American Hospital Association®

Regulatory Advisory

September 24, 2014

FINAL RULE OFFERS LIMITED FLEXIBILITY ON MEETING EHR MEANINGFUL USE IN 2014

AT A GLANCE

At Issue:

On Aug. 29, the Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology released a rule that finalized, as proposed, 10 different pathways for eligible hospitals, critical access hospitals and professionals to meet meaningful use under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs in 2014. To take advantage of the flexibility, eligible hospitals and professionals will need to attest that they could not fully implement 2014 Edition Certified EHR Technology (2014 Edition CEHRT) due to delays in availability of the technology. The rule clarifies that challenges such as installing software patches, completing training and implementing workflow changes all count as reasons for not being able to fully implement 2014 Edition CEHRT. Beginning in fiscal year (FY) 2015, the vast majority of eligible hospitals and professionals will be required to use 2014 Edition CEHRT to report meaningful use for a 365-day reporting period. The final rule does not change any of the individual requirements for Stage 1 or Stage 2. While the fiscal year ends on Sept. 30, hospitals have through Nov. 30 to complete their attestations, whether attesting under the previous rules or a new option. If taking advantage of the new pathways, however, a hospital will not be able to attest until after Oct. 1, due to limitations of the CMS website.

Our Take:

The AHA strongly advocated for greater flexibility in 2014 and appreciates the alternative approaches in the finalized rule because they increase the odds that eligible hospitals and professionals can attest to meeting meaningful use in 2014. However, given that the final rule was released so late in the fiscal year, it will be challenging for hospitals to take advantage of the flexibility offered by this final rule.

The AHA is very disappointed that most hospitals will be required to use the 2014 Edition CEHRT beginning Oct. 1 (the first day of FY 2015) and report on a full year of performance, rather than the 90-day reporting period we had requested for FY 2015 (hospitals attesting to meaningful use for the first time still report on a 90-day period). This 365-day policy seriously limits the benefit of the final rule. The AHA is pursuing additional regulatory and legislative avenues to address the timing challenges in 2015, as well as those Stage 2 requirements that are particularly onerous and hold hospitals accountable for the actions of others (i.e., patient portal and transitions of care). The AHA supports the Flexibility in Health IT Reporting (Flex-IT) Act (H.R. 5481), which would shorten the reporting period to 90 days in 2015.

What You Can Do:

- ✓ Share this advisory with your senior management team.
- ✓ Ask your chief information officer and quality officer to determine which option would best fit your circumstances and ensure that your vendor(s) can support that choice.
- ✓ Be sure that you attest to meaningful use by the Nov. 30 deadline, as outlined below.

Further Questions:

If you have questions about the final rule, please contact Chantal Worzala, AHA director of policy, at (202) 626-2313 or cworzala@aha.org.

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BACKGROUND

On Aug. 29, the Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) released a final rule that lays out for eligible hospitals, critical access hospitals (CAHs) and eligible professionals (EPs) multiple pathways to meet meaningful use under the Medicare Electronic Health Record (EHR) Incentive Program in 2014 *only*. CMS and ONC state that they are providing this flexibility in response to concerns from vendors that they did not have sufficient time to update their products to meet the 2014 Edition EHR certification criteria, leaving providers with insufficient time to fully implement 2014 Edition Certified EHR Technology (CEHRT). The rule is effective on Oct. 1. Until that date, the CMS website cannot accept attestations that follow one of the optional pathways finalized in the rule, but can accept attestations under the previous rules. All hospitals have until Nov. 30 to complete their attestation to meaningful use, whether attesting under the previous rules or a new option.

For simplicity, this advisory uses “hospital” to refer to both eligible hospitals and CAHs, unless otherwise stated.

Prior to the release of the Aug. 29 final rule, to successfully attest to meaningful use, a hospital needed to:

- Use 2014 Edition CEHRT;
- Meet specific meaningful use functional objectives and measures (such as collecting demographic data or using computerized provider order entry); and
- Report specific quality measures generated by CEHRT.

Hospitals have entered the meaningful use program at different times and, therefore, have different requirements in 2014. Some were scheduled to meet Stage 1 requirements, while others were scheduled to meet more stringent Stage 2 requirements. The final rule provides options that will allow certain hospitals to change the stage they attest to in 2014.

CMS previously established a special 90-day reporting period for 2014 only. Specifically, for all hospitals in their first year of meaningful use, the 2014 reporting period is any continuous 90-day period in the federal fiscal year (Oct. 1, 2013 – Sept. 30, 2014). For all other hospitals, the reporting period must match any quarter of the federal fiscal year (Oct. – Dec. 2013, Jan. – March 2014, April – June 2014, or July – Sept. 2014). Hospitals have until Nov. 30 to attest to meaningful use for any quarter of the fiscal year, including the first quarter (Oct. 1, 2013 - Dec. 31, 2013). The program operates on a calendar year for EPs, and allows them to report on a calendar quarter of performance in 2014.

The AHA strongly advocated for changes in 2014 to allow a larger number of hospitals to attest to meaningful use, receive the promised incentive payments and avoid future penalties. This advisory summarizes key elements of the final rule for hospitals, including pathways for attestation in 2014, electronic quality reporting requirements, changes to the future meaningful use timeline, and changes to the Medicaid rules for 2014 *only*. This advisory also provides an overview of the rules for physicians and other EPs. We encourage members to reference our previous advisories on the Stage 1 and Stage 2 final rules for detailed information on the current and previous meaningful use requirements referred to below.

AT ISSUE

Under the final rule, hospitals now have the flexibility to choose the technology they use to meet meaningful use in fiscal year (FY) 2014. Hospitals are able to:

- Retain and use their 2011 Edition CEHRT;
- Use a combination of 2011 and 2014 Edition CEHRT; or
- Use 2014 Edition CEHRT (as previously required).

The rule finalizes, as proposed, 10 different combinations of EHR versions and requirements that could be used to meet meaningful use successfully in 2014. The final rule also outlines how the required reporting of electronic clinical quality measures (eCQMs) varies by the version of CEHRT used. The rule does not change any of the individual functional objectives and measures or eCQMs already finalized for Stage 1 or Stage 2. The newly finalized options apply to *both* the Medicare and Medicaid EHR Incentive Programs.

In addition, CMS and ONC will require that all hospitals that elect to take advantage of the alternative approaches also attest that "they are unable to fully implement 2014 Edition CEHRT for the EHR reporting period in 2014 because of issues related to 2014 Edition CEHRT availability delays." **The AHA is disappointed that CMS maintained this attestation requirement, which we recommended be removed. We encourage any hospital that takes advantage of the new flexibility to maintain documentation**

supporting its choice in case of future audit. Examples of specific issues are provided below.

The agencies state that, beginning in FY 2015, all eligible hospitals will be required to use 2014 Edition CEHRT to report meaningful use, consistent with previous rules. The reporting period will be 365 days for all hospitals except those in their first year of meaningful use, for whom the reporting period will be 90 days. **The AHA is concerned about the full-year reporting requirement for FY 2015 and is pursuing additional legislative and regulatory approaches to shortening it.**

Pathways to Attest in 2014

In the final rule, CMS and ONC codify their proposal that the version of CEHRT used will determine the functional objectives and measures that a hospital can meet, as well as the eCQMs reported. The final rule references three distinct sets of meaningful use objectives and measures (see Appendix 1):

- Stage 1 objectives and measures that were in place for 2013 (originally laid out in the Stage 1 rule and modified somewhat in the Stage 2 final rule);
- Stage 1 objectives and measures that were previously in place for 2014 (further modified in the Stage 2 final rule); and
- Stage 2 objectives and measures that were previously in place for 2014 and later.

Specifically, CMS and ONC state that:

- If using only 2011 Edition CEHRT, hospitals must meet the 2013 Stage 1 objectives and measures.
- If using a combination of 2011 and 2014 Edition CEHRT, hospitals may choose to meet the 2013 Stage 1 objectives and measures or the 2014 Stage 1 objectives and measures; or if they are scheduled to begin Stage 2 in 2014 under existing policy, they may choose to meet the Stage 2 objectives and associated measures.
- If using only 2014 Edition CEHRT, hospitals may choose to meet either the 2014 Stage 1 objectives and measures or the Stage 2 objectives and measures.

Taken together, these combinations of technology used and meaningful use objectives supported result in 10 pathways to meet meaningful use in 2014:

Table 1 below outlines the four options for hospitals that were previously scheduled to meet the **Stage 1** requirements in FY 2014 using 2014 Edition CEHRT, including the functional objectives and measures and eCQMs required for each.

Table 1: Pathways to Meaningful Use in 2014 for Hospitals that were Scheduled to Meet *Stage 1* Requirements in 2014

Requirements Using 2011 Edition CEHRT	Requirements Using 2011 and 2014 Edition CEHRT	Requirements Using 2014 Edition CEHRT
Option 1: • Attest to using a 2011 Edition Certified EHR • Meet 2013 Stage 1 functional objectives and measures • Report 15 eCQMs as required under the original Stage 1 rules	**Option 2:** • Attest to using a combination of 2011 and 2014 Edition Certified EHRs • Meet 2013 Stage 1 functional objectives and measures • Report 15 eCQMs as required under the original Stage 1 rules **Option 3:** • Attest to using a combination of 2011 and 2014 Edition Certified EHRs • Meet 2014 Stage 1 functional objectives and measures • Report 16 of 29 eCQMs as required under the Stage 2 final rule	**Option 4 (Previous Rules):** • Attest to using a 2014 Edition Certified EHR • Meet 2014 Stage 1 functional objectives and measures. • Report 16 of 29 eCQMs as required under the Stage 2 final rule

Note: *For simplicity, the AHA has numbered the options presented in the final rule. Any option other than Option 4 also will require hospitals to attest that they are not able to fully implement 2014 Edition CEHRT for a full reporting period in 2014 due to delays in 2014 Edition CEHRT. Hospitals in their first year of meaningful use may report on any 90-day period in FY 2014; all other hospitals report on a single quarter of performance during FY 2014.*

Table 2 below outlines the six options for hospitals that were previously scheduled to meet the **Stage 2** requirements in FY 2014 using 2014 Edition CEHRT, including the functional objectives and measures and eCQMs required for each.

Table 2: Pathways to Meaningful Use in 2014 for Hospitals that were Scheduled to Meet *Stage 2* Requirements in 2014

Requirements Using 2011 Edition CEHRT	Requirements Using 2011 & 2014 Edition CEHRT	Requirements Using 2014 Edition CEHRT
Option 5: • Attest to using a 2011 Edition Certified EHR • Meet 2013 Stage 1 functional objectives and measures • Report 15 eCQMs as required under the original Stage 1 rules	**Option 6:** • Attest to using a combination of 2011 and 2014 Edition Certified EHRs • Meet 2013 Stage 1 functional objectives and measures • Report 15 eCQMs as required under the original Stage 1 rules **Option 7:** • Attest to using a combination of 2011 and 2014 Edition Certified EHRs • Meet 2014 Stage 1 functional objectives and measures • Report 16 of 29 eCQMs as required under the Stage 2 final rule **Option 8:** • Attest to using a combination of 2011 and 2014 Edition Certified EHRs • Meet Stage 2 functional objectives and measures. • Report 16 of 29 eCQMs as required under the Stage 2 final rule	**Option 9:** • Attest to using a 2014 Edition Certified EHR • Meet 2014 Stage 1 functional objectives and measures • Report 16 of 29 eCQMs as required under the Stage 2 final rule **Option 10 (Previous Rules):** • Attest to using a 2014 Edition Certified EHR • Meet Stage 2 functional objectives and measures • Report 16 of 29 eCQMs as required under the Stage 2 final rule

Note: *For simplicity, the AHA has numbered the options presented in the final rule. Any option other than Option 10 also will require hospitals to attest that they are not able to fully implement 2014 Edition for a full reporting period in 2014. Hospitals in their first year of meaningful use may report on any 90-day period in FY 2014; all other hospitals report on a single quarter of performance during FY 2014.*

Electronic Quality Reporting Requirements in 2014

In the final rule, CMS and ONC state that the version of CEHRT used by a hospital to record, calculate and report the eCQM data will determine the choice of eCQMs available for reporting and the method of eCQM submission to CMS. The rule references two distinct sets of eCQMs (see Appendix 2):

- The 15 eCQMs that were laid out in the original Stage 1 final rule; and
- The 29 eCQMs (of which hospitals must report 16) that were described in the Stage 2 final rule.

CMS and ONC declined the AHA's request to provide greater flexibility in choosing which eCQMs to report based on individual hospital circumstances. CMS states that providers are already permitted to use a different reporting period for the eCQMs than for the objectives and measures of meaningful use under existing regulatory language (section 495.6). The finalized requirements, organized by the stage of meaningful use the provider would meet and the version of EHR technology used, are outlined below:

- Hospitals that select 2011 Edition CEHRT for the 2013 Stage 1 meaningful use reporting must gather data, calculate and report via attestation the 15 eCQMs from the original Stage 1 rule.
- Hospitals that select a combination of 2011 and 2014 Edition CEHRT for 2013 Stage 1 meaningful use reporting must gather data, calculate and report via attestation the 15 eCQMs from the original Stage 1 rule. Eligible hospitals may attest to data derived exclusively from the 2011 Edition for the portion of the reporting period for which the 2011 Edition EHR was in place. This provides an option for providers using combination 2011 and 2014 and attesting to 2013 Stage 1 to use 2011 edition CEHRT for the period of time within the 90-day reporting period in which the 2011 edition CEHRT was in place and report on eCQMs for that period of time although it may be less than 90 days of data.
- Hospitals that select a combination of 2011 and 2014 Edition CEHRT for 2014 Stage 1 or Stage 2 reporting must gather data, calculate and report 16 of 29 eCQMs, as required under the Stage 2 final rule, including the eCQM submission requirements contained in the Stage 2 final rule.
- Hospitals that select 2014 Edition CEHRT for 2014 Stage 1 or 2 reporting must gather data, calculate and report 16 of 29 eCQMs as required under the Stage 2 final rule, including the eCQM submission requirements contained in the Stage 2 final rule (as previously required).

Reporting Periods

For FY 2014, hospitals in their second or later year of meaningful use may report on any one of the following quarters:

- October – December 2013
- January – March 2014
- April – June 2014
- July – September 2014

For hospitals in their first year of meaningful use, the 2014 reporting period is any continuous 90-day period in the federal fiscal year.

Attestation Requirements

The attestation deadline for FY 2014 is Nov. 30 for hospitals, which is 60 days after the close of the federal fiscal year. Hospitals have until then to attest to meeting meaningful use for any reporting period, including the first quarter (Oct. 1, 2013 - Dec. 31, 2013). Hospitals that have already attested for FY 2014 do not have to re-attest.

All hospitals that select one of the new pathways for attesting to meaningful use also must attest that "they are unable to fully implement 2014 Edition CEHRT for the EHR reporting period in 2014 because of issues related to 2014 Edition CEHRT availability delays." Further, the agencies "stress the delay in 2014 Edition CEHRT availability must be attributable to the issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor which affected 2014 CEHRT availability, which then results in the inability for a provider to fully implement 2014 Edition CEHRT."

In response to concerns about this requirement raised by the AHA and others, the agencies made clear that challenges with installing software patches, completing training and fully implementing workflow changes all count as reasons for not being able to fully implement the technology. In the preamble to the rule, they also make clear that, if a provider has fully implemented the 2014 Edition CEHRT but cannot find enough other providers capable of receiving a summary of care document to meet the transitions of care objective, they may take advantage of the flexibility, but must document their situation.

The rule also outlines certain circumstances that do not meet the requirement, such as financial issues, staff changes and turnovers, situations stemming from provider inaction or delay in implementing 2014 Edition CEHRT, and problems meeting specific objectives and measures of meaningful use, with the exception of transitions of care.

If a hospital selects one of the new options, no documentation will be needed at the time of attestation. but the documentation must be kept for at least six years in case of future audit. The agencies state that they will carefully instruct auditors about this provision.

The AHA is disappointed that CMS maintained this attestation requirement, which we recommended be removed. We encourage any hospital that takes advantage of the flexibility to maintain documentation of why they were unable to fully implement 2014 Edition CEHRT for the reporting period.

Attestation Process

The final rule details how a hospital will attest using the optional pathways, once the rule is effective on Oct. 1. The agencies expect the attestation process to be as follows:

- Hospital staff will first go to the ONC Certified Health IT Product List (CHPL) to identify the certified Complete EHR(s) or certified EHR Module(s) they used for the EHR reporting period in 2014. This can be 2011 Edition CEHRT, 2014 Edition CEHRT or a combination of the two.

- The ONC CHPL website will provide a "CMS EHR Certification ID" number that the hospital will use in the attestation process.

- Hospital staff will then go to the CMS registration and attestation website and provide the CMS EHR Certification ID number.

- The CMS website will then interpret the number to identify the mix of CEHRT used (2011 Edition, 2014 Edition or both). Based on that designation, the website will lead the hospital staff through the options available based on both the stage the hospital was scheduled to be at in 2014 and the mix of CEHRT used.

The agencies remind hospitals that they must retain all relevant supporting documentation for all aspects of their meaningful use attestation for six years in case of audit. Documentation to support payment calculations (such as cost report data) should follow existing document retention processes.

Interaction with FY 2015 Payment Penalties

Under provisions finalized in the Stage 2 rules, hospitals paid under the inpatient prospective payment system (PPS) are subject to penalties beginning in FY 2015 if they failed to meet meaningful use in a prior period. For FY 2015, the reporting period was FY 2013. However, special provisions were made for hospitals that first attested in FY 2014. Specifically, if those hospitals successfully attested by July 1, 2014 they could avoid the FY 2015 penalty. The final rule impacts penalties as follows:

- All inpatient PPS hospitals also were able to seek a hardship exception for the FY 2015 penalty, but applications were due on April 1, 2014. Any hospitals that received a hardship exception can still attest using the new pathways, and will receive both an incentive payment and protection from the FY 2015 payment penalty.

- If an inpatient PPS hospital successfully attests to meaningful use *for the first time* in FY 2014, but did not do so by July 1, that hospital will receive an incentive

payment in FY 2014, but will not be protected from a payment penalty in FY 2015, unless a hardship exception was granted.

- Inpatient PPS hospitals that successfully attest in FY 2014 will be protected from penalties in FY 2016.

- Payment penalties for critical access hospitals also begin in FY 2015. However, they are based on performance in the same fiscal year, and are not affected by performance in FY 2013 or FY 2014.

Looking forward, hospitals must continue to attest every year in order to avoid future payment penalties.

Changes to the Meaningful Use Timeline

Hospitals that were scheduled to begin Stage 2 in FY 2014, but instead chose to meet the Stage 1 criteria, will be required to begin Stage 2 in 2015, per current rules.

CMS also finalized an extension of Stage 2 into FY 2016. While this implies that Stage 3 will begin in FY 2017, there is no regulatory language to that effect. CMS has stated its intention to propose Stage 3 regulations that will address timing and requirements this winter.

The table below reflects the new timeline for the program (changes in bold).

Table 3: Stages of Meaningful Use by First Payment Year

First Payment Year	2011	2012	2013	2014	2015	2016	2017	2018
2011	1	1	1	**1 OR 2**	2	**2**	3	3
2012		1	1	**1 OR 2**	2	**2**	3	3
2013			1	1	2	2	3	3
2014				1	1	2	2	3

Medicaid Definition of "Adopt, Implement or Upgrade"

Under current rules, hospitals and EPs may receive an initial incentive payment under the Medicaid program to support their EHR adoption. In the first year of adoption only, hospitals and EPs are not required to meet meaningful use, but must show proof that they are working to adopt, implement or upgrade their EHRs. The agencies finalized their proposal to revise the definition of "adopt, implement or upgrade" to specify that, in 2014 and later, a provider must be working toward adoption, implementation or upgrade to 2014 Edition CEHRT to receive the first year Medicaid payment, and maintain documentation, as required by their state Medicaid program. The agencies stated that this requirement will ensure that hospitals and EPs invest in technology to support future attainment of meaningful use.

Provisions Affecting Physician and Other EPs

In general, the final rule affects physicians and other EPs in a manner analogous to hospitals. However, EPs report meaningful use for a calendar year (CY), and not a fiscal year. Thus, the rule affects CY 2014 meaningful use requirements for EPs.

The 10 options of technology used and stage of meaningful use laid out in Tables 1 and 2 apply equally to EPs and hospitals. However, the specific meaningful use and quality reporting requirements differ for EPs. While they follow the same pattern of tying the set of measures required for reporting to the technology chosen and the stage of meaningful use, the specific measures are different. More information on eCQMs for EPs can be found in the AHA's advisories on Stage 1 and Stage 2 final rules.

NEXT STEPS

Share this advisory with your senior management team. Ask your chief information officer and quality officer to determine how the options in the final rule will affect your hospital's approach to meeting meaningful use for FY 2014. Check with your EHR vendor to determine how it will support you under the options that will work for your institution.

The AHA encourages members to consult the additional educational materials available on the CMS website. Resources are also available at www.aha.org/meaningfuluse.

FURTHER QUESTIONS

If you have questions or comments about the final rule, please contact Chantal Worzala, AHA director of policy, at (202) 626-2313 or cworzala@aha.org.

Appendix 1: Functional Objectives of Meaningful Use Required for Hospitals, by Stage

2013 Stage 1 Objectives	2014 Stage 1 Objectives	Stage 2 Objectives
Core Set (Meet All): • CPOE for medications • Drug-drug/drug-allergy checks • Record demographics • Structured problem list • Structured medication list • Structured medication allergy list • Record and chart changes in vital signs • Record smoking status • 1 clinical decision support rule • Electronic health info to patients • Electronic copy of discharge instructions • Test capability to exchange key clinical information • Protect electronic health information **Menu Set (Meet 5 of 10, including at least one public health measure):** • Drug-formulary checks • Record advanced directives • Incorporate structured clinical-lab data • Generate patient lists by condition • Identify patient-specific education resources	**Core Set (Meet All):** • CPOE for medications • Drug-drug/drug-allergy checks • Record demographics • Structured problem list • Structured medication list • Structured medication allergy list • Record and chart changes in vital signs • Record smoking status • 1 clinical decision support rule • *Patient portal with ability to view, download and transmit information about an admission (ED and inpatient)* • Electronic copy of discharge instructions • Protect electronic health information **Menu Set (Meet 5 of 10, including at least one public health measure):** • Drug-formulary checks • Record advanced directives • Incorporate structured clinical-lab data • Generate patient lists by condition • Identify patient-specific education resources	**Core Set (Meet All):** • CPOE for medication, lab and radiology orders • Record demographics • Record and chart changes in vital signs • Record smoking status • 5 clinical decision support rules in addition to drug-drug and drug-allergy checks • Incorporate structured clinical-lab data • Generate patient lists by condition • Electronic medication administration record (eMAR) • Patient portal with ability to view, download and transmit information about an admission (ED and inpatient) • Identify patient-specific education resources • Medication reconciliation • Send summary of care record for transitions of care (ED and inpatient) • Send immunization data to public health • Send reportable lab results to public health • Send syndromic surveillance data to public health • Perform security risk

• Medication reconciliation • Summary care record transitioned or referred patients • Submit data to immunization registries (public health) • Submit lab results to public health • Submit syndromic surveillance data to public health	• Medication reconciliation • Summary care record transitioned or referred patients • Submit data to immunization registries (public health) • Submit lab results to public health • Submit syndromic surveillance data to public health	analysis **Menu Set (Meet 3 of 6):** • Advance directive • Imaging results accessible in EHR • Record patient family health history • E-prescribe discharge medications • Record clinical notes in EHR • Send lab data to ambulatory settings

Note: *More detail on the specific functional requirements for each stage of meaningful use can be found in the AHA's regulatory advisories on the Stage 1 and Stage 2 final rules. Hospitals must also report electronic clinical quality measures (eCQMs) to meet meaningful use (see Appendix 2). Additional educational materials are also available at the CMS website.*

Appendix 2: Electronic Clinical Quality Measures

The rule references two distinct sets of eCQMs, which are listed in the tables below.

Table A: Electronic Clinical Quality Measures from the Original Stage 1 Final Rule

NQF Number	Measure Title
0495	Emergency Department Throughput: Median time from ED arrival to ED departure for admitted patients
0497	ED Throughput: Admission decision time to ED departure time for admitted patients
0435	Stroke-2 Ischemic stroke –Discharged on anti-thrombotic therapy
0436	Stroke-3 Ischemic stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter
0437	Stroke-4 Ischemic stroke –Thrombolytic therapy for patients arriving within 2 hours of symptom onset
0438	Stroke-5 Ischemic stroke – Antithrombotic therapy by end of hospital day two
0439	Stroke-6 Ischemic stroke –Discharged on Statin Medication
0440	Stroke-8 Ischemic or hemorrhagic stroke – Stroke education
0441	Stroke-10 Ischemic or hemorrhagic stroke – Assessed for rehabilitation
0371	Venous Thromboembolism (VTE)-1 VTE prophylaxis within 24 hours of arrival
0372	VTE-2 Intensive Care Unit (ICU) VTE prophylaxis
0373	VTE-3 VTE Patients with Overlap of Anticoagulation Therapy
0374	VTE-4 VTE Patients Unfractionated Heparin (UFH) Dosages/Platelet Count Monitoring by Protocol (or Nomogram) Receiving Unfractionated Heparin (UFH) with Dosages/ Platelet Count Monitored by Protocol (or Nomogram)
0375	VTE-5 VTE discharge instructions
0376	Incidence of potentially preventable VTE

Table B: Electronic Clinical Quality Measures from the Stage 2 Final Rule

NQF Number	Measure Title
0495	Emergency Department (ED) – Median time from ED arrival to ED departure for admitted ED patients
0497	ED Throughput – Admit decision time to ED departure time for admitted patients
0440	Stroke – Education
0375	Venous Thromboembolism (VTE) – Discharge Instructions
0338	Home Management Plan of Care (HMPC) document given to patient/caregiver
0435	Stroke – Discharged on anti-thrombotic therapy
0436	Stroke – Anticoagulation therapy for Atrial Fibrillation/Flutter
0437	Stroke – Thrombolytic Therapy
0438	Stroke – Antithrombotic therapy by end of hospital day two
0439	Stroke – Discharged on Statin Medication
0373	VTE – Patients with Anticoagulation Overlap Therapy
0374	VTE – Patients receiving unfractionated heparin (UFH) with dosages/platelet count by Protocol (or Nomogram)
0142	Acute myocardial infarction (AMI) – Aspirin prescribed at discharge for AMI
0469	PC – Elective delivery prior to 39 completed weeks gestation
0164	AMI – Fibrinolytic Therapy received within 30 minutes of hospital arrival
0163	AMI – Primary PCI received within 90 minutes of hospital arrival
0639	AMI – Statin prescribed at discharge
0480	Exclusive Breast Milk Feeding
1354	EHDI – Hearing screening prior to hospital discharge
0441	Stroke – Ischemic or hemorrhagic stroke – assessed for rehabilitation
0496	ED – Median time from ED arrival to ED departure for discharged ED patients
0371	VTE- VTE prophylaxis
0372	VTE – Intensive Care Unit (ICU) Vte prophylaxis
0376	VTE – Incidence of potentially preventable VTE
0527	SCIP-INF – Prophylactic antibiotic received within 1 hour prior to surgical incision
0453	SCIP-INF – Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2)
0716	Healthy Term Newborn
0147	PN – Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients
0528	SCIP-INF – Prophylactic antibiotic selection for surgical patients