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Quality Reporting Under Meaningful Use Stage 2

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Lantana Consulting Group

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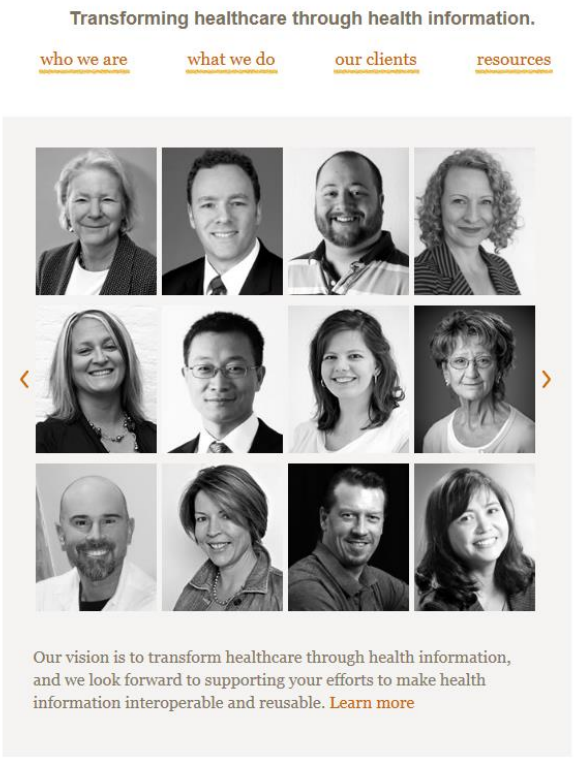
Mission: Information driven healthcare

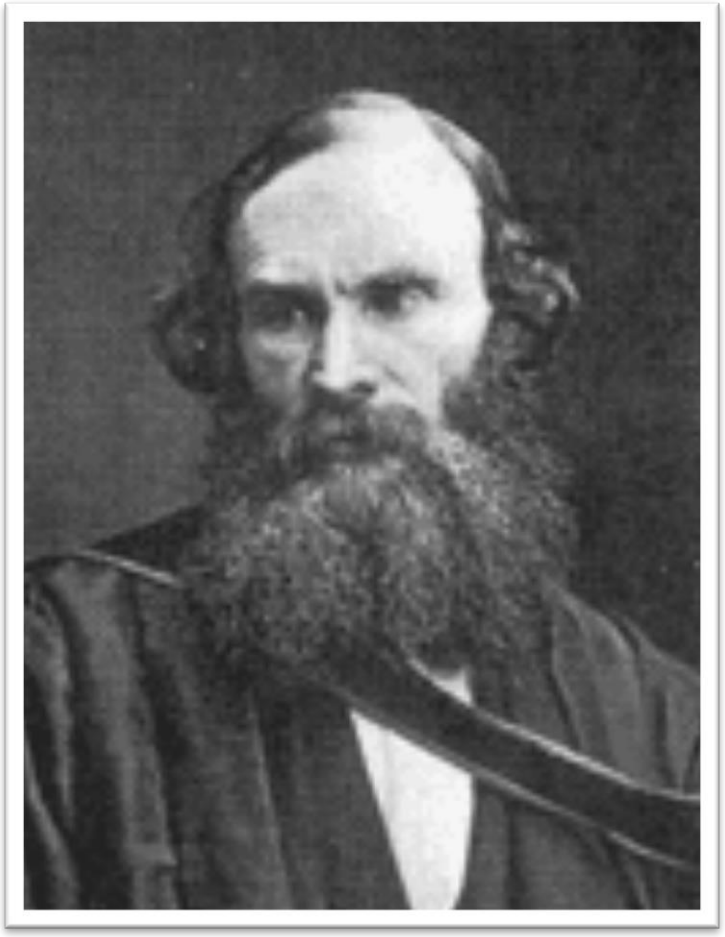
- Staff of 35, 26 consultants
- Interoperability experts
  - Over two dozen standards developed, including key requirements in Meaningful Use
  - Services include quality reporting, implementation, standards development, architecture, strategy, compliance and certification, terminology, and training
  - Clients include startups, Fortune 100 companies, public and private organizations



Agenda

I. Quality reporting in Meaningful Use Stage 2
II. Relationships between quality reporting standards
III. Putting it all together

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."

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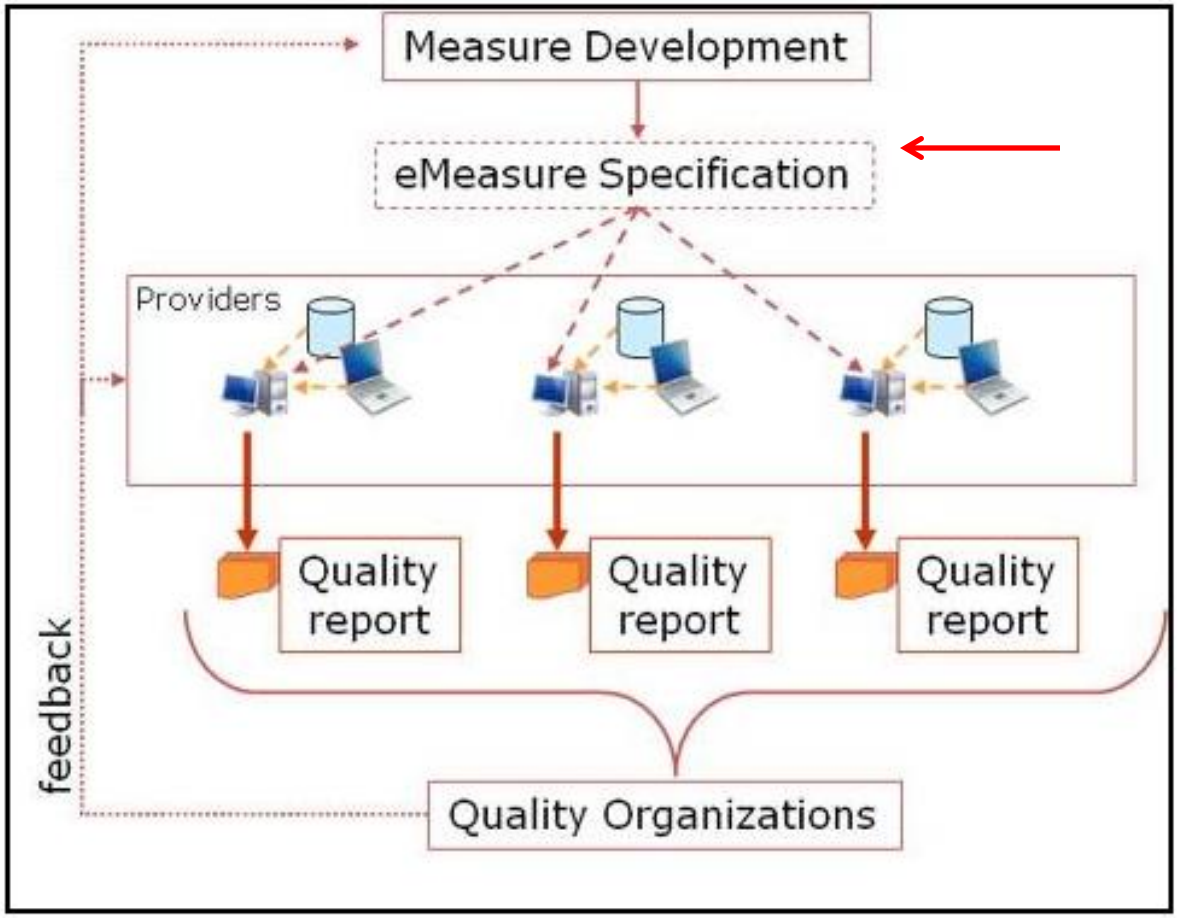
Big-picture View



QUALITY REPORTING IN MEANINGFUL USE STAGE 2

Quality Reporting in Meaningful Use Stage 2 (MU2)

§ 170.314 (c) Clinical Quality Measures (1) Clinical quality measures—capture and export	
(i) Capture	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."
(ii) Export	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.
(2) Clinical quality measures—import and calculate	
(i) Import	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).
(ii) Calculate	EHR technology must be able to electronically calculate each and every clinical quality measure for which it is presented for certification.
(3) Clinical quality measures—electronic submission	
	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.

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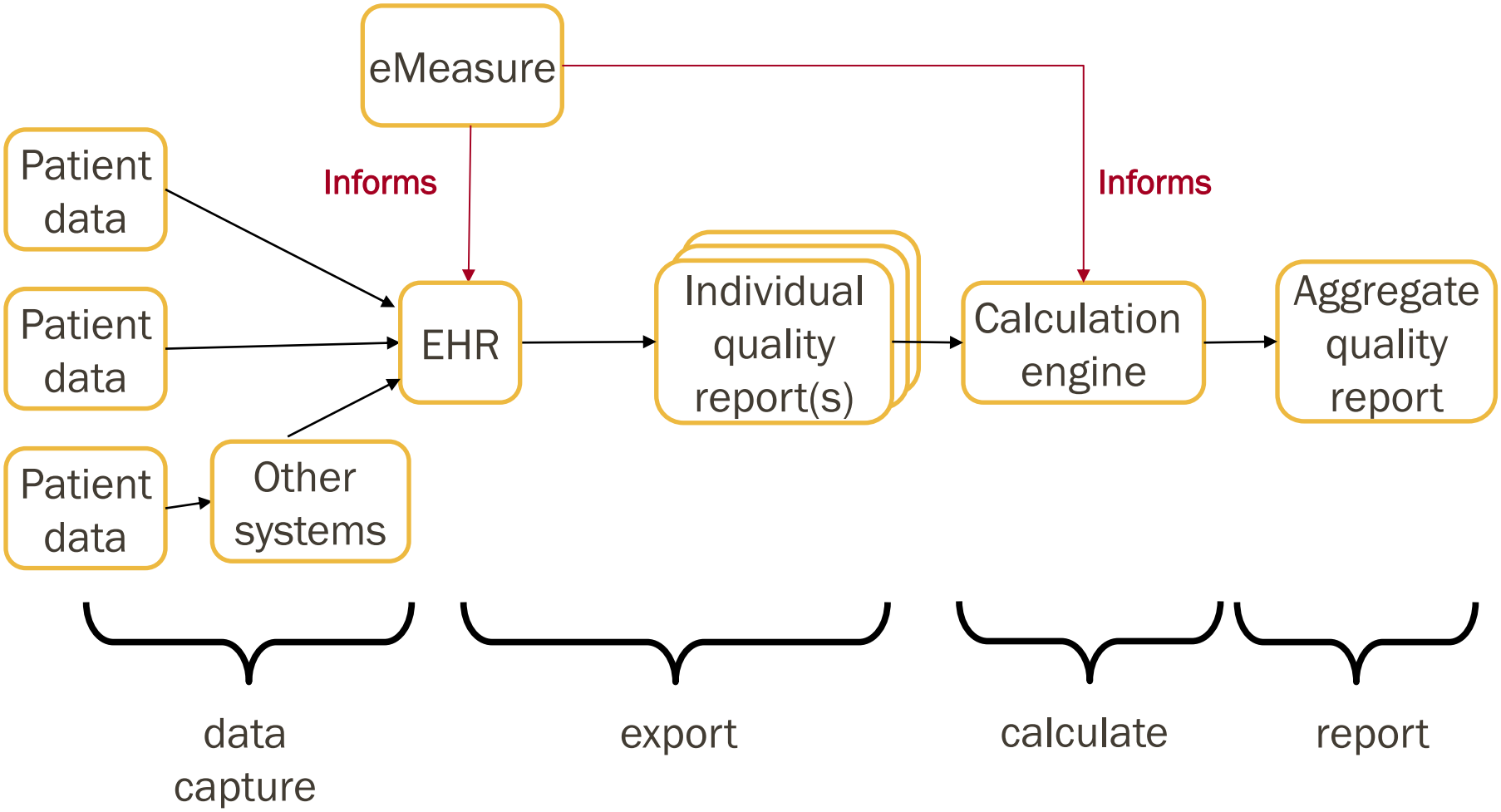
Quality Reporting in MU2



RELATIONSHIPS BETWEEN QUALITY REPORTING AND STANDARDS

Quality Reporting Standards

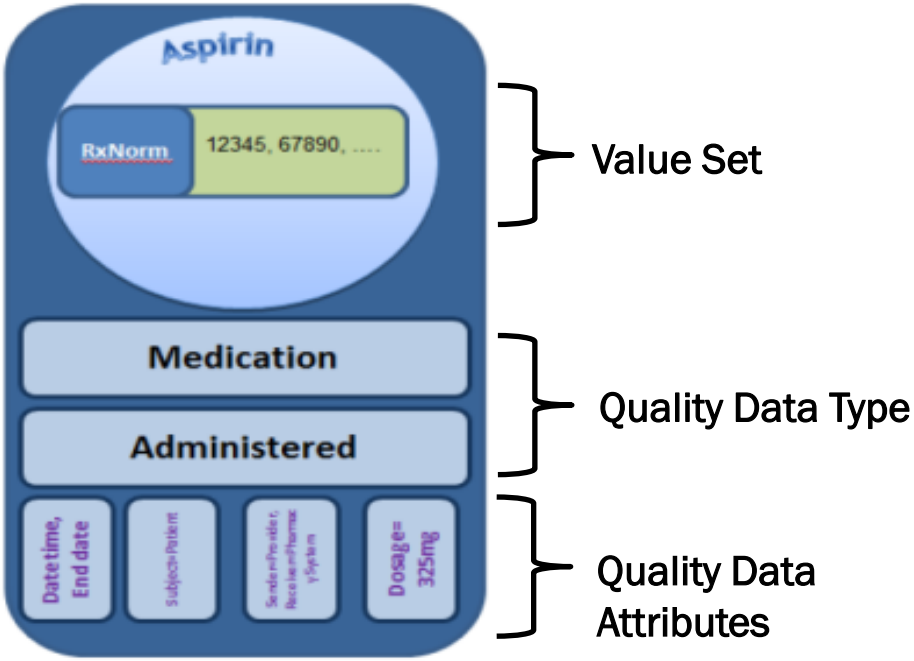
- National Quality Forum (NQF)
  - Quality Data Model (QDM)
- Health Level Seven International (HL7)
  - Clinical Document Architecture (CDA)
    - Quality Reporting Document Architecture (QRDA)
  - Health Quality Measure Format (HQMF/eMeasure)

Data Capture: Quality Data Model (QDM)

- A model of information used to express patient, clinical, and community characteristics as well as the basic logic required to express quality measure criteria.
- Describes the data elements and the states or contexts in which the data elements are expected to exist in clinical information systems.

Quality Data Model (QDM)

- Developed by the National Quality Forum
- QDM is a “Domain Analysis Model.”
- HL7 has implemented QDM in eMeasure and QRDA.



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
  - A standard for representing a health quality measure as an electronic document
  - Provides for quality measure consistency and unambiguous interpretation
  - HQMF 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

eMeasure Human-readable Example: Header

eMeasure Title	Anticoagulation Therapy for Atrial Fibrillation/Flutter		
eMeasure Identifier (Measure Authoring Tool)	71	**eMeasure Version number**	3
NQF Number	0436	**GUID**	03876d69-085b-415c-ae9d-9924171040c2
Measurement Period	January 1, 20xx through December 31, 20xx		
Measure Steward	The Joint Commission		
Measure Developer	The Joint Commission		
Endorsed By	National Quality Forum		
Description	Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.		
Copyright	Measure specifications are in the Public Domain. LOINC(R) is a registered trademark of the Regenstrief Institute. This material contains SNOMED Clinical Terms(R) (SNOMED CT(c)) copyright 2004–2010 International Health Terminology Standards Development Organization. All rights reserved.		
Disclaimer	None		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	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 80 to 89 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 68% 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 stroke risk-atrial fibrillation patients with TIA or prior stroke.		
Clinical Recommendation Statement	The administration of anticoagulation therapy, unless there are contraindications, is an established effective strategy in preventing recurrent stroke in high stroke risk atrial fibrillation patients with TIA or prior stroke.		
Improvement Notation	An increase in rate		
Reference	Connolly SJ, Ezekowitz MD, Yusuf S, Eikelboom J, et.al., the RE-LY Steering Committee and Investigators. Dabigatran versus Warfarin in Patients with Atrial Fibrillation. NEJM. 2009;361:1139-1151.		
Reference	Fuster et al., ACC/AHA/ESC Guidelines for the Management of Patients with Atrial Fibrillation, JACC Vol.38, August		

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Example: QDM in eMeasure

Data criteria (QDM Data Elements)

- "Diagnosis, Active: Atrial Fibrillation/Flutter" using "Atrial Fibrillation/Flutter Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.202)"
- "Diagnosis, Active: Hemorrhagic Stroke" using "Hemorrhagic Stroke Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.212)"
- "Diagnosis, Active: Ischemic Stroke" using "Ischemic Stroke Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.247)"
- "Diagnosis, Inactive: Atrial Fibrillation/Flutter" using "Atrial Fibrillation/Flutter Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.202)"
- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.292)"
- "Encounter, Performed: Non-Elective Inpatient Encounter" using "Non-Elective Inpatient Encounter SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.424)"
- "Intervention, Order: Palliative Care" using "Palliative Care SNOMED-CT Value Set (2.16.840.1.113883.3.526.2.1076)"
- "Intervention, Performed: Palliative Care" using "Palliative Care SNOMED-CT Value Set (2.16.840.1.113883.3.526.2.1076)"
- "Medication, Discharge not done: Medical Reason" using "Medical Reason SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.473)"
- "Medication, Discharge not done: Patient Refusal" using "Patient Refusal SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.93)"
- "Medication, Discharge: Anticoagulant Therapy" using "Anticoagulant Therapy RxNorm Value Set (2.16.840.1.113883.3.117.1.7.1.200)"
- "Patient Characteristic Birthdate: birth date" using "birth date LOINC Value Set (2.16.840.1.113883.3.560.100.4)"
- "Procedure, Performed: Atrial Ablation" using "Atrial Ablation Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.203)"
- Attribute: "Ordinality: Principal Diagnosis" using "Principal Diagnosis SNOMED-CT Value Set (2.16.840.1.113883.3.117.2.7.1.14)"
- Attribute: "Discharge status: Patient Expired" using "Patient Expired SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.309)"
- Attribute: "Discharge status: Discharge To Another Hospital" using "Discharge To Another Hospital SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.87)"
- Attribute: "Discharge status: Discharged to Health Care Facility for Hospice Care" using "Discharged to Health Care Facility for Hospice Care SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.207)"
- Attribute: "Discharge status: Discharged to Home for Hospice Care" using "Discharged to Home for Hospice Care SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.209)"
- Attribute: "Discharge status: Left Against Medical Advice" using "Left Against Medical Advice SNOMED-CT Value Set (2.16.840.1.113883.3.117.1.7.1.308)"

Reporting Stratification

- None

Supplemental Data Elements

- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDC Value Set (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer Source of Payment Typology Value Set (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race CDC Value Set (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex Administrative Sex Value Set (2.16.840.1.113762.1.4.1)"

Measure Set	eMeasure Stroke (eSTK)

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Example: QDM in eMeasure

- **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 <= 120 day(s))"
  - AND: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (discharge datetime)" during "Measurement Period"
  - AND:
    - OR: "Diagnosis, Active: Ischemic Stroke (ordinality: 'Principal Diagnosis')"
    - OR: "Diagnosis, Active: Hemorrhagic Stroke (ordinality: 'Principal Diagnosis')"
    - starts during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
- **Denominator** =
  - AND: "Initial Patient Population"
  - AND: "Diagnosis, Active: Ischemic Stroke (ordinality: 'Principal Diagnosis')" starts during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
  - AND:
    - 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 start of "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
- **Denominator Exclusions** =
  - AND:
    - OR: "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:
      - AND: "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter (admission datetime)" <= 1 hour(s) starts after start of "Occurrence A of Encounter, Performed: Emergency Department Visit (facility location departure datetime)"
      - AND:
        - OR:
          - AND: "Occurrence A of Intervention, Order: Palliative Care" starts after start of "Occurrence A of Encounter, Performed: Emergency Department Visit (facility location arrival datetime)"
          - AND: "Occurrence A of Intervention, Order: Palliative Care" starts before or during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
        - OR:
          - AND: "Occurrence A of Intervention, Performed: Palliative Care" starts after start of "Occurrence A of Encounter, Performed: Emergency Department Visit (facility location arrival datetime)"
          - AND: "Occurrence A of Intervention, Performed: Palliative Care" starts before or during "Occurrence A of Encounter, Performed: Non-Elective Inpatient Encounter"
    - OR:
      - OR: "Intervention, Performed: Palliative Care"
      - OR: "Intervention, Order: Palliative Care"
      - starts 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 RxNorm Value Set"
    - OR: "Medication, Discharge not done: Patient Refusal" for "Anticoagulant Therapy RxNorm Value Set"
    - during "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*

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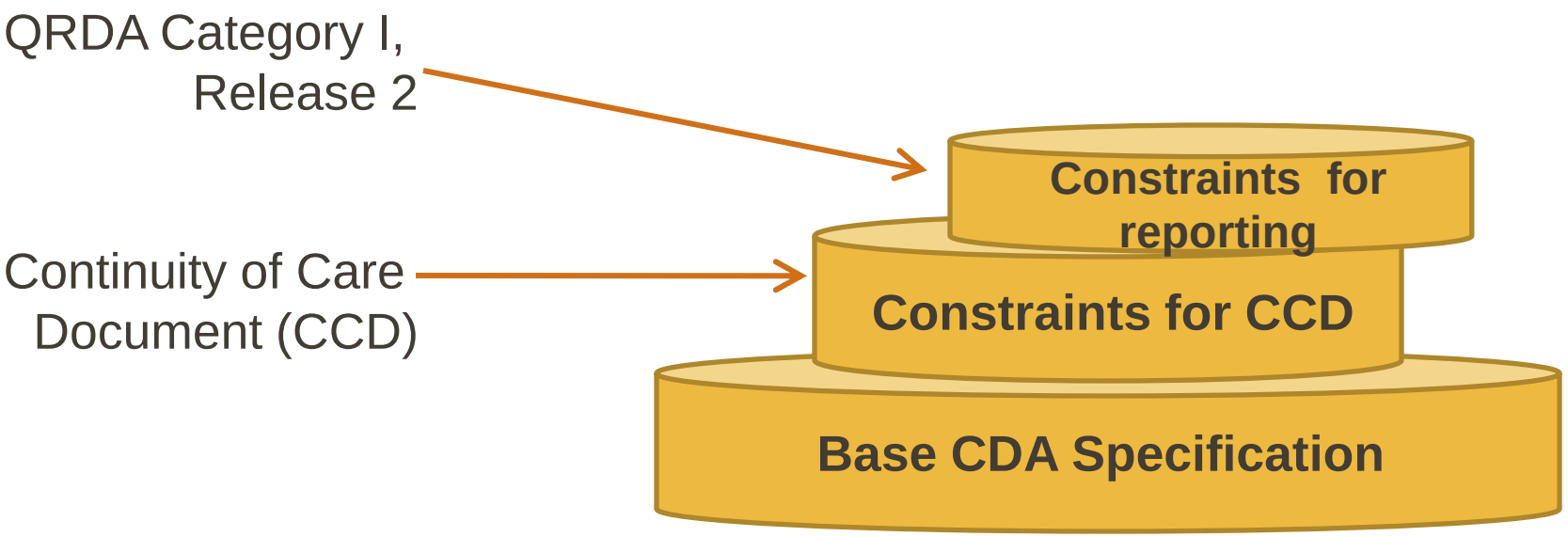
QRDA-I: A Kind of Templated CDA

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



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)).

Example: QRDA Category I – Patient Level Report

Contact info	1020 Healthcare Drive Burlington, MA 02368, US Tel: (555)555-1003
Author	Good Health Report Generator
Contact info	21 North Ave. Burlington, MA 02368, US Tel: (555)555-1003
Legal authenticator	Virgil Verify, MD of Good Health Hospital signed at December 31, 2011
Contact info	21 North Ave. Burlington, MA 02368, US Tel: (555)555-1003
Document maintained by	Good Health Hospital
Contact info	21 North Ave. Burlington, MA 02368, US Tel: (555)555-1003

Table of Contents

Measure Section

eMeasure Title	Version neutral identifier	eMeasure Version Number	NQF eMeasure Number	eMeasure Identifier (MAT)	Version specific identifier
Children's Asthma Care (CAC-1) Relievers for Inpatient Asthma	dc78ee5d-1487-4d79-84c3-1dfdaff0781c	1	0143	93	8a4d92b2-373f-82e2-0137-7b9e21cc5c8f
Children's Asthma Care (CAC-2) Systemic Corticosteroids for Inpatient Asthma	d7c71959-3991-457c-b8ea-774238c87248	1	0144	106	8a4d92b2-373f-82e2-0137-baed84f55f93

Reporting Parameters

- Reporting period: 01 Jan 2011 - 31 Dec 2011

Patient Data

Data Element	Value	Date/Time
Encounter, Performed: Emergency Department Visit	Emergency Department visit	03/01/2011 4:00 - 03/01/2011 8:30
Encounter, Performed: Encounter Inpatient	Hospital admission	03/01/2011 9:00 - 03/03/2011 10:30
Diagnosis, Active: Asthma	Asthma	01/01/2011
Medication, Administered not done: Patient refusal, Asthma Reliever: albuterol 1.25 MG (albuterol sulfate 1.5 MG) per 3 ML Inhalant Solution	Drug declined by patient - reason unknown	Null
Medication, Administered: Systemic Corticosteroids	Hydrocortisone 10 MG Oral Tablet	03/01/2011 15:00
Patient Characteristic Clinical Trial Participant	True	03/01/2011
Patient Characteristic Payer	Medicare	03/01/2011

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.
- Refers to identifiers in an eMeasure or other query.
- 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)).

Example: QRDA Category III – Aggregate Report

EHR Certification Number	medical record, device 1a2b3c (ONC) 98765 ()
Legal authenticator	Good Health Hospital signed at August 11, 2012
Document maintained by	Good Health Hospital

Table of Contents

Reporting Parameters

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

Measure Section

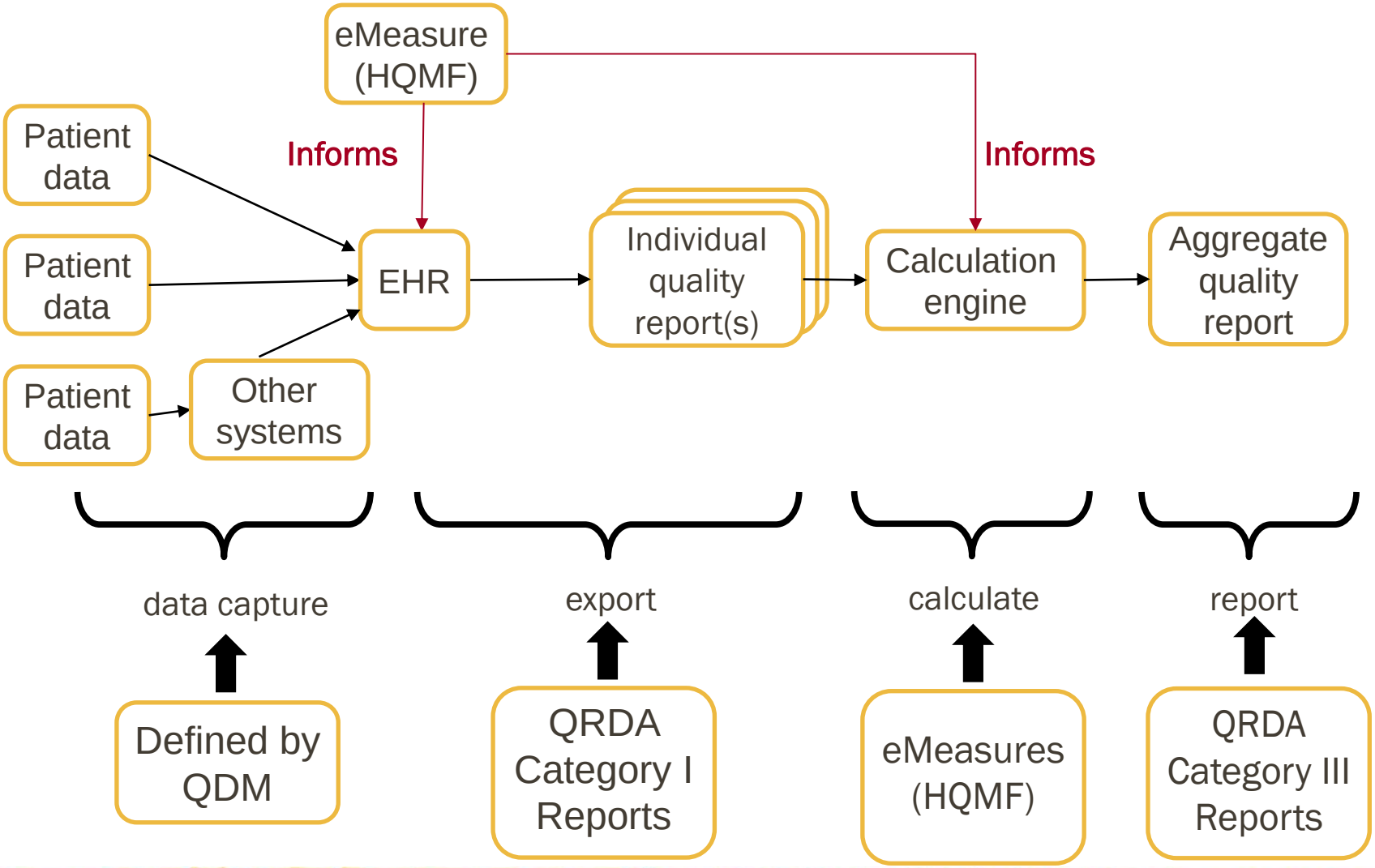
eMeasure Title	Version neutral identifier	eMeasure Version Number	NQF eMeasure Number	eMeasure Identifier (MAT)	Version specific identifier
Anticoagulation Therapy for Atrial Fibrillation/Flutter	03876d69-085b-415c-ae9d-9924171040c2	1	0436	71	8a4d92b2-3887-5df3-0139-013b0c87524a

Member of Measure Set: Clinical Quality Measure Set 2011-2012 - b6ac13e2-beb8-4e4f-94ed-fcc397406cd8

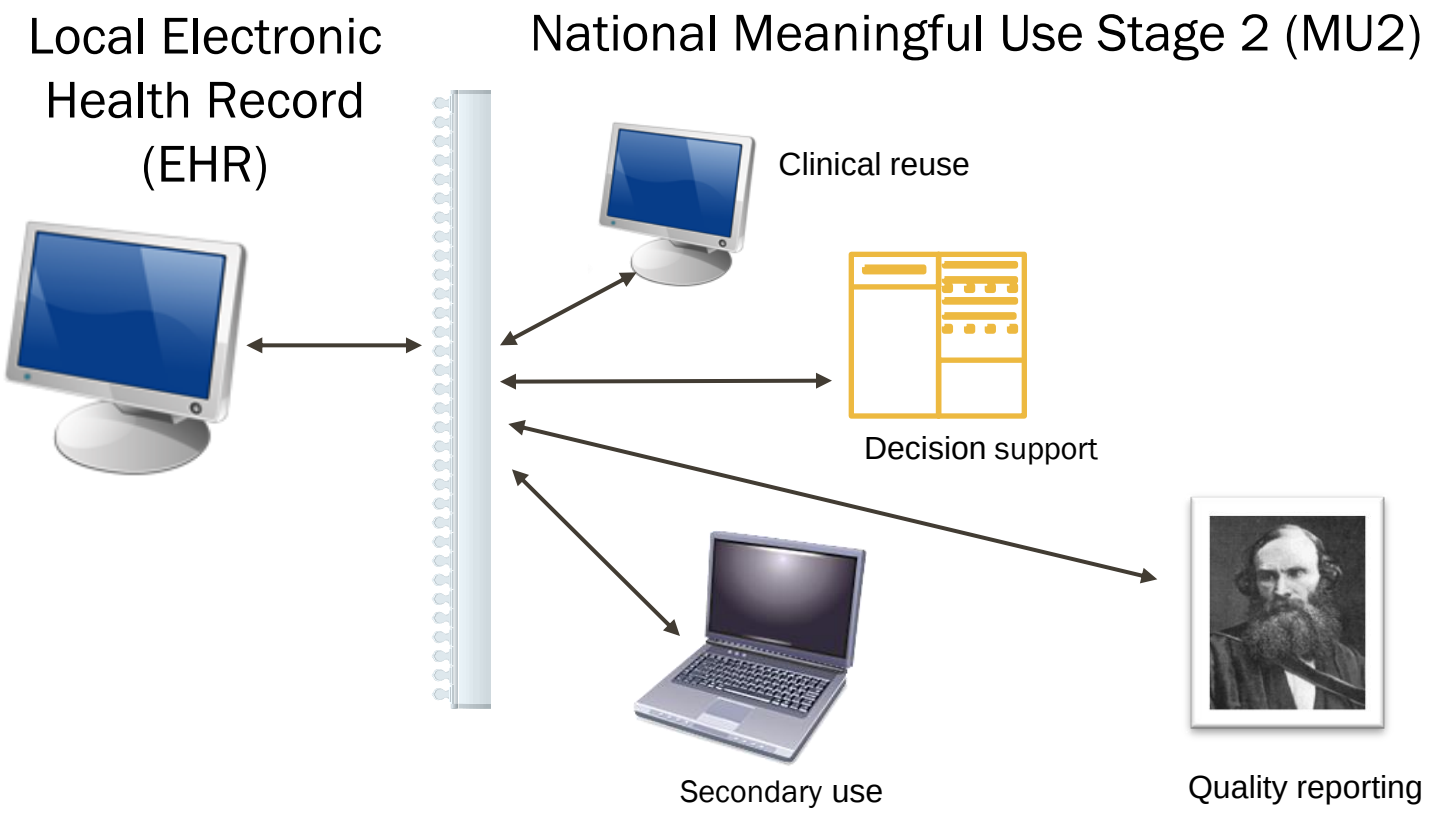
- **Performance Rate:** 83% (Predicted = 62%)
- **Reporting Rate:** 84%
- **Initial Patient Population:** 1000
  - **Male:** 400
  - **Female:** 600
  - **Not Hispanic or Latino:** 350
  - **Hispanic or Latino:** 650
  - **Black:** 300
  - **White:** 350
  - **Asian:** 350
  - **Payer - Medicare:** 250
  - **Payer - Medicaid:** 550
  - **Zipcode 92543:** 15
- **Denominator:** 500
  - **Male:** 200
  - **Female:** 300
  - **Not Hispanic or Latino:** 175
  - **Hispanic or Latino:** 325
  - **Black:** 150
  - **White:** 175
  - **Asian:** 175
  - **Payer - Medicare:** 125
  - **Payer - Medicaid:** 275
  - **Zipcode 92543:** 15
- **Numerator:** 400 (predicted=300)
  - **Male:** 100
  - **Female:** 300
  - **Not Hispanic or Latino:** 140
  - **Hispanic or Latino:** 260
  - **Black:** 120
  - **White:** 140
  - **Asian:** 140
  - **Payer - Medicare:** 100
  - **Payer - Medicaid:** 220
  - **Zipcode 92543:** 6
- **Denominator Exclusions:** 20
  - **Male:** 8

PUTTING IT ALL TOGETHER

MU2 and Quality Reporting



Big-picture View



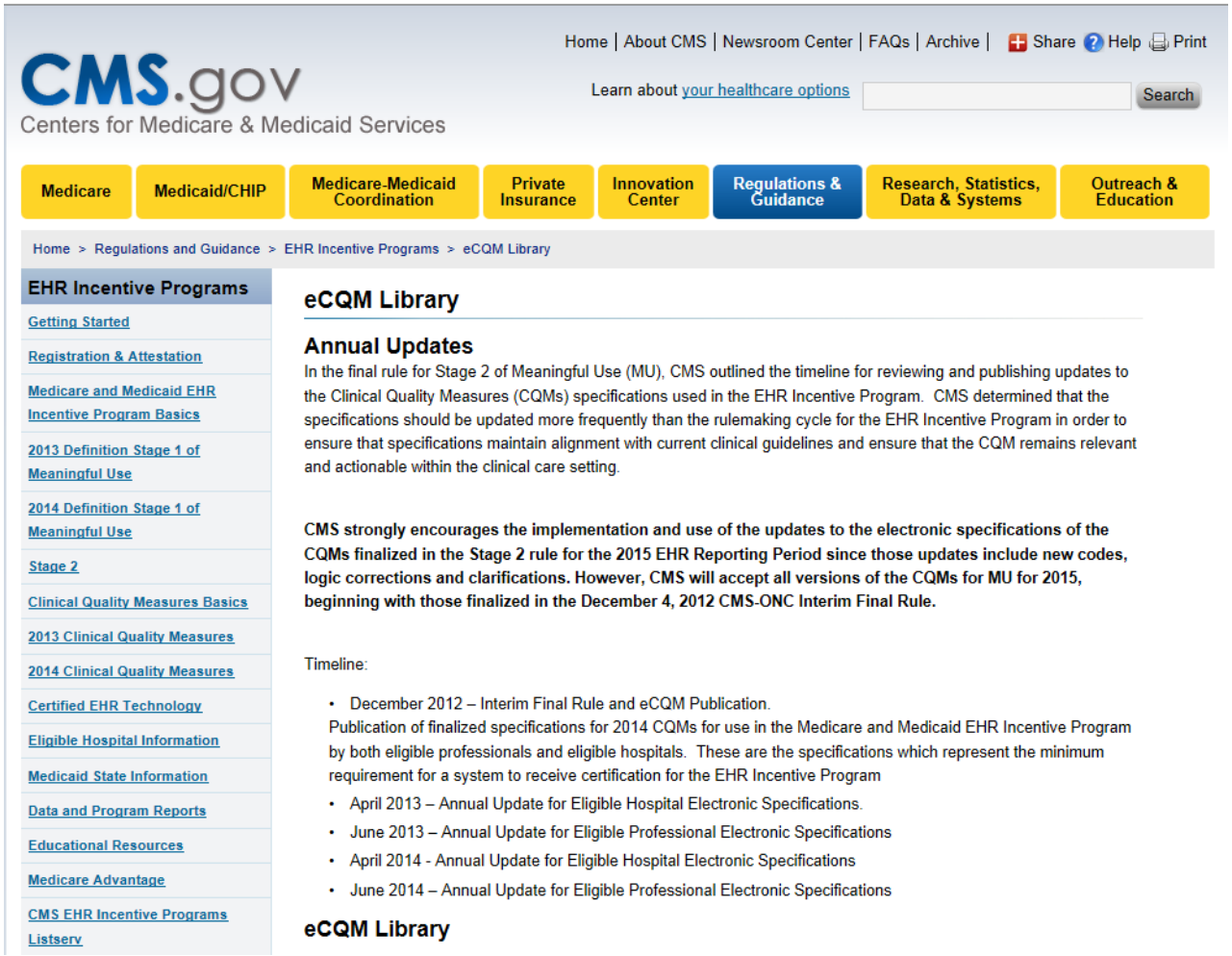
Beyond Meaningful Use

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

RESOURCES

CMS eCQM Library



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Home > Regulations and Guidance > EHR Incentive Programs > eCQM Library

EHR Incentive Programs

- Getting Started
- Registration & Attestation
- Medicare and Medicaid EHR Incentive Program Basics
- 2013 Definition Stage 1 of Meaningful Use
- 2014 Definition Stage 1 of Meaningful Use
- Stage 2
- Clinical Quality Measures Basics
- 2013 Clinical Quality Measures
- 2014 Clinical Quality Measures
- Certified EHR Technology
- Eligible Hospital Information
- Medicaid State Information
- Data and Program Reports
- Educational Resources
- Medicare Advantage
- CMS EHR Incentive Programs Listserv

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 for the 2015 EHR Reporting Period since those updates include new codes, logic corrections and clarifications. However, CMS will accept all versions of the CQMs for MU for 2015, beginning with those finalized in the December 4, 2012 CMS-ONC Interim Final Rule.

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
- April 2014 - Annual Update for Eligible Hospital Electronic Specifications
- June 2014 – Annual Update for Eligible Professional Electronic Specifications

eCQM Library

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

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Guide for 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

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Guide_Reading_EP_Hospital_eCQMs.pdf

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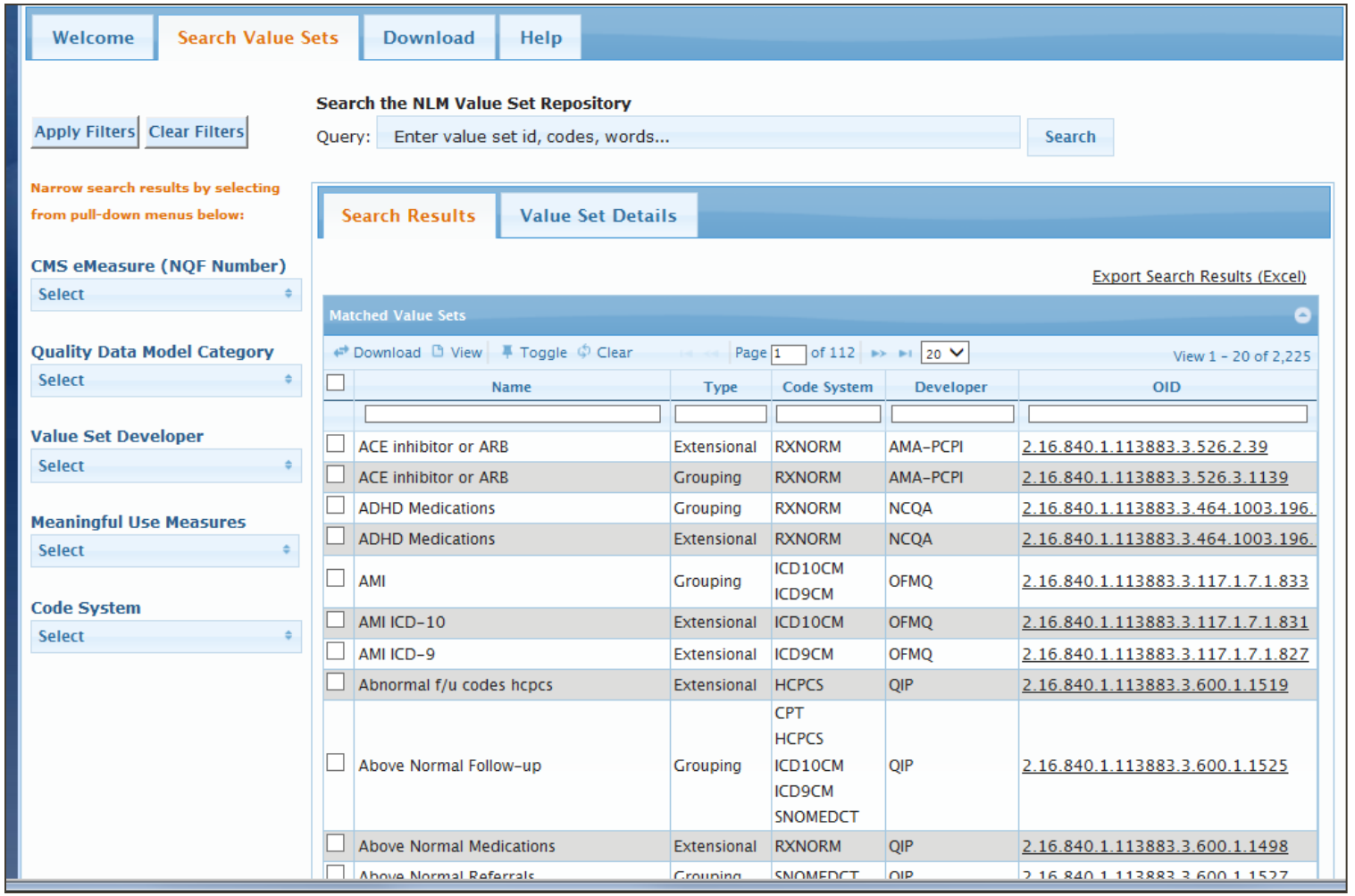
NLM Value Set Authority Center



Name	Type	Code System	Developer	OID
ACE inhibitor or ARB	Extensional	RXNORM	AMA-PCPI	2.16.840.1.113883.3.526.2.39
ACE inhibitor or ARB	Grouping	RXNORM	AMA-PCPI	2.16.840.1.113883.3.526.3.1139
ADHD Medications	Grouping	RXNORM	NCQA	2.16.840.1.113883.3.464.1003.196.
ADHD Medications	Extensional	RXNORM	NCQA	2.16.840.1.113883.3.464.1003.196.
AMI	Grouping	ICD10CM ICD9CM	OFMQ	2.16.840.1.113883.3.117.1.7.1.833
AMI ICD-10	Extensional	ICD10CM	OFMQ	2.16.840.1.113883.3.117.1.7.1.831
AMI ICD-9	Extensional	ICD9CM	OFMQ	2.16.840.1.113883.3.117.1.7.1.827
Abnormal f/u codes hcpcs	Extensional	HCPCS	QIP	2.16.840.1.113883.3.600.1.1519
Above Normal Follow-up	Grouping	CPT HCPCS ICD10CM ICD9CM SNOMEDCT	QIP	2.16.840.1.113883.3.600.1.1525
Above Normal Medications	Extensional	RXNORM	QIP	2.16.840.1.113883.3.600.1.1498
Above Normal Referrals	Grouping	SNOMEDCT	QIP	2.16.840.1.113883.3.600.1.1527

https://vsac.nlm.nih.gov/

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
    http://www.hl7.org/implement/standards/product_brief.cfm?product_id=35
  - QRDA Category III, DSTU Release 1 (US Realm), November 2012
    http://www.hl7.org/implement/standards/product_brief.cfm?product_id=286
- HL7 Health Quality Measure Format (HQMF)
  - HQMF DSTU, Release 1 (Universal Realm), March 2010

    http://www.hl7.org/implement/standards/product_brief.cfm?product_id=97

Questions

Thank you!

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