Quality Reporting Under Meaningful Use Stage 2

Crystal Kallem, Director of Business Analysis & Policy
Lantana Consulting Group
CDA, CCD, HL7, and Health Level Seven
are registered trademarks of
Health Level Seven International
Registered in U.S. Patent and Trademark Office
Crystal Kallem, RHIA, CPHQ
Director, Business Analysis & Policy
Lantana Consulting Group
• CDA Academy Faculty
• Leads Lantana’s Policy Center of Excellence
• Directs multiple client projects on healthcare quality
• Co-chair, HL7 Clinical Quality Information Work Group
Lantana Consulting Group

Mission: Information driven healthcare

Staff of 35, 26 consultants

• Interoperability experts
  – Over two dozen standards developed, including key requirements in Meaningful Use
  – Services include quality reporting, implementation, standards development, architecture, strategy, compliance and certification, terminology, and training
  – Clients include startups, Fortune 100 companies, public and private organizations
Outline

• Quality Reporting in Meaningful Use Stage 2
• Standards for Quality Reporting
• Putting it all Together
• Tools and Resources
• Questions
Standards Are a Prerequisite to Functionality

“If you cannot measure it, you cannot improve it.”
Lord Kelvin (1824-1907)

“If you cannot standardize it, you cannot measure it.”
QUALITY REPORTING IN MEANINGFUL USE STAGE 2
CDA in Meaningful Use  
Stage 2 (MU2)

<table>
<thead>
<tr>
<th>§ 170.205</th>
<th>Content exchange standards and implementation specifications for exchanging electronic health information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>170.205(a)(3)</td>
<td><strong>Consolidated CDA (C-CDA):</strong> Standardized representation of the Consult Note, Diagnostic Imaging Report, Discharge Summary, History and Physical, Operative Note, Procedure Note, Progress Note, and Continuity of Care Document (CCD).</td>
</tr>
<tr>
<td>170.205(h)</td>
<td><strong>CDA Guide for Quality Reporting Document Architecture, Category I (QRDA-I):</strong> Standardized representation of quality data for an individual patient. Data in a QRDA-I report can be consumed by a calculation engine to determine if the patient met the numerator or denominator criteria for a given quality measure.</td>
</tr>
<tr>
<td>170.205(i)</td>
<td><strong>CDA Guide for Reporting to Central Cancer Registries:</strong> Standardized cancer registry reporting format.</td>
</tr>
<tr>
<td>170.205(k)</td>
<td><strong>CDA Guide for Quality Reporting Document Architecture, Category III (QRDA-III):</strong> Standardized representation of aggregate quality data (e.g. number of patients meeting the numerator criteria for a given quality measure).</td>
</tr>
</tbody>
</table>
Quality Reporting in Meaningful Use Stage 2 (MU2)

<table>
<thead>
<tr>
<th>§ 170.314(c) Clinical Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Clinical quality measures—capture and export</td>
</tr>
<tr>
<td>(i) Capture</td>
</tr>
<tr>
<td>For each and every CQM for which the EHR technology is presented for certification, EHR technology must be able to electronically record all of the data identified in the standard specified at § 170.204(c) that would be necessary to calculate each CQM. Data required for CQM exclusions or exceptions must be codified entries, which may include specific terms as defined by each CQM, or may include codified expressions of “patient reason,” “system reason,” or “medical reason.”</td>
</tr>
<tr>
<td>(ii) Export</td>
</tr>
<tr>
<td>EHR technology must be able to electronically export a data file formatted in accordance with the standards specified at § 170.205(h) that includes all of the data captured for each and every CQM to which EHR technology was certified under paragraph (c)(1)(i) of this section.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) Clinical quality measures—import and calculate</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Import</td>
</tr>
<tr>
<td>EHR technology must be able to electronically import a data file formatted in accordance with the standard specified at § 170.205(h) and use such data to perform the capability specified in paragraph (c)(2)(ii) of this section. EHR technology presented for certification to all three of the certification criteria adopted in paragraphs (c)(1) through (3) of this section is not required to meet paragraph (c)(2)(i).</td>
</tr>
<tr>
<td>(ii) Calculate</td>
</tr>
<tr>
<td>EHR technology must be able to electronically calculate each and every clinical quality measure for which it is presented for certification.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) Clinical quality measures—electronic submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enable a user to electronically create a data file for transmission of clinical quality measurement data: (i) In accordance with the standards specified at § 170.205(h) and (k); and (ii) That can be electronically accepted by CMS.</td>
</tr>
</tbody>
</table>
Quality Reporting in MU2

Data capture

- Patient data
  - EHR
  - Other systems

Data export

- Individual quality report(s)

Data calculation

- Calculation engine

Data report

- Aggregate quality report

Other systems inform eMeasure, which in turn informs EHR and aggregate quality report.
RELATIONSHIPS BETWEEN QUALITY REPORTING AND STANDARDS
Quality Reporting Lifecycle
National Quality Forum

- NQF is a non-profit, nonpartisan, public service organization
- Reviews, endorses, and recommends use of standardized healthcare performance measures
- Works with NQF members and the public to define national healthcare improvement “to-do” lists, and encourage action and collaboration to accomplish quality improvement goals
- www.qualityforum.org
HEALTH LEVEL SEVEN INTERNATIONAL

- Heath Level Seven (HL7) is an ANSI-accredited Standards Developing Organization (SDO) operating in healthcare arena
- Not-for-profit organization made up of volunteers – providers, payers, vendors, government
- Provides standards for data exchange to allow interoperability between healthcare information systems
- HL7 focuses on the clinical and administrative data domains
- Key goal is syntactic and semantic interoperability
- Home of CDA, CCD, Consolidated CDA, QRDA, HQMF
- www.hl7.org
Quality Reporting Standards

• National Quality Forum (NQF)
  – Quality Data Model (QDM)

• Health Level Seven International (HL7)
  – Clinical Document Architecture (CDA)
    ▪ Quality Reporting Document Architecture (QRDA) Category I
    ▪ QRDA Category III
  – Health Quality Measure Format (HQMF/eMeasure)
Data Capture: Quality Data Model

- A model of information used to express patient, clinical, and community characteristics as well as basic logic required to express quality measure criteria.
- Describes the data elements and the states (or contexts) in which data elements are expected to exist in clinical information systems.
- QDM is a “domain analysis model”
- HL7 has implemented QDM in eMeasure and QRDA
QDM Composition

Category
Diagnosis Study, Laboratory Test, Medication

Datatype
Diagnostic Study, performed
Laboratory Test, order
Medication, administered

Attributes
Diagnostic Study, performed (method)
Laboratory test, order (reason)
Medication, administered (dose)

National Quality Forum: Quality Data Model December 2012
http://www.qualityforum.org/QualityDataModel.aspx#t=2&s=&p=3%7C
## QDM Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care goal</td>
<td>Laboratory Test</td>
</tr>
<tr>
<td>Individual Characteristics</td>
<td>Medication</td>
</tr>
<tr>
<td>Communication</td>
<td>Physical Examination</td>
</tr>
<tr>
<td>Condition/Diagnosis/Problem</td>
<td>Procedure</td>
</tr>
<tr>
<td>Device</td>
<td>Risk Category/Assessment</td>
</tr>
<tr>
<td>Diagnostic Study</td>
<td>Substance</td>
</tr>
<tr>
<td>Encounter</td>
<td>Symptom</td>
</tr>
<tr>
<td>Experience</td>
<td>System Characteristics</td>
</tr>
<tr>
<td>Functional Status</td>
<td>Transfer of Care</td>
</tr>
<tr>
<td>Intervention</td>
<td></td>
</tr>
</tbody>
</table>
Calculate: HQMF(eMeasure)

• HQMF
  – The first international standard for the formal representation of clinical quality measure as an electronic document (including metadata, data elements, and logic)
  – An HL7 Draft Standard for Trial Use (DSTU) since 2009 (Release 1)
  – Release 2 will be published soon
  – Provides for quality measure consistency and unambiguous interpretation
  – Describes the syntax, but doesn’t tell you what data is needed and how it should be constructed for a quality measure

• eMeasure
  – A quality measure encoded in HQMF format
<table>
<thead>
<tr>
<th>eMeasure Title</th>
<th>Anticoagulation Therapy for Atrial Fibrillation/Flutter</th>
</tr>
</thead>
<tbody>
<tr>
<td>eMeasure Identifier</td>
<td>71</td>
</tr>
<tr>
<td>(Measure Authoring Tool)</td>
<td>eMeasure Version number 3</td>
</tr>
<tr>
<td>NQF Number</td>
<td>0436</td>
</tr>
<tr>
<td>GUID</td>
<td>03B76d69-085b-415c-ae9d-9924171040c2</td>
</tr>
<tr>
<td>Measurement Period</td>
<td>January 1, 20xx through December 31, 20xx</td>
</tr>
<tr>
<td>Measure Steward</td>
<td>The Joint Commission</td>
</tr>
<tr>
<td>Measure Developer</td>
<td>The Joint Commission</td>
</tr>
<tr>
<td>Endorsed By</td>
<td>National Quality Forum</td>
</tr>
<tr>
<td>Description</td>
<td>Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.</td>
</tr>
<tr>
<td>Copyright</td>
<td>Measure specifications are in the Public Domain.</td>
</tr>
<tr>
<td>LSNOR(R) is a registered trademark of the Regenstrief Institute.</td>
<td></td>
</tr>
<tr>
<td>Disclaimer</td>
<td>This material contains SNOMED Clinical Terms(R) (SNOMED CT(c)) copyright 2004-2010 International Health Terminology Standards Development Organization. All rights reserved.</td>
</tr>
<tr>
<td>Measure Scoring</td>
<td>Proportion</td>
</tr>
<tr>
<td>Measure Type</td>
<td>Process</td>
</tr>
<tr>
<td>Stratification</td>
<td>None</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>None</td>
</tr>
<tr>
<td>Rate Aggregation</td>
<td>None</td>
</tr>
<tr>
<td>Rationale</td>
<td>Nonvalvular atrial fibrillation (NVAF) is a common arrhythmia and an important risk factor for stroke. It is one of several conditions and lifestyle factors that have been identified as risk factors for stroke. It has been estimated that over 2 million adults in the United States have NVAF. While the median age of patients with atrial fibrillation is 75 years, the incidence increases with advancing age. For example, the Framingham Heart Study noted a dramatic increase in stroke risk associated with atrial fibrillation with advancing age, from 1.5% for those 50 to 59 years of age to 23.5% for those 60 to 99 years of age. Furthermore, a prior stroke or transient ischemic attack (TIA) are among a limited number of predictors of high stroke risk within the population of patients with atrial fibrillation. Therefore, much emphasis has been placed on identifying methods for preventing recurrent ischemic stroke as well as preventing first stroke. Prevention strategies focus on the modifiable risk factors such as hypertension, smoking, and atrial fibrillation. Analysis of five placebo-controlled clinical trials investigating the efficacy of warfarin in the primary prevention of thromboembolic stroke, found the relative risk of thromboembolic stroke was reduced by 66% for atrial fibrillation patients treated with warfarin. The administration of anticoagulation therapy, unless there are contraindications, is an established effective strategy in preventing recurrent stroke in high risk atrial fibrillation patients with TIA or prior stroke.</td>
</tr>
<tr>
<td>Clinical Recommendation Statement</td>
<td>The administration of anticoagulation therapy, unless there are contraindications, is an established effective strategy in preventing recurrent stroke in high risk atrial fibrillation patients with TIA or prior stroke.</td>
</tr>
<tr>
<td>Improvement Notation</td>
<td>An increase in rate</td>
</tr>
</tbody>
</table>
Human-readable Example: eMeasure Population Criteria

Population criteria

- **Initial Patient Population**
  - AND: "Patient Characteristic: Birthdate: birth date" >= 18 year(s) starts before start of "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
  - AND: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (length of stay <= 150 day(s))"
  - AND: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (discharge datetime)" during "Measurement Period"
  - OR: "Diagnosis, Active: Ischemic Stroke (ordinality: 'Principal Diagnosis')"
  - OR: "Diagnosis, Active: Hemorrhagic Stroke (ordinality: 'Principal Diagnosis')"
  - OR: "Diagnosis, Active: Stroke (ordinality: 'Principal Diagnosis')"
  - OR: "Diagnosis, Active: Stroke - Other (ordinality: 'Principal Diagnosis')"
  - OR: "Diagnosis, Active: Stroke - Other (ordinality: 'Principal Diagnosis')"

- **Denominator**
  - AND: "Initial Patient Population"
  - AND: "Diagnosis, Active: Ischemic Stroke (ordinality: 'Principal Diagnosis')" starts during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
  - OR: "Procedure, Performed: Atrial Ablation" starts before start of "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
  - OR: "Diagnosis, Active: Atrial Fibrillation/Flutter" starts before or during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
  - OR: "Diagnosis, Inactive: Atrial Fibrillation/Flutter" starts before or during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"

- **Denominator Exclusions**
  - AND: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (discharge status: 'Patient Expired')"
  - OR: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (discharge status: 'Discharge To Another Hospital')"
  - OR: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (discharge status: Discharged to Health Care Facility for Hospice Care)"
  - OR: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (discharge status: Discharged to Home for Hospice Care)"
  - OR: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (discharge status: 'Left Against Medical Advice')"
  - OR: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (admission datetime) <= 1 hour(s) after start of "Occurrence A of Encounter, Performed: Emergency Department Visit (facility location departure datetime)"
    - AND:
      - OR: "Occurrence A of Intervention, Order: Palliative Care" starts after start of "Occurrence A of Encounter, Performed: Emergency Department Visit (facility location arrival datetime)"
      - OR: "Occurrence A of Intervention, Order: Palliative Care" starts before or during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"

- **Numerator**
  - AND: "Medication, Discharge: Anticoagulant Therapy" during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"

- **Denominator Exceptions**
  - AND:
    - OR: "Medication, Discharge not done: Medical Reason" for "Anticoagulant Therapy Reference Value Set"
    - OR: "Medication, Discharge not done: Patient Refusal" for "Anticoagulant Therapy Reference Value Set"
    - OR: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
What is QRDA?

QRDA is a Clinical Document Architecture (CDA)-based standard for reporting patient quality data for one or more quality measures:

- **QRDA Category I (Single-patient Report)**
  Individual patient-level report containing data defined in the measure

- **QRDA Category II (Patient List Report)**
  Multi-patient report across a defined population that may or may not identify individual patient data within the summary

- **QRDA Category III (Calculated Report)**
  Aggregate quality report with a result for a given population and period of time

*Not a DSTU*
QRDA is a Type of Templated CDA

QRDA is a CDA-based implementation guide (IG) that contains those data elements needed for quality measurement.

QRDA Category I

Continuity of Care Document (CCD)

Constraints for reporting

Constraints for CCD

Base CDA Specification
Export: QDM-Based QRDA Category I

- Individual patient-level report containing data defined in an electronic clinical quality measure
- Clinical measureable parameters are assembled into quality measures, which are then expressible as eMeasures.
- eMeasures guide the collection of EHR and other data, which are then assembled into QRDA quality reports and submitted to quality organizations.
- While there is no prerequisite that a QRDA document must be generated based on an eMeasure, the QDM-based QRDA Category I specification is written to tightly align with HQMF and the QDM.

QRDA Category I was published July 2012 and is required in MU2 (§ 170.205(h)).
QDM-based QRDA Category I

- The eMeasures guide the collection of electronic health record (EHR) data, which are then assembled into QDM-based QRDA quality reports and submitted to quality or other organizations.

- The QDM-based QRDA standard tightly aligns with National Quality Forum (NQF)-endorsed quality measures using Health Quality Measures Format (HQMF).
  - Does not provide QRDA templates for each eMeasure
  - Describes how to construct a QDM-based QRDA instance for any QDM-based eMeasure.
Report: QRDA Category III

- An aggregate quality report that contains calculated summary data for one or more measures for a specified population of patients within a particular health system over a specific period of time.
- Communicates data residing in health information systems that are stripped of all patient identifiers, protecting patients and healthcare providers from the risks of inadvertent leakage of private information.

Category III was published November 2012 and is required in MU2 (§ 170.205(k)).
Sample QRDA Category III Report

Table of Contents

- Reporting Parameters
- Measure Section

Reporting Parameters

- Reporting period: 01 January 2012 - 31 March 2012
- First encounter: 05 January 2012
- Last encounter: 24 March 2012

Measure Section

<table>
<thead>
<tr>
<th>eMeasure Title</th>
<th>Version neutral identifier</th>
<th>eMeasure Version Number</th>
<th>NQF eMeasure Identifier (MAT)</th>
<th>eMeasure Identifier</th>
<th>Version specific identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulation Therapy for Atrial Fibrillation/Flutter</td>
<td>038758f0-058b-415c-ae9d-062417104062</td>
<td>1</td>
<td>0436</td>
<td>71</td>
<td>8a4df2b3-3807-5df3-0139-04136c87324a</td>
</tr>
</tbody>
</table>

Member of Measure Set: Clinical Quality Measure Set 2011-2012 - b6ac13e2-bed6-4e4f-54ed-fcc397406c88

- Performance Rate: 83% (Predicted = 62%)
- Reporting Rate: 94%
- Initial Patient Population: 1000
  - Male: 460
  - Female: 540
  - Not Hispanic or Latino: 250
  - Hispanic or Latino: 550
  - White: 330
  - Asian: 350
  - Payer - Medicare: 100
  - Payer - Medicaid: 550
  - Zipcode 92543: 15

- Denominator: 500
  - Male: 260
  - Female: 300
  - Not Hispanic or Latino: 150
  - Hispanic or Latino: 350
  - Black: 150
  - White: 150
  - Asian: 150
  - Payer - Medicare: 125
  - Payer - Medicaid: 275
  - Zipcode 92543: 15

- Numerator: 400 (predicted = 300)
  - Male: 150
  - Female: 250
  - Not Hispanic or Latino: 100
  - Hispanic or Latino: 300
  - Black: 100
  - White: 150
  - Asian: 150
  - Payer - Medicare: 100
  - Payer - Medicaid: 220
  - Zipcode 92543: 15

- Denominator Exclusions: 20
  - Male: 8
PUTTING IT ALL TOGETHER
MU2 and Quality Reporting

- Patient data
- Other systems

Patient data

EHR

Individual quality report(s)

Calculation engine

Aggregate quality report

- Informs

eMeasure (HQMF)

- Informs

data capture

- Defined by QDM

Export

- QRDA Category I Reports

Calculate

- eMeasures (HQMF)

Report

- QRDA Category III Reports
Local Electronic Health Record (EHR)  

National Meaningful Use Stage 2 (MU2)  

Clinical reuse  

Decision support  

Secondary use  

Quality reporting  

Big-picture View
Beyond Meaningful Use

While considerable effort has gone into defining end-to-end quality reporting processes and technology for Meaningful Use, these efforts will fall short without:

- A common approach to quality measurement and reporting
- Alignment of quality measurement with decision support and transitions of care
- Patient engagement in quality measurement and improvement
TOOLS AND RESOURCES
CMS eCQM Library

eCQM Library

Annual Updates
In the final rule for Stage 2 of Meaningful Use (MU), CMS outlined the timeline for reviewing and publishing updates to the Clinical Quality Measures (CQMs) specifications used in the EHR Incentive Program. CMS determined that the specifications should be updated more frequently than the rulemaking cycle for the EHR Incentive Program in order to ensure that specifications maintain alignment with current clinical guidelines and ensure that the CQM remains relevant and actionable within the clinical care setting.

CMS strongly encourages the implementation and use of the updates to the electronic specifications of the CQMs finalized in the Stage 2 rule since those updates include new codes and logic corrections and clarifications. However, CMS will accept all versions of the CQMs for MU, beginning with those finalized in the December 4, 2012 CMS-OIG: Interim Final Rule and including all annual updates until the Stage 3 rulemaking and the establishment of a new edition of certification criteria for EHR technology.

Timeline:
- December 2012 – Interim Final Rule and eCQM Publication.
- Publication of finalized specifications for 2014 CQMs for use in the Medicare and Medicaid EHR Incentive Program by both eligible professionals and eligible hospitals. These are the specifications which represent the minimum requirement for a system to receive certification for the EHR Incentive Program.
- April 2013 – Annual Update for Eligible Hospital Electronic Specifications.
- June 2013 – Annual Update for Eligible Professional Electronic Specifications.

2014 CQM EQ

- [2014 CQMs for Eligible Professionals](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html)
- eSpec Navigator
- Value Set Authority Center [National Library of Medicine]
# NLM Value Set Authority Center

The NLM Value Set Authority Center provides a repository for various value sets, including medications, diagnoses, and other clinical metrics. The platform allows users to search for specific value sets using parameters such as CMS eMeasure (NQF Number), Quality Data Model Category, Value Set Developer, Meaningful Use Measures, and Code System. The search results can be filtered and sorted to find the desired value sets.

## Search Results

### Matched Value Sets

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Code System</th>
<th>Developer</th>
<th>OID</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE inhibitor or ARB</td>
<td>Extensional</td>
<td>RXNORM</td>
<td>AMA-PCPI</td>
<td>2.16.840.1.113883.3.526.2.39</td>
</tr>
<tr>
<td>ACE inhibitor or ARB</td>
<td>Grouping</td>
<td>RXNORM</td>
<td>AMA-PCPI</td>
<td>2.16.840.1.113883.3.526.3.1139</td>
</tr>
<tr>
<td>ADHD Medications</td>
<td>Grouping</td>
<td>RXNORM</td>
<td>NCQA</td>
<td>2.16.840.1.113883.3.464.1003.196</td>
</tr>
<tr>
<td>ADHD Medications</td>
<td>Extensional</td>
<td>RXNORM</td>
<td>NCQA</td>
<td>2.16.840.1.113883.3.464.1003.196</td>
</tr>
<tr>
<td>AMI</td>
<td>Grouping</td>
<td>ICD10CM</td>
<td>OFMQ</td>
<td>2.16.840.1.113883.3.117.7.1.833</td>
</tr>
<tr>
<td>AMI ICD-10</td>
<td>Extensional</td>
<td>ICD10CM</td>
<td>OFMQ</td>
<td>2.16.840.1.113883.3.117.7.1.833</td>
</tr>
<tr>
<td>AMI ICD-9</td>
<td>Extensional</td>
<td>ICD9CM</td>
<td>OFMQ</td>
<td>2.16.840.1.113883.3.117.7.1.827</td>
</tr>
<tr>
<td>Abnormal f/u codes hcpcs</td>
<td>Extensional</td>
<td>HCPCS</td>
<td>QIP</td>
<td>2.16.840.1.113883.3.600.1.1519</td>
</tr>
<tr>
<td>Above Normal Follow-up</td>
<td>Grouping</td>
<td>CPT HCPCS</td>
<td>QIP</td>
<td>2.16.840.1.113883.3.600.1.1525</td>
</tr>
<tr>
<td>Above Normal Medications</td>
<td>Extensional</td>
<td>RXNORM</td>
<td>QIP</td>
<td>2.16.840.1.113883.3.600.1.1498</td>
</tr>
<tr>
<td>Above Normal Referrals</td>
<td>Grouping</td>
<td>SNOMEDCT</td>
<td>QIP</td>
<td>2.16.840.1.113883.3.600.1.1527</td>
</tr>
</tbody>
</table>

Guide to Reading EP and EH eMeasures

- Overview of eMeasure Components
- eMeasure File Naming Conventions
- Downloading and Opening eMeasure Documents
- Understanding an eMeasure Human-readable Rendition
- Data Criteria (QDM Data Elements)
- Population Criteria
- Reporting Stratification
- Supplemental Data Elements
- Measure Observations
- Value Sets

Welcome to the ONC Project Tracking System (JIRA)

The Office of the National Coordinator maintains this system to provide a collaborative environment for the healthcare industry to implement meaningful use requirements. Here you will find links to the projects, as well as other useful information relative to the topics being discussed. Within each project you will find conversations related to implementing specific meaningful use measures.

If you have technical problems or other questions about this site, please send an email to questions@oncprojecttracking.org.

Activity Stream

Ady Oren created CERT-1016 - Replacing Modular EMR Components
Wednesday, December 11, 2013

Adi Associate changed the Assignee to 'Jeffery L. Garner' on CQM-956 - Difference between AND NOT and OR NOT terms in metrics
Wednesday, December 11, 2013

Adi Associate changed the Assignee to 'Michelle Hinterberg' on CQM-956 - Multiple values sets having similar codes
Wednesday, December 11, 2013

http://oncprojecttracking.org/
Standards

• NQF Quality Data Model (QDM)
  – QDM, December 2012
    http://www.qualityforum.org/QualityDataModel.aspx#t=2&s=&p=

• HL7 Quality Reporting Document Architecture (QRDA)
  – QRDA Category I (QRDA) DSTU, Release 2 (US Realm), July 2012
  – QRDA Category III, DSTU Release 1 (US Realm), November 2012

• HL7 Health Quality Measure Format (HQMF)
  – HQMF DSTU, Release 1 (Universal Realm), March 2010
Learn More!

Attend Lantana’s CDA Academy

- May 12-16, 2014
- Historic Inns of Annapolis, MD
- Early Bird Ends April 22, 2014

Contact Us / Connect with Us

- Leverage EHR data for quality reporting
- End-to-end reporting quality reporting strategy and implementation (HIEs, ACOs, QIOs)
- Quality measure assessment, development and e-Specification
- Meaningful Use certification
  readinessinfo@lantanagroup.com
- Blog: https://www.lantanagroup.com/blog
- LinkedIn: http://www.linkedin.com/company/410058
- Twitter: https://twitter.com/lantana_group
Acronyms

CDA – Clinical Document Architecture
DSTU – Draft Standard for Trial Use
EHR – Electronic Health Record
HL7 – Health Level 7, Inc.
HQMF – Health Quality Measure Format
IG – Implementation Guide
MU – Meaningful Use
NQF – National Quality Forum
QDM – Quality Data Model
QRDA – Quality Reporting Document Architecture