

**Table 1. Proposed Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings**

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
<b>AIM: Better Care for Individuals</b>					
1.	Patient/Care Giver Experience	<b>Clinician/Group CAHPS:</b> Getting Timely Care, Appointments, and Information	NQF #5	Survey	Patient Experience of Care
2.	Patient/Care Giver Experience	<b>Clinician/Group CAHPS:</b> How Well Your Doctors Communicate	NQF #5	Survey	Patient Experience of Care
3.	Patient/Care Giver Experience	<b>Clinician/Group CAHPS:</b> Helpful, Courteous, Respectful Office Staff	NQF #5	Survey	Patient Experience of Care
4.	Patient/Care Giver Experience	<b>Clinician/Group CAHPS:</b> Patients' Rating of Doctor	NQF #5	Survey	Patient Experience of Care
5.	Patient/Care Giver Experience	<b>Clinician/Group CAHPS:</b> Health Promotion and Education	NQF #5	Survey	Patient Experience of Care
6.	Patient/Care Giver Experience	<b>Clinician/Group CAHPS:</b> Shared Decision Making	NQF #5	Survey	Patient Experience of Care
7.	Patient/Care Giver Experience	<b>Medicare Advantage CAHPS:</b> Health Status/Functional Status	NQF #6	Survey	Patient Experience of Care
8.	Care Coordination/Transitions	<b>Risk-Standardized, All Condition Readmission:</b> The rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population.	CMS	Claims	Outcome

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
9.	Care Coordination/Transitions	<b>30 Day Post Discharge Physician Visit</b>	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
10.	Care Coordination/Transitions	<b>Medication Reconciliation:</b> Reconciliation After Discharge from an Inpatient Facility Percentage of patients aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NQF #554	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
11.	Care Coordination/Transitions	<b>Care Transition Measure:</b> Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan	NQF #228 or alternate	Survey or Group Practice Reporting Option (GPRO) Data Collection Tool	Patient Experience of Care

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
12.	Care Coordination	<p><b>Ambulatory Sensitive Conditions Admissions: Diabetes, short-term complications</b>                      (AHRQ Prevention Quality Indicator (PQI) #1)                      All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma), per 100,000 population.</p>	NQF #272	Claims	Outcome
13.	Care Coordination	<p><b>Ambulatory Sensitive Conditions Admissions: Uncontrolled Diabetes</b>                      (AHRQ Prevention Quality Indicator (PQI) #14)                      All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication, per 100,000 population.</p>	NQF # 638	Claims	Outcome
14.	Care Coordination	<p><b>Ambulatory Sensitive Conditions Admissions: Chronic obstructive pulmonary disease</b>                      (AHRQ Prevention Quality Indicator (PQI) #5)                      All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for COPD, per 100,000 population.</p>	NQF #275	Claims	Outcome

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
15.	Care Coordination	<p><b>Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure</b> (AHRQ Prevention Quality Indicator (PQI) #8 )</p> <p>All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF, per 100,000 population.</p>	NQF #277	Claims	Outcome
16.	Care Coordination	<p><b>Ambulatory Sensitive Conditions Admissions: Dehydration</b> (AHRQ Prevention Quality Indicator (PQI) #10)</p> <p>All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypovolemia, per 100,000 population.</p>	NQF # 280	Claims	Outcome
17.	Care Coordination	<p><b>Ambulatory Sensitive Conditions Admissions: Bacterial pneumonia</b> (AHRQ Prevention Quality Indicator (PQI) #11)</p> <p>All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for bacterial pneumonia, per 100,000 population.</p>	NQF # 279	Claims	Outcome

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
18.	Care Coordination	<p><b>Ambulatory Sensitive Conditions Admissions: Urinary infections</b>                      (AHRQ Prevention Quality Indicator (PQI) #12)</p> <p>All discharges of age 18 years and older with ICD-9-CM principal diagnosis code of urinary tract infection, per 100,000 population.</p>	NQF # 281	Claims	Outcome
19.	Care Coordination/Information Systems	<b>% All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements</b>	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool / EHR Incentive Program Reporting	Process
20.	Care Coordination/Information Systems	<b>% of PCPs Meeting Stage 1 HITECH Meaningful Use Requirements</b>	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool / EHR Incentive Program Reporting	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
21.	Care Coordination/Information Systems	<b>% of PCPs Using Clinical Decision Support</b>	CMS  EHR Incentive Program – Core Measure	Group Practice Reporting Option (GPRO) Data Collection Tool/ EHR Incentive Program Reporting	Process
22.	Care Coordination/Information Systems	<b>% of PCPs who are Successful Electronic Prescribers Under the eRx Incentive Program</b>	CMS  EHR Incentive Program – Core Measure	Group Practice Reporting Option (GPRO) Data Collection Tool / eRx Incentive Program Reporting	Process
23.	Care Coordination/Information Systems	<b>Patient Registry Use</b>	CMS  EHR Incentive Program – Menu Set Measure	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
24.	Patient Safety	<p><b>Health Care Acquired Conditions Composite:</b></p> <ul style="list-style-type: none"> <li>• Foreign Object Retained After Surgery</li> <li>• Air Embolism</li> <li>• Blood Incompatibility</li> <li>• Pressure Ulcer, Stages III and IV</li> <li>• Falls and Trauma</li> <li>• Catheter-Associated UTI</li> <li>• Manifestations of Poor Glycemic Control</li> <li>• Central Line Associated Blood Stream Infection (CLABSI)</li> <li>• Surgical Site Infection</li> <li>• AHRQ Patient Safety Indicator (PSI) 90 Complication/Patient Safety for Selected Indicators (composite)                             <ul style="list-style-type: none"> <li>○ Accidental puncture or laceration</li> <li>○ Iatrogenic pneumothorax</li> <li>○ Postoperative DVT or PE</li> <li>○ Postoperative wound dehiscence</li> <li>○ Decubitus ulcer</li> <li>○ Selected infections due to medical care (PSI 07: Central Venous Catheter-related Bloodstream Infection)</li> <li>○ Postoperative hip fracture</li> <li>○ Postoperative sepsis</li> </ul> </li> </ul>	CMS (HACs), NQF #531 (AHRQ PSI)	Claims or CDC National Healthcare Safety Network	Outcome

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
25.	Patient Safety	<b>Health Care Acquired Conditions: CLABSI Bundle</b>	NQF #298	Claims or CDC National Healthcare Safety Network	Process
<b>AIM: Better Health for Populations</b>					
26.	Preventive Health	<b>Influenza Immunization:</b> Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	Physician Quality Reporting System Measure #110  EHR Incentive Program – Clinical Quality Measure  NQF #41	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
27.	Preventive Health	<b>Pneumococcal Vaccination:</b> Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine.	Physician Quality Reporting System Measure #111  EHR Incentive Program – Clinical Quality Measure  NQF #44	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
28.	Preventive Health	<b>Mammography Screening:</b> Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months.	Physician Quality Reporting System Measure #112  EHR Incentive Program – Clinical Quality Measure  NQF #31	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
29.	Preventive Health	<b>Colorectal Cancer Screening:</b> Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening.	Physician Quality Reporting System Measure #113  EHR Incentive Program – Clinical Quality Measure  NQF #34	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
30.	Preventive Health	<p><b>Cholesterol Management for Patients with Cardiovascular Conditions:</b></p> <ul style="list-style-type: none"> <li>The percentage of members 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year.LDL-C screening</li> <li>LDL-C control (&lt;100 mg/dL)</li> </ul>	<p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF # 75</p>	<p>Group Practice Reporting Option (GPRO) Data Collection Tool</p>	<p>Process &amp; Outcome</p>
31.	Preventive Health	<p><b>Adult Weight Screening and Follow-up:</b></p> <p>Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.</p> <p>Parameters:                      Age 65 and older BMI ≥ 30 or &lt; 22;                      Age 18-64 BMI ≥ 25 or &lt; 18.5</p>	<p>Physician Quality Reporting System Measure #128</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #421</p>	<p>Group Practice Reporting Option (GPRO) Data Collection Tool</p>	<p>Process</p>

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
32.	Preventive Health	<p><b>Blood Pressure Measurement:</b></p> <p>Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients aged &gt; 18 years with diagnosed hypertension.</p>	<p>Physician Quality Reporting System #TBD</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #13</p>	<p>Group Practice Reporting Option (GPRO) Data Collection Tool</p>	Process
33.	Preventive Health	<p><b>Tobacco Use Assessment and Tobacco Cessation Intervention:</b></p> <p>Percentage of patients who were queried about tobacco use. Percentage of patients identified as tobacco users who received cessation intervention.</p>	<p>Physician Quality Reporting System #TBD</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #28</p>	<p>Group Practice Reporting Option (GPRO) Data Collection Tool</p>	Process
34.	Preventive Health	<p><b>Depression Screening:</b></p> <p>Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented.</p>	<p>Physician Quality Reporting System #134</p> <p>NQF #418</p>	<p>Group Practice Reporting Option (GPRO) Data Collection Tool</p>	Process
35.	At Risk Population - Diabetes	<p><b>Diabetes Composite (All or Nothing Scoring):</b></p> <ul style="list-style-type: none"> <li>• Hemoglobin A1c Control (&lt;8%)</li> <li>• Low Density Lipoprotein (&lt;100)</li> <li>• Blood Pressure &lt;140/90</li> <li>• Tobacco Non Use</li> <li>• Aspirin Use</li> </ul>	<p>NQF #575*, 64*, 61*, 28*, TBD</p>	<p>Group Practice Reporting Option (GPRO) Data Collection Tool</p>	Process & Outcome

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
36.	At Risk Population – Diabetes	<b>Diabetes Mellitus: Hemoglobin A1c Control (&lt;8%)</b> Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c less than 8.0%.	EHR Incentive Program – Clinical Quality Measure  NQF #575	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
37.	At Risk Population – Diabetes	<b>Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus</b>  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl).	Physician Quality Reporting System Measure #2  EHR Incentive Program – Clinical Quality Measure  NQF #64	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
38.	At Risk Population - Diabetes	<b>Diabetes Mellitus: Tobacco Non Use</b> Tobacco use assessment and cessation	Physician Quality Reporting System #TBD  EHR Incentive Program – Clinical Quality Measure  NQF #28	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
39.	At Risk Population - Diabetes	<b>Diabetes Mellitus: Aspirin Use</b> Daily aspirin use for patients with diabetes & cardiovascular disease	NQF TBD	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
40.	At Risk Population - Diabetes	<b>Diabetes Mellitus: Hemoglobin A1c Poor Control(&gt;9%):</b> Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%.	Physician Quality Reporting System Measure #1  EHR Incentive Program – Clinical Quality Measure  NQF #59	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
41.	At Risk Population - Diabetes	<b>Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus:</b> Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).	Physician Quality Reporting System Measure #3  EHR Incentive Program – Clinical Quality Measure  NQF #61	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
42.	At Risk Population - Diabetes	<b>Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients</b> Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months.	Physician Quality Reporting System Measure #119  EHR Incentive Program – Clinical Quality Measure  NQF #62	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
43.	At Risk Population - Diabetes	<p><b>Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients</b></p> <p>Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam.</p>	<p>Physician Quality Reporting System Measure #117</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #55</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
44.	At Risk Population - Diabetes	<p><b>Diabetes Mellitus: Foot Exam</b></p> <p>The percentage of patients aged 18 through 75 years with diabetes who had a foot examination.</p>	<p>Physician Quality Reporting System Measure #163</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #56</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
45.	At Risk Population - Heart Failure	<p><b>Heart Failure: Left Ventricular Function (LVF) Assessment</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded.</p>	<p>Physician Quality Reporting System Measure #198</p> <p>NQF # 79</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
46.	At Risk Population - Heart Failure	<b>Heart Failure: Left Ventricular Function (LVF) Testing</b>  Percentage of patients with LVF testing during the current year for patients hospitalized with a principal diagnosis of heart failure (HF) during the measurement period.	Physician Quality Reporting System Measure #228  CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
47.	At Risk Population - Heart Failure	<b>Heart Failure: Weight Measurement</b>  Percentage of patient visits for patients aged 18 years and older with a diagnosis of heart failure with weight measurement recorded.	Physician Quality Reporting System #227  NQF # 85	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
48.	At Risk Population - Heart Failure	<b>Heart Failure: Patient Education</b>  Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months.	Physician Quality Reporting System #199  NQF # 82	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
49.	At Risk Population - Heart Failure	<b>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</b>  Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.	Physician Quality Reporting System Measure # 8  EHR Incentive Program – Clinical Quality Measure  NQF #83	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

	<b>Domain</b>	<b>Measure Title &amp; Description</b>	<b>CMS Program, NQF Measure Number, Measure Steward</b>	<b>Method of Data Submission</b>	<b>Measure Type</b>
50.	At Risk Population - Heart Failure	<p><b>Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF &lt; 40%) who were prescribed ACE inhibitor or ARB therapy.</p>	<p>Physician Quality Reporting System Measure #5</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #81</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
51.	At Risk Population - Heart Failure	<p><b>Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation</b></p> <p>Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.</p>	<p>Physician Quality Reporting System Measure #200</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #84</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

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52.	At Risk Population – Coronary Artery Disease	<p><b>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring</b></p> <ul style="list-style-type: none"> <li>• Oral Antiplatelet Therapy Prescribed for Patients with CAD</li> <li>• Drug Therapy for Lowering LDL-Cholesterol</li> <li>• Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)</li> <li>• LDL Level &lt;100 mg/dl</li> <li>• Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)</li> </ul>	NQF #67, 74, 70, 64, 66	Group Practice Reporting Option (GPRO) Data Collection Tool	Process & Outcome
53.	At Risk Population – Coronary Artery Disease	<p><b>Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.</p>	<p>Physician Quality Reporting System Measure # 6</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #67</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

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54.	At Risk Population – Coronary Artery Disease	<p><b>Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).</p> <p>The LDL-C treatment goal is &lt;100 mg/dl. Persons with established coronary heart disease (CHD) who have a baseline LDL-C 130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of nonlipid risk factors (National Cholesterol Education Program (NCEP).</p>	<p>Physician Quality Reporting System #197</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #74</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
55.	At Risk Population – Coronary Artery Disease	<p><b>Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.</p>	<p>Physician Quality Reporting System Measure # 7</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #70</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
56.	At Risk Population – Coronary Artery Disease	<p><b>Coronary Artery Disease (CAD): LDL level &lt; 100 mg/dl</b></p>	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome

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57.	At Risk Population – Coronary Artery Disease	<p><b>Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF &lt; 40%) who were prescribed ACE inhibitor or ARB therapy.</p>	<p>Physician Quality Reporting System Measure #118</p> <p>NQF #66</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
58.	At Risk Population – Hypertension	<p><b>Hypertension (HTN): Blood Pressure Control</b></p> <p>Percentage of patients with last BP &lt; 140/90 mmHg</p>	<p>Physician Quality Reporting System #TBD</p> <p>EHR Incentive Program – Clinical Quality Measure</p> <p>NQF #18</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
59.	At Risk Population – Hypertension	<p><b>Hypertension (HTN): Plan of Care</b></p> <p>Percentage of patient visits for patients aged 18 years and older with a diagnosis of HTN with either systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care for hypertension.</p>	<p>Physician Quality Reporting System #TBD</p> <p>NQF # 17</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

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60.	At Risk Population – COPD	<p><b>Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented.</p>	<p>Physician Quality Reporting System Measure # 51</p> <p>NQF #91</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
61.	At Risk Population – COPD	<p><b>Chronic Obstructive Pulmonary Disease (COPD): Smoking Cessation Counseling Received</b></p>	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
62.	At Risk Population – COPD	<p><b>Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy based on FEV1</b></p> <p>Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator.</p>	<p>Physician Quality Reporting System Measure # 52</p> <p>NQF #102</p>	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
63.	At Risk Population – Frail Elderly	<p><b>Falls: Screening for Fall Risk</b></p> <p>Percentage of patients aged 65 years and older who were screened for fall risk at least once within 12 months</p>	NQF #101	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

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64.	At Risk Population – Frail Elderly	<p><b>Osteoporosis Management in Women Who had a Fracture</b></p> <p>Percentage of women 65 years and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the 6 months after the date of fracture</p>	NQF #53	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
65.	At Risk Population – Frail Elderly	<p><b>Monthly INR for Beneficiaries on Warfarin</b></p> <p>Average percentage of monthly intervals in which Part D beneficiaries with claims for warfarin do not receive an INR test during the measurement period</p>	NQF #555	Claims	Process

\*Individual measure within composite measure is used in the EHR Incentive Program .