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eCW Clinical Documentation Guide

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0108-1: Behavioral Measure]* MIPS Clinical Quality Measure *[CMS 136 (EHR): Process Measure]*
Measure Definition	***The percentage of patients, 6-12 years old and newly dispensed a medication for Attention-DeficitHyperactivity Disorder (ADHD), who had one follow-up visit with a practioner with prescribing authority during the 30-day Initiation Phase in the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Intake Period	The **Intake Period** is defined as the 12-month window beginning March 1 of the year prior to the Measurement Period and ending February 28 of the Measurement Period
Index Prescription Start Date	**Index Prescription Start Date (IPSD)** is defined as the earliest dispensing date, for an ADHD medication, that falls within the Intake Period and for which there is a Negative Medication History
Negative Medication History	**Negative Medication History** is defined as a period of 4 months (120 days), prior to the IPSD, when the patient had no ADHD medications dispensed for either new or refill prescriptions
Initiation Phase	The **Initiation Phase** is defined as the 30 days following the IPSD
Denominator	The **Denominator** consists of patients who: I. Are ≥ 6 and < 12 years of age at the beginning of the Measurement Period II. **AND**, Had their first prescription for an ADHD medication issued ≤ 90 days prior to, or ≤ 60 days after, the start of the Measurement Period III. **AND**, Were seen for an applicable E&M encounter during the Measurement Period

	(continued)
Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Numerator	The **Numerator** consists of patients, from the Denominator, who were seen for an applicable visit encounter ≤ 30 days after the ADHD medication, from the Denominator, was prescribed
Exclusions and/or Exceptions	Patients are **excluded** from this measure for one of the following reasons: I. They have an active diagnosis for Narcolepsy during the Measurement Period II. **OR**, They had an inpatient encounter within the Initiation Phase A. **AND**, They had an active diagnosis for a mental health disorder at the time of the inpatient encounter B. **OR**, They had an active, and primary, diagnosis of substance abuse at the time of the inpatient encounter
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient was issued a new prescription for an ADHD medication (within 90 days prior to the beginning of the Measurement Period through 60 days after the beginning of the Measurement Period)** **A. The following (generic) medications are considered ADHD medications** (see Table ADD-A_2017 @www.ncqa.com) 1. Amphetamine-Dextroamphetamine 2. Atoxmetine 3. Clonidine 4. Dexmethylphenidate 5. Dextroamphetamine 6. Guanfacine 7. Lisdexamfetamine 8. Methamphetamine 9. Methylphenidate

(continued)

Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Measure Documentation *(continued)*	**B. Document the ADHD medication in the "Current Medications" section of the patient's chart in eCW** **1. Record the prescription from one of the following locations:** a. *Progress Notes → Treatment → Add* b. *Telephone/Web Encounter → Rx Tab → Select Rx* c. *Telephone/Web Encounter → Virtual Visit Tab → Treatment → Add* d. *Progress Notes → Current Medications* **2. If a medication cannot be prescribed due to a medication allergy or intolerance, document the allergy/intolerance in the "Allergies" section of the patient's chart in eCW** **3. If a medication is discontinued, document the reason for stopping the medication in a Progress Note or Telephone/Web Encounter in the patient's chart in eCW** **II. The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing*)
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **See the patient for an applicable visit encounter <u>≤</u> 30 days after prescribing the ADHD medication**

	(continued)
Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Measure Documentation *(continued)*	**A. The following E&M codes identify applicable ADHD visit encounters** 1. 90791 - 90792, 90832, 90834, 90837, 90845, 90847, 90849, 90853, 90875 and 90876 2. 96150 - 96154 3. 98960 - 98962 4. 99078, 99201 - 99205, 99212 - 99215, 99217 - 99220, 99241 - 99245, 99341 - 99345, 99347 - 99350, 99381 - 99384 99391 - 99394, 99401 - 99404, 99411 - 99412 and 99510 **B. Record the appropriate E&M Code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing*)
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* **I. If applicable, document a diagnosis for Narcolepsy in the patient's chart in eCW** **A. The following ICD-10 codes identify Narcolepsy: G47.411, G47.419, G47.421 and G47.429** **B. Record the appropriate ICD-10 code in the Problem List of the patient's chart in eCW, as follows** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* **<u>OR</u>** 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" **3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field**

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**II. If applicable, document the following in the patient's chart in eCW** **A. Record an inpatient encounter occurring ≤ 30 days after issuing the prescription for the ADHD medication** **1. Document the inpatient encounter in one of the following structured data fields** a. For a discharge from the hospital, use the following structured data path: ***Progress Notes → HPI → Interim History → Transition of care from hospital → Date of admission to hospital*** b. For discharge from another inpatient facility, use the following structured data path: ***Progress Notes → HPI → Interin History → Transition of care from other inpatient facility → Date of admission to other inpatient facility*** **2. For each of the above options, the required structured data fields are outlined (boxed)** **3. Record the admission to the inpatient facility in the appropriate structured data field** **a. Some configuration and mapping may first be required** 1) If necessary, add the "Transition of care from hospital" and/or "Transition of care from other inpatient facility" items to the "Interim History folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "HPI" link b) Click on the "Interim History" folder c) If "Transition of care from hospital" or "Transition of care from other inpatient facility" is not an available option (1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open

	(continued)
Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Exclusion and/or Exception Documentation (continued)	(b) Type "Transition of care from hospital" or "Transition of care from other inpatient facility" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) (a) Section = HPI (b) Category = Interim History (c) Item = "Transition of care from hospital" or "Transition of care from inpatient facility" (3) From the Community side, select the desired reporting field (a) E.g., "Date of admission to the hospital" (b) E.g., "Date of admission to an other inpatient facility"" (4) Click "Add" (a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped

	(continued)
Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Exclusion and/or Exception Documentation (continued)	**b. Enter the date of the inpatient admission in the appopriate structured data field** **B. <u>AND</u>, Record a diagnosis for a Mental Health Disorder, active at the time of the above inpatient encounter, in the patient's chart in eCW** **1. The following ICD-10 codes identify Mental Health Disorders** F03.90 and F03.91 F20.0 - F20.3, F20.5, F20.81, F20.89, F20.9, F21 - F24, F25.0, F25.1, F25.8, F25.9, F28 and F29 F30.10 - F30.13, F30.2 - F30.4, F30.8 - F30.9, F31.0, F31.10 - F31.13, F31.2, F31.30 - F31.32, F31.4 - F31.5, F31.60 - F31.64, F31.70 - F31.78 , F31.81 F31.89, F31.9, F32.0 - F32.5, F32.8 - F32.9, F33.0 - F33.3, F33.40 - F33.42, F33.8 - F33.9, F34.0 - F34.1, F34.8 - F34.9 and F39 F40.00 - F40.02, F40.10 - F40.11, F40.210, F40.218, F40.220, F40.228, F40.230 - F4-.233, F40.240 - F40.243, F40.248, F40.290 - F40.291, F40.298 F40.8 - F40.9, F41.0 -F41.1, F41.2, F41.8 - F41.9, F42, F43.0, F43.10 - F43.12, F43.20 - F43.25, F43.29, F43.8 - F43.9, F44.0 - F44.2, F44.4 - F44.7 F44.81, F44.89, F44.9, F45.0 - F45.1, F45.20 - F45.22, F45.29, F45.41 - F45.42, F45.8 - F45.9, F48.1 - F48.2 and F48.8 - F48.9 F50.00 - F50.02, F50.2, F50.8 - F50.9, F51.01 - F51.09, F51.11 - F51.13, F51.19, F51.3 - F51.5, F51.8 - F51.9, F52.0 - F52.1, F52.21 - F52.22, F52.31, F52.32, F52.4 - F52.6, F52.8 - F52.9, F53 and F59 F60.0 - F60.7, F60.81, F60.89, F60.9, F63.0 - F63.3, F63.81, F63.89, F63.9, F64.1 - F64.2, F64.8 - F64.9, F65.0 - F65.4, F65.50 - F65.52, F65.81, F65.89 F65.9, F66, F68.10 - F68.13, F68.8 and F69 F80.0 - F80.2, F80.4, F80.81, F80.89, F80.9, F81.0, F81.2, F81.81, F81.89, F81.9, F82, F84.0, F84.2 - F84.3, F84.5, F84.8 - F84.9, F88 and F89 F90.0 - F90.2, F90.8 - F90.9, F91.0 - F91.3, F91.8 - F91.9, F93.0, F93.8 - F93.9, F94.0 - F94.2, F94.8 - F94.9, F95.0 - F95.2, F95.8 - F95.9, F98.0 - F98.1 F98.21, F98.29, F98.3 - F98.5, F98.8 - F98.9 and F99 **2. Document the appropriate diagnosis in a Progress Note associated with the inpatient visit** (*Progress Notes* → *Assessments* → *Problem List*)

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Exclusion and/or Exception Documentation (continued)	**3. Helpful Hint: When adding a new diagnosis to a Problem list, enter the onset date for the disorder, of known, in the associated "Onset Date" field** **C. <u>OR</u>, Record a diagnosis for Substance Abuse, active at the time of the above inpatient encounter, in the patient's chart in eCW** **1. The following ICD-10 codes indicate Substance Abuse disorders** F10.10, F10.120 - F10.121, F10.129, F10.14, F10.150 - F10.151, F10.159, F10.180 - F10.182, F10.188, F10.19, F10.20 - F10.21, F10.220 - F10.221 F10.229 - F10.232, F10.239, F10.24, F10.250 - F10.251, F10.259, F10.26 - F10.27, F10.280 - F10.282, F10.288, F10.29, F10.920 - F10.921, F10.929 F10.94, F10.950 - F10.951, F10.959, F10.96 - F10.97, F10.980 - F10.982, F10.988 and F10.99 F11.10, F11.120 - F11.122, F11.129, F11.14, F11.150 - F11.151, F11.159, F11.181 - F11.182, F11.188, F11.19 - F11.21, F11.220 - F11.222, F11.229 F11.23 - F11.24, F11.250 - F11.251, F11.259, F11.281 - F11.282, F11.288, F11.29, F11.90, F11.920 - F11.922, F11.929, F11.93 - F11.94, F11.950 - F11.951, F11.959, F11.981 - F11.982, F11.988 and F11.99 F12.10, F12.120 - F12.122, F12.129, F12.150 - F12.151, F12.159, F12.180, F12.188, F12.19 - F12.21, F12.220 - F12.222, F12.229, F12.250 - F12.251 F12.259, F12.280, F12.288, F12.29, F12.90, F12.920 - F12.922, F12.929, F12.950 - F12.951, F12.959, F12.980, F12.988 and F12.99 F13.10, F13.120 - F13.121, F13.129, F13.14, F13.150 - F13.151, F13.159, F13.180 - F13.182, F13.188, F13.19 - F13.21, F13.220 - F13.221, F13.229 F13.230 - F13.232, F13.239, F13.24, F13.250 - F13.251, F13.259, F13.26 - F13.27, F13.280 - F13.282, F13.288, F13.29, F13.90, F13.920 - F13.921 F13.929 - F13.932, F13.939, F13.94, F13.950 - F13.951, F13.959, F13.96 - F13.97, F13.980 - F13.982, F13.988 and F13.99 F14.10, F14.120 - F14.122, F14.129, F14.14, F14.150 - F14.151, F14.159, F14.180 - F14.182, F14.188, F14.19 - F14.21, F14.220 - F14.222, F14.229 F14.23 - F14.24, F14.250 - F14.251, F14.259, F14.280 - F14.282, F14.288, F14.29, F14.90, F14.920 - F14.922, F14.929, F14 94, F14.950 - F14.951 F14.959, F14.980 - F14.982, F14.988 AND f14.99 F15.10, F15.120 - F15.122, F15.129, F15.14, F15.150 - F15.151, F15.159, F15.180 - F15.182, F15.188. F15.19 - F15.21, F15.220 - F15.222, F15.229 F15.23 - F15.24, F15.250 - F15.251, F15.259, F15.280 - F15.282, F15.288, F15.29, F15.90, F15.920 - F15.922, F15.929, F15.93 - F15.94, F15.950 - F15.951, F15.959, F15.980 - F15.982, F15.988 AND F15.99 F16.10, F16.120 - F16.122, F16.129, F16.14, F16.150 - F16.151, F16.159, F16.180, F16.183, F16.188, F16.19 - F16.21, F16.220 - F16.221, F16.229

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Exclusion and/or Exception Documentation (continued)	F16.24, F16.250 - F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.90, F16.920 - F16.921, F16.929, F16.94, F16.950 - F16.951, F16.959 F16.980, F16.983, F16.988 AND f16.99 F18.10, F18.120 - F18.121, F18.129, F18.14, F18.150 - F18.151, F18.159, F18.17, F18.180, F18.188, F18.19 - F18.21, F18.220 - F18.221, F18.229 F18.24, F18.250 - F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.920 - F18.921, F18.929, F18.94, F18.950 - F18.951, F18.959 F18.97, F18.980, F18.988 and F18.99 F19.10, F19.120 - F19.122, F19.129, F19.14, F19.150 - F19.151, F19.159, F19.16 - F19.17, F19.180 - F19.182, F19.188, F19.19 - F19.21, F19.220 - F19.222, F19.229 - F19.232, F19.239, F19.24, F19.250 - F19.251, F19.259, F19.26 - F19.27, F19.280 - F19.282, F19.288, F19.29, F19.90, F19.920 - F19.922, F19.929 - F19.932, F19.939, F19.94, F19.950 - F19.951, F19.959, F19.96 - F19.97, F19.980 - F19.982, F19.988 and F19.99
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that an applicable visit encounter E&M code was recorded in the Billing section of a Progress Note within the required timeframe (< 30 days after the ADHD medication was prescribed)**
	II. Verify that all structured data fields used are mapped to the correct Community elements in your EMR A. For further assistance with mapping problems, contact an eCW Technical Service representative B. **<u>OR</u>**, Contact Ed Worthington or Kelly Saxton @ NPO
	III. Document a new allergy or intolerance in the "Allergies" section of the patient's chart, as follows" A. Access the "Allergies" section of the patient's chart in one of the following ways: 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open

	(continued)
Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Trouble-Shooting *(continued)*	a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **Or**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **Or,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase** *(continued)*
Trouble-Shooting *(continued)*	2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list
	IV. Verify that all applicable diagnoses have been added to the patient's Problem List A. Be aware of diagnoses assessed by other physicians involved in the patient's care B. Add and remove diagnoses, as necessary, to keep the patient's Problem List accurate
	V. Verify that all medications, currently being used by the patient, are listed in the "Current Medications" section of the patient's chart A. Reconcile the Current Medication list provided from other physicians in the patient's Care Team with the Current Medication List in the patient''s chart in your EMR B. Add new medications and remove old medications, as necessary, to keep the patient's Current Medication list accurate
	VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**<u>For More Information</u>** I. 2017 HEDIS for QRS Version : "**Follow-Up Care for Children Prescribed ADHD Medication (ADD)**" II. eClinicalWorks "**MIPS - CMS 136 - ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication**"

	(continued)
Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Measure Documentation *(continued)*	**A. The following (generic) medications are considered ADHD medications** (see Table ADD-A_2017 @www.ncqa.com) 1. Amphetamine-Dextroamphetamine 2. Atoxmetine 3. Clonidine 4. Dexmethylphenidate 5. Dextroamphetamine 6. Guanfacine 7. Lisdexamfetamine 8. Methamphetamine 9. Methylphenidate **B. Document the ADHD medication in the "Current Medications" section of the patient's chart in eCW** **1. The prescription must contain enough dispensing events to cover the next 7-10 months (210 - 300 cumulative days)** **2. Record the prescription from one of the following locations:** a. *Progress Notes → Treatment → Add* b. *Telephone/Web Encounter → Rx Tab → Select Rx* c. *Telephone/Web Encounter → Virtual Visit Tab → Treatment → Add* d. *Progress Notes → Current Medications* **3. If a medication cannot be prescribed due to a medication allergy or intolerance, document the allergy/intolerance in the "Allergies" section of the patient's chart in eCW** **4. If a medication is discontinued, document the reason for stopping the medication in a Progress Note or Telephone/Web Encounter in the patient's chart in eCW** **II. The patient must be seen for an applicable visit encounter during the Measurement Period**

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Measure Documentation *(continued)*	**A. The following E&M codes identify applicable visit encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes* → *Billing*)
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **I. See the patient for an applicable visit encounter <u>≤</u> 30 days after prescribing the ADHD medication** **A. The following E&M codes identify applicable ADHD visit encounters** 1. 90791 - 90792, 90832, 90834, 90837, 90845, 90847, 90849, 90853, 90875 and 90876 2. 96150 - 96154 3. 98960 - 98962 4. 99078, 99201 - 99205, 99212 - 99215, 99217 - 99220, 99241 - 99245, 99341 - 99345, 99347 - 99350, 99381 - 99384 99391 - 99394, 99401 - 99404, 99411 - 99412 and 99510 **B. Record the appropriate E&M Code in the Billing section of the Progress Note for the visit** (*Progress Notes* → *Billing*) **II. <u>AND</u>, See the patient for at least two additional applicable visit encounters <u>≥</u> 31 and <u>≤</u> 300 days after the ADHD medication was prescribed** A. The E&M codes identifying applicable visit encounters are the same as above (Numerator Documentation Step I) **B. Record the appropriate E&M Code in the Billing section of the Progress Note for the visit** (*Progress Notes* → *Billing*)

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Measure Documentation *(continued)*	**III. OR, See the patient for at least 1 applicable visit encounter (as above) and at least 1 applicable Telehealth and/or Telephone Management services encounter (≥ 31 and ≤ 300 days, or 1-10 months, after the ADHD medication was prescribed)** **A. The following E&M codes identify an applicable Telehealth encounter:** 1. 99444 2. OR, Bill a traditional E&M code with a Telehealth modifier (GT , GQ, or 95) **B. The following E&M codes identify an applicable Telephone Management service** 1. 98966 - 98968 2. 99441 - 99444 **C. Record the appropriate E&M Code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing*)
Exclusion and/or Exception Documentation	**To Exclude a Patient From This Measure** *(Exclusion/Exception Documentation)* **I. If applicable, document a diagnosis for Narcolepsy in the patient's chart in eCW** **A. The following ICD-10 codes identify Narcolepsy: G47.411, G47.419, G47.421 and G47.429** **B. Record the appropriate ICD-10 code in the Problem List of the patient's chart in eCW, as follows** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* **OR** 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
	b. Click "Add" **3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field**
Exclusion and/or Exception Documentation *(continued)*	**II. If applicable, document the following in the patient's chart in eCW** **A. Record an inpatient encounter occurring ≤ 30 days after issuing the prescription for the ADHD medication** **1. Document the inpatient encounter in one of the following structured data fields** a. For a discharge from the hospital, use the following structured data path: ***Progress Notes → HPI → Interim History →*** ***Transition of care from hospital*** **→** ***Date of admission to hospital*** b. For discharge from another inpatient facility, use the following structured data path: ***Progress Notes → HPI → Interin History →*** ***Transition of care from other inpatient facility*** **→** ***Date of admission to other inpatient facility*** **2. For each of the above options, the required structured data fields are outlined (boxed)** **3. Record the admission to the inpatient facility in the appropriate structured data field** **a. Some configuration and mapping may first be required** 1) If necessary, add the "Transition of care from hospital" and/or "Transition of care from other inpatient facility" items to the "Interim History folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "HPI" link b) Click on the "Interim History" folder c) If "Transition of care from hospital" or "Transition of care from other inpatient

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	facility" is not an available option (1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Transition of care from hospital" or "Transition of care from other inpatient facility" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) (a) Section = HPI (b) Category = Interim History (c) Item = "Transition of care from hospital" or "Transition of care from inpatient facility" (3) From the Community side, select the desired reporting field (a) E.g., "Date of admission to the hospital" (b) E.g., "Date of admission to an other inpatient facility"" (4) Click "Add"

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Exclusion and/or Exception Documentation (continued)	(a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped **b. Enter the date of the inpatient admission in the appopriate structured data field** **B. <u>AND</u>, Record a diagnosis for a Mental Health Disorder, active at the time of the above inpatient encounter, in the patient's chart in eCW** **1. The following ICD-10 codes identify Mental Health Disorders** F03.90 and F03.91 F20.0 - F20.3, F20.5, F20.81, F20.89, F20.9, F21 - F24, F25.0, F25.1, F25.8, F25.9, F28 and F29 F30.10 - F30.13, F30.2 - F30.4, F30.8 - F30.9, F31.0, F31.10 - F31.13, F31.2, F31.30 - F31.32, F31.4 - F31.5, F31.60 - F31.64, F31.70 - F31.78 , F31.81 F31.89, F31.9, F32.0 - F32.5, F32.8 - F32.9, F33.0 - F33.3, F33.40 - F33.42, F33.8 - F33.9, F34.0 - F34.1, F34.8 - F34.9 and F39 F40.00 - F40.02, F40.10 - F40.11, F40.210, F40.218, F40.220, F40.228, F40.230 - F4-.233, F40.240 - F40.243, F40.248, F40.290 - F40.291, F40.298 F40.8 - F40.9, F41.0 -F41.1, F41.2, F41.8 - F41.9, F42, F43.0, F43.10 - F43.12, F43.20 - F43.25, F43.29, F43.8 - F43.9, F44.0 - F44.2, F44.4 - F44.7 F44.81, F44.89, F44.9, F45.0 - F45.1, F45.20 - F45.22, F45.29, F45.41 - F45.42, F45.8 - F45.9, F48.1 - F48.2 and F48.8 - F48.9 F50.00 - F50.02, F50.2, F50.8 - F50.9, F51.01 - F51.09, F51.11 - F51.13, F51.19, F51.3 - F51.5, F51.8 - F51.9, F52.0 - F52.1, F52.21 - F52.22, F52.31, F52.32, F52.4 - F52.6, F52.8 - F52.9, F53 and F59 F60.0 - F60.7, F60.81, F60.89, F60.9, F63.0 - F63.3, F63.81, F63.89, F63.9, F64.1 - F64.2, F64.8 - F64.9, F65.0 - F65.4, F65.50 - F65.52, F65.81, F65.89 F65.9, F66, F68.10 - F68.13, F68.8 and F69 F80.0 - F80.2, F80.4, F80.81, F80.89, F80.9, F81.0, F81.2, F81.81, F81.89, F81.9, F82, F84.0, F84.2 - F84.3, F84.5, F84.8 - F84.9, F88 and F89

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Exclusion and/or Exception Documentation (continued)	F90.0 - F90.2, F90.8 - F90.9, F91.0 - F91.3, F91.8 - F91.9, F93.0, F93.8 - F93.9, F94.0 - F94.2, F94.8 - F94.9, F95.0 - F95.2, F95.8 - F95.9, F98.0 - F98.1, F98.21, F98.29, F98.3 - F98.5, F98.8 - F98.9 and F99 **2. Document the appropriate diagnosis in a Progress Note associated with the inpatient visit** (*Progress Notes* → *Assessments* → *Problem List*) **3. Helpful Hint: When adding a new diagnosis to a Problem list, enter the onset date for the disorder, of known, in the associated "Onset Date" field** **C. <u>OR</u>, Record a diagnosis for Substance Abuse, active at the time of the above inpatient encounter, in the patient's chart in eCW** **1. The following ICD-10 codes indicate Substance Abuse disorders** F10.10, F10.120 - F10.121, F10.129, F10.14, F10.150 - F10.151, F10.159, F10.180 - F10.182, F10.188, F10.19, F10.20 - F10.21, F10.220 - F10.221 F10.229 - F10.232, F10.239, F10.24, F10.250 - F10.251, F10.259, F10.26 - F10.27, F10.280 - F10.282, F10.288, F10.29, F10.920 - F10.921, F10.929 F10.94, F10.950 - F10.951, F10.959, F10.96 - F10.97, F10.980 - F10.982, F10.988 and F10.99 F11.10, F11.120 - F11.122, F11.129, F11.14, F11.150 - F11.151, F11.159, F11.181 - F11.182, F11.188, F11.19 - F11.21, F11.220 - F11.222, F11.229 F11.23 - F11.24, F11.250 - F11.251, F11.259, F11.281 - F11.282, F11.288, F11.29, F11.90, F11.920 - F11.922, F11.929, F11.93 - F11.94, F11.950 - F11.951, F11.959, F11.981 - F11.982, F11.988 and F11.99 F12.10, F12.120 - F12.122, F12.129, F12.150 - F12.151, F12.159, F12.180, F12.188, F12.19 - F12.21, F12.220 - F12.222, F12.229, F12.250 - F12.251 F12.259, F12.280, F12.288, F12.29, F12.90, F12.920 - F12.922, F12.929, F12.950 - F12.951, F12.959, F12.980, F12.988 and F12.99 F13.10, F13.120 - F13.121, F13.129, F13.14, F13.150 - F13.151, F13.159, F13.180 - F13.182, F13.188, F13.19 - F13.21, F13.220 - F13.221, F13.229 F13.230 - F13.232, F13.239, F13.24, F13.250 - F13.251, F13.259, F13.26 - F13.27, F13.280 - F13.282, F13.288, F13.29, F13.90, F13.920 - F13.921 F13.929 - F13.932, F13.939, F13.94, F13.950 - F13.951, F13.959, F13.96 - F13.97, F13.980 - F13.982, F13.988 and F13.99 F14.10, F14.120 - F14.122, F14.129, F14.14, F14.150 - F14.151, F14.159, F14.180 - F14.182, F14.188, F14.19 - F14.21, F14.220 - F14.222, F14.229 F14.23 - F14.24, F14.250 - F14.251, F14.259, F14.280 - F14.282, F14.288, F14.29, F14.90, F14.920 - F14.922, F14.929, F14 94, F14.950 - F14.951 F14.959, F14.980 - F14.982, F14.988 and F14.99

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	F15.10, F15.120 - F15.122, F15.129, F15.14, F15.150 - F15.151, F15.159, F15.180 - F15.182, F15.188. F15.19 - F15.21, F15.220 - F15.222, F15.229 F15.23 - F15.24, F15.250 - F15.251, F15.259, F15.280 - F15.282, F15.288, F15.29, F15.90, F15.920 - F15.922, F15.929, F15.93 - F15.94, F15.950 - F15.951, F15.959, F15.980 - F15.982, F15.988 and F15.99 F16.10, F16.120 - F16.122, F16.129, F16.14, F16.150 - F16.151, F16.159, F16.180, F16.183, F16.188, F16.19 - F16.21, F16.220 - F16.221, F16.229 F16.24, F16.250 - F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.90, F16.920 - F16.921, F16.929, F16.94, F16.950 - F16.951, F16.959 F16.980, F16.983, F16.988 and F16.99 F18.10, F18.120 - F18.121, F18.129, F18.14, F18.150 - F18.151, F18.159, F18.17, F18.180, F18.188, F18.19 - F18.21, F18.220 - F18.221, F18.229 F18.24, F18.250 - F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.920 - F18.921, F18.929, F18.94, F18.950 - F18.951, F18.959 F18.97, F18.980, F18.988 and F18.99 F19.10, F19.120 - F19.122, F19.129, F19.14, F19.150 - F19.151, F19.159, F19.16 - F19.17, F19.180 - F19.182, F19.188, F19.19 - F19.21, F19.220 - F19.222, F19.229 - F19.232, F19.239, F19.24, F19.250 - F19.251, F19.259, F19.26 - F19.27, F19.280 - F19.282, F19.288, F19.29, F19.90, F19.920 - F19.922, F19.929 - F19.932, F19.939, F19.94, F19.950 - F19.951, F19.959, F19.96 - F19.97, F19.980 - F19.982, F19.988 and F19.99 **2. Document the appropriate diagnosis in a Progress Note associated with the inpatient visit** (*Progress Notes* → *Assessments* → *Problem List*) **3. Helpful Hint: When adding a new diagnosis to a Problem list, enter the onset date for the disorder, of known, in the associated "Onset Date" field**
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that an applicable visit encounter E&M code was recorded in the Billing section of a Progress Note within the required timeframe (< 30 days after the ADHD medication was prescribed)**
	II. Verify that all structured data fields used are mapped to the correct Community elements in your EMR

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Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase *(continued)*
	A. For further assistance with mapping problems, contact an eCW Technical Service representative B. **OR**, Contact Ed Worthington or Kelly Saxton @ NPO
Trouble-Shooting *(continued)*	**III. Document a new allergy or intolerance in the "Allergies" section of the patient's chart, as follows"** A. Access the "Allergies" section of the patient's chart in one of the following ways: 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy

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Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase *(continued)*
Trouble-Shooting *(continued)*	a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **Or**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **Or,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. Verify that all applicable diagnoses have been added to the patient's Problem List A. Be aware of diagnoses assessed by other physicians involved in the patient's care B. Add and remove diagnoses, as necessary, to keep the patient's Problem List accurate
	V. Verify that all medications, currently being used by the patient, are listed in the "Current Medications" section of the patient's chart

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Measure Name	**Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase** *(continued)*
Trouble-Shooting *(continued)*	A. Reconcile the Current Medication list provided from other physicians in the patient's Care Team with the Current Medication List in the patient''s chart in your EMR B. Add new medications and remove old medications, as necessary, to keep the patient's Current Medication list accurate
	VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. 2017 HEDIS for QRS Version : "**Follow-Up Care for Children Prescribed ADHD Medication (ADD)**" II. eClinicalWorks "**MIPS - CMS 136 - ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication**"

Measure Name	Avoidance of Antibiotics in Adults with Bronchitis (Inverse Measure)
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0058: Respiratory Measure]* MIPS Clinical Quality Measure *[Registry 116: Process Measure]*
Measure Definition	***The percentage of patients, 18 - 64 years of age and with a diagnosis of Acute Bronchitis*, who were prescribed, or dispensed, an Antibiotic medication on, or within three days after, the episode*** *Note: The NPO Population Clinical Quality Dashboard version of this measure is configured as an inverse measure; the above Measure Definition is the opposite of the definition provided in the NQF and MIPS documents cited as references
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are 18 - 64 years of age on the Date of Service during the Measurement Period II. **AND,** Have been seen for an applicable outpatient or Emergency Department visit during the Measurement Period III. **AND,** Had an active diagnosis of Acute Bronchitis during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Were prescribed an Antibiotic medication II. During, or within three days of, the initial Date of Service for Acute Bronchitis
Exclusions and/or Exceptions	Patients are **excluded** from this measure if an antibiotic medication was precribed within the 30 days prior to being diagnosed with Acute Bronchitis *(continued)*

Measure Name	Avoidance of Antibiotics in Adults with Bronchitis (Inverse Measure) *(continued)*
Measure Documentation	**To Qualify For This Measure** (Denominator Documentation) **I. The patient must be seen for an applicable E&M visit (outpatient or Emergency Room) during the Measurement Period** **A. The following E&M codes identify applicable visit encounters:** 1. 99201 - 99205, 99211 - 99215, 99217 - 99220 and 99281 - 99285 2. 99341 - 99345 and 99347 - 99350 3. G0402, G0438 - G0439, G0463 and T1015 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing*) **II. The patient must have an active diagnosis of Acute Bronchitis documented during the Measurement Period** **A. The following ICD-10 codes indicate Acute Bronchitis: J20.3 - J20.9** **B. The appropriate ICD-10 diagnosis code must be recorded as an Assessment in the Progress Note for the applicable visit** (Progress Notes → *Assessments)*
	To Satisfy This Measure (Numerator Documentation) **I. Document an Antibiotic medication, initiated within 3 days of the initial Date of Service for Acute Bronchitis** **A. The following medications are considered applicable Antibiotics:** 1. Aminoglycosides *(e.g., Amikacin, Gentamicin, Kanamycin, Streptomycin and Tobramycin)* 2. Aminopenicillins *(e.g., Amoxicillin and Ampicillin)* *(continued)*

Measure Name	**Avoidance of Antibiotics in Adults with Bronchitis (Inverse Measure)** *(continued)*
Measure Documentation *(continued)*	3. Beta-lactamase Inhibitors *(e.g., Amoxicillin-Clavulanate, Ampicillin-Sulbactam, Piperacillin-Tazobactam, and Ticarcillin - Clavulanate)* 4. First-Generation Cephalosporins *(e.g., Cefadroxil, Cefazolin and Cephalexin)* 5. Fourth-Generation Cephalosporins *(e.g., Cefepime)* 6. Ketolides *(e.g., Telithromycin)* 7. Lincomycin Derivatives *(Clindamycin and Lincomycin)* 8. Macrolides *(Azithromycin, Clarithromycin, Erythromycin, Erythromycin Ethylsuccinate, Erythromycin Lactobionate and Erythromycin Stearate*) 9. Miscellaneous Antibiotics *(Aztreonam, Chloramphenicol, Dalfopristin-Quinupristin, Daptomycin, Erythromycin-Sulfisoxazole Linezolid, Metronidazole and Vancomycin)* 10. Natural Penicillins *(e.g., Penicillin G Benzathine - Procaine, Penicillin G Potassium, Penicillin G Procaine, Penicillin G Sodium Penicillin V Potassium, Penicillin G Benzathine)* 11. Penicillinase-Resistant Penicillins *(e.g., Dicloxicillin, Nafcillin and Oxacillin)* 12. Quinolones *(Ciprofloxacin, Gemifloxacin, Levofloxacin, Moxifloxacin, Norfloxacin and Ofloxacin)* 13. Rifamycin Derivatives *(e.g., Rifampin)* 14. Second-Generation Cephalosporin *(e.g., Cefaclor, Cefotetan, Cefoxitin, Cefprozil and Cefuroxime)* 15. Sulfonamides *(e.g., Sulfadiazine and Sulfamethoxazol e-Trimethoprim)* 16. Tetracyclines *(Doxycycline, Minocycline and Tetracycline)* 17. Third-Generation Cephalosporins *(e.g., Cefdinir, Cefditoren, Cefixime, Cefotaxime, Cefpodoxime, Ceftazidime, Ceftibuten and Ceftriaxone)* 18. Urinary Anti-Infectives *(e.g., Fosfomycin, Nitrofurantoin, Nitrofurantoin Macrocrystals, Nitrofuantoin Macrocrystals - Monohydrate and Trimethoprim)* B. A comprehensive list of medications and NDC codes is available at www.ncqa.org **C. If an antibiotic is prescribed, record it in the "Current Medications" section of the patient's chart from one of the following locations:** ***Progress Notes*** → ***Treatment*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) ***Progress Notes*** → ***Current Medications*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) *(continued)*

Measure Name	**Avoidance of Antibiotics in Adults with Bronchitis (Inverse Measure)** *(continued)*
Measure Documentation *(continued)*	***Telephone Encounter*** → ***Rx tab*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) ***Telephone Encounter*** → ***Virtual Visit tab*** → ***Treatment*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) ***Telephone Encounter*** → ***Virtual Visit tab*** → ***Current Medications*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) **D. Record the Antibiotic in the patient's chart within three days of assessing the Acute Bronchitis diagnosis** **II. As an Inverse Measure, the goal for this measure is actually the lowest performance rate possible**
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion and/or Exception Documentation)* Documentation, in the patient's chart, of initiation, or continuation, of an Antibiotic medication, within 30 days prior to assessment of a diagnosis for Acute Bronchitis, will render the patient ineligible for this measure
Trouble-Shooting	**<u>Having problems? Check out the following Trouble-Shooting tips</u>** **I. Confirm diagnoses assessed by ER and/or other physicians** A. Add applicable diagnoses to the patient's Problem List in your EMR B. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical History section of the patient's chart
	II. Confirm medications prescribed by specialists, ER and hospital physicians A. Add new medications to the patient's Current Medications list in the patient's chart in your EMR B. Keep the Current Medications list accurate by removing medications that are no longer being taken *(continued)*

Measure Name	Avoidance of Antibiotics in Adults with Bronchitis (Inverse Measure) *(continued)*
Trouble-Shooting *(continued)*	**III. Document any adverse reactions (allergy or intolerance) to an Antibiotic medication in the "Allergies" section of the patient's chart,** as follows: A. Access the "Allergies" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box *(continued)*

Measure Name	**Avoidance of Antibiotics in Adults with Bronchitis (Inverse Measure)** *(continued)*
Trouble-Shooting *(continued)*	d) **Or**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **Or,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0058: "**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**" II. eClinicalWorks "**MIPS - Registry 116 (NQF 0058) - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**"

Measure Name	Appropriate Testing for Children with Pharyngitis
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0002: Pediatric Measure]* MIPS Clinical Quality Measure *[CMS 146 (EHR): Process Measure]*
Measure Definition	***The percentage of children, 2-18 years old, who, during the Measurement Period, were diagnosed with pharyngitis, dispensed an antibiotic and received a Group A Streptococcus (Strep A) test for the episode. A higher rate represents better performance (i.e., appropriate testing)***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Were ≥ 2 and < 18 years of age at the start of the Measurement Period II. **AND,** Were seen for an applicable ambulatory or ED encounter during the Measurement Period III. **AND,** Were assessed an active diagnosis of Acute Pharyngitis just prior to, during, or shortly after (+ 3 days) the applicable encounter IV. **AND,** Were dispensed an antibiotic medication ≤ 3 days after the diagnosis assessment
Numerator	The **Numerator** consists of patients, from the Denominator, who : I. Were administered a Group A Streptococcus test II. **AND**, Had the results of the test recorded, in the patient's medical record, within 3 days of (before or after) the applicable encounter
Exclusions and/or Exceptions	Patients are **excluded** from the Denominator for the following reason: I. The Antibiotic medication was dispensed prior to the assessment of the diagnosis for Acute Pharyngitis *(continued)*

Measure Name	**Appropriate Testing for Children with Pharyngitis** *(continued)*
Exclusions and/or Exceptions *(continued)*	**II.** **And**, This was the only Antibiotic medication dispensed to the patient ≤ 30 days prior to assessment of the diagnosis for Acute Pharyngitis
Measure Documentation	**To Qualify For This Measure:** *(Denominator Documentation)* **I. The patient must have been seen for an applicable E&M visit (outpatient or Emergency Room) during the Measurement Period** **A. The following E&M codes identify applicable vist encounters:** 1. 99201 - 99205, 99212 - 99215, 99217 - 99220, 99241 - 99245, and 99281 - 99285 2. 99341 - 99345, 99347 - 99350, 99381 - 99387 and 99391 - 99397 3. 99401 - 99404, 99411 - 99412, 99420, 99429 and 99455 - 99456 **B. Record the appropriate E&M code in the Billing section for the visit** *(Progress Notes → Billing)* **II. An Antibiotic medication must have been prescribed within three days of the above encounter** A. The following medications are considered applicable Antibiotics: 1. Aminopenicillins *(e.g., Amoxicillin, Ampicillin)* 2. Beta-Lactamase Inhibitors *(e.g., Amoxicillin-Clavulanate)* 3. First-Generation Cephalosporins *(e.g., Cefadroxil, Cefazolin, Cephalexin)* 4. Folate Antagonist *(e.g., Trimethoprim)* 5. Lincomycin Derivatives *(e.g., Clindamycin)* 6. Macrolides *(e.g., Azithromycin, Clarithromycin, Erythromycin,* Erythromycin Ethylsuccinate,Erythromycin Lactobionate and Erythromycin Stearate) 7. Miscellaneous Antibiotics *(e.g., Erythromycin - Sulfisoxazole)* 8. Natural Penicillins *(e.g., Penicillin G Potassium, Penicillin G Sodium, Penicillin V Potassium)* *(continued)*

Measure Name	**Appropriate Testing for Children with Pharyngitis** *(continued)*
Measure Documentation *(continued)*	c. **Results** **MANDATORY** 1) Check the "Received" box in the Results section **MANDATORY** 2) Enter the date the test was performed **MANDATORY** 3) Enter the result (Positive or Negative) in the yellow grid **MANDATORY** d. **Reviewed**: Check the "Reviewed" box
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* **Documentation, in the patient's chart, of initiation, or continuation, of an Antibiotic medication, within 30 days prior to the Acute Pharyngitis assessment will render the patient ineligible for this measure**
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that an appropriate LOINC code is linked to the *Strep A* lab test in your EMR** **A. The following LOINC codes identify a *Strep A* lab:** 11268-0, 17656 -0, 18481-2, 31971-5, 49610-9, 5026-9, 60489-2, 626-2, 6557-36558-1, 6559-9, 68954-7 **B. To associate a new, or update an existing, LOINC code with a Lab, do the following:** 1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Attribute Codes" button c. A new window specific to the selected lab will open *(continued)*

Measure Name	Appropriate Testing for Children with Pharyngitis *(continued)*
Trouble-Shooting *(continued)*	1) Click the "Update LOINC" button 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window 3) Click "OK" to exit the Lab-specific window d. Click the X (in the top, right-hand corner) to close the "Labs" window
	II. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results) A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked
	III. Confirm diagnoses assessed by ER and/or other physicians A. Add new medications to the Current Medications list in the patient's chart in your EMR B. Keep the Current Medications list accurate by removing medications that are no longer being taken
	IV. Document any adverse reactions (allergy or intolerance) to an Antibiotic medication in the "Allergies" section of the patient's chart, as follows: A. Access the "Allergies" section of the patient's chart in one of the following ways: *(continued)*

Measure Name	Appropriate Testing for Children with Pharyngitis *(continued)*
Trouble-Shooting *(continued)*	1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **Or**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of *(continued)*

Measure Name	**Appropriate Testing for Children with Pharyngitis** *(continued)*
Trouble-Shooting *(continued)*	options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **Or,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	V. Verify medications prescribed by ER and/or other physicianss A. Add new medications to the patient's Current Medications list in the patient's chart in your EMR B. Keep the Current Medications list accurate by removing medications that are no longer being taken
	VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
Fro More Information	**For More Information** **I.** 2017 HEDIS for QRS Version: "**Appropriate Testing for Children with Pharyngitis (CWP)**" **II.** eClinicalWorks "**MIPS - CMS 146 - Appropriate Testing for Children with Pharyngitis**"

Measure Name	Appropriate Treatment for Children with URI (Inverse Measure)
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0069: Pediatric Measure]* MIPS Clinical Quality Measure *[CMS 154: Process Measure]*
Measure Definition	***The percentage of patients, 3 months through 18 years of age, who were diagnosed with an Upper Respiratory Infection (URI)* and subsequently issued a prescription for an Antibiotic medication on, or within three days after, the episode*** *Note: The NPO Population Clinical Quality Dashboard version of this measure is configured as an inverse measure, the above Measure Definition is the opposite of the definition provided in the NQF and MIPS documents, cited as references
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 3 months and < 18 years old at the start of the Measurement Period II. **AND**, Were seen for an applicable outpatient or Emergency Department visit during the Measurement Period III. **AND**, Were diagnosed with an Upper Respiratory Infection during one of the above applicable encounters
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Were prescribed an Antibiotic medication II. During, or within three days of, the Date of Service for the URI
Exclusions and/or Exceptions	Patients are **excluded** from this measure for one of the following reasons: I. They had an active diagnosis for a competing medical condition that began within 3 days of being diagnosed with the URI II. They had an Antibiotic medication prescribed within the 30 days prior to being diagnosed with the URI *(continued)*

Measure Name	Appropriate Treatment for Children with URI (Inverse Measure) *(continued)*
Measure Documentation	**To Qualify For This Measure** (Denominator Documentation) **I. The patient must have been seen for an applicable (outpatient or Emergency Room) encounter during the Measurement Period** **A. The following E&M codes identify applicable encounters** 1. 99201 - 99205, 99212 - 99215, 99217 - 99220 and 99281 - 99285 2. 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. A diagnosis for URI must be recorded during the above encounter** **A. The following ICD-10 codes identify an Upper Respiratory Infection: J00, J06.0 and J06.9** **B. Record the apppropriate ICD-10 code as an Assessment in the Progress Note for the visit** (*Progress Notes → Assessments*)
	To Satisfy This Measure (Numerator Documentation) **I. Documentation of an antibiotic medication, initiated within 3 days of the initial Date of Service for the URI, satisfies this measure** A. The following medications are considered applicable Antibiotics: 1. Aminopenicillins *(e.g., Amoxicillin and Ampicillin)* 2. Beta-Lactamase Inhibitors *(e.g., Amoxicillin-Clavulanate)* 3. First-Generation Cephalosporins *(e.g., Cefadroxil, Cefazolin and Cephalexin)* *(continued)*

Measure Name	Appropriate Treatment for Children with URI (Inverse Measure) *(continued)*
Measure Documentation *(continued)*	4. Folate Antagonist *(e.g., Trimethoprim)* 5. Lincomycin Derivatives *(e.g., Clindamycin)* 6. Macrolides *(e.g., Azithromycin, Clarithromycin, Erythromycin, Erythromycin Ethylsuccinate, Erythromycin Lactobionate and Erythromycin Stearate)* 7. Miscellaneous Antibiotics *(e.g., Erythromycin - Sulfisoxazole)* 8. Natural Penicillins *(e.g., Penicillin G Potassium, Penicillin G Sodium, Penicillin V Potassium)* 9. Penicillinase - Resistant Penicillins *(e.g., Dicloxacillin)* 10. Quinolones *(e.g., Ciprofloxin, Levofloxcin, Moxifloxacin and Ofloxacin)* 11. Second-Generation Cephalosporins *(e.g., Cefaclor, Cefprozil and Cefuroxime)* 12. Sulfonamides *(e.g., Sulfamethoxazole - Trimethoprim and Sulfisoxazole)* 13. Tetracyclines *(e.g., Doxycycline, Minocycline and Tetracycline)* 14. Third-Generation Cephalosporins *(e.g., Cefdinir, Cefixime, Cefpodoxime, Ceftibuten, Cefditoren and Ceftriaxone)* B. A comprehensive list of medications and NDC codes is available at www.ncqa.org **C. If an antibiotic is prescribed, record it in the "Current Medications" section of the patient's chart from one of the following locations:** ***Progress Notes → Treatment*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) ***Progress Notes → Current Medications*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) ***Telephone Encounter → Rx tab*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) ***Telephone Encounter → Virtual Visit tab → Treatment*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) ***Telephone Encounter → Virtual Visit tab → Current Medications*** → (Prescribe, Refill, Continue, Start, etc. an Antibiotic medication) **D. Record the Antibiotic in the patient's chart within three days of assessing the URI diagnosis** **II. As an Inverse Measure, the goal for this measure is actually the lowest performance rate possible** *(continued)*

Measure Name	Appropriate Treatment for Children with URI (Inverse Measure) *(continued)*
Exclusion and/or Exception Documentation	**To Exclude a Patient From This Measure** (Exclusion and/or Exception Documentation) **I. If applicable, document an active diagnosis for a competing medical condition, for the URI** **A. The following ICD-10 codes identify Competing Conditions for Respiratory Conditions** A00.0 - A00.1, A00.9, A01.00 - A01.05, A01.09, A01.1 - A01.4, A02.0 - A02.1, A02.20 - A02.25, A02.29, A02.8, A02.9, A03.0 - A03.3, A03.8 - A03.9 A04.0 - A04.9, A05.0 - A05.5, A05.8 - A05.9, A06.0 - A06.7, A06.81 - A06.82, A06.89, A06.9, A07.0 - A07.4, A07.8 - A07.9, A08.0, A08.11, A08.19, A08.2 A08.31 - A08.32, A08.39, A08.4, A08.8, A09, A22.1, A37.00 - A37.01, A37.10 - A37.11, A37.80 - A37.81, A37.90 - A37.91, A44.0 - A44.1, A44.8 - A44.9 A48.1,A49.9, A50.09, A50.1 - A50.2, A50.31, A50.40 - A50.42, A50.45, A50.49, A50.52, A50.57, A50.59, A50.6 - A50.7, A50.9, A51.0 - A51.2, A51.31 - A51.32, A51.39, A51.41 - A51.46, A51.49, A51.5, A51.9, A52.00 - A52.06, A52.09 - A52.17, A52.19, A52.2 - A52.3, A52.71 -A52.79, A52.8 - A52.9, A53.0 A53.9, A54.00 - A54.03, A54.09, A54.1, A54.21 - A54.24A54.29 - A54.33, A54.39 - A54.43, A54.49, A54.5 - A54.6, A54.81 - A54.86, A54.89, A54.9 A56.00 - A56.02, A56.09, A56.11, A57 - A58, A59.00 - A59.03, A59.09, A59.8 - A59.9, A63.8, A64, A69.20 - A69.23, A69.29, A74.89 and A74.9 B25.0, B44.0, B60.0, B60.8, B64, B78.1 and B96.89; E83.2 H66.001 - H66.007, H66.009, H66.011 - H66.017, H66.019, H66.10 - H66.13, H66.20 -H66.23, H66.3X1 - H66.3X3, H66.3X9, H66.40 - H66.43, H66.90 - H66.93, H67/1 - H67.3, H67.9, H70.001 - H70.003, H70.009, H70.011 - H70.013, H70.019, H70.091 - H70.093, H70.099, H70.10 - H70.13, H70.201 - H70.203, H70.209, H70.211-H70.213, H70.219, H70.221 -H70.223, H70.229, H70.811 - H70.813, H70.819, H70.891 - H70.893, H70.899, H70.90 - H70.93, H75.00 - H75.03, H75.80 - H75.83, H95.00 - H95.03, H95.111 - H95.113, H95.119, H95.121 - H95.123, H95.129, H95.131 - H95.133, H95.139 H95.191 - H95.193, and H95.199 J01.00 - J01.01, J01.10 - J01.11, J01.20 - J01.21, J01.30 - J01.31, J01.40 - J01.41, J01.80 - J01.81, J01.90 - J01.91J02.0, J02.8 - J02.9, J03.00 - J03.03 J03.80 - J03.81, J03.90 - J03.91, J04.10 - J04.11, J04.2, J05.0, J05.10, J05.11, J13, J14, J15.0 - J15.1, J15.20, J15.211 - J15.212, , J15.29, J15.3 - J16.0 J16.8, J17, J18.0 - J18.1, J18.9, J32.0 - J34.4, J32.8 - J32.9, J35.01 -J35.03, J35.1 - J35.3 and J39.0 - J39.2; K12.2 L01.00 - L01.03, L01.09, L01.1, L02.01, L02.11, L02.211 - L02.216, L02.219, L02.31, L02.411 - L02.416, L02.419, L02.511 - L02.512, L02.519, L02.611 - L02.612, L02.619, L02.811, L02.818, L03.011 - L03.012, L03.019, L03.021-L03.022, L03.029, L03.031 - L03.032, L03.039, L03.041 -L03.042, L03.049 L03.111 - L03.116, L03.119, L03.121, L03.126, L03.129, L03.211 - L03.212, L03.221 - L03.222, L03.311 - L03.317, L03.319, L03.321 - L03.327, L03.329 L03.811, L03.818, L03.891, L03.898, L04.0-L04.3, L04.8-L04.9, L08.0, L08.81-L08.82, L08.89, L08.9, L70.0-L70.5, L70.8-L70.9, L73.0, L88, L92.8, L98.0 *(continued)*

Measure Name	Appropriate Treatment for Children with URI (Inverse Measure) *(continued)*
Exclusions and/or Exceptions Documentation	M02.30, M02.311-M02.312, M02.319, M02.321-M02.322,M02.329, M02.331-M02.332, M02.339, M02.341-M02.342, M02.349, M02.351-M02.352 M02.359, M02.361-M02.362, M02.369, M02.371-M02.372, M02.379, M02.38-M02.39, M46.20 M46.28, M46.30-M46.39, M86.00, M86.011 M86.012, M86.019, M86.021-M86.022, M86.029, M86.031-M86.032, M86.039, M86.041-M86.042, M86.049, M86.051-M86.052, M86.059 M86.061, M86.062, M86.069, M86.071 - M86.072, M86.079, M86.08 - M86.10, M86.111 - M86.112, M86.119, M86.121 - M86.122, M86.129 M86.131 - M86.132, M86.139, M86.141, M86.142, M86.149, M86.151, M86.152, M86.159, M86.161, M86.162, M86.169, M86.171, M86.172 M86.179, M86.18-M86.20M86.211 - M86.212, M86.219, M86.221- M86.222, M86.229, M86.231 - M86.232, M86.241 - M86.242, M86.249 M86.251 - M86.252, M86.259, M86.261, M86.262, M86.269, M86.271, M86.272, M86.279, M86.28 - M86.30, M86.311, M86.312, M86.319 M86.321, M86.322, M86.329, M86.331, M86.332, M86.339, M86.341 - M86.342, M86.349, M86.351, M86.352, M86.359, M86.361 - M86.362 M86.369, M86.371 - M86.372, M86.379, M86.38 - M86.40, M86.411 - M86.412, M86.419, M86.421 - M86.422, M86.429, M86.431 - M86.432 M86.439, M86.441, - M86.442,M86.449, M86.451 - M86.452, M86.459, M86.461 - M86.462, M86.469, M86.471 - M86.472, M86.479, M86.48 - M86.50, M86.511 - M86.512, M86.519, M86.521 - M86.522, M86.529, M86.531 - M86.532, M86.539, M86.541, M86.542, M86.549, M86.551 - M86.552, M86.559, M86.571- M86.572, M86.579, M86.58 -M86.60, M86.611 - M86.612, M86.619, M86.621 - M86.622, M86.629, M86.631 - M86.632, M86.639, M86.641 - M86.642, M86.649, M86.651, M86.652, M86.659, M86.661 - M86.662, M86.669, M86.671 - M86.672, M86.679 M86.68 - M86.69, M86.8X0 - M86.8X9, M89.60, M89.611, M89.612, M89.619, M89.621, M89.622, M89.629, M89.631,M89.632, M89.639, M89.641 M89.642, M89.649, M89.651, M89.652, M89.659, M89.661, M89.662, M89.669, M89.671, M89.672, M89.679, M89.68 - M89.69, M90.80, M90.811 M90.812, M90.819, M90.821, M90.822, M90.829, M90.831 - M90.832, M90.839, M90.841 - M90.842, M90.849, M90.851 - M90.852, M90.859 M90.861 - M90.862, M90.869, M90.871, M90.872, M90.879 and M90.88 N10, N11.0 - N11.1, N11.8 - N11.9, N12, N13.6, N15.1, N15.9, N16, N28.84 - N28.86, N30.00, N30.01, N30.10, N30.11, N30.20, N30.21, N30.30, N30.31 N30.40, N30.41, N30.80, N30.81, N30.90, N30.91, N34.1, N39.0, N41.0, N41.4, N41.8, N41.9, , N51, N70.01, N70.03, , N70.11 -N70.13, N70.91 - N70.93 N71.0 - N71.1, N71.9, N72, N73.1 - N73.6, N73.8 - N73.9, N74, N75.0, N75.1, N75.8 - N75.9, N76.0 - N76.6, N76.81, N76.89, N77.0 - N77.1 **B. Record the appropriate diagnosis in the Problem List in the patient's chart in eCW from one of the following locations** 1. *Progress Notes → Assessments* 2. *Progress Notes → Treatment → Problem List* **C. Record the competing diagnosis in the patient's chart within 3 days of recording the URI diagnosis** **II. Documentation, in the patient's chart, of initiation, or continuation, of an Antibiotic medication, within 30 days prior to assessment of a diagnosis for URI, will also render the patient ineligible for this measure** *(continued)*

Measure Name	Appropriate Treatment for Children with URI (Inverse Measure) *(continued)*
Trouble-Shooting	**Having problems? Check out the following Trouble-Shooting tips** **I. Confirm diagnoses assessed by ER and/or other physicians** A. Add applicable diagnoses to the patient's Problem List in your EMR B. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical
	II. Verify medications prescribed by ER and/or other physicians A. Add new medications to the patient's Current Medications list in the patient's chart in your EMR B. Keep the Current Medications list accurate by removing medications that are no longer being taken
	III. If applicable, document an adverse reaction (allergy or intolerance) to an Antibiotic medication in the "Allergies" section of the patient's chart, as follows: A. Access the "Allergies" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy *(continued)*

Measure Name	Appropriate Treatment for Children with URI (Inverse Measure) *(continued)*
Trouble-Shooting *(continued)*	b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **Or**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list *(continued)*

Measure Name	**Appropriate Treatment for Children with URI (Inverse Measure)** *(continued)*
Trouble-Shooting *(continued)*	**IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)**
For More Information	**For More Information** I. NQF 0069: "**Apprpriate Treatment for Children with Upper Respiratory Infection (URI)**" II. eClinicalWorks "**MIPS - CMS 154 - Appropriate Treatment for Childrem with Upper Respiratory Infection URI)**"

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Relevance	ACO Quality Measure #42 *[GPRO: Preventive Measure]*
Measure Definition	***The percentage of patients, considered at high risk of cardiovascular events, who were prescribed, or already on, statin therapy during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who were seen for an applicable visit encounter during the Measurement Period AND met one of the following criteria: I. Were ≥ 21 years old at the beginning of the Measurement Period **AND** had a diagnosis (active or historical) of Atherosclerotic Cardiovascular Disease (ASCVD) at any time before the end of the Measurement Period A. ASCVD is defined as: 1. Acute Coronary Syndromes 2. History of Myocardial Infarction 3. Stable or Unstable Angina 4. Coronary or Other Arterial Revascularization 5. Stroke or Trans Ischemic Attack (TIA) 6. Periphral Artery Disease (PAD) ofr Atherosclerotic Origin B. "Active Diagnosis" is defined as: 1. A diagnosis that is on the patient's Problem List 2. **OR**, A diagnosis code that is listed on an encounter 3. **OR**, A diagnosis code that is documented in a Progress Note, indicating that the patient is being treated or managed for the disease or condition at the time of the encounter *(continued)*

Measure Name	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease** *(continued)*
Denominator *(continued)*	**OR** II. Were ≥ 21 years old at the beginning of the Measurement Period **AND** have EVER had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL **OR** III. Were 40-75 years old at the start of the Measurement Period A. **AND,** Had an active diagnosis of Diabetes (Type 1 or Type 2) B. **AND** had a fasting or direct low-density lipoprotein cholesterol(LDL-C) level of 70-189 mg/dL during the Measurement Period or during the two years prior to the beginning of the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who had a prescription for statin therapy, documented as either initiated or continued, during the Measurement Period
Exclusions and/or Exceptions	Patients are **excepted** from the Denominator if the patient was not prescribed statin therapy, during the Measurement Period, due to one of the following medical reasons: I. The patient had a documented adverse effect (allergy or intolerance) to statin therapy II. The patient had an active diagnosis of Pregnancy III. The patient was breastfeeding IV. The patient was receiving Palliative Care V. The patient had an active diagnosis of Liver Disease or Hepatic Disease or Insufficiency VI. The patient had an active diagnosis of End-Stage Renal Disease (ESRD) VII. The most recent fasting or direct LDL-C level, for patients with Diabetes (and not currently receiving statin medication) was < 70 mg/dL
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must be seen for an applicable visit encounter during the Measurement Period** *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
Measure Documentation *(continued)*	**A. The following E&M codes identify applicable encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397 3. G0438 and G0439 **2. The E&M code must be recorded in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. If applicable, document a diagnosis (active or historical) for ASCVD in the patient's chart in eCW** **A. The following ICD-10 codes identify ASCVD** 1. I20.0 - I20.1, I20.8 - I20.9 and I23.7 2. I23.0 - I23.6 and I23.8 3. I24.0 and I24.8 - I24.9 4. I25.10, I25.110 - I25.111, I25.6, I25.700 - I25.701, I25.708 - I25.711, I25.718 - I25.721, I25. 728 - I25.731, I25.738 - I25.739 I25.750 - I25.751, I25.758 - I25.761, I25.768 - I25.769, I25.810 - I25.812, I25.83 - I25.84, I25.89 and I25.9 5. I63.00, I63.30 - I63.31, I63.311 - I63.312, I63.322, I63.40, I63.411 - I63.412, I63.419, I63.421, I63.422, I63.50 and I63.9 6. I65.1 7. I67.2 8. I69.80 - I69.81, I69.820 - I69.822, I69.831 - I69.834, I69.831, I69.841 - I69.844, I69.849, I69.863 - I69.865, I69.869 I69.890, I69.892 - I69.893, I69.898, I69.90 - I69.92, I69.920 -I69.922, I69.928, I69.934, I69.939, I69.941 - I69.944 I69.949, I69.96, I69.965, I69.990 - I69.993 and I69.998 9. I70.0 - I70.1, I70.201 - I70.203, I70.208 - I70.209, I70.211 - I70.213, I70.218 - I70.219, I70.229, I70.235, I70.245, I70.25 I70.269, I70.308, I70.393, I70.398 - I70.399, I70.8, and I70.90 -I70.91 10. E08.51 - E08.52 and E09.51 - E09.52 11. G45.0 - G45.1, G45.8 - G45.9 and G46.3 - G46.4 12. Z86.73 **B. Record the ASCVD diagnosis code in the patient's active Problem List or Medical History** *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
Measure Documentation *(continued)*	**C. If applicable, document a diagnosis code for Diabetes in the patient's chart in eCW** **1. The following ICD-10 codes identify Diabetes:** a. E10.8 - E10.11, E10.21 - E10.22, E10.29, E10.36, E10.39, E10.40 - E10.44, E10.49, E10.51 - E10.52, E10.59 E10.65, E10.69, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359 E10.610, E10.618, E10.620 - E10.622, E10.628, E10.630, E10.638, E10.641, and E10.649 b. E11.00 - E11.01, E11.8 - E11.9, E11.21 - E11.22, E11.29, E11.36, E11.39, E11.40 - E11.44, E11.49 E11.51 - E1.52, E11.59, E11.65, E11.69, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341 E11.349, E11.351, E11.359, E11.610, E11.618, E11.620 - E11.622, E11.628, E11.630, E11.638, E11.641, E11.649 c. E13.00 - E13.01, E13.8 - E13.11, E13.21 - E13.22, E13.29, E13.36, E13.39 - E13.44, E13.49, E13.51 - E13.52 E13.59, E13.65, E13.69, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351 E13.359, E13.610, E13.618, E13.620 - E13.622, E13.628, E13.630, E13.638, E13.641 and E13.649 d. O24.019, O24.02 - O24.03, O24. 011 - O24.013, O24.12 - O24.13, O24.32 - O24.33, O24.82 - O24.83 O24.111 - O24.113, O24.119, O24.311 - O24.313, O24.319, O24.811 - O24.813 and O24.819 **2. Record the Diabetes diagnosis code in the Problem List of the patient's chart in eCW** **D. Document LDL-C lab test results in the "Labs" section of the patient's chart in eCW** **1. If an LDL-C lab order has been electronically-generated and resulted in your EMR, no further action is necessary** **2. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** a. Access the "Labs" section of the patient's chart b. If necessary, click "New" to create a new Lab order 1) Click the "SEL" button, adjacent to the "Lab" search field *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
Measure Documentation *(continued)*	2) Find and select the appropriate LDL-C lab from the list of Lab options **c. Complete the following fields:** 1) **Order Date** a) If necessary, enter the date the lab was ordered b) Hint: if you do not know the order date, enter the date the test was performed 2) **Collection Date** **(MANDATORY)** a) Check the box in the "Collection Date" field b) Enter the date the sample was collected c) Hint: If you do not know the Collection Date, enter the date the test was performed 3) **Results** **(MANDATORY)** a) Check the "Received" box in the Results section **(MANDATORY)** b) Enter the date the test was performed **(MANDATORY)** c) Enter the numerical result in the yellow grid **(MANDATORY)** 4) **Reviewed**: Check the "Reviewed" box **E. Helpful Hints** 1. Maintain an accurate Problem List a. Remove diagnoses that are no longer active (Archive them to the Medical History section of the patient's chart) 2. If applicable, add diagnoses assessed by other physicians (e.g., specialist physicians, hospital/ER physicians, *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
	physicians seen in other states, previous physicians etc.) to the patient's Problem List (even if you are not managing the condition) 3. When adding a diagnosis to the Problem List, document the onset date (if known) in the associated "Onset Date" field 4. Search outside sources for missing and/or historical LDL-C lab test results a. Review documentation from outside sources (e.g., Progress Notes from other physicians, lab reports from other/independent lab facilities (e.g., VA or Quest labs), Powerchart etc.) for LDL-C lab results b. Manually-enter outside LDL-C lab results into a lab order that has been manually-generated in your EMR, as detailed above
Measure Documentation *(continued)*	**<u>To Satisfy This Measure</u>** *(Numerator Documentation)* **I. Document current statin medication therapy in the "Current Medications" section of the patient's chart in eCW** **A. Only the use of statins (HMG-CoA Reductase Inhibitors), NOT other cholesterol-lowering medications, satisfies this measure** 1. The statin medication must be documented as either "Initiated" or "Continued" during the Measurement Period 2. Document the presciption, or continued use, of a statin medication in one of the following ways: a. *Progress Notes → Treatment → Add* b. *Telephone/Web Encounter → Rx tab → Select Rx* c. *Telephone/Web Encounter → Virtual Visit → Current Medications* d. *Telephone/Web Encounter → Virtual Visit tab → Treatment → Add* e. *Progress Notes → Current Medications* *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
Measure Documentation *(continued)*	**II. Helpful Hints** A. If a statin medication is started and then stopped, document the reason for discontinuing the medication in a Progress Note or Telephone Encounter in the patient's chart in eCW B. If a medical reason exists for not prescribing a statin medication, document the reason, as detailed below (see "Exclusion and/or Exception Documentation")
Exclusion and/or Exception Documentation	**<u>To Exclude Patients From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If applicable, document an adverse effect (allergy or intolerance) to a statin medication in the "Allergies" section of the patient's chart** **A. Access the "Allergies" section of the patient's chart in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **<u>OR</u>**, From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**III. If applicable, document an active diagnosis for Pregnancy or Breastfeeding, during the Measurement Period, in the Problem List of the patient's chart in eCW** *(Note: The list of pregnancy-related ICD-10 codes is too extensive to include in this document)*
	IV. If applicable, document a diagnosis for a Palliative Care encounter (ICD-10 code Z51.5), during the Measurement Period, in the Problem List of the patient's chart in eCW
	V. If applicable, document a diagnosis of active Liver Disease or Hepatic Disease or Insufficiency, in the Problem List of the patient's chart in eCW **A. The following ICD-10 codes identify Liver Disease:** 1. B17.0, B17.2, B17.8, B17.10 - B17.11, B18.2, B18.8 - B18.9, B19.0 and B19.20 - B19.21 2. K70.0, K70.9, K70.30 - K70.31, K70.40 - K70.41, K71.3 - K71.4, K71.9 - K71.11, K71.50 - K71.51, K72.00 - K72.01 K72.10 - K72.11, K72.90 - K72.91, K73.0, K73.2, K73.8 - K73.9, K74.0 - K74.5, K74.60, K74.69, K75.4, K76.0 K76.2 - K76.3, K76.7, K76.9 and K76.89 3. O98.419 **B. The following ICD-10 codes identify Hepatitis A disease:** B15.0 and B15.9 **C. The following ICD-10 codes identify Hepatitis B disease** 1. B16.0 - B16.2, B16.9, B18.0 - B18.1 and B19.10 - B19.11 2. Z22.51
	VI. If applicable, document the diagnosis of End-Stage Renal Disease (ESRD) (N18.6) in the Problem List of of the patient's chart in eCW *(continued)*

Measure Name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *(continued)*
Trouble-Shooting *(continued)*	**Having Problems? Check Out These Trouble-Shooting Tips** **I. Confirm diagnoses assessed by specialists, ER and hospital physicians** A. Add applicable diagnoses to the patient's Problem List in your EMR B. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical History section of the patient's chart
	II. Confirm medications prescribed by specialists, ER and hospital physicians A. Add new medications to the patient's Current Medications list in the patient's chart in your EMR B. Keep the Current Medications list accurate by removing medications that are no longer being taken
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. "**PREV - 13 Preventive Care & Screening: Statin Therapy for Prevention & Treatment of Cardiovascular Disease**" II. **2016 GPRO PREV Supporting Documents**

Measure Name	Medication Management for People with Asthma
Relevance	NPO Population Clinical Quality Dashboard *[NQF 1799: Respiratory Measure]*
Measure Definition	***The percentage of patients, 5-64 years old and with a diagnosis of Persistent Asthma, who were dispensed a controller medication for Asthma that they remained on for at least 75% of their Treatment Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Treatment Period	The **Treatment Period** is defined as the period of time beginning with the prescription start date through the last day of the Measurement Period (12/31 of the current calendar year)
Proportion of Days Covered	The **Proportion of Days Covered (PDC)** is defined as the number of days that a patient is covered by at least one Asthma controller medication, divided by the number of days in the Treatment Period
Denominator	The **Denominator** consists of patients who: I. Are ≥ 5 and < 64 years of age at the start of the Measurement Period II. **AND,** Have been seen for an applicable E&M encounter during the Measurement Period III. **AND,** Have an active diagnosis for Persistent Asthma* during the Measurement Period IV. **AND,** Were dispensed an Asthma controller medication during the Measurement Period *Note: A patient is identified as having Persistent Asthma if at least one of the following criteria are met during both the Measurement Period and the year prior to the Measurement Period (Criteria need not be the same across both years): I. The patient had at least one ED visit with a principal diagnosis of Asthma II. The patient had at least one acute inpatient encounter with a principal diagnosis of Asthma III. The patient had at least 4 outpatient or Observations visits, on different dates of service, with any diagnosis of Asthma **AND** *(continued)*

Measure Name	**Medication Management for People with Asthma** *(continued)*
Denominator *(continued)*	at least 2 Asthma medication dispensing events (Visit type need not be the same for the four visits) IV. The patient had at least 4 Asthma medication dispensing events
Numerator	The **Numerator** consists of patients, from the Denominator, who remained on their Asthma controller medication for at least 75% of their treatment days in the Measurement Period
Exclusions and/or Exceptions	Patients are **excluded** from the Denominator for one of the following reasons: I. They have an active diagnosis for Acute Respiratory Failure during the Measurement Period II. They have an active diagnosis for COPD during the Measurement Period III. They have an active diagnosis for Cystic Fibrosis during the Measurement Period IV. They have an active diagnosis for Emphysema during the Measurement Period
Measure Documentation	**<u>To Qualify For This Measure</u>** *(Denominator Documentation)* **I. The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable Asthma office visits:** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99387 and 99391 - 99397 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Note → Billing*) **II. The patient must have an active diagnosis for Persistent Asthma documented in the chart in eCW** *(continued)*

Measure Name	Medication Management for People with Asthma *(continued)*
Measure Documentation *(continued)*	**A. The following ICD-10 codes indicate Persistent Asthma: J45.30 - J45.32, J45.40 - J45.42 and J45.50 - J45.52** **B. Record the diagnosis in the Problem List in the patient's chart in eCW** **<u>To Satisfy This Measure</u>** *(Numerator Documentation)* **I. Document a prescription for an Asthma controller medication in the patient's chart in eCW** **A. The following (generic) medications are considered Asthma controller medications** 1. Aminophylline 2. Beclomethasone 3. Budesonide 4. Budesonide - Formoterol 5. Ciclesonide 6. Cromolyn 7. Dyphylline 8. Dyphylline-Guaifenesin 9. Flunisolide 10. Fluticasone 11. Fluticasone CFC Free 12. Fluticasone Furoate 13. Fluticasone - Salmeterol 14. Formoterol - Mometasone 15. Guaifenesin - Theophylline 16. Mometasone 17. Montelukast 18. Omalizumab 19. Theophylline *(continued)*

Measure Name	Medication Management for People with Asthma *(continued)*
Measure Documentation *(continued)*	21. Zafirlukast 22. Zileuton **B. For more information on applicable Asthma controller medications (including dosages, routes, and corresponding NDC codes)** see Table MMA-B at www.ncqa.org **C. Record the Asthma controller medication in the "Current Medications" section of the patient's chart in one of the following ways:** 1. *Progress Note → Treatment → Add* 2. *Progress Note → Current Medications → Add Medication* 3. *Telephone/Web Encounter → Rx Tab → Select Rx* 4. *Telephone/Web Encounter → Virtual Visit → Treatment → Add* **D. To meet this measure, the Asthma controller medication prescription must contain enough doses to cover at least 75% of the days remaining in the current Measurement Period** **II. Determine the "Proportion of Days Covered" (PDC)** A. To determine if this measure is being met, calculate the PDC for a specific patient as follows: 1. Identify the "Index Prescription Start Date" (IPSD), which is the **earliest** dispensing event for any Asthma controller medication during the Measurement Period 2. Determine the Treatment Period, which is the number of of days, in the Measurement Period, beginning with the IPSD and ending with the last day of the Measurement Period 3. Count the number of days covered by at least one presciption for an Asthma controller medication 4. Calculate the PDC using the following equation: *(continued)*

Measure Name	Medication Management for People with Asthma *(continued)*
Trouble-Shooting *(continued)*	1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field **C. Confirm diagnoses assessed by specialists, ER and hospital physicians** 1. Add applicable diagnoses to the patient's Problem List in your EMR 2. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical History section of the patient's chart
	II. Confirm medications prescribed by specialists, ER and hospital physicians A. Add new medications to the patient's "Current Medications" list in the patient's chart in your EMR B. Keep the "Current Medications" list accurate by removing medications that are no longer being taken
	III. Document any adverse reactions (allergy or intolerance) to an Asthma controller medication in the "Allergies" section of the patient's chart **A. Access the "Allergies" section of the patient's chart in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** *(continued)*

Measure Name	Medication Management for People with Asthma *(continued)*
Trouble-Shooting *(continued)*	1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **Or**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) Or, free-type a reaction into the empty field *(continued)*

Measure Name	Medication Management for People with Asthma *(continued)*
Trouble-Shooting (continued)	d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**<u>For More Information</u>** I. HEDIS: "**Medication Management for People with Asthma (MMA)"** II. 2017 HEDIS for QRS Version: "**Comprehensive Diabetes Care (CDC)**"

Measure Name	Use of Appropriate Medications for People with Asthma
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0036: Respiratory Measure]*
Measure Definition	***The percentage of patients, 5-64 years of age and with a diagnosis of Persistent Asthma, who were appropriately prescribed medication during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 5 and < 64 years of age at the start of the Measurement Period II. **And** Have been seen for an applicable E&M encounter during the Measurement Period III. **And** Have an active diagnosis for Persistent Asthma* during the Measurement Period *Note: A patient is identified as having Persistent Asthma if at least one of the following criteria are met during both the Measurement Period and the year prior to the Measurement Period (Criteria need not be the same across both years): I. The patient had at least one ED visit with a principal diagnosis of Asthma II. The patient had at least one acute inpatient encounter with a principal diagnosis of Asthma III. The patient had at least 4 outpatient or Observations visits, on different dates of service, with any diagnosis of Asthma **AND** at least 2 Asthma medication dispensing events (Visit type need not be the same for the four visits) IV. The patient had at least 4 Asthma medication dispensing events
Numerator	The Numerator consists of patients, from the Denominator, who were dispensed at least one prescription for an Asthma controller medication during the Measurement Period *(continued)*

Measure Name	**Use of Appropriate Medications for People with Asthma** *(continued)*
Exclusions and/or Exceptions	Patients are **excluded** from the Denominator for one of the following reasons: I. They have an active diagnosis for Acute Respiratory Failure during the Measurement Period II. They have an active diagnosis for COPD during the Measurement Period III. They have an active diagnosis for Cystic Fibrosis during the Measurement Period IV. They have an active diagnosis for Emphysema during the Measurement Period
Measure Documentation	**<u>To Qualify For This Measure:</u>** *(Denominator Documentation)* **I. The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable Asthma office visits:** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99387 and 99391 - 99397 **B. The appropriate E&M code is recorded in the Billing section of the Progress Note for the visit** (*Progress Note → Billing*) **II. An active diagnosis for Persistent Asthma must be documented in the patient's chart in eCW** **A. The following ICD-10 codes indicate Persistent Asthma:** J45.30 - J45.32, J45.40 - J45.42 and J45.50 - J45.52 **B. Add the appropriate diagnosis to the Problem List in the patient's chart in eCW**
	<u>To Satisfy This Measure:</u> *(Numerator Documentation)* **I. Document a prescription for, and use of, an Asthma controller medication in the "Current Medications" section of the patient's chart in eCW** *(continued)*

Measure Name	Use of Appropriate Medications for People with Asthma *(continued)*
Measure Documentation *(continued)*	**A. The following (generic) medications are considered Asthma controller medications:** 1. Aminophylline 2. Beclomethasone 3. Budesonide 4. Budesonide - Formoterol 5. Ciclesonide 6. Cromolyn 7. Dyphylline 8. Dyphylline-Guaifenesin 9. Flunisolide 10. Fluticasone 11. Fluticasone CFC Free 12. Fluticasone Furoate 13. Fluticasone - Salmeterol 14. Formoterol - Mometasone 15. Guaifenesin - Theophylline 16. Mometasone 17. Montelukast 18. Omalizumab 19. Theophylline 20. Zafirlukast 21. Zileuton **B. Record the Asthma controller medication in the patient's chart from one of the following locations:** 1. *Progress Note → Treatment → Add* 2. *Progress Note → Current Medications → Add Medication* 3. *Telephone/Web Encounter → Rx Tab → Select Rx* 4. *Telephone/Web Encounter → Virtual Visit → Treatment → Add* *(continued)*

Measure Name	Use of Appropriate Medications for People with Asthma *(continued)*
Measure Documentation *(continued)*	**C. Document any allergy or intolerance to an Asthma controller medication, in the "Allergies" section of the patient's chart in eCW** 1. Also, if an Asthma controller medication is discontinued, for any reason, document the reason for stopping the medication in a Progress Note or Telephone Encounter in the patient's chart 2. See the "Trouble-Shooting" section, below, for instructions on how to add a new allergy or intolerance to the patient's chart **II. For more information on applicable Asthma controller medications (including dosages, routes, and corresponding NDC codes), see Table MMA-B at www.ncqa.org**
Exclusion and/or Exception Documentation	**To Exclude a Patient from the Denominator** *(Exclusion and/or Exception Documentation)* **I. If applicable, document one of the following ICD-10 codes for Acute Respiratory Failure in the Problem List of the patient's chart in eCW** J96.00 - J96.02 and J96.20 - J96.22
	II. If applicable, document one of the following ICD-10 codes for Persistent COPD in the Problem List of the patient's chart in eCW J44.0, J44.1 and J44.9
	III. If applicable, document one of the following ICD-10 codes for Cystic Fibrosis in the Problem List of the patient's chart in eCW E84.0, E84.11, E84.19, E84.8 and E84.9
	IV. If applicable, document one of the following ICD-10 codes for Emphysema in the Problem List of the patient's chart in eCW J43.0 - J43.2, J43.8 - J43.9, J68.4 and J98.2 - J98.3 *(continued)*

Measure Name	Use of Appropriate Medications for People with Asthma *(continued)*
Trouble-Shooting	**Having Problems? Check Out the Following Trouble-Shooting Tips** **I. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR** **A. Verify that the correct ICD-10 diagnosis code has been added** **B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field **C. Confirm diagnoses assessed by specialists, ER and hospital physicians** 1. Add applicable diagnoses to the patient's Problem List in your EMR 2. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical History section of the patient's chart
	II. Confirm medications prescribed by specialists, ER and hospital physicians A. Add new medications to the patient's "Current Medications" list in the patient's chart in your EMR B. Keep the "Current Medications" list accurate by removing medications that are no longer being taken *(continued)*

Measure Name	Use of Appropriate Medications for People with Asthma *(continued)*
Trouble-Shooting *(continued)*	**III. Document any adverse reactions (allergy or intolerance) to an Asthma controller medication in the "Allergies" section of the patient's chart** **A. Access the "Allergies" section of the patient's chart in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. **"Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **Or**, free-type an Allergy into the "Agent/Substance" field *(continued)*

Measure Name	Use of Appropriate Medications for People with Asthma *(continued)*
Trouble-Shooting *(continued)*	c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **Or,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. HEDIS: "**Use of Appropriate Medications for People with Asthma**" II. eClinicalWorks "**CMS 126 - Use of Appropriate Medications for Asthma**" (October, 2015)

Measure Name	Body Mass Index (BMI) Screening and Follow-Up
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0421: Prevention & Screening Measure]* ACO Quality Measure #16 *[GPRO: Preventive Measure}* MIPS Clinical Quality Measure *[CMS 69 (EHR)/Registry 128: Process Measure]*
Measure Definition	***The percentage of pages, 18 years of age and older, with a calculated BMI documented during the most recent visit, or within the previous 6 months, and, if the BMI is outside of normal parameters, a follow-up plan is documented during the current visit, or within the previous 6 months*** Normal range is defined as: 18.5 < BMI < 25 for patients 18 years of age and older
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are 18 years of age or older II. **AND,** Have been seen for at least one applicable E&M encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Have had a calculated BMI documented A. During the most recent encounter B. **Or,** within the 6 months prior to the most recent encounter II. **And**, if the BMI value is outside of normal parameters, have had a follow-up plan documented A. During the most recent encounter *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Numerator *(continued)*	B. **Or,** within the 6 months prior to the most recent encounter III. Examples of follow-up plans include, but are not limited to: A. Documentation of education B. Referral 1. E.g., To a Registered Dietician 2. E.g., To a Nutritionist 3. E.g., To an Occupational Therapist 4. E.g., To a Physical Therapist 5. To a Primary Care Provider 6. E.g., To an Exercise Physiologist 7. E.g., To a Mental Health Professional specializing in weight management 8. E.g., To a Bariatric Surgeon C. Pharmocological Interventions (including dietary supplements) D. Exercise Counseling (including suggestions for an exercise plan)
Exclusions and/or Exceptions	Patients are **excluded/excepted** from the Denominator for one of the following reasons: I. They have an active diagnosis of Pregnancy during the Measurement Period II. A medical reason exists for failure to calculate and document a BMI duirng the Measurement Period (I.e., The patient is in an urgent or emergent medical situation where time is of the essence) III. A patient reason exists for failure to calculate and document a BMI during the Measurement Period (I.e., The patient has refused measurement of weight and/or height) *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient has been seen for an applicable E&M encounter during the Measurement Period** A. The following E&M codes identify applicable visit enounters 1. 90791 - 90792 2. 90832, 90834, and 90837 3. 96150 - 96152 4. 97001 and 97003 5. 97802 - 97803 6. 98960 7. 99201 - 99205 and 99212 - 99215 8. G0101, G0108, G0270 - G0271, G0402, G0438 - G0439, and G0447 9. D7140 and D7210 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** **(***Progress Notes → Billing*)
	To Satisfy This Measure *(Numerator Documentation)* **I. Document a calculated BMI for the patient during the E&M visit** A. Measure the patient's height and weight **B. Document the height and weight in the "Vitals" section of the Progress Note for the visit** 1. I.e., *Progress Notes → Vitals → Height and Weight → BMI* 2. A calculated BMI should display in the Vitals section of the Progress Note *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Measure Documentation *(continued)*	**II. Document an abnormal BMI follow-up plan in a structured data field** **A. eCW suggests the following path for an Above-Normal BMI Follow-Up Plan** ***Progress Notes → Preventive Medicine → Counseling*** ↓ ***BMI Care Goal Follow-Up Plan*** → ***Above-Normal BMI Follow-Up*** ↓ ***Select Option*** 1. The required structured data fields are outlined (boxed) in the pathway above 2. If necessary, generate (and map) the above structured data path, as follows a. Add "BMI Care Goal Follow-Up Plan" as an item in the Counseling folder in Preventive Medicine 1) From within a Progress Note or Virtual Visit, click on the "Preventive Medicine" link 2) Click on the Counseling folder 3) If "BMI Care Goal Follow Up" is not listed in the options that subsequently display a) Click the carat adjacent to the "Custom" button b) Select "New Item" c) Type "BMI Care Goal Follow-Up Plan" in the "Name" field d) Check the "Structured Data" box e) Click "OK" to close the window b. To map the field, click the "Community" tab in the top menu bar c. Select "Mappings" d. Select "Structured Data" 1) A Structured Data "Mapper" window will open 2) Enter the following information for both the Community and Local sides: *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Measure Documentation *(continued)*	a) Section = "Preventive Medicine" b) Category = "Counseling" c) Item = "BMI Care Goal Follow-Up Plan" 3) A list of structured data options will appear on the Community side (Items in black font have not yet been mapped) a) Select "Above Normal BMI Follow-Up" from the Community side b) Click "Add" to add the option to the Local side and map it to the Community element c) Both options should now be displayed in blue font 4) A new window, containing the structured options for "Above Normal BMI Follow-Up" will then appear a) Select an option from the Community side b) Click "Add" to add it to the Local side and map it to its Community counterpart c) Repeat with the remaining Community options B. eCW suggests the following path for a "Below-Normal BMI Follow-Up Plan ***Progress Notes*** → ***Preventive Medicine*** → ***Counseling*** ↓ ***BMI Care Goal Follow-Up Plan*** → ***Below-Normal BMI Follow-Up*** ↓ ***Select Option*** 1. The required structured data fields are outlined (boxed) in the pathway above 2. If necessary, generate (and map) the "Below-Normal BMI Follow-Up Plan" structured data field (and associated options), as detailed above **C. Record an abnormal BMI follow-up plan in the appropriate structured data field in the Progress Note for the visit** *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Measure Documentation *(continued)*	

1. *Progress Notes → Assessments*
2. *Progress Notes → Assessments → Problem List*

V. **<u>Or</u>, Record a dietary consultation order in a structured data field**

A. eCW recommends the following path for a dietary consultation order

Progress Notes → Preventive Medicine → Counseling

↓

Provider to Provider Communication → *Dietary Consultation Order Provided*

↓

Select Yes or No

1. The required structured data fields are outlined (boxed) in the path above
2. If necessary, generate (and map) the above structured data path, as follows

a. Add "Provider to Provider Communication" as an item in the "Counseling" folder in Preventive Medicine

1) From within a Progress Note or Virtual Visit, click on the "Preventive Medicine" link
2) Click on the "Counseling" folder
3) If "Provider to Provider Communication" is not listed in the options that subsequently display

a) Click the carat adjacent to the "Custom" button
b) Select "New Item"
c) Type "Provider to Provider Communication" in the "Name" field
d) Check the "Structured Data" box
e) Click "OK" to close the window

b. To map the fields, click the "Community" tab in the top menu bar in eCW

(continued)

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Measure Documentation *(continued)*	1) Select "Mappings" 2) Select "Structured Data" a) A Structured Data "Mapper" window will open b) Enter the following information for both the Community and Local sides: (1) Section = Preventive Medicine (2) Category = Counseling (3) Item = Provider to Provider Communication c) A list of structured data options will appear on the Community side (Items in black font have not yet been mapped) (1) Select "Above Normal BMI Follow-Up" from the Community side (2) Click "Add" to add the option to the Local side and map it to the Community element (3) Both options should now be displayed in blue font 3. Record the dietary consultation in the structured data field in the Progress Note for the visit 4. Variations of the above structured data path (e.g., created in a different section of the Progress Note are acceptable as long as the fields are mapped to their Community counterparts delineated in the path above **VI. <u>Or</u>, Initiate a referral for (Reason = Over- or Underweight) for BMI management** A. The referral must be made to one of the following specialties: 1. Physical Medicine & Rehabilitation 2. Psychiatry 3. Community-Based Dietician 4. Community-Based Occupational Therapist *(continued)*

Measure Name	**Body Mass Index (BMI) Screening and Follow-Up** *(continued)*
Measure Documentation *(continued)*	5. Dietician 6. General Physician 7. General Practitioner 8. Hospital-Based Dietician 9. Hospital-Based Occupational Therapist 10. Liaison Psychiatry Service 11. Mental Health Counseling 12. Mental Health Counselor 13. Mental Health Counseling Service 14. Mental Health Counselor 15. Mental Health Team 16. Mental Health Worker 17. Occupational Therapy 18. Psychiatry Service 19. Physician **B. Record this referral in the following location for the Progress Note for the visit:** **(Progress Notes** → *Treatment → Outgoing Referral → Specialty)* **VII. <u>OR</u>, Order a medication (for being over- or underweight) from one of the following locations within the Progress Note for the visit** A. *Progress Notes → Treatment → Add* B. *Telephone/Web Encounter → Rx tab → Select Rx* C. *Telephone/Web Encounter → Virtual Visit tab → Treatment → Add*
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If applicable, document an appropriate diagnosis for Pregnancy in the Problem List of the patient's chart in eCW** *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**II. If applicable, document the inability to record a calculated BMI, during the Measurement Period, due to a medical or patient reason, in a structured data field, as follows:** **A. eCW recommends the following data path** *Progress Notes → Examination → CQM Exceptions* ↓ *BMI not documented* → *Reason* → *Select Medical or Patient Reason* ↓ *Select type of (Medical or Patient) reason* 1. The required structured data fields are outlined (boxed) in the path above **2. If necessary, generate (and map) the above structured data path, as follows:** a. Add "BMI Not Documented" as an item in the "CQM Exceptions" folder in Examination 1) From within a Progress Note or Virtual Visit, click on the "Examination" link 2) Click on the "CQM Exceptions" folder 3) If "BMI Not Documented" is not listed in the options that subsequently display a) Click the carat adjacent to the "Custom" button b) Select "New Item" c) Type "BMI Not Documented" in the "Name" field d) Check the "Structured Data" box e) Click "OK" to close the window b. To map the fields, click on the "Community" tab in the top menu bar within eCW 1) Select "Mappings" 2) Select "Structured Data" *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a) A Structured Data "Mapper" window will open b) Enter the following information for both the Community and Local sides: (1) Section = Examination (2) Category = CQM Exceptions (3) Item = BMI Not Documented c) A list of structured data options will appear on the Community side (Items in black font have not yet been mapped) (1) Select "Reason" from the Community side (2) Click "Add" to add the option to the Local side and map it to the Community element (3) Both options should now be displayed in blue font d) A new window, containing the structured options for "Reason" will then appear (1) Select an option from the Community side (2) Click "Add" to add it to the Local side and map it to its Community counterpart (3) Repeat with the remaining Community options (4) Repeat the process until all necessary items on the Community side have been added to the Local side and mapped
Trouble-Shooting	**Having Problems? Check Out the Following Trouble-Shooting Tips** **I. Verify that the Vitals fields in your EMR are properly configured** A. From the EMR menu, select "Vitals" B. Select "Configure Vitals" *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
Trouble-Shooting *(continued)*	C. Verify that the BMI parameter is selected to display in the Progress Note
	II. Verify that all structured data fields used are mapped to the correct Community elements in your EMR For further assistance with structured data fields and mapping issues, contact an eCW Technical Service representative
	III. Verify that, for every abnormal BMI recorded, a follow-up plan of action has been documented, either at the time of the current visit or within the 6 months prior to the current visit
	IV. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Verify that the correct ICD-10 diagnosis code has been added **B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505) *(continued)*

Measure Name	Body Mass Index (BMI) Screening and Follow-Up *(continued)*
For More Information	**For More Information** I. NQF 0421: "**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**" II. eClinicalWorks "**MIPS - CMS 69- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up"** III. eClinicalWorks "**MIPS - Registry 128 (NQF 0421) (MIPS - CMS 69) - Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan**" IV. **2016 GPRO PREV Supporting Documents**

Measure Name	Controlling High Blood Pressure
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0018: Cardiac Measure]* ACO Quality Measure #28 *[GPRO: At-Risk Measure]* MIPS Clinical Quality Measure *[CMS 165 (EHR)/Registry 236: Intermediate Outcome Measure]*
Measure Definition	The percentage of patients, 18-85 years of age and with a diagnosis of Hypertension, whose blood ***pressure was adequately controlled (< 140/90) during the Measurement Period***
Measuremrnt Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Have had a diagnosis of Eseential Hypertension within the first 6 months of the Measurement Period or at any time prior to the Measurement Period II. **AND,** Have been seen for an applicable encounter during the Measurement Period III. **AND**, Are 18-85 years of age on the date of the encounter Note: Patients MUST be diagnosed with Hypertension within the first 6 months of the Measurement Period (Jan. 1 - June 30) or at any time prior to the start of the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, whose most recent blood pressure during the Measurement Period was < 140/90 Please note the following: **I. Only blood pressures readings obtained by a clinician in the provider's office are acceptable. The following types of blood pressure readings DO NOT satisy this measure:** A. Blood pressure readings from the patient's home (including readings directly from monitoring devices *(continued)*

Measure Name	**Controlling High Blood Pressure** *(continued)*
Numerator *(continued)*	B. Blood pressure readings taken at an outpatient visit for which the sole purpose of the visit is the performance of a diagnostic test or surgical procedure (e.g., sigmoidoscopy, removal of a mole etc.) C. Blood pressure readings obtained the same day as a major diagnostic or surgical procedure (e.g., a stress test, endoscopy, administration of IV contrast dye for a radiologic procedure etc.) **II. If multiple blood pressure readings are obtained on the same date of service, report the lowest systolic and lowest diastolic readings as the representative blood pressure on that date**
Exclusions and/or Exceptions	Patients are **excluded** from the Denominator for one of the following reasons: I. They have a diagnosis for Pregnancy during the Measurement Period II. They have a diagnosis for End Stage Renal Disease (ESRD) during the Measurement Period III. They have a diagnosis for Chronic Kidney Disease, stage 5 during the Measurement Period IV. They have had a Kidney Transplant procedure performed before the end of the Measurement Period V. They have had a Dialysis service or procedure performed during the Measurement Period VI. They have had an ESRD monthly outpatient services procedure performed before the end of the Measurement Period
Measure Documentation	**<u>To Qualify For This Measure</u>** *(Denominator Documentation)* **I. The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes indicate applicable encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 -99397 3. G0438 - G0439 *(continued)*

Measure Name	Controlling High Blood Pressure *(continued)*
Measure Documentation *(continued)*	**B. Add the appropriate E&M code to the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. If necessary, add a diagnosis of Essential Hypertension to the Problem List in the patient's chart in eCW** **A. The following ICD-10 code identifies Essential Hypertension:** I10 **B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	To Satisfy This Measure *(Numerator Documentation)* **I. Take the patient's blood pressure and record it in the Vitals section of the Progress Note for the visit** **A. Record the Blood Pressure in the yellow "BP (mmHg)" box in Vitals** 1. Record the Blood Pressure in the format xxx/xx 2. Do not enter initials or any other special characters in the field 3. The Blood Pressure reading recorded in the yellow box is the only Blood Pressure reading that qualifies for satisfaction of this measure *(continued)*

Measure Name	Controlling High Blood Pressure *(continued)*
Measure Documentation *(continued)*	a. If additional Blood Pressure readings are taken during the encounter, record only the lowest Systolic and Diastolic values in the yellow box b. The additional Blood Pressure measurements can be recorded in the " Notes" area of the "Vitals" section of the Progress Note **B. Only the most recent Blood Pressure reading of the Measurement Period is considered (I.e., the last Blood Pressure reading recorded during the calendar year)** 1. Only a final Systolic value < 140 and a final Diastolic value < 90 satisfy this measure 2. It is expected that Blood Pressure will be measured every time the patient presents for one of the applicable visit types 3. I.e., If a patient's Blood Pressure is not measured and/or documented during an applicable encounter, the patient's Blood Pressure is assumed to be "uncontrolled"
Exclusion and/or Exception Documentation	**<u>To Exclude Patients From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. To exclude a patient who is pregnant during the Measurement Period, document a diagnosis for Pregnancy in one of the following locations:** A. As an Assessment for an applicable encounter (*Progress Notes →Assessment*) B. In the Problem List of the patient's chart in eCW
	II. To exclude a patient who has a diagnosis of End Stage Renal Disease (ESRD) during the Measurement Period, document the diagnosis code for ESRD (N18.6) **in one of the following locations:** A. As an Assessment for an applicable encounter (*Progress Notes →Assessment*) B. In the Problem List of the patient's chart in eCW *(continued)*

Measure Name	Controlling High Blood Pressure *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**III. To exclude a patient who has a diagnosis of Chronic Kidney Disease, Stage 5 (CKD Stage 5) during the Measurement Period, document the diagnosis code for CKD Stage 5** (N18.5) **in one of the following locations:** A. As an Assessment for an applicable encounter (*Progress Notes →Assessment*) B. In the Problem List of the patient's chart in eCW
	IV. To exclude a patient that has had a kidney transplant (performed any time before the end of the Measurement Period), document a CPT code for a kidney transplant procedure in a Progress Note or Virtual Visit **A. The following CPT codes identify a kidney transplant procedure:** 50340, 50360, 50365, 50370 and 50380 **B. Document the CPT code in one of the following places:** 1. *Progress Notes (or Virtual Visit) → Treatment → Procedures* 2. *Progress Notes (or Virtual Visit) → Billing*
	V. To exclude a patient who has received a Dialysis service or procedure during the Measurement Period, record a CPT code for the dialysis service or procedure in a Progress Note or Virtual Visit **A. The following CPT codes identify Dialysis services and procedures:** 1. 36147-36148, 36800, 36810, 36845, 36818 - 36821 and 36831 - 36833 2. 90920 - 90921, 90924 - 90925, 90935, 90937, 90940, 90945 and 90947 3. G0257 **B. Document the CPT code in one of the following places:** 1. *Progress Notes (or Virtual Visit) → Treatment → Procedures* 2. *Progress Notes →Billing* *(continued)*

Measure Name	Controlling High Blood Pressure *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**VI. To exclude a patient who has received ESRD outpatient services during the Measurement Period, record a CPT code for the ESRD outpatient service in a Progress Note or Virtual Visit** **A. The following CPT codes identify ESRD outpatient services:** 1. 90957 - 90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997 and 90999 2. 99512 **B. Document the CPT code in one of the following places:** 1. *Progress Notes (or Virtual Visit) → Treatment → Procedures* 2. *Progress Notes →Billing*
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that the Blood Pressure vital field has been configured in your EMR** A. From within eClinicalWorks, go to *EMR → Vitals → Configure Vitals → BP* B. Verify that the Blood Pressure vital is selected
	II. Verify that no additional special characters or letters have been entered in the Blood Pressure "Vitals" field
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505) *(continued)*

Measure Name	**Controlling High Blood Pressure** *(continued)*
For More Information	**For More Information** I. NQF 0018: "**Controlling High Blood Pressure**" II. eClinical Works "**MIPS - CMS 165 - Controlling High Blood Pressure**" III. eClinicalWorks "**MIPS - Registry 236 (NQF 0018) (MIPS - CMS 165) - Controlling High Blood Pressure**"

Measure Name	Breast Cancer Screening
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0031/2372: Prevention and Screening Measure]* ACO Quality Measure #20 [GPRO: Preventive Measure] MIPS Clinical Quality Measure *[CMS 125 (EHR)/Registry 112: Process Measure]*
Measure Definition	***The percentage of patients, 50-74 years of age, who had a mammogram to screen for breast cancer within the Measurement Period or the 15 months prior to the start of the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are female II. **And**, Are ≥ 50 and < 74 years of age at the beginning of the Measurement Period III. **And**, Have been seen for an applicable encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have had one or mammograms during the Measurement Period or the 15 months prior to the Measurement Period
Exclusions and/or Exceptions	Patients are **excluded** from the Denominator for one of the following reasons: I. The patient has had 2 unilateral mastectomies performed before the end of the Measurement Period II. The patient has had a bilateral mastectomy before the end of the Measurement Period *(continued)*

Measure Name	Breast Cancer Screening *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must have been seen for one of the following applicable E&M encounters during the Measurement Period** A. 99201 -99205 and 99212 - 99215 B. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397 C. G0402 and G0438 - G0439 **II. Record the E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure (Numerator Documentation) **I. A Mammogram must have been performed (during the Measurement Period or within the 15 months prior to the Measurement Period) and documented as a Diagnostic Image (DI) in the "DI" section of the patient's chart in eCW** **A. If the mammogram DI order has been electronically-generated and resulted in your EMR, no further action is necessary** **B. Otherwise, generate a new DI order and/or manually-enter the mammogram results, as follows:** 1. Access the "DI" section of the patient's chart 2. If necessary, click "New" to generate a new DI order a. Click the "SEL" button adjacent to the DI name field b. Find and select the appropriate Mammogram test from the list of DI options 3. Complete the following fields: *(continued)*

Measure Name	Breast Cancer Screening *(continued)*
Measure Documentation *(continued)*	a. **Order Date** 1) Enter the date the test was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** 1) Check the box in the "Collection Date" field **(MANDATORY)** 2) Enter the date the sample was collected c. **Results** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Select an option from the "Results" drop-down box (e.g., Positive or Negative, Normal or Abnormal) d. **Reviewed**: Check the "Reviewed" box **(MANDATORY)** II. Helpful Hints A. If you are not the ordering physician, instruct your patients to have a copy of the report sent directly to your office B. For quick and easy reference, enter the date of the Mammogram in the "Gynecologic History" section of the patient's chart C. If the patient is reporting a previous Mammogram, documentation in the Medical Record must include both the date **AND** the result of the test *(continued)*

Measure Name	Breast Cancer Screening *(continued)*
Exclusion and/or Exception Documentation	**To Exclude Patients From This Measure** *(Exclusion and/or Exception Documentation)* **I. Identify patients that have had two unilateral Mastectomies, or 1 bilateral Mastectomy (before the end of the Measurement Period)** **A. Document the mastectomy by adding the following ICD-10 diagnosis code to the Problem List in the patient's chart in the EMR** Z90.13 (Acquired Absence of Bilateral Breasts and Nipples) B. Hint: For quick reference, you may also wish to document the mastectomy in the "Gynecologic History" section of the patient's chart in eCW
	II. For exclusion from the MIPS version of this measure, document a CPT code for a Bilateral Mastectomy (1 count) or Unilateral Mastectomy (2 counts) in the Billing section of a Progress Note or Virtual Visit **A. The following CPT codes identify a Bilateral Mastectomy:** 19180, 19200, 19220, 19240, 19303, and 19305 - 19307 (A 50 modifier may be required) **B. The following CPT codes identify Unilateral Mastectomies:** 19180, 19200, 19220, 19240, 19303 and 19305 - 19307
Trouble-Shooting	**Having Problems? Check Out the Following Trouble-Shooting Tips** **I. Verify that the Mammogram DIs are properly mapped to their Community element counterparts in your EMR** A. The following Mammogram DIs must be mapped to Community elements 1. Mammogram, Uni Right 2. Mammogram, Uni Left 3. Mammogram, Screening *(continued)*

Measure Name	Breast Cancer Screening *(continued)*
Trouble-Shooting *(continued)*	4. Mammogram, Diagnostic **B. To verify mapping** 1. From within eCW, click the Community tab in the top toolbar 2. Click on "Mappings" 3. Click on "Diagnostic Imaging" 4. Find "Mammogram, Screening" on the Community side a. Verify that the test is displayed in blue font, indicating that mapping has occurred b. Verify that all variations of bilateral screening Mammogram tests available to you are included in the list of associated local links c. If a specific Mammogram test is not included in the associated local links, map it 1) Select "Mammogram, Screening" on the Community side 2) Find and select the missing Mammogram test(s) on the Local side 3) Click "Map" 5. Repeat the procedure for the remaining Mammogram types (Uni Right, Uni Left and Diagnostic) 6. For further assistance with mapping issues, contact eCW
	II. Verify that all mandatory fields have been completed for manually-entered Mammogram DIs **A. I.e., Verify the following:** 1. I.e., Verify that the "Performed Date" box has been checked 2. I.e., Verify that the (Results) "Received" box has been checked 3. I.e., Verify that a "Results" date has been entered 4. I.e., Verify that the Result has been entered in the "Result" field 5. I.e., Verify that the "Reviewed" box has been checked *(continued)*

Measure Name	**Breast Cancer Screening** *(continued)*
Trouble-Shooting *(continued)*	**B. Helpful Hints** 1. Search all available sources (e.g., Powerchart etc.) for missing Mammogram DI information 2. For quick reference, add the patient's OB/GYN physician, if applicable, to the "Circle of Care" section of the patient's chart
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
References	**<u>For More Information</u>** I. NQFs 0031 and 2372: "**Preventive Care and Screening: Breast Cancer Screening"** II. eClinicalWorks "**CMS 125 - Breast Cancer Screening**" III. eClinicalWorks "**MIPS - Registry 112 (NQF 2372) (MIPS - CMS 125) - Breast Cancer Screening**" IV. **2016 GPRO PREV Supporting Documents**

Measure Name	Cervical Cancer Screening
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0032: Prevention & Screening Measure]* MIPS Clinical Quality Measure *[CMS 124 (EHR): Process Measure]*
Measure Definition	***The percentage of women, 21 - 64 years of age, who were screened for cervical cancer according to one of the following criteria:*** ***I. Women, 21 - 64 years of age, who have had a cervical cytology test performed at least once every three years (i.e., within the current Measurement Period, or the two years prior to the current Measurement Period)*** ***II. Women, 30-64 years of age, who have had a cervical cytology test performed, in conjunction with a Human Papillomavirus (HPV) DNA co-test at least once every five years (i.e., within the current Measurement Period or the four years prior to the current Measurement Period)***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 23 and < 64 years of age at the start of the Measurement Period II. **And,** Are female III. **And,** Have been seen for an applicable visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: **I. Have had a Gynecologic Cytology lab test performed at least once within the past 3 years** A. Valid for any patient from the Denominator B. Lab test must be documented within the Measurement Period or the two years prior *(continued)*

Measure Name	**Cervical Cancer Screening** *(continued)*
Numerator *(continued)*	II. **Or**, Have had a Gynecologic Cytology lab test performed at least one within the past 5 years A. Valid for patients, from the Denominator, aged 30-64 years only B. Valid only if the Gynecologic Cytology lab test is performed concurrent with, or within one day of, an HPV DNA co-test C. Lab tests must be documented within the current Measurement Period or the four years prior
Exclusions and/or Exceptions	Patients are **excluded** from the Denominator if they have had a Total Hysterectomy performed before the end of the Measurement Period "Total Hysterectomy" is defined as the complete removal of both the uterus and cervix; No residual cervix remains, but ovaries may, or may not, be present
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **I. Document the results of a Gynecologic Cytology test in the "Labs" section of the patient's chart in eCW** *(continued)*

Measure Name	Cervical Cancer Screening *(continued)*
Measure Documentation *(continued)*	**A. If the Gynecologic Cytology Test lab order has been electronically-generated and resulted in your EMR, no further action is necessary** **B. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** 1. Access the "Labs" section of the patient's chart 2. If necessary, click "New" to create a new Lab order a. Click the "SEL" button, adjacent to the "Lab" search field b. Find and select the appropriate Gynecologic Cytology lab from the list of Lab options **3. Complete the following fields:** a. **Order Date** 1) If necessary, enter the date the lab was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Type the result (Positive or Negative, Normal or Abnormal) in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box *(continued)*

Measure Name	Cervical Cancer Screening *(continued)*
Measure Documentation *(continued)*	**II. If applicable, enter the results of the HPV DNA co-test in the "Labs" section of the patient's chart in eCW** **A. The HPV DNA co-test lab order will need to be manually-generated and resulted** **B. Follow the procedure, detailed above, to manually generate, and result, the lab order, taking note of the following:** 1. Select "HPV DNA, High Risk Analysis" as the Lab 2. If you do not know the Order Date, use the same entered for the Gynecologic Cytology lab 3. Be sure to check the box in the "Collection Date" field **4. Enter the same Collection Date as that entered for the Gynecologic Cytology lab (MANDATORY)** 5. If you do not know the Results Date, use the same date entered for the Gynecologic Cytology lab 6. Be sure to check the "Received" box in the Results section 7. Be sure to enter a result (i.e., Positive or Negative) in the yellow grid in the "Results" section 8. Be sure to check the "Reviewed" box
Exclusions and/or Exceptions Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion and/or Exception Documentation)* **If applicable, document a Total Hysterectomy in the patient's chart in eCW, as follows** **A. Add the ICD-10 code** Z90.710 **(Acquired Absence of both Cervix and Uterus) to the Problem List of the patient's chart in eCW** *(Required for exclusion from the NPO Population Clinical Data Dashboard measure)* **B. Note: A CPT code is required to also exclude these patients from a corresponding MIPS clinical quality measure** **1. The following CPT codes identify a Total Hysterectomy (with no residual cervix) procedure** a. 51925 b. 57540 and 57545 *(continued)*

Measure Name	Cervical Cancer Screening *(continued)*
Exclusion and/or Exception Documentation *(continued)*	c. 57550 and 57555 - 57556 d. 58150 and 58152 e. 58200, 58210, 58240, 58260, 58262 - 58263, 58267, 58270, 58275, 58280, 58285, and 58290 - 58294 g. 59135 **2. Record the appropriate CPT code in one of the following sections of a Progress Note or Virtual Visit** a. *Progress Notes → Treatment → Procedures* b. *Progress Notes → Billing*
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that the correct LOINC code is linked to the Gynecologic Cytology and/or HPV DNA co-test labs** **A. One of the following LOINC codes must be linked to the Gynecologic Cytology (Pap Smear) lab** 1. 10524-7 2. 18500-9 3. 19762-4, 19764-0, 19765-7, 19766-5 and 19774-9 4. 33717-0 5. 47527-7 and 47528-5 **B. The following LOINC code must be linked to the HPV DNA co-test lab:** 59420-0 **C. To associate a new, or update an existing, LOINC code with a Lab, do the following:** 1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open *(continued)*

Measure Name	Cervical Cancer Screening *(continued)*
Trouble-Shooting *(continued)*	a. Find and select the appropriate lab b. Click the "Attribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window 3) Click "OK" to exit the Lab-specific window 4. Click the X (in the top, right-hand corner) to close the "Labs" window
	II. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results) A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked
	III. Verify that the Collection date is the same for both a Gynecogic cytology lab and it's HPV DNA co-test counterpart
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)

(continued)

Measure Name	Chlamydia Screening: Ages 16-20 *(continued)*
Measure Documentation *(continued)*	**A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 -99345, 99347 - 99350, 99381 - 99384 and 99391 - 99397 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **Document the result of a *Chlamydia* Test in the "Labs" section of the patient's chart in eCW** **A. If the Chlamydia Test lab order has been electronically-generated <u>and</u> resulted in your EMR, no further action is necessary** **B. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** 1. Access the "Labs" section of the patient's chart 2. If necessary, click "New" to create a new Lab order a. Click the "SEL" button, adjacent to the "Lab" search field b. Find and select the appropriate Chlamydia lab from the list of Lab options **3. Complete the following fields:** a. **Order Date** 1) If necessary, enter the date the lab was ordered 2) Hint: if you do not know the order date, enter the date the test was performed *(continued)*

Measure Name	Chlamydia Screening: Ages 16-20 *(continued)*
Measure Documentation *(continued)*	**b. Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed **c. Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Type the result (Positive or Negative) in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box
Exclusion and/or Exception Documentation	**<u>To Exclude Patients From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If the Chlamydia Test need not be performed because a prescription for the medication isotretinoin (Retinoid) was dispensed < 7 days after a Pregnancy Test was ordered (for a sexually-inactive patient)** **A. Document the medication order in the patient's chart in eCW in one of the following ways** 1. *Progress Notes → Treatment → Add* 2. *Telephone/Web Encounter → Rx Tab → Select Rx* 3. *Telephone/Web Encounter → Virtual Visit tab → Treatment → Add* **B. Also, document the Negative Pregnancy Test result in the "Labs" section of the patient's chart in eCW** *(continued)*

Measure Name	Chlamydia Screening: Ages 16-20 *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**II. If the Chlamydia Test need not be performed because an x-ray study was performed ≤ 7 days after a Pregnancy Test was ordered (for a sexually-inactive patient), document the x-ray study in the "DI"section of the patient's chart in eCW, as follows:** **A. Access the DI section of the chart from one of the following locations** 1. *Progress Notes (or Virtual Visit) → Diagnostic Imaging* 2. *Progress Notes (or Virtual Visit) → Treatment → DI* 3. *Patient Hub → DI tab* **B. If the x-ray study DI order was electronically-generated in your EMR** 1. Enter a result into the "Results" field of the order 2. Verify that the following boxes are checked a. "Performed Date" box b. Results "Received" box c. Status "Reviewed" box **C. If the x-ray study DI order was not electronically-generated in/by your EMR (e.g., the study was ordered by another provider), manually create a DI order and enter the result, as follows:** 1. Access the DI section of the patient's chart **2. Click click "New" to generate a new DI order** a. Click the "SEL" button adjacent to the DI name field b. Find and select the appropriate x-ray test from the list of DI options **3. Complete the following fields:** *(continued)*

Measure Name	Chlamydia Screening: Ages 16-20 *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. **Order Date** 1) Enter the date the test was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed
Trouble-Shooting	**Having Problems? Check Out the Following Trouble-Shooting Tips** **I. Verify that a correct LOINC code has been linked with the *Chlamydia* Test lab in your EMR** **A. One of the following LOINC codes must be linked to the *Chlamydia* Test lab:** 1. 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9 and 16601-7 2. 21189-6, 21190-4, 21191-2, 21192-0, 21613-5 and 23838-6 3. 31771-9, 31772-7, 31775-0, 31777-6, 36902-5 and 36903-3 4. 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0,45074-2, 45076-7 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1 and 4993-2 5. 50387-0, 53925-4, 53926-2, 557-9 and 560-3 6. 6349-5, 6354-5, 6355-2, 6356-0 and 6357-8 *(continued*

Measure Name	Chlamydia Screening: Ages 16-20 *(continued)*
Trouble-Shooting *(continued)*	**B. To associate a new, or update an existing, LOINC code with a Lab, do the following:** 1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Attribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window 3) Click "OK" to exit the Lab-specific window 4) Click the X (in the top, right-hand corner) to close the "Labs" window
	II. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results) A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked
	III. For Exception criteria, if applicable, verify that all mandatory DI fields have been completed for an x-ray *(continued)*

Measure Name	Chlamydia Screening: Ages 16-20 *(continued)*
Trouble-Shooting *(continued)*	A. I.e., Verify that the "Performed Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the "Result" field E. I.e., Verify that the "Reviewed" box has been checked
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. HEDIS "**Chlamydia Screening in Women**" II. eClinicalWorks "**MIPS - CMS 153 - Chlamydia Screening for Women**"

Measure Name	Chlamydia Screening: Ages 21-24
Relevance	NPO Population Clinical Data Dashboard *[NQF 0033-1: Prevention & Screening Measure]* MIPS Clinical Quality Measure *[CMS 153 (EHR): Process Measure]*
Measure Definition	***The percentage of women, aged 21-24 years, who were identified as sexually-active and who completed at least one test for Chlamydia during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are female II. **AND,** Are ≥ 21 and < 24 years of age at the start of the Measurement Period III. **AND,** Are seen for an applicable E&M encounter during the Measurement Period IV. **AND,** Are identified as sexually active by one of the following methods: A. They have an active diagnosis, during the Measurement Period, for: 1. An other female reproductive condition 2. Genital Herpes 3. Gonococcal infection and venereal disease 4. An inflammatory disease of the reproductive organs 5. Chlamydia 6. HIV 7. Syphilis 8. Complications of pregnancy (childbirth and puerperium) B. They are taking, or prescribed, a contraceptive medication during the Measurement Period *(continued)*

Measure Name	**Chlamydia Screening: Ages 21-24** *(continued)*
Denominator *(continued)*	C. They have a lab test ordered, during the Measurement Period, for: 1. Pregnancy 2. Lab test during pregnancy 3. Sexually-transmitted infections 4. Pap Smear D. They have a procedure performed, during the Measurement Period, for: 1. Live birth delivery 2. Procedure during pregnancy 3. Procedure involving contraceptive devices 4. Diagnostic study during pregnancy E. Any relevant documentation of marital or intimate partner status in the medical record
Numerator	The **Numerator** consists of patients, from the Denominator, who had a *Chlamydia* lab test result recorded during the Measurement Period
Exclusions and/or Exceptions	Patients are **excluded** from the Denominator for one of the following reasons: I. They qualified for the Denominator **solely** because a Pregnancy Test was performed II. **AND,** The medication isotretinoin was prescribed ≤ 7 days after the Pregnancy Test was ordered III. **OR,** An X-Ray study was performed ≤ 7 days after the Pregnancy Test was ordered
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** *(continued)*

Measure Name	Chlamydia Screening: Ages 21-24 *(continued)*
Measure Documentation *(continued)*	**A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 -99345, 99347 - 99350, 99381 - 99384 and 99391 - 99397 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **Document the result of a *Chlamydia* Test in the "Labs" section of the patient's chart in eCW** **A. If the Chlamydia Test lab order has been electronically-generated <u>and</u> resulted in your EMR, no further action is necessary** **B. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** 1. Access the "Labs" section of the patient's chart 2. If necessary, click "New" to create a new Lab order a. Click the "SEL" button, adjacent to the "Lab" search field b. Find and select the appropriate Chlamydia lab from the list of Lab options **3. Complete the following fields:** a. **Order Date** 1) If necessary, enter the date the lab was ordered 2) Hint: if you do not know the order date, enter the date the test was performed *(continued)*

Measure Name	Chlamydia Screening: Ages 21-24 *(continued)*
Measure Documentation *(continued)*	**b. Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed **c. Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Type the result (Positive or Negative) in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box
Exclusion and/or Exception Documentation	**<u>To Exclude Patients From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If the Chlamydia Test need not be performed because a prescription for the medication isotretinoin (Retinoid) was dispensed < 7 days after a Pregnancy Test was ordered (for a sexually-inactive patient)** **A. Document the medication order in the patient's chart in eCW in one of the following ways** 1. *Progress Notes → Treatment → Add* 2. *Telephone/Web Encounter → Rx Tab → Select Rx* 3. *Telephone/Web Encounter → Virtual Visit tab → Treatment → Add* **B. Also, document the Negative Pregnancy Test result in the "Labs" section of the patient's chart in eCW** *(continued)*

Measure Name	Chlamydia Screening: Ages 21-24 *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**II. If the Chlamydia Test need not be performed because an x-ray study was performed ≤ 7 days after a Pregnancy Test was ordered (for a sexually-inactive patient), document the x-ray study in the "DI"section of the patient's chart in eCW, as follows:** **A. Access the DI section of the chart from one of the following locations** 1. *Progress Notes (or Virtual Visit) → Diagnostic Imaging* 2. *Progress Notes (or Virtual Visit) → Treatment → DI* 3. *Patient Hub → DI tab* **B. If the x-ray study DI order was electronically-generated in your EMR** 1. Enter a result into the "Results" field of the order 2. Verify that the following boxes are checked a. "Performed Date" box b. Results "Received" box c. Status "Reviewed" box **C. If the x-ray study DI order was not electronically-generated in/by your EMR (e.g., the study was ordered by another provider), manually create a DI order and enter the result, as follows:** 1. Access the DI section of the patient's chart **2. Click click "New" to generate a new DI order** a. Click the "SEL" button adjacent to the DI name field b. Find and select the appropriate x-ray test from the list of DI options **3. Complete the following fields:** *(continued)*

Measure Name	Chlamydia Screening: Ages 21-24 *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. **Order Date** 1) Enter the date the test was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed
Trouble-Shooting	**Having Problems? Check Out the Following Trouble-Shooting Tips** **I. Verify that a correct LOINC code has been linked with the *Chlamydia* Test lab in your EMR** **A. One of the following LOINC codes must be linked to the *Chlamydia* Test lab:** 1. 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9 and 16601-7 2. 21189-6, 21190-4, 21191-2, 21192-0, 21613-5 and 23838-6 3. 31771-9, 31772-7, 31775-0, 31777-6, 36902-5 and 36903-3 4. 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0,45074-2, 45076-7 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1 and 4993-2 5. 50387-0, 53925-4, 53926-2, 557-9 and 560-3 6. 6349-5, 6354-5, 6355-2, 6356-0 and 6357-8 *(continued*

Measure Name	Chlamydia Screening: Ages 21-24 *(continued)*
Trouble-Shooting *(continued)*	**B. To associate a new, or update an existing, LOINC code with a Lab, do the following:** 1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Attribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window 3) Click "OK" to exit the Lab-specific window 4) Click the X (in the top, right-hand corner) to close the "Labs" window
	II. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results) A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked
	III. For Exception criteria, if applicable, verify that all mandatory DI fields have been completed for an x-ray *(continued)*

Measure Name	Chlamydia Screening: Ages 21-24 *(continued)*
Trouble-Shooting *(continued)*	A. I.e., Verify that the "Performed Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the "Result" field E. I.e., Verify that the "Reviewed" box has been checked
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. HEDIS "**Chlamydia Screening in Women**" II. eClinicalWorks "**MIPS - CMS 153 - Chlamydia Screening for Women**"

Measure Name	Colorectal Cancer Screening
Relevance	NPO Population Clinical Data Dashboard *[NQF 0034: Prevention & Screening Measure]* ACO Quality Measure #19 *[GPRO: Preventive Measure]* MIPS Clinical Quality Measure *(CMS 130 (EHR)/Registry 113: Process Measure]*
Measure Definition	***The percentage of patients, 50-75 years of age, who received appropriate screening for colorectal cancer***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patient who: I. Are ≥ 50 and < 75 years old at the start of the Measurement Period II. **AND**, Had an applicable E&M encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been screened for colorectal cancer by one of the following methods: I. A **Fecal Occult Blood Test (FOBT)** performed during the Measurement Period II. A **FIT-DNA (Cologuard) test** performed either: A. Within the Measurement Period B. **Or**, Within the two years prior to the Measurement Period III. A **Colonoscopy** performed either: A. Within the Measurement Period B. **Or**, Within the nine years prior to the Measurement Period *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Numerator *(continued)*	IV. A **Flexible Sigmoidoscopy** performed either: A. Within the Measurement Period B. **Or**, Within the four years prior to the Measurement Period V. A **CT Colonography** performed either: A. During the Measurement Period B. **OR**, Within the 4 years prior to the Measurement Period *Note: The analysis of stool collected during a digital rectal exam does not qualify as an appropriate colorectal cancer screen and does NOT satisfy this measure*
Exclusions and/or Exceptions	Patients are **excluded/excepted** from the Denominator for one of the following reasons: I. They have had a diagnosis (active, inactive, or resolved) for Malignant Neoplasm of the Colon before the end of the Measurement Period II. They have had a total colectomy performed before the end of the Measurement Period
Measure Documentation	**To Qualify For this Measure** *(Denominator Documentation)* **I. The patient must be seen for an applicable encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397 *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Measure Documentation *(continued)*	3. G0438 and G0439 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. If applicable, document FOBT results in the "Labs" section of the patient's chart in eCW** **A. If the FOBT Test lab order has been electronically-generated and resulted in your EMR, no further action is necessary** **B. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** 1. Access the "Labs" section of the patient's chart 2. If necessary, click "New" to create a new Lab order a. Click the "SEL" button, adjacent to the "Lab" search field b. Find and select the appropriate FOBT lab from the list of Lab options 3. Complete the following fields: a. **Order Date** 1) If necessary, enter the date the lab was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Measure Documentation *(continued)*	c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Type the result (Positive or Negative) in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box **III. If applicable, document Cologuard results in the "Labs" section of the patient's chart in eCW** **A. The Cologuard lab must first be manually-entered into the Lab compendium in your EMR** 1. From the EMR menu within eCW, select "Labs, DI & Procedures" 2. Select "Labs" from the list of options 3. The "Labs" window will open a. Click the "New" button at the bottom of the window b. A "Lab New Item/Category" window will open c. Type "Cologuard" into the "Name" field d. Click "OK"to close the window 4. Click the "Attribute Codes" button a. A new window will open b. Click the "Update LOINC" button c. The "Associate LOINC with Test" window will open 1) Enter the LOINC code 77354-9 into the LOINC search field 2) Click "OK" 5. The Cologuard lab will need to be mapped to a Community element in your EMR *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Measure Documentation *(continued)*	a. From within eCW, click the "Community" tab in the top menu bar b. Select "Mappings" c. Select "Labs" from the drop-down menu of options d. The "Community Lab Mapper" window will open 1) Find and select "Cologuard" on the Community side 2) If Cologuard is not available on the Community side, log a ticket with eCW to have it added 3) Find and select "Cologuard" on the Local side 4) Click "Map" **B. Cologuard results must be manually-entered into a newly-created Lab order** 1. Access the "Labs" section of the patient's chart 2. Click "New" to create a new lab order 3. Click the "SEL" button associated with the Lab name field 4. Find and select the Cologuard lab from the list of Lab options 5. Complete the remaining fields as detailed (for FOBT), above **IV. If applicable, document Colonoscopy results in the "DI" (Diagnostic Imaging) section of the patient's chart in eCW** **A. Colonoscopy results must be manually-entered into a newly-created DI order** 1. Access the "DI" section of the patient's chart 2. If necessary, click "New" to generate a new DI order a. Click the "SEL" button adjacent to the DI name field b. Find and select the appropriate Colonoscopy test from the list of DI options 3. Complete the following fields: *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Measure Documentation *(continued)*	a. **Order Date** 1) Enter the date the test was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed 3) Select an option from the "Results" drop-down box (e.g., Positive or Negative, Normal or Abnormal) **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box **B. The MIPS version of this measure may also satisfied by recording a specific CPT or HCPCS code for the Colonoscopy procedure** 1. The following CPT or HCPCS codes identify a Colonoscopy procedure a. 44388 - 44394 and 44397 b. 45355, 45378 - 45387 and 45391 - 45392 c. G0105 and G0121 2. Document the CPT or HCPCS code from one of the following locations in a Progress Note a. *Progress Note → Treatment → Procedures* *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Measure Documentation *(continued)*	b. *Progress Note → Billing* **V. If applicable, document Flexible Sigmoidoscopy results in the "DI" (Diagnostic Imaging) section of the patient's chart in eCW** **A. Flexible Sigmoidoscopy results must be manually-entered into a newly-created DI order** 1. Access the DI section of the chart 2. Click "New" to generate a new DI order a. Click the "SEL" button adjacent to the DI name field b. Find and select the appropriate Flexible Sigmoidoscopy test from the list of DI options 3. Complete the remaining fields as detailed (for Colonoscopy), above B. The MIPS version of this measure may also satisfied by recording a specific CPT or HCPCS code for the Flexible Sigmoidoscopy procedure 1. The following CPT or HCPCS codes identify a Flexible Sigmoidoscopy procedure a. 45330 - 45335, 45337 - 45339, 45340 - 45342 and 45345 b. G0104 2. Document the CPT or HCPCS code from one of the following locations in a Progress Note a. *Progress Note → Treatment → Procedures* b. *Progress Note → Billing* **VI. If applicable, document CT Colonography results in the "DI" (Diagnostic Imaging) section of the patient's chart in eCW** **A. The CT Colonography test must first be manually-entered into the DI compendium in your EMR** *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Measure Documentation *(continued)*	1. From the EMR menu within eCW, select "Labs, DI & Procedures" 2. Select "Diagnostic Imaging" from the list of options 3. The "Diagnostic Imaging" window will open a. Click the "New" button at the bottom of the window b. A "Lab New Item/Category" window will open c. Type "CT Colonography" into the "Name" field d. Click "OK"to close and return to the Diagnostic Imaging window 4. From the Diagnostic Imaging window, find and select the newly-created "CT Colonography" DI a. Click the "Associate CPTs" button b. The "Associate CPTs" window will open c. Click the "Add" button d. Type "CT Colonography" into the search field of the new window that opens e. Select the appropriate CPT code from the list of options and click "Apply" f. The following CPT codes identify CT Colonography procedures 1) 74261 (CT Colonography without Dye) 2) 74262 (CT Colonography with Dye) 3) 74263 (CT Colonography Screening) 5. To map the test to it's Community counterpart, click the "Community" tab in the top menu bar a. Select "Mappings" b. Select "Diagnostic Imaging" 1) A Diagnostic Imaging "Mapper" window will open 2) Find and select "CT Colonography on both the Community and Local sides 3) Click "Map" 4) Note: If "CT Colonography" is not present on the Community side, log a ticket with eCW to *(continued)*

<table>
<tr><th>Measure Name</th><th>Colorectal Cancer Screening (continued)</th></tr>
<tr><td>Measure Documentation
(continued)</td><td>have it added

B. The CT Colonography test results will need to be manually-entered into a newly-created DI order in the "Diagnostic Imaging" section of the patient's chart

1. Follow the procedure detailed above (for Colonoscopy)
2. Attach a copy of the CT Colonography report to the patient's chart (i.e., scan it into the "Patient Documents" section of the patient's chart</td></tr>
<tr><td rowspan="2">Exclusion and/or Exception Documentation
(continued)</td><td><u>To Exclude Patients From This Measure</u>
(Exclusion and/or Exception Documentation)

I. Exclude patients with a diagnosis (active, inactive, or resolved) for Malignant Neoplasm of the Colon by the end of the Measurement Period

A. The following ICD-10 codes identify a Malignant Neoplasm of the Colon

1. C18.0 - C18.9 and C19
2. C20, C21.0 - C21.2 and C21.8
3. C78.5

B. Record the ICD-10 code in the Problem List of the patient's chart in eCW</td></tr>
<tr><td>II. Exclude patients that have had a Total Colectomy performed before the end of the Measurement Period

A. The following CPT codes identify a Total Colectomy procedure: 44150 - 44158 and 44210 - 44212

B. Record the CPT code in one of the following locations of a Progress Note (or Virtual Visit)

1. Progress Notes → Treatment → Procedures

(continued)</td></tr>
</table>

Measure Name	Colorectal Cancer Screening *(continued)*
Exclusion and/or Exception Documentation *(continued)*	2. *Progress Notes → Billing*
Trouble-Shooting	**Having Problems? Check Out the Following Trouble-Shooting Tips** **I. Verify that the correct LOINC code is attached to the FOBT and Cologuard labs** **A. The following LOINC codes identify the FOBT lab:** 1. 12503-9, 12504-7, 14563-1, 14564-9 and 14565-6 2. 2335-8, 27396-1, 27401-9, 27925-7, 27926-5 and 29771-3 3. 56490-6, 56491-4, 57905-2 and 58453-2 **B. The following LOINC code identifies the Cologuard lab: 77354-9**
	II. Verify that all mandatory fields have been completed for all manually-entered Labs and DIs A. For the FOBT and Cologuard Labs: 1. I.e., Verify that the "Collection Date" box has been checked 2. I.e., Verify that the (Results) "Received" box has been checked 3. I.e., Verify that a "Results" date has been entered 4. I.e., Verify that the Result has been entered in the yellow grid 5. I.e., Verify that the "Reviewed" box has been checked B. For the Colonoscopy, Flexible Sigmoidoscopy, and CT Colonography DIs: 1. I.e., Verify that the "Performed Date" box has been checked 2. I.e., Verify that the (Results) "Received" box has been checked 3. I.e., Verify that a "Results" date has been entered *(continued)*

Measure Name	Colorectal Cancer Screening *(continued)*
Trouble-Shooting *(continued)*	4. I.e., Verify that the Result has been entered in the "Result" field 5. I.e., Verify that the "Reviewed" box has been checked
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0034: "**Colorectal Cancer Screening"** II. eClinicalWorks "**MIPS - CMS 130- Colorectal Cancer Screening "** III. eClinicalWorks "**MIPS - PQRS 113 (NQF 0034) (MIPS - CMS 130) - Colorectal Cancer Screening"** IV. **2016 GPRO PREV Supporting Documents**

Measure Name	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0577: Respiratory Measure]*
Measure Definition	***The percentage of patients, 40 years of age or older and with a new, or newly active, diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who received appropriate spirometry testing to confirm the diagnosis***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Intake Period	The **Intake Period** is defined as the 12-month period beginning on July 1 of the year prior to the Measurement Period and ending on June 30 of the Measurement Period (The Intake Period captures the first COPD diagnosis)
Index Episode Start Date	The **Index Episode Start Date (IESD)** is the earliest date of service for any eligible visit (Outpatient, Emergency, Observation or Acute Inpatient) during the Intake Period, with any diagnosis of COPD A. For an outpatient visit, the IESD is the date of service B. For an acute inpatient visit, the IESD is the date of discharge C. For a transfer or readmission, the IESD is the discharge date of the original admission
Denominator	The **Denominator** consists of patients who: I. Are ≥ 40 years of age at the end of the Measurement Period (12/31 of the current calendar year) II. **AND**, Have had no visits with a diagnosis of COPD within the 18-30 months prior to the beginning of the Measurement Period (Negative Diagnosis History) III. **AND**, Were seen for one of the following applicable visit types during the Intake Period A. Outpatient Visit B. Emergency Department Visit *(continued)*

Measure Name	Use of Spirometry Testing in the Assessment and Diagnosis of COPD *(continued)*
Denominator *(continued)*	C. Observation Visit D. Acute Inpatient Visit IV. **AND**, Were newly assessed one of the following diagnoses at one of the above applicable encounters* during the Intake Period A. Chronic Obstructive Pulmonary Disease (COPD) B. Emphysema C. Chronic Bronchitis *Note: The first date of diagnosis, during the Intake Period, is the Index Episode Start Date (IESD)
Numerator	The **Numerator** consists of patients, from the Denominator, who had a Spirometry test performed within the 2 years (730 days) prior to the Index Episode Start Date (IESD) OR within the 6 months (180 days) after the Index Episode Start Date
Exclusions and/or Exceptions	None
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must have been seen for an applicable visit encounter during the Intake Period (i.e., 6 months before or after the start of the Measurement Period)** **A. The following CPT codes identify applicable Outpatient visit encounters** 1. 99201 - 99205, 99211 - 99215 and 99241 - 99245 2. 99341 - 99345, 99347 - 99350, 99381 - 99387, and 99391 - 99397 3. 99401 - 99404, 99411 - 99412, 99420, 99429, and 99455 - 99456 4. G0402, G0438 and G0439 *(continued)*

Measure Name	Use of Spirometry Testing in the Assessment and Diagnosis of COPD *(continued)*
Measure Documentation *(continued)*	**B. The following CPT codes identify an Emergency Department visit : 99281 - 99285** **C. The following CPT codes identify Observation visits: 99217 - 99220** **D. The following CPT codes identify Acute Inpatient visits: 99221 - 99223, 99231 - 99233, 99238 - 99239, 99251 - 99255 and 99291** **E. Document the appropriate CPT code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing*) **II. The patient must also have been newly assessed a diagnosis of COPD, Emphysema or Chronic Bronchitis during the above applicable encounter** **A. The following ICD-10 codes identify COPD: J44.0, J44.1 and J44.9** **B. The following ICD-10 codes identify Emphysema: J43.0, J43.1, J43.2, J43.8 and J43.9** **C. The following ICD-10 codes identify Chronic Bronchitis: J41.0, J41.1, J41.8 and J42** **D. Record the appropriate ICD-10 code as an Assessment in the Progress note for the visit** (*Progress Notes → Assessments*) 1. If necessary, add the diagnosis to the Problem List in the patient's chart in eCW 2. Enter the date of onset for the diagnosis in the associated "Onset Date" field in the Problem List **<u>To Satisfy This Measure</u>** *(Numerator Documentation)* **The patient must complete a Spirometry test (within the 2 years prior through 6 months after the IESD)** **A. Document the date the Spirometry test was performed in a structured data data field** **1. eCW recommends the following structured data path** *(continued)*

Measure Name	Use of Spirometry Testing in the Assessment and Diagnosis of COPD *(continued)*
Measure Documentation *(continued)*	***Progress Notes*** → ***HPI*** → ***Pulmonology*** → ***COPD*** → ***Spirometry**** → ***Last Spirometry*** → ***Enter Date***

* or Lung Function Test or Pulmonary Function Test (PFT)

2. **The required structured data fields are outlined (boxed) in the path above**

3. **The above structured data fields may need to be configured and mapped prior to use**

   a. From within a Progress Note or Virtual Visit, click the "HPI" link
   b. Select the "Pulmonology" folder
   c. Select the "COPD" subfolder

      1) **If "Spirometry" (or Lung function Test or Pulmonary Function Test) is not included in the list of items that display, add it as follows:**

         a) Click "Custom" to open a "Properties List" window
         b) Click "New" to open the "Proerties" window and add a new item to the list
         c) Type "Spirometry" (or "Lung Function Test" or "Pulmonary Function Test") in the "Name" field
         d) Click "OK" to close the "Properties" window
         e) Check the "Structured" field adjacent to the new item name (to flag the field as a structured data field)
         f) Click "OK" to close the "Properties List" window

      2) Click on the "Spirometry" (or Lung Function Test" or Pulnary Function Test") item to open the "HPI Notes" window
      3) Click "Custom" to open the "Structured data" window
      4) Click "Add"

         a) Type "Last Spirometry" (or "Last Lung Function Test" or "Last Pulmonary Function Test") in the "Name" field of the new window that opens

(continued)

Measure Name	Use of Spirometry Testing in the Assessment and Diagnosis of COPD *(continued)*
Measure Documentation *(continued)*	b) Select "Date" for the data "Type" c) Click "OK" to close the window **d. To map the fields to the Community counterparts delineated in the above structured data pathway, click the "Community" tab in the top menu bar within eCW** 1) Select "Mappings" 2) Select "Structured Data" a) A "Mapper" window will open b) Enter the following information on both the "Community" and "Local" sides (1) Section = HPI (2) Category = Pulmonology/COPD* (3) Item = Spiromtery (or Lung Function Test or Pulmonary Function Test) **(4) *Note: if the Pulmonology and/or COPD categories are not present on the Community side of the Mapper, log a ticket with eCW to have the category added** c) Select both the "Last Spirometry" item on the Community side and the corresponding "Last Spirometry" (or "Last Lung Function Test" or "Last Pulmonary Function Test" on the Local side and click "Map" **4. Enter the date of the most recent Spirometry (or Lung Function or Pulmonary Function) test in the strucured data field** **B. Alternatively, document a CPT code for a Spirometry test in the Billing section of a Progress Note or Virtual Visit** **1. The following CPT codes identify a Spirometry procedure: 94010, 94014 - 94016, 94060, 94070, 94375 and 94620** **2. The following CPT II code also satisfies the Numerator: 3023F ("Spirometry Results Documented and Reviewed")** **3. Record the appropriate code form the following location: *Progress Notes* → *Billing*** *(continued)*

Measure Name	Use of Spirometry Testing in the Assessment and Diagnosis of COPD *(continued)*
Exclusion and/or Exception Documentation	None
Trouble-Shooting	**Having Problems? Check Out These Trouble-Shooting Tips** **I. Verify that any structured data fields used are properly mapped to their Community element counterparts in your EMR** Contact an eCW Technical Representative for further assistance with structured data fields and Community mapping
	II. Search all outside health records and databases available to you for evidence of a Spirometry test (e.g., consult notes from specialists, Powerchart, etc.) Be sure to attach a copy of the Spirometry report to the patient's chart in your EMR (i.e., scan the report into the "Patient Documents" section of the chart)
	III. Verify that all applicable diagnoses have been added to the patient's Problem List A. Be aware of diagnoses assessed by other physicians involved in the patient's care B. Add and remove diagnoses, as necessary, to keep the patient's Problem List accurate
	IV. Verify that an applicable visit encounter code was recorded in the Billing section of a Progress Note within the required timeframe (6 months before or after the beginning of the Measurement Period)
	V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505) *(continued)*

Measure Name	Use of Spirometry Testing in the Assessment and Diagnosis of COPD *(continued)*
For Further Information	**For Further Information** I. HEDIS: "**Use of Spirometry Testing in the Assessment and Diagnosis of COPD**" II. AHRQ/NQCM: "**Use of Spirometry Testing in the Assessment and Diagnosis of COPD**" III. eClinicalWorks: "**MIPS - Registry 51 (NQF 0091) - Chronic Obstructuve Pulmonary Disease (COPD): Spirometry Evaluatio**n"

Measure Name	Screening for Clinical Depression and Follow-Up
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0418: Behavioral Measure]* ACO Quality Measure # 18 *[GPRO: Preventive Measure]* MIPS Clinical Quality Measure *[CMS 2 (EHR)/Registry 134: Process Measure]*
Measure Definition	***The percentage of patients, 12 years of age and older, who were screened for Clinical Depression during the Measurement Period, using an age-appropriate standardized Depression screen tool AND, if positive, had a follow-up plan documented on the date of the positive screen***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 12 years old at the start of the Measurement Period II. **And,** Have been seen for an appropriate E&M visit during the Measurement Period III. **And**, Have had a Depression Screen administered, and documented, during the E&M visit
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Had an adolescent (< 18 years of age) or adult (≥ 18 years of age) Depression Screen administered A. With a Negative result B. **AND**, Recorded as structured data C. **AND**, During an applicable E&M encounter D. **AND**, Within the Measurement Period II. **Or,** Had an adolescent (< 18 years of age) or adult (≥ 18 years of age) Depression Screen administered *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Numerator *(continued)*	A. With a Positive result 1. **AND**, Recorded as structured data 2. **AND**, During an applicable E&M encounter 3. **AND**, Within the Measurement Period B. **And**, Had an additional (psychiatric or psychological) evaluation for Depression 1. Recorded as structured data 2. ≤ 1 day after the Positive Depression screen C. **Or,** Had a follow-up evaluation for Depression 1. Recorded as structured data 2. ≤ 1 day after the Positive Depression screen D. **Or,** Had a Suicide Risk Assessment 1. Recorded as structured data 2. ≤ 1 day after the Positive Depression screen E. **Or,** Had a referral 1. To a Depression specialist 2. Ordered ≤ 1 day after the Positive Depression screen F. **Or,** Had a Depression medication ordered, ≤ 1 day after the Positive Depression screen *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Exclusions and/or Exceptions	Patients are **excluded/excepted** from the Denominator for one of the following reasons: I. They have an active diagnosis for Depression (diagnosed prior to the first day of the Measurement Period) II. They have an active diagnosis for Bipolar Disorder (diagnosed prior to the first day of the Measurement Period) III. They have a medical reason for not having had a Depression screen performed duirng the Measurement Period A. E.g., Medical Reason: Procedure Contraindicated B. E.g., Medical Reason: Medical Contraindication C. E.g., Medical Reason: Treatment Not Tolerated D. E.g., Medical Reason: Procedure Not Indicated IV. They have a patient reason for not having had a Depression screen performed during the Measurement Period A. E.g., Patient Reason: Refusal of Treatment by Patient B. E.g., Patient Reason: Procedure Refused C. E.g., Patient Reason: Procedure Refused for Religious Reason D. E.g., Patient Reason: Patient Refused Access to Services E. E.g., Patient Reason: Patient Refused Intervention/Support F. E.g., Patient Reason: Patient Refused Service
Measure Documentation	**<u>To Qualify for This Measure</u>** *(Denominator Documentation)* **The patient must be seen for an applicable encounter during the Measurement Period** A. The following E&M codes identify applicable visit enounters 1. 90791 - 90792, 90832, 90834 and 90837 *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Measure Documentation *(continued)*	2. 92625 3. 96116, 96118, 96150 and 96151 4. 97003 5. 99201 - 99205 and 99212 - 99215 6. G0101, G0402, G0438, G0439, and G0444 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (Progress Notes → *Billing)* **<u>To Satisfy this Measure</u>** *(Numerator Documentation)* **II. Screen the patient for Clinical Depression, during the applicable E&M encounter, using an age-appropriate, standardized, clinical Depression Screening Tool** **A. Examples of Standardized Clinical DepressionScreening Tools include:** **1. For adolescents (12-17 years)** a. Patient Health Questionnaire for Adolescents (PHQ-A) b. Beck Depression Inventory - Primary Care Version (BDI-PC) c. Mood Feeling Questionnaire (MFQ) d. Center for Epidemiologic Studies Depression Scale (CES-D) e. PHQ-2 f. PRIME MD-PHQ-2 **2. For adults (18 years and older)** a. Patient Health Questionnaire (PHQ-9) b. Beck Depression Inventory (BDI or BDI-II) *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Measure Documentation *(continued)*	c. Center for Epidemiologic Studies Depression Scale (CES-D) d. Depression Scale (DEPS) e. Geriatric Depression Scale (GDS) f. Cornell Scale Screening g. PHQ-2 h. PRIME MD-PHQ-2 **B. If utilizing the PHQ-2 or PHQ-9 Depression Screening Tool:** 1. Access the tool as follows: a. From within the open Progress Note for the visit, click on the carat for the Smart Forms (SF; top, left-hand corner of note) b. Select the desired questionnaire c. A new window, with the questionnaire displayed, will open 2. Document the patient's answers to **all** questions a. When all questions have been answered, a numerical score will be generated b. Click "Save" c. Click "OK" to close **C. If utilizing a Depression Screening Tool other than PHQ-2 or PHQ-9** 1. Note the name of the Depression screening tool used in the Progress Note for the visit 2. Attach the resulted Depression screening tool to the patient's chart in the EMR a. E.g., integrate the questions and answers into the Progress Note for the visit b. E.g., scan a paper copy of the questions and answers into the patient's Documents *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Measure Documentation *(continued)*	**III. Interpret the Depression Screen result as Positive or Negative for Clinical Depression** A. Consult the guidelines for your specific Depression Screening tool for the definition of a Positive versus Negative screen B. If utilizing the PHQ-2 or PHQ-9 Depression Screening Tool 1. Results are automatically recorded as structured data in eCW 2. **But**, eCW considers any PHQ-9 score ≥ 1 as Positive for Clinical Depression (requiring documentation of a Depression follow-up plan for satisfaction of this measure) 3. Use the structured data fields, below, to enter the physician's interpretation of the Depression Screen results **IV. Document the Depression Screen results in a structured data field, as follows:** A. eCW recommends the following structured data path ***Progress Note → HPI → Depression Screening*** ↓ ***Interventions*** → ***Depression Screening Findings*** → ***Select Positive or Negative*** 1. The required structured fields are outlined (boxed) in the above pathway 2. If necessary, generate (and map) the above structured data fields, as follows a. Add "Interventions" to the "Depression Screening" folder in HPI 1) From within a Progress Note or Virtual Visit, click on the "HPI" link 2) Click on the "Depression Screening" folder 3) If "Interventions" is not listed in the options that subsequently display a) Click the carat adjacent to the "Custom" button b) Select "New Item" *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Measure Documentation *(continued)*	c) Type "Interventions" in the "Name" field d) Check the "Structured Data" box e) Click "OK" to close the window b. To map the fields, click the "Community" tab in the top menu bar in eCW 1) Select "Mappings" 2) Select "Structured Data" a) A Structured Data "Mapper" window will open b) Enter the following information for both the Community and Local sides: (1) Section = HPI (2) Category = Depression Screening (3) Item = Intervention c) A list of structured data options will appear on the Community side (Items in black font have not yet been mapped) (1) Select "Depression Screening Findings" from the Community side (2) Click "Add" to add the option to the Local side and map it to the Community element (3) Both options should now be displayed in blue font 3. Variations of the above structured data path (e.g., created in a different section of the Progress Note are acceptable as long as the fields are mapped to their Community counterparts delineated in the path above **B. If the result of the Depression screen is Negative, no further action is necessary** **C. However, if the result of the Depression screen is Positive, a Depression follow-up plan must be documented in one of the following way** *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Exclusion and/or Exception Documentation	1. Document an "**Additional Evaluation for Depression**" (≤ 1 day after the Positive Depression Screen) ***Progress Note → HPI → Depression Screening*** ↓ ***Intervention*** → ***Additional Evaluation for Depression*** → ***Select an Optior*** a. The required structured fields are outlined (boxed) in the above pathway b. If necessay, configure and map the structured data fields, as detailed above 2. **Or**, Document a "**Follow-Up Evaluation for Depression**" (≤ 1 day after the Positive Depression Screen) ***Progress Note → HPI → Depression Screening*** ↓ ***Intervention*** → ***Follow-Up Evaluation for Depression*** → ***Select an Option*** a. The required structured fields are outlined (boxed) in the above pathway b. If necessay, configure and map the structured data fields, as detailed above 3. **Or**, Document that a "**Suicide Risk Assessment**" was performed (≤ 1 day after the Positive Depression screen) ***Progress Note → HPI → Depression Screening*** ↓ ***Intervention*** → ***Suicide Risk Assessment Performed*** → ***Enter Date*** a. The required structured fields are outlined (boxed) in the above pathway b. If necessay, configure and map the structured data fields, as detailed above 4. **Or,** Refer the patient to one of the following Depression Specialists (≤ 1 day after the Positive Depression screen) *(Progress Note (or Virtual Visit) → Treatment → Outgoing Referral → Specialty)* *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Measure Documentation *(continued)*	a. Psychiatry b. Child & Adolescent Psychiatry c. Clinic d. Clinical Psychologist e. Depression Management Program f. Emergency Clinic g. Liaison Psychiatry Service h. Mental Handicap Psychiatry Service i. Mental Health Counseling j. Mental Health Counseling Service k. Mental Health Counselor l. Mental Health Team m. Mental Health Worker n. Psychiatric Aftercare o. Psychiatrist for the Elderly Mentally Ill p. Psychiatry Service q. Psychogeriatric Day Hospital r. Psychogeriatric Service s. Psychologist 5. **Or**, Order a Depression medication in one of the following ways (≤ 1 day after the Positive Depression screen) a. *Progress Notes → Treatment → Add* b. *Telephone/Web Encounter → Rx tab → Select Rx* c. *Telephone/Web encounter → Virtual Visit tab → Treatment → Add*
Exclusion and/or Exception Documentation	**To Exclude a Patient From This Measure** *(Exclusion/Exception Documentation)* **I. If applicable, document one of the following ICD-10 diagnosis codes for Depression in the Problem List of the patient's chart in eCW** *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Trouble-Shooting *(continued)*	A. F01.51 B. F32.0 - F32.5, F32.8 - F32.9, F33.0 - F33.3, F33.42, F33.9 and F34.1
	II. If applicable, document one of the following ICD-10 diagnosis codes for Bipolar Disorder in the Problem List of the patient's chart in eCW F31.11 - F31.13, F31.2, F31.73 - F31.74 and F31.9
	III. If applicable, document a medical reason for failure to perform a Depression Screen, as follows: ***Progress Notes → HPI → Depression Screening → Screening Not Performed → Reason → Select Medical Reason*** ↓ ***Select an option for type of medical reason*** A. eCW recommends the above structured data path 1. The required structured data fields are outlined (boxed) in the path above 2. If necessary, generate (and map) the above structured data fields, as follows a. Add "Screening Not Performed" as an item in the "Depression Screening" folder in HPI 1) From within a Progress Note or Virtual Visit, click on the "HPI" link 2) Click on the "Depression Screening" folder 3) If "Screening Not Performed" is not listed in the options that subsequently display a) Click the carat adjacent to the "Custom" button b) Select "New Item" c) Type "Screening Not Performed" in the "Name" field d) Check the "Structured Data" box e) Click "OK" to close the window *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Exclusion and/or Exception Documentation *(continued)*	b. To map the fields, click the "Community" tab in the top menu bar in eCW 1) Select "Mappings" 2) Select "Structured Data" a) A Structured Data "Mapper" window will open b) Enter the following information for both the Community and Local sides: (1) Section = HPI (2) Category = Depression Screening (3) Item = Screening Not Performed c) A list of structured data options will appear on the Community side (Items in black font have not yet been mapped) (1) Select "Reason" from the Community side (2) Click "Add" to add the option to the Local side and map it to the Community element (3) Both options should now be displayed in blue font 3. Record the medical reason (for not performing a Depression screen) in the structured data field in the Progress Note for the visit **B. Options for "Medical Reason" include:** 1. Medical Reason: Procedure contraindicated 2. Medical Reason: Medical contraindication 3. Medical Reason: Treatment not tolerated 4. Medical reason: Procedure not indicated *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**IV. If applicable, document a patient reason for failure to perform a Depression Screen, as follows:** ***Progress Notes → HPI → Depression Screening →*** ***Screening Not Performed*** **→** ***Reason*** **→** ***Select Patient Reason*** ↓ ***Select an option for type of patient reason*** A. eCW recommends the above structured data path 1. The required structured data fields are outlined (boxed) in the path above 2. If necessary, generate (and map) the above structured data fields, as detailed above (for "Medical Reason") 3. Record the patient reason for not performing a Depression screen in the structured data field in the Progress Note for the visit **B. Options for "Patient Reason" include:** 1. Patient Reason: Refusal of treatment by patient 2. Patient Reason: Procedure refused 3. Patient reason: Procedure refused for religious reason 4. Patient Reason: Patient refused access to services 5. Patient Reason: Patient refused intervention/support 6. Patient Reason: Patient refused service
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that all questions for the Depression Screening Tool have been answered**
	II. Verify that the Depression Screening result was documented in a structured data field on the same date the patient was seen for an applicable E&M encounter *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
Trouble-Shooting *(continued)*	**III. Verify that, for any Positive Depression Screen result, a follow-up plan for Depression has been documented, in a structured data field, no later than 1 day after the date the Positive Depression Screen result was documented**
	IV. Verify that the structured data fields are properly mapped to corresponding Community elements A. Verify mapping at *Community →Mappings → Structured Data* 1. Match each structured field from the Community side with it's counterpart on the Local side 2. Mapped elements will be displayed in blue font B. For further assistance with structured data fields and mapping issues, contact an eClinicalWorks Technical Representative
	V. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Verify that the correct ICD-10 diagnosis code has been added B. Add a diagnosis to the patient's Problem List in one of the following ways: 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* **2. <u>OR</u>,** From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" **3. Helpful Hint: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field**
	VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505) *(continued)*

Measure Name	Screening for Clinical Depression and Follow-Up *(continued)*
For More Information	**For More Information** I. NQF 0418**: "Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**" II. eClinicalWorks **"MIPS - CMS 2- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan"** III. eClinicalWorks "**MIPS - Registry 134 (NQF 0418) (MIPS - CMS 2) - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**" IV. **2016 GPRO PREV Supporting Documents**

Measure Name	Depression Remission at Twelve Months
Relevance	NPO Population Clinical Quality Dashboard [*NQF 0710: Behavioral Measure]* ACO Quality Measure #40 *[GPRO: "At Risk" Measure]* MIPS Clinical Quality Measure *[CMS 159 (EHR): Outcome Measure]*
Measure Definition	***The percentage of patients, 18 years of age and older, with a diagnosis (new or existing) of Major Depression or Dysthymia and an initial PHQ-9 score > 9, who demonstrate remission at 12 months, as defined by a PHQ-9 score < 5***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Index Date	The **Index Date** is defined as the date of the first PHQ-9 score > 9 occurring between 13 months (December 1) and 1 month (November 30) prior to the start of the Measurement Period
Denominator	The **Denominator** consists of patients who: I. Are ≥ 18 years of age at the beginning of the Measurement Period II. **AND**, Have been seen for an applicable visit encounter during, or within the 12 months prior to, the Measurement Period A. **AND**, Scored > 9 on a PHQ-9 Depression assessment administered during the above applicable encounter B. **AND**, Had an active diagnosis for Major Depression (including Remission) at the time of the above applicable encounter C. **OR**, Had an active diagnosis of Dysthymia at the time of the above applicable encounter
Numerator	The **Numerator** consists of patients, from the Denominator, who scored < 5 on a follow-up PHQ-9 Depression assessment, administered 12 months (+/- 30 days) after the Index Date *(continued)*

Measure Name	**Depression Remission at Twelve Months** *(continued)*
Exclusions and/or Exceptions	Patients are **excluded** from this measure for one of the following reasons: I. They received palliative care services during the Measurement Period II. **OR**, They had an active diagnosis for a Personality Disorder during the Measurement Period III. **OR**, They had an active diagnosis for Bipolar Disorder during the Measurement Period IV. **OR**, They received care in a long-term residential facility during the Measurement Period
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must have been seen for an applicable visit encounter during, or within the 12 months prior to, the Measurement Period** **A. The following E&M codes identify applicable visit encounters:** 1. 90791 - 90792, 90832, 90834 and 90837 2. 99201 - 99205 and 99212 - 99215 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes* → *Billing*) **II. The patient must have had an active diagnosis for Major Depression or Dysthymia documented at the time of the above applicable visit** **A. The following ICD-10 codes indicates Major Depression (including Remission):** 1. F32.0 - F32.5 and F32.9 2. F33.0 - F33.3, F33.40 - F33.42 and F33.9 **B. The following ICD-10 code indicates Dysthymia: F34.1** **C. Document the appropriate diagnosis code in the Problem List of the patient's chart in eCW** *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Measure Documentation *(continued)*	1. Add a diagnosis to the patient's Problem List in one of the following ways: a. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* b. From the ICW (Right-Hand Chart Panel), click the "Overview" tab 1) Click the orange button (with three dots) in the Progress Note band 2) Click "Add" 2. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field **III. The patient must have scored > 9 on a PHQ-9 Depression assessment administered between 1 and 13 months prior to the beginning of the Measurement Period** **A. Access the PHQ-9 Depression Assessment tool as follows:** 1. From within the open Progress Note for the visit, click on the carat adjacent to the "Smart Forms" field (SF; top, left-hand corner of note) 2. Select the PHQ-9 questionnaire from the drop-down list of options 3. A new window, with the questionnaire displayed, will open **B. Document the patient's answers to <u>all</u> of the PHQ-9 questions** 1. When the answers to all questions have been recorded, a numerical score will be generated 2. Click "Save" 3. Click "OK" to close a. The PHQ-9 questions, responses and final score will import into the Progress Note b. The PHQ-9 responses and final score will alos be saved as structured data within the EMR *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Measure Documentation *(continued)*	**To Satisfy This Measure** *(Numerator Documentation)* **I. Recall the patient for an applicable visit encounter 12 months (+/- 30 days) after the Index Date (the date of the initial PHQ-9 > 9 Depression assessment administered during the year prior to the Measurement Period)** **II. Administer a follow-up PHQ-9 Depression assessment at the above applicable encounter** A. Access the PHQ-9 Depression Assessment tool from the "Smart Forms" section of a Progress Note, as described above B. Record the patient's answers to all PHQ-9 questions C. Save and close the PHQ-9 Depression assessment 1. The PHQ-9 responses and final score will automatically import into the Progress Note for the visit 2. The PHQ-9 responses and final score are stored as structured data in the patient's chart in the EMR **D. A follow-up PHQ-9 score < 5 indicates Depression remission and satisfies this measure** E. Note:If more than 1 PHQ-9 Depression assessment is administered during the 11-13 month follow-up window, select the most recent PHQ-9 date and score within that window to determine if Depression remission has been achieved
Exclusion and/or Exception Documentation	**To Exclude a Patient From This Measure** *(Exclusion/Exception Documentation)* **I. If applicable, document the receipt of Palliative Care services during the Measurement Period** **A. Document a Palliative Care intervention as structured data** **1. eCW recommends the following structured data path:** ***Progress Notes → Preventive Medicine → Counseling → Provider to Provider Communication → Palliative Care*** *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Exclusion and/or Exception Documentation *(continued)*	2. The required structured data fields are outlined (boxed) in the path, above **a. Some configuration and mapping may first be required** 1) If necessary, add the "Provider to Provider Communication" item to the "Counseling" folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "Preventive Medicine" link b) Click on the "Counseling" folder c) If "Provider to Provider Communication" is not listed in the options displayed: (1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Provider to Provider Communication" in the Name field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options d) Enter the following information on both sides (Community and Local): (a) Section = Preventive Medicine (b) Category =Counseling (c) Item = Provider to Provider Communication *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Exclusion and/or Exception Documentation (continued)	(3) From the Community side, select the desired reporting field (E.g., "Palliative Care") (4) Click "Add" (a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped **b. Document the Palliative Care encounter within the structured data field** **B. <u>OR</u>, Document the ICD-10 diagnosis code for a Palliative Care encounter as an Assessment in a Progress Note or Virtual Visit** **1. The following ICD-10 code identifies a Palliative Care encounter: Z51.5** 2. Record the Palliative Care diagnosis code from one of the following locations: a. *Progress Notes* → *Assessments* b. *Progress Notes* → *Assessments* → *Problem List*
	II. If applicable, record a diagnosis for Personality Disorder in the Problem List of the patient's chart in eCW **A. The following ICD-10 codes indicate Personality Disorder** 1. F21 2. F34.0 3. F60.0 - F60.7, F60.81, F60.89 and F60.9 4. F68.10 - F68.13 *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Exclusion and/or Exception Documentation (continued)	**B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	III. If applicable, record a diagnosis for Bipolar Disorder in the Problem List of the patient's chart in eCW **A. The following ICD-10 codes indicate Bipolar Disorder** 1. F30.10 - F30.13, F30.2 - F30.4 and F30.8 - F30.9 2. F31.0, F31.10 - F31.13, F31.2, F31.30 - F31.32, F31.4 - F31.5, F31.60 - F31.64, F31.70 - F31.78, F31.81, F31.89 and F31.9 B. Add the appropriate diagnosis code to the Problem List, as detailed above C. Also, indicate the onset date of the disorder, if known, in the associated "Onset Date" field in the Problem List
	IV. If applicable, record an E&M code for care services received at a long-term residential facility in the patient's chart in eCW **A. The following E&M codes identify long-term residential facility care encounters: 99324 -99328 and 99334 - 99337** **B. Record the appropriate E&M code in the Billing section of a Progress Note or Virtual Visit** (*Progress Notes → Billing*) *(continued)*

Measure Name	Depression Remission at Twelve Months *(continued)*
Trouble-Shooting	**Having Problems? Check Out These Trouble-Shooting Tips** **I. Verify that ALL questions for the PHQ-9 Depression Screening Tool have been answered**
	II. Verify that the PHQ-9 Depression Screening results were documented in the Progress Notes for applicable E&M encounters
	III. Verify that the PHQ-9 Depression Screens were administered during the appropriate timeframes
	IV. Verify that any structured data fields used have been properly mapped to corresponding Community elements
	V. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Confirm diagnoses assessed by specialists, ER and hospital physicians B. Add applicable diagnoses to the patient's Problem List in your EMR C. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical History section of the patient's chart
	VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0710: "**Depression Remission at Twelve Months**" II. eClinicalWorks "**MIPS - CMS 159 - Depression Remission at Twelve Months**" III. **2016 GPRO Supporting Documentation**

Measure Name	Diabetes: Eye Exam
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0055: Diabetic Measure]* ACO Quality Measure #41 [*GPRO: "At-Risk" Population Measure*] MIPS Clinical Quality Measure *[CMS 131 (EHR)/Registry 117: Process Measure]*
Measure Definition	***The percentage of patients, 18-75 years of age and with a diagnosis of Diabetes, who had a retinal or dilated eye exam performed, by an eye care professional, within the Measurement Period OR who had a negative retinal eye exam (i.e., no evidence of retinopathy) within the 12 months prior to the Measurement Period***
Measurement Period	The **Measurement Period** is defined at the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 18 and < 75 years of age at the start of the Measurement Period II. **AND**, Have an active diagnosis for Diabetes during the Measurement Period III. **AND**, Have been seen for an applicable visit encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Have had a retinal, or dilated, eye exam performed during the Measurement Period II. **Or**, Had a Negative retinal, or dilated, eye exam performed within the 12 months prior to the Measurement Period
Exclusions and/or Exceptions	None *(continued)*

Measure Name	**Diabetes: Eye Exam** *(continued)*
Measure Documentation	**<u>To Qualify For This Measure</u>** *(Denominator Documentation)* **I. The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable encounters:** 1. 92002, 92004, 92012, 92014, 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397 3. G0402 and G0438 - G0439 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing)* **II. The patient must have an active diagnosis for Diabetes documented during the Measurement Period** **A. The following ICD-10 codes identify Diabetes:** E10.10 - E10.11, E10.21 - E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36 E10.39, E10.40 - E10.44, E10.49, E10.51 - E10.52, E10.59, E10.610, E10.618, E10.620 - E10.622, E10.628, E10.630 , E10.641, E10.649, E10.65 E10.69, E10.8, and E10.9 E11.00 - E11.01, E11.21 - E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39 E11.40 - E11.44, E11.49, E11.51 - E11.52, E11.59, E11.610, E11.618, E11.620 - E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65 E11.69, E11.8 and E11.9 E13.00 - E13.01, E13.10 - E13.11, E13.21 - E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351 E13.359, E13.36, E13.39, E13.40 - E13.44, E13.49, E13.51 - E13.52, E13.59, E13.610, E13.618, E13.620 - E13.622, E13.628, E13.630, E13.638, E13.641 E13.649, E13.65, E13.69, E13.8 and E13.9 O24.011 - O24.013, O24.019, O24.02 - O24.03, O24.111 - O24.113, O24.119, O24.12 - O24.13, O24.311 - O24.313, O24.319, O24.32 - O24.33 *(continued)*

Measure Name	**Diabetes: Eye Exam** *(continued)*
Measure Documentation *(continued)*	O24.811 - O24.813, O24.819 and O24.82 - O24.83 **B. The Diabetes diagnosis should be documented in the "Problem List" section of the patient's chart in eCW** **C. Helpful Hints** 1. When adding a diagnosis to a patient's Problem List, record the onset date of the disorder, if known, in the associated "Onset Date" field 2. For quick and easy reference, add the patient's Endocrinologist, if applicable, to the "Circle of Care" section of the patient's chart
	To Satisfy This Measure *(Numerator Documentation)* **I. The patient must have the results of a retinal, or dilated, eye exam recorded as structured data in the EMR** A. The exam must be performed: 1. By an eye care professional (e.g., ophthalmologist or optometrist) 2. **And**, Within the Measurement Period (Positive or Negative result) 3. **Or**, within the 12 months prior to the Measurement Period (Negative Result only) **B. Record the date and result of a diabetic retinal eye exam in structured data fields, as follows:** 1. eCW recommends the following structured data paths ***Progress Note or Virtual Visit → Examination → Ophthalmology → Diabetes Eye Exam*** ↓ ***Date of Exam Performed*** *(continued)*

Measure Name	**Diabetes: Eye Exam** *(continued)*
Measure Documentation *(continued)*	**AND** ***Progress Note or Virtual Visit → Examination → Ophthalmology → Diabetes Eye Exam*** ↓ ***Findings of Diabetes Eye Exam → Select an option*** a. The required structured fields are outlined (boxed) in the above pathways b. If necessary, generate (and map) the above structured data fields, as follows 1) Add "Diabetes Eye Exam " to the "Ophthalmology" folder in "Examination" a) From within a Progress Note or Virtual Visit, click on the "Examination" link b) Click on the "Ophthalmology" folder c) If "Diabetes Eye Exam" is not listed in the options that subsequently display (1) Click the carat adjacent to the "Custom" button (2) Select "New Item" (3) Type "Diabetes Eye Exam" in the "Name" field (4) Check the "Structured Data" box (5) Click "OK" to close the window 2) To map the fields, click the "Community" tab in the top menu bar in eCW a) Select "Mappings" b) Select "Structured Data" (1) A Structured Data "Mapper" window will open (2) Enter the following information for both the Community and Local sides: (a) Section = Examination *(continued)*

Measure Name	**Diabetes: Eye Exam** *(continued)*
Measure Documentation *(continued)*	(2) Category = Ophthalmology (3) Item = Diabetes Eye Exam c) A list of structured data options will appear on the Community side (Items in black font have not yet been mapped) (1) Select "Date of Exam Performed" from the Community side (2) Click "Add" to add the option to the Local side and map it to the Community element (3) (Mapped fields display in in blue font) (4) Associated options are also automatically added and mapped (5) If necessary, repeat the procedure for the "Findings of Diabetes Eye Exam" field **c. Note: These structured data fields can be located in another customizable section of the Progress Note (e.g., HPI) as long as they are mapped to the Community elements identified in the paths above** **2. Information must be entered into <u>BOTH</u> structured data fields (i.e., the date the exam was performed and the result (findings) of the exam) to satisfy this measure** 3. The options for "Findings of Diabetic Eye Exam" are as follows: a. No Retinopathy b. No Maculopathy, Left Eye c. No Maculopathy, Right Eye d. Diabetic Maculopathy Absent in Both Eyes e. Retinopathy **C. Helpful Hints** 1. Educate your patients to instruct their optical provider to always send a copy of the retinal eye exam report to your office *(continued)*

Measure Name	**Diabetes: Eye Exam** *(continued)*
Measure Documentation *(continued)*	2. Record the name of the optical provider in the "Circle of Care" section of each patient's chart (so you know who to contact in the event of missing eye exam information)
Exclusion and/or Exception Documentation	None
Trouble-Shooting	**Having Problems? Check Out the Following Trouble-Shooting Tips** **I. Verify that each Retinal Eye Exam date and results are documented in the correct structured data fields**
	II. Verify that the required structured data fields are mapped to the correct Community counterparts in eCW For further assistance with structured data fields and mapping questions, contact an eCW Technical Representative
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Verify that the correct ICD-10 diagnosis code has been added B. Add a diagnosis to the patient's Problem List in one of the following ways: 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field *(continued)*

Measure Name	**Diabetes: Eye Exam** *(continued)*
Trouble-Shooting *(continued)*	**IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)**
For More Information	**For More Information** I. **2016 GPRO PREV Supporting Documents** II. eClinicalWorks **"MIPS - CMS 131 - Diabetes: Eye Exam"** III. eClinicalWorks **"MIPS - Registry 117 (NQF 0055)(MIPS - CMS 131) - Diabetes: Eye Exam"** IV. NQF 0055: "**Diabetes: Eye Exam**"

Measure Name	**Diabetes: A1c Screening**
Relevance	NPO Clinical Quality Dashboard *[NQF 0057: Diabetic Measure]*
Measure Definition	***The percentage of patients, 18-75 years of age and with a diagnosis of Diabetes (Type I or II), who had at least one HbA1c test performed during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 18 and ≤ 75 years of age on the first day (January 1) of the Measurement Period II. **AND,** Have a diagnosis of Diabetes during the Measurement Period or the year prior to the Measurement Period III. **AND,** Have been seen for, at least, two face-to-face visits, with a Diabetes diagnosis, with an eligible provider, in the Measurement Period or the year prior to the Measurement Period IV. **AND**, Have been seen for at least one face-to face visit, for any reason, with an eligible provider during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who had an HbA1c lab test performed during the Measurement Period
Exclusions and/or Exceptions	None
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must be seen for an applicable face-to-face encounter during the Measurement Period** A. The following E&M codes identify applicable visit encounters *(continued)*

Measure Name	Diabetes: A1c Screening *(continued)*
Measure Documentation *(continued)*	1. 97802 - 97804 2. 99201 - 99205, 99211 - 99215, 99217 - 99219, 99220 - 99223, 99231 - 99233 and 99238 - 99239, 99281 - 99285, 99291 3. 99304 - 99309, 99310, 99315, 99316, 99318, 99324 - 99328, 99334 -99337, 99341-99345 and 99347 - 99350 4. G0270, G0271, G0402, G0438 and G0439 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing* **II. Verify that a diagnosis for Diabetes is documented in the patient's chart in your EMR** **A. The following ICD-10 codes indicate Diabetes** 1. E10.10 - E10.11, E10.21 - E10.22, E10.29, E10.311, E10.319, E10.3211 - E10.3213, E10.3219, E10.3291 -E10.3293 E10.3299, E10.3311 - E10.3313, E10.3319, E10.3391 - E10.3393, E10.3399, E10.3411 - E10.3413, E10.3419, E10.3491 - E10.3493, E10.3499 E10.3511-E10.3513, E10.3519, E10.3521-E10.3523, E10.3529, E10.3531-E10.3533, E10.3539, E10.3541-E10.3543, E10.3549, E10.3551-E10.3533 E10.3591 -E10.3593, E10.3599, E10.36, E10.37X1 - E10.37X3, E10.37X9, E10.39, E10.40 -E10.44, E10.49, E10.51 - E10.52, E10.59, E10.610, E10.618 E10.620 - E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8 and E10.9 2. E11.00 - E11.01, E11.21 - E11.22, E11.29, E11.311, E11.319, E11.3211 - E11.3213, E11.3219, E11.3291 -E11.3293 E11.3299, E11.3311 -E11.3313, E11.3319, E11.3391 - E11.3393, E11.3399, E11.3411 - E11.3413, E11.3419, E11.3491 - E11.3493, E11.3499 E11.3511 - E11.3513 , E11.3519, E11.3521 - E11.3523, E11.3529, E11.3531 - E11.3533, E11.3539, E11.3541 - E11.3543, E11.3549 E11.3551 - E11.3553, E11.3559, E11.3591 -E11.3593, E11.3599, E11.36, E11.37X1 - E11.37X3, E11.37X9, E11.39, E11.40 - E11.44, E11.49 E11.51 - E11.52, E11.59, E11.610, E11.618, E11.620 - E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8 and E11.9 3. E13.00 - E13.01, E13.10 - E13.11, E13.21 - E13.22, E13.29, E13.311, E13.319, E13.3211 - E13.3213, E13.3219 E13.3291 -E13.3293, E13.3299, E13.3311 - E13.3313, E13.3319, E13.3391 - E13.3393, E13.3399, E13.3411 - E13.3413, E13.3419, E13.3491 -E13.3493 E13.3499, E13.3511 - E13.3513, E13.3519, E13.3521 - E13.3523, E13.3529, E13.3531 -E13.3533, E13.3539, E13.3541 - E13.3543, E13.3549 E13.3551 - E13.3553, E13.3559, E13.3591 -E13.3593, E13.3599, E13.36, E13.37X1 - E13.37X3, E13.37X9, E13.39, E13.40 - E13.44, E13.49 E13.51 - E13.52, E13.59, E13.610, E13.618, E13.620 - E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8 and E13.9 4. O24.011 - O24.013, O24.019, O24.02 - O24.03, O24.111 - O24.113, O24.119, O24.12 - O24.13, O24.311 - O24.313 *(continued)*

Measure Name	Diabetes: Hemoglobin A1c Poor Control (> 9.0) - Labs Only (Inverse Measure)
Trouble-Shooting (continued)	1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Attribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code 3) Click "OK" to exit the Lab-specific window 4. Click the X (in the top, right-hand corner) to close the "Labs" window
	II. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results) A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Verify that the correct ICD-10 diagnosis code has been added *(continued)*

Measure Name	Diabetes: Hemoglobin A1c Poor Control (> 9.0) - Labs Only (Inverse Measure)
Trouble-Shooting *(continued)*	B. Add a diagnosis to the patient's Problem List in one of the following ways: 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	IV. Search all available data sources (e.g., Endocrinology notes, Powerchart, Quest and VA lab reports, etc.) for missing HbA1c lab results and manually enter the HbA1c lab order and results into the Labs section of the patient's chart in your EMR
	V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0059: "**Diabetes: Hemoglobin A1c Poor Control**" II. eClinical Works "**MIPS - CMS 122 - Diabetes: Hemoglobin A1c Poor Control**" III. eClinicalWorks "**MIPS - Registry 1 (NQF 0059)(MIPS - CMS 122) - Diabetes: Hemoglobin A1c Poor Control**" IV. **2016 GPRO PREV Supporting Documents**

Measure Name	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients
Relevance	NPO Population Clinical Data Dashboard *[NQF 0060: Pediatric Measure]*
Measure Definition	***The percentage of patients, 5-17 years of age and with a diagnosis of Diabetes (Type I or Type II), who had a Hemoglobin A1c (HbA1c) test during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: **I.** Are ≥ 5 and < 17 years of age on the first day (January 1) of the Measurement Period **II.** **AND,** Have an active diagnosis of Diabetes (Type I or Type II) during the Measurement Period or the year prior to the Measurement Period **III.** **AND**, Have been seen for, at least, two face-to-face visits, with a Diabetes diagnosis and with an eligible provider, in the Measurement Period or the year prior to the Measurement Period **IV.** **AND**, Have been seen for at least one face-to-face visit, for any reason, with an eligible provider during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who had an HbA1c lab test performed during the Measurement Period
Exclusions and/or Exceptions	None
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must have been seen for an applicable visit encounter during the Measurement Period** **A. The Following E&M codes identify applicable visit encounters:** *(continued)*

Measure Name	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients *(continued)*
Measure Documentation *(continued)*	1. 97802 - 97804 2. 99201 - 99205, 99211 - 99215, 99217 - 99219, 99220 - 99223, 99231 - 99233, 99238 - 99239, 99281 - 99285, 99291 99304 - 99309, 99310, 99315, 99316, 99318, 99324 - 99328, 99334 - 99337, 99341 - 99345, 99347 - 99350 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing)* **II. Verify that a diagnosis for Diabetes is documented in the patient's chart in your EMR** **A. The following ICD-10 codes indicate Diabetes:** E10.10 - E10.11, E10.21 - E10.22, E10.29, E10.311, E10.319, E10.3211 - E10.3213, E10.3219, E10.3291 -E10.3293, E10.3299, E10.3311-E10.3313 E10.3319, E10.3391 - E10.3393, E10.3399, E10.3411 - E10.3413, E10.3419, E10.3491 - E10.3493, E10.3499, E10.3511 - E10.3513, E10.3519 E10.3521 - E10.3523, E10.3529, E10.3531 -E10.3533, E10.3539, E10.3541 - E10.3543, E10.3549, E10.3551 - E10.3533, E10.3559, E10.3591 -E10.3593 E10.3599, E10.36, E10.37X1 - E10.37X3, E10.37X9, E10.39, E10.40 -E10.44, E10.49, E10.51 - E10.52, E10.59, E10.610, E10.618, E10.620 - E10.622 E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8 and E10.9 E11.00 - E11.01, E11.21 - E11.22, E11.29, E11.311, E11.319, E11.3211 - E11.3213, E11.3219, E11.3291 -E11.3293, E11.3299, E11.3311 - E11.3313 E11.3319, E11.3391-E11.3393, E11.3399, E11.3411- E11.3413, E11.3419, E11.3491-E11.3493, E11.3499, E11.3511-E11.3513, E11.3519, E11.3521 - E11.3523, E11.3529, E11.3531 -E11.3533, E11.3539, E11.3541 - E11.3543, E11.3549, E11.3551 - E11.3553, E11.3559, E11.3591 -E11.3593, E11.3599 E11.36, E11.37X1 - E11.37X3, E11.37X9, E11.39E11.40 - E11.44, E11.49, E11.51 - E11.52, E11.59, E11.610, E11.618, E11.620 - E11.622, , E11.628 E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8 and E11.9 E13.00-E13.01, E13.10-E13.11, E13.21-E13.22, E13.29, E13.311, E13.319, E13.3211-E13.3213, E13.3219, E13.3291 -E13.3293, E13.3299, E13.3311 - E13.3313, E13.3319, E13.3391 - E13.3393, E13.3399, E13.3411 - E13.3413, E13.3419, E13.3491 -E13.3493, E13.3499, E13.3511 - E13.3513, E13.3519 E13.3521-E13.3523, E13.3529, E13.3531-E13.3533, E13.3539, E13.3541 - E13.3543, E13.3549, E13.3551 - E13.3553, , E13.3559, E13.3591 - E13.3593 E13.3599, E13.36, E13.37X1 - E13.37X3, E13.37X9, E13.39, E13.40 - E13.44, E13.49, E13.51 - E13.52, E13.59, E13.610, E13.618, E13.620 -E13.622 E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8 and E13.9 O24.011 - O24.013, O24.019, O24.02 - O24.03, O24.111 - O24.113, O24.119, O24.12 - O24.13, O24.311 - O24.313, O24.319, O24.32 - O24.33 O24.811 - O24.813, O24.819 and O24.82 - O24.83 *(continued)*

Measure Name	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients *(continued)*
Measure Documentation *(continued)*	**B. Record the diagnosis in the Problem List of the patient's chart in eCW**

To Satisfy This Measure

(Numerator Documentation)

III. Document the result of an HbA1c test in the "Labs" section of the patient's chart in eCW, as follows:

A. If the HbA1c lab order has been electronically-generated and resulted in your EMR, no further action is necessary

B. Otherwise, manually generate the lab order and/or enter the lab result, as follows:

1. Access the "Labs" section of the patient's chart
2. If necessary, click "New" to create a new Lab order

a. Click the "SEL" button, adjacent to the "Lab" search field
b. Find and select the appropriate HbA1c lab from the list of Lab options

3. Complete the following fields:

a. **Order Date**

1) If necessary, enter the date the lab was ordered
2) Hint: if you do not know the order date, enter the date the test was performed

b. **Collection Date**

(MANDATORY)

1) Check the box in the "Collection Date" field
2) Enter the date the sample was collected
3) Hint: If you do not know the collection date, enter the date the test was performed

(continued)

Measure Name	**Hemoglobin A1c (HbA1c) Testing for Pediatric Patients** *(continued)*
Measure Documentation *(continued)*	c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Enter the numerical result in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box
Exclusion and/or Exception Documentation	None
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that an appropriate LOINC code is associated with the HbA1c lab** **A. The following LOINC codes identify the HbA1c lab:** 4548-4, 4549-2 and 17856-6 **B. To associate a new, or update an existing, LOINC code with a Lab, do the following:** 1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Attribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open *(continued)*

Measure Name	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients *(continued)*
Trouble-Shooting *(continued)*	a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window 3) Click "OK" to exit the Lab-specific window d. Click the X (in the top, right-hand corner) to close the "Labs" window
	II. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results) A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List **A. Verify that the correct ICD-10 diagnosis code has been added** **B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field *(continued)*

Measure Name	**Hemoglobin A1c (HbA1c) Testing for Pediatric Patients** *(continued)*
Trouble-Shooting *(continued)*	**IV. Search all available data sources (e.g., Endocrinology notes, Powerchart, Quest and VA lab reports, etc.) for missing HbA1c lab results, and manually-enter the HbA1c lab order and results into the "Labs" section of the patient's chart in your EMR**
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** NQF 0060: "**Hemoglobin A1c (HbA1c) Testing for Pediatric Patients**"

Measure Name	Diabetes: Nephropathy Screening
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0062: Diabetic Measure]* MIPS Clinical Quality Measure *[CMS 134 (EHR)/Registry 119: Process Measure]*
Measure Definition	***The percentage of patients, 18-75 years of age and with a diagnosis of Diabetes, who had a nephropathy screening test, or evidence of nephropathy, during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 18 and < 75 years of age at the beginning of the Measurement Period II. **AND**, Have a diagnosis for Diabetes during the Measurement Period III. **AND**, Have been seen for an applicable visit encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Had a Urine Protein test result recorded during the Measurement Period **OR** II. Had evidence for Nephropathy documented in the medical record, as follows: A. An ACE Inhibitor or ARB medication was prescribed during the Measurement Period B. The patient has one of the following active diagnoses during the Measurement Period 1. Hypertensive Chronic Kidney Disease 2. Glomerulonephritis and Nephrotic Syndrome 3. Diabetic Nephropathy 4. Proteinuria *(continued)*

Measure Name	**Diabetes: Nephropathy Screening** *(continued)*
Numerator *(continued)*	5. Kidney Failure C. The patient has had one of the following procedures or services performed during the Measurement 1. Kidney Transplant 2. Dialysis 3. Vascular Access for Dialysis 4. Monthly ESRD Outpatient Services
Exclusions and/or Exceptions	None
Measure Documentation	**<u>To Qualify For This Measure</u>** *(Denominator Documentation)* **I. The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit encounters** 1. 99201- -99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397 3. G0402 and G0438 - G0439 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. Verify that a diagnosis for Diabetes is documented in the patient's chart in your EMR** A. The following ICD-10 codes indicate Diabetes *(continued)*

Measure Name	Diabetes: Nephropathy Screening *(continued)*
Measure Documentation *(continued)*	1. E10.10 - E10.11, E10.21 - E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349 E10.351, E10.359, E10.36, E10.39, E10.40 -E10.44, E10.49, E10.51 - E10.52, E10.59, E10.610, E10.618, E10.620 - E10.622, E10.628, , E10.630 E10.638, E10.641, E10.649, E10.65, E10.69, E10.8 and E10.9 2. E11.00 - E11.01, E11.21 - E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349 E11.351, E11.359, E11.36, E11.39, E11.40 - E11.44, E11.49, E11.51 - E11.52, E11.59, E11.610, E11.618, E11.620 - E11.622, E11.628, E11.630 E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9 3. E13.00 - E13.01, E13.10 - E13.11, E13.21 - E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341 E13.349, E13.351, E13.359, E13.36, E13.39, E13.40 - E13.44, E13.49, E13.51 - E13.52, E13.59, E13.610, E13.618, E13.620 - E13.622, E13.628 E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8 and E13.9 4. O24.011 - O24.013, O24.019, O24.02 - O24.03, O24.111 - O24.113, O24.119 , O24.12 - O24.13, O24.311 - O24.313 O24.319, O24.32 - O24.33, O24.811 - O24.813, O24.819 and O24.82 - O24.83 **B. Record the diagnosis in the Problem List of the patient's chart in eCW**
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **I. Document a Urine Protein lab result in the "Labs" section of the patient's chart in eCW** **A. The following urine protein labs are accepted** 1. Macroalbumin Protein labs 2. Microalbumin Protein labs 3. Microalbumin/Creatinine Ratio labs **B. If the Urine Protein lab order has been electronically-generated and resulted in your EMR, no further action is necessary** *(continued)*

Measure Name	Diabetes: Nephropathy Screening *(continued)*
Measure Documentation *(continued)*	**C. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** 1. Access the "Labs" section of the patient's chart 2. If necessary, click "New" to create a new Lab order a. Click the "SEL" button, adjacent to the "Lab" search field b. Find and select the appropriate Urine Protein lab from the list of Lab options **3. Complete the following fields:** a. **Order Date** 1) If necessary, enter the date the lab was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Type the result (Positive or Negative) in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box **II. If a Urine Protein test is not necessary, because the patient already has evidence of of diabetic nephropathy, do one of the following:** *(continued)*

Measure Name	Diabetes: Nephropathy Screening *(continued)*
Measure Documentation *(continued)*	**A. If applicable, document a prescription for an ACE Inhibitor or ARB medication in the "Current Medications" section of the patient's chart in eCW** 1. The medication can be added from one of the following locations in eCW: a. *Progress Notes → Treatment → Add* b. *Telephone Encounter → Rx tab → Select Rx* c. *Telephone Encounter → Virtual Visit tab → Treatment → Add* d. *Telephone Encounter → Virtual Visit tab → Current Medication → Add* e. *Progress Notes → Current Medications* **2. Note: A Urine Protein lab is still required by some payers (i.e., Priority Health) to satisy this measure for their specific managed-care incentive program** **B. If applicable, document one of the following active diagnoses in the Problem List of the patient's chart in eCW** **1. The following ICD-10 codes indicate Hypertensive Chronic Kidney Disease** a. I12.0 and I12.9 b. I13.0, I13.10 - I13.11 and I13.2 **2. The following ICD-10 codes indicate Glomerulonephritis and Nephrotic Syndrome** a. N00.0 - N00.9 b. N01.0 - N01.9 c. N02.0 - N02.9 d. N03.0 - N03.9 e. N04.0 - N04.9 f. N05.0 - N05.9 g. N06.0 - N06.9 h. N07.0 - N07.9 *(continued)*

Measure Name	Diabetes: Nephropathy Screening *(continued)*
Measure Documentation *(continued)*	i. N08 j. N25.0 - N25.1, N25.81, N25.89 and N25.9 **3. The following ICD-10 codes indicate Diabetic Nephropathy** a. E08.21 - E08.22 and E08.29 b. E09.21 - E09.22 and E09.29 c. E10.21 - E10.22 and E10.29 d. E11.21 - E11.22 and E11.29 e. E13.21 - E13.22 and E13.29 **4. The following ICD-10 codes indicate Proteinuria:** R80.1 and R80.8 - R80.9 **5. The following ICD-10 codes indicate Kidney Failure** a. N17.0 - N17.2 and N17.8 - N17.9 b. N18.1 - N18.6 and N18.9 c. N19 **C. If applicable, document the CPT code for one of the following services or procedures in a Progress Note or Virtual Visit** **1. The following CPT codes identify Kidney Transplant procedures** a. 50340, 50360, 50365, 50370 and 50380 b. S2065 **2. The following CPT codes identify Dialysis procedures** a. 90920 - 90921, 90924 - 90925, 90935, 90937, 90940, 90945 and 90947 b. G0257 *(continued)*

Measure Name	**Diabetes: Nephropathy Screening** *(continued)*
Measure Documentation *(continued)*	**3. The following CPT codes identify Vascular Access for Dialysis procedures** a. 36147 - 36148 b. 36800, 36810, 3685, 36818, 36819 - 36821 and 36831 - 36833 **4. The following CPT codes identify ESRD Monthly Outpatient services** a. 90957 - 90962, 90965 - 90966, 90969 - 90970, 90989, 90993, 90997 and 90999 b. 99512 **5. Document the appropriate CPT code in one of the following locations in a Progress Note or Virtual Visit:** a. *Progress Notes → Treatment → Procedures* b. *Progress Notes → Billing*
Exclusion and/pr Exception Documentation	None
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that an appropriate LOINC code is linked to the Urine Protein lab** **A. The following LOINC codes identify Urine Protein labs** 1. 11218-5, 12842-1, 13705-9, 13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 1753-3, 1754-1, 1755-8 1757-4, and 18373-1 2. 20454-5, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 2887-8, 2888-6, 2889-4 and 2890-2 3. 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5 and 35663-4 4. 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2 and 49023-5 5. 50561-0, 50949-7, 53121-0, 53525-2, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 57735-3, 5804-0, 58448-2, *(continued)*

Measure Name	Diabetes: Nephropathy Screening *(continued)*
Trouble-Shooting *(continued)*	58992-9 and 59159-4 6. 60678-0 and 63474-1 7. 9318-7 **B. To associate a new, or update an existing, LOINC code with a Lab, do the following:** 1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Attribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window 3) Click "OK" to exit the Lab-specific window 4. Click the X (in the top, right-hand corner) to close the "Labs" window
	II. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results) A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid *(continued)*

Measure Name	Diabetes: Nephropathy Screening *(continued)*
Trouble-Shooting *(continued)*	E. I.e., Verify that the "Reviewed" box has been checked
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Verify that the correct ICD-10 diagnosis code has been added B. Add a diagnosis to the patient's Problem List in one of the following ways: 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	IV. Search all available data sources (e.g., Endocrinology notes, Powerchart, Quest and VA lab reports, etc.) for Urine Protein lab results and manually enter the Urine Protein order and results into the Labs section of the patient's chart in your EMR
	V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**<u>For More Information</u>** I. NQF 0062: "**Diabetes: Urine Protein Screening**" II. eClinicalWorks "**MIPS - CMS 134 - Diabetes: Urine Protein Screening**" *(continued)*

Measure Name	Diabetes: Nephropathy Screening *(continued)*
For More Information *(continued)*	III. eClinicalWorks "**MIPS - Registry 119 (NQF 0062) (MIPS-CMS 134) - Diabetes: Medical Attention for Nephropathy**", IV. **2017 HEDIS for QRS Version**

Measure Name	Falls: Screening for Fall Risk
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0101: Prevention & Screening Measure]* ACO Quality Measure #13 *[GPRO: Care Coordination/Patient Safety Measure]* MIPS Clinical Quality Measure *[CMS 139 (EHR)/Registry 154: Process Measure]*
Measure Definition	***The percentage of patients, 65 years of age and older, who were assessed for risk of falls at least once during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 65 years old at the start of the Measurement Period II. **AND**, Have been seen for an applicable encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been screened for Fall Risk during the Measurement Period I. Numerator Note: A "Fall" is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force II. Numerator Note: Documentation of future Fall Risk assessment must include a history of falls within the past 12 months A. I.e., No falls within the past year B. I.e., One fall without injury within the past year C. I.e., One fall with injury within the past year *(continued)*

Measure Name	Falls: Screening for Fall Risk *(continued)*
umerator *(continue*	D. I.e., two or more falls without injury within the past year E. I.e., Two or more falls with injury wihtin the past year III. Numerator Note: Patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year
Exclusions and/or Exceptions	Patients are **excepted** from the Denominator for one of the following reasons: I. The patient has a medical reason for not having a Fall Risk assessment performed during the Measurement Period II. The patient is not ambulatory A. E.g., The patient is bed-ridden B. E.g., The patient is immobile C. E.g., The patient is confined to a chair or wheelchair-bound
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must have been seen for an applicable E&M encounters during the Measurement Period** **A. The following E&M codes identify applicable visit encounters** 1. 92540 - 92542 and 92548 2. 97161 - 97168 3. 99201 - 99205 and 99212 - 99215 4. 99304 - 99310, 99324 - 99328, 99334 - 99337, 99341 - 99345 and 99347 -99350 5. 99401 - 99404 6. G0402 and G0438 - G0439 *(continued)*

Measure Name	Falls: Screening for Fall Risk *(continued)*
Measure Documentation *(continued)*	B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit *(Progress Notes → Billing)*

To Satisfy This Measure

(Numerator Documentation)

Document Fall Risk assessment results in structured data fields in the Progress Note for the visit

A. eCW suggests the following path for the documentation of Fall Risk assessment results:

Progress Notes → Preventive Medicine

↓

Screenings → Fall Risk Screening → Fall Risk Assessment

1. The required structured data fields are outlined (boxed) in the pathway above
2. If necessary, generate (and map) the above structured data path, as follows

a. Add "Fall Risk Screening" as an item in the "Screenings" folder in Preventive Medicine

1) From within a Progress Note or Virtual Visit, click on the "Preventive Medicine" link
2) Click on the "Screenings" folder
3) If "Fall Risk Screening" is not listed in the options that subsequently display

a) Click the carat adjacent to the "Custom" button
b) Select "New Item"
c) Type "Fall Risk Screening" in the "Name" field
d) Check the "Structured Data" box
e) Click "OK" to close the window

b. To map the field, click the "Community" tab in the top menu bar

(continued)

Measure Name	Falls: Screening for Fall Risk *(continued)*
Measure Documentation *(continued)*	c. Select "Mappings" d. Select "Structured Data" 1) A Structured Data "Mapper" window will open 2) Enter the following information for both the Community and Local sides: a) Section = "Preventive Medicine" b) Category = "Screenings" c) Item = "Fall Risk Screening" 3) A list of structured data options will appear on the Community side (Items in black font have not yet been mapped) a) Select "Fall Risk Assessment" from the Community side b) Click "Add" to add the option to the Local side and map it to the Community element c) Both options should now be displayed in blue font 4) A new window, containing the structured options for "Fall Risk Assessment" will then appear a) Select an option from the Community side b) Click "Add" to add it to the Local side and map it to its Community counterpart c) Repeat with the remaining Community options 3. The "**Fall Risk Screening**" contains the following structured text options: 1) Performed 2) Not performed 4. The "**Fall Risk Assessment**" contains the following structured text options: *(continued)*

Measure Name	**Falls: Screening for Fall Risk** *(continued)*
Measure Documentation *(continued)*	1) No falls within the past year 2) One fall without injury within the past year 3) One fall with injury within the past year 4) Two or more falls without injury within the past year 5) Two or more falls with injury wihtin the past year **3. An answer needs to be entered into both structured data fields (i.e., "Fall Risk Screening" and "Fall Risk Assessment") in order to satisfy this measure** **B. The structured data fields may be located in any customizable section of a Progress Note (e.g.,HPI, Preventive Medicine etc.) as long as they are mapped to the Community counterparts identified in the path above** C. If the above structured data fields are not already set up in your EMR, contact an eCW Technical Representative for assistance
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If applicable, document the inability to perform a Fall Risk assessment (due to an interfering medical reason or because the patient is not ambulatory) in a structured data field** **A. eCW recommends the following path for documenting the inability to perform a Fall Risk assessment:** ***Progress Notes → Preventive Medicine → Screenings →*** ***Fall Risk Screening*** ↓ **Select "Not Performed"** ↓ **Select "Medical Reason" or "Patient Not Ambulatory"** ↓ **Select an option from the pick list that displays** *(continued)*

Measure Name	Falls: Screening for Fall Risk *(continued)*
Exclusion and/or Exception Documentation *(continued)*	1. The required structured data fields are outlined (boxed) in the pathway above 2. If necessary, generate (and map) the above structured data path, as detailed above **3. "Medical Reason" options include (but are not limited to):** a. Procedure not indicated b. Procedure contraindicated **4. The "Patient Not Ambulatory" option applies to patients that are bed-ridden, wheelchair-bound, etc.** **B. The structured data fields may be located in any customizable section of a Progress Note (e.g., HPI, Preventive Medicine etc.) as long as they are mapped to the Community counterparts identified in the path above** C. If the above structured data fields are not already set up in your EMR, contact an eCW Technical Representative for assistance
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that the Fall Risk assessment results are documented in the correct structured data fields**
	II. Verify that the required structured data fields are mapped to their Community counterparts in eCW A. From within eCW, click the "Community" tab in the top menu bar 1. Click "Mappings" 2. Click "Structured Data" a. A "Mapper" window open b. Enter the eCW path on the "Community" side *(continued)*

Measure Name	**Falls: Screening for Fall Risk** *(continued)*
Trouble-Shooting *(continued)*	1) I.e., Section = Preventive Medicine 2) I.e., Category = Screenings 3) I.e., Item = Fall Risk Screening 3. Similarly, enter the location of your structured data fields on the Local side 4. Verify that: a. Each structured text option on the Local side is paired with its counterpart on the Community side b. All options are displayed in blue font (mapped) **B. Verify that, if applicable, a reason for not performing a Fall Risk analysis (medical or ambulatory) is also documented in a properly - mapped structured data field**
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0101: "**Falls: Risk Assessment"** II. **2016 GPRO PREV Supporting Documents** III. eClinicalWorks "**MIPS - CMS 139- Falls: Screening for Future Fall Risk"** IV. eClinicalWorks "**MIPS - Registry 154 (NQF 0101) (MIPS - CMS 139) - Falls: Risk Assessment"**

Measure Name	Influenza Immunization
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0041: Prevention & Screening Measure]* ACO Quality Measure # 14 *[GPRO: Preventive Measure]* MIPS Clinical Quality Measure *[CMS 147 (EHR)/Registry 110: Process Measure]*
Measure Definition	***The percentage of patients, 6 months of age and older, who were seen for a visit during Flu season (between October 1 and March 31) AND received an Influenza immunization OR reported previous receipt of an Influenza (Flu) immunization*** Measure Notes: A. "*Flu* Season" occurs between October 1 of each year through March 31 of the following year B. This measure spans two *Flu* seasons 1. October 1 of the year prior to the Measurement Period through March 31 of the Measurement Period 2. October 1 of the Measurement Period through March 31 of the year following the Measurement Period C. This measure is reported a minimum of once for patients seen between January 1 and March 31 of the Measurement Period AND a minimum of once for patients seen between October 1 and December 31 of the Measurement Period D. For each *Flu* season, applicable *Influenza* immunizations may be administered beginning August 1 of each year and ending March 31 of the following year E. "Previous Receipt" (of the *Influenza* immunization) is defined as: 1. Administration of the *Influenza* immunization, during the current *Flu* season, from another provider 2. **OR**, Administration of the *Influenza* immunization, prior to the current Flu season (i.e., August 1 - September 30) by any provider
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31) *(continued)*

Measure Name	**Influenza Immunization** *(continued)*
Denominator	The **Denominator** consists of patients who: I. Are ≥ 6 months of age at the beginning of the Measurement Period II. **AND**, Are seen for at least two applicable General visits or at least one applicable Preventive Care visit during the Measurement Period III. **AND**, Are seen for at least one visit between October 1 of the year prior to the Measurement Period and March 31 of the Measurement Period IV. **AND/OR,** Are seen for at least one applicable encounter between October 1 of the Measurement Period and March 31 of the year following the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who are administered, or reported the administration of, an *Influenza* immunization I. Between August 1 of the year prior to the Measurement Period through March 31 of the Measurement Period II. **AND/OR**, Between August 1 of the Measurement Period through March 31 of the year following the Measurement Period
Exclusions and/or Exceptions	Patients are **excepted** (from the Denominator) from this measure if the *Influenza* vaccine was not administered due to one of the following reasons: I. Communication from the patient to the provider, that *Influenza* immunization has been declined, is documented in the patient's chart in the EMR (between August 1 and March 31) II. **OR**, There is documentation, in the patient's chart in the EMR, of an active allergy to eggs during the Measurement Period III. **OR**, There is documentation, in the patient's chart in the EMR, of an active allergy or intolerance to *Influenza* vaccine during the Measurement Period IV. **OR**, There is documentation, in the patient's chart in the EMR, of another reason (Medical, Patient, or System) for not administering the immunization *(continued)*

Measure Name	**Influenza Immunization** *(continued)*
Measure Documentation	**<u>To Qualify For This Measure</u>** *(Denominator Documentation)* **I. The patient is seen for at least two applicable General visit encounters or at least one applicable Preventive Care encounter during the Measurement Period** **A. The following E&M codes identify applicable General visit encounters** 1. 99201 - 99205, 99212 - 99215 and 99241 - 99245 2. 99324 - 99328, 99334 - 99337, 99341 - 99345 and 99347 - 99350 3. Note: E&M codes with Telehealth modiferes (GQ or GT) are **<u>NOT</u>** acceptable for this measure **B. The following E&M codes identify applicable Preventive Care visit encounters** 1. 90945, 90947 and 90951 - 90970 2. 96160 and 96161 3. 99304 -99310, 99315 - 99316, 99381 - 99387, and 99391 - 99397 4. 99401 - 99404, 99411 - 99412, 99420 and 99429 5. G0438 and G0439 6. Note: E&M codes with Telehealth modifiers (GQ or GT) are **<u>NOT</u>** acceptable for this measure **C. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. The patient was/is also seen for one of the above applicable encounters:** A. Between October 1, of the year prior to the Measurement Period, and March 31 of the Measurement Period B. **<u>AND/OR</u>**, Between October 1 of the Measurement Period and March 31 of the year following the Measurement Period *(continued)*

Measure Name	**Influenza Immunization** *(continued)*
Measure Documentation *(continued)*	**To Satisfy This Measure** *(Numerator Documentation)* **I. Document the administration/receipt of the *Influenza* immunization(s) in the "Immunizations/T. Injections" section of the patient's chart** **A. If the vaccine was administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "immunization Details" window 4. Select the applicable vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close **B. If the vaccine was administered at another health facility** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the applicable vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR *(continued)*

Measure Name	**Influenza Immunization** *(continued)*
Measure Documentation *(continued)*	**II. <u>OR</u>, Document an *Influenza* immunization as a procedure** **A. The following CPT codes identify an *Influenza* administration procedure:** 90653, 90655- 90658, 90660 -90662, 90664, 90666 -90668, 90672, 90685 - 90688 **B. The following CPT II code identifies the previous receipt of an *Influenza* immunization:** G8482: "*Influenza* immunization administered or previously received **C. Record the appropriate CPT or CPT II code in the Billing section of the Progress Note for the visit during which the immunization was** administered *(Progress Notes → Billing)* **D. Note: For ease of reference, documentation of the immunization in the "Immunizations/T. Injections" section of the patient's chart is the preferred method of documentation for this measure**
Exclusion and/or Exception Documentation	**<u>To Except a Patient From This Measure</u>** *(Exclusion/Exception documentation)* **I. If the immunization cannot be administered because the patient has refused the service:** **A. Document the non-administration of the *Influenza* vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub in eCW 2. Click "Add" to open the "Immunization Details" window 3. Select the appropriate *Flu* vaccine from the left-hand panel 4. In the right-hand panel: *(continued)*

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documenation *(continued)*	a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Click the "Patient Decision" radio button 3) Click OK to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. <u>AND/OR</u>, Document the non-administration of the *Influenza* vaccine, due to patient refusal, in a structured data field** **1. eCW recommends the following structured data path:** *Progress Note* → *Examination* → *CQM Exceptions* ↓ *Influenza Vaccine Not Administered* → *Patient Reason* → *Type of Patient Reason* ↓ *Select option* 2. For the above option, the required structured data fields are outlined (boxed) 3. Record the patient's refusal in the Progress Note for the applicable visit, using the structured data path, above **a. Some configuration and mapping may first be required** 1) If necessary, add the "Influenza Vaccine Not Administered" item to the "CQM Exceptions" folder in the "Examination" section of the Progress Note, as follows: *(continued)*

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a) From within a Progress Note or Virtual Visit, click on the "Examination" link b) Click on the "CQM Exceptions" folder c) If "Communication to Patient" is not an available option: (1) Click the carat adjacent to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Influenza Vaccine Not Administered" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) (a) Section = Examination (b) Category = CQM Exceptions (c) Item = Influenza Vaccine Not Administered (3) From the Community side, select the desired reporting field (i.e., "Patient Reason") (4) Click "Add" (a) The field will automatically be added to the Local side *(continued)*

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documentation *(continued)*	(b) The Community and Local fields will automatically map to each other (c) (Mapped fields display in blue font) (d) Associated Community options will also automatically be added to the Local side and mapped b. Select "Patient Refused Service" or "Procedure Refused" from the list of options for "Type of Patient Reason" **C. Note: For ease of reference, documentation of the immunization in the "Immunizations/T. Injections" section of the patient's chart is the preferred method of documentation for this measure**
	II. If the immunization cannot be administered because the patient has an allergy to eggs **A. Document the non-administration of the *Influenza* vaccine in the "Immunizations/T. Injections" section of the patient's chart, in eCW as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub in eCW 2. Click "Add" to open the "Immunization Details" window 3. Select the appropriate *Flu* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Allergy to Eggs" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit *(continued)*

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. <u>AND/OR</u>, Document the non-administration of the *Influenza* vaccine, due to allergy to eggs, in a structured data field** **1. eCW recommends the following structured data path:** ***Progress Note* → *Examination* → *CQM Exceptions*** ↓ ***Influenza Vaccine Not Administered*** → ***Medical Reason*** → ***Type of Medical Reason*** ↓ ***Select option*** 2. For the above option, the required structured data fields are outlined (boxed) **3. Record the patient's allergy to eggs in the Progress Note for the applicable visit, using the structured data path, above** a. If necessary, configure and map the required structured data fields, as detailed above b. Select "Drug Allergy" from the list of options for "Type of Medical Reason" **C. <u>AND</u>, Document the egg allergy in the "Allergies" section of the patient's chart in eCW** **D. Note: For ease of reference, documentation of the immunization in the "Immunizations/T. Injections" section of the patient's chart is the preferred method of documentation for this measure**
	III. If the *Influenza* vaccine cannot be administered because the patient has an other allergy or intolerance to *Influenza* vaccine **A. Document the non-administration of the *Influenza* vaccine in the "Immunizations/T. Injections" section of the patient's chart, in eCW as follows:** *(continued)*

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documentation *(continued)*	1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub in eCW 2. Click "Add" to open the "Immunization Details" window 3. Select the appropriate *Flu* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Allergy/Intolerance to *Influenza* vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. <u>AND/OR</u>, Document the non-administration of the *Influenza* vaccine, due to an other allergy or intolerance to *Influenza* vaccine, in a structured data field** 1. Follow the procedure detailed for non-administration due to egg allergy, above 2. Select "Drug Intolerance" or "Drug Allergy" from the list of options for "Type of Medical Reason" **C. <u>AND</u>, Document the *Influenza* vaccine allergy or intolerance in the "Allergies" section of the patient's chart in eCW** **D. Note: For ease of reference, documentation of the immunization in the "Immunizations/T. Injections" section of the patient's chart is the preferred method of documentation for this measure** *(continued)*

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**IV. If the *Influenza* vaccine is not administered due to another (Patient, Medical, or System) reason** **A. Patient reasons include:** Did Not Attend; Dissatisfied with Doctor; Drug Declined by PAtient Drug Declined by Patient - Cannot Pay Script; Drug Declined by Patient - Patient Beliefs; Drug Declined by Patient - Side Effects Drugs Not Taken/Completed; Economic Problem; Family Illness Financial Circumstances Change; Financial Problem; Further Opinion Sought Income Insufficient to Buy Necessities; Income Sufficient to Buy Only Necessities; Medication Refused Patient Defaulted From Follow-Up; Patient Discharge, Signed Out Against Medical Advice Patient Dissatisfied with Result; Patient Forgets to Take Medication; Patient Has Moved Away Patient Noncompliance - General; Patient Refused Access to Services; Patient Refused Intervention/Support Patient Refused Service; Patient Requests Alternative Treatment; Patient Self-Discharge Against Medical Advice Procedure Not Wanted; Procedure Refused; Procedure Refused for Religious Reason Refusal of Treatment by Patient; Refused; Rejected by Recipient Stopped by Patient; Treatment Delay - Patient Choice; Variable Income **B. Medical Reasons include:** Absent Response to Treatment; Adverse Reaction to Drug; Complication of Medical Care Contraindicated; Drug Allergy; Drug Interaction Drug Intolerance; Drug Resistance; Drug Therapy Discontinued Drug Treatment Not Indicated; Failure in Dosage; History of Drug Allergy Late Effect of Medical and Surgical Care Complication; Medical Contraindication Not Indicated; Procedure Contraindicated; Procedure Discontinued Procedure Not Indicated; Treatment Changed; Treatment Modification Treatment Not Indicated; Treatment Not Tolerated *(continued)*

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documentation *(continued)*	

C. System Reasons include:

Appointment Canceled by Hospital	Delay in Receiving Benefits	Drug Not Available - Off Market
Drug Not Available - Out of Stock	Drug Not Available for Administration	Finding Related to Health Insurance Issues
Loss of Benefits	Medical Care Unavailable	Not Entitled to Benefits
Patient on Waiting List	Patient Transfer	Referred to Doctor
Treatment Not Available	Uninsured Medical Expenses	

D. Document the non-administration of the *Influenza* vaccine in the "Immunizations/T. Injections" section of the patient's chart, in eCW as follows:

1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub in eCW
2. Click "Add" to open the "Immunization Details" window
3. Select the appropriate *Flu* vaccine from the left-hand panel
4. In the right-hand panel:
    a. Change the "Status" to "Not Administered"
    b. Click the selection button (with three dots) for the "Reason" field
        1) A "Select reason for not administered" window will open
        2) Type the reason for non-administration of the vaccine in the field labeled "Other"
        3) Click "OK" to close the window
5. Click "OK" to exit
    a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered)
    b. The vaccine, and the reason given for non-administration, will push to MCIR

(continued)

Measure Name	Influenza Immunization *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**E. <u>AND/OR</u>, Document the non-administration of the *Influenza* vaccine, due to an other patient, Medical or system reason, in one of the following structured data fields** ***Progress Note → Examination → CQM Exceptions*** ↓ ***Influenza Vaccine Not Administered*** ↙ ↓ ↘ **Patient Reason** **Medical Reason** **System Reason** ↘ ↓ ↙ ***Type of (Patient, Medical, System) Reason*** ↓ ***Select Option*** 1. If necessary, configure and map the structured data field as previously described in this document 2. Select the appropriate structured data field and the appropriate option for "Type of Reason" to document the non-administration of the *Influenza* vaccine **F. Note: For ease of reference, documentation of the immunization in the "Immunizations/T. Injections" section of the patient's chart is the preferred method of documentation for this measure**
Trouble-Shooting	**<u>Having problems? Check out the following Trouble-Shooting tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. One of the following CVX codes must be linked to the *Influenza* immunization: 1112 135, 140, 141, 144, 149, 150, 151 and 168** **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options *(continued)*

Measure Name	Influenza Immunization *(continued)*
Trouble-Shooting *(continued)*	3. The "Immunizations/Therapeutic Injections" window will open **a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* *(continued)*

Measure Name	Influenza Immunization *(continued)*
Trouble-Shooting *(continued)*	2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options *(continued)*

Measure Name	**Influenza Immunization** *(continued)*
Trouble-Shooting *(continued)*	2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** Free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0041: "**Preventive Care and Screening: Influenza Immunization**" II. eClinicalWorks "**MIPS - CMS 147 - Preventive Care and Screening: Influenza Immunization**" III. eClinicalWorks "**MIPS - Registry 110 (NQF 0041) (MIPS-CMS 147) - Preventive Care and Screening: Influenza Immunization**" IV. **2016 GPRO PREV Supporting Documents**

Measure Name	Pneumonia Vaccination for Patients 65 Years and Older
Relevance	NPO Population Clinical Data Dashboard Measure *[NQF 0043: Prevention & Screening Measure]* ACO Quality Measure #15 *[GPRO: Preventive Measure]* MIPS Clinical Quality Measure *[CMS 127 (EHR)/Registry 111: Process Measure]*
Measure Definition	***The percentage of patients, aged 65 years and older, who have ever received a Pneumococcal vaccine***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 65 years of age at the start of the Measurement Period II. **AND**, Were seen for an applicable E&M encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Were administered a *Pneumococcal* vaccine (either Pneumococcal Conjugate or Pneumococcal Polysaccharide) before the end of the Measurement Period II. **Or,** Have documentation, in their chart in the EMR, of a *Pneumococcal* vaccine given in the past (documented before the end of the Measurement Period
Exclusions and/or Exceptions	None *(continued)*

Measure Name	Pneumonia Vaccination for Patients 65 Years and Older *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be/have been seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99385 -99387 and 99395 - 99397 3. G0438 and G0439 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing*)
	To Satisfy This Measure *(Numerator Documentation)* **I. Document the administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** **A. If the vaccine is administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "Immunization Details" window 4. Select the appropriate *Pneumococcal* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close (continued)

Measure Name	Pneumonia Vaccination for Patients 65 Years and Older *(continued)*
Measure Documentation *(continued)*	**B. If the vaccine was administered at another health facility** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub in eCW 2. Click "Add" to open the "Immunization Details" window 3. Select the appropriate *Pneumococcal* vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR **C. Measure Notes** 1. Credit is provided for any adult, 65 years of age or older, who have ever received either the PCV13 or PPSV23 vaccine (or both) 2. However, the ACIP recommends that patients receive both vaccines **3. If a patient is reporting the previous receipt of a *Pneumococcal* vaccine, documentation in the medical record must contain the following** a. The Date (year) the vaccine was administered b. The type of vaccine that was administered (PPSV23 or PCV13) *(continued)*

Measure Name	Pneumonia Vaccination for Patients 65 Years and Older *(continued)*
Measure Documentation *(continued)*	**II. <u>OR</u>, Document a *Pneumococcal* immunization as a procedure** A. The following CPT codes identify a *Pneumococcal* vaccine administration procedure: 90670 and 90732 B. The following CPT II code identifies the previous receipt of a *Pneumococcal* immunization: 4040F: "*Pneumococcal* vaccine administered or previously received" **C. Record the appropriate CPT or CPT II code in the Billing section of the Progress Note for the visit during which the immunization was** administered *(Progress Notes → Billing)* **D. Note: For ease of reference, documentation of the immunization in the "Immunizations/T. Injections" section of the patient's chart is the preferred method of documentation for this measure** **III. If the *Pneumococcal* vaccine should not or cannot, be administered due to a medical reason, or is not administered due to patient refusal:** **A. Document the non-administration of the *Pneumococcal* vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub in eCW 2. Click "Add" to open the "Immunization Details" window 3. Select the appropriate *Pneumococcal* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open *(continued)*

Measure Name	**Pneumonia Vaccination for Patients 65 Years and Older** *(continued)*
Measure Documentation *(continued)*	a) If the patient has refused, click the "patient Decision" radio button b) For any other reason, type the reason in the field labeled "Other" 2) Click OK to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document any allergies or intolerances to the *Pneumococcal* vaccine in the "Allergies" section of the patient's chart in eCW**
Exception and/or Exclusion Documentation	None
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. One of the following CVX codes must be linked to the *Pnuemococcal* vaccine:** 1. Pneumococcal Polysaccharide (PPSV23) = 33 2. Pneumococcal Conjugate (Prevnar 13) = 133 **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open

Measure Name	Pneumonia Vaccination for Patients 65 Years and Older *(continued)*
Trouble-Shooting *(continued)*	**a. To add or update the CVX code for an existing immunization:** 1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 2) A "New Immunization" window will open 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon *(continued)*

Measure Name	Pneumonia Vaccination for Patients 65 Years and Older *(continued)*
Trouble-Shooting *(continued)*	**B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** Free-type a reaction into the empty field *(continued)*

Measure Name	**Pneumonia Vaccination for Patients 65 Years and Older** *(continued)*
Trouble-Shooting *(continued)*	d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0043: "**Pneumonia Vaccination Status for Older Adults**" II. eClinicalWorks "**MIPS - CMS 127 - Pneumonia Vaccination Status for Older Adults**" III. eClinicalWorks "**MIPS - Registry 111 (NQF 0043) (CMS 127) - Pneumonia Vaccination Status for Older Adults**" IV. **2016 GPRO PREV Supporting Documents**

Measure Name	Human Papillomavirus Vaccine for Female Adolescents
Relevance	NPO Population Clinical Quality Dashboard *[NQF 1959: Prevention & Screening Measure]*
Measure Definition	***The percentage of female patients, 13 years of age, who have had three doses of the Human Papillomavirus vaccine (HPV) by the time of their 13th birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who I. Are Female II. **AND**, Are ≥ 12 and < 13 years of age at the beginning of the Measurement Period III. **AND**, Were seen for an applicable E&M encounter during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered three instances of the HPV vaccine: A. At least 6 months, or more, apart from each other B. After the patient is ≥ 9 years of age C. **AND**, By the time the patient is ≤ 13 years of age
Exclusions and/or Exceptions	Patients are **excluded** from this measure if there is documentation of anaphylactic reaction to HPV vaccine or its components

(continued)

Measure Name	**Human Papillomavirus Vaccine for Female Adolescents** *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable E&M encounter during the Measurement Period** **A. The following E&M codes identify applicable visit encounters:** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **Document each instance of administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** **A. If the vaccine is administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "immunization Details" window 4. Select the *HPV* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents** *(continued)*
Measure Documentation *(continued)*	**B. If the vaccine was administered at another health facility** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HPV* vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to Administered d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* **If the vaccine cannot be administered due to anaphylactic reaction to HPV vaccine or its components:** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HPV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to Not Administered

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *HPV* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *HPV* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW**
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the *HPV* immunization in your EMR** **A. One of the following CVX codes must be linked to the *HPV* immunization: 62, 118 and 165** **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open **a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents** *(continued)*
Trouble-Shooting *(continued)*	3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR A. If necessary, obtain the immunization information from an outside health facility or MCIR B. If applicable, provide a reason for any immunization with a Status of "Not Administered"
	III. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways:

(continued)

Measure Name	Human Papillomavirus Vaccine for Female Adolescents *(continued)*

Trouble-Shooting
(continued)

1. *Progress Note (or Virtual Visit) → Allergies/Intolerances*
2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon

B. Add a new Allergy or Intolerance as follows:

1. From the "Allergies/Intolerance" window, click "Add"
2. The "Past Medical History" window will open

a. "**Structured/Non-Structured**" Field

1) Select "Structured" if documenting a Drug allergy
2) Select "Non-Structured" if documenting a non-Drug allergy

b. "**Agent/Substance**" Field

1) For a Structured (Drug) Allergy

a) Click on the field to open the "Select Rx" window
b) Find and select the appropriate medication
c) Click "OK" to save the information and exit the window

2) For a Non-Structured (Non-Drug/Other) Allergy

a) Click in the empty field to reveal a carat for a drop-down box
b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options
c) Select an Allergy from the list of options in the drop-down box
d) **OR**, free-type an Allergy into the "Agent/Substance" field

c. "**Reaction**" Field

1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents** *(continued)*
Trouble-Shooting *(continued)*	options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** Free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information:** I. HEDIS: "**Human Papillomaviris Vaccine for Female Adolescents (HPV)**" II. NQF 1959: "**Human Papillomavirus Vaccine for Female Adolescents (HPV)**"

Measure Name	Human Papillomavirus Vaccine for Female Adolescents with One HPV
Relevance	NPO Population Clinical Quality Dashboard *[NQF 1959: Prevention & Screening Measure]*
Measure Definition	***The percentage of female patients, 13 years of age and with one administered dose of the Human Papillomavirus vaccine (HPV), who receive the remaining two doses of HPV vaccine by the time of their 13th birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are Female II. **AND**, Are ≥ 12 and < 13 years of age at the beginning of the Measurement Period III. **AND**, Were seen for an applicable E&M encounter during the Measurement Period IV. **AND**, Have been administered one dose of *HPV* vaccine
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered the remaining two instances of HPV vaccine: A. At least 6 months apart from each other and at least 6 months after the administration of the first (most recent) dose of *HPV* vaccine B. After the patient is ≥ 9 years of age C. **AND**, By the time the patient is ≤ 13 years of age
Exclusions and/or Exceptions	Patients are **excluded** from this measure if there is documentation of anaphylactic reaction to *HPV* vaccine or its components

(continued)

Measure Name	**Human Papillomavirus Vaccine for Female Adolescents with One HPV** *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient musthave been seen for an applicable E&M encounter during the Measurement Period** **A. The following E&M codes identify applicable visit encounters:** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. The patient must have already received one dose of the *HPV* vaccine** **Document the administration/receipt of *HPV* vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** **1. If the vaccine was administered in your office:** a. From within the open Progress Note, click on the "Immunizations" link b. The "Immunizations/T. Injections" window will open c. Click "Add" to open the "immunization Details" window d. Select the *HPV* vaccine from the left-hand panel e. Complete all open fields in the right-hand panel f. Click "OK" to save and close **2. If the vaccine was administered at another health facility** a. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents with One HPV** *(continued)*
Measure Documentation *(continued)*	b. Click "Add" to open the "Immunization Details" window c. Select the *HPV* vaccine from the left-hand panel d. In the right-hand panel: 1) Check the "Y" radio button for "Vaccination Given in the Past" 2) Enter the "Dose Number" 3) Change the "Status" to Administered 4) Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known 5) Enter the date the vaccine was administered in the "Given Date/Time" field e. Click "OK" to close f. Note: Vaccines marked "Given in the Past" should not push to MCIR
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **Document each instance of administration/receipt of the remaining two doses of *HPV* vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as detailed above**
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* **If the vaccine cannot be administered due to anaphylactic reaction to *HPV* vaccine or its components:** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub

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Measure Name	Human Papillomavirus Vaccine for Female Adolescents with One HPV *(continued)*
Exclusion and/or Exception Documentation *(continued)*	2. Click "Add" to open the "Immunization Details" window 3. Select the *HPV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to Not Administered b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *HPV* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *HPV* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW**
Trouble-Shooting	**<u>Having problems? Check out the following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the *HPV* immunization in your EMR** **A. One of the following CVX codes must be linked to the *HPV* immunization: 62, 118 and 165** **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open

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Measure Name	**Human Papillomavirus Vaccine for Female Adolescents with One HPV** *(continued)*
Trouble-Shooting *(continued)*	**a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR A. If necessary, obtain the immunization information from an outside health facility or MCIR B. If applicable, provide a reason for any immunization with a Status of "Not Administered"

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Measure Name	Human Papillomavirus Vaccine for Female Adolescents with One HPV *(continued)*
Trouble-Shooting *(continued)*	**III. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW** A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field

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Measure Name	**Human Papillomavirus Vaccine for Female Adolescents with One HPV** *(continued)*
Trouble-Shooting *(continued)*	c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** Free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information:** I. HEDIS: "**Human Papillomaviris Vaccine for Female Adolescents (HPV)**" II. NQF 1959: "**Human Papillomavirus Vaccine for Female Adolescents (HPV)**"

Measure Name	Human Papillomavirus Vaccine for Female Adolescents with Two HPV
Relevance	NPO Population Clinical Quality Dashboard *[NQF 1959: Prevention & Screening Measure]*
Measure Definition	***The percentage of female patients, 13 years of age and with two administered doses of the Human Papillomavirus vaccine (HPV), who receive the remaining dose of HPV vaccine by the time of their 13th birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are Female II. **AND**, Are ≥ 12 and < 13 years of age at the beginning of the Measurement Period III. **AND**, Were seen for an applicable E&M encounter during the Measurement Period IV. **AND**, Have been administered two doses of *HPV* vaccine
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered the remaining instance of HPV vaccine: A. At least 6 months after the administration of the second (most recent) dose of *HPV* vaccine B. After the patient is ≥ 9 years of age C. **AND**, By the time the patient is ≤ 13 years of age
Exclusions and/or Exceptions	Patients are **excluded** from this measure if there is documentation of anaphylactic reaction to *HPV* vaccine or its components

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents with One HPV** *(continued)*
Measure Documentation *(continued)*	b. Click "Add" to open the "Immunization Details" window c. Select the *HPV* vaccine from the left-hand panel d. In the right-hand panel: 1) Check the "Y" radio button for "Vaccination Given in the Past" 2) Enter the "Dose Number" 3) Change the "Status" to Administered 4) Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known 5) Enter the date the vaccine was administered in the "Given Date/Time" field e. Click "OK" to close f. Note: Vaccines marked "Given in the Past" should not push to MCIR
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **Document the administration/receipt of the final dose of *HPV* vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as detailed above**
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* **If the vaccine cannot be administered due to anaphylactic reaction to HPV vaccine or its components:** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents with Two HPV** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	2. Click "Add" to open the "Immunization Details" window 3. Select the *HPV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to Not Administered b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *HPV* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *HPV* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW**
Trouble-Shooting	**<u>Having problems? Check out the following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the *HPV* immunization in your EMR** **A. One of the following CVX codes must be linked to the *HPV* immunization: 62, 118 and 165** **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open

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Measure Name	Human Papillomavirus Vaccine for Female Adolescents with Two HPV *(continued)*
Trouble-Shooting *(continued)*	**a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR A. If necessary, obtain the immunization information from an outside health facility or MCIR B. If applicable, provide a reason for any immunization with a Status of "Not Administered"

(continued)

Measure Name	Human Papillomavirus Vaccine for Female Adolescents with Two HPV *(continued)*
Trouble-Shooting *(continued)*	**III. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW** A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field 1) For a Structured (Drug) Allergy a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured (Non-Drug/Other) Allergy a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field

	(continued)
Measure Name	**Human Papillomavirus Vaccine for Female Adolescents with Two HPV** *(continued)*
Trouble-Shooting *(continued)*	c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** Free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information:** I. HEDIS: "**Human Papillomaviris Vaccine for Female Adolescents (HPV)**" II. NQF 1959: "**Human Papillomavirus Vaccine for Female Adolescents (HPV)**"

Measure Name	Immunizations for Adolescents: Meningococcal
Relevance	NPO Populations Clinical Quality Dashboard *[NQF 1407: Prevention & Screening Measure]*
Measure Definition	***The percentage of patients, 13 years of age, who were administered one dose of Meningococcal vaccine by the time of their 13th birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 12 and < 13 years of age at the start of the Measurement Period II. **AND**, Were seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Were administered at least one instance of *Meningococcal* vaccine II. **AND,** The vaccine was administered by the time the patient turned 13 years old
Exclusions and/or Exceptions	Patients are **excluded** from this measure if there is documentation of anaphylactic reaction to *Meningococcal* vaccine or its components
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable E&M encounter during the Measurement Period** **A. The following E&M codes identify applicable visit encounters**

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Measure Name	**Immunizations for Adolescents: Meningococcal** *(continued)*
Measure Documentation *(continued)*	1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **<u>To Satisfy This Measure</u>** *(Numerator Documentation)* **Document each instance of administration/receipt of the *Meningococcal* vaccine in the "Immunizations/T. Injections"section of the patient's chart** **A. If the vaccine was administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "immunization Details" window 4. Select the applicable vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close **B. If the vaccine was administered at another health facility** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the applicable vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered"

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Measure Name	**Immunizations for Adolescents: Meningococcal** *(continued)*
Measure Documentation *(continued)*	d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* If the vaccine cannot be administered due to an anaphylactic reaction to the vaccine or its components: **A. Document the non-Administration of the vaccine in the "Immunizations/T.injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the applicable vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *Meningococcal* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit

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Measure Name	**Immunizations for Adolescents: Meningococcal** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *TDap* or *TD* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW**
Trouble-Shooting	**<u>Having problems? Check out the following Trouble-Shooting tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. One of the following CVX codes must be linked with the *Meningococcal* immunization:** **1. 162, 163, 148, 136, 114, 32** a. These CVX codes are Active b. They may be used to record new administratons of *Meningococcal* vaccine 2. 108, 147 and 167 a. These CVX codes are Inactive b. They should not be used to record newly-administered immunizations c. But, they may be used to report historical immunizations **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open

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Measure Name	Immunizations for Adolescents: Meningococcal *(continued)*
Trouble-Shooting *(continued)*	**a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR **A. If necessary, obtain the immunization information from an outside health facility or MCIR** **B. If applicable, provide a reason for any immunization with a Status of "Not Administered"**

(continued)

Measure Name	Immunizations for Adolescents: Meningococcal *(continued)*
Trouble-Shooting *(continued)*	**III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR** A. Verify that the correct ICD-10 diagnosis code has been added B. Add a diagnosis to the patient's Problem List in one of the following ways: 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	IV. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field

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Measure Name	Immunizations for Adolescents: Meningococcal *(continued)*
Trouble-Shooting *(continued)*	1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** Free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options

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Measure Name	**Immunizations for Adolescents: Meningococcal** *(continued)*
Trouble-Shooting *(continued)*	e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. HEDIS: "**Immunizations for Adolescents (MA)**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**" III. 2017 HEDIS for QRS Version: "**Immunizations for Adolescents (IMA)**"

Measure Name	Immunizations for Adolescents: TDaP/Td
Relevance	NPO Populations Clinical Quality Dashboard *[NQF 1407: Prevention & Screening Measure]*
Measure Definition	***The percentage of patients, 13 years of age, who were administered one dose of Tetanus - Acellular Pertussis - Diptheria Toxoids (TDaP) vaccine OR one dose of Tetanus - Diptheria Toxoids (Td) vaccine by the time of their 13th birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 12 and < 13 years of age at the start of the Measurement Period II. **AND**, Were seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Were administered at least one instance of *TDaP* vaccine II. **OR**, Were administered at least one instance of *Td* vaccine III. **AND,** The vaccine was administered by the time the patient turned 13 years old
Exclusions and/or Exceptions	Patients are **exlcluded** from this measure if they: I. Have documentation of anaphylactic reaction to *TDaP* vaccine or its components II. **OR**, Have documentation of anaphylactic reaction to *Td* vaccine or its components

(continued)

Measure Name	**Immunizations for Adolescents: TDaP/Td** *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable E&M encounter during the Measurement Period** **A. The following E&M codes identify applicable visit encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **Document each instance of administration/receipt of the (*TDaP or Td*) vaccine in the "Immunizations/T. Injections"section of the patient's chart** **A. If the vaccine was administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "immunization Details" window 4. Select the applicable vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close

	(continued)
Measure Name	**Immunizations for Adolescents: TDaP/Td** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. Change the "Status" to Not Administered b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to (*TDaP or Td*) Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *TDap* or *TD* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW**
Trouble-Shooting	**<u>Having problems? Check out the following Trouble-Shooting tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. The following CVX code must be linked to the *TDaP* immunization:** 115 **B. One of the following CVX codes must be linked with the *Td* immunization:** 19, 113, 138 or 139 **C. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open **a. To add or update the CVX code for an existing immunization**

	(continued)
Measure Name	**Immunizations for Adolescents: TDaP/Td** *(continued)*
Trouble-Shooting *(continued)*	1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR **A. If necessary, obtain the immunization information from an outside health facility or MCIR** **B. If applicable, provide a reason for any immunization with a Status of "Not Administered"**
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR

(continued)

Measure Name	**Immunizations for Adolescents: TDaP/Td** *(continued)*
	A. Verify that the correct ICD-10 diagnosis code has been added **B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the
Trouble-Shooting *(continued)*	**IV. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW** A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR,** From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field

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Measure Name	Immunizations for Adolescents: TDaP/Td *(continued)*
Trouble-Shooting *(continued)*	**1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** Free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options

	(continued)
Measure Name	**Immunizations for Adolescents: TDaP/Td** *(continued)*
Trouble-Shooting *(continued)*	**V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)**
For More Information	**For More Information** I. HEDIS: "**Immunizations for Adolescents (MA)**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**" III. 2017 HEDIS for QRS Version: "**Immunizations for Adolescents (IMA)**"

Measure Name	Childhood Immunization Status: COMBO2
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-12: Pediatric Measures]* MIPS Clinical Quality Measure *[CMS 117 (EHR): Process Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered the following vaccines by the time of their second birthday: four Diptheria, Tetanus and Acellular Pertussis (DTaP), three Polio IPV), one Measles, Mumps and Rubella (MMR), three Influenza Type B (HiB), three Hepatitis B (HepB) and one Chicken Pox (VZV)***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who, by the time of their second birthday (during the Measurement Period)have been administered: I. Four instances of *DTaP* vaccine, at least one day or more apart from each other II. **AND**, Three instances of *IPV* vaccine, at least one day, or more, apart from each other III. **AND**, One instance of *MMR* vaccine IV. **AND**, Three instances of *HiB* vaccine, at least one day, or more apart from each other V. **AND**, Three instances of *HepB* vaccine, at lest one day, or more, apart from each other VI. **AND**, One instance of *VZV* vaccine
Exclusions and/or Exceptions	See any **Exclusions and/or Exceptions** allowed for each individual vaccine

Exceptions	*(continued)*
Measure Name	**Childhood Immunization Status: COMBO2**
Measure Documentation	**See the Measure Documentation for each indiviual vaccine**
Exclusion and/or Exception Documentation	See the **Exclusion and/or Exception** Documentation for each individual vaccine
Trouble- Shooting	See the **Trouble-Shooting Tips** provided for each individual vaccine
For More Information	**For More Information** I. HEDIS: "**Childhood Immunization Status**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**"

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Measure Name	**Childhood Immunization Status: COMBO3**
Exclusions and/or Exceptions	See any **Exclusions and/or Exceptions** allowed for each individual vaccine
Measure Documentation	**See the Measure Documentation for each indiviual vaccine**
Exclusion and/or Exception Documentation	See the **Exclusion and/or Exception Documentation** for each individual vaccine
Trouble - Shooting	See the **Trouble-Shooting Tips** provided for each individual vaccine
For More Information	**For More Information** I. HEDIS: "**Childhood Immunization Status**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**"

Measure Name	Childhood Immunization Status: DTaP
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-2: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered four Diptheria, Tetanus and acellular Pertussis (DTaP) vaccines by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered four instances of *DTaP* vaccine: A. At least one day, or more, apart from each other B. **AND**, After the patient is ≥ 6 weeks (42 days) of age C. **AND,** By the time the patient turns 2 years of age
Exclusions and/or Exceptions	Patients may be **excluded** from this measure for one of the following reasons: I. They have had an anaphylactic reaction to *DTaP* vaccine by the time they reach 2 years of age II. **OR**, They have had a diagnosis for Encephalopathy (active or resolved) by the time they reach 2 years of age

(continued)

Measure Name	**Childhood Immunization Status: DTaP** *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **Document each instance of administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** **A. If the vaccine is administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "Immunization Details" window 4. Select the *DTaP* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close **B. If the vaccine was administered at another health facility**

	(continued)
Measure Name	**Childhood Immunization Status: DTaP** *(continued)*
Measure Documentation *(continued)*	1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *DTaP* vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If the vaccine cannot be administered due to anaphylactic reaction to *DTaP* vaccine** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *DTaP* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field

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Measure Name	Childhood Immunization Status: DTaP *(continued)*
Exclusion and/or Exception Documentation *(continued)*	1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *DTaP* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *DTaP* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW** **II. If the vaccine cannot be administered because the patient has/had Encephalopathy** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *DTaP* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Encephalopathy" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit

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Measure Name	**Childhood Immunization Status: DTaP** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, add the ICD-10 code for Encephalopathy (G04.32) to the Problem List in the patient's chart in eCW**
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. One of the following CVX codes must be linked to the DTaP immunization:** 106, 110, 120 130, 20 or 50 **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open **a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu

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Measure Name	**Childhood Immunization Status: DTaP** *(continued)*
Trouble-Shooting *(continued)*	**b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR A. If necessary, obtain the immunization information from an outside health facility or MCIR B. If applicable, provide a reason for any immunization with a Status of "Not Administered"
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Verify that the correct ICD-10 diagnosis code has been added B. Add a diagnosis to the patient's Problem List in one of the following ways: 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated

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Measure Name	**Childhood Immunization Status: DTaP** *(continued)*
Trouble-Shooting *(continued)*	b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **Or**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
References	**For More Information** I. HEDIS: "**Childhood Immunization Status**"

Measure Name	Childhood Immunization Status: HepA
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-3: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered one Hepatitis A (HepA) vaccine by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (01/01 - 12/31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Were seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered one instance of the *HepA* vaccine by the tiime the patient is < 2 years of age
Exclusions and/or Exceptions	Patients can be **excluded** from this measure for one of the following reasons: I. They have had an anaphylactic reaction to the *HepA* vaccine (≤ 2 years of age) II. **OR**, They have a diagnosis (active or resolved) for Hepatitis A (≤ 2 years of age) III. **OR**, They have had a seropositive result for the Hepatitis A antigen test (≤ 2 years of age)

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
Measure Documentation	**<u>To Qualify For This Measure</u>** *(Numerator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** (*Progress Notes → Billing)*
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **Document the administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** **A. If the vaccine is administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "Immunization Details" window 4. Select the *HepA* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close **B. If the vaccine was administered at another health facility** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
Measure Documentation *(continued)*	2. Click "Add" to open the "Immunization Details" window 3. Select the *HepA* vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If the vaccine cannot be administered due to anaphylactic reaction to HepA vaccine** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HepA* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
	1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *HepA* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *HepA* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW**
Exclusion and/or Exception Documentation *(continued)*	**II. If the vaccine need not be administered because the patient has had Hepatitis A disease** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HepA* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to Not Administered b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Click the selection button (with three dots) for the "History of Immunity" field 3) Find and select "Viral Hepatitis, type A" 4) Click "OK" to close the window 5. Click "OK" to exit

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, add the appropriate ICD-10 diagnosis code for Hepatitis A (B15.0 or B15.9) to the Problem List in the patient's chart in eCW**
	III. If the vaccine need not be administered because the patient has had a seropositive result to a Hepatitis A antigen test **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart exactly as detailed above (for Hepatitis A disease)** **B. Also, document the Hepatitis A antigen seropositive test result in the "Labs" section of the patient's chart in eCW** **1. If the Hepatitis A Antigen lab order has been electronically-generated and resulted in your EMR, no further action is necessary** **2. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** a. Access the "Labs" section of the patient's chart b. If necessary, click "New" to create a new Lab order 1) Click the "SEL" button, adjacent to the "Lab" search field 2) Find and select the appropriate HepA Antigen lab from the list of Lab options **3. Complete the following fields:** a. **Order Date** 1) If necessary, enter the date the lab was ordered 2) Hint: if you do not know the order date, enter the date the test was performed

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Type the result (Positive or Negative) in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. One of the following CVX codes must be linked to the HepA immunization:** 104 or 83 **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open **a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
Trouble-Shooting *(continued)*	3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
	II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR A. If necessary, obtain the immunization information from an outside health facility or MCIR B. If applicable, provide a reason for any immunization with a Status of "Not Administered"
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR A. Verify that the correct ICD-10 diagnosis code has been added

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Measure Name	Childhood Immunization Status: HepA *(continued)*
Trouble-Shooting *(continued)*	**B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. Progress Note (or Virtual Visit) → Assessments → Problem List → Add 2. **OR**, From the ICW (Right-Hand Char Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	IV. Verify that the appropriate LOINC code has been associated with any applicable Lab **A. The Following LOINC codes must be linked to the HepA IgG Antibody Test: 22312-3, 22313-1, 22315-6, 5179-7, 5181-3 and 5183-9** **B. To associate a new, or update an existing, LOINC code with a Lab, do the following:** 1. From the EMR menu in eCW, click on "Labs, DI & Procedures" 2. Select "Labs" from the drop-down list of options 3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Atribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
Trouble-Shooting *(continued)*	3) Click "OK" to exit the Lab-specific window 4. Click the X (in the top, right-hand corner) to close the "Labs" window **V. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results** A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked **VI. Verify that any all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW** **A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR**, From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy

(continued)

Measure Name	Childhood Immunization Status: HepA *(continued)*
Trouble-Shooting *(continued)*	b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A(Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., allergy versus intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of

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Measure Name	**Childhood Immunization Status: HepA** *(continued)*
Trouble-Shooting *(continued)*	options
	VII. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. HEDIS: "**Childhood Immunization Status**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**"

Measure Name	Childhood Immunization Status: HepB
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-4: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered three Hepatitis B (HepB) vaccines by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered three instances of *HepB* vaccine: A. At least one day, or more, apart from each other B. **AND**, By the time the patient turns 2 years of age
Exclusions and/or Exceptions	Patients may be **excluded** from this measure for one of the following reasons: I. They have had an anaphylactic reaction to the *HepB* vaccine (≤ 2 years of age) II. **OR,** They have had an anaphylactic reaction to Baker's Yeast (≤ 2 years of age) III. **OR**, They have an active, or inactive, diagnosis for Hepatitis B (≤ 2 years of age) IV. **OR,** They have had a seropositive result for the Hepatitis B antigen test (≤ 2 years of age)

(continued)

Measure Name	Childhood Immunization Status: HepB
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **Document each instance of administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** **A. If the vaccine is administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "Immunization Details" window 4. Select the *HepB* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close **B. If the vaccine was administered at another health facility**

(continued)

Measure Name	**Childhood Immunization Status: HepB** *(continued)*
Measure Documentation *(continued)*	1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HepB* vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR
Exclusion and/or Exception Documentation	**<u>To Exclude Patients From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If the vaccine cannot be administered due to anaphylactic reaction to *HepB* vaccine** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HepB* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field

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Measure Name	**Childhood Immunization Status: HepB** *(continued)*
	1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *HepB* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to *HepB* vaccine in the "Allergies/Intolerances" section of the patient's chart in eCW**
Exclusion and/or Exception Documentation *(continued)*	**II. If the vaccine cannot be administered because the patient has had an anaphylactic reaction to Baker's Yeast** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HepB* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to Baker's Yeast" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit

	(continued)
Measure Name	**Childhood Immunization Status: HepB** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR B. Also, document the anaphylactic reaction to Baker's Yeast in the "Allergies/Intolerances" section of the patient's chart in eCW
	III. If the vaccine need not be administered because the patient has had Hepatitis B disease A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows: 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HepB* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Click the selection button (with three dots) for the "History of Immunity" field 3) Find and select "Type B Viral Hepatitis" 4) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR

(continued)

Measure Name	Childhood Immunization Status: HepB *(continued)*
	B. Also, document one of the following ICD-10 diagnosis codes for Hepatitis B disease in the Problem List in the patient.s chart in eCW B16.0 - B16.2, B16.9, B17.0, B18.0 - B18.1, B19.10 - B19.11 and Z22.51
Exclusion and/or Exception Documentation *(continued)*	**V. If the vaccine need not be administered because the patient has had a seropositive result to a Hepatitis B antigen test** A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart, as follows: 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *HepB* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Click the selection button (with three dots) for the "History of Immunity" field 3) Find and select "Hepatitis B Immune" 4) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the Hepatitis B antigen seropositive test result in the "Labs" section of the patient's chart in eCW** **1. If the Hepatitis B Antigen Test lab order has been electronically-generated <u>AND</u> resulted in your EMR, no further action is necessary**

Measure Name	Childhood Immunization Status: Influenza
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-6: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered two Influenza (Flu) vaccines by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered two instances of the *Flu* vaccine: A. Between August 1 of the year prior to the Measurement Period and March 31 of the Measurement Period B. **AND**, At least one day, or more, apart from each other C. **AND**, After the patient is ≥ 6 months (180 days) of age D. **AND,** By the time the patient turns 2 years of age
Exclusions and/or Exceptions	Patients are **excluded** from this measure for one of the following reasons: I. They have had had an anaphylactic reaction to the *Flu* vaccine (≤ 2 years of age) II. **OR,** They have had an anaphylactic reaction to Neomycin (≤ 2 years of age) III. **OR**, They have an active diagnosis for Malignant Neoplasm of Lymphatic Tissue (≤ 2 years of age)

(continued)

Measure Name	**Childhood Immunization Status: Influenza** *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **Document each instance of administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** **A. If the vaccine is administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "Immunization Details" window 4. Select the *Flu* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close **B. If the vaccine was administered at another health facility**

	(continued)
Measure Name	**Childhood Immunization Status: IPV** *(continued)*
	c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu **b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu
Trouble-Shooting *(continued)*	**II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR** A. If necessary, obtain the immunization information from an outside health facility or MCIR B. If applicable, provide a reason for any immunization with a Status of "Not Administered" **III. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW** A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR**, From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:**

(continued)

Measure Name	Childhood Immunization Status: IPV *(continued)*
Trouble-Shooting *(continued)*	1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field

	(continued)
Measure Name	**Childhood Immunization Status: IPV** *(continued)*
Trouble-Shooting *(continued)*	1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**<u>For More Information</u>** I. HEDIS: "**Childhood Immunization Status**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**"

Measure Name	Childhood Immunization Status: MMR
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-8: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered one Measles, Mumps and Rubella (MMR) vaccine by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered one instance of the MMR vaccine by the time the patient turns 2 years of age
Exclusion and/or Exception Documentation	Patients are **excluded** from this measure for one of the following reasons: I. They have an active diagnosis for a Disorder of the Immune System (≤ 2 years of age) II. **OR**, They have an active diagnosis for HIV (≤ 2 years of age) III. **OR**, They have an active diagnosis for Malignant Neoplasm of Lymphatic Tissue (≤ 2 years of age) IV. **OR,** They have had an anaphylactic reaction to Neomycin (≤ 2 years of age) V. **OR**, They have had: A. An active, or resolved, diagnosis for Measles (≤ 2 years of age) B. **OR**, An IgG antibody titer ≥ 1.10 for the Measles antibody test (≤ 2 years of age)

	(continued)
Measure Name	**Childhood Immunization Status: MMR** *(continued)*
Exclusions and/or Exceptions	C. **OR,** A *Positive* result (for IgG antibody presence) for the Measles antibody test (≤ 2 years of age) **AND** D. An active, or resolved, diagnosis for Mumps (≤ 2 years of age) E. **OR**, An IgG antibody titer ≥ 1.10 for the Mumps antibody test (≤ 2 years of age) F. **OR**, A *Positive* result (for IgG antibody presence) for the Mumps antibody test (≤ 2 years of age) **AND** G. An active, or resolved, diagnosis for Rubella (≤ 2 years of age) H. **OR,** An IgG antibody titer ≥ 1.10 for the Rubella antibody test (≤ 2 years of age) I. **OR,** A *Positive* result (for IgG antibody presence) for the Rubella antibody test (≤ 2 years of age)
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **Document the administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:**

	(continued)
Measure Name	**Childhood Immunization Status: MMR** *(continued)*
Measure Documentation *(continued)*	**A. If the vaccine is administered in your office:** 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "Immunization Details" window 4. Select the *MMR* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close **B. If the vaccine was administered at another health facility** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *MMR* vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR

(continued)

Measure Name	**Childhood Immunization Status: MMR** *(continued)*
Exclusion and/or Exception Documentation	**To Exclude Patients From This Measure** *(Exclusion and/or Exception Documentation)* **I. If the vaccine should not be administered because the patient has an active diagnosis for a Disorder of the Immune System** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *MMR* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Diagnosis of a Disorder of the Immune System" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document one of the following ICD-10 diagnosis codes for a Disorder of the Immune System in the Problem List of the patient's chart in eCW** 1. D80.0 - D80.9 2. D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89 and D81.9 3. D82.0 - D82.4, D82.8 and D82.9

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Measure Name	**Childhood Immunization Status: MMR** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	4. D83.0 - D83.2, D83.8 and D83.9 5. D84.0, D84.1, D84.8 and D84.9 6. D89.3, D89.810 - D89.813, D89.82, D89.89 and D89.9 **II. If the vaccine should not be administered because the patient has an active diagnosis for HIV:** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *MMR* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Diagnosis of HIV" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document one of ICD-10 diagnosis codes for HIV (B20, B97.35 and Z21) in the Problem List of the patient's chart in eCW**

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Measure Name	**Childhood Immunization Status: MMR** *(continued)*
Trouble-Shooting *(continued)*	3. The "Labs" window will open a. Find and select the appropriate lab b. Click the "Attribute Codes" button (at the bottom of the window) c. A new window specific to the selected lab will open 1) Click the "Update LOINC" button (at the bottom of the window) 2) The "Associate LOINC" window will open a) Find and select the apprpriate LOINC code b) Click "OK" to close the LOINC window 3) Click "OK" to exit the Lab-specific window 4. Click the X (in the top, right-hand corner) to close the "Labs" window
	V. Verify that all mandatory Lab fields have been completed (especially for manually-created Lab orders and/or manually-entered Lab results A. I.e., Verify that the "Collection Date" box has been checked B. I.e., Verify that the (Results) "Received" box has been checked C. I.e., Verify that a "Results" date has been entered D. I.e., Verify that the Result has been entered in the yellow grid E. I.e., Verify that the "Reviewed" box has been checked
	VI. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances*

(continued)

Measure Name	**Childhood Immunization Status: MMR** *(continued)*
Trouble-Shooting *(continued)*	2. **OR**, From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis)

	(continued)
Measure Name	**Childhood Immunization Status: MMR** *(continued)*
Trouble-Shooting *(continued)*	3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance
	VII. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. HEDIS: "**Childhood Immunization Status**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**"

Measure Name	Childhood Immunization Status: PCV
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-9: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered four Pneumococcal Conjugate (PCV) vaccines by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered four instances of *PCV* vaccine: I. At least one day, or more, apart from each other II. **AND**, After the patient is ≥ 6 weeks (42 days) of age III. **AND**, By the time the patient turns 2 years of age
Exclusions and/or Exceptions	Patients are **excluded** from this measure if they have had an anaphylactic reaction to *PCV* vaccine (≤ 2 years of age)
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must have been seen for an applicable visit encounter during the Measurement Period**

(continued)

Measure Name	**Childhood Immunization Status: PCV** *(continued)*

A. The following E&M codes identify applicable visit enounters

1. 99201 - 99205 and 99212 - 99215
2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394

B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit
(Progress Notes → Billing)

Measure Documentation *(continued)*

<u>To Satisfy This Measure</u>

(Numerator Documentation)

Document each instance of administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:

A. If the vaccine is administered in your office:

1. From within the open Progress Note, click on the "Immunizations" link
2. The "Immunizations/T. Injections" window will open
3. Click "Add" to open the "Immunization Details" window
4. Select the *PCV* vaccine from the left-hand panel
5. Complete all open fields in the right-hand panel
6. Click "OK" to save and close

B. If the vaccine was administered at another health facility

1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub
2. Click "Add" to open the "Immunization Details" window
3. Select the *PCV* vaccine from the left-hand panel
4. In the right-hand panel:

	(continued)
Measure Name	**Childhood Immunization Status: PCV** *(continued)*
Measure Documentation *(continued)*	a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR
Exclusion and/or Exception Documentation	**<u>To Exclude Patients From This Measure</u>** *(Exclusion and/or Exception Documentation)* **If the vaccine cannot be administered due to anaphylactic reaction to *PCV* vaccine** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *PCV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to *PCV* Vaccine" in the field labeled "Other" 3) Click "OK" to close the window

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Measure Name	**Childhood Immunization Status: PCV** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. One of the following CVX codes must be linked to the PCV immunization**: 100, 133 or 33 **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open **a. To add or update the CVX code for an existing immunization** 1) Select the immunization to be modified 2) Click the carat next to the "New" button 3) Select "Update" from the drop-down list of options 4) The "Update Immunization" window will open a) Click the "Sel" button adjacent to the "CVX Code" field b) Select the appropriate CVX code from the drop-down list of options c) Click "OK" to exit the window 5) Click "Close" to save the information and return to the EMR menu

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Measure Name	**Childhood Immunization Status: PCV** *(continued)*
Trouble-Shooting *(continued)*	**b. To add a new immunization and associated CVX code** 1) From the "Immunizations/Therapeutic Injections" window, click the "New" button 2) A "New Immunization" window will open a) Enter the information for the new immunization in the displayed fields b) Click "OK" to exit the window 3) Click "Close" to save the information and return to the EMR menu **II. Verify that an immunization (Status = Administered or Non Administered) has been documented in the patient's chart in the EMR** A. If necessary, obtain the immunization information from an outside health facility or MCIR B. If applicable, provide a reason for any immunization with a Status of "Not Administered" **III. Verify that any/all applicable Allergies have been documented in the "Allergies/Intolerances" section of the patient's chart in eCW** A. Access the "Allergies/Intolerances" section of the patient's chart in one of the following ways: 1. *Progress Note (or Virtual Visit) → Allergies/Intolerances* 2. **OR**, From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open

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Measure Name	**Childhood Immunization Status: PCV** *(continued)*
Trouble-Shooting *(continued)*	a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options

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Measure Name	**Childhood Immunization Status: PCV** *(continued)*
Trouble-Shooting *(continued)*	e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**<u>For More Information</u>** I. HEDIS: "**Childhood Immunization Status**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**"

Measure Name	Childhood Immunization Status: Rotatvirus
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-10: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, whowere administered two or three Rotavirus vaccines by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered: I. Two instances of the *Rotavirus* vaccine (two-dose schedule) **OR** II. Three instances of the *Rotavirus* vaccine (three-dose schedule) **OR** III. Two instances of the three-dose schedule plus one instance of the two-dose schedule A. At least one day, or more, apart from each other B. **AND,** After the patient is ≥ 6 weeks (42) days of age C. **AND,** By the time the patient turns 2 years of age
Exclusions and/or Exceptions	Patients are excluded from this measure if they have had an anaphylactic reaction to *Rotavirus* vaccine (≤ 2 years of age)

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Measure Name	Childhood Immunization Status: Rotatvirus *(continued)*
Trouble-Shooting *(continued)*	2. **OR**, From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis)

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Measure Name	**Childhood Immunization Status: Rotatvirus** *(continued)*
Trouble-Shooting *(continued)*	3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. Hedis 2014 "**Childhood Immunization Status**" II. eClinicalWorks "**MIPS - CMS 117 - Childhood Immunization**"

Measure Name	Childhood Immunization Status: VZV
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0038-11: Pediatric Measure]*
Measure Definition	***The percentage of children, 2 years of age, who were administered one Chicken Pox (VZV) vaccine by the time of their second birthday***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 to December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 1 year of age before the start of the Measurement Period II. **AND,** Turn 2 years of age before the end of the Measurement Period III. **AND,** Are seen for an applicable E&M visit during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have been administered one instance of *VZV* vaccine by the time the patient turns 2 years of age
Exclusions and/or Exceptions	Patients are **excluded** from this measure for one of the following reasons: I. They have an active diagnosis for a Disorder of the Immune System (≤ 2 years of age) II. **OR**, They have an active diagnosis for HIV (≤ 2 years of age) III. **OR**, They have an active diagnosis for Malignant Neoplasm of Lymphatic Tissue (≤ 2 years of age) IV. **OR**, They have had an active, inactive, or resolved diagnosis for Varicella Zoster (≤ 2 years of age) V. **OR**, They have had a *Positive* result (for IgG antibody presence) for the Varicella Zoster Antibody Test (< 2 years of age) VI. **OR**, They have had an anaphylactic reaction to Neomycin (≤ 2 years of age)

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Measure Name	**Childhood Immunization Status: VZV** *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable visit enounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* Document the administration/receipt of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows: A. If the vaccine is administered in your office: 1. From within the open Progress Note, click on the "Immunizations" link 2. The "Immunizations/T. Injections" window will open 3. Click "Add" to open the "Immunization Details" window 4. Select the *VZV* vaccine from the left-hand panel 5. Complete all open fields in the right-hand panel 6. Click "OK" to save and close B. If the vaccine was administered at another health facility 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit or from the patient's Hub

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Measure Name	**Childhood Immunization Status: VZV** *(continued)*
Measure Documentation *(continued)*	2. Click "Add" to open the "Immunization Details" window 3. Select the *VZV* vaccine from the left-hand panel 4. In the right-hand panel: a. Check the "Y" radio button for "Vaccination Given in the Past" b. Enter the "Dose Number" c. Change the "Status" to "Administered" d. Enter the name of the Provider or Health Facility that administered the vaccine in the "Given By" field, if known e. Enter the date the vaccine was administered in the "Given Date/Time" field 5. Click "OK" to close 6. Note: Vaccines marked "Given in the Past" should not push to MCIR
Exclusion and/or Exception Documentation	**<u>To Exclude Patients From This Measure</u>** *(Exclusion and/or Exception Documentation)* **I. If the vaccine should not be administered because the patient has an active diagnosis for a Disorder of the Immune System** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *VZV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field

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Measure Name	Childhood Immunization Status: VZV *(continued)*
Exclusion and/or Exception Documentation *(continued)*	1) A "Select reason for not administered" window will open 2) Type "Diagnosis of a Disorder of the Immune System" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document one of the following ICD-10 diagnosis codes for a Disorder of the Immune System in the Problem List of the patient's chart in eCW** 1. D80.0 - D80.9 2. D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89 and D81.9 3. D82.0 - D82.4, D82.8 and D82.9 4. D83.0 - D83.2, D83.8 and D83.9 5. D84.0, D84.1, D84.8 and D84.9 6. D89.3, D89.810 - D89.813, D89.82, D89.89 and D89.9
	II. If the vaccine should not be administered because the patient has an active diagnosis for HIV: **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *VZV* vaccine from the left-hand panel 4. In the right-hand panel:

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Measure Name	**Childhood Immunization Status: VZV** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Diagnosis of HIV" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document one of ICD-10 diagnosis codes for HIV (B20, B97.35 and Z21) in the Problem List of the patient's chart in eCW**
	III. If the vaccine should not be administered because the patient has an active diagnosis for a Malignant Neoplasm of Lymphatic Tissue **A. Document the non-administration of this vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *VZV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Malignant Neoplasm of Lymphatic Tissue" in the field labeled "Other"

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Measure Name	**Childhood Immunization Status: VZV** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document one of the following ICD-10 diagnosis codes for Malignant Neoplasm of Lymphatic Tissue in the Problem List of the patient's chart in eCW** 1. C81.00 - C81.49, C81.70 - C81.79 and C81.90 - C81.99 2. C82.00 - C82.69 and C82.00 - C82.99 3. C83.00 - C83.19, C83.30 - C83.39, C83.50 - C83.59, C83.70 - C83.99 4. C84.00 - C84.19, C84.40 - C84.49, C84.60 - C84.79 and C84.90 - C84.99 5. C84.A0 - C84.A9 and C84.Z0 - C84.Z9 6. C85.10 - C85.29, C85.80 - C85.99 7. C86.0 - C86.6 8. C88.2 - C88.4 and C88.8 - C88.9 9. C90.00 - C90.02, C90.10 - C90.12, C90.20 - C90.22 and C90.30 - C90.32 10. C91.00 - C91.02, C91.10 - C91.12, C91.30 - C91.32, C91.40 - C91.42, C91.50 - C91.52, C91.60 - C91.62 C91.90 - C91.92, C91.A0 - C91.A2 and C91.Z0 - C91. Z2 11. C92.00 - C92.02, C92.10 - C92.12, C92.20 - C92.22, C92.30 - C92.32, C92.40 - C92.42, C92.50 - C92.52, C92.60 - C92.62, ,C92.90 - C92.92, C92.A0 - C92.A2 and C92.Z0 - C92.Z2 12. C93.00 - C93.02, C93.10 - C93.12, C93.30 - C93.32, C93.90 - C93.92 and C93.Z0 - C93.Z1 13. C94.00 - C94.02, C94.20 - C94.22 and C94.30 - C94.32 14. C95.00 - C95.02, C95.10 - C95.12, C95.90 - C95.92 15. C96.0, C96.2, C96.4, C96.9, C96.A and C96.Z

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Measure Name	Childhood Immunization Status: VZV *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**IV. If this vaccine need not be administered because the patient has had Varicella Zoster disease** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *VZV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Click the selection button (with three dots) for the "History of Immunity" field 3) Find and select "Varicella" 4) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document one of the following ICD-10 diagnosis codes for Varicella Zoster disease in the Problem List in the patient's chart** 1. B01.0, B01.11 - B01.12, B01.2, B01.81, B01.89 and B01.9 2. B02.0 - B02.1, B02.21 - B02.24, B02.29 - B02.34, B02.39 and B02.7 - B02.9

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Measure Name	Childhood Immunization Status: VZV *(continued)*
Exclusion and/or Exception Documentation *(continued)*	**V. If the vaccine need not be administered because the patient has had a Positive result for a Varicella Zoster Antibody Test** **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub 2. Click "Add" to open the "Immunization Details" window 3. Select the *VZV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Positive Result for Varicella Zoster Antibody Test" in the field marked "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the (Positive) Varicella Zoster Antibody Test result in the "Labs" section of the patient's chart in eCW** **1. If the Varicella Zoster Antibody Test lab order has been electronically-generated and resulted in your EMR, no further action is necessary** **2. Otherwise, manually generate the lab order and/or enter the lab result, as follows:** a. Access the "Labs" section of the patient's chart b. If necessary, click "New" to create a new Lab order

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Measure Name	**Childhood Immunization Status: VZV** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	1) Click the "SEL" button, adjacent to the "Lab" search field 2) Find and select the appropriate *VZV* Antigen lab from the list of Lab options 3. Complete the following fields: a. **Order Date** 1) If necessary, enter the date the lab was ordered 2) Hint: if you do not know the order date, enter the date the test was performed b. **Collection Date** **(MANDATORY)** 1) Check the box in the "Collection Date" field 2) Enter the date the sample was collected 3) Hint: If you do not know the collection date, enter the date the test was performed c. **Results** **(MANDATORY)** 1) Check the "Received" box in the Results section **(MANDATORY)** 2) Enter the date the test was performed **(MANDATORY)** 3) Type the result (Positive or Negative) in the yellow grid **(MANDATORY)** d. **Reviewed**: Check the "Reviewed" box
	VI. If the vaccine cannot be administered because the patient has had an anaphylactic reaction to Neomycin **A. Document the non-administration of the vaccine in the "Immunizations/T. Injections" section of the patient's chart in eCW, as follows:** 1. Access the "Immunizations/T. Injections" window from an open Progress Note, Virtual Visit, or from the patient's Hub

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Measure Name	**Childhood Immunization Status: VZV** *(continued)*
Exclusion and/or Exception Documentation *(continued)*	2. Click "Add" to open the "Immunization Details" window 3. Select the *VZV* vaccine from the left-hand panel 4. In the right-hand panel: a. Change the "Status" to "Not Administered" b. Click the selection button (with three dots) for the "Reason" field 1) A "Select reason for not administered" window will open 2) Type "Anaphylaxis to Neomycin" in the field labeled "Other" 3) Click "OK" to close the window 5. Click "OK" to exit a. The vaccine will display in the "Immunizations/T. Injections" section of the patient's chart with an Immunization Status of "NA" (for Not Administered) b. The vaccine, and the reason given for non-administration, will push to MCIR **B. Also, document the anaphylactic reaction to Neomycin in the "Allergies/Intolerances" section of the patient's chart in eCW**
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that a correct CVX code has been linked with the immunization in your EMR** **A. One of the following CVX codes must be linked to the *VZV* immunization:** 21 or 94 **B. To link a CVX code to an immunization, do the following:** 1. From the EMR menu in eCW, click on "Immunizations/Therapeutic Injections" 2. Select "Immunizations/Therapeutic Injections" from the drop-down list of options 3. The "Immunizations/Therapeutic Injections" window will open

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Measure Name	Childhood Immunization Status: VZV *(continued)*
Trouble-Shooting *(continued)*	a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options

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Measure Name	**Childhood Immunization Status: VZV** *(continued)*
Trouble-Shooting *(continued)*	e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	VII. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**<u>For More Information</u>** I. HEDIS: ″**Childhood Immunization Status**″ II. eClinicalWorks"**MIPS - CMS 117 - Childhood Immunization**"

Measure Name	IVD: Daily Aspirin Use
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0068: Cardiac Measure]* ACO Quality Measure # 30 *[GPRO: At-Risk Population Measure]* MIPS Clinical Quality Measure *[CMS 164 (EHR)/Registry 204: Process Measure]*
Measure Definition	***The 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 Intervention (PCI) in the 12 months prior to the Measurement Period <u>or</u> who had an active diagnosis of Ischemic Vascular Disease (IVD) during the Measurement Period <u>and</u> who had documentation of use of aspirin or another antithrombotic during the Measurement Period***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. <u>></u> 18 years of age at the start of the Measurement Period II. **<u>AND</u>**, Have been seen for an applicable encounter during the Measurement Period III. **<u>AND</u>**, Have at least one of the following: A. An active diagnosis for Acute Myocardial Inffarction (AMI) within the 12 months prior to the Measurement Period B. **<u>OR</u>**, A Percutaneous Coronary Intervention (PCI) procedure performed within the 12 months prior to the Measurement Period C. **<u>OR</u>**, A Coronary Artery Bypass Graft (CABG) procedure performed within the 12 months prior to the Measurement Period D. **<u>OR</u>**, An active diagnosis for Ischemic Vascular Disease (IVD) during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who have documentation of use of aspirin or another antithrombotic during the Measurement Period *(continued)*

Measure Name	**IVD: Daily Aspirin Use** *(continued)*
Exclusions and/or Exceptions	None
Measure Documentation	**To Qualify For This Measure:** *(Denominator Documentation)* **I. The patient must be seen for an applicable visit encounter during the Measurement Period** **A. The following E&M codes identify applicable encounters:** 1. 99201 - 99205 and 99212 - 99215 2. 99341 -99345, 99347 - 99350, 99385 - 99387 and 99395 - 99397 3. G0402 and G0438 - G0439 **B. The appropriate E&M code ahould be recorded in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)* **II. If applicable, a diagnosis for Acute Myocardial Infarction (AMI) and/or Ischemic Vascular Disease (IVD) should be listed in the Problem List in the patient's chart in eCW** **A. The following ICD-10 codes indicate AMI:** 1. I21.01 - I21.02, I21.09, I21.11, I21.19, I21.21, I21.29 and I21.3 - I21.4 2. I22.0 - I22.2 and I22.8 - I22.9 3. I23.0 - I23.8 **B. The following ICD-10 codes indicate IVD:** 1. I20.0 and I20.8 - I20.9 2. I24.0 - I24.1 and I24.8 - I24.9 *(continued)*

Measure Name	IVD: Daily Aspirin Use *(continued)*
Measure Documentation *(continued)*	3. I25.10, I25.110 - I25.111, I25.118 - I25.119, I25.5 - I25.6, I25.700 - I25.701, I25.708 - I25.711, I25.718 - I25.721 I25.728 - I25.731, I25.738 - I25.739, I25.750 - I25.751, I25.758 - I25.761, I25.768 - I25.769, , I25.790 - I25.791, I25.798 -I25.799, I25.810 - I25.812 I25.82-I25.84, I25.89 and I25.9 4. I63.00, I63.011 - I63.012, I63.019, I63.02, I63.031 - I63.032, I63.039, I63.09 - I63.10, I63.111 -I63.112, I63.119, I63.12 I63.131 - I63.132, I63.139, I63.19 - I63.20, I63.211 - I63.212, I63.219, I63.22, I63.231 - I63.232, I63.239, I63.29 - I63.30, I63.311 - I63.312, I63.319 I63.321 - I63.322, I63.329, I63.331 - I63.332, I63.339, I63.341 - I63.342, I63.349, I63.39 - I63.40, I63.411-I63.412, I63.419, I63.421-I63.422, I63.429 I63.431-I63.432, I63.439, I63.441-I63.442, I63.449, I63.49-I63.50, I63.511 - I63.512, I63.519, I63.521 - I63.522, I63.529, I63.31 - I63.532, I63.539 I63.541 -I63.542, I63.549, I63.59, I63.6, I63.8 and I63.9 5. I65.01 - I65.03, I65.09, I65.1, I65.21 - I65.23, I65.29, and I65.8 - I65.9 6. I66.01 - I66.03, I66.09, I66.11 - I66.13, I66.19, I66.21 - I66.23, I66.29, I66.3, I66.8 - I66.9 and 167.2 7. I70.0 - I70.1, I70.201 -I70.203, I70.208 - I70.209, I70 211 - I70.213, I70.218 - I70.219, I70.221 -I70.223, I70.228, I70.229 I70.231 - I70.235, I70.238 - I70.239, I70.241 - I70.245, I70.248 -I70.249, I70.25, I70.261 - I70.263, I70.268, I70.269, I70.291 - I70.293, I70.298 I70.299, I70.301 - I70.303, I70.308 - I70.309, I70.311 - I70.313, I70.318 - I70.319, I70.321 - I70.323, I70.328 - I70.329, I70.331- I70.335, I70.338 I70.339, I70.341 - I70.345, I70.348 - I70.349, I70.35, I70.361 - I70.363, I70.368 - I70.369, I70.391 - I70.393, I70.398 - I70.399, I70.401 - I70.403 I70.408 - I70.409, I70.411 - I70.413, I70.418 - I70.419, I70.421 - I70.423, I70.428 - I70.429, I70.431 - I70.435, I70.438 - I70.439, I70.441 - I70.445 I70.448 - I70.449, I70.45, I70.461 -I70.463, I70.468 - I70.469, I70.491 - I70.493, I70.498 - I70.499, I70.501 - I70.503, I70.508 - I70.509, I70.511 170.512, I70.513, I70.518 - I70.519, I70.521 - I70.523, I70.528 - I70.529, I70.531 - I70.535, I70.538 - I79.539, I70.541 - I70.545, I70.548 - I70.549 I70.55, I70.561 -I70.563, I70.568 - I70.569, I70.591 - I70.593, I70.598 - I70.559, I70.601 - I70.603, I70.608 - I70.609, I70.611 - I70.613, I70.618 I70.619, I70.621 - I70.623, I70.628 - I70.629, I70.631 - I70.635, I70.638 - I70.639, I70.641 - I70.645, I70.648 - I70.649, I70.65, I70.661 - I70.663 I70.668 - I70.669, I70.691 - I70.693, I70.698 - I70.699, I70.701 - I70.703, I70.708 - I70.709 , I70.711 - I70.713, I70.718 - I70.719, I70.721 - I70.723 I70.728 - I70.729, I70.731 - I70.735, I70.738 - I70.739, I70.741 - I70.745, I70.748 - I70.749, I70.75, I70.761 - I70.763, I70.768 -I70.769, I70.791 170.792 - I70.793, I70.798 - I70.799, I70.8 and 170.790 - I70.792 8. I74.01, I74.09 - I74.11, I74.19, I74.2 - I74.5 and I74.8 - I74.9 9. I75.011 - I75.013, I75.019, I75.021 - I75.023, I75.029, I75.81 and I75.89 **C. And/or, a CPT code for one of the following procedures should have been reported in a Progress Note within the year prior to the Measurement Period** *(continued)*

Measure Name	IVD: Daily Aspirin Use *(continued)*
Measure Documentation *(continued)*	**1. The following CPT codes identify Percutaneous Coronary Intervention (PCI) procedures** 92920, 92924, 92928, 92933, 92937, 92941 and 92943 **2. The following CPT codes identify Coronary Artery Bypass Graft (CABG) procedures** a. 33510 - 33514, 33516 - 33519, 33521 - 33523 and 33533 - 33536 b. S2205 - S2209 **3. The CPT codes should have been recorded in one of the following locations in a Progress Note** a. *Progress Notes → Treatment → Procedures* b. *Progress Notes → Billing* D. Helpful Hints 1. When adding a diagnosis to a patient's Problem List, record the onset date of the disorder, if known, in the associated "Onset Date" field 2. For quick and easy reference, document any PCI or CABG procedures in the "Surgical History" section of the patient's chart, as well 3. For quick and easy reference, add the patient's Cardiologist" to the "Circle of Care" section of the patient's chart
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **Document a prescription for, and use of, an aspirin or other anti-thrombotic medication in the "Current Medications" section of the patient's chart in eCW** 1. Examples of acceptable medications for this measure include: *(continued)*

Measure Name	**IVD: Daily Aspirin Use** *(continued)*
Measure Documentation *(continued)*	a. All variations of aspirin medications b. Prasugrel c. Clopidogrel d. Ticlopidine **2. Document the medication from one of the following locations** a. *Progress Notes → Treatment → Add* b. *Telephone/Web Encounter → Rx tab → Select Rx* c. *Telephone/Web Encounter → Virtual Visit → Current Medications* d. *Telephone/Web Encounter → Virtual Visit tab → Treatment → Add* e. *Progress Notes → Current Medications* B. Helpful Hints 1. Document any allergy or intolerance to aspirin or antithrombotics in the "Allergy" section of the patient's chart 2. If an aspirin or antithrombotic medication is started and then stopped, document the reason for stopping the medication in a Progress Note or Telephone Encounter in the patient's chart
Exclusion and/or Exception Documentation	None
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Confirm diagnoses assessed by specialists, ER and hospital physicians** A. Add applicable diagnoses to the patient's Problem List in your EMR B. Keep the Problem List accurate by archiving diagnoses that are no longer valid to the Medical History section of the patient's chart

Measure Name	**Medication Reconciliation Post-Discharge** *(continued)*
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Had the discharge medications reconciled with the current medication list A. Performed by a prescribing practioner, clinical pharmacist, or registered nurse B. **AND**, performed within 30 days of discharge II. **Numerator Notes** A. This measure is to be reported at an outpatient visit occurring within 30 days of each inpatient facility discharge during the Measurement Period B. This measure is not to be reported unless the patient has been discharged from an inpatient facility within 30 days prior to the outpatient visit C. There is no diagnosis associated with this measure
Exclusions and/or Exceptions	A patient is **excluded** from this measure if hospice services were provided during the Measurement Period
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must have been discharged from an inpatient facility during the Measurement Period** **A. Qualifying inpatient facilities include:** 1. Hospital (excluding Observation and Emergency Department) 2. Skilled Nursing Facility 3. Rehabilitation Facility **B. Document the discharge from an inpatient facility in a structured data field** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	**1. For a discharge from the hospital, use the following structured data path:** *Progress Notes → HPI → Interim History →* [*Transition of care from hospital*] → [*Date of discharge from hospital*] **2. For discharge from another inpatient facility, use the following structured data path:** *Progress Notes → HPI → Interin History →* [*Transition of care from other inpatient facility*] → [*Date of discharge from inpatient facility*] 3. For each of the above options, the required structured data fields are outlined (boxed) 4. Record the discharge from the inpatient facility in the appropriate structured data field **a. Some configuration and mapping may first be required** 1) If necessary, add the "Transition of care from hospital" and/or "Transition of care from other inpatient facility" items to the "Interim History folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "HPI" link b) Click on the "Interim History" folder c) If "Transition of care from hospital" or "Transition of care from other inpatient facility" is not an available option (1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Transition of care from hospital" or "Transition of care from other inpatient facility" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*

a) From within eCW, click the "Community" tab (top Menu bar)
b) Select "Mappings"
c) Select "Structured Data" from the list of options

(1) A "Mapper" window will open
(2) Complete the following fields for both sides (Community and Local)

(a) Section = HPI
(b) Category = Interim History
(c) Item = "Transition of care from hospital" or "Transition of care from inpatient facility"

(3) From the Community side, select the desired reporting field

(a) E.g., "Date of discharge from the hospital"
(b) E.g., "Date of discharge from other inpatient facility""

(4) Click "Add"

(a) The field will automatically be added to the Local side
(b) The fields will automatically be mapped to each other
(c) (Mapped fields display in blue font)
(d) Associated options are also automatically added and mapped

b. Enter the date of the inpatient discharge in the appopriate structured data field

II. The patient must be seen for an applicable outpatient visit within 30 days of discharge from the inpatient facility

A. The following E&M codes identify applicable outpatient encounters:

(continued)

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	1. 90791 -90792 2. 90832, 90834, 90837, 90839 and 90845 3. 99201 - 99205 and 99211 - 99215 4. 99324 - 99328, 99334 - 99337, 99341 - 99345, and 99347 - 99350 5. 99495-99496 6. G0402, and G0438 - G0439 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **I. Perform a Medication Reconciliation on or within 30 days of discharge** **A. Medication Reconciliation is defined as:** 1. Documentation of the current medications with a notation that references the discharge medications a. E.g., No changes in meds since discharge b. E.g., Same meds at discharge c. E.g., Discontinue all discharge meds 2. Documentation of the patient's current medications with a notation that the discharge medications were reviewed 3. Documentation that the provider "reconciled the current and discharge meds" 4. Documentation of a current medication list, a discharge medication list and notation that the appropriate practioner reviewed both lists on the same date of service 5. Notation that no medications were prescribed or ordered upon discharge **B. The Medication Reconciliation must be performed by one of the following clinicians:** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	1. Physician 2. Prescribing Practioner 3. Clinical Pharmacist 4. Registered Nurse **C. The current medication list must include the following:** 1. All medications, including: a. Prescription Medications b. Over-the-Counter Medications c. Herbals d. Supplements 2. Dose 3. Frequency 4. Route 5. Reason for taking the medication D. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed **II. Document that Medication Reconciliation was performed in one of the following ways:** **A. Record the performance of Medication Reconciliation in structured data fields** **1. For discharge from a hospital, use the following structured data path:** ***Progress Notes → HPI → Interim History*** ↓ ***Transition of care from hospital*** → ***Discharge medications reviewed and reconciled from hospital*** → ***Select option*** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	a. The required structured data fields are outlined (boxed) b. If necessary, configure and map the sturctured data fields, as detailed previously in this document c. Note: These structured data fields can be located in another customizable section of the Progress Note as long as they are mapped to the Community elements identified in the path above d. Options for the final structured data field ("Select option") are: 1) Medications left unchanged 2) Medications changed (e.g., discontinued, changed or added) **2. For discharge from another inpatient facility (Skilled Nursing Facility or Rehabilitation Facility, use the following structured data path:** ***Progress Notes → HPI → Interim History*** ↓ ***Transition of care fromother inpatient facility*** → ***Discharge medications reviewed and reconciled from hospital*** → ***Select option*** a. The required structured data fields are outlined (boxed) b. If necessary, configure and map the sturctured data fields, as detailed previously in this document c. Note: These structured data fields can be located in another customizable section of the Progress Note as long as they are mapped to the Community elements identified in the path above d. Options for the final structured data field ("Select option") are: 1) Medications left unchanged 2) Medications changed (e.g., discontinued, changed or added) **3. Document the reason for discontinuing a medication in the associated Progress Note** **4. Document any medication allergies or intolerances in the "Allergies" section of the patient's chart in eCW** **B. <u>OR</u>, Record the performance of Medication Reconciliation as a procedure** **1. The following CPTII code satisfies the Numerator:** 1111F ("Discharge medications reconciled with the current medication *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	list in outpatient medical record) **2. Record the CPT II code in the Billing section of the Progress Note for the subsequent face-to-face visit (within 30 days of discharge)** *(Progress Notes → Billing)* **3. Document the reason for discontinuing a medication in the associated Progress Note** **4. Document any medication allergies or intolerances in the "Allergies" section of the patient's chart in eCW**
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* **Document that Hospice services were provided to the patient during the Measurement Period** **A. Record the receipt of Hospice services in a structured data field** **1. eCW recommends the following structured data path:** ***Progress Notes → HPI → Interim History*** ↓ ***Specialized Care*** → ***Patient received Hospice care*** → ***Select "Yes"*** 2. The required structured data fields are outlined (boxed) in the path, above **a. Some configuration and mapping may first be required** 1) If necessary, add the "Specialized Care" item to the "Interim History folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "HPI" link b) Click on the "Interim History" folder c) If "Specialized Care" is not an available option *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Exclusion and/or Exception Documentation *(continued)*	(1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Specialized Care" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) (a) Section = HPI (b) Category = Interim History (c) Item = Specialized Care (3) From the Community side, select the desired reporting field (E.g., "Patient received Hospice care") (4) Click "Add" (a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Exception and/or Exclusion Documentation *(continued)*	**B. <u>OR</u>, Record the receipt of Hospice services as a procedure** 1. The following CPT II code satisfies the Numerator: G9691 ("Hospice service provided during the measurement period") 2. Record the CPT II code in the Billing section of a Progress Note or Virtual Visit *(Progress Note/Virtual Visit → Billing)*
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that all structured data fields used are mapped to the correct Community elements in your EMR** A. For further assistance with mapping problems, contact an eCW Technical Service representative B. **<u>OR</u>**, Contact Ed Worthington or Kelly Saxton @ NPO
	II. Document a new allergy or intolerance in the "Allergies" section of the patient's chart, as follows" A. Access the "Allergies" section of the patient's chart in one of the following ways: 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Trouble-Shooting *(continued)*	a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505) *(continued)*

Measure Name	**Tobacco Status: Assessment** *(continued)*
Measure Documentation *(continued)*	**2. <u>OR</u>, Configure and map the required structured data field in the Social History section of the Progress Note** a. From within a Progress Note or Virtual Visit, click the "Social History" link **b. If "Tobacco Use" is not included in the list of "Social Info" options that display:** 1) Click the carat adjacent to the "Custom" button (at the bottom of the window) 2) Select "New Item" from the drop-down list of options 3) A "New Item/Category" window will open a) Type "Tobacco Use" into the "Name" field b) Check the "Structured Data" box c) Click "OK" to save and close **c. Map the "Tobacco Use" field to its corresponding Community element** 1) Click the "Community" tab (in the top menu bar) 2) Select "Mappings" 3) Select "Structured Data" a) A "Mapper" window will open b) Complete the following fields on the "Community" side: (1) Section = Social History (2) Category = Tobacco Use (3) Item = Smoking c) Complete the following fields on the "Local" side: (1) Section = Social History (2) Category = Social History (this field will auto-fill) (3) Item = Tobacco Use *(continued)*

Measure Name	**Tobacco Status: Assessment** *(continued)*
Measure Documentation *(continued)*	d) Select the "Are you a:" option on the Community side e) Click "Add" to add it to the Local side f) Click "Map" g) A new window with the available selection options will open (1) Select the "Current Smoker" option on the "Community" side (2) Click "Add" to add it to the Local side and map it to the Community counterpart (3) Repeat for each of the remaining options on the "Community" side (4) Mapped items display in blue font **C. The patient's tobacco status should be assessed and recorded at every applicable visit encounter during the Measurement Period or the year prior to the Measurement Period** **D. Note: The "Social History Verified" box MUST be checked in order to satisfy the Numerator for this measure** **E. These structured data fields can be located in another customizable section of the Progress Note as long as they are mapped to the Community elements identified in the paths above**
Exclusion and/or Exception Documentation	**To Except Patients From This Measure** *(Exclusion/Exception Documentation)* **The patient can be excepted from this measure for one of the following reasons:** **A. The patient has limited life expectancy** **B. A valid medical reason exists for not performing the tobacco use assessment** **C. Document the reason for exception in a structured field, as follows:** **1. eCW recommends the following structured data path:** *(continued)*

Measure Name	**Tobacco Status: Assessment** *(continued)*

Exclusion and/or Exception Documentation

Progress Notes → ***Social History*** → ***Tobacco Use*** → ***Screening Not Performed*** → ***Reason***

Limited Life Expectancy → ***Details*** → ***Select option***

Medical Reason → ***Type of Medical Reason*** → ***Select Option***

2. The required structured data fields are outline (boxed) in the path above
3. **Options for each reason include the following:**

a. For "Limited Life Expectancy"

Patient Status Determination, Pre-Terminal	Prognosis Bad	Terminal Illness
Terminal Illness - Early Stage	Terminal Illness - Late Stage	

b. For "Medical Reason"

Absent Respnse to Treatment	Adverse Reaction to Drug	Complication of Medical Care
Contraindicated	Drug Allergy	Drug Interaction
Drug Intolerance	Drug Resistance	Drug Therapy Discontinued
Drug Treatment Not Indicated	Failure in Dosage	History of Drug Allergy
Late Effect of Medical and Surgical Care Complication	Medical Contraindication	Not Indicated
Procedure Contraindicated	Procedure Discontinued	Procedure Not Indicated
Treatment Changed	Treatment Modification	Treatment Not Indicated
Treatment Not Tolerated		

c. Prior to use, the required structured data fields may need to be configured and mapped

1) From within a Progress Note or Virtual Visit, click the Social History link
2) Select "Tobacco Use" from the list of displayed items

(continued)

Measure Name	Tobacco Status: Assessment *(continued)*
Exclusion and/or Exception Documentation *(continued)*	3) The "Social History Notes" window will open **a) If "Screening Not Performed" is not listed as an option, click the "Custom" button at the bottom of the window** b) A "Structured Data" window will open (1) Click the "Add" button at the top pf the window (2) Type "Screening Not Performed" in the "Name" field (3) Select "Structured Text" as the data "Type" (4) Click "OK" to save and close c) Select "Screening Not Performed" and click the "Customize Structured Text" button at the bottom of the window (1) Click "Add" and type "Limited Life Expectancy" (2) Click "Add" and type "Medical Reason" (3) Click "OK" to save and close d) Select "Screening Not Performed" again and click the "Add Child" button at the top of the window (1) Enter "Type of Medical Reason" in the "Name" field (2) Select "Structured Text" as the data "Type" (3) Select "Medical Reason" as the "Trigger" (4) Click "OK" to save and close e) Select "Screening Not Performed" again and click the "Add Child" button at the top of the window (1) Enter "Details" in the "Name" field (2) Select "Structured Text" as the data "Type" *(continued)*

Measure Name	Tobacco Status: Assessment *(continued)*
Exclusion and /or Exception Documentation *(continued)*	(3) Select "Limited Life Expectancy" as the "Trigger" (4) Click "OK" to save and close **4) To map the fields, click the "Community" tab in the top menu bar** a) Select "Mappings" b) Select "Structured Data" c) A "Mapper" window will open (1) Enter the following for the "Community" side: (a) Section = Social History (b) Category = Tobacco Use (c) Item = Screening Not Performed (2) Enter the following for the Local side: (a) Section = Social History (b) Category = Social History (field should auto-fill) (c) Item = Tobacco Use d) Select "Reason" on the Community side and "Screening Not Performed" on the Local side and click "Map" (1) A new window with associated Community options will open (2) Select each idividual option on the Community side and click "Add" to add and map it to the Local side e) Repeat the mapping process for both "Details" and "Type of Medical Reason" *(continued)*

Measure Name	**Tobacco Status: Assessment** *(continued)*
Exlusion and/or Exception Documentation *(continued)*	**4. If applicable, document a reason for excepting the patient from this measure in the appropriate structured data fields**
Trouble-Shooting *(continued)*	**<u>Having Problems? Check Out These Trouble Shooting Tips</u>** **I. Verify that tobacco assessment data is recorded in appropriate structured data fields within a Progress Note for an applicable visit**
	II. Verify that all structured data fields are mapped to the correct Community counterparts in your EMR **A. This includes the structured fields included in the "Tobbaco Control" Smart Form** **1. To determine if the "Tobacco Control" Smart Form fields are mapped, do the following:** a. From within eCW, click the "Community" tab in the top menu bar b. Click "Mappings" c. Click "Smart Forms" 1) A "Smart Form Mapper" window will open 2) Select the "Tobacco Control" Smart Form on the "Master" side a) The "Tobacco Control" Smart Form questions will be displayed b) Mapped questions will display in blue font c) Unmapped questions will display in black font **2. If mapping of the Smart Form fields is required** a. From above, on the "Local" side of the Smart Form Mapper window, enter the following: 1) Section = Social History 2) Category = Social History (field should auto-fill) *(continued)*

Measure Name	Tobacco Status: Assessment *(continued)*
Trouble-Shooting *(continued)*	3) Item = Tobacco Use b. The "Tobacco Control" Smart Form questions should also display on the "Local" side c. Select each matching pair of questions (from both the "Master" and "Local" side) and click "Map" **B. Mapping of non-Smart Form "Tobacco Use" structured data fields is detailed in the "Measure Documentation" section, above** **C. For additional assistance with structured fields or mapping, contact an eCW technical representative**
	III. Verify that the "Social History Verified" box has been checked in the Progress Note
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For Further Information	**<u>For Further Information</u>** I. NQF 0028: "**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**" II. eClinicalWorks "**MIPS - CMS 138 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**" III. eClinicalWorks "**MIPS - Registry 226 (NQF 0028) (MIPS - CMS 138) - Preventive Care and Screening: Tobacco Use - Screening and Cessation Intervention**"

Measure Name	Tobacco Status: Cessation Intervention
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0028-1: Prevention & Screening Measure]* ACO Quality Measure #17 *[GPRO: Preventive Measure]* MIPS Clinical Quality Measure *[CMS 138 (EHR)/Registry 226:Process Measure]*
Measure Definition	***The percentage of patients, aged 18 years and older, who were screened for tobaco use at least one or more times within 24 months (the Measurement Period plus the 12 months prior to the Measurement Period) AND , if identified as a tobacco user, received tobacco cessation intervention***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are ≥ 18 years old at the beginning of the Measurement Period II. **AND**, Were seen for two or more or more of the following applicable encounter types during the Measurement Period A. Psychiatric B. Occupational Therapy C. Office Visit D. Ophthalmological Services E. Health and Behavioral Assessment F. Home Healthcare III. **OR**, Were seen for one or more applicable Preventive Care or Annual Wellness encounters during the Measurement Period IV. **AND**, Were identified as a Tobacco User at any time during the Measurement Period or the 12 months prior to the Measurement Period *(continued)*

(continued)

Measure Name	Tobacco Status: Cessation Intervention *(continued)*
Trouble-Shooting *(continued)*	**II. Verify that all structured data fields are mapped to the correct Community counterparts in your EMR** **A. See the "Tobacco Status: Assessment" measure for further details on structured data fields and mapping** **B. Or, For further assistance, contact an eCW technical representative**
	III. If applicable, Document an allergy or intolerance to a Smoking Cessation Agent in the "Allergies" section of the patient's chart, as follows: **A. Access the "Allergies" section of the patient's chart in one of the following ways:** **1.** *Progress Note (or Virtual Visit) → Allergies/Intolerances* **2.** **OR**, From the Progress Note Dashboard, click the Allergies/Intolerance icon **B. Add a new Allergy or Intolerance as follows:** **1. From the "Allergies/Intolerance" window, click "Add"** **2. The "Past Medical History" window will open** **a. "Structured/Non-Structured" Field** 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window

(continued)

Measure Name	Tobacco Status: Cessation Intervention *(continued)*
Trouble-Shooting *(continued)*	**2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	IV. Verify that the "Social History Verified" box has been checked in the Progress Note
	V. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)

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Measure Name	**Tobacco Status: Cessation Intervention** *(continued)*
For Further Information	**For Further Information** I. NQF 0028: "**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**" II. eClinicalWorks "**MIPS - CMS 138 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**" III. eClinicalWorks "**MIPS - Registry 226 (NQF 0028) (MIPS - CMS 138) - Preventive Care and Screening: Tobacco Use - Screening and Cessation Intervention**"

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0024-1: Prevention & Screening Measure]* MIPS Clinical Quality Measure *[CMS 155 (EHR): Process Measure]*
Measure Definition	***The percentage of patients, 3-16 years of age, who were seen for an outpatient visit with a Primary Care Provider (PCP) or Obstetrician/Gynecologist (OB/GYN) AND who had evidence of the following during the Measurement Period: 1) Documentation of height, weight and body mass index percentile values, 2) Counseling for nutrition and 3) Counseling for physical activity***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: **I.** Are ≥ 3 and < 16 years of age at the start of the Measurement Period **II.** **AND**, Have been seen for an applicable office visit, by a PCP or OB/GYN, during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: **I.** Have their height, weight and BMI recorded during an applicable encounter in the Measurement Period **II.** **AND**, Have had counseling for Nutrition recorded during an applicable encounter in the Measurement Period **III.** **AND**, Have had counseling for Physical Activity recorded during an applicable encounter in the Measurement Period
Exclusions and/or Exceptions	Patients are **excluded** from this measure if they have an active diagnosis of Pregnancy during the Measurement Period *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an office visit for weight assessment during the Measurement Period** **A. The following E&M codes identify applicable encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 3. 99401 - 99404 and 99411 - 99412 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Note → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **I. Record the patient's height, weight and calculated BMI (percentile) in the "Vitals" section of the Progress Note for the Visit** A. The documented height, weight and BMI percentile must be from the same visit encounter B. Ranges and thresholds do not meet the criteria for this measure 1. A distinct BMI percentile is required for Numerator compliance 2. Documentation of > 99% or < 1% meets criteria because a distinct BMI percentile is evident (i.e., 100 % or 0 %) C. Document any reason for the inability to record a calculated BMI in the "Notes" field of the "Vitals" section **II. Provide, and document, counseling for Nutrition during the applicable encounter** A. Counseling for Nutrition includes, but is not limited to, the following: *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*
Measure Documentation *(continued)*	1. Discussion of current Nutrition behaviors (e.g., eating habits, dieting behaviors) 2. Checklist indicating Nutrition was addressed 3. Counseling or referral for Nutrition education 4. Member received educational materials on Nutrition during a face-to-face visit 5. Anticipatory guidance for Nutrition 6. Weight or obesity counseling **B. Document the Nutrition counseling in structured data fields, as follows:** **1. eCW recommends either one of the following structured data paths** **a.** ***Progress Notes → Preventive Medicine → Counseling*** ↓ ***Communication to Patient → Nutrition counseling consisting of → Select option*** **OR** **b.** ***Progress Notes → Preventive Medicine → Counseling*** ↓ ***Communication to Patient → Counseling for Nutrition Provided*** ↓ ***Select Yes or No*** 2. For each of the above options, the required structured data fields are outlined (boxed) **3. Record the provision of Nutrition counseling in the Progress Note for the applicable visit, using one of the structured data paths, above** **a. Some configuration and mapping may first be required** **1) If necessary, add the "Communication to Patient" item to the Counseling folder in Preventive Medicine, as follows:** *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*
Measure Documentation *(continued)*	a) From within a Progress Note or Virtual Visit, click on the "Preventive Medicine" link b) Click on the "Counseling" folder c) If "Communication to Patient" is not an available option: (1) Click the carat adjacent to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Communication to Patient" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) (a) Section = Preventive Medicine (b) Category = Counseling (c) Item = Communication to Patient (3) From the Community side, select the desired reporting field (a) E.g., "Nutrition Counseling consisting of" (b) E.g., "Counseling for Nutrition provided" (4) Click "Add" *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*
Measure Documentation *(continued)*	(a) The field will automatically be added to the Local side (b) The Community and Local fields will automatically map to each other (c) (Mapped fields display in blue font) (d) Associated Community options will also automatically be added to the Local side and mapped b. Associated options for the "Nutrition Counseling consisting of" field include: 1) Counseling for Eating Disorder 2) Diet Education 3) Diet Leaflet 4) Dietary Education for Weight Gain 5) Dietary Management Education, Guidance and Counseling 6) Dietary Needs Education 7) Eating Disorders Management 8) Food Education, Guidance and Counseling 9) High Fiber Diet Education 10) High Protein Diet Education 11) Lifestyle Education Regarding Diet 12) Low Carbohydrate Diet Education 13) Low Cholesterol Diet Education 14) Nutrition Education 15) Nutrition Surveillance 16) Nutritionist Education, Guidance and Counseling 17) Obesity Diet Education 18) Patient Referral to Dietician 19) Recommendation to Carer Regarding Child's Diet 20) Recommendation to Change Carbohydrate Intake 21) Recommendation to Change Diet 22) Recommendation to Change Dietary Fiber Intake *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*
Measure Documentation *(continued)*	23) Recommendation to Change Dietary Intake 24) Recommendation to Change Food and Drink Intake 25) Recommendation to Change Food Intake 26) Recommendation to Change Nutrient Intake 27) Referral to Community-Based Dietetics Service 28) Referral to Community-Based Dietician 29) Referral to Dietetics Service 30) Referral to Eating Disorders Clinic 31) Referral to Hospital-Based Dietetics 32) Referral to Hospital-Based Dietician 33) Toddler Nutrition Education 34) Vegan Diet Education 35) Vegetarian Diet Education 36) Weight Control Education 37) Weight-Reducing Diet Education **III. Provide, and document, counseling for Physical Activity during the applicable encounter** A. Counseling for Physical Activity includes, but is not limited to: 1. Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation 2. Checklist indicating physical activity was addressed 3. Counseling or referral for physical activity 4. Member received educational materials on physical activity during a face-to-face visit 5. Anticipatory guidance specific to the child's physical activity 6. Weight or obesity counseling **B. Document the Physical Activity counseling in structured data fields, as follows:** **1. eCW recommends either one of the following structured data paths:** *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*

Measure Documentation *(continued)*

a. ***Progress Notes → Preventive Medicine → Counseling***
↙
Communication to Patient → Physical Activity counseling consisting of → Select option

OR

b. ***Progress Notes → Preventive Medicine → Counseling***
↓
Communication to Patient → Counseling for Physical Activity Provided
↓
Select Yes or No

2. For each of the above options, the required structured data fields are outlined (boxed)
3. **Record the provision of Physical Activity counseling in the Progress Note for the applicable visit, using one of the structured data paths, above**

   a. **If necessary, configure and map the structured data fields for Physical Activity, as detailed above**
   b. Associated options for the "Physical Activity counseling consisting of" field include:

      1) Determination of Physical Activity Tolerance
      2) Exercise Education
      3) Exercise Leaflet Given
      4) Exercise on Prescription
      5) Exercise on Promotion: Strength Training
      6) Exercise on Promotion: Stretching
      7) Exercise Case Management
      8) Exercise, Guidance and Counseling
      9) Giving Encouragement to Exercise
      10) History and Physical Examination - Sports Participation
      11) Patient Advised re Exercise
      12) Patient Given Written Advice on Benefits of Physical Activity

(continued)

Measure Name	**Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16** *(continued)*
Measure Documentation *(continued)*	13) Physical Activity Assessment 14) Prescribed Activity/Exercise Education 15) Reassuring About Exercise 16) Recommendation to Exercise 17) Recommendation to Mobilize Part 18) Recommendation to Undertake Activity 19) Referral for Exercise Therapy 20) Referral to Physical Activity Program 21) Referral to Weight Maintenance Regimen Service **C. The required structured data fields can actually be located in any customizable section of the Progress Note, as long as they are mapped to the correct Community counterparts, identified by the structured data pathways, above**
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* If applicable, document a diagnosis for Pregnancy in the Problem List of the patient'a chart in eCW *(Note: The list of Pregnancy-related ICD-10 codes is too extensive to include here)*
Trouble-Shooting	**Having problems? Check out the following Trouble-Shooting tips** **I. Verify that the Vitals fields in your EMR are properly configured** A. From the EMR menu, select "Vitals" B. Select "Configure Vitals" C. Verify that the height, weight, and BMI parameters are selected to display in the Progress Note *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*
Trouble-Shooting *(continued)*	**II. Verify that all structured data fields used are mapped to the correct Community elements in your EMR** A. For further assistance with mapping problems, contact an eCW Technical Service representative B. **OR**, Contact Ed Worthington or Kelly Saxton @ NPO
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR **A. Verify that the correct ICD-10 diagnosis code has been added** **B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0024: "**Weight Assessment and Counseling for Children and Adoloescents**" II. eClinicalWorks "**MIPS - CMS 155 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**", *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged 3-16 *(continued)*
For More Information *(continued)*	III. 2017 HEDIS for QRS Version: "**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**"

Measure Name	**Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17**
Relevance	NPO Population Clinical Quality Dashboard *[NQF 0024-1: Prevention & Screening Measure]* MIPS Clinical Quality Measure *[CMS 155 (EHR): Process Measure]*
Measure Definition	***The percentage of patients, 16-17 years of age, who were seen for an outpatient visit with a Primary Care Provider (PCP) or Obstetrician/Gynecologist (OB/GYN) AND who had evidence of the following during the Measurement Period: 1) Documentation of height, weight and body mass index percentile values, 2) Counseling for nutrition and 3) Counseling for physical activity***
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: **I.** Are ≥ 16 and < 17 years of age at the start of the Measurement Period **II.** **AND**, Have been seen for an applicable office visit, by a PCP or OB/GYN, during the Measurement Period
Numerator	The **Numerator** consists of patients, from the Denominator, who: **I.** Have their height, weight and BMI recorded during an applicable encounter in the Measurement Period **II.** **AND**, Have had counseling for Nutrition recorded during an applicable encounter in the Measurement Period **III.** **AND**, Have had counseling for Physical Activity recorded during an applicable encounter in the Measurement Period
Exclusions and/or Exceptions	Patients are **excluded** from this measure if they have an active diagnosis of Pregnancy during the Measurement Period *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17 *(continued)*
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **The patient must be seen for an office visit for weight assessment during the Measurement Period** **A. The following E&M codes identify applicable encounters** 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 3. 99401 - 99404 and 99411 - 99412 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Note → Billing)*
	To Satisfy This Measure *(Numerator Documentation)* **I. Record the patient's height, weight and calculated BMI (percentile) in the "Vitals" section of the Progress Note for the Visit** A. The documented height, weight and BMI percentile must be from the same visit encounter B. Ranges and thresholds do not meet the criteria for this measure 1. A distinct BMI percentile is required for Numerator compliance 2. Documentation of > 99% or < 1% meets criteria because a distinct BMI percentile is evident (i.e., 100 % or 0 %) C. Document any reason for the inability to record a calculated BMI in the "Notes" field of the "Vitals" section **II. Provide, and document, counseling for Nutrition during the applicable encounter** A. Counseling for Nutrition includes, but is not limited to, the following: *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17 *(continued)*

Measure Documentation *(continued)*

1. Discussion of current Nutrition behaviors (e.g., eating habits, dieting behaviors)
2. Checklist indicating Nutrition was addressed
3. Counseling or referral for Nutrition education
4. Member received educational materials on Nutrition during a face-to-face visit
5. Anticipatory guidance for Nutrition
6. Weight or obesity counseling

B. Document the Nutrition counseling in structured data fields, as follows:

1. eCW recommends either one of the following structured data paths

a. ***Progress Notes → Preventive Medicine → Counseling***
↓
Communication to Patient → Nutrition counseling consisting of → Select option

OR

b. ***Progress Notes → Preventive Medicine → Counseling***
↓
Communication to Patient → Counseling for Nutrition Provided
↓
Select Yes or No

2. For each of the above options, the required structured data fields are outlined (boxed)
3. **Record the provision of Nutrition counseling in the Progress Note for the applicable visit, using one of the structured data paths, above**

a. Some configuration and mapping may first be required

1) If necessary, add the "Communication to Patient" item to the Counseling folder in Preventive Medicine, as follows:

(continued)

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17 *(continued)*
Measure Documentation *(continued)*	a) From within a Progress Note or Virtual Visit, click the "Preventive Medicine" link b) Click on the "Counseling" folder c) If "Communication to Patient" is not an available option: (1) Click the carat adjacent to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Communication to Patient" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) (a) Section = Preventive Medicine (b) Category = Counseling (c) Item = Communication to Patient (3) From the Community side, select the desired reporting field (a) E.g., "Nutrition Counseling consisting of" (b) E.g., "Counseling for Nutrition provided" (4) Click "Add" *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17 *(continued)*
Measure Documentation *(continued)*	(a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped b. Associated options for the "Nutrition Counseling consisting of" field include: 1) Counseling for Eating Disorder 2) Diet Education 3) Diet Leaflet 4) Dietary Education for Weight Gain 5) Dietary Management Education, Guidance and Counseling 6) Dietary Needs Education 7) Eating Disorders Management 8) Food Education, Guidance and Counseling 9) High Fiber Diet Education 10) High Protein Diet Education 11) Lifestyle Education Regarding Diet 12) Low Carbohydrate Diet Education 13) Low Cholesterol Diet Education 14) Nutrition Education 15) Nutrition Surveillance 16) Nutritionist Education, Guidance and Counseling 17) Obesity Diet Education 18) Patient Referral to Dietician 19) Recommendation to Carer Regarding Child's Diet 20) Recommendation to Change Carbohydrate Intake 21) Recommendation to Change Diet 22) Recommendation to Change Dietary Fiber Intake 23) Recommendation to Change Dietary Intake *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17 *(continued)*
Measure Documentation *(continued)*	24) Recommendation to Change Food and Drink Intake 25) Recommendation to Change Food Intake 26) Recommendation to Change Nutrient Intake 27) Referral to Community-Based Dietetics Service 28) Referral to Community-Based Dietician 29) Referral to Dietetics Service 30) Referral to Eating Disorders Clinic 31) Referral to Hospital-Based Dietetics 32) Referral to Hospital-Based Dietician 33) Toddler Nutrition Education 34) Vegan Diet Education 35) Vegetarian Diet Education 36) Weight Control Education 37) Weight-Reducing Diet Education **III. Provide, and document, counseling for Physical Activity during the applicable encounter** A. Counseling for Physical Activity includes, but is not limited to: 1. Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation 2. Checklist indicating physical activity was addressed 3. Counseling or referral for physical activity 4. Member received educational materials on physical activity during a face-to-face visit 5. Anticipatory guidance specific to the child's physical activity 6. Weight or obesity counseling **B. Document the Physical Activity counseling in structured data fields, as follows:** **1. eCW recommends either one of the following structured data paths:** *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17 *(continued)*
Measure Documentation *(continued)*	a. ***Progress Notes → Preventive Medicine → Counseling*** ↙ ***Communication to Patient → Physical Activity counseling consisting of → Select option*** **OR** b. ***Progress Notes → Preventive Medicine → Counseling*** ↓ ***Communication to Patient → Counseling for Physical Activity Provided*** ↓ ***Select Yes or No*** 2. For each of the above options, the required structured data fields are outlined (boxed) **3. Record the provision of Physical Activity counseling in the Progress Note for the applicable visit, using one of the structured data paths, above** **a. If necessary, configure and map the structured data fields for Physical Activity, as detailed above** b. Associated options for the "Physical Activity counseling consisting of" field include: 1) Determination of Physical Activity Tolerance 2) Exercise Education 3) Exercise Leaflet Given 4) Exercise on Prescription 5) Exercise on Promotion: Strength Training 6) Exercise on Promotion: Stretching 7) Exercise Case Management 8) Exercise, Guidance and Counseling 9) Giving Encouragement to Exercise 10) History and Physical Examination - Sports Participation 11) Patient Advised re Exercise 12) Patient Given Written Advice on Benefits of Physical Activity *(continued)*

Measure Name	**Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17** *(continued)*
Measure Documentation *(continued)*	13) Physical Activity Assessment 14) Prescribed Activity/Exercise Education 15) Reassuring About Exercise 16) Recommendation to Exercise 17) Recommendation to Mobilize Part 18) Recommendation to Undertake Activity 19) Referral for Exercise Therapy 20) Referral to Physical Activity Program 21) Referral to Weight Maintenance Regimen Service **C. The required structured data fields can actually be located in any customizable section of the Progress Note, as long as they are mapped to the correct Community counterparts, identified by the structured data pathways, above**
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* If applicable, document a diagnosis for Pregnancy in the Problem List of the patient'a chart in eCW *(Note: The list of Pregnancy-related ICD-10 codes is too extensive to include here)*
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that the Vitals fields in your EMR are properly configured** A. From the EMR menu, select "Vitals" B. Select "Configure Vitals" C. Verify that the height, weight, and BMI parameters are selected to display in the Progress Note *(continued)*

Measure Name	Weight Assessment, Nutritional & Activity Counseling for Adolescents, Aged Between 16 and 17 *(continued)*
Trouble-Shooting *(continued)*	**II. Verify that all structured data fields used are mapped to the correct Community elements in your EMR** A. For further assistance with mapping problems, contact an eCW Technical Service representative B. **OR**, Contact Ed Worthington or Kelly Saxton @ NPO
	III. Verify that any applicable ICD-10 diagnosis code(s) have been added to the Problem List in the patient's chart in the EMR **A. Verify that the correct ICD-10 diagnosis code has been added** **B. Add a diagnosis to the patient's Problem List in one of the following ways:** 1. *Progress Note (or Virtual Visit) → Assessments → Problem List → Add* 2. **OR**, From the ICW (Right-Hand Chart Panel), click the "Overview" tab a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
	IV. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)
For More Information	**For More Information** I. NQF 0024: "**Weight Assessment and Counseling for Children and Adoloescents**" II. eClinicalWorks "**MIPS - CMS 155 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**" *(continued)*

	(continued)
Measure Name	**Adolescent Well-Care Visits: 12-21 Years** *(continued)*
Numerator *(continued)*	D. Services that occur over multiple visits may be counted towards satisfaction of this measure as long as all required services have been performed, and documented in the medical record, prior to the end of the Measurement Period (December 31)
Exclusions and/or Exceptions	None
Measure Documentation	**<u>To Qualify For This Measure</u>** *(Denominator Documentation)* Qualification is based upon age only; Verify that the patient's date of birth is accurately recorded in your EMR
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **I. See the patient for at least one applicable well-care visit during the Measurement Period** **A. Documentation in the medical record must include the following:** 1. A Progress Note indicative of a visit to a PCP or OB/GYN practitioner 2. The date on which the well-care visit occurred 3. Evidence of the following: a. A health and developmental history (physical and mental) b. A physical exam c. Health education/anticipatory guidance **B. The following CPT/HCPCS codes identify applicable adolescent well-care visits:** 99383- 99385 and 99393 - 99395

	(continued)
Measure Name	**Adolescent Well-Care Visits: 12-21 Years** *(continued)*
Measure Documentation *(continued)*	**C. The following ICD-10 codes identify an adolescent well-care visit** 1. Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.70, Z00.71 and Z00.8 2. Z02.0 - Z02.6, Z02.82 and Z02.89 **II. Document the well-care visit in one of the following ways:** **A. Record the appropriate CPT code for the well-care visit in the Billing section of the associated Progress Note** (*Progress Notes → Billing*) **B. <u>OR</u>, Record the appropriate ICD-10 code in the Problem List of the patient's chart in eCW** 1. Add a diagnosis to the patient's Problem List by recording it as an assessment on a Progress Note *(Progress Note (or Virtual Visit) → Assessments → Problem List → Add)* 2. **<u>OR</u>**, Add a diagnosis to the Problem List from the Right-Hand Chart Panel a. From the Right-Hand Chart Panel, click the "Overview" tab 1) Click the orange button (with three dots) in the Progress Note band 2) Click "Add" b. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field
Exclusion and/or Exception Documentation	None
Trouble-Shooting	None

	(continued)
Measure Name	**Adolescent Well-Care Visits: 12-21 Years** *(continued)*
For More Information	**For More Information** HEDIS: "**Adolescent Well-Care Visits (AWC)**"