Practice Fusion 2014 Clinical Quality Measure Guide

This guide will provide in depth information on the clinical quality measures that are available in Practice Fusion.

WHAT ARE CLINICAL QUALITY MEASURES?

Clinical quality measures, also called CQMs, are tools that help us measure and monitor the quality of healthcare and the contribution of those healthcare services towards improved health outcomes. In the past, quality measures primarily used data that came from claims, but as technology has improved and become more prominent in the healthcare setting, many quality measures now use data that comes from a provider’s electronic health record (EHR). These electronic CQMs (eCQMs) use EHR data to measure health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagement, and population and public health improvement.

IMPORTANT TERMS

The definitions below will help you better use this guide to measure and monitor the quality of care that you provide to your patients.

- **Denominator** – The population of patients or encounters for which the measure applies.
- **Numerator** - The population of patients from the denominator who meet the measure specified clinical requirements or the population of encounters from the denominator where the measure specific requirement has been performed.
- **Exclusion/Exception** – Specifications that would remove a patient from the denominator of a specific quality measure. These exclusions and exceptions include certain diagnoses that make it clinically unnecessary for the patient to receive the numerator clinical action and/or provider or patient determined reasons for refusing certain clinical actions.
- **Measurement period** – This is also known as the EHR reporting period and refers to the time frame for which the CQMs will be calculated. For more information on determining your CQM reporting period, refer to the reporting requirements at the end of this guide.
- **United States Health Information Knowledgebase (USHIK)** – For a one-stop shop, visit the [USHIK meaningful use portal](https://www.ushik.gov) where you can readily view, easily download, and accurately compare the 2014 CQMs, data elements, value sets, and codes for each quality measure. This site is produced by the Agency for Healthcare Research and Quality (AHRQ) in partnership with CMS and the National Library of Medicine (NLM). A free [Unified Medical Language System®](https://www.nlm.nih.gov/umu/) (UMLS) license, available from NLM, is required to access USHIK.
National Quality Strategy (NQS) Domains – The NQS outlines the federal plan to improve the quality of healthcare delivered in the United States and was developed as a result of the Affordable Care Act. The six NQS domains, one of which is assigned to each CMS eCQM, are: Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, and Clinical Processes/Effectiveness.

National Quality Forum (NQF) - NQF reviews, endorses, and recommends use of standardized quality measures. Not all quality measures are “NQF-endorsed,” but those that are have an assigned NQF number.

Value sets - Lists of specific values (terms and their codes) derived from single or multiple standard vocabularies used to define clinical concepts (e.g. patients with diabetes, clinical visit, reportable diseases) used in clinical quality measures and to support effective health information exchange. Although there are many uses for value sets, a primary purpose of the value sets is to support the 2014 Clinical Quality Measures prescribed for Meaningful Use. Most of the value sets are therefore used to define the patient populations that should be included in the denominators and in the numerators when computing a clinical quality measure.

Quality Reporting Document Architecture (QRDA) – An HL7-based standard document format for the exchange of clinical quality measure data. QRDA reports contain data extracted from electronic health records (EHRs) and other information technology systems. QRDA reports are used for the exchange of CQM data between systems for a variety of quality measurement and reporting initiatives, including Meaningful Use and PQRS. These programs require the submission of QRDA Category I reports, which utilize patient-level data, or QRDA Category III reports, which utilize aggregated patient data.

CQM CALCULATION INFORMATION

CQM values can be monitored in the Practice Fusion Clinical Quality Measures Report, which can be accessed under the Reports section of the EHR. After selecting the “2014 Clinical Quality Measure Report” link, you will need to select the correct provider and reporting period from the drop-down menus. These values will be retained until they are actively changed.

The tables below provide information on each of the current Practice Fusion clinical quality measures. For information on what codes are included in each numerator and denominator, please refer to the Help Forum post on accessing USHIK. For detailed measure specification logic flows, refer to the CMS CQM flow sheet documents, which can be downloaded from the CMS website or the More Information section at the end of this guide.

In the tables below, the top row lists the measure title, the CMS eMeasure ID number, the NQF number (if applicable), and the NQS Domain. The PF Suggested Workflow includes more details about the measure and information on how the measure can be fulfilled using the Practice Fusion EHR.
### Controlling High Blood Pressure: CMS 165v2 (NQF 0018)

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.</td>
<td>Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure &lt; 140 mmHg and diastolic blood pressure &lt; 90 mmHg) during the measurement period.</td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

Record blood pressure in the chart note for all patients who have a diagnosis for hypertension during each encounter. Patients whose blood pressure is uncontrolled should be monitored and have their vital signs updated at each follow-up visit.

The diagnosis of hypertension must be active and include a valid start date in order to be recognized by the calculation.

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### Use of High-Risk Medications in the Elderly: CMS156v2 (NQF 0022)

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 66 years and older who had a visit during the measurement period.</td>
<td>Numerator 1: Patients with an order for at least one high-risk medication during the measurement period. Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period.</td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

“High-risk” medications are those that can result in adverse events or medications that are clinically inappropriate for seniors. This measure is calculated based on the medications that are prescribed to patients who meet the denominator criteria. Utilize the resources on the USHIK website to become familiar with the list of medications that are categorized as “high-risk” for the purposes of this CQM.

Examples of high risk medications as defined by this measure include certain dosages and strengths of:

- Acetaminophen
- Butabarbital sodium
- Diphenhydramine Hydrochloride
- Estrogens

Patients are identified as having a visit during the measurement period if they have a signed chart note labeled with an encounter type of “office visit.”

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### Preventive Care and Screening: Tobacco Use: CMS138v2 (0028)

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Cessation Intervention</td>
<td></td>
</tr>
</tbody>
</table>
All patients aged 18 years and older.

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user.

**PRACTICE FUSION SUGGESTED WORKFLOW**

Record a smoking status in the *Lifestyle* section for all patients and if the patient’s smoking status indicates they are a tobacco user, document a tobacco cessation counseling intervention in the Screenings/Assessments/Interventions section of the chart note.

The smoking statuses that are used to identify if a patient is a “tobacco user” are: *Current every day smoker; Current some day smoker; Smoker, current status unknown; Heavy tobacco smoker;* and *Light tobacco smoker*. The smoking status of *Unknown if ever smoked* is not used to determine numerator credit for this measure.

Examples of smoking cessation interventions that you can choose are “smoking cessation education (procedure)” or “referral to stop smoking clinic (procedure)”.

The smoking cessation intervention that is added in the Screenings/Assessments/Interventions section of the chart can be “performed” or “ordered”. You do not need to enter a result to receive credit for this measure. New and/or active prescriptions of Tobacco cessation medications also count as tobacco cessation counseling interventions.

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<table>
<thead>
<tr>
<th>Colorectal Cancer Screening</th>
<th>CMS130v2 (NQF 0034)</th>
<th>Clinical Process/Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENOMINATOR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 50-75 years of age with a visit during the measurement period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NUMERATOR</strong></td>
<td>Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Fecal occult blood test (FOBT) during the measurement period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Colonoscopy during the measurement period or the nine years prior to the measurement period</td>
<td></td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

Colorectal cancer screenings can be recorded in the patient chart in the Screenings/Interventions/Assessments section or by receiving structured lab results.

To record the colorectal cancer screening, search for the screening that the patient received and select the appropriate screening. Use the modal to indicate that the screening was “performed” and the date that the screening occurred. For patients given a Fecal Occult Blood Test (FOBT), they will be included in the numerator once a structured lab result, which can be identified by a LOINC code, is received in the EHR. Only screenings that occur during the appropriate timeframe listed in the numerator description will receive numerator credit for this measure.

Patients are identified as having a visit during the measurement period if they have a signed chart note labeled with an encounter type of “office visit.”
**Use of Imaging Studies for Low Back Pain**

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 18-50 years of age with a diagnosis of low back pain during an outpatient or emergency department visit.</td>
<td>Patients without an imaging study conducted on the date of the outpatient or emergency department visit or in the 28 days following the outpatient or emergency department visit.</td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

This CQM is an inverse measure, meaning patients who fall into the numerator have not received the clinically recommended treatment. The numerator value for this measure is determined after a 28 day period following each relevant encounter. Practice Fusion only uses encounters that are labeled with “Office Visit” in the denominator of this measure.

Examples of eligible diagnoses for “low back pain” include:

- Sciatica, unspecified side
- Low back pain
- Lumbago
- Backache, unspecified

Imaging studies that have been performed should be recorded in the **Screenings/Interventions/Assessments** section of the chart note. Practice Fusion will also use imaging results that are sent to the EHR for the purposes of calculating this measure.

The diagnosis of low back pain must include a valid start date in order to be recognized by the calculation.

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**Diabetes: Eye Exam**

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 18-75 years of age with diabetes with a visit during the measurement period.</td>
<td>Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following:</td>
</tr>
</tbody>
</table>

- A retinal or dilated eye exam by an eye care professional in the measurement period, or
- A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period.
PRACTICE FUSION SUGGESTED WORKFLOW

After performing the required exam or confirming that the patient has received the exam from an eye care professional, search for and record that an “Examination of the retina (procedure)” has been performed in the Screenings/Interventions/Assessments section.

The diagnosis of diabetes must include a valid start date in order to be recognized by the calculation.

### Diabetes: Foot Exam CMS123v2 (NQF 0056) Clinical Process/Effectiveness

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
</table>
| Patients 18-75 years of age with diabetes with a visit during the measurement period. | Patients who received visual, pulse and sensory foot examinations during the measurement period.

PRACTICE FUSION SUGGESTED WORKFLOW

This measure requires that the patient receive all three of the foot exams listed in the numerator description. After performing the required foot exams or confirming that the patient has received the exams from another medical professional during the measurement period, search for and record that a “Diabetic foot exam (visual, sensory, and pulse)” has been performed in the Screenings/Interventions/Assessments section of the chart note. This selection is mapped to the coded values for all three required exams.

The diagnosis of diabetes must include a valid start date in order to be recognized by the calculation.

### Diabetes: Hemoglobin A1c Poor Control CMS122v2 (NQF 0059) Clinical Process/Effectiveness

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
</table>
| Patients 18-75 years of age with diabetes with a visit during the measurement period. | Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or patients who don’t have an A1C test during the measurement period.

PRACTICE FUSION SUGGESTED WORKFLOW

This measure uses structured lab results that are received in the EHR to determine whether a patient falls into the numerator. This is an inverse measure, which means that patients who fall into the numerator do not meet the clinical guidelines.

If a patient does not have a structured hemoglobin A1c lab result, they are included in the numerator by default. Only structured HbA1c lab results that include a valid LOINC code that are received in the EHR from a lab connection can be used to calculate this measure.

The diagnosis of diabetes must include a valid start date in order to be recognized by the calculation.
## Depression and Follow-Up Plan

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.</td>
<td>Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.</td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

Patients who meet the denominator criteria should be screened for depression using an age-appropriate depression screening instrument. After conducting the appropriate screening record “Adult [or Adolescent] depression screening assessment” in the *Screenings /Interventions /Assessments* section. After selecting that the screening was performed, you must select the result of “depression screening negative” or “depression screening positive.” If positive, record the appropriate follow-up plan in the same section.

Examples of data elements that meet the requirements for a follow-up plan include “Mental health care education (procedure),” “Referral to psychologist (procedure),” and “Case management follow up (procedure).”

Patients are identified as having a visit during the measurement period if they have a signed chart note labeled with an encounter type of “office visit.”

## Documentation of Current Medications in the Medical Record

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period.</td>
<td>Eligible professional attests to documenting, updating or reviewing the patient’s current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosages, frequency and route of administration.</td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

This measure uses a denominator unit of measurement of all encounters for patients age 18 and older, which means that the numerator criteria must be documented for each encounter labeled “Office Visit” or “Home Visit.” To record your attestation that the patient’s current medication list is documented in the chart, select the “Documentation of Current Medications” checkbox under the *Quality of Care* section.

## Preventive Care and Screening: Body Mass (BMI) Screening and Follow-Up

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CMS69v2 (NQF 0421) Population/Public Health Index**
Denominator 1: All patients 65 years of age and older before the beginning of
the measurement period with at least one eligible encounter during the
measurement period NOT INCLUDING encounters where the patient is
receiving palliative care, refuses measurement of height and/or weight, the
patient is in an urgent or emergent medical situation where time is of the
essence and to delay treatment would jeopardize the patient’s health status, or
there is any other reason documented in the medical record by the provider
explaining why BMI measurement was not appropriate.

Denominator 2: All patients 18 through 64 years before the beginning of the
measurement period with at least one eligible encounter during the
measurement period NOT INCLUDING encounters where the patient is
receiving palliative care, refuses measurement of height and/or weight, the
patient is in an urgent or emergent medical situation where time is of the
essence and to delay treatment would jeopardize the patient’s health status, or
there is any other reason documented in the medical record by the provider
explaining why BMI measurement was not appropriate.

PRACTICE FUSION SUGGESTED WORKFLOW

Record height and weight for all patients during eligible encounters (encounters labeled “Office Visit” or “Home
Visit”); Practice Fusion automatically calculates and records the patient’s BMI. Determine whether the patient’s
BMI falls above or below the normal parameters listed below.

Normal Parameters:

Age 65 years and older BMI ≥ 23 and < 30

Age 18-64 years BMI ≥ 18.5 and < 25

For patients whose BMI falls outside the normal parameters for their age range, record that an appropriate follow-
up plan was performed in the Screenings/ Interventions/Assessments section of the chart note. After selecting an
appropriate follow-up plan, you will need to record the reason for the follow-up, e.g. “overweight” or
“underweight” depending on where the patient falls in relation to the normal parameters.

Examples of follow-up plans for BMI management include: “Dietary counseling and surveillance,”
“Lifestyle education regarding diet (procedure),” and “Nutrition therapy (regime/therapy).”

Closing the referral loop: receipt of specialist report

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.</td>
<td>Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.</td>
</tr>
</tbody>
</table>
PRACTICE FUSION SUGGESTED WORKFLOW

Referrals that occur in the Practice Fusion referral workflow are tracked in the referral tab of the patient chart or the messages section. After receiving a follow-up consultation report from the provider to whom the patient was referred, select the checkbox next to each completed referral to meet the numerator criteria.

Referrals that occur outside of Practice Fusion can be recorded by selecting the appropriate referral data element (e.g. “Referral to endocrinologist”) from the Screenings/Interventions/Assessments section of the chart note.

When a consultation report has been received from the provider to whom the patient was referred, this can be logged in a subsequent chart note under the Screenings/Interventions/Assessments section by recording “Confirmatory consultation report (record artifact)”.

<table>
<thead>
<tr>
<th>Functional Status Assessment for Complex Chronic Conditions</th>
<th>Patient and Family Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENOMINATOR</strong></td>
<td></td>
</tr>
<tr>
<td>Adults aged 65 years and older who had two outpatient encounters during the measurement year and an active diagnosis of heart failure.</td>
<td></td>
</tr>
<tr>
<td><strong>NUMERATOR</strong></td>
<td></td>
</tr>
<tr>
<td>Patients with patient reported functional status assessment results (e.g., VR-12; VR-36; MLHF-Q; KCCQ; PROMIS-10 Global Health, PROMIS-29) present in the EHR at least two weeks before or during the initial encounter and the follow-up encounter during the measurement year.</td>
<td></td>
</tr>
</tbody>
</table>

PRACTICE FUSION SUGGESTED WORKFLOW

This measure requires that patients with heart failure are given functional status assessments at least twice a year and that the functional status results be recorded in the EHR at least two weeks before or during the first and follow-up encounter.

Functional status assessment results can be recorded in the chart note by searching for and selecting the appropriate functional status assessment result in the Screenings/Interventions/Assessments section. Data elements for functional status assessments can be found by searching for the assessment name as listed in the numerator description above.

Only patients who have at least two encounters during the measurement period (after January 1, 2014) and an active diagnosis of heart failure are included in the denominator of this measure.

To be included in the denominator, the patient’s first encounter must have occurred sometime before or within 185 days of the start of the measurement period and the second encounter must be at least 30 days after but no more than 180 days after the first encounter.

The diagnosis of heart failure must include a valid start date in order to be recognized by the calculation.
Patients aged 18 and older before the start of the measurement period.

Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is pre-hypertensive or hypertensive.

**PRACTICE FUSION SUGGESTED WORKFLOW**

After recording the patient’s blood pressure in the chart, determine if the patient is pre-hypertensive or hypertensive, and then record the following in the Screenings/Interventions/Assessments section of the new chart:

- Follow-up time frame (4 weeks, 1 year, etc.)
- The selected intervention as “Ordered, Reason (Finding of hypertension)”

Recommended Blood Pressure Follow-Up Interventions:

- Normal BP: No follow-up required for Systolic BP < 120 mmHg AND Diastolic BP < 80 mmHg
- Pre-Hypertensive BP: Follow-up with a re-screening every year with systolic BP of 120-139 mmHg OR diastolic BP of 80-89 mmHg AND recommend lifestyle modifications OR “referral to Alternative/Primary Care Provider”
- First Hypertensive BP Reading: Patients with 1 reading of systolic BP >= 140 mmHg OR diastolic BP >= 90 mmHg: Follow-up with a re-screening > 1 day and < 4 weeks AND recommend lifestyle modifications OR “referral to Alternative/Primary Care Provider”
- Second Hypertensive BP Reading: Patients with 2nd elevated reading of systolic BP >=140 mmHg OR diastolic BP >= 90 mmHg: Follow-up with Recommended lifestyle recommendations AND one or more of the Second Hypertensive Reading Interventions OR “referral to Alternative/Primary Care Provider”

**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic**

**DENOMINATOR**

Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period.

**NUMERATOR**

Patients who have documentation of use of aspirin or another antithrombotic during the measurement period.

**PRACTICE FUSION SUGGESTED WORKFLOW**

Medications that meet the numerator criteria for this measure include the following:

- Prasugrel (5mg and 10mg oral tablet)
- Aspirin (varying dosages and tablet types, for example: 81 mg chewable tablet, 80 mg oral tablet, 228 mg chewing gum, 300 mg oral capsule, 162 mg enteric coated tablet, etc.)
- Clopidogrel (300mg and 75 mg oral tablet)

Diagnoses must include a start date and be “active” (no end date) to qualify the patient for the denominator.
- The Dx start date does not need to be during the measurement year.

Prescriptions and medications added to the patient’s medication list that are “active” will qualify the patient for the numerator.
- A start date must be recorded for these medications to be included in CQM calculations (but the start date does not need to be during the measurement year).
- Active medications and prescriptions are those without a stop date.

### Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period.</td>
<td>Numerator 1: Patients with a complete lipid profile performed during the measurement period</td>
</tr>
</tbody>
</table>

**Practice Fusion Suggested Workflow**

Only structured lab results that include a valid LOINC code that are received in the EHR from a lab connection can be used to calculate this measure. The following lab results meet the criteria for Numerator 1 of this CQM:

- Lipid panel with direct LDL - Serum or Plasma, OR
- Lipid 1996 panel - Serum or Plasma, OR
- ALL of the following together during the measurement period:
  - Total cholesterol Laboratory test
  - HDL-C Laboratory test
  - LDL-C Laboratory Test
  - Triglycerides Laboratory test

### Pneumonia Vaccination Status for Older Adults

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 65 years of age and older with a visit during the measurement period.</td>
<td>Patients who have ever received a pneumococcal vaccination.</td>
</tr>
</tbody>
</table>

**Practice Fusion Suggested Workflow**

Vaccines (both administered and historical) are entered in the Practice Fusion in the **immunizations** screen.

The pneumococcal vaccine can be recorded in the patient chart under the Immunizations section of the EHR as “administered” or “historical.”

Data of vaccine must be before or during the measurement period to count in the numerator.

- The only pneumococcal vaccine that meets this measure is Pneumococcal polysaccharide vaccine, 23 valent (CVX 33)
### Breast Cancer Screening

**DENOMINATOR**  
Women 41–69 years of age with a visit during the measurement period.

**NUMERATOR**  
Women with one or more mammograms during the measurement period or the year prior to the measurement period.

**PRACTICE FUSION SUGGESTED WORKFLOW**

Breast cancer screenings must be recorded as “Performed” in the Screenings/Intervention/Assessments section of the new chart note.

Screenings that are dated during the measurement year or in the year prior to the measurement year will count towards this measure.

Screening assessments that meet the numerator of this measure include:

- Screening mammography
- Diagnostic mammography
- Breast mammogram screening
- Right mammogram screening
- Bilateral mammogram screening
- Breast mammogram spot
- Breast mammogram grid

### Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

**DENOMINATOR**  
All patients aged 18 years and older with at least two encounters during the measurement period, AND:

1) An Dx of heart failure, AND
2) One of the following:
   - LVEF result that is <40%, OR
   - Dx of moderate or severe LVSD,

That occurs before or during the second encounter for the patient during the measurement year.

**NUMERATOR**  
Patients who were prescribed beta-blocker therapy within a 12 month period when seen in the outpatient setting.
PRACTICE FUSION SUGGESTED WORKFLOW

Patient is added to the measure denominator after their 2nd encounter of the measurement period.

Beta-blockers that meet the numerator criteria for this measure include (but are not limited to):

- 24 HR Hydrochlorothiazide 12.5 MG / Metoprolol Tartrate 50 MG Extended Release Tablet
- 24 HR Metoprolol Tartrate 50 MG Extended Release Tablet (other dosages qualify as well)
- 24 HR carvedilol phosphate 80 MG Extended Release Capsule (other dosages qualify as well)
- Bisoprolol Fumarate 5 MG / Hydrochlorothiazide 6.25 MG Oral Tablet (other dosages qualify as well)
- Carvedilol 25 MG Oral Tablet (other dosages qualify as well)

### Preventative Care and Screening: Influenza Immunization

<table>
<thead>
<tr>
<th><strong>DENOMINATOR</strong></th>
<th><strong>NUMERATOR</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 6 months and older with at least two encounters during the measurement period and one encounter that occurred between October 1st of the previous measurement period and March 31st of the current measurement period.</td>
<td>Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.</td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

This measure is looking to see whether patients received the influenza vaccine during a single flu season that occurs between October 1st of the previous year and March 31st of the current year. The vaccination must be administered/documented during one of the qualifying encounters between October 1st of the previous measurement period and March 31st of the current measurement period.

Influenza vaccines that meet this measure include:

- Influenza, seasonal injectable (CVX 141)
- Influenza seasonal, injectable, preservative free (CVX 140)
- Influenza, high dose seasonal, preservative-free (CVX 135)
- Influenza, live, intranasal, quadrivalent (CVX 149)
- Seasonal influenza, intradermal, preservative free (CVX 144)
- Influenza, injectable, quadrivalent, preservative free (CVX 150)
- Influenza virus vaccine, live, attenuated, for intranasal use (CVX 111)

### Falls: Screening for Future Fall Risk

<table>
<thead>
<tr>
<th><strong>DENOMINATOR</strong></th>
<th><strong>NUMERATOR</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged 65 years and older with a visit during the measurement period</td>
<td>Patients who were screened for future fall risk at least once within the measurement period</td>
</tr>
</tbody>
</table>
## PRACTICE FUSION SUGGESTED WORKFLOW

**Future fall risk:** Patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year.

Search for “Falls Risk Assessment” in the Screenings/Interventions/Assessments section of the chart note and indicate that it has been “performed.”

The start date defaults to the date of the chart note but can be backdated if needed.

A result is not needed for the Falls Risk Assessment.

### Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
</table>
| Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period. | Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period  
Numerator 2: Patients who had counseling for nutrition during the measurement period  
Numerator 3: Patients who had counseling for physical activity during the measurement period |

### PRACTICE FUSION SUGGESTED WORKFLOW

Determine the patient’s BMI percentile by looking at the growth chart in the Practice Fusion EHR.

The “BMI percentile” is calculated automatically as long as the patient has values for height and weight.

Counseling for nutrition and physical activity are recorded under the Screenings/Interventions/Assessments section

- Examples of interventions for counseling for nutrition (numerator 2) include: “nutrition education,” “lifestyle education regarding diet”, and “weight control education.”
- Examples of interventions for counseling for physical activity (numerator 3) include: “exercise education,” “patient advised about exercise,” and “recommendation to exercise.”

### Use of Appropriate Medications for Asthma

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 5-64 years of age with persistent asthma and a visit during the measurement period.</td>
<td>Patients who were dispensed at least one prescription for a preferred asthma therapy during the measurement period.</td>
</tr>
</tbody>
</table>
PRACTICE FUSION SUGGESTED WORKFLOW

This is required CQM for Comprehensive Primary Care Initiative. Providers not participating in CPCi should not select this CQM for reporting unless absolutely necessary.

“Persistent Asthma” for the purposes of this CQM must be recorded using SNOMED by searching for and adding one of the following diagnoses with a start date on or before the encounter:

- Moderate persistent asthma
- Mild persistent asthma
- Severe persistent asthma

Patients whose charts only include the ICD-9 code 493.90 (Asthma) will not be included in this measure denominator.

### Diabetes: Low Density Lipoprotein (LDL) Management

<table>
<thead>
<tr>
<th>Clinical Processes/Effectiveness CMS163v2 (NQF 0064)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENOMINATOR</strong></td>
</tr>
<tr>
<td>Patients 18-75 years of age with diabetes with a visit during the measurement period.</td>
</tr>
</tbody>
</table>

**PRACTICE FUSION SUGGESTED WORKFLOW**

The LDL-C test results that meet the numerator criteria for this measure include:

- Cholesterol in LDL [Mass/volume] in Serum or Plasma (LOINC 2089-1)
- Cholesterol in LDL [Mass/volume] in Serum or Plasma by Direct assay (LOINC 18262-6)
- Cholesterol in LDL [Mass/volume] in Serum or Plasma by calculation (LOINC 13457-7)

### Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Clinical Processes/Effectiveness CMS124v2 (NQF 0032)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENOMINATOR</strong></td>
</tr>
<tr>
<td>Women 23-64 years of age with a visit during the measurement period.</td>
</tr>
</tbody>
</table>
**PRACTICE FUSION SUGGESTED WORKFLOW**

Pap test results must be sent to the Practice Fusion EHR by a lab partner.

The lab test results that meet the numerator criteria for this measure include (but are not limited to):

- Cytology report of Cervical or vaginal smear or scraping Cyto stain (LOINC 47528-5)
- Cytology report of Cervical or vaginal smear or scraping Cyto stain.thin prep (LOINC 47527-7)
- Cytology Cervical or vaginal smear or scraping study (LOINC 33717-0)
- Cytology study comment Cervical or vaginal smear or scraping Cyto stain (LOINC 19774-9)
- Microscopic observation [Identifier] in Cervix by Cyto stain.thin prep (LOINC 18500-9)
- Microscopic observation [Identifier] in Cervix by Cyto stain (LOINC 10524-7)

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**Chlamydia Screening for Women**

**DENOMINATOR**

Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period.

**NUMERATOR**

Women with at least one chlamydia test during the measurement period.

**PRACTICE FUSION SUGGESTED WORKFLOW**

Codes to identify sexually active women include codes for:

- pregnancy
- sexually transmitted infections
- contraceptives
- contraceptive devices
- infertility treatments

Chlamydia test results must come through structured lab results into the EHR.

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**Dementia: Cognitive Assessment**

**DENOMINATOR**

All patients, regardless of age, with a diagnosis of dementia and at least two encounters during the measurement period.

**NUMERATOR**

Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.
PRACTICE FUSION SUGGESTED WORKFLOW

Cognitive assessments are conducted outside of the EHR but can be recorded in the patient chart under Screenings/Intervention/Assessments. Standardized assessments that meet this CQM criteria include:

- Total score BOMC
- Total score MoCA
- Total score MMSE
- Total score AD8
- Total score IQCODE
- Total score SLUMS
- Prior assessment brief interview for mental status (BIMS) summary score MDSv3
CMS QUALITY MEASURE REPORTING

Meaningful Use CQM Reporting

Under the 2014 Medicare Physician Fee Schedule Final Rule, CMS made some changes to the rules that govern how providers will need to report CQMs for Meaningful Use.

- Providers can manually submit CQM values during Meaningful Use attestation. This option is now available to providers in any stage of Meaningful Use and will allow providers to receive incentive payments sooner since they will not have to wait until January 2015 to submit CQM values to CMS.
- Providers submitting CQM values to CMS for attestation will need to report for at least 9 measures covering at least 3 of the NQS domains. Zero values are acceptable if you do not have 9 CQMs in your Practice Fusion Clinical Quality Measures report with values.
- Providers who submit CQMs via Meaningful Use attestation can still use electronic submission with Practice Fusion for the purposes of 2014 PQRS reporting in January 2015.
- Providers who choose to submit CQMs electronically for the purposes of dual credit for PQRS and Meaningful Use will still be able to do this via their EHR vendor, but reporting will not occur until 2015 since the reporting period would be a full calendar year.

PQRS CQM Reporting

As in past years, PQRS offers multiple reporting mechanisms including claims, registry, or EHR reporting. Providers who wish to report PQRS via their EHR will be required to report 9 measures covering at least 3 of the National Quality Strategy domains using CERHT that has been certified to the most recent version of the CMS electronic CQMs.

- If a provider’s CEHRT does not contain patient data for at least 9 measures covering at least 3 NQS domains, then the provider will need to report the measures for which there is Medicare patient data.
- In order to use the EHR reporting option for PQRS, a provider must report on at least 1 measure for which there is Medicare patient data. As in past years, measures with a zero value denominator cannot be used for PQRS.
- The PQRS measurement period length is a full calendar year, so for 2014 it would run from January 1, 2014 through December 31, 2014.

Electronic Reporting of CQMs

Practice Fusion will submit CQM data to CMS at the end of the CQM measurement period for providers who choose the EHR reporting mechanism to report CQMs to CMS for the purposes of PQRS or for Meaningful Use. CQM data will be electronically submitted to CMS as a file that meets the HL7 standards for the Quality Reporting Data Architecture (QRDA). Practice Fusion will begin accepting requests for data submission as part of Meaningful Use and PQRS in the end of 2014.
MAKING QUALITY MEASUREMENT AND MONITORING PART OF YOUR WORKFLOW

As you prepare for quality reporting in 2014, you should become familiar with the CQMs that are available in your certified EHR so that you can incorporate them into your daily workflow and make improvement to the care that you deliver, as needed. Quality measurement and reporting is a key part of improving our healthcare system and Practice Fusion is dedicated to making that easier for health care providers in 2014.

MORE INFORMATION ON CQMS

Providers who are interested in learning more about the detailed CQM specifications can use USHIK to locate specific measures and to find the detailed codes and value sets that are included in the specifications of that measure. This site is produced by the Agency for Healthcare Research and Quality (AHRQ) in partnership with CMS and the National Library of Medicine (NLM). A free Unified Medical Language System® (UMLS) license, available from NLM, is required to access USHIK.

From the USHIK website, click on the link for Clinical Quality Measures, select the measure or measures you want to know more about, and select the measure title link to get more information on the measure logic, included code lists, exclusions, and reference information. From this screen, you can also download the applicable codes as a PDF file, Excel File, or CSV File. Make sure you select the correct version of the measure (Practice Fusion’s CQMs utilize the June 2013 EP specifications.)

CMS also has several resources that may be useful to providers wanting to learn more about the PQRS and Meaningful Use quality measures:

- CMS Guide for Eligible Professional eMeasures
- 2014 CMS eCQM Measure Logic Flows for EPs June 2013 1 of 2 (download the ZIP file and select the PDF for the measures you need based on the CMS eMeasure ID number)
- 2014 CMS eCQM Measure Logic Flows for EPs June 2013 2 of 2 (download the ZIP file and select the PDF for the measures you need based on the CMS eMeasure ID number)