Meaningful Use of an EHR System: Final Federal Rule

A Summary for Physicians

California Medical Association

On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) released the final rule defining "meaningful use" of an electronic health record (EHR) system. The original version of this rule was released in mid-January, with a public comment period that closed in March. The California Medical Association (CMA) filed formal comments based on the recommendations of the CMA Information Technology Council.

Overall, CMA is very pleased with the direction that CMS has taken in this final rule. The final rule has greatly simplified the meaningful use reporting requirements, while providing physicians more flexibility in choosing measures that apply to their specialty. The final rule also builds in protections for physicians who may practice in areas where there does not exist health information technology (HIT) infrastructure, such as health information exchanges and immunization registries.

Many of the changes that have been made to this final rule were directly responsive to CMA's comments.

Background

In order to qualify for federal incentive payments under the Stimulus Act, physicians must demonstrate "meaningful use" of an EHR system. Meaningful use is demonstrated by meeting a set of criteria established in federal regulations.

On July 13, 2010, CMS released its final "meaningful use" definition. Since this rule is final, there will be no further opportunities for changes or for public comment. The rule will take effect 60 days after it is officially noticed in the *Federal Register*. We anticipate the effective date will be in mid-September 2010.

By the provisions of the Stimulus Act, there are two routes through which physicians can qualify for incentive funding. Generally all non-hospital-based Medicare providers will qualify for up to $44,000 in incentive payments and non-hospital-based Medi-Cal providers can qualify for up to $63,750 in incentive payments. In both programs, hospital-based physicians will qualify if they practice in outpatient settings or hospital-owned clinics.

This rule only finalizes the definition of meaningful use for the Medicare program. Since Medi-Cal is a joint federal/state program, the State of California will have the ability to define meaningful use for Medi-Cal providers, with certain limitations laid out below.

Provisions Affecting both Medicare and Medi-Cal

Although there are two concurrent incentive programs, one through Medicare and one through Medi-Cal, they are similar in many regards. Therefore, the final rule lays out some definitions that apply to both programs. A summary of these is below.

STAGED APPROACH

CMS proposed a "staged" approach to meaningful use. The rule released on July 13, 2010, only defines Stage 1 of meaningful use, which physicians have to meet in the first year they receive an incentive payment. A subsequent federal rulemaking will define Stage 2, which will not take effect until 2013.

Unlike an earlier version of this rule, CMS does not propose a Stage 3 of meaningful use. They have not abandoned the concept of a third stage, but they have chosen to revisit that at a later date. For the moment, they have not defined the expectation after 2014.

The dates by which a physician must demonstrate Stage 2 of meaningful use will depend on when they achieve Stage 1. The chart below lays out graphically how the stages of meaningful use correspond to provider incentive payments (Medicare only):

Table 1: Stages of Meaningful Use, by Physician Payment Year

FIRST PAYMENT YEAR				
Payment Year	**2011 Temporary Certification**	**2012 Permanent Certification Begins**	**2013**	**2014**
2011	**Stage 1** $18,000			
2012	**Stage 1** $12,000	**Stage 1** $18,000		
2013	**Stage 2** $8,000	**Stage 1** $12,000	**Stage 1** $15,000	
2014	**Stage 2** $4,000	**Stage 2** $8,000	**Stage 1** $12,000	**Stage 1** $12,00
2015	**TBD** $2,000	**TBD** $4,000	**TBD** $8,000	**TBD** $8,000
2016	**TBD** n/a	**TBD** $2,000	**TBD** $4,000	**TBD** $4,000
Total	**$44,000**	**$44,000**	**$39,000**	**$24,000**

PAYMENT YEAR

In both the Medi-Cal and Medicare programs, physicians can begin demonstrating meaningful use on January 1, 2011.

In the first year that a physician expects to achieve meaningful use, he or she must demonstrate meaningful use for any 90-day period that falls completely within that calendar year. For example, a physician could begin demonstrating meaningful use on January 1, 2011, and finish at the beginning of April. After that first year, physicians will need to report meaningful use for the entire calendar year to qualify.

Hospitals, while still operating under the same 90-day rules, will need to demonstrate meaningful use based on their fiscal year, not calendar year.

METHOD OF DEMONSTRATING MEANINGFUL USE

For both programs, physicians will initially use self-attestation to report meaningful use. After the first year, CMS expects to have an internet-based system in place for Medicare physicians to report. CMS will be working with the states to develop similar systems for the Medi-Cal incentive program.

Medicare Incentive Program

For the Medicare program, the meaningful use rule lays out the measures that physicians will have to report in order to demonstrate meaningful use.

Compared to an earlier proposed version of this rule, CMS has greatly simplified meaningful use for the Medicare program. Physicians will now have to report on fewer measures, and will have greater flexibility in selecting measures to report. In addition, for almost all measures that are based on percentages (i.e., "50% of prescriptions transmitted electronically"), the required percentages have been reduced.

Overall, a physician will have to report on 15 objectives in order to achieve meaningful use. One of the objectives, reporting on clinical quality measures, will require reporting on six quality measures. Therefore, including these six quality measures, a physician will have to report on 20 measures.

OBJECTIVES AND MEASURES

The main set of items physicians will report are known as "objectives" and "measures." The objectives are broad policy goals that CMS hopes to achieve through meaningful use – such as encouraging electronic prescribing. The measures are the actual criteria that physicians will have to meet to realize that objective.

The objectives and measures are broken into two parts, known as "core" objectives and "menu" objectives. The core objectives and measures are a list of 15 items on which all physicians will have to report. In addition, physicians will select five of the 10 menu items that are most relevant to their clinical specialty.

Objectives: Core Set

- Record patient demographics.
- Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children).
- Maintain up-to-date problem list of current and active diagnoses.
- Maintain active medication list.
- Maintain active medication allergy list.
- Record smoking status for patients 13 years of age or older.
- Provide patients with clinical summaries for each office visit.
- On request, provide patients with an electronic copy of their health information
- Generate and transmit permissible prescriptions electronically.
- Computer provider order entry (CPOE) for medication orders.
- Implement drug-drug and drug-allergy interaction checks.

- Implement capability to electronically exchange key clinical information among providers and patient-authorized entities.
- Implement one clinical decision support rule and ability to track compliance with the rule.
- Implement systems to protect privacy and security of patient data in the EHR.
- Report clinical quality measures to CMS or states.

A complete list of the objectives and measures is in Table 3 below.

Clinical Quality Measure Reporting

As described above, one of the objectives is that physicians will report on clinical quality measures. Physicians must report clinical quality measures to CMS or to the state, depending on whether they are receiving incentive payments via Medicare or Medi-Cal.

Within the clinical quality measure objective, three of the quality measures will be "core" measures on which all physicians will have to report – adult weight screening and follow-up, hypertension: blood pressure management, and tobacco screening and cessation. If a physician feels that one of these core measures does not apply to his or her specialty, then that physician may report on one of three "alternate core" quality measures – influenza screening for patients over the age of 50, weight assessment and counseling for children and adolescents, and childhood immunization status.

Table 2: Objective: Report Clinical Quality Measures to CMS or States – Core Measures

CORE MEASURES	DESCRIPTION:
Preventive Care and Screening Measure Pair: **a.** Tobacco Use Assessment **b.** Tobacco Cessation Intervention.	**a.** Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months. **b.** Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
Hypertension: Blood Pressure Measurement	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
Adult Weight Screening and Follow-Up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

In addition, physicians will select three clinical quality measures from a list of 41 options. For example, physicians may choose to report on the percentage of their female patients who receive breast cancer screening or the percentage of their patients who receive proper asthma treatments. This will give physicians the flexibility to select measures that are most applicable to their practice specialty.

A chart of both the mandatory and optional clinical quality measures is in Table 4.

Physician Protections

Physicians who believe that a core objective or core quality measure is inapplicable to their specialty (for example, radiologists who do not see patients) will be allowed to report that to CMS and will not be held responsible for that objective.

In addition, the final rule builds in protections for physicians who practice in communities where health information technology infrastructure may not be fully developed. For example, many local immunization registries are not ready to receive electronic transmissions. In those cases, physicians will report that, although they are ready to transmit the information, the registry cannot receive it electronically.

Medi-Cal Incentive Program

While the final determination of meaningful use for the Medi-Cal program will be left to the State of California, this rule lays out the broad guidelines of the Medi-Cal incentive program.

The incentive payments for Medi-Cal physicians will be calculated using a different methodology than the one used in Medicare. Unlike in Medicare where the incentives are not based on cost of implementing an EHR, Medi-Cal incentives are based on incurred cost. In the first year of the program, Medi-Cal physicians can receive incentive payments for "adoption, implementation, or upgrade" of a system. Only after that first year will the physician be responsible for meeting meaningful use.

In any given year, the maximum incentive for a Medi-Cal physician will be 85 percent of the "net allowable average cost" (NAAC). NAAC is set at $25,000 for the first year, and $10,000 for each of the next five years. Thus, the maximum allowed incentive is 85 percent of $75,000, or $63,750. Physicians will be responsible for the other 15 percent.

ELIMINATION OF REPORTING PERIOD IN FIRST YEAR

In the first year, Medi-Cal physicians have the option to receive incentive payments for adoption, implementation or upgrade of an EHR system, as opposed to demonstrating meaningful use. A physician who accesses this option will only need to report this information to Medi-Cal once. There is no reporting period needed.

LIMITATION ON STATE FLEXIBILITY

In comments on an earlier version of the rule, CMA had raised a concern that, if states added too many extra provisions to the Medi-Cal definition of meaningful use, it could create an undue burden for safety net physicians who are trying to qualify for the program.

In this final rule, CMS acknowledged that problem. They have now severely limited the ability of states to implement their own definitions of meaningful use. States will only be allowed to add criteria with regards to reporting to public health agencies or immunization registries.

CALCULATION OF INCENTIVE PAYMENTS

For purposes of calculating the physician's 15 percent contribution to NAAC, the rule clarifies what may be counted. For example, the rule clarifies that, along with purchase or upgrade of a system, a physician

may also count items such as staff training toward the match. It also makes clear that an outside entity, such as an IPA or a clinic, may pay the 15 percent share on behalf of the physician. NAACs can include relevant costs incurred prior to adoption of the meaningful use rules.

Special Considerations for Clinic-Based Physicians

For the purposes of both the Medicare and Medi-Cal programs, clinic-based physicians have several unique considerations. They are not, for the purposes of either program, "hospital-based," and thus they qualify for their own incentive payment independent of the facility. Unlike hospitals, however, the facility cannot apply for incentive payments on the physician's behalf. Seeing this unique situation, CMS has established several provisions for clinic-based physicians.

ASSIGNMENT OF INCENTIVE PAYMENTS

Any physician is allowed, at his or her own discretion, to assign their incentive payments to a facility or employer. For example, if a physician is employed by a Federally-Qualified Health Center or a Rural Health Clinic, and uses the facility's EHR system, that physician could designate the clinic to receive incentive payments. The physician is still responsible for demonstrating meaningful use. States will be required to ensure that this reassignment is voluntary on behalf of the physician.

PHYSICIANS WHO PRACTICE IN MULTIPLE LOCATIONS

Many clinic-based physicians practice in multiple locations. They may practice in several clinics, or they may have a clinic practice and a private practice. For the purposes of assignment of incentives (see above), the rule clarifies that a physician must designate only one of their practice sites to receive their incentive. A physician cannot divide the incentive among various sites.

PRACTICE-LEVEL CALCULATION OF PATIENT VOLUME

As described above, in the Medi-Cal incentive program physicians must achieve certain thresholds of patient volume in order to qualify. In a clinic or medical group setting, physicians are allowed to use a practice-level determination. That is, if more than 30 percent of a clinic's patient volume is Medi-Cal, every physician in the clinic can qualify under that program, regardless of whether they qualify individually. Similarly, if a capitated medical group had 30 percent of its patient panel assigned by a Medi-Cal managed care plan, every physician in the group would then qualify for Medi-Cal incentives.

Timelines and Next Steps

As of the writing of this summary, the final rule has not been officially noticed in the *Federal Register*. Once it is noticed, it will take effect 60 days later. Once the rule is final, the State of California will make a final decision about whether to establish a different definition of meaningful use for the Medi-Cal program. We anticipate that this rule will be noticed in the very near future, and thus will take effect in the middle of September 2010.

Under both programs, physicians are allowed to begin demonstrating meaningful use in January of 2011. It is expected that the first incentive payments will be paid in May 2011.

Table 3: Summary Overview of Meaningful Use Objectives

OBJECTIVE	MEASURE
Core set:	
Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality).	More than 50% of patients' demographic data recorded as structured data.
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children).	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data.
Maintain up-to-date problem list of current and active diagnoses.	More than 80% of patients have at least one entry recorded as structured data.
Maintain active medication list.	More than 80% of patients have at least one entry recorded as structured data.
Maintain active medication allergy list.	More than 80% of patients have at least one entry recorded as structured data.
Record smoking status for patients 13 years of age or older.	More than 50% of patients 13 years of age or older have smoking status recorded as structured data.
For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request and electronic copy of their discharge instructions are provided with it.
On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures).	More than 50% of requesting patients receive electronic copy within 3 business days.
Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	More than 40% are transmitted electronically using certified EHR technology.
Computer provider order entry (CPOE) for medication orders.	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE.
Implement drug-drug and drug-allergy interaction checks.	Functionality is enabled for these checks for the entire reporting period.
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities.	Perform at least one test of EHR's capacity to electronically exchange information.
Implement one clinical decision support rule and ability to track compliance with the rule.	One clinical decision support rule implemented.
Implement systems to protect privacy and security of patient data in the EHR.	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies.
Report clinical quality measures to CMS or states.	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures.

Table 3: Summary Overview of Meaningful Use Objectives (cont…)

OBJECTIVE	MEASURE
Menu set:	
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period.
Incorporate clinical laboratory test results into EHRs as structured data.	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one listing of patients with a specific condition.
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate.	More than 10% of patients are provided patient-specific education resources.
Perform medication reconciliation between care settings.	Medication reconciliation is performed for more than 50% of transitions of care.
Provide summary of care record for patients referred or transitioned to another provider or setting.	Summary of care record is provided for more than 50% of patient transitions or referrals.
Submit electronic immunization data to immunization registries or immunization information systems.	Perform at least one test data submission and follow-up submission (where registries can accept electronic submissions).
Submit electronic syndromic surveillance data to public health agencies.	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for hospitals and critical access hospitals:	
Record advance directives for patients 65 years of age or older.	More than 50% of patients 65 years of age or older have an indication of an advance directive status recorded.
Submit of electronic data on reportable laboratory results to public health agencies.	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data).
Additional choices for eligible professionals:	
Send reminders to patients (per patient preference) for preventive and follow-up care.	More than 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders.
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies).	More than 10% of patients are provided electronic access to information within 4 days or its being updated in the EHR.

Table 4: Clinical Quality Measures from Submission by Medicare of Medicaid EPs for the 2011 and 2012 Payment Year

Clinical Quality Measure Title & Description	
CORE MEASURES	**DESCRIPTION:**
Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention	Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months. b. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
Hypertension: Blood Pressure Measurement	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
Adult Weight Screening and Follow-Up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
ALTERNATE CORE MEASURES	**DESCRIPTION:**
Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertusis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
OPTIONAL MEASURES	**DESCRIPTION**
Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.
Diabetes: Low Density Lipoprotein (LDL) Management	Percentage of patients 18-75 years of age with

and Control	diabetes (type 1 or type 2) who had LDL-C < 100mg/dL).
Diabetes: Blood Pressure Management	Percentage of Patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure < 140/90mmHg.
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.
Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age or older who have ever received a pneumococcal vaccine.
Breast Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
Anti-depressant medication management: a. Effective Acute Phase Treatment b. Effective Continuation Phase Treatment	The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits with 12 months.
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
Asthma Pharmacologic Therapy	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred

	long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
Asthma Assessment	Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.
Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external bean radiotherapy to the prostate, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smoking and Tobacco Users to Quit b. Discussing Smoking and Tobacco Use Cessation Medications c. c. Discussing Smoking and Tobacco Use Cessation Strategies.	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods, or strategies.
Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal eye exam (no evidence of retinopathy) by an eye care professional.
Diabetes: Urine Screening	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
Diabetes: Foot Exam	The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
Heart Failure (HF): Warfarin Therapy Patients with	Percentage of all patients aged 18 years and older with

Atrial Fibrillation	a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.
Ischemic Vascular Disease (IVD): Blood Pressure Management	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis ischemic vascular disease (IVD) during the measurement year and whose recent blood pressure is in control (< 140/90mmHg).
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PCTA) FROM January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and who had documentation of the use of aspirin or another antithrobotic during the measurement year.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation b. Engagement	The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.
Prenatal Care: Anti-D Immune Globulin	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
Controlling High Blood Pressure	The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one of more Pap tests to screen for cervical cancer.
Chlamydia Screening for Women	Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
Use of Appropriate Medications for Asthma	Percentage of patients 5-50 years of age who were identified as having persistent asthma and were

	appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
Low Back Pain: Use of Imaging Studies	Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.
Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100mg/dL.
Diabetes: Hemoglobin A1c Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c<8.0%.