[⊗] Allscripts[−]

Implementing Million Hearts® Measures using Allscripts Sunrise Ambulatory™ and Clinical Performance Manager™

Overview

Introduction	This document provides guidance on features and functionality of Allscripts Sunrise Ambulatory™ and Clinical Performance Manager™** to track eCQM data included in Million Hearts®.
	Million Hearts® is a national initiative co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS)
	The goal of this initiative is to prevent one million heart attacks and strokes by 2017 by implementing proven and effective interventions in clinical settings and communities
	 The initiative aims to drive adoption and use of a focused set of impactful clinical quality measures for the ABCS and align these measures across public and private quality measures reporting initiatives: National Quality Forum CMS Physician Quality Reporting System CMS Medicare Electronic Health Record (EHR) Incentive Program http://millionhearts.hhs.gov/Docs/MH_CQM.pdf
Who Should Read this Document	Anyone within your organization responsible for configuring and tracking Million Hearts® Quality Data
Resources	The following list contains active hyperlinks to useful resources: <u>Million Hearts® - The Initiative</u> <u>eCQM Library</u>

** Clinical Performance Manager™ (CPM) is the Allscripts solution for Meaningful Use Clinical Quality Measure and Functional Measure reporting. CPM is purchased separately from Sunrise Ambulatory™



Meeting Million Hearts® Using Sunrise

- Allscripts Functionality
- All eCQM data is collected in Sunrise Ambulatory
- Clinical Performance Manager™ (purchased separately) pulls Sunrise data into the ABCS dashboard
- Health Manager, Patient Reminders, and Achieve functionality are tools to that assist in improving Million Hearts® outcomes
 - This guide provides you an overview of:
 - How to use the ABCS Dashboard and run reports in Allscripts CPM (purchased separately)
 - The Achieve workflow and configuration
 - How to use Health Manager and Patient Reminders

Clinical Performance Manager™ Reporting

Million 1. Measure Summary for office administrators to view overall performance Hearts® CPM

Profile

	Measure Summary Provider Results Provider List Profile: Million	Hearts, Visits from 1,	/1/2012 t	0 12/31/20	14			
		Numerator Den	ominator	Measure Ra	ite	IPP	Exclusions	Exception
Million	Hearts Measures Measures							
1001	Hypertension BP Control MH	6	19	32 %	0	22	3	N/A
1002	Tobacco Screen and Intervention MH	136	136	100 %	9	136	N/A	0
1003	Diabetes LDLControlled MH	2	76	3 %		83	7	N/A
1004	IVD Use of Aspirin or Another AntithromboticMH	5	20	25 %	0	20	N/A	N/A
1005	IVD Complete Lipid Panel and LDL Control MH	5	21	24 %		21	N/A	N/A
1006	IVD Complete Lipid Panel and LDL Control LT 100 MH	2	21	10 %	0	21	N/A	N/A
1007	Risk Stratified Cholesterol Fasting LDLc less than 100 MH	15	20	75 %	0	259	1	N/A
1008	Risk Stratified Cholesterol Fasting LDLc less than 130 MH	0	4	0 %	0	259	0	N/A
1009	Risk Stratified Cholesterol Fasting LDLc less than 160 MH	6	6	100 %	9	259	0	N/A
1010	Screening for High Blood Pressure and Follow Up Documented MH	4	4	100 %	9	260	26	230

2. Ability to drill down to individual provider performance

	Facey,	Ivana Demographics	Provider Summary Numerato	r Denominator	Measure Rate	IPP	Exclusions	Exceptions
Milon Hearts	1001	Hypertension BP Control MH		2 4	0.0 % 🛞	5	N/A	0
Measures	1002	Tobacco Screen and Intervention MH	2	4 24	100.0 % 🦻	24	N/A	N/A
	1003	Diabetes LDLControlled MH		0 4	0.0 % 😣	4	N/A	N/A
	1004	IVD Use of Asprin or Another AntthromboticMH		3 5	60.0 % 😝	5	N/A	N/A
	1005	IVD Complete Lipid Panel and LDL Control MH		3 5	60.0 % 😣	5	N/A	N/A
	1005	IVD Complete Lpid Panel and LDL Control LT 100 MH		1 5	20.0 % 😣	5	N/A	N/A
	1007	Risk Stratified Cholesterol Fasting LDLc less than 100 MH	1	7 9	77.8 % 😏	29	N/A	N/A
	1008	Risk Stratified Cholesterol Fasting LDLc less than 130 MH	1	0 1	0.0 % 😣	29	N/A	N/A
	1009	Risk Stratified Cholesterol Fasting LDLc less than 160 MH	1	1 1	100.0 % 🥝	29	N/A	N/A
	1010	Screening for High Blood Pressure and Follow Up Docum	ented MH	1 1	0.0 % 3	29	N/A	23



3. Assess further by individual measure. View compliant versus non-compliant patients.



4. From individual measure, capability to view additional patient details

Chapma	n, Cecil		М	RN: 1	103324													
	CARD index fixed		Patient	Dem	nogra	phic	s				Pati	ent Dia	ignos	sis H	istory	Sum	ma	ary
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1	Gender		Male	E	Ethnicity	y	Not His	panic or	Lating)	CAD		Yes		MRSA			No
	Language		Unknown	F	Race		Amer Ir	ndian/Ala	askan		CHF		Yes		Depre	ssion		No
Observation	s Prefers Prima	iry Language	No	F	Religion	1	Unknov	wn			COPD		Yes		AFib			No
Triggered R	Interpreter R	equired	No	C	Clergy V	/isit	Yes				Diabetes	;	No		VRE			No
- mggorou re	Marital Status	;		H	las Ema	ail	No				Hyperter	nsion	No					
Patient \	/isit History, 1/1	l/2011 to 12	2/31/2014															
Encounter	Visit Date	Attending Prov	ider	Admit Reaso			Discharge Dispositio		Last E	3P	Visit Type		Discha	rge Dal	ie	LOS		ED Admit
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1000004273	3/1/2012 12:00:00 PM	Facey, Ivana		Unknov	wn	70y l	Unknown		Not re	corded	Outpatient					1	0	0
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Care Te	am																	
Encounter	Visit Date	Provider		NPI		Ro	le		Ту	be	Scope Level		A	ctive				
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eport	Population	Demo- All Outpetient Visits 20	015	Providor	John Smith MD		
	Visita From	1/1/2015		Visita to	1/15/2015	3	
	Diagnosis List	Hypertension	-	Diagnosis Type	Ambulatory Da]	
	Number of Diagnoses (First to Last), Leave Blank to See A	1) L	T NULL	Number of Most Recent 8P Readings	1		
	S8P Goal Below	150 mm *		D8P Goal Below	90 mm 💌		
	Report Template: Diagnosis and Observatic	ns Population Demo	All Outpatient	Visits 2015 Age 60 or older		Patient Demographics Br	eport Criteri
	Encounter Number Patien	t DOB	Age	Diagnosis	Blood Pressure	Blood Pressure Measured	
			80	HTN (hypertension)	115/60	1/12/2015 3:27:00 PM	4
			72	Hyperbension	128/70	1/12/2015 4:05:00 PM	4
			63	Hypertension	145/80	1/7/2015 12:02:00 PM	4
			-79	Hypertension	146/69	1/7/2015 9:46:00 AM	
			64	Benign essential hypertension	137/81	1/5/2015 12:53:00 PM	•
			81	Berign hypertansive heart disease	138/71	1/5/2015 10:15:00 AM	*
			67	Uncontrolled hypertension	151/75	1/12/2015 11:30:00 AM	4
			61	Benign hypertension	136/86	1/5/2015 2:04:00 PM	4
			71	Uncontrolled hypertension	170/74	1/9/2015 11:34:00 AM	4
			65	Hypertension, accelerated	206/112	1/5/2015 4:26:00 PM	4
			68	Uncontrolled hypertension	182/95	1/13/2015 2:41:00 PM	4
			61	Hypertension	129/84	1/13/2015 3:34:00 PM	4
			67	Benign hypertension	143/85	1/2/2015 4:18:00 Ph	4
			73	Hypertension	132/80	1/2/2015 2:43:00 PM	4
			65	(States we state)	199/116	1/9/2015 4:47:00 PM	

Red text denotes results out of goal range .

CPM Sample Report cont.

Sample report by provider of patient's with diagnosis of Diabetes

spulation	Demo-All C	Outpatient Visits 201!		Provider	John Smith MD	1
uits from	1/1/2015			Visits to	1/15/2015	a 📉
lagnosis List	Diabetes	-		Diagnosis Type	Ambulatory Da	3
untherof Diagnoses (First to Last), Leas	e Blank to See All 1	r	NULL	Number of Most Recent BP Readings	1	-
8P Goal Below	140 mm			DBP Goal Below	90 mm 💌	
					and the second s	
Report Template: Diagnosis an	d Observations Pop	ulation- Demo- All	Outpatient \	/isits 2015 Age 60 or older		Patient Demographics E
Encounter Number	Patient	DOB	Age	Diagnosis	Blood Pressure	Blood Pressure Measured
			62	Diabetes mellitus	138/85	1/13/2015 9:12:00 A
			80	Diabetes mellitus	163/83	1/5/2015 10:23:00 A
			44	Diabetes melitus	112/72	1/14/2015 2:51:00 P
			86	Diabetes mellitus	94/54	1/8/2015 1:10:00 P
			73	Diabetes mellitus	97/56	1/15/2015 1:02:00 P
			64	Diabetes mellitus	123/53	1/13/2015 12:56:00 #
			- 63	Diabetes mellitus	154/82	1/8/2015 3:22:00 9
			73	Diabetes mellitus	158/73	1/5/2015 10:08:00 A
			69	Type 2 diabetes mellitus, controlled	132/77	1/6/2015 9:00:00 A
			83	Controlled type 2 diabetes melitus with diabetic nephropathy	138/59	1/12/2015 9:25:00 A
			71	Type 2 diabetes mellitus	170/74	1/9/2015 11:34:00 A
			77	Type 2 diabetes mellitus	136/81	1/10/2015 9:49:00 A
				with renal manifestations		
			67	with renal manifestations Uncontrolled diabates melitius	143/85	1/2/2015 4:18:00 #



Health Manager and Patient Reminders

Health Manager Overview Use Health Manager to improve outcomes by creating wellness events for activities such as blood pressure screening, cholesterol checks, and smoking cessation. Health Manager provides functionality to monitor wellness events for follow-up and generate patient reminders for upcoming or missed events.

Workflow benefits include:

- Streamlined management of preventative care
- Immunizations and wellness events in one place
- Single view
- Population reporting
- Ability to assign schedules or customize Wellness and Immunization events
- Reminders for vaccines and exams

Health Manager Summary View with ABCS relevant wellness events

🫞 Health Manager - Drake,	Mary							
Drake, Mary 1 East-101-A S2V Allergies: No Known All	ergies					100277 / 100000036	6	
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Pending Status:		View Selection Options	Ор	tions	Order [Done Not Done	1	Log E
Due now		P All events Sorted by: Schedule	d occ	urrence	date			
Near due		Event	19y	20-29y	30-39y	40-49y	50-59y	60-64y
 Future pending Ordered 		🕅 Blood Pressure Check				(Every 3 Month(s))		
Charted Status:						Due: 09-Apr-2015		
🕑 Done		Brout a t				(Every 1 Year(s))		
Not done		🕅 Cholesterol				Due: 09-Apr-2015		
Invalid Deleted		🕅 Smoking & Tobacco Use Cessation				(Once) Due: 09-Apr-2015		
 Discontinued Inactive 								

Health Manager and Patient Reminder Workflow

1. Add schedules from Manager Schedules window

e. Mary East-101-A S2V	100277 / 1000000365	47y (05-05-1967)	
Masage Scheckle - Drake, Mary			
Current Schedules Current Events		2	0
Assignment Type 👗 Name Description Priority Re	niew Status Assigned Date/Time Assigned By 19 Action (01-Apr-2015 00022) Oracle Sana (Pro	El include inective Espiny Date Las	5000
		•	
Conditions Beerts Conditions are not applicable to a menually assigned adhedule			
Schedule Conditions No conditions available.			
	Ackzowledge file	New Nobification on Close	
ieed Helw7		Close	



2. Add Event to Patient Schedule

Nane	Cholesterol Cheol		
Description			
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	Standard Adult > 18 Years		
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3. Select Event and Frequency

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4. View Scheduled Events in Health Manager

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Patient Reminder Workflow

- Use Report engine to send Reminders based on patient's communication preference
 - Interpret patient's communication preference
 - Use Reminder Letter report to send Reminders for patients whose communication preference are mail, SHM or not entered
 - Use Patient List report to print phone list report for patients whose communication preference are Phone
 - Optionally log to education log
- The patients will have due wellness activities, only if patients have wellness schedule/events assigned
- Note: 'Not entered' may be the largest group of patients. Communication preference is defaulted to 'Mail'





View Reminder Letters from Documents Tab

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ision Status/Author:	
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Sample Patient Reminder List Report

Patient Name	Patient ID	Age	Ser	Last Visit Date/Time	Phone	Communication Method
Walker, Laura	000006794	67y	female	09-Dec-2014 09:00	404-9568465	Mail
H ealth Management Events	2)", "Pap S					munization; 04-Sep-2014; Dose 'ision E xam including glaucom
Pow ell, John	000006813	76y	male	02-Dec-2014 06:55	720-344-6767	Mail
Health Management Events		bod sugar (Well 02-Dec-2014)''	ness; 02-Dec-2014)", "I	Influenza (Immunization; 02-I	Dec-2014; Dose 1)", "	Vision Exam including glaucon
Campbell, Mark	000006777	65y	male	02-Dec-2014 01:52		Phone
Health Management Events				olood sugar (Wellness; 02-Dec "Pneumococcal (Immunization		Immunization; 02-Dec-2014; Do 1)"
Easterly, Robin	000007002	56y	female	02-Dec-2014 10:38	605-645-8979	E-mail
Health Management Event:	1)", "Mam	mogram (Wellne		e le Skin Exam (Wellness; 02-1		n munization; 02-Dec-2014; Dos ear (Wellness; 21-Oct-2014)",
•	1)", "Mam	mogram (Wellne	iss; 21-Oct-2014)", "Mo	e le Skin Exam (Wellness; 02-1		

For a more detailed explanation of functionality and configuration, please see the PowerPoint – Million Hearts® Health Manager and Patient Reminders.



Achieve Workflow and Configuration in Sunrise Ambulatory and FollowMyHealth

Achieve Overview

Achieve is a monitoring and compliance application to improve high-risk patient outcomes. It requires use of Sunrise Ambulatory and FollowMyHealth (FMH) Patient Portal. Achieve leverages EHR workflows and the patient portal to engage the patient, improve outcomes, and lower costs through patient engagement, home monitoring, and care coordination. Achieve has the ability to integrate with wireless devices to automatically capture data.

Requirements

- Sunrise version 6.1 or higher
- Must be using FollowMyHealth

Patient Accepts Data Collected Patient Follows the Data Analyzed by Achieve Order(s) in Automatically or -Order(s) FMH Achieve Manually entered FMH Care Team Contacts Patient Receives and Configures Wireless Patient for Non-Compliant? Devices in FMH Compliance or (optional) Intervention Yes No. Keep No Monitoring START Send SHM Message **Provider Places** Notification and **Rules Violation?** Achieve Order(s) in Order Results SCM No FINISH Order(s) Completed Order Results Available in Complete? SCM

1. Clinician places an Achieve Goal order in Sunrise Ambulatory for patient to monitor at home post clinic visit, MLM is triggered

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9

Achieve Workflow



2. Patient receives message in FollowMyHealth Inbox - Provider has set a new goal

FollowMyHealth 🛖 🔔	Schedule an Appointment 📃 Hello Skyler My Account 👻 Español				
Universal Health Record	Home Inbox (1) My Health - My Info -				
Back Search:	Compose Delete Move To 🔻 Print				
Inbox	From: The Office of FollowMyHealth To: Skyler Test				
The Office of FollowMyHealth New Goal 1/16/2014 6:49 PM Expand	To: Skyler Test Date: 1/16/2014 6:49 PM Subject: New Goal				
FollowMyHealth™ Welcome to the family! 1/15/2014 11:56 AM Expand	Hello Skyler, Your provider has set new goals for you. Please go to MyHealth and select the Goals tab to get started.				

3. Patient accepts or declines goal - can set reminders to input readings and alerts for out of range results

H	ome	Inbox (2)	My Health	- N	ly Info
mary Conditions Medications Allergies	Immunizations	Results Vitals Do	cuments Goals Cl	hart	
oals				_	
Goals					
towards this goal. By accepting this goal you are a can be used by your care team to assist you in reac FollowMyHealth goals are not info In the	ching this goal. ended for situati		ent or emergency attent		rmation
Goal		Requested By		Accept	Decline
Maintain a blood pressure less than 140 / 90 mmHg	g for 30 days	Peter Johnson - Sunr	se Medical Center 2		0
				-	
to take your weight or blood pressure if you have no	ot done so. In ac	ldition alerts can be sent	by email or text message ext messages. Check the	Ith TM can rer e informing y	to uot
to take your weight or blood pressure if you have no results that need your attention. A valid cell phone i would like to receive clerts and reminders.	ot done so. In ac	ldition alerts can be sent eive alert and reminder t	by email or text message ext messages. Check the	Ith TM can rer e informing y	to uot
results that need your attention. A volid cell phone i would like to receive alerts and reminders. Email: mrubyfmh8gmail.com Change	ot done so. In ac	ldition alerts can be sent eive alert and reminder t Add A Cell Phone num	by email or text message ext messages. Check the	Ith TM can rer e informing y	to uot
to take your weight or blood pressure if you have no results that need your attention. A valid cell phone i would like to receive alerts and reminders. Email: mrubyfmh8gmail.com Change My Reminders	ot done so. In ac	idition alerts can be sent leive alert and reminder t Add A Cell Phone num Goal Alerts	by email or text message ext messages. Check the	Ith TM can rer e informing y	to uot



4. Patient enters readings per goal instructions, alerts show based on parameters set in Sunrise Ambulatory order

Maintain a blood	pressure less than 14	0 / 90 mmHg for 30 days	Start: 1/20/2014 End:	2/20/2014
it up straight with yo	our legs uncrossed. Take	t in a chair for 5 to 10 minutes with your arm at he e it at different times during the day. Make sure to ments field for the blood pressure reading in Follow	keep track of what you were MyHealth.	
Date	Blood Pressure	Comments	Source	Options

5. As the patient completes the goal, a summary of the result attained by the patient is provided by Achieve to Sunrise Ambulatory



Expanded Result Achieve Measure BP Turner, Edward Mid	
Order: Maintain a blood pressure less than 140 / 90 mmHg for 30 days	
Ordering Provider: Provider Tw Allscripts	
Dradered On: 1/1/2014	
that Date: 1/1/2014	
Ind Date: //1/2014	
HR Order Id: 001BBF807	
nk ofder 1d: oolsbroo/	
- Send notification if the patient does not consent to the order 3 days after it was placed.	
- Send notification if the patient does not consent to the order 5 days after it was placed. - Send notification if no measurements are taken over a 3 day period.	
 Send notification if no measurements are taken over a 3 day period. Send notification if systolic blood pressure is less than or equal to 90 mmHq. 	
- Send notification if systolic blood pressure is greater than or equal to 150 mmHg.	
- Send notification if diastolic blood pressure is less than or equal to 50 mmHg.	
- Send notification if diastolic blood pressure is greater than or equal to 100 mmHg.	
Patient Instructions:	
Rest in a chair for 5 to 10 minutes with your arm at heart level before taking your blood pressure. Sit up strai	ght with
Notification History:	
- 1/4/2014 - Patient is non-compliant. No measurements were taken for at least 3 days.	
- Diastolic blood pressure was greater than or equal to 100 mmHg.	
Measurement that broke the rule:	
1/7/2014 12:45 PM - 151/101 mmHg - Patient Entered (I took this right after jogging)	
- Systolic blood pressure was greater than or equal to 150 mmHg.	
Measurement that broke the rule:	
1/7/2014 12:45 FM - 151/101 mmHg - Patient Entered (I took this right after jogging)	
- Diastolic blood pressure was less than or equal to 50 mmHg.	
Measurement that broke the rule:	
1/5/2014 12:44 PM - 89/49 mmHg - Patient Entered	
 Systolic blood pressure was less than or equal to 90 mmHg. 	
Measurement that broke the rule:	
1/5/2014 12:44 PM - 89/49 mmHg - Patient Entered	
Measurements:	
- 1/5/2014 12:54 PM 151/101 mmHg - Withings Device (I took this right after jogging)	
Print.Result	Close



6. Physician can respond directly from the results notification via SHM



For a more detailed explanation of functionality and configuration, please see the PowerPoint – Million Hearts® FollowMyHealth Achieve Workflow and Configuration.



Details

 Measure
 Specification Index

 Measure
 The following measure information was obtained from the <u>Centers for Medicare and Medicaid Services (CMS)</u>
 website in March 2015. Your organization should routinely reference the CMS website to manage any measure information changes or additional information provided after the publication of this document.

- A. Appropriate Aspirin Therapy
- B. Blood Pressure Control
- **Cholesterol Management** C.
- S. Smoking Cessation

Α

Term	CMS Specification
Measure	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
Description	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 coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.
eMeasure Identifier	164
NQF	0068
Initial Patient Population	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	N/A
Numerator	Patients who have documentation of use of aspirin or another antithrombotic during the measurement period
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS164v3_Ischemic Vascular Disease Use of Aspirin or Another Antithrombotic

	CMS Specification
Measure	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up
	Documented
Description	Percentage of patients aged 18 years and older seen during the reporting period who w screened for high blood pressure AND a recommended follow-up plan is documented
	based on the current blood pressure (BP) reading as indicated
eMeasure	22
Identifier	
NQF	N/A
Initial Patient	All patients aged 18 years and older before the start of the measurement period
Population	
Denominator	Equals Initial Patient Population
Denominator	Patient has an active diagnosis of hypertension
Exclusions	
Numerator	Patients who were screened for high blood pressure AND have a recommended follow
-	plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive
Numerator	N/A
Exclusions	
Denominator	Patient Reason(s):
Exceptions	Patient refuses to participate
	OR
	UR
	Medical Reason(s):
	Patient is in an urgent or emergent medical situation where time is of the essence and
	delay treatment would jeopardize the patient's health status. This may include but is no
	limited to severely elevated BP when immediate medical treatment is indicated. CMS22v3 Preventive Care and Screening Screening for High Blood Pressure and Fol
Allscripts Reference Guide	Up Documented
Term	CMS Specification
-	Controlling High Blood Pressure
Measure	
Description	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and who blood pressure was adequately controlled (<140/90mmHg) during the measurement
	period.
eMeasure	165
Identifier	
NQF	0018
Initial Patient	Patients 18-85 years of age who had a diagnosis of essential hypertension within the fi
Population	six months of the measurement period or any time prior to the measurement period
Denominator	Equals Initial Patient Population
Denominator	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant
Exclusions	before or during the measurement period. Also exclude patients with a diagnosis of
	pregnancy during the measurement period.
Numerator	Patients whose blood pressure at the most recent visit is adequately controlled (systolic
	blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Numerator	N/A
Exclusions	
Denominator	None
Exceptions	
Allscripts	CMS165v3 Controlling High Blood Pressure

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С

Term	CMS Specification
Measure	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed
Description	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.
eMeasure Identifier	61
NQF	N/A
Initial Patient Population	All patients 20 through 79 years of age before the beginning of the measurement period
Denominator	Denominator 1: (High Risk) All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent OR 10-Year Framingham Risk > 20%
	Denominator 2 : (Moderate Risk) All patients aged 20 through 79 years who have 2 or more Major CHD Risk Factors OR 10-Year Framingham Risk 10-20%
	Denominator 3 : (Low Risk) All patients aged 20 through 79 years who have 0 or 1 Major CHD Risk Factors OR 10- Year Framingham Risk <10%
	** For Denominator 2 and Denominator 3, Fasting HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)
Denominator Exclusions	Patients who have an active diagnosis of pregnancy OR Patients who are receiving palliative care
	When a fasting LDL-C test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed
Numerator	Numerator 1: (High Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period
	Numerator 2 : (Moderate Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period
	Numerator 3 : (Low Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period or up to four (4) years prior to the current measurement period
Numerator Exclusions	N/A
Denominator Exceptions	Patient Reason(s):
	Patient Refusal When a fasting LDL-C test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed
Allscripts Reference Guide	CMS61v4_Preventive Care and Screening_Cholesterol-Fasting Low Density Lipoprotein (LDL-C) Test Performed



Term	CMS Specification
Measure	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)
Description	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.
eMeasure Identifier	64
NQF	N/A
Initial Patient Population	All patients 20 through 79 years of age before the beginning of the measurement period
Denominator	Denominator 1: (High Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have CHD or CHD Risk Equivalent OR 10 year Framingham risk > 20% Denominator 2: (Moderate Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have 2 or more Major CHD Risk Factors OR 10 year Framingham Risk 10-20%. Denominator 3: (Low Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed up to 4 years prior to the current measurement period and have 0 or 1 Major CHD Risk Factors OR 10 year Framingham risk <10%.
	** For Denominator 2 and Denominator 3, HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)
Denominator Exclusions	Patients who have an active diagnosis of pregnancy OR Patients who are receiving palliative care
Numerator	Numerator 1: Patients whose most recent fasting LDL-C test result is in good control, defined as <100 mg/dL Numerator 2: Patients whose most recent fasting LDL-C test result is in good control, defined as <130 mg/dL Numerator 3: Patients whose most recent fasting LDL-C test result is in good control, defined as <160 mg/dL
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS64v4 Preventive Care and Screening Risk-Stratified Cholesterol Fasting Low Density Lipoprotein (LDL-C)



Term	CMS Specification
Measure	Diabetes: Low Density Lipoprotein (LDL) Management
Description	Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.
eMeasure Identifier	163
NQF	0064
Initial Patient Population	Patients 18-75 years of age with diabetes with a visit during the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	None
Numerator	Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS163v3_Diabetes Low Density Lipoprotein (LDL) Management

Term	CMS Specification
Measure	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
Description	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 coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).
eMeasure Identifier	182
NQF	0075
Initial Patient Population	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	Not Applicable
Numerator	Numerator 1: Patients with a complete lipid profile performed during the measurement period Numerator 2: Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS182v4 Ischemic Vascular Disease Complete Lipid Panel and LDL Control



S

Term	CMS Specification
Measure	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Description	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
eMeasure Identifier	138
NQF	0028
Initial Patient Population	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	None
Numerator	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user
Numerator Exclusions	N/A
Denominator Exceptions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)
Allscripts Reference Guide	CMS132v3 Cataracts Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

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