TOOLKIT FOR THE PRACTICE FACILITATOR

NYC Health

HealthyHeartsNYC

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Introduction ABCS

With 8.5 million residents, New York City is the most populous city in the United States. It is also the most diverse: 26 percent Latino, 26 percent Black and 13 percent Asian.[1] Heart disease is a primary cause of death and prevalence of heart disease risk factors is high. A 2014 survey found that 28 percent of city residents had hypertension (HTN), 28 percent had high blood cholesterol and 14 percent used tobacco.[2] Residents of the city's poorest neighborhoods consistently have higher mortality rates from almost all diseases, including heart disease, compared with residents of higher income neighborhoods.[3,4]

Strategies to help reduce the risk and burden of heart disease focus on the "ABCS" of prevention and control:

Aspirin as appropriate: Increase use of low dose aspirin therapy according to recognized prevention guidelines.

Blood pressure control: Prevent and control high blood pressure (BP).

Cholesterol management: Adopt recognized guidelines for cholesterol management, with a focus on lifestyle modifications and statin use.

Smoking cessation: Document smoking status and increase the number of smokers counseled to quit or referred to State "quit lines." Increase availability of cessation products.

ABOUT THE ABCS TOOLKIT

This toolkit is a quality improvement change package for practice facilitators working with health care providers on the ABCS of heart health. It is designed to assist practice facilitators as they support meaningful improvement in primary care practices. The toolkit is not a comprehensive practice facilitator training curriculum. It is intended for the practice facilitator with a basic understanding of the concepts of practice facilitation. There are many resources available in the training of new practice facilitators, such as "The Practice Facilitation Handbook" developed by the Agency for Healthcare Research and Quality, which may be viewed at **ahrq.gov**.

The ABCS Toolkit is organized around actionable tasks. To complete the requirements of each task, corresponding resources and references are provided.

The tasks within this toolkit are not meant to replace strategies as described by the Chronic Care Model, Patient Centered Medical Home, Meaningful Use and other quality improvement models. This toolkit is intended to be used along with such strategies that encourage:

- Team-based care to maximize the expertise of every member of the health care team
- Patient education and activation to engage patients and their families in chronic care prevention and management
- Regular and timely feedback on performance to drive improvement

For more information on:

- The Chronic Care Model, visit **improvingchroniccare.org**
- Patient Centered Medical Home, visit **pcmh.ahrq.gov**
- Meaningful Use, visit **healthIT.gov**

The tasks, corresponding resources and references in the toolkit are designed to fit into a framework referred to as "The 4 R's," which groups quality improvement activities into four distinct categories:

- **Recognize risks** specific to the ABCS of heart health.
- **Respond quickly** to high-risk patients, using evidence-based guidelines and clinic-based protocols that help standardize care treatment and allow practices to reduce cardiovascular risk in a timely manner.
- **Reinforce control** by recommending care plans and activities that promote self-management through patient education and referral to community resources.
- **Review quality data** in order to assess population health needs, determine gaps in care and make supported decisions regarding areas to target with limited resources.

HOW TO USE THIS TOOLKIT

This toolkit is designed to be used as a guide when working with primary care practices on the ABCS of heart health. The tasks provide a checklist of actions that should be taken when working with a health care practice. Resources and references to help with the successful completion of tasks are also provided.

Tasks focus on approaches that help primary care practices transform health care delivery and apply the latest evidence-based guidelines to improve the heart health of their patients.

For successful completion of tasks:

- The practice facilitator should have an understanding of eight core components of quality improvement:
    1) **Patient Lists:** Also known as patient registries – lists of patients by specific condition or treatment
        - Focus on ways to use patient lists to identify non-compliant or high risk patients for quality improvement or outreach.
    2) **Patient Outreach:** Activities that seek to engage the patient in actively managing his or her own health
        - Focus on ways to optimize patient reminders and ensure routine follow-up.
    3) **Medication Adherence:** Patient's ability to take medications as agreed upon with his or her provider
        - Focus on activities to improve adherence.
    4) **Planned Visits:** Activities that provide proactive management of chronic conditions
        - Focus on ways to provide pre-visit planning to make the most of the care encounter.
    5) **Patient Education:** Activities or tools that promote self-management and activation
        - Focus on ways to encourage and improve a patient's knowledge of, skill and confidence in managing chronic conditions.

6) **Clinical Decision Supports (CDS):** Tools commonly integrated into the Electronic Health Record (EHR) that assist in making evidence-based decisions
   – Focus on ways to optimize CDS tools to alert providers and guide care plans.
7) **Evidence-based Guidelines:** Systematically developed recommendations designed to help providers and patients make decisions about health care
   – Focus on incorporating evidence-based guidelines into care plans.
8) **Dashboards:** Performance feedback tools based on data extracted from the EHR
   – Focus on using dashboards to assess performance on chronic conditions and provide routine feedback.

- The practice facilitator should use the Model for Improvement's Plan-Do-Study-Act (PDSA) approach to test changes. PDSA uses rapid cycles to accelerate improvement, using goal setting, measurement and planned changes. A PDSA cycle is completed in small, rapid steps to determine if a change leads to an improvement and is feasible within the practice workflow. Each cycle includes four stages:
  - Plan: objective, predictions, execution
  - Do: execution of the proposed change, documentation of results, data analysis
  - Study: thorough data analysis, comparison of results with predictions
  - Act: refinement of the proposed change, reflection on what was learned or accomplished, discussion of modifications, preparation for the next cycle

  The Institute for Healthcare Improvement provides additional information, which may be viewed at **ihi.org**.
- The practice facilitator should be able to demonstrate basic competency skills for EHR use. This toolkit references two specific EHRs: eClinical Works (eCW) and MDLand.
- The practice facilitator should have an understanding of the quality data that will be measured. This will be addressed in greater detail in the next section, Getting Started.
- The practice facilitator should be able to map workflow at a practice. For an example of one workflow mapping tool, refer to the Workflow Mapping Worksheet (page 104).

The ABCS Toolkit materials may be shared with the health care team and patient as appropriate. Guidelines suggesting which content is applicable to each user (the practice facilitator, the care team and/or the patient) can be found in the table of contents at the start of each section.

GETTING STARTED

Review Your Quality Data: An Introduction to ABCS Measures

Data from quality measures is key for driving quality improvement. In order to create transparency and a collaborative relationship, it is important for the practice to understand what will be measured and why. The practice also needs to believe in the accuracy of the data. Before working on quality improvement activities, the practice facilitator should review ABCS measures with the practice. If the practice does not trust the accuracy of the data presented, the practice facilitator should engage the practice in an exercise to validate the data.

ABCS Measures

This section discusses measures related to the ABCS of heart health. Measures noted here are from the Primary Care Information Project (PCIP) Prevention and Care Dashboard and the Hypertension Panel Summary. This is not meant to be a comprehensive list of all quality measures. Quality measures as defined by other organizations may differ.

	What is measured	Why it is measured
Aspirin as appropriate	Percent of patients 18 and older diagnosed with ischemic vascular disease (IVD) who are on aspirin or another antithrombotic.	To determine if patients with IVD are on aspirin or another antithrombotic. Long-term aspirin therapy confers conclusive net benefits on risk of subsequent myocardial infarction (MI), stroke and vascular death among patients with a wide range of prior manifestations of cardiovascular disease (CVD).[5]
Blood pressure control	Percent of patients 18 to 85 years of age diagnosed with hypertension (HTN) who had last blood pressure (BP) controlled (< 140/90).	To determine the number of patients with controlled hypertension. HTN increases the risk for heart disease and stroke.[6]
	Percent of patients 18 to 85 years of age diagnosed with HTN (and diabetes mellitus [DM], and patients 18 to 85 years of age diagnosed with HTN (and IVD) who had last BP controlled (< 140/90).	To determine the number of patients with diabetes and IVD with controlled HTN. DM – Those with diabetes have an increased risk of cardiovascular related injury and death. In 2009-2012, 71 percent of adults aged 18 years or older with diagnosed diabetes had blood pressure ≥ 140/90 or used prescription medications to lower high blood pressure.[7] In 2003-2006, after adjusting for population age differences, cardiovascular disease death rates were about 1.7 times higher among adults aged 18 years or older with diagnosed diabetes than among adults without diagnosed diabetes.[7] IVD – Those with IVD have an increased risk for cardiovascular related injury and death. HTN accounts for an estimated 47 percent of all ischemic heart disease events globally.[8]
	Percent of patients 18 to 85 years of age diagnosed with HTN who had last BP uncontrolled (140-159/90-99).	To determine the number of patients with uncontrolled HTN (stage 1). HTN increases the risk for heart disease and stroke.[6]

	What is measured	Why it is measured
	Percent of patients 18 to 85 years of age diagnosed with HTN who had last BP uncontrolled (≥ 160/100).	To determine the number of patients with uncontrolled HTN (stage 2). HTN increases the risk for heart disease and stroke.[6]
	Percent of patients 18 to 85 years of age diagnosed with HTN (separated into controlled, stage 1 and stage 2) or undiagnosed HTN (patients who have had BP readings ≥ 140/90 on two or more occasions and do not have a diagnosis of HTN) with a documented prescription for BP lowering medications.	To determine the number of patients with diagnosed and undiagnosed HTN who are treated with a BP lowering medication. This gap may be indicative of issues in documentation or clinical inertia.
	Percent of patients who have had BP readings ≥ 140/90 on two or more occasions and do not have a diagnosis of HTN (undiagnosed HTN).	To determine if patients with uncontrolled high BP are being seen but remain undiagnosed. This gap may be indicative of issues in documentation or clinical inertia.
Cholesterol management	Percent of patients 21 and older diagnosed with atherosclerotic cardiovascular disease (ASCVD) who are on statin therapy.	To determine if statin therapy for prevention and treatment of ASCVD is being prescribed for those who will most likely benefit from therapy.[9] Intervention trial data collected over the past several decades have demonstrated that cholesterol modification, especially statin therapy (3-hyroxy-3-methylglutaryl coenzyme A [HMG-CoA] reductase inhibitor therapy) and its resulting reduction in low-density lipoprotein cholesterol (LDL-C) levels, is associated with favorable effects on reduction in coronary heart disease (CHD) events – especially in patients at high risk for CHD or those who have already manifested CHD.[10]
	Percent of patients 21 and older with history of low-density lipoprotein (LDL) ≥ 190 mg/dL who are on statin therapy.	To determine if statin therapy for prevention and treatment of CVD is being prescribed for those with LDL greater than or equal to 190 mg/dL.[9] There is good evidence that lipid-lowering drug therapy substantially decreases the incidence of CHD in people with abnormal lipid levels. The absolute benefits of lipid-lowering treatment depend on a person's underlying risk of CHD. Men older than 35 years and women older than 45 years who are at increased risk of CHD will realize a substantial benefit from treatment.[9]

	What is measured	Why it is measured
	Percent of patients 40 to 75 years of age with diabetes who are on statin therapy.	To determine if statin therapy for prevention and treatment of CVD is being prescribed for those with diabetes.[9] In 2003-2006, after adjusting for population age differences, CVD death rates were about 1.7 times higher among adults aged 18 years or older with diagnosed diabetes than among adults without diagnosed diabetes.[7] Intervention trial data collected over the past several decades have demonstrated that cholesterol modification, especially statin therapy and its resulting reduction in LDL-C levels, is associated with favorable effects on reduction in CHD events – especially in patients at high risk for CHD or those who have already manifested CHD.[10]
Smoking cessation	Percent of patients 18 and older who had smoking status updated in the last two years.	To determine the number of patients who were screened for smoking status. Although this measure shows a two-year look back for documentation of smoking status, the best practice guideline is to make sure that for every patient at every clinic visit, tobacco use status is assessed and documented.[11]
	Percent of patients 18 and older identified as current smokers who received cessation intervention or counseling.	To determine the number of patients who were counseled on tobacco use. Counseling includes smoking cessation intervention in the form of cessation counseling and/or pharmacologic therapy.

ASCVD = atherosclerotic cardiovascular disease; BP = blood pressure; CHD = coronary heart disease; CVD = cardiovascular disease; DM = diabetes mellitus; HTN = hypertension; HMG-CoA = 3-hyroxy-3-methylglutaryl coenzyme A; IVD = ischemic vascular disease; LDL = low-density lipoprotein; LDL-C = low-density lipoprotein cholesterol; MI = myocardial infarction

For a more detailed explanation of quality measures, refer to the Prevention and Care Dashboard – Hub Quality Measures Checklist (page 112) and the Hypertension Panel Summary (page 144).

Process Measures

In addition to the quality measures defined by the ABCS of heart health, there are performance measures that reflect workflow processes. These process measures may be used to determine, reflect and act on gaps in the care process. Examples include:

	What is measured	Refection of possible gap in car e
Future appointments scheduled at point-of-care	Percent of patients with hypertension (HTN) who left a recent office visit with a future appointment scheduled.	This gap may be indicative of a need for workflow redesign, which ensures that high-risk patients schedule future appointments during a visit.
No visit in three months and no recent appointments scheduled	Percent of patients with HTN that have not been seen in three months and do not have a future appointment scheduled.	This gap may be indicative of a need for workflow redesign to identify and prioritize patients in need of follow-up.

For an example of process measures, refer to the Hypertension Panel Summary (page 144).

An Exercise on Data Validation

If the practice feels that the quality measure(s) is incorrect, review the status of 10 patients and determine if results align with the quality measure(s). Note that the quality measure(s) in question may not be related to the ABCS of heart health, but a review should be conducted even so. A talking point may be: "There are many reasons why the quality measure score you see is not an accurate refection of your practice' s performance. Let's review how these quality measures look in your system."

Examples of issues to check on with the practice:

- ☐ Is BP filled out in the right box?
- ☐ Is primary care giver (PCG) entered for that patient?
- ☐ Are Current Procedural Terminology (CPT) codes entered in the progress notes?
- ☐ Is the EHR receiving structured lab results (i.e., lab interface for cholesterol screening values, Logical Observation Identifiers Names and Codes [LOINC] match)?
- ☐ Is the smart form on smoking filled out?
- ☐ Is the date range the same as what is used in the dashboard?
- ☐ Are codes the same as what is used in the dashboard (i.e., encounter codes, diagnosis codes, treatment codes)?
- ☐ Is the age range the same as what is used in the dashboard?
- ☐ Are exclusion criteria used in the dashboard taken into account?

Resources

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ASPIRIN AS APPROPRIATE

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Tasks

Toolkit Reference Page	Tasks for the Practice Facilitator
Key Facts	☐ A1. Provide an overview of strategies to improve the use of aspirin or other antiplatelet medications as appropriate. • Discuss the 4 R's for aspirin as appropriate.
Appendix: Prevention and Care Dashboard	☐ A2. Solicit feedback to determine the practice's readiness for change. • Show the dashboard and discuss related quality measure(s). • Ask the practice to discuss thoughts and concerns on working on the measure: "What are your thoughts on improving the use of aspirin or other antiplatelet medications in your practice?"
	☐ A3. Respond quickly to improve use of aspirin or other antiplatelet medications by optimizing use of EHRs. • Clinical decision support (CDS) alerts: Ensure the CDS alert is working (use of aspirin or another antithrombotic in people with ischemic vascular disease [IVD]). • CDS alerts: Teach the practice how to use CDS alerts and ask provider how he or she responds to them: "How do you usually respond to this alert?" • Quality reports: Train and assist the practice in setting up quality reports (i.e., Enterprise Business Optimizer [EBO] reports for eCW). • Quality reports: Train and assist the practice in incorporating the use of quality reports into office workflow to help identify non-compliant patients.
Aspirin for Secondary Prevention in the Ambulatory Care Practice	☐ A4. Respond quickly to increase the use of aspirin or other antiplatelet medications by adopting a protocol. Provide the health care team with evidence for adopting a protocol and train them on how to use it. • Ensure that proper documentation is taking place. Determine who is involved in documenting aspirin use (e.g., medical assistant, nurse, provider). Determine if over-the-counter (OTC) use, including use of aspirin, is assessed and documented during intake. Patients may have been recommended aspirin by a different provider, so it is important to emphasize that all medications, including OTC, need to be recorded. Teach the practice to document aspirin use correctly in the Electronic Health Record (EHR) (under medication list). • Refer to "Aspirin for Secondary Prevention in the Ambulatory Care Practice" for guidelines, and discuss the adoption of this evidence-based guideline. Recommendations are based on the American Heart Association (AHA)/American College of Cardiology Foundation (ACCF) guidelines on secondary prevention.
Appendix: Key Facts **Appendix: Prevention and Care Dashboard – Hub Quality Measures Checklist**	☐ A5. Review quality data. Have all care team members routinely review quality data and provide feedback.

Key Facts

BACKGROUND

For secondary prevention of ischemic vascular disease (IVD), antiplatelet agents are recommended in all patients and reduces recurrent vascular events by one fourth.[1]

Aspirin is the antiplatelet of choice since it is of comparable efficacy to other currently available antiplatelet agents, is widely available and is inexpensive.

Clopidogrel (Plavix©) is an effective alternative in patients who cannot take aspirin and is recommended in combination with aspirin in some instances, such as after an acute cardiac event or percutaneous coronary intervention (PCI) with stent placement (for up to 12 months).[1,2] This toolkit does not address the use of clopidogrel in combination with aspirin.

TERMINOLOGY

- What are antithrombotic drugs?

There are two classes of antithrombotic drugs: anticoagulants and antiplatelet drugs. Both prevent harmful clots from forming and growing. Anticoagulants slow down clotting while antiplatelet drugs prevent platelets from clumping.

For the purpose of quality measures reporting, the term antithrombotic or antithrombotic therapy is used in place of antiplatelet or antiplatelet therapy. In addition, clinical support systems in the EHR often use the term antithrombotic or antithrombotic therapy for alerts in place of antiplatelet or antiplatelet therapy. This toolkit does not address anticoagulant drug use.

- What is ischemic vascular disease?

Ischemic vascular disease (IVD) includes a group of diseases caused by the buildup of a waxy substance called plaque inside blood vessels, which causes blockage and restricts the normal flow of blood. When plaque builds up in the arteries, the condition is called atherosclerosis. Atherosclerosis can affect any artery in the body, including those in the heart, brain, arms, legs, pelvis and kidneys. As a result, various other diseases may develop based on which arteries have been affected.

IVD includes:

- History of ischemic stroke
- History of transient ischemic attack
- Symptomatic peripheral artery disease
- Coronary artery disease

- What is primary and secondary prevention?

Primary prevention refers to efforts to prevent or delay the onset of disease. In the case of "use of aspirin as appropriate," primary prevention refers to the prevention or delay of IVD. This toolkit does not address the use of aspirin or other antiplatelet agents for primary prevention.

Secondary prevention refers to the effort to prevent additional manifestations of disease after the first event has occurred. In the case of "use of aspirin as appropriate," secondary prevention refers to the prevention of additional vascular events in people with IVD. This toolkit addresses the use of aspirin or other antiplatelet agent for secondary prevention in those with a history of stable IVD.

QUALITY MEASURE

The "quality measure" is defined as the percent of patients 18 and older diagnosed with IVD who are on aspirin or another antithrombotic.

Use the 4 R's to Recommend Aspirin as Appropriate

Recognize risks: Aspirin can be beneficial to individuals with a history of stable IVD. Providers may recommend aspirin use for people with this condition unless there is another medical reason why these individuals should not take aspirin.

Respond quickly: Aspirin 75-162 mg daily is recommended in those with IVD unless contraindicated.[1,2,3,4,5] Clopidogrel 75 mg daily is an alternative for patients who are intolerant of or allergic to aspirin.[2,6]

Reinforce control: Aspirin protocols should support consultation between a physician and patient about appropriate use.

Review quality data: The quality measure is defined as percent of patients 18 and older diagnosed with IVD who are on aspirin or another antithrombotic.

Resources

1. Antithrombotic Trialists' Collaboration; Baigent C, Blackwell L, Collins R, Emberson J, Godwin J, Peto R, Buring J, Hennekens C, Kearney P, Meade T, Patrono C, Roncaglioni MC, Zanchetti A. Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomised trials. Lancet. 2009; 373:1849-1860.
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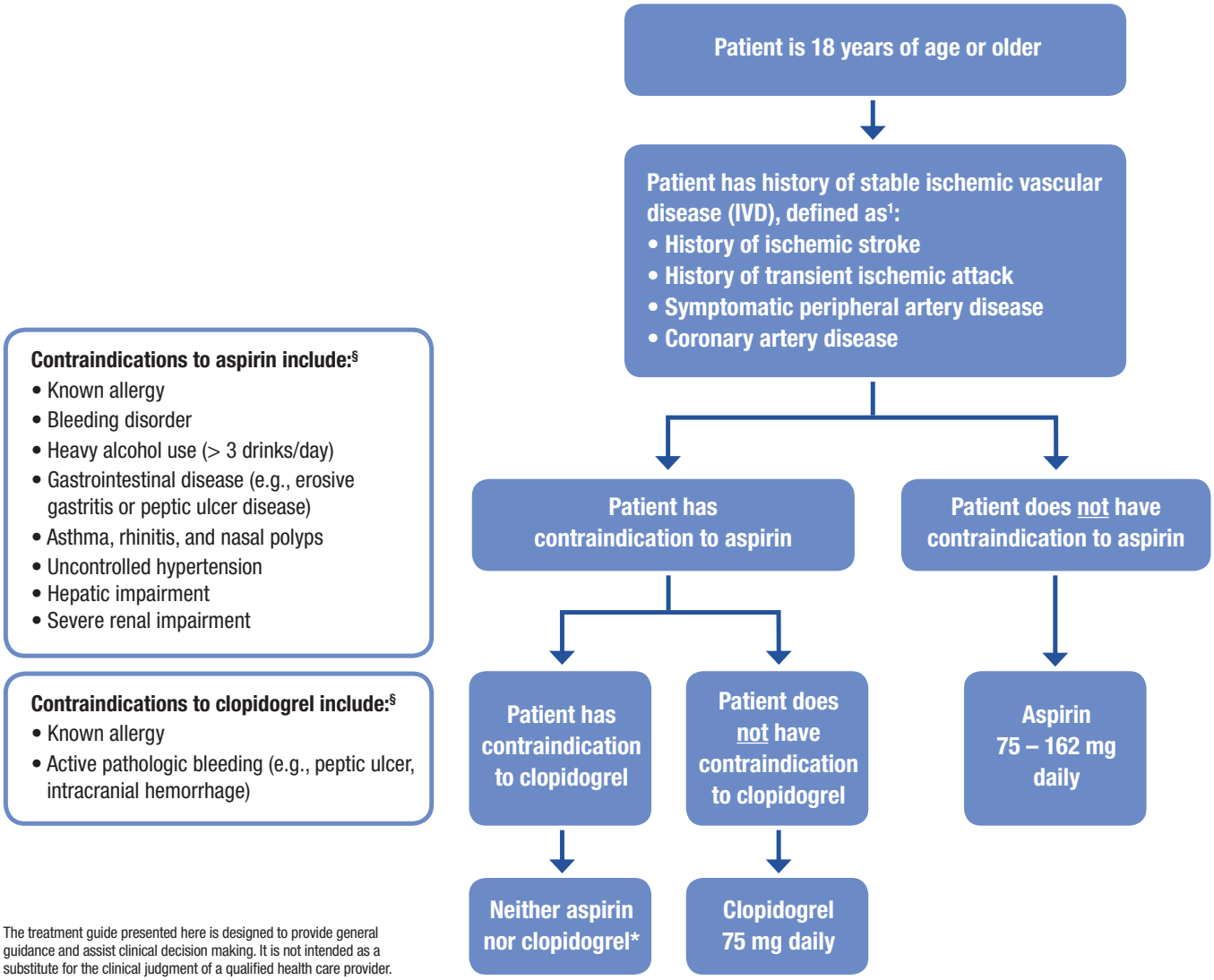
6. CAPRIE Steering Committee. A randomized, blinded, trial of clopidogrel versus aspirin in patients at risk of ischaemic events (CAPRIE). Lancet. 1996; 348:1329-1339.

(A) ASPIRIN FOR SECONDARY PREVENTION IN THE AMBULATORY CARE PRACTICE

This treatment guide is based on information from the 2011 AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease.[1] This is not intended for those who would benefit from dual therapy.‡



The treatment guide presented here is designed to provide general guidance and assist clinical decision making. It is not intended as a substitute for the clinical judgment of a qualified health care provider.

Patient Education: Patients should be advised to talk to their doctor immediately if any of the unlikely but serious side effects occur: easy bruising or bleeding, difficulty hearing, ringing in the ears, change in the amount of urine, persistent or severe nausea or vomiting, unexplained tiredness, dizziness, dark urine, yellowing eyes or skin.

‡ Dual therapy is a short-term combination of aspirin and clopidrogel that may be beneficial for some patients, such as after acute coronary syndrome (ACS) or percutaneous coronary intervention (PCI) with stent placement.[1]

§ For a complete and detailed listing of contraindications, warnings, precautions, drug interactions and use in special populations, including pregnant women, please refer to the medication package insert.

* For further guidance, refer to AHA/ACCF secondary prevention and risk reduction therapy for patients with coronary and other atherosclerotic vascular disease: 2011 update: a guideline from the American Heart Association and American College of Cardiology Foundation. Circulation, 124, 2458-2473. http://circ.ahajournals.org/content/124/22/2458/

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1. Smith, S. C., Benjamin, E. J., Bonow, R. O., Braun, L. T., Creager, M. A., Franklin, B. A., Taubert, K. A. (2011). AHA/ACCF secondary prevention and risk reduction therapy for patients with coronary and other atherosclerotic vascular disease: 2011 update: a guideline from the American Heart Association and American College of Cardiology Foundation. Circulation, 124, 2458-2473. http://circ.ahajournals.org/content/124/22/2458/

B BLOOD PRESSURE CONTROL

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Tasks

Toolkit Reference Page	Tasks for the Practice Facilitator
Key Facts	☐ B1. Provide an overview of strategies to improve blood pressure (BP) control. • Discuss the 4R's of BP control.
Appendix: Prevention and Care Dashboard	B2. Solicit feedback to determine the practice's readiness for change. • Show current dashboard and discuss related quality measures. • Ask practice to discuss thoughts and concerns about working on this measure: "What are your thoughts on working to improve BP control in your practice?"
Assessment of Hypertension Protocols and Procedures	B3. Assess the practice using the Assessment of Hypertension Protocols and Procedures to determine if there are gaps with the current workflow for BP control. • Review results with the practice. • To prioritize which strategy to focus on first, ask: "For blood pressure control, which 'R' do you think is most important to work on?"
Measuring Blood Pressure the Right Way **Trainer Observation Assessment** **Self-Assessment** **Tips on Taking Your Blood Pressure**	☐ B4. Recognize the risks of inaccurate blood pressure readings. • Discuss the most common causes of inaccurate blood pressure (BP) measurements and share ways to get the right BP number. The goal is to develop a systematic approach to ensure accurate BP measurements. • Help the practice inspect the BP station and determine if small changes can be made, e.g., a footstool made available to ensure that feet are placed on a flat surface. • If the practice is open to purchasing a new BP monitor, validated monitors can be viewed at: **dableducational.org** • Training videos can be found at: **nejm.org/doi/full/10.1056/NEJMvcm0800157**. or **dl.dropboxusercontent.com/u/82855974/Blood_Pressure_Training.wmv** or search the keyword: "blood pressure measurement NEJM" on YouTube • Show and encourage the practice to use tools to get an accurate BP reading. This toolkit includes two assessment tools and one visual tool (provide to practice if appropriate): 1. The Trainer Observation Assessment form is used when a "trainer" observes measurement techniques. 2. The Self-Assessment Tool is used by staff taking the measurement to self-monitor. 3. The visual tool, a poster called *Tips on Taking Your Blood Pressure*, is available in English, Spanish, Russian and Chinese. Best practice: Display this poster in all areas where BP is measured. Encourage the care team and patients to refer to the poster to ensure proper positioning and technique. In addition, use it as an educational tool to encourage meaningful discussion about BP numbers and what they mean. To learn more, visit nyc.gov and search for "blood pressure."
	B5. Respond quickly to control elevated BP by optimizing Electronic Health Record (EHR) use. • Clinical Decision Support (CDS) alerts: Ensure the CDS alert related to blood pressure (BP) control is working, and encourage the care team to respond to alerts. • Quality reports: Train and assist the practice in setting up quality reports (i.e., Enterprise Business Optimizer (EBO) reports for eCW). • Quality reports: Train and assist the practice in incorporating the use of quality reports into office workflow to help identify non-compliant patients.

Toolkit Reference Page	Tasks for the Practice Facilitator

Appendix: Hypertension Panel Summary
 	
Action Plans to Target Undiagnosed Hypertension, Example 1 and Example 2
	☐ B6. Respond quickly to control elevated BP by targeting undiagnosed hypertension (HTN).
	• Review with the practice the percent of patients with undiagnosed HTN. This information is available on the Hypertension Panel Summary or can be generated using patient lists/registries.
	• Ask which criteria the practice uses to diagnose HTN: "How do you diagnose HTN?"
	• Discuss evidence-based guidelines for the diagnosis of HTN and agree on a criteria for diagnosis. The classification of HTN is based on the average of two or more properly measured, seated BP readings on each of two or more office visits.
	• Agree on a goal for decreasing the number of patients who meet clinical guidelines but do not have a diagnosis of HTN.
	• Rule out improper documentation:
	  ○ Teach the practice to code using ICD-9 796.2 or ICD-10 R03.0 (white-coat hypertension or elevated BP) when applicable. If white-coat hypertension is suspected, suggest the use of ambulatory BP monitoring.
	  ○ Ensure that the diagnosis is entered as a diagnosis code – not as free text.
	• Decide on an action plan, which may include:
	  ○ Flagging patients identified as potentially undiagnosed for HTN and addressing elevated BP at next office visit, and/or
	  ○ Recalling patients identified as potentially undiagnosed for HTN and addressing elevated BP at recall visit

Improved Blood Pressure Control Using a Standardized Protocol Example
 	
Blood Pressure Control: Hypertension Diagnosis and Treatment for Adults
	☐ B7. Respond quickly to control elevated BP by adopting a protocol. Provide the health care team with evidence for adopting a protocol and train them on how to use it.
	• Discuss how protocols allow standardized treatment for HTN and are shown to be effective, i.e., Kaiser Permanente Northern California was able to raise their BP control from 44 percent in 2001 to 87 percent in 2011 with the adoption of a protocol that emphasized routine feedback on quality measures, promotion of single-pill combination therapy and medical assistant visits for follow-up measurements.
	• Agree on a BP goal (For the purpose of the ABCS toolkit, BP control is defined as < 140 and < 90).
	• Review the guide available in this toolkit with the practice. If the practice would like to create their own protocol for controlling HTN, a fillable template may be downloaded at: **millionhearts.hhs.gov/fles/Hypertension-Pr otocol.pdf**
	• Assure the practice that a protocol is never meant to counter the treating health care provider's best clinical judgment.
	• Key points to discuss with the practice regarding adoption of this (or any other) guide:
	  1. Recommending lifestyle modification AND prescribing BP-lowering agents.
	  2. When prescribing:
	  • Start with the lowest dose, as side effect profile is often dose-dependent.
	  • Titrate upward to maximum effective dose or to goal.
	  • Prescribe fixed-dose combination pills to simplify regimen.
	  • Prescribe 90-day supply when possible.
	  3. When HTN is not controlled, assess medication adherence (side effect profile, clarify instructions and refer to pharmacist for additional support).
	  4. Emphasize the value of home BP monitoring when appropriate.

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Toolkit Reference Page	Tasks for the Practice Facilitator
The American Medical Association and The Johns Hopkins University M.A.P. IT Tools: Act Rapidly	☐ B8. Respond quickly to control BP by assessing the role of clinical inertia: Determine whether clinical inertia is a contributing factor to lack of BP control. • Follow instructions on the AMA/Johns Hopkins University M.A.P. IT Tools: Act Rapidly. Discuss findings with the practice and solicit feedback by asking: "What do you think of the results?"
Suggested Workfow for Blood Pressure Control	☐ B9. Respond quickly to control elevated BP by implementing a recall workflow. Determine and then discuss how the practice schedules follow-up care and performs recalls. • Questions to ask: 1. Does the practice have a policy in place to schedule future appointments at point-of-care, and does time to next visit follow an evidence-based guideline? Ask: "How do you schedule patients for their next office visit?" and "How do you determine when the patient should return?" 2. How does the practice determine and recall high risk patients? Ask: "How do you determine which patients to recall?" and "How often is it done?" 3. During patient outreach, determine what is discussed besides scheduling. Ask: "What is usually discussed when you reach out to a patient?" Key concerns that may be addressed include medication refill, medication concerns and adherence, and instructions for next visit, i.e., bring all medications to upcoming visit, bring BP log to upcoming visit, be prepared for a BP reading (no smoking or caffeine intake at least 30 minutes before reading). • Teach and assist the practice in implementing a recall workflow. Suggested workflow: 1. At point-of-care, schedule a future appointment at the end of each visit. 2. Run monthly patient lists/quality reports (e.g., EBO report) to determine patients who have not been seen in three months and do not have a future appointment. To prioritize outreach needs, determine high-risk patients (i.e., stage 2 > stage 1 > controlled or HTN + diabetes mellitus [DM] or IVD) and perform outreach on a monthly basis. • Agree on a goal for improvement of these performance measures.
Suggested Workfow for Blood Pressure Control **The Morisky Green Levine Medication Adherence Scale** **eCW How to Add a Medication Adherence Questionnaire by Creating Structured Data** **eCW External Rx History Check: RxHub** **eCW Drug Formulary Review** **MDLand External Rx History Check** **MDLand Medication Adherence: Medication History (Internal)** **MDLand Medication Adherence: Medication Reports**	☐ B10. Respond quickly to control elevated BP by targeting medication adherence. • Optimize use of the EHR: 1. Create a structured data field in the EHR for a medication adherence questionnaire (e.g., the Morisky Green Levine Medication Adherence Scale). 2. Determine if the EHR has the ability to access insurance plan formularies and pharmacy claims data (e.g., RxHub on eCW or Medication History Check on MDLand) to check insurance drug formulary and adherence. • Teach and assist the practice in implementing a medication adherence workflow. Suggested workflow: 1. For Medical Assistant/Nurse: With every visit, ssk and assess medication adherence using the four-question Morisky Green Levine Scale and flag patients that score 3-4 (low adherence). Best practice: Ask and assess medication adherence at every visit. To improve adherence, consider referring to a pharmacist and/or a nurse for additional counseling. 2. For Front Desk: Run batch eligibility check for all patients on a daily basis. 3. For Providers: Before prescribing new medications, check which are covered on the patient's insurance plan by using the EHR to check formulary. Whenever possible, prescribe generic fixed-dose combination pills that can be taken once daily.

MDLand Medication Adherence: Rx Eligibility	4. For Providers: Before adjusting medication, use the EHR external Rx history check to help determine if the patient has been adherent to current medication. 5. For Front Desk: For every patient that has a new or adjusted medication, schedule telephone encounter for two weeks later. Call patient as scheduled to ask whether they have picked up medication, taken medication as prescribed and experienced any adverse effects. If any concerns arise with the call, the Front Desk should communicate concerns to the care team.
Suggested Workfow for Blood Pressure Control **Patient Self-monitoring of Blood Pressure: A Provider's Guide** **How to Take Your Blood Pressure**	☐ B11. Reinforce control by recommending self-measured blood pressure monitoring (SMBP) as part of self-management. Discuss SMBP and advocate using it as a valuable addition to improved HTN control. Ask: "What do you think of SMBP?" • Refer to Patient SMBP: A Provider's Guide. • Provide patient education: How to Take Your BP. • Ask if the practice currently performs (or will establish, adopt and implement) a clear protocol that includes advising patients to use SMBP. * "Do you currently promote SMBP?"__ Yes __ No. * If no, ask: "Do you plan to promote SMBP?" __ Yes __ No. * If yes, follow up at the next visit by asking: "Was your practice able to integrate SMBP into the care plan?" ___Yes ___No. (If no, discuss barriers: "What barriers did you encounter?") • Encourage the use of a non-physician team member to educate patients on SMBP.
Appendix: Evidence-based Interventions: Provider and Offce Staff Toolkit	☐ B12. Reinforce control by recommending referrals to the National Diabetes Prevention Program (NDPP) or other evidence-based lifestyle modification programs. • Highlight NDPP as an evidence-based lifestyle modification program to prevent type 2 diabetes. Skills learned in NDPP are applicable to HTN prevention and control. • Provide details on class content and program duration. • Teach and assist the practice in designing a workflow to identify and refer patients using QTAC.
Appendix: How Community Pharmacists Can Help with the Common Reasons for Non-Adherence **Appendix: MTM Fact Sheet and FAQs** **Appendix: MTM Patient Brochure** **Appendix: About the Big Apple Rx Card**	☐ B13. Reinforce control by recommending and referring patients to community pharmacists to improve medication adherence and assist with BP monitoring. • Highlight services offered by community pharmacists.
Appendix: NYC Farmers Markets Map **Appendix: Shape Up NYC**	☐ B14. Reinforce control by recommending community resources that support healthy lifestyle modifications. • Highlight local farmers markets as a source of fresh fruits and vegetables. Farmers market locations may change yearly. For accurate locations, visit **nyc.gov** and search for "farmers markets." • Highlight Shape Up NYC as a source for free exercise classes.
Key Facts **Appendix: Prevention and Care Dashboard – Hub Quality Measures Checklist**	☐ B15. Review quality data. • Have all care team members routinely review quality data and provide feedback.

Key Facts

BACKGROUND

- Cardiovascular diseases (CVD), including heart disease, hypertension (HTN) and heart failure, along with stroke, continue to be leading causes of death in the United States.[1,2]
- HTN currently affects nearly 78 million adults in the United States and is also a major modifiable risk factor for other CVD and stroke.[1]
- According to data from the National Health and Nutrition Evaluation Survey (NHANES), in 2007-2010 81.5 percent of people with HTN were aware they had it and 74.9 percent were being treated. Only 52.5 percent of cases were under control, with significant variation across different patient subgroups.[1,3,4,5,6]

TERMINOLOGY

- What is blood pressure (BP)?

BP is measured with two numbers. It is written as one number "over" the other.

- The top number, the systolic BP, which is also the higher of the two numbers, measures the pressure in the arteries when the heart beats (as the heart muscle contracts).
- The bottom number, the diastolic BP, which is also the lower of the two numbers, measures pressure in the arteries between heartbeats (when the heart muscle is resting between beats and refilling with blood).

- What is hypertension?

The following chart reflects the BP categories defined by the American Heart Association: normal, pre-hypertension, hypertension stage 1, hypertension stage 2 and hypertensive crisis.

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	less than **120**	and	**less than 80**
Pre-hypertension	**120-139**	or	**80-89**
High Blood Pressure (Hypertension) Stage 1	**140-159**	or	**90-99**
High Blood Pressure (Hypertension) Stage 2	**160** or higher	or	**100** or higher
Hypertensive Crisis (Emergency care needed)	Higher than **180**	**or**	Higher than **110**

- What is undiagnosed hypertension (HTN)?

An additional category called "undiagnosed hypertension" is defined as BP readings of $\geq$ 140 or $\geq$ 90 on two or more occasions, without a diagnosis of HTN.

QUALITY MEASURES

	Measure	Description
Blood Pressure Control	BP control (140/90)	Percent of patients age 18-85 diagnosed with HTN who had last BP controlled (< 140/90).
	BP control in those with HTN and diabetes mellitus (DM) or ischemic vascular disease (VD) (140/90)	Percent of patients age 18-85 diagnosed with HTN and diabetes (type 1, type 2, secondary and IVD) who had last BP controlled (< 140/90).
	Stage 1 HTN	Percent of patients age 18-85 diagnosed with HTN who had last BP uncontrolled (140-159/90-99).
	Stage 2 HTN	Percent of patients age 18-85 diagnosed with HTN who had last BP uncontrolled (≥ 160/100).
	Undiagnosed HTN	Percent of patients who have had BP readings ≥ 140/90 on two or more occasions and do not have a diagnosis of HTN. The NACHC Million Hearts Technical Advisory Group (TAG) considered factors that impact the clinical criteria to identify potentially hypertensive patients and concluded: • Number of elevated BP readings to qualify for a diagnosis of HTN: "Work in the field on undiagnosed HTN has used both two and three elevated readings as thresholds to identify potentially undiagnosed HTN patients. The TAG felt that the most recent BP reading, regardless of whether two or three are used, should be elevated in order to increase the sensitivity of the algorithm (true positive rate). The TAG, while initially undecided between two and three readings, opted to recommend two due to the challenges many Federally Qualified Health Center (FQHC) patients have with making medical visits – the lower threshold means patients who have fewer visits will not 'slip through the cracks' and remain at risk for stroke or heart attack. Moreover, two readings is simpler from a data management perspective. However, the group did recommend capturing reading count (as opposed to simply two+) to allow for comparison of patients who had two readings with those who had three."[1] • Other diagnoses that may impact blood pressure: "Exclusions for pregnancy and end stage renal disease (ESRD) both align with Uniform Data System (UDS) and National Quality Forum (NQF) 0018 specifications; the TAG did not exclude non-acute inpatient admissions, in the spirit of casting a wider net and because admissions may not always be documented in structured/discrete data fields, requiring medical record review to validate; In-patient, emergency department (ED), or ambulatory surgery BP readings were excluded, as these readings would not be documented in the vitals section for a medical visit (so would not be extracted for reporting purposes anyway); Geisinger Health found that over half of men and one-third of women aged 75+ without evidence of HTN take medication for HTN for other purposes – thus, excluding medication as a proxy for a HTN diagnosis could potentially eliminate patients who are truly hypertensive."[7] • HTN diagnosis location: "While there are patients who may be diagnosed on their Electronic Health Record's (EHR) Problem List and not in an Assessment, according to CDC, research shows patients with Problem List entries only (free text entries without a diagnosis code) are much less likely to receive treatment for HTN."[1]

Future appointments scheduled at point-of-care	Percent of patients with a diagnosis of HTN (controlled, stage 1, stage 2) or who have had blood pressure readings ≥ 140/90 on two or more occasions and do not have a diagnosis of hypertension (undiagnosed HTN) who left a recent office visit with a future appointment scheduled.
No visit in three months and no recent appointments scheduled	Percent of patients with a diagnosis of HTN (controlled, stage 1, stage 2) or who have had BP readings ≥ 140/90 on two or more occasions and do not have a diagnosis of HTN (undiagnosed HTN) that have not been seen in three months and do not have a future appointment scheduled.
BP medication prescribed	Percent of patients who have had a BP medication prescribed and who have a diagnosis of HTN or who have had BP readings ≥ 140/90 on two or more occasions and do not have a diagnosis of HTN (undiagnosed HTN).

Use the 4 R's to Control Blood Pressure

Recognize risks: The diagnosis and management of hypertension (HTN) is dependent on blood pressure (BP) measurements. Inaccurate numbers may lead to incorrect decisions. There are simple ways to ensure getting the right number each time.[8,9] Create a system to ensure accurate BP measuring.

Respond quickly: The adoption and use of standardized, evidence-based protocol can reduce clinical variability, promote team-based care, direct efficient and cost effective selection of medications and treatment approaches and facilitate evaluation of quality of care and impact of care.[10]

Reinforce control: The importance of BP control can be reinforced by offering patient education, promoting self-management (such as self-measured blood pressure monitoring [SMBP]) and referring to community resources (such as pharmacy linkages).

Review quality data: Evaluating quality data will help determine quality of care and impact of care. BP control is defined as less than 140/90.

Resources

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Assessment of Hypertension Protocols and Procedures

Practice Name: Date:

How will you assess the practice? ☐ By observing the practice ☐ By asking the practice staff

The following questions provide insight into how the practice handles hypertension (HTN). Using a scale of 1 to 5, please answer how often this happens, where 5 = this always happens in the practice and 1 = this never happens in the practice. If you do not know, mark "don't know" (D/K).	NEVER	RARELY	SOMETIMES	MOST OF THE TIME	ALWAYS	DON'T KNOW
When it comes to measuring blood pressure (BP), how often do the following happen in the practice?	**1**	**2**	**3**	**4**	**5**	**D/K**
1. Staff checks exam room and equipment before use						
2. Staff selects cuff size based on size of patient						
3. Patient is positioned with feet flat, back supported, arm elevated and supported at heart level						
4. Patient is prepared before (rested for at least five minutes, no smoking/ drinking/activity, empty bladder)						
5. Staff takes at least two BP measurements (≥ 1 minute apart)						
6. Patient has their BP taken at each visit						
When a BP reading is elevated, how often do the following happen in the practice?	**1**	**2**	**3**	**4**	**5**	**D/K**
7. Staff alerts providers of elevated BP						
8. Staff makes a plan of action based on an established protocol						
9. Staff schedules future appointments at point-of-care						
10. Staff recalls high risk patients based on an established protocol						
During an offce visit with a patient who has HTN, how often do the following happen in the practice?	**1**	**2**	**3**	**4**	**5**	**D/K**
11. Staff talks to patient about lifestyle modifications						
12. Staff asks patient about barriers to taking their medication as directed						
13. Patient is asked to bring in all their medications						
14. Staff refers patient to a pharmacy for counseling or staff counsels on medication adherence and reconciles medication list						
15. Staff shows patient how to monitor BP at home and patient is encouraged to self-measure BP, record readings and bring it in at next visit						
When it comes to planning for visits and reviewing practice performance, how often do the following happen in the practice?	**1**	**2**	**3**	**4**	**5**	**D/K**
16. Staff assesses number of uncontrolled HTN patients (BP ≥ 140/90)						
17. Staff assesses number of HTN patients that have no visit in three months and no future appointment scheduled						
18. Staff assesses number of HTN patients with future appointments scheduled at point-of-care						
19. Staff assesses number of antihypertensive medications prescribed						
20. Staff assesses number of patients with BP ≥ 140/90 on two or more occasions who do not have a diagnosis of HTN						

- Which type of blood pressure monitor is used by the practice? Choose all that apply:
  ☐ Automated office blood pressure (AOBP) ☐ Mercury ☐ Aneroid
- If this is a small practice, how many BP monitors are available and in working condition? Please fill in number: _____
- How many cuff sizes are available? Please fill in number: _____

Adapted from the American Medical Association and Johns Hopkins University

Measuring Blood Pressure the Right Way

Blood pressure (BP) measurement is one of the most important tests in clinical medicine, yet it is one of the most inaccurately performed.[1] Diagnosis of hypertension (HTN) is based on the average of two or more properly measured BP readings on each of two or more office visits.[2] Management of HTN is also dependent on BP measurements.

Small inaccuracies in BP measurement may lead to considerable consequences. Underestimating BP by as little as 5 mm Hg would mislabel more than 20 million U.S. adults with pre-HTN when true HTN is present.[3] Overestimating true BP by as little as 5 mm Hg would lead to inappropriate treatment with BP lowering medications in an estimated 30 million U.S. adults.[3]

Many factors impact the ability to take an accurate BP measurement.

COMMON CAUSES OF INACCURATE BP MEASUREMENTS[5,6]

Case	Systolic Effect
Cuff size: (This is the most common source of error)	
• Cuff is too small	+10-40 mm Hg
• Cuff is too large	-5-25 mm Hg
Patient positioning:	
• Arm is above heart level	+2 mm Hg per inch
• Arm is below the heart	-2 mm Hg per inch
• Feet are not flat on the floor	+5-15 mm Hg
• Back is not supported	+5-15 mm Hg
• Legs are crossed	+5-8 mm Hg
Patient factors:	
• Patient in pain	+10-30 mm Hg
• Patient talking	+10-15 mm Hg
• Patient has full bladder	+10-15 mm Hg
• Recent tobacco or caffeine use	+6-11 mm Hg
• White-coat syndrome	+11-20 mm Hg
Method factors:	
• Patient not rested for three to five minutes prior	+10-20 mm Hg
• Cuff is placed over clothing	+10-40 mm Hg

IMPORTANT STEPS TO ENSURE ACCURATE BP MEASUREMENT

1. Equipment Type and Maintenance

- Ensure that equipment is regularly inspected, calibrated as directed by manufacturer and validated.
- The type of BP monitor used is critical. Lists of approved monitors can be found at: **dableducational.org**
- Using a validated automated upper arm BP monitor (AOBP), many of which can be programmed to take multiple readings without a clinical staff member present, can improve the accuracy and reliability of office BP measurements by reducing human error.
- A standard adult cuff, small adult cuff, large adult cuff and thigh cuff should be available for use in measuring.

2. Staff Training

- Ensure staff responsible for measuring BP is properly trained and regularly re-trained. Training videos can be found at:
  nejm.org/doi/full/10.1056/NEJMvcm0800157.
  or
  dl.dropboxusercontent.com/u/82855974/Blood_Pressure_Training.wmv
  or search the keyword: "blood pressure measurement NEJM" on YouTube
- Use performance checklists and guides. Examples may be found in this toolkit or refer to:
  measureuppressuredown.com

3. Patient Preparation and Positioning

- Set up a process for preparation of patients and proper positioning once they are in the exam room
- Involve the patient by informing them of their role in ensuring accurate BP readings

Tips for Care Team:[7]

1. Ask if the patient avoided caffeinated beverages and smoking for at least 30 minutes before the examination.
2. Have the patient sit calmly for five minutes, with their back supported and feet flat on the floor.
3. Patient's arm should be bare. Cuff may be applied over a smoothly rolled-up sleeve, provided there is no tourniquet effect.
4. Support the patient's arm on a firm surface at heart level, slightly flexed at the elbow.
5. Both the health care team member and the patient should refrain from talking while BP is measured.
6. Use appropriate cuff size. The inflatable part of the cuff should be long enough to encircle at least 80 percent of the arm and wide enough to encircle 40 percent of the arm at midpoint. When in doubt, select the larger cuff size.

Recommended Cuff Sizes	
Arm Circumference	**Adult Cuff Size**
22 to 26 cm	Small adult (12 x 22 cm)
27 to 34 cm	Adult (16 x 30 cm)
35 to 44 cm	Large adult (16 x 36 cm)
45 to 52 cm	Adult thigh (16 x 42 cm)

7. Wrap the cuff snugly around bare upper arm. The lower edge should be centered two finger-widths above the bend of the elbow, and the midline of the cuff bladder should be over the brachial artery pulsation.
8. The aneroid dial or mercury column should be clearly visible and facing care team member.
9. Using light pressure, position stethoscope over brachial artery but not touching the cuff.
10. Measure and record to the nearest 2 mm hg ("Round numbers" are not acceptable).

Resources

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Blood Pressure (BP) Measurement Trainer Observation Assessment

Note: Skip steps 10-17 if an automated upper arm blood pressure monitor is used.

Participant:	
Trainer:	Date:

STEPS	PERFORMANCE ITEM	SATISFACTORY	UNSATISFACTORY
1	Inspects exam room/equipment		
2	Greets patient and/or family member/caregiver		
3	Explains procedure, positioning and need to avoid conversation during measurement		
4	Determines if patient has rest period, empty bladder, no caffeine/alcohol		
5	Washes hands		
6	Positions patient		
7	Selects correct cuff size		
8	Palpitates artery before applying cuff		
9	Ensures cuff placement is correct - cuff bladder centered over brachial artery - lower edge of cuff approximately 2.5 cm above elbow crease - cuff is smooth and snug		
10	Chooses appropriate stethoscope bell size according to patient's body size		
11	Places stethoscope earpiece in ears and bell directly over artery		
12	Ensures BP cuff valve stem is in closed position		
13	Inflates cuff until beats cannot be heard		
14	Opens valve stem slowly to release pressure from cuff		
15	Listens for systolic beat		
16	Listens until diastolic beat is heard		
17	Opens wide BP cuff valve stem to release air pressure from cuff		
18	Removes BP cuff from patient		
19	Repeats BP reading at least once (≥ 1 minute interval between)		
20	Documents appropriate forms or medical records (no rounding up or down)		
21	Repeats BP reading in opposite arm, if reading is abnormal		
22	Informs patient care provider if BP is abnormal		
FINAL RESULTS			

Adapted from Providence Medical Group

Blood Pressure (BP) Measurement Self-Assessment

Clinician Name:	Date:

Equipment/Room Assessment		
1. The following equipment was present:		
- Chair with back support	☐ YES	☐ NO
- Table or counter	☐ YES	☐ NO
- Four cuff sizes	☐ YES	☐ NO
- Tape measure	☐ YES	☐ NO
2. The chair can be positioned correctly so that seated BP can be easily taken in both arms.	☐ YES	☐ NO
3. The table/counter is positioned to ensure that both arms are at heart level.	☐ YES	☐ NO
4. The equipment is working and in good position.	☐ YES	☐ NO
5. The space is quiet.	☐ YES	☐ NO
BP Positioning and Other Factors That May Infuence Measur ement Assessment		
1. Patient is seated with back support.	☐ YES	☐ NO
2. Patient has feet flat on floor or footstool.	☐ YES	☐ NO
3. Patient's legs are uncrossed.	☐ YES	☐ NO
4. Patient's arm is bare.	☐ YES	☐ NO
5. Patient's arm is supported.	☐ YES	☐ NO
6. Patient's arm is at heart level.	☐ YES	☐ NO
7. Patient rested quietly for at least five minutes before measurement.	☐ YES	☐ NO
8. Patient was asked to empty bladder.	☐ YES	☐ NO
9. Correct cuff size was chosen (cuff bladder circling at least 80 percent of arm).	☐ YES	☐ NO
10. At least two measurements were taken (≥ 1 minute apart).	☐ YES	☐ NO

Adapted from the American Medical Association and Johns Hopkins University

Tips on Taking Your Blood Pressure

Taking Your Blood Pressure

Before:

- Sit quietly for five minutes
- Do not exercise for at least 30 minutes
- Do not drink caffeinated beverages (coffee, soda), alcohol, or smoke for at least 30 minutes
- Use the bathroom

During:

- Sit in a chair with back support, uncross your legs and keep your feet flat on the ground
- Roll-up your sleeve and remove any tight-sleeved clothing
- Rest your arm on a desk or table, keeping it level with your heart

Use a **blood pressure cuff** that fits your arm. A cuff that's too large or too small can give you a wrong reading. Check with your doctor to see what cuff is right for you.

Know Your Numbers

Blood pressure is measured with two numbers. A change in one number can affect whether your blood pressure is normal or high.

Systolic (heart pumps blood) **115**

Diastolic (heart relaxes) **75**

Blood Pressure Levels

Chart figures apply if a doctor has not told you that you have hypertension. *If you were told you have hypertension, talk to your doctor about your targets and any questions about your medications.*

Below **120** **and** Below **80**	**120** to **139** **or** **80** to **89**	**140** or higher **or** **90** or higher
Normal *goal for most people*	**At Risk** *close to high blood pressure*	**Hypertension** *high blood pressure*

NYC Health

To learn more, visit nyc.gov and search for blood pressure.

Consejos para tomarse la presión arterial

Cómo tomar la presión arterial

Antes:

- Siéntese tranquilo durante cinco minutos
- No haga ningún ejercicio durante por lo menos 30 minutos
- No tome ninguna bebida con cafeína (café o soda), ni alcohol ni fume durante por lo menos 30 minutos
- Vaya al baño

Durante:

- Siéntese en una silla con respaldo, no cruce las piernas y mantenga sus pies en el piso
- Súbase las mangas y quítese la ropa que pueda tener muy apretada la manga
- Coloque su brazo sobre un escritorio o mesa, manteniéndolo al mismo nivel de su corazón

Utilice un **manguito de presión arterial** que se ajuste a su brazo. Un manguito muy grande o muy pequeño puede dar error en la lectura. Consulte a su médico para encontrar el manguito adecuado para usted.

Conozca sus resultados

La presión arterial se mide con dos números. Un cambio en un número puede hacer que su presión arterial sea normal o alta.

Niveles de presión arterial

Las cifras de la tablas aplican a menos que un médico le haya dicho que usted tiene hipertensión. *Si le han dicho que tiene hipertensión, hable con su médico sobre sus objetivos y sobre cualquier pregunta que tenga sobre sus medicamentos.*

Por debajo de **120** y por debajo de **80**	**120** a **139** o **80** a **89**	**140** o mayor o **90** o mayor
Normal *este es el objetivo para la mayoría de las personas*	**En riesgo** *está muy cerca de tener presión arterial alta*	**Hipertensión** *presión arterial alta*

NYC Health

Para obtener más información, visite nyc.gov y busque blood pressure.

Action Plans to Target Undiagnosed Hypertension[1]

Hypertension (HTN) can be undiagnosed- essentially "hiding in plain sight" within a clinical setting.

Million Hearts®, a national effort to prevent one million heart attacks and strokes by 2017, has made BP control a priority. Million Hearts® encourages health care providers to take these four critical steps to help identify patients with potentially undiagnosed HTN:

1. **Establish clinical criteria** for potentially undiagnosed HTN using current evidence-based guidance. Work with your health care team to determine the number of elevated BP readings and the degree of elevation that should trigger a red flag for a patient.
2. **Search Electronic Health Record (EHR) data** for patients who meet your established clinical criteria. For example, some providers have searched EHR registries using algorithms to extract relevant information. Pick the approach that works best for your practice based on your available resources.
3. **Implement a plan** to communicate with these patients and to treat those with HTN. The plan could include 24-hour ambulatory or home BP monitoring, automated office BP readings, or repeated in-office measurement. For patients with confirmed HTN, follow standardized treatment protocols and provide feedback to your care team about how best to support patients in achieving and maintaining BP control.
4. **Calculate the HTN prevalence in your practice** and compare your data against local, state, or national prevalence data. Comparing the prevalence of HTN among your patients to national or local values could add much-needed context to BP control rates and may help identify more patients who might benefit from additional clinical action.

Once you have identified potentially undiagnosed HTN in the practice, determine what next steps are most appropriate. Options may include:

1. Identify enhancements to clinical workflows that improve detection and diagnosis of HTN.
2. Implement a workflow to recall patients "hiding in plain sight" with undiagnosed HTN.
3. Use pre-visit planning to identify patients "hiding in plain sight" with undiagnosed HTN.

The following examples demonstrate steps that may be employed in a clinical setting to address undiagnosed HTN.

Example 1: This example uses pre-visit planning to target undiagnosed HTN.
Health Center Staff Engagement Material: Hiding in Plain Sight (HIPS), *Grace Community Health Center*

Hiding In Plain Sight (HIPS)

Patients with Undiagnosed and Untreated Hypertension

Grace Community Health Care is collaborating with other community health centers across the country to (1) evaluate information about our clinic patients who may have HTN but are neither diagnosed nor treated and (2) develop work flows that will ensure we find those patients who are undiagnosed with high blood pressure so proper diagnosis and treatment can be made. As with any performance improvement project, data will be monitored each month during the collaborative. Our **goal** is to decrease the number of patients who meet clinical criteria but do not have a diagnosis of HTN over the next six months.

High blood pressure (HTN) is a prevalent condition affecting millions of adults; unfortunately millions more are unaware, undiagnosed, and untreated—they are **hiding in plain sight**. Because high BP is a major contributing risk factor for heart failure, heart attack, stroke and chronic kidney disease, it is important to find these undiagnosed and untreated patients and ensure appropriate interventions are implemented when indicated. The initial information for our clinics reflects that we have an opportunity to improve detection and medical record documentation of these patients HIPS.

What Can We Do? Where Do We Start?

1) Accurate and reliable BP measurements – Are we using a properly sized cuff? Is arm placement and feet positioning accurate? Is the patient talking during the measurement? Do you take a second BP as indicated? Support staff should be required to review information related to BP measurement and demonstrate competency by the end of March.
2) Revise the Pre Planning form and Recognition of At-Risk Patients – Support staff should review and call attention to the patient's BP trend as indicated when planning for patient huddles!
3) Improve Provider Documentation – Ensure a diagnosis is listed in the medical record if your patient is on an anti-hypertensive, review BP trending, document cognition of elevated BP readings, diagnosis and treatment plan as indicated.

Do you have recommendations that could help identify these patients HIPS?

Example 2: This example uses pre-visit planning and patient recalls to address undiagnosed HTN.

Hiding in Plain Site (HIPS Strategy), *La Maestra Community Health Centers*

Use of the Hiding in Plain Sight (HIPS) Algorithm

Prior to the visit:

1. Make sure patients confirmed one or two days prior to their visit.
2. During huddle time, make sure that each medical assistant identifies the patient(s) marked as BP check/Hiding in Plain Site (HIPS) patients.
3. If the patient is a recipient of a courtesy visit, be sure to inform the provider.

During the visit:

1. When the patient arrives, be sure to inform the provider that they are a HIPS patient, and also whether they are a courtesy visit recipient.
2. If BP is elevated the first time, inform the provider and let the patient rest. Re-take BP five to ten minutes later.
3. Provider should give HTN diagnosis or elevated BP as appropriate.

After the visit:

1. Schedule a follow-up visit for patients who were diagnosed with elevated BP without a diagnosis of hypertension (HTN).
2. Quality Improvement department meets with providers/provider champion to gain feedback and ensure provider and patient satisfaction in addressing any issues.
3. Run reports to proactively recall HIPS patients that have not been identified in other reports.

Ensuring Blood Pressure Accuracy

1. Install automatic BP machine that automatically inputs BP value into the patient's electronic chart.
2. Train medical assistants to ensure that they are knowledgeable about proper technique.

Hypertension Diagnosis Protocol

1. Once health center staff have identified patients who have had one or two BP readings elevated in one year (> 140/90, based on registry reporting), recall the patients (see Recall Process).
2. If the first BP reading is elevated at recall visit, BP will be retaken after five to ten minutes.
3. If the patient still has elevated BP upon re-measurement (but only one prior elevated BP within the year), the provider should address the elevated BP without diagnosing with HTN – but schedule a follow-up visit within one month. Patient will receive dietary, exercise and lifestyle change recommendations.
4. If the patient has two elevated BP readings within one year, and during their appointment both first and second readings (within ten minutes) are elevated, then the provider will diagnose the patient with HTN.
5. After a patient is diagnosed with HTN, patient is referred to Health Education to learn more about their condition and how they can manage it.

Note: The provider is the one that ultimately classifies a patient as hypertensive or not, but they have agreed on a three-readings protocol before classifying a patient as hypertensive.

Recall Process

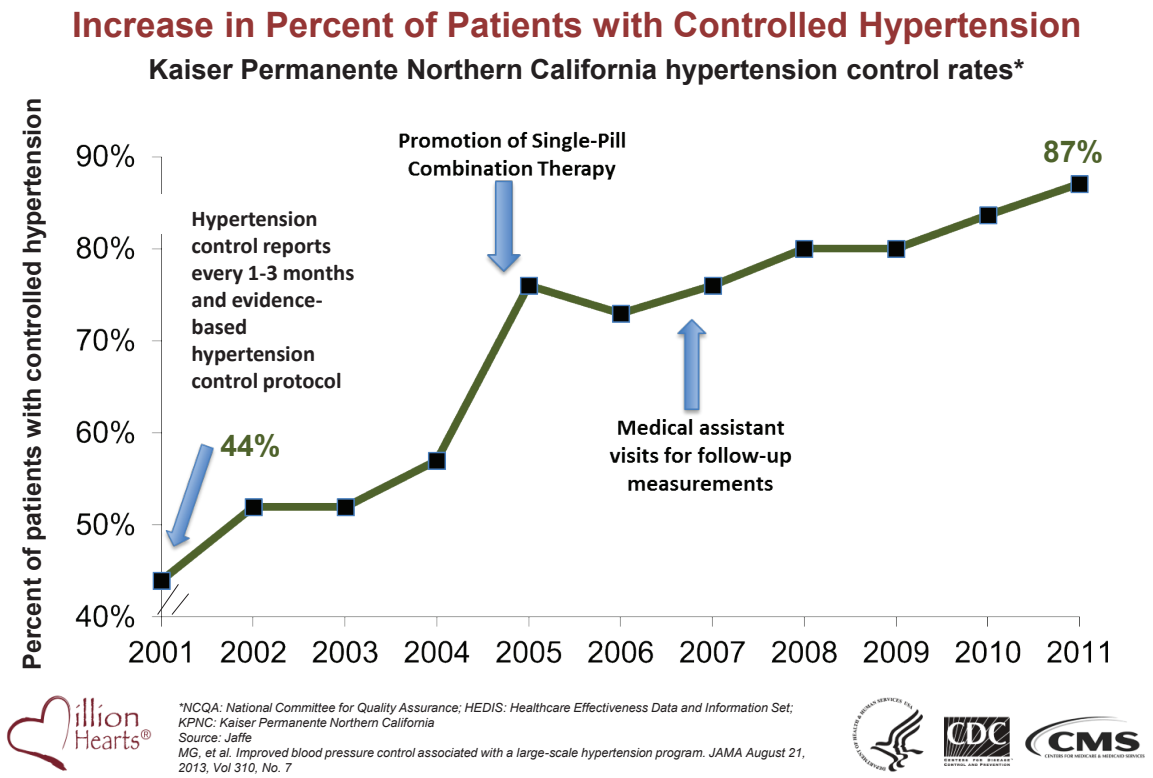
1. If the patient has an upcoming appointment, their chart is flagged to make sure that the history of elevated BP gets addressed during the visit.
2. If the patient does not have a scheduled appointment to address BP, the nurse/medical assistant is to recall the patient to schedule an appointment.
3. If the patient is uninsured or is not assigned to La Maestra, we will recall the patient and schedule an appointment with a nurse. The nurse will evaluate the need for the patient to see the provider.

1. Million Hearts: Leveraging Health Information Technology (HIT), Quality Improvement (QI), and Primary Care Teams to Identify Hypertensive Patients Hiding in Plain Sight (HIPS) Consolidated Change Package. National Association of Community Health Centers. 2015. http://mylearning.nachc.com/diweb/fs/file/id/229350

Improved BP Control Using a Standardized Protocol Example

Kaiser Permanente Northern California (KPNC) is a not-for-profit, integrated health care delivery system. In 2000, KPNC developed a large-scale program to improve blood pressure (BP) control. The KPNC hypertension (HTN) protocol included a multifaceted approach to BP control. The example provided shows how Kaiser Permanente Northern California improved HTN control rates by implementing a protocol that focused on promoting single-pill combination therapy and expanding the types of staff that can assist in timely follow-up of patients.

Be one in a Million Hearts® | millionhearts.hhs.gov



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M.A.P. IT Tools: Act Rapidly

Version 1.0

Improving Health Outcomes: Blood Pressure

ACT RAPIDLY

Introduction

Problem statement: "*Clinical inertia,*" sometimes called "*therapeutic inertia*" occurs when clinical practices detect a patient's elevated blood pressure, but fail to intervene.

Clinical inertia is one of the most common factors contributing to uncontrolled hypertension. Issues leading to clinical inertia include uncertainty about a patient's "true" blood pressure, competing priorities during a visit, uncertainty about a patient's medication adherence, patient resistence to intensifying therapy and simply being unaware that it exists. Clinicians and Quality Improvement (QI) leaders often object to this term because it can be perceived as unfairly blaming clinicians for a multifactorial problem. Although we agree with this sentiment, we use "clinical inertia" in this tool because it is the term used in the scientific literature.

Did you know? Your hypertension control rates may guide you to the most valuable improvement strategies for your practice or health center. If your team's hypertension control rates are in the area of 65% or lower, consider starting with interventions to ACT RAPIDLY. If your practice's control rates are higher than 80%, interventions to PARTNER WITH PATIENTS to improve self-management and medication adherence often are worthwhile. In the end, all practices probably need to ACT RAPIDLY and PARTNER WITH PATIENTS, but this rule-of-thumb can help your practice decide where to start.

Purpose of these tools: The ACT RAPIDLY module consists of two parts: an *Assessment* tool and a *Solutions* tool. Your team can use these tools to measure the extent to which clinical inertia occurs in your practice, and identify evidence-based ideas for overcoming it.

How to use these tools: Your practice can use the ACT RAPIDLY tools in three steps:

- Use the ACT RAPIDLY *Assessment* Tool to measure how often clinical inertia occurs and to identify contributing factors in your practice.
- Together with the rest of your QI team, review the data you collected in Step 1. Use the ACT RAPIDLY *Solutions* Tool to generate potential ways to reduce clinical inertia in your practice.
- Repeat Steps 1 and 2 quarterly to evaluate whether your solutions have worked.

Please adapt these tools: Clinicians and improvement experts designed the Measure Accurately tools for ambulatory practices, but you may want to modify them so they best fit your team's work and needs. If you do adapt these tools, please let us know how you improved them.

We welcome your feedback. If you have comments or questions about these tools specifically, please email ihobp.surveys@ama-assn.org.

ACT RAPIDLY

IHO: BP ACT RAPIDLY Assessment Tool

Time required:

- For a provider or staff member to use the tool: 30 minutes.

What you need:

- Your EMR or charts from office visits eight weeks prior to the self-assessment.
- The ACT RAPIDLY Assessment tool.
- The ACT RAPIDLY Microsoft™ Excel Workbook.

Guidance for practice site

I. Identify your sample
   - For each provider in your practice or health center, review patient charts from visits that were scheduled during the week that began eight weeks before the assessment. Identify 12 visits during that week in which a patient had uncontrolled blood pressure (>140/90 mmHg).
   - Exclude a visit if it was a new patient encounter or for a procedure (e.g., stress test or biopsy).

II. Complete the ACT RAPIDLY Assessment tool using the ACT RAPIDLY Microsoft™ Excel Workbook (Instructions in **Table 1)**.

Table 1. Instructions for ACT RAPIDLY Assessment tool

Column Name	Information for Medical Record Reviewer
Date of visit	
Patient's name	You may want to record another identifier, such as date of birth or medical record number, so you can easily locate the patient's records later.
BP at visit	• Record the BP from the completed visit in the EMR. If more than one BP was obtained, record the "decision-making blood pressure" that *your* practice uses, if it is available. Note: The "decision-making blood pressure" often is the same value that your practice or health center would report for quality measures such as HEDIS and that providers use to take action.[1]
Action taken	Look at the provider's plan to see what, if any, actions were taken. If a provider took more than one action, check all the boxes that apply. • None if you did not take action on the high blood pressure • Arranged for f/u BP* if you arranged for a follow-up blood pressure measurement (e.g., a nurse visit) • Prescribed home BP monitor/ABPM if you advised the patient to use a home BP monitor or prescribed an ambulatory BP monitor (ABPM) • Increased/added medication if you adjusted the patient's antihypertensive medication regimen • Counseled diet/lifestyle change if you advised the patient on how to

[1] Providers have different ways of recording this value. Some only take action on the BP value they recorded themselves. Others use the last value, while others still use the lowest value. Whichever way your practice or health center records the decision-making BP, use *that* value for this tool.

ACT RAPIDLY

Table 1. Instructions for ACT RAPIDLY Assessment tool	
	lower BP through lifestyle changes such as diet or exercise • Other if you took other actions to lower the patient's blood pressure
8-week outcome	Scan the medical record for blood pressure readings since this office visit. • If no new BP values were recorded in the eight weeks following the visit date, mark BP unknown. • If one or more follow-up blood pressure values are recorded, and the lowest value is ≥140/90 mmHg, mark BP still uncontrolled. • If one or more follow-up blood pressure values are recorded, and the lowest is <140/90 mmHg, mark BP controlled.
Notes	For visits with no action taken, indicate why you think the provider did not take action during the visit. Mark all of the contributing factors that apply. **For "none" action taken** • Unsure about "true" BP – uncertainty about the patient's true BP prevented your practice/health center from acting on the high BP value • Competing priorities – issues unrelated to hypertension prevented your practice/health center from acting on the high BP value • Medication complexity concern – concerns such as side-effects or too many medications prevented your practice/health center from taking action • Medication adherence concern – concerns about whether or not the patient is taking medications as prescribed prevented your practice/health center from acting on the high BP value • Patient does not want treatment – patient factors, such as not wanting a medication, prevent your practice from taking action • Other – other factors for why the practice/health center did not act on a high BP value For visits where action was taken but follow-up BP values either are unknown or uncontrolled, indicate this. **For "BP unknown" or "BP still high" under eight-week outcome** • Follow-up issue – your practice or health center acted on the high BP reading during the visit AND you have not recorded a follow-up BP • Uncontrolled hypertension – your practice or health center acted on the high BP reading during the visit AND you have recorded a follow-up BP AND the lowest repeat BP is ≥140/90 mmHg You can use the remaining space to write down any other information that might help the team understand the patient visit better.

ACT RAPIDLY

***Remember!** There are many ways, other than scheduling a return visit, to obtain follow-up BP values. For example, patients could check their BP at home and phone the results to your office.

- The Microsoft™ Excel ACT RAPIDLY Workbook will automatically calculate the **Clinical Inertia Index** (CI Index) using the methodology below –
    - Add up all of the visits where you either indicated any of the following under "Action Taken": None, or under "Eight-Week Outcome": BP unknown or BP still high.
    - Divide this number by all of the visits that you reviewed during this assessment.

  For example, after reviewing the medical records for 12 visits with high BP readings, if you discover that your practice or health center did not address the patient's blood pressure during one visit and has not obtained follow-up blood pressures for the three other visits, then the CI index is (1+3)/12 = 4/12 = 0.33. When your practice successfully acts rapidly, its CI Index will be close to zero.

You can use the CI Index as a quarterly benchmark to track how well your quality improvement efforts are working.

ACT RAPIDLY

Sample ACT RAPIDLY Assessment Tool (Please use the Microsoft™ Excel ACT RAPIDLY Workbook.)

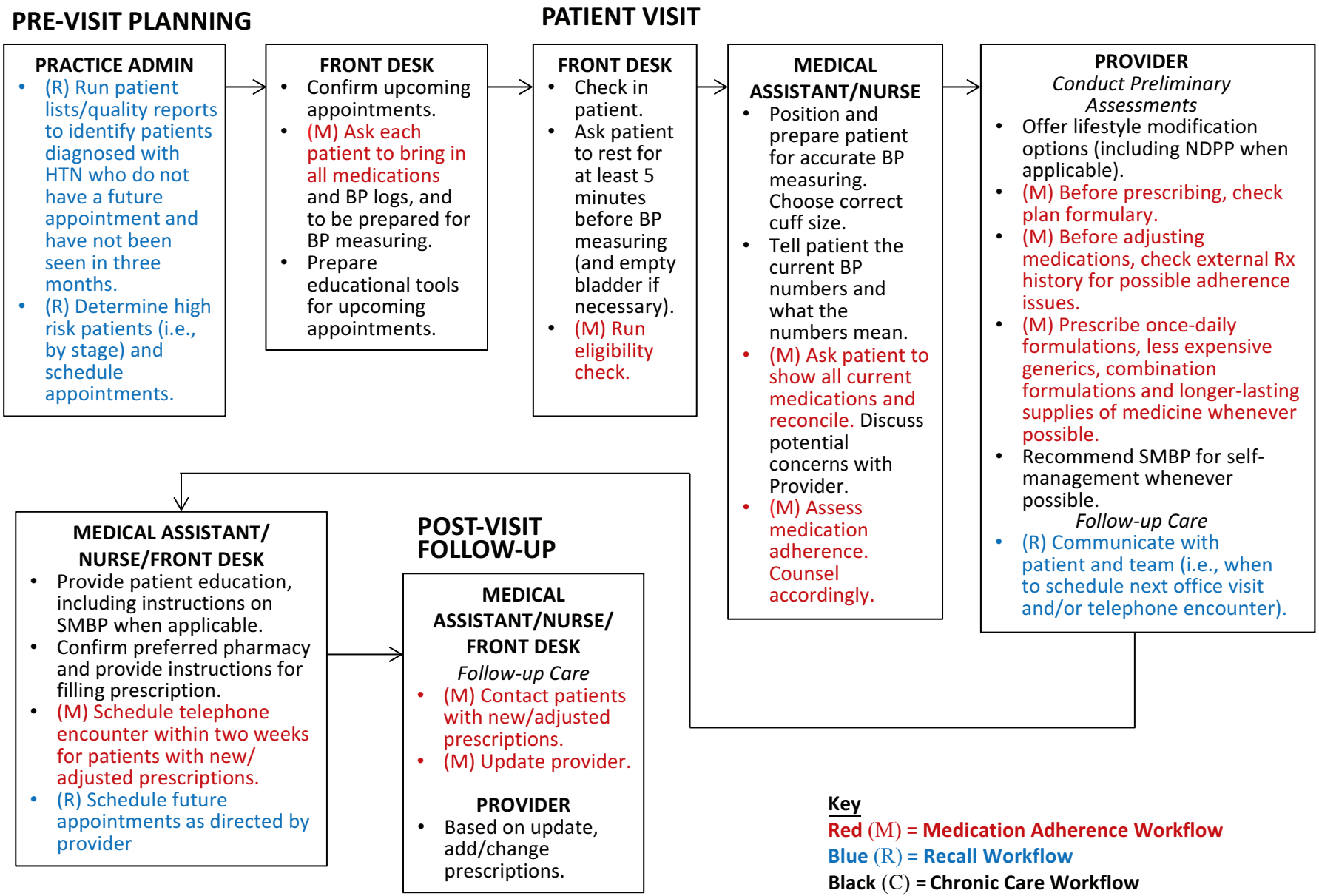
Review date: **Provider:** **CI Index*:** **Page: 1**

Visit Date	Patient Identifier (+/- DOB or MR#)	BP at visit	Action Taken *(Select all that apply)*	Eight - Week Outcome *(Select one)*	Notes *(Select all that apply)*
___/___		____/____	☐ None ☐ Arranged for follow-up BP ☐ Prescribed home BP monitor/ABPM ☐ Increased/added medication ☐ Counseled diet/lifestyle change ☐ Other:	☐ BP unknown ☐ BP still high ☐ BP controlled	☐ Unsure about "true" BP ☐ Competing priorities ☐ Medication complexity concern ☐ Medication adherence concern ☐ Patient does not want treatment ☐ Other: ☐ Follow-up issue ☐ Uncontrolled hypertension
___/___		____/____	☐ None ☐ Arranged for follow-up BP ☐ Prescribed home BP monitor/ABPM ☐ Increased/added medication ☐ Counseled diet/lifestyle change ☐ Other	☐ BP unknown ☐ BP still high ☐ BP controlled	☐ Unsure about "true" BP ☐ Competing priorities ☐ Medication complexity concern ☐ Medication adherence concern ☐ Patient does not want treatment ☐ Other: ☐ Follow-up issue ☐ Uncontrolled hypertension
___/___		____/____	☐ None ☐ Arranged for follow-up BP ☐ Prescribed home BP monitor/ABPM ☐ Increased/added medication ☐ Counseled diet/lifestyle change ☐ Other	☐ BP unknown ☐ BP still high ☐ BP controlled	☐ Unsure about "true" BP ☐ Competing priorities ☐ Medication complexity concern ☐ Medication adherence concern ☐ Patient does not want treatment ☐ Other: ☐ Follow-up issue ☐ Uncontrolled hypertension

Clinical Inertia (CI) Index = Sum[For each row, count 1 if "None" (column 4) or "BP unknown" (column 5) or "BP still high" (Column 5)] / [Total Number of Visits You Reviewed

Blood Pressure Control

Suggested Workflow for Blood Pressure Control



(B) BLOOD PRESSURE CONTROL
HYPERTENSION DIAGNOSIS AND TREATMENT FOR ADULTS

Aim for target systolic BP of < 140 and diastolic BP of < 90 for most patients including those > 60 years old

Prescribing Tips

- Start with the lowest dose; side effect profile is often dose-dependent
- ACE-I and ARB should not be used in combination
- Change ACE-I to ARB if persistent cough is present
- Adhere to maximal dosing standards for simvastain when prescribed with CCB (≤ 10 mg with verapamil or diltiazem, ≤ 20 mg with amlodipine)

Examples of Fixed Dose Combination Pills†

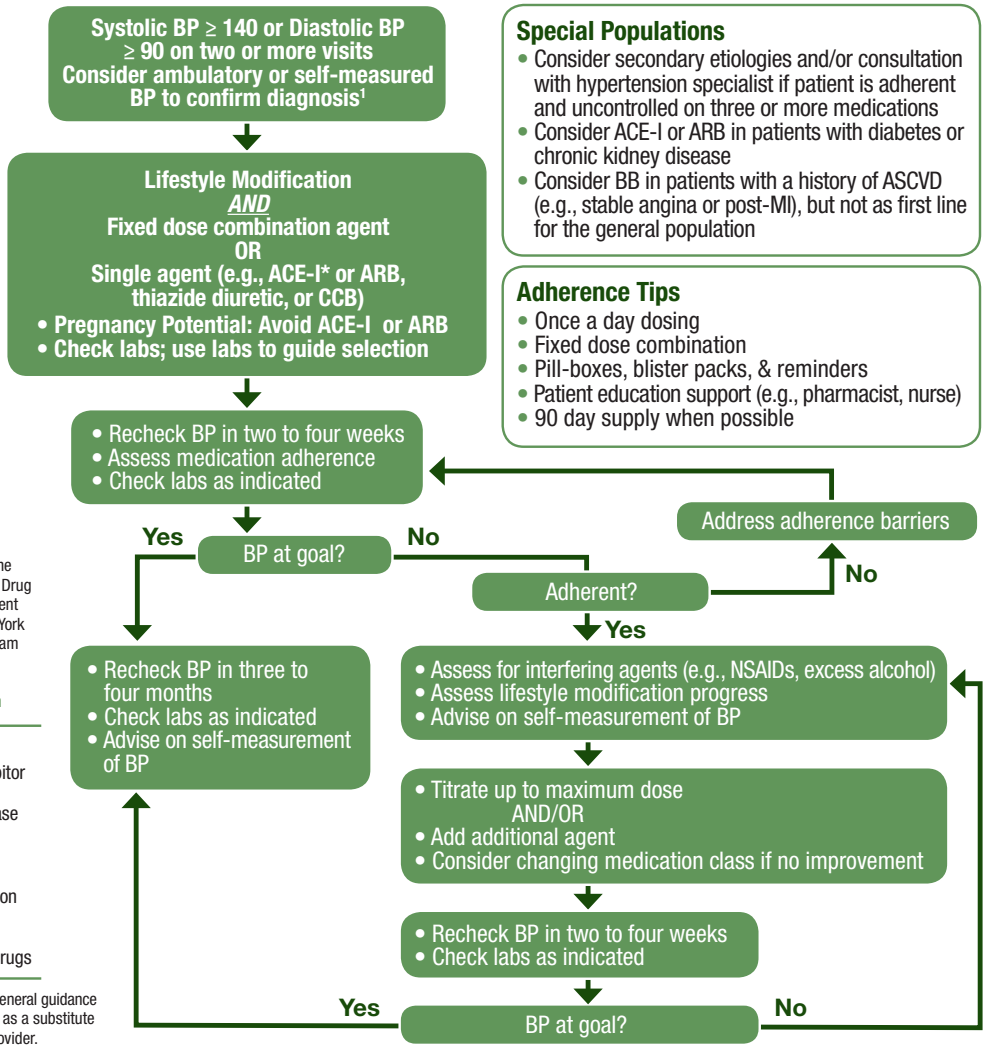
- Lisinopril + HCTZ
- Losartan + HCTZ
- Benazepril + amlodipine
- Valsartan + amlodipine

† Examples of fixed dose combination pills are from the New York State Medicaid Fee-For-Service Preferred Drug List. This list is subject to change. For the most current version of preferred products, please view the New York State Medicaid Fee-For-Service Preferred Drug Program List at https://newyork.fhsc.com and the New York State Medicaid Managed Care Pharmacy Benefit at http://mmcdruginformation.nysdoh.suny.edu/search

Abbreviations

ACE-I = Angiotensin converting enzyme inhibitor
ARB = Angiotensin II receptor blocker
ASCVD= Atherosclerotic cardiovascular disease
BB = Beta blocker
BP = Blood pressure
CCB = Calcium channel blocker
DASH = Dietary approaches to stop hypertension
HCTZ = Hydrochlorothiazide
MI = Myocardial infarction
NSAIDs = Non-steroidal, anti-inflammatory drugs

The algorithm presented here is designed to provide general guidance and assist clinical decision making. It is not intended as a substitute for the clinical judgment of a qualified health care provider.



Special Populations

- Consider secondary etiologies and/or consultation with hypertension specialist if patient is adherent and uncontrolled on three or more medications
- Consider ACE-I or ARB in patients with diabetes or chronic kidney disease
- Consider BB in patients with a history of ASCVD (e.g., stable angina or post-MI), but not as first line for the general population

Adherence Tips

- Once a day dosing
- Fixed dose combination
- Pill-boxes, blister packs, & reminders
- Patient education support (e.g., pharmacist, nurse)
- 90 day supply when possible

Lifestyle Modifications to Prevent and Manage Hypertension**

Modification	Recommedation	Approximate Systolic BP Reduction (range)
Weight reduction	Maintain a normal body weight (body mass index 18.5-24.9 kg/m^2). If overweight or obese, weight loss of 5% to 10% can improve BP.	3-4 mmHg/5 kg[4,5]
Adopt DASH* eating plan[6]**	Consume a diet rich in fruits, vegetables and low-fat dairy products with a reduced content of saturated and total fat.	8-14 mmHg
Dietary sodium reduction	Reduce dietary sodium intake to less than 2,300 mg of sodium.	2-8 mmHg
Physical activity	Engage in at least 30 minutes of moderate physical activity (such as a brisk walk) at least five days a week.	4-9 mmHg
Moderation of alcohol consumption	Limit alcohol consumption to no more than 2 drinks per day for most men, and no more than 1 drink per day for women and lighter weight persons (1 drink =12 oz. beer, 5 oz. wine, or 1.5 oz. spirits).	2-4 mmHg
Always recommend smoking cessation for overall cardiovascular risk reduction.		

*ACE-I may have a smaller blood pressure effect in Black patients[2,3]
**Adapted from The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure
***DASH = Dietary Approaches to Stop Hypertension

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The Morisky Green Levine Medication Adherence Scale[1]

Measuring adherence can lead to better patient compliance. Self-report is a commonly used tool to evaluate medication adherence and can be easily incorporated into routine clinical workflows. The Morisky Green Levine Medication Adherence Scale is a four-itemed self-reported adherence measure that addresses barriers to medication-taking. Measure of specific medication-taking behavior is based on patient responses to "yes or no" questions. The scale takes into account that the failure to adhere to medication regimen could occur due to several factors, including forgetfulness and problems with the complexity of the medication regimen.

The Morisky Green Levine Medication Adherence Scale asks the following four questions to evaluate medication-taking behavior:

1. Do you ever forget to take your medicine?
2. Are you careless at times about taking your medicine?
3. If you feel worse when you take the medicine, do you stop taking it?
4. When you feel better, do you sometimes stop taking your medicine?

Scoring the Morisky Green Levine Scale

Yes= 0 and No= 1

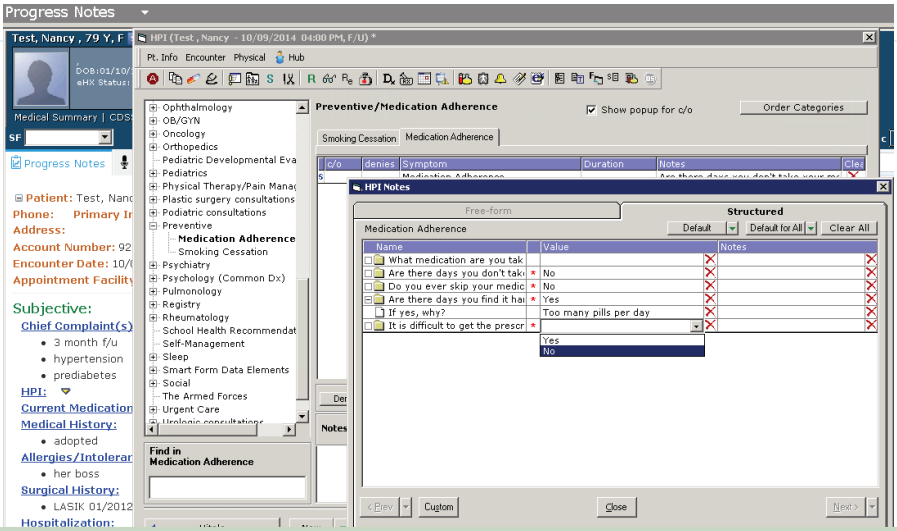
- Zero is the lowest level of medication adherence.
- Four is the highest level of medication adherence.
- Patients scoring zero or one would benefit most from intervention to improve medication adherence.
- Goal: Evaluate medication-taking behavior at every encounter and identify those who would benefit from improved adherence to medication regimen.

1. Morisky DE, Green LW, Levine DW. Concurrent and predictive validity of a self-reported measure of medication adherence. *Medical Care* 1986;24:67-74.

eCW-How to Add a Medication Adherence Questionnaire by Creating Structured Data

Self-reported questions can be added to the EHR to better gauge a patient's medication adherence risks.

Medical Assistants can ask these questions to patients after taking the patient's vitals.



The questions can be added into the **HPI notes** or **Preventative** section as structured data.

Please refer to the following slides for instructions on how to create structured data.

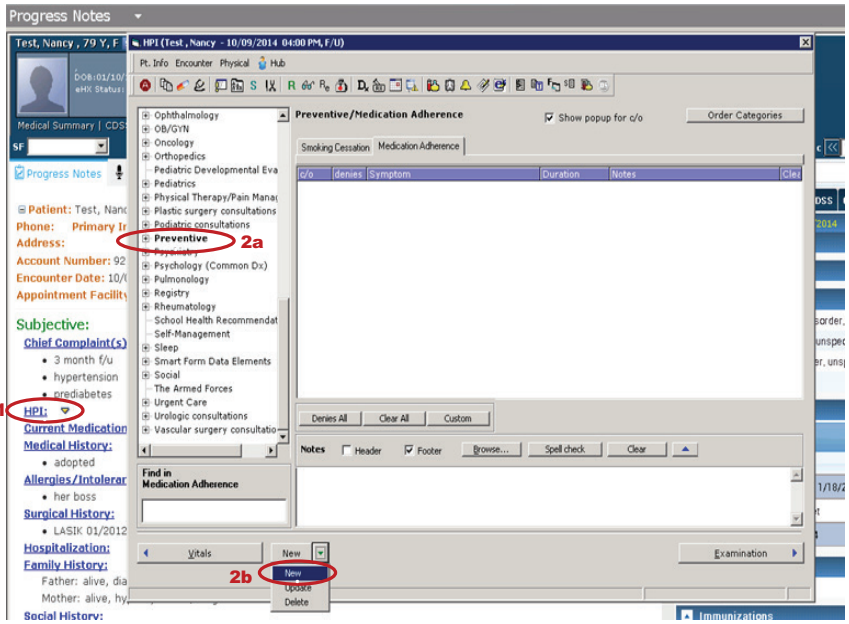
STEP BY STEP

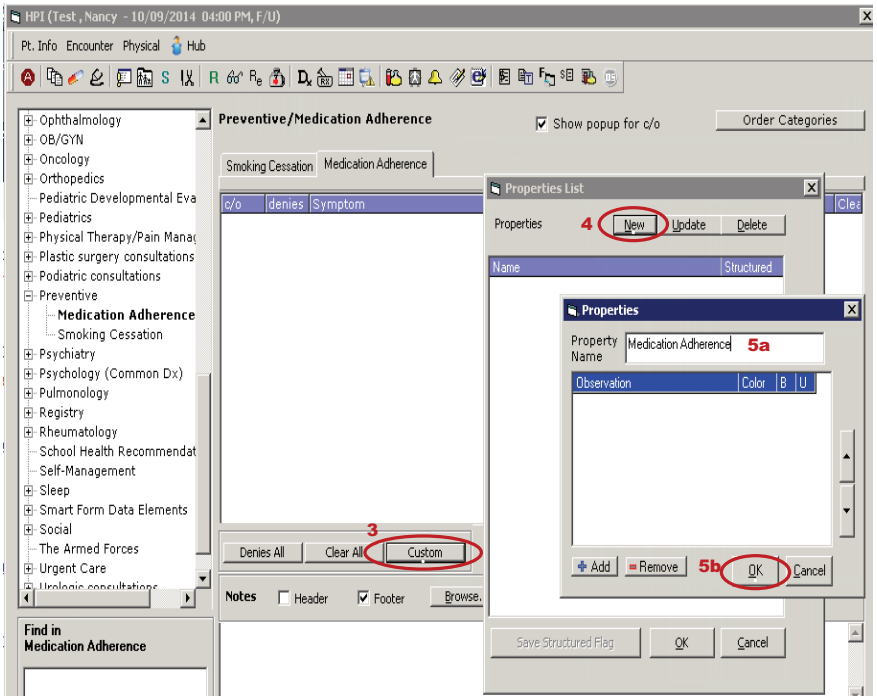
1. In Progress Notes, select **HPI**

Create a New Category

2a. Click **Preventive** in left side panel

2b. Click **New**





STEP BY STEP

3. Click **Custom**

*The **Properties List** window will open*

In the **Properties List** window:

4. Click **New**

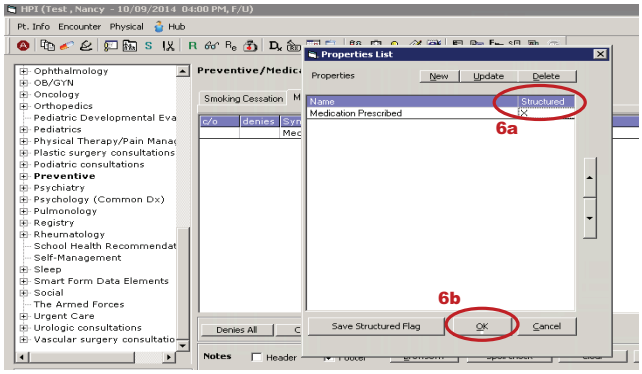
*The **Properties** window will open*

In the **Properties** window:

5a. Type in **a property name** (e.g. Medication Adherence)

5b. Click **OK**

*The **Properties** window will close*



STEP BY STEP

In the **Properties List** Window:

6a. Click **X** in **Structured** cell for the new category created.

6b. Click **OK**

*The **Properties List** Window will close*

STEP BY STEP

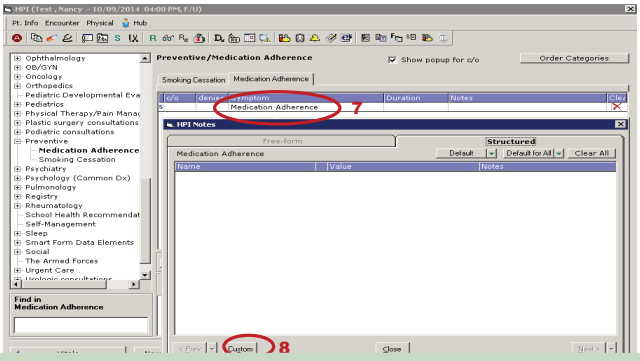
In the **HPI** window:

7. Double click **new item** created (e.g. Medication Adherence)

*The **HPI Notes** window will open*

In the **HPI Notes** window:

8. Click **Custom**



STEP BY STEP

In the **Structured Data** window:

9. Click **Add** (type in Morisky scale questions)

*A smaller **Structured Data** window will open*

In the **Structured Data** window:

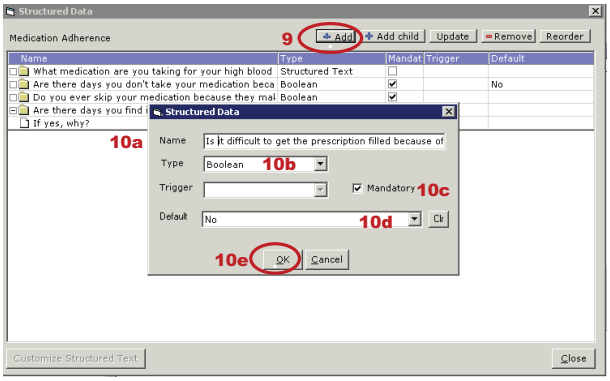
10a. Type **question**

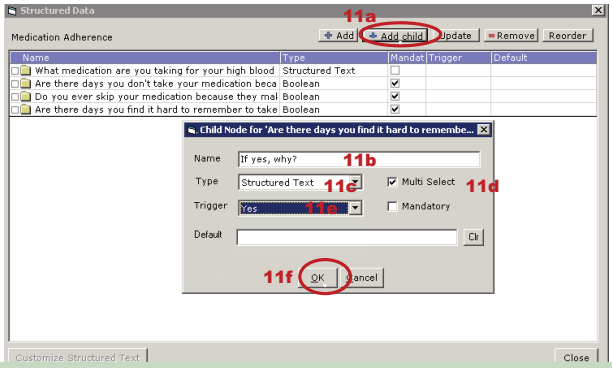
10b. Select type of question (e.g. Boolean, Structured Text, etc.)

10c. Click **Mandatory**

10d. Select **Default Answer** (e.g. No), if applicable

10e. Click **OK** when done





STEP BY STEP

To add **follow-up question**:

11a. Click **Add Child**

*The **Child Node** window will open*

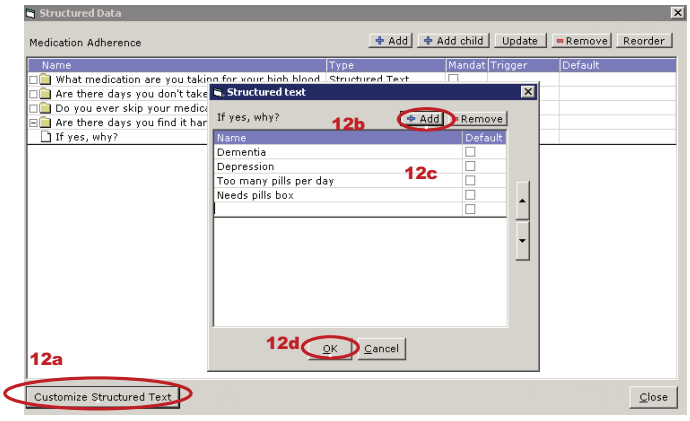
11b. Type **follow-up question** (e.g. If yes, why?)

11c. Select **Structured Text**

11d. Click **Multi Select**

11e. Select **Yes** as trigger

11f. Click **OK** when done



STEP BY STEP

To add in drop down menu (Structured Text) response options:

12a. Click **Customize Structured Text**

*A smaller **Structured Data** window will open*

12b. Click **Add** and type response choice. Repeat until all possible responses are entered.

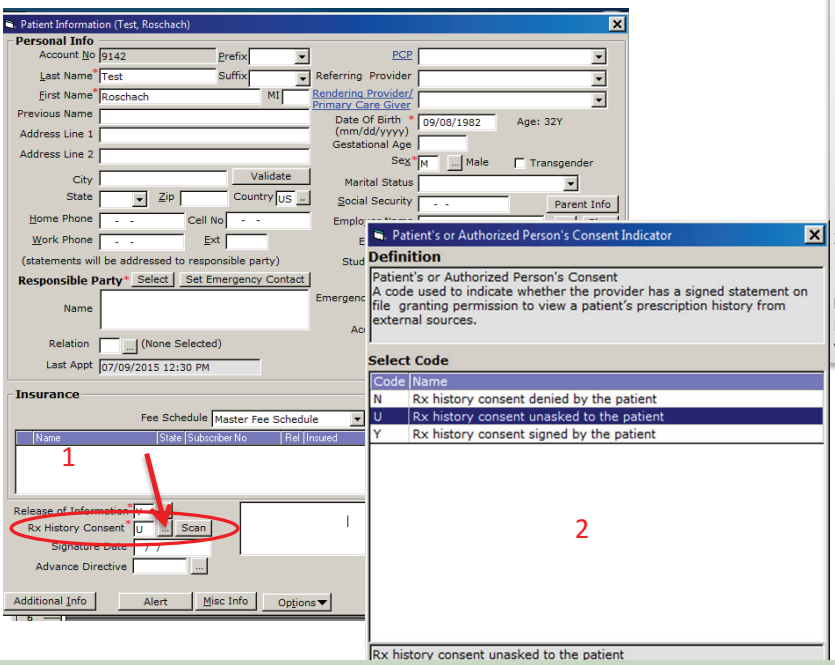
12c. Type answer choice (i.e. Dementia)

Check default question if necessary

12d. Click **OK**

eCW's External Rx History Check: RxHub

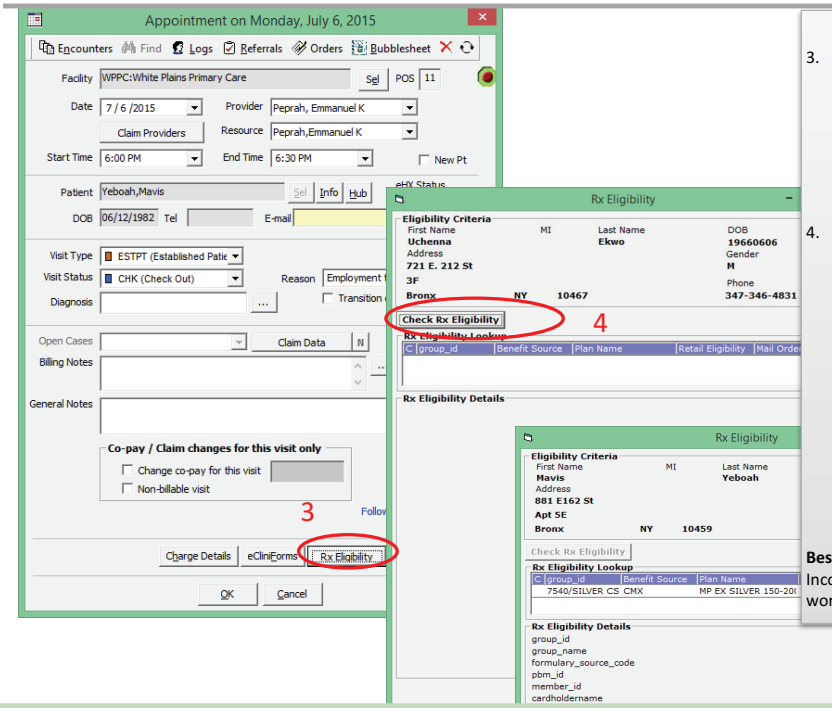
Practices may be interested in knowing the last date of prescription refills, as well as other medication history information for their patients. eCW makes it possible to search for external medication history.



Step by Step

1. Rx History Consent must be set to "Y" for each patient using RxHub. "Y" designates that the patient has given consent to access pharmacy benefit data. A consent form can be scanned into EHR. To check, go to the Patient Information screen and find Rx History Consent. If not set to "Y", click on the button located between Rx History Consent and the Scan tab.
2. A second window will pop up. Choose "Y," then click "OK."

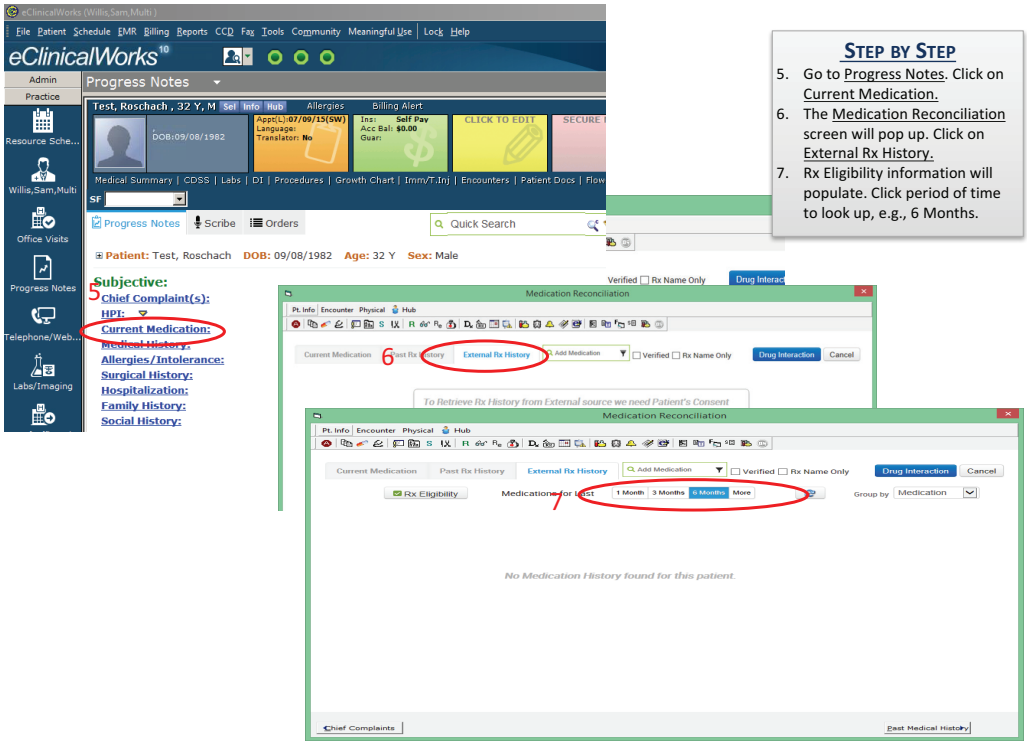
Best Practice Suggestion
Incorporate this step into front desk workflow.



Step by Step

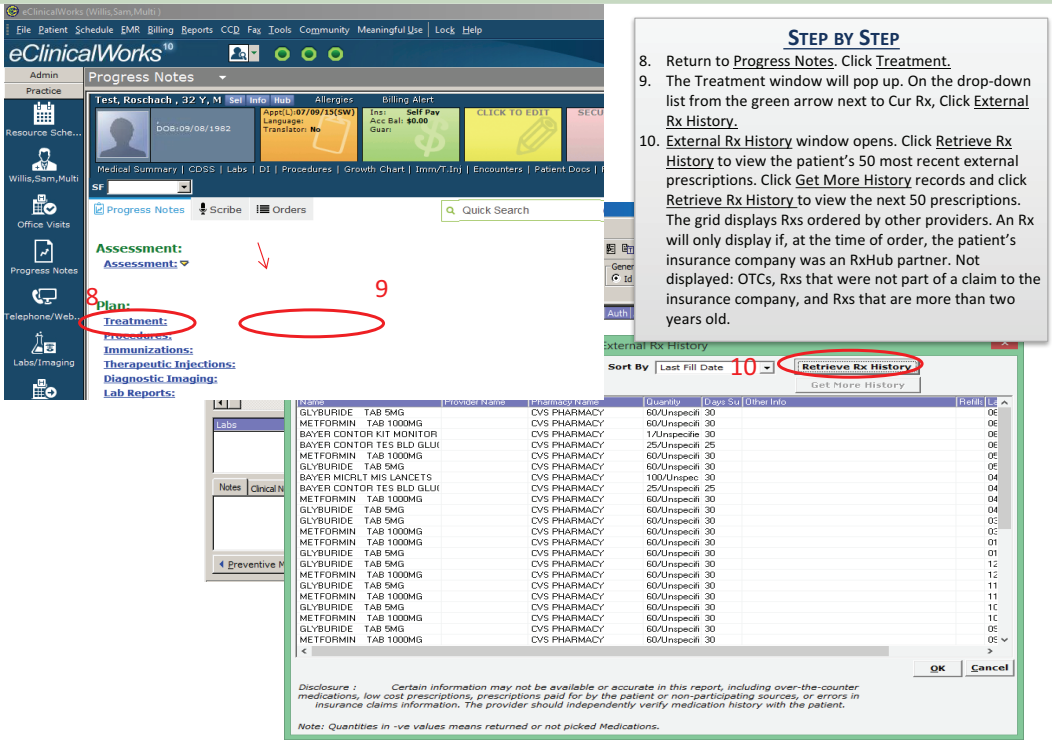
3. Next, check eligibility for an individual patient. Go to Appointment. Click Rx Eligibility at the bottom of the Appointment window.
   Note: If you have already done a batch eligibility check and there were no errors in the eligibility, this step may be skipped.
4. A pop-up will appear. Click Check Rx Eligibility. The Rx Eligibility lookup grid displays information about the patient's insurance policy. The Rx Eligibility Details section of the window displays policy information. There are several reasons for eligibility check errors:
   • Patient information sent could not be matched
   • Patient's insurance company is not an RxHub partner or does not authorize the release of patient information
   • There was a problem with transmission of the data.

Best Practice Suggestion
Incorporate this step into front desk workflow and use a batch eligibility check.



Step by Step

5. Go to Progress Notes. Click on Current Medication.
6. The Medication Reconciliation screen will pop up. Click on External Rx History.
7. Rx Eligibility information will populate. Click period of time to look up, e.g., 6 Months.



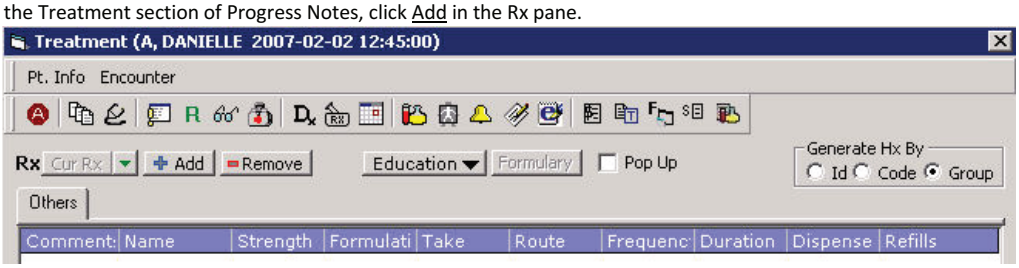
Step by Step

8. Return to Progress Notes. Click Treatment.
9. The Treatment window will pop up. On the drop-down list from the green arrow next to Cur Rx, Click External Rx History.
10. External Rx History window opens. Click Retrieve Rx History to view the patient's 50 most recent external prescriptions. Click Get More History records and click Retrieve Rx History to view the next 50 prescriptions. The grid displays Rxs ordered by other providers. An Rx will only display if, at the time of order, the patient's insurance company was an RxHub partner. Not displayed: OTCs, Rxs that were not part of a claim to the insurance company, and Rxs that are more than two years old.

eCW's Drug Formulary Review

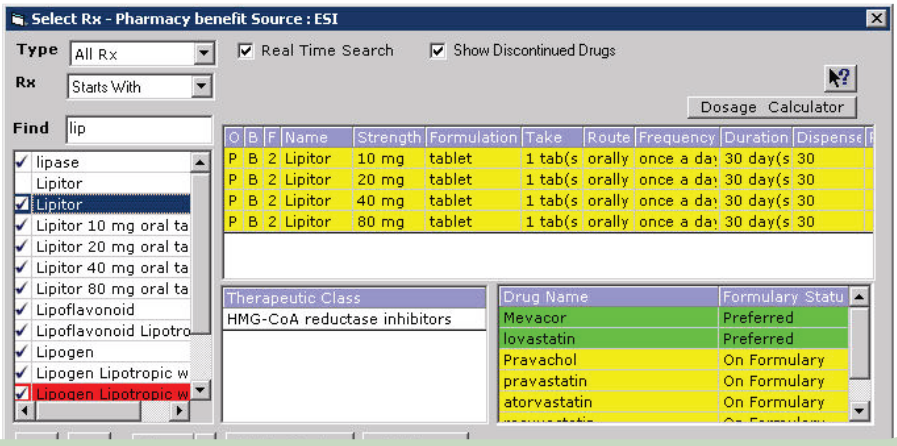
To check if select drugs are on the patient's formulary using RxHub:

1. From the Treatment section of Progress Notes, click Add in the Rx pane.



2. Search for the drug to prescribe:

- Select the Real Time Search check box to filter the list of drugs with each letter you enter in the Find field.
- To include discontinued drugs in your search, select the Show Discontinued Drugs check box.
- Select the category of the drug from the Type drop-down list. (Multum drugs are preceded by a check mark.)
- From the Rx drop-down list, select the type of filter for the search.
- Enter the search string for the drug in the Find field.
- Use the << and >> keys to page through the list.



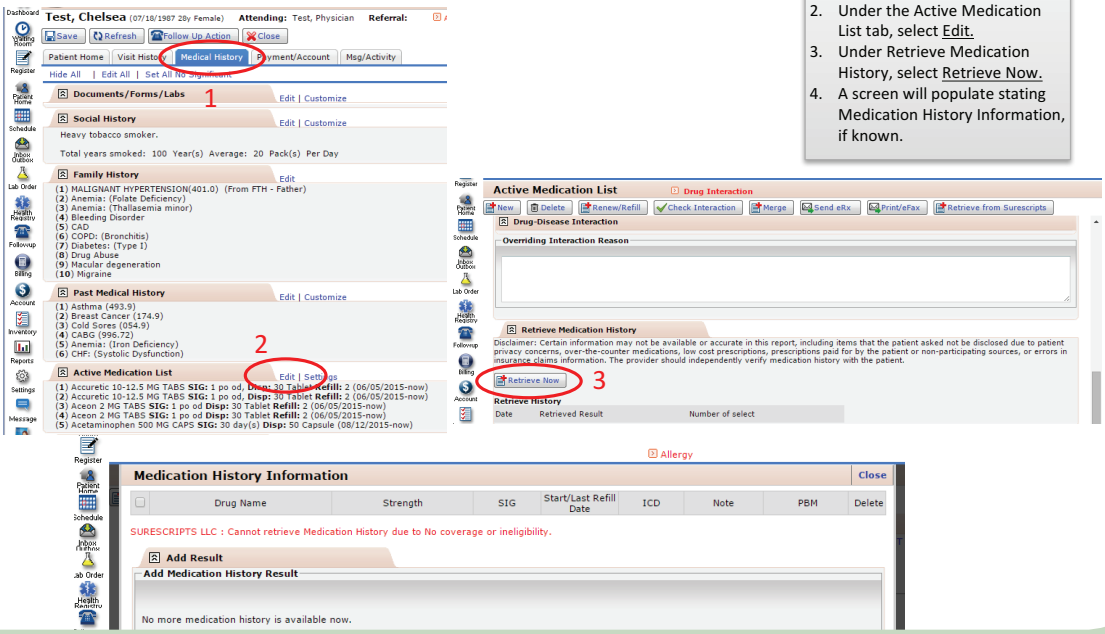
MDLand External Rx History Check

and External Rx History Check

Practice may be interested in knowing the last date of prescription refills, as well as other medication history information for their patients. MDLand makes it possible to search for external medication history.

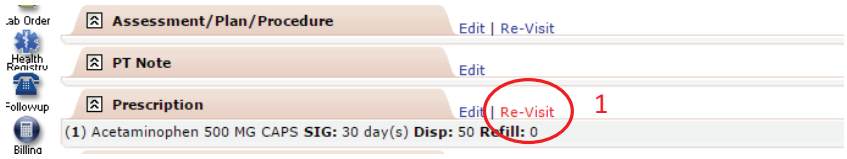
Step by Step

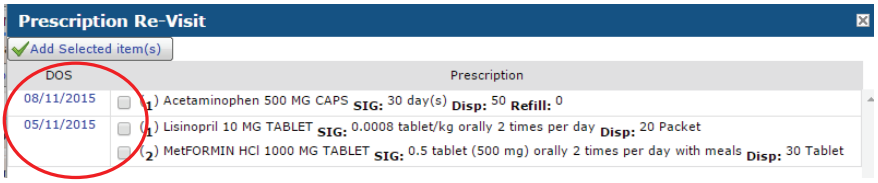
1. From the patient's chart, select Medical History.
2. Under the Active Medication List tab, select Edit.
3. Under Retrieve Medication History, select Retrieve Now.
4. A screen will populate stating Medication History Information, if known.



MDLand Medication Adherence: Medication History (Internal)

Additionally, providers may choose to see what the patient has previously been prescribed in their own practice. To do this, they may "Re-Visit" prescription history from the patient's previous visits.





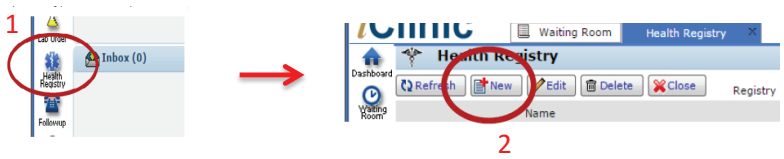
Step by Step

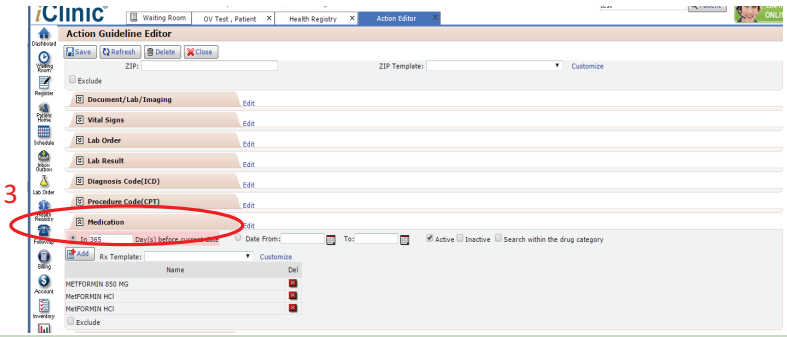
1. From Current Office Visit, under the Prescription tab, select Re-Visit.
2. Patient's prescription history will appear, including date medication was prescribed.

   2a. Select any of the patient's past medications to prescribe during the current office visit.

MDLand Medication Adherence: Medication Reports

Providers may know that certain medications are at higher risk for patients than others, and certain patient populations are less likely to take or refill their prescribed medications than others. Use a Health Registry report to check up on any patient that has been prescribed a certain medication.



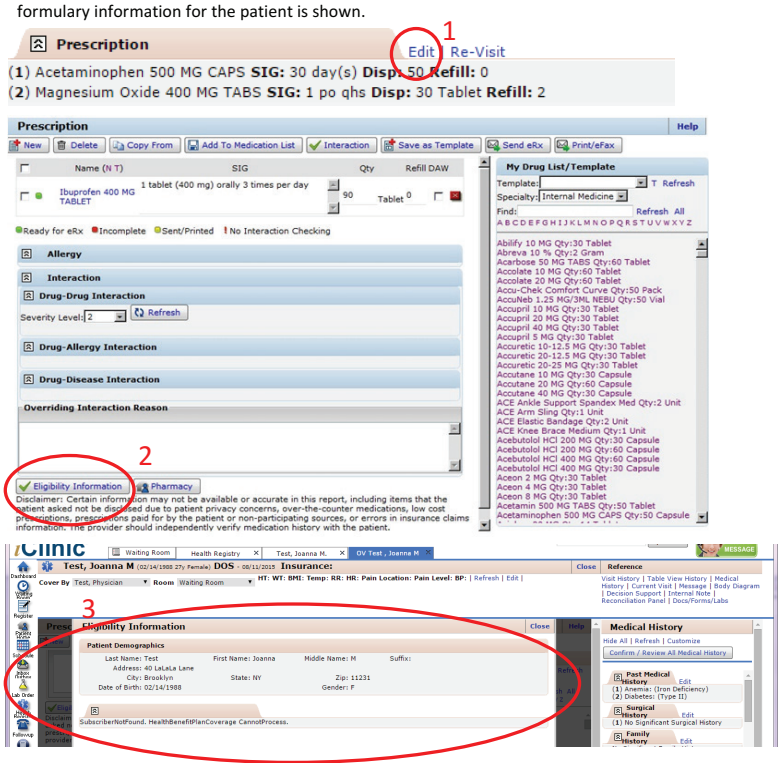


STEP BY STEP

1. Select Health Registry in the left-hand navigation panel.
2. Select New.
3. Select the Medications tab to include only particular medications that were prescribed in the chose timeframe.

MDLand Medication Adherence: Rx Eligibility

Providers know that when they prescribe a medication in the correct tier of a patient's insurance, the patient is more likely to take their prescribed medication – and to refill it. By checking Rx Eligibility, formulary information for the patient is shown.



Step by Step

1. From Current Office Visit, under the Prescription tab, select Edit.
2. Under the Prescription module, scroll down until you see Eligibility Information. Select this box.
3. If know, formulary information for the patient will appear.

Patient Self-Monitoring of Blood Pressure: A Provider's Guide

Patient self-monitoring of blood pressure is a valuable addition to the management of hypertension, supported by the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC-7), the American Heart Association and the American Society of Hypertension.

- Self-monitoring is especially useful for patients with poorly controlled hypertension.
- It can be used to titrate medications, improve control, and screen for white-coat hypertension.
- Home readings may be an equal or better predictor of cardiovascular risk and of target organ damage than office readings.
- Self-monitoring can enable and motivate patient participation in managing a condition that is often asymptomatic.

While self-monitoring can be done by most patients, it may be contraindicated for those with certain conditions: cardiac arrhythmias, and certain physical and mental disabilities. Because home monitors are not covered by most insurance plans, cost may be a barrier.

INTRODUCING SELF-MONITORING TO YOUR PATIENT

1. **Explain the value of the home monitor in controlling high blood pressure. Encourage patients to "know their numbers," and describe what the numbers mean.**
2. **Provide guidance on selecting a monitor.** Recommend:
   - A validated monitor only. For a list, see: **http://www.dableducational.org/sphygmomanometers/devices_2_sbpm.html#UpperArm**
   - A brachial cuff model. Wrist and finger models are often used incorrectly.
   - A monitor with a fully automated – rather than a manual – inflation cuff.
   - An appropriate sized cuff. (Standard adult cuffs are too small for about a third of patients.)
   - Models equipped with printers or memory may improve reliability in record keeping, though they are also more expensive.
3. **Validate the monitor.**
   Ask your patient to bring it in so you can check it against your office equipment. After that, check for accuracy about every 6 months (or per monitor instructions) and/or if faulty readings are suspected.
4. **Teach patients proper techniques.**
   - Rest 5 minutes before taking your blood pressure.
   - Don't smoke or drink caffeinated beverages for at least 30 minutes before.
   - Take your blood pressure before (not after) you eat.
   - Sit comfortably with your back supported and both feet on the floor (don't cross your legs).
   - Elevate your arm to heart level on a table or a desk.
   - Use the proper sized cuff. It should fit smoothly and snugly around your bare upper arm. There should be enough room to slip a fingertip under the cuff. The bottom edge of the cuff should be 1 inch above the crease of the elbow.
   - Ideally, take 3 measurements at one sitting and record the average.
5. **Provide self-blood pressure monitoring tools for patients to easily keep track of their numbers at home.**

See reverse for more information

The New York City Department of Health and Mental Hygiene

PRESCRIBE SELF-MONITORING FREQUENCY

Initially, blood pressure measurements should be taken in the morning and evening for 3-4 consecutive days. Disregard the first day when averaging outpatient readings. Home blood pressures are generally lower than office pressures (mean 8/6 mmHg lower).

RECOMMENDED PROTOCOL

CIRCUMSTANCE	MONITORING FREQUENCY/DURATION
Titrating Medication	• Titrate medication until mean out-of-office blood pressure levels are below 135/85. • To assess peaks and troughs, compare morning and evening readings to those obtained 3-4 hours after medication is taken.
Self-Management Tool to Enhance Medication Adherence and to Improve and Maintain Control of High Blood Pressure	• Emphasize patient education. • Adjust frequency of monitoring to complement patient self-management goals (could vary from once a day to once a week). • Encourage the recording of lifestyle changes and their observed impact on pressure (e.g., increased or decreased salt intake).
Screen for White-Coat Hypertension	• Measurements should be taken in the morning and evening until next visit (2-4 weeks). • If no evidence of target organ damage and mean is below 130/80, medication may not be necessary. • Some guidelines recommend confirmation with ambulatory blood pressure monitoring.

- **Make sure your patients know how to respond to an emergency.**
  - Ensure that patients know to call 911 immediately if they have signs or symptoms of a heart attack or stroke.
  - Advise patients what to do in case of an exceptionally high or low reading.
- **Create office systems to easily integrate home blood pressure monitoring into your practice.**
  - Identify a support staff member who can teach patients how to use monitors, validate devices, and review action plans and blood pressure logs.
  - Develop a protocol to address frequency of office visits, handle inquiries from patients about home monitor concerns, etc.
  - Consider organizing hypertension support groups for your patients or using peer educators to teach patients how to measure blood pressure at home.

TOOLS FOR PATIENT SELF-MONITORING OF BLOOD PRESSURE

- **Keep Your Heart Healthy: Blood Pressure Tracking Card**
- **Health Bulletin #30: Healthy Heart - Blood Pressure**

To order these patient tools for your office, call 311.

How to Take Your Blood Pressure

1 Before taking your blood pressure.

- Don't smoke, eat, drink caffeine (like coffee, tea or soda) or exercise at least 30 minutes before.
- Sit quietly for 5 to 10 minutes.
- Sit in a chair with your back supported and both feet on the floor.
- Roll up your sleeve or remove tight clothing from your upper arm.

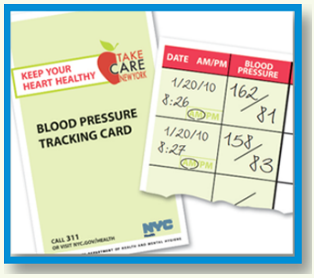
2 How to put on the cuff.

- Put your arm through the cuff loop and slide it up your arm. Your left arm is recommended.
- The bottom edge of the cuff should be about one inch above the crease of your elbow.
- The tube should run along the inside of your arm in line with your little (pinky) finger.
- Tighten the cuff and secure the Velcro®.

3 Take your blood pressure twice.

First time:

- Rest your forearm on a table with the cuff at heart level and your palm up.
- Press "START."
- The cuff will automatically inflate. After a few seconds, it will begin to deflate, and you'll hear beeps. After a long beep, you'll see your blood pressure numbers on the screen.
- Write the numbers in your Blood Pressure Tracking Card. For example, 162/81. The top number is your systolic (SYS) pressure. The bottom is your diastolic (DIA) pressure.



Second time:

- Wait one minute, then take your blood pressure again. Write the numbers in your card.
- Please don't press any other buttons. Your readings will be automatically saved.

4 Bring your card to your next doctor's visit.

- Go over your numbers with your doctor.
- Find out:
  - Your blood pressure goal.
  - How often to take your blood pressure.
  - What to do if your blood pressure is very high or low.
  - What you can do to control your blood pressure.

NYC Health

Cómo tomarse la presión arterial

1 Antes de tomarse la presión arterial.

- No fume, coma, consuma cafeína (como café, té o gaseosa) ni haga ejercicios al menos 30 minutos antes.
- Siéntese tranquilo durante 5 ó 10 minutos.
- Siéntese en una silla con la espalda apoyada y los pies sobre el piso.
- Arremánguese o quítese la ropa ajustada de la parte superior de su brazo.

2 Cómo colocar el brazalete.

- Coloque su brazo a través del brazalete y deslícelo hacia arriba. Se recomienda que use su brazo izquierdo.
- El borde inferior del brazalete debe estar a una distancia de una pulgada por encima de la articulación del codo.
- El tubo se debe colocar a lo largo del interior del brazo a la altura del dedo meñique.
- Ajuste el brazalete y sujételo con el Velcro.

3 Tome su presión arterial dos veces.

Primera vez:

- Apoye el antebrazo sobre una mesa con el brazalete ubicado a la altura del corazón y la palma de la mano hacia arriba.
- Presione “START” (Inicio).
- El brazalete se inflará automáticamente. Después de unos segundos, comenzará a desinflarse y usted escuchará unos sonidos. Después de escuchar un sonido largo, verá los números de su presión arterial en la pantalla.
- Escriba los números en su tarjeta de seguimiento de la presión arterial. Por ejemplo, 162/81. El número de arriba es su presión sistólica (SYS). El número de abajo es su presión diastólica (DIA).

Segunda vez:

- Espere un minuto, luego tómese la presión nuevamente. Escriba los números en su tarjeta.
- No presione ningún otro botón. Sus datos se guardarán automáticamente.

4 Lleve su tarjeta a la próxima visita al médico.

- Revise los números con su médico.
- Averigüe:
  - Cuál es su presión arterial objetivo.
  - La frecuencia con la que se debe tomar la presión.
  - Qué debe hacer en caso de tener la presión arterial muy alta o muy baja.
  - Qué puede hacer para controlar la presión arterial.

NYC Health

CHOLESTEROL MANAGEMENT

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66	2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: Five Points to Remember	○		
67	The Risk Estimator	○	○	○
70	Cholesterol Management: A Summary of the ACC/ AHA Cholesterol Treatment Guidelines	○	○	
71	Helping Patients Make Better Treatment Choices with Decision Aids	○		
72	Decision Aid Sample	○	○	○

Tasks

Toolkit Reference Page	Tasks for the Practice Facilitator
Key Facts	☐ C1. Provide an overview of strategies to improve cholesterol management. • Discuss the 4R's of cholesterol management.
Appendix: Prevention and Care Dashboard	☐ C2. Solicit feedback to determine the practice's readiness for change. • Show current dashboard. • Ask the practice to discuss thoughts and concerns about working on this measure: "What are your thoughts on working to improve cholesterol management?"
Recognize Risk Factors **2013 ACC/AHA: Five Points to Remember** **The Risk Estimator**	☐ C3. Recognize the role of risk factors in cholesterol management. • Discuss the goal of cholesterol management as described by the 2013 ACC/AHA guidelines. The goal is to reduce the risk of heart attack, stroke or death. • Discuss the focus behind the strategy to recognize risk factors. The strategy is identifying whether someone already has or is at risk for atherosclerotic cardiovascular disease (ASCVD) and could benefit from treatment. • Discuss and show the practice how to use a risk estimator. The risk estimator is used as a companion to the 2013 ACC/AHA guidelines. • Highlight possible overestimates with a risk estimator. • Improve access to a risk estimator by either bookmarking a web resource, downloading an app or downloading an Excel format.
	☐ C4. Respond quickly to cholesterol management by optimizing use of the Electronic Health Record (EHR). • Clinical Decision Support (CDS) alerts: Ensure the CDS alert is working. Note: CDS alerts may not be aligned with new guidelines, but can be used to alert the provider to patients with ASCVD and diabetes mellitus (DM). • CDS alerts: Teach the practice how to use the CDS alerts, and ask the provider how he/she responds to it: "How do you usually respond to this alert?" • Quality reports: Train and assist the practice in setting up quality reports (i.e., Enterprise Business Optimizer [EBO] reports for eCW). • Quality reports: Train and assist the practice in incorporating the use of quality reports into office workflow. • Lab interface/LOINC: Ensure lab interface exists and LOINC codes are correct. LOINC codes may differ according to various laboratories, and can be found on company websites or by contacting a sales associate.
Cholesterol Management: A Summary of the ACC/AHA Cholesterol Treatment Guidelines	☐ C5. Respond quickly to improve cholesterol management by adopting a protocol. • Review the guide available in this toolkit. • Highlight the following: 1. The guidelines focus on four statin benefit groups. 2. For the purpose of the ABCS Toolkit, the quality measures determine statin use in three benefit groups: those with any form of ASCVD, those with LD-C levels of 190 or greater and those 40 to 75 years of age with DM and LDL of 70-189. 3. Lifestyle components remain critical.

Helping Patients Make Better Treatment Choices with Decision Aids	☐ C6. Reinforce control through the use of decision aids. • Discuss the goal of decision aids. • Show decision aids provided in the toolkit. • Provide resources for decision aids and, *if requested,* add the interactive electronic version as a browser "favorite" for easy access.
Appendix: Evidence-based Interventions: Provider and Offce Staff Toolkit	☐ C7. Reinforce control by recommending referrals to the National Diabetes Prevention Program (NDPP) or other evidence-based lifestyle modification programs. • Highlight NDPP as an evidence-based lifestyle modification program to prevent type 2 diabetes. Skills learned in NDPP are applicable to cholesterol management. • Provide details on class content and program duration. • Teach and assist the practice in designing a workflow to identify and refer patients using the Quality & Technical Assistance of NY online portal.
Appendix: How Community Pharmacists Can Help with the Common Reasons for Non-Adherence **Appendix: About the Big Apple Rx Card** **Appendix: MTM Fact Sheet and FAQ** **Appendix: MTM Patient Brochure**	☐ C8. Reinforce control by recommending and referring to community pharmacists to improve medication adherence. • Highlight services offered by community pharmacists.
Appendix: NYC Farmers Markets Map **Appendix: Shape Up NYC**	☐ C9. Reinforce control by recommending community resources that support healthy lifestyle modifications. • Highlight local farmers markets as a source of fresh fruits and vegetables. Farmers market locations may change yearly. For accurate locations, visit **nyc.gov** and search for "farmers markets." • Highlight Shape Up NYC as a source of free exercise classes.
Key Facts **Appendix: Prevention and Care Dashboard – Hub Quality Measures Checklist**	☐ C10. Review quality data. Have all care team members routinely review quality data and provide feedback.

Key Facts

BACKGROUND

- The American College of Cardiology (ACC) and the American Heart Association (AHA) developed new standards for treating blood cholesterol in 2013.[1,2]
- The ultimate goal of the new cholesterol practice guidelines is to reduce a person's risk of heart attack, stroke and death.[1,2] For this reason, the focus is not just on measuring and treating cholesterol, but identifying whether someone already has or is at risk for atherosclerotic cardiovascular disease (ASCVD) and could benefit from treatment.
- The guidelines focus on two types of treatment: 1) lifestyle modifications, and 2) statins for people who would most likely benefit.[1,2]
- The new guidelines also call for health care providers to engage in shared decision-making regarding treatment options. Shared decision-making is a collaborative process that allows patients and providers to make health care decisions together, taking into account the best scientific evidence available as well as the patient's values and preferences.
- Quality measures in this toolkit focus on three out of the four statin benefit groups as defined by the ACC/AHA guidelines: statin use in those with any form of ASCVD, those with LDL-C levels of 190 or greater, and those 40 to 75 years of age with diabetes mellitus (DM) and LDL of 70-189.

TERMINOLOGY

- What are statins?

"Statins" is the common term for a group of drugs listed under the drug class HMG-CoA reductase inhibitors. Statins reduce elevated total cholesterol, LDL cholesterol, apolipoprotein B and triglycerides, and increase HDL cholesterol.

- What is atherosclerotic cardiovascular disease?

Atherosclerotic cardiovascular disease (ASCVD) is a type of cardiovascular disease (CVD) caused by plaque buildup in arterial walls. ASCVD includes:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral artery disease

- What is primary and secondary prevention?

Primary prevention refers to the effort to prevent or delay the onset of disease. For cholesterol management, the disease is ASCVD.

Secondary prevention refers to the effort to prevent or delay the progression of disease. For cholesterol management, the disease is ASCVD.

QUALITY MEASURES

	Measure	Description
Cholesterol Management	Cholesterol (general screening)	Males over 35 years of age and females over 45 years of age (with no diabetes mellitus [DM], ischemic vascular disease [IVD] or dyslipidemia) who had a cholesterol screen in last five years
	Statin use in those with clinical ASCVD	Percent of patients 21 years of age and older diagnosed with ASCVD who are on statin therapy
	Statin use in those with primary elevations of LDL-C	Percent of patients 21 years of age and older with history of LDL ≥ 190 mg/dL who are on statin therapy
	Statin use in those with diabetes	Percent of patients 40 to 75 years of age with diabetes who are on statin therapy

Use the 4 R's to Manage Cholesterol

Recognize risks: The focus of management is identifying whether someone already has or is at risk for ASCVD and could benefit from treatment.

Respond quickly: The new guideline provides a guide for statin use in those who would most benefit.

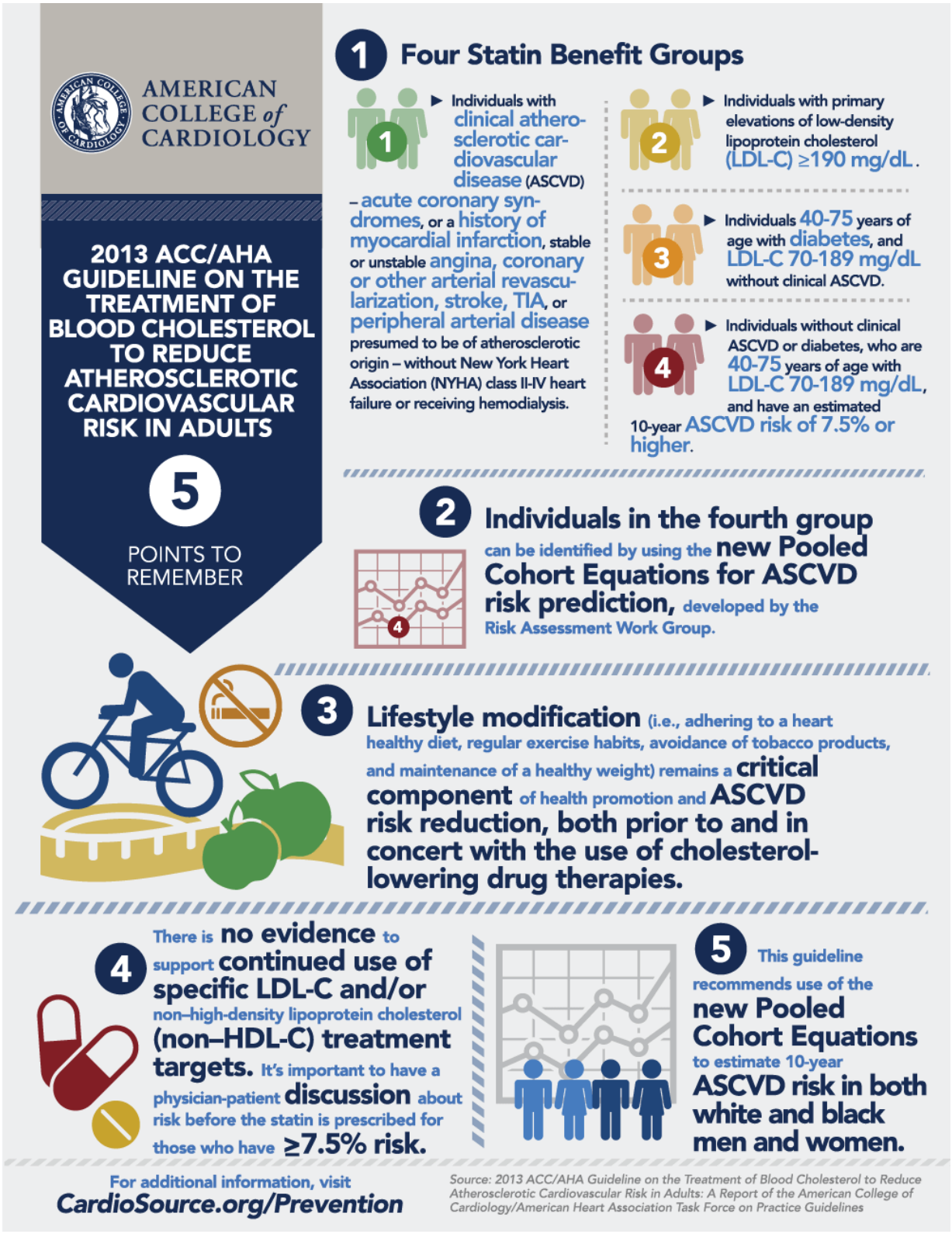
Reinforce control: Lifestyle modifications and adherence to statin therapy are the cornerstones of treatment. The importance of improving cholesterol management can be reinforced through patient education, such as decision aids, promoting self-management and offering access to community resources like lifestyle modification programs.

Review quality data: Quality measures in this toolkit focus on three out of four statin benefit groups as defined by the ACC/AHA guidelines: statin use in those with any form of ASCVD, those with LDL-C levels of 190 or greater, and those 40 to 75 years of age with DM and LDL of 70-189.

Resources

1. Goff DC, Jr., Lloyd-Jones DM, Bennett G, et al. 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines [published online ahead of print. November 12, 2013]. Circulation.
2. Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines [published online ahead of print. November 12, 2013]. Circulation.

2013 ACC/AHA: Five Points to Remember [1]



ACC/AHA= American College of Cardiology/American Heart Association

1. ACC in Touch Blog. 5 Points to Remember on the Cholesterol Guideline [Internet]. Washington (DC): American College of Cardiology. 2013 Dec 8 [cited 2017 Feb 13]. Available from: http://blog.acc.org/post/5-points-to-remember-on-the-cholesterol-guideline.

The Risk Estimator

The 2013 guidelines from the ACC/AHA focus on primary and secondary prevention of atherosclerotic cardiovascular disease (ASCVD).

The Risk Estimator is intended as a companion tool to the 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk and the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. This Risk Estimator enables health care providers and patients to estimate 10-year and lifetime risks for ASCVD — defined as coronary death or nonfatal myocardial infarction (MI), or fatal or nonfatal stroke, and based on Pooled Cohort Equations and lifetime risk prediction tools.

The Risk Estimator is used to determine the statin beneft in those without ASCVD or diabetes with a LDL-cholesterol < 190 mg/dL, and to determine intensity of statin therapy in those 40 to 75 years of age with diabetes and LDL-cholesterol 70-189 mg/dL.

Required Fields for the Risk Estimator

The information required to estimate ASCVD risk includes age, sex, race, total cholesterol, HDL cholesterol, systolic blood pressure, blood pressure lowering medication use, diabetes status and smoking status.

Risk Estimator Resources

- Web version available at: **tools.cardiosource.org/ASCVD-Risk-Estimator/**
- iTunes app (for iPhones, iPads) available at: **itunes.apple.com/us/app/ascvd-risk-estimator/id808875968?mt=8**
- Google Play app (for Galaxy, Nexus, other android devices) available at: **play.google.com/store/apps/details?id=org.acc.cvrisk&hl=en**
- Downloadable Excel format available at: **my.americanheart.org/professional/StatementsGuidelines/Prevention-Guidelines_UCM_457698_SubHomePage.jsp**

FREQUENTLY ASKED QUESTIONS

Adapted from Quest Diagnostics: **http://education.questdiagnostics.com/faq/FAQ142**

Q Which guidelines support the use of 10-year and lifetime ASCVD risk estimates?

A Two guidelines recommend the use of atherosclerotic cardiovascular disease (ASCVD) risk estimates. The first is the American College of Cardiology (ACC) and the American Heart Association (AHA) guideline on assessment of cardiovascular risk.[1] It recommends use of the new race- and sex-specific pooled cohort equations to estimate 10-year risk of a first ASCVD event. First ASCVD event is defined as a nonfatal MI, coronary heart disease death or stroke (fatal or nonfatal). This guideline also supports assessing lifetime ASCVD risk.

The second is the ACC/AHA joint guideline on treatment of blood cholesterol to ASCVD risk in adults.[2] It gives statin therapy recommendations based on 10-year and lifetime ASCVD risk estimates.

Q The guidelines recommend 10-year and lifetime ASCVD risk assessment for which patients?

A The guidelines recommend 10-year ASCVD risk assessment using the pooled cohort equations for African Americans and non-Hispanic whites, regardless of diabetes status, who are 40 to 79 years of age and without clinical cardiovascular disease.[1]

The guidelines also state that an estimation of ASCVD risk in patients from populations other than African American and non-Hispanic white may be considered.[1] **The sex-specifc pooled cohort equations for non-Hispanic whites should be used for this purpose. However, risk may be overestimated in Hispanics and Asian Americans.** The guidelines recommend lifetime ASCVD risk assessment for 20- to 59-year-old patients who are without clinical cardiovascular disease and not at high 10-year risk.[1]

Q No ASCVD risk was reported for my patient. Why?

A Neither 10-year nor lifetime risks or risk goals will be calculated when:

- There is missing patient information. The following details are required for 10-year ASCVD risk estimates: age, sex, race, systolic blood pressure, blood pressure lowering medication use, diabetes status and smoking status. All details except race are required for lifetime ASCVD risk estimates.
- A patient's information is not in the range accepted for risk calculation. Accepted ranges are:
  - Total cholesterol: 130-320 mg/dL
  - HDL-cholesterol: 20-100 mg/dL (not required for lifetime ASCVD risk estimates)
  - Systolic blood pressure: 90-200 mm/Hg
  - Age: 40-79 for 10-year ASCVD risk and 20-59 for lifetime ASCVD risk

Q **How does the 10-year ASCVD risk estimate differ from the Framingham Study 10-year Coronary Heart Disease (CHD) risk estimate?**

A The 10-year ASCVD risk estimate assesses risk of nonfatal and fatal stroke in addition to assessing risk of CHD. The ASCVD risk estimate is based on data from multiple community-based cohorts and takes into account differences in risk between non-Hispanic whites and African Americans.[1] In contrast, the Framingham 10-year CHD risk estimate does not assess risk of stroke, is based on data from a single population-based study and does not take into account differences in risk between non-Hispanic whites and African Americans.[3]

Resources

1. Goff DC, Jr., Lloyd-Jones DM, Bennett G, et al. 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines [published online ahead of print. November 12, 2013]. Circulation.
2. Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines [published online ahead of print. November 12, 2013]. Circulation.
3. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). JAMA. 2001; 285:2486-2497.

(C) CHOLESTEROL MANAGEMENT: A SUMMARY OF THE ACC/AHA CHOLESTEROL TREATMENT GUIDELINES[1]

Clinical ASCVD
Patients 21-75 years old with ACS, prior MI, stable/unstable angina, prior coronary or arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be atherosclerotic. Incidental findings of coronary artery calcification, atherosclerosis of the aorta, or AAA are not considered clinical ASCVD.

YES → **High Dose Statin (A)**
Atorvastatin 40-80 mg or Rosuvastatin 20-40 mg with the aim to reduce LDL-C by > 50% in 4-12 weeks (E)

NO ↓

LDL≥ 190 mg/dL and 40 to 75 years old?

YES → **High Dose Statin (B)**
Atorvastatin 40-80 mg or Rosuvastatin 20-40 mg with the aim to reduce LDL-C by > 50% in 4-12 weeks

NO ↓

Diabetes, LDL 70-189 mg/dL, and 40 to 75 years old?

YES → **10-year ASCVD risk ≥ 7.5%?**

YES → **High Dose Statin (E)**

NO → **Moderate Dose Statin (A)**
Atorvastatin 10-20 mg, Rosuvastatin 5-10 mg, Pravastatin 40-80 mg, Simvastatin 20-40 mg, etc., with the aim to reduce LDL by 30-50% in 4-12 weeks

NO ↓

10-year ASCVD risk ≥ 7.5% and LDL 70-189 mg/dL?

YES → **Moderate to High Dose Statin (A)**
Consider additional risk factors to help decide potency.

NO ↓

10-year ASCVD risk < 7.5% but ≥ 5.0% & LDL 70-189 mg/dL?

YES → **Clinician Thought (C)**
Additional factors that may lead to benefit from statin or more intensive lifestyle modification:
- High lifetime ASCVD risk (included in calculator) but 10-year ASCVD risk ≤ 7.5%
- American Indian patients have ASCVD risks higher than Whites, while Hispanic and Asian patients have a lower risk of ASCVD (not accounted for by calculator)
- Increased risk for patients with family history of early CVD (M < 55 or F < 65), ABI ≤ 0.9, hsCRP > 2.0, or Coronary Calcium Score > 75th percentile

Discussion with Patient
- Risks (0.1-0.3 cases of diabetes/100 patients treated with statin) vs. benefits (ASCVD risk reduction) vs. alternatives (exercise, diet, smoking cessation, meds)
- Patient preferences and likeliness to adhere

Patients > 75 years old
- RCT evidence supports the continuation of statins beyond 75 years of age in people already on a statin.
- Data supports the use of moderate-intensity statin therapy for secondary prevention in individuals with clinical ASCVD > 75 years of age.
- Current data does not support the initiation of statins for primary prevention of ASCVD in individuals > 75 years of age. Consideration of increasing comorbidities, safety considerations, and priorities of care in addition to clinical judgment should apply.

The treatment guide presented here is designed to provide general guidance and assist clinical decision making. It is not intended as a substitute for the clinical judgment of a qualified health care provider.

Summary of 2013 ACC/AHA Cholesterol Treatment Guidelines – Abbreviated by Statin Category

Levels of evidence: A, B, C, E (expert opinion)

High Dose Statin
- Clinical atherosclerotic disease and age 21-75 (includes MI or angina syndrome, prior arterial revascularization, CVA/TIA, PAD) (A)
- LDL > 190, age 40-75 (B)

Moderate OR High Dose Statin
- Diabetes, age 40-75
  - High dose if 10-year ASCVD risk > 7.5% (E)
  - Moderate dose if 10-year ASCVD risk < 7.5% (A)
- 10-year ASCVD risk > 7.5% and LDL 70-190 (A)

Clinical Judgement
- 10-year ASVCD risk 5-7.5% and LDL 70-190 (C)

ACC/AHA ASCVD Calculator:
http://tools.cardiosource.org/ASCVD-Risk-Estimator/
http://clincalc.com/Cardiology/ASCVD/PooledCohort.aspx

Abbreviations
AAA = Abdominal aortic aneurysm
ABI = Ankle-brachial index
ACS = Acute coronary syndromes
ACC/AHA = The American College of Cardiology/the American Heart Association
ASCVD = Atherosclerotic cardiovascular disease
CVA = Cerebrovascular accident
CVD = Cardiovascular disease
hsCRP = High-sensitivity C-reactive protein
LDL = Low-density lipoprotein
LDL-C = Low-density lipoprotein cholesterol
MI = Myocardial infarction
PAD = Peripheral arterial disease
RCT= Randomized controlled trial (or randomized control trial)
TIA = Transient ischemic attack

1. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in AdultsNeil J. Stone, Jennifer Robinson, Alice H. Lichtenstein, C. Noel Bairey Merz, Conrad B. Blum, Robert H. Eckel, Anne C. Goldberg, David Gordon, Daniel Levy, Donald M. Lloyd-Jones, Patrick McBride, J. Sanford Schwartz, Susan T. Shero, Sidney C. Smith, Karol Watson and Peter W.F. WilsonCirculation. 2013;01. cir.0000437738.63853.7a, published online before print November 12, 2013

Adapted from Columbia Medical Center

Helping Patients Make Better Treatment Choices with Decision Aids

What is a decision aid?

A decision aid is a tool used to inform patients about available treatments, along with potential benefits, risks and costs, during clinical encounters. Decision aids use a shared, informed approach to clinical decision-making. Potential outcomes of decision aids include increased patient knowledge of available treatments, greater patient participation in decision-making and improved patient health status and quality of life.[1]

Identifying and making a decision about the best health treatment or screening option can be difficult for patients.

- Decision aids can be used when there is more than one reasonable option, when no option has a clear advantage in terms of health outcomes and when each option has benefits and harms that patients may value differently.
- Decision aids make decisions explicit, describe options available, and help people understand options – as well as possible benefits and harms.
- Decision aids help patients consider options from a personal viewpoint (e.g., how important are possible benefits and harms) and help them participate in decision-making along with their health care practitioner.

Statin Decision Aid

Compared with usual care, patients using the statin decision aid were 22 times more likely to have an accurate sense of their baseline risk and risk reduction with statins.[2]

An example of a statin decision aid created by the Mayo Clinic is provided in the link below and in this toolkit. The goal of the tool is to help patients and providers have meaningful conversations about whether to use statins to reduce cardiovascular risk.

Resources for Cholesterol Management Decision Aids

Mayo Clinic electronic interactive tool:
statindecisionaid.mayoclinic.org

As an example of a decision aid, the Mayo Clinic tool shown in this toolkit can be downloaded at:
shareddecisions.mayoclinic.org

A video demonstration of the decision aid in practice can be viewed at:
youtube.com/embed/xlmUvAcb-sM

1. Mayo Clinic Center for Innovation. Mayo Foundation for Medical Education and Research [Internet]. Decision Aids. 2016 [cited 2017 Feb 3]. Available from: http://centerforinnovation.mayo.edu/decision-aids

2. Weymiller AJ et al. Helping patients with type 2 diabetes mellitus make treatment decisions: statin choice randomized trial. Arch Intern Med. 2007; 167 (10): 1076-82.

Decision Aid Sample[1]

SHOULD I TAKE STATINS?

A decision making tool

Average Risk (<15%)

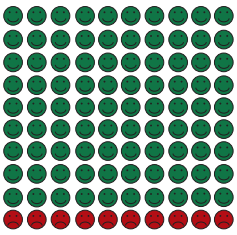
1 What is my risk of having a heart attack in the next 10 years?

NO STATIN

90 people **DO NOT** have a heart attack (green)

10 people **DO** have a heart attack (red)

The risk for 100 people like you who **DO NOT** take statins.



YES STATIN

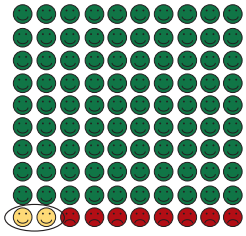
90 people still **DO NOT** have a heart attack (green)

2 people **AVOIDED** a heart attack (yellow)

8 people still **DO** have a heart attack (red)

98 people experienced **NO BENEFIT** from taking statins

The risk for 100 people like you who **DO** take statins.



had a heart attack

avoided a heart attack

didn't have a heart attack

2 What are the downsides of taking statins (cholesterol pill)?

- Statins need to be ***taken every day*** for a long time (maybe forever).
- Statins cost money. (to you or your drug plan)
- **Common side effects:** nausea, diarrhea, constipation (most patients can tolerate)
- **Muscle aching/stiffness:** 5 in 100 patients (some need to stop statins because of this)
- **Liver blood test goes up** (no pain, no permanent liver damage): 2 in 100 patients (some need to stop statins because of this)
- **Muscle and kidney damage:** 1 in 20,000 patients (requires patients to stop statins)

3 What do you want to do now?

- ☐ Take (or continue to take) statins
- ☐ Not take (or stop taking) statins
- ☐ Prefer to decide at some other time

Resources

1. Mayo Clinic Shared Decision Making National Resource Center. Mayo Foundation for Education and Research [Internet]. Should I Take Statins? A decision making tool: Average Risk, <15%. 2010 [cited 2017 Feb 3]. Available from: http://shareddecisions.mayoclinic.org/files/2011/08/Statin_DA_avg21.pdf

Decision Aid Sample[1]

SHOULD I TAKE STATINS?

A decision making tool

Elevated Risk (15-30%)

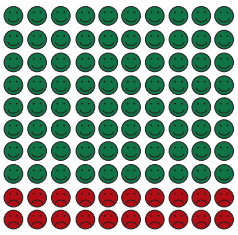
1 What is my risk of having a heart attack in the next 10 years?

NO STATIN

80 people **DO NOT** have a heart attack (green)

20 people **DO** have a heart attack (red)

The risk for 100 people like you who **DO NOT** take statins.



YES STATIN

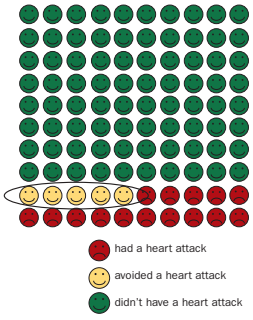
80 people still **DO NOT** have a heart attack (green)

5 people **AVOIDED** a heart attack (yellow)

15 people still **DO** have a heart attack (red)

95 people experienced **NO BENEFIT** from taking statins

The risk for 100 people like you who **DO** take statins.



had a heart attack

avoided a heart attack

didn't have a heart attack

2 What are the downsides of taking statins (cholesterol pill)?

- Statins need to be ***taken every day*** for a long time (maybe forever).
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1. Mayo Clinic Shared Decision Making National Resource Center. Mayo Foundation for Education and Research [Internet]. Should I Take Statins? A decision making tool: Elevated Risk, 15-30%. 2010 [cited 2017 Feb 3]. Available from: http://shareddecisions.mayoclinic.org/files/2011/08/Statin_DA_elevated2.pdf

Decision Aid Sample[1]

SHOULD I TAKE STATINS?

A decision making tool

High Risk (>30%)

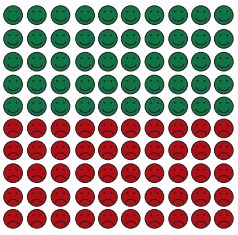
1 What is my risk of having a heart attack in the next 10 years?

NO STATIN

50 people **DO NOT** have a heart attack (green)

50 people **DO** have a heart attack (red)

The risk for 100 people like you who **DO NOT** take statins.



YES STATIN

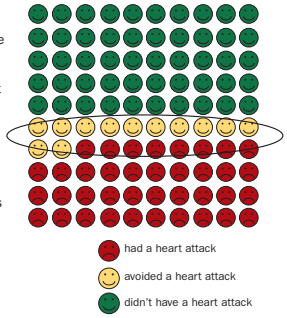
50 people still **DO NOT** have a heart attack (green)

12 people **AVOIDED** a heart attack (yellow)

38 people still **DO** have a heart attack (red)

88 people experienced **NO BENEFIT** from taking statins

The risk for 100 people like you who **DO** take statins.



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Resources

1. Mayo Clinic Shared Decision Making National Resource Center. Mayo Foundation for Education and Research [Internet]. Should I Take Statins? A decision making tool: High Risk, >30%. 2010 [cited 2017 Feb 3]. Available from: http://shareddecisions.mayoclinic.org/files/2011/08/Statin_DA_high2.pdf

S SMOKING CESSATION

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Tasks

Toolkit Reference Page	Tasks for the Practice Facilitator
Key Facts	☐ S1. Provide an overview of strategies to improve quit rates. • Discuss the 4R's of smoking cessation.
Appendix: Prevention and Care Dashboard	☐ S2. Solicit feedback to determine the practice's readiness for change. • Show current dashboard. • Ask the practice to discuss thoughts and concerns about working on this measure: "What are your thoughts on working to improve quit rates in your practice?"
Evaluate the Current System	☐ S3. Evaluate the current system. • Determine how the practice currently addresses tobacco cessation activities. Engage the practice in discussing and assessing the system currently in place to assist with smoking cessation: "Think about how the practice currently functions and identify small changes that can be made to integrate tobacco cessation activities. Briefly answer these questions...." • Use answers from this preliminary evaluation as a guide through the remaining tasks.
eCW Tobacco Use Documentation of Smoking Status **MDLand Tobacco Use Documentation of Smoking Status** **Examples of Ways to Assess Smoking Patterns**	☐ S4. Recognize the risks of missed opportunities. Ask, assess and document smoking status at every visit to avoid the risk of missing new smokers or relapsed smokers. • Determine how smoking status is currently documented and determine how the process may be improved. Is the practice using a smart form? • Key points to address: 1. To capture new and relapsed tobacco users, ask every patient at every visit about use. The practice should ask about use of all tobacco products, not just cigarettes. 2. Assess smoking patterns (i.e., How many cigarettes do you smoke each day? How soon after waking do you smoke your first cigarette?) to determine the level of intervention required. The Tobacco Patient Questionnaire featured in this toolkit may be useful and is available as part of the public health detailing action kit at nyc.gov. The smart form in the Electronic Health Record (EHR) may also prompt users to ask questions related to smoking patterns.
	☐ S5. Respond quickly to improve quit rates by optimizing use of the EHR. • Clinical Decision Supports (CDS) alerts: Ensure the CDS alert is working – and advocate for its use. • Quality reports: Train and assist the practice in setting up quality reports (i.e., Enterprise Business Optimizer [EBO] reports for eCW). • Quality reports: Train and assist the practice in incorporating the use of quality reports into office workflow.
Smoking Cessation Treatment Guide **Smoking Cessation Medication Prescribing Chart** **Nicotine Replacement Therapy (NRT) and Non-NRT Medication Crosswalk**	☐ S6. Respond quickly to improve quit rates by adopting a protocol. • Discuss with the practice the Smoking Cessation Treatment Guide featured in this toolkit or download the Tobacco Treatment Guide available as part of the public health detailing action kit at nyc.gov. • Point out key steps of the guide (counsel, prescribe when applicable and follow up). Determine how these key steps may be incorporated into the current practice workflow.

How to Order More Provider and Patient Materials **eCW Documenting Tobacco Cessation Counseling** **MDLand Tobacco Use Intervention** **New York State Tobacco Cessation Counseling information and Billing Codes**	1. Assist by providing counseling and prescribing medication, if applicable. All patients who use tobacco should receive counseling but only some will require a prescription. Best practice is to assess smoking patterns to determine the level of intervention required. Counseling guides are available as part of the public health detailing action kit at **nyc.gov**. The Smoking Cessation Medication Prescribing Chart is featured in this toolkit and is also available in the public health detailing action kit at **nyc.gov**. Coverage of prescriptions is addressed in the nicotine replacement therapy (NRT) and non-NRT Medication Crosswalk. 2. Provide follow-up care, which may also be done remotely. Best practice is to provide supportive counseling within 48 hours of the patient's quit date – and again six weeks later. Teach the practice to schedule phone encounters to monitor patient progress. The New York State Smokers' Quitline is an additional source of support (see task S7 below for more details). 3. Ensure that proper documentation is taking place. Is the practice documenting over-the-counter NRT? Are they using the correct codes? The New York State Tobacco Cessation Counseling Information and Billing Codes document is featured in this toolkit and is also available as part of the public health detailing action kit at **nyc.gov**.
New York State Smokers' Quitline **Fax-to-Quit Directly from eCW** **How to Get a Free Nicotine Replacement Therapy Starter Kit Online**	☐ S7. Reinforce control by referring patients to the New York State Smokers' Quitline or other smoking cessation programs in New York City. • Provide a brief description of the New York State Smokers' Quitline. • Teach the practice how to refer patients to the Quitline and determine who in the practice is responsible for doing so. If a patient is getting NRT from the Quitline, the provider still needs to issue a prescription since the Quitline only provides a two-week supply. Note: Use of NRT should always be documented in the EHR. - If using the EHR, ensure it is set up with referral forms and that it works. - If using the fax line, ensure the fax is set up and that it works. Give the practice referral forms. - If requesting free NRT online, add the New York State Smokers' Quitline site as a browser "favorite." • Additional New York City smoking cessation programs are listed in the Still Smoking? brochure, available as part of the public health detailing action kit at **nyc.gov**.
How to Order More Provider and Patient Materials	☐ S8. Reinforce control by providing patient education. • Determine how patient education will be handed out and show the practice materials that are available. Patient education is available as part of the public health detailing action kit at **nyc.gov** or by calling 311.
Appendix: How Community Pharmacists Can Help with the Common Reasons for Non-Adherence **Appendix: About the Big Apple Rx Card** **Appendix: MTM Fact Sheet and FAQ** **Appendix: MTM Patient Brochure**	☐ S9. Reinforce control by recommending and referring to community pharmacists to improve mediation adherence. • Highlight services offered by community pharmacists.
Key Facts **Appendix: Prevention and Care Dashboard – Hub Quality Measures Checklist**	☐ S10. Review quality data. Have all care team members routinely review quality data and provide feedback.

Key Facts

BACKGROUND

- Tobacco use kills an estimated 12,000 New Yorkers each year – and many more suffer from tobacco-related illnesses.[1]
- Most smokers want to quit, and more than two-thirds try to quit each year.[2]
- With proper counseling and appropriate use of nicotine replacement and other pharmacotherapies including combination regimens, long-term quit rates rise as high as 20 to 30 percent.[3]
- There are numerous ways to develop a culture that promotes tobacco cessation. It is important to get the entire practice involved to make sure every patient who uses tobacco is identified, advised to quit and offered evidence-based treatments.

QUALITY MEASURES DEFINITION

	Measure	Description
Smoking Cessation	Tobacco use screening	Percent of patients 18 years of age and older who had smoking status updated in the last two years
	Tobacco use counseling	Percent of patients 18 years of age and older identified as current smokers who received cessation intervention or counseling

Use the 4 R's to Improve Rates of Smoking Cessation

Recognize risks: Ask, assess and document smoking status at every visit to avoid the risk of missing new smokers or relapsed smokers.

Respond quickly: Develop a treatment plan that includes counseling and pharmacotherapy (including combination regimens) and follow up to ensure routine assessment of patient progress.

Reinforce control: Further encourage quit attempt by providing patient education materials and referring to the New York State Smokers' Quitline.

Review quality data: Evaluate rate of smoking status screening and smoking intervention to help determine quality of care and impact of care.

Resources

1. Levy DT, Bauer JE, Lee HR. Simulation modeling and tobacco control: creating more robust public health policies. Am J Public Health 2006;96:494–8.
2. Epiquery: NYC Interactive Health Data System. Community Health Survey 2013 [Internet]. New York: New York City Department of Health and Mental Hygiene. [cited 2017 Feb 13]. Available from: http://nyc.gov/health/epiquery.
3. Quit rates from counseling/NRT come from this source: Tobacco Use and Dependence Guideline Panel. Treating tobacco use and dependence: 2008 update. Rockville (MD): US Department of Health and Human Services; 2008 May. Chapter 6, Evidence and Recommendations. [cited 2017 Feb 13]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK63943/.

Evaluate the Current System

This section will help the practice think about how it currently functions and identify small changes that can be made to integrate tobacco cessation activities.

Assess the Practice Environment and Systems

The practice can demonstrate a commitment to tobacco cessation and facilitate patient-centered conversations with a physical environment that supports tobacco cessation efforts.

Conduct a brief, informal assessment of the practice by answering the following questions:

1. How does the practice currently identify and document tobacco use by patients? Whose responsibility is this?

2. When asking patients about smoking status, how often does the practice inquire about other forms of tobacco products other than cigarettes, such as chewing tobacco?

3. How does the practice environment currently communicate to patients the importance of quitting and its ability to assist them? Select all that apply:
   - ☐ Signs at entrance stating that the practice is tobacco free
   - ☐ Posters in waiting rooms
   - ☐ Posters in exam rooms
   - ☐ Self-help materials in waiting rooms
   - ☐ Self-help materials in exam rooms
   - ☐ Other _____

4. How does the practice currently help patients quit smoking? Select all that apply:
   - ☐ Distribute educational materials
   - ☐ Refer patients to the New York State Smokers' Quitline
   - ☐ Refer patients to outside support groups or counseling options
   - ☐ Conduct tobacco cessation group visits
   - ☐ Prescribe medications at visits
   - ☐ Provide follow-up for patients making a quit attempt

5. What systems does the practice have in place to make sure tobacco use is addressed at patient visits? Select all that apply:
   - ☐ Prompts in the Electronic Health Record (EHR)
   - ☐ Tobacco use status as a part of vital signs
   - ☐ Patient lists/registry of patients who use tobacco
   - ☐ Feedback to clinicians on adherence to guidelines
   - ☐ Regular staff training
   - ☐ Other _____

6. What are some challenges the practice faces in identifying patients who smoke/use tobacco and helping them quit?

7. What has worked in terms of helping patients quit and providing counseling and resources?

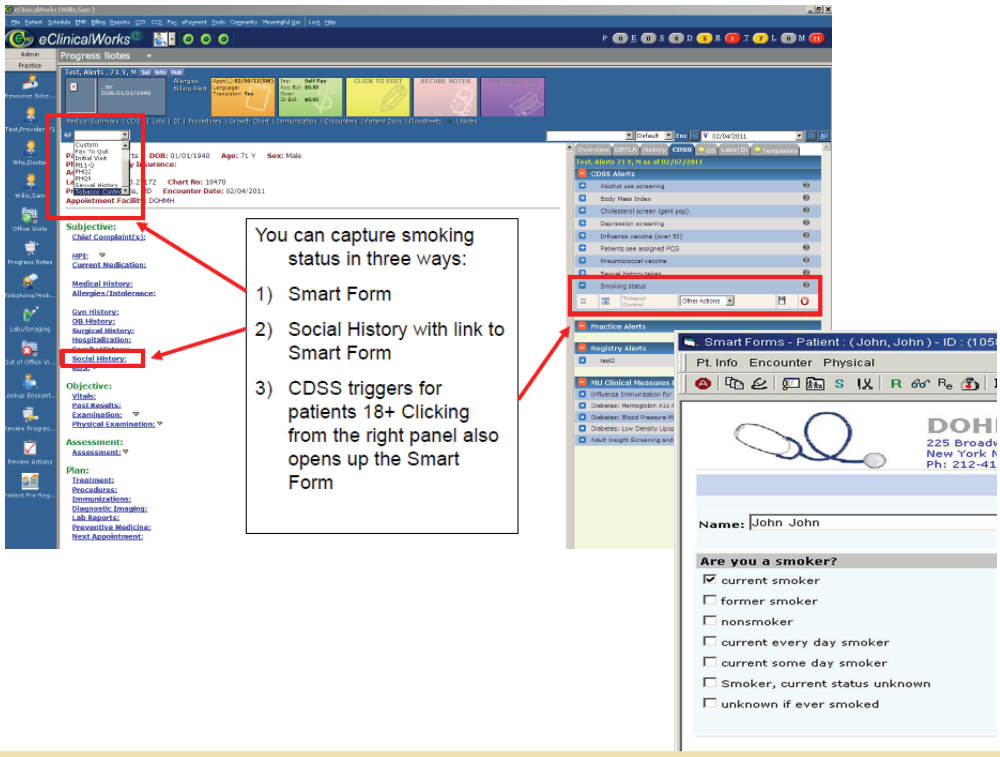
8. How successful has the practice been with billing for tobacco cessation interventions?

9. When prescribing over-the-counter nicotine replacement therapy (NRT), how often is it documented?

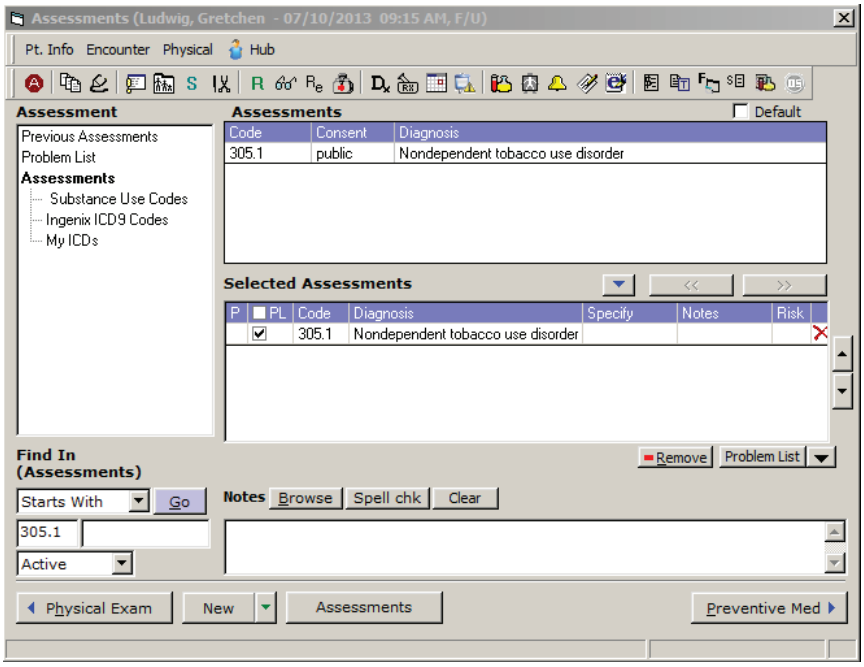
10. What resources are available in the community that patients could access to help with their quit attempts?

Adapted from the American Academy of Family Physicians' Treating Tobacco Dependence Practice Manual

eCW Tobacco Use Documentation

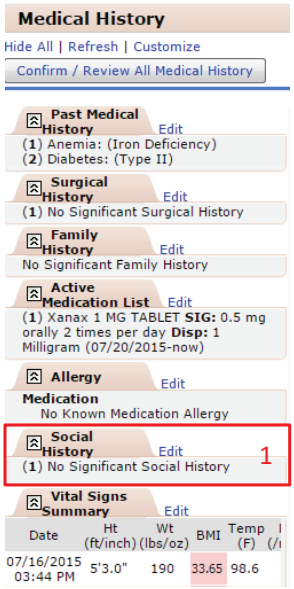


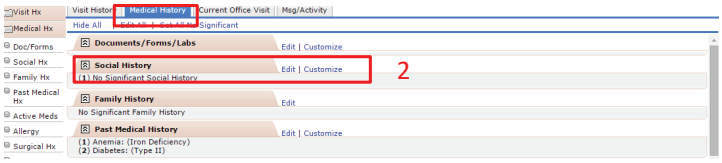
Under the assessment, add Tobacco Use Disorder

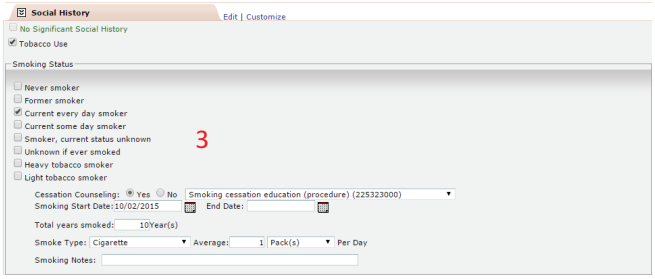


MDLand Tobacco Use Documentation

You can document a social history of smoking via the Social History Tab in the right-hand Medical History Panel of the patients current office visit, or via the Medical History Tab in the patients chart.



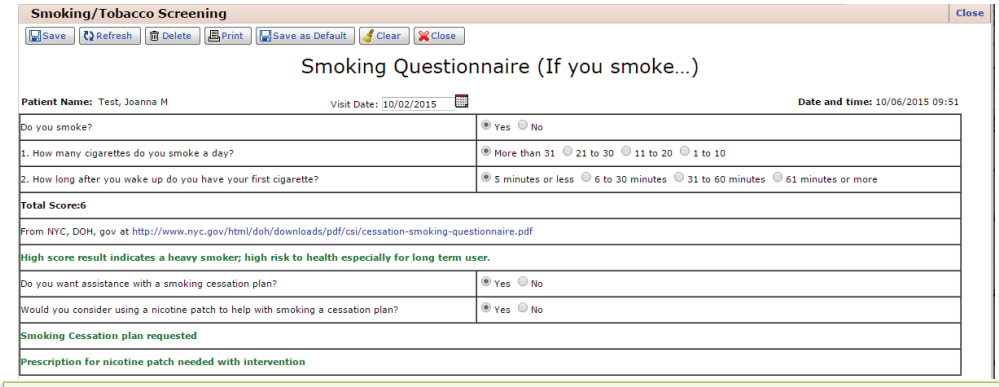




STEP BY STEP

1. Select the Social History Tab
2. Click Edit
    1. This will bring you to the Medical History Tab of the Patients Chart
3. This will allow you to fill out a Social History Form with Tobacco use information

You may also use the Risk Screening/Plan/Intervention section during the patient's current office visit. From there you may document a Smoking/Tobacco Screening score, as well as an Intervention/Plan



STEP BY STEP

1. Select the Social History Tab
2. Choose Smoking/Tobacco Questionnaire
3. You may see the patient's overall score in their chart. By clicking on the Questionnaire, you may also see if they have requested a Smoking Cessation plan, or a prescription for a nicotine patch.
    1. You may also print directly from this Questionnaire

Example of Ways to Assess Smoking Patterns

☐ Have patients fill out a form:

Do You Smoke?

If you do, fill this out and give it to your provider. It will help your provider better understand your health needs.

1. How many cigarettes do you smoke each day?

☐ 1 to 10 ☐ More than 10 ☐ I do not smoke every day

2. How soon after waking do you smoke your frst cigar ette?

☐ 30 minutes or less after waking
☐ More than 30 minutes after waking
☐ I do not smoke every day

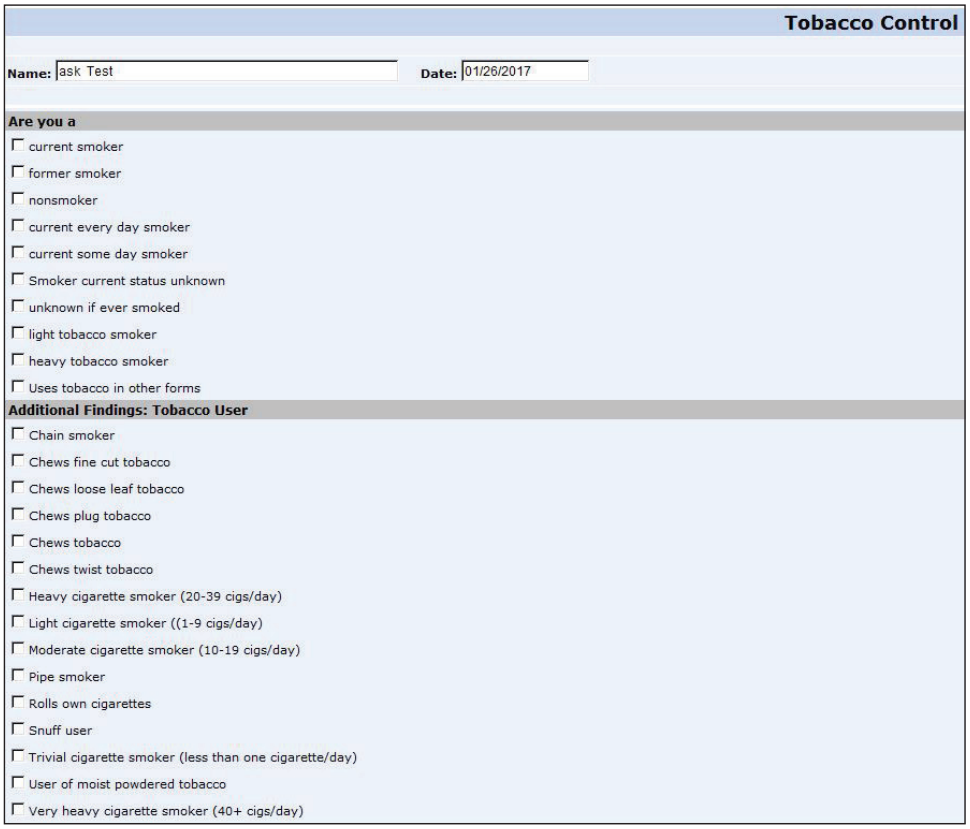
Note to Providers: Use the Tobacco Treatment Guide for prescribing recommendations.

Adapted from Heatherton TF; Kozlowski LT; Frecker RC; Rickert W; Robinson J. Measuring the Heaviness of Smoking: Using self-reported time to the first cigarette of the day and number of cigarettes smoked per day. *Br J Addict* 1989;84(7):791-799.

NYC He

▼ Español al reverso

☐ Complete a Smart Form in the EHR:



Tobacco Control

Name: ask Test **Date:** 01/26/2017

Are you a

- ☐ current smoker
- ☐ former smoker
- ☐ nonsmoker
- ☐ current every day smoker
- ☐ current some day smoker
- ☐ Smoker current status unknown
- ☐ unknown if ever smoked
- ☐ light tobacco smoker
- ☐ heavy tobacco smoker
- ☐ Uses tobacco in other forms

Additional Findings: Tobacco User

- ☐ Chain smoker
- ☐ Chews fine cut tobacco
- ☐ Chews loose leaf tobacco
- ☐ Chews plug tobacco
- ☐ Chews tobacco
- ☐ Chews twist tobacco
- ☐ Heavy cigarette smoker (20-39 cigs/day)
- ☐ Light cigarette smoker ((1-9 cigs/day)
- ☐ Moderate cigarette smoker (10-19 cigs/day)
- ☐ Pipe smoker
- ☐ Rolls own cigarettes
- ☐ Snuff user
- ☐ Trivial cigarette smoker (less than one cigarette/day)
- ☐ User of moist powdered tobacco
- ☐ Very heavy cigarette smoker (40+ cigs/day)

SMOKING CESSATION TREATMENT GUIDE

1 ASK

Ask every patient at every visit, "Do you smoke?" and assess smoking pattern.
Avoid asking if a person is a "smoker" as some light and non-daily smokers may not self-identify as "smokers."

Sample questionnaire to determine smoking pattern.

1. How many cigarettes do you smoke each day?
   ☐ 1 to 10 ☐ More than 10 ☐ I do not smoke everyday
2. How soon after waking do you smoke your first cigarette?
   ☐ 30 minutes or less after waking
   ☐ More than 30 minutes after waking
   ☐ I do not smoke everyday

- **Who will assess smoking status at the beginning of each visit (for example, front desk, medical assistant, nurse or provider)?**
- **Who will document smoking status in the patient record?**

2 ASSIST

Based on smoking pattern, counsel and discuss importance of quitting with *all* smokers, including non-daily. Prescribe medication to daily smokers *only*.*

For daily smokers, **choose only one** of these sample regimens.**
Reassess at six weeks:

1 to 10 cigarettes/day:

☐ 2 or 4 mg*** of short-acting NRT such as nicotine gum or lozenge based on time to first cigarette
☐ 14 mg nicotine patch

More than 10 cigarettes/day:

☐ 21 mg nicotine patch *AND* 2 or 4 mg*** of short-acting NRT such as nicotine gum or lozenge based on time to first cigarette
☐ Bupropion SR (150 mg) with or without 2 or 4 mg*** of short-acting NRT such as nicotine gum or lozenge based on time to first cigarette
☐ Varenicline only

- **Who will counsel and discuss the importance of quitting (for example, medical assistant, nurse or provider)?**
- **Who will provide patient education materials?**
- **Who will document the treatment plan in the patient chart?**

3 FOLLOW UP

Within 48 hours of the patient's quit date, provide supportive counseling.

- Ask, and make note of, patient's preferred communication method (phone, email, etc.).
- Ask about withdrawal symptoms.
- Ask how the medication is working.
- Ask if there were any problems filling the prescription.
- Provide encouragement and support.
- Refer the patient to the New York State Quitline (1-866-NY-QUITS) for additional counseling and support between visits free-of-charge.

Six weeks after the quit date, assess progress.

- Assess medication use and effectiveness.
- Modify prescription as needed.
- Provide additional supportive counseling.
- Schedule additional follow-up as needed.

- **Who will follow up on the quit attempt within 48 hours? Who will follow up six weeks later?**
- **Who will provide supportive counseling?**
- **Who will document in the patient record?**
- **Who will schedule the six-week and subsequent follow up visits?**

The treatment guide presented here is designed to provide general guidance and assist clinical decision making. It is not intended as a substitute for the clinical judgment of a qualified health care provider.

* If uninsured: 1) The New York State Quitline offers a free two-week NRT starter kit for eligible patients, 2) Big Apple Rx offers discounts on both Rx and OTC cessation aids with a prescription.

** Visit nyc.gov and search "Tobacco Quit Kit" to see the Smoking Cessation Medication Prescribing Chart for specific instructions on dosing, duration, precautions and contraindications, including those for pregnant women.

*** Choose 2 mg nicotine gum or lozenge if patient smokes first cigarette more than 30 minutes after waking; choose 4 mg nicotine gum or lozenge if patient smokes first cigarette 30 minutes or less after waking.

Smoking Cessation Medication Prescribing Chart

(See reverse for instructions and FAQs)

When a person stops smoking, you may need to adjust dosage of medications that interact with tobacco smoke. Visit www.nysmokefree.com/CME for further guidance.

Medication*	Suggested Regimen	Precautions	Contraindications	Potential Adverse Effects
Nicotine Replacement Therapy (NRT)				
Patch† Long acting NRT	≤10 cig/d, start with 14 mg/qd x 6 weeks, followed by 7 mg/qd x 2 weeks >10 cig/d, start with 21 mg/qd x 6 weeks, followed by 14 mg/qd x 2 weeks, followed by 7 mg/qd x 2 weeks	■ Pregnancy Class D‡ ■ Uncontrolled hypertension ■ TMJ disease, dental work, dentures (gum) ■ Skin disorders (patch) ■ MRI (patch) ■ Allergy to adhesive tape (patch) ■ Stomach ulcer (gum, lozenge, nasal spray, inhaler) ■ Sodium-restricted diet (gum, lozenge, nasal spray) ■ Reactive airway disease (inhaler, nasal spray) ■ Sinusitis, rhinitis (nasal spray) ■ Advise starting with the highest-dose patch available except for patients weighing less than 100 lbs	■ Heart attack within 2 weeks ■ Serious cardiac arrhythmia ■ Unstable angina	■ Symptoms of too much nicotine, like nausea, headache, dizziness, fast heartbeat ■ Jaw pain, dry mouth (gum) ■ Hiccups, heartburn (gum, lozenge) ■ Skin irritation, insomnia (patch) ■ Mouth and throat irritation (inhaler) ■ Bronchospasm (nasal spray, inhaler) ■ Nasal irritation, tearing, sneezing (nasal spray)
Gum† Short acting NRT	1st cig >30 mins after awakening, 2 mg/hr 1st cig ≤30 mins after awakening, 4 mg/hr (both up to 24 pcs/day)			
Lozenge† Short acting NRT	1st cig >30 mins after awakening, 2 mg/hr 1st cig ≤30 mins after awakening, 4 mg/hr (both up to 20 pcs/day)			
Nasal spray Short acting NRT	1–2 sprays/hr, as needed (max 40/d up to 3 mos)			
Inhaler Short acting NRT	Frequent continuous puffing for up to 20 mins at a time every hour, as needed (6 –16 cartridges/d up to 6 months)			
The nicotine patch can be combined with a short acting NRT.				
Bupropion SR (Zyban®, Wellbutrin®)	Days 1–3: 150 mg po qd Day 4 to 7–12 weeks (or end of treatment): 150 mg po bid Can be maintained up to 6 months (24 weeks) ***Can be combined with NRT***	■ Pregnancy Class C‡ ■ Uncontrolled hypertension ■ Severe cirrhosis – dose adjustment required ■ Mild-mod hepatic & mod-severe renal impairment – consider dose adjustment	■ MAO inhibitor in past 14 days ■ Seizure disorder, bulimia/anorexia ■ Abrupt discontinuation of ethanol or sedatives	■ Insomnia, dry mouth, headaches, pruritis, pharyngitis, tachycardia, seizures, neuropsychiatric effects and suicide risk **Boxed warning:** Monitor for mood and behavior changes
Varenicline (Chantix®)	**Starting month pack:** (start 1 week before quit date‖) 0.5 mg po qd x 3 days; THEN 0.5 mg po bid x 4 days; THEN 1 mg po bid x 3 weeks **Continuing month pack:** Week 5 to 12 (or end of treatment): 1 mg po bid Can be maintained up to 6 months (24 weeks) ***CANNOT be combined with NRT***	■ Pregnancy Class C‡ ■ Seizure disorder ■ CrCl <30 or dialysis – dose adjustment required ■ May increase risk of CV events in patients with CVD ■ Operate heavy machinery ■ May lower alcohol tolerance	■ Known history of serious hypersensitivity or skin reactions to varenicline	■ Nausea, insomnia, abnormal dreams, constipation, neuropsychiatric effects, seizures, suicide risk and cardiovascular events **Boxed warning:** Monitor for mood and behavior changes

*Consult the plan administrator or formulary to see the current medications covered – a list of all Medicaid Managed Care formularies can be found on **pbic.nysdoh.suny.edu**. New York State Medicaid Fee for Service covers all medications. Uninsured patients or those with gaps in coverage may want to consider New York City's official prescription discount card, BigAppleRx, which provides savings even on OTC medications (with a prescription).

† In 2013, the FDA did not identify any safety risks associated with longer-term use of OTC NRT products. Tailor to patient's needs if longer duration is necessary. Modifications to Labeling of NRT Products for OTC Human Use, 78 Fed. Reg 19718 (proposed 4/13/2013).

‡ May consider if counseling alone is ineffective, the patient is highly motivated to quit, and the risk-benefit has been carefully assessed with patient.

‖ Alternative regimen for varenicline is to instruct patient to take 1mg bid then select target quit date between Days 8 and 35 of treatment.

NRT and Non-NRT Medication Crosswalk

FORM	Inhaler	Spray	Gum				Lozenge			
TYPE	Brand*	Brand*	Generic	Brand	Generic	Brand	Generic	Brand	Generic	Brand
NAME	Nicotrol	Nicotrol NS	Nicotine Polacrilex	Nicorette	Nicotine Polacrilex	Nicorette	Nicotine Polacrilex	Nicorette	Nicotine Polacrilex	Nicorette
STRENGTH	10 mg	10 mg/ml	2 mg	2 mg	4 mg	4 mg	2 mg	2 mg	4 mg	4 mg
Amida Care	Covered	Covered	Covered	Covered	Covered	Covered	Covered	NC	Covered	NC
Amerigroup	NC	NC	Covered	NC	Covered	NC	Covered	NC	Covered	NC
Affinity Health Plan	NC	NC	Covered	NC	Covered	NC	NC	NC	NC	NC
Capital District Physicians' Health Plan	NC	NC	Covered	NC	Covered	NC	Covered	NC	Covered	NC
Excellus/Univera	Covered	Covered	Covered	NC	Covered	NC	Covered	NC	Covered	NC
Fidelis Care	NC	NC	Covered	NC	Covered	NC	Covered	NC	Covered	NC
Healthfirst	Covered	Covered	Covered	NC	Covered	Covered	Covered	Covered	Covered	Covered
Hudson Health Plan	NC	NC	Covered	Covered	Covered	Covered	NC	Covered	NC	Covered
HIP/Emblem Health	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Health Now, Inc/BCBS of Western NY	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Independent Health Plan	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
MetroPlus Health Plan	NC	NC	Covered	NC	Covered	NC	NC	NC	NC	NC
MVP Health Care	NC	NC	Covered	Covered	Covered	Covered	NC	Covered	NC	Covered
Total Care	Covered	Covered	Covered	NC	Covered	NC	NC	NC	NC	NC
United Healthcare	Covered	Covered	Covered	NC	Covered	NC	Covered	NC	Covered	NC
VNSNY Choice Health Plans	NC	NC	Covered	Covered	Covered	Covered	NC	NC	NC	NC
WellCare Health Plans, Inc	NC	NC	Covered	NC	Covered	NC	NC	NC	NC	NC

KEY: *No generic available

NC: Not Covered

Disclaimer: Coverage information comes from http://pbic.nysdoh.suny.edu/. The New York State Department of Health (NYSDOH) obtains drug formulary information from Medicaid participating managed care plans on a quarterly basis. Please note NYSDOH publishes the drug formulary information as it is received. This information was last updated on July 28, 2015. As a best practice, always contact or visit each managed care plan's website to obtain the most current information regarding drug coverage.

NRT and Non-NRT Medication Crosswalk

FORM	Patch						Non-NRT Medication (Tablet)			
TYPE	Generic	Brand	Generic	Brand	Generic	Brand	Brand*	Brand*	Generic	Brand
NAME	Nicotine	Nicoderm CQ	Nicotine	Nicoderm CQ	Nicotine	Nicoderm CQ	Chantix	Chantix	Bupropion HCl ER (SR)	Zyban
STRENGTH	7 mg/24 h	7 mg/24 h	14 mg/24 h	14 mg/24 h	21 mg/24 h	21 mg/24 h	0.5 mg	1 mg	150 mg	150 mg
Amida Care	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Amerigroup	Covered	NC	Covered	NC	Covered	NC	NC	NC	Covered	NC
Affinity Health Plan	NC	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Capital District Physicians' Health Plan	NC	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Excellus/Univera	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Fidelis Care	NC	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Healthfirst	NC	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Hudson Health Plan	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
HIP/Emblem Health	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Health Now, Inc/BCBS of Western NY	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Independent Health Plan	NC	NC	NC	NC	NC	NC	Covered	Covered	Covered	NC
MetroPlus Health Plan	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
MVP Health Care	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
Total Care	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC
United Healthcare	NC	NC	NC	NC	NC	NC	Covered	Covered	NC	NC
VNSNY Choice Health Plans	Covered	NC	Covered	NC	Covered	NC	NC	NC	Covered	Covered
WellCare Health Plans, Inc	Covered	NC	Covered	NC	Covered	NC	Covered	Covered	Covered	NC

KEY: *No generic available

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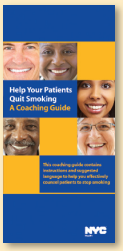
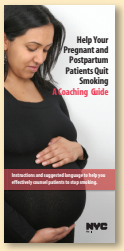
How to Order More Provider and Patient Materials

Call 866-692-3641

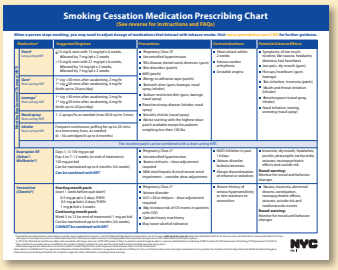
Provider Resources



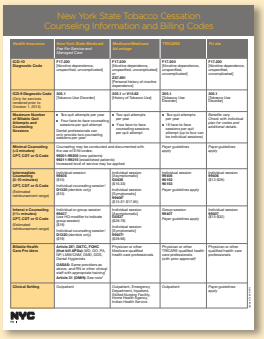


Help Your Patients Quit Smoking A Coaching Guide

Help Your Pregnant and Postpartum Patients Quit Smoking A Coaching Guide

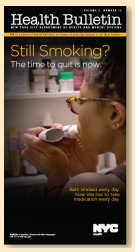


Smoking Cessation Medication Prescribing Chart



New York State Smoking Cessation Counseling Information and Billing Codes

Patient Education



Health Bulletins

Still Smoking?

English, Spanish, Chinese, Russian, Korean

How to Make Your Home Smoke-Free

English, Spanish, Chinese, Russian, Korean

New York State Medicaid Smoking Cessation Beneft Fact Car d

English, Spanish

Quit to Save Brochure

English, Spanish Chinese

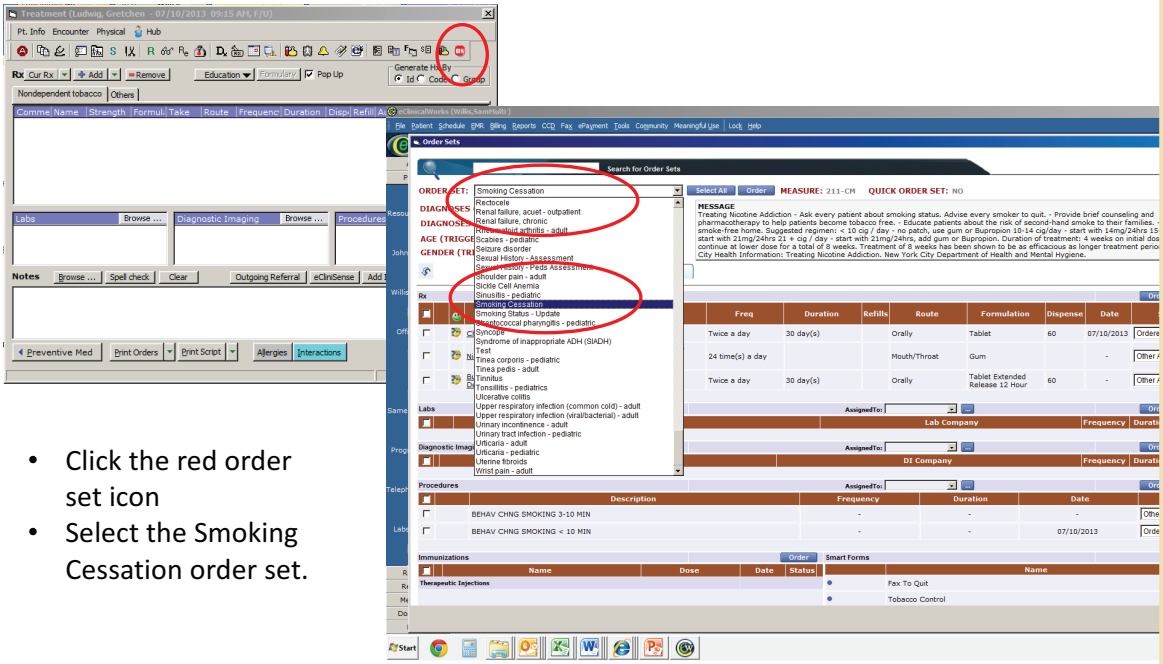
Big Apple Rx Prescription Discount Card

This free card provides discounts for prescription and over-the-counter (OTC) smoking cessation aids, like nicotine replacement therapy (NRT), as long as a patient has a prescription. To receive a shipment of BigAppleRx cards for your office, please contact the Customer Service Helpline at 877-348-2030.

Visit nyc.gov and search for "Tobacco Clinicians" to view these materials and additional resources.

For more information, email NYCTobacco@health.nyc.gov.

eCW Documenting Tobacco Cessation Counseling



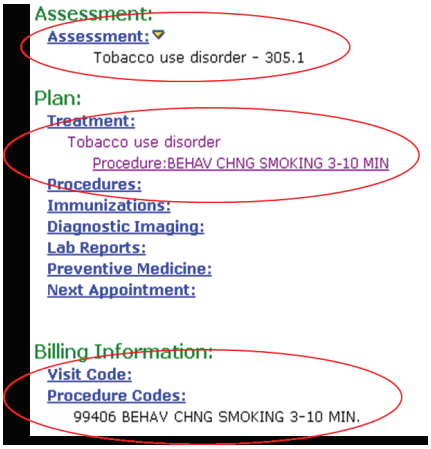
- Click the red order set icon
- Select the Smoking Cessation order set.

To provide smoking cessation counseling and medication intervention for current smokers, use the Smoking Cessation Intervention CDSS alert and Smoking Cessation order set.

- Select and open Smoking Cessation order set.
- Mandatory: Choose BEAHAV CHNG SMOKING 3-10 MIN or BEHAV CHNG SMOKING > 10 MIN, as appropriate
- Optional: Prescribe medications and/or send “Fax to Quit” form.

After closing the Smoking Cessation order set, make sure the Progress Note includes:

- Under the Assessment section, ICD-9 code i.e. Tobacco use disorder – 305.1 or ICD-10 code i.e. Nicotine dependence, unspecified, uncomplicated – F17.200
- Under the Treatment section, procedure for BEAHAV CHNG SMOKING 3-10 MIN or BEHAV CHNG SMOKING > 10 MIN, as appropriate
- Under the Procedure Codes section, either CPT code 99406 for BEAHAV CHNG SMOKING 3-10 MIN or CPT code 99407 for BEHAV CHNG SMOKING > 10 MIN

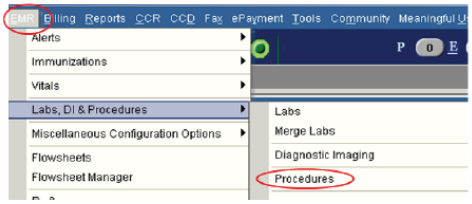


- Documentation (any of the following):
  - Current smoker: select current smoker" in Smart Form
  - Smoking Cessation Counseling procedure via Treatment screen (CPT codes 99406/99407)
    - Order Set
    - Procedure codes
    - Smoking cessation classes (HCPCS code S9453)

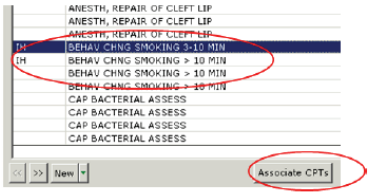
- Timing:
  - Medical visit based on CPT code during measurement year.
  - Cessation intervention documented at any visit during measurement year.

Note: Administrative codes are not available for all types of assessment or counseling that would be considered a positive finding for this numerator. Medical records should be used in conjunction with administrative codes to accurately calculate this numerator.

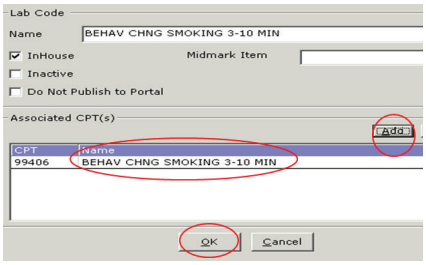
Adding Procedure Codes for Tobacco Use



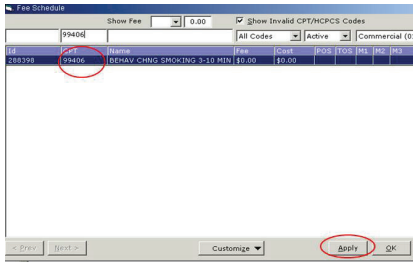
1. Under EMR menu, open Procedures.



2. Highlight BEHAV CHNG SMOKING 3-10 MIN, then click Associate CPTS.



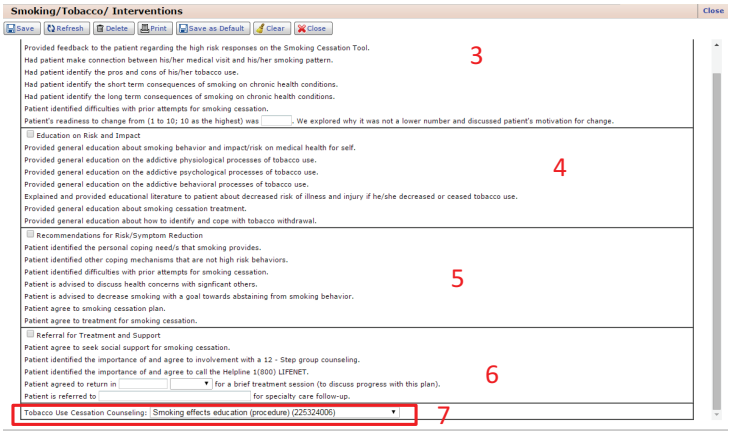
3. If 99406 BEHAV CHNG SMOKING 3-5 MIN is visible, click OK. If not click Add.



4. Type 99406 for BEHAV CHNG SMOKING 3-5 MIN. Highlight and Apply. CPT code will be attached to procedure.

MDLand Documenting Tobacco Cessation Counseling

You may also use the Risk Screening/Plan/Intervention section during the patient's current office visit. From there you may document a Smoking/Tobacco Screening score, as well as an Intervention/Plan

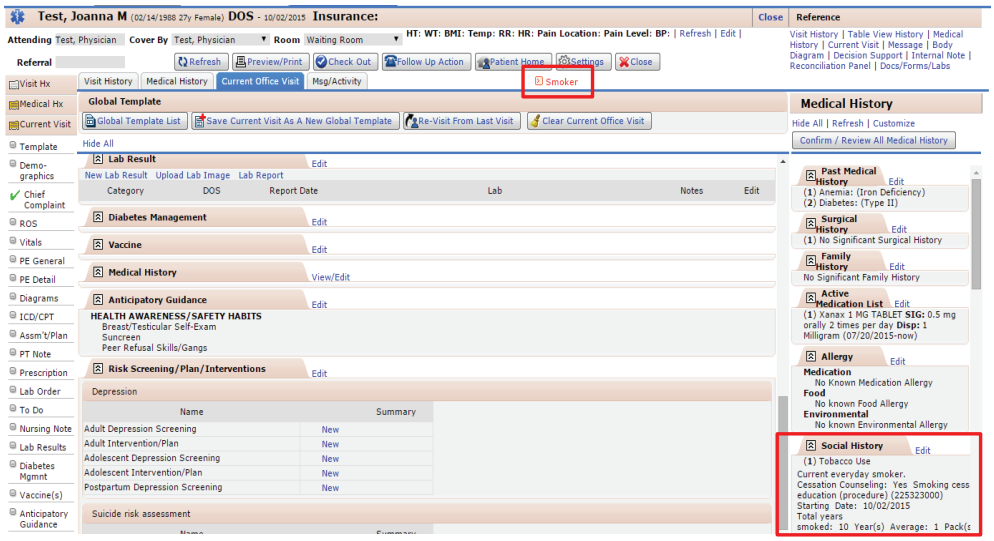


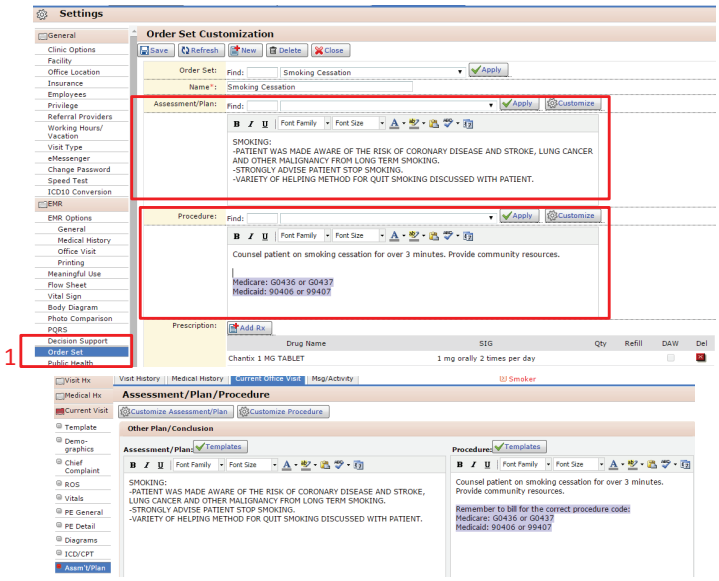
STEP BY STEP

1. Select the Social History Tab
2. Click on Smoking/Tobacco Intervention/Plan
3. Document if Screening Result Feedback was provided to the patient, based on earlier screening.
4. Document if patient was informed about risk and impact of smoking
5. Document if you recommended symptom reduction methods and risks to these methods
6. Document if you referred for treatment/support, and when the patient would like to return for a visit
7. Record the correct procedure code for counseling

TIPS:

When Smoking Status has been documented in the patient's chart, a red alert will populate, reminding the provider to counsel on smoking cessation. If you click on this red arrow, it directs you to the Social History section of the patient's chart.

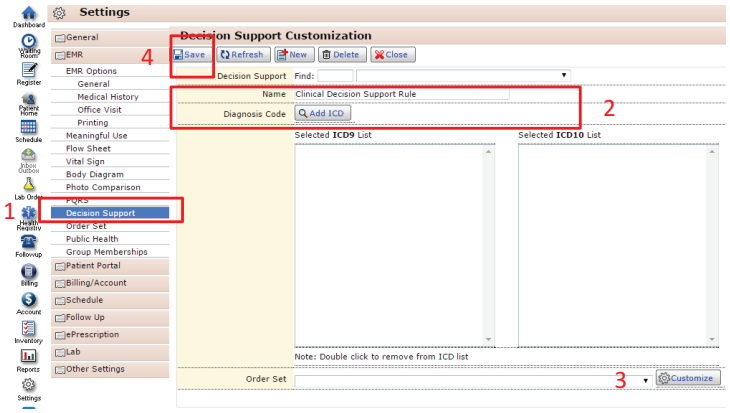


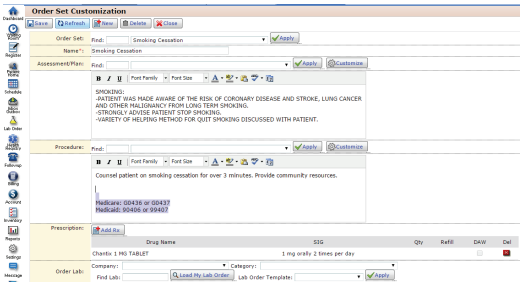


STEP BY STEP:

1. From Settings >> EMR >> Order Set, you can create a custom Order Set for documenting Smoking Counseling. A free text Assessment/Plan allows you to document what is typically discussed, and the Procedure section allows you to remind the doctor which CPT code to use.
2. You may also add in any relevant prescriptions for patients that smoke
3. You can select this template in the Assessment/Plan section of the patient's current office visit

Triggering Tobacco Use Order Set Via ICD Code





STEP BY STEP

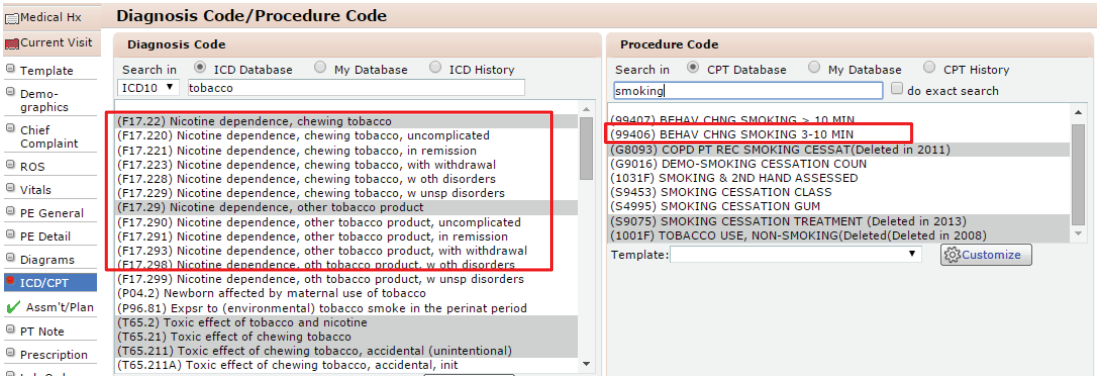
1. Go to Settings >> EHR >> Decision Support
2. Name the CDSS Rule, and add in a diagnosis that will trigger the alert
3. Associate a customized order set with the rule by selecting your Smoking Cessation Order Set

4. Remember to Save your rule

5. The provider will receive a pop-up alert at the patient's next office visit, where they can apply the customized order set

4

Adding Procedure Code for Tobacco Use



STEP BY STEP:

1. Under ICD/CPT, document the patient's diagnosis as well as associated procedure related to tobacco use counseling

New York State Tobacco Cessation Counseling Information and Billing Codes

Health Insurance	New York State **Medicaid** *Fee For Service and Managed Care*	Medicare/ **Medicare Ad antage**	TRICARE	Pri ate
ICD-10 Diagnostic Code	**F17.200** [Nicotine dependence, unspecified, uncomplicated]	**F17.200** [Nicotine dependence, unspecified, uncomplicated] or **Z87.891** [Personal history of Nicotine dependence]	**F17.200** [Nicotine dependence, unspecified, uncomplicated]	**F17.200** [Nicotine dependence, unspecified, uncomplicated]
ICD-9 Diagnostic Code (Only for services rendered prior to October 1, 2015)	**305.1** [Tobacco Use Disorder]	**305.1** or **V15.82** [History of Tobacco Use]	**305.1** [Tobacco Use Disorder]	**305.1** [Tobacco Use Disorder]
Maximum Number of Billable Quit Attempts and Counseling Sessions	▪ Two quit attempts per year ▪ Four face-to-face counseling sessions per quit attempt Dental professionals can only provide two counseling sessions per year†	▪ Two quit attempts per year ▪ Four face-to-face counseling sessions per quit attempt	▪ Two quit attempts per year ▪ 18 face-to-face sessions per quit attempt (up to four can be individual sessions)	*Benefits vary. Check with individual plan for codes and additional details.*
Minimal Counseling (<3 minutes) **CPT, CDT or G Code**	Counseling may be conducted and documented with the use of E/M codes: **99201-99205** (new patients) **99211-99215** (established patients) Increased level of service may be applied.		*Payer guidelines apply*	*Payer guidelines apply*
Intermediate Counseling (3-10 minutes) **CPT, CDT or G Code** (Estimated reimbursement range)	Individual session **99406** ($10) Individual counseling session† **D1320** *(dentists only)* ($10)	Individual session [Asymptomatic] **G0436*** ($16.33) Individual session [Symptomatic] **99406**§ ($15.37-$17.95)	Individual session **99406** **96152** **96153** *Payer guidelines apply*	Individual session **99406** ($12-$29)
Intensi e Counseling (11+ minutes) **CPT, CDT or G Code** (Estimated reimbursement range)	Individual or group session **99407** (use HQ modifier to indicate group session) ($19) Individual counseling session† **D1320** *(dentists only)* ($19)	Individual session [Asymptomatic] **G0437*** ($29.78) Individual session [Symptomatic] **99407**§ ($29.96)	Group session **99407** *Payer guidelines apply*	Individual session **99407** ($15-$32)
Billable Health Care Pro iders	**Article 28**¶**, D&TC, FQHC (that bill APGs):** MD, DO, PA, NP, LMW/CNM, DMD, DDS, Dental Hygienists **OASAS:** Same providers as above, andRN or other clinical staff with appropriate training‡ **Article 31 (OMH):** See note*	Physician or other Medicare-qualified health care professionals	Physician or other TRICARE-qualified health care professionals (with prior approval)€	Physicians or other qualified health care professionals
Clinical Setting	Outpatient	Outpatient, Emergency Department, Inpatient, Skilled Nursing Facility, Home Health Agency, Indian Health Service	Outpatient	*Payer guidelines apply*

Updated: October 2015

NYC Health

* Effective September 30, 2016 codes G0436 and G0437 should not be used. Use existing CPT codes 99406 and 99407 for smoking and tobacco-use counseling visits.

Billing Reminders

✓ If different evaluation and management (E/M) services are conducted by the same health care provider on the same day, such as treatment in addition to counseling, the appropriate modifier (e.g., Modifier 25) must be added to the code for payment.

✓ Counseling conducted and documented with use of level 1 E/M code 99211 can be done by an approved health care professional (MD/DO, PA, NP, LMW/CNM) and does not require the practitioner.

✓ For some capitation plans, payment may be included with the capitation payment.

Billing Considerations

† Dental professionals: See May 2014 Medicaid Update for required documentation.

¶ In Article 28 facilities, smoking cessation counseling should only take place during a dental visit as an adjunct when providing a dental service and not billed as a stand-alone service.

‡ See page 7 of the NYS Office of Alcoholism and Substance Abuse Services (OASAS) Ambulatory Patient Groups (APG) Policy and Medicaid Billing Guidance Manual for details.

⁎ If cessation counseling is part of a psychotherapy session (group or individual), time spent can be counted toward the psychotherapy session but cannot be billed as an additional smoking cessation session. If not part of a psychotherapy session, cessation counseling is billable using the same codes and approved providers as Article 28 clinics.

§ Medicare and Medicaid allow other E/M services on the same day. Medicare requires that any other services be reported with Modifier 25 to indicate they are separately identifiable from the tobacco use service.

€ TRICARE beneficiaries can access TRICARE's smoking cessation resource line seven days a week for coaching services: 1-866-459-8766 (North - HealthNet Federal Services).

Sources

Medicaid: NYS Department of Health April 2011 Medicaid Update and May 2014 Medicaid Update; NYS Office of Mental Health Clinic FAQs; NYS OASAS APG Policy and Medicaid Billing Guidance Manual

Medicare: MLN Matters Number MM7133. Medicare Learning Network. December 2012

TRICAR : Smoking Cessation Counseling benefit page

Services available for uninsured patients:

NYC Smoking Cessation Programs provide supportive counseling and medication at little or no cost.

New York State Quitline provides individualized counseling and a free two-week starter kit of quit-smoking medications.

For more information or to access the hyperlinks in the electronic version of this file, visit **nyc.gov** and search **Tobacco Clinicians.**

New York State Smokers' Quitline

New York State Smokers' Quitline
1-866-NY-QUITS
(1-866-697-8487) www.nysmokefree.com
Deaf, Hard of Hearing & Speech Disabled:
Call NY Relay Service 7-1-1 (Voice or TTY)
Request NYS Quitline: 1-866-697-8487

FAX TO QUIT Program

The New York State Smokers' Quitline offers our *Fax to Quit* program to all health care providers to help their patients stop smoking. As a confidential service, we offer counseling and other cessation-related services to patients who use tobacco products.

How *Fax to Quit* Works:

- Health care providers can refer their tobacco-using patients to the New York State Smokers' Quitline using the *Fax to Quit* referral form.
- Patients will receive a follow-up call from a ***Quit-Coach*** who will provide a stop smoking or stop smokeless-tobacco counseling session.
- Patients will receive a Stop Smoking or Stop Smokeless Tobacco packet in the mail with information tailored to their specific situation and a listing of local stop smoking programs.
- A progress report (feedback form) with information about the patient's tobacco-use status will be
- faxed back to the health care provider from the ***Quit-Coach***.
- Patients can be referred to the New York State Smokers' Quitline as often as needed.
- Patients can call the New York State Smokers' Quitline as often as needed.
- There is no limit to the number of patients a health care provider may refer.

Services and Information provided by the New York State Smokers' Quitline:

- Telephone counseling to callers who wish to stop using tobacco or to learn more about the dangers
- of tobacco use.
- Posters and materials for health care providers and community organizations.
- A variety of literature on tobacco use and stop-smoking strategies.
- Quitsite at www.nysmokefree.com containing a variety of helpful stop-smoking advice and
- Internet resources.
- Statewide listing of local Stop-Smoking Programs.
- Statewide listing of local Tobacco Control Coalitions and contacts.
- Information and enforcement referrals for the New York State Expanded Clean Indoor Air Act of 2003.

New York State Smokers' Quitline 1 (866) – NY – QUITS (1 866 697 8487)

FAX REFERRAL FORM

FAX TO 1-866-QUIT-FAX

(1-866-784-8329)

PATIENT CONTACT INFORMATION			
Today's date:			
Patient's name:			
Date of birth:			
Telephone Number (include area code):	( ) _____ - _____		
Best time of day to call:	**Morning**: _____ *(9 am to Noon)*	**Afternoon**: _____ *(Between Noon & 5 pm)*	**Evening**: _____ *(Between 5 pm & 9 pm)*

HEALTH CARE PROVIDER CONTACT INFORMATION	
Health Care Provider Name	
Provider Fax Number (include area code)	( ) _____ - _____
Provider Telephone (include area code)	( ) _____ - _____

PATIENT QUESTIONS

About how many cigarettes do you smoke each day? _____

Do you plan to quit within the next 30 days? (Circle one) **YES** **NO**

If you have set a quit date, write it here: _____

Are you currently using any of these stop-smoking products? *(If yes, which ones, how many, and what dose do you use?)*

Patch	Nasal Spray	Inhaler	Lozenge	Gum
_____ mg	_____ sprays/day	_____ cartridges/day	_____ lozenges/day	_____ pieces/day
___ 16 hr ___24 hr			___2 mg ___4 mg	___2 mg ___4 mg

Bupropion: _____mg/day **Wellbutrin®:** _____mg/day **Zyban®:** _____mg/day

Do you have health insurance? **YES** **NO** **If yes, which carrier?** _____

If Medicaid, what is your Medicaid number? _____

PERMISSION

I (undersigned) give permission for the support staff of the New York State Smokers' Quitline to contact me, coach me in quitting smoking, and give feedback regarding my progress to the health care provider listed above, and permission for that provider to forward the information to other relevant health care providers.

Signature: _____ **Date:** ____/____/____

New York State Smokers' Quitline 1 – (866) – NY – QUITS (1-866-697-8487)

Fax to Quit FEEDBACK FORM

CONTACT ATTEMPTS BY NYS SMOKERS' QUITLINE

Patient's Name:		**Quitline Counselor:**			
1st Call Attempt:		**2nd Call Attempt:**		**Final Attempt:**	
Contact Made on:					
Your patient was contacted, provided assistance and advised regarding their stop-smoking process. Materials were mailed, including a listing of local stop-smoking programs.			**YES**		**NO**

PHARMACOTHERAPIES USED BY PATIENT (Circle all that apply.)

Nicotine Patch	Nicotine Gum	Nicotine Lozenge	Nicotine Inhaler	Nicotine Spray	Zyban/Wellbutrin/Bupropion SR
_____ mg	2 mg 4 mg	2 mg 4 mg	____ cartridges/day	____ sprays/day	_____ mg/day

STOP SMOKING STAGE

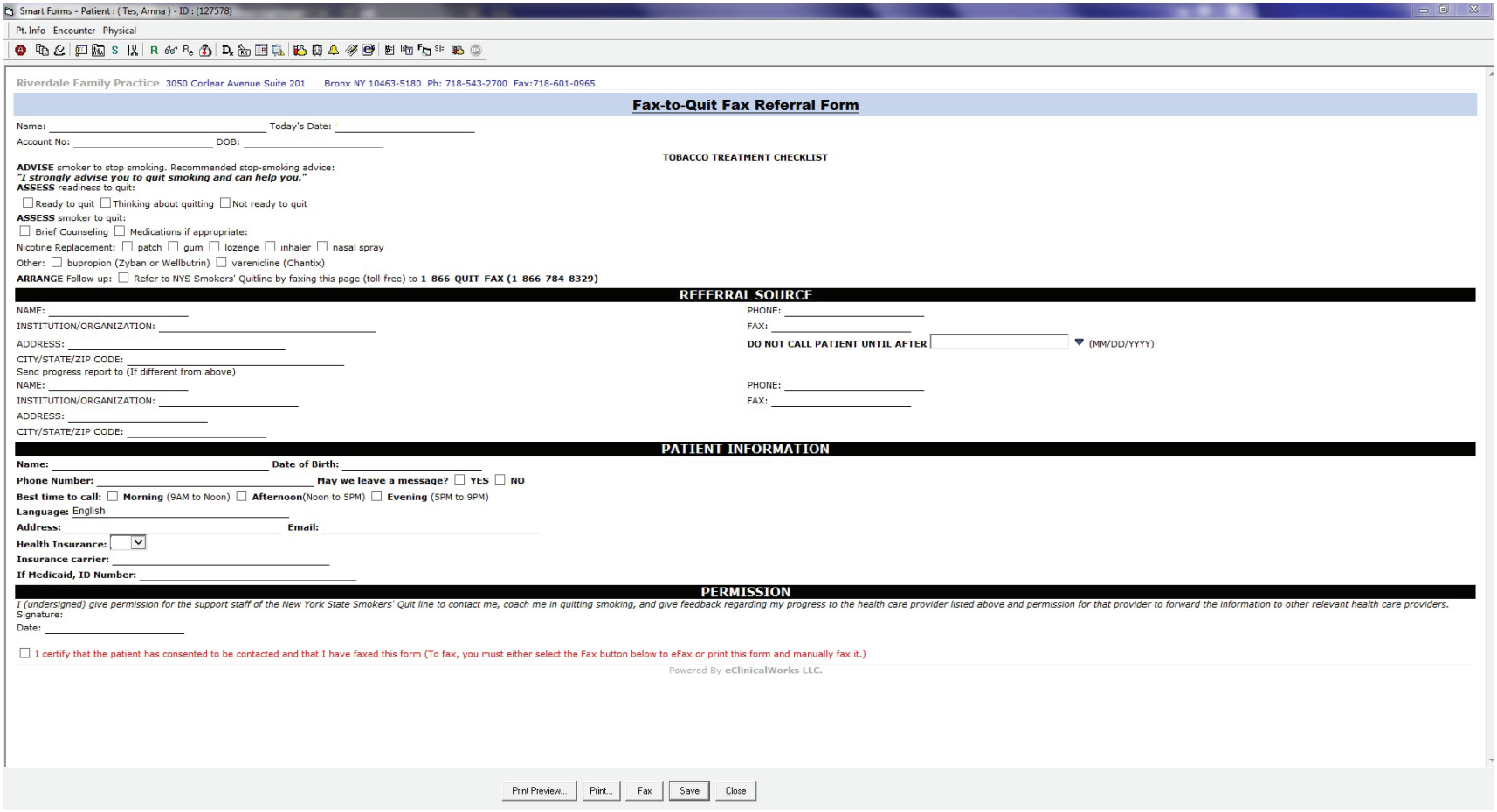
Your patient's stage in the stop-smoking process has been assessed below and is followed by a recommended support intervention for their next office visit.

✓	Stage	Description	Recommended Intervention
	Pre-contemplation	Not ready and not interested in quitting.	Advise to stop, listen and question any expression of concern about smoking to get patient thinking about changing by personalizing their risk factors.
	Contemplation	Not ready to quit, but interested in learning what quitting will entail.	Advise to stop, discuss particular concerns about stopping smoking (e.g., withdrawal symptoms) and emphasize the benefits of quitting. Recommend re-referral to the NYS Smokers' Quitline and provide stop-smoking materials (Can be obtained from Quitline).
	Preparation	Ready to learn about quitting and setting a date.	CONGRATULATE, foster motivation by reinforcing patient's commitment and determination to quit. Ask if they have set a quit date or urge them to do so. Recommend/prescribe appropriate stop-moking pharmacotherapy and refer to the NYS Smokers' Quitline for support services and stop-smoking material.
	Action	The stop smoking stage. This stage may last up to six months or longer.	CONGRATULATE on success of staying off cigarettes and allow patient to talk about close calls or relapses. Reinforce their need to make changes in daily routine and learn new ways to fend off "triggers" (e.g., handling stress). Assess the need for pharmacotherapy. Recommend the NYS Smokers' Quitline for ongoing support.
	Maintenance	Smoke-free for approximately six months.	CONGRATULATE on success of staying smoke-free, confirm patient's new non-smoking identity (improved health, lower blood pressure, etc.), and advise the patient to remind him/herself of their reasons for quitting. Recommend the NYS Smokers' Quitline for continued support.
	Relapse	Patient returned to smoking.	Remind patient that most smokers relapse. Many get "back on track" and slipping doesn't mean they have become a smoker again. Discourage patient from feeling guilty and encourage him or her to remember their successes. Recommend NYS Smokers' Quitline as a support service.

ADDITIONAL COUNSELOR COMMENTS: _____

_____

Fax-to-Quit Directly from eCW



Smart Forms - Patient : (Tes, Amna) - ID : (127578)

Pt. Info Encounter Physical

Riverdale Family Practice 3050 Corlear Avenue Suite 201 Bronx NY 10463-5180 Ph: 718-543-2700 Fax:718-601-0965

Fax-to-Quit Fax Referral Form

Name: _____ Today's Date: _____

Account No: _____ DOB: _____

TOBACCO TREATMENT CHECKLIST

ADVISE smoker to stop smoking. Recommended stop-smoking advice:
"I strongly advise you to quit smoking and can help you."
ASSESS readiness to quit:

☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

ASSESS smoker to quit:

☐ Brief Counseling ☐ Medications if appropriate:

Nicotine Replacement: ☐ patch ☐ gum ☐ lozenge ☐ inhaler ☐ nasal spray

Other: ☐ bupropion (Zyban or Wellbutrin) ☐ varenicline (Chantix)

ARRANGE Follow-up: ☐ Refer to NYS Smokers' Quitline by faxing this page (toll-free) to **1-866-QUIT-FAX (1-866-784-8329)**

REFERRAL SOURCE

NAME: _____ PHONE: _____

INSTITUTION/ORGANIZATION: _____ FAX: _____

ADDRESS: _____ **DO NOT CALL PATIENT UNTIL AFTER** _____ (MM/DD/YYYY)

CITY/STATE/ZIP CODE: _____

Send progress report to (If different from above)

NAME: _____ PHONE: _____

INSTITUTION/ORGANIZATION: _____ FAX: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Phone Number: _____ **May we leave a message?** ☐ **YES** ☐ **NO**

Best time to call: ☐ **Morning** (9AM to Noon) ☐ **Afternoon**(Noon to 5PM) ☐ **Evening** (5PM to 9PM)

Language: English

Address: _____ **Email:** _____

Health Insurance:

Insurance carrier: _____

If Medicaid, ID Number: _____

PERMISSION

I (undersigned) give permission for the support staff of the New York State Smokers' Quit line to contact me, coach me in quitting smoking, and give feedback regarding my progress to the health care provider listed above and permission for that provider to forward the information to other relevant health care providers.

Signature:

Date: _____

☐ I certify that the patient has consented to be contacted and that I have faxed this form (To fax, you must either select the Fax button below to eFax or print this form and manually fax it.)

Powered By **eClinicalWorks LLC.**

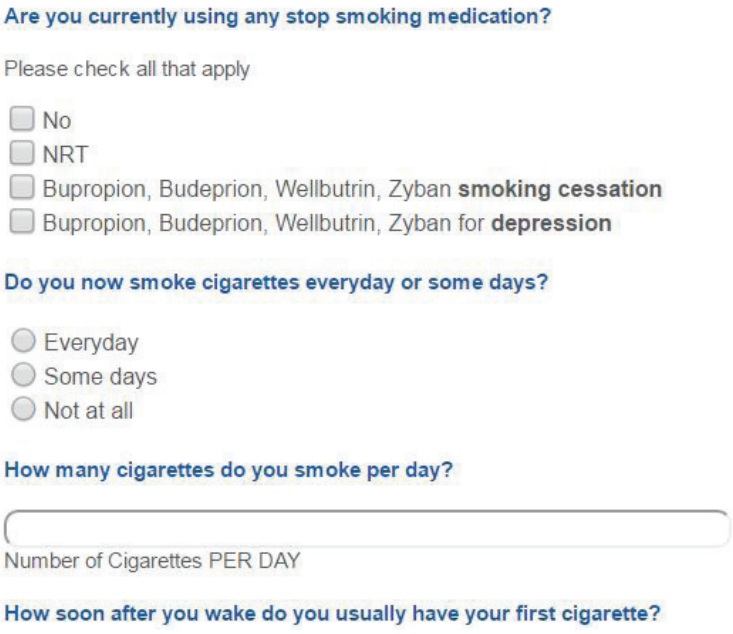
Print Preview... Print... Fax Save Close

How to Get a Free Nicotine Replacement Therapy Starter Kit Online

Directions for a free nicotine replacement therapy starter kit (14 patches) from the New York State Smokers' Quitline

1. Log on to **nysmokefree.com** (Tip: mark as a browser "favorite").
2. Go to "Resources" at the bottom of the web page and click on "Free Nicotine Replacement Therapy."

3. You will be prompted to register and complete a few questions about the smoker. One question asks: "Do you smoke cigarettes every day or some days?" To be eligible for free nicotine replacement therapy (NRT) through the New York State Smokers' Quitline, the smoker must:
   - Be at least 18 years old
   - Smoke every day
   - Smoke over 10 cigarettes a day
   - Currently not be using any smoking cessation medication



4. Smokers should expect their free NRT starter kit in approximately two weeks.

APPENDIX ABCS

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169	Medication Therapy Management (MTM) Patient Brochure
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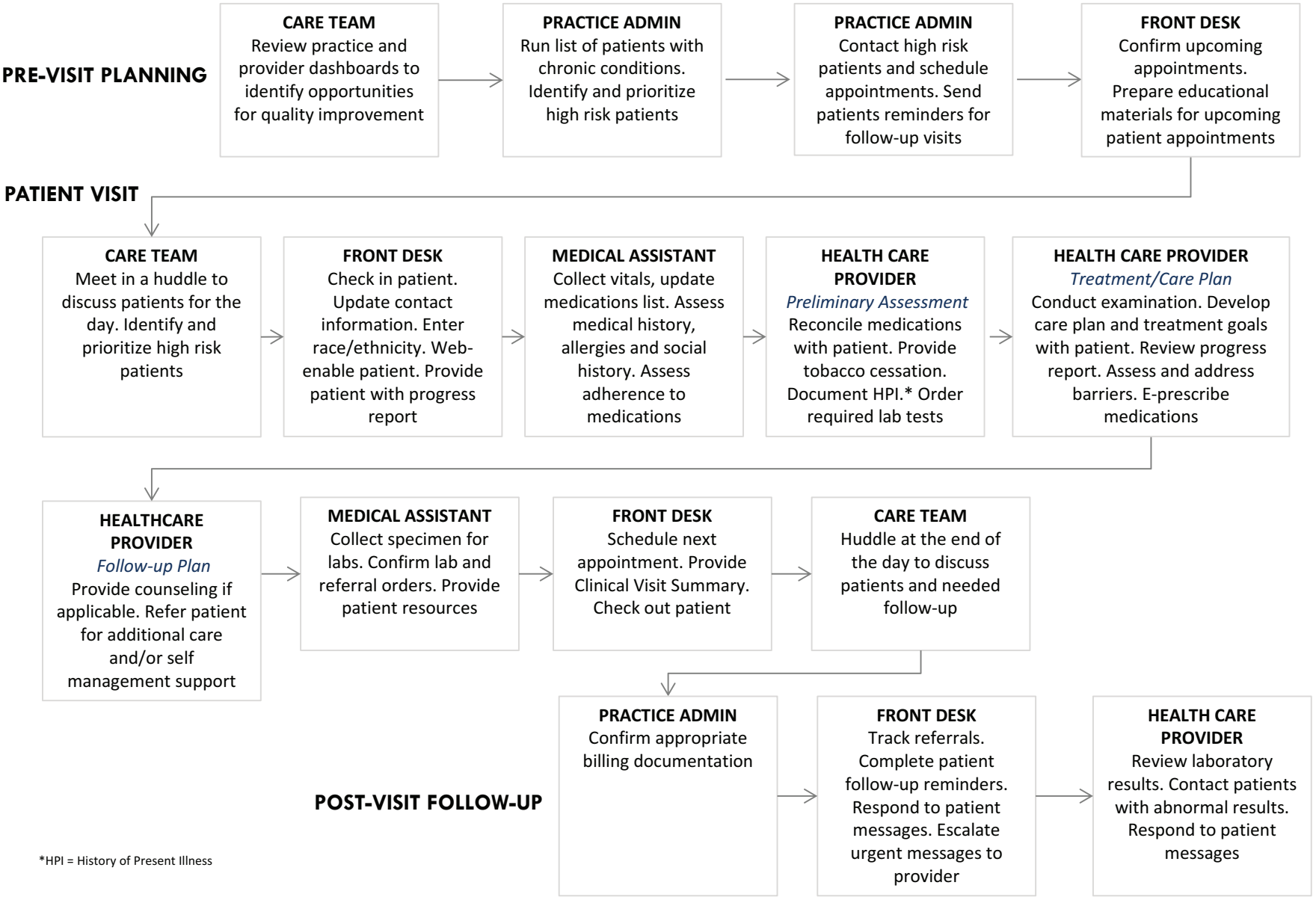
173	Shape Up NYC

WORKFLOW MAPPING WORKSHEET: EXAMPLE OF CHRONIC CARE BEST PRACTICE



*HPI = History of Present Illness

WORKFLOW MAPPING WORKSHEET: PRE-VISIT PLANNING

BEST PRACTICE PRE-VISIT PLANNING

CARE TEAM	PRACTICE ADMIN	PRACTICE ADMIN	FRONT DESK
Review practice and provider dashboards to identify opportunities for quality improvement	Run list of patients with chronic conditions. Identify and prioritize high risk patients	Contact high risk patients and schedule appointments. Send patients reminders for follow-up visits	Confirm upcoming appointments. Prepare educational materials for upcoming patient appointments

CURRENT PRE-VISIT PLANNING

CARE TEAM	PRACTICE ADMIN	PRACTICE ADMIN	FRONT DESK

POTENTIAL PRE-VISIT PLANNING

CARE TEAM	PRACTICE ADMIN	PRACTICE ADMIN	FRONT DESK

ADDITIONAL NOTES:

WORKFLOW MAPPING WORKSHEET: PRE-VISIT PLANNING

Practice Workflow Cues and Assessment for Patient Visit

Process	Current Process	Barriers/Duplication	Ideal Process
1. Does the practice conduct any pre-visit planning? Describe the process.			
Registry and Reporting	**Current Process**	**Barriers/Duplication**	**Ideal Process**
2. How does the practice monitor and track patients with chronic conditions?			
3. Does the practice monitor at-risk populations? How is the physician alerted?			
4. What are the current reporting requirements for the practice (e.g., patient-specific populations, time studies, clinical operating reports, incoming referrals, patient care measures)? How frequently are these reports run?			
5. Does anyone at the practice conduct chart reviews? How frequently? Describe this process.			

Additional Notes:

WORKFLOW MAPPING WORKSHEET: PATIENT VISIT

BEST PRACTICE PATIENT VISIT

CARE TEAM
Meet in a huddle to discuss patients for the day. Identify and prioritize high risk patients

→

FRONT DESK
Check in patient. Update contact information. Enter race/ethnicity. Web-enable patient. Provide patient with progress report

→

MEDICAL ASSISTANT
Collect vitals, update medications list. Assess medical history, allergies and social history. Assess adherence to medications

→

HEALTH CARE PROVIDER
Preliminary Assessment
Reconcile medications with patient. Provide tobacco cessation. Document HPI.* Order required lab tests

→

HEALTH CARE PROVIDER
Treatment/Care Plan
Conduct examination. Develop care plan and treatment goals with patient. Review progress report. Assess and address barriers. E-prescribe medications

↓

HEALTH CARE PROVIDER
Follow-up Plan
Provide counseling if applicable. Refer patient for additional care and/or self management support

→

MEDICAL ASSISTANT
Collect specimen for labs. Confirm lab and referral orders. Provide patient resources

→

FRONT DESK
Schedule next appointment. Provide Clinical Visit Summary. Check out patient

→

CARE TEAM
Huddle at the end of the day to discuss patients and needed follow-up

CURRENT PATIENT VISIT

CARE TEAM → **FRONT DESK** → **MEDICAL ASSISTANT** → **HEALTH CARE PROVIDER** *Preliminary Assessment* → **HEALTH CARE PROVIDER** *Treatment/Care Plan*

↓

HEALTH CARE PROVIDER *Follow-up Plan* → **CARE TEAM** → **CARE TEAM** → **CARE TEAM**

POTENTIAL PATIENT VISIT

CARE TEAM → **FRONT DESK** → **MEDICAL ASSISTANT** → **HEALTH CARE PROVIDER** *Preliminary Assessment* → **HEALTH CARE PROVIDER** *Treatment/Care Plan*

↓

HEALTH CARE PROVIDER *Follow-up Plan* | **CARE TEAM** | **CARE TEAM** | **CARE TEAM**

WORKFLOW MAPPING WORKSHEET: PATIENT VISIT

Practice Workflow Cues and Assessment for Patient Visit

Rooming the Patient	Current Process	Barriers/Duplication	Ideal Process
1. Are walk-in appointments available? How are walk-in patients roomed?			
2. What is the average patient wait time for triage and to see the doctor?			
3. How does the front office notify the medical assistant that the patient is ready to be taken back?			
Vitals/Intake	**Current Process**	**Barriers/Duplication**	**Ideal Process**
4. Does the practice have a triage room/area? Who conducts triage, where is it conducted and how? What is measured? How is it recorded?			
5. Who conducts initial screenings, i.e., chief complaints, subjective history, etc.?			
6. Who reviews current medications in the medical record? Is it completed for every visit?			
7. Does the practice perform tobacco screening and cessation counseling for tobacco users?			
8. Does the practice utilize clinical decision alerts (CDS)? If so, for which condition(s)?			
Provider	**Current Process**	**Barriers/Duplication**	**Ideal Process**
9. What is the communication and handoff between the medical assistant and the provider (e.g., reviewing of vitals, concerns)?			
10. Review how the provider manages patients with chronic conditions, i.e., referrals, medication reconciliation and adherence, treatment procedures, etc.			
11. How does the provider communicate to the medical assistant that the patient is ready for check out? What action is taken, i.e., super bill given, lab orders, vaccines, etc.?			
12. How long does it take the provider to write encounter notes? Does the provider complete during or after the visit? When does the provider sign-off the chart?			
Clinical Discharge	**Current Process**	**Barriers/Duplication**	**Ideal Process**
13. Are prescriptions provided to the patient or sent directly to the pharmacy?			
14. What is the practice's ability/eligibility for e-prescribing?			
15. Who gives the patient their prescriptions and associated prescription education (i.e., pharmacist or physician during visit)?			
16. Who provides patient education? How (i.e., paper, electronic)?			

Workflow Mapping Worksheet: Patient Visit

Practice Workflow Cues and Assessment for Patient Visit

Referrals	Current Process	Barriers/Duplication	Ideal Process
17. Who executes outgoing referrals and summary of care (for specialists only)?			
18. Do you have a list of providers you commonly refer patients to? Is this list in the EHR?			
Check Out	**Current Process**	**Barriers/Duplication**	**Ideal Process**
19. How does the patient get directed to check out? Describe the check-out process.			
20. Is a follow-up visit scheduled? Are instructions/education provided?			
21. Does the practice provide the patient with any forms during check-out? Portal access?			

Additional Notes:

WORKFLOW MAPPING WORKSHEET: POST-VISIT FOLLOW-UP

BEST PRACTICE POST-VISIT FOLLOW-UP

PRACTICE ADMIN	FRONT DESK	HEALTH CARE PROVIDER
Confirm appropriate billing documentation	Track referrals. Complete patient follow-up reminder. Respond to patient messages. Escalate urgent messages to provider	Review laboratory results. Contact patients with abnormal results. Respond to patient messages

CURRENT POST-VISIT FOLLOW-UP

PRACTICE ADMIN	FRONT DESK	HEALTH CARE PROVIDER

POTENTIAL POST-VISIT FOLLOW-UP

PRACTICE ADMIN	FRONT DESK	HEALTHCARE PROVIDER

ADDITIONAL NOTES:

Workflow Mapping Worksheet: Post-Visit Follow-Up

Practice Workflow Cues and Assessment for Patient Visit

Referrals	Current Process	Barriers/Duplication	Ideal Process
1. How is the loop closed to ensure continuity of care (e.g., nurse, medical assistant, practice administrator)?			
2. Does the practice commonly generate outgoing referrals? Receive incoming referrals? Which is more common? Describe overall processes.			
Clinical Telephone Encounters	**Current Process**	**Barriers/Duplication**	**Ideal Process**
3. What are the most common telephone encounters (e.g., refills, test results, referrals)? Describe the process. Are there specific policies in place regarding turnaround time?			
4. How are incoming calls tracked (i.e., is a telephone encounter created for each call)?			
5. What is the process for returning calls? Outgoing calls (e.g., lab results)?			
Clinical Telephone Encounters	**Current Process**	**Barriers/Duplication**	**Ideal Process**
6. Does the provider offer after-hours or weekend calls? How are these documented? Describe the process.			

Additional Notes:

Prevention and Care Dashboard – Hub Quality Measures Checklist

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C_ANT_IVD *IVD Aspirin Use*

Denominator: Patients ages 18 and older at start of reporting period with a diagnosis of IVD during or prior to the reporting period and with an encounter during the reporting period
Numerator: Patients in denominator who have documentation of use of aspirin/antithrombotic during the reporting period or the year prior

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: 'G0438', 'G0439', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99395', '99396', '99397', '99385', '99386', '99387'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 – 100 years old	
☐	Patient's diagnosis of **ischemic vascular disease** in the Problem List or Assessment during or prior to the reporting period **(Denominator)**	Documented using the following ICD-10 codes: 'I20.0', 'I20.1', 'I20.8', 'I20.9', 'I21.01', 'I21.02', 'I21.09', 'I21.11', 'I21.19', 'I21.21', 'I21.29', 'I21.3', 'I21.4', 'I24.0', 'I24.1', 'I24.8', 'I24.9', 'I25.10', 'I25.110', 'I25.111', 'I25.118', 'I25.119', 'I25.5', 'I25.6', 'I25.700', 'I25.701', 'I25.708', 'I25.709', 'I25.710', 'I25.711', 'I25.718', 'I25.719', 'I25.720', 'I25.721', 'I25.728', 'I25.729', 'I25.730', 'I25.731', 'I25.738', 'I25.739', 'I25.750', 'I25.751', 'I25.758', 'I25.759', 'I25.760', 'I25.761', 'I25.768', 'I25.769', 'I25.790', 'I25.791', 'I25.798', 'I25.799', 'I25.810', 'I25.811', 'I25.812', 'I25.82', 'I25.84', 'I25.89', 'I25.9', 'I63.00', 'I63.011', 'I63.012', 'I63.019', 'I63.02', 'I63.031', 'I63.032', 'I63.039', 'I63.09', 'I63.10', 'I63.111', 'I63.112', 'I63.119', 'I63.12', 'I63.131', 'I63.132', 'I63.139', 'I63.19', 'I63.20', 'I63.211', 'I63.212', 'I63.219', 'I63.22', 'I63.231', 'I63.232', 'I63.239', 'I63.29', 'I63.30', 'I63.311', 'I63.312', 'I63.319', 'I63.321', 'I63.322', 'I63.329', 'I63.331', 'I63.332', 'I63.339', 'I63.341', 'I63.342', 'I63.349', 'I63.39', 'I63.40', 'I63.411', 'I63.412', 'I63.419', 'I63.421', 'I63.422', 'I63.429', 'I63.431', 'I63.432', 'I63.439', 'I63.441', 'I63.442', 'I63.449', 'I63.49', 'I63.50', 'I63.511', 'I63.512', 'I63.519', 'I63.521', 'I63.522', 'I63.529', 'I63.531', 'I63.532', 'I63.539', 'I63.541', 'I63.542', 'I63.549', 'I63.59', 'I63.6', 'I63.8', 'I63.9', 'I65.01', 'I65.02', 'I65.03', 'I65.09', 'I65.1', 'I65.21', 'I65.22', 'I65.23', 'I65.29', 'I65.8', 'I65.9', 'I66.01', 'I66.02', 'I66.03', 'I66.09', 'I66.11', 'I66.12', 'I66.13', 'I66.19', 'I66.21', 'I66.22', 'I66.23', 'I66.29', 'I66.3', 'I66.8', 'I66.9', 'I70.1', 'I70.201', 'I70.202', 'I70.203', 'I70.208', 'I70.209', 'I70.211', 'I70.212', 'I70.213', 'I70.218', 'I70.219', 'I70.221', 'I70.222', 'I70.223', 'I70.228', 'I70.229', 'I70.231', 'I70.232', 'I70.233', 'I70.234', 'I70.235', 'I70.238', 'I70.239', 'I70.241', 'I70.242', 'I70.243', 'I70.244', 'I70.245', 'I70.248', 'I70.249', 'I70.25', 'I70.261', 'I70.262', 'I70.263', 'I70.268', 'I70.269', 'I70.291', 'I70.292', 'I70.293', 'I70.298', 'I70.299', 'I70.92', 'I74.01', 'I74.09', 'I74.10', 'I74.11', 'I74.19', 'I74.2', 'I74.3', 'I74.4', 'I74.5', 'I74.8', 'I74.9', 'I75.011', 'I75.012', 'I75.013', 'I75.019', 'I75.021', 'I75.022', 'I75.023', 'I75.029', 'I75.81', 'I75.89' Documented using the following ICD-9 codes: '36.10', '36.11', '36.12', '36.13', '36.14', '36.15', '36.16', '36.17', '36.19', '410.01', '410.11', '410.21', '410.31', '410.41', '410.51', '410.61', '410.71', '410.81', '410.91', '411.0', '411.1', '411.81', '411.89', '413.0', '413.1', '413.9', '414.00', '414.01', '414.02', '414.03', '414.04', '414.05', '414.06', '414.07', '414.2', '414.8', '414.9', '429.2', '433.00', '433.01', '433.10', '433.11', '433.20', '433.21', '433.30', '433.31', '433.80', '433.81', '433.90', '433.91', '434.00', '434.01', '434.10', '434.11', '434.90', '434.91', '440.1', '440.20', '440.21', '440.22', '440.23', '440.24', '440.29', '440.4', '444.01', '444.09', '444.1', '444.21', '444.22', '444.81', '444.89', '444.9', '445.01', '445.02', '445.81', '445.89'	
☐	Patients in the numerator have documentation of use of	Drug name is in the following list of 'Antithrombotic meds, AHRQ, comprehensive': 'Adult Aspirin EC Low Strength', 'Adult Aspirin Low Strength', 'AF-Aspirin Childrens', 'Aggrenox', 'Albertsons Aspirin', 'Albertsons Buffered Aspirin',	

	aspirin/antithrombotic during the reporting period	'Albertsons EC Aspirin', 'ASA', 'ASA 325', 'ASA 81', 'ASA 81ec', 'ASA Buff (Mag Carb-Al Glyc)', 'ASA EC', 'ASA enteric coated', 'ASA-EC', 'Ascriptin', 'Ascriptin A/D', 'Ascriptin AP', 'Ascriptin Enteric', 'Ascriptin Extra Strength', 'Ascriptin MS', 'ASP 300/200/20', 'Aspergum', 'Aspir 81', 'Aspir 81 oral enteric coated tablet', 'Aspir-81', 'Aspir-81*', 'Aspirin', 'ASPIRIN CHEW', 'ASPIRIN EC', 'ASPIRIN EC', 'ASPIRIN EC MG', 'ASPIRIN EC (STOCK)', 'Aspirin **(OTC)**', 'Aspirin 161 mg', 'Aspirin 325 mg', 'aspirin 325 mg oral tablet', 'aspirin 81 mg oral delayed release capsule', 'aspirin 81 mg oral enteric coated tablet', 'aspirin 81 mg oral tablet', 'aspirin 81 mg oral tablet, chewable', 'Aspirin AD/Antacid', 'Aspirin Adult Low Strength', 'Aspirin Buf(AlHyd-MgHyd-CaCar)', 'Aspirin Buf(CaCarb-MgCarb-MgO)', 'Aspirin Buff (Al Hyd-Mg Hyd)', 'Aspirin Buff(MgCarb-AlAminoac)', 'Aspirin Buffered', 'Aspirin Child Chewable', 'Aspirin Childrens', 'Aspirin Children's Orange', 'Aspirin EC', 'Aspirin EC (blood thinner)', 'Aspirin EC Extra Strength', 'Aspirin EC Lo-Dose', 'Aspirin EC Low Dose', 'Aspirin EC Low Strength', 'Aspirin EC Maximum Strength', 'Aspirin EC-81', 'Aspirin Effervescent', 'Aspirin Enteric Coated', 'Aspirin Lite Coat', 'Aspirin Litecoat', 'Aspirin Low Dose', 'Aspirin Low Strength', 'Aspirin Regimen Bayer/Calcium', 'aspirin tablets', 'Aspirin/Antacid', 'Aspirin-Calcium Carbonate', 'Aspirin-Dipyridamole', 'Aspirin-Dipyridamole ER', 'Aspir-Low', 'Aspir-Mox', 'Aspir-Mox IB', 'Aspirtab', 'Aspirtab Maximum Strength', 'Aspir-Trin', 'Aspridrox', 'Baby ASA', 'Baby Aspirin', 'Bayer Advanced Aspirin Ex St', 'Bayer Advanced Aspirin Reg St', 'Bayer Aspirin', 'Bayer aspirin EC', 'Bayer Aspirin EC Low Dose', 'Bayer Aspirin Extra Strength', 'Bayer Aspirin Regimen', 'Bayer Aspirin Sugar Free', 'Bayer Aspirin Sugar Free 81 mg oral enteric coated tablet', 'Bayer Childrens Aspirin', 'Bayer Low Dose', 'Bayer Low Strength', 'Bayer Plus Extra Strength', 'Bayer Womens', 'BL Adult Aspirin Low Strength', 'BL Aspirin', 'Buffasal', 'Buffered Aspirin', 'Bufferin', 'Bufferin Extra Strength', 'Bufferin Low Dose', 'Bufpirin', 'Childrens Aspirin', 'Childrens Aspirin Low Strength', 'clopidogrel', 'clopidogrel 75 mg oral tablet', 'Clopidogrel Bisulfate', 'CVS Aspirin', 'CVS Aspirin Adult Low Dose', 'CVS Aspirin Adult Low Strength', 'CVS Aspirin Child', 'CVS Aspirin EC', 'CVS Aspirin Extra Strength', 'CVS Aspirin Low Dose', 'CVS Aspirin Low Strength', 'CVS Childrens Aspirin', 'Easprin', 'EC ASA 81', 'EC-81 Aspirin', 'ECK Aspirin', 'ECK Aspirin Double Plus', 'ECK Aspirin EC', 'ECK Aspirin Plus Antacid', 'ECK Childrens Aspirin', 'Ecotrin', 'Ecotrin - Chan', 'Ecotrin 325', 'Ecotrin 325 mg oral enteric coated tablet', 'Ecotrin Low Strength', 'Ecotrin Low Strength Adult', 'Ecotrin Maximum Strength', 'Ecotrin*', 'EcPirin', 'Effient', 'EFFIENT [PRASUGREL]', 'ENTERIC COATED ASA', 'Enteric Coated Aspirin', 'EQ Adult Aspirin Low Strength', 'EQ Aspirin', 'EQ Aspirin EC', 'EQ Aspirin Low Dose', 'EQ Buffered Aspirin', 'EQ Childrens Aspirin', 'EQL Aspirin', 'EQL Aspirin EC', 'EQL Aspirin Low Dose', 'EQL Buffered Aspirin', 'EQL Childrens Aspirin', 'FP Aspirin Adult Low Strength', 'FP Aspirin EC', 'Genacote', 'GNP Adult Aspirin Low Strength', 'GNP Aspirin', 'GNP Aspirin Low Dose', 'GNP Childrens Aspirin', 'GNP Safety Coated Aspirin', 'GoodSense Aspirin Low Dose', 'Halfprin', 'HCA Aspirin', 'HCA Aspirin EC', 'HCA Childrens Aspirin', 'HM Aspirin', 'HM Aspirin EC', 'HM Aspirin EC Low Dose', 'KLS Aspirin EC', 'KLS Aspirin Low Dose', 'Lo-Dose Aspirin EC', 'Longs Adult Low Strength ASA', 'Low Dose ASA 81 mg oral tablet', 'Low-Dose Aspirin', 'Meijer Aspirin EC', 'MP Aspirin', 'MP Child Aspirin', 'MP Encoprin', 'MP Encoprin E/S', 'MP Regriprin', 'MP Tri-Buffered Aspirin', 'Ninoprin', 'Norwich Aspirin', 'Plavix', 'Plavix (blood thinner)', 'Plavix 3x/wk (blood thinner)', 'Plavix 75 mg oral tablet', 'PLAVIX 75 MG TABS', 'PLAVIX 75 MG TABS (90)', 'Plavix other dose', 'Plavix*', 'Plavix/Clopidogrel Bisulfate', 'Prasugrel', 'Prasugrel HCl', 'PX Aspirin', 'PX Enteric Aspirin', 'QC Adult Aspirin Low Strength', 'QC Aspirin', 'QC Aspirin Extra Strength', 'QC Aspirin Low Dose', 'QC Childrens Aspirin', 'QC Lo-Dose Aspirin', 'QC Tri-Buffered Aspirin', 'RA Aspirin', 'RA Aspirin Adult Low Dose', 'RA Aspirin Adult Low Strength', 'RA Aspirin Childrens', 'RA Aspirin EC', 'RA Aspirin EC Adult Low St', 'RA Aspirin EC Maximum Strength', 'RA Tri-Buffered Aspirin', 'SB Aspirin', 'SB Aspirin EC', 'SB Buffered Aspirin', 'SB Childrens Aspirin', 'SB Low Dose ASA EC', 'SG Childrens Aspirin', 'SG Enteric Coated Aspirin', 'SG Low Dose Aspirin EC', 'SM Aspirin', 'SM Aspirin Adult Low Strength', 'SM Aspirin EC', 'SM Aspirin EC Low Strength', 'SM Aspirin Low Dose', 'SM Aspirin Tri-Buffered', 'SOBA Analgesic', 'SOBA Aspirin', 'SOBA Aspirin Extra Strength', 'SOBA Enteric Coated Aspirin', 'St Joseph Adult', 'St Joseph Adult Low Dose', 'St Joseph Aspirin', 'Sureprin 81', 'TGT Aspirin', 'TGT Aspirin EC', 'TGT Aspirin Low Dose', 'TH Aspirin', 'TH Aspirin Low	

		Dose', 'TH Enteric Aspirin', 'Therapy Bayer EC', 'Ticlid', 'ticlopidine', 'Ticlopidine HCl', 'Tri-Buffered Aspirin', 'Triple Buffered Aspirin', 'Uni-Tren', 'V-R Aspirin EC Max Str', 'Zero-Order Release Aspirin'	

S_CHL_GEN *Cholesterol Screening of the General Population*

Denominator: Male patients (ages 35-100) and female patients (ages 45-100) who have no diagnosis of IVD, diabetes, or dyslipidemia

Numerator: Patients in denominator with valid total cholesterol level lab returned by LOINC in the 60 months prior to the reporting period

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	***Male patients*** are between the ages of 35-100 ***Female patients*** are between the ages of 45-100	
☐	Patient's does ***not*** have a diagnosis of **IVD, diabetes,** or **dyslipidemia** in the Problem List or Assessment during or prior to the reporting period. **(Denominator)**	*Excludes* patients with the following ICD-10 codes: ***IVD***- 'I20.0', 'I20.1', 'I20.8', 'I20.9', 'I21.01', 'I21.02', 'I21.09', 'I21.11', 'I21.19', 'I21.21', 'I21.29', 'I21.3', 'I21.4', 'I24.0', 'I24.1', 'I24.8', 'I24.9', 'I25.10', 'I25.110', 'I25.111', 'I25.118', 'I25.119', 'I25.5', 'I25.6', 'I25.700', 'I25.701', 'I25.708', 'I25.709', 'I25.710', 'I25.711', 'I25.718', 'I25.719', 'I25.720', 'I25.721', 'I25.728', 'I25.729', 'I25.730', 'I25.731', 'I25.738', 'I25.739', 'I25.750', 'I25.751', 'I25.758', 'I25.759', 'I25.760', 'I25.761', 'I25.768', 'I25.769', 'I25.790', 'I25.791', 'I25.798', 'I25.799', 'I25.810', 'I25.811', 'I25.812', 'I25.82', 'I25.84', 'I25.89', 'I25.9', 'I63.00', 'I63.011', 'I63.012', 'I63.019', 'I63.02', 'I63.031', 'I63.032', 'I63.039', 'I63.09', 'I63.10', 'I63.111', 'I63.112', 'I63.119', 'I63.12', 'I63.131', 'I63.132', 'I63.139', 'I63.19', 'I63.20', 'I63.211', 'I63.212', 'I63.219', 'I63.22', 'I63.231', 'I63.232', 'I63.239', 'I63.29', 'I63.412', 'I63.419', 'I63.421', 'I63.422', 'I63.429', 'I63.431', 'I63.432', 'I63.439', 'I63.441', 'I63.442', 'I63.449', 'I63.49', 'I63.50', 'I63.511', 'I63.512', 'I63.519', 'I63.521', 'I63.522', 'I63.529', 'I63.531', 'I63.532', 'I63.539', 'I63.541', 'I63.542', 'I63.549', 'I63.59', 'I63.6', 'I63.8', 'I63.9', 'I65.01', 'I65.02', 'I65.03', 'I65.09', 'I65.1', 'I65.21', 'I65.22', 'I65.23', 'I65.29', 'I65.8', 'I65.9', 'I66.01', 'I66.02', 'I66.03', 'I66.09', 'I66.11', 'I66.12', 'I66.13', 'I66.19', 'I66.21', 'I66.22', 'I66.23', 'I66.29', 'I66.3', 'I66.8', 'I66.9', 'I70.1', 'I70.201', 'I70.202', 'I70.203', 'I70.208', 'I70.209', 'I70.211', 'I70.212', 'I70.213', 'I70.218', 'I70.219', 'I70.221', 'I70.222', 'I70.223', 'I70.228', 'I70.229', 'I70.231', 'I70.232', 'I70.233', 'I70.234', 'I70.235', 'I70.238', 'I70.239', 'I70.241', 'I70.242', 'I70.243', 'I70.244', 'I70.245', 'I70.248', 'I70.249', 'I70.25', 'I70.261', 'I70.262', 'I70.263', 'I70.268', 'I70.269', 'I70.291', 'I70.292', 'I70.293', 'I70.298', 'I70.299', 'I70.92', 'I74.01', 'I74.09', 'I74.10', 'I74.11', 'I74.19', 'I74.2', 'I74.3', 'I74.4', 'I74.5', 'I74.8', 'I74.9', 'I75.011', 'I75.012', 'I75.013', 'I75.019', 'I75.021', 'I75.022', 'I75.023', 'I75.029', 'I75.81', 'I75.89', 'G45.0', 'G45.1', 'G45.2', 'G45.3', 'G45.4', 'G45.8', 'G45.9', 'G46.0', 'G46.1', 'G46.2', 'G46.3', 'G46.4', 'G46.5', 'G46.6', 'G46.7', 'G46.8', 'K55.0', 'K55.1' ***DM***- 'E08.00', 'E08.01', 'E08.10', 'E08.11', 'E08.21', 'E08.22', 'E08.29', 'E08.311', 'E08.319', 'E08.321', 'E08.329', 'E08.331', 'E08.339', 'E08.341', 'E08.349', 'E08.351', 'E08.359', 'E08.36', 'E08.39', 'E08.40', 'E08.41', 'E08.42', 'E08.43', 'E08.44', 'E08.49', 'E08.51', 'E08.52', 'E08.59', 'E08.610', 'E08.618', 'E08.620', 'E08.621', 'E08.622', 'E08.628', 'E08.630', 'E08.638', 'E08.641', 'E08.649', 'E08.65', 'E08.69', 'E08.8', 'E08.9', 'E09.00', 'E09.01', 'E09.10', 'E09.11', 'E09.21', 'E09.22', 'E09.29', 'E09.311', 'E09.319', 'E09.321', 'E09.329', 'E09.331', 'E09.339', 'E09.341', 'E09.349', 'E09.351', 'E09.359', 'E09.36', 'E09.39', 'E09.40', 'E09.41', 'E09.42', 'E09.43', 'E09.44', 'E09.49', 'E09.51', 'E09.52', 'E09.59', 'E09.610', 'E09.618', 'E09.620', 'E09.621', 'E09.622', 'E09.628', 'E09.630', 'E09.638', 'E09.641', 'E09.649', 'E09.65', 'E09.69', 'E09.8', 'E09.9', 'E10.10', 'E10.11', 'E10.21', 'E10.22', 'E10.29', 'E10.311', 'E10.319', 'E10.321', 'E10.329', 'E10.331', 'E10.339', 'E10.341', 'E10.349', 'E10.351', 'E10.359', 'E10.36', 'E10.39', 'E10.40', 'E10.41', 'E10.42', 'E10.43', 'E10.44', 'E10.49', 'E10.51', 'E10.52', 'E10.59', 'E10.610', 'E10.618', 'E10.620', 'E10.621', 'E10.622', 'E10.628', 'E10.630', 'E10.638', 'E10.641', 'E10.649', 'E10.65', 'E10.69', 'E10.8', 'E10.9', 'E11.00', 'E11.01', 'E11.21', 'E11.22', 'E11.29', 'E11.311', 'E11.319', 'E11.321', 'E11.329', 'E11.331', 'E11.339', 'E11.341', 'E11.349',	DM includes secondary, but not gestational diabetes

		'E11.351', 'E11.359', 'E11.36', 'E11.39', 'E11.40', 'E11.41', 'E11.42', 'E11.43', 'E11.44', 'E11.49', 'E11.51', 'E11.52', 'E11.59', 'E11.610', 'E11.618', 'E11.620', 'E11.621', 'E11.622', 'E11.628', 'E11.630', 'E11.638', 'E11.641', 'E11.649', 'E11.65', 'E11.69', 'E11.8', 'E11.9', 'E13.00', 'E13.01', 'E13.10', 'E13.11', 'E13.21', 'E13.22', 'E13.29', 'E13.311', 'E13.319', 'E13.321', 'E13.329', 'E13.331', 'E13.339', 'E13.341', 'E13.349', 'E13.351', 'E13.359', 'E13.36', 'E13.39', 'E13.40', 'E13.41', 'E13.42', 'E13.43', 'E13.44', 'E13.49', 'E13.51', 'E13.52', 'E13.59', 'E13.610', 'E13.618', 'E13.620', 'E13.621', 'E13.622', 'E13.628', 'E13.630', 'E13.638', 'E13.641', 'E13.649', 'E13.65', 'E13.69', 'E13.8', 'E13.9' ***Dyslipidemia*** - 'E78.0', 'E78.1', 'E78.2', 'E78.3', 'E78.4', 'E78.5' *Excludes* patients with the following ICD-9 codes: ***IVD*** **-** '411.0', '411.1', '411.81', '411.89', '412', '413.0', '413.1', '413.9', '414.00', '414.01', '414.02', '414.03', '414.04', '414.05', '414.06', '414.07', '414.2', '414.8', '414.9', '429.2', '429.79', '429.9', '433', '433.0', '433.00', '433.01', '433.1', '433.10', '433.11', '433.2', '433.20', '433.21', '433.3', '433.30', '433.31', '433.8', '433.80', '433.81', '433.9', '433.90', '433.91', '434.00', '434.01', '434.10', '434.11', '434.90', '434.91', '435.0', '435.1', '435.2', '435.3', '435.8', '435.9', '436', '437.0', '437.1', '437.4', '437.5', '437.6', '437.7', '437.8', '437.9', '438.0', '438.10', '438.11', '438.12', '438.19', '438.20', '438.21', '438.22', '438.30', '438.31', '438.32', '438.40', '438.41', '438.42', '438.50', '438.51', '438.52', '438.53', '438.6', '438.7', '438.81', '438.82', '438.83', '438.84', '438.85', '438.89', '438.9', '440.0', '440.1', '440.2', '440.20', '440.21', '440.22', '440.23', '440.24', '440.29', '440.30', '440.31', '440.32', '440.4', '440.8', '440.9', '443.9', '444.0', '444.1', '444.21', '444.22', '444.81', '444.89', '444.9', '445.01', '445.02', '445.81', '445.89' ***DM*** - '249', '249.0', '249.00', '249.01', '249.1', '249.10', '249.11', '249.2', '249.20', '249.21', '249.3', '249.30', '249.31', '249.4', '249.40', '249.41', '249.5', '249.50', '249.51', '249.6', '249.60', '249.61', '249.7', '249.70', '249.71', '249.8', '249.80', '249.81', '249.9', '249.90', '249.91', '250', '250.0', '250.00', '250.01', '250.02', '250.03', '250.1', '250.10', '250.11', '250.12', '250.13', '250.2', '250.20', '250.21', '250.22', '250.23', '250.3', '250.30', '250.31', '250.32', '250.33', '250.4', '250.40', '250.41', '250.42', '250.43', '250.5', '250.50', '250.51', '250.52', '250.53', '250.6', '250.60', '250.61', '250.62', '250.63', '250.7', '250.70', '250.71', '250.72', '250.73', '250.8', '250.80', '250.81', '250.82', '250.83', '250.9', '250.90', '250.91', '250.92', '250.93', '357.2', '362.0', '362.01', '362.02', '362.03', '362.04', '362.05', '362.06', '362.07', '366.41', '648.0', '648.00', '648.01', '648.02', '648.03', '648.04' ***Dyslipidemia*** - '272.0', '272.1', '272.2', '272.3', '272.4', '272.7', '272.8', '272.9'	
☐	The Patient's most recent lab result numeric value is ***between 50 and 750 (inclusive)*** and is within the reporting period. **(Numerator)**	Result documented using the following LOINC codes (Cholesterol, Total): '5932-9', '2093-3', '35200-5', '9342-7', '14647-2', '32308-9', '2084-2', '55840-3', '14154-9', '48620-9', '54373-6', '2565-0', '2094-1'	Lab returned by LOINC in the ***60 months prior*** to the reporting period.

C_SMK_SMK3 *Smoking Cessation Intervention*

Denominator: Patients ages 18 and older at start of reporting period, with 2 or more encounters during the last 2 years, who had a smoking status of current smoker as of latest screening
Numerator: Patients in denominator who received smoking cessation intervention in form of smoking cessation counseling (documented by CPT) and/or pharmacologic therapy during the last 2 years

Checklist	*Block*	*Specification*	*Notes*
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	Patients in the denominator have a visit during the reporting period and an additional visit in the 2 years prior to the reporting period
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 – 100 years old	
☐	Patient's Smoking Smartform Answer indicates current smoker or diagnosis of current smoker in the Problem List or Assessment during or prior to the reporting period **(Denominator)**	Diagnosis documented using the following ICD-10 codes: 'F17.200', 'F17.208', 'F17.209', 'F17.210', 'F17.218', 'F17.219', 'F17.220', 'F17.228', 'F17.229', 'F17.290', 'F17.298', 'F17.299', 'O99.330', 'O99.331', 'O99.332', 'O99.333', 'O99.334', 'O99.335', 'Z72.0' Diagnosis documented using the following ICD-9 codes: '649.00', '649.01', '649.02', '649.03', '649.04', '989.84', '305.1'	Patients in the denominator have "current" smoking status according to ICD-9/10 or Smartform within the reporting period or the ***24 months prior***
☐	Patients received Smoking Cessation Intervention within the reporting period **or** within **24 months** preceding the end of the reporting period **(Numerator)**	Smoking Cessation Intervention is documented using the following CPT codes: '4004F', '4000F', '4001F', '99406', '99407' , 'G0436', 'G0437'	
☐	***OR*** Patients in the numerator with smoking cessation meds prescribed within the reporting period **or** within **24 months** preceding the end of the reporting period **(Numerator)**	Drug name is in the following list of 'Smoking cessation meds (ECW specific): BL Nicotine 'Buproban', 'Buproban 150 mg/12 hours oral tablet', 'extended release bupropion', 'buPROPion 100 mg oral tablet', 'buPROPion 150 mg oral tablet, extended release', 'buPROPion 150 mg/12 hours oral tablet, extended release', 'buPROPion 150 mg/24 hours oral extended release tablet', 'buPROPion 300 mg/24 hours oral extended release tablet', 'BuPROPion HBr', 'BuPROPion HBr ER', 'BuPROPion HCl', 'BuPROPion HCl (Smoking Deter)', 'BuPROPion HCl (SR)', 'BuPROPion HCl (XL)', 'Bupropion HCl ER', 'BuPROPion HCl ER (SR)', 'BuPROPion HCl ER (XL)', 'BuPROPion Hydrochloride', 'BuPROPion Hydrochloride SR', 'BuPROPion Hydrochloride XL', 'bupropion sr', 'BuPROPion XL', 'Buproprion', 'Catapres', 'Catapres-TTS-1', 'Catapres-TTS-2', 'Catapres-TTS-3', 'Chantix', 'chantix bid', 'Chantix continuation pak', 'Chantix Continuing', 'Chantix Continuing Month', 'Chantix Continuing Month Box', 'Chantix Continuing Month Pak', 'Chantix Continuing',' Chantix Starter Pack', 'Chantix starter pak', 'Chantix Starting Month Pak', 'Chantix Starting', 'chantix tablets', 'Chantix', 'Clonidine	Event is not 'Stopped', Discontinued, or 'Not Taking"

		patch 0.1mg/24hr weekly', 'Commit', 'CVS Nicotine', 'CVS Nicotine Polacrilex', 'ECK Nicotine', 'EQ Nicotine', 'EQ Nicotine Polacrilex', 'EQ Nicotine', ' Step 3 EQL Nicotine', 'EQL Nicotine Polacrilex', 'FP Nicotine', 'GNP Nicotine', 'GNP Nicotine Polacrilex', 'Goodsense Nicotine', 'Habitrol', 'HM Nicotine Polacrilex', 'Leader Nicotine Polacrilex', 'Leader Nicotine Transdermal', 'Nicoderm', 'Nicoderm 14 mg/24 hr transdermal film, extended release', 'Nicoderm CQ', 'Nicoderm C-Q', 'Nicoderm C-Q Clear', 'nicoderm patch 7mg/24 hr', 'Nicorelief', 'Nicorette', 'Nicorette Cherry', 'Nicorette ', 'Cinnamon Surge', 'Nicorette Fruit Chill', 'Nicorette Mini', 'Nicorette Mint', 'Nicorette Refill', 'Nicorette Starter Kit', 'Nicorette White Ice Mint', 'Nicotine', 'nicotine 21 mg/24 hr transdermal film, extended release', 'Nicotine Gum', 'Nicotine Mini', 'Nicotine Mint', 'Nicotine Patch', 'Nicotine Patch S-2', 'Nicotine Patch Step 1', 'Nicotine Polacrilex', 'Nicotine Step 1', 'Nicotine Step 2', 'Nicotine Step 3', 'Nicotine Sulfate', 'Nicotrol', 'Nicotrol Inhaler', 'Nicotrol NS', 'nortriptyline', 'NORTRIPTYLINE 10 MG', 'NORTRIPTYLINE 10 MG (90)', 'nortriptyline 10 mg oral capsule', 'NORTRIPTYLINE 25 MG(90)', 'nortriptyline 25 mg oral capsule', 'NORTRIPTYLINE 50 MG', 'nortriptyline 50 mg oral capsule', 'Nortriptyline HCl', 'Nortriptyline Hydrochloride', 'Pamelor', 'Pamelor 10 MG', 'PAMELOR 25 MG', 'Pamelor 5 week', 'Pamelor 50 MG', 'RA Nicotine', 'RA Nicotine Polacrilex', 'SM Nicotine', 'SM Nicotine Polacrilex', 'SW Nicotine Polacrilex', 'TGT Nicotine', 'TGT Nicotine Polacrilex', 'TGT Nicotine Step One', 'TGT Nicotine Step Three', 'TGT Nicotine Step Two', 'Topamax', 'Topamax 1/7', 'Topamax 100 mg oral tablet', 'Topamax 2/7', 'Topamax 3/7', 'Topamax 4/7', 'Topamax 50 mg oral tablet', 'TOPAMAX 50 MG TABS', 'Topamax Sprinkle', 'Topamax Sprinkle 15 MG', 'Topamax Sprinkle 25 MG', 'topamax tablet', 'Topiragen', 'Topiragen 25 mg oral tablet', 'topiramate', 'TOPIRAMATE TABLET', 'Topiramate 100 MG', 'Topiramate 25 MG', 'topiramate 25 mg oral tablet', 'Topiramate 50 MG', 'Topiramate ER', 'Topiramate Sprinkle', 'Trokendi XR', 'Trokendi XR (Topiramate)', 'varenicline', 'Varenicline Tartrate', 'Wellbutrin', 'Wellbutrin 100 mg oral tablet', 'Wellbutrin 75 mg oral tablet', 'Wellbutrin SR', 'Wellbutrin SR 150 mg oral tablet, extended release', 'Wellbutrin SR 150 mg/12 hours oral tablet, extended release', 'Wellbutrin SR 200 mg oral tablet, extended release', 'Wellbutrin XL', 'Wellbutrin XL 150 mg', 'WELLBUTRIN XL 150 MG TABS', 'Wellbutrin XL 150 mg/24 hours oral tablet, extended release','Wellbutrin XL 300 mg/24 hours oral tablet, extended release', 'Wellbutrin XL(150)', 'Wellbutrin_XL','Zyban', 'Zyban SR', 'Zyban SR Refill'	

S_SMK_ALL2 *Tobacco Use Screening*

Denominator Patients ages 18 and older at start of reporting period, with 2 or more encounters during the last 2 years
Numerator: Patients in denominator with smoking status recorded during the last 2 years

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	Patients in the denominator have a visit during the reporting period and an additional visit in the 2 years prior to the reporting period
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 – 100 years old	
☐	Patient's **Smoking Smartform** is not blank. **(Numerator)**	Any patient's smoking smartform questions answered within ***24 months*** preceding the end of the reporting period	Patients in the denominator had any Smartform questions answered within the reporting period or the ***24 months prior***

S_HIV_ALL *HIV Screening*

Denominator: Patients ages 13-64, excluding those with an HIV diagnosis prior to the reporting period.
Numerator: Patients in the denominator who have an HIV test result received by LOINC.

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	'99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 13-64 years old	
☐	Patient has ***no diagnosis of HIV*** prior to the reporting period	*Excludes* patients with the following ICD-10 codes: 'B20', 'B97.35', 'Z21' *Excludes* patients with the following ICD-9 codes: 'V08', '042', '795.71', '079.53'	
☐	Patients who have an HIV test result received by LOINC. **(Numerator)**	Result documented using the following LOINC codes (HIV Test): '12855-3', '12856-1', '12857-9', '12858-7', '12859-5', '12870-2', '12871-0', '12872-8', '12875-1', '12876-9', '12893-4', '12894-2', '12895-9', '13499-9', '14092-1', '14126-7', '16132-3', '16974-8', '16975-5', '16976-3', '16977-1', '16978-9', '16979-7', '18396-2', '19110-6', '21007-0', '21331-4', '21332-2', '22356-0', '22357-8', '24012-7', '24013-5', '25835-0', '28004-0', '28052-9', '29327-4', '29893-5', '30245-5', '31072-2', '31201-7', '31430-2', '32602-5', '32827-8', '32842-7', '33508-3', '33660-2', '33866-5', '34591-8', '34592-6', '35437-3', '35438-1', '35439-9', '35440-7', '35441-5', '35442-3', '35443-1', '35444-9', '35445-6', '35446-4', '35447-2', '35448-0', '35449-8', '35450-6', '35452-2', '35564-4', '35565-1', '38998-1', '40437-6', '40438-4', '40439-2', '40732-0', '40733-8', '41143-9', '41144-7', '41145-4', '41290-8', '42339-2', '42600-7', '42627-0', '42768-2', '43008-2', '43009-0', '43010-8', '43011-6', '43012-4', '43013-2', '43185-8', '43599-0', '44531-2', '44532-0', '44533-8', '44607-0', '44871-2', '44872-0', '44873-8', '47359-5', '48023-6', '48345-3', '48346-1', '49483-1', '49580-4', '49718-0', '49905-3', '5017-9', '50790-5', '5220-9', '5221-7', '5222-5', '5223-3', '53379-4', '53601-1', '53825-6', '53923-9', '54086-4', '56888-1', '57182-8', '57974-8', '57975-5', '58900-2', '59052-1', '6429-5', '6430-3', '61199-6', '68961-2', '69668-2', '7917-8', '7918-6', '9660-2', '9661-0', '9662-8', '9663-6', '9664-4', '9665-1', '9666-9', '9667-7', '9668-5', '9669-3', '9821-0', '9836-8', '9837-6'	Patients whose HIV test result is during the ***12 months prior*** to the reporting period through ***one month*** after the reporting period.

S_SHX_ALL *Sexual History Screening*

Denominator: Patients between the ages of 12-100 by the start of the reporting period.
Numerator: Patients in the denominator who have had sexual history recorded by smartform in the 12 months prior through the end of the reporting period.

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 12-100 years old	
☐	Patient's **Sexual History Smartform** is not blank. **(Numerator)**	First question **(sex in last 12 months)** of sexual history form completed in **12 months prior** through **the end** of the reporting period.	

S_DP_ALL *Depression Screening*

Denominator: Patients age 18-100 by the start of the reporting period.
Numerator: Patients in the denominator who have been screened for depression with either a PHQ-9 or a negative PHQ-2 smartform.

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	'99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 – 100 years old	
☐	Patient is screened for **depression**. **(Numerator)**	*PHQ-2* is complete and result is negative ***OR*** *PHQ-9* is complete	Result is entered anytime in the **12 months prior** through **the end** of the reporting period.

S_HEP_BB *Hepatitis C Screening*

Denominator: Patients born between 1945 and 1965.

Numerator: Patients in denominator who ever had a Hepatitis C test result received by LOINC or a Hepatitis C diagnosis.

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	'99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth	Patients who are born between January 1, 1945 – December 31, 1965 *(inclusive)*	
☐	Patient's diagnosis of **Hepatitis C** in the Problem List or Assessment the reporting period. **(Numerator)**	Documented using the following ICD-10 codes: 'B17.10', 'B17.11', 'B18.2', 'B19.20', 'B19.21', 'Z22.52' Documented using the following ICD-9codes: '070.41', '070.44', '070.51', '070.54', '070.70', '070.71', 'V02.62'	
	OR		
☐	Patients who have ever had a Hep C test result received by LOINC. **(Numerator)**	Result documented using the following LOINC codes (Hepatitis C screen): '11076-7', '11077-5', '13955-0', '16128-1', '16129-9', '16936-7', '22324-8', '22325-5', '22326-3', '22327-1', '22329-7', '23870-9', '23871-7', '24011-9', '24313-9', '33462-3', '34162-8', '38998-1', '39008-8', '40726-2', '42191-7', '42506-6', '44813-4', '44831-6', '47365-2', '47441-1', '48159-8', '51649-2', '51656-7', '51657-5', '51824-1', '5198-7', '5199-5', '53376-0', '53825-6', '56926-9', '56927-7', '56928-5', '56929-3', '56930-1', '57006-9', '59052-1', '72376-7', '9608-1', '9609-9', '9610-7'	Patients whose Hep C test result is received by LOINC through **one month after** the period, or a Hep C diagnosis **during or prior** to the reporting period.

C_BP_HTN *Hypertension Control*

Denominator: Patients ages 18-85 at start of reporting period with a diagnosis of HTN, and with an encounter during the reporting period and a valid BP taken (SBP 60-250, DBP 0-150).

Numerator: Patients in denominator whose most recent blood pressure (BP) reading in the reporting period is controlled (< 140/90)

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 – 85 years old	
☐	Patient's diagnosis of **hypertension** in the Problem List or Assessment during or prior to the reporting period **(Denominator)**	Documented using the following ICD-10 codes: 'I10', 'I11', 'I11.0', 'I11.9', 'I12', 'I12.0', 'I12.9', 'I13', 'I13.0', 'I13.1', 'I13.10', 'I13.11', 'I13.2', 'H35.031', 'H35.032', 'H35.033', 'H35.039', 'I67.4' Documented using the following ICD-9 codes: '362.11', '401.0', '401.1', '401.9', '402.00', '402.01', '402.1', '402.10', '402.11', '402.9', '402.90', '402.91', '403', '403.0', '403.00', '403.01', '403.1', '403.10', '403.11', '403.9', '403.90', '403.91', '404', '404.0', '404.00', '404.01', '404.02', '404.03', '404.1', '404.10', '404.11', '404.12', '404.13', '404.9', '404.90', '404.91', '404.92', '404.93', '437.2'	
☐	Patient's most recent BP is taken within the reporting period	Patients in the **numerator** had: *BP Systolic Values* between 60 and 139 *BP Diastolic Values* between 0 and 89 Patients in the **denominator** had: *BP Systolic Values* between 60 and 250 *BP Diastolic Values* between 0 and 150	Values are all inclusive within their range

C_BP_DM *Blood Pressure Control in DM*

Denominator: Patients ages 18-75 at start of reporting period with a history of DM and a valid BP taken, at an encounter during reporting period

Numerator: Patients in denominator whose most recent blood pressure (BP) reading in the reporting period is controlled (< 140/90)

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 –85 years old	
☐	Patient's diagnosis of **diabetes** in the Problem List or Assessment during or prior to the reporting period. **(Denominator)**	Documented using the following ICD-10 codes: 'E08.00', 'E08.01', 'E08.10', 'E08.11', 'E08.21', 'E08.22', 'E08.29', 'E08.311', 'E08.319', 'E08.321', 'E08.329', 'E08.331', 'E08.339', 'E08.341', 'E08.349', 'E08.351', 'E08.359', 'E08.36', 'E08.39', 'E08.40', 'E08.41', 'E08.42', 'E08.43', 'E08.44', 'E08.49', 'E08.51', 'E08.52', 'E08.59', 'E08.610', 'E08.618', 'E08.620', 'E08.621', 'E08.622', 'E08.628', 'E08.630', 'E08.638', 'E08.641', 'E08.649', 'E08.65', 'E08.69', 'E08.8', 'E08.9', 'E09.00', 'E09.01', 'E09.10', 'E09.11', 'E09.21', 'E09.22', 'E09.29', 'E09.311', 'E09.319', 'E09.321', 'E09.329', 'E09.331', 'E09.339', 'E09.341', 'E09.349', 'E09.351', 'E09.359', 'E09.36', 'E09.39', 'E09.40', 'E09.41', 'E09.42', 'E09.43', 'E09.44', 'E09.49', 'E09.51', 'E09.52', 'E09.59', 'E09.610', 'E09.618', 'E09.620', 'E09.621', 'E09.622', 'E09.628', 'E09.630', 'E09.638', 'E09.641', 'E09.649', 'E09.65', 'E09.69', 'E09.8', 'E09.9', 'E10.10', 'E10.11', 'E10.21', 'E10.22', 'E10.29', 'E10.311', 'E10.319', 'E10.321', 'E10.329', 'E10.331', 'E10.339', 'E10.341', 'E10.349', 'E10.351', 'E10.359', 'E10.36', 'E10.39', 'E10.40', 'E10.41', 'E10.42', 'E10.43', 'E10.44', 'E10.49', 'E10.51', 'E10.52', 'E10.59', 'E10.610', 'E10.618', 'E10.620', 'E10.621', 'E10.622', 'E10.628', 'E10.630', 'E10.638', 'E10.641', 'E10.649', 'E10.65', 'E10.69', 'E10.8', 'E10.9', 'E11.00', 'E11.01', 'E11.21', 'E11.22', 'E11.29', 'E11.311', 'E11.319', 'E11.321', 'E11.329', 'E11.331', 'E11.339', 'E11.341', 'E11.349', 'E11.351', 'E11.359', 'E11.36', 'E11.39', 'E11.40', 'E11.41', 'E11.42', 'E11.43', 'E11.44', 'E11.49', 'E11.51', 'E11.52', 'E11.59', 'E11.610', 'E11.618', 'E11.620', 'E11.621', 'E11.622', 'E11.628', 'E11.630', 'E11.638', 'E11.641', 'E11.649', 'E11.65', 'E11.69', 'E11.8', 'E11.9', 'E13.00', 'E13.01', 'E13.10', 'E13.11', 'E13.21', 'E13.22', 'E13.29', 'E13.311', 'E13.319', 'E13.321', 'E13.329', 'E13.331', 'E13.339', 'E13.341', 'E13.349', 'E13.351', 'E13.359', 'E13.36', 'E13.39', 'E13.40', 'E13.41', 'E13.42', 'E13.43', 'E13.44', 'E13.49', 'E13.51', 'E13.52', 'E13.59', 'E13.610', 'E13.618', 'E13.620', 'E13.621', 'E13.622', 'E13.628', 'E13.630', 'E13.638', 'E13.641', 'E13.649', 'E13.65', 'E13.69', 'E13.8', 'E13.9' Documented using the following ICD-9 codes: '249', '249.0', '249.00', '249.01', '249.1', '249.10', '249.11', '249.2', '249.20', '249.21', '249.3', '249.30', '249.31', '249.4', '249.40', '249.41', '249.5', '249.50', '249.51', '249.6', '249.60', '249.61', '249.7', '249.70', '249.71', '249.8', '249.80', '249.81', '249.9', '249.90', '249.91', '250', '250.0', '250.00', '250.01', '250.02', '250.03', '250.10', '250.11', '250.12', '250.13', '250.20', '250.21', '250.22', '250.23', '250.30', '250.31', '250.32', '250.33', '250.41', '250.42', '250.43', '250.50', '250.51', '250.52', '250.53', '250.60', '250.61', '250.62', '250.63', '250.70', '250.71', '250.72', '250.73', '250.80', '250.81', '250.82', '250.83', '250.90', '250.91', '250.92', '250.93', '648.01', '648.02', '648.03', '648.04'	Includes secondary, does not include gestational diabetes

☐	Patient's BP is taken within the reporting period	Patients in the **numerator** had most recent: *BP Systolic Values* between 60 and 139 *BP Diastolic Values* between 0 and 89 Patients in the **denominator** had most recent: *BP Systolic Values* between 60 and 250 *BP Diastolic Values* between 0 and 150	Values are all inclusive within their range

C_BP_IVD *Blood Pressure Control in IVD*

Denominator: Patients ages 18-75 at start of reporting period with a history of IVD and valid BP taken, with an encounter during the reporting period

Numerator: Patients in denominator whose most recent blood pressure (BP) reading in the reporting period is controlled (< 140/90)

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 –85 years old	
☐	Patient's diagnosis of **ischemic vascular disease** in the Problem List or Assessment during or prior to the reporting period. **(Denominator)**	Documented using the following ICD-10 codes: 'I20.0', 'I20.1', 'I20.8', 'I20.9', 'I21.01', 'I21.02', 'I21.09', 'I21.11', 'I21.19', 'I21.21', 'I21.29', 'I21.3', 'I21.4', 'I24.0', 'I24.1', 'I24.8', 'I24.9', 'I25.10', 'I25.110', 'I25.111', 'I25.118', 'I25.119', 'I25.5', 'I25.6', 'I25.700', 'I25.701', 'I25.708', 'I25.709', 'I25.710', 'I25.711', 'I25.718', 'I25.719', 'I25.720', 'I25.721', 'I25.728', 'I25.729', 'I25.730', 'I25.731', 'I25.738', 'I25.739', 'I25.750', 'I25.751', 'I25.758', 'I25.759', 'I25.760', 'I25.761', 'I25.768', 'I25.769', 'I25.790', 'I25.791', 'I25.798', 'I25.799', 'I25.810', 'I25.811', 'I25.812', 'I25.82', 'I25.84', 'I25.89', 'I25.9', 'I63.00', 'I63.011', 'I63.012', 'I63.019', 'I63.02', 'I63.031', 'I63.032', 'I63.039', 'I63.09', 'I63.10', 'I63.111', 'I63.112', 'I63.119', 'I63.12', 'I63.131', 'I63.132', 'I63.139', 'I63.19', 'I63.20', 'I63.211', 'I63.212', 'I63.219', 'I63.22', 'I63.231', 'I63.232', 'I63.239', 'I63.29', 'I63.30', 'I63.311', 'I63.312', 'I63.319', 'I63.321', 'I63.322', 'I63.329', 'I63.331', 'I63.332', 'I63.339', 'I63.341', 'I63.342', 'I63.349', 'I63.39', 'I63.40', 'I63.411', 'I63.412', 'I63.419', 'I63.421', 'I63.422', 'I63.429', 'I63.431', 'I63.432', 'I63.439', 'I63.441', 'I63.442', 'I63.449', 'I63.49', 'I63.50', 'I63.511', 'I63.512', 'I63.519', 'I63.521', 'I63.522', 'I63.529', 'I63.531', 'I63.532', 'I63.539', 'I63.541', 'I63.542', 'I63.549', 'I63.59', 'I63.6', 'I63.8', 'I63.9', 'I65.01', 'I65.02', 'I65.03', 'I65.09', 'I65.1', 'I65.21', 'I65.22', 'I65.23', 'I65.29', 'I65.8', 'I65.9', 'I66.01', 'I66.02', 'I66.03', 'I66.09', 'I66.11', 'I66.12', 'I66.13', 'I66.19', 'I66.21', 'I66.22', 'I66.23', 'I66.29', 'I66.3', 'I66.8', 'I66.9', 'I70.1', 'I70.201', 'I70.202', 'I70.203', 'I70.208', 'I70.209', 'I70.211', 'I70.212', 'I70.213', 'I70.218', 'I70.219', 'I70.221', 'I70.222', 'I70.223', 'I70.228', 'I70.229', 'I70.231', 'I70.232', 'I70.233', 'I70.234', 'I70.235', 'I70.238', 'I70.239', 'I70.241', 'I70.242', 'I70.243', 'I70.244', 'I70.245', 'I70.248', 'I70.249', 'I70.25', 'I70.261', 'I70.262', 'I70.263', 'I70.268', 'I70.269', 'I70.291', 'I70.292', 'I70.293', 'I70.298', 'I70.299', 'I70.92', 'I74.01', 'I74.09', 'I74.10', 'I74.11', 'I74.19', 'I74.2', 'I74.3', 'I74.4', 'I74.5', 'I74.8', 'I74.9', 'I75.011', 'I75.012', 'I75.013', 'I75.019', 'I75.021', 'I75.022', 'I75.023', 'I75.029', 'I75.81', 'I75.89', 'G45.0', 'G45.1', 'G45.2', 'G45.3', 'G45.4', 'G45.8', 'G45.9', 'G46.0', 'G46.1', 'G46.2', 'G46.3', 'G46.4', 'G46.5', 'G46.6', 'G46.7', 'G46.8', 'K55.0', 'K55.1' Documented using the following ICD-9 codes: '411.0', '411.1', '411.81', '411.89', '413.0', '413.1', '413.9', '414.00', '414.01', '414.02', '414.03', '414.04', '414.05', '414.06', '414.07', '414.2', '414.8', '414.9', '429.2', '433.00', '433.01', '433.10', '433.11', '433.20', '433.21', '433.30', '433.31', '433.80', '433.81', '433.90', '433.91', '434.00', '434.01', '434.10', '434.11', '434.90', '434.91', '440.1', '440.20', '440.21', '440.22', '440.23', '440.24', '440.29', '440.4', '444.01', '444.09', '444.1', '444.21', '444.22', '444.81', '444.89', '444.9', '445.01', '445.02', '445.81', '445.89'	

☐	Patient's BP is taken within the reporting period	Patients in the **numerator** had most recent: *BP Systolic Value*s between 60 and 139 *BP Diastolic Values* between 0 and 89 Patients in the **denominator** had most recent: *BP Systolic Values* between 60 and 250 *BP Diastolic Values* between 0 and 150	Values are all inclusive within their range

C_CHL_CVD *Statin Therapy in ASCVD*

Denominator: Patients ages 21 and older at start of reporting period with a diagnosis of ASCVD during or prior to the reporting period and with an encounter during the reporting period
Numerator: Patients in denominator who have documentation of use of statin during the reporting period

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: 'G0438', 'G0439', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99395', '99396', '99397', '99385', '99386', '99387'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 21-100 years old	
☐	Patient's diagnosis of **ischemic vascular disease** in the Problem List or Assessment during or prior to the reporting period. **(Denominator)**	Documented using the following ICD-10 codes: 'I20.0', 'I20.1', 'I20.8', 'I20.9', 'I21.01', 'I21.02', 'I21.09', 'I21.11', 'I21.19', 'I21.21', 'I21.29', 'I21.3', 'I21.4', 'I24.0', 'I24.1', 'I24.8', 'I24.9', 'I25.10', 'I25.110', 'I25.111', 'I25.118', 'I25.119', 'I25.5', 'I25.6', 'I25.700', 'I25.701', 'I25.708', 'I25.709', 'I25.710', 'I25.711', 'I25.718', 'I25.719', 'I25.720', 'I25.721', 'I25.728', 'I25.729', 'I25.730', 'I25.731', 'I25.738', 'I25.739', 'I25.750', 'I25.751', 'I25.758', 'I25.759', 'I25.760', 'I25.761', 'I25.768', 'I25.769', 'I25.790', 'I25.791', 'I25.798', 'I25.799', 'I25.810', 'I25.811', 'I25.812', 'I25.82', 'I25.84', 'I25.89', 'I25.9', 'I63.00', 'I63.011', 'I63.012', 'I63.019', 'I63.02', 'I63.031', 'I63.032', 'I63.039', 'I63.09', 'I63.10', 'I63.111', 'I63.112', 'I63.119', 'I63.12', 'I63.131', 'I63.132', 'I63.139', 'I63.19', 'I63.20', 'I63.211', 'I63.212', 'I63.219', 'I63.22', 'I63.231', 'I63.232', 'I63.239', 'I63.29', 'I63.30', 'I63.311', 'I63.312', 'I63.319', 'I63.321', 'I63.322', 'I63.329', 'I63.331', 'I63.332', 'I63.339', 'I63.341', 'I63.342', 'I63.349', 'I63.39', 'I63.40', 'I63.411', 'I63.412', 'I63.419', 'I63.421', 'I63.422', 'I63.429', 'I63.431', 'I63.432', 'I63.439', 'I63.441', 'I63.442', 'I63.449', 'I63.49', 'I63.50', 'I63.511', 'I63.512', 'I63.519', 'I63.521', 'I63.522', 'I63.529', 'I63.531', 'I63.532', 'I63.539', 'I63.541', 'I63.542', 'I63.549', 'I63.59', 'I63.6', 'I63.8', 'I63.9', 'I65.01', 'I65.02', 'I65.03', 'I65.09', 'I65.1', 'I65.21', 'I65.22', 'I65.23', 'I65.29', 'I65.8', 'I65.9', 'I66.01', 'I66.02', 'I66.03', 'I66.09', 'I66.11', 'I66.12', 'I66.13', 'I66.19', 'I66.21', 'I66.22', 'I66.23', 'I66.29', 'I66.3', 'I66.8', 'I66.9', 'I70.1', 'I70.201', 'I70.202', 'I70.203', 'I70.208', 'I70.209', 'I70.211', 'I70.212', 'I70.213', 'I70.218', 'I70.219', 'I70.221', 'I70.222', 'I70.223', 'I70.228', 'I70.229', 'I70.231', 'I70.232', 'I70.233', 'I70.234', 'I70.235', 'I70.238', 'I70.239', 'I70.241', 'I70.242', 'I70.243', 'I70.244', 'I70.245', 'I70.248', 'I70.249', 'I70.25', 'I70.261', 'I70.262', 'I70.263', 'I70.268', 'I70.269', 'I70.291', 'I70.292', 'I70.293', 'I70.298', 'I70.299', 'I70.92', 'I74.01', 'I74.09', 'I74.10', 'I74.11', 'I74.19', 'I74.2', 'I74.3', 'I74.4', 'I74.5', 'I74.8', 'I74.9', 'I75.011', 'I75.012', 'I75.013', 'I75.019', 'I75.021', 'I75.022', 'I75.023', 'I75.029', 'I75.81', 'I75.89', 'G45.0', 'G45.1', 'G45.2', 'G45.3', 'G45.8', 'G45.9', 'G46.0', 'G46.1', 'G46.2', 'G46.3', 'G46.4','G46.5','G46.6','G46.7','G46.8','K55.0','K55.1' Documented using the following ICD-9 codes: '411.0', '411.1', '411.81', '411.89', '413.0', '413.1', '413.9', '414.00', '414.01', '414.02', '414.03', '414.04', '414.05', '414.06', '414.07', '414.2', '414.8', '414.9', '429.2', '433.00', '433.01', '433.10', '433.11', '433.20', '433.21', '433.30', '433.31', '433.80', '433.81', '433.90', '433.91', '434.00', '434.01', '434.10', '434.11', '434.90', '434.91', '440.1', '440.20', '440.21', '440.22', '440.23', '440.24', '440.29', '440.4', '444.01', '444.09', '444.1', '444.21', '444.22', '444.81', '444.89', '444.9', '445.01', '445.02', '445.81', '445.89' *Excludes* active diagnosis of pregnancy during the reporting period *Excludes* history of liver disease: 'B15.0', 'B15.9', 'B16.0', 'B16.1', 'B16.2', 'B16.9', 'B18.0', 'B18.1', 'B19.10', 'B19.11', 'K70.0', 'K70.10', 'K70.11', 'K70.2', 'K70.30', 'K70.31', 'K70.40', 'K70.41', 'K70.9',	

		'K71.0', 'K71.10', 'K71.11', 'K71.2', 'K71.3', 'K71.4', 'K71.50', 'K71.51', 'K71.6', 'K71.7', 'K71.8', 'K71.9', 'K72.00', 'K72.01', 'K72.10', 'K72.11', 'K72.90', 'K72.91', 'K73.0', 'K73.1', 'K73.2', 'K73.8', 'K73.9', 'K74.0', 'K74.1', 'K74.2', 'K74.3', 'K74.4', 'K74.5', 'K74.60', 'K74.69', 'K75.2', 'K75.3', 'K75.4', 'Z22.51', '070.0', '070.1', '070.2', '070.21', '070.22', '070.23', '070.30', '070.31', '070.32', '070.33', '070.41', '070.42', '070.43', '070.44', '070.49', '070.51', '070.52', '070.53', '070.54', '070.59', '070.6', '070.70', '070.71', '070.9', '570', '571.0', '571.1', '571.2', '571.3', '571.40', '571.41', '571.42', '571.49', '571.5', '571.6', '571.8', '571.9', '572.2', '572.4', '572.8', '573.1', '573.2', 'V02.61') *Excludes* history of ESRD: 'N18.6', '585.6' *Excludes* allergy to statin	
☐	Patients have a documented use of statin during the reporting period **(Numerator)**	Drug name is in the following list of 'Statin meds, AHRQ, comprehensive" : 'Advicor', 'Altoprev', 'Amlodipine Besylate-Atorvastatin', 'Amlodipine-Atorvastatin', 'atorvastatin', 'Atorvastatin (10)', 'Atorvastatin (20)', 'atorvastatin 10 mg oral tablet', 'atorvastatin 20 mg oral tablet', 'atorvastatin 40 mg oral tablet', 'atorvastatin 80 mg oral tablet', 'Atorvastatin Calcium', 'atorvastatin-amlodipine', 'atorvastatin-ezetimibe', 'Caduet', 'Crestor', 'Crestor (choles)', 'Crestor 10 mg oral tablet', 'Crestor 10mg', 'Crestor 20 mg oral tablet', 'Crestor 5 mg oral tablet', 'Crestor 5mg', 'crestor tablet', 'Crestor*', 'Ezetimibe-Atorvastatin', 'Ezetimibe-Simvastatin', 'fluvastatin', 'Fluvastatin Sodium', 'Fluvastatin Sodium ER', 'Lescol', 'Lescol XL', 'Lipitor', 'LIPITOR TAB', 'Lipitor (choles)', 'Lipitor 10 mg', 'Lipitor 10 mg oral tablet', 'LIPITOR 10 MG TABS', 'LIPITOR 10 MG TABS (90)', 'Lipitor 20 mg', 'Lipitor 20 mg oral tablet', 'LIPITOR 20 MG TABS', 'LIPITOR 20 MG TABS (90)', 'Lipitor 40 mg oral tablet', 'LIPITOR 40 MG TABS', 'LIPITOR 40 MG TABS (90)', 'LIPITOR 80 MG TABS', 'LIPITOR 80 MG TABS (90)', 'Lipitor BRAND NAME ONLY', 'LIPITOR TAB', 'LIPITOR TABLET', 'Lipitor(DAW)', 'Lipitor*', 'Lipitor/Atorvastatin Calcium', 'Liptruzet', 'Livalo', 'Lovastatin', 'LOVASTATIN TABLET', 'LOVASTATIN 20 MG TABS', 'lovastatin 40 mg oral tablet', 'Lovastatin ER', 'LOVASTATIN TABLET', 'Mevacor', 'Niacin-Lovastatin ER', 'Niacin-Simvastatin', 'Niacin-Simvastatin ER', 'pitavastatin', 'Pitavastatin Calcium', 'Pravachol', 'Pravachol (choles)', 'Pravachol 20 mg oral tablet', 'PRAVACHOL 40 MG TABS', 'pravastatin', 'Pravastatin 20 mg', 'pravastatin 20 mg oral tablet', 'Pravastatin 40 mg', 'pravastatin 80 mg oral tablet', 'Pravastatin Na', 'Pravastatin Sodium', 'rosuvastatin', 'Rosuvastatin Calcium', 'Simcor', 'Simvastatin', 'SIMVASTATIN TABLET', 'simvastatin tablets', 'simvastatin 10 mg oral tablet', 'Simvastatin 10mg', 'simvastatin 20 mg oral tablet', 'Simvastatin 20mg', 'simvastatin 40 mg oral tablet', 'Simvastatin 40mg', 'simvastatin 80 mg oral tablet', 'simvastatin gluten-free (Ran Baxy or TEVA)', 'SIMVASTATIN TABLET', 'Simvastatin(20)', 'Simvastatin(40)', 'simvastatin-sitaGLIPtin', 'Sitagliptin-Simvastatin', 'Vytorin', 'Vytorin 10 mg-10 mg oral tablet', 'Vytorin 10/20', 'VYTORIN 10-20 MG TABS', 'Zocor', 'Zocor (10mg)/Simvastatin', 'Zocor (20mg)/Simvastatin', 'Zocor (choles)', 'Zocor 10 mg oral tablet', 'ZOCOR 10 MG TABS', 'ZOCOR 10 MG TABS (90)', 'Zocor 20 mg oral tablet', 'ZOCOR 20 MG TABS', 'ZOCOR 20 MG TABS (90)', 'Zocor 40 mg oral tablet', 'ZOCOR 40 MG TABS', 'ZOCOR 40 MG TABS (90)', 'ZOCOR 5 MG TABS', 'ZOCOR 5 MG TABS (90)', 'ZOCOR 80 MG TABS', 'Zocor*', 'Zocor/Simvastatin'	

C_CHL_LDL *Statin Therapy for History of LDL≥ 190*

Denominator: Patients ages 21 and older at start of reporting period without ASCVD, with an LDL greater than 190 mg/dL ever, and with an encounter during the reporting period
Numerator: Patients in denominator who have documentation of use of statin during the reporting period

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: 'G0438', 'G0439', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99395', '99396', '99397', '99385', '99386', '99387'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 21-100 years old	
☐	Patient's **without** diagnosis of **ischemic vascular disease** in the Problem List or Assessment during or prior to the reporting period *(exclusive)***(Denominator)**	Documented using the following ICD-10 codes: 'I20.0', 'I20.1', 'I20.8', 'I20.9', 'I21.01', 'I21.02', 'I21.09', 'I21.11', 'I21.19', 'I21.21', 'I21.29', 'I21.3', 'I21.4', 'I24.0', 'I24.1', 'I24.8', 'I24.9', 'I25.10', 'I25.110', 'I25.111', 'I25.118', 'I25.119', 'I25.5', 'I25.6', 'I25.700', 'I25.701', 'I25.708', 'I25.709', 'I25.710', 'I25.711', 'I25.718', 'I25.719', 'I25.720', 'I25.721', 'I25.728', 'I25.729', 'I25.730', 'I25.731', 'I25.738', 'I25.739', 'I25.750', 'I25.751', 'I25.758', 'I25.759', 'I25.760', 'I25.761', 'I25.768', 'I25.769', 'I25.790', 'I25.791', 'I25.798', 'I25.799', 'I25.810', 'I25.811', 'I25.812', 'I25.82', 'I25.84', 'I25.89', 'I25.9', 'I63.00', 'I63.011', 'I63.012', 'I63.019', 'I63.02', 'I63.031', 'I63.032', 'I63.039', 'I63.09', 'I63.10', 'I63.111', 'I63.112', 'I63.119', 'I63.12', 'I63.131', 'I63.132', 'I63.139', 'I63.19', 'I63.20', 'I63.211', 'I63.212', 'I63.219', 'I63.22', 'I63.231', 'I63.232', 'I63.239', 'I63.29', 'I63.30', 'I63.311', 'I63.312', 'I63.319', 'I63.321', 'I63.322', 'I63.329', 'I63.331', 'I63.332', 'I63.339', 'I63.341', 'I63.342', 'I63.349', 'I63.39', 'I63.40', 'I63.411', 'I63.412', 'I63.419', 'I63.421', 'I63.422', 'I63.429', 'I63.431', 'I63.432', 'I63.439', 'I63.441', 'I63.442', 'I63.449', 'I63.49', 'I63.50', 'I63.511', 'I63.512', 'I63.519', 'I63.521', 'I63.522', 'I63.529', 'I63.531', 'I63.532', 'I63.539', 'I63.541', 'I63.542', 'I63.549', 'I63.59', 'I63.6', 'I63.8', 'I63.9', 'I65.01', 'I65.02', 'I65.03', 'I65.09', 'I65.1', 'I65.21', 'I65.22', 'I65.23', 'I65.29', 'I65.8', 'I65.9', 'I66.01', 'I66.02', 'I66.03', 'I66.09', 'I66.11', 'I66.12', 'I66.13', 'I66.19', 'I66.21', 'I66.22', 'I66.23', 'I66.29', 'I66.3', 'I66.8', 'I66.9', 'I70.1', 'I70.201', 'I70.202', 'I70.203', 'I70.208', 'I70.209', 'I70.211', 'I70.212', 'I70.213', 'I70.218', 'I70.219', 'I70.221', 'I70.222', 'I70.223', 'I70.228', 'I70.229', 'I70.231', 'I70.232', 'I70.233', 'I70.234', 'I70.235', 'I70.238', 'I70.239', 'I70.241', 'I70.242', 'I70.243', 'I70.244', 'I70.245', 'I70.248', 'I70.249', 'I70.25', 'I70.261', 'I70.262', 'I70.263', 'I70.268', 'I70.269', 'I70.291', 'I70.292', 'I70.293', 'I70.298', 'I70.299', 'I70.92', 'I74.01', 'I74.09', 'I74.10', 'I74.11', 'I74.19', 'I74.2', 'I74.3', 'I74.4', 'I74.5', 'I74.8', 'I74.9', 'I75.011', 'I75.012', 'I75.013', 'I75.019', 'I75.021', 'I75.022', 'I75.023', 'I75.029', 'I75.81', 'I75.89' Documented using the following ICD-9 codes: '00.61', '00.62', '00.63', '00.64', '00.65', '00.66', '36.10', '36.11', '36.12', '36.13', '36.14', '36.15', '36.16', '36.17', '36.19', '410.01', '410.11', '410.21', '410.31', '410.41', '410.51', '410.61', '410.71', '410.81', '410.91', '411.0', '411.1', '411.81', '411.89', '413.0', '413.1', '413.9', '414.00', '414.01', '414.02', '414.03', '414.04', '414.05', '414.06', '414.07', '414.2', '414.8', '414.9', '429.2', '433.00', '433.01', '433.10', '433.11', '433.20', '433.21', '433.30', '433.31', '433.80', '433.81', '433.90', '433.91', '434.00', '434.01', '434.10', '434.11', '434.90', '434.91', '440.1', '440.20', '440.21', '440.22', '440.23', '440.24', '440.29', '440.4', '444.01', '444.09', '444.1', '444.21', '444.22', '444.81', '444.89', '444.9', '445.01', '445.02', '445.81', '445.89' *Excludes* active diagnosis of pregnancy during the reporting period *Excludes* history of liver disease: 'B15.0', 'B15.9', 'B16.0', 'B16.1', 'B16.2', 'B16.9', 'B18.0', 'B18.1', 'B19.10', 'B19.11', 'K70.0', 'K70.10', 'K70.11', 'K70.2', 'K70.30', 'K70.31', 'K70.40', 'K70.41', 'K70.9',	

		'K71.0', 'K71.10', 'K71.11', 'K71.2', 'K71.3', 'K71.4', 'K71.50', 'K71.51', 'K71.6', 'K71.7', 'K71.8', 'K71.9', 'K72.00', 'K72.01', 'K72.10', 'K72.11', 'K72.90', 'K72.91', 'K73.0', 'K73.1', 'K73.2', 'K73.8', 'K73.9', 'K74.0', 'K74.1', 'K74.2', 'K74.3', 'K74.4', 'K74.5', 'K74.60', 'K74.69', 'K75.2', 'K75.3', 'K75.4', 'Z22.51', '070.0', '070.1', '070.2', '070.21', '070.22', '070.23', '070.30', '070.31', '070.32', '070.33', '070.41', '070.42', '070.43', '070.44', '070.49', '070.51', '070.52', '070.53', '070.54', '070.59', '070.6', '070.70', '070.71', '070.9', '570', '571.0', '571.1', '571.2', '571.3', '571.40', '571.41', '571.42', '571.49', '571.5', '571.6', '571.8', '571.9', '572.2', '572.4', '572.8', '573.1', '573.2', 'V02.61') *Excludes* history of ESRD: 'N18.6', '585.6' *Excludes* allergy to statin	
☐	The Patient's lab result numeric value is *190 or above,* ***ever*** *(inclusive)* **(Denominator)**	Result documented using the following LOINC codes '12773-8', '13457-7', '18261-8', '18262-6', '2089-1', '22748-8', '39469-2', '49132-4', '55440-2'	
☐	Patients have a documented use of statin during the reporting period **(Numerator)**	Drug name is in the following list of 'Statin meds, AHRQ, comprehensive" : 'Advicor', 'Altoprev', 'Amlodipine Besylate-Atorvastatin', 'Amlodipine-Atorvastatin', 'atorvastatin', 'Atorvastatin (10)', 'Atorvastatin (20)', 'atorvastatin 10 mg oral tablet', 'atorvastatin 20 mg oral tablet', 'atorvastatin 40 mg oral tablet', 'atorvastatin 80 mg oral tablet', 'Atorvastatin Calcium', 'atorvastatin-amlodipine', 'atorvastatin-ezetimibe', 'Caduet', 'Crestor', 'Crestor (choles)', 'Crestor 10 mg oral tablet', 'Crestor 10mg', 'Crestor 20 mg oral tablet', 'Crestor 5 mg oral tablet', 'Crestor 5mg', 'crestor tablet', 'Crestor*', 'Ezetimibe-Atorvastatin', 'Ezetimibe-Simvastatin', 'fluvastatin', 'Fluvastatin Sodium', 'Fluvastatin Sodium ER', 'Lescol', 'Lescol XL', 'Lipitor', 'LIPITOR TAB', 'Lipitor (choles)', 'Lipitor 10 mg', 'Lipitor 10 mg oral tablet', 'LIPITOR 10 MG TABS', 'LIPITOR 10 MG TABS (90)', 'Lipitor 20 mg', 'Lipitor 20 mg oral tablet', 'LIPITOR 20 MG TABS', 'LIPITOR 20 MG TABS (90)', 'Lipitor 40 mg oral tablet', 'LIPITOR 40 MG TABS', 'LIPITOR 40 MG TABS (90)', 'LIPITOR 80 MG TABS', 'LIPITOR 80 MG TABS (90)', 'Lipitor BRAND NAME ONLY', 'LIPITOR TAB', 'LIPITOR TABLET', 'Lipitor(DAW)', 'Lipitor*', 'Lipitor/Atorvastatin Calcium', 'Liptruzet', 'Livalo', 'Lovastatin', 'LOVASTATIN TABLET', 'LOVASTATIN 20 MG TABS', 'lovastatin 40 mg oral tablet', 'Lovastatin ER', 'LOVASTATIN TABLET', 'Mevacor', 'Niacin-Lovastatin ER', 'Niacin-Simvastatin', 'Niacin-Simvastatin ER', 'pitavastatin', 'Pitavastatin Calcium', 'Pravachol', 'Pravachol (choles)', 'Pravachol 20 mg oral tablet', 'PRAVACHOL 40 MG TABS', 'pravastatin', 'Pravastatin 20 mg', 'pravastatin 20 mg oral tablet', 'Pravastatin 40 mg', 'pravastatin 80 mg oral tablet', 'Pravastatin Na', 'Pravastatin Sodium', 'rosuvastatin', 'Rosuvastatin Calcium', 'Simcor', 'Simvastatin', 'SIMVASTATIN TABLET', 'simvastatin tablets', 'simvastatin 10 mg oral tablet', 'Simvastatin 10mg', 'simvastatin 20 mg oral tablet', 'Simvastatin 20mg', 'simvastatin 40 mg oral tablet', 'Simvastatin 40mg', 'simvastatin 80 mg oral tablet', 'simvastatin gluten-free (Ran Baxy or TEVA)', 'SIMVASTATIN TABLET', 'Simvastatin(20)', 'Simvastatin(40)', 'simvastatin-sitaGLIPtin', 'Sitagliptin-Simvastatin', 'Vytorin', 'Vytorin 10 mg-10 mg oral tablet', 'Vytorin 10/20', 'VYTORIN 10-20 MG TABS', 'Zocor', 'Zocor (10mg)/Simvastatin', 'Zocor (20mg)/Simvastatin', 'Zocor (choles)', 'Zocor 10 mg oral tablet', 'ZOCOR 10 MG TABS', 'ZOCOR 10 MG TABS (90)', 'Zocor 20 mg oral tablet', 'ZOCOR 20 MG TABS', 'ZOCOR 20 MG TABS (90)', 'Zocor 40 mg oral tablet', 'ZOCOR 40 MG TABS', 'ZOCOR 40 MG TABS (90)', 'ZOCOR 5 MG TABS', 'ZOCOR 5 MG TABS (90)', 'ZOCOR 80 MG TABS', 'Zocor*', 'Zocor/Simvastatin'	

C_CHL_DM *Statin Therapy in People with Diabetes*

Denominator: Patients ages 40 to 75 at start of reporting period without ASCVD or max LDL 190 mg/dL ever, with DM and LDL between 70-189 mg/dL, and with an encounter during the reporting period
Numerator: Patients in denominator who have documentation of use of statin during the reporting period

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes: 'G0438', 'G0439', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99395', '99396', '99397', '99385', '99386', '99387'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 40-75 years old	
☐	Patients **without** diagnosis of **ischemic vascular disease** in the Problem List or Assessment during or prior to the reporting period. *(exclusive)***(Denominator)**	Documented using the following ICD-10 codes: 'I20.0', 'I20.1', 'I20.8', 'I20.9', 'I21.01', 'I21.02', 'I21.09', 'I21.11', 'I21.19', 'I21.21', 'I21.29', 'I21.3', 'I21.4', 'I24.0', 'I24.1', 'I24.8', 'I24.9', 'I25.10', 'I25.110', 'I25.111', 'I25.118', 'I25.119', 'I25.5', 'I25.6', 'I25.700', 'I25.701', 'I25.708', 'I25.709', 'I25.710', 'I25.711', 'I25.718', 'I25.719', 'I25.720', 'I25.721', 'I25.728', 'I25.729', 'I25.730', 'I25.731', 'I25.738', 'I25.739', 'I25.750', 'I25.751', 'I25.758', 'I25.759', 'I25.760', 'I25.761', 'I25.768', 'I25.769', 'I25.790', 'I25.791', 'I25.798', 'I25.799', 'I25.810', 'I25.811', 'I25.812', 'I25.82', 'I25.84', 'I25.89', 'I25.9', 'I63.00', 'I63.011', 'I63.012', 'I63.019', 'I63.02', 'I63.031', 'I63.032', 'I63.039', 'I63.09', 'I63.10', 'I63.111', 'I63.112', 'I63.119', 'I63.12', 'I63.131', 'I63.132', 'I63.139', 'I63.19', 'I63.20', 'I63.211', 'I63.212', 'I63.219', 'I63.22', 'I63.231', 'I63.232', 'I63.239', 'I63.29', 'I63.30', 'I63.311', 'I63.312', 'I63.319', 'I63.321', 'I63.322', 'I63.329', 'I63.331', 'I63.332', 'I63.339', 'I63.341', 'I63.342', 'I63.349', 'I63.39', 'I63.40', 'I63.411', 'I63.412', 'I63.419', 'I63.421', 'I63.422', 'I63.429', 'I63.431', 'I63.432', 'I63.439', 'I63.441', 'I63.442', 'I63.449', 'I63.49', 'I63.50', 'I63.511', 'I63.512', 'I63.519', 'I63.521', 'I63.522', 'I63.529', 'I63.531', 'I63.532', 'I63.539', 'I63.541', 'I63.542', 'I63.549', 'I63.59', 'I63.6', 'I63.8', 'I63.9', 'I65.01', 'I65.02', 'I65.03', 'I65.09', 'I65.1', 'I65.21', 'I65.22', 'I65.23', 'I65.29', 'I65.8', 'I65.9', 'I66.01', 'I66.02', 'I66.03', 'I66.09', 'I66.11', 'I66.12', 'I66.13', 'I66.19', 'I66.21', 'I66.22', 'I66.23', 'I66.29', 'I66.3', 'I66.8', 'I66.9', 'I70.1', 'I70.201', 'I70.202', 'I70.203', 'I70.208', 'I70.209', 'I70.211', 'I70.212', 'I70.213', 'I70.218', 'I70.219', 'I70.221', 'I70.222', 'I70.223', 'I70.228', 'I70.229', 'I70.231', 'I70.232', 'I70.233', 'I70.234', 'I70.235', 'I70.238', 'I70.239', 'I70.241', 'I70.242', 'I70.243', 'I70.244', 'I70.245', 'I70.248', 'I70.249', 'I70.25', 'I70.261', 'I70.262', 'I70.263', 'I70.268', 'I70.269', 'I70.291', 'I70.292', 'I70.293', 'I70.298', 'I70.299', 'I70.92', 'I74.01', 'I74.09', 'I74.10', 'I74.11', 'I74.19', 'I74.2', 'I74.3', 'I74.4', 'I74.5', 'I74.8', 'I74.9', 'I75.011', 'I75.012', 'I75.013', 'I75.019', 'I75.021', 'I75.022', 'I75.023', 'I75.029', 'I75.81', 'I75 .89' Documented using the following ICD-9 codes: '00.61', '00.62', '00.63', '00.64', '00.65', '00.66', '36.10', '36.11', '36.12', '36.13', '36.14', '36.15', '36.16', '36.17', '36.19', '38.02', '38.12', '38.22', '38.30', '38.31', '38.32', '38.42', '39.28', '88.41', '410.01', '410.11', '410.21', '410.31', '410.41', '410.51', '410.61', '410.71', '410.81', '410.91', '411.0', '411.1', '411.81', '411.89', '413.0', '413.1', '413.9', '414.00', '414.01', '414.02', '414.03', '414.04', '414.05', '414.06', '414.07', '414.2', '414.8', '414.9', '429.2', '433.00', '433.01', '433.10', '433.11', '433.20', '433.21', '433.30', '433.31', '433.80', '433.81', '433.90', '433.91', '434.00', '434.01', '434.10', '434.11', '434.90', '434.91', '440.1', '440.20', '440.21', '440.22', '440.23', '440.24', '440.29', '440.4', '444.01', '444.09', '444.1', '444.21', '444.22', '444.81', '444.89', '444.9', '445.01', '445.02', '445.81', '445.89' *Excludes* active diagnosis of pregnancy during the reporting period *Excludes* history of liver disease: 'B15.0', 'B15.9', 'B16.0', 'B16.1', 'B16.2', 'B16.9', 'B18.0', 'B18.1', 'B19.10', 'B19.11',	

		'K70.0', 'K70.10', 'K70.11', 'K70.2', 'K70.30', 'K70.31', 'K70.40', 'K70.41', 'K70.9', 'K71.0', 'K71.10', 'K71.11', 'K71.2', 'K71.3', 'K71.4', 'K71.50', 'K71.51', 'K71.6', 'K71.7', 'K71.8', 'K71.9', 'K72.00', 'K72.01', 'K72.10', 'K72.11', 'K72.90', 'K72.91', 'K73.0', 'K73.1', 'K73.2', 'K73.8', 'K73.9', 'K74.0', 'K74.1', 'K74.2', 'K74.3', 'K74.4', 'K74.5', 'K74.60', 'K74.69', 'K75.2', 'K75.3', 'K75.4', 'Z22.51', '070.0', '070.1', '070.2', '070.21', '070.22', '070.23', '070.30', '070.31', '070.32', '070.33', '070.41', '070.42', '070.43', '070.44', '070.49', '070.51', '070.52', '070.53', '070.54', '070.59', '070.6', '070.70', '070.71', '070.9', '570', '571.0', '571.1', '571.2', '571.3', '571.40', '571.41', '571.42', '571.49', '571.5', '571.6', '571.8', '571.9', '572.2', '572.4', '572.8', '573.1', '573.2', 'V02.61') *Excludes* history of ESRD: 'N18.6', '585.6' *Excludes* allergy to statin	
☐	The Patient's lab result numeric value **has never been** *190 or above, (exclusive)* **(Denominator)**	Result documented using the following LOINC codes : '12773-8', '13457-7', '18261-8', '18262-6', '2089-1', '22748-8', '39469-2', '49132-4', '55440-2'	
☐	The Patient's lab result numeric value is between 70-189 within 36 months preceding end of the reporting period *(inclusive)* **(Denominator**)	Result documented using the following LOINC codes (Cholesterol, Total): '12773-8', '13457-7', '18261-8', '18262-6', '2089-1', '22748-8', '39469-2', '49132-4', '55440-2'	
☐	Patient's diagnosis of **diabetes** in the Problem List or Assessment during or prior to the reporting period. *(inclusive)* **(Denominator)**	Documented using the following ICD-10 codes: 'E10.10', 'E10.11', 'E10.21', 'E10.22', 'E10.29', 'E10.311', 'E10.319', 'E10.321', 'E10.329', 'E10.331', 'E10.339', 'E10.341', 'E10.349', 'E10.351', 'E10.359', 'E10.36', 'E10.39', 'E10.40', 'E10.41', 'E10.42', 'E10.43', 'E10.44', 'E10.49', 'E10.51', 'E10.52', 'E10.59', 'E10.610', 'E10.618', 'E10.620', 'E10.621', 'E10.622', 'E10.628', 'E10.630', 'E10.638', 'E10.641', 'E10.649', 'E10.65', 'E10.69', 'E10.8', 'E10.9', 'E11.00', 'E11.01', 'E11.21', 'E11.22', 'E11.29', 'E11.311', 'E11.319', 'E11.321', 'E11.329', 'E11.331', 'E11.339', 'E11.341', 'E11.349', 'E11.351', 'E11.359', 'E11.36', 'E11.39', 'E11.40', 'E11.41', 'E11.42', 'E11.43', 'E11.44', 'E11.49', 'E11.51', 'E11.52', 'E11.59', 'E11.610', 'E11.618', 'E11.620', 'E11.621', 'E11.622', 'E11.628', 'E11.630', 'E11.638', 'E11.641', 'E11.649', 'E11.65', 'E11.69', 'E11.8', 'E11.9', 'E13.00', 'E13.01', 'E13.10', 'E13.11', 'E13.21', 'E13.22', 'E13.29', 'E13.311', 'E13.319', 'E13.321', 'E13.329', 'E13.331', 'E13.339', 'E13.341', 'E13.349', 'E13.351', 'E13.359', 'E13.36', 'E13.39', 'E13.40', 'E13.41', 'E13.42', 'E13.43', 'E13.44', 'E13.49', 'E13.51', 'E13.52', 'E13.59', 'E13.610', 'E13.618', 'E13.620', 'E13.621', 'E13.622', 'E13.628', 'E13.630', 'E13.638', 'E13.641', 'E13.649', 'E13.65', 'E13.69', 'E13.8', 'E13.9', 'O24.011', 'O24.012', 'O24.013', 'O24.019', 'O24.02', 'O24.03', 'O24.111', 'O24.112', 'O24.113', 'O24.119', 'O24.12', 'O24.13', 'O24.311', 'O24.312', 'O24.313', 'O24.319', 'O24.32', 'O24.33', 'O24.811', 'O24.812', 'O24.813', 'O24.819', 'O24.82', 'O24.83' Documented using the following ICD-9 codes: '250.00', '250.01', '250.02', '250.03', '250.1', '250.10', '250.11', '250.12', '250.13', '250.2', '250.20', '250.21', '250.22', '250.23', '250.3', '250.30', '250.31', '250.32', '250.33', '250.4', '250.40', '250.41', '250.42', '250.43', '250.5', '250.50', '250.51', '250.52', '250.53', '250.6', '250.60', '250.61', '250.62', '250.63', '250.7', '250.70', '250.71', '250.72', '250.73', '250.8', '250.80', '250.81', '250.82', '250.83', '250.9', '250.90', '250.91', '250.92', '250.93', '357.2', '362.0', '362.01', '362.02', '362.03', '362.04', '362.05', '362.06', '362.07', '366.41', '648.0', '648.00', '648.01', '648.02', '648.03', '648.04'	

	Patients have a documented use of statin during the reporting period **(Numerator)**	Drug name is in the following list of "Statin meds, AHRQ, comprehensive" : 'Advicor', 'Altoprev', 'Amlodipine Besylate-Atorvastatin', 'Amlodipine-Atorvastatin', 'atorvastatin', 'Atorvastatin (10)', 'Atorvastatin (20)', 'atorvastatin 10 mg oral tablet', 'atorvastatin 20 mg oral tablet', 'atorvastatin 40 mg oral tablet', 'atorvastatin 80 mg oral tablet', 'Atorvastatin Calcium', 'atorvastatin-amlodipine', 'atorvastatin-ezetimibe', 'Caduet', 'Crestor', 'Crestor (choles)', 'Crestor 10 mg oral tablet', 'Crestor 10mg', 'Crestor 20 mg oral tablet', 'Crestor 5 mg oral tablet', 'Crestor 5mg', 'crestor tablet', 'Crestor*', 'Ezetimibe-Atorvastatin', 'Ezetimibe-Simvastatin', 'fluvastatin', 'Fluvastatin Sodium', 'Fluvastatin Sodium ER', 'Lescol', 'Lescol XL', 'Lipitor', 'LIPITOR TAB', 'Lipitor (choles)', 'Lipitor 10 mg', 'Lipitor 10 mg oral tablet', 'LIPITOR 10 MG TABS', 'LIPITOR 10 MG TABS (90)', 'Lipitor 20 mg', 'Lipitor 20 mg oral tablet', 'LIPITOR 20 MG TABS', 'LIPITOR 20 MG TABS (90)', 'Lipitor 40 mg oral tablet', 'LIPITOR 40 MG TABS', 'LIPITOR 40 MG TABS (90)', 'LIPITOR 80 MG TABS', 'LIPITOR 80 MG TABS (90)', 'Lipitor BRAND NAME ONLY', 'LIPITOR TAB', 'LIPITOR TABLET', 'Lipitor(DAW)', 'Lipitor*', 'Lipitor/Atorvastatin Calcium', 'Liptruzet', 'Livalo', 'Lovastatin', 'LOVASTATIN TABLET', 'LOVASTATIN 20 MG TABS', 'lovastatin 40 mg oral tablet', 'Lovastatin ER', 'LOVASTATIN TABLET', 'Mevacor', 'Niacin-Lovastatin ER', 'Niacin-Simvastatin', 'Niacin-Simvastatin ER', 'pitavastatin', 'Pitavastatin Calcium', 'Pravachol', 'Pravachol (choles)', 'Pravachol 20 mg oral tablet', 'PRAVACHOL 40 MG TABS', 'pravastatin', 'Pravastatin 20 mg', 'pravastatin 20 mg oral tablet', 'Pravastatin 40 mg', 'pravastatin 80 mg oral tablet', 'Pravastatin Na', 'Pravastatin Sodium', 'rosuvastatin', 'Rosuvastatin Calcium', 'Simcor', 'Simvastatin', 'SIMVASTATIN TABLET', 'simvastatin tablets', 'simvastatin 10 mg oral tablet', 'Simvastatin 10mg', 'simvastatin 20 mg oral tablet', 'Simvastatin 20mg', 'simvastatin 40 mg oral tablet', 'Simvastatin 40mg', 'simvastatin 80 mg oral tablet', 'simvastatin gluten-free (Ran Baxy or TEVA)', 'SIMVASTATIN TABLET', 'Simvastatin(20)', 'Simvastatin(40)', 'simvastatin-sitaGLIPtin', 'Sitagliptin-Simvastatin', 'Vytorin', 'Vytorin 10 mg-10 mg oral tablet', 'Vytorin 10/20', 'VYTORIN 10-20 MG TABS', 'Zocor', 'Zocor (10mg)/Simvastatin', 'Zocor (20mg)/Simvastatin', 'Zocor (choles)', 'Zocor 10 mg oral tablet', 'ZOCOR 10 MG TABS', 'ZOCOR 10 MG TABS (90)', 'Zocor 20 mg oral tablet', 'ZOCOR 20 MG TABS', 'ZOCOR 20 MG TABS (90)', 'Zocor 40 mg oral tablet', 'ZOCOR 40 MG TABS', 'ZOCOR 40 MG TABS (90)', 'ZOCOR 5 MG TABS', 'ZOCOR 5 MG TABS (90)', 'ZOCOR 80 MG TABS', 'Zocor*', 'Zocor/Simvastatin'	

C_A1C_DM *A1C Poorly Controlled (> 9.0%) in People with Diabetes*

Denominator: Patients between the ages of 18-75 with a diagnosis of diabetes (type 1, type 2, or secondary) and an A1c test result recorded during the 12 months prior to the reporting period through one month after the reporting period

Numerator: Patients in denominator whose most recent recorded A1C level is > 9.0%

***Note:* for this measure only, a higher rate indicates worse performance**

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes in list "E&M codes (office visits), Adults and adolescents [v1.00]": '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth as of the day before the reporting period	Between the ages of 18 – 75 years old	
☐	Patient's diagnosis of **diabetes** in the Problem List or Assessment during or prior to the reporting period	Documented using the following ICD-10 codes in list "Diabetes type 1, type 2, and secondary (not gestational), 10 [v1.00]": 'E08.00', 'E08.01', 'E08.10', 'E08.11', 'E08.21', 'E08.22', 'E08.29', 'E08.311', 'E08.319', 'E08.321', 'E08.329', 'E08.331', 'E08.339', 'E08.341', 'E08.349', 'E08.351', 'E08.359', 'E08.36', 'E08.39', 'E08.40', 'E08.41', 'E08.42', 'E08.43', 'E08.44', 'E08.49', 'E08.51', 'E08.52', 'E08.59', 'E08.610', 'E08.618', 'E08.620', 'E08.621', 'E08.622', 'E08.628', 'E08.630', 'E08.638', 'E08.641', 'E08.649', 'E08.65', 'E08.69', 'E08.8', 'E08.9', 'E09.00', 'E09.01', 'E09.10', 'E09.11', 'E09.21', 'E09.22', 'E09.29', 'E09.311', 'E09.319', 'E09.321', 'E09.329', 'E09.331', 'E09.339', 'E09.341', 'E09.349', 'E09.351', 'E09.359', 'E09.36', 'E09.39', 'E09.40', 'E09.41', 'E09.42', 'E09.43', 'E09.44', 'E09.49', 'E09.51', 'E09.52', 'E09.59', 'E09.610', 'E09.618', 'E09.620', 'E09.621', 'E09.622', 'E09.628', 'E09.630', 'E09.638', 'E09.641', 'E09.649', 'E09.65', 'E09.69', 'E09.8', 'E09.9', 'E10.10', 'E10.11', 'E10.21', 'E10.22', 'E10.29', 'E10.311', 'E10.319', 'E10.321', 'E10.329', 'E10.331', 'E10.339', 'E10.341', 'E10.349', 'E10.351', 'E10.359', 'E10.36', 'E10.39', 'E10.40', 'E10.41', 'E10.42', 'E10.43', 'E10.44', 'E10.49', 'E10.51', 'E10.52', 'E10.59', 'E10.610', 'E10.618', 'E10.62', 'E10.620', 'E10.621', 'E10.622', 'E10.628', 'E10.63', 'E10.630', 'E10.638', 'E10.64', 'E10.641', 'E10.649', 'E10.65', 'E10.69', 'E10.8', 'E10.9', 'E11.00', 'E11.01', 'E11.21', 'E11.22', 'E11.29', 'E11.311', 'E11.319', 'E11.331', 'E11.339', 'E11.341', 'E11.349', 'E11.351', 'E11.359', 'E11.36', 'E11.39', 'E11.40', 'E11.41', 'E11.42', 'E11.43', 'E11.44', 'E11.49', 'E11.51', 'E11.52', 'E11.59', 'E11.610', 'E11.618', 'E11.620', 'E11.621', 'E11.622', 'E11.628', 'E11.630', 'E11.638', 'E11.641', 'E11.649', 'E11.65', 'E11.69', 'E11.8', 'E11.9', 'E13.00', 'E13.01', 'E13.10', 'E13.11', 'E13.21', 'E13.22', 'E13.29', 'E13.311', 'E13.319', 'E13.321', 'E13.329', 'E13.331', 'E13.339', 'E13.341', 'E13.349', 'E13.351', 'E13.359', 'E13.36', 'E13.39', 'E13.40', 'E13.41', 'E13.42', 'E13.43', 'E13.44', 'E13.49', 'E13.51', 'E13.52', 'E13.59', 'E13.610', 'E13.618', 'E13.62', 'E13.620', 'E13.621', 'E13.622', 'E13.628', 'E13.63', 'E13.630', 'E13.638', 'E13.64', 'E13.641', 'E13.649', 'E13.65', 'E13.69', 'E13.8', 'E13.9' Documented using the following ICD-9 codes in list "Diabetes type 1, type 2, and secondary (not gestational), 10 [v1.00]": '249', '249.0', '249.00', '249.01', '249.10', '249.11', '249.20', '249.21',	Includes secondary, does not include gestational diabetes

		'249.30', '249.31', '249.40', '249.41', '249.50', '249.51', '249.60', '249.61', '249.70', '249.71', '249.80', '249.81', '249.90', '249.91', '250', '250.0', '250.00', '250.01', '250.02', '250.03', '250.1', '250.10', '250.11', '250.12', '250.13', '250.2', '250.20', '250.21', '250.22', '250.23', '250.3', '250.30', '250.31', '250.32', '250.33', '250.4', '250.40', '250.41', '250.42', '250.43', '250.5', '250.50', '250.51', '250.52', '250.53', '250.6', '250.60', '250.61', '250.62', '250.63', '250.7', '250.70', '250.71', '250.72', '250.73', '250.8', '250.80', '250.81', '250.82', '250.83', '250.9', '250.90', '250.91', '250.92', '250.93', '357.2', '362.0', '362.01', '362.02', '362.03', '362.04', '362.05', '362.06', '362.07', '366.41', '648.0', '648.00', '648.01', '648.02', '648.03', '648.04'	
☐	The Patient's most recent lab result numeric value is ***between 3.0 and 30.0 (inclusive)*** and is within the reporting period. **(Denominator)**	Result documented using the following LOINC codes in list Hemoglobin A1c [v2.00] : '4548-4', '4549-2', '41995-2', '55454-3', '17855-8', '17856-6', '62388-4', '71875-9', '59261-8','54039-3', '67761-7'	Recorded A1c level during the ***12 months prior*** to the reporting period through ***one month*** after the reporting period.
☐	The Patient's most recent lab result numeric value is ***between 9.01 and 30 (inclusive)*** and is within the reporting period. **(Numerator)**	Result documented using the following LOINC codes in list Hemoglobin A1c [v2.00]: '4548-4', '4549-2', '41995-2', '55454-3', '17855-8', '17856-6', '62388-4', '71875-9', '59261-8', '54039-3', '67761-7'	Recorded A1c level during the ***12 months prior*** to the reporting period through ***one month*** after the reporting period.

S_A1C_DM *Diabetes A1C Screening*

Denominator: Patients between the ages of 18-75 with a diagnosis of diabetes (type 1, type 2, or secondary)
Numerator: Patients in denominator with an A1c test result during the 12 months prior through one month after the reporting period.

Checklist	Block	Specification	Notes
☐	Patients came in for an office visit within the reporting period	Office visit documented using the following CPT codes in list "E&M codes (office visits), Adults and adolescents [v1.00]": '99201', '99202', '99203', '99204', '99205', '99212', '99213', '99214', '99215', '99241', '99242', '99243', '99244', '99245', '99341', '99342', '99343', '99344', '99345', '99347', '99348', '99349', '99350', '99384', '99385', '99386', '99387', '99394', '99395', '99396', '99397', '99401', '99402', '99403', '99404', '99420', '99429'	
☐	Patients Date of Birth by the start of the reporting period	Between the ages of 18 – 75 years old	
☐	Patient's diagnosis of **diabetes** in the Problem List or Assessment during or prior to the reporting period	Documented using the following ICD-10 codes in list "Diabetes type 1, type 2, and secondary (not gestational), 10 [v1.00]": 'E08.00', 'E08.01', 'E08.10', 'E08.11', 'E08.21', 'E08.22', 'E08.29', 'E08.311', 'E08.319', 'E08.321', 'E08.329', 'E08.331', 'E08.339', 'E08.341', 'E08.349', 'E08.351', 'E08.359', 'E08.36', 'E08.39', 'E08.40', 'E08.41', 'E08.42', 'E08.43', 'E08.44', 'E08.49', 'E08.51', 'E08.52', 'E08.59', 'E08.610', 'E08.618', 'E08.620', 'E08.621', 'E08.622', 'E08.628', 'E08.630', 'E08.638', 'E08.641', 'E08.649', 'E08.65', 'E08.69', 'E08.8', 'E08.9', 'E09.00', 'E09.01', 'E09.10', 'E09.11', 'E09.21', 'E09.22', 'E09.29', 'E09.311', 'E09.319', 'E09.321', 'E09.329', 'E09.331', 'E09.339', 'E09.341', 'E09.349', 'E09.351', 'E09.359', 'E09.36', 'E09.39', 'E09.40', 'E09.41', 'E09.42', 'E09.43', 'E09.44', 'E09.49', 'E09.51', 'E09.52', 'E09.59', 'E09.610', 'E09.618', 'E09.620', 'E09.621', 'E09.622', 'E09.628', 'E09.630', 'E09.638', 'E09.641', 'E09.649', 'E09.65', 'E09.69', 'E09.8', 'E09.9', 'E10.10', 'E10.11', 'E10.21', 'E10.22', 'E10.29', 'E10.311', 'E10.319', 'E10.321', 'E10.329', 'E10.331', 'E10.339', 'E10.341', 'E10.349', 'E10.351', 'E10.359', 'E10.36', 'E10.39', 'E10.40', 'E10.41', 'E10.42', 'E10.43', 'E10.44', 'E10.49', 'E10.51', 'E10.52', 'E10.59', 'E10.610', 'E10.618', 'E10.62', 'E10.620', 'E10.621', 'E10.622', 'E10.628', 'E10.63', 'E10.630', 'E10.638', 'E10.64', 'E10.641', 'E10.649', 'E10.65', 'E10.69', 'E10.8', 'E10.9', 'E11.00', 'E11.01', 'E11.21', 'E11.22', 'E11.29', 'E11.311', 'E11.319', 'E11.331', 'E11.339', 'E11.341', 'E11.349', 'E11.351', 'E11.359', 'E11.36', 'E11.39', 'E11.40', 'E11.41', 'E11.42', 'E11.43', 'E11.44', 'E11.49', 'E11.51', 'E11.52', 'E11.59', 'E11.610', 'E11.618', 'E11.620', 'E11.621', 'E11.622', 'E11.628', 'E11.630', 'E11.638', 'E11.641', 'E11.649', 'E11.65', 'E11.69', 'E11.8', 'E11.9', 'E13.00', 'E13.01', 'E13.10', 'E13.11', 'E13.21', 'E13.22', 'E13.29', 'E13.311', 'E13.319', 'E13.321', 'E13.329', 'E13.331', 'E13.339', 'E13.341', 'E13.349', 'E13.351', 'E13.359', 'E13.36', 'E13.39', 'E13.40', 'E13.41', 'E13.42', 'E13.43', 'E13.44', 'E13.49', 'E13.51', 'E13.52', 'E13.59', 'E13.610', 'E13.618', 'E13.62', 'E13.620', 'E13.621', 'E13.622', 'E13.628', 'E13.63', 'E13.630', 'E13.638', 'E13.64', 'E13.641', 'E13.649', 'E13.65', 'E13.69', 'E13.8', 'E13.9' Documented using the following ICD-9 codes in list "Diabetes type 1, type 2, and secondary (not gestational), 10 [v1.00]": '249', '249.0', '249.00', '249.01', '249.10', '249.11', '249.20', '249.21', '249.30', '249.31', '249.40', '249.41', '249.50', '249.51', '249.60', '249.61', '249.70', '249.71', '249.80', '249.81', '249.90', '249.91', '250',	Includes secondary, but does not include gestational diabetes

		'250.0', '250.00', '250.01', '250.02', '250.03', '250.1', '250.10', '250.11', '250.12', '250.13', '250.2', '250.20', '250.21', '250.22', '250.23', '250.3', '250.30', '250.31', '250.32', '250.33', '250.4', '250.40', '250.41', '250.42', '250.43', '250.5', '250.50', '250.51', '250.52', '250.53', '250.6', '250.60', '250.61', '250.62', '250.63', '250.7', '250.70', '250.71', '250.72', '250.73', '250.8', '250.80', '250.81', '250.82', '250.83', '250.9', '250.90', '250.91', '250.92', '250.93', '357.2', '362.0', '362.01', '362.02', '362.03', '362.04', '362.05', '362.06', '362.07', '366.41', '648.0', '648.00', '648.01', '648.02', '648.03', '648.04'	
☐	The Patient's most recent lab result numeric value is ***between 3.0 and 30.0 (inclusive)*** and is within the reporting period. **(Numerator)**	Result documented using the following LOINC codes in list Hemoglobin A1c [v2.00] : '4548-4', '4549-2', '41995-2', '55454-3', '17855-8', '17856-6', '62388-4', '71875-9', '59261-8','54039-3', '67761-7'	Recorded A1c level during the ***12 months prior*** to the reporting period through ***one month*** after the reporting period.

Prevention and Care Dashboard Sample

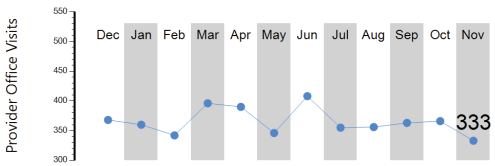
Jun - Nov, 2016

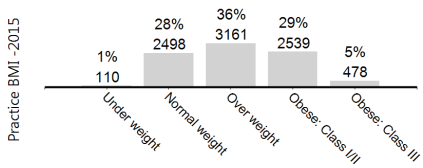
NYC Health — Primary Care Information Project

Prevention and Care Dashboard

☆Aspirin Prophylaxis in CVD Eligible Patients: 41	Goal 93% **61%** (14 more patients to goal)	☆BP Control < 140/90 (HTN) Eligible Patients: 152	Goal 84% **70%** (22 more patients to goal)
Cholesterol Screen (general population) Eligible Patients: 43	Goal 94% **81%** (6 more patients to goal)	☆BP Control < 140/90 (DM) Eligible Patients: 55	Goal 90% **73%** (10 more patients to goal)
Smoking Intervention Eligible Patients: 40	Goal 85% **78%** (3 more patients to goal)	☆BP Control < 140/90 (IVD) Eligible Patients: 51	Goal 92% **75%** (9 more patients to goal)
Smoking Status Eligible Patients: 322	Goal 100% **97%** (10 more patients to goal)	Cholesterol Control: Statin therapy in ASCVD Eligible Patients: 41	Goal 93% **93%**
HIV Screening Eligible Patients: 227	Goal 48% **3%** (103 more patients to goal)	Cholesterol Control: Statin therapy for history of LDL >= 190 Eligible Patients: 16	Goal 100% **75%** (4 more patients to goal)
Sexual History Taken Eligible Patients: 346	Goal 92% **28%** (223 more patients to goal)	Cholesterol Control: Statin therapy in diabetes Eligible Patients: 34	Goal 81% **76%** (2 more patients to goal)
Depression Screening Eligible Patients: 333	Goal 93% **96%**	A1C in poor control > 9% (lower is better) Eligible Patients: 51	Goal 6% **8%** (1 more patient to goal)
Hepatitis C Screen Eligible Patients: 142	Goal 54% **6%** (68 more patients to goal)	A1C testing last 12 months Eligible Patients: 58	Goal 100% **88%** (7 more patients to goal)

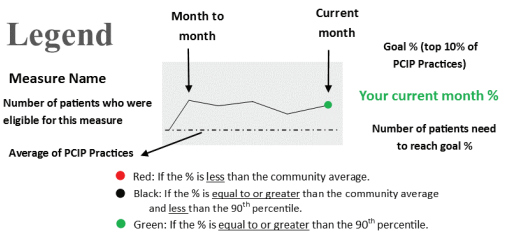
☆High priority clinical initiatives





Percent of your patients with chronic disease diagnosis - 2015

Diabetes	13%	(No. of patients = 182)
Hypertension	38%	(No. of patients = 561)
Ischemic Vascular Disease	12%	(No. of patients = 168)



If you have any questions or comments, please contact pcip_development@health.nyc.gov or your NYC REACH representative. To take a brief survey, please click here

Provider Dashboard Information Sheet

The purpose of this report is to show you how you've fared in the last 6 months, based on the data that PCIP has received. The report gives you feedback on EHR quality measures. We hope that receiving this feedback gives you the opportunity to optimize your EHR experience. These graphs are designed to show:

- ✓ Your performance trend over the last 6 months (the thick black line).
- ✓ Your performance last month (the large colored dot and percentage under "Goal").
- ✓ The PCIP average over the last 6 months (the gray dotted line).
- ✓ Performance is coded:

  Green: If the % for the current report month is equal to or greater than the 90th percentile.

  Black: If the % for the current report month is equal to or greater than the community average and less than the 90th percentile.

  Red: If the % for the current report month is less than the community average.
- ✓ Missing data (perhaps a transmission issue) appears as a shorter, missing, or broken line and/or NA

☆What's new?
Target goals are updated to reflect the top 10th percentile of performance, as based on all the providers participating in PCIP. Note that these target goals have been updated based on quality information from participating providers from calendar year 2015.
If you feel the report data is not indicative of your actual EHR use, please contact us at pcip_development@health.nyc.gov.

☆Aspirin Prophylaxis in CVD - Percent of patients age 18-100 with a diagnosis of IVD who are on antithrombotics

Cholesterol Screen (general population) - Males age 35+ and females age 45+ (with no DM, IVD, or dyslipidemia) who had a cholesterol screen in last 5 years

Smoking Intervention - Percent of patients age 18-100 identified as current smokers who received cessation interventions or counseling

Smoking Status - Percent of patients age 18-100 who had smoking status updated in the last two years

HIV Screening - Percent of patients age 13-64 with an HIV test result

Sexual History Taken - Percent of patients age 12-100 who had a sexual history taken within the past year

Depression screening - Percent of patients age 18-100 with a negative PHQ-2 or a complete PHQ-9 in the past year

Hepatitis C Screen - Percent of patients born in 1945-1965 who have ever had a Hep C diagnosis or screening test

☆BP control in HTN (140/90) - Percent of patients age 18-85 with hypertension who had their last BP controlled (< 140/90)

☆BP Control in DM (140/90) - Percent of patients age 18-75 with diabetes (type 1, type 2, secondary) who had their last BP controlled (< 140/90)

☆BP Control in IVD (140/90) - Percent of patients age 18-75 with IVD who had their last BP controlled (< 140/90)

Cholesterol Control: Statin therapy in ASCVD - Percent of patients 21 and older diagnosed with ASCVD who are on statin therapy

Cholesterol Control: Statin therapy for history of LDL>=190 - Percent of patients 21 and older with history of LDL of 190mg/dL or greater who are on statin therapy

Cholesterol Control: Statin therapy in diabetes - Percent of patients 40-75 with diabetes who are on statin therapy

A1C in poor control (> 9%) - Percent of patients age 18-75 with diabetes (type 1, type 2, secondary) whose most recent HbA1c level in the 12 month lookback was greater than 9% (poor control)

A1C testing last 12 months - Percent of patients age 18-75 with DM who had at least one HbA1c measured in the past 12 months

Hypertension Panel Summary Sample

Practice Name

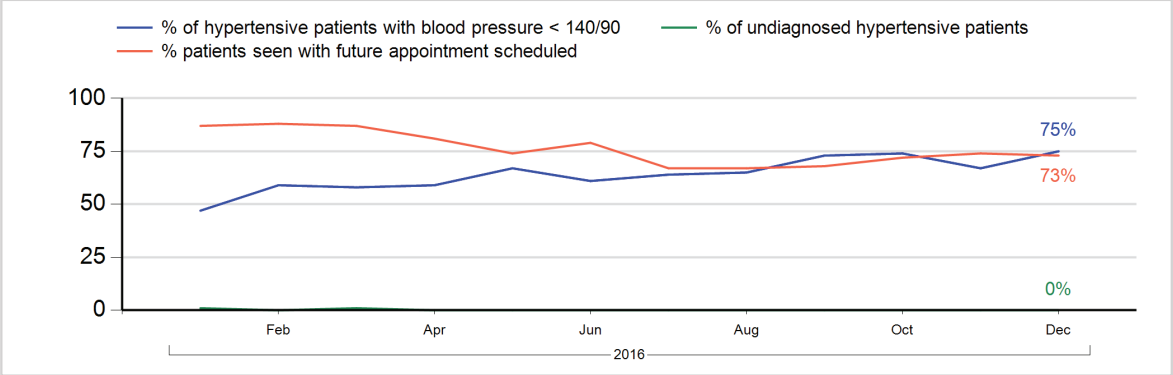
Hypertension Panel Summary

December, 2016

NYC Health Primary Care Information Project

Hypertension Trend

Community average this month for BP Controlled 140/90: 60% Community average this month for future appointments scheduled: 51%



December, 2016

Last Blood Pressure	Stage 2 > 160/100	Stage 1 140-159/90-99	Controlled BP < 140/90	Undiagnosed HTN	Total
Hypertensive patients seen	6	27	99	0	*132*
Antihypertensive meds prescribed	6	24	87	0	*117*
Voice enabled patients [1]	5	23	88	0	*116*
Future appointments scheduled at point of care [2,3]	**5**	**21**	**71**	**0**	*97*

Last 12 Months

Hypertensive patients seen	30	170	483	3	*686*
Antihypertensive meds prescribed	29	144	413	1	*587*
Voice enabled patients	27	146	432	3	*608*
No Visit in 3 months and no future appointment scheduled [4]	**16**	**87**	**182**	**1**	*286*

* See page 2 instructions to identify patients in need of follow-up care

Recommendations

1. Consider using voice messaging to send patient reminders.
2. Consider contacting Stage 1 and 2 hypertensive patients without future appointments.
3. Consider workflow design that encourages Stage 1 and 2 hypertensive patients to schedule future appointments during recent visit.
4. Consider using eClinicalWorks Enterprise Business Optimizer(eBO) to run reports to identify and prioritize patients in need of follow-up.

If you have any questions, please contact pcip_development@health.nyc.gov.

Using the Registry as back up to eBO

NYC Health — Primary Care Information Project

The Registry can be used to identify hypertensive patients that are in need of follow up, in the event that eBO is down. See screen shots below. Click here to see a sample eBO report.

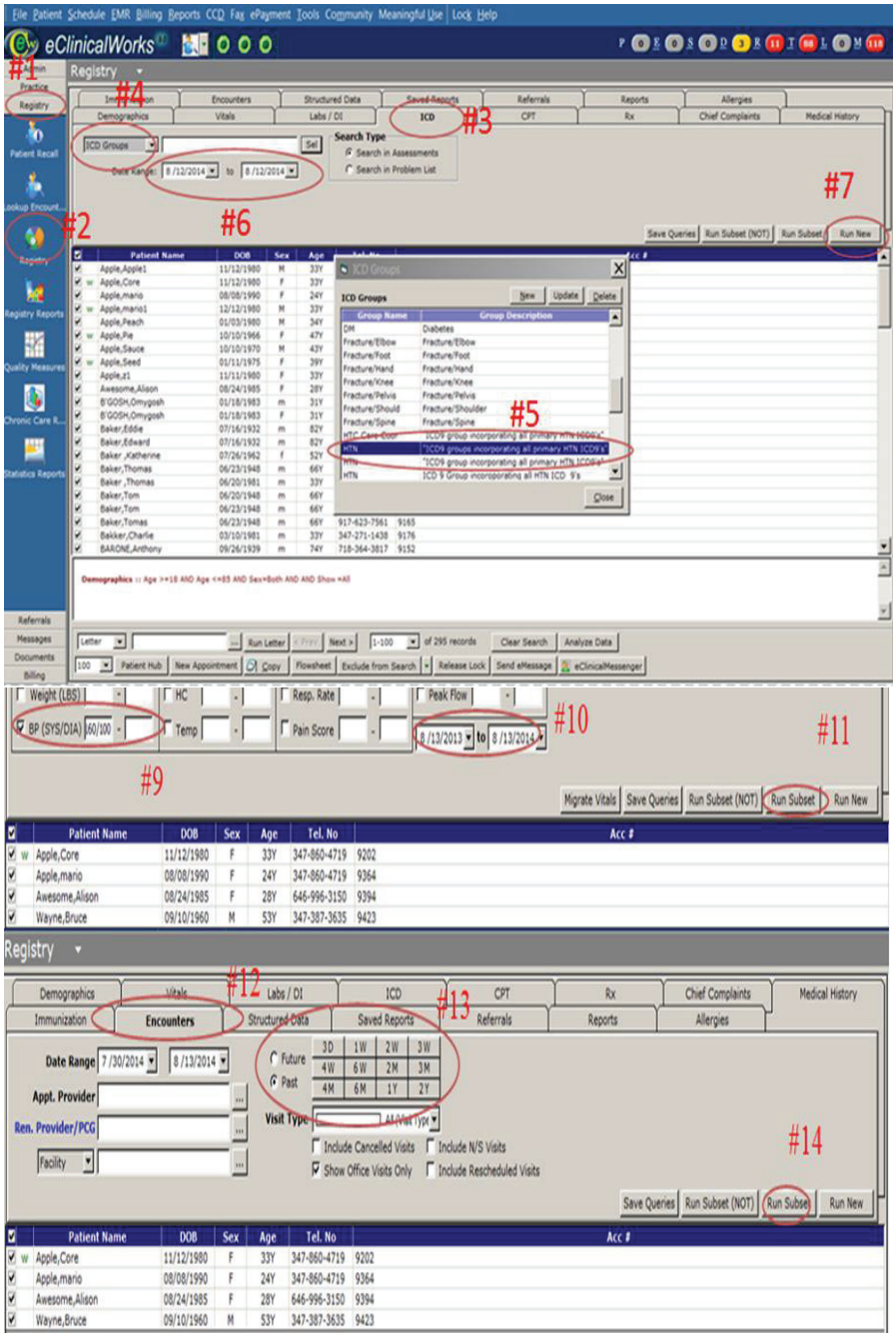
Creating patient lists using the Registry

#1 Select Registry
#2 Select Registry
#3 Select the ICD Tab
#4 Select ICD Groups
#5 Select the HTN group (Click here to learn how to make an ICD 10 group)
#6 Select date range
#7 Click Run New

NOTE: Once this list has been generated, subsets can be run in order to identify patient's risk levels via the vitals tab.

Identifying patients:

#8 Choose Vitals
#9 Choose BP range(ex:160/100-)
#10 Enter date range
#11 Run subset
In order to find out if any of the patients listed have not been seen, or have a future appointment scheduled follow these steps:
#12 Encounters tab
#13 Set date range (if selecting Past, run Subset (Not) to see which patients have not been seen. Run Subset to see which patients have been seen. Use the same methodology for Future visits.
#14 Click Run Subset/Subset (Not)



Evidence Based Interventions:

Provider and Office Staff Toolkit *Small Practice*

By: Clinical-Community Program Linkages (CCPL)

NYC Health | Primary Care Information Project
For quesons and more information, please contact Clinical-Community Program Linkages
E-mail: EBI_Referrals@health.nyc.gov

“These programs are so important for our community.
Through them, we have developed a reputation in the community as an organization that cares.”

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Appendix A: Patient Facing CDC Prediabetes Flyer

(English) Appendix B: Patient Facing NDPP Flyer (English)

Appendix C: Patient Facing NDPP Flyer (Spanish)

Clinical-Community Program Linkages

The goal of Clinical-Community Program Linkages (CCPL) at the Primary Care Information Project (PCIP) is to develop sustainable and scalable pathways from the clinical environment to Evidence Based Interventions (EBI). CCPL aims to:

Collaborate with providers and colleagues to increase EBI referrals
Support clinicians and worksites to offer EBI
Increase patient participation with EBI

Evidence Based Interventions

CCPL assists with generating clinical referrals and setting up workshops for the following Evidence Based Interventions:

Program	Details
National Diabetes Prevention Program (NDPP)	**Prevention**: Lifestyle change program designed to help participants prevent/delay the onset of Type 2 Diabetes.
Diabetes Self-Management Program (DSMP)	**Self-Management:** Provides participants with the tools and knowledge to help manage their diabetes.
Chronic Disease Self-Management Program (CDSMP)	**Self-Management:** Program intended for participants with different chronic health problems to help manage their health condition.

National Diabetes Prevention Program

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What is the National Diabetes Prevention Program?

The National Diabetes Prevention Program (NDPP) is a Centers for Disease Control and Prevention (CDC) recognized evidence-based lifestyle change prevention program for adults with prediabetes.

The program consists of 16 weekly sessions of core classes at 1 hour per week and is followed by monthly maintenance sessions for the combined duration of one year. The classes are facilitated by a ceriified lifestyle coach who follows a CDC approved curriculum including concepts related to physical activity, coping mechanisms, healthy eating, and stress management.

- The overall objective of the NDPP is for participants to lose at least 7% of their body weight and adopt healthier habits into their lifestyles.

Patient Outcomes:

Participants **prevented or delayed type 2 diabetes** by losing a modest amount of weight through diet and physical activity.
Participants **reduced their risk** of developing the disease by an **average of 58%.**
Participants **aged 60+ reduced their risk** of developing type 2 diabetes by **an average of 71%** .

Who is eligible for the NDPP?

In order to be eligible for this program, a patient/participant must:

Be **≥ 18 years old**
Have a **Body Mass Index (BMI) ≥ 24**, ≥ 22 if Asian
Have **not** ever been medically **diagnosed with type 1 or type 2 diabetes**
Have **evidence** of **impaired glucose metabolism**
Recent blood test in prediabetes range (**A1c 5.7%-6.4%**; **fasting plasma glucose 100-125 mg/dL**)
OR
History of gestational diabetes

Workshop Topics:

1. Core principles of getting active and increasing physical activity
2. Core principles of healthy eating, tracking food, and caloric balance
3. How to reduce and deal with stress
4. How to cope with triggers of unhealthy behavior
5. How to stay motivated

NATIONAL Diabetes PREVENTION PROGRAM

*Source: National Institutes of Health. Diabetes Prevention Program (DPP). (n.d.). Retrieved April 19, 2016, from http://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/Pages/default.aspx

Diabetes Self-Management Program

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What is the Diabetes Self-Management Program?

The Diabetes Self-Management Program (DSMP), developed by Stanford University's Patient Education Research Center, is designed to assist patients in managing type 2 diabetes.

The DSMP teaches self-managed lifestyle change and coping strategies to enable participants to manage their diabetes, medications, and increase physical activity levels.

Patients with type 2 diabetes attend the workshop in small groups for 2½ hours per week, for six weeks. Workshops are facilitated by two trained leaders, one or both of whom is a peer leader with diabetes.

Patient Outcomes:

- Significant **improvements** in **depression***
- **Improvements in** symptoms of **hypoglycemia***
- **Better communication** with physicians*
- Improvements in **healthy eating** and reading food labels*
- Significant improvements in **patient activation***

Who is eligible for the DSMP?

In order to be eligible for this program, a patient/participant must:

- Be **≥ 18 years old**
- Have been **diagnosed** with **Type 2 Diabetes**

Workshop Topics:

1. Techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress
2. Techniques to deal with emotional problems such as depression, anger, fear and frustration
3. Appropriate exercise for maintaining and improving strength and endurance
4. Healthy eating
5. Appropriate use of medication
6. Working more effectively with health care providers

*Source: Stanford Medicine. Diabetes Self-Management Program. (n.d.). Retrieved April 19, 2016, from http://patienteducation.stanford.edu/programs/diabeteseng.html

Chronic Disease Self-Management Program

NYC Health Primary Care Information Project

What is the Chronic Disease Self-Management Program?

The Chronic Disease Self-Management Program (CDSMP), developed by Stanford University's Patient Education Research Center, is designed to assist patients in managing their chronic or ongoing health condition.

The CDSMP teaches self-managed lifestyle change and coping strategies to enable participants to manage their health condition(s), medications, and increase physical activity levels.

Patients with different chronic health conditions attend the workshop in small groups for 2½ hours per week, for six weeks. Workshops are facilitated by two trained leaders

Patient Outcomes:

Significant **improvements** in **exercise***
Better communication with physicians*
Fewer days in the **hospital** and **fewer** outpatients visits and **hospitalizations***
Cost to savings ratio of approximately **1:4***
Better self-reported **general health***

Who is eligible for the CDSMP?

In order to be eligible for this program, a patient/participant must:

Be **≥ 18 years old**
Have been **diagnosed** with **a chronic health condition**

Workshop Topics:

1. Techniques to deal with problems such as frustration, fatigue, pain and isolation
2. Appropriate exercise for maintaining and improving strength, exibility, and endurance
3. Appropriate use of medications
4. Communicating effectively with family, friends, and health professionals
5. Nutrition
6. Decision making
7. How to evaluate new treatments

*Source: Stanford Medicine. Chronic Disease Self-Management Program. (n.d.). Retrieved April 19, 2016, from http://patienteducation.stanford.edu/programs/cdsmp.html

Quality and Technical Assistance Center

The Center for Excellence in Aging & Community Wellness has developed a unique free online portal administered by the New York State Quality & Technical Assistance Center, or more commonly referred to as QTAC.

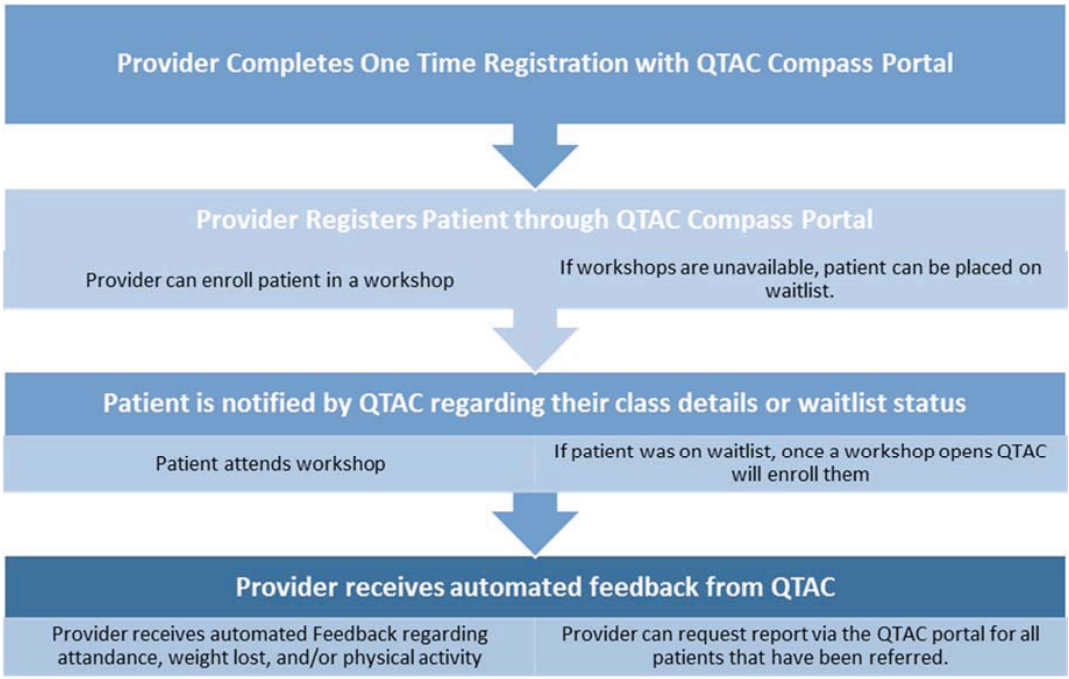
QTAC operates an online registration and data management portal called Compass. Providers can use the QTAC Compass Portal to refer and enroll patients in evidence based interventions (EBI) such as the National Diabetes Prevention Program (NDPP), Diabetes Self-Management Program (DSMP), and the Chronic Disease Self-Management Program (CDSMP).

By registering patients through the QTAC Compass Portal, providers will join a nationally recognized quality improvement-driven organization committed to supporting partners in improving population health

Benefits of Using QTAC Compass Portal:

Ability to **directly enroll** patients in evidence based interventions in real time
Patients can choose **workshops** from a variety of providers at a **variety of locations**
Provider receives **automated feedback** regarding their **patient's attendance**, **physical activity**, and **weight loss** throughout the course of the program

How Does the QTAC Compass Portal Work?



Quality and Technical Assistance Center Physician Registration

Before providers can refer patients to Evidence Based Interventions (EBI) such as the National Diabetes Prevention Program (NDPP), the Diabetes Self-Management Program (DSMP), and the Chronic Disease Self-Management Program (CDSMP), providers must register on the Quality and Technical Assistance Center (QTAC) Compass Portal.

- **One time** registration
- **No** "logins" or **passwords** required
- **Multiple providers** at small practices and community health centers can register
- Registration is **free**!

How to complete the Physician Registration on QTAC Compass Portal:

1. **Go to** https://compass.qtacny.org/physicians
2. Under New Physicians, **click** on **Register as Physician**
3. **Complete** Physician Information Page with the physicians information
4. **Choose** the **Preferred** Evidence Based Intervention **Programs**
   - Moves selected programs to the top of the list for the provider:
     - Select NDPP in relevant language(s), DSMP, and CDSMP
     - DSMP Spanish: Tomando Control de su Diabetes
     - CDSMP Spanish: Tomando Control de su Salud
5. **Confirm** Provider Registration Information, **click Continue**
6. The physician will **receive** a **verification code** to the fax number that was provided during registration
7. **Enter** the **verification code** to ensure completion of a successful physician registration
8. After submitting the verification code, the physician will see a **screen confirming registration**
9. Provider will **now** be **able to refer patients!**

QTAC NY

Quality and Technical Assistance Center Patient Registration

After completing the physician registration, providers can use the Quality and Technical Assistance Center (QTAC) Compass portal to refer their patients into evidence based intervention (EBI) programs such as the National Diabetes Prevention Program (NDPP), the Diabetes Self-Management Program (DSMP), and the Chronic Disease Self-Management Program (CDSMP).

- **No** logins or **password** required
- Ability to **directly enroll patient** into a workshop
- Provider receives **automated feedback** on patient's attendance and progress
- Referring patients is **free**!

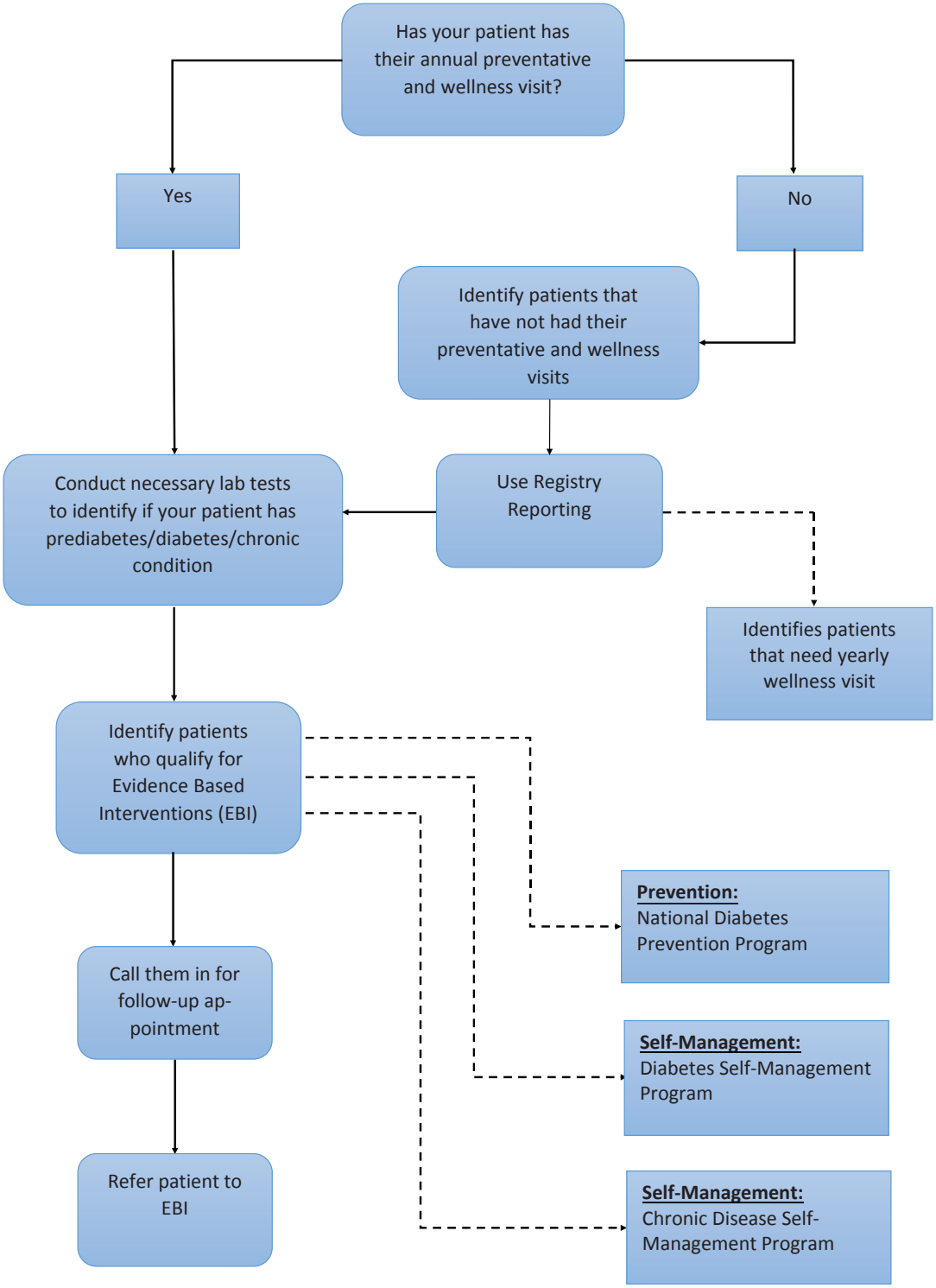
How to Refer a Patient using QTAC Compass Portal:

1. **Go to** https://compass.qtacny.org/physicians
2. Under Returning Physicians, **click** on **Register a Patient**
3. **Enter** the provider's license number
4. **Enter** the **Patient's** demographic information
5. **Select Both Checkboxes** regarding feedback on patient's attendance and progress
6. Select the type of program the provider would like to enroll patient
7. Complete Eligibility Requirement Form
    a. **NDPP:** Complete all questions
    b. **DSMP:** Only complete patient's **Date of Birth**
    c. **CDSMP:** Only complete patient's **Date of Birth**
8. If **classes** are available that are **convenient** to the patient, **select the workshop** and click continue.
9. If there are **no classes** convenient to the patient, click S**kip to Patient Waitlist.**
10. **Confirm** the patients information, and click continue.
11. Provider will see the home screen, with a **message confirming** patient has been **referred!**

QTAC NY

Clinical-Community Program Linkages
Workflow Best Practices

NYC Health | Primary Care Information Project



Evidence Based Interventions Cheat Sheet for Providers and Office Staff

The National Diabetes Prevention Program (NDPP), Diabetes Self-Management Program (DSMP), and the Chronic Disease Self-Management Program (CDSMP) are Evidence Based Intervention (EBI) programs.

	What is it?	Who is Eligible?	Benefits

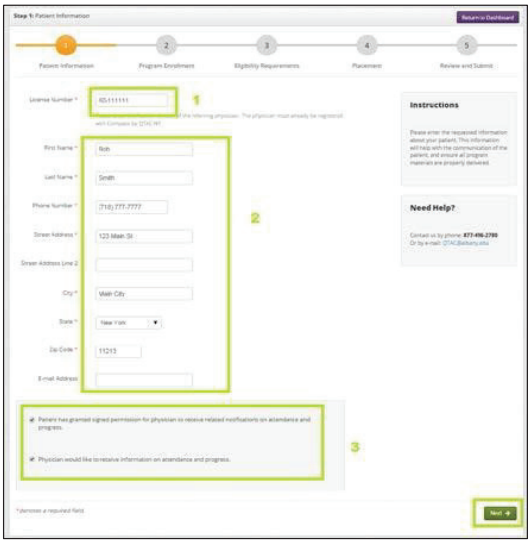
For patients with Prediabetes:
 	
National Diabetes Prevention Program (NDPP)
	Lifestyle Modification Program
	• Facilitated by a **certified lifestyle coach**
	• 1 Year Program
	  ○ First six months: 16 weekly sessions at 1 hour per week
	  ○ Last six months: 1 hour session, once per month
	Topics Covered:
	• Physical activity
	• Coping mechanisms
	• Healthy eating
	• Stress management, etc.
		• Be ≥ **18 years old**
		• Have a BMI ≥ 24; ≥ 22 if Asian
		• Have a **BMI >24; >22 if Asian**
		• Have never been **diagnosed with type 1 or type 2 diabetes**
		• Have evidence of impaired glucose metabolism (A1C 5.7%-6.4%; fasting plasma glucose 100-125 mg/dL OR history of gestation diabetes)
			• Proven to **reduce risk** of diabetes by over 50%
			• For participants to **lose at least 7% of their body weight**
			• Adopt **health habits** into their lifestyles

For patients with Diabetes: **Diabetes Self-Management Program (DSMP)**	**Self-Management Program** • Facilitated by **2 trained leaders** • 6 week program ○ 2 ½ hours, once per week **Topics Covered:** • How to deal with fatigue, pain, stress, & emotional problems • Appropriate exercise • Healthy eating • Appropriate use of medication • Work more effectively with health care providers	1. Be ≥ **18 years old** 2. Have been **diagnosed with Type 2 Diabetes**	**Significant improvements in:** • Depression • Symptoms of hypoglycemia • Communication with physicians • Healthy eating
For patients with Chronic Disease **Chronic Disease Self-Management Program (CDSMP)**	**Self-Management Program** • Facilitated by 2 trained leaders • 6 week program ○ 2 ½ hours, once per week **Topics Covered:** • How to deal with fatigue, pain, stress, & emotional problems • Appropriate exercise • Healthy eating • Appropriate use of medication • Work more effectively with health care providers	1. Be ≥ **18 years old** 2. Have been **diagnosed with a chronic disease**	**Significant improvements in:** • Exercise • Cognitive symptom management • Self-reported general health • Fewer days in the hospital • Few outpatient visits and hospitalizations

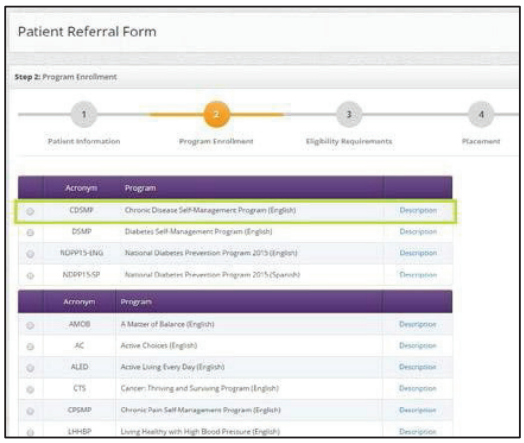
Refer your Patient today using QTAC!
https://compass.qtacny.org/physicians
✓ **Enroll Patient Directly into class or a waitlist**
Receive feedback on Patient's: Attendance, Weight loss, and Physical Activity!

How to Complete Referrals for the NDPP, DSMP, & the CDSMP using QTAC:

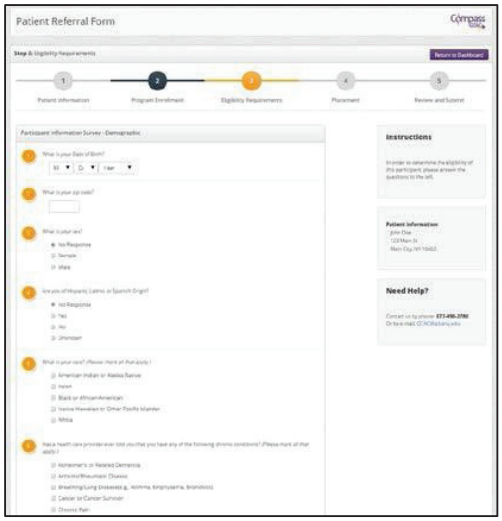
1. **Enter Provider's license number**
2. **Patient's information**
3. **Select both checkboxes**



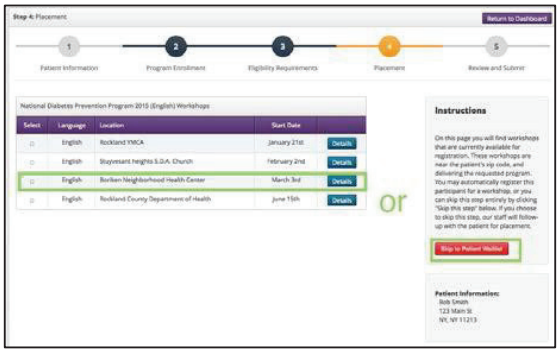
4. **Select the program to refer the patient**



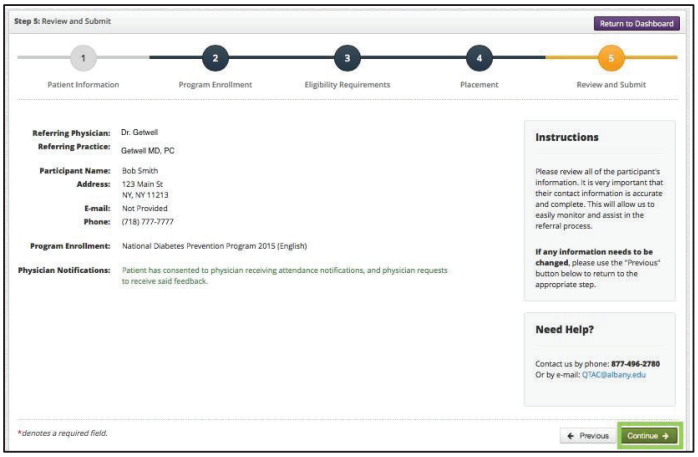
5. **Complete Eligibility Form**[a]



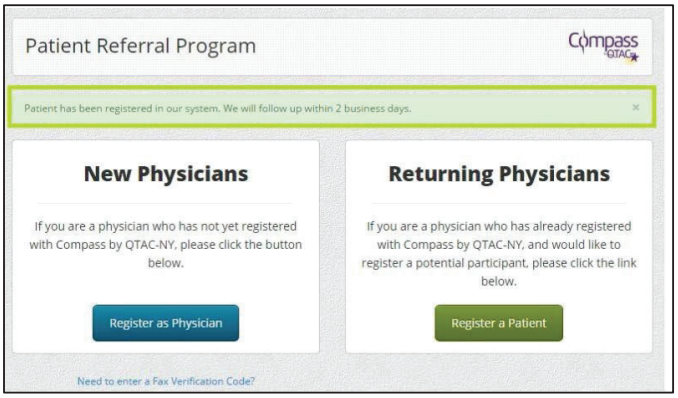
6. **Select Class & Next Or Skip to Waitlist**



7. **Confirm Patient's information & Continue**



8. **Patient has been referred!**



a. For CDSMP & DSMP Eligibility Form:

Only complete the patient's Date of Birth & Zip Code.

Questions?
Call: 347-396-4729
Email: EBI_Referrals@health.nyc.gov
QTAC Technical Assistance: 877-496-2780

Evidence Based Interventions Patient Materials

The following pages contain materials that can be distributed to patients:

- CDC Prediabetes Flyer
- NDPP Flyer (English)
- NDPP Flyer (Spanish)

If you would like to obtain additional copies, please contact :

Clinical-Community Program Linkages

Email EBI_Referrals@health.nyc.gov

NATIONAL DIABETES PREVENTION PROGRAM

WORKING TOGETHER TO PREVENT TYPE 2 DIABETES

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

THE GROWING THREAT OF PREDIABETES

Prediabetes is identified when your blood sugar level is higher than normal but not high enough yet to be diagnosed as type 2 diabetes

86 MILLION adults have prediabetes

9 OUT OF 10 people with prediabetes don't know they have it

Without weight loss and moderate physical activity

15–30% of people with prediabetes will develop type 2 diabetes within 5 years

REDUCING THE IMPACT OF DIABETES

Congress authorized CDC to establish the NATIONAL DIABETES PREVENTION PROGRAM (National DPP)—a public-private initiative to offer evidence-based, cost effective interventions in communities across the United States to prevent type 2 diabetes

It brings together:

to achieve a greater impact on reducing type 2 diabetes

Research shows structured lifestyle interventions can cut the risk of type 2 diabetes in

HALF

Groups in the National Diabetes Prevention Program are working to:

Build a workforce that can implement the lifestyle change program effectively

Ensure quality and standardized reporting

Deliver the lifestyle change program through organizations nationwide

Increase referrals to and participation in the lifestyle change program

A key part of the National DPP is a lifestyle change program that provides:

A TRAINED LIFESTYLE COACH

CDC-APPROVED CURRICULUM

GROUP SUPPORT OVER THE COURSE OF A YEAR

JOIN IN THIS NATIONAL EFFORT

Everyone can play a part in preventing type 2 diabetes

RAISE AWARENESS of prediabetes

SHARE INFORMATION about the National DPP

ENCOURAGE PARTICIPATION in a local lifestyle change program

PROMOTE the National DPP as a covered health benefit

Find out how to get involved with the National Diabetes Prevention Program

www.cdc.gov/diabetes/prevention

CDC'S DIVISION OF DIABETES TRANSLATION WORKS TOWARD A WORLD FREE OF THE DEVASTATION OF DIABETES.

Join a **Lifestyle Change Class** Offered by the National Diabetes Prevention Program (NDPP)

Reduce Your Risk of Getting Type 2 Diabetes

Lifestyle Change Classes Offer:

- A **proven** diabetes prevention curriculum
- Skills needed to **lose weight**, be more **physically active** and **manage stress**
- **Trained lifestyle coaches** to guide and encourage you
- **Support from others** with similar goals
- Weekly classes and monthly follow-up sessions to help you **maintain a healthy lifestyle**

About Prediabetes

- **One in three adults has prediabetes and doesn't know it.** Prediabetes means that your blood glucose (sugar) level is higher than normal, but not yet high enough to be called type 2 diabetes.
- Without action, many people with prediabetes will develop type 2 diabetes. Type 2 diabetes can lead to heart attack, stroke, blindness, kidney failure or loss of toes, feet or legs.
- Losing weight and being physically active can help control prediabetes.
- **You may be more likely to have prediabetes if you have any risk factors, including:**
  - Being overweight
  - Having a family history of type 2 diabetes
  - Not getting regular physical activity
  - Having had diabetes while pregnant (gestational diabetes) or giving birth to a baby that weighed more than nine pounds
  - Being 45 or older

If you have prediabetes, make a change today.

- Read more about the programs available through the NDPP and get involved. Programs and classes are available for adults 18 and older.
- Share this information with your doctor and ask to be tested for prediabetes.
- **Ask your health care provider to refer you to a Lifestyle Change class today.**
- **Classes are free.**

For more information,
visit www.cdc.gov/diabetes/prevention

NYC Health

Únase a la clase **en inglés para cambiar su estilo de vida *Lifestyle Change***,
ofrecida por el Programa Nacional de Prevención de la Diabetes

Reduzca su riesgo de enfermarse de diabetes tipo 2

Las clases en inglés para cambiar su estilo de vida *Lifestyle Change* ofrecen:

- Un programa de estudio **comprobrado** para la prevención de la diabetes
- Las habilidades necesarias para **bajar de peso**, realizar **más actividad física** y **manejar el estrés**
- **Entrenadores de estilo de vida** para darle ánimo
- **Apoyo de otras personas** con metas similares
- Clases semanales y sesiones mensuales de seguimiento para **mantener un estilo de vida saludable**

Sobre la prediabetes

- **Uno de cada tres adultos tiene prediabetes y no lo sabe.** *Prediabetes* significa que el nivel de glucosa (azúcar) en su sangre es más alto de lo normal, pero no lo suficientemente alto como para llamarle diabetes tipo 2.
- Si no toman medidas al respecto, muchas personas con prediabetes desarrollarán diabetes tipo 2. La diabetes tipo 2 puede causar infarto al corazón, accidente cerebrovascular (derrame cerebral), ceguera, insuficiencia renal o pérdida de los dedos de los pies, los pies o las piernas.
- Bajar de peso y realizar actividad física pueden ayudarle a controlar la prediabetes.
- **Puede ser más probable que usted desarrolle diabetes si presenta factores de riesgo, incluyendo:**
  - Tener sobrepeso
  - Tener una familia con historial de diabetes tipo 2
  - No realizar actividad física regularmente
  - Haber tenido diabetes mientras estuvo embarazada (diabetes gestacional) o haber dado a luz a un bebé que pesó más de nueve libras
  - Haber cumplido los 45 años

Si tiene prediabetes, haga un cambio hoy mismo.

- Lea más sobre los programas disponibles a través del Programa Nacional de Prevención de la Diabetes (NDPP, por sus siglas en inglés) e involúcrese. Hay programas y clases disponibles para adultos que ya hayan cumplido los 18 años.
- Comparta esta información con su médico y pida que le realicen la prueba de diagnóstico de prediabetes.
- **Pídale a su proveedor de atención de salud que le remita a una clase para cambiar su estilo de vida *Lifestyle Change* hoy mismo.**
- **Las clases son gratis.**

Para obtener más información,
visite **www.cdc.gov/diabetes/prevention**

NYC Health

How Community Pharmacists Can Help with the Common Reasons for Non-Adherence

Community pharmacists offer many services that support patients with chronic conditions. Pharmacists are in a unique position to help because:

- Pharmacists have the clinical expertise to make a difference in the way patients manage chronic conditions for which they may be taking multiple medications.
- Pharmacists are an accessible health care resource. For many patients, it is easy to consult with a pharmacist.
- Pharmacists already play an active role in coaching patients on potential side effects of their medications and why it is important to take them exactly as prescribed.

Common Reasons Given by Patients for Skipping Doses or Stopping Medications	How Community Pharmacists Can Help
I don't think I need it. I feel just fne. **This medicine isn't working. I think it's making me sick. I feel worse now than I did before.** **I don't understand the labels. I can't read them, so I can't follow the instructions.**	☐ Pharmacists are trained to offer medication counseling. In fact, regulations state that pharmacists must offer both written and verbal counseling with each prescription. Refer patients to pharmacists for additional support. ☐ Pharmacy chains (pharmacies with eight or more stores) must offer language services in the most commonly spoken languages. In 2016, these languages were Chinese, Italian, Russian and Spanish for New York City. This means that pharmacies must offer translations of medication labels, warning labels and other written materials, as well as provide verbal counseling in Chinese, Italian, Russian and Spanish. Encourage patients to ask for translation services. ☐ Pharmacies may offer Medication Therapy Management (MTM) services to eligible patients. MTM is a billable counseling service under Medicare Part D and is aimed at selected patients. The overall goals for MTM are to: ✓ Improve compliance with medication protocols. ✓ Reduce medication problems. ✓ Increase patient knowledge of the drugs they take. ✓ Improve communication among prescribers, pharmacists, caregivers and patients. Encourage patients to ask their pharmacists if they are eligible for MTM. For more on MTM, refer to the MTM Fact Sheet and FAQs, and the patient brochure, Medication Therapy Management: Save Money and Get the Best Out of Your Treatment. ☐ Many pharmacies offer free blood pressure monitoring. In between office visits, routine blood pressure monitoring at home or at a pharmacy will reinforce the importance of taking medications as prescribed and adhering to lifestyle modifications. Encourage patients to monitor blood pressure at home or at a pharmacy.

Common Reasons Given by Patients for Skipping Doses or Stopping Medications	How Community Pharmacists Can Help
Too complicated. **Too many pills!** **Too many schedules!** **I can't keep track of them all.**	☐ Many pharmacies offer unit dosing and blister packing of medications to help improve adherence. Unit dosing and blister packing are compliance-prompting packaging that reminds patients to take their medications. Most pharmacies will only provide this packaging when prompted by the prescriber. Find out which pharmacies offer this packaging – and prescribe it for your patients.
I just can't remember. **I forget to order refills.**	☐ Many pharmacies offer texting services to remind patients to refill their medications. Encourage patients to opt-in. ☐ Many pharmacies provide automatic refills. Encourage patients to opt-in. ☐ Many pharmacies will synchronize prescription refills so patients can pick up all their medications on the same day of the month. Encourage patients to opt-in.
I can't afford it. **This costs too much.** **I'll just take less.**	☐ All pharmacies must provide the retail price of the 150 most commonly prescribed medications. Consumers may request a computer-generated list to take with them when they leave the pharmacy. The list may be helpful to patients who are paying out-of-pocket. Recommend that patients compare costs. ☐ Many pharmacies accept the Big Apple Rx Card or other prescription discount cards. For more information on the Big Apple Rx Card, refer to "About the Big Apple Rx Card" or visit: bigapplerx.com. Recommend that patients always ask, "Is this the lowest price?" ☐ Many pharmacies offer their own store discount cards or prices. Recommend that patients always ask "is this the lowest price?"

Best practice: Consult with local pharmacies to see which services are offered.

Medication Therapy Management (MTM) Fact Sheet

Description of MTM Services

Medication therapy management (MTM) is a patient-centered counseling service provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for patients.

During an initial MTM consultation, the pharmacist will:

- Provide an interactive, person-to-person or telehealth consultation about the patient's medications.
- Reconcile medications, including prescriptions, over-the-counter (OTC) medications, herbal therapies, and dietary supplements.
- Address medication adherence.
- Collaborate with the provider to develop an action plan and determine appropriate interventions for resolution of medication-related issues.

The Need for MTM

It is estimated that 50 percent of patients do not take their medications as prescribed.[1,2]

Benefts to Pr oviders

The pharmacist can identify and resolve medication-related problems and monitor changes in therapy and medication adherence in collaboration with the provider.

Resources

1. Sackett DL, Snow JC. The magnitude of adherence and nonadherence. In: Haynes RB, Taylor DW, Sackett DL, eds. Compliance in Health Care. Baltimore, MD: Johns Hopkins University Press. 1979; 11-22.
2. Haynes RB, Ackloo E, Sahota N, Mcdonald HP, Yao X. Interventions for enhancing medication adherence. Cochrane Database System Review. 2008 (2). Cd000011.

Medication Therapy Management (MTM) Frequently Asked Questions

Q What is medication therapy management (MTM)?

A Medication therapy management is a counseling service between a pharmacist (or other health professional) and a patient (or caregiver).

Q What is the difference between MTM and routine pharmacist counseling?

A MTM is distinct from the counseling that occurs as a result of OBRA-90 requirements. Specifically, MTM is patient-centered, involves an analysis of a patient's total medication experience and involves activities designed to improve patient use of medication. Also, it is a billable service that is covered under Medicare Part D and under select Medicaid and private plans.

Q What happens at an MTM session?

A Elements of an MTM session include:

- **Comprehensive Medication Review (CMR)** – This is a review that is conducted between the patient (or caregiver) and a pharmacist. It is meant to be comprehensive. During the interview, the patient is asked to present all prescription and non-prescription therapies they currently use.
- **Personal Medication Record (PMR)** – At the conclusion of the CMR, the patient gets a comprehensive list of all medications covered in the session, including all prescription, non-prescription, herbals and dietary supplements. The record is a simple patient-centered tool that serves as an important information guide.
- **Medication Action Plan (MAP)** – Given to each patient at the end of the session, the MAP is a patient-centered document that is a comprehensive yet simple guide to help the patient keep track of all important information.
- **Intervention and/or Referral** – The pharmacist provides consultative services during the CMR and intervenes to address medication-related problems. Interventions may include actions by the pharmacist or other health care providers. Patient goals should also be established for each intervention.
- **Documentation and Follow-up** – Services provided should be documented in a way that is consistent and sufficient for: a) evaluating patient progress, b) informing other health care providers about care provided to the patient, c) billing purposes, and d) questions on follow-up. The patient is then scheduled for a follow-up visit if necessary.

Q **Will the pharmacist change treatment without approval of the prescribing clinician?**

A No, the pharmacist cannot alter therapy without the approval of the prescribing clinician.

Q **What does the prescribing clinician have to do?**

A No additional steps are required, but it is helpful to advocate for MTM by building relationships with community pharmacies to promote improved communication. It is also helpful to educate patients about the benefits of MTM services.

Q **Who is eligible for MTM?**

A MTM is available free of charge to eligible Medicare Part D patients. Patients who are eligible under Medicare Part D, have multiple chronic diseases and take several drugs, which, when combined, exceed an annual dollar amount (in 2016, $3,017). MTM is also available under select Medicaid and private plans; coverage under these plans varies. Patients should talk to their insurance providers and/or pharmacists to determine coverage.

A pharmacist trained in MTM can:

- Recommend less expensive alternatives or brands for your medications
- Help you create a single list of all of your medications, including dosages and instructions
- Review all of your medications to identify any duplications or conflicts
- Discuss possible side-effects and provide tips on how to prevent or control them
- Review new prescriptions with you and follow up to make sure they are working well
- Check if any over-the-counter medications, vitamins or herbal supplements are unsafe to take with your medications
- Work with you and your doctor(s) to find what works best for you. *Your pharmacist may make recommendations to you and your doctor(s), but only your doctor can change your prescription.*

Ask your health plan about MTM today!

Medication Therapy Management

Save money and get the best out of your treatment

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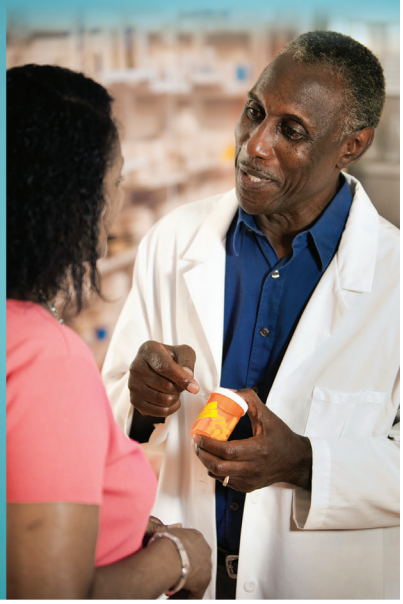


Medication Therapy Management (MTM)

is a health care service provided by a trained pharmacist.

A pharmacist trained in MTM reviews all of your medications to help you check for problems, meet health goals and save on out-of-pocket costs.

Getting Started

Am I eligible for MTM services?
Many insurance plans offer low- or no cost MTM services. Contact your health plan to find out if you are eligible.

Will I have to pay for MTM?
You may qualify for free or low cost MTM services. Call your health plan for more information.

Even if you do not qualify, all pharmacists are qualified to answer questions about your prescription medications. Just ask!

Where can I find a pharmacist trained in MTM?
Ask your pharmacist if he or she has had MTM training, or contact your health plan for a list of pharmacies that provide MTM in your area.

If you are eligible, the pharmacist will work with you to schedule a comprehensive medication review.

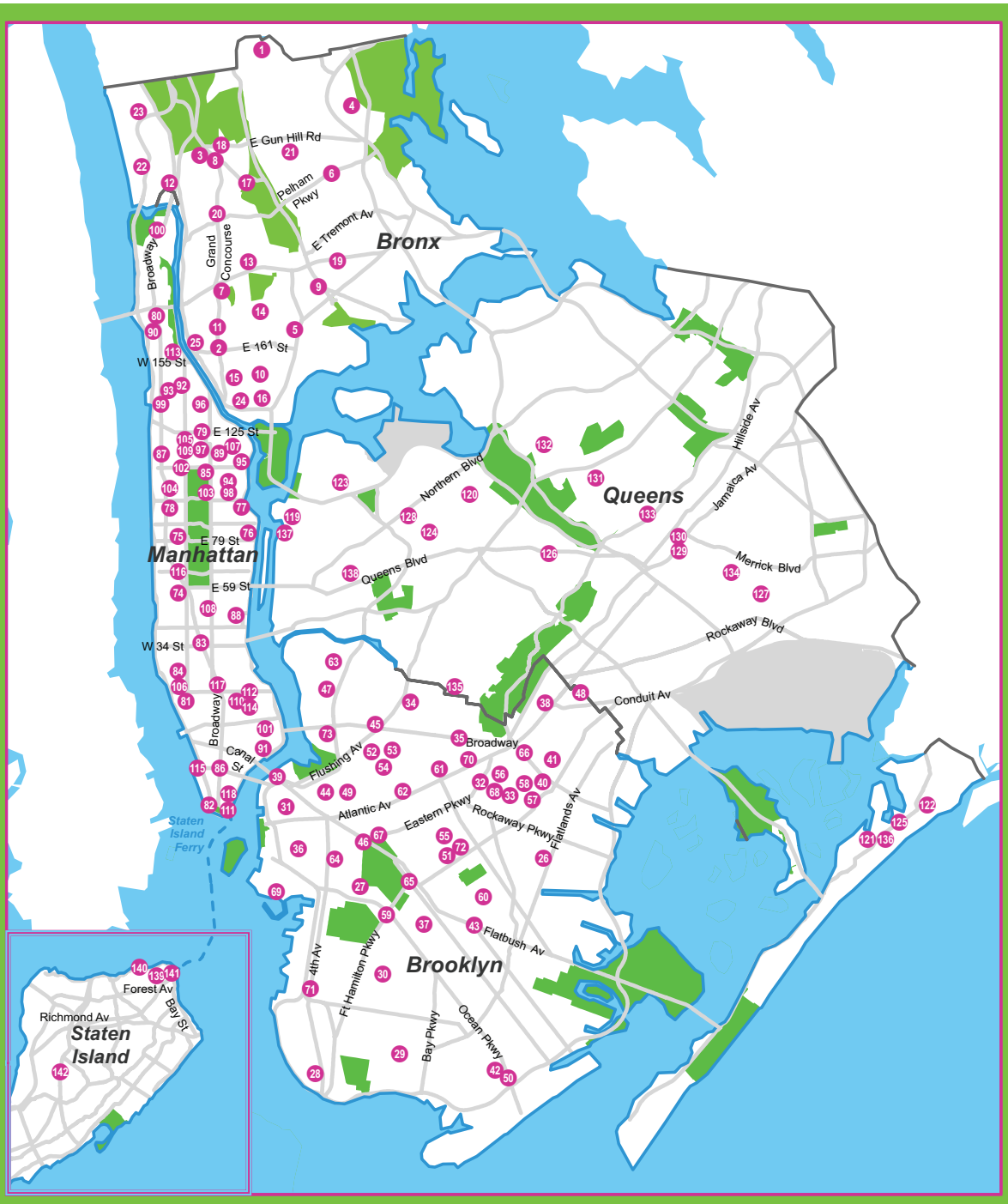
How long does an MTM session last?
MTM sessions can last from 15 minutes to an hour, depending on your specific needs. Some MTM sessions can be done over the phone.

What should I take to my MTM visits?
Bring a list of your health conditions, any new prescriptions, and all your medications, including over-the counter drugs, vitamins and herbal supplements.

About the Big Apple Rx Card

- Big Apple Rx is the City of New York's official prescription discount card developed to help New York City consumers save on medication costs.
- Since the card's launch in May 2011, Big Apple Rx has saved New Yorkers over $30 million in prescription costs, with savings up to 50 percent; 18 percent for brand and 55 percent on generic medications.
- The card is free and available to everyone living, working or visiting New York City, regardless of age, income, citizenship or health insurance status. No personal information or enrollment is required to use the card.
- The card is of greatest benefit to people without health insurance or prescription drug coverage. However, it can be used by people with health insurance by providing discounts on some medications not covered by insurance plans.
- The card provides discounts for most FDA-approved prescription medications, as well as OTC medications like smoking cessation aids and diabetic supplies with a valid prescription.
- The card is NOT insurance. A discount is taken off the regular price of the prescription when the card is presented at a participating pharmacy.
- The card is accepted at over 2,000 New York City pharmacies, including chain and independent stores throughout the five boroughs, as well as at over 50,000 pharmacies nationwide.
- The card can be printed at **www.BigAppleRx.com**, and educational information about prescriptions, comparative drug prices and locations of the nearest participating pharmacies is also available. The program has a customer service helpline that can be accessed by dialing 311.
- Big Apple Rx is an integrated benefit of IDNYC, the free identification card launched in 2015 by the City of New York and is available to all New York City residents. The back of the IDNYC card includes Big Apple Rx BIN and Group numbers, which consumers can present to a pharmacy to receive discounts when filling a prescription.

For an up-to-date list of farmers markets, visit **nyc.gov** and search "farmers markets" or text "SoGood" to 877877 to find a market.



Use Your EBT Card and Get MORE!

Use your EBT card at NYC farmers' markets and get free fruits and vegetables. For every $5 spent in EBT, get an additional $2. Learn how to prepare farmers market produce at free cooking demonstrations.

See inside for a list of farmers' markets or text "SoGood" to 877877 to find a market near you.

Farmers' Market Map 2016

Use Your EBT Card at These Markets and Get MORE!

Bronx

1. **Bissel Gardens Farmers' Market**
   Baychester Ave & 241st St
   • Wednesday & Saturday (9am-5pm)
2. **Bronx Borough Hall Greenmarket**
   Grand Concourse bet 161st & 162nd Sts
   • Tuesday (8am-4pm)
3. **Friends of Van Cortlandt Park Amalgamated Housing Youth Farmstand**
   Orloff Ave & Gale Pl
   • Wednesday (2pm-7pm)
4. **Harvest Home Co-op City Farmers' Market**
   Asch Loop & Aldrich St
   • Wednesday (8am-4pm)
5. **Harvest Home Hunts Point Farmers' Market**
   163rd St & Hunts Point Ave
   • Wednesday (8am-4pm)
6. **Harvest Home Jacobi Hospital Farmers' Market**
   1400 Pelham Pkwy at Eastchester Rd
   • Tuesday & Friday (8am-4pm)
7. **Harvest Home Mt. Eden Farmers' Market**
   Mt. Eden & Morris Aves
   • Tuesday & Thursday (8am-4pm)
8. **Harvest Home North Central Bronx Farmers' Market**
   Mosholu Pkwy & Jerome Ave
   • Wednesday (8am-4pm)
9. **Harvest Home Soundview Farmers' Market**
   Morrison Ave & Harrod Pl
   • Saturday (8am-4pm)
10. **Harvest Home St. Mary's Park Farmers' Market**
    149th St & St. Ann's Ave
    • Thursday (8am-4pm)
11. **Harvest Home Sunday Farmers' Market**
    Bronx Museum, 165th St & Grand Concourse
    • Sunday (8am-4pm)
12. **Kingsbridge-Riverdale Farmers' Market**
    231st St at Kingsbridge Ave
    • Sunday (9am-5pm)
13. **La Familia Verde Farmers' Market**
    E Tremont Ave bet LaFontaine & Arthur Aves
    • Tuesday (8am-2pm)
14. **Learn it, Grow it, Eat it Youthmarket**
    McKinley Sq at 169th St & Boston Rd
    • Wednesday (10am-3pm)
15. **Lincoln Hospital Greenmarket**
    149th St bet Park & Morris Aves
    • Tuesdays & Friday (8am-3pm)
16. **Mott Haven Farmers' Market**
    139th St & St. Ann's Ave, at Padre Plaza Success Garden
    • Tuesday (10am-4pm)
17. **New York Botanical Gardens Greenmarket**
    Southern Blvd bet Mosholu Pkwy & Bedford Park Blvd
    • Wednesday (9am-3pm)
18. **Norwood Youthmarket**
    E Gun Hill Rd & Dekalb Ave
    • Thursday (12pm-7pm)
19. **Parkchester Greenmarket**
    Westchester Ave & White Plains Rd
    • Friday (8am-4pm)
20. **Poe Park Greenmarket**
    192nd St bet Grand Concourse & Valentine Ave
    • Tuesday (8am-3pm)
21. **Project EATS Montefiore Farmstand**
    3011 Boston Rd bet Adee & Burke Aves
    • Wednesday (2pm-6pm)
22. **Riverdale Y Sunday Farmers' Market** (NO EBT)
    MS/HS 141, Independence Ave bet 236th & 237th Sts
    • Sunday (9am-2pm)
23. **Riverdale Youthmarket (July - Oct only)**
    256th St & Mosholu Ave
    • Thursday (2pm-7pm)
24. **South Bronx Farmers' Market**
    138th St bet Willis & Alexander Aves
    • Saturday (10am-4pm)
25. **Taqwa Community Farmers' Market**
    90 West 164th St bet Ogden & Nelson Aves
    • Saturday (9am-4pm)

Brooklyn

26. **Agape's Bounty Farmers' Market**
    8712 Glenwood Rd bet 87th & 88th St
    • Saturday (8am-2pm)
27. **Bartel-Pritchard Square Greenmarket**
    Prospect Park W at 15th St
    • Wednesday (8am-3pm)
      Sunday (9am-3pm)
28. **Bay Ridge Greenmarket**
    3rd Ave & 95th St
    • Saturday (8am-3pm)
29. **Bensonhurst Greenmarket**
    18th Ave bet 81st & 82nd Sts
    • Sunday (9am-4pm)
30. **Boro Park Greenmarket**
    14th Ave bet 49th & 50th Sts
    • Thursday (8am-3pm)
31. **Brooklyn Borough Hall Greenmarket**
    Court & Montague Sts
    • Tuesday, Thursday & Saturday (8am-6pm)
32. **Brownsville Pitkin Avenue Youthmarket**
    Pitkin Ave & Thomas Boyland St
    • Saturday (10am-3pm)
33. **Brownsville Rockaway Youthmarket**
    Rockaway & Livonia Aves
    • Friday (12pm-5pm)
34. **Bushwick Farmers' Market at Maria Hernandez Park**
    Knickerbocker Ave & Starr St
    • Saturday (9am-4pm)
35. **Bushwick Farmers' Market on Broadway**
    Halsey St & Broadway
    • Thursday (2pm-7pm)
36. **Carroll Gardens Greenmarket**
    Carroll St bet Court & Smith Sts
    • Sunday (8am-3pm)
37. **Cortelyou Greenmarket**
    Cortelyou Rd bet Argyle & Rugby Rds
    • Sunday (8am-3pm)
38. **Cypress Hills Youthmarket**
    Fulton & Richmond Sts
    • Friday (11am-6pm)
39. **DUMBO Down to Earth Farmers' Market**
    Pearl & Water Sts
    • Wednesday (12pm-7pm)
40. **East New York Farm Stand**
    New Lots Ave bet Alabama & Georgia Aves
    • Wednesday (3:30pm-6:30pm)
41. **East New York Farmers' Market**
    Schenck Ave bet New Lots & Livonia Aves
    • Saturday (9am-3pm)
42. **Edible Schoolyard NYC's Farm Stand at PS 216 (Sept-Nov only)**
    Avenue X & East 1st St
    • Friday (1:45pm-2:45pm)
43. **Flatbush Junction Youthmarket**
    Nostrand & Flatbush Aves by subway entrance
    • Saturday (8:30am-3pm)
44. **Fort Greene Park Greenmarket**
    Washington Park bet DeKalb & Willoughby Aves
    • Saturday (8am-4pm)
45. **Graham Avenue Farmers' Market**
    Cook St & Graham Ave
    • Saturday (8am-5pm)
46. **Grand Army Plaza Greenmarket**
    Prospect Park W & Flatbush Ave
    • Saturday (8am-4pm)
47. **Greenpoint McCarren Park Greenmarket**
    Union Ave bet Driggs Ave & N 12th St
    • Saturday (8am-3pm)
48. **Harvest Home Cityline Farmers' Market**
    Drew St bet 101 & Liberty Aves
    • Saturday (8am-4pm)
49. **Harvest Home Clinton Hill Farmers' Market**
    Lafayette bet Waverly & Washington Aves
    • Tuesday (8am-4pm)
50. **Harvest Home Coney Island Hospital Farmers' Market**
    Ocean Pkwy bet Ave Z & Shore Pkwy
    • Wednesday & Friday (8am-4pm)
51. **Harvest Home Kings County Hospital Farmers' Market**
    Clarkson Ave bet E 37th and E 38th Sts
    • Wednesday (8am-4pm)
52. **Harvest Home Marcy Park Farmers' Market**
    Myrtle & Marcy Aves
    • Thursday (8am-4pm)
53. **Hattie Carthan After Church Farmers' Market**
    49 Van Buren St bet Tompkins & Throop Aves
    • Sunday (1pm-6pm)
54. **Hattie Carthan Community Farmers' Market**
    Marcy Ave & Clifton Pl
    • Saturday (9am-3pm)
55. **High School for Public Service Youth Farm Farmers' Market**
    600 Kingston Ave bet Rutland Rd & Winthrop St
    • Wednesday (2:30pm-6:30pm)
56. **Isabahlia Farm Stand**
    Rockaway & Sutter Aves
    • Friday (12pm-5pm)
57. **Isabahlia Farm Stand Winter Market (Nov-Dec only)**
    New Lots Ave & Sackman St, inside greenhouse
    • Saturday (8am-1pm)
58. **Isabahlia Farmers' Market**
    Livonia Ave bet Powell & Junius Sts
    • Saturday (8am-4pm)
59. **Kensington Youthmarket**
    Ft. Hamilton Pkwy bet E 4th & E 5th Sts
    • Saturday (8am-4pm)
60. **LIVE Market**
    Paerdegat Park, E 40th St bet Foster Ave & Farragut Rd
    • Sunday (9am-3pm)
61. **Malcolm X Blvd Farmers' Market**
    Malcolm X Blvd bet Marion & Chauncey Sts
    • Saturday (8am-3pm)
62. **Marcy Plaza Community Farmers' Market**
    Fulton St & Marcy Ave
    • Wednesday (11am-6pm)
63. **McGolrick Park's Down to Earth Farmers' Market**
    Russell St & Nassau Ave, center of park
    • Sunday (10am-4pm)
64. **Park Slope's Down to Earth Farmers' Market**
    5th Ave & 4th St
    • Wednesday (3-7pm)
      Sunday (10am-5pm)
65. **Parkside Plaza Greenmarket**
    Parkside & Ocean Aves
    • Sunday (8am-4pm)
66. **Pitkin Verde Farmers' Market**
    2094 Pitkin Ave at Pennsylvania Ave
    • Tuesday (9am-5pm)
67. **Project EATS Brooklyn Museum Farm Market**
    200 Eastern Parkway
    • Thursday (10am-4pm)
68. **Project EATS Marcus Garvey Village Farm Market**
    300 Chester St at Dumont Ave
    • Tuesday (10am-4pm)
69. **Red Hook Farmers' Market**
    580 Columbia St
    • Saturday (8am-3pm)
70. **Saratoga Youth Market**
    Saratoga Ave & Fulton St
    • Saturday (10am-2pm)
71. **Sunset Park Greenmarket**
    4th Ave bet 59th & 60th Sts
    • Saturday (8am-3pm)
72. **Urban Oasis Farmers' Market**
    Clarkson & Troy Aves
    • Wednesday (2pm-5:30pm)
73. **Williamsburg Greenmarket**
    Taylor St & Lee Ave
    • Thursday (8am-4pm)

Manhattan

74. **57th Street Greenmarket**
    57th St & 9th Ave
    • Wednesday & Saturday (8am-5pm)
75. **79th Street Greenmarket**
    Columbus Ave bet 78th & 81st Sts
    • Sunday (9am-5pm)
76. **82nd Street Greenmarket**
    82nd St bet 1st and York Aves
    • Saturday (9am-2:30pm)
77. **92nd Street Greenmarket**
    92nd St & 1st Ave
    • Sunday (9am-4pm)
78. **97th Street Greenmarket**
    97th St bet Columbus & Amsterdam Aves
    • Friday (8am-2pm)
79. **125th Street FreshConnect Farmers' Market**
    125th St & Adam Clayton Powell Jr Blvd
    • Tuesday (10am-7pm)
80. **175th Street Greenmarket**
    175th St bet Wadsworth Ave & Broadway
    • Thursday (8am-5pm)
81. **Abingdon Square Greenmarket**
    12th St & 8th Ave
    • Saturday (8am-2pm)
82. **Bowling Green Greenmarket**
    Broadway & Battery Pl
    • Tuesday & Thursday (8am-5pm)
83. **Broadway French Market** (NO EBT)
    Broadway bet 35th & 36th Sts
    • Wednesday, Thursday & Friday (11am-6pm)
84. **Chelsea's Down to Earth Farmers' Market**
    23rd Street between 8th and 9th Aves
    • Saturday (9am-5pm)
85. **Chenchita's Community Garden**
    112th St & Madison Ave
    • Saturday (9am-3pm)
86. **City Hall Greenmarket**
    Broadway & Chambers St
    • Tuesday & Friday (8am-4pm)
87. **Columbia University Greenmarket**
    Broadway bet 114th & 116th Sts
    • Thursday & Sunday (8am-5pm)
88. **Dag Hammarskjold Plaza Greenmarket**
    47th St & 2nd Ave
    • Wednesday (8am-4pm)
89. **El Barrio Youth Marqueta**
    116th St & Park Ave
    • Thursday & Saturday (11am-5pm)
90. **Fort Washington Greenmarket**
    168th St & Ft. Washington Ave
    • Tuesday (8am-4pm)
91. **Gouverneur Health Youthmarket**
    Madison St bet Clinton & Jefferson Sts
    • Thursday (8:30am-3pm)
92. **Grass Roots Farmers' Market**
    145th St bet Edgecombe & Bradhurst Aves
    • Tuesday (9am-4pm)
93. **Hamilton Heights Green Youth Market**
    Amsterdam between 143rd & 144th Sts
    • Wednesday (11am-5pm)
94. **Harvest Home East Harlem Farmers' Market**
    104th St & 3rd Ave
    • Thursday (8am-4pm)
95. **Harvest Home East River Farmers' Market**
    1st Ave bet 108th & 109th Sts
    • Sunday (9am-4pm)
96. **Harvest Home Harlem Hospital Farmers' Market**
    506 Lenox Ave between 135th & 137th Sts
    • Friday (8am-6pm)
97. **Harvest Home Lenox Ave Farmers' Market**
    Lenox Ave bet 117th & 118th Sts
    • Saturday (8am-5pm)
98. **Harvest Home Metropolitan Farmers' Market**
    99th St & 3rd Ave
    • Friday (8am-4pm)
99. **Harvest Home West Harlem Farmers' Market**
    Broadway bet 137th & 138th Sts
    • Tuesday (8am-4pm)
100. **Inwood Park Greenmarket**
     Isham St bet Seaman Ave & Cooper St
     • Saturday (8am-3pm)
101. **Lower East Side Youthmarket**
     Grand Ave bet Pitt & Willet Sts
     • Thursday (8am-4pm)
102. **Morningside Park's Down to Earth Farmers' Market**
     110th St & Manhattan Ave
     • Saturday (9am-5pm)
103. **Mount Sinai Hospital Greenmarket**
     99th St & Madison Ave
     • Wednesday (8am-5pm)
104. **Project EATS Frederick Douglass Houses Farmers' Market**
     100th St bet Amsterdam and Columbus Aves
     • Saturday (10am-4pm)
105. **Project Harmony People's Market**
     122nd St bet 7th and 8th Aves
     • Thursday (1pm-7pm)
106. **PS 11 Farm Market**
     21st St bet 8th and 9th Aves
     • Wednesday (8am-10am)
107. **PS 7 Farm Stand**
     119th St & Lexington Ave, in schoolyard
     • Wednesday (2:15pm-3:30pm)
108. **Rockefeller Center Greenmarket** (NO EBT)
     Rockefeller Plaza at 50th St
     • Wednesday, Thursday & Friday (8am-5pm)
109. **SoHA Square Farmers' Market**
     117th St & St. Nicholas Ave
     • Saturday & Sunday (9am-4pm)
110. **St. Mark's Church Greenmarket**
     10th St & 2nd Ave
     • Tuesday (8am-6pm)
111. **Staten Island Ferry Whitehall Terminal Greenmarket**
     4 South St, inside terminal
     • Tuesday & Friday (8am-7pm)
112. **Stuyvesant Town Greenmarket**
     14th St Loop bet 1st Ave & Ave A
     • Sunday (9:30am-4pm)
113. **Sugar Hill Greenmarket**
     155th St & St. Nicholas Ave
     • Saturday (8am-4pm)
114. **Tompkins Square Greenmarket**
     7th St & Ave A
     • Sunday (9am-6pm)
115. **Tribeca Greenmarket**
     Greenwich & Chambers Sts
     • Wednesday (8am-3pm)
       Saturday (8am-3pm)
116. **Tucker Square Greenmarket**
     66th St & Columbus Ave
     • Thursday & Saturday (8am-5pm)
117. **Union Square Greenmarket**
     17th St & Broadway
     • Monday, Wednesday, Friday & Saturday (8am-6pm)
118. **Water Street Greenmarket**
     Water Street & Coenties Slip
     • Thursday (8am-6pm)

Queens

119. **Astoria Greenmarket**
     14th St bet 31st Ave & 31st Rd
     • Wednesday (8am-3pm)
120. **Corona Greenmarket**
     Roosevelt Ave & 103rd St
     • Friday (8am-3pm)
121. **Culinary Kids Farm Rockaway**
     444 Beach 58th St & Beach Channel Dr
     • Saturday & Sunday (10am-4pm)
122. **Culinary Kids Farmers' Market (July - Sept only)**
     30-15 Seagirt Blvd
     • Saturday (10am-3pm)
123. **Ditmars Park Youthmarket**
     Steinway St bet Ditmars Blvd & 23rd Ave
     • Saturday (9am-4pm)
124. **Elmhurst Hospital Greenmarket**
     41st Ave bet 80th & 81st Sts
     • Tuesday (8am-4pm)
125. **Far Rockaway Youth Market**
     Beach 45th St & Beach Channel Dr
     • Saturday (10am-2pm)
126. **Forest Hills Greenmarket**
     Queens Blvd & 70th Ave
     • Sunday (8am-3pm)
127. **Harvest Home Rochdale Mall Farmers' Market**
     Baisley Blvd bet Guy R Brewer & Bedell St
     • Saturday (8am-4pm)
128. **Jackson Heights Greenmarket**
     34th Ave & 78th St
     • Sunday (8am-3pm)
129. **Jamaica's Down to Earth Farmers' Market - Friday market**
     Parsons Blvd bet Jamaica and Archer Aves
     • Friday (8:30am-4pm)
130. **Jamaica's Down to Earth Farmers' Market - Saturday market**
     160th St & Jamaica Ave
     • Saturday (8:30am-4pm)
131. **Pomonok Community-Run Farmers' Market**
     67-09 Kissena Blvd
     • Wednesday (9am-6pm)
132. **Queens Botanical Garden's Down to Earth Farmers' Market**
     Dahlia Ave at Main St
     • Friday (8:30am-4pm)
133. **Queens Hospital Center Farmers' Market**
     82-68 164th St, in front of Ambulatory Care Pavilion
     • Thursday (8am-5pm)
134. **Queens Hospital Center Farmers' Market II**
     114-02 Guy R Brewer Blvd, Jamaica
     • Thursday (8am-4pm)
135. **Ridgewood Youthmarket**
     Cypress Ave bet Myrtle & Putnam Aves
     • Saturday (8am-4pm)
136. **Rockaway Beach Youthmarket**
     Beach 58th St & Beach Channel Dr
     • Saturday (9am-3pm)
137. **Socrates Sculpture Park Greenmarket**
     Vernon Blvd & Broadway, inside park
     • Saturday (8am-4pm)
138. **Sunnyside Greenmarket**
     Skillman Ave bet 42nd & 43rd Sts
     • Saturday (8am-3pm)

Staten Island

139. **Skyline Youth Farmers' Market** (NO EBT)
     Clyde Pl bet Prospect & Harvard Aves
     • Saturday (9am-12pm)
140. **Snug Harbor Farmers' Market** (NO EBT)
     1000 Richmond Terrace
     • Friday (3pm-5pm)
141. **St. George Greenmarket**
     St. Marks Pl & Hyatt St
     • Saturday (8am-2pm)
142. **Staten Island Mall Greenmarket**
     Marsh Ave & Ring Rd
     • Saturday (8am-3pm)

- = NYC Cooking Demonstrations
- = NYC Food Activities for Kids
- = Year-Round Farmers' Market

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