

Registry Supplemental Resources: Appendix

**1524 - Atrial Fibrillation and Atrial Flutter: Assessment of
Thromboembolic Risk Factors**

Included:

PINNACLE Registry Data Dictionary
PINNACLE Registry Data Collection Form
PINNACLE Registry Algorithm & Flow Diagram
Supplemental Testing Data

1. General Information

Seq. #: 1500 **Name:** Medical Record Number (MRN)

Coding Instructions: Indicate the patient's medical record number as assigned by the medical practice.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1510 **Name:** Encounter Date

Coding Instructions: Indicate the date of the patient encounter or visit to the physician office.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1520 **Name:** Practice ID

Coding Instructions: Indicate the Practice Identification number assigned to the Practice by the ACC-NCDR.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1530 **Name:** Location ID

Coding Instructions: Indicate the Location Identification number assigned for the office location by the ACC-NCDR.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1540 **Name:** Provider Last Name

Coding Instructions: Indicate the evaluating provider's last name.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1541 **Name:** Provider First Name

1. General Information

Seq. #: 1542 Name: Provider Middle Name

Coding Instructions: Indicate the evaluating provider's middle name.

Note(s):

It is acceptable to specify the provider's middle initial.

If the provider does not have a middle name, leave field blank.

If the provider has multiple middle names, enter each middle name separated by a single space.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1550 Name: NPI

Coding Instructions: Indicate the evaluating provider's National Provider Identifier (NPI).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 1560 Name: Patient New to the Practice

Coding Instructions: Indicate if this encounter is the first time the patient was treated by the practice.

Note(s):

If the patient was treated at the same practice but a different location, then code No.

Target Value: The value on current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
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	No	
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	Yes	
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Supporting Definitions: (none)

A. Patient Demographics

Seq. #: 2000 Name: Patient Last Name

Coding Instructions: Indicate the patient's last name. Hyphenated names should be recorded with a hyphen.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2010 Name: Patient First Name

Coding Instructions: Indicate the patient's first name.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2020 Name: Patient Middle Name

Coding Instructions: Indicate the patient's middle name(s).

Note(s):

It is acceptable to specify the patient's middle initial.

If the patient has multiple middle names, enter all of the middle names sequentially.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2030 Name: SSN

Coding Instructions: Indicate the patient's United States Social Security Number (SSN).

Note(s):

If the patient does not have a US Social Security Number (SSN), leave blank.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 2050 Name: Date of Birth

Coding Instructions: Indicate the patient's date of birth.

Target Value: The value on current encounter

Selections: (none)

A. Patient Demographics

Seq. #: 2070 Name: Race - White

Coding Instructions: Indicate if the patient is White as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: **White (Race):**

Having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Seq. #: 2071 Name: Race - Black/African American

Coding Instructions: Indicate if the patient is Black or African American as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Black/African American (Race):**

Having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Seq. #: 2072 Name: Race - Asian

Coding Instructions: Indicate if the patient is Asian as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Asian (Race):**

Having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent

A. Patient Demographics

Seq. #: 2073 Name: Race - American Indian/Alaskan Native

Coding Instructions: Indicate if the patient is American Indian or Alaskan Native as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: **American Indian or Alaskan Native (Race):**

Having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Seq. #: 2074 Name: Race - Native Hawaiian/Pacific Islander

Coding Instructions: Indicate if the patient is Native Hawaiian or Pacific Islander as determined by the patient/family.

Note(s):

If the patient has multiple race origins, specify them using the other race selections in addition to this one.

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: **Native Hawaiian or Pacific Islander (Race):**

Having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

Seq. #: 2076 Name: Hispanic or Latino Ethnicity

Coding Instructions: Indicate if the patient is of Hispanic or Latino ethnicity as determined by the patient/family.

Target Value: The value on arrival at this facility

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions :

A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

Source: U.S. Office of Management and Budget. Classification of Federal Data on Race and Ethnicity

A. Patient Demographics

Seq. #: 3020 Name: Insurance - Private Health Insurance

Coding Instructions: Indicate if the patient's insurance payor(s) included private health insurance.

Note(s):

A health maintenance organization (HMO) is considered private health insurance.

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: Private Health Insurance:

Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company.

Source: U.S.Census Bureau

Seq. #: 3022 Name: Insurance - Medicaid

Coding Instructions: Indicate if the patient's insurance payor(s) included Medicaid.

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: Medicaid:

Medicaid is a program administered at the state level, which provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names in different states.

Source: U.S.Census Bureau

Seq. #: 3023 Name: Insurance - Military Health Care

Coding Instructions: Indicate if the patient's insurance payor(s) included Military Health Care.

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

A. Patient Demographics

Seq. #: 3024 Name: Insurance - State Specific Plan (non-Medicaid)

Coding Instructions: Indicate if the patient's insurance payor(s) included State-specific Plan.

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: **State Specific Plan:**

State-specific plan - Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states. (Non-Medicaid)

Source: U.S.Census Bureau

Seq. #: 3025 Name: Insurance - Indian Health Service

Coding Instructions: Indicate if the patient's insurance payor(s) included Indian Health Service (IHS).

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: **Indian Health Service:**

Indian Health Service (IHS) is a health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities.

Source: U.S.Census Bureau

Seq. #: 3026 Name: Insurance - Non-US Insurance

Coding Instructions: Indicate if the patient's insurance payor(s) included Non-US Insurance.

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has no insurance (coded as None).

Target Value: The value on current encounter

Selections:

Selection Text	Definition
No	
Yes	

A. Patient Demographics

Seq. #: 3027 Name: Insurance - None

Coding Instructions: Indicate if the patient has no insurance payor(s).

Note(s):

This is one of 9 possible selections for Insurance. This selection is not applicable if patient has any form of insurance.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: None:

None refers to individuals with no or limited health insurance thus, the individual is the payor regardless of ability to pay.

Source: NCDR

Seq. #: 3028 Name: Insurance - Medicare (Fee for service)

Coding Instructions: Indicate if the patient's insurance payor(s) included Medicare Fee for Service.

Note(s):

This is one of the 9 selections for the Insurance element, mutually exclusive with the selection of None.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: Medicare:

Medicare is the Federal program which helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.

The traditional system of reimbursement under health insurance and Medicare. Health care providers bill patients for services supplied, and costs are shared according to a contractual agreement between the patient and insurance company. A fee-for-service system allows patients maximum flexibility in the choice of providers and services.

Source: U.S.Census Bureau

Seq. #: 3029 Name: Insurance - Medicare (Managed care)

Coding Instructions: Indicate if the patient is insured by Medicare (managed care/HMO).

Note(s):

This is one of the 9 selections for the Insurance element, mutually exclusive with the selection of None.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

A. Patient Demographics

Seq. #: 3100 **Name:** Payer ID

Coding Instructions: Indicate the Payer ID of the patient's primary insurance payer. Payer ID is a national numbering system that identifies healthcare payers authorized by CMS for healthcare claims processing and other electronic data interchange transactions.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4000 Name: Coronary Artery Disease

Coding Instructions: Indicate if the patient has been diagnosed with Coronary Artery Disease (CAD).

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No
Yes

Supporting Definitions: Coronary Artery Disease:

A history of coronary artery disease (CAD) is evidenced by one of the following:

1. Currently receiving medical treatment for CAD
2. History of Myocardial Infarction
3. Prior CV intervention including, but not limited to, CABG and/or PCI

Source: STS

Seq. #: 4005 Name: Atrial Fibrillation or Flutter

Coding Instructions: Indicate if the patient has been diagnosed with atrial fibrillation or atrial flutter.

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No
Yes

Supporting Definitions: Atrial Fibrillation::

Atrial Fibrillation is a supraventricular tachyarrhythmia characterized by uncoordinated atrial activity with consequent deterioration of atrial mechanical function. On the electrocardiogram (ECG), atrial fibrillation is characterized by the replacement of consistent P waves with rapid oscillations or fibrillation waves that vary in amplitude, shape and timing, associated with an irregular, frequently rapid ventricular response when atrioventricular conduction is intact.

Atrial Flutter is characterized by a sawtooth pattern of regular atrial activation called flutter waves on the ECG, particularly visible in leads II, III, aVF and v1.

Source: ACC/AHA 2006 Data Standards for Measuring Clinical Management and Outcomes of Patients with Atrial Fibrillation

Seq. #: 4010 Name: Dyslipidemia

Coding Instructions: Indicate if the patient has been diagnosed with Dyslipidemia.

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No
Yes

Supporting Definitions: Dyslipidemia:

Dyslipidemia is defined by the National Cholesterol Education Program criteria and includes documentation of the following:

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4015 Name: Diabetes Mellitus

Coding Instructions: Indicate if the patient has a history of diabetes mellitus regardless of duration of disease or need for antidiabetic agents.

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: Diabetes Mellitus:

Diabetes mellitus is diagnosed by a physician or can be defined as a fasting blood sugar greater than 7 mmol/l or 126 mg/dL. It does not include gestational diabetes.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Seq. #: 4020 Name: Hypertension

Coding Instructions: Indicate if the patient has been diagnosed with Hypertension.

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: Hypertension:

Hypertension is defined by any one of the following:

1. History of hypertension diagnosed and treated with medication, diet and/or exercise.
2. Prior documentation of blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure greater than 130 mm Hg systolic and/or 80 mm Hg diastolic on at least two occasions for patients with diabetes or chronic kidney disease.
3. Currently on pharmacologic therapy for treatment of hypertension.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Seq. #: 4025 Name: Systemic Embolism

Coding Instructions: Indicate if the patient has been diagnosed with a systemic embolism.

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: Systemic Embolism:

A blood clot that travels through the circulation system and becomes stuck in an artery, blocking blood flow.

Source: NCDR

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4030 Name: Peripheral Arterial Disease

Coding Instructions: Indicate if the patient has been diagnosed with Peripheral Arterial Disease (PAD).

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No
Yes

Supporting Definitions: **PAD:**

Peripheral arterial disease can include:

1. Claudication, either with exertion or at rest.
2. Amputation for arterial vascular insufficiency.
3. Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities (excluding dialysis fistulas and vein stripping).
4. Documented aortic aneurysm with or without repair.
5. Positive non-invasive test (e.g., ankle brachial index ≤ 0.9); ultrasound, magnetic resonance, computed tomography, or angiographic imaging of $> 50\%$ diameter stenosis in any peripheral artery (e.g., renal, subclavian, femoral, iliac).

For purposes of the Registry, peripheral arterial disease excludes disease in the carotid and cerebrovascular arteries.

Source: ACC Clinical Data Standards, The Society of Thoracic Surgeons

Seq. #: 4035 Name: Prior Stroke or TIA

Coding Instructions: Indicate if the patient has been diagnosed with a prior Stroke or CVA.

Target Value: Any occurrence between birth and completion of current encounter

Selections: *Selection Text* *Definition*

No
Yes

Supporting Definitions: **Cerebrovascular Disease:**

Cerebrovascular Disease is documented by any one of the following:

1. Cerebrovascular Accident (CVA): Patient has a history of stroke, i.e., loss of neurological function with residual symptoms at least 24 hours after onset, presumed to be from vascular etiology.
2. Transient Ischemic Attack (TIA): Patient has a history of loss of neurological function that was abrupt in onset but with complete return of function within 24 hours, presumed to be due to vascular etiology.
3. Non-invasive/invasive carotid test with greater than 79% occlusion.
4. Previous carotid artery surgery/ intervention for carotid artery stenosis.

This does not include neurological disease processes such as metabolic and/or anoxic ischemic encephalopathy.

Source: NCDR, The Society of Thoracic Surgeons

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4040 Name: Unstable Angina

Coding Instructions: Indicate if the patient has been diagnosed with unstable angina.

Note(s):

There are three principal presentations of unstable angina: 1. Rest angina (occurring at rest and prolonged, usually >20 minutes); 2. Newonset angina (within the past 2 months, of at least Canadian Cardiovascular Society Class III severity); or 3. Increasing angina (previously diagnosed angina that has become distinctly more frequent, longer in duration, or increased by 1 or more Canadian Cardiovascular Society class to at least CCS III severity).

Target Value: Any occurrence between birth and completion of current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 4045 Name: Heart Failure

Coding Instructions: Indicate if the patient has been diagnosed with heart failure (HF).

Target Value: Any occurrence between birth and completion of current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **Heart Failure:**

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

Seq. #: 4050 Name: Heart Failure new diagnosis (within 12 months)

Coding Instructions: Indicate if the patient has been diagnosed with heart failure (HF) within the last 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and completion of current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: **Heart Failure:**

Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest x-ray presumed to be cardiac dysfunction. A low ejection fraction without clinical

B. Diagnoses/Conditions/Comorbidities

Seq. #: 4055 **Name:** Stable Angina

Coding Instructions: Indicate if the patient has been diagnosed with stable angina.

Note(s):

Angina without a change in frequency or pattern for the 6 weeks prior to this visit. Angina is controlled by rest and/or oral or transcutaneous medications.

Target Value: Any occurrence between birth and completion of current encounter

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

Seq. #: 4060 **Name:** Stable Angina new diagnosis (within 12 months)

Coding Instructions: Indicate if the patient has been diagnosed with stable angina within the past 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and completion of current encounter

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

C. Cardiac Events

Seq. #: 5000 **Name:** Myocardial Infarction (any history of)

Coding Instructions: Indicate if the patient was diagnosed with having a myocardial infarction (MI).

Target Value: Any occurrence between birth and start of current encounter

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: **Myocardial Infarction:**

A myocardial infarction is evidenced by any of the following:

1. A rise and fall of cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory [typically above the 99th percentile of the upper reference limit (URL) for normal subjects] together with at least one of the following manifestations of myocardial ischemia:
 - a. Ischemic symptoms.
 - b. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R-wave voltage).
 - c. Development of pathological Q- waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI).
 - d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
 - e. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in a-d due to conditions that may mask their appearance (e.g., peri-operative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing).
2. ECG changes associated with prior myocardial infarction can include the following (with or without prior symptoms):
 - a. Any Q-wave in leads V2-V3 ≥ 0.02 seconds or QS complex in leads V2 and V3.
 - b. Q-wave ≥ 0.03 seconds and ≥ 0.1 mV deep or QS complex in leads I, II, aVL, aVF, or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF).
 - c. R-wave ≥ 0.04 seconds in V1-V2 and R/S ≥ 1 with a concordant positive Twave in the absence of a conduction defect.
3. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic cause. This can be manifest as:
 - a. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis).
 - b. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).
4. Medical record documentation of prior myocardial infarction.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force Consensus Document
"Universal Definition of Myocardial Infarction"

C. Cardiac Events

Seq. #: 5005 **Name:** Myocardial Infarction (within 12 months)

Coding Instructions: Indicate if the patient was diagnosed with having an Myocardial Infarction (MI) in the past 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and start of current encounter

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: **Myocardial Infarction:**

A myocardial infarction is evidenced by any of the following:

1. A rise and fall of cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory [typically above the 99th percentile of the upper reference limit (URL) for normal subjects] together with

at least one of the following manifestations of myocardial ischemia:

a. Ischemic symptoms.

b. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R-wave voltage).

c. Development of pathological Q- waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI).

d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

e. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in a-d due to conditions that may mask their appearance (e.g., peri-operative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing).

2. ECG changes associated with prior myocardial infarction can include the following (with or without prior symptoms):

a. Any Q-wave in leads V2-V3 ≥ 0.02 seconds or QS complex in leads V2 and V3.

b. Q-wave ≥ 0.03 seconds and ≥ 0.1 mV deep or QS complex in leads I, II, aVL, aVF, or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF).

c. R-wave ≥ 0.04 seconds in V1-V2 and R/S ≥ 1 with a concordant positive Twave in the absence of a conduction defect.

3. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic cause. This can be manifest as:

a. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis).

b. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).

4. Medical record documentation of prior myocardial infarction.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force Consensus Document

"Universal Definition of Myocardial Infarction"

C. Cardiac Events

Seq. #: 5015 Name: PCI - Bare Metal Stent Implant (within 12 months)

Coding Instructions: Indicate if the patient had a percutaneous coronary intervention (PCI) that resulted in the implant of a bare metal stent in the past 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and start of current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5020 Name: Cardiac Valve Surgery (within 12 months)

Coding Instructions: Indicate if the patient had cardiac valve surgery in the past 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and start of current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5025 Name: PCI - Drug Eluting Stent Implant (within 12 months)

Coding Instructions: Indicate if the patient had a percutaneous coronary intervention (PCI) that resulted in the implant of a drug eluting stent (DES) in the past 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and start of current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5030 Name: Heart Transplantation (within 12 months)

Coding Instructions: Indicate if the patient had a heart transplantation surgery in the past 12 months.

Target Value: Any occurrence between 12 months prior to current encounter and start of current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 5035 Name: PCI - Other (non-stent) Intervention (within 12 months)

Coding Instructions: Indicate if the patient had percutaneous coronary intervention (PCI) that did not include a stent implant in the past 12 months.

Note(s):

This includes non-stenting procedures such as balloon angioplasty, atherectomy and thrombectomy.

D. Encounter Information

Seq. #: 6000 Name: Height (in)

Coding Instructions: Indicate the patient's Height in inches (in).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6001 Name: Height (cm)

Coding Instructions: Indicate the patient's Height in centimeters (cm).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6010 Name: Systolic Blood Pressure

Coding Instructions: Indicate the patient's systolic blood pressure in mmHg.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6011 Name: Diastolic Blood Pressure

Coding Instructions: Indicate the patient's diastolic blood pressure in mmHg.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6015 Name: Heart Rate

Coding Instructions: Indicate the patient's heart rate in beats per minute.

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6020 Name: Weight (lbs)

D. Encounter Information

Seq. #: 6021 Name: Weight (kg)

Coding Instructions: Indicate the patient's weight in kilograms (kg).

Target Value: The value on current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 6025 Name: Patient unable to be weighed

Coding Instructions: Indicate if the patient was unable to be weighed during the encounter.

Target Value: The value on current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 6030 Name: Tobacco Use

Coding Instructions: Indicate the patient's use of tobacco products. Tobacco products include smoke (cigarettes, cigars, pipe) and smokeless (chewing tobacco).

Target Value: The value on current encounter

Selections:	Selection Text	Definition
	Never	
	Current	
	Quit within past 12 months	
	Quit more than 12 months ago	

Supporting Definitions: (none)

Seq. #: 6035 Name: Cigarettes

Coding Instructions: Indicate if the patient is a cigarette smoker currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 6036 Name: Cigars

Coding Instructions: Indicate if the patient is a cigar smoker currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections:	Selection Text	Definition
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D. Encounter Information

Seq. #: 6037 Name: Pipe

Coding Instructions: Indicate if the patient is a pipe smoker currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6038 Name: Smokeless

Coding Instructions: Indicate if the patient uses smokeless tobacco currently or quit within the past 12 months.

Target Value: The value between 12 months prior to current encounter and current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6040 Name: Smoking Cessation Counseling/Pharmacological Therapy

Coding Instructions: Indicate if the patient received smoking cessation counseling or pharmacological therapy for smoking cessation if they are a current smoker or quit within 12 months.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6045 Name: Patient asked during any previous encounter in the past 24 months about the use of tobacco

Coding Instructions: Indicate if the patient was asked, during any previous encounter in the past 24 months, about the use of tobacco.

Target Value: Any occurrence between 24 months prior to current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6050 Name: Advance Care Plan Discussed or Discussion of Advance Care Plan Documented

Coding Instructions: For patients 65 and older, indicate if an advance care plan was documented in the medical record or the creation of an advance care plan was discussed with the patient or surrogate decision maker.

Target Value: The value between start of current encounter and completion of current encounter

D. Encounter Information

Seq. #: 6100 Name: Canadian Cardiovascular Society (CCS) Class

Coding Instructions: Indicate the patient's Canadian Cardiovascular Society (CCS) classification for angina.

Target Value: The value on current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No angina	
I		Ordinary physical activity (for example, walking or climbing stairs) does not cause angina; angina occurs with strenuous or rapid or prolonged exertion at work or recreation,
II		Slight limitation of ordinary activity (for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress, or only during the few hours after awakening; walking more than 2 blocks on the level or climbing more than 1 flight of ordinary stairs at a normal pace; and in normal conditions).
III		Marked limitation of ordinary activity (for example, angina occurs with walking 1 or 2 blocks on the level or climbing 1 flight of stairs in normal conditions and at a normal pace).
IV		Inability to perform any physical activity without discomfort; angina syndrome may be present at rest.

Supporting Definitions: (none)

Seq. #: 6105 Name: Seattle Angina Questionnaire (SAQ) Completed

Coding Instructions: Indicate if the patient has completed the Seattle Angina Questionnaire (SAQ).

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

Seq. #: 6115 Name: Other Tool/Method used to assess Angina Symptoms and Activity Completed

Coding Instructions: Indicate if another tool/method was used to assess the patient's angina symptoms and activity other than the CCS or SAQ.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
	No	
	Yes	

Supporting Definitions: (none)

D. Encounter Information

Seq. #: 6200 Name: New York Heart Association Functional Classification for Heart Failure

Coding Instructions: Indicate the patient's New York Heart Association functional classification for Heart Failure.

Target Value: The value on current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
I		Patient has cardiac disease but without resulting limitations of ordinary physical activity. Ordinary physical activity (e.g., walking several blocks or climbing stairs) does not cause undue fatigue, palpitation, dyspnea, or anginal pain. Limiting symptoms may occur with marked exertion.
II		Patient has cardiac disease resulting in slight limitation of ordinary physical activity. Patient is comfortable at rest. Ordinary physical activity such as walking more than two blocks or climbing more than one flight of stairs results in limiting symptoms (e.g., fatigue, palpitation, dyspnea, or anginal pain)
III		Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. Less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitation, dyspnea, or anginal pain.
IV		Patient has dyspnea at rest that increases with any physical activity. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Supporting Definitions: (none)

Seq. #: 6205 Name: Kansas City Cardiomyopathy Questionnaire Completed

Coding Instructions: Indicate if the patient has completed the Kansas City Cardiomyopathy Questionnaire (KCCQ).

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
No		
Yes		

Supporting Definitions: (none)

Seq. #: 6220 Name: Chronic Heart Failure Questionnaire from Guyatt Completed

Coding Instructions: Indicate if the patient completed the Chronic Heart Failure Questionnaire from Guyatt.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
No		
Yes		

Supporting Definitions: (none)

Seq. #: 6225 Name: Minnesota Living with Heart Failure Questionnaire Completed

Coding Instructions: Indicate if the patient has completed the Minnesota Living with Heart Failure Questionnaire.

Target Value: Any occurrence between start of current encounter and completion of current encounter

D. Encounter Information

Seq. #: 6230 Name: Other Tool/Method used to assess Heart Failure Activity Completed

Coding Instructions: Indicate if another tool/method was used to assess the patient's heart failure symptoms and activity other than the NYHA, KCCQ, Minnesota Living with Heart Failure Questionnaire or Chronic Heart Failure Score from Guyatt.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6300 Name: Dyspnea Present

Coding Instructions: Indicate if the patient has dyspnea.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6305 Name: Orthopnea Present

Coding Instructions: Indicate if the patient has orthopnea.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6400 Name: Rales Present

Coding Instructions: Indicate if the patient has rales.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6405 Name: Peripheral Edema Present

Coding Instructions: Indicate if the patient has peripheral edema.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

D. Encounter Information

Seq. #: 6420 Name: Ascites Present

Coding Instructions: Indicate if the patient has Ascites.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6425 Name: Hepatomegaly Present

Coding Instructions: Indicate if the patient has Hepatomegaly.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6430 Name: S4 Gallop Present

Coding Instructions: Indicate if the patient has an S4 gallop.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6435 Name: Jugular Venous Distention Present

Coding Instructions: Indicate if the patient has jugular venous distention.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6500 Name: Hypertension Plan of Care Documented

Coding Instructions: Indicate if the patient has a documented plan of care for hypertension.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

D. Encounter Information

Seq. #: 6505 Name: Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months

Coding Instructions: Indicate if the patient had a cardiac event within the past 12 months requiring cardiac rehabilitation. Cardiac events includes Myocardial Infarction, Valve Replacement, Heart Transplant, CABG or PCI.

Note(s):

Cardiac rehabilitation is a medically supervised program to help cardiac patients slow and stabilize the progression of cardiovascular disease thus reducing the risk of heart disease, another cardiac event or death. Cardiac rehabilitation programs include patient counseling, an exercise program, nutrition counseling and risk factor education (smoking, obesity, high blood pressure, high cholesterol).

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections:

Selection Text	Definition
Yes - Referral/Plan documented	
No qualifying event/diagnosis	
Patient already participating in rehab	
No Referral/Plan - Medical Reason	
No Referral/Plan - Patient Reason	
No Referral/Plan - System Reason	

Supporting Definitions: Referral:

A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an outpatient CR program. This also includes a written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate to the CR program [the patient's cardiovascular history, testing, and treatments, for instance]. According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report once the patient has completed the program. All communications must maintain an appropriate level of confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act [HIPAA].)

Source: Thomas RJ, King M, Lui K, et al. "AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services." Journal of American College of Cardiology. 2007; 50(14), pp 1400-1433

Seq. #: 6509 Name: HF Education Completed/Documented

Coding Instructions: Element retired (v1.2)

Target Value: N/A

Selections:

Selection Text	Definition
No	
Yes	

Supporting Definitions: (none)

D. Encounter Information

Seq. #: 6511 Name: HF Education - Weight Monitoring

Coding Instructions: Indicate if the patient received weight monitoring education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6512 Name: HF Education - Diet (Sodium Restriction)

Coding Instructions: Indicate if the patient received a sodium-restricted dietary education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6513 Name: HF Education - Symptom Management

Coding Instructions: Indicate if the patient received symptom management education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6514 Name: HF Education - Physical Activity

Coding Instructions: Indicate if the patient received physical activity education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6515 Name: HF Education - Smoking Cessation

Coding Instructions: Indicate if the patient received smoking cessation education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

D. Encounter Information

Seq. #: 6517 Name: HF Education - Prognosis/End-of-Life Issues

Coding Instructions: Indicate if the patient received prognosis/end-of-life issues education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6518 Name: HF Education - Minimizing or Avoiding use of NSAIDs

Coding Instructions: Indicate if the patient received minimizing or avoiding use of NSAIDs education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6519 Name: HF Education - Referral for visiting nurse or specific education or management programs

Coding Instructions: Indicate if the patient received a referral for visiting nurse or specific education or management programs education for heart failure.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6600 Name: AFib/Flutter Duration

Coding Instructions: Indicate the duration of the patient's AFib/Flutter.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

First episode detected

Chronic - paroxysmal

Chronic - persistent/permanent

Supporting Definitions: (none)

Seq. #: 6605 Name: AFib/Flutter Type

Coding Instructions: Indicate the if the patient has valvular of non-valvular AFib/Flutter

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

D. Encounter Information

Seq. #: 6610 Name: Etiology - Transient/reversible Cause

Coding Instructions: Indicate if the patient's AFib/Flutter is due to a transient and/or reversible cause.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6611 Name: Etiology - Cardiac Surgery within past 3 months

Coding Instructions: Indicate if the patient's Afib/Flutter is due to cardiac surgery within the past 3 months.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6612 Name: Etiology - Pregnancy

Coding Instructions: Indicate if the patient's Afib/Flutter is due to a current pregnancy.

Target Value: The value on current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 6615 Name: Thromboembolic Risk Factors Assessed

Coding Instructions: Indicate if the patient's thromboembolic risk factors for atrial fibrillation or flutter were assessed and documented in the chart.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

Yes (All risk factors assessed)

No - Medical Reason

No - Patient Reason

No - System Reason

Selection Retired (v1.2)

Supporting Definitions: (none)

E. Laboratory Results

Seq. #: 7000 Name: Left Ventricular Ejection Fraction (LVEF) Date

Coding Instructions: Indicate the date of the most recent left ventricular ejection fraction.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7005 Name: Left Ventricular Ejection Fraction (LVEF) Percent

Coding Instructions: Indicate the patient's left ventricular quantitative assessment.

Note(s):

The "LVEF percent" element should only be used if a single percentage is documented in the medical record.

If a LVEF range or a descriptive term (e.g., Moderately reduced) is documented in the medical record, then report the LV function using the "LV Qualitative Assessment" element.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7010 Name: Left Ventricular Qualitative Assessment

Coding Instructions: Indicate the patient's LV Qualitative Assessment.

Note(s):

If a percentage is documented in the medical record, use the "LVEF Percent" element to document the percentage.

If a LVEF percentage range is documented in the medical record, average the percentages, round up and reference the "LV Qualitative Assessment" selections to report.

Target Value: The last value between birth and completion of current encounter

Selections:

Selection Text	Definition
Normal: >=50	
Mildly reduced: 40 - 49	
Moderately reduced: 26 - 39	
Severely reduced: <=25	

Supporting Definitions: (none)

Seq. #: 7015 Name: Lipid Panel Obtained Date

Coding Instructions: Indicate the date blood was drawn for the most recent lipid panel.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

E. Laboratory Results

Seq. #: 7025 Name: Total Cholesterol

Coding Instructions: Indicate the patient's most recent cholesterol in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7030 Name: High Density Lipoprotein (HDL)

Coding Instructions: Indicate the patient's most recent high density lipoproteins (HDL) in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7035 Name: Low Density Lipoprotein (LDL)

Coding Instructions: Indicate the patient's most recent low density lipoproteins (LDL) in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7040 Name: Triglycerides

Coding Instructions: Indicate the patient's most recent triglycerides in milligrams per deciliter (mg/dL) for the most recent lipid panel.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7045 Name: Lipid Panel Ordered

Coding Instructions: Indicate if the physician ordered a lipid panel.

Target Value: Any occurrence between start of current encounter and completion of current encounter

Selections: *Selection Text* *Definition*

No

Yes

Supporting Definitions: (none)

Seq. #: 7050 Name: Serum Glucose Ordered

E. Laboratory Results

Seq. #: 7055 Name: Glucose Date

Coding Instructions: Indicate the date blood was drawn for the most recent serum glucose test.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7060 Name: Glucose

Coding Instructions: Indicate the patient's serum glucose level in milligrams per deciliter (mg/dL) for the most recent serum glucose test..

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7065 Name: Glucose Timing

Coding Instructions: Indicate the timing of the serum glucose test with respect to food intake for the most recent serum glucose test.

Target Value: The last value between birth and completion of current encounter

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Fasting

2 hr Glucose Tolerance Testing

Random

Unknown

Supporting Definitions: (none)

Seq. #: 7070 Name: HbA1c Date

Coding Instructions: Indicate the date blood was drawn for the most recent Hemoglobin A1c (HbA1c) test.

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

Seq. #: 7075 Name: HbA1c Percentage

Coding Instructions: Indicate the patient's Hemoglobin A1c (HbA1c) percentage for the most recent Hemoglobin A1c (HbA1c) test..

Target Value: The last value between birth and completion of current encounter

Selections: (none)

Supporting Definitions: (none)

F. Prescriptions

Seq. #: 8000 **Name:** Prescription given for any Medication

Coding Instructions: Indicate if at least one prescription was given for any medication to the patient during the encounter.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Selection Text	Definition
No	
Yes	

No

Yes

Supporting Definitions: (none)

Seq. #: 8005 **Name:** Prescription generated and transmitted using an e-prescribing system

Coding Instructions: Indicate if at least one prescription was generated and transmitted using a qualified e-prescribing system during the encounter.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Selection Text	Definition
No	
Yes	

No

Yes

Supporting Definitions: (none)

G. Medications

Seq. #: 9000 Name: ACE Inhibitor prescribed or continued

Coding Instructions: Indicate if the patient had an ACE Inhibitor prescribed or continued.

Note(s):

An Angiotensin-Converting Enzyme inhibitor (ACE inhibitor) reduces the conversion of angiotensin I to angiotensin II, a potent vasoconstrictor and is also involved in the inactivation of bradykinin, a potent vasodilator.

Examples of ACE Inhibitors include benazopril (Lotensin), fosinopril (Monopril), enalapril (Vasotec), lisinopril (Prinivil, Zestril), moexipril (Univasc), perindopril (Aceon), quinapril (Accupril), ramipril (Altace), and trandolapril (Mavik).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Yes

No - Medical reason

No - Patient reason

No - System reason

Supporting Definitions: (none)

Seq. #: 9005 Name: Clopidogrel prescribed or continued

Coding Instructions: Indicate if the patient had Clopidogrel prescribed or continued.

Note(s):

Clopidogrel, an adenosine diphosphate (ADP) receptor inhibitor, is an antiplatelet agent. The brand name for Clopidogrel is Plavix.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Yes

No - Medical reason

No - Patient reason

No - System reason

Supporting Definitions: (none)

G. Medications

Seq. #: 9010 Name: Ticlopidine prescribed or continued

Coding Instructions: Indicate if the patient had Ticlopidine prescribed or continued.

Note(s):

Ticlopidine, an adenosine diphosphate (ADP) receptor inhibitor, is an antiplatelet agent. The brand name for Ticlopidine is Ticlid.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Yes

No - Medical reason

No - Patient reason

No - System reason

Supporting Definitions: (none)

Seq. #: 9015 Name: Prasugrel prescribed or continued

Coding Instructions: Indicate if the patient had Prasugrel prescribed or continued.

Note(s):

Prasugrel, an adenosine diphosphate (ADP) receptor inhibitor, is an antiplatelet agent. The brand name for Prasugrel is Effient.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Yes

No - Medical reason

No - Patient reason

No - System reason

Supporting Definitions: (none)

Seq. #: 9020 Name: Aggrenox prescribed or continued

Coding Instructions: Indicate if the patient had Aggrenox prescribed or continued.

Note(s):

Aggrenox is an a combination antiplatelet agent that contains Dipyridamole and Aspirin.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

G. Medications

Seq. #: 9025 Name: Angiotensin Receptor Blocker (ARB) prescribed or continued

Coding Instructions: Indicate if the patient had an ARB prescribed or continued.

Note(s):

Angiotensin receptor blockers (ARBs) are medications that block the action of angiotensin II which is a very potent chemical that causes the muscles surrounding the blood vessels to contract, thereby narrowing the blood vessels. Examples of Angiotensin Receptor Blockers include irbesartan (Avapro), candesartan (Atacand), losartan (Cozaar), valsartan (Diovan), telmisartan (Micardis), eprosartan (Tevetan), and olmesartan (Benicar).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Yes

No - Medical reason

No - Patient reason

No - System reason

Supporting Definitions: (none)

Seq. #: 9030 Name: Aspirin prescribed or continued

Coding Instructions: Indicate if the patient had Aspirin prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

<i>Selection Text</i>	<i>Definition</i>
-----------------------	-------------------

Yes

No - Medical reason

No - Patient reason

No - System reason

Supporting Definitions: (none)

Seq. #: 9035 Name: Beta Blocker prescribed or continued

Coding Instructions: Indicate if the patient had a Beta Blocker prescribed or continued.

Note(s):

Beta blockers are a class of drugs used for various indications, but particularly for the management of cardiac arrhythmias and cardio protection after myocardial infarction.

Examples of Beta blockers include acebutolol (Sectral), atenolol (Tenormin), bisoprolol (Zebeta), metoprolol (Lopressor, Lopressor LA, Toprol XL), nadolol (Corgard) and timolol (Blocadren).

G. Medications

Seq. #: 9040 Name: Calcium Channel Blockers

Coding Instructions: Indicate if the patient had a Calcium Channel Blocker prescribed or continued.

Note(s):

Calcium channel blockers are a class of drugs that block the entry of calcium into the muscle cells of the heart and the arteries.

Examples of CCBs include nisoldipine (Sular), nifedipine (Adalat, Procardia), nicardipine (Cardene), bepridil (Vascor), isradipine (Dynacirc), nimodipine (Nimotop), felodipine (Plendil), amlodipine (Norvasc), diltiazem (Cardizem), and verapamil (Calan, Isoptin).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Selection Text	Definition
Yes	
No - Medical reason	
No - Patient reason	
No - System reason	

Supporting Definitions: (none)

Seq. #: 9045 Name: Diuretics prescribed or continued

Coding Instructions: Indicate if the patient had a Diuretic prescribed or continued.

Note(s):

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Selection Text	Definition
Yes	
No - Medical reason	
No - Patient reason	
No - System reason	

Supporting Definitions: (none)

Seq. #: 9050 Name: Lipid-lowering Non-Statin Medication prescribed or continued

Coding Instructions: Indicate if the patient had a Non-Statin Lipid-lowering Medication prescribed or continued.

Note(s):

Lipid-lowering non-statin medications assist in lowering lipid levels. Examples of non-statin lipid lowering agents

include fibrates (e.g. Clofibrate, Bezafibrate, or Ciprofibrate), colestyramine (Questran/Questran Light),

colestipol

(Colestid), and nicotinic acid (Niacin)

G. Medications

Seq. #: 9055 **Name:** Lipid-lowering Statin Medication prescribed or continued

Coding Instructions: Indicate if the patient had a Statin Lipid-lowering Medication prescribed or continued.

Note(s):

Lipid-lowering statin medications assist in lowering lipid levels. Examples of statin lipid lowering agents include lovastatin (Mevacor), pravastatin (Pravachol), simvastatin (Zocor), atorvastatin (Lipitor) and rosuvastatin (Crestor).

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Selection Text	Definition
Yes	
No - Medical reason	
No - Patient reason	
No - System reason	

Supporting Definitions: (none)

Seq. #: 9060 **Name:** Warfarin prescribed or continued

Coding Instructions: Indicate if the patient had Warfarin prescribed or continued.

Note(s):

Warfarin is an anticoagulant. Examples of Warfarin include Coumadin, Jantoven, Marevan, and Waran.

If the medication was not prescribed or discontinued, indicate the reason why.

If no documentation exists as to why a medication was not prescribed, then leave the field blank.

Target Value: The value between start of current encounter and completion of current encounter

Selections:

Selection Text	Definition
Yes	
No - Medical reason	
No - Patient reason	
No - System reason	

Supporting Definitions: (none)

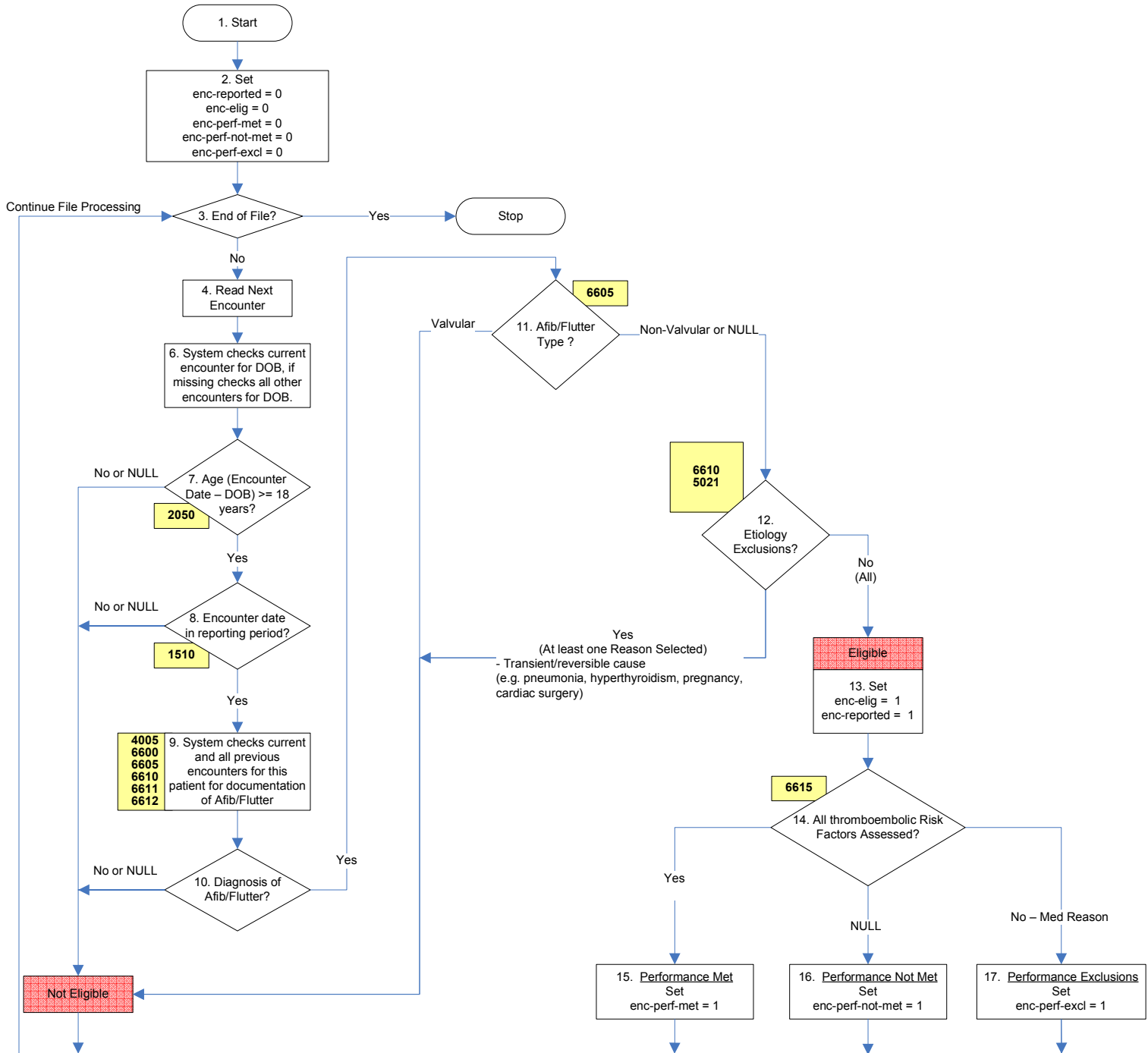
<div>PINNACLE Registry[®]</div> <div>Quality improvement solutions for the outpatient setting</div>		<div>NCDR[®] PINNACLE Registry[®] v1.3</div> <div>Data Collection Form</div> <div>Practice Innovation and Clinical Excellence</div>	
MRN ¹⁵⁰⁰ :	Encounter Date ¹⁵¹⁰ : mm / dd / yyyy	Practice ID ¹⁵²⁰ :	Location ID ¹⁵³⁰ :
Provider Name (Last, First, MI) ^{1540, 1541, 1542} :		Patient new to the Practice ¹⁵⁶⁰ : <input type="radio"/> No <input type="radio"/> Yes	
Provider NPI ¹⁵⁵⁰ :	Encounter Reason ¹⁵⁶⁵ : <input type="radio"/> Atrial Fibrillation <input type="radio"/> Coronary Artery Disease <input type="radio"/> Diabetes <input type="radio"/> Heart Failure <input type="radio"/> Hypertension <input type="radio"/> Other Cardiac <input type="radio"/> Non-Cardiac		
Encounter TIN ¹⁵⁵⁵ :			
A. PATIENT DEMOGRAPHICS			
Patient Name (Last, First, MI) ^{2000, 2010, 2020} :		SSN ²⁰³⁰ :	Patient ID ²⁰⁴⁰ : (auto) Patient Zip ²²⁰⁰ :
Date of Birth ²⁰⁵⁰ : mm / dd / yyyy	Sex ²⁰⁶⁰ : <input type="radio"/> Male <input type="radio"/> Female	<input type="checkbox"/> Patient Deceased ²⁰⁶⁵ → Date ²⁰⁶⁷ mm / dd / yyyy	
Race: (Check all that apply) <input type="checkbox"/> White ²⁰⁷⁰ <input type="checkbox"/> Black/African American ²⁰⁷¹ <input type="checkbox"/> Hispanic or Latino Ethnicity ²⁰⁷⁶ <input type="checkbox"/> American Indian/Alaska Native ²⁰⁷³ <input type="checkbox"/> Asian ²⁰⁷² <input type="checkbox"/> Native Hawaiian/Pacific Islander ²⁰⁷⁴			
Insurance Payers: (Check all that apply) <input type="checkbox"/> Medicaid (fee for service) ³⁰³⁰ <input type="checkbox"/> Medicare (fee for service) ³⁰²⁸ <input type="checkbox"/> Private Health Insurance ³⁰²⁰ <input type="checkbox"/> Medicaid (managed care) ³⁰³¹ <input type="checkbox"/> Medicare (managed care) ³⁰²⁹ <input type="checkbox"/> Military Health Care ³⁰²³ <input type="checkbox"/> State Specific Plan (non-Medicaid) ³⁰²⁴ <input type="checkbox"/> Indian Health Service ³⁰²⁵ <input type="checkbox"/> Non-US Insurance ³⁰²⁶ <input type="checkbox"/> None ³⁰²⁷ Payer ID ³¹⁰⁰ : _____			
B. DIAGNOSES/CONDITIONS/CO-MORBIDITIES (Check all that apply) Note: Indicate if the patient has a history of any of the following.			
<input type="checkbox"/> Coronary Artery Disease ⁴⁰⁰⁰	→ Date ⁴⁰⁰² mm / dd / yyyy	<input type="checkbox"/> Heart Failure ⁴⁰⁴⁵	→ Date ⁴⁰⁴⁷ mm / dd / yyyy
<input type="checkbox"/> Atrial Fibrillation/Flutter ⁴⁰⁰⁵	→ Date ⁴⁰⁰⁷ mm / dd / yyyy	→ If Yes, <input type="checkbox"/> New diagnosis ⁴⁰⁵⁰ (within 12 months)	
<input type="checkbox"/> Dyslipidemia ⁴⁰¹⁰	→ Date ⁴⁰¹² mm / dd / yyyy	<input type="checkbox"/> Stable Angina ⁴⁰⁵⁵	→ Date ⁴⁰⁵⁷ mm / dd / yyyy
<input type="checkbox"/> Diabetes Mellitus ⁴⁰¹⁵	→ Date ⁴⁰¹⁷ mm / dd / yyyy	→ If Yes, <input type="checkbox"/> New diagnosis ⁴⁰⁶⁰ (within 12 months)	
<input type="checkbox"/> Hypertension ⁴⁰²⁰	→ Date ⁴⁰²² mm / dd / yyyy	<input type="checkbox"/> Ischemic Vascular Disease ⁴⁰⁶⁵	→ Date ⁴⁰⁶⁷ mm / dd / yyyy
<input type="checkbox"/> Peripheral Arterial Disease ⁴⁰³⁰	→ Date ⁴⁰³² mm / dd / yyyy	<input type="checkbox"/> Peripheral Vascular Disease ⁴⁰⁷⁰	→ Date ⁴⁰⁷² mm / dd / yyyy
<input type="checkbox"/> Unstable Angina ⁴⁰⁴⁰	→ Date ⁴⁰⁴² mm / dd / yyyy	<input type="checkbox"/> Chronic Kidney Disease ⁴⁰⁷⁵	→ Date ⁴⁰⁷⁷ mm / dd / yyyy
		<input type="checkbox"/> Chronic Liver Disease ⁴⁰⁸⁰	→ Date ⁴⁰⁸² mm / dd / yyyy
C. CARDIAC EVENTS (Check all that apply) Note: Indicate if the patient has a history of any of the following.			
<input type="checkbox"/> Myocardial Infarction ⁵⁰⁰⁰	→ Date ⁵⁰⁰⁷ mm / dd / yyyy	<input type="checkbox"/> Coronary Artery Bypass Graft ⁵⁰¹¹	→ Date ⁵⁰¹² mm / dd / yyyy
<input type="checkbox"/> PCI - Bare Metal Stent Implant ⁵⁰¹⁶	→ Date ⁵⁰¹⁷ mm / dd / yyyy	<input type="checkbox"/> Cardiac Valve Surgery ⁵⁰²¹	→ Date ⁵⁰²² mm / dd / yyyy
<input type="checkbox"/> PCI - Drug Eluting Stent Implant ⁵⁰²⁶	→ Date ⁵⁰²⁷ mm / dd / yyyy	<input type="checkbox"/> Heart Transplantation ⁵⁰³¹	→ Date ⁵⁰³² mm / dd / yyyy
<input type="checkbox"/> PCI - Other (non-stent) Intervention ⁵⁰³⁶	→ Date ⁵⁰³⁷ mm / dd / yyyy	<input type="checkbox"/> Cardiac Therapeutic Procedure ⁵⁰⁴⁰	→ Date ⁵⁰⁴² mm / dd / yyyy
<input type="checkbox"/> Systemic Embolism ⁵⁰⁴⁵	→ Date ⁵⁰⁴⁷ mm / dd / yyyy	<input type="checkbox"/> Cardioversion ⁵⁰⁵⁰	→ Date ⁵⁰⁵² mm / dd / yyyy
<input type="checkbox"/> Minor Hemorrhage ⁵⁰⁵⁵	→ Date ⁵⁰⁵⁷ mm / dd / yyyy	<input type="checkbox"/> LVAD ⁵⁰⁶⁰	→ Date ⁵⁰⁶² mm / dd / yyyy
<input type="checkbox"/> Intracranial Hemorrhage ⁵⁰⁶⁵	→ Date ⁵⁰⁶⁷ mm / dd / yyyy	<input type="checkbox"/> CRT ⁵⁰⁷⁰	→ Date ⁵⁰⁷² mm / dd / yyyy
<input type="checkbox"/> Non-Intracranial Major Hemorrhage ⁵⁰⁷⁵	→ Date ⁵⁰⁷⁷ mm / dd / yyyy	<input type="checkbox"/> CRT-D ⁵⁰⁹⁰	→ Date ⁵⁰⁹² mm / dd / yyyy

MRN:		Encounter Date: mm / dd / yyyy		Practice ID:		Location ID:	
D. ENCOUNTER INFORMATION (CONTINUED)				Note: Complete only if assessed during today's encounter. If not assessed, leave blank.			
Tobacco Use⁶⁰³⁰: <input type="radio"/> Never <input type="radio"/> Current <input type="radio"/> Quit within past 12 months <input type="radio"/> Quit more than 12 months ago <input type="radio"/> Screening not performed for medical reasons → If Current or Quit within 12 months, Tobacco Type (Check all that apply): <input type="checkbox"/> Cigarettes ⁶⁰³⁵ <input type="checkbox"/> Cigars ⁶⁰³⁶ <input type="checkbox"/> Pipe ⁶⁰³⁷ <input type="checkbox"/> Smokeless ⁶⁰³⁸ → If Current or Quit within 12 months, Smoking Cessation Counseling Provided⁶⁰⁴⁰: <input type="radio"/> No <input type="radio"/> Yes							
Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco⁶⁰⁴⁵: <input type="radio"/> No <input type="radio"/> Yes							
Alcohol Use⁶⁰⁴⁷: <input type="radio"/> None <input type="radio"/> <1 drinks/wk <input type="radio"/> 2-7 drinks/wk <input type="radio"/> 8-14 drinks/wk <input type="radio"/> >= 15 drinks/wk							
Advance Care Plan OR Discussion of Advance Care Plan Documented⁶⁰⁵⁰: <input type="radio"/> No <input type="radio"/> Yes							
ANGINA SYMPTOMS AND ACTIVITY ASSESSMENT(S) Note: Complete at least one to meet measure.							
CAD	CCS Class⁶¹⁰⁰: <input type="radio"/> No angina <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="checkbox"/> Other Tool/Method to Assess Angina Symptoms and Activity Completed⁶¹¹⁵ <input type="checkbox"/> Seattle Angina Questionnaire Completed⁶¹⁰⁵						
	HEART FAILURE ACTIVITY ASSESSMENT(S) Note: Complete at least one to meet measure.						
HF	NYHA Class⁶²⁰⁰: <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="checkbox"/> Kansas City Cardiomyopathy Questionnaire Completed⁶²⁰⁵ <input type="checkbox"/> Chronic Heart Failure Questionnaire from Guyatt Completed⁶²²⁰ <input type="checkbox"/> Minnesota Living with HF Questionnaire Completed⁶²²⁵ <input type="checkbox"/> Other Tool/Method to Assess Heart Failure Activity Completed⁶²³⁰						
	HEART FAILURE SYMPTOMS ASSESSMENT(S) Note: Complete at least one to meet measure.						
HF	Dyspnea Present⁶³⁰⁰: <input type="radio"/> No <input type="radio"/> Yes		Orthopnea Present⁶³⁰⁵: <input type="radio"/> No <input type="radio"/> Yes				
HEART FAILURE PHYSICAL ASSESSMENT(S) Note: Complete at least one to meet measure.							
HF	Rales Present⁶⁴⁰⁰: <input type="radio"/> No <input type="radio"/> Yes		Peripheral Edema Present⁶⁴⁰⁵: <input type="radio"/> No <input type="radio"/> Yes		S₃ Gallop Present⁶⁴¹⁰: <input type="radio"/> No <input type="radio"/> Yes		
	Ascites Present⁶⁴²⁰: <input type="radio"/> No <input type="radio"/> Yes		Hepatomegaly Present⁶⁴²⁵: <input type="radio"/> No <input type="radio"/> Yes		S₄ Gallop Present⁶⁴³⁰: <input type="radio"/> No <input type="radio"/> Yes		
	Jugular Venous Distention Present⁶⁴³⁵: <input type="radio"/> No <input type="radio"/> Yes						
PLAN OF CARE							
BMI	<input type="checkbox"/> Body Mass Index Screen Performed⁶⁴⁵⁰ → Date⁶⁴⁵² mm / dd / yyyy <input type="checkbox"/> BMI Management Plan⁶⁴⁵⁵						
CAD	Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months⁶⁵⁰⁵: <input type="radio"/> Yes – Referral/Plan Documented <input type="radio"/> No Referral/Plan – Medical Reason <input type="radio"/> No Qualifying Event/Diagnosis <input type="radio"/> No Referral/Plan – System Reason <input type="radio"/> Patient Already Participating in Rehab (Note: Cardiac event/diagnoses includes Myocardial Infarction, Valve surgery, Heart Transplant, CABG, PCI or new Stable Angina diagnosis.)						
	Referral for Consideration for Coronary Revascularization⁶⁵⁰⁶: <input type="radio"/> No <input type="radio"/> Yes						
	Referral for Additional Evaluation/Treatment of Anginal Symptoms⁶⁵⁰⁷: <input type="radio"/> No <input type="radio"/> Yes						
	Discussion of Lifestyle Modifications Documented⁶⁵⁰⁸: <input type="radio"/> No <input type="radio"/> Yes						
HF	HF Education Completed/Documented (Check all that apply): <input type="checkbox"/> All of the following ⁶⁵¹⁰ <input type="checkbox"/> Weight Monitoring ⁶⁵¹¹ <input type="checkbox"/> Diet (Sodium Restriction) ⁶⁵¹² <input type="checkbox"/> Symptom Management ⁶⁵¹³ <input type="checkbox"/> Physical Activity ⁶⁵¹⁴ <input type="checkbox"/> Smoking Cessation ⁶⁵¹⁵ <input type="checkbox"/> Medication Instruction ⁶⁵¹⁶ <input type="checkbox"/> Prognosis/end-of-life Issues ⁶⁵¹⁷ <input type="checkbox"/> Minimizing or Avoiding use of NSAIDs ⁶⁵¹⁸ <input type="checkbox"/> Referral for visiting nurse or specific educational or management programs ⁶⁵¹⁹						
	ICD Counseling⁶⁵⁵⁰: <input type="radio"/> Yes – Patient Counseled <input type="radio"/> No – Patient Not Counseled <input type="radio"/> No Counseling – Medical Reason						
	HF Plan of Care⁶⁵⁵⁵: <input type="radio"/> No <input type="radio"/> Yes						
	ATRIAL FIBRILLATION/FLUTTER ASSESSMENT AND TREATMENT						
	AFib/Flutter Duration⁶⁶⁰⁰: <input type="radio"/> First episode detected <input type="radio"/> Chronic – paroxysmal <input type="radio"/> Chronic – persistent/permanent						

MRN:		Encounter Date: mm / dd / yyyy		Practice ID:		Location ID:	
E. LABORATORY RESULTS Note: Enter most recent lab results and/or indicate the labs ordered during this encounter.							
CAD/HF	LVEF Assessed Date ⁷⁰⁰⁰ : mm / dd / yyyy						
	LVEF ⁷⁰⁰⁵ : _____ % -OR- LV Qualitative Assessment ⁷⁰¹⁰ : <div style="display: flex; justify-content: space-between; font-size: 0.9em;"> <div> (Note: If a LVEF range is documented, take the average, round up and refer to the LVEF Status ranges (right) to code.) </div> <div> <input type="radio"/> Hyperdynamic: > 70 <input type="radio"/> Mildly reduced: 40 – 49 <input type="radio"/> Severely reduced: ≤ 29 </div> <div> <input type="radio"/> Normal: 50 – 70 <input type="radio"/> Moderately reduced: 30 – 39 </div> </div>						
CAD	Lipid Panel Obtained Date ⁷⁰¹⁵ : mm / dd / yyyy <input type="checkbox"/> Fasting ⁷⁰²⁰ Total Cholesterol ⁷⁰²⁵ : _____ mg/dL High Density Lipoprotein (HDL) ⁷⁰³⁰ : _____ mg/dL Low Density Lipoprotein (LDL) ⁷⁰³⁵ : _____ mg/dL Triglycerides ⁷⁰⁴⁰ : _____ mg/dL <input type="checkbox"/> Lipid Panel Ordered ⁷⁰⁴⁵			<input type="checkbox"/> Serum Glucose Ordered ⁷⁰⁵⁰ (If not known Diabetic) Glucose Date ⁷⁰⁵⁵ : mm / dd / yyyy Glucose ⁷⁰⁶⁰ : _____ mg/dL Glucose timing ⁷⁰⁶⁵ : <div style="display: flex; justify-content: space-between; font-size: 0.8em;"> <input type="radio"/> Fasting <input type="radio"/> 2hr Glucose Tolerance Testing <input type="radio"/> Random <input type="radio"/> Unknown </div> HbA1c Date ⁷⁰⁷⁰ : mm / dd / yyyy HbA1c ⁷⁰⁷⁵ : _____ %			
	<input type="checkbox"/> Initial Labs ordered for newly diagnosed Heart Failure (within past 12 months) or patient new to the practice ⁷⁰⁸⁰ (Note: Initial labs for HF include Serum Electrolytes (including Ca+ and Mg+), CBC, U/A, TSH, Liver Function tests, BUN, Creatinine and Glucose.)						
Renal	Estimated GFR (EMR) ⁷⁰⁹⁰ : _____ mL/min Estimated GFR (Imputed) ⁷⁰⁹⁵ : _____ mL/min			Creatinine Clearance ⁷¹⁰⁰ : _____ → Date ⁷¹⁰² mm / dd / yyyy Creatinine Clearance Units ⁷¹⁰⁵ : _____ Serum Creatinine ⁷¹¹⁰ : _____ mg/dL → Date ⁷¹¹² mm / dd / yyyy			
F. PRESCRIPTIONS Note: Record for prescription(s) given during this encounter only.							
Prescription Given for Any Medication ⁸⁰⁰⁰ : <input type="radio"/> No <input type="radio"/> Yes → If Yes, Prescription Generated and Transmitted Using a Qualified e-Prescribing System ⁸⁰⁰⁵ : <input type="radio"/> No <input type="radio"/> Yes							
G. MEDICATIONS Note: If no documentation exists as to if a medication was prescribed/continued, then leave blank.							
		Indicate prescribed/continued medications or reason not prescribed.					
Medication		Yes (Prescribed)	No (Medical Reason)	No (Patient Reason)	No (System Reason)		
ANTIANGINAL	Nitroglycerin ⁹¹⁰⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Ranolazine ⁹¹⁰⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
ANTIARRHYTHMIC	Antiarrhythmic (Unspecified) ⁹¹¹⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Amiodarone ⁹¹²⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Dronedarone ⁹¹²⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
ANTICOAGULANT	ADP ANTAGONIST						
	Clopidogrel ⁹⁰⁰⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Ticlopidine ⁹⁰¹⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Prasugrel ⁹⁰¹⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Ticagrelor ⁹¹³⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Aspirin ⁹⁰³⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
	Aggrenox ⁹⁰²⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Apixaban ⁹⁰⁸⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			

MRN:		Encounter Date: mm / dd / yyyy		Practice ID:		Location ID:		
G. MEDICATIONS (CONTINUED) Note: If no documentation exists as to if a medication was prescribed/continued, then leave blank.								
		Indicate prescribed/continued medications or reason not prescribed.						
Medication		Yes (Prescribed)	No (Medical Reason)	No (Patient Reason)	No (System Reason)			
ANTIHYPERTENSIVE	ACE Inhibitor ⁹⁰⁰⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	ARB ⁹⁰²⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Calcium Channel Blocker ⁹⁰⁴⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Diuretic ⁹⁰⁴⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Combination Antihypertensive ⁹⁰⁹⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
BETA BLOCKER	Beta Blocker (Unspecified) ⁹⁰³⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Atenolol ⁹¹⁵⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Metoprolol ⁹¹⁶⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Nebivolol ⁹¹⁶⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Bisoprolol ⁹²¹⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Carvedilol ⁹²¹⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Sustained release metoprolol succinate ⁹²²⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
LIPID LOWERING	Lipid Lowering Non-Statin ⁹⁰⁵⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	STATIN	Lipid Lowering Statin (Unspecified) ⁹⁰⁵⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		Atorvastatin ⁹¹⁷⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		Rosuvastatin ⁹¹⁷⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		Simvastatin ⁹¹⁸⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
SMOKING CESSATION	Bupropion ⁹⁰⁷⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Nicotine Replacement Therapy ⁹⁰⁷⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Varenicline ⁹⁰⁶⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
OTHER	Corticosteroids ⁹¹⁸⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Digoxin ⁹¹⁹⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	NSAID ⁹¹⁹⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	Proton Pump Inhibitor ⁹²⁰⁰	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
	SSRI ⁹²⁰⁵	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
H. Hospitalizations								
Hospital Admission Date⁹⁵⁰⁰: mm / dd / yyyy →If Admitted, Primary Reason⁹⁵⁰⁵ _____ Coding Standard⁹⁵¹⁰: <input type="radio"/> ICD-9 <input type="radio"/> ICD-10								

American College of Cardiology Foundation PINNACLE Registry™
ACC/AHA/PCPI Performance Measure
PINN #160: Non-Valvular Atrial Fibrillation or Atrial Flutter: Assessment of Thromboembolic Risk Factors



Aggregation of Encounters for a Given Patient

pt-elig = max(enc-elig)
 pt-perf-met = max(enc-perf-met)
 pt-perf-not-met = max(enc-perf-not-met) and not max(enc-perf-met)
 pt-perf-excl = max(enc-perf-excl) and not max(enc-perf-not-met) and not max(enc-perf-met)
 pt-reported = max(enc-reported)

Aggregation of Patients for a Given Provider

eligible-instances = sum(pt-elig)
 performance-met-instances = sum(pt-perf-met)
 performance-not-met-instances = sum(pt-perf-not-met)
 performance-exclusion-instances = sum(pt-perf-excl)
 reported-instances = sum(pt-reported)
 reporting-rate = reported-instances / eligible-instances
 performance-rate = performance-met-instances / (performance-met-instances + performance-not-met-instances)

Assumptions

1. If any eligible encounter meets performance, then patient meets performance; otherwise, if any eligible encounter does not meet performance, then patient does not meet performance; otherwise patient is excluded from performance.
2. If multiple DOBs found for a patient the most recent DOB recorded (resulting in youngest age) will be used.

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

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NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

1. Performance measure name

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

2. Performance gap

2.1 Descriptive statistics of Performance-met rate (1b.2)

2011

# of providers	# of Patients	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
705	137949	0.00%	0.39%	22.8%	32.0%	100%	31.6%	33.2%

	Mean rate
Decile 3	0.1%
Decile 4	1.2%
Decile 5	2.8%
Decile 6	6.5%
Decile 7	13.2%
Decile 8	34.2%
Decile 9	75.0%
Decile 10	94.4%

2012

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

# of providers	# of patients	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
912	222063	0.00%	0.00%	20.5%	25.4%	100%	25.4%	30.6%

	Mean Rate
Decile 3	0.0%
Decile 4	0.8%
Decile 5	2.9%
Decile 6	6.9%
Decile 7	14.3%
Decile 8	26.3%
Decile 9	58.7%
Decile 10	93.9%

2.2 Stratified descriptive statistics of Performance rate (1b.4)

2011

label	# of Providers	# of patients	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
Male	701	61518	0.00%	0.00%	22.3%	29.6%	100%	29.6%	33.2%
Female	699	49890	0.00%	0.00%	22.1%	30.3%	100%	30.3%	33.7%
Age: <60	683	13009	0.00%	0.00%	22.8%	33.3%	100%	33.3%	34.5%
Age: 60 -< 70	700	21894	0.00%	0.00%	23.3%	33.3%	100%	33.3%	34.4%
Age: 70 -< 80	696	35291	0.00%	0.00%	21.9%	28.7%	100%	28.7%	33.4%
Age: >= 80	695	41281	0.00%	0.00%	21.4%	27.5%	100%	27.5%	34.0%
Insurance: None	206	9126	0.00%	0.00%	17.7%	0.00%	100%	0.00%	35.8%
Insurance: Private	645	51071	0.00%	0.00%	22.8%	33.7%	100%	33.7%	33.5%
Insurance: Medicaid	638	31193	0.00%	0.00%	19.7%	20.0%	100%	20.0%	32.8%
Insurance: Medicare	338	1188	0.00%	0.00%	15.8%	0.00%	100%	0.00%	33.4%

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

label	# of Providers	# of patients	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
Insurance: Other	150	600	0.00%	0.00%	14.6%	16.7%	100%	16.7%	29.3%
Race: White	642	54865	0.00%	0.00%	23.8%	37.0%	100%	37.0%	34.7%
Race: Black	445	4223	0.00%	0.00%	25.6%	50.0%	100%	50.0%	39.3%
Race: Other	288	782	0.00%	0.00%	18.6%	0.00%	100%	0.00%	36.5%

2012

label	# of Providers	# of patients	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
Male	909	102666	0.00%	0.00%	20.2%	24.4%	100%	24.4%	30.6%
Female	909	81422	0.00%	0.00%	20.0%	25.0%	100%	25.0%	31.0%
Age: <60	898	20924	0.00%	0.00%	19.7%	25.0%	100%	25.0%	30.5%
Age: 60 -< 70	904	36035	0.00%	0.00%	20.6%	27.1%	100%	27.1%	30.9%
Age: 70 -< 80	908	59056	0.00%	0.00%	20.4%	25.8%	100%	25.8%	31.2%
Age: >= 80	905	68086	0.00%	0.00%	19.4%	24.0%	100%	24.0%	31.1%
Insurance: None	314	11735	0.00%	0.00%	14.6%	0.00%	100%	0.00%	32.0%
Insurance: Private	871	97786	0.00%	0.00%	21.0%	25.6%	100%	25.6%	31.3%
Insurance: Medicaid	852	59143	0.00%	0.00%	18.1%	22.1%	100%	22.1%	29.4%
Insurance: Medicare	447	1804	0.00%	0.00%	19.6%	25.0%	100%	25.0%	35.4%
Insurance: Other	202	712	0.00%	0.00%	10.2%	0.00%	100%	0.00%	23.8%
Race: White	848	121269	0.00%	0.00%	21.1%	25.9%	100%	25.9%	31.6%
Race: Black	587	6580	0.00%	0.00%	24.3%	40.0%	100%	40.0%	37.4%
Race: Other	451	1598	0.00%	0.00%	17.3%	0.00%	100%	0.00%	35.3%

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

label	# of providers	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
Male	909	0.00%	0.00%	20.2%	24.4%	100%	24.4%	30.6%
Female	909	0.00%	0.00%	20.0%	25.0%	100%	25.0%	31.0%
Age: <60	898	0.00%	0.00%	19.7%	25.0%	100%	25.0%	30.5%
Age: 60 -< 70	904	0.00%	0.00%	20.6%	27.1%	100%	27.1%	30.9%
Age: 70 -< 80	908	0.00%	0.00%	20.4%	25.8%	100%	25.8%	31.2%
Age: >= 80	905	0.00%	0.00%	19.4%	24.0%	100%	24.0%	31.1%
Insurance: None	314	0.00%	0.00%	14.6%	0.00%	100%	0.00%	32.0%
Insurance: Private	871	0.00%	0.00%	21.0%	25.6%	100%	25.6%	31.3%
Insurance: Medicaid	852	0.00%	0.00%	18.1%	22.1%	100%	22.1%	29.4%
Insurance: Medicare	447	0.00%	0.00%	19.6%	25.0%	100%	25.0%	35.4%
Insurance: Other	202	0.00%	0.00%	10.2%	0.00%	100%	0.00%	23.8%
Race: White	848	0.00%	0.00%	21.1%	25.9%	100%	25.9%	31.6%
Race: Black	587	0.00%	0.00%	24.3%	40.0%	100%	40.0%	37.4%
Race: Other	451	0.00%	0.00%	17.3%	0.00%	100%	0.00%	35.3%

2.3 Dates of data (1.3)

2011 – Jan 1, 2011 through Dec 31 2011

2012 – Jan 1, 2012 through Dec 31 2012

2.4 Description of providers (measure entities 1.5).

2011

705 providers met the minimum number of eligible patients (10) for inclusion in the reliability analysis. The average number of eligible patients for providers included is 195.7 for a total of 137,949 patients. The range of number of patients for providers included is from 1,242 to 10.

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

	Total n = 705
Provider gender	
(1) Male	548 (77.8%)
(2) Female	156 (22.2%)
Missing (.)	1
Provider categories	
NP/PA	86 (12.3%)
MD/DO	597 (85.5%)
RN/nurses	15 (2.1%)
Missing (.)	7
Region	
(1) Northeast	155 (22.0%)
(2) Midwest	192 (27.2%)
(3) South	181 (25.7%)
(4) West	177 (25.1%)

2012

912 providers met the minimum number of eligible patients (10) for inclusion in the reliability analysis. The average number of eligible patients for providers included is 243.5 for a total of 222,063 patients. The range of number of patients for providers included is from 1,885 to 10.

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

	Total n = 912
Provider gender	
(1) Male	716 (78.8%)
(2) Female	193 (21.2%)
Missing (.)	3
Provider categories	
NP/PA	100 (11.1%)
MD/DO	767 (85.2%)
RN/nurses	33 (3.7%)
Missing (.)	12
Region	
(1) Northeast	151 (16.6%)
(2) Midwest	255 (28.0%)
(3) South	317 (34.8%)
(4) West	189 (20.7%)

2.5 Description of patients (1.6)

2011

	Total n = 137949
Race	
(1) White	69627 (91.8%)
(2) Black	5250 (6.9%)
(3) Other	1004 (1.3%)
Missing (.)	62068
Insurance	
(0) No insurance	9545 (8.3%)
(1) Private	66410 (58.0%)
(2) Medicare	35649 (31.1%)
(3) Medicaid	1695 (1.5%)
(4) Other	1166 (1.0%)
Missing (.)	23484
Age	
18 to <60	21045 (15.3%)
60 to <70	31637 (22.9%)
70 to <80	42101 (30.5%)
80 to 112	43166 (31.3%)
Sex	
(1) Male	77244 (56.0%)
(2) Female	60616 (44.0%)
Missing (.)	89
BMI	29.6 ± 6.7
Missing	48240
Diabetes	40236 (29.2%)
CAD	87516 (63.4%)
Hypertension	119472 (86.6%)
AFib	137949 (100.0%)
HF	45780 (33.2%)
PAD	28769 (20.9%)
Prior Stroke/TIA	35037 (25.4%)

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

MI history	41687 (30.2%)
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2012

	Total n = 222063
Race	
(1) White	145446 (93.8%)
(2) Black	7660 (4.9%)
(3) Other	1926 (1.2%)
Missing (.)	67031
Insurance	
(0) No insurance	13218 (6.4%)
(1) Private	123434 (59.8%)
(2) Medicare	66025 (32.0%)
(3) Medicaid	2348 (1.1%)
(4) Other	1278 (0.6%)
Missing (.)	15760
Age	
18 to <60	32312 (14.6%)
60 to <70	50550 (22.8%)
70 to <80	69007 (31.1%)
80 to 112	70194 (31.6%)
Sex	
(1) Male	125556 (56.5%)
(2) Female	96489 (43.5%)
Missing (.)	18
BMI	29.7 ± 6.8
Missing	51041
Diabetes	63705 (28.7%)
CAD	140797 (63.4%)
Hypertension	195878 (88.2%)
AFib	222063 (100.0%)
HF	86545 (39.0%)
PAD	42596 (19.2%)

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

	Total n = 222063
Prior Stroke/TIA	54804 (24.7%)
MI history	61456 (27.7%)

3. Reliability testing (2a2.1 - 2a2.4)

Reliability of the computed measure score was measured as the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in physician performance. Reliability at the level of the specific physician is given by:
$$\text{Reliability} = \text{Variance (physician-to-physician)} / [\text{Variance (physician-to-physician)} + \text{Variance (physician-specific-error)}]$$

Reliability is the ratio of the physician-to-physician variance divided by the sum of the physician-to-physician variance plus the error variance specific to a physician. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in physician performance.

Reliability testing was performed by using a beta-binomial model. The beta-binomial model assumes the physician performance score is a binomial random variable conditional on the physician's true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates.

Reliability is estimated five different points: at the minimum number of quality reporting events for the measure; at the mean number of quality reporting events per physician; and at the 25th, 50th and 75th percentiles of the number of quality reporting events.

Data shown below

2011

Description	Number of Patients	Signal-to-Noise Ratio
Minimum	10	0.990
25th percentile	91	0.996
50th percentile	159	0.997
75th percentile	247	0.998
Average	196	0.998

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

2012

Description	Number of Patients	Signal-to-Noise Ratio
Minimum	10	0.993
25th percentile	133	0.996
50th percentile	216	0.997
75th percentile	309	0.998
Average	244	0.997

This measure has excellent reliability.

4. Exclusion analysis(2b3.1 - 2b3.3)

Exclusion: Documented medical reason for not assessing risk factors.

2011

98.4%(n=694) of the providers do not have exceptions. Among the 11 providers who do have exceptions, the exclusion rate ranges from 0.2% to 9.8%, mean is 3.1%.

2012

98.9%(n=902) of the providers do not have exceptions. Among the providers who do have exceptions, the exclusion rate ranges from 0.3% to 6.9%, mean is 2.1%.

5. Identification of differences in performance (2b5)

2011

# of providers	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
705	0.00%	0.39%	22.8%	32.0%	100%	31.6%	33.2%

NQF application

AF: Assessment of Thromboembolic Risk Factors (PINNACLE)

A large amount of variability was noted among providers. The performance-met rate range was 0-100% with the inter-quartile range being 0.4% to 32%. This yielded a Median Rate Ratio of 7.9(7.0, 9.0). The Median Rate Ratio measures the variation between clusters by comparing 2 persons from two randomly chosen different clusters. A MRR of 7.9 indicates a large amount of variation among the clusters.

2012

# of providers	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
912	0.00%	0.00%	20.5%	25.4%	100%	25.4%	30.6%

A large amount of variability was noted among providers. The performance-met rate range was 0-100% with the inter-quartile range being 0% to 25%. This yielded a Median Rate Ratio of 9.13(8.16, 10.34). The Median Rate Ratio measures the variation between clusters by comparing 2 persons from two randomly chosen different clusters. A MRR of 9.13 indicates a large amount of variation among the clusters.

6. Missing data(2b7)

In PINNACLE, missing values are interpreted as 'No' for most of the variables. For example, Thromboembolic Risk Factors Assessed: missing - not assessed; 1 - Yes (All risk factors assessed); 2 - No - Medical Reason; 3 - No - Patient Reason; 4 - No - System Reason. It's challenging to distinguish real missing vs 'No'. However, we do think it's reasonable to assume that data were not collected(missing) if all records from a practice are missing. For 2011 data, we identified 44 such practices for Thromboembolic Risk Factors Assessed. For 2012 data, we identified 33 such practices for Thromboembolic Risk Factors Assessed. These practices are excluded from the.