PINNACLE Registry®
Quality improvement solutions for the outpatient setting

NCDR® PINNACLE Registry® v1.3
Data Collection Form
Practice Innovation and Clinical Excellence

MRN[1500]**:**	**Encounter Date**[1510]**:** mm / dd / yyyy	**Practice ID**[1520]**:**	**Location ID**[1530]**:**
Provider Name(Last, First, MI)[1540, 1541, 1542]**:**		**Patient new to the Practice**[1560]**:** O No O Yes	
Provider NPI[1550]**:**	**Encounter Reason**[1565]**:** O Atrial Fibrillation O Coronary Artery Disease O Diabetes O Heart Failure O Hypertension O Other Cardiac O Non-Cardiac		
Encounter TIN[1555]**:**			

A. Patient Demographics

Patient Name(Last, First, MI)[2000, 2010, 2020]**:**	**SSN**[2030]**:**	**PatientID**[2040]**:** (auto)	**Patient Zip**[2200]**:**
Date of Birth[2050]**:** mm / dd / yyyy	**Sex**[2060]**:** O Male O Female	☐ **Patient Deceased**[2065] →**Date**[2067] mm / dd / yyyy	

Race: (Check all that apply) ☐ White[2070] ☐ Black/African American[2071] ☐ American Indian/Alaska Native[2073] ☐ Asian[2072] ☐ Native Hawaiian/Pacific Islander[2074]

☐ **Hispanic or Latino Ethnicity**[2076]

Insurance Payers: (Check all that apply)
☐ Private Health Insurance[3020] ☐ Medicaid (fee for service)[3030] ☐ Medicare (fee for service)[3028]
☐ Military Health Care[3023] ☐ State Specific Plan (non-Medicaid)[3024] ☐ Indian Health Service[3025] ☐ Medicaid (managed care)[3031] ☐ Medicare (managed care)[3029] ☐ Non-US Insurance[3026] ☐ None[3027]

Payer ID[3100]**:** _____ _____ _____ _____ _____

B. Diagnoses/Conditions/Co-Morbidities (Check all that apply)

Note: Indicate if the patient has a history of any of the following.

☐ **Coronary Artery Disease**[4000]	→**Date**[4002] mm / dd / yyyy	☐ **Heart Failure**[4045]	→**Date**[4047] mm / dd / yyyy
☐ **Atrial Fibrillation/Flutter**[4005]	→**Date**[4007] mm / dd / yyyy	→If Yes, ☐ **New diagnosis**[4050] (within 12 months)	
☐ **Dyslipidemia**[4010]	→**Date**[4012] mm / dd / yyyy	☐ **Stable Angina**[4055]	→**Date**[4057] mm / dd / yyyy
☐ **Diabetes Mellitus**[4015]	→**Date**[4017] mm / dd / yyyy	→If Yes, ☐ **New diagnosis**[4060] (within 12 months)	
☐ **Hypertension**[4020]	→**Date**[4022] mm / dd / yyyy	☐ **Ischemic Vascular Disease**[4065]	→**Date**[4067] mm / dd / yyyy
☐ **Peripheral Arterial Disease**[4030]	→**Date**[4032] mm / dd / yyyy	☐ **Peripheral Vascular Disease**[4070]	→**Date**[4072] mm / dd / yyyy
☐ **Unstable Angina**[4040]	→**Date**[4042] mm / dd / yyyy	☐ **Chronic Kidney Disease**[4075]	→**Date**[4077] mm / dd / yyyy
		☐ **Chronic Liver Disease**[4080]	→**Date**[4082] mm / dd / yyyy

C. Cardiac Events (Check all that apply)

Note: Indicate if the patient has a history of any of the following.

☐ **Myocardial Infarction**[5000]	→**Date**[5007] mm / dd / yyyy	☐ **Coronary Artery Bypass Graft**[5011]	→**Date**[5012] mm / dd / yyyy
☐ **PCI - Bare Metal Stent Implant**[5016]	→**Date**[5017] mm / dd / yyyy	☐ **Cardiac Valve Surgery**[5021]	→**Date**[5022] mm / dd / yyyy
☐ **PCI - Drug Eluting Stent Implant**[5026]	→**Date**[5027] mm / dd / yyyy	☐ **Heart Transplantation**[5031]	→**Date**[5032] mm / dd / yyyy
☐ **PCI - Other (non-stent) Intervention**[5036]	→**Date**[5037] mm / dd / yyyy	☐ **Cardiac Therapeutic Procedure**[5040]	→**Date**[5042] mm / dd / yyyy
☐ **Systemic Embolism**[5045]	→**Date**[5047] mm / dd / yyyy	☐ **Cardioversion**[5050]	→**Date**[5052] mm / dd / yyyy
☐ **Minor Hemorrhage**[5055]	→**Date**[5057] mm / dd / yyyy	☐ **LVAD**[5060]	→**Date**[5062] mm / dd / yyyy
☐ **Intracranial Hemorrhage**[5065]	→**Date**[5067] mm / dd / yyyy	☐ **CRT**[5070]	→**Date**[5072] mm / dd / yyyy
☐ **Non-Intracranial Major Hemorrhage**[5075]	→**Date**[5077] mm / dd / yyyy	☐ **CRT-D**[5090]	→**Date**[5092] mm / dd / yyyy
→If Yes, **Location**[5080] _____		☐ **ICD**[5100]	→**Date**[5102] mm / dd / yyyy
☐ **TIA**[5095]	→**Date**[5097] mm / dd / yyyy	☐ **PTCA**[5110]	→**Date**[5112] mm / dd / yyyy
☐ **Ischemic Stroke**[5105]	→**Date**[5107] mm / dd / yyyy	☐ **Permanent Pacemaker**[5120]	→**Date**[5122] mm / dd / yyyy
☐ **Hemorrhagic Stroke**[5115]	→**Date**[5117] mm / dd / yyyy	☐ **Vascular Complication**[5130] (requiring intervention)	→**Date**[5132] mm / dd / yyyy

D. Encounter Information

Note: Complete only if assessed during today's encounter. If not assessed, leave blank.

Height: _____ O in[6000] O cm[6001]	**Blood Pressure**[6010, 6011]**:** _____ / _____ mmHg	**Heart Rate**[6015]**:** _____ bpm
Weight: _____ O lbs[6020] O kg[6021] ☐ **Patient unable to be weighed**[6025]		

MRN: **Encounter Date:** mm / dd / yyyy **Practice ID:** **Location ID:**

D. ENCOUNTER INFORMATION (CONTINUED)

Note: Complete only if assessed during today's encounter. If not assessed, leave blank.

Tobacco Use[6030]: O Never O Current O Quit within past 12 months O Quit more than 12 months ago O Screening not performed for medical reasons

→ If Current or Quit within 12 months, **Tobacco Type** (Check all that apply): ☐ Cigarettes[6035] ☐ Cigars[6036] ☐ Pipe[6037] ☐ Smokeless[6038]

→ If Current or Quit within 12 months, **Smoking Cessation Counseling Provided**[6040]: O No O Yes

Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco[6045]: O No O Yes

Alcohol Use[6047]: O None O <1 drinks/wk O 2-7 drinks/wk O 8-14 drinks/wk O >= 15 drinks/wk

Advance Care Plan OR Discussion of Advance Care Plan Documented[6050]: O No O Yes

ANGINA SYMPTOMS AND ACTIVITY ASSESSMENT(S)

Note: Complete at least one to meet measure.

CAD

CCS Class[6100]: O No angina O I O II O III O IV ☐ **Other Tool/Method to Assess Angina Symptoms and Activity Completed**[6115]

☐ **Seattle Angina Questionnaire Completed**[6105]

HEART FAILURE ACTIVITY ASSESSMENT(S)

Note: Complete at least one to meet measure.

HF

NYHA Class[6200]: O I O II O III O IV

☐ **Kansas City Cardiomyopathy Questionnaire Completed**[6205] ☐ **Chronic Heart Failure Questionnaire from Guyatt Completed**[6220]

☐ **Minnesota Living with HF Questionnaire Completed**[6225] ☐ **Other Tool/Method to Assess Heart Failure Activity Completed**[6230]

HEART FAILURE SYMPTOMS ASSESSMENT(S)

Note: Complete at least one to meet measure.

HF

Dyspnea Present[6300]: O No O Yes **Orthopnea Present**[6305]: O No O Yes

HEART FAILURE PHYSICAL ASSESSMENT(S)

Note: Complete at least one to meet measure.

HF

Rales Present[6400]: O No O Yes **Peripheral Edema Present**[6405]: O No O Yes **S_3 Gallop Present**[6410]: O No O Yes

Ascites Present[6420]: O No O Yes **Hepatomegaly Present**[6425]: O No O Yes **S_4 Gallop Present**[6430]: O No O Yes

Jugular Venous Distention Present[6435]: O No O Yes

PLAN OF CARE

BMI

☐ **Body Mass Index Screen Performed**[6450] →**Date**[6452] mm / dd / yyyy ☐ **BMI Management Plan**[6455]

CAD

Cardiac Rehabilitation Referral or Plan for Qualifying Event/Diagnosis in past 12 months[6505]: O Yes – Referral/Plan Documented O No Qualifying Event/Diagnosis O Patient Already Participating in Rehab O No Referral/Plan – Medical Reason O No Referral/Plan – System Reason

(**Note:** Cardiac event/diagnoses includes Myocardial Infarction, Valve surgery, Heart Transplant, CABG, PCI or new Stable Angina diagnosis.)

Referral for Consideration for Coronary Revascularization[6506]: O No O Yes

Referral for Additional Evaluation/Treatment of Anginal Symptoms[6507]: O No O Yes

Discussion of Lifestyle Modifications Documented[6508]: O No O Yes

HF

HF Education Completed/Documented (Check all that apply):

☐ All of the following[6510] ☐ Weight Monitoring[6511] ☐ Diet (Sodium Restriction)[6512] ☐ Symptom Management[6513]
☐ Physical Activity[6514] ☐ Smoking Cessation[6515] ☐ Medication Instruction[6516] ☐ Prognosis/end-of-life Issues[6517]
☐ Minimizing or Avoiding use of NSAIDs[6518] ☐ Referral for visiting nurse or specific educational or management programs[6519]

ICD Counseling[6550]: O Yes – Patient Counseled O No – Patient Not Counseled O No Counseling – Medical Reason

HF Plan of Care[6555]: O No O Yes

ATRIAL FIBRILLATION/FLUTTER ASSESSMENT AND TREATMENT

AFib

AFib/Flutter Duration[6600]: O First episode detected O Chronic – paroxysmal O Chronic – persistent/permanent

AFib/Flutter Type[6605]: O Non-Valvular O Valvular

☐ **Afib/Flutter Etiology - Transient/Reversible Cause**[6610] (e.g., pneumonia, hyperthyroidism, pregnancy, post-surgery)

All Thromboembolic Risk Factors Assessed[6615]: O Yes (All risk factors assessed) O No – Medical Reason

(**Note:** Thromboembolic risk factors include all of the following: 1. Prior Stroke/TIA 2. Age ≥75 3. Hypertension 4. Diabetes Mellitus 5. HF or LVSD.)

INR Value[6618]: _____ →**Date**[6617] mm / dd / yyyy

☐ **EP Study**[6620] →**Date**[6622] mm / dd / yyyy

☐ **Atrial Ablation**[6625] →**Date**[6627] mm / dd / yyyy

☐ **Atrial Fibrilation Recurrence**[6630] →**Date**[6632] mm / dd / yyyy

Atrial Fibrillation Symptom Frequency[6635]: (every) _____ days

Atrial Fibrillation Symptom Duration[6640]: O < 48 hours O >= 48 hours – 7 days O >7 days – 3 months O > 3 months

☐ **Rate Control Therapy**[6645]

☐ **Rhythm Control Therapy**[6650]

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E. LABORATORY RESULTS

Note: Enter **most recent** lab results and/or indicate the labs ordered during this encounter.

CAD/HF

LVEF Assessed Date[7000]**:** mm / dd / yyyy

LVEF[7005]**:** _____ **%** **-OR-** **LV Qualitative Assessment**[7010]**:** → O Hyperdynamic: > 70 O Normal: 50 – 70 O Mildly reduced: 40 – 49 O Moderately reduced: 30 – 39 O Severely reduced: ≤ 29

(**Note**: If a LVEF range is documented, take the average, round up and refer to the **LVEF Status** ranges (right) to code.)

CAD

Lipid Panel Obtained Date[7015]**:** mm / dd / yyyy

☐ **Fasting**[7020]

Total Cholesterol[7025]**:** _____ mg/dL

High Density Lipoprotein (HDL)[7030]**:** _____ mg/dL

Low Density Lipoprotein (LDL)[7035]**:** _____ mg/dL

Triglycerides[7040]**:** _____ mg/dL

☐ **Lipid Panel Ordered**[7045]

☐ **Serum Glucose Ordered**[7050] (If not known Diabetic)

Glucose Date[7055]**:** mm / dd / yyyy

Glucose[7060]**:** _____ mg/dL

Glucose timing[7065]**:** O Fasting O 2hr Glucose Tolerance Testing O Random O Unknown

HbA1c Date[7070]**:** mm / dd / yyyy

HbA1c[7075]**:** _____ %

HF

☐ **Initial Labs ordered for newly diagnosed Heart Failure** (within past 12 months) **or patient new to the practice**[7080]

(**Note**: Initial labs for HF include Serum Electrolytes (including Ca+ and Mg+), CBC, U/A, TSH, Liver Function tests, BUN, Creatinine and Glucose.)

Renal

Estimated GFR (EMR)[7090]**:** _____ mL/min

Estimated GFR (Imputed)[7095]**:** _____ mL/min

Creatinine Clearance[7100]**:** _____ →**Date**[7102] mm / dd / yyyy

Creatinine Clearance Units[7105]**:** _____

Serum Creatinine[7110]**:** _____ mg/dL →**Date**[7112] mm / dd / yyyy

F. PRESCRIPTIONS

Note: Record for prescription(s) given during this encounter only.

Prescription Given for Any Medication[8000]**:** O No O Yes → If Yes, **Prescription Generated and Transmitted Using a Qualified e-Prescribing System**[8005]**:** O No O Yes

G. MEDICATIONS

Note: If no documentation exists as to if a medication was prescribed/continued, then leave blank.

	Medication	Indicate prescribed/continued medications or reason not prescribed.			
		Yes (Prescribed)	No (Medical Reason)	No (Patient Reason)	No (System Reason)
ANTIANGINAL	Nitroglycerin[9100]	O	O	O	O
ANTIANGINAL	Ranolazine[9105]	O	O	O	O
ANTIARRYTHMIC	Antiarrhythmic (Unspecified)[9115]	O	O	O	O
ANTIARRYTHMIC	Amiodarone[9120]	O	O	O	O
ANTIARRYTHMIC	Dronedarone[9125]	O	O	O	O
ANTICOAGULANT / ADP ANTAGONIST	Clopidogrel[9005]	O	O	O	O
ANTICOAGULANT / ADP ANTAGONIST	Ticlopidine[9010]	O	O	O	O
ANTICOAGULANT / ADP ANTAGONIST	Prasugrel[9015]	O	O	O	O
ANTICOAGULANT / ADP ANTAGONIST	Ticagrelor[9130]	O	O	O	O
ANTICOAGULANT	Aspirin[9030]	O	O	O	O
ANTICOAGULANT	Aggrenox[9020]	O	O	O	O
ANTICOAGULANT	Apixaban[9080]	O	O	O	O
ANTICOAGULANT	Dabigatran[9085]	O	O	O	O
ANTICOAGULANT	Rivaroxaban[9090]	O	O	O	O
ANTICOAGULANT	Warfarin[9060]	O	O	O	O
ANTIDIABETIC	Insulin[9135]	O	O	O	O
ANTIDIABETIC	Metformin[9140]	O	O	O	O
ANTIDIABETIC	Pioglitazone[9145]	O	O	O	O
ANTIDIABETIC	Rosiglitazone[9150]	O	O	O	O

MRN: **Encounter Date:** mm / dd / yyyy **Practice ID:** **Location ID:**

G. MEDICATIONS (CONTINUED)

Note: If no documentation exists as to if a medication was prescribed/continued, then leave blank.

	Medication	Indicate prescribed/continued medications or reason not prescribed.			
		Yes (Prescribed)	No (Medical Reason)	No (Patient Reason)	No (System Reason)
ANTIHYPERTENSIVE	ACE Inhibitor[9000]	O	O	O	O
	ARB[9025]	O	O	O	O
	Calcium Channel Blocker[9040]	O	O	O	O
	Diuretic[9045]	O	O	O	O
	Combination Antihypertensive[9095]	O	O	O	O
BETA BLOCKER	Beta Blocker (Unspecified)[9035]	O	O	O	O
	Atenolol[9155]	O	O	O	O
	Metoprolol[9160]	O	O	O	O
	Nebivolol[9165]	O	O	O	O
	Bisoprolol[9210]	O	O	O	O
	Carvedilol[9215]	O	O	O	O
	Sustained release metoprolol succinate[9220]	O	O	O	O
LIPID LOWERING	Lipid Lowering Non-Statin[9050]	O	O	O	O
STATIN	Lipid Lowering Statin (Unspecified)[9055]	O	O	O	O
	Atorvastatin[9170]	O	O	O	O
	Rosuvastatin[9175]	O	O	O	O
	Simvastatin[9180]	O	O	O	O
SMOKING CESSATION	Bupropion[9075]	O	O	O	O
	Nicotine Replacement Therapy[9070]	O	O	O	O
	Varenicline[9065]	O	O	O	O
OTHER	Corticosteroids[9185]	O	O	O	O
	Digoxin[9190]	O	O	O	O
	NSAID[9195]	O	O	O	O
	Proton Pump Inhibitor[9200]	O	O	O	O
	SSRI[9205]	O	O	O	O

H. Hospitalizations

Hospital Admission Date[9500]**:** mm / dd / yyyy →If Admitted**, Primary Reason**[9505] _____ **Coding Standard**[9510]**:** O ICD-9 O ICD-10