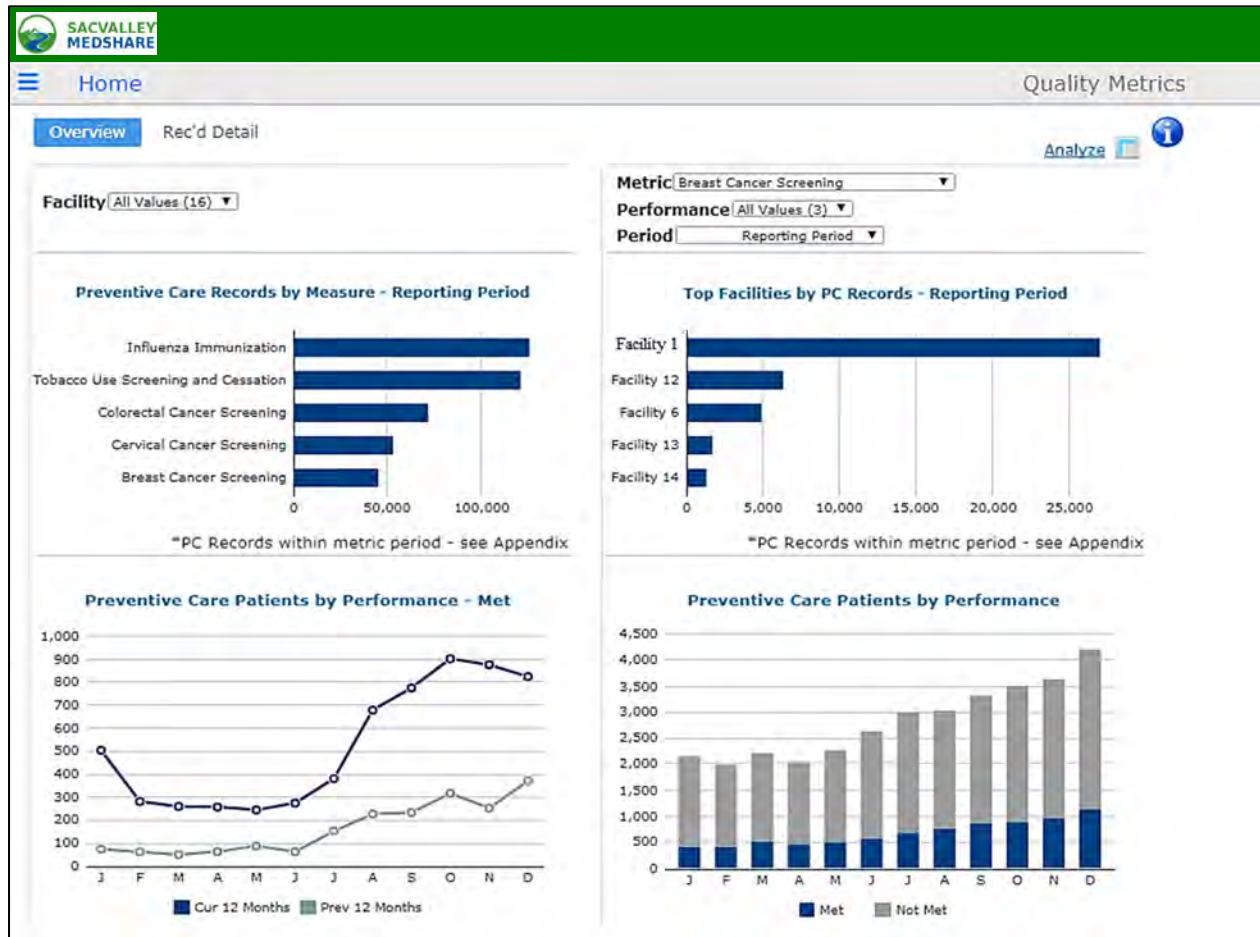




The **Quality Metrics dashboard** displays client results and analysis of preventive care procedures commonly required and approved for quality reporting programs for ambulatory practices. Individual measures are structured to meet NCQA, CMS and HEDIS requirements.

Measures include screening for colorectal, cervical and breast cancers, osteoporosis, pneumonia and influenza vaccines, controlled high blood pressure, diabetes and tobacco use.



**Patient eligibility** all patients in total client population that meet the QM guidelines. Individual measures may have exclusions based on age, gender or previous conditions Details of the requirements for each condition and measure can be found in the Appendix.

'**Performance**' is a breakdown of how the patient can be categorized per the metric of interest.

**Met** - The patient has fallen into both the numerator and denominator requirements for the metric including any office visit criteria.

**Not Met** - The patient meets the denominator criteria, but does not meet the numerator criteria for the metric.

**Unreported** - The patient meets the numerator requirements for the metric, however the patient does **not** have the required office visit, excluding them from the denominator population to be considered "Met".

**Period** The 'Period' dropdown is a breakdown timeframes.

The three 'Period' options are:

**Current** -The current calendar year.     **Previous** - The previous calendar year.     **Historical** - Anything prior to the previous calendar year.

**Measures** help clients meet their MIPS Quality reporting requirements and other health insurance mandates by completing their records with dates and evidence of preventive screenings performed outside their facility. Export format allows ease of filtering and import into EMR or other tracking software.

Patient list for each measure display from each bar chart on the overview dashboard. Report columns vary dependent on the chart selection.

Patient List

Facility: All Values (16) ▼

Metric: Controlled High Blood Pressure

Performance Period: Controlled High Blood Pressure

Patient Name	DOB	Sex	Ethnicity	Race	Activity Date	Most Recent Facility	Act Type	Act Desc	Record #
1577045, PATIENT	10/03/1939	M	Not Hisp	White	08/09/2018	Facility 8	Vital Sign	Vitals In Control - 110 / 66	102
2794729, PATIENT	05/28/1948	M	Hispanic		08/09/2018	Facility 8	Vital Sign	Vitals In Control - 122 / 68	1
474383, PATIENT	08/24/1934	F		White	08/08/2018	Facility 1	Vital Sign	Vitals In Control - 100 / 45	1
1262432, PATIENT	09/11/1944	F	Not Hisp	White	08/07/2018	Facility 8	Vital Sign	Vitals In Control - 124 / 70	1
1938695, PATIENT	07/28/1939	M	Not Hisp	White	08/07/2018	Facility 10	Vital Sign	Vitals In Control - 121 / 71	1
3981333, PATIENT	08/06/1943	F	Not Hisp	White	08/07/2018	Facility 15	Vital Sign	Vitals In Control - 120 / 70	1
592333, PATIENT	11/23/1962	M	Not Hisp	White	08/06/2018	Facility 10	Vital Sign	Vitals In Control - 132 / 84	1
2826896, PATIENT	08/04/1956	M	Not Hisp	White	08/06/2018	Facility 8	Vital Sign	Vitals In Control - 134 / 56	1
421069, PATIENT	07/17/1938	F	Not Hisp	White	08/01/2018	Facility 8	Vital Sign	Vitals In Control - 108 / 60	1
567239, PATIENT	08/25/1961	F	Not Hisp	White	08/01/2018	Facility 3	Vital Sign	Vitals In Control - 110 / 73	1
963710, PATIENT	04/16/1936	F	Not Hisp		08/01/2018	Facility 8	Vital Sign	Vitals In Control - 112 / 70	1
1293051, PATIENT	02/21/1935	M	Not Hisp	White	08/01/2018	Facility 8	Vital Sign	Vitals In Control - 112 / 60	1

Patient List example from Preventive Care Records by Measure 12 months.

**Facility Charts by Records and by Patients** display most frequent facility for a single measure. Selecting the Metric drop down changes display of charts on right. Patient list detail for each is obtained by selecting bar on chart.

**Potential Use:** Facilities may want to see where their patients have completed the preventive care measures. Gives indication of referral patterns and utilization. May be of particular interest to integrated network of hospital and physician clinics.

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