR incentive payment for EPs under Medicare based on the allowed charges for covered professional services furnished by the EP. Incentives total 75% of secretary's estimate of allowed charges for covered services furnished by eligible professional during relevant payment year, as indicated below. EPs providing services in designated a Healthcare Professional Shortage Area (HPSA) receive an additional 10%.

Medicare Payments for EPs*:

	Adopt 2011	Adopt 2012	Adopt 2013	Adopt 2014	Adopt 2015+
2011	$18K	--	--	--	--
2012	$12K	$18K	--	--	--
2013	$8K	$12K	$15K	--	--
2014	$4K	$8K	$12K	$12K	--
2015	$2K	$4K	$8K	$8K	$0
2016	$0	$2K	$4K	$4K	$0
2017	$0	$0	$0	$0	$0
TOTAL	**$44K**	**$44K**	**$39K**	**$24K**	**$0**
HPSA (+ 10%)	$48,400	$48,400	$42,900	$26,400	$0

* Physicians who furnish substantially all, defined as 90% or more, of their covered professional services in either an inpatient (POS 21) or emergency department (POS 23) of a hospital are not eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs.

Medicaid Incentive:

Eligible Professionals (EP)

Medicaid incentive payments to EPs equal Net Average Allowable Costs (NAAC) for EHR. NAAC is Average Allowable Costs (capped at $25K in yr 1 and $10K in yrs 2-6) net of cash payments attributable to EHR technology or support services from sources other than state and local governments, subject to 15% EP responsibility, as shown below.

Medicaid Payments for EPs:

Calendar Year	First CY in which EP Receives an Incentive Payment					
	2011	2012	2013	2014	2015	2016
2011	$21,250	---	---	---	---	---
2012	$8,500	$21,250	---	---	---	---
2013	$8,500	$8,500	$21,250	---	---	---
2014	$8,500	$8,500	$8,500	$21,250	---	---
2015	$8,500	$8,500	$8,500	$8,500	$21,250	---
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	---	$8,500	$8,500	$8,500	$8,500	$8,500
2018	---	---	$8,500	$8,500	$8,500	$8,500
2019	---	---	---	$8,500	$8,500	$8,500
2020	---	---	---	---	$8,500	$8,500
2021	---	---	---	---	---	$8,500
Total	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Medicare Incentive:

Rural Health Clinics (RHC)

Since services provided by EPs while working in RHCs are not billed under the Part B physician fee schedule, they do not meet the HITECH Act definition of "covered professional services" and therefore would not qualify for the Medicare EHR incentive.

Medicaid Incentive:

Rural Health Clinics (RHC)

EPs in RHCs may still qualify for the Medicaid EHR incentive payment if they, or the whole RHC as a proxy, meet the 30% threshold for "needy individuals" as defined in statute and other program requirements.

- Needy individuals are defined as persons who:
  - received medical assistance from Medicaid or the Children's Health Insurance Program *or*
  - were furnished uncompensated care *or*
  - were furnished services either at no cost or reduced cost based on a sliding scale determined by individuals' ability to pay

Q. Can eligible hospitals and eligible professionals participate in both incentive programs (Medicare & Medicaid)?

A. Eligible hospitals can participate in BOTH programs (Medicare AND Medicaid) if they qualify for both. Eligible professionals must choose EITHER Medicare OR Medicaid.

Q. When calculating Total Inpatient Days for Medicare Share, are Critical Access hospitals allowed "carve outs" for specific bed types (i.e. swing beds)?

A. Swing bed days are excluded when the swing bed is used to furnish SNF care, because only the days used for inpatient hospital care will be included in the count of "inpatient bed-days… attributable to individuals with respect to whom payment may be made under part A."

Q. Can Critical Access hospitals that have already implemented an EHR, and can achieve meaningful use; depreciate the costs of an upgrade under the stimulus incentives?

A. Although the regulations that describe depreciable assets do not explicitly address the issue of upgrades to software, the regulations state that the costs of "betterments and improvements" are includable in capital-related costs. The regulations define "betterments and improvements" as changes which extend the estimated useful life of an asset at least two years beyond its original estimated useful life, or increase the productivity of an asset significantly over its original productivity.

Q. How will hospitals demonstrate meaningful use?

A. For FY 2011, eligible hospitals (including CAHs) must demonstrate that they satisfy each of the proposed meaningful use objectives through attestation. For payment years beginning in FY 2012 and subsequent years, eligible hospitals will also demonstrate the meaningful use objectives through attestation, with the exception of the objective "report hospital quality measures to CMS or, in the case of Medicaid eligible hospitals, the States" which will be submitted electronically to CMS in the form and manner specified by CMS.

Eligible hospitals must provide attestation through a secure mechanism, such as through claims based reporting or an online portal. CMS proposes that an eligible hospital would identify the Certified EHR Technology they are using and the results of their performance on all the measures associated with the objectives of meaningful use through a one-time attestation following the completion of the EHR reporting period for a given payment year. As health IT matures, CMS expects to base demonstration on automated reporting.

Q. How quickly will providers begin to see the financial incentives once they prove meaningful use?

A. The timing for initial incentive payments is approximately 45-90 days after the submission of attestation. Incentive payments for the Medicare EHR Incentive Program will be made approximately four to six weeks after an eligible professional (EP), eligible hospital, or Critical Access Hospital (CAH) successfully attests that they have demonstrated meaningful use of certified EHR technology.

Payments to Medicare providers will be made through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Hospitals can receive their initial payment as early as May 2011. Final payment will be determined at the time of settling the cost report.

<table>
<tr><th colspan="2">30 Days</th><th colspan="2">30 Days</th><th colspan="2">30 Days</th><th colspan="2">30 Days</th><th colspan="2">30 Days</th><th colspan="2">30 Days</th></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td colspan="2">Submit Attestation</td><td colspan="2">Attestation Approved</td><td colspan="2">Payment Received</td></tr>
<tr><td colspan="6">EHR Reporting Period</td><td colspan="3">CMS Review of Attestation</td><td colspan="3">Payment Processed</td></tr>
<tr><td colspan="6">90 days</td><td colspan="3">15-45 days</td><td colspan="3">4-6 weeks</td></tr>
</table>

Appendix A

Core Set Objectives *(must meet all 14)*

	Objective	Measure
1	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	More than 30% of unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department
2	Implement drug-drug and drug-allergy interaction checks	Interaction checks functionality is enabled
3	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry or an indication that no problems are known for the patient recorded as structured data
4	Maintain active medication list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
5	Maintain active medication allergy list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data
6	Record the following demographics: • Preferred language • Insurance Type • Gender • Race • Ethnicity • Date of Birth • Date and preliminary cause of death in the event of mortality	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have the specified demographics recorded as structured data

	Objective	Measure
	in the eligible hospital or CAH	
7	Record and track changes in vital signs for the following: • Height • Weight • Blood Pressure • Calculate and display the body mass index (BMI) • Plot and display growth charts for children 2 to 20 years, including BMI	More than 50% of all unique patients age 2 years or older admitted to the eligible hospital's or CAH's inpatient or emergency department – height, weight, and blood pressure are recorded as structured data
8	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department have "smoking status" recorded
9	Report hospital quality measures to CMS or the States	2011 - Provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of the final rule 2012 – Electronically submit the clinical quality measures as discussed in section II(A)(3) of the final rule
10	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule
11	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, and procedures), upon request	More than 50% of all patients of the inpatient or emergency departments of an eligible hospital or CAH who request an electronic copy of their health information are provided it within 3 business days
12	Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department and who request an electronic copy of their discharge instructions and procedures are provided it

	Objective	Measure
13	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, and diagnostic test results) among providers of care and patient-authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
14	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 in accordance with the requirements under 45 CFR 164.308(a)(1) (HIPAA Security Rule) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Menu Set Objectives *(may defer up to 5)*

	Objective	Measure
1	Implement drug-formulary checks	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
2	Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research and outreach	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition
4	Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department have an indication of an advance directive status recorded
5	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department are provided patient-specific education resources
6	The 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.	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department

	Objective	Measure
7	The eligible hospital or CAH 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	The eligible hospital or CAH 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% of transitions of care or referrals
8	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capability 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 eligible hospital or CAH submits such information have the capacity to receive the information electronically)
9	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow up submission if the test is successful (unless none of the public health agencies to which the eligible hospital or CAH submits such information have the capacity to receive the information electronically)
10	Capability to provide electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	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 the eligible hospital or CAH submits such information have the capacity to receive the information electronically)

Clinical Quality Measures (CQMs) *(must meet all 15)*

Measure Number Identifier	Measure
Emergency Department (ED)-1 NQF 0495	**Title:** Emergency Department Throughput – admitted patients Median time from ED arrival to ED departure for admitted patients **Description:** Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department
Emergency Department (ED)-2 NQF 0497	**Title:** Emergency Department Throughput – admitted patients Admission decision time to ED departure time for admitted patients **Description:** Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status
Stroke-2 NQF 0435	**Title:** Ischemic stroke – Discharge on anti-thrombotics **Description:** Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge
Stroke-3 NQF 0436	**Title:** Ischemic stroke – Anticoagulation for A-fib/flutter **Description:** Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.
Stroke-4 NQF 0437	**Title:** Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset **Description:** Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well.
Stroke-5 NQF 0438	**Title:** Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2 **Description:** Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.

Measure Number Identifier	Measure
Stroke-6 NQF 0439	**Title:** Ischemic stroke – Discharge on statins **Description:** Ischemic stroke patients with LDL≥100 mg/dL, or LDL not measured, or, who were on a lipid lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.
Stroke-8 NQF 0440	**Title:** Ischemic or hemorrhagic stroke – Stroke education **Description:** Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.
Stroke-10 NQF 0441	**Title:** Ischemic or hemorrhagic stroke – Rehabilitation assessment **Description:** Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.
Venous Thromboembolism (VTE)-1 NQF 0371	**Title:** VTE prophylaxis within 24 hours of arrival **Description:** This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
Venous Thromboembolism (VTE)- 2 NQF 0372	**Title:** Intensive Care Unit VTE prophylaxis **Description:** This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).

Measure Number Identifier	Measure
Venous Thromboembolism (VTE)- 3 NQF 0373	**Title:** Anticoagulation overlap therapy **Description:** This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR)≥ 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.
Venous Thromboembolism (VTE)- 4 NQF 0374	**Title:** Platelet monitoring on unfractionated heparin **Description:** This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.
Venous Thromboembolism (VTE)- 5 NQF 0375	**Title:** VTE discharge instructions **Description:** This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health, home hospice or discharged/transferred to court/law enforcement on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.
Venous Thromboembolism (VTE)- 6 NQF 0376	**Title:** Incidence of potentially preventable VTE **Description:** This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.