PINNACLE and Diabetes Qualified Clinical Data Registry (QCDR)

Measure	Measure Title	Measure Description	Measure Type	NQS Domain	Meaningful Measure Area	Comparable PINN / DC ID
CQMS 326 (NQF 1525)	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Percentage of patients aged 18 years and older with nonvalvular atrial fibrillation (AF) or atrial flutter who were prescribed warfarin OR another FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-161
CQMS 243 (NQF 0643)	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program.	Process High Priority	Communication and Care Coordination	Preventive Care	PINN-108
CQMS 47 (NQF 0326)	Advance Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Process High Priority	Communication and Care Coordination	Care is Personalized and Aligned with Patient's Goals	PINN-14 DCR-10

Measure	Measure Title	Measure Description	Measure Type	NQS Domain	Meaningful Measure Area	Comparable PINN / DC ID
eCQM:CMS50v9	Closing the Referral Loop: Receipt of Specialist Report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	Process High Priority	Communication and Care Coordination	Transfer of Health Information and Interoperability	
CQMS 118 (NQF 0066)	Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy-Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-107 DCR-2
CQMS 6 (NQF 0067)	Coronary Artery Disease: Antiplatelet Therapy	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-105
CQMS 7 (NQF 0070)	Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Percentage of patients aged ≥18 years with a diagnosis of coronary artery disease seen within a 12-month period who also have prior myocardial infarction or a current or prior LVEF <40% who were prescribed beta-blocker therapy. ***2 performance rates***	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-106
eCQM: CMS145v9	Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Percentage of patients aged ≥18 years with a diagnosis of coronary artery disease seen within a 12-month period who also have prior myocardial infarction or a current or prior LVEF <40% who were prescribed beta-blocker therapy. ***2 performance rates***	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-106
CQMS 1 (NQF 0059)	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Intermediate Outcome High Process Inverse	Effective Clinical Care	Management of Chronic Conditions	DCR-1

Measure	Measure Title	Measure Description	Measure Type	NQS Domain	Meaningful Measure Area	Comparable PINN / DC ID
eCQM:CMS122v9	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (12 months from date of encounter).	Outcome Inverse	Effective Clinical Care	Management of Chronic Conditions	DCR-1
CQMS 119 (NQF 0062)	Diabetes: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes who had a nephropathy-screening test or evidence of nephropathy during the measurement period.	Process	Effective Clinical Care	Management of Chronic Conditions	DCR-3
eCQM:CMS134v9	Diabetes: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes who had a nephropathy-screening test or evidence of nephropathy during the measurement period.	Process	Effective Clinical Care	Management of Chronic Conditions	DCR-3
CQMS 130 (NQF 0419)	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Process High Priority	Patient Safety	Medication Management	
eCQM: CMS68v10	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible clinicians attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Process	Patient Safety	Medication Management	

Measure	Measure Title	Measure Description	Measure Type	NQS Domain	Meaningful Measure Area	Comparable PINN / DC ID
CQMS 8 (NQF 0083)	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-144
eCQM:CMS144v9	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction LVSD	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-144
CQMS 5 (NQF 0081)	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy or Anginotensin Receptor-Neprilysin Inhibitor (ARNI) therpay for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-145
eCQM:CMS135v9	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy or Anginotensin Receptor-Neprilysin Inhibitor (ARNI) therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-145

Measure	Measure Title	Measure Description	Measure Type	NQS Domain	Meaningful Measure Area	Comparable PINN / DC ID
ACCPIN8	Hypertension Control (Stage 1 or 2)	Proportion of patients with hypertension who had adequately controlled blood pressure.	Intermediate Outcome High Priority	Effective Clinical Care	Management of Chronic Conditions	PINN-123
ACCPIN7	Peripheral Artery Disease: Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk	Percentage of Patients 18-75 years of age with PAD who were offered moderate-to-high intensity statin.	Process	Effective Clinical Care	Management of Chronic Conditions	PINN-170 DCR-7
ACCPIN11	Heart Failure: Patient Self Education	Percentage of patients aged >=18 years with a diagnosis of heart failure who were provided with self-care education on >=3 elements of education during >=1 visit within a 12-month period.	Process High Priority	Community/Population Health	Management of Chronic Conditions	PINN-143
CQMS 441	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: • Most recent blood pressure (BP) measurement is less than or equal to 140/90 mm Hg -- AND • Most recent tobacco status is Tobacco Free -- AND • Daily Aspirin or Other Antiplatelet Unless Contraindicated -- AND • Statin Use Unless Contraindicated	Intermediate Outcome High Priority	Effective Clinical Care	Management of Chronic Conditions	
CQMS 128 (NQF 0421)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.	Process	Community/Population Health	Preventive Care	

Measure	Measure Title	Measure Description	Measure Type	NQS Domain	Meaningful Measure Area	Comparable PINN / DC ID
eCQM: CMS69v9	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.	Process	Community/Population Health	Preventive Care	
CQMS 226 (NQF 0028)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (AMA-PCPI)	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. ***3 performance rates***	Process	Community/Population Health	Prevention and Treatment of Opioid and Substance Use Disorders	PINN-104 DCR-4
eCQM:CMS138v9	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. ***3 performance rates***	Process	Community/Population Health	Prevention and Treatment of Opioid and Substance Use Disorders	PINN-104 DCR-4

2021 CQMS Requirements

Individual Provider Reporting: Eligible providers must report at least six measures, including one outcome measure. If an outcome measure is not available that is applicable to your specialty or practice, choose a high priority measure. Measures must be calculated with at least 70 percent of the providers patients (all-payer) included in the denominator.

Group Practice Reporting (GPRO): A group is defined as a single tax identification number (TIN) with two or more clinicians (at least one clinician within the group must be MIPS eligible) as identified by their national provider identifier (NP)I, who have reassigned their Medicare billing rights to a single TIN must report at least six measures, including one outcome measure. If an outcome measure is not available that is applicable to your specialty or practice, choose a high priority measure. Measures must be calculated with at least 70 percent of the providers patients (all-payer) included in the denominator.

Measure specifications for CQMS measures are available where hyperlinked. All measures are proportional, traditional (unless indicated differently under *Measure Type*) and are NOT risk adjusted.

The PINNACLE Registry® and Diabetes Collaborative Registry® are operated in association with the American College of Cardiology

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