

# CrystalPM - AOA MORE Integration and MIPS (CQM) Tutorial



## Introduction:

This is a full overview of the logic of the Clinical Quality Measures (CQMs) supported by AOA MORE and CrystalPM, as well as examples of the data entry required in CrystalPM that will result in the passing of the numerator and denominator for each of the CQMs for a particular patient.

You could also treat this as a tutorial for MIPS, but specifically related to the CQMs and not the Meaningful Use Measures.

We'll also go over the HIE Data Completion prompts, which will appear as green or flashing red buttons in CrystalPM's status bar.

Before that, we'll explain how to ensure that the integration is enabled, and that the required software is installed on your server.

## Enabling the Integration:

To enable the AOA MORE integration in CrystalPM, go to Admin->Integrations->HIEs. Check the "Enable" checkbox and click "Save."

A screenshot of a web-based configuration form for the AOA MORE integration. At the top left is the AOA MORE logo, which includes a stylized blue and white graphic and the text "AOA MORE MEASURES AND OUTCOMES REGISTRY FOR EYECARE BY PROMETHEUS | RESEARCH". To the right of the logo is a small blue square with a white question mark. Below the logo is a checkbox labeled "Enable" which is checked. Underneath are three input fields: "Company Name:", "NPI:", and "TIN:". Each field has a greyed-out section on the left and a white section on the right. At the bottom left of the form is a blue "Save" button.

## CrystalPM Windows Services Install on the Server:

Just enabling the integration in CrystalPM does not mean you're generating and sending messages to AOA MORE. It is required that you schedule a time for our staff to install our services on your server. These three services are:

CpmHI7LocalService  
CpmUpdaterService  
CpmMonitorService

The CpmHI7LocalService generates and sends the patient messages to our HIE web server, which then sends those messages directly to AOA MORE.

The CpmUpdaterService checks for, downloads, and installs updates to the CpmHI7LocalService, and optionally for CrystalPM.

The CpmMonitorService restarts the other two services every 12 hours, and that's all it does.

It is mandatory that all three services are running. For example, if the CpmHI7LocalService stopped getting updates from the CpmUpdaterService, it's possible that the CpmHI7LocalService would continue sending messages with an outdated format or structure. This is important point, because messages sent to AOA MORE in an invalid format will basically be thrown out.

It's recommended to have automatic CrystalPM updates enabled during the install for a similar reason. We want you to always have to most up-to-date version of CrystalPM when doing this integration, because there could be valuable updates (changes and optimizations) related specifically to this integration.

## Automatic CrystalPM Updates with a Cloud Office:

If you're a cloud office, where you use RDP (Remote Desktop Protocol) to run CrystalPM on client machines, as well as hosting your server, it is not recommended that you have automatic CrystalPM updates. However, automatic updates to the CpmHI7LocalService are required, which will work just fine in this setup, because the service is only ever being run by the server and is in the background.

With cloud offices, it's just the way the CrystalPM installation was done initially. Each of your client machines is accessing the same machine remotely over RDP, just with a different user account. Therefore, they're most likely using the same install folder to run CrystalPM, so the same Crystal.exe (in C://Program Files/CrystalPM/), as well as other required files. So, if other users are already using CrystalPM, and another machine starts CrystalPM on that machine, when an update is available, it can't replace the files that are required for the update (like Crystal.exe), because they're already being used by other users. This issue would apply to manual updates as well, if other users were still using CrystalPM at that time.

If you're a cloud office, and you still want to enable automatic updates for CrystalPM at the time of the service install, or you just want to avoid this issue (described above) altogether, there is a fairly simple solution. You just need to make a different CrystalPM installation folder for each RDP user account.

As stated above, by default, each RDP user is running the same Crystal.exe in the same folder (C://Program Files/CrystalPM/) on the same machine. So as an example, your front desk machine logs in as user\_01 over RDP. Your first exam room machine logs in as user\_02 over RDP.

The solution would be to copy the entire CrystalPM install folder (C://Program Files/CrystalPM/) to a location specific to each user (i.e. C//Users/user\_01/Program Files/CrystalPM). You'd still have to create a folder called Program Files in the user's folder before copying over the CrystalPM install folder, and you should create a shortcut on the Desktop and the task bar to the CrystalPM.exe (not Crystal.exe) in the new user-specific install folder.

If this is done, then the next time an update is retrieved, the CrystalPM.exe, which is the program that performs the update, will be able to replace the Crystal.exe and other required files, without being interrupted by another user already running the same install of the program.

## Preparation:

Make sure that each doctor's NPI and TIN is set in Admin->Employees.

**Employee Edit**

Track this employee's sales (also a dropdown option on the frame order page)?

Is this employee a Provider?

**Name**  
Last: [ ] First: [ ] Middle: [ ] Type: [ ]

**Initials**  
[ ] Suffix: [ ]

**Address**  
Street: [ ] City: [ ] State: [ ] Zip Code: [ ]

**Contact Numbers**  
Home Phone #: ( ) - [ ]  
Mobile Phone #: ( ) - [ ]  
Email: [ ]  
Password: [ ]

Auto Logout Interval (seconds)

**Provider Information**  
Blue Cross #: [ ] Medicare #: [ ] Medicaid #: [ ]  
CHAMPUS ID: [ ] Other 1: [ ] Other 2: [ ]  
DEA #: [ ] Provider UPIN: [ ]  
OD License #: [ ]  
Tax ID (if different than company, start with an \* for SSN): [ ]  
NPI: [ ] Taxonomy: [Optometrist]  
Custom Name on Med Recs and Invoices (leave blank for default): [ ]  
Signature (image size = 310,40)  Check Sig (RX)  
[Find Signature] [Clear]

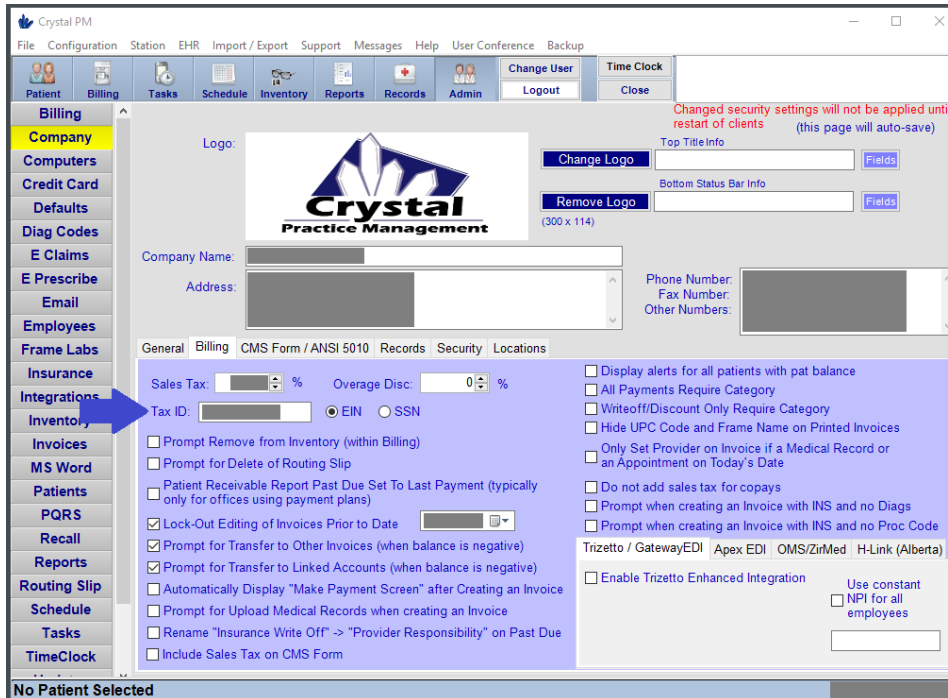
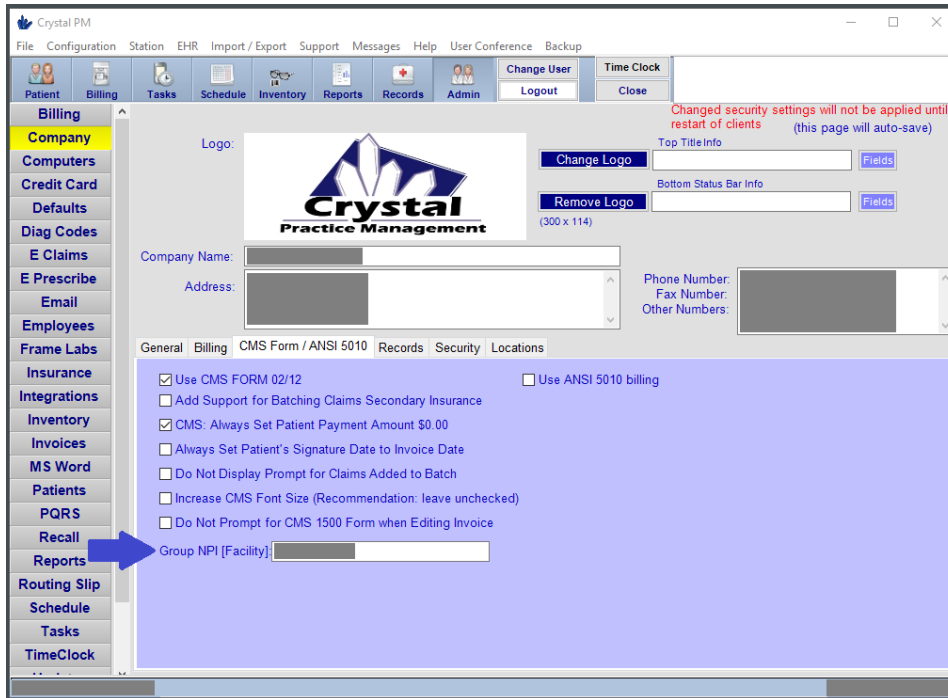
E Prescribe Username: [ ] Password: [ ] [TEST]  
E Prescribe User GUID <Generated by E Prescribe Provider>: [ ] [SSO]

**Pages Viewable**  
 Patients  
 Billing  
 Tasks  
 Schedule  
 Inventory  
 Reports  
 Records  
 Admin

Create / Edit Employees (including security access)  
 Change Schedule Colors  
 Cannot Save Changes to Appointments  
 Cannot Delete Appointments  
 Delete Recurring Appointments  
 Delete From Inventory  
 Allow Export of Patients  
 View All Tasks (including private)  
 Cannot Merge Patient  
 Cannot Set Patient as Active/Inactive  
 Cannot View Reports Other Than Own

[Set Inactive] [Update] [Clear All (No Access)]  Master Admin

Make sure your location's NPI and TIN is set in Admin->Company.



By default, the NPI and/or TIN set for a doctor will be included in the messages generated and sent to AOA MORE. If those are not set, it will use the NPI and/or TIN for the location.

## **Workflow with Prompts:**

There are certain demographics and medical record fields that are required or desired to be filled out. To make this apparent, we've included the HIE Data Completion Prompts.

The prompts are triggered by any user viewing or modifying patient data for a patient that is definitely or potentially missing data.

Patients will build up as tabs in the prompt window as you view and/or modify them. The set of patients that builds up is not tied to the user you're logged in as. It's tied to the instance of CrystalPM you're running. The list is lost when you close CrystalPM. However, the list will persist if you log out and someone else logs in.

It would be most efficient to have employees other than the doctor(s) fill out the required demographics (name, address, race, ethnicity, etc...) before a patient's exam begins.

The prompts related to medical record fields (other than Race and Ethnicity) are related to the patient's medical record for today. It will not prompt for these fields on medical records that took place on any other day than today. This will change in a future update, but it makes sense for now, considering you will most likely not know the specific information required to fill out the fields the next day. These medical record fields should be filled out during the exam or right afterwards, since they are directly related to the exam ("Exam Type", "Findings Type", etc...).

## **Future Updates:**

In an update that will be coming out soon, there will be an HIE Data Completion Report, so you'll be able to see the prompts for patients and their medical records that had an encounter (medical record, appointment, invoice, or routing slip) in a date range. When that becomes available, this documentation will be updated with the instructions on how to use that report and other new functionality.

## Data Completion Prompts:

When any user views or modifies a patient that is missing demographic or medical record data required or desired for the integration, flashing red buttons will appear in status bar of CrystalPM on the bottom-right portion of the screen.

The screenshot displays the Crystal PM software interface. The top menu bar includes File, Configuration, Station, EHR, Import / Export, Support, Messages, Help, User Conference, Backup, and Schedule. Below the menu is a toolbar with icons for Patient, Billing, Tasks, Schedule, Inventory, Reports, Records, and Admin. A secondary toolbar contains buttons for Change User, Time Clock, Logout, and Close. The main content area is divided into several sections:

- Patient Info:** Shows location (Orange, TX), contact numbers (Home, Work, Cell, Other), and preferred contact method (Cell Phone).
- Insurance:** Displays Insurance Balance (0.00), Patient Balance (0.00), and various order types (Last Exam, Last Paid, Last Frame Order, Last CL Order, Courtesy Discount 0%).
- Alert Comment / Misc/ Guardians:** Includes fields for Account #, SS#, Birthdate, Age, and Doctor.
- Next Appointments / Previous Appointments:** Two tables with columns for Date, Time, Emp, Billin..., Type, and Status.
- Insurance Table:** A table with columns for Type, Insurance, and Copay.
- Linked Accounts Table:** A table with columns for Name, Age, Last Exam, Next Ex, Balance, and Ins Balance. A blue arrow points to the bottom of this table.
- Image Placeholder:** A grey silhouette with the text "No Image Available" and buttons for Scan Image, Find Image, and Card Shape.
- Image Management:** Buttons for Start Webcam, Rotate Image, Remove Image, Send Office, and Print Intake.

The status bar at the bottom right shows "HIE Data Completion: Demographics: MR: Patients Not Verified: 1".

When either of the buttons is flashing red (demographics or medical record), clicking either will bring up this prompt window.

The screenshot shows a window titled "HL7 Prompts" with the following content:

It is recommended that you add the missing information described below, so patient records can be sent to HIEs (Admin->Integrations->HIEs). Close

Patient Count: 1

All Patients Verified: No, 1 left

Double-click each row to add the desired information to the patient's record.

AcaTutorial, AoaTutorial (648644)

1 Refresh

Patient: Remove

All Fields Verified: No, 5 left

Appointment Today: No

Count	Name	Description	Status	Location	Requiring HIE(s)
1	First Name	First name of patient	Set	Patient	AOA More
2	Last Name	Last name of patient	Set	Patient	AOA More
3	Date of Birth	Patient's date of birth	Set	Patient	AOA More
4	Address 1	Address 1 of patient	Missing	Patient	AOA More
5	City	Patient's city	Set	Patient	AOA More
6	State	Patient's state	Set	Patient	AOA More
7	Zip Code	Patient's zip code	Missing	Patient	AOA More
8	Gender	Patient's gender	Missing	Patient	AOA More
9	Race	Patient's race	Missing	Records	AOA More
10	Ethnicity	Patient's ethnicity	Missing	Records	AOA More
11	Medication Form Type	Form Type associated with medi...	Set	Medication	AOA More

In this example, the patient is just missing demographics data. However, the race and ethnicity fields are located in the medical record, so a user would not only need access to the Patient page, but also to the Record page to fill out all of these fields.

Double-clicking on a specific row will take you directly to the related field for the patient to fill it out.

As the fields are filled out and the data is saved, the prompt will automatically refresh to represent this. When all of the required fields are filled out and the data is saved, the tab for the particular patient will disappear, or the entire prompt window will disappear, if this was the only patient with potentially missing data that had been viewed and/or modified.

The same idea applies to the buttons in the status bar. If there are no viewed/modified patients that are potentially missing data, the buttons will be solid green again.

Clicking the "Remove" button for a patient tab in the prompt will remove the prompts for a patient until they're viewed/modified again. Removing them does not mean a message will not potentially be generated in the background. It just means they won't be tracked or represented by a tab in this prompt window until you view/modify the patient again.



## Clinical Quality Measures:

In the proceeding sections, we'll be explaining the standard logic and the applied data entry in CrystalPM for each Clinical Quality Measure (CQM) that's officially supported by AOA MORE and CrystalPM's integration. They are as follows:

***50v6 - Closing the Referral Loop Receipt of Specialist Report***

***68v7 - Documentation of Current Medications in the Medical Record (Patient Safety)***

***122v6 - Diabetes Hemoglobin A1c Poor Control***

***131v6 - Diabetes Eye Exam***

***138v6 - Preventative Care and Screening Tobacco Use Screening and Cessation Intervention***

***142v6 - Diabetic Retinopathy Communication with the Physician Managing Ongoing Diabetes Care***

***143v6 - Primary Open-Angle Glaucoma (POAG) Optic Nerve Evaluation***

***165v6 - Controlling High Blood Pressure***

***167v6 - Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy***

Even the "human readable" documentation of the CQM logic can be tricky to read and understand, but we'll try to break this down piece by piece.

The included screenshots are from the official specification sheets for each CQM. Links these files are included at beginning of each CQM section below.

These sheets are broken down into three basic parts: header, logic, and value sets. The header contains general information about the CQM (measure title, identifier number, version number, description, etc..). The logic describes how to anticipate or evaluate whether a patient will pass specific portions or all of the CQM logic (numerator, denominator, etc..). The value sets are the groups of codes referenced by the logic.

Many triggering codes are automatically included in the messages generated for a patient, just based on the values selected in dropdown fields in a medical record. But in the case of manually entered procedure (i.e. CPT) or diagnosis (i.e. ICD10, SNOMED) codes, you might want to know exactly which codes trigger a particular portion of a CQM. At the end, we'll cover how to get access to these raw value sets.

# 50v6 - Closing the Referral Loop Receipt of Specialist Report

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS50v6\\_0.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS50v6_0.html)

### Population Criteria

- **Initial Population =**
  - AND: First: "Occurrence A of Intervention, Performed: Referral" during "Measurement Period"
  - AND: Union of:
    - "Encounter, Performed: Preventive Care- Initial Office Visit, 0 to 17"
    - "Encounter, Performed: Preventive Care - Established Office Visit, 0 to 17"
    - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
    - "Encounter, Performed: Office Visit"
    - "Encounter, Performed: Face-to-Face Interaction"
    - "Encounter, Performed: Ophthalmological Services"
    - during "Measurement Period"
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND: "Communication: From Provider to Provider: Consultant Report" satisfies all:
    - fulfills "Occurrence A of Intervention, Performed: Referral"
    - starts after start of "Occurrence A of Intervention, Performed: Referral"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - None
- **Stratification =**
  - None

In this documentation, we're just going to focus on the following portions: initial population, denominator and numerator. In this measure and many others, the initial population is equivalent to the denominator (Denominator = AND: Initial Population), so if a patient passes the initial population, they pass the denominator.

The initial population or denominator usually represents the encounter types (i.e. CPT codes), diagnoses (i.e. ICD10 codes), age group, or other basic criteria that creates a general group of patients, of which, are considered eligible to be in the numerator.

Looking at the first line of the initial population, a patient would need a referral during the "Measurement Period." The "Measurement Period" represents the very beginning to the end of the current year (January 1<sup>st</sup>, 2018 to December 31<sup>st</sup>, 2018).

The patient would also need at least one encounter during the measurement period. The code (i.e. CPT) representing that type of encounter has to be in one of the specified value sets listed (i.e. 99201 is in the Office Visit value set).

To pass the numerator, there needs to have been a consultation report that fulfills the initial referral and starts after the start of the referral.

# 50v6 - Closing the Referral Loop Receipt of Specialist Report

## Applied

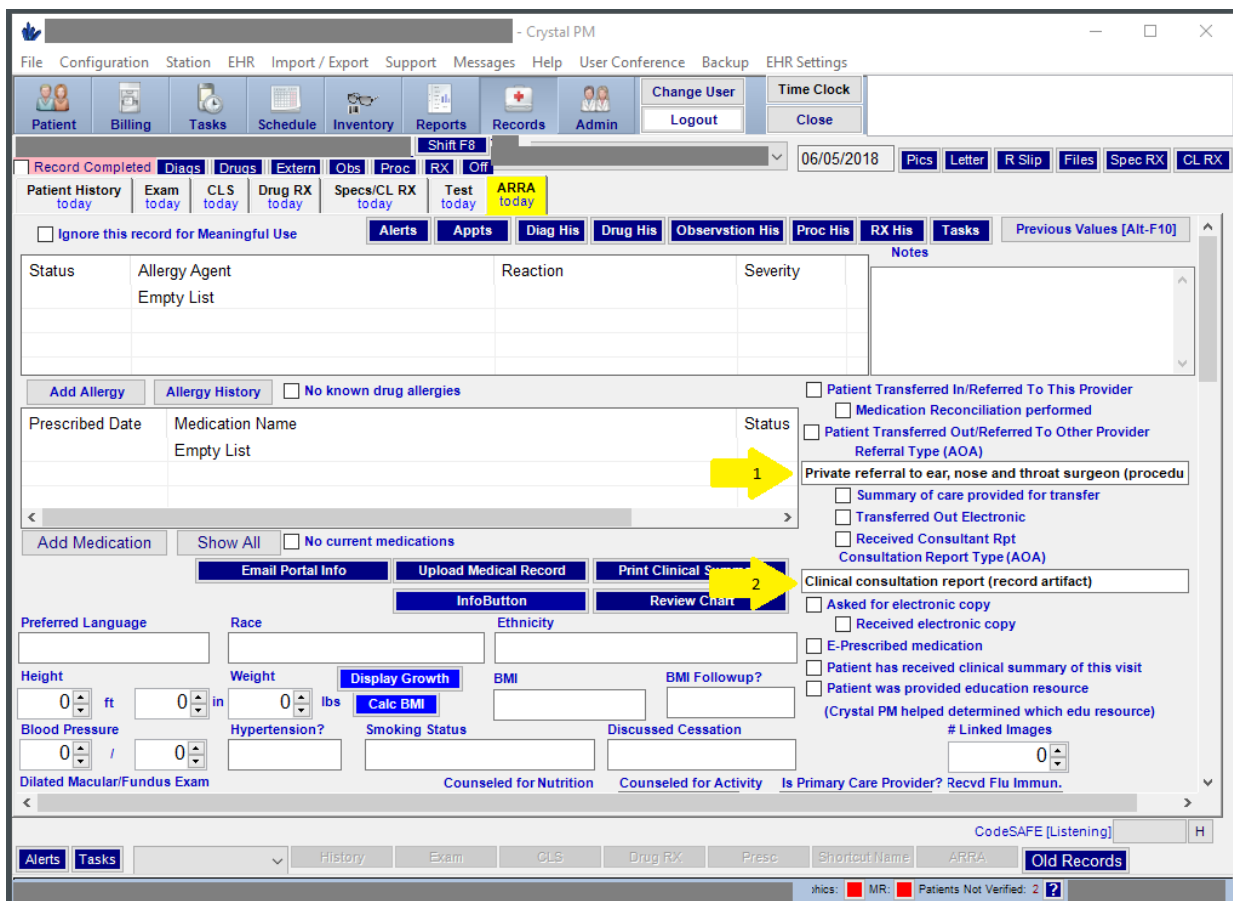
Now let's apply this logic a hypothetical patient in CrystalPM. For this and every other example, we'll create a test patient that passes the initial population, denominator, and numerator.

To pass the "Occurrence A of Intervention, Performed: Referral during Measurement Period" in the IPP, we select an option from the "Referral Type" field (screenshot #1, arrow #1).

To pass the "Encounter, Performed: ... during Measurement Period" in the IPP, we need the occurrence of a matching procedure code (i.e. CPT 99201) in the medical record, appointment, invoice or routing slip (screenshot #2, arrow #1).

To pass the "Communication: From Provider to Provider: Consultant Report" in the numerator, we select an option from the "Consultation Report Type" field (screenshot #1, arrow #2). This field can be set on the same medical record as where the "Referral Type" field was set or any medical record afterward.

There are currently no data completion prompts associated with this measure. There will be in the near future. It would remind you that the "Referral Type" was set previously and that a matching "Consultation Report" has still not been set, if that is the case.



- Crystal PM

File Configuration Station EHR Import / Export Support Messages Help User Conference Backup EHR Settings

Patient Billing Tasks Schedule Inventory Reports Records Admin Change User Time Clock  
Logout Close

Shift F8 06/05/2018 Pics Letter R Slip Files Spec RX CL RX

Record Completed Diags Drugs Extern Obs Proc RX Off

Patient History today Exam today CLS today Drug RX today Specs/CL RX today Test today **ARRA today**

Reason Macular Exam Not Done (AOA) Communicated to Diabetes Care Provider: Exam Findings Severity of Retinopathy HBA1C TEST 0.00

Macular Edema Findings Type Macular Edema Retinal or Dilated Eye Exam Type

Retinal/Dilated Eye Exam Retinopathy Severity Level Optic Nerve Evaluation Optic disc or retinal nerve abnormalities: Optic Disc Struct Abnorm (AOA) OD OS

Cup to Disc ratio OD Cup to Disc ratio OS Optic Disc Exam for Struct. Abnorm. - Result Right Eye Optic Disc Exam for Struct. Abnorm. - Result Left Eye

0.00 H 0.00 V 0.00 H 0.00 V Graphs

Diagnosis Code Description Convert ICD10 Code Finder Pharmacy

Bill ID	CPT	Description
99201	99201	Level 1 Exam - New

Billing Modifiers Description

CodeSAFE [Listening] H

Alerts Tasks History Exam CLS Drug RX Presc Shortcut Name ARRA Old Records

shics: MR: Patients Not Verified: 2 ?

# 68v7 - Documentation of Current Medications in the Medical Record

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS68v7\\_0.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS68v7_0.html)

### Population Criteria

- **Initial Population =**
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND: "Occurrence A of Encounter, Performed: Medications Encounter Code Set" during "Measurement Period"
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND: "Procedure, Performed: Current Medications Documented SNMD" during "Occurrence A of Encounter, Performed: Medications Encounter Code Set"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - OR: "Procedure, Performed not done: Medical or Other reason not done" for "Current Medications Documented SNMD" during "Occurrence A of Encounter, Performed: Medications Encounter Code Set"
- **Stratification =**
  - None

Once again, the denominator equals the initial population.

To pass the initial population, the patient needs to be 18 years of age or older ("*Age >= 18 year(s) at: Measurement Period*").

Also, an "*Occurrence A of Encounter, Performed: Medications Encounter Code Set during Measurement Period*" needs to occur (i.e. CPT 99201) at least once during the year.

To pass the numerator, the patient needs a "*Procedure, Performed: Current Medications Documented SNMD during Occurrence A of Encounter, Performed: Medications Encounter Code Set*", which would mean this needs to occur during the encounter mentioned above. The "*Current Medications Documented SNMD*" code and containing entry is included in the message automatically, if certain conditions are met in the medical record, which we'll discuss next.

# 68v7 - Documentation of Current Medications in the Medical Record

## Applied

The patient's age is determined by their date of birth, which is already a required and prompted demographic field.

The patient needs an encounter code (i.e. CPT 99201) at least once, now or in a previous medical record, appointment, invoice or routing slip during this year. An example of this was shown for 50v6.

For fulfilling "Procedure, Performed: Current Medications Documented SNMD during Occurrence A of Encounter, Performed: Medications Encounter Code Set", there are two scenarios. If the patient has at least one active medication (screenshot #1, arrow #1), you don't have to do anything. If the patient has no medications, then you need to check the "No Current Medications" checkbox (screenshot #1, arrow #2).

This applies to every measure, but every medication needs to have a form type (i.e. capsule, injectable, etc..) set, which is prompted (screenshot #2, arrow #1).

The screenshot displays the Crystal PM software interface. At the top, there is a menu bar with options like File, Configuration, Station, EHR, Import/Export, Support, Messages, Help, User Conference, Backup, and EHR Settings. Below the menu bar is a toolbar with icons for Patient, Billing, Tasks, Schedule, Inventory, Reports, Records, and Admin. A secondary toolbar contains buttons for Change User, Time Clock, Logout, and Close. The main interface area is divided into several sections. On the left, there are tabs for Record Completed, Diags, Drugs, Extern, Obs, Proc, RX, and Off. The central area contains a table for Allergy Agent with columns for Status, Allergy Agent, Reaction, and Severity. Below this is a section for Prescribed Date, Medication Name, and Status. A prominent 'Add Medication' button is highlighted with a yellow arrow labeled '1'. To its right, the 'No current medications' checkbox is checked and highlighted with a yellow arrow labeled '2'. The bottom section of the interface includes various input fields for patient demographics such as Preferred Language, Race, Ethnicity, Height, Weight, Blood Pressure, and Hypertension. There are also checkboxes for 'Counseled for Nutrition' and 'Counseled for Activity'. The bottom status bar shows 'CodeSAFE [Listening]' and 'Patients Not Verified: 4'.



List Of Current Medications (Input New Medications By Manually Filling Out Medication Form, Selecting A Default From The F9 List, Or Searching Online Below.)

Prescribed Date	Medication Name	Status	Fom
06/05/2018	Tylenol	Active	

Medication Form

202433

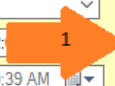
F9

Use as representative of a class

Tylenol

Status Active

Dose Amount   Route   
 Frequency   Route    
 Start Date  06/05/2018 12:00  Form   
 End Date  06/05/2018 10:39 AM  Duration



- 
- 
- 

If medication is not in the default list above, then search online. [ Prescription Drugs, Over-The-Counter Medications, Herbs, Vitamins and Supplements]

Search Online

Ingredients\*

Brands\*

Clinical Drug Or Pack\*

Branded Drug Or Pack\*

[Library Version](#)

\*Double Click Row To Load Item

Meds  ALL

# 122v6 - Diabetes Hemoglobin A1c Poor Control

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS122v6\\_0.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS122v6_0.html)

### Population Criteria

- **Initial Population =**
  - AND: "Diagnosis: Diabetes" overlaps "Measurement Period"
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND: Age < 75 year(s) at: "Measurement Period"
  - AND: Union of:
    - "Encounter, Performed: Office Visit"
    - "Encounter, Performed: Face-to-Face Interaction"
    - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
    - "Encounter, Performed: Home Healthcare Services"
    - "Encounter, Performed: Annual Wellness Visit"
    - during "Measurement Period"
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - OR: "Encounter, Performed: Encounter Inpatient (discharge status: Discharged to Home for Hospice Care)" ends during "Measurement Period"
  - OR: "Encounter, Performed: Encounter Inpatient (discharge status: Discharged to Health Care Facility for Hospice Care)" ends during "Measurement Period"
  - OR: Union of:
    - "Intervention, Order: Hospice care ambulatory"
    - "Intervention, Performed: Hospice care ambulatory"
    - overlaps "Measurement Period"
- **Numerator =**
  - AND:
    - OR: "Laboratory Test, Performed: HbA1c Laboratory Test" satisfies all:
      - Most Recent: (result) during "Measurement Period"
      - (result > 9 %)
    - OR:
      - AND: Most Recent: "Occurrence A of Laboratory Test, Performed: HbA1c Laboratory Test" during "Measurement Period"
      - AND NOT: "Occurrence A of Laboratory Test, Performed: HbA1c Laboratory Test (result)"
    - OR NOT: "Laboratory Test, Performed: HbA1c Laboratory Test" during "Measurement Period"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - None
- **Stratification =**
  - None

To pass the initial population, the patient needs to be 18 years of age or older and less than 75 years of age.

The patient needs an active diagnosis of diabetes.

The patient needs a matching encounter at least once during the year.

To pass numerator, the patient needs a HbA1c lab test result where the most recent value is greater than 9% or no result at all during the year.



# 122v6 - Diabetes Hemoglobin A1c Poor Control

## Applied

The patient needs have an encounter code (i.e. CPT 99201) set at least once, now or in a previous medical record, appointment, invoice or routing slip during this year (screenshot #1, arrow #3).

The patient needs an active diabetes diagnosis (i.e. ICD10's E10.10) (screenshot #1, arrow #2). A matching SNOMED code in the Problem List would also suffice.

To pass the numerator, the HbA1c field needs a value greater than 9% (i.e. 10%) (screenshot #1, arrow #1), or no value at all (0). The older method discussed in the first AOA MORE integration tutorial video, of entering a lab test and result, will also still suffice.

The screenshot displays the Crystal PM EHR interface for a patient record dated 04/26/2018. The interface includes a menu bar at the top with options like File, Configuration, Station, EHR, Import/Export, Support, Messages, Help, User Conference, Backup, and EHR Settings. Below the menu is a toolbar with icons for Patient, Billing, Tasks, Schedule, Inventory, Reports, Records, and Admin, along with buttons for Change User, Time Clock, Logout, and Close. The main data entry area is divided into several sections:

- Demographics:** Fields for Preferred Language, Race, and Ethnicity.
- Vitals:** Height (0 ft, 0 in), Weight (0 lbs), BMI, and BMI Followup? (with a "Calc BMI" button).
- Medical History:** Blood Pressure (0 / 0), Hypertension?, Smoking Status, and Discussed Cessation.
- Diabetes Management:** Dilated Macular/Fundus Exam, Reason Macular Exam Not Done (AOA), Macular Edema Findings Type, Retinal/Dilated Eye Exam, Retinopathy Severity Level, Optic Nerve Evaluation, and Optic disc or retinal nerve abnormalities: Optic Disc Struc Abnorm (AOA) (with fields for OD and OS).
- Diagnosis:** A table with columns for Diagnosis Code, Description, and Pharmacy. The entry E10.10 Type 1 diabetes mellitus with ketoacidosis without cc is highlighted with a yellow arrow #2.
- Encounter Code:** A table with columns for Bill ID, CPT, and Description. The entry 99201 99201 Level 1 Exam - New is highlighted with a yellow arrow #3.
- HbA1c Test:** A field labeled "HBA1C TEST" with a value of 10.0% is highlighted with a yellow arrow #1.

At the bottom of the interface, there are buttons for Alerts, Tasks, History, Exam, GLS, Drug RX, Presc, Shortcut Name, ARRA, and Old Records. A status bar at the very bottom shows "on: Demographics: MR: Patients Not Verified: 1".

This measure is more flexible when it comes to the performing or start dates of the data. The diabetes diagnosis could be from years ago, as long as it's still active. The encounter code and the HbA1c test result don't have to be on the same date. They just both have to be during the year to pass the initial population and denominator.

# 131v6 - Diabetes Eye Exam

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS131v6\\_1.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS131v6_1.html)

### Population Criteria

- **Initial Population =**
  - AND: "Diagnosis: Diabetes" overlaps "Measurement Period"
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND: Age < 75 year(s) at: "Measurement Period"
  - AND: Union of:
    - "Encounter, Performed: Office Visit"
    - "Encounter, Performed: Face-to-Face Interaction"
    - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
    - "Encounter, Performed: Home Healthcare Services"
    - "Encounter, Performed: Annual Wellness Visit"
    - "Encounter, Performed: Ophthalmological Services"
    - during "Measurement Period"
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - OR: "Encounter, Performed: Encounter Inpatient (discharge status: Discharged to Home for Hospice Care)" ends during "Measurement Period"
  - OR: "Encounter, Performed: Encounter Inpatient (discharge status: Discharged to Health Care Facility for Hospice Care)" ends during "Measurement Period"
  - OR: Union of:
    - "Intervention, Order: Hospice care ambulatory"
    - "Intervention, Performed: Hospice care ambulatory"
    - overlaps "Measurement Period"
- **Numerator =**
  - AND: "Physical Exam, Performed: Retinal or Dilated Eye Exam" satisfies any:
    - (result: Negative Finding) < 12 month(s) ends before start of "Measurement Period"
    - during "Measurement Period"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - None
- **Stratification =**
  - None

To pass the initial population, the patient needs to be 18 years of age or older and less than 75 years of age.

The patient needs an active diagnosis of diabetes.

The patient needs a matching encounter at least once during the year.

To pass the numerator, the patient needs a recorded "Retinal or Dilated Eye Exam", where result is negative and the exam was done in the previous year, or where the result was not negative and the exam was done during the year.

# 131v6 - Diabetes Eye Exam

## Applied

The patient needs have an encounter code (i.e. CPT 99201) set at least once, now or in a previous medical record, appointment, invoice or routing slip during this year (screenshot #1, arrow #4).

The patient needs an active diabetes diagnosis (i.e. ICD10's E10.10) (screenshot #1, arrow #3). A matching SNOMED code in the Problem List would also suffice.

In order to sufficiently document the retinal/dilated eye exam, there are three fields that need to be filled out: "Retinal/Dilated Eye Exam", "Retinal or Dilated Eye Exam Type", and "Retinal or Dilated Eye Exam Type (AOA)."

The "Retinal/Dilated Eye Exam" field (screenshot #1, arrow #1) needs a value of "Yes" or "No." To pass the numerator, it would need to be yes. For the two exam type dropdown fields (screenshot #1, arrow #2 and screenshot #2, arrow #1), pick the option that most matches the type of exam that was actually performed.

The screenshot displays the Crystal PM EHR interface for a patient's Diabetes Eye Exam. The form is titled "Diabetes Eye Exam" and includes various sections for patient information, vitals, and exam results. Four yellow arrows highlight specific fields:

- Arrow 1 points to the "Retinal/Dilated Eye Exam" field, which is set to "Yes".
- Arrow 2 points to the "Retinal or Dilated Eye Exam Type" dropdown menu, which is set to "Evaluation of retina (procedure)".
- Arrow 3 points to the "Diagnosis Code" field, which is set to "E10.10".
- Arrow 4 points to the "CPT" field, which is set to "99201".

The form also includes fields for "Retinopathy Severity Level", "Optic Disc Exam for Struct. Abnorm. - Result Right Eye", and "Optic Disc Exam for Struct. Abnorm. - Result Left Eye". The "Diagnosis Code" field is set to "E10.10" and the "CPT" field is set to "99201". The "Description" field is set to "Level 1 Exam - New".

Crystal PM

File Configuration Station EHR Import / Export Support Messages Help User Conference Backup EHR Settings

Patient Billing Tasks Schedule Inventory Reports Records Admin Change User Time Clock  
Logout Close

Add Addendum EDIT 04/26/2018 Pics Letter R Slip Files Spec RX CL RX

Record Completed Diags Drugs Extern Obs Proc RX Off  
Patient History Exam CLS Drug RX Specs/CL RX Test ARRA  
today today today today today today today

Date	Type	Primary	Status	Problem
- MU Measures Outside Of Crystal PM				
Medication Orders				
Lab Orders				
Radiology Orders				
Imaging Orders (non-Radiology)				

AOA MORE (sm) Show Active

Tobacco Non User Tobacco Use

1 Tobacco Use Screening Not Done Tobacco Use Screening

Retinal or Detailed Eye Exam Type (AOA) Tobacco Use Cessation Counseling

Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist document

Relationship Disease or Condition  
Empty List

Family History  Unknown family history

Type Plan

ARRA 04/26/2018 CodeSAFE [Listening] H

Alerts Tasks History Exam CLS Drug RX Presc Shortcut Name ARRA 04/26/2018:ARF

ON: Demographics: MR: Patients Not Verified: 2

# 138v6 - Preventative Care and Screening Tobacco Use Screening and Cessation Intervention

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS138v6\\_0.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS138v6_0.html)

138v6 has three population criteria, so it's almost like three measures in one. The initial population logic is identical, but every other portion is different for each.

### Population Criteria

#### ----- Population Criteria 1 -----

- **Initial Population =**
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND:
    - OR: Count >= 2 : Union of:
      - "Encounter, Performed: Face-to-Face Interaction"
      - "Encounter, Performed: Health & Behavioral Assessment - Individual"
      - "Encounter, Performed: Health and Behavioral Assessment - Initial"
      - "Encounter, Performed: Health and Behavioral Assessment, Reassessment"
      - "Encounter, Performed: Home Healthcare Services"
      - "Encounter, Performed: Occupational Therapy Evaluation"
      - "Encounter, Performed: Office Visit"
      - "Encounter, Performed: Ophthalmological Services"
      - "Encounter, Performed: Psych Visit - Diagnostic Evaluation"
      - "Encounter, Performed: Psych Visit - Psychotherapy"
      - "Encounter, Performed: Psychoanalysis"
      - "Encounter, Performed: Speech and Hearing Evaluation"
      - during "Measurement Period"
    - OR: Count >= 1 : Union of:
      - "Encounter, Performed: Annual Wellness Visit"
      - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
      - "Encounter, Performed: Preventive Care Services - Group Counseling"
      - "Encounter, Performed: Preventive Care Services - Other"
      - "Encounter, Performed: Preventive Care Services-Individual Counseling"
      - "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
      - during "Measurement Period"

## Population #1:

- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND:
    - OR: \$TobaccoUseScreeningNonUser
    - OR: \$TobaccoUseScreeningUser
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - OR:
    - AND: "Occurrence A of Diagnosis: Limited Life Expectancy" starts before end of "Measurement Period"
    - AND NOT: "Occurrence A of Diagnosis: Limited Life Expectancy" ends before end of "Measurement Period"
  - OR: "Assessment, Performed not done: Medical Reason" for "Tobacco Use Screening" <= 24 month(s) starts before end of "Measurement Period"
- **Stratification =**
  - None

## Population #2:

- **Denominator =**
  - AND: Initial Population
  - AND: \$TobaccoUseScreeningUser
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND: Occurrence A of \$TobaccoCessationIntervention starts after or concurrent with start of \$TobaccoUseScreeningUser
  - AND: Occurrence A of \$TobaccoCessationIntervention starts before end of "Measurement Period"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - OR:
    - AND: "Occurrence A of Diagnosis: Limited Life Expectancy" starts before end of "Measurement Period"
    - AND NOT: "Occurrence A of Diagnosis: Limited Life Expectancy" ends before end of "Measurement Period"
  - OR: \$CounselingNotPerformed starts after or concurrent with start of \$TobaccoUseScreeningUser
  - OR: \$MedicationNotOrdered starts after or concurrent with start of \$TobaccoUseScreeningUser
- **Stratification =**
  - None

### **Population #3:**

- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND:
    - OR: \$TobaccoUseScreeningNonUser
    - OR:
      - AND: Occurrence A of \$TobaccoCessationIntervention starts after or concurrent with start of \$TobaccoUseScreeningUser
      - AND: Occurrence A of \$TobaccoCessationIntervention starts before end of "Measurement Period"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - OR:
    - AND: "Occurrence A of Diagnosis: Limited Life Expectancy" starts before end of "Measurement Period"
    - AND NOT: "Occurrence A of Diagnosis: Limited Life Expectancy" ends before end of "Measurement Period"
  - OR: "Assessment, Performed not done: Medical Reason" for "Tobacco Use Screening" <= 24 month(s) starts before end of "Measurement Period"
  - OR: \$CounselingNotPerformed starts after or concurrent with start of \$TobaccoUseScreeningUser
  - OR: \$MedicationNotOrdered starts after or concurrent with start of \$TobaccoUseScreeningUser
- **Stratification =**
  - None

### **Alias Definitions:**

#### **Data Criteria (QDM Variables)**

- **\$TobaccoCessationIntervention =**
  - Union of:
    - "Intervention, Performed: Tobacco Use Cessation Counseling"
    - "Medication, Active: Tobacco Use Cessation Pharmacotherapy"
    - "Medication, Order: Tobacco Use Cessation Pharmacotherapy"
- **\$TobaccoUseScreeningNonUser =**
  - "Assessment, Performed: Tobacco Use Screening" satisfies all:
    - Most Recent: <= 24 month(s) starts before end of "Measurement Period"
    - (result: Tobacco Non-User)
- **\$CounselingNotPerformed =**
  - "Intervention, Performed not done: Medical Reason" for "Tobacco Use Cessation Counseling" starts before end of "Measurement Period"
- **\$TobaccoUseScreeningUser =**
  - "Assessment, Performed: Tobacco Use Screening" satisfies all:
    - Most Recent: <= 24 month(s) starts before end of "Measurement Period"
    - (result: Tobacco User)
- **\$MedicationNotOrdered =**
  - "Medication, Order not done: Medical Reason" for "Tobacco Use Cessation Pharmacotherapy" starts before end of "Measurement Period"

To pass the initial population, the patient needs to be 18 years of age or older.

For certain types of encounters, the patient needs at least two encounters, represented by codes in specific value sets, during the year.

The population criteria #1 and #3, the initial population is equivalent to the denominator.

For population #2, the denominator passes if the initial population is met and a tobacco use screening was done, where patient was found to be a tobacco user, where that screening was done during the year or previous year ("<= 24 months before end of Measurement Period").

As implied above, each of the three population criteria has a different numerator logic.

For population #1, the patient would have a tobacco use screening, with the result being that they are a tobacco user or non-user, where the screening was done during the year or previous year.

For population #2, the patient would receive a tobacco use screening, with the result being that they are a tobacco user, where the screening was done during the year or previous year. In response, the patient would receive tobacco use cessation counseling or prescribed tobacco use cessation medication. The counseling would be performed or that medication would start on the same day or after the counseling was performed and would start before the end of the year.

For population #1, the patient would have a tobacco use screening, with the result being that they are a tobacco non-user, where the screening was done during the year or previous year. Or they would match the numerator logic from population #2.



## **138v6 - Preventative Care and Screening Tobacco Use Screening and Cessation Intervention**

### **Applied**

To pass the initial population with certain types encounter codes, such as the value set that CPT 99201 is in, there would need to be at least two entries of that type of encounter code. Not the same code, but codes in the same group of value sets (i.e. two or more encounters using codes from “Face-to-Face Interaction, Office Visit, etc...”, or one or more encounter using codes from “Annual Wellness Visit”, etc...). Looking the encounter logic of the initial population logic above might make this easier to understand.

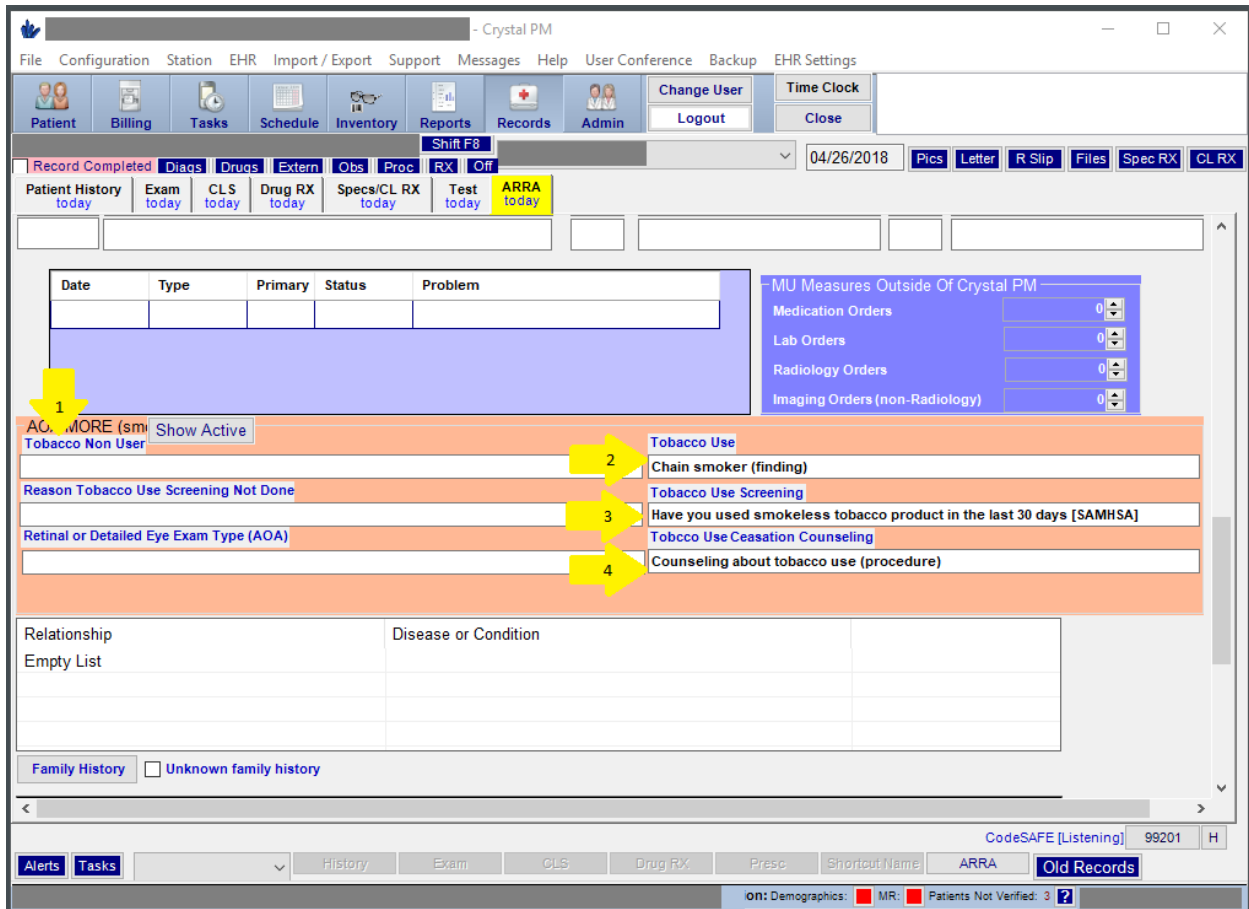
Instead of using the logic above to explain how to pass the numerator, we’ll just break down what data you should enter into branching steps (continued below).

You should always start with the "Tobacco Use Screening" field (screenshot #1, arrow #3). If the patient refuses the screening, you should not fill out the screening field and instead select an option from the "Reason Tobacco Use Screening Not Done" field (2<sup>nd</sup> field below screenshot #1, arrow #1), and you're done.

If you completed the screening and you know whether the patient is a tobacco user or non-user, select an option from the "Tobacco Use Screening" field (screenshot #1, arrow #3), and select an option from the "Tobacco Use" (screenshot #1, arrow #2) or "Tobacco Non-User" field (1<sup>st</sup> field below screenshot #1, arrow #1). If they're a tobacco non-user, you're done.

If they're a tobacco user, you have the option to perform an intervention. You can perform tobacco use cessation counseling and/or you can prescribe cessation medication. If you perform cessation counseling, select an option from the "Tobacco Use Cessation Counseling" field (screenshot #1, arrow #4). If you prescribed tobacco cessation medication, you would add that as an active medication in their medication history, just like adding a medication in 68v7.

You will be prompted for these fields if data is detected as missing.



# 142v6 - Diabetic Retinopathy Communication with the Physician Managing Ongoing Diabetes Care

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS142v6\\_0.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS142v6_0.html)

### Population Criteria

- **Initial Population** =
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND: "Diagnosis: Diabetic Retinopathy" overlaps Occurrence A of \$EyeCareEncounters
- **Denominator** =
  - AND: Initial Population
  - AND: "Diagnostic Study, Performed: Macular Exam (result)" during Occurrence A of \$EyeCareEncounters
- **Numerator Exclusions** =
  - None
- **Numerator** =
  - AND: "Communication: From Provider to Provider: Level of Severity of Retinopathy Findings" starts after start of Occurrence A of \$EyeCareEncounters
  - AND: Union of:
    - "Communication: From Provider to Provider: Macular Edema Findings Present"
    - "Communication: From Provider to Provider: Macular Edema Findings Absent"
    - starts after start of Occurrence A of \$EyeCareEncounters
- **Numerator Exclusions** =
  - None
- **Denominator Exceptions** =
  - OR: Union of:
    - "Communication: From Provider to Provider not done: Medical Reason" for "Macular Edema Findings Absent"
    - "Communication: From Provider to Provider not done: Patient Reason" for "Macular Edema Findings Absent"
    - "Communication: From Provider to Provider not done: Medical Reason" for "Macular Edema Findings Present"
    - "Communication: From Provider to Provider not done: Patient Reason" for "Macular Edema Findings Present"
    - "Communication: From Provider to Provider not done: Medical Reason" for "Level of Severity of Retinopathy Findings"
    - "Communication: From Provider to Provider not done: Patient Reason" for "Level of Severity of Retinopathy Findings"
    - starts after start of Occurrence A of \$EyeCareEncounters
- **Stratification** =
  - None

To pass the initial population, the patient needs to be 18 years of age or older.

The patient needs an active diagnosis of diabetes, where the diagnosis starts before or on the same day as a matching encounter.

The patient needs a matching encounter at least once during the year.

To pass the denominator, the patient needs to pass the initial population, as well as having a macular exam with a result during a matching encounter.

To pass the numerator, the "Level of Severity of Retinopathy Findings" and the "Macular Edema Findings Present" or "Absent" needs to be recorded. And the "Level of Severity of Retinopathy Findings" and "Macular Edema Findings Present" or "Absent" need to be recorded as communicated to another provider. The exam, findings, and the indication of communication of the findings need to be recorded on the same day and the same day as the matching encounter.

# 142v6 - Diabetic Retinopathy Communication with the Physician Managing Ongoing Diabetes Care

## Applied

To pass the initial population, the patient has a diagnosis of diabetic retinopathy (ICD10's E08.311) (screenshot #1, arrow #7). If the patient already had an active diabetic retinopathy diagnosis from a previous medical record, this would not need to be repeated.

To pass the initial population and the denominator, the patient has a matching encounter code (CPT 99201) (screenshot #1, arrow #8), which is on the same day as the dilated/macular fundus exam, and the active diabetic retinopathy diagnosis overlaps it.

To pass the numerator, the "Dilated Macular/Fundus Exam" exam field (screenshot #1, arrow #1) needs to have a value of "Yes." The "Macular Edema" field (screenshot #1, arrow #6) needs to have a value of "Yes" or "No." If the value for "Macular Edema" is "Yes", then an option should be selected from the "Macular Edema Findings Type" field (screenshot #1, arrow #4). An option also needs to be selected from the "Retinopathy Severity Level" field (screenshot #1, arrow #5).

For recording the communication to another provider, the "Communicated to Diabetes Care Provider: Exam Findings" (screenshot #1, arrow #2) and "... Severity of Retinopathy" (screenshot #1, arrow #3) fields both need a value of yes.

The screenshot displays the Crystal PM EHR interface for a patient on 04/26/2018. The form is divided into several sections:

- Demographics:** Includes fields for Preferred Language, Race, Ethnicity, Height, Weight, BMI, and BMI Followup?.
- Vitals and Risk Factors:** Includes Blood Pressure, Hypertension?, Smoking Status, and Discussed Cessation.
- Exam Fields:** Includes Dilated Macular/Fundus Exam (set to Yes), Reason Macular Exam Not Done (AOA), Macular Edema Findings Type (set to Advanced diabetic maculopathy (disorder)), Macular Edema (set to Yes), Retinal or Dilated Eye Exam Type (set to Binocular indirect ophthalmoscopy (procedure)), Retinopathy Severity Level (set to Mild non-proliferative), and Optic Nerve Evaluation.
- Communication:** Includes Communicated to Diabetes Care Provider: Exam Findings (set to Yes) and Severity of Retinopathy (set to Yes).
- Diagnosis and Procedure:** Includes Diagnosis Code E08.311 (Diab due to undrl cond w unsp diabetic rtnop w macu) and CPT 99201 (Level 1 Exam - New).

Yellow arrows indicate the following fields:

- 1: Dilated Macular/Fundus Exam (Yes)
- 2: Communicated to Diabetes Care Provider: Exam Findings (Yes)
- 3: Communicated to Diabetes Care Provider: Severity of Retinopathy (Yes)
- 4: Macular Edema Findings Type (Advanced diabetic maculopathy (disorder))
- 5: Retinopathy Severity Level (Mild non-proliferative)
- 6: Macular Edema (Yes)
- 7: Diagnosis Code (E08.311)
- 8: CPT (99201)

# 143v6 - Primary Open-Angle Glaucoma (POAG) Optic Nerve Evaluation

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS143v6\\_1.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS143v6_1.html)

### Population Criteria

- **Initial Population =**
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND: "Diagnosis: Primary Open-Angle Glaucoma" overlaps Occurrence A of \$EyeCareEncounters
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND: "Diagnostic Study, Performed: Cup to Disc Ratio (result)" during Occurrence A of \$EyeCareEncounters
  - AND: "Diagnostic Study, Performed: Optic Disc Exam for Structural Abnormalities (result)" during Occurrence A of \$EyeCareEncounters
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - OR: Union of:
    - "Diagnostic Study, Performed not done: Medical Reason" for "Cup to Disc Ratio"
    - "Diagnostic Study, Performed not done: Medical Reason" for "Optic Disc Exam for Structural Abnormalities"
    - starts during Occurrence A of \$EyeCareEncounters
- **Stratification =**
  - None

To pass the initial population, the patient needs to be 18 years of age or older.

The patient needs an active diagnosis of primary open-angle glaucoma, where the diagnosis starts before or on the same day as a matching encounter.

The patient needs a matching encounter at least once during the year.

The initial population is equivalent to the denominator.

To pass the numerator, the patients needs a cup to disc ratio test with a result during the matching encounter. They also need an optic disc exam for structural abnormalities with a result during the matching encounter.

# 143v6 - Primary Open-Angle Glaucoma (POAG) Optic Nerve Evaluation

## Applied

To pass the initial population, the patient has a diagnosis of primary open angle glaucoma (ICD10's H40.10X0) (screenshot #1, arrow #5). If the patient already had an active primary open angle glaucoma diagnosis from a previous medical record, this would not need to be repeated.

The patient has a matching encounter code (CPT 99201) (screenshot #1, arrow #6), which is on the same day as the cup to disc ratio test and the optic disc exam for structural abnormalities, and the active primary open-angle glaucoma diagnosis overlaps it.

To pass the numerator, the patient needs a cup to disc ratio result for the left and/or right eye (screenshot #1, arrow #1 & #2). They also need a result for an optic disc exam for structural abnormalities for the left and/or right eye (screenshot #1, arrow #3). If you want to specify a result other than "normal" or "abnormal", which are implied by these fields, use the other result fields to specify a free text answer (screenshot #1, arrow #4).

The screenshot displays the Crystal PM EHR interface for a patient on 04/26/2018. The interface includes a menu bar (File, Configuration, Station, EHR, Import/Export, Support, Messages, Help, User Conference, Backup, EHR Settings) and a toolbar with icons for Patient, Billing, Tasks, Schedule, Inventory, Reports, Records, and Admin. Below the toolbar, there are tabs for Record Completed, Diags, Drugs, Extern, Obs, Proc, RX, and Off. The main content area shows patient demographics (Preferred Language, Race, Ethnicity), physical exam data (Height, Weight, Blood Pressure, Hypertension?, Smoking Status), and various clinical notes and tests. Yellow arrows highlight specific fields: arrow 1 points to the Retinal/Dilated Exam field; arrow 2 points to the Macular Edema Findings Type field; arrow 3 points to the HBA1C TEST field; arrow 4 points to the Optic Disc Exam for Struct. Abnorm. - Result Right Eye field; arrow 5 points to the Diagnosis Code field (H40.10X); and arrow 6 points to the CPT field (99201). The bottom of the screen shows a status bar with alerts, tasks, and a legend for demographics, MR, and patients not verified.

# 165v6 - Controlling High Blood Pressure

## Logic

[https://ecqi.healthit.gov/system/files/ecqm/measures/CMS165v6\\_1.html](https://ecqi.healthit.gov/system/files/ecqm/measures/CMS165v6_1.html)

### Population Criteria

- **Initial Population =**
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND: Age < 85 year(s) at: "Measurement Period"
  - AND: "Occurrence A of Diagnosis: Essential Hypertension" satisfies any:
    - < 6 month(s) starts after or concurrent with start of "Measurement Period"
    - satisfies all:
      - starts before start of "Measurement Period"
      - overlaps "Measurement Period"
  - AND: Union of:
    - "Encounter, Performed: Office Visit"
    - "Encounter, Performed: Face-to-Face Interaction"
    - "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
    - "Encounter, Performed: Home Healthcare Services"
    - "Encounter, Performed: Annual Wellness Visit"
    - during "Measurement Period"
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - OR: "Encounter, Performed: Encounter Inpatient (discharge status: Discharged to Home for Hospice Care)" ends during "Measurement Period"
  - OR: "Encounter, Performed: Encounter Inpatient (discharge status: Discharged to Health Care Facility for Hospice Care)" ends during "Measurement Period"
  - OR: Union of:
    - "Intervention, Order: Hospice care ambulatory"
    - "Intervention, Performed: Hospice care ambulatory"
    - overlaps "Measurement Period"
  - OR: Union of:
    - "Diagnosis: Pregnancy"
    - "Diagnosis: End Stage Renal Disease"
    - "Diagnosis: Chronic Kidney Disease, Stage 5"
    - overlaps "Measurement Period"
  - OR: Union of:
    - "Procedure, Performed: Vascular Access for Dialysis"
    - "Encounter, Performed: ESRD Monthly Outpatient Services"
    - "Procedure, Performed: Kidney Transplant"
    - "Procedure, Performed: Dialysis Services"
    - starts before end of "Measurement Period"
- **Numerator =**
  - AND: Most Recent:
    - "Occurrence A of Encounter, Performed: Adult Outpatient Visit" satisfies all:
      - during "Measurement Period"
      - overlaps "Physical Exam, Performed: Diastolic Blood Pressure (result)"
      - overlaps "Physical Exam, Performed: Systolic Blood Pressure (result)"
      - overlaps "Occurrence A of Diagnosis: Essential Hypertension"
  - AND: "Occurrence A of Diagnosis: Essential Hypertension" satisfies all:
    - starts before start of "Occurrence A of Encounter, Performed: Adult Outpatient Visit"
    - overlaps "Occurrence A of Encounter, Performed: Adult Outpatient Visit"
  - AND: "Physical Exam, Performed: Diastolic Blood Pressure" satisfies all:
    - Most Recent: during "Occurrence A of Encounter, Performed: Adult Outpatient Visit"
    - (result < 90 mmHg)
  - AND: "Physical Exam, Performed: Systolic Blood Pressure" satisfies all:
    - Most Recent: during "Occurrence A of Encounter, Performed: Adult Outpatient Visit"
    - (result < 140 mmHg)

To pass the initial population, the patient needs to be 18 years of age or older and less than 85 years of age.

The patient needs an active diagnosis of essential hypertension, which starts at the very beginning of the year, starts less than 6 months into the year, or where it starts before this year and is active.

The patient needs a matching encounter at least once during the year.

To pass the numerator, the patient needs a recorded diastolic blood pressure result that's less than 90mmHg and a systolic result that's less than 140mmHg, and these results need to be recorded during the most recent matching encounter.



# 165v6 - Controlling High Blood Pressure

## Applied

To pass the initial population, the patient has a diagnosis of essential hypertension (screenshot #2, arrow #1). If the patient already had an active essential hypertension diagnosis from a previous medical record, this would not need to be repeated. In this example, it's added in the Problem List. A matching ICD10 code in a diagnosis field would also suffice.

The patient has a matching encounter code (CPT 99201) (screenshot #1, arrow #2), which is on the same day as the when the blood pressure was taken.

To pass the numerator, the diastolic and systolic blood pressure fields (screenshot #1, arrow #1) both have a value of 50.

The screenshot displays the Crystal PM EHR interface. At the top, there is a menu bar with options like File, Configuration, Station, EHR, Import / Export, Support, Messages, Help, User Conference, Backup, and EHR Settings. Below the menu bar, there are several tabs for navigation: Patient, Billing, Tasks, Schedule, Inventory, Reports, Records, and Admin. The main content area is divided into several sections. The top section includes patient information such as Preferred Language, Race, Ethnicity, Height, Weight, BMI, and Blood Pressure. The Blood Pressure field shows a value of 50 / 50. Below this, there are sections for Dilated Macular/Fundus Exam, Reason Macular Exam Not Done (AOA), Macular Edema Findings Type, Retinal/Dilated Eye Exam, and Cup to Disc ratio OD/OS. At the bottom of the main content area, there is a table for the Procedure List. The table has columns for Bill ID, CPT, and Description. A yellow arrow labeled '2' points to the first row of the table, which contains the following data:

Bill ID	CPT	Description
99201	99201	Level 1 Exam - New

At the bottom of the interface, there is a status bar with various indicators and a help icon.

Crystal PM

File Configuration Station EHR Import / Export Support Messages Help User Conference Backup EHR Settings

Patient Billing Tasks Schedule Inventory Reports Records Admin Change User Time Clock  
Logout Close

Shift F8 No Doctor Assigned 04/26/2018 Pics Letter R Slip Files Spec RX CL RX

Record Completed Diags Drugs Extern Obs Proc RX Off  
Patient History today Exam today CLS today Drug RX today Specs/CL RX today Test today **ARRA today**

Recommended Eye Exam Recommended Vision Exam Optic Disc Exam Optic Disc Exam for Struct. Abnorm. - Result Right Eye Optic Disc Exam for Struct. Abnorm. - Result Left Eye

Cup to Disc ratio OD Cup to Disc ratio OS  
0.00 H 0.00 V 0.00 H 0.00 V Graphs

Diagnosis Code Description Convert ICD10 Code Finder Pharmacy

Bill ID	CPT	Description
99201	99201	Level 1 Exam - New

Billing Modifiers Description

Date	Type	Primary	Status	Problem
05/11/2018			Active	Benign hypertension

MU Measures Outside Of Crystal PM

- ion Orders 0
- Lab Orders 0
- Radiology Orders 0
- Imaging Orders (non-Radiology) 0

CodeSAFE [Listening] 99201 H

Alerts Tasks History Exam CLS Drug RX Presc Shortcut Name ARRA Old Records

ON: Demographics: MR: Patients Not Verified: 6

# 167v6 - Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

## Logic

<https://ecqi.healthit.gov/system/files/ecqm/measures/CMS167v6.html>

### Population Criteria

- **Initial Population =**
  - AND: Age >= 18 year(s) at: "Measurement Period"
  - AND: "Diagnosis: Diabetic Retinopathy" overlaps Occurrence A of \$EyeCareEncounters
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND: "Diagnostic Study, Performed: Macular Exam" satisfies all:
    - (result: Level of Severity of Retinopathy Findings) during Occurrence A of \$EyeCareEncounters
    - satisfies any:
      - (result: Macular Edema Findings Absent)
      - (result: Macular Edema Findings Present)
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - OR: Union of:
    - "Diagnostic Study, Performed not done: Medical Reason" for "Macular Exam"
    - "Diagnostic Study, Performed not done: Patient Reason" for "Macular Exam"
    - during Occurrence A of \$EyeCareEncounters
- **Stratification =**
  - None

### Data Criteria (QDM Variables)

- **\$EyeCareEncounters =**
  - Union of:
    - "Encounter, Performed: Ophthalmological Services"
    - "Encounter, Performed: Care Services in Long-Term Residential Facility"
    - "Encounter, Performed: Nursing Facility Visit"
    - "Encounter, Performed: Office Visit"
    - "Encounter, Performed: Outpatient Consultation"
    - "Encounter, Performed: Face-to-Face Interaction"
    - during "Measurement Period"

To pass the initial population, the patient needs to be 18 years of age or older.

The patient needs an active diagnosis of diabetic retinopathy, where the diagnosis starts before or on the same day as a matching encounter.

The patient needs a matching encounter at least once during the year.

To pass the numerator, the patient needs a "Macular Exam" with the "Level of Severity of Retinopathy Findings" and the "Macular Edema Findings Present" or "Absent." The exam and findings need to be recorded on the same day and the same day as the matching encounter.

# 167v6 - Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

## Applied

To pass the initial population, the patient has a diagnosis of diabetic retinopathy (ICD10's E08.311) (screenshot #1, arrow #5). If the patient already had an active diabetic retinopathy diagnosis from a previous medical record, this would not need to be repeated.

The patient has a matching encounter code (CPT 99201) (screenshot #1, arrow #6), which is on the same day as the dilated/macular fundus exam, and the active diabetic retinopathy diagnosis overlaps it.

To pass the numerator, the "Dilated Macular/Fundus" exam field (screenshot #1, arrow #1) needs to have a value of "Yes." The "Macular Edema" field (screenshot #3, arrow #2) needs to have a value of "Yes" or "No." If the value for "Macular Edema" is "Yes", then an option should be selected from the "Macular Edema Findings Type" field (screenshot #1, arrow #3). An option also needs to be selected from the "Retinopathy Severity Level" field (screenshot #1, arrow #4).

The screenshot displays the Crystal PM EHR interface for a patient visit on 04/26/2018. The interface includes a menu bar at the top with options like File, Configuration, Station, EHR, Import/Export, Support, Messages, Help, User Conference, Backup, and EHR Settings. Below the menu is a toolbar with icons for Patient, Billing, Tasks, Schedule, Inventory, Reports, Records, and Admin, along with buttons for Change User, Time Clock, Logout, and Close. The main content area is divided into several sections:

- Record Completed:** Shows a list of completed records for today, including Patient History, Exam, CLS, Drug RX, Specs/CL RX, Test, and ARRA.
- Demographics:** Fields for Preferred Language, Race, Ethnicity, Height, Weight, BMI, and BMI Followup?.
- Medical History:** Fields for Hypertension?, Smoking Status, Discussed Cessation, and Received electronic copy.
- Exam Details:** Fields for Dilated Macular/Fundus Exam (Yes), Reason Macular Exam Not Done (AOA), Macular Edema (Yes), Macular Edema Findings Type (Advanced diabetic maculopathy), Retinopathy Severity Level (Mild non-proliferative), and Retinal or Dilated Eye Exam Type.
- Diagnosis:** A table showing the ICD10 code E08.311 (Diab due to undrl cond w unsp diabetic rtnop w mac) and the CPT code 99201 (Level 1 Exam - New).

Yellow arrows point to the following fields:

1. Dilated Macular/Fundus Exam (Yes)
2. Macular Edema (Yes)
3. Macular Edema Findings Type (Advanced diabetic maculopathy)
4. Retinopathy Severity Level (Mild non-proliferative)
5. ICD10 Code (E08.311)
6. CPT Code (99201)

## Value Sets:

At the bottom of each of the CQM specification sheets is a list of value sets that are referenced.

For example, let's look at the specification sheet for 50v6. One of the value sets referenced is for "Encounter, Performed: Office Visit", and its value set is "2.16.840.1.113883.3.464.1003.101.12.1001." One of the codes in this value set is CPT "99201."

To find out what all of the codes are in this value set, go to:

<https://ushik.ahrq.gov/ValueSets?&system=mu&filterLetter=O&resultsPerPage=50&sortField=100&sortDirection=ascending>

Right above the list view on this page, there's a field for OID. Copy and paste that OID (i.e. "2.16.840.1.113883.3.464.1003.101.12.1001") into the OID field and hit the search button (magnifying glass).

Now you'll just see available versions of that value set. Select the link (i.e. "Office Visit") from the "Value Set" column on the last row, since the last row will be the most up-to-date version of the value set (i.e. Version: "eCQM Update 2018 EP-EC and EH").

To access the list of codes in the value set, you need UMLS login credentials to be able to look at the individual codes in the value set.

Go here to sign up for a UMLS account:

<https://uts.nlm.nih.gov/license.html>

When you eventually get the login credentials, you'll be able to sign in on the ushik.ahrq.gov so you can view the codes.

## Assigning Doctor to Patients:

It's important that you specify what doctor is responsible for a patient and/or a patient's medical record, especially if you plan to do individual MIPS reporting instead of group reporting.

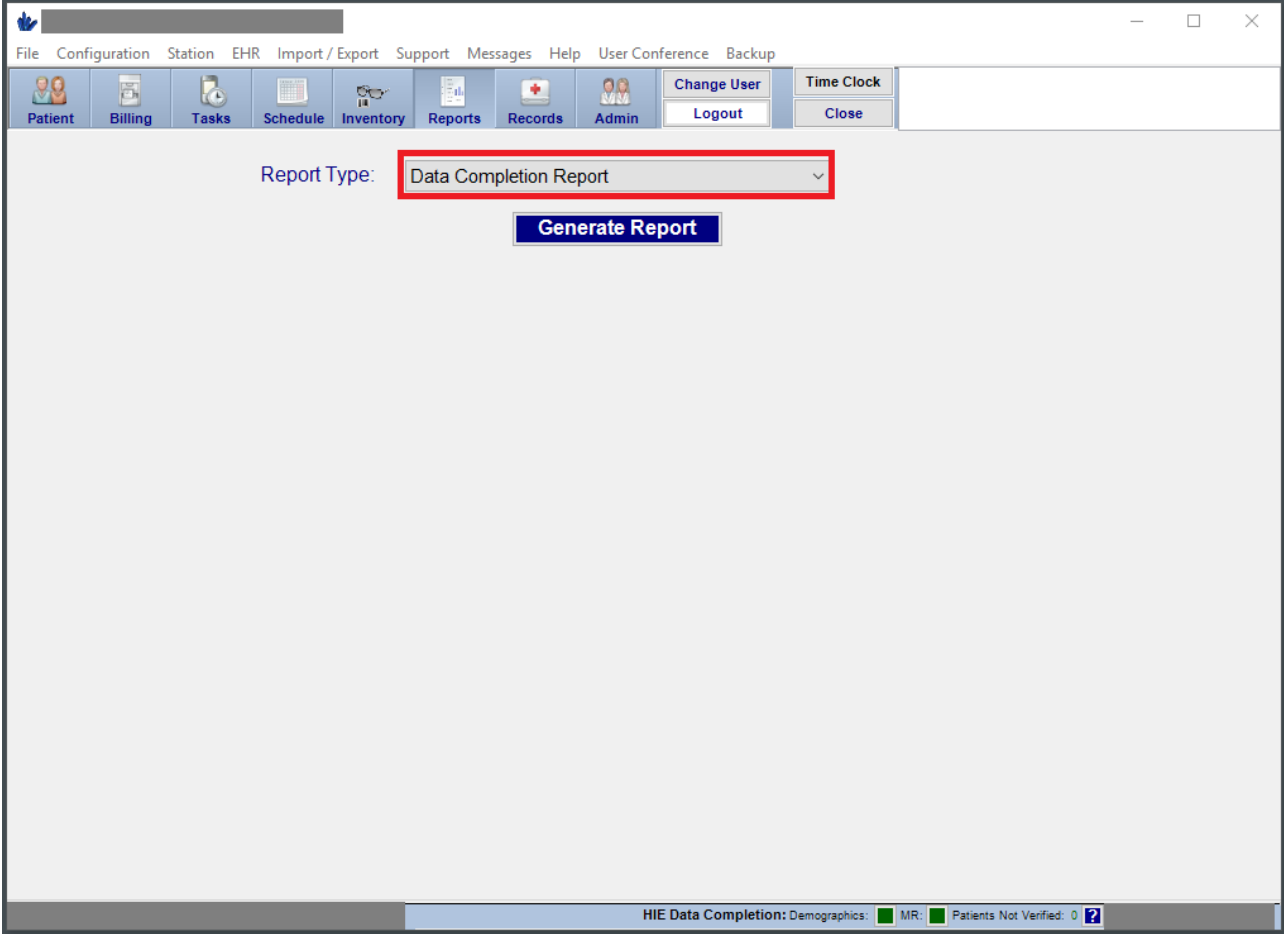
The doctor assigned in the medical record will always override the doctor set for the patient. If a doctor is not assigned in the medical record, it will be interpreted as being assigned to the doctor set for the patient.

The screenshot shows the 'Records' tab in a medical software interface. A dropdown menu is open, displaying 'Dr. TestDoctor, TestDoctor' as the selected option. The interface includes various medical history questions and a 'Print Check In' button. The 'Records' tab is highlighted, and the 'Change User' and 'Logout' buttons are visible. The 'Patient' and 'Billing' tabs are also visible. The 'Records' tab is selected, and the 'Dr. TestDoctor, TestDoctor' dropdown is highlighted. The 'Print Check In' button is visible. The 'Records' tab is selected, and the 'Dr. TestDoctor, TestDoctor' dropdown is highlighted. The 'Print Check In' button is visible.

The screenshot shows the 'Patient Info' tab in a medical software interface. The 'Primary Doctor' field is highlighted with a red box, showing 'Dr. TestDoctor, TestDoctor' selected. The interface includes fields for patient name, address, phone numbers, and other personal information. The 'Patient Info' tab is selected, and the 'Primary Doctor' dropdown is highlighted. The 'Print Check In' button is visible. The 'Patient Info' tab is selected, and the 'Primary Doctor' dropdown is highlighted. The 'Print Check In' button is visible.

# Data Completion Report:

This report will tell you what patients are potentially missing data that had a medical record, appointment, invoice, or routing slip during a specified period.





Clicking the refresh button will retrieve and evaluate the patient data based on the criteria in the filter options.

Even if a patient is not missing data, it will still appear in the results, but it's "Missing Data" cell will be empty and green.

You can sort by any of the columns by clicking on the column headers.

Double-clicking on any of the rows will show the Data Completion window with the patient selected represented as a tab. Unlike the traditional prompting, which is based on the medical records you've viewed and/or modified at the time, all medical records with missing data will be included in the list of fields.

Clicking the "Trigger Submission for all Patients Listed" button is there for emergency cases, so it is not recommended you use this unless it is absolutely necessary. If you're going through each of these patients and modifying records to satisfy the prompts, there's no need to press this button, because an equivalent action is taking place. Just modifying a patient's data triggers submission.

**Filter:**  
Patients with  Medical Record  Appointment  Invoice  Routing Slip (And/Or)  
Between Start Date: 01/01/2018 12:00 AM End Date: 12/31/2018 11:59 PM  
For HIE: None Add Remove Selected

Patient Acctid	Patient Name	Last Record or Appointment Date	Data missing for HIE(s)	Missing Data
648562		03/15/2018 12:00 AM	AOA MORE	Records
648605		03/15/2018 12:00 AM	AOA MORE	Records
648609		03/15/2018 12:00 AM	AOA MORE	Records
648612		03/15/2018 12:00 AM	AOA MORE	Records
648625		03/15/2018 12:00 AM	AOA MORE	Records
648628		04/03/2018 10:09 AM	AOA MORE	Demographics, Records
648629		04/10/2018 12:00 AM	AOA MORE	Demographics, Records
648630		04/18/2018 12:00 AM	AOA MORE	Demographics, Records
648632		04/25/2018 12:00 AM	AOA MORE	Demographics, Records
648633		04/25/2018 12:00 AM	AOA MORE	Demographics, Records
648635		05/24/2018 05:35 PM	AOA MORE	Demographics, Records
648636		04/26/2018 12:00 AM	AOA MORE	Demographics, Records
648637		04/26/2018 12:00 AM	AOA MORE	Demographics, Records

**Refresh** **Trigger Submission for all Patients Listed**

**Patients:** \*Double-click row to open Data Completion Prompt for patient

If a field has a date in the “Date” column, that field is in a specific medical record. Double-clicking the row will take you directly to that medical record and that field.

Clicking the “Refresh” button will reload and re-evaluate the data and reload the prompts, but this is done automatically when you select this window.

Clicking the “Remove” button will remove the patient’s tab from the window. Double-clicking the patient’s row in the results of the Data Completion Report, or modifying or viewing the patient’s data, will re-add a tab for the patient in the window. If modifying or view a patient’s data manually, a tab will only be added for patient if they’re missing required or optional data, and it will only be based on the most recent medical record or the one you were modifying or viewing.

The screenshot shows a window titled "HL7 Prompts" with a close button in the top right. The main content area contains the following text:

It is recommended that you add the missing information described below, so patient records can be sent to HIEs (Admin->Integrations->HIEs). Close

Patient Count: 1

All Patients Verified: No, 1 left

Double-click each row to add the desired information to the patient's record.

mcTest1, mcTest1 (648629)

1 Refresh

Patient: mcTest1, mcTest1 (648629) Remove

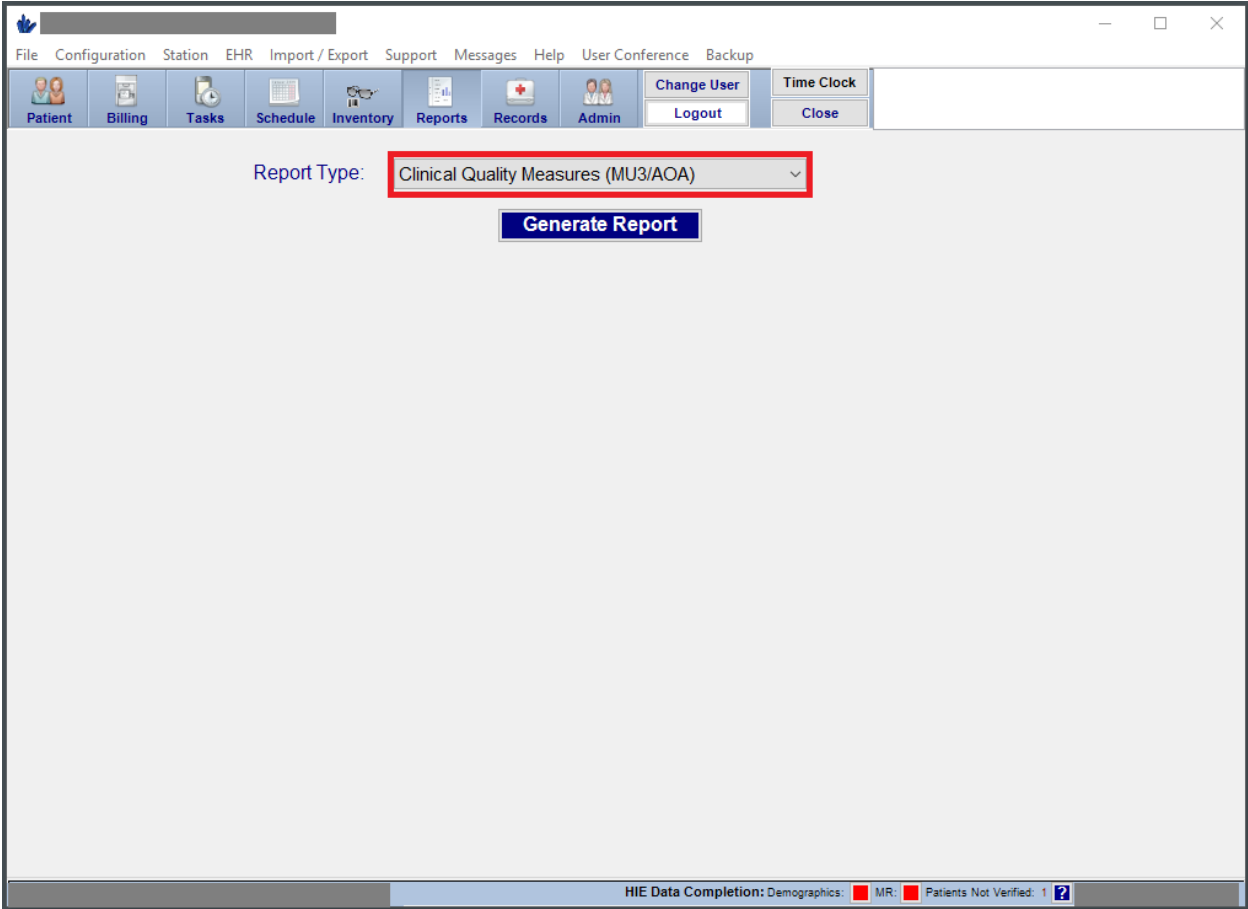
All Fields Verified: No, 4 left

Appointment Today: No

Count	Name	Description	Status	Location	Date	Requiring HIE(s)	
1	First Name	First name of patient	Set	Patient		AOA More	
2	Last Name	Last name of patient	Set	Patient		AOA More	
3	Date of Birth	Patient's date of birth	Set	Patient		AOA More	
4	Address 1	Address 1 of patient	Missing	Patient		AOA More	
5	City	Patient's city	Set	Patient		AOA More	
6	State	Patient's state	Set	Patient		AOA More	
7	Zip Code	Patient's zip code	Missing	Patient		AOA More	
8	Gender	Patient's gender	Set	Patient		AOA More	
9	Race	Patient's race	Missing	Records		AOA More	
10	Ethnicity	Patient's ethnicity	Missing	Records		AOA More	

# Clinical Quality Measures (MU3/AOA) Report:

This newer version of the CQM report is more up-to-date in terms of the CQM logic, more thorough, faster, flexible, and customizable. And it can give you a better idea of what's actually automatically submitted to AOA MORE.



The first tab lets you run the report for all patients or any number of manually selected patients.

Clicking the “Next” button will take you to the doctor selection tab.

Clinical Quality Measure Report

Patient(s) Doctor(s) Criteria Results

All Patients  
or  
 Selected Patients:

Add Clear

ID	Name	Gender	Date of Birth
----	------	--------	---------------

Next

Most of the controls on the lower area of this tab can be ignored for now. In this case, I just clicked the "Add All" button, to include patients under all doctors in the results.

Click the "Next" button to continue and select the CQM criteria.

Clinical Quality Measure Report

Patient(s) Doctor(s) Criteria Results

Doctor:  **Add** **Remove** **Set as Main Doctor** **Add All** **Remove All**

Doctor	NPI	TIN	Is Main Doctor
Joseph Doctor			No
Jane Doctor			No
			No
			Yes
			No
			No
			No
			No
			No
			No

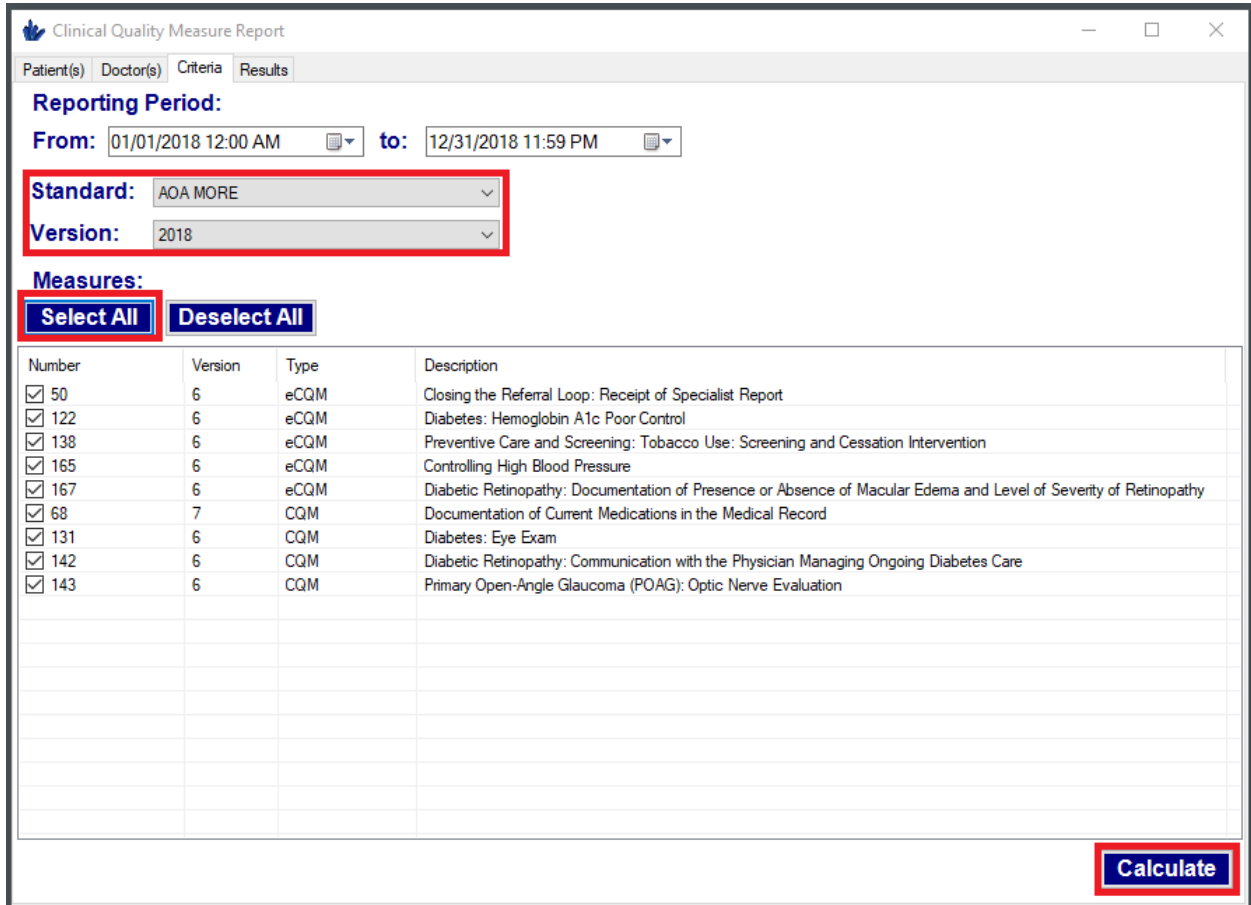
NPI:   Group NPI (Admin->Company)  Main Doctor NPI (Admin->Employees)  Custom  
 TIN:   Group TIN (Admin->Company)  Main Doctor TIN (Admin->Employees)  Custom  
 MIPS Submission Type:  Group  Individual  None

**Next**

For the standard, I selected "AOA MORE." Under that, I selected "2018" as the sub-version. This is the version of the CQM logic being used to generate QRDA Category 1 CCDs to be submitted to AOA MORE.

I clicked the "Select All" button to include all of the supported CQMs in the results.

Clicking the "Calculate" button will run the report and display the results in the "Results" tab.



The screenshot shows the "Clinical Quality Measure Report" window with the following elements:

- Reporting Period:** From: 01/01/2018 12:00 AM to: 12/31/2018 11:59 PM
- Standard:** AOA MORE
- Version:** 2018
- Measures:** Select All (highlighted), Deselect All
- Table of Measures:**

Number	Version	Type	Description
<input checked="" type="checkbox"/> 50	6	eCQM	Closing the Referral Loop: Receipt of Specialist Report
<input checked="" type="checkbox"/> 122	6	eCQM	Diabetes: Hemoglobin A1c Poor Control
<input checked="" type="checkbox"/> 138	6	eCQM	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
<input checked="" type="checkbox"/> 165	6	eCQM	Controlling High Blood Pressure
<input checked="" type="checkbox"/> 167	6	eCQM	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
<input checked="" type="checkbox"/> 68	7	CQM	Documentation of Current Medications in the Medical Record
<input checked="" type="checkbox"/> 131	6	CQM	Diabetes: Eye Exam
<input checked="" type="checkbox"/> 142	6	CQM	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
<input checked="" type="checkbox"/> 143	6	CQM	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

**Calculate** (highlighted)

Selecting a measure will show the specific results for that measure. Under that, you can select the logic portion (“Initial Population”, “Numerator”, “Denominator”, etc...) and the Population Criteria, if a measure has multiple populations.

Clicking the “Export QRDA Category 3 CCD” button will export a single QRDA Category 3 CCD to a specified folder. The QRDA Category 3 CCD is a statistical summary of all or the selected patients, based on all of the selected CQMs.

Clicking the “Export QRDA Category 1 CCDs” button will export a QRDA Category 1 CCD for each qualifying patient to a specified folder. The data will include demographics, procedures, diagnoses, etc... This is the type of message that’s generated and submitted to AOA MORE automatically at an integrated office.

Continue by clicking on the “Individual Patient” tab.

The screenshot shows the 'Clinical Quality Measure Report' window. At the top, there are tabs for 'Patient(s)', 'Doctor(s)', 'Criteria', and 'Results'. Below the tabs, there are two radio buttons: 'All Patients' and 'Individual Patient', with 'Individual Patient' selected. The 'Standard' dropdown is set to 'Standard CQMs'. Below this is a table with columns 'Stat' and 'Value':

Stat	Value
Encounter (First)	05/31/2015
Encounter (Last)	06/29/2018

The 'Measure' dropdown is set to '50v6: Closing the Referral Loop: Receipt of Specialist Report'. Below this is another table with columns 'Stat' and 'Value':

Stat	Value
Performance Rate	133%
Reporting Rate	133%

The 'Portion' dropdown is set to 'Initial Population' and the 'Population' dropdown is set to 'Population Criteria #1'. Below these is a table with columns 'Stat' and 'Value':

Stat	Value
Total	3
Gender (Female)	0

At the bottom, there are two blue buttons with white text: 'Export QRDA Category 3 CCD (All Patients, Aggregate Report)' and 'Export QRDA Category 1 CCDs (All Patients, one for each)'. Both buttons are highlighted with a red border.

This tab lets you look at the statistical results and generate messages for individual patients.

Clinical Quality Measure Report

Patient(s) Doctor(s) Criteria Results

All Patients Individual Patient

**Patient:** Test\_AOA\_2018\_142v6, Test\_AOA\_2018\_142v6 (648640)

**Standard:** Standard CQMs

**Measure:** 142v6: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

**Population:** Population Criteria #1

Stat	Value
Initial Population	1
Numerator	1
Denominator	1
Denominator Exception	0
Patient Characteristic Payer	1
Eye Care Encounters	1

**Export QRDA Category 1 CCDs (Selected Patient)**