American Heart Association.
Outpace CVD™

2027 DATA COLLECTION WORKSHEET

COMBINED FOR AWARD ACHIEVEMENT IN

American Heart Association.
Check. Change. Control. Cholesterol™

American Heart Association.
Target: BP™

American Heart Association.
Target: Type 2 Diabetes℠

INSTRUCTIONS

Enter your healthcare organization's adult patient data to prepare for the formal data submission process. Beginning in 2027, healthcare organizations that participate in multiple Outpace CVD™ programs (Target: BP™, Check. Change. Control. Cholesterol™ and/or Target: Type 2 Diabetes℠) can submit their data on one form in our data submission platform (https://aha.infosarioregistry.com).

This worksheet provides an overview of all questions asked across programs in the following sections:

- Participant Information
- Outpace CVD Optional Measure Submission
- Target: BP Evidence-Based Activities
- Target: BP Measure Submission
- Check. Change. Control. Cholesterol Clinical Practices
- Check. Change. Control. Cholesterol Measure Submission
- Target: Type 2 Diabetes Evidence-Based Activities
- Target: Type 2 Diabetes Measure Submission
- Target: Type 2 Diabetes Cardiovascular Disease-Related Measures
- Payor Group Guidance

Key Reminders:

- **The deadline to submit 2026 data for 2027 achievement awards is May 21, 2027 at 11:59 p.m. Eastern Time**. Data submission deadlines are firm to ensure fair opportunities for all submitters. Early submission is highly encouraged to ensure the deadline is met.
- **The 2027 recognition cycle is based on the performance period of the 2026 calendar year** (1/1/2026-12/31/2026).
- **All data must be submitted in the data platform, and all fields are required unless stated as optional.** Completing this worksheet does not constitute data submission. For any questions, contact your local American Heart Association staff member or reach out at bit.ly/AQContactUs.

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Outpace CVD™

PARTICIPANT INFORMATION

Q1	**Does your organization diagnose and manage adult patients with chronic disease conditions (hypertension, dyslipidemia and/or diabetes) including prescribing and managing medications?** Only organizations directly diagnosing and managing chronic disease conditions (blood pressure for Target: BP, dyslipidemia for Check. Change. Control. Cholesterol and diabetes for Target: Type 2 Diabetes) are eligible for awards. This must include both diagnosis and prescribing and managing medications. Organizations that screen and refer only are ineligible.	☐ Yes ☐ No
Q2	**I am a designated representative of my organization and certify that the following attestations are accurate to the best of my knowledge.** A "yes" response is required for award eligibility.	☐ Yes ☐ No
Q3	**What is the total number of adult patients (≥18 years of age) for the healthcare organization, regardless of diagnosis? Patients must have had at least one 2026 visit (in-office or telehealth encounter). Exclude acute care visits.** This answer should represent all adult patients that could be considered for management of hypertension, dyslipidemia and/or diabetes during their visit. You will be asked to break down this total by primary payor and race/ethnicity in subsequent questions.	_____
Q4	**How many clinicians are in the healthcare organization?** Include all physicians, nurse practitioners and physician assistants.	_____

Q5 **How many people in 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 2026 Health Center Data)?**

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 is known [Any], but unknown if Hispanic, Latino/a or Spanish Origin)		
Race Unknown/Ethnicity either Unknown, Undisclosed or not Hispanic, Latino/a or Spanish Origin (Race is unknown and ethnicity is unknown or not Hispanic, Latino/a or Spanish Origin)		
Subtotals		
Total Patients		

NOTES: Patient population totals will auto-populate in the data submission platform. Your sum must equal your Q3 response.

Questions continue on next page.

Q6	**How many people in your total adult patient population (≥18 years of age) are primarily attributed to the following payor groups?** Sum must equal total patient count in question 3. See additional guidance in the Payor Group Guidance section. • Medicare: • Medicaid: • Private Health Insurance: • Other Public: • Uninsured/Self-Pay: • Other/Unknown:

OUTPACE CVD™ | OPTIONAL MEASURE SUBMISSION

Help shape the future of cardiovascular quality measurement! As Outpace CVD™ continues to align with the latest clinical guidelines, this submission provides an opportunity for your organization to contribute data that will inform the next generation of program measures and reporting strategies. Your participation will help the American Heart Association better understand current data capabilities, identify trends across organizations and guide future enhancements to the program. Organizations that complete questions OP 1 – OP 3 will be recognized for their leadership and commitment to advancing cardiovascular health.

OP 1	**Does your organization currently pull from the American Heart Association's Optimally Managed Blood Pressure (<130/80 mmHg) (OMBP) measure (or a similar measure with BP controlled at <130/80 mmHg)?** Please describe your organization's current ability to pull and use of this measure.	☐ Yes, we can pull these criteria and currently practice/report on this measure (or a similar measure with BP controlled at <130/80 mmHg). ☐ Yes, we can pull these criteria but do not currently practice/report on this measure (or a similar measure with BP controlled at <130/80 mmHg). ☐ No, we cannot pull these criteria but intend to add the capability in the next 12 months. ☐ No, we cannot currently pull these criteria; we have no plans to add them. ☐ I am not sure.
OP 2	**DENOMINATOR: Using the Heart Association's OMBP measure, how many adult patients (18-85 years of age) at the start of the measurement period with a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period who had at least 1 visit at the clinical unit during the measurement period.** Include patients with an essential hypertension diagnosis present sometime between 1/1/2025– 6/30/2026 with at least one visit in 2026. Exclude patients meeting the Denominator Exclusions criteria in the OMBP specifications.	_____
OP 3	**NUMERATOR: Of the patients in OP 2, what is the number of patients whose blood pressure measurement at the most recent visit was optimally controlled (<130/80 mmHg)?** If a patient has multiple blood pressure readings from their office visit, use the lowest systolic and lowest diastolic blood pressure on that visit as the representative BP.	_____

American Heart Association.
Target: BP™

TARGET: BP™ | EVIDENCE-BASED ACTIVITIES

ALL of the practice attestation questions below must be answered (by selecting Yes, No, or Unsure) to complete your data submission and to be eligible for any Target: BP achievement award. Eligibility for Silver, Silver+ and Gold+ is tied to your responses in all these pillars (Measure Accurately, Act Rapidly, Partner with Patients, Self-Measured Blood Pressure and Equitable Health Outcomes). For clarification on what "counts" and resources to achieve each pillar, please see our **Evidence-Based Activities Resources & Examples Toolkit**.

An individual familiar with blood pressure devices, staff training and the clinical policies and practices within your organization should answer or be consulted on these questions. Responses should be based on activities completed between January 1 - December 31, 2026. **Learn more and access additional resources**.

Measure Accurately Pillar (BP 1a – BP 6)

The Measure Accurately pillar will determine eligibility for the Silver, Silver+ and Gold+ achievement awards. Each unique attestation question equals 1 activity of 6 within each pillar. Questions BP 1a and BP 1b count together as 1 activity.

I attest that my organization:

BP 1a	**Calibrates ALL aneroid devices per the 2019 American Heart Association Scientific Statement: Measurement of BP in Humans** Every 2–4 weeks for handheld devices and every 6 months for wall-mounted devices in 2026.	☐ **Yes** ☐ **No** ☐ **No aneroid devices** ☐ **Unsure**	
BP 1b	**Calibrates ALL oscillometric devices per the 2019 American Heart Association Scientific Statement: Measurement of BP in Humans** Nearly all manufacturers recommend that oscillometric devices, including Ambulatory Blood Pressure Monitors, be calibrated at regular intervals, e.g., every 1 or 2 years.	☐ **Yes** ☐ **No** ☐ **No oscillometric devices** ☐ **Unsure**	
BP 2	**Please review the devices listed on ValidateBP.org or similar international sources. Report the percentage of your organization's oscillometric devices (semi- or fully-automated) that are validated for clinical accuracy. Approximate percentages are acceptable.** Validated devices are those listed on the US Blood Pressure Validated Device Listing (VDL™) on ValidateBP.org or similar sources. SELECT ONE OPTION. If you have no oscillometric devices, select 0%. *Any percentage range selected (from 0% to 91-100%) = completion of 1 activity for Silver/Silver+/Gold+ eligibility. An "Unsure" answer does not equate to completion of 1 activity for Silver/Silver+/Gold+ eligibility.*	☐ **Unsure** ☐ **0%** ☐ **1-10%** ☐ **11-20%** ☐ **21-30%** ☐ **31-40%**	☐ **41-50%** ☐ **51-60%** ☐ **61-70%** ☐ **71-80%** ☐ **81-90%** ☐ **91-100%**
BP 3	**Strengthens BP measurement knowledge every 6-12 months for all staff who measure blood pressure or train staff to measure blood pressure (using CME/CE Course: Measuring Blood Pressure Accurately - Step 1 in Hypertension Control (free webinar), or another structured curriculum).** Training can be delivered through any format, but curriculum must be 30+ minutes, completion must be systematically tracked and at least one training must have been completed in 2026.	☐ **Yes** ☐ **No** ☐ **Unsure**	

Questions continue on next page.

BP 4	**Tests staff's BP measurement skills every 6-12 months (using the BP Measurement Skills Assessment or similar objective assessment).** At least one check must have been completed in 2026.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 5	**Uses a blood pressure measurement protocol to consistently obtain accurate BP measurements, including confirmatory repeat in-office BP measurements – or – ambulatory blood pressure monitoring – or – home blood pressure monitoring with self-measured blood pressure when indicated.** A protocol must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 6	**Posts a positioning graphic, such as the In-Office Measuring Blood Pressure Infographic, next to every place where blood pressures are taken.** BP measurement graphic must already have been displayed in 2026 **or** be newly posted adjacent to every BP measurement device in 2026.	☐ **Yes** ☐ **No** ☐ **Unsure**

Act Rapidly Pillar (BP 7 – BP 12)

The Act Rapidly pillar will help determine eligibility for the Silver+ and Gold+ achievement awards. Each unique attestation question number equals 1 activity of 6 within each pillar for award purposes.

I attest that my organization uses a practice-wide* hypertension protocol that includes (at a minimum):

BP 7	**Formal approval and systematic implementation into clinical practice.** A protocol must already be in use in 2026 **or** be newly defined and implemented in 2026. "Systematic implementation" could be through integration into the EMR, a paper-based record or tool or other means that provide consistent access to the standard of care for every patient.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 8	**Monitoring to assess the use of the protocol in practice.** "Monitoring" can be achieved through means such as but not limited to manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a minimum level of adherence to the policy/protocol.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 9	**A blood pressure control treatment goal of <130/80 mmHg.** For all adults with additional considerations for those who are pregnant, require institutional/hospital care or have limited life expectancy. **Note:** Stating this individual patient treatment goal of <130/80 mm Hg in a protocol is different from the overall patient population performance measure of <140/90 mm Hg used in BP 32.	☐ **Yes** ☐ **No** ☐ **Unsure**

Questions continue on next page.

BP 10	**Prompts for clinicians/prescribers to intensify treatment with additional medication classes or increased doses for patients who have uncontrolled hypertension.**	☐ Yes ☐ No ☐ Unsure
BP 11	**Strategies designed to improve patient adherence such as once-daily dosing and single-pill combinations when appropriate.**	☐ Yes ☐ No ☐ Unsure
BP 12	**Follow-up contact within a 1-month period for patients with Stage 1-2 hypertension who have not yet reached their hypertension goal.**	☐ Yes ☐ No ☐ Unsure

**** The intent of "practice-wide" protocol means that the protocol (or algorithm) has been formally adopted, is systematically available across care settings where the patient population being reported in your control rate is receiving care, which could be, for example, an individual clinic site or an entire health system.***

Partner with Patients Pillar (BP 13 – BP 17)

The Partner with Patients pillar will help determine eligibility for the Silver+ and Gold+ achievement awards. Each unique question number equals 1 activity for award purposes.

I attest that my organization provides systematic* risk-factor assessment and non-pharmacological interventions for patients with hypertension to support positive lifestyle changes that includes a systematic:

BP 13	**Standard process for the assessment of risk-factors and use of non-pharmacological interventions.** A protocol must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ Yes ☐ No ☐ Unsure
BP 14	**Monitoring to assess the use of the policy in practice.** "Monitoring" can be achieved through means such as, but not limited to, manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a minimum level of adherence to the policy/protocol.	☐ Yes ☐ No ☐ Unsure
BP 15	**Assessment of nutrition (including sodium and potassium intake), physical activity, weight and body mass index or other indicators of obesity.**	☐ Yes ☐ No ☐ Unsure
BP 16	**Intervention to improve nutrition, reduce sodium intake, increase dietary potassium intake (except in the presence of CKD or use of drugs that reduce potassium excretion where monitoring of serum potassium levels is indicated), increase physical activity and reduce weight as medically indicated.** "Intervention" includes, but is not limited to, education, counseling and/or referral such as educational hand-outs, consultation with a Registered Dietitian, participation in an exercise or cooking class or use of physical activity and nutrition prescriptions.	☐ Yes ☐ No ☐ Unsure

Questions continue on next page.

BP 17	**Assessment of stress, alcohol consumption and tobacco use.**	☐ Yes ☐ No ☐ Unsure
BP 18	**Intervention to address alcohol moderation/cessation and tobacco cessation.** "Intervention" includes, but is not limited to, education, counseling/or referral such as educational hand-outs or referral to smoking cessation or substance use disorder counseling.	☐ Yes ☐ No ☐ Unsure

**** Systematic implementation" could be through integration into the EMR, a paper-based record or tool, or other means that provide consistent access to the standard of care for every patient.***

Self-Measured Blood Pressure (SMBP) Pillar (BP 19 – BP 24)

The Self-Measured Blood Pressure (SMBP) pillar will help determine eligibility for the Silver+ and Gold+ achievement awards. Each unique attestation question number equals 1 activity of 6 within each pillar for award purposes.

I attest that my organization utilizes self-measured blood pressure to confirm a diagnosis, guide treatment intensification or support longer-term lifestyle change and/or medication adherence for hypertension. Our self-measured blood pressure program includes (at a minimum), systematic:

BP 19	**Standard process defining the steps to prepare patients for SMBP monitoring.** A protocol must already be in use in 2026 or be newly defined and implemented in 2026.	☐ Yes ☐ No ☐ Unsure
BP 20	**Monitoring to assess the use of the policy in practice.** "Monitoring" can be achieved through means such as, but not limited to, manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a minimum level of adherence to the policy/protocol.	☐ Yes ☐ No ☐ Unsure
BP 21	**Assessment to ensure the appropriate BP cuff size for the patient and education to prepare patients to use SMBP including, at a minimum, measurement training to properly position and use the device.**	☐ Yes ☐ No ☐ Unsure
BP 22	**Approach to establishing a measurement schedule, ideally two times in the morning and two times in the evening for 3-7 consecutive days.**	☐ Yes ☐ No ☐ Unsure
BP 23	**Receipt of readings from the patient via any means and review and averaging of a minimum number of 12 SMBP readings from a month of home monitoring to inform diagnostic and treatment decisions.** "Means" include, but are not limited to, return of paper recording logs, review of readings stored on the device, use of device app or remote patient monitoring (RPM) platform or direct transmission into the electronic health record (EHR).	☐ Yes ☐ No ☐ Unsure

Questions continue on next page.

BP 24	**A minimum of 30 patients or 10% of our patient population with hypertension per year (whichever is larger) utilize SMBP monitoring as described above.**	☐ **Yes** ☐ **No** ☐ **Unsure**

Equitable Health Outcomes Pillar (BP 25a – BP 30)

The Equitable Health Outcomes pillar will help determine eligibility for the Silver+ and Gold+ achievement awards. Each unique attestation question number equals 1 activity of 6 within each pillar for award purposes. Questions BP 25a and BP 25b count together as 1 activity.

I attest that my organization embraces the collection and use of patient population data to assess for equitable healthcare improvements and outcomes in blood pressure control that includes:

BP 25a	**Adoption of a standard process to systematically gather race and ethnicity (R/E) data** "Standard process" refers to any protocol or practice that is documented or organizationally accepted and is systematically available. A protocol must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 25b	**Adoption of a standard process to systematically assess patient level Social Drivers of Health (SDoH).** "Standard process" refers to any protocol or practice that is documented or organizationally accepted and is systematically available. A protocol must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 26	**Monitoring of team adherence to the standard process.** "Monitoring" can be achieved through means such as, but not limited to, manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a minimum level of adherence to the policy/protocol.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 27	**Training our care team on techniques to gather data per the standard process.** In order to select "Yes": • You must have selected "Yes" for BP 25a (R/E standard process) and/or BP 25b (SDoH standard process). • A training must be mandatory for whichever data collection standard processes are in place (R/E and/or SDoH). • The frequency of training should be specified in your standard processes. A minimum training is not required, it could be quarterly, annually, biannually, etc.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 28	**Training the care team on impacts of SDoH and the resources available to address identified SDoH when appropriate.** The frequency of training should be specified in your standard processes, but a minimum training amount is not required. It could be quarterly, annually, biannually, etc.	☐ **Yes** ☐ **No** ☐ **Unsure**

Questions continue on next page.

BP 29	**Stratification of control rate data at least annually by 2 sub-groups at risk for inequitable health outcomes such as patients from racial or ethnic groups, without insurance, by zip code and/or by SDoH elements.** "Stratification" includes, but is not limited to, examining control rates by age, sex, gender identity, race, ethnicity, primary language, insurance status, zip code, or housing status.	☐ **Yes** ☐ **No** ☐ **Unsure**
BP 30	**Examining stratified data and taking action to address gaps and outcomes across groups.** A minimum level of performance or improvement is not specified.	☐ **Yes** ☐ **No** ☐ **Unsure**

TARGET: BP™ | MEASURE SUBMISSION

To be eligible to receive a Target: BP achievement award, organizations are required to enter their denominator and numerator data values for CMS MIPS Measure 236: Controlling High Blood Pressure in questions BP 31 and BP 32, and BP 31a and/or BP 32a if prompted.

BP 31	**DENOMINATOR: Using MIPS #236 criteria, what is the number of patients 18-85 years of age who had a 2026 visit (in-office or qualifying telehealth encounter) and a diagnosis of essential hypertension starting before and continuing into, or starting during, the first six months of the measurement period (measurement period = January 1 – December 31, 2026)?** Include patients with an essential hypertension diagnosis present sometime between 1/1/2025–6/30/2026 with at least one visit in 2026. Exclude patients meeting the Denominator Exclusions criteria in the MIPS #236 specifications such as pregnancy or hospice. **NOTE:** These data are based on MIPS #236, eCQM CMS#165v14, PQRS #236 or ACO #28, Controlling High Blood Pressure.	_____
BP 31a	**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**: BP 31a is a conditional question based on your answer to BP 31. You may not be prompted to answer in the data platform, but it is REQUIRED if your answer to BP 31 is 10 or fewer. _____ _____	

Questions continue on next page.

BP 32	**<u>NUMERATOR:</u> Using MIPS #236 criteria, of the patients qualifying for the denominator (BP 31), what is the number of patients whose BP from their most recent 2026 visit is adequately controlled (systolic BP <140 mmHg and diastolic BP <90 mmHg)?** If a patient has multiple blood pressure readings from their office visit, use the lowest systolic and lowest diastolic blood pressure on that visit as the representative BP. **NOTE:** Readings from a patient's remote BP monitoring device are acceptable, following the guidance outlined in MIPS #236.	_____
BP 32a	**Your control rate on the measure is above 90% control. Please verify your data if accurate, provide details that may be contributing to your above average performance.** **NOTE:** BP 32a is a conditional question based on your answer to BP 32. You may not be prompted to answer in the data platform, but it is REQUIRED if your control rate (BP 32 divided by BP 31) is 90% or higher. _____ _____	
BP 33	**Did your numerator data include digitally transmitted blood pressure readings from a patient's remote monitoring device?**	☐ **Yes** ☐ **No** ☐ **Unsure**

NOTE: If you are also submitting data for Target: Type 2 Diabetes, data from BP 31 and BP 32 will automatically populate in question T2D 30 and T2D 31.

CHECK. CHANGE. CONTROL. CHOLESTEROL™ | CLINICAL PRACTICES

As part of the Check. Change. Control. Cholesterol program, the American Heart Association advocates use of guideline-based atherosclerotic cardiovascular disease (ASCVD) Risk Assessment. 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.

CH 1	**Which of the following describes your organization's use of ASCVD Risk Calculators (utilizing either the Pooled Cohort Equations CV Risk Calculator or the PREVENT™ Calculator) as part of standard process?** Select all that apply but note that conflicting answers cannot be selected. ☐ 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). ☐ 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). ☐ Clinicians at my organization discuss ASCVD Risk Estimation results with patients. ☐ None of the above. ☐ I am not sure.

Questions continue on next page.

CH 2	**The 2026 ACC/AHA Guideline on the Management of Dyslipidemia defines patients with existing clinical ASCVD as being at "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 features despite maximally tolerated statin plus ezetimibe. Does your organization operationalize a specific treatment plan, such as use of a clinical decision support tool or workflow following the ACC/AHA guideline for managing patients considered very high-risk for future ASCVD events?**	☐ **Yes** ☐ **No**

CH 2a

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 2026 ACC/AHA Guideline on the Management of Blood Cholesterol
- ☐ Protocol for follow-up with repeat lipid measurement 4-12 weeks after treatment initiation or dose adjustment and every 6-12 months thereafter or referral to a specialist
- ☐ Using an EHR-based clinical decision support tool for intensifying statins or prescribing ezetimibe or PCSK9 therapy
- ☐ Supplying the ACC/AHA guideline algorithm for "Secondary ASCVD Prevention for Adults at Very High Risk" to clinicians
- ☐ Educating care teams every 12 months about guideline-based management of very high-risk patients
- ☐ Standard protocol for clinician-patient shared decision making, including discussion of other possible risk factors, social needs, cost considerations and lifestyle
- ☐ None of the above

CH 3	**My organization is committed to continuously improving use and data capture of ASCVD Risk Estimations into our workflows and EHR systems.**	☐ **Yes** ☐ **No**

The following are selections from the "Top Things to Know" from the 2026 ACC/AHA Guideline on the Management of Dyslipidemia. For each item, please select the option that best describes your organization's current practices.

CH 4

The American Heart Association launched a tool 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. Is your organization currently utilizing the PREVENT™ calculator?

- ☐ Yes, all clinicians at my organization are utilizing the PREVENT calculator.
- ☐ Some clinicians at my organization are utilizing the PREVENT calculator.
- ☐ No clinicians at my organization are utilizing the PREVENT calculator.
- ☐ I am not sure.

Questions continue on next page.

CH 4a	**If you selected that any clinicians are using the PREVENT™ calculator, how are the results being calculated and captured?** ☐ Our EHR automatically calculates the PREVENT™ risk score and captures results in a discrete field. ☐ Clinicians manually activate the PREVENT™ calculator within our EHR and capture the results in a discrete field. ☐ Clinicians utilize the PREVENT™ calculator as a standalone tool, but it is not integrated into the EHR.

The following are selections from the "Top Things to Know" from the 2026 ACC/AHA Guideline on the Management of Dyslipidemia. For each item, please select the option that best describes your organization's current practices.

CH 5a	**Measuring LP(a) at least once for all adults to identify those individuals at higher risk of ASCVD. (COR 1)** ☐ Implementation completed ☐ Implementation in progress ☐ Implementation to start in the next 12 months ☐ No plan for implementation ☐ Unsure
CH 5b	**Utilizing ApoB testing to guide decision-making for lipid-lowering therapy in adults once LDL-C and non–HDL-C goals are met. (COR 2a)** ☐ Implementation completed ☐ Implementation in progress ☐ Implementation to start in the next 12 months ☐ No plan for implementation ☐ Unsure
CH 5c	**Utilizing CAC scoring (in men ≥40 yrs, women ≥45 yrs) to improve risk assessment and guide LDL-C and non-HDL-C. [1]** ☐ Implementation completed ☐ Implementation in progress ☐ Implementation to start in the next 12 months ☐ No plan for implementation ☐ Unsure

Questions continue on next page.

CH 5d	**In secondary prevention, utilizing a goal of LDL-C <55 mg/dL (1.4 mmol/L) and non–HDL-C <85 mg/dL (2.2 mmol/L) for those at very high risk of ASCVD events.[2]** ☐ Implementation completed ☐ Implementation in progress ☐ Implementation to start in the next 12 months ☐ No plan for implementation ☐ Unsure

[1.] Utilizing coronary artery calcium (CAC) scoring in adults at intermediate risk and select adults at borderline risk with no prior ASCVD (men ≥40 yrs, women ≥45 yrs) to enhance risk stratification and guide decisions on lipid-lowering therapy (COR 1). 4d. Utilizing coronary artery calcium (CAC) scoring in adults at intermediate or high risk with no prior ASCVD (men ≥40 yrs, women ≥45 yrs) to refine treatment goals and decide whether to intensify lipid-lowering therapy (COR 2a).

[2.] See Figure 1. Lipoprotein Goals for ASCVD Risk Reduction in the Guideline for additional guidance.

CHECK. CHANGE. CONTROL. CHOLESTEROL™ | MEASURE SUBMISSION

To be eligible to receive a Check. Change. Control. Cholesterol™ achievement award, organizations are required to enter their denominator and numerator data values for CMS MIPS Measure 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease in questions CH 6 and CH 7. If prompted, CH 6a, CH 7a, CH 8 and CH 9 or CH 10 must be completed.

DENOMINATOR:
All patients who meet one or more of the criteria below would be considered at high risk for cardiovascular events. 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? If not, do they meet criteria #4?) Avoid double-counting patients who fall into more than one risk category.

CH 6	**Identify the number of patients in EACH of the below risk groups. What is the sum of patients in all four risk groups?**	_____

NOTE:

- **All four risk groups must be factored into the final denominator.**
- You must use the MIPS #438 measure (or the equivalent eCQM CMS347v9) 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.

Risk Groups:

1. All patients who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure; **or**

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

3. Patients aged 40 to 75 years at the beginning of the performance 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 percent

Questions continue on next page.

CH 6a	**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:** CH 6a is a conditional question based on your answer to CH 6. You may not be prompted to answer in the data platform, but it is REQUIRED if your answer to CH 6 is 10 or fewer. _____ _____	
CH 7	**NUMERATOR: Using MIPS #438 criteria, of the patients given in Question CH 6, how many were prescribed or were actively using statins at any point during 2026?**	_____
CH 7a	**Your control rate on the measure is above 90% control. Please verify your data, and if accurate, provide details that may be contributing to your above average performance.** **NOTE:** CH 7a is a conditional question based on your answer to CH 7. You may not be prompted to answer in the data platform, but it is REQUIRED if your control rate (CH 7 divided by CH 6) is 90% or higher. _____ _____	

NOTE: If you are also submitting data for Target: Type 2 Diabetes, data from CH 6 and CH 7 will automatically populate in questions T2D 28 and T2D 29.

The following section is conditional based on your provided answer to question 6.

CH 8	**Was the denominator (CH 6) determined based on a subset or sample of patients in your organization?** This is REQUIRED if your denominator is less than 6% of your total population (i.e., Question 6 total is <6% of the Question 3 total). **Ex:** If Question 6 = 50 patients and Question 3 = 1,000 patients, Question 8 is required for award eligibility. ☐ Yes. Record sampling, or a specific subset of patients, was used to determine measure compliance. ☐ No. The denominator includes all patients in our total patient population who meet the MIPS #438 measure criteria as specified for CMS use.
CH 9	**If "Yes" on CH 8, please describe your sampling method (including initial population sampled, sample size and selection methods) and reason for sampling. (500 character limit)** _____ _____
CH 10	**If "No" on CH 8, denominator entered in CH 6 may be considered small compared to your overall population in Q3. Please ensure your denominator includes ALL patients in ALL four risk groups, and all other measure logic is appropriately applied. If the measure has been appropriately applied, 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)** _____ _____

TARGET: TYPE 2 DIABETES℠ | EVIDENCE BASED ACTIVITIES

Target: Type 2 Diabetes℠ aims to support meaningful, evidence-based efforts to reduce cardiovascular disease risk in patients with, or at risk for, Type 2 diabetes. ALL of the practice attestation questions below must be answered (by selecting Yes, No or Unsure) to complete your data submission and to be eligible for any Target: Type 2 Diabetes achievement award. Eligibility for Silver and Gold+ is tied to your responses in all these pillars (Assessment, Treatment, Patient Partnership and Lifestyle Modifications and Equitable Health Outcomes). For clarification on what "counts" and resources to achieve each pillar, please visit our Evidence-Based Activities website and see our Evidence-Based Activities Resources & Examples Toolkit.

T2D 1	**Which of the following guideline-directed treatment and prevention efforts does your organization deploy for patients with prediabetes:** Select all that apply but note that conflicting answers cannot be selected. ☐ Monitoring HbA1c and/or fasting blood sugar for the development of diabetes at least annually or more often if clinically indicated ☐ Prescription of Metformin ☐ Education of lifestyle modifications including healthy eating and physical activity ☐ Referral to diabetes prevention program (DPP) ☐ Promotion of weight loss through lifestyle modification or pharmacotherapy when indicated for those with obesity or overweight ☐ I don't know / I'm not sure

Assessment Pillar (T2D 2 – T2D 7)

The Assessment pillar will determine eligibility for the Silver and Gold+ achievement awards. Each unique attestation question number equals 1 activity of 6 within each pillar. Questions T2D 5a – T2D 5c will together as 1 activity.

I attest that my organization uses a medical standard of care* focused on diabetes management and CVD risk that includes (at a minimum):

T2D 2	**An established diabetes standards of care policy that is documented and available across the continuum of care.**	☐ Yes ☐ No ☐ Unsure
T2D 3	**Monitoring to assess the use of the standard of care in practice.** "Monitoring" can be achieved through means such as but not limited to manual chart review, peer review, sampling or analysis of EMR or population health data, at least annually to assess If the policy/protocol is being followed. This requirement does not specify a level of adherence to the policy/protocol.	☐ Yes ☐ No ☐ Unsure
T2D 4	**Assessment of glycemic control as measured by HbA1c at least 2 times/year or every 3 months for patients not at goal.**	☐ Yes ☐ No ☐ Unsure
T2D 5a	**Assessment of eGFR annually.**	☐ Yes ☐ No ☐ Unsure

Questions continue on next page.

T2D 5b	**Assessment of UACR annually.**	☐ Yes ☐ No ☐ Unsure
T2D 5c	**Use of the KDIGO heat map for kidney health classification based on the results of both eGFR and uACR measurements.**	☐ Yes ☐ No ☐ Unsure
T2D 6	**Assessment of and evaluation of comorbidities into the standard of care.**	☐ Yes ☐ No ☐ Unsure
T2D 6a	**If "Yes" on T2D 6, please select which of the following are included into the standard of care.** Select all that apply. ☐ Chronic Kidney Disease ☐ Hypertension ☐ Dyslipidemia ☐ Atherosclerotic Cardiovascular Disease (ASCVD) ☐ Obesity **NOTE:** All comorbidities must be selected to equal 1 activity.	
T2D 7	**Collaboration through a team-based care model that provides comprehensive continuity of care for patients with diabetes.** "Team-based care model" is inclusive but not limited to internal/ external collaboration for the purposes of promoting continuity of care such as partnership with community pharmacies, diabetes educators, specialist referrals, community health workers, etc.	☐ Yes ☐ No ☐ Unsure

"Standard of care" is inclusive of any policy, protocol or formally adopted process that is routinely and systematically used across the entire organization as part of standard practice.

Treatment Pillar (T2D 8 – T2D 13)

The Treatment pillar will help determine eligibility for the Silver and Gold+ achievement awards. Each unique attestation question number equals 1 activity of 6 within each pillar for award purposes.

I attest that my organization uses a guideline-directed standard of care to treat patients with diabetes that includes:

T2D 8	**Standardized use of a treatment algorithm or protocol.** Standardized use" refers to any protocol that is documented or organizationally accepted and is systematically available. An algorithm or protocol must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ Yes ☐ No ☐ Unsure

Questions continue on next page.

T2D 9	**Monitoring to assess the use of the protocol in practice.** "Monitoring" can be achieved through means such as but not limited to manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a minimum level of adherence to the policy/protocol.	☐ Yes ☐ No ☐ Unsure
T2D 10	**Setting a treatment goal of HbA1c < 7% when clinically indicated.** Less stringent glycemic goals may be appropriate for individuals with limited life expectancy or where the harms of treatment are greater than the benefits.	☐ Yes ☐ No ☐ Unsure
T2D 11	**Prioritizing SGLT2i and GLP1 RA's in the treatment algorithm or protocol when clinically indicated.**	☐ Yes ☐ No ☐ Unsure
T2D 12	**Setting a cholesterol treatment goal of LDL-C < 70 mg/dL for patients with ASCVD risk factors.**	☐ Yes ☐ No ☐ Unsure
T2D 13	**Setting a blood treatment goal of < 130/80 mmHg for patients with hypertension.** For all adults with confirmed hypertension with additional considerations for those who are pregnant, require institutional/hospital care or have limited life expectancy.	☐ Yes ☐ No ☐ Unsure

Patient Partnership & Lifestyle Modifications Pillar (T2D 14 – T2D 19)

The Patient Partnership & Lifestyle Modifications pillar will help determine eligibility for the Silver and Gold+ achievement awards. Each unique question number equals 1 activity for award purposes.

I attest that my organization provides systematic risk-factor assessment and non-pharmacological interventions for patients with hypertension to support positive lifestyle changes that include:

T2D 14	**A standard of care for the assessment of risk-factors and use of non-pharmacological interventions.** Standard of care" is inclusive of any policy, protocol or formally adopted process that is routinely and systematically used across the entire organization as part of standard practice. This must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ Yes ☐ No ☐ Unsure
T2D 15	**Monitoring to assess the use of the standard of care in practice.** "Monitoring" can be achieved through means such as, but not limited to, manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a minimum level of adherence to the policy/protocol.	☐ Yes ☐ No ☐ Unsure

Questions continue on next page.

T2D 16	**Provides access to Diabetes Self-Management Education and Support (DSMES) or equivalent services.** Minimum requirements of DSMES or equivalent services include delivery of content addressing 1. Pathophysiology of diabetes and treatment options, 2. Healthy coping, 3. Healthy eating, 4. Being active, 5. Taking medication, 6. Monitoring of blood sugars, 7. Reducing risk (treating acute and chronic complications), 8. Problem solving & behavior change strategies	☐ Yes ☐ No ☐ Unsure
T2D 17	**Provides access to obesity counselling and weight management.**	☐ Yes ☐ No ☐ Unsure
T2D 18	**A discussion of ASCVD Risk Estimation results derived from CVD risk assessment models including but not limited to the Pooled Cohort Equation (PCE) or Predicting Risk of cardiovascular disease EVENTs (PREVENT).**	☐ Yes ☐ No ☐ Unsure
T2D 19	**Engaging patients in interventions to address tobacco/vaping cessation, alcohol moderation/cessation and depression as indicated by validated screening tools.**	☐ Yes ☐ No ☐ Unsure

Equitable Health Outcomes Pillar (T2D 20a - T2D 25)

The Equitable Health Outcomes pillar will help determine eligibility for the Silver and Gold+ achievement awards. Each unique attestation question number equals 1 activity of 6 within each pillar for award purposes. Questions T2D 20a and T2D 20b count together as 1 activity.

I attest that my organization embraces the collection and use of patient population data to assess for equitable healthcare improvements and outcomes in blood pressure control that includes:

T2D 20a	**Adoption of a standard process to systematically gather race and ethnicity (R/E) data.** "Standard process" refers to any protocol or practice that is documented or organizationally accepted and is systematically available. A protocol must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ Yes ☐ No ☐ Unsure
T2D 20b	**Adoption of a standard process to systematically assess patient level Social Drivers of Health (SDoH).** "Standard process" refers to any protocol or practice that is documented or organizationally accepted and is systematically available. A protocol must already be in use in 2026 **or** be newly defined and implemented in 2026.	☐ Yes ☐ No ☐ Unsure
T2D 21	**Monitoring of team adherence to the standard process.** "Monitoring" can be achieved through means such as, but not limited to, manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a minimum level of adherence to the policy/protocol.	☐ Yes ☐ No ☐ Unsure

Questions continue on next page.

T2D 22	**Training our care team on techniques to gather data per the standard process** In order to select "Yes": • You must have selected "Yes" for T2D 20a (R/E standard process) and/or T2D 20b (SDoH standard process). • A training must be mandatory for whichever data collection standard processes are in place (R/E and/or SDoH). • The frequency of training should be specified in your standard processes. • A minimum training is not required, it could be quarterly, annually, biannually, etc.	☐ **Yes** ☐ **No** ☐ **Unsure**
T2D 23	**Training the care team on impacts of SDoH and the resources available to address identified SDoH when appropriate.** The frequency of training should be specified in your standard processes, but a minimum training is not required, it could be quarterly, annually, biannually, etc.	☐ **Yes** ☐ **No** ☐ **Unsure**
T2D 24	**Stratification of HbA1c data at least annually by 2 sub-groups at risk for inequitable health outcomes such as patients from racial or ethnic groups, without insurance, by zip code and/or by SDoH elements.** "Stratification" includes, but is not limited to, examining control rates by age, sex, gender identity, race, ethnicity, primary language, insurance status, zip code or housing status.	☐ **Yes** ☐ **No** ☐ **Unsure**
T2D 25	**Examining stratified data and taking action to address gaps and outcomes across groups.** A minimum level of performance or improvement is not specified.	☐ **Yes** ☐ **No** ☐ **Unsure**

TARGET: TYPE 2 DIABETES℠ | MEASURE SUBMISSION

To be eligible to receive a Target: Type 2 Diabetes℠ achievement award, organizations are required to enter their denominator and numerator data values for CMS MIPS Measure #001: Glycemic Status Assessment Greater Than 9% (questions T2D 26 and T2D 27 and T2D 26a if prompted) and either Cardiovascular Disease Related Measure option 1 (CMS MIPS #438) or option 2 (CMS MIPS #236).

T2D 26	**DENOMINATOR: Using MIPS #001 criteria, what is the number of adult patients (18-75 years of age) with diabetes who had a visit during 2026 and who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) >9.0% during the measurement period?** Include patients with an essential Exclude patients meeting the Denominator Exclusions criteria in the MIPS #001 specifications such as pregnancy or hospice. **NOTE:** These data are based on MIPS #001, or equivalent measures eCQM ID: CMS122v14 and NQF 0059.	_____

Questions continue on next page.

T2D 26a	**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:** T2D 26a is a conditional question based on your answer to T2D 26. You may not be prompted to answer in the data platform, but it is REQUIRED if your answer to T2D 26 is 10 or fewer. _____ _____	
T2D 27	**NUMERATOR: Using MIPS #001 criteria, of the patients with diabetes and a 2026 visit (from T2D 26), what is the number of patients whose most recent glycemic status assessment (HbA1c or GMI) level performed during 2026 is > 9.0% or who had no HbA1c level performed in 2026?**	_____

CARDIOVASCULAR DISEASE-RELATED MEASURES

Must complete at least 1 option to be eligible for recognition.

Option 1: CMS MIPS Measure 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

T2D 28	**DENOMINATOR:** All patients who meet one or more of the criteria below would be considered at high risk for cardiovascular events. 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? If not, do they meet criteria #4?) **Identify the number of patients in EACH of the below risk groups. What is the sum of patients in all four risk groups?**	_____

NOTE:
- All four risk groups must be factored into the final denominator.
- You must use the MIPS #438 measure (or the equivalent eCQM CMS347v9) 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.
- Avoid double-counting patients who fall into more than one risk category.
- Find denominator exclusions and exceptions in the measure description.

Risk Groups:

1. All patients who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure; **or**
2. Patients aged 20 to 75 years at the beginning of the performance period 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 performance 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 percent.

T2D 29	**NUMERATOR: Using MIPS #438 criteria, of the patients given in Question T2D 28, how many were prescribed or were actively using statins at any point during 2026?**	_____

NOTE: If you are also submitting data for Check. Change. Control. Cholesterol, data from CH 6 and CH 7 will automatically populate in questions T2D 28 and T2D 29.

Questions continue on next page.

Option 2: CMS MIPS Measure 236: Controlling High Blood Pressure

T2D 30	**DENOMINATOR: Using MIPS #236 criteria, what is the number of patients 18-85 years of age who had a 2026 visit (in-office or qualifying telehealth encounter) and a diagnosis of essential hypertension starting before and continuing into, or starting during, the first six months of the measurement period (measurement period = January 1 – December 31, 2026)?** Include patients with an essential hypertension diagnosis present sometime between 1/1/2025– 6/30/2026 with at least one visit in 2026. Exclude patients meeting the Denominator Exclusions criteria in the MIPS #236 specifications such as pregnancy or hospice. **NOTE:** These data are based on MIPS #236, eCQM CMS#165v14, PQRS #236 or ACO #28, Controlling High Blood Pressure.	_____
T2D 31	**NUMERATOR: Using MIPS #236 criteria, of the patients qualifying for the denominator (T2D 30), what is the number of patients whose BP from their most recent 2026 visit is adequately controlled (systolic BP <140 mmHg and diastolic BP <90 mmHg)?** If a patient has multiple blood pressure readings from their office visit, use the lowest systolic and lowest diastolic blood pressure on that visit as the representative BP. Readings from a patient's remote BP monitoring device are acceptable, following the guidance outlined in MIPS #236.	_____

NOTE: If you are also submitting data for Target: BP, data from BP 31 and BP 32 will automatically populate in questions T2D 30 and T2D 31.

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 healthcare 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 2026 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	- -

For additional resources to support you for the 2027 Outpace CVD™ Data Submission cycle, please visit **heart.org/OutpaceCVDPlatform**.

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