

## A.1 Appendix

### **Measure Title: Heart Failure: Symptom and Activity Assessment (Outpatient)**

Supplemental materials for NQF submission for endorsement maintenance

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## Text Description for PCPI eSpecification

<b>Clinical Topic</b>	<b>Heart Failure</b>
<b>Measure Title</b>	<b>Symptom and Activity Assessment (Outpatient)</b>
<b>Measure #</b>	<b>HF-3 / NQF # 0077</b>
<b>Measure Description</b>	Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented
<b>Measurement Period</b>	12 Consecutive Months
<b>Initial Patient Population</b>	All patient visits for those patients aged 18 years and older with a diagnosis of heart failure
<b>Denominator Statement</b>	Equals Initial Patient Population
<b>Denominator Exclusions</b>	None
<b>Numerator Statement</b>	<p>Patient visits with quantitative results of an evaluation of both current level of activity and clinical symptoms documented</p> <p>Evaluation and quantitative results documented should include:</p> <ul style="list-style-type: none"> <li>• Documentation of New York Heart Association (NYHA) Class OR</li> <li>• Documentation of completion of a valid, reliable, disease-specific instrument (eg, Kansas City Cardiomyopathy Questionnaire, Minnesota Living with Heart Failure Questionnaire, Chronic Heart Failure Questionnaire)</li> </ul> <p><u>Definitions:</u>  The NYHA functional classification reflects a subjective assessment by a healthcare provider of the severity of a patient's symptoms. Patients are assigned to one of the following 4 classes</p> <p>Class I: patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.</p> <p>Class II: patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.</p> <p>Class III: patients with marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.</p> <p>Class IV: patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.</p> <p>Patient-reported health status as assessed by a structured survey/questionnaire instrument offers another, more patient-centric approach to assessing and summarizing the patient's overall heart failure symptom burden. These instruments serve as important constructs for delivering and evaluating heart failure care.</p>
<b>Denominator Exceptions</b>	None

**Heart Failure**  
Data Requirements Table for PCPI eSpecification

**Measure #3 : Symptom and Activity Assessment (Outpatient)**

Measure Component	QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale	
Supplemental Data Elements	Individual Characteristic	Patient Characteristic	ONC Administrative Sex	Administrative Sex (HL7 v2.5)	2.16.840.1.113762.1.4.1	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.	
	Individual Characteristic	Patient Characteristic	Race	CDC	2.16.840.1.114222.4.11.836	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.	
	Individual Characteristic	Patient Characteristic	Ethnicity	CDC	2.16.840.1.114222.4.11.837	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.	
	Individual Characteristic	Patient Characteristic	Preferred Language	CDC	2.16.840.1.114222.4.11.831	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.	
	Individual Characteristic	Patient Characteristic	Payer	Source of Payment Typology	2.16.840.1.113883.221.5	during measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.	
Initial Patient Population	Measure Timing	n/a	Measurement Start Date	n/a	n/a	TBD by Measure Implementer		
	Measure Timing	n/a	Measurement End Date	n/a	n/a	TBD by Measure Implementer		
	Individual Characteristic	Patient Characteristic	Birth Date	LOINC		starts before the start of measurement period		
	Individual Characteristic	Patient Characteristic	age	Calculation	n/a	starts before the start of measurement period	Measurement start date minus Birth Date must be greater than or equal to 18 years.	
	Encounter	Encounter, Performed	Office Visit	GROUPING CPT	2.16.840.1.113883.3.464.1003.101.12.1001 2.16.840.1.113883.3.464.1003.101.11.1005	during measurement period		
	Encounter	Encounter, Performed	Outpatient Consultation	GROUPING CPT	2.16.840.1.113883.3.464.1003.101.12.1008 2.16.840.1.113883.3.464.1003.101.11.1040	during measurement period		
	Encounter	Encounter, Performed	Nursing Facility Visit	GROUPING CPT	2.16.840.1.113883.3.464.1003.101.12.1012 2.16.840.1.113883.3.464.1003.101.11.1060	during measurement period		
	Encounter	Encounter, Performed	Face-to-Face Interaction	GROUPING SNOMED-CT	2.16.840.1.113883.3.464.1003.101.12.1048 2.16.840.1.113883.3.464.1003.101.11.1216	during measurement period		
	Encounter	Encounter, Performed	Home Healthcare Services	GROUPING CPT	2.16.840.1.113883.3.464.1003.101.12.1016 2.16.840.1.113883.3.464.1003.101.11.1080	during measurement period		
	Encounter	Encounter, Performed	Care Services in Long-Term Residential Facility	GROUPING CPT	2.16.840.1.113883.3.464.1003.101.12.1014 2.16.840.1.113883.3.464.1003.101.11.1070	during measurement period		
	Condition / Diagnosis / Problem	Diagnosis, Active	Heart Failure	GROUPING  ICD-9-CM  ICD-10-CM  SNOMED-CT	2.16.840.1.113883.3.526.3.376  2.16.840.1.113883.3.526.2.23  2.16.840.1.113883.3.526.2.24  2.16.840.1.113883.3.526.2.25	starts before or during ['Encounter, Performed: Office Visit', OR 'Encounter, Performed: Outpatient Consultation', OR 'Encounter, Performed: Nursing Facility Visit', OR 'Encounter, Performed: Face-to-Face Interaction' OR 'Encounter, Performed: Home Healthcare Services' OR 'Encounter, Performed: Care Services in Long-Term Residential Facility']		
	Denominator	Equals Initial Patient Population						
	Denominator Exclusions	None						

\*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

**Heart Failure**  
Data Requirements Table for PCPI eSpecification

**Measure #3 : Symptom and Activity Assessment (Outpatient)**

Measure Component	QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Numerator	Risk Category / Assessment	Risk Category Assessment Performed	New York Heart Association (NYHA) Class	GROUPING  LOINC	2.16.840.1.113883.3.526.3.1508  2.16.840.1.113883.3.526.2.1734	starts before or during [Encounter, Performed: Office Visit', OR 'Encounter, Performed: Outpatient Consultation', OR 'Encounter, Performed: Nursing Facility Visit', OR 'Encounter, Performed: Face-to-Face Interaction' OR 'Encounter, Performed: Home Healthcare Services' OR 'Encounter, Performed: Care Services in Long-Term Residential Facility']	
	Risk Category / Assessment	Risk Category Assessment Performed	Kansas City Cardiomyopathy Questionnaire	GROUPING  LOINC	2.16.840.1.113883.3.526.3.1509  2.16.840.1.113883.3.526.2.1735	starts before or during [Encounter, Performed: Office Visit', OR 'Encounter, Performed: Outpatient Consultation', OR 'Encounter, Performed: Nursing Facility Visit', OR 'Encounter, Performed: Face-to-Face Interaction' OR 'Encounter, Performed: Home Healthcare Services' OR 'Encounter, Performed: Care Services in Long-Term Residential Facility']	
	Risk Category / Assessment	Risk Category Assessment Performed	Minnesota Living with Heart Failure Questionnaire	GROUPING  LOINC	2.16.840.1.113883.3.526.3.1510  2.16.840.1.113883.3.526.2.1736	starts before or during [Encounter, Performed: Office Visit', OR 'Encounter, Performed: Outpatient Consultation', OR 'Encounter, Performed: Nursing Facility Visit', OR 'Encounter, Performed: Face-to-Face Interaction' OR 'Encounter, Performed: Home Healthcare Services' OR 'Encounter, Performed: Care Services in Long-Term Residential Facility']	
	Risk Category / Assessment	Risk Category Assessment Performed	Chronic Heart Failure Questionnaire	GROUPING  LOINC	2.16.840.1.113883.3.526.3.1511  2.16.840.1.113883.3.526.2.1737	starts before or during [Encounter, Performed: Office Visit', OR 'Encounter, Performed: Outpatient Consultation', OR 'Encounter, Performed: Nursing Facility Visit', OR 'Encounter, Performed: Face-to-Face Interaction' OR 'Encounter, Performed: Home Healthcare Services' OR 'Encounter, Performed: Care Services in Long-Term Residential Facility']	
	Attribute	Attribute, Result	Present	n/a	n/a	n/a	This attribute is to be applied to value sets 'New York Heart Association (NYHA) Class' or ' Kansas City Cardiomyopathy Questionnaire' or 'Minnesota Living with Heart Failure Questionnaire' or 'Chronic Heart Failure Questionnaire'.
Denominator Exceptions	None						

\*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

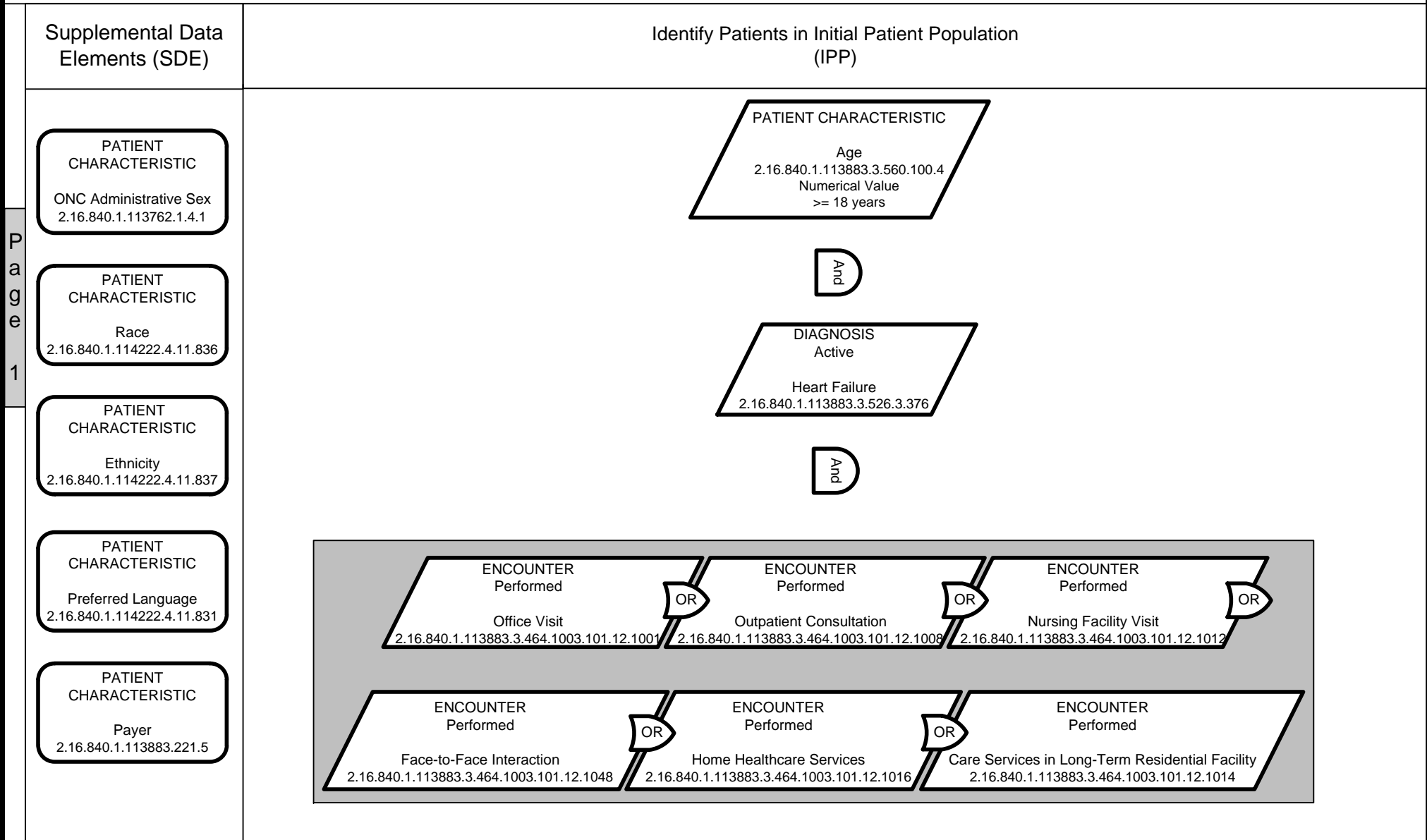
# Measure Logic for PCPI eSpecification

## Measure Logic for Heart Failure : Symptom and Activity Assessment (Outpatient)

**Measure Description:** Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented

**Measurement Period:** 12 Consecutive Months

**PCPI Measure #: HF-3 / NQF #0077**



See Data Requirements Table for timing constraints and relationship between data elements.

## Measure Logic for PCPI eSpecification

### Measure Logic for Heart Failure : Symptom and Activity Assessment (Outpatient)

**Measure Description:** Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented

**Measurement Period:** 12 Consecutive Months

**PCPI Measure #: HF-3 / NQF #0077**

	Identify Patients in Denominator (D)	Identify Patients in Denominator Exclusion (EXCL)	Identify Patients in Numerator (N)	Identify Patients in Denominator Exceptions (EXCEP)
Page 2	<div data-bbox="92 440 382 573">All Patients Identified within the Initial Patient Population</div>	<div data-bbox="420 440 730 573">No Valid Denominator Exclusions for this Measure</div>	<div data-bbox="1075 440 1373 557">All Patients Identified within the Denominator</div> <div data-bbox="1192 610 1264 678">And</div> <div data-bbox="751 753 1239 951"> <div data-bbox="756 753 1234 951"> RISK CATEGORY ASSESSMENT Performed  New York Heart Association (NYHA) Class  2.16.840.1.113883.3.526.3.1508  Attribute: Result Present </div> </div> <div data-bbox="1176 862 1234 906">OR</div> <div data-bbox="1201 753 1688 951"> <div data-bbox="1205 753 1684 951"> RISK CATEGORY ASSESSMENT Performed  Kansas City Cardiomyopathy Questionnaire  2.16.840.1.113883.3.526.3.1509  Attribute: Result Present </div> </div> <div data-bbox="1621 862 1680 906">OR</div> <div data-bbox="751 1110 1226 1334"> <div data-bbox="756 1110 1222 1334"> RISK CATEGORY ASSESSMENT Performed  Minnesota Living with Heart Failure Questionnaire  2.16.840.1.113883.3.526.3.1510  Attribute: Result Present </div> </div> <div data-bbox="1163 1219 1222 1263">OR</div> <div data-bbox="1201 1110 1688 1315"> <div data-bbox="1205 1110 1684 1315"> RISK CATEGORY ASSESSMENT Performed  Chronic Heart Failure Questionnaire  2.16.840.1.113883.3.526.3.1511  Attribute: Result Present </div> </div>	<div data-bbox="1717 440 2028 573">No Valid Denominator Exceptions for this Measure</div>

See Data Requirements Table for timing constraints and relationship between data elements.

**Measure #3: Symptom and Activity Assessment (Outpatient)**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
National Quality Forum	2.16.840.1.113883.3.560.100.4	birth date	Individual Characteristic	LOINC	2.36	21112-8	Birth date
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	4525004	emergency department patient visit (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	12843005	subsequent hospital visit by physician (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	18170008	subsequent nursing facility visit (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	19681004	nursing evaluation of patient and report (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	87790002	follow-up inpatient consultation visit (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	90526000	initial evaluation and management of healthy individual (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	185349003	encounter for "check-up" (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	185463005	visit out of hours (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	185465003	weekend visit (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	207195004	history and physical examination with evaluation and management of nursing facility patient (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	270427003	patient-initiated encounter (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	270430005	provider-initiated encounter (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	308335008	patient encounter procedure (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	390906007	follow-up encounter (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	406547006	urgent follow-up (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1216	Face-to-Face Interaction	Encounter	SNOMED-CT	07/2011	439708006	home visit (procedure)
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99201	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99202	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99203	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99204	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99205	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99212	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99213	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99214	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1005	Office Visit	Encounter	CPT	2013	99215	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.12.1001	Office Visit	Encounter	Grouping	Grouping	2.16.840.1.113883.3.464.1003.101.11.1005	"Office Visit" CPT code list
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99324	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99325	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99326	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99327	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99328	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99334	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99335	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99336	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1070	Care Services in Long-Term Residential Facility	Encounter	CPT	2013	99337	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.12.1014	Care Services in Long-Term Residential Facility	Encounter	Grouping	Grouping	2.16.840.1.113883.3.464.1003.101.11.1070	"Care Services in Long-Term Residential Facility" CPT code list
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99341	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99342	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99343	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99344	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99345	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99347	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99348	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99349	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1080	Home Healthcare Services	Encounter	CPT	2013	99350	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.12.1016	Home Healthcare Services	Encounter	Grouping	Grouping	2.16.840.1.113883.3.464.1003.101.11.1080	"Home Healthcare Services" CPT code list
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1060	Nursing Facility Visit	Encounter	CPT	2013	99304	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1060	Nursing Facility Visit	Encounter	CPT	2013	99305	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1060	Nursing Facility Visit	Encounter	CPT	2013	99306	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1060	Nursing Facility Visit	Encounter	CPT	2013	99307	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1060	Nursing Facility Visit	Encounter	CPT	2013	99308	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1060	Nursing Facility Visit	Encounter	CPT	2013	99309	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1060	Nursing Facility Visit	Encounter	CPT	2013	99310	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.12.1012	Nursing Facility Visit	Encounter	Grouping	Grouping	2.16.840.1.113883.3.464.1003.101.11.1060	"Nursing Facility Visit" CPT code list
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1040	Outpatient Consultation	Encounter	CPT	2013	99241	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1040	Outpatient Consultation	Encounter	CPT	2013	99242	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1040	Outpatient Consultation	Encounter	CPT	2013	99243	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1040	Outpatient Consultation	Encounter	CPT	2013	99244	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.11.1040	Outpatient Consultation	Encounter	CPT	2013	99245	NA
National Committee for Quality Assurance	2.16.840.1.113883.3.464.1003.101.12.1008	Outpatient Consultation	Encounter	Grouping	Grouping	2.16.840.1.113883.3.464.1003.101.11.1040	"Outpatient Consultation" CPT code list
American Medical Association-convoked Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.1508	New York Heart Association (NYHA) Class	Risk Category Assessment	Grouping	Grouping	2.16.840.1.113883.3.526.2.1734	"New York Heart Association (NYHA) Class" LOINC value set
American Medical Association-convoked Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.1734	New York Heart Association (NYHA) Class	Risk Category Assessment	LOINC	TBD	TBD	New York Heart Association (NYHA) Class assessment
American Medical Association-convoked Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.1509	Kansas City Cardiomyopathy Questionnaire	Risk Category Assessment	Grouping	Grouping	2.16.840.1.113883.3.526.2.1735	"Kansas City Cardiomyopathy Questionnaire" LOINC value set
American Medical Association-convoked Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.1735	Kansas City Cardiomyopathy Questionnaire	Risk Category Assessment	LOINC	TBD	TBD	Kansas City Cardiomyopathy Questionnaire assessment
American Medical Association-convoked Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.1510	Minnesota Living with Heart Failure Questionnaire	Risk Category Assessment	Grouping	Grouping	2.16.840.1.113883.3.526.2.1736	"Minnesota Living with Heart Failure Questionnaire" LOINC value set
American Medical Association-convoked Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.1736	Minnesota Living with Heart Failure Questionnaire	Risk Category Assessment	LOINC	TBD	TBD	Minnesota Living with Heart Failure Questionnaire assessment

**Heart Failure**  
Coding Spreadsheet for PCPI eSpecifications

**Measure #3: Symptom and Activity Assessment (Outpatient)**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.1511	Chronic Heart Failure Questionnaire	Risk Category Assessment	Grouping	Grouping	2.16.840.1.113883.3.526.2.1737	"Chronic Heart Failure Questionnaire" LOINC code list
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.1737	Chronic Heart Failure Questionnaire	Risk Category Assessment	LOINC	TBD	TBD	Chronic Heart Failure Questionnaire assessment
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.376	Heart Failure	Condition/Diagnosis/Problem	Grouping	Grouping	2.16.840.1.113883.3.526.2.23	"Heart Failure" ICD-9-CM code list
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.376	Heart Failure	Condition/Diagnosis/Problem	Grouping	Grouping	2.16.840.1.113883.3.526.2.24	"Heart Failure" ICD-10-CM code list
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.3.376	Heart Failure	Condition/Diagnosis/Problem	Grouping	Grouping	2.16.840.1.113883.3.526.2.25	"Heart Failure" SNOMED-CT code list
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	402.01	Malignant hypertensive heart disease with heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	402.11	Benign hypertensive heart disease with heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	402.91	Unspecified hypertensive heart disease with heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.0	Congestive heart failure, unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.1	Left heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.20	Systolic heart failure, unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.21	Acute systolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.22	Chronic systolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.23	Acute on chronic systolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.30	Diastolic heart failure, unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.31	Acute diastolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.32	Chronic diastolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.33	Acute on chronic diastolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.40	Combined systolic and diastolic heart failure, unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.41	Acute combined systolic and diastolic heart failure



**Heart Failure**  
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**Measure #3: Symptom and Activity Assessment (Outpatient)**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.42	Chronic combined systolic and diastolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.43	Acute on chronic combined systolic and diastolic heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.23	Heart Failure	Condition/Diagnosis/Problem	ICD-9-CM	2013	428.9	Heart failure, unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I11.0	Hypertensive heart disease with heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.1	Left ventricular failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.20	Unspecified systolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.21	Acute systolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.22	Chronic systolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.23	Acute on chronic systolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.30	Unspecified diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.31	Acute diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.32	Chronic diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.33	Acute on chronic diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.24	Heart Failure	Condition/Diagnosis/Problem	ICD-10-CM	2013	I50.9	Heart failure, unspecified
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	10091002	High output heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	10335000	Chronic right-sided heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	10633002	Acute congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	111283005	Chronic left-sided heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	128404006	Right heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	194767001	Benign hypertensive heart disease with congestive cardiac failure (disorder)

**Heart Failure**  
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**Measure #3: Symptom and Activity Assessment (Outpatient)**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	194779001	Hypertensive heart and renal disease with (congestive) heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	194781004	Hypertensive heart and renal disease with both (congestive) heart failure and renal failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	195111005	Decompensated cardiac failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	195112003	Compensated cardiac failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	195114002	Acute left ventricular failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	206586007	Congenital cardiac failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	233924009	Heart failure as a complication of care (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	25544003	Low output heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	277639002	Sepsis-associated right ventricular failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	314206003	Refractory heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	359617009	Acute right-sided heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	359620001	Acute right heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	364006	Acute left-sided heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	367363000	Right ventricular failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	410431009	Cardiorespiratory failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	417996009	Systolic heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	418304008	Diastolic heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	42343007	Congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	424404003	Decompensated chronic heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	426012001	Right heart failure due to pulmonary hypertension (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	426263006	Congestive heart failure due to left ventricular systolic dysfunction (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	426611007	Congestive heart failure due to valvular disease (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	43736008	Rheumatic left ventricular failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	441481004	Chronic systolic heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	441530006	Chronic diastolic heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	44313006	Right heart failure secondary to left heart failure (disorder)

**Heart Failure**  
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**Measure #3: Symptom and Activity Assessment (Outpatient)**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	46113002	Hypertensive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	48447003	Chronic heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	5053004	Cardiac insufficiency due to prosthesis (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	5148006	Hypertensive heart disease with congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	5375005	Chronic left-sided congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	56675007	Acute heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	60856006	Cardiac insufficiency following cardiac surgery (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	66989003	Chronic right-sided congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	74960003	Acute left-sided congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	77737007	Benign hypertensive heart disease with congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	80479009	Acute right-sided congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	82523003	Congestive rheumatic heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	83105008	Malignant hypertensive heart disease with congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	84114007	Heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	85232009	Left heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	88805009	Chronic congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	90727007	Pleural effusion due to congestive heart failure (disorder)
American Medical Association-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI)	2.16.840.1.113883.3.526.2.25	Heart Failure	Condition/Diagnosis/Problem	SNOMED-CT	07/2011	92506005	Biventricular congestive heart failure (disorder)

**Heart Failure**  
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**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	F	Female
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	M	Male
National Library of Medicine	2.16.840.1.113762.1.4.1	ONC Administrative Sex	Individual Characteristic	Administrative Sex	HL7 v2.5	U	Unknown
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	1	MEDICARE
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	2	MEDICAID
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3	OTHER GOVERNMENT (Federal/State/Local) (excluding Department of Corrections)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	4	DEPARTMENTS OF CORRECTIONS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	5	PRIVATE HEALTH INSURANCE
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	6	BLUE CROSS/BLUE SHIELD
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	7	MANAGED CARE, UNSPECIFIED(to be used only if one can't distinguish public from private)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	8	NO PAYMENT from an Organization/Agency/Program/Private Payer Listed
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	9	MISCELLANEOUS/OTHER
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	11	Medicare (Managed Care)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	12	Medicare (Non-managed Care)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	19	Medicare Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	21	Medicaid (Managed Care)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	22	Medicaid (Non-managed Care Plan)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	23	Medicaid/SCHIP
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	24	Medicaid Applicant
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	25	Medicaid - Out of State
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	29	Medicaid Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	31	Department of Defense
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32	Department of Veterans Affairs
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	33	Indian Health Service or Tribe
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	34	HRSA Program
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	35	Black Lung
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	36	State Government
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	37	Local Government
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	38	Other Government (Federal, State, Local not specified)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	39	Other Federal
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	41	Corrections Federal
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	42	Corrections State
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	43	Corrections Local
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	44	Corrections Unknown Level
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	51	Managed Care (Private)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	52	Private Health Insurance - Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	53	Managed Care (private) or private health insurance (indemnity), not otherwise specified
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	54	Organized Delivery System
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	55	Small Employer Purchasing Group
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	59	Other Private Insurance
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	61	BC Managed Care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	62	BC Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	63	BC (Indemnity or Managed Care) - Out of State
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	64	BC (Indemnity or Managed Care) - Unspecified
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	69	BC (Indemnity or Managed Care) - Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	71	HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	72	PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	73	POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	79	Other Managed Care, Unknown if public or private
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	81	Self-pay
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	82	No Charge
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	83	Refusal to Pay/Bad Debt
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	84	Hill Burton Free Care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	85	Research/Donor
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	89	No Payment, Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	91	Foreign National
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	92	Other (Non-government)

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**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	93	Disability Insurance
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	94	Long-term Care Insurance
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	95	Worker's Compensation
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	96	Auto Insurance (no fault)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	98	Other specified (includes Hospice - Unspecified plan)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	99	No Typology Code available for payment source
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	111	Medicare HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	112	Medicare PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	113	Medicare POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	119	Medicare Managed Care Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	121	Medicare FFS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	122	Drug Benefit
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	123	Medicare Medical Savings Account (MSA)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	129	Medicare Non-managed Care Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	211	Medicaid HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	212	Medicaid PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	213	Medicaid PCCM (Primary Care Case Management)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	219	Medicaid Managed Care Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	311	TRICARE (CHAMPUS)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	312	Military Treatment Facility
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	313	Dental --Stand Alone
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	321	Veteran care--Care provided to Veterans
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	322	Non-veteran care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	331	Indian Health Service - Regular
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	332	Indian Health Service - Contract
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	333	Indian Health Service - Managed Care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	334	Indian Tribe - Sponsored Coverage
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	341	Title V (MCH Block Grant)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	342	Migrant Health Program
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	343	Ryan White Act
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	349	Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	361	State SCHIP program (codes for individual states)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	362	Specific state programs (list/ local code)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	369	State, not otherwise specified (other state)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	371	Local - Managed care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	372	FFS/Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	379	Local, not otherwise specified (other local, county)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	381	Federal, State, Local not specified managed care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	382	Federal, State, Local not specified - FFS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	389	Federal, State, Local not specified - Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	511	Commercial Managed Care - HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	512	Commercial Managed Care - PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	513	Commercial Managed Care - POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	514	Exclusive Provider Organization
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	515	Gatekeeper PPO (GPPO)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	519	Managed Care, Other (non HMO)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	521	Commercial Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	522	Self-insured (ERISA) Administrative Services Only (ASO) plan
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	523	Medicare supplemental policy (as second payer)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	529	Private health insurance--other commercial Indemnity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	611	BC Managed Care - HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	612	BC Managed Care - PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	613	BC Managed Care - POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	619	BC Managed Care - Other
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	821	Charity
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	822	Professional Courtesy
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	823	Hispanic or Latino
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	951	Worker's Comp HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	953	Worker's Comp Fee-for-Service
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	954	Worker's Comp Other Managed Care

**Heart Failure**  
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**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	959	Worker's Comp, Other unspecified
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3111	TRICARE Prime--HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3112	TRICARE Extra--PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3113	TRICARE Standard - Fee For Service
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3114	TRICARE For Life--Medicare Supplement
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3115	TRICARE Reserve Select
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3116	Uniformed Services Family Health Plan (USFHP) -- HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3119	Department of Defense - (other)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3121	Enrolled Prime--HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3122	Non-enrolled Space Available
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3123	TRICARE For Life (TFL)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3211	Direct Care--Care provided in VA facilities
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3212	Indirect Care--Care provided outside VA facilities
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3221	Civilian Health and Medical Program for the VA (CHAMPVA)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3222	Spina Bifida Health Care Program (SB)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3223	Children of Women Vietnam Veterans (CWVV)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3229	Other non-veteran care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3711	HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3712	PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3713	POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3811	Federal, State, Local not specified - HMO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3812	Federal, State, Local not specified - PPO
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3813	Federal, State, Local not specified - POS
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	3819	Federal, State, Local not specified - not specified managed care
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	9999	Unavailable / Unknown
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32121	Fee Basis
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32122	Foreign Fee/Foreign Medical Program(FMP)
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32123	Contract Nursing Home/Community Nursing Home
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32124	State Veterans Home
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32125	Sharing Agreements
PHDSC	2.16.840.1.113883.221.5	Payer	Individual Characteristic	Source of Payment Typology	4.0	32126	Other Federal Agency
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	1002-5	American Indian or Alaska Native
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2028-9	Asian
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2054-5	Black or African American
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2076-8	Native Hawaiian or Other Pacific Islander
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2106-3	White
CDC NCHS	2.16.840.1.114222.4.11.836	Race	Individual Characteristic	CDC	1.0	2131-1	Other Race
CDC NCHS	2.16.840.1.114222.4.11.837	Ethnicity	Individual Characteristic	CDC	1.0	2135-2	Hispanic or Latino
CDC NCHS	2.16.840.1.114222.4.11.837	Ethnicity	Individual Characteristic	CDC	1.0	2186-5	Not Hispanic or Latino
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	abk	Abkhazian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ace	Achinese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ach	Acoli
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ada	Adangme
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ady	Adyghe; Adyghe
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aar	Afar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	afh	Afrihili
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	afr	Afrikaans
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	afa	Afro-Asiatic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ain	Ainu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aka	Akan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	akk	Akkadian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	alb	Albanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ale	Aleut
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	alg	Algonquian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tut	Altaic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	amh	Amharic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	anp	Angika
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	apa	Apache languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ara	Arabic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arg	Aragonese

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**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arp	Arapaho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arw	Arawak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arm	Armenian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rup	Aromanian; Arumanian; Macedo-Romanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	art	Artificial (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	asm	Assamese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ast	Asturian; Bable; Leonese; Asturleonese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ath	Athapaskan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aus	Australian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	map	Austronesian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ava	Avaric
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ave	Avestan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	awa	Awadhi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aym	Aymara
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	aze	Azerbaijani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ban	Balinese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bat	Baltic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bal	Baluchi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bam	Bambara
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bai	Bamileke languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bad	Banda languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bnt	Bantu (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bas	Basa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bak	Bashkir
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	baq	Basque
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	btk	Batak languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bej	Beja; Bedawiyet
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bel	Belarusian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bem	Bemba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ben	Bengali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ber	Berber (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bho	Bhojpuri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bih	Bihari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bik	Bikol
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bin	Bini; Edo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bis	Bislama
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	byn	Blin; Bilin
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zbl	Blissymbols; Blissymbolics; Bliss
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nob	Bokmål, Norwegian; Norwegian Bokmål
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bos	Bosnian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bra	Braj
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bre	Breton
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bug	Buginese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bul	Bulgarian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bua	Buriat
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bur	Burmese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cad	Caddo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cat	Catalan; Valencian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cau	Caucasian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ceb	Cebuano
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cel	Celtic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cai	Central American Indian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	khm	Central Khmer
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chg	Chagatai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cmc	Chamic languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cha	Chamorro
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	che	Chechen
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chr	Cherokee
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chy	Cheyenne
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chb	Chibcha

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**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nya	Chichewa; Chewa; Nyanja
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chi	Chinese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chn	Chinook jargon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chp	Chipewyan; Dene Suline
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cho	Choctaw
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chu	Church Slavlic; Old Slavonic; Church Slavonic; Old Bulgarian; Old Church Slavonic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chk	Chuukese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chv	Chuvash
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nwc	Classical Newari; Old Newari; Classical Nepal Bhasa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	syx	Classical Syriac
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cop	Coptic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cor	Cornish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cos	Corsican
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cre	Cree
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mus	Creek
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	crp	Creoles and pidgins (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cpe	Creoles and pidgins, English based (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cpf	Creoles and pidgins, French-based (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cpp	Creoles and pidgins, Portuguese-based (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	crh	Crimean Tatar; Crimean Turkish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hrv	Croatian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cus	Cushitic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	cze	Czech
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dak	Dakota
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dan	Danish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dar	Dargwa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	del	Delaware
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	din	Dinka
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	div	Divehi; Dhivehi; Maldivian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	doi	Dogri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dgr	Dogrib
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dra	Dravidian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dua	Duala
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dum	Dutch, Middle (ca.1050-1350)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dut	Dutch; Flemish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dyu	Dyula
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dzo	Dzongkha
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	frs	Eastern Frisian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	efi	Efik
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	egy	Egyptian (Ancient)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	eka	Ekajuk
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	elx	Elamite
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	eng	English
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	enm	English, Middle (1100-1500)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ang	English, Old (ca.450-1100)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	myv	Erzya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	epo	Esperanto
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	est	Estonian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ewe	Ewe
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ewo	Ewondo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fan	Fang
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fat	Fanti
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fao	Faroese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fij	Fijian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fil	Filipino; Pilipino
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fin	Finnish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fiu	Finno-Ugrian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fon	Fon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fre	French



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Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	frm	French, Middle (ca.1400-1600)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fro	French, Old (842-ca.1400)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fur	Friulian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ful	Fulah
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gaa	Ga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gla	Gaelic; Scottish Gaelic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	car	Galibi Carib
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	glg	Galician
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lug	Ganda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gay	Gayo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gba	Gbaya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gez	Geez
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	geo	Georgian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ger	German
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gmh	German, Middle High (ca.1050-1500)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	goh	German, Old High (ca.750-1050)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gem	Germanic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gil	Gilbertese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gon	Gondi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gor	Gorontalo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	got	Gothic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	grb	Grebo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	grc	Greek, Ancient (to 1453)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gre	Greek, Modern (1453-)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	grn	Guarani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	guj	Gujarati
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gwi	Gwich'in
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hai	Haida
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hat	Haitian; Haitian Creole
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hau	Hausa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	haw	Hawaiian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	heb	Hebrew
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	her	Herero
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hil	Hiligaynon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	him	Himachali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hin	Hindi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hmo	Hiri Motu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hit	Hittite
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hmn	Hmong
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hun	Hungarian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hup	Hupa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iba	Iban
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ice	Icelandic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ido	Ido
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ibo	Igbo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ijo	Ijo languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ilo	Iloko
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smn	Inari Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	inc	Indic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ine	Indo-European (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ind	Indonesian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	inh	Ingush
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ina	Interlingua (International Auxiliary Language Association)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ile	Interlingue; Occidental
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iku	Inuktitut
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ipk	Inupiaq
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ira	Iranian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	gle	Irish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mga	Irish, Middle (900-1200)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sga	Irish, Old (to 900)

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**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iro	Iroquoian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ita	Italian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jpn	Japanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jav	Javanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jrb	Judeo-Arabic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jpr	Judeo-Persian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kbd	Kabardian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kab	Kabyle
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kac	Kachin; Jingpho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kal	Kalaallisut; Greenlandic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	xal	Kalmyk; Oirat
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kam	Kamba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kan	Kannada
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kau	Kanuri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	krc	Karachay-Balkar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kaa	Kara-Kalpak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	krl	Karelian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kar	Karen languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kas	Kashmiri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	csb	Kashubian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kaw	Kawi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kaz	Kazakh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kha	Khasi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	khi	Khoisan (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kho	Khotanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kik	Kikuyu; Gikuyu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kmb	Kimbundu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kin	Kinyarwanda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kir	Kirghiz; Kyrgyz
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tlh	Klingon; tlhIngan-Hol
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kom	Komi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kon	Kongo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kok	Konkani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kor	Korean
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kos	Kosraean
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kpe	Kpelle
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kro	Kru languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kua	Kuanyama; Kwanyama
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kum	Kumyk
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kur	Kurdish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kru	Kurukh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	kut	Kutenai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lad	Ladino
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lah	Lahnda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lam	Lamba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	day	Land Dayak languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lao	Lao
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lat	Latin
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lav	Latvian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lez	Lezghian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lim	Limburch; Limburger; Limburgish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lin	Lingala
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lit	Lithuanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	jbo	Lojban
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nds	Low German; Low Saxon; German, Low; Saxon, Low
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	dsb	Lower Sorbian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	loz	Lozi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lub	Luba-Katanga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lua	Luba-Lulua
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lui	Luiseno

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**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smj	Lule Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lun	Lunda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	luo	Luo (Kenya and Tanzania)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lus	Lushai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ltz	Luxembourgish; Letzeburgesch
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mac	Macedonian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mad	Madurese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mag	Magahi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mai	Maithili
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mak	Makasar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mlg	Malagasy
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	may	Malay
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mal	Malayalam
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mlt	Maltese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mnc	Manchu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mdr	Mandar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	man	Mandingo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mni	Manipuri
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mno	Manobo languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	glv	Manx
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mao	Maori
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	am	Mapudungun; Mapuche
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mar	Marathi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	chm	Mari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mah	Marshallese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mwr	Marwari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mas	Masai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	myn	Mayan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	men	Mende
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mic	Mikmaq; Micmac
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	min	Minangkabau
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mwj	Mirandese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	moh	Mohawk
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mdf	Moksha
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mol	Moldavian; Moldovan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	lol	Mongo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mon	Mongolian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mkh	Mon-Khmer (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mos	Mossi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mul	Multiple languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mun	Munda languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nah	Nahuatl languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nau	Nauru
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nav	Navajo; Navaho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nde	Ndebele, North; North Ndebele
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nbl	Ndebele, South; South Ndebele
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ndo	Ndonga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nap	Neapolitan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	new	Nepal Bhasa; Newari
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nep	Nepali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nia	Nias
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nic	Niger-Kordofanian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ssa	Nilo-Saharan (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	niu	Niuean
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nqo	N'Ko
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zxx	No linguistic content; Not applicable
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nog	Nogai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	non	Norse, Old
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nai	North American Indian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	frf	Northern Frisian

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Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sme	Northern Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nor	Norwegian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nno	Norwegian Nynorsk; Nynorsk, Norwegian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nub	Nubian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nym	Nyamwezi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nyn	Nyankole
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nyo	Nyoro
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nzi	Nzima
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oci	Occitan (post 1500); Provençal
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	arc	Official Aramaic (700-300 BCE); Imperial Aramaic (700-300 BCE)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oji	Ojibwa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ori	Oriya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	orm	Oromo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	osa	Osage
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oss	Ossetian; Ossetic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	oto	Otomian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pal	Pahlavi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pau	Palauan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pli	Pali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pam	Pampanga; Kapampangan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pag	Pangasinan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pan	Panjabi; Punjabi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pap	Papiamentu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	paa	Papuan (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	nso	Pedi; Sepedi; Northern Sotho
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	per	Persian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	peo	Persian, Old (ca.600-400 B.C.)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	phi	Philippine (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	phn	Phoenician
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pon	Pohnpeian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pol	Polish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	por	Portuguese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pra	Prakrit languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pro	Provençal, Old (to 1500)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	pus	Pushto; Pashto
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	que	Quechua
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	raj	Rajasthani
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rap	Rapanui
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rar	Rarotongan; Cook Islands Maori
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	qaa-qtz	Reserved for local use
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	roa	Romance (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rum	Romanian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	roh	Romansh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rom	Romany
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	run	Rundi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	rus	Russian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sal	Salishan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sam	Samaritan Aramaic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smi	Sami languages (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	smo	Samoan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sad	Sandawe
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sag	Sango
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	san	Sanskrit
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sat	Santali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srd	Sardinian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sas	Sasak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sco	Scots
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sel	Selkup
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sem	Semitic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srp	Serbian

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CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srr	Serer
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	shn	Shan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sna	Shona
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	iii	Sichuan Yi; Nuosu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	scn	Sicilian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sid	Sidamo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sgn	Sign Languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	bla	Siksika
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	snd	Sindhi
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sin	Sinhala; Sinhalese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sit	Sino-Tibetan (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sio	Siouan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sms	Skolt Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	den	Slave (Athapascan)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sla	Slavic (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	slo	Slovak
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	slv	Slovenian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sog	Sogdian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	som	Somali
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	son	Songhai languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	snk	Soninke
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wen	Sorbian languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sot	Sotho, Southern
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sai	South American Indian (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	alt	Southern Altai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sma	Southern Sami
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	spa	Spanish; Castilian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	srn	Sranan Tongo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	suk	Sukuma
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sux	Sumerian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sun	Sundanese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sus	Susu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	swa	Swahili
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ssw	Swati
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	swe	Swedish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	qsw	Swiss German; Alemannic; Alsatian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	syr	Syriac
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tgl	Tagalog
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tah	Tahitian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tai	Tai (Other)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tgk	Tajik
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tmh	Tamashek
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tam	Tamil
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tat	Tatar
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tel	Telugu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ter	Tereno
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tet	Tetum
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tha	Thai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tib	Tibetan
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tig	Tigre
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tir	Tigrinya
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tem	Timne
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tiv	Tiv
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tli	Tlingit
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tpi	Tok Pisin
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tkl	Tokelau
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tog	Tonga (Nyasa)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ton	Tonga (Tonga Islands)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tsi	Tsimshian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tso	Tsonga

**Heart Failure**  
Coding Spreadsheet for PCPI eSpecification

**Supplemental Data Element Value Sets**

Value Set Developer	Value Set OID	Value Set Name	QDM Category	Code System	Code System Version	Code	Descriptor
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tsn	Tswana
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tum	Tumbuka
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tup	Tupi languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tur	Turkish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ota	Turkish, Ottoman (1500-1928)
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tuk	Turkmen
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tlv	Tuvalu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	tyv	Tuvinian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	twi	Twí
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	udm	Udmurt
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	uga	Ugaritic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	uig	Uighur; Uyghur
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ukr	Ukrainian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	umb	Umbundu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	mis	Uncoded languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	und	Undetermined
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	hsb	Upper Sorbian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	urd	Urdu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	uzb	Uzbek
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vai	Vai
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ven	Venda
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vie	Vietnamese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vol	Volapük
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	vot	Votic
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wak	Wakashan languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wal	Walamo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wln	Walloon
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	war	Waray
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	was	Washo
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wel	Welsh
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	fry	Western Frisian
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	wol	Wolof
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	xho	Xhosa
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	sah	Yakut
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yao	Yao
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yap	Yapese
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yid	Yiddish
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	yor	Yoruba
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	ypk	Yupik languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	znd	Zande languages
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zap	Zapotec
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zza	Zaza; Dimili; Dimli; Kirdki; Kirmanjki; Zazaki
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zen	Zenaga
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zha	Zhuang; Chuang
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zul	Zulu
CDC	2.16.840.1.114222.4.11.831	Preferred Language	Individual Characteristic	CDC	20080708	zun	Zuni

## Measure Performance Rate Calculation:

$$\frac{N}{(D - EXCL - EXCEP)} = \text{Performance Rate}$$

**(D- EXCL – EXCEP)**

The PCPI strongly recommends that exception rates also be computed and reported alongside performance rates as follows:

## Measure Exception Rate Calculation:

$$\frac{EXCEP}{(D - EXCL)} = \text{Exception Rate}$$

## Exception Types:

EXCEP= E1 (Medical Exceptions) + E2 (Patient Exceptions) + E3 (System Exceptions)

For patients who have more than one valid exception, only one exception should be counted when calculating the exception rate.

Initial Patient Population (IPP)	Denominator (D)	Exclusions (EXCL)	Numerator (N)	Exceptions (EXCEP)
<b>Definition:</b> The group of patients that a set of performance measures is designed to address; usually focused on a specific clinical condition (e.g., coronary artery disease, asthma). For example, a patient aged 18 years and older with a diagnosis of CAD who has at least 2 visits during the measurement period.	<b>Definition:</b> The specific group of patients for inclusion in a specific performance measure based on specific criteria (e.g., patient's age, diagnosis, prior MI). In some cases, the denominator may be identical to the initial patient population.	<b>Definition:</b> The specific group of patients who should be subtracted from the measure population and denominator before determining if the numerator criteria are met.	<b>Definition:</b> The group of patients in the denominator for whom a process or outcome of care occurs (e.g., flu vaccine received).	<b>Definition:</b> The valid reasons why patients who are included in the denominator population did not receive a process or outcome of care (described in the numerator). Patients may have Exceptions for medical reasons (e.g., patient has an egg allergy so they did not receive flu vaccine); patient reasons (e.g., patient declined flu vaccine); or system reasons (e.g., patient did not receive flu Vaccine due to vaccine shortage). These cases are subtracted from the denominator population for the performance calculation, however the number of patients with valid exceptions should be calculated and reported. This group of patients constitutes the Exception reporting population – patients for whom the numerator was not achieved and a there is a valid Exception.
Find the patients who meet the Initial Patient Population criteria (IPP)	Find the patients who qualify for the Denominator (D): From the patients within the Patient Population criteria (IPP) select those people who meet Denominator selection criteria.  (In some cases the IPP and D are identical).	Find the patients who qualify for the Exclusion: (EXCL): From the patients within the Denominator criteria, select those patients who meet Exclusion criteria. The patients meeting exclusion criteria should be removed from the Denominator.	Find the patients who qualify for the Numerator (N): From the patients within the Denominator (D) criteria, select those people who meet Numerator selection criteria. Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.	From the patients who did not meet the Numerator criteria, determine if the patient meets any criteria for the Exception (E1 + E2+E3). If they meet any criteria, they should be removed from the Denominator for performance calculation. As a point of reference, these cases are removed from the denominator population for the performance calculation, however the number of patients with valid exceptions should be calculated and reported.

## 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

**Coding Instructions:** Indicate the evaluating provider's first name.

**Target Value:** The value on current encounter

**Selections:** (none)

**Supporting Definitions:** (none)

---



### 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:	Selection Text	Definition
	No	
	Yes	

**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)

**Supporting Definitions:** (none)

---

**Seq. #: 2060    Name: Sex**

**Coding Instructions:** Indicate the patient's sex at birth.

**Target Value:** The value on current encounter

**Selections:**

Selection Text	Definition
Male	
Female	

**Supporting Definitions:** (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 including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

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

### 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

**Seq. #: 2200 Name:** Patient Zip Code

**Coding Instructions:** Indicate the patient's United States Postal Service zip code of their primary residence.

**Note(s):**

If the patient does not have a U.S residence, or is homeless, leave blank.

**Target Value:** The value on arrival at this facility

**Selections:** (none)

**Supporting Definitions:** (none)

### 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	
Yes	

**Supporting Definitions: Military Health Care:**

Military Health care - Military health care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA).

Source: U.S.Census Bureau

### 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	

**Supporting Definitions: Non-US Insurance:**

Non-U.S. Insurance refers to individuals with a payor that does not originate in the United States.

Source: U.S.Census Bureau

### 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	
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.

A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in Original Medicare.

Source: U.S.Census Bureau

### 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:

1. Total cholesterol greater than 200 mg/dL (5.18 mmol/l); or
2. Low-density lipoprotein (LDL) greater than or equal to 130 mg/dL (3.37mmol/l); or
3. High-density lipoprotein (HDL) less than 40 mg/dL (1.04 mmol/l).

For patients with known coronary artery disease, treatment is initiated if LDL is greater than 100 mg/dL (2.59 mmol/l), and this would qualify as hypercholesterolemia.

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

### 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  $\leq 0.9$ ); 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 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

### 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  $\geq 0.02$  seconds or QS complex in leads V2 and V3.

b. Q-wave  $\geq 0.03$  seconds and  $\geq 0.1$  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  $\geq 0.04$  seconds in V1-V2 and R/S  $\geq 1$  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  $\geq 0.02$  seconds or QS complex in leads V2 and V3.

b. Q-wave  $\geq 0.03$  seconds and  $\geq 0.1$  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  $\geq 0.04$  seconds in V1-V2 and R/S  $\geq 1$  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".

**Seq. #: 5010 Name:** Coronary Artery Bypass Graft (CABG) (within 12 months)

**Coding Instructions:** Indicate if the patient had coronary artery bypass graft (CABG) 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)

### 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.

**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)



### D. Encounter Information

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**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)

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**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)

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**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)

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**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)

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**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)**

**Coding Instructions:** Indicate the patient's weight in pounds (lbs).

**Target Value:** The value on current encounter

**Selections:** (none)

**Supporting Definitions:** (none)

### D. Encounter Information

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**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:**

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

No

Yes

**Supporting Definitions:** (none)

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**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:**

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

Never

Current

Quit within past 12 months

Quit more than 12 months ago

**Supporting Definitions:** (none)

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**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:**

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

No

Yes

**Supporting Definitions:** (none)

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**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:**

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

No

Yes

**Supporting Definitions:** (none)

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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

Selections:	Selection Text	Definition
	No	
	Yes	

**Supporting Definitions:** (none)

### 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

<b>Selections:</b>	<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

<b>Selections:</b>	<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

<b>Selections:</b>	<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

<b>Selections:</b>	<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

<b>Selections:</b>	<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

<b>Selections:</b>	<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

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

**Supporting Definitions:** (none)

### 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	
	Yes	

**Supporting Definitions:** (none)

**Seq. #: 6410 Name:** S3 Gallop Present

**Coding Instructions:** Indicate if the patient has an S3 gallop.

**Target Value:** The value on current encounter

Selections:	Selection Text	Definition
	No	
	Yes	

**Supporting Definitions:** (none)

### 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	

**Supporting Definitions:** (none)

### 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

<b>Selections:</b>	<i>Selection Text</i>	<i>Definition</i>
	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

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

**Supporting Definitions:** (none)

**Seq. #: 6510 Name:** HF Education - All of the following

**Coding Instructions:** Indicate if the patient received all of the following education for heart failure.

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

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

**Supporting Definitions:** (none)

---

**Seq. #: 6516    Name: HF Education - Medication Instruction**

**Coding Instructions:** Indicate if the patient received medication instruction education for heart failure.

**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. #: 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:	<i>Selection Text</i>	<i>Definition</i>
	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:	<i>Selection Text</i>	<i>Definition</i>
	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:	<i>Selection Text</i>	<i>Definition</i>
	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:	<i>Selection Text</i>	<i>Definition</i>
	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 or non-valvular AFib/Flutter

**Target Value:** The value on current encounter

Selections:	<i>Selection Text</i>	<i>Definition</i>
	Non - valvular	
	Valvular	

**Supporting Definitions:** (none)

---

### 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)

---

**Seq. #: 7020 Name: Lipid Panel Fasting**

**Coding Instructions:** Indicate if the patient fasted or not prior to having blood drawn for the most recent lipid panel.

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

**Selections:**

Selection Text	Definition
No	
Yes	

**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:**

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

**Supporting Definitions:** (none)

---

**Seq. #: 7050    Name: Serum Glucose Ordered**

**Coding Instructions:** Indicate if the physician ordered a serum glucose test.

**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)

### 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:**

Selection Text	Definition
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)

---

**Seq. #: 7080    Name: Initial Labs ordered for newly diagnosed Heart Failure (within past 12 months) or patient new to the practice**

**Coding Instructions:** Indicate if the physician ordered Initial Labs for newly diagnosed Heart Failure. Newly diagnosed Heart Failure is defined as HF diagnosed within the past 12 months.

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

**Selections:**

Selection Text	Definition
No	
Yes	

**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:**

<i>Selection Text</i>	<i>Definition</i>
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:**

<i>Selection Text</i>	<i>Definition</i>
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), andtrandolapril (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:**

Selection Text	Definition
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:**

Selection Text	Definition
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:**

Selection Text	Definition
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:**

Selection Text	Definition
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.

**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)

### 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:**

Selection Text	Definition
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:**

Selection Text	Definition
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).

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)

### 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).

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)

### 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)

# NQF application

## HF: Symptom and Activity Assessment (Outpatient) (PINNACLE)

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HF: Symptom and Activity Assessment (Outpatient) (PINNACLE)

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### 1. Performance measure name

HF: Symptom and Activity Assessment (Outpatient) (PINNACLE)

### 2. Performance gap

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

2011

# of providers	# of visits	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
1262	456547	0.00%	0.43%	36.8%	79.6%	100%	79.2%	39.3%

	Mean
Decile 3	0.2%
Decile 4	3.7%
Decile 5	10.7%
Decile 6	25.5%
Decile 7	55.0%
Decile 8	78.7%
Decile 9	94.1%
Decile 10	99.5%

2012

# of providers	# of visits	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
1270	539430	0.00%	1.06%	35.3%	73.3%	100%	72.2%	37.5%

	Mean
Decile 3	0.3%
Decile 4	4.8%

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	Mean
Decile 5	11.7%
Decile 6	24.1%
Decile 7	49.4%
Decile 8	73.1%
Decile 9	90.1%
Decile 10	98.7%

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

**2011**

label	# of providers	# of visits	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
Male	1261	251890	0.00%	0.10%	37.5%	81.1%	100%	81.0%	39.7%
Female	1261	204304	0.00%	0.00%	35.9%	76.9%	100%	76.9%	39.3%
Age: <60	1252	97158	0.00%	0.00%	38.3%	82.4%	100%	82.4%	40.0%
Age: 60 -< 70	1258	110148	0.00%	0.00%	36.7%	80.0%	100%	80.0%	39.8%
Age: 70 -< 80	1253	127786	0.00%	0.00%	36.7%	80.0%	100%	80.0%	39.7%
Age: >= 80	1249	121455	0.00%	0.00%	35.7%	78.0%	100%	78.0%	40.0%
Insurance: None	573	25742	0.00%	0.00%	40.3%	100%	100%	100%	43.9%
Insurance: Private	1178	206909	0.00%	0.18%	38.5%	83.5%	100%	83.3%	40.0%
Insurance: Medicaid	1181	149328	0.00%	0.00%	39.0%	83.3%	100%	83.3%	40.2%
Insurance: Medicare	744	8174	0.00%	0.00%	34.1%	86.6%	100%	86.6%	42.7%
Insurance: Other	385	3416	0.00%	0.00%	37.5%	100%	100%	100%	46.4%
Race: White	1152	244177	0.00%	0.00%	40.8%	85.7%	100%	85.7%	40.5%
Race: Black	904	31683	0.00%	0.00%	42.4%	94.7%	100%	94.7%	42.8%
Race: Other	564	4698	0.00%	0.00%	38.1%	100%	100%	100%	45.8%

**2012**

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### HF: Symptom and Activity Assessment (Outpatient) (PINNACLE)

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label	# of providers	# of visits	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
Male	1269	297783	0.00%	0.99%	36.1%	74.7%	100%	73.7%	37.9%
Female	1270	241608	0.00%	0.19%	34.4%	71.1%	100%	70.9%	37.5%
Age: <60	1263	109912	0.00%	0.00%	36.3%	75.8%	100%	75.8%	38.4%
Age: 60 -< 70	1267	130544	0.00%	0.00%	35.3%	75.0%	100%	75.0%	38.0%
Age: 70 -< 80	1269	153103	0.00%	0.00%	35.3%	74.1%	100%	74.1%	38.0%
Age: >= 80	1257	145871	0.00%	0.00%	34.1%	71.4%	100%	71.4%	37.7%
Insurance: None	559	28518	0.00%	0.00%	36.7%	80.0%	100%	80.0%	41.1%
Insurance: Private	1184	275693	0.00%	1.26%	36.9%	75.8%	100%	74.5%	38.1%
Insurance: Medicaid	1205	172172	0.00%	0.14%	36.7%	77.1%	100%	77.0%	38.4%
Insurance: Medicare	787	10925	0.00%	0.00%	37.4%	84.6%	100%	84.6%	41.8%
Insurance: Other	378	3455	0.00%	0.00%	24.7%	44.4%	100%	44.4%	38.9%
Race: White	1150	325420	0.00%	0.53%	37.2%	77.7%	100%	77.2%	38.7%
Race: Black	899	39807	0.00%	0.00%	40.4%	87.5%	100%	87.5%	40.9%
Race: Other	644	8313	0.00%	0.00%	32.7%	85.4%	100%	85.4%	42.8%

### 2.3 Dates of data (1.3)

**2011** – Jan 1, 2011 through Dec 31 2011

**2012** – Jan 1, 2012 through Dec 31 2012



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## 2.4 Description of providers (measure entities 1.5).

2011

1262 providers met the minimum number of eligible visits (10) for inclusion in the reliability analysis. The average number of eligible visits for providers included is 316.8 for a total of 456,547 visits. The range of number of visits for providers included is from 4,798 to 10.

	Total
	n = 1262
Provider gender	
(1) Male	1001 ( 79.6% )
(2) Female	257 ( 20.4% )
Missing (.)	4
Provider categories	
NP/PA	135 ( 10.9% )
MD/DO	1076 ( 86.7% )
RN/nurses	30 ( 2.4% )
Missing (.)	21
Region	
(1) Northeast	230 ( 18.2% )
(2) Midwest	395 ( 31.3% )
(3) South	424 ( 33.6% )
(4) West	213 ( 16.9% )

## NQF application

### HF: Symptom and Activity Assessment (Outpatient) (PINNACLE)

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#### 2012

1270 providers met the minimum number of eligible visits (10) for inclusion in the reliability analysis. The average number of eligible visits for providers included is 424.7 for a total of 539,430 visits. The range of number of visits for providers included is from 5059 to 10.

	Total n = 1270
Provider gender	
(1) Male	1003 ( 79.2% )
(2) Female	264 ( 20.8% )
Missing (.)	3
Provider categories	
NP/PA	138 ( 11.0% )
MD/DO	1074 ( 85.9% )
RN/nurses	38 ( 3.0% )
Missing (.)	20
Region	
(1) Northeast	207 ( 16.3% )
(2) Midwest	408 ( 32.1% )
(3) South	436 ( 34.3% )
(4) West	219 ( 17.2% )

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### HF: Symptom and Activity Assessment (Outpatient) (PINNACLE)

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## 2.5 Description of visits (1.6)

2011

	<b>Total</b> <b>n = 456547</b>
Race	
(1) White	247438 ( 87.2% )
(2) Black	31652 ( 11.2% )
(3) Other	4670 ( 1.6% )
Missing (.)	172787
Insurance	
(0) No insurance	25873 ( 6.5% )
(1) Private	210335 ( 52.6% )
(2) Medicare	152312 ( 38.1% )
(3) Medicaid	8277 ( 2.1% )
(4) Other	3321 ( 0.8% )
Missing (.)	56429
Age	
18 to <60	95950 ( 21.0% )
60 to <70	109135 ( 23.9% )
70 to <80	127610 ( 28.0% )
80 to 112	123852 ( 27.1% )
Sex	
(1) Male	251851 ( 55.2% )
(2) Female	204341 ( 44.8% )
Missing (.)	355
BMI	29.8 ± 6.9
Missing	140954
Diabetes	150886 ( 33.0% )
CAD	320820 ( 70.3% )
Hypertension	394686 ( 86.5% )
AFib	179189 ( 39.2% )
HF	456547 ( 100.0% )
PAD	108832 ( 23.8% )
Prior Stroke/TIA	116700 ( 25.6% )
MI history	134647 ( 29.5% )

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2012

	Total n = 539430
Race	
(1) White	328264 ( 87.2% )
(2) Black	39865 ( 10.6% )
(3) Other	8444 ( 2.2% )
Missing (.)	162857
Insurance	
(0) No insurance	31177 ( 6.3% )
(1) Private	272809 ( 55.4% )
(2) Medicare	174165 ( 35.4% )
(3) Medicaid	10854 ( 2.2% )
(4) Other	3354 ( 0.7% )
Missing (.)	47071
Age	
18 to <60	108378 ( 20.1% )
60 to <70	129264 ( 24.0% )
70 to <80	153026 ( 28.4% )
80 to 112	148762 ( 27.6% )
Sex	
(1) Male	297783 ( 55.2% )
(2) Female	241608 ( 44.8% )
Missing (.)	39
BMI	30.0 ± 7.0
Missing	128702
Diabetes	192369 ( 35.7% )
CAD	402086 ( 74.5% )
Hypertension	489445 ( 90.7% )
AFib	228161 ( 42.3% )
HF	539430 ( 100.0% )
PAD	131347 ( 24.3% )
Prior Stroke/TIA	147720 ( 27.4% )
MI history	169501 ( 31.4% )

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### 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	0.992
25th percentile	100	0.996
50th percentile	217	0.998
75th percentile	449	0.999
Average	362	0.999

**2012**

Description	Number of Patients	Signal-to-Noise Ratio
Minimum	10	0.994

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Description	Number of Patients	Signal-to-Noise Ratio
25th percentile	141	0.997
50th percentile	280	0.998
75th percentile	508	0.999
Average	425	0.999

This measure has excellent reliability.

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

**Exclusion:** none

## 5. Identification of differences in performance (2b5)

**2011**

# of providers	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
1262	0.00%	0.43%	36.8%	79.6%	100%	79.2%	39.3%

A large variability was noted among providers. The performance-met rate range was 0-100% with the inter-quartile range being 0.4% to 79.6%. This yielded a Median Rate Ratio of 9.03(8.21, 10.02). The Median Rate Ratio measures the variation between clusters by comparing 2 persons from two randomly chosen different clusters. A MRR of 9.03 indicates a moderate amount of variation among the clusters.

**2012**

# of providers	Minimum	Lower Quartile	Mean	Upper Quartile	Maximum	Quartile Range	Std Dev
1270	0.00%	1.06%	35.3%	73.3%	100%	72.2%	37.5%

A large variability was noted among providers. The performance-met rate range was 0-100% with the inter-quartile range being 1.1% to 73.3%. This yielded a Median Rate Ratio of 8.34(7.62, 9.22). The Median Rate Ratio measures the variation between clusters by comparing 2 persons from two

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randomly chosen different clusters. A MRR of 8.34 indicates a moderate 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'. So we assume there is no missing data.