2025 DATA COLLECTION WORKSHEET

FOR CHECK. CHANGE. CONTROL. CHOLESTEROL AWARD ACHIEVEMENT

INSTRUCTIONS

Enter your health care organization's adult patient data to prepare for the formal data submission process. Use only numbers when entering data into the data submission platform. (No commas or decimals).

The deadline to submit 2024 data for 2025 recognition is May 16, 2025, 11:59 p.m. ET. Data submission deadlines are firm to safeguard fair opportunities for all submitters. Early submission is highly encouraged to allow time for resolving any issues and to ensure the deadline is met.

All data must be submitted using our data submission platform (**https://aha.infosarioregistry.com**) by the deadline to be eligible for an award. Completing this worksheet does not constitute data submission. For any questions, contact your local AHA staff member or reach out at **bit.ly/AQContactUs**.

NOTE: *These data are based on MIPS Measure #438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. You may use eCQM CMS347v7. Also, the AHA/ASA advocates use of ASCVD Risk Assessment tools which enable healthcare providers and patients to estimate 10-year and lifetime risk for atherosclerotic cardiovascular disease (ASCVD), or denote very high-risk patients for secondary prevention. You will need to provide information regarding your organization's current use of ASCVD Risk Assessment.*

ALL FIELDS ARE REQUIRED

The 2025 recognition cycle is based on the performance period of the 2024 calendar year (1/1/2024-12/31/2024).

1. **Does your organization diagnose and manage adult patients with high cholesterol, including prescribing and managing medications?** ☐ Yes ☐ No
   Only organizations directly diagnosing and managing high cholesterol are eligible for awards as of 2021. A "yes" response is required for award eligibility.

2. **I am a designated representative of my organization and certify that the following attestations are accurate to the best of my knowledge.** ☐ Yes ☐ No
   A "yes" response is required for award eligibility.

3. **What is the total number of adult patients (≥ 18 years of age) for the health care organization, regardless of diagnosis? Patients must have had at least one 2024 visit (in-office or telehealth encounter). *Exclude acute care visits.*** ______________
   This answer should represent all adult patients that could be considered for management of high cholesterol during their visit. You will be asked to break down this total by primary payor and race/ethnicity in subsequent questions. These questions are the same in Target: BP and Target: Type 2 Diabetes.

4. **How many providers are in the health care organization?** ______________
   Include all clinicians, physicians, nurse practitioners, and physician assistants.

Questions continue on the next page.

5. **How many people of your total adult patient population (≥18 years of age) self-identify as the following race and ethnicity (based on Table 3B of the HRSA Uniform Data System Reporting Requirements for 2024 Health Center Data)?**

Sum must equal total patient count in question 3.

Race	Non-Hispanic, Latino/a, or Spanish Origin (Total Patients – Ages 18+)	Hispanic, Latino/a, or Spanish Origin (Total Patients – Ages 18+)
Asian		
Native Hawaiian		
Other Pacific Islander		
Black/African American		
American Indian or Alaska Native		
White		
More than one race		
Unreported/Unknown Race — (Ethnicity is known to be Hispanic, Latino/a, or Spanish origin but Race is unknown)		
Race Known Unreported/ Unknown Ethnicity — (Race Known [Any], but unknown if Hispanic, Latino/a, or Spanish origin)		
Unreported or Unknown Race & Ethnicity		
Subtotals*		
Total Patients* (Must equal Question 3 response)		

**NOTE: The totals for your patient population will auto-populate in the data submission platform.*

6. **How many of your total adult patients (≥ 18 years of age) are *primarily* attributed to the following payor groups?** *Sum must equal total patient count in question 3.*

See page 7 for additional guidance on payor groups.

_______ Medicare _______ Medicaid _______ Private Health Insurance

_______ Other Public _______ Uninsured/Self-Pay _______ Other/Unknown

ORGANIZATIONAL INFORMATION & ASCVD RISK ASSESSMENTS

As part of the Check. Change. Control. Cholesterol Program, the American Heart Association advocates use of guideline-based atherosclerotic cardiovascular disease (ASCVD) Risk Assessment which enables health care providers and patients to estimate 10-year and lifetime risk for ASCVD or denote very high-risk patients for secondary prevention. In this section, we look to understand your organization, its current use of ASCVD Risk Assessment, and ask participating organizations to commit to improving risk-assessment and clinical activation in their patient populations.

The American Heart Association launched a new ASCVD and Heart Failure risk estimation tool in November 2023 to predict a person's long-term risk of cardiovascular disease that includes broader measures of health including social determinants, renal function, and glycemic control and provides sex-specific results. The PREVENT™ calculator aims to help clinicians implement risk assessment for cardiovascular disease and facilitate clinician-patient discussion to optimize prevention for cardiovascular disease, including atherosclerotic cardiovascular disease and heart failure. Clinicians and patients should use this information on risk assessment to personalize prevention efforts in the context of patient preferences for taking medications, potential adverse drug reactions or interactions, and which treatment intervention approach for underlying risk factors may be most successful for a particular patient.

Questions continue on the next page.

7. Does your organization or its individual clinical providers consistently calculate ASCVD Risk (utilizing the Pooled Cohort Equations CV Risk Calculator)?

☐ Yes ☐ No

If yes, where?

☐ My organization currently calculates ASCVD Risk Estimations in our EHR

☐ My organization relies on clinicians to calculate ASCVD Risk Estimation external to our EHR (our EHR does not have this functionality).

8. Does your organization or its individual clinical providers document the ASCVD Risk score (calculated utilizing the Pooled Cohort Equations CV Risk Calculator)?

☐ Yes ☐ No

If yes, where?

☐ My organization currently collects the results of ASCVD Risk Estimations in a discrete field in our EHR.

☐ My organization currently collects the results of ASCVD Risk Estimations in a notes field or other non-discrete field in our EHR (there is not a dedicated space in our EHR to capture this information).

9. The 2018 AHA/ACC Guideline on the Management of Blood Cholesterol defines patients with existing clinical ASCVD as "very high-risk" of a future event if they have a history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions.

Does your organization operationalize a specific treatment plan, such as use of a clinical decision support tool or workflow following the AHA/ACC guideline algorithm, for managing patients considered very high-risk for future ASCVD events?

☐ Yes ☐ No

If yes, does this treatment plan include: (Select all that apply)

☐ Detailed collection of past medical history including major ASCVD Events and High-Risk Conditions as defined in the **2018 AHA/ACC Guideline on the Management of Blood Cholesterol**

☐ Supplying the AHA/ACC guideline algorithm for "**Secondary prevention in patients with clinical ASCVD**" to clinicians

☐ Protocol for follow-up with repeat lipid measurement 4-12 weeks after treatment initiation or referral to a specialist

☐ Educating care teams every 12 months about guideline-based management of very high-risk patients

☐ Using an EHR-based clinical decision support tool for intensifying statins or prescribing ezetimibe or PCSK9 therapy

☐ Standard protocol for clinician-patient shared decision making, including discussion of other possible risk factors, social needs, cost considerations, and lifestyle

10. My organization is committed to continuously improving use and data capture of ASCVD Risk Estimations into our workflows and EHR systems. *A "yes" response is required for award eligibility.*

☐ Yes ☐ No

Questions continue on the next page.

11. The American Heart Association launched a new tool in November 2023 to predict a person's long-term risk of cardiovascular disease. The Predicting Risk of cardiovascular disease EVENTs (PREVENT™) calculator aims to help clinicians implement risk assessment for cardiovascular disease and facilitate clinician-patient discussion to optimize prevention for cardiovascular disease, including ASCVD and heart failure. This tool factors in kidney disease and metabolic disease, including Type 2 diabetes and obesity, as well as indicators of social deprivation.

Please describe your organization's familiarity and use of the PREVENT calculator:

- ☐ My organization currently utilizes the PREVENT calculator and automatically collects the results and calculates the risk scores in a discrete field in our EHR.
- ☐ My organization currently utilizes the PREVENT calculator and requires the clinicians to manually insert data for risk score calculations.
- ☐ Some clinicians in my organization use the PREVENT tool as a standalone tool, but it is not integrated into the EHR.
- ☐ The clinicians at my organization are familiar with the PREVENT calculator but have not yet utilized the tool.
- ☐ My organization is currently unfamiliar with the PREVENT calculator.
- ☐ I am not sure.

Resource: Development and Validation of the American Heart Association's PREVENT Equations

QUALITY IMPROVEMENT ACTIVITIES

The American Heart Association wants to learn more about your efforts to improve quality of health care delivery in your organization during the last year. This information helps us understand trends in health care quality improvement and design programs that meet our participants' needs. Please review the following question and choose any that may apply.

12. Which quality improvement (QI) activities for high cholesterol and/or ASCVD management has your health care organization engaged in during the last year? . *Note: Your response will not affect award status*

- ☐ AHA resources *(Ex. pocket guides or the "Ready. Set. Go. Standardizing Lipid Management: Implementation Guide")*
- ☐ Check. Change. Control. Cholesterol activities with a local AHA representative
- ☐ AHA National QI collaborative *(Ex. ASCVD Initiative)*
- ☐ State or Regional Level Learning Collaboratives
- ☐ Third-party QI consulting services *(Ex. Quality Improvement Organization (QIO)*
- ☐ Internal QI activities *(led by your own organization)*
- ☐ None / I am not sure
- ☐ Other(s) – Include details below (optional):

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Resource: Ready. Set. Go. Standardizing Lipid Management: Implementation Guide

Questions continue on the next page.

MEASURE SUBMISSION – NUMERATOR/DENOMINATOR DATA

MIPS Measure #438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

13. DENOMINATOR: All patients who meet one or more of the criteria below would be considered at high risk for cardiovascular events under the ACC/AHA guidelines. When reporting this measure, determine if the patient meets denominator eligibility in order of each risk category *(i.e. Does the patient meet criteria #1? If not, do they meet criteria #2? If not, do they meet criteria #3?).*

Identify the number of patients in EACH of the below risk groups.

What is the sum of patients in all four risk groups? *Avoid double-counting patients who fall into more than one risk group.* ________________

NOTE:

- **All four risk groups must be factored into the final denominator.** Please note that an additional risk group has been added in 2024.
- You must use the MIPS #438 measure criteria as specified – using a different measure, using a custom definition of at-risk patients, or pulling in only patients with ASCVD is NOT acceptable for award eligibility.
- Find denominator exclusions and exceptions in the measure description.

1. ALL patients, regardless of age, who were previously diagnosed with or currently have an active diagnosis of clinical ASCVD, including an ASCVD procedure;

-OR-

2. Patients aged 20 to 75 years who have ever had a laboratory result of low-density lipoprotein cholesterol (LDL-C) ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia;

-OR-

3. Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes;

-OR-

4. Patients aged 40 to 75 years at the beginning of the performance period with a 10-year ASCVD risk score of ≥ 20%

13a. Please provide context on why your organization has ≤10 adult patients meeting the denominator criteria and, if applicable, why your overall patient population may be small. Examples may include unique characteristics of your patient demographics or location. *(500-character limit).*

Note: Q13a is a conditional question based on your answer to Q13. You may not be prompted to answer in the data platform, but 13a is REQUIRED if your answer to Q13 is 10 or fewer.

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Questions continue on the next page.

14. NUMERATOR: Using MIPS #438 criteria, of the patients given in Question 13, how many were prescribed or were actively using statins at any point during 2024? ______________

14a. Your performance on the measure is above 90%. Please verify your data, and if accurate, provide details that may be contributing to your above average performance.
(500-character limit).
Note: Q14a is a conditional question based on your answer to Q13. You may not be prompted to answer in the data platform, but 14a is REQUIRED if your control rate (Q14 divided by Q13) is 90% or higher.

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The following section is conditional based upon the answer you provided in question 13.
You may not be prompted to answer them all in the data platform.

15. Was the denominator (question 13) determined based on a subset or sample of patients in your organization? This question is REQUIRED if your denominator is less than 6% of your total adult population (i.e., Question 13 total is <6% of the Question 3 total).

☐ Yes ☐ No

[**Example:** If Question 13 = 50 patients and Question 3 = 1,000 patients, Question 15 is required for award eligibility.]

16. Please describe your sampling method (including initial population sampled, sample size, and selection methods) and reason for sampling. *(500 character limit)*

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17. If "no" on Question 15, the denominator entered in question 13 may be considered low compared to your overall population in question 3. Check that your denominator includes ALL patients in ALL four risk groups, and all other measure logic is appropriately applied. If yes, please describe any unique characteristics of your patients or organization for consideration that might contribute to having a small number of patients at risk for ASCVD. *(500 character limit)*

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Questions continue on the next page.

PAYOR GROUP GUIDANCE

For question 6, all patients ≥18 years of age for the Total Population reported in question 3 should be grouped by their primary health care payor at the time of their last visit.

Medicaid – Report patients ages 18+ covered by state-run Medicaid programs, including those known by state names (e.g. MassHealth). Report patients covered by Medicaid and Medicare (dual eligible) with Medicare as a primary insurer.

Medicare – Report patients ages 18+ covered by federal Medicare programs. Report patients covered by Medicaid and Medicare (dual eligible) with Medicare as a primary insurer.

Private Insurance – Report patients ages 18+ covered by commercial or private insurers. This includes employer-based insurance and insurance purchased through federal and state exchanges unless part of state Medicare exchanges.

> ***NOTE:*** *For Federally Qualified Health Centers (FQHCs) reporting to the Uniform Data System (UDS): Insurance purchased for public employees or retirees, such as TRICARE or the Federal Employees Benefits Program, may be grouped with "Private Health Insurance" (as reported in UDS), or as "Other Public".*

Other Public – Report patients ages 18+ covered by programs such as state health plans, Department of Veterans Affairs, Department of Defense, Department of Corrections, Indian Health Services Plans, Title V, Ryan White Act, Migrant Health Program, other public insurance programs, and insurance purchased for public employees or retirees, such as TRICARE.

> ***NOTE:*** *For Federally Qualified Health Centers (FQHCs) reporting to the Uniform Data System (UDS): Insurance purchased for public employees or retirees, such as TRICARE or the Federal Employees Benefits Program, may be grouped with "Private Health Insurance" (as reported in UDS), or as "Other Public".*

Uninsured/Self-Pay - Report patients ages 18+ who did not have medical insurance at the time of their last visit. This may include patients whose visit was paid for by a third-party source that was not an insurance provider.

Other / Unknown - Report patients ages 18+ where the payment source is not documented or unable to be determined, or the payment source does not coincide with one of the above options.

UNIFORM DATA SYSTEM (UDS) ALIGNMENT

For Federally Qualified Health Centers (FQHCs) reporting to the Uniform Data System (UDS):
The table below outlines alignment with the "**Uniform Data System Reporting Instructions for 2024 Health Center Data**" manual for "Table 4: Selected Patient Characteristics."

PROGRAM PAYOR GROUP	UDS TABLE 4 ALIGNED ROWS
Medicare	**Row 9** *(ages 18+)*
Medicaid	**Row 8** *(8a and 8b - ages 18+ only)*
Private Health Insurance	**Row 11** *(ages 18+)*
Other Public	**Row 10** *(10a and 10b - ages 18+ only)*
Uninsured/Self-Pay	**Row 7** *(ages 18+)*
Other / Unknown	--

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