

Eligible Hospital (EH) Meaningful Use Measures Applicable for Stage 2 in Program Year 2014

Note that pdf upload will overwrite all saved meaningful use information.

Meaningful Use Core Measures - EHs must fill out all 16 Meaningful Use Core Measures

#	Measure Information	Measure Values
1	Objective: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. All three measures must be attested to.	
	Measure 1: More than 60 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	
	Numerator 1: The number of medication orders in the denominator recorded using CPOE.	
	Denominator 1: Number of medication orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	
	Measure 2: More than 30 percent of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	
	Numerator 2: The number of radiology orders in the denominator recorded using CPOE.	
	Denominator 2: Number of radiology orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	
	Measure 3: More than 30 percent of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	
	Numerator 3: The number of laboratory orders in the denominator recorded using CPOE.	
Denominator 3: Number of laboratory orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period		
2	Objective: Record all of the following demographics: (A) Preferred language (B) Sex (C) Race (D) Ethnicity (E) Date of birth (F) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	
	Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.	
	Numerator: The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.	
Denominator: Number of unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.		
3	Objective: Record and chart changes in the following vital signs: (A) Height (no age limit) (B) Weight (no age limit) (C) Blood pressure (ages 3 and over) (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for patients 0-20 years, including BMI.	
	Measure: More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and/or height/length and weight (for all ages) recorded as structured data.	

	Numerator: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.	
	Denominator: Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	
	Objective: Record smoking status for patients 13 years old or older.	
	Measure: More than 80 percent of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.	
	Exclusion: Any eligible hospital or CAH that neither sees nor admits any patients 13 years old or older.	
4	Does this exclusion apply to you?	YES NO
	Numerator: The number of patients in the denominator with smoking status recorded as structured data.	
	Denominator: Number of unique patients age 13 or older seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	
	Objective: Use clinical decision support to improve performance on high-priority health conditions.	
	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH's patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency.	
5	Eligible hospitals and CAHs must attest YES to implementing five clinical decision support interventions to meet this measure.	YES NO
	Measure 2: The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	
	Eligible hospitals and CAHs must attest YES to enabling and implementing functionality for drug-drug and drug-allergy interaction to meet this measure.	YES NO
	Objective: Provide patients the ability to view online, download, and transmit information about a hospital admission.	
	Measure 1: More than 50 percent of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period have their information available online within 36 hours of discharge.	
	Numerator: The number of patients in the denominator whose information is available online within 36 hours of discharge.	
	Denominator: Number of unique patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	
6	Measure 2: More than 5 percent of all unique patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the EHR reporting period.	
	Exclusion: Any eligible hospital or CAH will be excluded from the second measure if it is located in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.	YES NO
	Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the discharge information provided by the eligible hospital or CAH.	
	Denominator: Number of unique patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	
	Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	
7	Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for eligible hospitals.	

	Eligible hospitals and CAHs must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.	YES	NO
8	<p>Objective: Incorporate clinical lab-test results into Certified EHR Technology as structured data</p> <p>Measure: More than 55 percent of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data.</p> <p>Numerator: Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.</p> <p>Denominator: Number of lab tests ordered during the EHR reporting period by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.</p>		
9	<p>Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p> <p>Measure: Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.</p> <p>The Eligible Hospital or CAH must attest YES to generating at least one report listing patients of the eligible hospital or CAH with a specific condition.</p>	YES	NO
10	<p>Objective: Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.</p> <p>Measure: More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.</p> <p>Numerator: Number of patients in the denominator who are subsequently provided patient-specific education resources identified by CEHRT.</p> <p>Denominator: Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.</p>		
11	<p>Objective: 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.</p> <p>Measure: The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).</p> <p>Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.</p> <p>Denominator: Number of transitions of care during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.</p>		
12	<p>Objective: 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 provides a summary care record for each transition of care or referral.</p> <p>Measure 1: The eligible hospital or CAH that 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.</p> <p>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided.</p> <p>Denominator: Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.</p> <p>Measure 2: The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.</p>		

	<p>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was</p> <p>a) electronically transmitted using CEHRT to a recipient or</p> <p>b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.</p>	
	<p>Denominator: Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.</p>	
	<p>Measure 3: The eligible hospital or CAH must satisfy one of the two following criteria:</p> <p>1. Conducts one or more successful electronic exchanges of a summary of care document, which is counted in "measure 2" (for eligible hospitals and CAHs the measure at §95.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or</p> <p>2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.</p>	
	<p>The eligible hospital or CAH attests YES to one of the two criteria:</p> <p>1. Conducts one or more successful electronic exchanges of a summary of care document, which is counted in "measure 2" with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or</p> <p>2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.</p>	<p>YES NO</p>
13	<p>Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.</p> <p>Exclusion: Any eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective.</p>	
	<p>Exclusion 1: Does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.</p>	<p>YES NO</p>
	<p>Exclusion 2: Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for Certified EHR Technology at the start of their EHR reporting period.</p>	<p>YES NO</p>
	<p>Exclusion 3: Operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data.</p>	<p>YES NO</p>
	<p>Exclusion 4: Operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.</p>	<p>YES NO</p>
	<p>The eligible hospital or CAH must attest YES to meeting one of the following criteria under the umbrella of ongoing submission:</p> <ul style="list-style-type: none"> - Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period using either the current standard at 45 CFR 170.314(f)(1) and (f)(2) or the standards included in the 2011 Edition EHR certification criteria adopted by ONC during the prior EHR reporting period when ongoing submission was achieved. - Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved. - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission. - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation. 	

14	<p>Objective: Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to a public health agency for the entire EHR reporting period.</p> <p>Exclusion: Any eligible hospital or CAH that meets one or more of the below criteria.</p>	
	<p>Exclusion 1: Operates in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required for Certified EHR Technology at the start of their EHR reporting period.</p>	<p>YES NO</p>
	<p>Exclusion 2: Operates in a jurisdiction for which no public health agency provides information timely on capability to receive electronic reportable laboratory results.</p>	<p>YES NO</p>
	<p>Exclusion 3: Operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.</p>	<p>YES NO</p>
	<p>Eligible hospitals or CAHS must attest YES to meeting one of the below criteria under the umbrella of ongoing submission:</p> <ul style="list-style-type: none"> - Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period. - Registration with the public health agency or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved. - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission. - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation. 	<p>YES NO</p>
15	<p>Objective: Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.</p> <p>Exclusion: Any eligible hospital or CAH that meets one or more of the below criteria may be excluded from this objective.</p>	
	<p>Does not have an emergency or urgent care department.</p>	<p>YES NO</p>
	<p>Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by Certified EHR Technology at the start of their EHR reporting period.</p>	<p>YES NO</p>
	<p>Operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data.</p>	<p>YES NO</p>
	<p>Operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.</p>	<p>YES NO</p>
	<p>Eligible hospitals or CAHS must attest YES to meeting one of the below criteria under the umbrella of ongoing submission:</p> <ul style="list-style-type: none"> - Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period. - Registration with the public health agency or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved. - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission. - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation. 	<p>YES NO</p>
16	<p>Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).</p> <p>Measure: More than 10 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.</p> <p>Exclusion: Any eligible hospital or CAH with an average daily inpatient census of fewer than 10 patients.</p>	
	<p>Does this exclusion apply to you?</p>	<p>YES NO</p>

	Numerator: The number of orders in the denominator for which all doses are tracked using eMAR.	
	Denominator: Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	

Meaningful Use Menu Measures - EHs must fill 3 out of 6 Meaningful Use Menu Measures until there are at least 3 non-excluded objectives or all 6 objectives are responded to.

#	Measure Information	Measure Values
1	Objective: Record whether a patient 65 years old or older has an advance directive.	
	Measure: More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	
	Exclusion: Any eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.	
	Does this exclusion apply to you?	YES NO
	Numerator: The number of patients in the denominator who have an indication of an advance directive status entered using structured data.	
	Denominator: The number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.	
2	Objective: Record electronic notes in patient records.	
	Measure: Enter at least one electronic progress note created, edited and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.	
	Numerator: The number of unique patients in the denominator who have at least one electronic progress note from an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) recorded as text searchable data.	
	Denominator: Number of unique patients admitted to an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	
3	Objective: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.	
	Measure: More than 10 percent of all tests whose result is one or more images ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period are accessible through Certified EHR Technology .	
	Numerator: The number of results in the denominator that are accessible through Certified EHR Technology.	
	Denominator: Number of tests whose result is one or more images ordered by an authorized provider on behalf of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period.	
4	Objective: Record patient family health history as structured data.	
	Measure: More than 20 percent of all unique patients admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.	
	Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives.	

	Denominator: Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	
5	Objective: Generate and transmit permissible discharge prescriptions electronically (eRx).	
	Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using certified EHR technology.	
	Exclusion: Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period.	
	Does this exclusion apply to you?	YES NO
	Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically.	
	Denominator: Number of new, changed, or refill prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances for patients discharged during the EHR reporting period.	
6	Objective: Provide structured electronic lab results to ambulatory providers.	
	Measure: Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of electronic lab orders received.	
	Numerator: The number of structured clinical lab results sent to the ordering provider.	
	Denominator: The number of electronic lab orders received.	

Meaningful Use Clinical Quality Measures - Eligible Hospitals and CAHs must report on 16 of the 29 CQMs across 3 domains.

CQM Domain 1 - Patient and Family Engagement: These are CQMs that reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient reported data and the ability to impact care at the individual patient level as well as the population level through greater involvement of patients and families in decision making, self care, activation, and understanding of their health condition and its effective management.

#	Measure Information	Measure Values
NQF0338	Objective: An assessment that there is documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric asthma patient/caregiver.	
	Numerator: Pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care (HMPC) document that addresses all of the following: 1. Arrangements for follow-up care 2. Environmental control and control of other triggers 3. Method and timing of rescue actions 4. Use of controllers 5. Use of relievers	
	Denominator: Pediatric asthma inpatients with an age of 2 through 17 years, length of stay less than or equal to 120 days, and discharged to home or police custody.	
NQF0495	Objective: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.	
	Numerator 1: Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department	
	Denominator 1: All patients seen in the ED and admitted to the facility as an inpatient	
	Numerator 2: Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	
	Denominator 2: All patients seen in the ED and admitted as an inpatient who do not have a diagnosis consistent with psychiatric/mental health disorders.	
	Numerator 3: Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.	
	Denominator 3: All patients seen in the ED and admitted as an inpatient who have a diagnosis consistent with psychiatric/mental health disorders.	

NQF0440	Objective: 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.	
	Numerator: Ischemic or hemorrhagic stroke patients with documentation that they or their caregivers were given educational material addressing all of the following: 1. Activation of emergency medical system 2. Follow-up after discharge 3. Medications prescribed at discharge 4. Risk factors for stroke 5. Warning signs and symptoms of stroke.	
	Denominator: Ischemic stroke or hemorrhagic stroke patients discharged home.	
	Exclusion: - Patients less than 18 years of age. - Patients who have a length of stay greater than 120 days - Patients with Comfort Measures Only documented. - Patients admitted for elective carotid intervention.	
NQF0375	Objective: This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care 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.	
	Numerator: Patients with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all of the following: 1. compliance issues 2. dietary advice 3. follow-up monitoring 4. potential for adverse drug reactions and interactions	
	Denominator: Patients with a diagnosis of venous thromboembolism (VTE), a patient age greater than or equal to 18 years, and a length of stay less than or equal to 120 days with confirmed VTE discharged to home or court/law enforcement on warfarin therapy.	
	Exclusion: Patients without VTE confirmed by diagnostic testing	
NQF0497	Objective: Median time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.	
	Numerator 1: Median time (in minutes) from Decision to Admit to ED departure for patients admitted to the facility from the emergency department.	
	Denominator 1: All patients seen in the ED and admitted to the facility as an inpatient.	
	Numerator 2: Median time (in minutes) from Decision to Admit to ED departure for patients admitted to the facility from the emergency department.	
	Denominator 2: All patients seen in the ED and admitted as an inpatient who do not have a diagnosis consistent with psychiatric/mental health disorders.	
	Numerator 3: Median time (in minutes) from Decision to Admit to ED departure for patients admitted to the facility from the emergency department.	
Denominator 3: All patients seen in the ED and admitted as an inpatient who have a diagnosis consistent with psychiatric/mental health disorders.		

CQM Domain 2 - Patient Safety: These are CQMs that reflect the safe delivery of clinical services in both hospital and ambulatory settings and include processes that would reduce harm to patients and reduce burden of illness. These measures should enable longitudinal assessment of condition specific, patient-focused episodes of care.

#	Measure Information	Measure Values
NQF0371	Objective: 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.	
	Numerator: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given: -the day of or the day after hospital admission -the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission	

	<p>Denominator: Patients admitted to the hospital for inpatient acute care with no diagnosis of obstetrics or venous thromboembolism (VTE with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission.</p>	
	<p>Exclusion:</p> <ul style="list-style-type: none"> - Patients who have a length of stay less than 2 days. - Patients with comfort measures only documented by the day after hospital admission. - Patients with comfort measures only documented by the day after surgery end date for surgeries that start the day of or the day after hospital admission. - Patients who are direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU length of stay greater than or equal to one day. - Patients with a principal diagnosis of mental disorders or stroke. - Patients with a diagnosis of obstetrics or VTE. - Patients with a principal procedure of Surgical Care Improvement Project (SCIP) VTE selected surgeries. 	
NQF0376	<p>Objective: This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.</p>	
	<p>Numerator: Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date.</p>	
	<p>Denominator: Patients admitted to the hospital for inpatient acute care with no principal diagnosis code for venous thromboembolism (VTE), with at least one other diagnosis code for venous thromboembolism (VTE) with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission who developed confirmed VTE during hospitalization.</p>	
	<p>Exclusion:</p> <ul style="list-style-type: none"> - Patients with comfort measures only documented. - Patients with a principal diagnosis of VTE. - Patients with VTE present at admission. - Patients with reasons for not administering mechanical and pharmacologic prophylaxis. - Patients without VTE confirmed by diagnostic testing. 	
NQF0527	<p>Objective: Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.</p>	
	<p>Numerator 1: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.</p>	
	<p>Denominator 1: Denominator for population 1 - Coronary artery bypass graft (CABG) procedures</p>	
	<p>Exclusion 1: All patient groups are excluded for all denominators</p> <ul style="list-style-type: none"> - Patients who had a hysterectomy and a caesarean section performed during this hospitalization - Patients who had a principal diagnosis suggestive of preoperative infectious diseases (as defined in Appendix A, Table 5.09 for ICD-9-CM codes) - Patients enrolled in clinical trials-this exclusion is limited to patients participating in a clinical trial for the same conditions as covered by the measure. Other clinical trials are not valid reasons for exclusion. - Patients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interest - Patients who had other procedures requiring general or spinal anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stay - Patients who were receiving antibiotics more than 24 hours prior to surgery - Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics) 	
	<p>Numerator 2: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.</p>	
	<p>Denominator 2: Denominator for population 2 - Other cardiac surgery</p>	
	<p>Exclusion 2: Exclusion for denominator 2. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.</p>	
	<p>Numerator 3: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.</p>	

	Denominator 3: Denominator for population 3 - Hip arthroplasty	
	Exclusion 3: Exclusion for denominator 3. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 4: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.	
	Denominator 4: Denominator for population 4 - Knee arthroplasty	
	Exclusion 4: Exclusion for denominator 4. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 5: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.	
	Denominator 5: Denominator for population 5 - Colon surgery	
	Exclusion 5: Exclusion for denominator 5. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 6: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.	
	Denominator 6: Denominator for population 6 - Abdominal hysterectomy	
	Exclusion 6: Exclusion for denominator 6. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 7: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.	
	Denominator 7: Denominator for population 7 - Vaginal hysterectomy	
	Exclusion 7: Exclusion for denominator 7. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 8: Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin or a fluoroquinolone) in the denominator.	
	Denominator 8: Denominator for population 8 - Vascular surgery	
	Exclusion 8: Exclusion for denominator 8. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Objective: Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	
	Numerator: Number of surgical patients whose urinary catheter is removed on postoperative day (POD) 1 or postoperative day (POD) 2 with day of surgery being day zero.	
	Denominator: All hospital discharges for selective surgery with hospital stays <= 120 days during the measurement year for patients age 18 and older at the time of hospital admission with a catheter in place postoperatively. All selected surgical patients 18 years of age and older with a catheter in place postoperatively with An ICD-9-CM Principal Procedure Code of selected surgeries.	
NQF0453	Exclusion: - Patients enrolled in clinical trials. Patients who had a urological, gynecological or perineal procedure performed. - Patients whose ICD-9-CM principal procedure occurred prior to the date of admission. - Patients who had other procedures requiring general or spinal anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stay. - Patients who expired perioperatively. - Patients whose length of stay was less than two days postoperatively. - Patients who had a suprapubic catheter or had intermittent catheterization preoperatively. - Patients who had a urethral catheter, a suprapubic catheter or who were being intermittently catheterized prior to the perioperative period. - Patients who did not have a catheter in place postoperatively. - Patients who had physician/APN/PA documentation of a reason for not removing the urinary catheter postoperatively.	
NQF0716	Objective: Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.	

	Numerator: The absence of conditions or procedures reflecting morbidity that happened during birth and nursery care to an otherwise normal infant.	
	Denominator: The denominator is composed of singleton, term (≥ 37 weeks), inborn, livebirths in their birth admission. The denominator further has eliminated fetal conditions likely to be present before labor. Maternal and obstetrical conditions (e.g. hypertension, prior cesarean, malpresentation) are not excluded unless evidence of fetal effect prior to labor (e.g. IUGR/SGA).	
	Exclusion: - Multiple gestations. - Preterm. - Congenital anomalies. - Fetuses affected by selected maternal conditions.	
	Objective: 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).	
	Numerator: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given: -the day of or the day after ICU admission (or transfer) -the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)	
NQF0372	Denominator: Patients admitted to the hospital for inpatient acute care with no diagnosis of obstetrics or, venous thromboembolism (VTE), or obstetrics - VTE with hospital stays ≤ 120 days during the measurement period for patients age 18 and older at the time of hospital admission who were either directly admitted or transferred to ICU during the hospitalization.	
	Exclusion: - Patients who have a hospital length of stay (LOS) less than two days. - Patients with comfort measures only documented during the specified date range. - Patients with ICU length of stay less than one day without VTE prophylaxis administered and documentation for no VTE prophylaxis. - Patients with a principal or other diagnosis code of obstetrics or VTE. - Patients with a principal procedure of surgical care improvement Project (SCIP) VTE selected surgeries that start the day of or the day after ICU admission or transfer.	
	Exception: Patients with ICU LOS less than one day without VTE prophylaxis administered and documentation for no VTE prophylaxis.	

CQM Domain 3 - Care Coordination: These are CQMs that demonstrate appropriate and timely sharing of information and coordination of clinical and preventive services among health professionals in the care team and with patients, caregivers, and families in order to improve appropriate and timely patient and care team communication.

#	Measure Information	Measure Values
	Objective: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.	
	Numerator 1: Median time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	
	Denominator 1: All patients discharged home.	
	Numerator 2: Median time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	
NQF0496	Denominator 2: All patients with diagnosis consistent with mental disorders.	
	Numerator 3: Median time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	
	Denominator 3: All patients transferred to another acute care hospital.	
	Numerator 4: Median time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	
	Denominator 4: All patients transferred to observation status.	
NQF0441	Objective: Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.	
	Numerator: Ischemic or hemorrhagic stroke patients assessed for or who received rehabilitation services.	

	Denominator: Patients admitted to the hospital for inpatient acute care with a principal diagnosis code for ischemic or hemorrhagic stroke with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission.	
	Exclusion: - Patients with Comfort Measures Only documented. - Patients admitted for elective carotid intervention. - Patients discharged to another hospital. - Patients who left against medical advice. - Patients who expired. - Patients discharged to home for hospice care. - Patients discharged to a health care facility for hospice care.	

CQM Domain 4 - Efficient Use of Healthcare Resources: These are CQMs that reflect efforts to significantly improve outcomes and reduce errors. These CQMs also impact and benefit a large number of patients and emphasize the use of evidence to best manage high priority conditions and determine appropriate use of healthcare resources.

#	Measure Information	Measure Values
NQF0528	Objective: Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	
	Numerator 1: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	
	Denominator 1: Denominator for population 1 - Coronary artery bypass graft (CABG) procedures	
	Exclusion 1: All patient groups are excluded for all denominators. - Patients who had a Hospital Measures-Principal diagnosis suggestive of preoperative infectious diseases. - Patients enrolled in clinical trials-this exclusion is limited to patients participating in a clinical trial for the same conditions as covered by the measure. Other clinical trials are not valid reasons for exclusion. - Patients with physician/advanced practice nurse/physician assistant (physician/APN/PA) documented infection prior to surgical procedure of interest. - Patients who expired perioperatively - Patients who were receiving antibiotics more than 24 hours prior to surgery (except colon surgery patients taking oral prophylactic antibiotics). - Patients who had other procedures requiring general or spinal anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the procedure of interest (during separate surgical episodes) during this hospital stay - Patients who were receiving antibiotics within 24 hours prior to arrival (except colon surgery patients taking oral prophylactic antibiotics). - Patients who did not receive any antibiotics before or during surgery, or within 24 hours after Anesthesia End Time (i.e., patient did not receive prophylactic antibiotics). - Patients who did not receive any antibiotics during this hospitalization.	
	Numerator 2: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	
	Denominator 2: Denominator for population 2 - Other cardiac surgery	
	Exclusion 2: Exclusion for denominator 2. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 3: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	
	Denominator 3: Denominator for population 3 - Hip arthroplasty	
	Exclusion 3: Exclusion for denominator 3. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 4: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	
	Denominator 4: Denominator for population 4 - Knee arthroplasty	
	Exclusion 4: Exclusion for denominator 4. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
Numerator 5: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.		
Denominator 5: Denominator for population 5 - Colon surgery		

	Exclusion 5: Exclusion for denominator 5. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 6: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	
	Denominator 6: Denominator for population 6 - Abdominal hysterectomy	
	Exclusion 6: Exclusion for denominator 6. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 7: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	
	Denominator 7: Denominator for population 7 - Vaginal hysterectomy	
	Exclusion 7: Exclusion for denominator 7. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	Numerator 8: Number of surgical patients who received prophylactic antibiotics recommended for their specific surgical procedure.	
	Denominator 8: Denominator for population 8 - Vascular surgery	
	Exclusion 8: Exclusion for denominator 8. Patient groups excluded from this denominator are same as the ones mentioned in denominator 1 exclusion.	
	<p>Objective: (PN-6) Immunocompetent patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines</p> <p>(Population 1) Immunocompetent ICU patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines</p> <p>(Population 2) Immunocompetent non-Intensive Care Unit (ICU) patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines</p>	
	<p>Numerator 1: Pneumonia patients who received an initial antibiotic regimen consistent with current guidelines during the first 24 hours of their hospitalization.</p> <p>Numerator 1 (in population 1) defines appropriate antibiotics for ICU patients.</p>	
	<p>Numerator 2: Pneumonia patients who received an initial antibiotic regimen consistent with current guidelines during the first 24 hours of their hospitalization.</p> <p>Numerator 2 (in population 2) defines appropriate antibiotics for non-ICU patients.</p>	
NQF0147	<p>Denominator: Pneumonia patients 18 years of age and older at the time of admission with a discharge diagnosis of ICD-9-CM Hospital Measures-Principal Diagnosis Code of pneumonia, OR ICD-9-CM Hospital Measures-Principal Diagnosis Code of septicemia or respiratory failure (acute or chronic) and also a secondary ICD-9-CM Other Diagnosis Code of pneumonia.</p>	
	<p>Exclusion:</p> <ul style="list-style-type: none"> - Patients with Cystic Fibrosis. - Patients with Comfort Measures Only documented on day of or day after arrival. - The exclusion for patients who are clinical trial participants is limited to patients participating in a clinical trial for pneumonia, the same condition as covered by the measure. Other clinical trials are not valid reasons for exclusions. - Patients received as a transfer from the emergency/observation department of another hospital. - Patients received as a transfer from an inpatient or outpatient department of another hospital. - Patients received as a transfer from an ambulatory surgery center. - Patients who have no diagnosis of pneumonia either as the ED final diagnosis/impression or direct admission diagnosis/impression. - Patients with Healthcare Associated pneumonia or are immunocompromised. - Patients transferred/admitted to the ICU within 24 hours after arrival to this hospital, with a beta-lactam allergy (population 1 only). - Patients who have duration of stay less than or equal to one day. - Pneumonia patients with Another Source of Infection who did not receive an antibiotic regimen recommended for pneumonia, but did receive antibiotics within the first 24 hours of hospitalization. 	

CQM Domain 5 - Clinical Processes/Effectiveness: These are CQMs that reflect clinical care processes closely linked to outcomes based on evidence and practice guidelines.

#	Measure Information	Measure Values
NQF0480	Objective: Exclusive breast milk feeding during the newborn's entire hospitalization	
	Numerator: Newborns that were fed breast milk only since birth	
	Denominator: Single term newborns discharged from the hospital who has no diagnosis of galactosemia, no performed procedure of parenteral infusion, no diagnosis of premature newborn, and length of stay less than or equal to 120 days.	
	Exclusion: Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization; Experienced death; Had documented reason for not exclusively feeding breast milk; Patients transferred to another hospital.	
NQF0639	Objective: Acute myocardial infarction (AMI) patients who are prescribed a statin at hospital discharge.	
	Numerator: AMI patients who are prescribed a statin medication at hospital discharge	
	Denominator: AMI patients > = 18 years of age with length of stay < = 120 days	
	Exclusion: - Patients with Comfort Measures Only documented. - Patients enrolled in clinical trials. - Patients discharged to another hospital. - Patients who left against medical advice - Patients who expired - Patients discharged to home for hospice care - Patients discharged to a health care facility for hospice care - Patients with LDL less than 100 mg/dL within the first 24 hours after hospital arrival or 30 days prior to hospital arrival and not discharged on a statin. - Patients with a Reason for Not Prescribing Statin Medication at Discharge.	
NQF1354	Objective: This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.	
	Numerator: All live births during the measurement time period born at a facility and screened for hearing loss prior to discharge, or screened but still not discharged; Or not being screened due to medical reasons or medical exclusions.	
	Denominator: All live births during the measurement time period born at a facility and, discharged without being screened, or screened prior to discharge, or screened but still not discharged.	
	Exclusion: Patient deceased prior to discharge and has not received hearing screening.	
NQF0163	Objective: Acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.	
	Numerator: AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less Denominator: All hospital discharges for acute myocardial infarction (AMI) with hospital stays <= 120 days during the measurement year for patients age 18 and older at the time of hospital admission with ST-elevation or left bundle branch block (LBBB) on electrocardiogram (ECG) who received primary percutaneous coronary intervention (PCI). AMI patients age 18 and older with ST-elevation or LBBB on ECG who received primary PCI with An ICD-9-CM Principal Diagnosis Code for AMI AND PCI (ICD-9-CM Principal and Other Procedure Codes for PCI) AND ST-segment elevation or LBBB on the ECG performed closest to hospital arrival AND PCI performed within 24 hours after hospital arrival Exclusion: - Patients enrolled in clinical trials. - Patients received as a transfer from an inpatient or outpatient department of another hospital. - Patients received as a transfer from the emergency/observation department of another hospital. - Patients received as a transfer from an ambulatory surgery center. - Patients administered fibrinolytic agent prior to PCI. - PCI described as non-primary by a physician/advanced practice nurse/physician assistant (physician/APN/PA). - Patients who did not receive PCI within 90 minutes and had a reason for delay documented by a physician/APN/PA (e.g., social, religious, initial concern or refusal, cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation).	

NQF0164	Objective: Acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less	
	Numerator: AMI patients whose time from hospital arrival to fibrinolysis is 30 minutes or less.	
	Denominator: All hospital discharges for acute myocardial infarction (AMI) with hospital stays <= 120 days during the measurement year for patients age 18 and older at the time of hospital admission with ST-elevation or left bundle branch block (LBBB) on electrocardiogram (ECG) who received fibrinolytic therapy with an ICD-9-CM Principal Diagnosis Code for AMI AND ST-segment elevation or LBBB on the ECG performed closest to hospital arrival AND Fibrinolytic therapy within 6 hours after hospital arrival AND Fibrinolytic therapy is primary reperfusion therapy	
	Exclusion: <ul style="list-style-type: none"> - Patients enrolled in clinical trials. - Patients received as a transfer from an inpatient or outpatient department of another hospital. - Patients received as a transfer from the emergency/observation department of another hospital. - Patients received as a transfer from an ambulatory surgery center. - Patients who did not receive fibrinolytic therapy within 30 minutes and had a reason for delay documented by a physician/advanced practice nurse/physician assistant (e.g., social, religious, initial concern or refusal, cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation). 	
NQF0436	Objective: Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.	
	Numerator: Ischemic stroke patients prescribed anticoagulation therapy at hospital discharge.	
	Denominator: Patients admitted to the hospital for inpatient acute care with a Principal Diagnosis Code for ischemic or hemorrhagic stroke with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission with documented atrial fibrillation/flutter.	
	Exclusion: <ul style="list-style-type: none"> - Patients with comfort measures only documented. - Patients admitted for elective carotid intervention. - Patients discharged to another hospital. - Patients who left against medical advice. - Patients who expired. - Patients discharged to home for hospice care. - Patients discharged to a health care facility for hospice care 	
	Exception: Patients with a documented reason for not prescribing anticoagulation therapy	
NQF0438	Objective: Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.	
	Numerator: Ischemic stroke patients who had antithrombotic therapy administered by end of hospital day 2.	
	Denominator: Patients admitted to the hospital for inpatient acute care with a Principal Diagnosis Code for ischemic stroke with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission.	
	Exclusion: <ul style="list-style-type: none"> - Patients who have a duration of stay less than 2 days. - Patients with comfort measures only documented on day or the day after arrival. - Patients admitted for elective carotid intervention. - Patients discharged prior to the end of hospital day 2. - Patients with IV OR IA Thrombolytic (t-PA) Therapy administered at this hospital or within 24 hours prior to arrival. 	
	Exception: Patients with a documented reason for not administering antithrombotic therapy by end of hospital day 2.	
NQF0373	Objective: 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 should be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.	

	<p>Numerator: Patients who received overlap therapy (warfarin and parenteral anticoagulation): Five or more days, with an INR greater than or equal to 2 prior to discontinuation of parenteral therapy, or Five or more days, with an INR less than 2 and discharged on overlap therapy, or Less than five days and discharged on overlap therapy, or With documentation of reason for discontinuation of overlap therapy, or With documentation of a reason for no overlap therapy</p>	
	<p>Denominator: Patients with a diagnosis code for venous thromboembolism (VTE), a patient age greater than or equal to 18 years, and a length of stay less than or equal to 120 days with confirmed VTE who received warfarin.</p>	
	<p>Exclusion: - Patients with Comfort Measures Only documented. - Patients discharged to a health care facility for hospice care. - Patients discharged to home for hospice care. - Patients who expired. - Patients who left against medical advice. - Patients discharged to another hospital. - Patients without warfarin therapy during hospitalization. - Patients without VTE confirmed by diagnostic testing.</p>	
	<p>Objective: 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.</p>	
NQF0437	<p>Numerator: Acute ischemic stroke patients for whom IV thrombolytic therapy was initiated at this hospital within 3 hours (less than or equal to 180 minutes) of time last known well.</p>	
	<p>Denominator: Patients admitted to the hospital for inpatient acute care with a Principal Diagnosis Code for ischemic or hemorrhagic stroke with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission whose time of arrival is within 2 hours (less than or equal to 120 minutes) of time last known well.</p>	
	<p>Exclusion: - Patients admitted for Elective Carotid Intervention. - Patients with a documented Reason For Not Initiating IV Thrombolytic.</p>	
	<p>Objective: Acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge</p>	
	<p>Numerator: Acute Myocardial Infarction patients who are prescribed aspirin at hospital discharge.</p>	
	<p>Denominator: All Acute Myocardial Infarctions patients age 18 and older with an ICD-9-CM Principal Diagnosis Code for Acute Myocardial Infarction.</p>	
NQF0142	<p>Exclusion: - Patients with Comfort Measures Only documented. - Patients enrolled in clinical trials. - Patients discharged to another hospital. - Patients who left against medical advice. - Patients who expired. - Patients discharged to home for hospice care. - Patients discharged to a health care facility for hospice care. - Patients with a documented Reason for No Aspirin at Discharge.</p>	
	<p>Objective: Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge</p>	
	<p>Numerator: Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.</p>	
	<p>Denominator: Patients admitted to the hospital for inpatient acute care with a principal diagnosis code for ischemic stroke with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission.</p>	
NQF0435	<p>Exclusion: - Patients with Comfort Measures Only documented. - Patients admitted for elective carotid intervention. - Patients discharged to another hospital. - Patients who left against medical advice. - Patients who expired. - Patients discharged to home for hospice care. - Patients discharged to a health care facility for hospice care.</p>	
	<p>Exception: Patients with a documented reason for not prescribing antithrombotic therapy at discharge.</p>	

NQF0439	Objective: Ischemic stroke patients with LDL greater than or equal to 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.	
	Numerator: Ischemic stroke patients prescribed statin medication at hospital discharge.	
	Denominator: Patients admitted to the hospital for inpatient acute care with a principal diagnosis code for ischemic or hemorrhagic stroke with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission who are Ischemic stroke patients with an LDL greater than or equal to 100 mg/dL, OR LDL not measured, OR who were on a lipid-lowering medication prior to hospital arrival.	
	Exclusion: <ul style="list-style-type: none"> - Patients with comfort measures only documented. - Patients admitted for elective carotid intervention. - Patients discharged to another hospital. - Patients who left against medical advice. - Patients who expired. - Patients discharged to home for hospice care. - Patients discharged to a health care facility for hospice care. 	
Exception: Patients with a reason for not prescribing statin medication at discharge		
NQF0374	Objective: 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.	
	Numerator: Patients who have their IV UFH therapy dosages AND platelet counts monitored according to defined parameters such as a nomogram or protocol.	
	Denominator: Patients with a diagnosis of venous thromboembolism (VTE), a patient age greater than or equal to 18 years, and a length of stay less than or equal to 120 days and confirmed VTE receiving IV UFH therapy.	
	Exclusion: <ul style="list-style-type: none"> - Patients with Comfort Measures Only documented. - Patients discharged to another hospital. - Patients who left against medical advice. - Patients who expired. - Patients discharged to home for hospice care. - Patients discharged to a health care facility for hospice care. 	
NQF0469	Objective: Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed	
	Numerator: Patients with elective deliveries.	
	Denominator: Patients admitted to the hospital for inpatient acute care are included if they have a diagnosis related to pregnancy with reference to delivery, a patient age >= 18 years and < 65, and a length of stay < 120 days and delivering newborns with >= 37 and < 39 weeks of gestation completed.	
	Exclusion: <ul style="list-style-type: none"> - Patients who experienced a prior uterine surgery (classical cesarean section or myomectomy). - Patients with conditions possibly justifying elective delivery prior to 39 weeks gestation. 	