Implementing Million Hearts® Measures using Allscripts Sunrise Ambulatory™ and Clinical Performance Manager™

Overview

Introduction

This document provides guidance on features and functionality of Allscripts Sunrise Ambulatory™ and Clinical Performance Manager™** to track eCQM data included in Million Hearts®.

Million Hearts® is a national initiative co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS)

The goal of this initiative is to prevent one million heart attacks and strokes by 2017 by implementing proven and effective interventions in clinical settings and communities

The initiative aims to drive adoption and use of a focused set of impactful clinical quality measures for the ABCS and align these measures across public and private quality measures reporting initiatives:

- National Quality Forum
- CMS Physician Quality Reporting System
- CMS Medicare Electronic Health Record (EHR) Incentive Program

http://millionhearts.hhs.gov/aboutmh/overview.html http://millionhearts.hhs.gov/Docs/MH_CQM.pdf

Who Should Read this Document

Anyone within your organization responsible for configuring and tracking Million Hearts® Quality Data

Resources

The following list contains active hyperlinks to useful resources:

- Million Hearts® - The Initiative
- eCQM Library

** Clinical Performance Manager™ (CPM) is the Allscripts solution for Meaningful Use Clinical Quality Measure and Functional Measure reporting. CPM is purchased separately from Sunrise Ambulatory™

Meeting Million Hearts® Using Sunrise

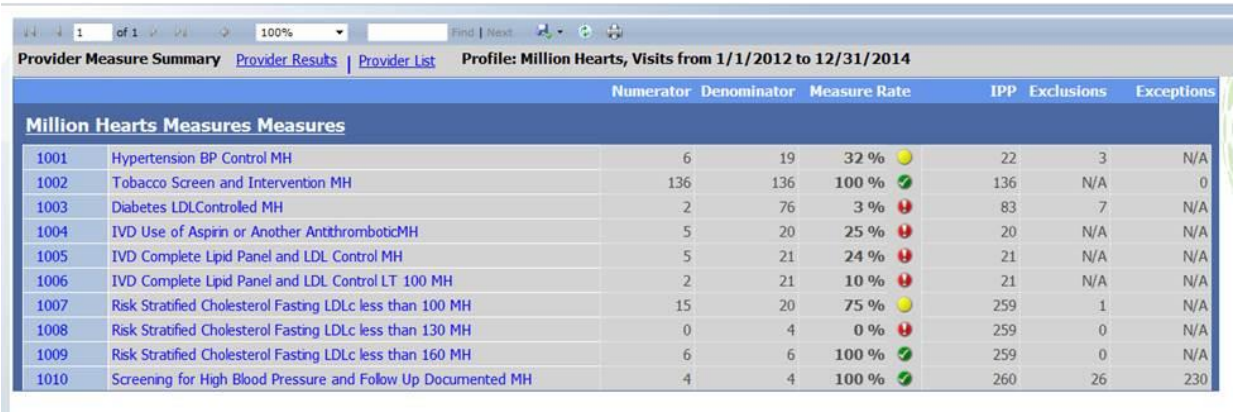
Allscripts Functionality

- All eCQM data is collected in Sunrise Ambulatory
- Clinical Performance Manager™ (purchased separately) pulls Sunrise data into the ABCS dashboard
- Health Manager, Patient Reminders, and Achieve functionality are tools to that assist in improving Million Hearts® outcomes
- This guide provides you an overview of:
  - How to use the ABCS Dashboard and run reports in Allscripts CPM (purchased separately)
  - The Achieve workflow and configuration
  - How to use Health Manager and Patient Reminders

Clinical Performance Manager™ Reporting

Million Hearts® CPM Profile

1. Measure Summary for office administrators to view overall performance



Provider Measure Summary | Provider Results | Provider List | Profile: Million Hearts, Visits from 1/1/2012 to 12/31/2014

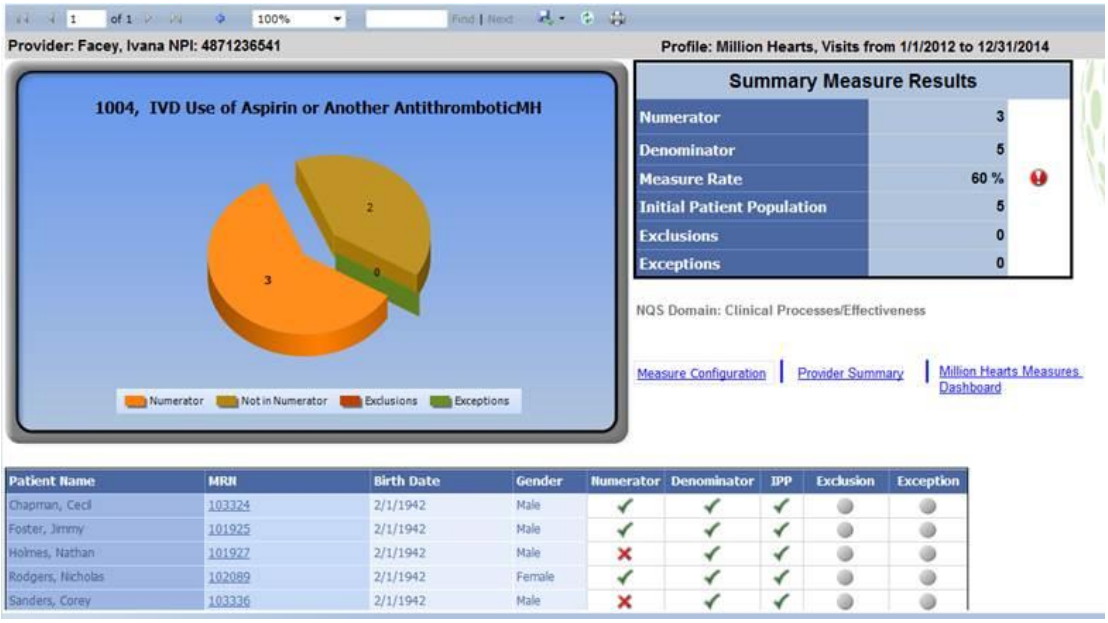
		Numerator	Denominator	Measure Rate	IPP	Exclusions	Exceptions
Million Hearts Measures Measures							
1001	Hypertension BP Control MH	6	19	32 %	22	3	N/A
1002	Tobacco Screen and Intervention MH	136	136	100 %	136	N/A	0
1003	Diabetes LDLControlled MH	2	76	3 %	83	7	N/A
1004	IVD Use of Aspirin or Another AntithromboticMH	5	20	25 %	20	N/A	N/A
1005	IVD Complete Lipid Panel and LDL Control MH	5	21	24 %	21	N/A	N/A
1006	IVD Complete Lipid Panel and LDL Control LT 100 MH	2	21	10 %	21	N/A	N/A
1007	Risk Stratified Cholesterol Fasting LDLc less than 100 MH	15	20	75 %	259	1	N/A
1008	Risk Stratified Cholesterol Fasting LDLc less than 130 MH	0	4	0 %	259	0	N/A
1009	Risk Stratified Cholesterol Fasting LDLc less than 160 MH	6	6	100 %	259	0	N/A
1010	Screening for High Blood Pressure and Follow Up Documented MH	4	4	100 %	260	26	230

2. Ability to drill down to individual provider performance

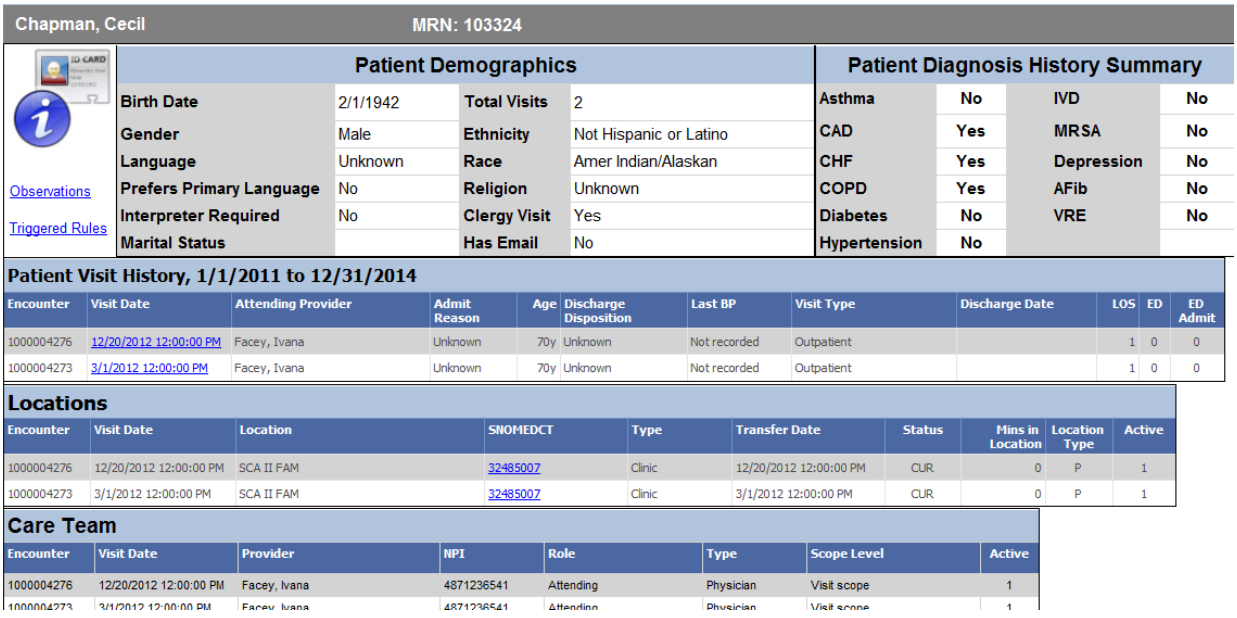
Facey, Ivana | Demographics | Provider Summary

			Numerator	Denominator	Measure Rate	IPP	Exclusions	Exceptions
Million Hearts Measures	1001	Hypertension BP Control MH	2	4	0.0 %	5	N/A	0
	1002	Tobacco Screen and Intervention MH	24	24	100.0 %	24	N/A	N/A
	1003	Diabetes LDLControlled MH	0	4	0.0 %	4	N/A	N/A
	1004	IVD Use of Aspirin or Another AntithromboticMH	3	5	60.0 %	5	N/A	N/A
	1005	IVD Complete Lipid Panel and LDL Control MH	3	5	60.0 %	5	N/A	N/A
	1006	IVD Complete Lipid Panel and LDL Control LT 100 MH	1	5	20.0 %	5	N/A	N/A
	1007	Risk Stratified Cholesterol Fasting LDLc less than 100 MH	7	9	77.8 %	29	N/A	N/A
	1008	Risk Stratified Cholesterol Fasting LDLc less than 130 MH	0	1	0.0 %	29	N/A	N/A
	1009	Risk Stratified Cholesterol Fasting LDLc less than 160 MH	1	1	100.0 %	29	N/A	N/A
	1010	Screening for High Blood Pressure and Follow Up Documented MH	1	1	0.0 %	29	N/A	23

3. Assess further by individual measure. View compliant versus non-compliant patients.



4. From individual measure, capability to view additional patient details



CPM Sample Report

Sample report by provider of patient's with diagnosis of Hypertension

Population	Demo- All Outpatient Visits 201	Provider	John Smith MD
Visits From	1/1/2015	Visits to	1/15/2015
Diagnosis List	Hypertension	Diagnosis Type	Ambulatory Dx
Number of Diagnoses (First to Last), Leave Blank to See All	1 NULL	Number of Most Recent BP Readings	1
SBP Goal Below	150 mm	DBP Goal Below	90 mm

Report Template: Diagnosis and Observations Population- Demo- All Outpatient Visits 2015 Age 60 or older Patient Demographics Report Criteria

Encounter Number	Patient	DOB	Age	Diagnosis	Blood Pressure	Blood Pressure Measured
			80	HTN (hypertension)	115/60	1/12/2015 3:27:00 PM
			72	Hypertension	128/70	1/12/2015 4:05:00 PM
			65	Hypertension	145/80	1/7/2015 12:02:00 PM
			79	Hypertension	146/69	1/7/2015 9:46:00 AM
			64	Benign essential hypertension	137/81	1/5/2015 12:53:00 PM
			81	Benign hypertensive heart disease	138/71	1/5/2015 10:15:00 AM
			67	Uncontrolled hypertension	151/75	1/12/2015 11:38:00 AM
			61	Benign hypertension	136/86	1/5/2015 2:04:00 PM
			71	Uncontrolled hypertension	170/74	1/9/2015 11:34:00 AM
			65	Hypertension, accelerated	206/112	1/5/2015 4:26:00 PM
			68	Uncontrolled hypertension	182/95	1/13/2015 2:41:00 PM
			64	Hypertension	129/84	1/13/2015 3:34:00 PM
			67	Benign hypertension	143/85	1/2/2015 4:18:00 PM
			73	Hypertension	132/80	1/2/2015 2:43:00 PM
			65	Uncontrolled hypertension	199/116	1/9/2015 4:47:00 PM
			66	Benign hypertension	115/55	1/15/2015 4:00:00 PM

- Red text denotes results out of goal range

CPM Sample Report cont.

Sample report by provider of patient's with diagnosis of Diabetes

Population	Demo- All Outpatient Visits 201	Provider	John Smith MD
Visits From	1/1/2015	Visits to	1/15/2015
Diagnosis List	Diabetes	Diagnosis Type	Ambulatory Dx
Number of Diagnoses (First to Last), Leave Blank to See All	1 NULL	Number of Most Recent BP Readings	1
SBP Goal Below	140 mm	DBP Goal Below	90 mm

Report Template: Diagnosis and Observations Population- Demo- All Outpatient Visits 2015 Age 60 or older Patient Demographics Re

Encounter Number	Patient	DOB	Age	Diagnosis	Blood Pressure	Blood Pressure Measured
			62	Diabetes mellitus	138/85	1/13/2015 9:12:00 AM
			80	Diabetes mellitus	163/83	1/5/2015 10:23:00 AM
			64	Diabetes mellitus	112/72	1/14/2015 2:51:00 PM
			86	Diabetes mellitus	94/54	1/8/2015 1:10:00 PM
			73	Diabetes mellitus	97/56	1/15/2015 1:02:00 PM
			64	Diabetes mellitus	123/53	1/13/2015 12:56:00 PM
			63	Diabetes mellitus	154/82	1/8/2015 3:22:00 PM
			73	Diabetes mellitus	158/73	1/5/2015 10:08:00 AM
			69	Type 2 diabetes mellitus, controlled	132/77	1/6/2015 9:08:00 AM
			81	Controlled type 2 diabetes mellitus with diabetic nephropathy	138/59	1/12/2015 9:25:00 AM
			71	Type 2 diabetes mellitus	170/74	1/9/2015 11:34:00 AM
			77	Type 2 diabetes mellitus with renal manifestations	136/81	1/10/2015 9:49:00 AM
			67	Uncontrolled diabetes mellitus	143/85	1/2/2015 4:18:00 PM
			73	Diabetes	132/80	1/2/2015 2:43:00 PM

Health Manager and Patient Reminders

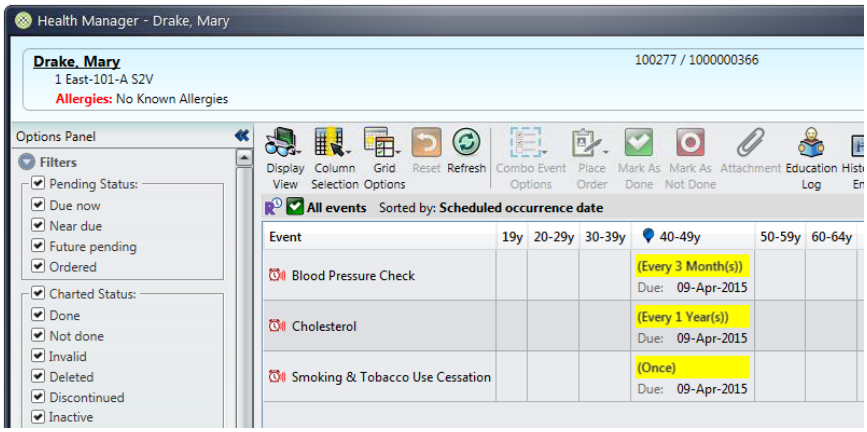
Health Manager Overview

Use Health Manager to improve outcomes by creating wellness events for activities such as blood pressure screening, cholesterol checks, and smoking cessation. Health Manager provides functionality to monitor wellness events for follow-up and generate patient reminders for upcoming or missed events.

Workflow benefits include:

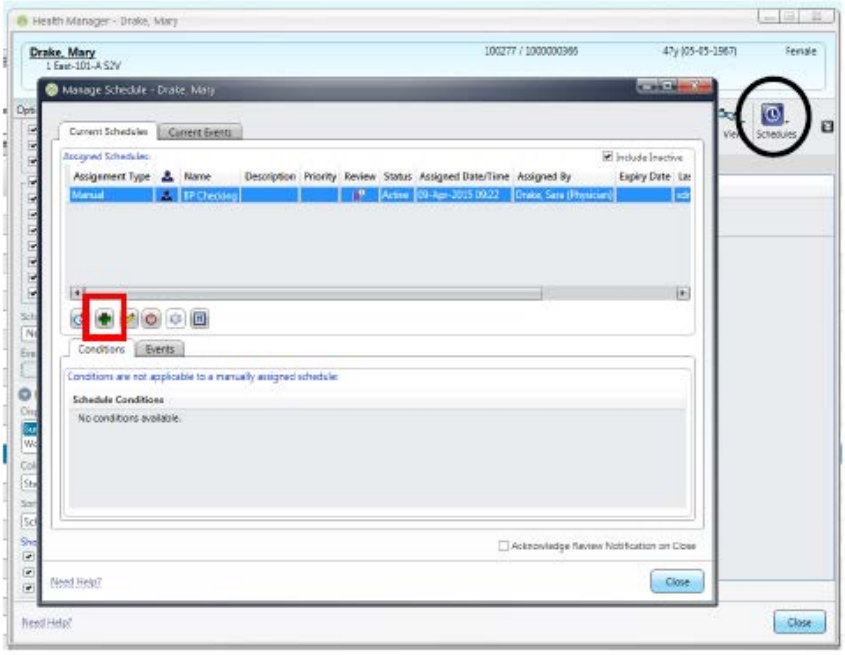
- Streamlined management of preventative care
- Immunizations and wellness events in one place
- Single view
- Population reporting
- Ability to assign schedules or customize Wellness and Immunization events
- Reminders for vaccines and exams

Health Manager Summary View with ABCS relevant wellness events

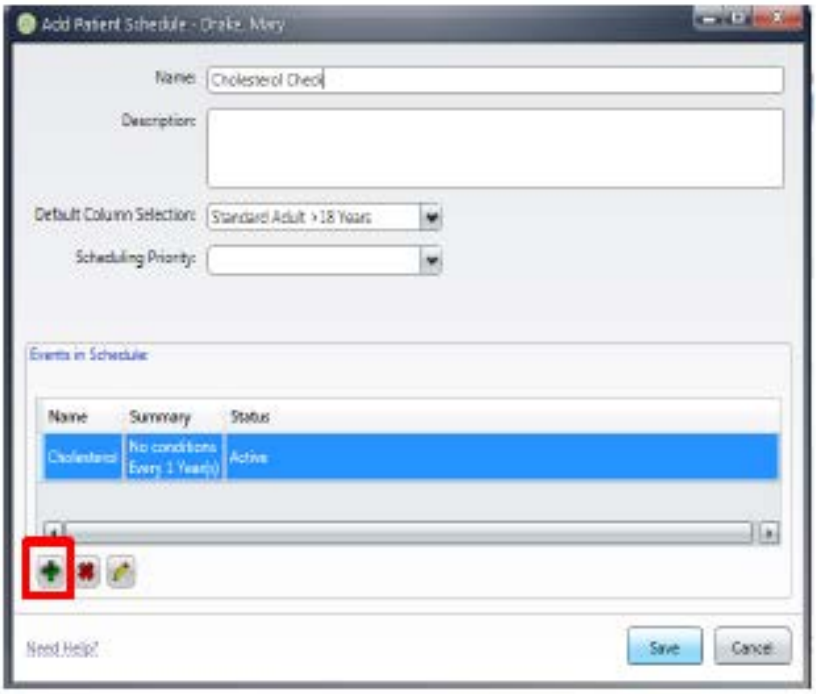


Health Manager and Patient Reminder Workflow

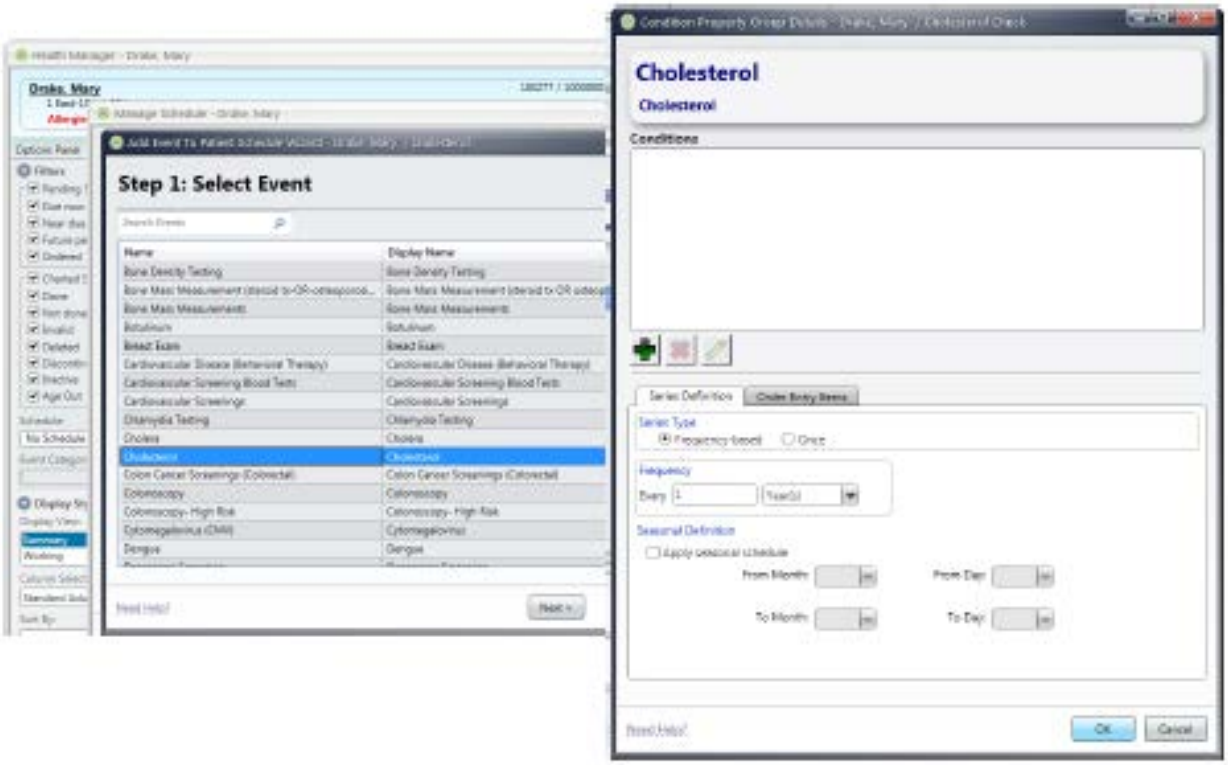
1. Add schedules from Manager Schedules window



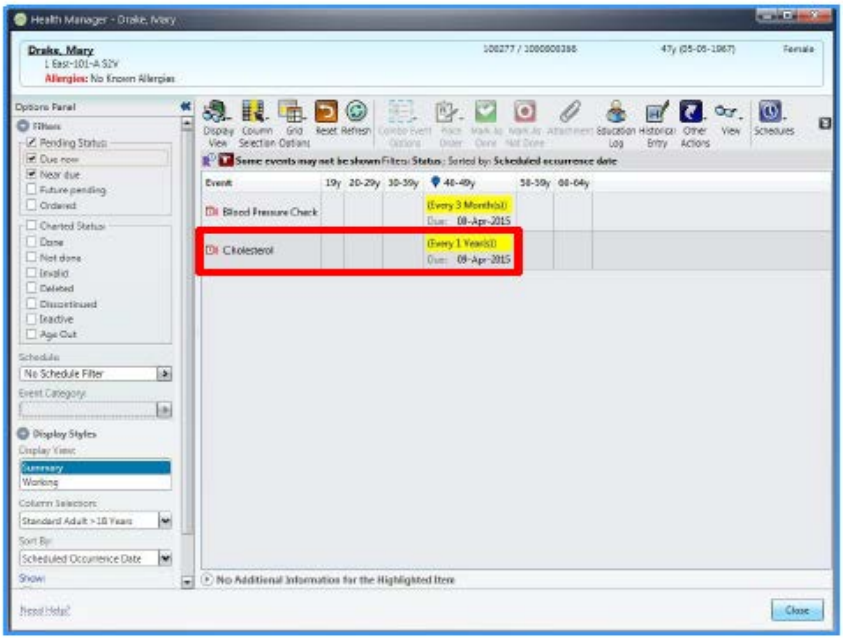
2. Add Event to Patient Schedule



3. Select Event and Frequency

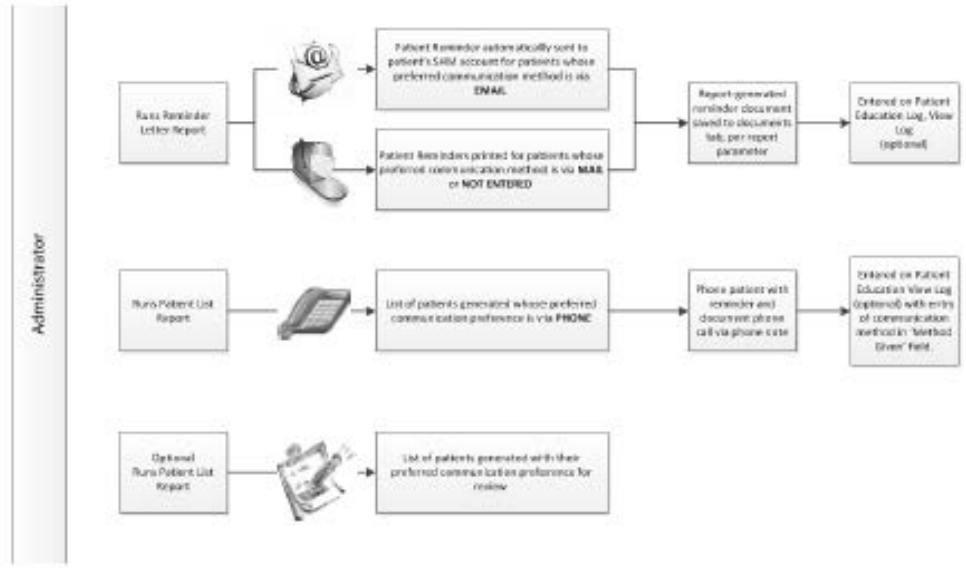


4. View Scheduled Events in Health Manager

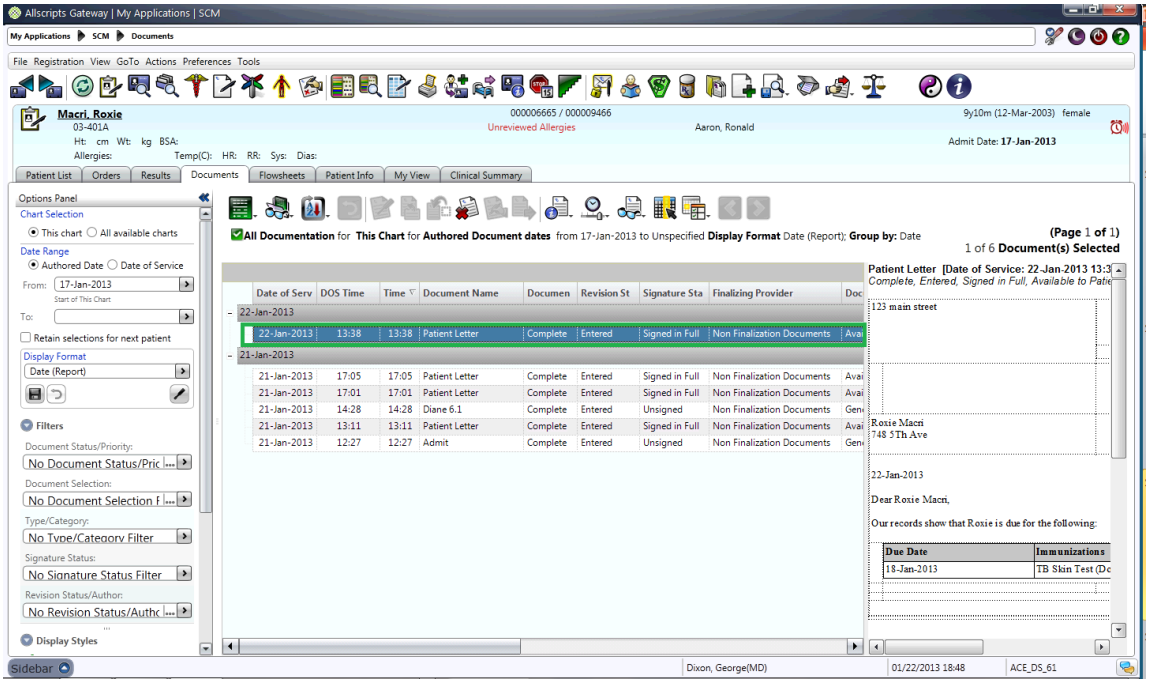


Patient Reminder Workflow

- Use Report engine to send Reminders based on patient's communication preference
  - Interpret patient's communication preference
  - Use Reminder Letter report to send Reminders for patients whose communication preference are mail, SHM or not entered
  - Use Patient List report to print phone list report for patients whose communication preference are Phone
  - Optionally log to education log
- The patients will have due wellness activities, only if patients have wellness schedule/events assigned
- Note: 'Not entered' may be the largest group of patients. Communication preference is defaulted to 'Mail'



View Reminder Letters from Documents Tab



Sample Patient Reminder List Report

Patient Name	Patient ID	Age	Sex	Last Visit Date/Time	Phone	Communication Method
Walker, Laura	000006794	67y	female	09-Dec-2014 09:00	404-9568465	Mail
Health Management Events :	"Body Mass Index (Wellness; 11-Jul-2014)", "Breast Exam (Wellness; 11-Jul-2014)", "Influenza (Immunization; 04-Sep-2014; Dose 2)", "Pap Smear (Wellness; 11-Jul-2014)", "Pneumococcal (Immunization; 02-Dec-2014; Dose 1)", "Vision Exam including glaucoma (Wellness; 02-Dec-2014)"					
Powell, John	000006813	76y	male	02-Dec-2014 06:55	720-344-6767	Mail
Health Management Events :	"Fasting blood sugar (Wellness; 02-Dec-2014)", "Influenza (Immunization; 02-Dec-2014; Dose 1)", "Vision Exam including glaucoma (Wellness; 02-Dec-2014)"					
Campbell, Mark	000006777	68y	male	02-Dec-2014 01:52		Phone
Health Management Events :	"Cholesterol (Wellness; 02-Dec-2014)", "Fasting blood sugar (Wellness; 02-Dec-2014)", "Influenza (Immunization; 02-Dec-2014; Dose 1)", "Mole Skin Exam (Wellness; 02-Dec-2014)", "Pneumococcal (Immunization; 02-Dec-2014; Dose 1)"					
Easterly, Robin	000007002	56y	female	02-Dec-2014 10:38	605-645-8979	E-mail
Health Management Events :	"Body Mass Index (Wellness; 02-Dec-2014)", "Breast Exam (Wellness; 21-Oct-2014)", "Influenza (Immunization; 02-Dec-2014; Dose 1)", "Mammogram (Wellness; 21-Oct-2014)", "Mole Skin Exam (Wellness; 02-Dec-2014)", "Pap Smear (Wellness; 21-Oct-2014)", "Vision Exam including glaucoma (Wellness; 02-Dec-2014)"					
Kopp, JoAnn	000002417	66y	female	02-Dec-2014 10:53		Phone
Health Management Events :	"Blood Pressure Check (Wellness; 02-Dec-2014)", "Body Mass Index (Wellness; 02-Dec-2014)", "Breast Exam (Wellness; 02-Dec-2014)", "Cholesterol (Wellness; 02-Dec-2014)", "Fasting blood sugar (Wellness; 02-Dec-2014)", "Influenza (Immunization; 02-Dec-2014; Dose 1)", "Mammogram (Wellness; 02-Dec-2014)", "Mole Skin Exam (Wellness; 02-Dec-2014)", "Pap Smear (Wellness; 02-Dec-2014)", "Vision Exam including glaucoma (Wellness; 02-Dec-2014)"					

For a more detailed explanation of functionality and configuration, please see the PowerPoint – Million Hearts® Health Manager and Patient Reminders.

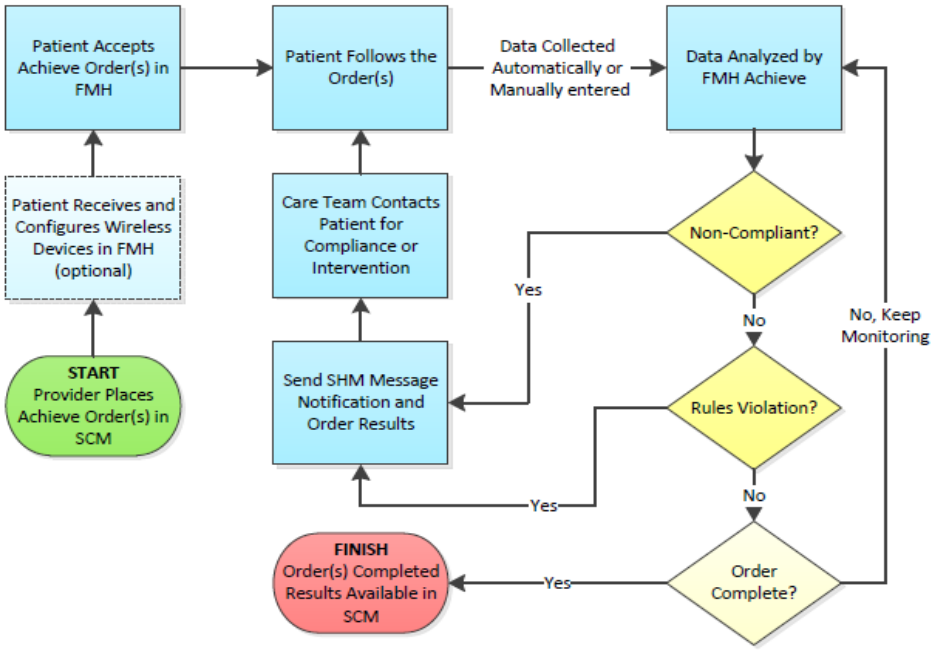
Achieve Workflow and Configuration in Sunrise Ambulatory and FollowMyHealth

Achieve Overview

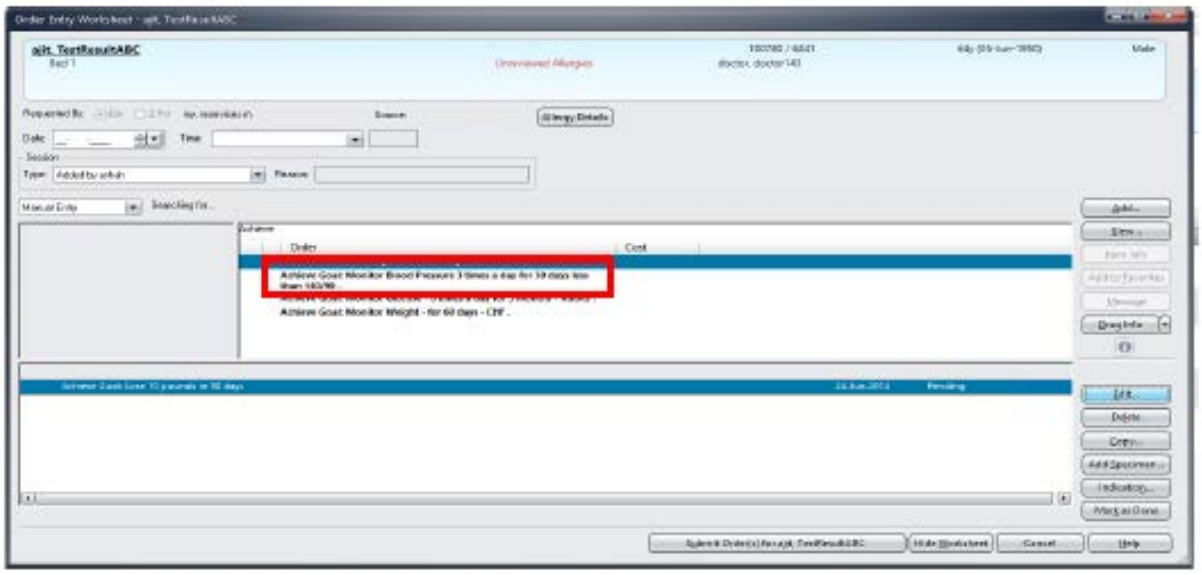
Achieve is a monitoring and compliance application to improve high-risk patient outcomes. It requires use of Sunrise Ambulatory and FollowMyHealth (FMH) Patient Portal. Achieve leverages EHR workflows and the patient portal to engage the patient, improve outcomes, and lower costs through patient engagement, home monitoring, and care coordination. Achieve has the ability to integrate with wireless devices to automatically capture data.

Requirements
- Sunrise version 6.1 or higher
- Must be using FollowMyHealth

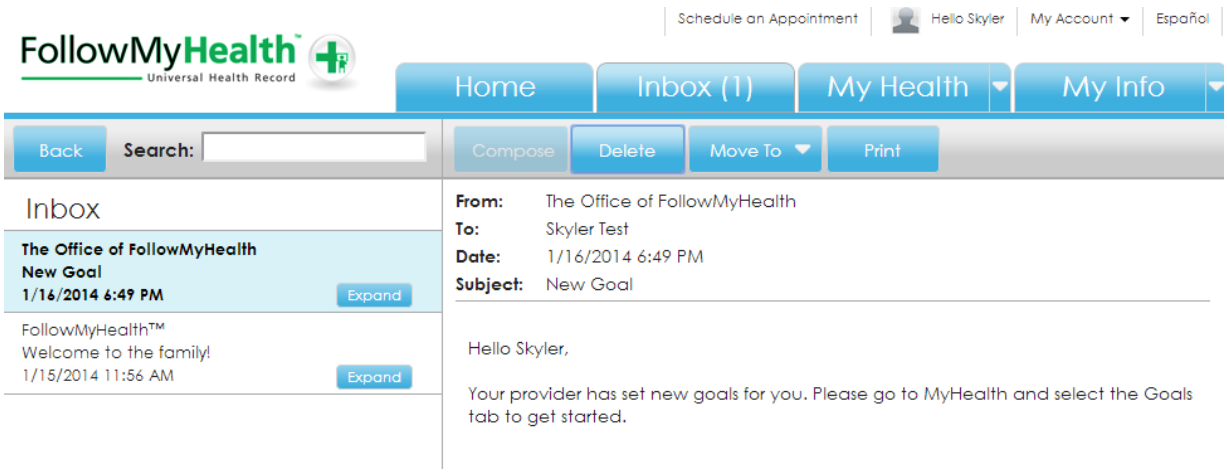
Achieve Workflow



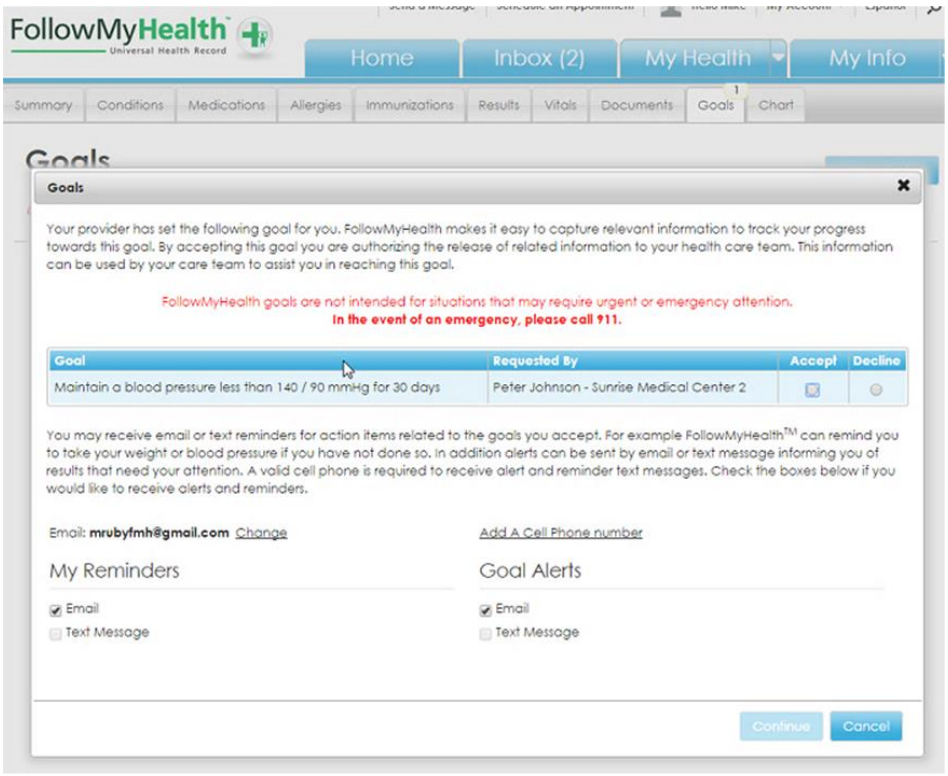
1. Clinician places an Achieve Goal order in Sunrise Ambulatory for patient to monitor at home post clinic visit, MLM is triggered



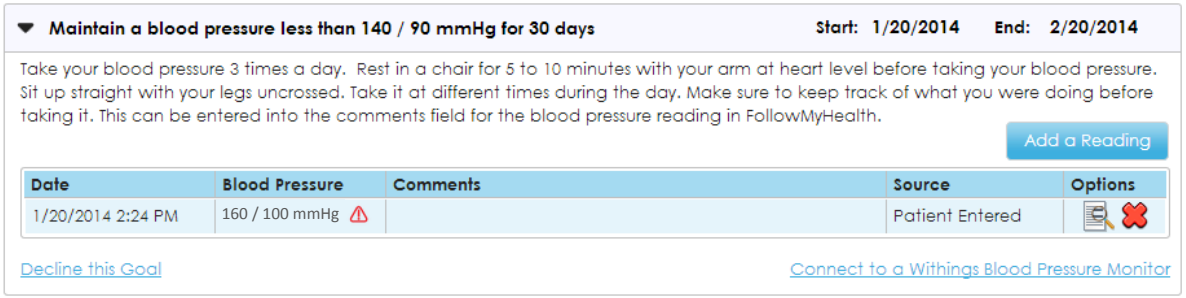
2. Patient receives message in FollowMyHealth Inbox – Provider has set a new goal



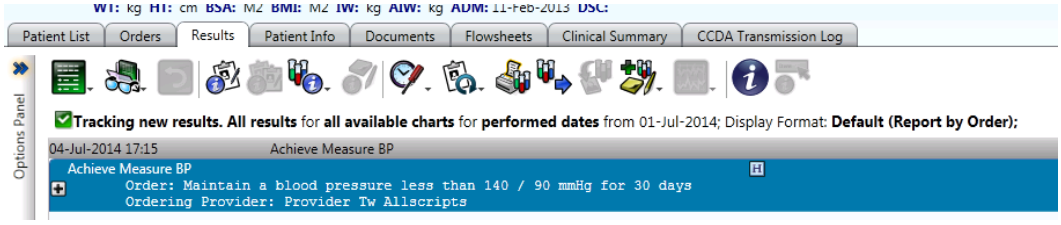
3. Patient accepts or declines goal – can set reminders to input readings and alerts for out of range results

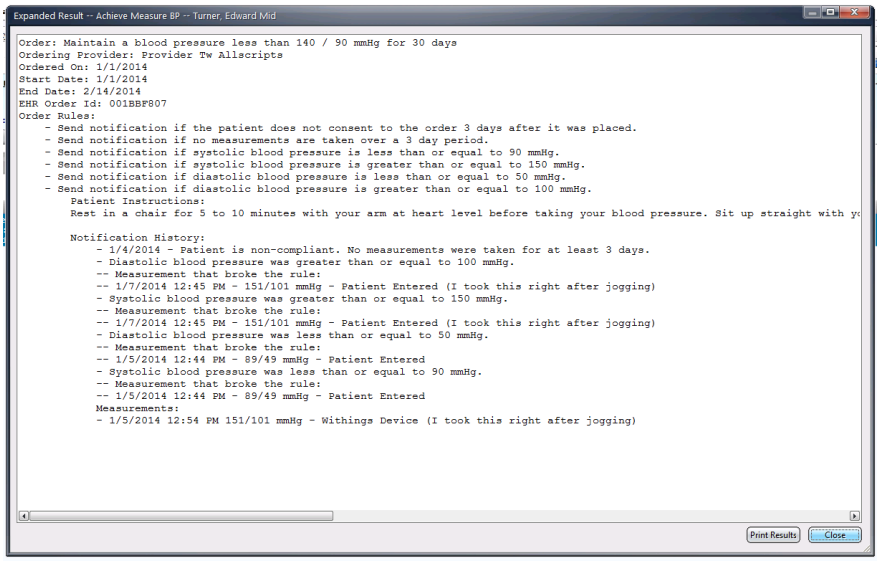


4. Patient enters readings per goal instructions, alerts show based on parameters set in Sunrise Ambulatory order

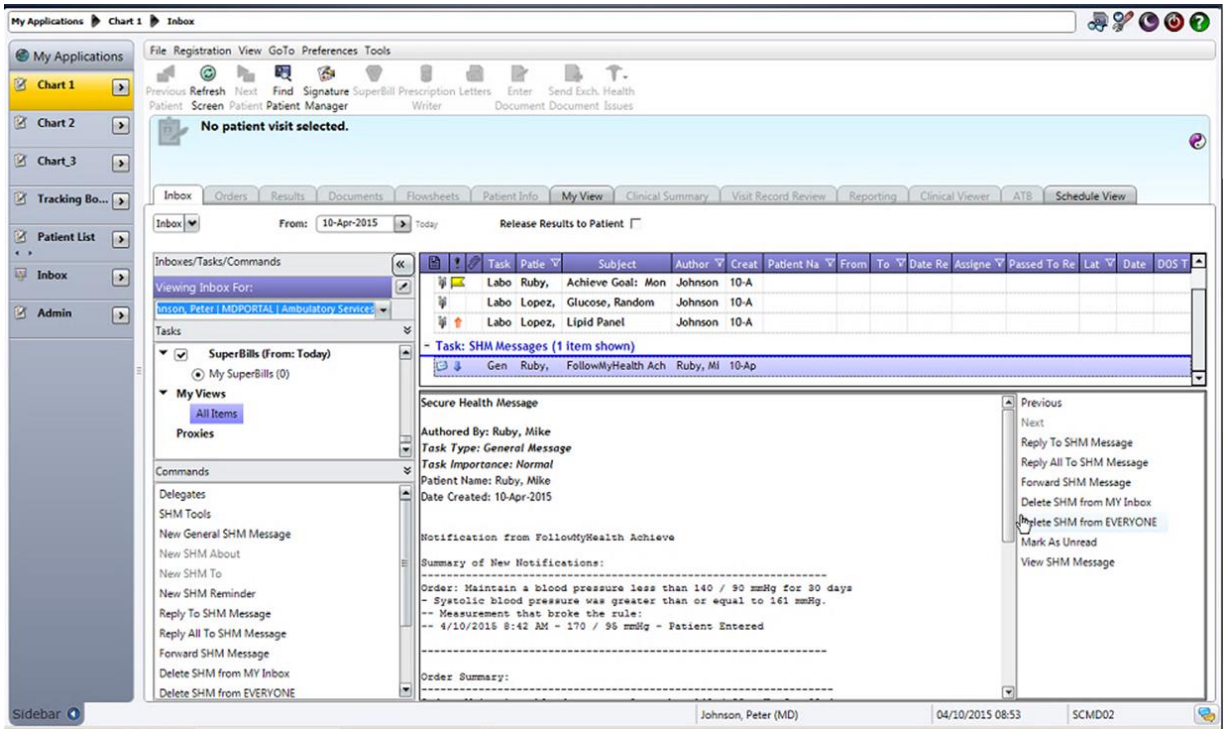


5. As the patient completes the goal, a summary of the result attained by the patient is provided by Achieve to Sunrise Ambulatory





6. Physician can respond directly from the results notification via SHM



For a more detailed explanation of functionality and configuration, please see the PowerPoint – Million Hearts® FollowMyHealth Achieve Workflow and Configuration.

Measure Details The following measure information was obtained from the Centers for Medicare and Medicaid Services (CMS) website in March 2015. Your organization should routinely reference the CMS website to manage any measure information changes or additional information provided after the publication of this document.

- **A.** Appropriate Aspirin Therapy
- **B.** Blood Pressure Control
- **C.** Cholesterol Management
- **S.** Smoking Cessation

A

Term	CMS Specification
Measure	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
Description	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.
eMeasure Identifier	164
NQF	0068
Initial Patient Population	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	N/A
Numerator	Patients who have documentation of use of aspirin or another antithrombotic during the measurement period
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS164v3_Ischemic Vascular Disease Use of Aspirin or Another Antithrombotic

B

Term	CMS Specification
Measure	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Description	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated
eMeasure Identifier	22
NQF	N/A
Initial Patient Population	All patients aged 18 years and older before the start of the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	Patient has an active diagnosis of hypertension
Numerator	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive
Numerator Exclusions	N/A
Denominator Exceptions	Patient Reason(s): Patient refuses to participate OR Medical Reason(s): Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated.
Allscripts Reference Guide	CMS22v3_Preventive Care and Screening_Screening for High Blood Pressure and Follow Up Documented

Term	CMS Specification
Measure	Controlling High Blood Pressure
Description	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
eMeasure Identifier	165
NQF	0018
Initial Patient Population	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.
Numerator	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS165v3_Controlling High Blood Pressure

Allscripts

C

Term	CMS Specification
Measure	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed
Description	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.
eMeasure Identifier	61
NQF	N/A
Initial Patient Population	All patients 20 through 79 years of age before the beginning of the measurement period
Denominator	Denominator 1: (High Risk) All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent OR 10-Year Framingham Risk > 20% Denominator 2 : (Moderate Risk) All patients aged 20 through 79 years who have 2 or more Major CHD Risk Factors OR 10-Year Framingham Risk 10-20% Denominator 3 : (Low Risk) All patients aged 20 through 79 years who have 0 or 1 Major CHD Risk Factors OR 10-Year Framingham Risk <10% ** For Denominator 2 and Denominator 3, Fasting HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)
Denominator Exclusions	Patients who have an active diagnosis of pregnancy OR Patients who are receiving palliative care When a fasting LDL-C test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed
Numerator	Numerator 1: (High Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period Numerator 2 : (Moderate Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period Numerator 3 : (Low Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period or up to four (4) years prior to the current measurement period
Numerator Exclusions	N/A
Denominator Exceptions	Patient Reason(s): Patient Refusal When a fasting LDL-C test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed
Allscripts Reference Guide	CMS61v4_Preventive Care and Screening_Cholesterol-Fasting Low Density Lipoprotein (LDL-C) Test Performed

Term	CMS Specification
Measure	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)
Description	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.
eMeasure Identifier	64
NQF	N/A
Initial Patient Population	All patients 20 through 79 years of age before the beginning of the measurement period
Denominator	Denominator 1: (High Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have CHD or CHD Risk Equivalent OR 10 year Framingham risk > 20% Denominator 2: (Moderate Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have 2 or more Major CHD Risk Factors OR 10 year Framingham Risk 10-20%. Denominator 3: (Low Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed up to 4 years prior to the current measurement period and have 0 or 1 Major CHD Risk Factors OR 10 year Framingham risk <10%. ** For Denominator 2 and Denominator 3, HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)
Denominator Exclusions	Patients who have an active diagnosis of pregnancy OR Patients who are receiving palliative care
Numerator	Numerator 1: Patients whose most recent fasting LDL-C test result is in good control, defined as <100 mg/dL Numerator 2: Patients whose most recent fasting LDL-C test result is in good control, defined as <130 mg/dL Numerator 3: Patients whose most recent fasting LDL-C test result is in good control, defined as <160 mg/dL
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS64v4 Preventive Care and Screening Risk-Stratified Cholesterol Fasting Low Density Lipoprotein (LDL-C)

Term	CMS Specification
Measure	Diabetes: Low Density Lipoprotein (LDL) Management
Description	Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.
eMeasure Identifier	163
NQF	0064
Initial Patient Population	Patients 18-75 years of age with diabetes with a visit during the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	None
Numerator	Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS163v3_Diabetes Low Density Lipoprotein (LDL) Management

Term	CMS Specification
Measure	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
Description	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).
eMeasure Identifier	182
NQF	0075
Initial Patient Population	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	Not Applicable
Numerator	Numerator 1: Patients with a complete lipid profile performed during the measurement period Numerator 2: Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL
Numerator Exclusions	N/A
Denominator Exceptions	None
Allscripts Reference Guide	CMS182v4_Ischemic Vascular Disease_Complete Lipid Panel and LDL Control

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Term	CMS Specification
Measure	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Description	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
eMeasure Identifier	138
NQF	0028
Initial Patient Population	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Denominator	Equals Initial Patient Population
Denominator Exclusions	None
Numerator	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user
Numerator Exclusions	N/A
Denominator Exceptions	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)
Allscripts Reference Guide	CMS132v3 Cataracts Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures