# SETMA's Disease Management tools For *Diabetes, Hypertension and Lipids* Used for patient activation and engagement via written Plans of Care and Treatment Plans

Providing our patients a written, personalized Treatment Plan and Plan of Care is a critical aspect in patient activation and engagement. These documents serve as a "baton" which empowers the patient to care for themselves. The following poster which appears in all SETMA's examination rooms and a framed copy of which appears in all public places at SETMA symbolizes the "baton."



#### Firmly in the providers hand --The baton - the care and treatment plan Must be confidently and securely grasped by the patient, If change is to make a difference 8,760 hours a year.

The poster illustrates:

- 1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
- 2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
- 3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
- 4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.
- 5. That the imperative for the plan the "baton" is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.
- 6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
- 7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

The genius and the promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display will continually remind the provider and will inform the patient, that to be successful, the patient's care must be coordinated, which must result in coordinated care. As we expand the scope of SETMA's Department of Care Coordination, we know that coordination begins at the points of transitions of care, and that the work of the healthcare team -- patient and provider -- is that together they evaluate, define and execute that care.

Since 2003, SETMA has been producing Follow-up Documents for each of the chronic diseases tools which we have deployed in our EMR. We have now made modifications in these tools so that the Follow-up Document have become written Treatment Plans and Plans of Care. (This tutorial addresses only the Treatment Plan and Plan of Care. For a full review of the disease management tools see the tutorial on each.)

## Assessing Cardiovascular Risk Score of Each Patient

#### SETMA's Innovative Use of the Framingham Risk

A plan of care should be founded on the patient's relative risk of disease. The best tool we have for assessing that risk, particularly cardiovascular risk is the Framingham Risk Scores. SETMA's deployment of these scores can be found at: <u>http://www.jameslhollymd.com/epm-tools/framingham-tutorial</u>. This tutorial explains the changes and use of SETMA's deployment of the 12 risk calculators published by the Framingham Heart Study. These tools are not absolute and must be used simply as an indication of potential cardiovascular and cerebrovascular risk and not as an absolute indicator of future disease.

#### If You Make a Change it Will Make a Difference

The most innovative use of the Framingham Risk Calculators were suggested by SETMA's associates at the Joslin Diabetes Center in Boston (SETMA is the only multi-specialty Affiliate of the Joslin Diabetes Center). Drs. Richard Jackson and Ken Snow, while visiting SETMA, recommended the adding of a "What If Scenario" to our display of all twelve calculators.

The concept is that we are asking patients to make changes which will not show up as benefits for decades. Of course, ignoring those changes will result in irrevocable deterioration in the patient's health over those decades. But how do you "prove" to a patient that "if you make a change, it will make a difference?" One way is with the Framingham Risk Calculators being presented to the patient with the inclusion of the changes which would result if the patient improved the elements of the risk calculator.

Even though these risk calculators are not perfect, they are still the best we have. And, it is imperative that patients know and that their provider knows what their risk is, because it is with the knowledge of the patient's cardiovascular risk that a plan of care and a treatment plan can be designed to help preserve the patient's health.

Remember, "Risk" is an attempt to determine what the future might be like which means it is imprecise. Some people with a high risk will not experience poor health and some who have low risk will. Overall, however, those with high risk will have more heart attacks and strokes than those with low risk.

#### **Dynamic Complexity**

The problem with biological systems is that change, even change which results in deterioration of your health, does not occur quickly and it often occurs without any signs or symptoms until the illness, or disease process has already caused significant damage. There is no explanation of this principle more apt to our use of "risk calculators" than Peter Senge's explanation of "dynamic complexity" in *The Fifth Discipline*.

Senge defines "dynamic complexity" as a situation "where cause and effect are subtle, and where the effects over time of interventions are not obvious." This perfectly describes the development of many disease states and the benefit of their treatment. We know that obesity causes, or contributes to most diseases including diabetes, hypertension, heart disease, cancer, etc. In these conditions, "obesity" is the cause; "cancer" is the effect, but the change is slow and is not apparent. Also, the results of treatment are very slow. Consequently, it is hard to sustain the changes necessary to eliminate the "cause," which is obesity, in order to avoid the "effect" which is cancer.

#### Shifting the Burden

There are structural problems which aggravate the obvious solutions to a business or a health problem; Senge addresses one of these and calls it "the shifting the burden." He defines "shifting the burden," as "an underlying problem generates symptoms that demand attention. But the underlying problem is difficult for people to address, either because it is obscure or costly to confront. So people 'shift the burden' of their problem to other solutions - well intentioned, easy fixes which seem extremely efficient. Unfortunately, the easier 'solutions' only ameliorate the symptoms; they leave the underlying problem unaltered. The underlying problem grows worse, unnoticed because the symptoms apparently clear up, and the system loses whatever ability it had to solve the underlying problem."

This happens in healthcare when a person looks to healthcare providers or medications to solve a problem which can only be solved by their own habits, choices, decisions and resolution. A pill, or a procedure, or a prescription is sought in order to overcome the "obesity." It will work for a short while but not long term. When it fails, more aggressive interventions are tried without addressing the fundamental problem.

#### The Quick Fix Deception

Senge's business prescription is a good one for healthcare, also. He says, "Beware the symptomatic solution, that address only the symptoms ,not fundamental causes tend to have short-term benefits at best. In the long term, the problem resurfaces and there is increased pressure for symptomatic response. Meanwhile, the capability for fundamental solutions can atrophy." Senge adds, "The 'easy solution, the 'quick fix', solves the problem temporarily, (but) a shifting of burden structure lurks behind many 'solutions (and) explains a wide range of behaviors where well-intentioned 'solutions' actually makes matters worse over the long term."

#### Senge and Medicine

The longer a person delays addressing the "real" cause of their problem, the fewer options and the fewer resources they have for dealing with the "real" cause of the problem. For instance, the longer a person fails to exercise, often resulting in gaining weight and diminishing heart function, the more difficult effective solutions will be once a person determines to improve their health. If a person continues to "shift the burden" of their own irresponsibility to another, expecting an artificial solution to relieve the burden created by the rejection of the real solution, they will never achieve their goal. In this case, the harder the patient pushes for solutions from a healthcare system which cannot solve their problem, for which a natural and obvious solution exists, the less benefit the patient will achieve. It is possible to ignore the real solutions - i.e., activity such as walking - until the knees and other joints have deteriorated and it is not possible to become active. In that case, more and more pressure is placed on the artificial system with less and less satisfaction with the results.

#### **Risk Calculators: Dynamic Complexity and Shifting the Burden**

These are the reasons for our using "risk calculators." Because in a biological system proving the benefit of fundamental solutions by waiting for the negative consequences of poor health choices is not acceptable, we use "risk calculators" to project what those poor choices will lead to. Hopefully, those risk calculators will help patients make a decision to make a change.

At SETMA's website under Your Life Your Health, twenty-two articles can be found under View Articles by Subject and by accessing Cardiovascular Disease Risk Factors.

#### What If?

Because it takes SETMA only one second (really) to calculate all twelve risk calculators, we thought we were doing great. However, when we showed this function to our new colleagues from Joslin Diabetes Center, Dr. Richard Jackson commented that these scores overstate the risk and Dr. Kenneth Snow asked if we could show the patient how their risk would be affected if they make a change in their habits? Sadly, we had to admit that we could not. That was on Tuesday November 30, 2010.

We realized that while the patient has to know their risk, to understand "dynamic complexity" and its dangers for their ignoring their health until it is too late, and to avoid "shifting the burden" of responsibility from themselves to another, their healthcare providers have a responsibility to show them that if "they make a change that it will make a difference."

#### Completing the Treatment Plan and Plan of Care

In order for the Treatment Plan and the Plan of Care to be precise and specific for each patient, it is important that you first complete the **Framingham Cardiovascular and Cerebrovascular Risk Scores** and the **Global Cardiovascular Risk Score** before using the below functions. (Note: You only have to complete the risk scores once on each visit, after which the score is displayed on all of the disease management tools and will work interactively with the Treatment Plan and Plan of Care.)

In completing the Risk Scores, you will also be fulfilling another of the NCQA Medical Home Requirements which is the assessment of the risk of future disease for patients.

## Using the Framingham Cardiovascular Risk Score

You can find the **Framingham Risk Scores calculation tools** on each of the Diabetes, Hypertension and Lipid Disease Management tools. The following illustrates its location on the Diabetes Template.

Diabetes	GDM O Pr	e-Diabetes Other Mi	Diabetes S	ince Patient Chart Age	QTest 43 Sex M	Navigation
Joslin Treatm	nent Goals	mp Diabetes Concepts		Current Freque	ency of SMBG	<ul> <li>Diabetes</li> <li>General</li> </ul>
Diagnostic Criteria	Screening Cr	iteria Evidenced-Base	ed Recs	Garronerroque		Return
Adherence				100000		Diab Sys Review
Dental Care	11	Smoker E-mail	+ 0 -	Most Recent Labs	Check for New Labs	Diabetic History
Dilated Eye Exam	11	Metabolic Syndrome	+ 0 -	HqA1C	11	Diabetic motory
Flu Shot	11	Energia de la Dista Casara		Previous	11	Eye Exam
Foot Exam	11	Framingham Risk Scores			11	Nasopharynx
Monofilament	11	10-Year General Risk	%	eAG		Cardio Exam
HgbA1C	11	10-Year Stroke Risk	%	Mean Plasma Glucose	Insulin	
Pneumovax	11	Global Cardio Score	pts	C-Peptide	11	Foot Exam
Urinalysis		Weight Management   in	ids Managemer	Fructosamine	11	Neurological Exam
Aspirin	Yes O No	HPT Management Imr	nunizations	Cholesterol	11	
Statin	Yes 🔿 No			LDL	11	Complications/Education
Vital Signs	4	Finger Stick		HDL	11	Initiating Insulin
Height 0.00	Waist	Glucose		Triglycerides	11	Insulin Pump
Weight	Hips	Pulse		Trig/HDL Ratio		
BMI	Chest	Blood Press	ure	Glucose	11	Lifestyle Changes
Body Fat %	Abdomen		/	Fasting	11	Diabetes Plan
Protein Req	Ratio	0.00 BP Ir	Diabetics	Insulin	11	Education Devided Officer Oc
BMR	BER	Vitals	Over Time	HOMA-IR		Education Booklet Given Un
				Na	11	11
				к	11	Diabetes Education
Current SQ Insulin D	ose as of /	Blood Suga	rs	Magnesium	11	Telephone Record
Time of day Units	ype Units	iype mg/di		BUN	11	
0.00	0.00			Creatinine	11	Last DE / /
0.00	0.00		Diary	- U Microalbumin	11	
0.00	0.00			Albumin/Creat	11	
0.00	0.00			Urinalysis	Labs Over Time	Manual Lab Results

This launches the following template. When this template is opened, all of the Framingham risk scores will be automatically calculated.

Framing	ham Heart Last Updated/Revie	Study F	Risk Cal	culator	S	
General Cardiovascular Disea	<u>se, 10-Year Risk</u>	Total Points	16	Total Risk	25.3 %	Relative Heart Age 76 year
Real Heart Age 54 ye	ars					
	WHAT IF?					
	All Elen	nents To Goal	10		9.4	54
	Overall 20%	Improvement	10		9.4	54
	Blood Pres	sure To Goal	16		25.3	76
	L	ipids To Goal.	14		18.4	68
	Smoking Cessation	(if applicable)	0		N/A	N/A
Clabel Cardinana andra Biala Ca		Tatal Dalata	11			
Global Cardiovascular Risk Sc	ore	Total Points	A score shove	A indicates	increased riel	of a cardiovascular aver
	WHAT IF?		A SCOLE ADOVE	+ indicates	increased ris	tor a cardiovascular ever
	Overall 20%	Improvement	-0.5			
	Blood Pres	sure To Goal	0.1			
	L	ipids To Goal.	3.1			
	Hgi	bA1c To Goal	-0.5			
	Smoking Cessation	(if applicable)	0.0			
					40	
Coronary Heart Disease, 10-Ye	ear Risk	Total Points	<u> </u>	Total Risk	10 %	
	WHAT IF?					
	Overall 20%	Improvement	5		8	
	Blood Pres	ssure To Goal	8		16	
	L	ipids To Goal.	4			
	Smoking Cessation	(if applicable)	6		10	
Coronary Heart Disease, 2-Yea	ar Risk	Total Points	12	Total Risk	1 %	
Stroke, 10-Year Risk		Total Points	9	Total Risk	5 %	
	WHAT IF?					
	0 1000		6		2	
	Overall 20%	improvement	11			
	Biood Pres	(Sure to Goal			N/A	
	Smoking Cessation	(ir applicable)				
Atrial Fibrillation, 10-Year Risk		Total Points	12	Total Risk	>30 %	
Stroke After Atrial Fibrillation		Total Pointe	5	Total Diek	8 %	
Stroke Arter Athar Hormation		Total Folinta		Total Nak		
			45		42	
Stroke or Death After Atrial Fi	brillation	Total Points	15	Total Risk	12 %	
Congestive Heart Failure		Total Points	10	Total Risk	3 %	
Hard Coronary Artery Disease	, 10-Year Risk	Total Points	11	Total Risk	8 %	
Intermittent Claudication		Total Pointe	14	Total Risk	2 %	
intermition claudication		rotal Points		Total Nok		
Recurring Coronary Heart Dise	ease	Total Points		Total Risk	7 %	

The Risk Score will now be displayed on this template, on each of the disease management tools and it will also be used in preparing your Treatment Plan and your Plan of Care for each patient.

## Using the Global Cardiovascular Risk Score

Several years ago, it was recognized that the Framingham Score weighted the patient's age so heavily that some young people with high cardiovascular risk were missed and some older patients with lower cardiovascular risk were misjudged as being at high risk.

An analysis was done of the Framingham Data and the **Global Cardiovascular Risk Score** was created. This score uses the Framingham Data but eliminates the age and gender bias, adding Hemoglobin A1C to the assessment. If the score is above 4, the patient is considered to have high Cardiovascular Risk.

To view the detailed elements of the Global Cardiovascular Risk Score, click the following button on the main Framingham template.

Framingham Heart Study R Last Updated/Reviewed 09/20	isk Calculators Return
General Cardiovascular Disease, 10-Year Risk Total Points Real Heart Age 54 years WHAT IF?	Relative Heart Age 13 Total Risk 15.6 % 64 years
All Elements To Goal Overall 20% Improvement Blood Pressure To Goal Lipids To Goal Smoking Cessation (if applicable)	7     5.6     45       7     5.6     45       13     15.6     64       11     11.2     57       0     N/A     N/A
Global Cardiovascular Risk Score Total Points	1.1 score above 4 indicates increased risk of a cardiovascular event.
Overall 20% Improvement Blood Pressure To Goal Lipids To Goal HgbA1c To Goal Smoking Cessation (if applicable)	-0.5 0.1 3.1 0.0 0.0

This launches the following pop-up. Activate the button entitled **Import**. This will aggregate the data required to calculate the score.

Global Cardiovascular Risk Score Last Updated/Reviewed	What If Analysis
Enter each of the five parameters below and click "Calculate." You may click "Import" to pull the values in from the physical exam.	Select What If Scenario
Cholesterol HDL HgbA1c Systolic BP Packs Per Day	Cholesterol HDL HgbA1c Systolic BP Packs Per Day
Calculate >> points	Calculate New >> points
A Global Cardiovascular Risk Sco the patient is at increased risk o	ore below 4 is desirable. Above 4, f a cardiovascular event.
Complete Formula <u>Cholesterol</u> + (HgbA1C - 7.0) + HDL	+ Systolic BP - 130 + Packs Per Day 10
ОК	Cancel

To complete this process, activate the button entitled **Calculate** 

Global Cardiovascular Risk Score	What If Analysis
Enter each of the five parameters below and click "Calculate." You may click "Import" to pull the values in from the physical exam.	Select What If Scenario
Cholesterol	Cholesterol
HDL	HDL
HgbA1c Import >>	HgbA1c
Systolic BP	Systolic BP
Packs Per Day	Packs Per Day
Calculate >> points	Calculate New >> points
A Global Cardiovascular Risk Sco the patient is at increased risk o	ore below 4 is desirable. Above 4, of a cardiovascular event.
Complete Formula	
Cholesterol + (HgbA1C - 7.0)	+ Systolic BP - 130 + Packs Per Day
ОК	Cancel

The score will be displayed on this screen, on all of the disease management tools and will be used in preparing your Plan of Care and Treatment Plan on each patient. A value above 4 indicates that the patient is at increased risk.

The principle difference which you will find is that at times young people who have a low

Framingham risk score, will have a high Global Cardiovascular risk score and older people who have a high Framingham Score will have a lower Global cardiovascular risk score. This is because of the elimination of the age as a factor.

# SETMA's Disease Management tools For *Diabetes, Hypertension and Lipids* Used for patient activation and engagement via written Plans of Care and Treatment Plans

Definitions:

- **Treatment Plan:** "A written plan detailing the medical regimen as ordered by the physician, including periodic monitoring for adverse reactions and other follow-up care."
- **Plan of Care:** "a written plan for services that will be provided to the patient to meet their identified needs."

#### **Diabetes Treatment Plan and Plan of Care**

You will find the Diabetes Disease management Tool by going to AAA Home



Diabetes	Manage	ment	Diabetes	Since Patient Chart	QTest	
Туре I 🔿 Туре II	🔿 GDM 🔿 Pre	Diabetes Other Mo	onth Yea	r Age	43 Sex M	Navigation
Joslin Treatm	ent Goals In	p Diabetes Concepts		Current Freque	ancy of SMBG	Diabetes  General
)iagnostic Criteria	Screening Crit	eria Evidenced-Base	d Recs	Current reque	sincy of Simbo	Return
dherence	11					Diab Sys Review
Dilated Eve Exam	11	Smoker E-mail	+ 0 -	Most Recent Labs	Check for New Labs	Diabetic History
Flu Shot	11	Metabolic Syndrome	+ 🖓 -	HqA1C		Eve Exam
Foot Exam	11	Framingham Risk Scores		Previous		Naconhanyny
Monofilament	11	10-Year General Risk	%	eAG		Nasopharynx
HgbA1C	11	10-Year Stroke Risk	%	Mean Plasma Glucose	Insulin	Candia Disan
Pneumovax	11	Global Cardio Score	pts	C-Peptide	11	Foot Exam
Urinalysis	11	Weight Management Lin	ids Manageme	nt Fructosamine	11	Neurological Exam
Aspirin C	Yes O No	HPT Management Imr	nunizations	Cholesterol	11	Complications/Education
Statin	Tes No			LDL	11	ComplicationarEducation
ital Signs	16/- 1-4	Finger Stick	_	HDL	11	Initiating Insulin
	vvaist	Glucose		Triglycerides		Insulin Pump
veight	Hips	Pulse		Trig/HDL Ratio		Lifestyle Changes
MI	Chest	Blood Press		Glucose		Lifestyle Changes
ody Fat %	Abdomen	0.00	1	Fasting		Diabetes Plan
rotein Req	Ratio	BP Ir	Diabetics	Insulin		Education Booklet Given C
MR J	BER	Vitals	Over Time	HOMA-IR		11
				K		Diabetes Education
urrent SQ Insulin D	ose as of //	Blood Suga	rs	Magnesium	11	Telephone Decord
ne of day Units I	ype Units	lype mg/dl		BUN	11	
0.00	0.00			Creatinine	11	Last DE / /
0.00	0.00		Diary	- U Microalbumin	11	
0.00	0.00			Albumin/Creat	11	
0.00	0.00			Urinalysis	Labs Over Time	Manual Lab Results

Click on the button entitled **Diabetes** and the Disease Management tool is launched.

All of the evaluation and documentation which you have done on GP Master will populate this tool as well. While this tool can be used as a complete guide to the treatment of diabetes, it may also be used for our current purpose.

To use the tool for Treatment Plan and Plan of Care, make certain that the "10 Gm Monofilament foot examination" has been done. You will find that examination by clicking on "**Foot Exam**" above

From the Diabetes Management template, click on the navigation button entitled **Lifestyle Changes**.

Diabetes		ement e-Diabetes Other Mo	Diabetes Sin	ce Patient Chart	QTes 43 Sex	M	Navigation
Joslin Treatn Diagnostic Criteria	nent Goals <u>Screening Cr</u>	mp Diabetes Concepts iteria Evidenced-Base	ed Recs	Current Frequ	ency of SMBG		Diabetes O General     Return
Adherence Dental Care Dilated Eye Exam	11	Smoker E-mail	+ 0 - + 0 -	Most Recent Labs	Check for New	Labs	Diab Sys Review Diabetic History
Flu Shot Foot Exam Monofilament		Framingham Risk Scores		Previous			Eye Exam Nasopharynx
HgbA1C Pneumovax		10-Year Stroke Risk Global Cardio Score	% % pts	eAG Mean Plasma Glucos C-Peptide		Insulin	Cardio Exam Foot Exam
Aspirin C Statin	Yes O No Yes O No	Weight Management         Lip           HPT Management         Imm	<u>ids Management</u> nunizations	Fructosamine Cholesterol			Neurological Exam Complications/Education
Vital Signs Height 0.00 Weight	Waist Hips	Finger Stick Glucose Pulse		HDL Triglycerides			Initiating Insulin Insulin Pump
BMI Body Fat %	Chest Abdomen Ratio	0.00 Bp //	Ure /	Glucose Fasting			Lifestyle Changes Diabetes Plan
BMR	BER	Vitals	over Time	HOMA-IR Na		_	Education Booklet Given On
Current SQ Insulin I Time of day Units	Oose as of / Type Units 0.00	/ Blood Suga Type mg/dl	rs	K Magnesium BUN		Ξ	Telephone Record
0.00 0.00 0.00	0.00 0.00 0.00		Diary	U Microalbumin Albumin/Creat		=	Manual ab Desuits
				Urinalysis	Labs over Th	lie	

You will then see the following template

Diet Type	Print	Information	Return
rinciples of Dietary	/ Management for Diabetes	Health Risks and Obesity	
Caloric restrictio	on to achieve weight loss	Consequences of Couch Potato	
Carbohydrate-lin	mited diet	Benefits of Physical Activity	
<ul> <li>Uniform distribution of calories throughout the day</li> <li>No caloric intake after 6-7 PM (will result in lower first morning blood sugar levels)</li> <li>Very high fat meals may result in delayed hyperglycemia</li> <li>Limit alcohol consumption (no more than 2 drinks per day)</li> </ul>		"Diabetic Diet"	
		Print All	
Poor dental hygiene	is associated with complications in diabetic patients	Importance of Glycemic Index	
Encourage p	atient to clean teeth with flossing daily	Applying the Glycemic Index	
Encourage annual dental examination and teeth cleaning		Glycemic Load	
Europeico Milita	ht Management Condition	Processing and Glycemic Level	

This template automatically selects the **Principles of Dietary Management for Diabetes**. Click on **Return**.

et Type Print	Information	Return		
inciples of Dietary Management for Diabetes	Health Risks and Obesity			
Caloric restriction to achieve weight loss	Consequences of Couch Potato			
Carbohydrate-limited diet	Benefits of Physical Activity			
Uniform distribution of calories throughout the day	"Diabetic Diet"			
<ul> <li>No caloric intake after 6-7 PM (will result in lower first morning blood sugar levels)</li> <li>✓ Very high fat meals may result in delayed hyperglycemia</li> </ul>	Print All			
Limit alcohol consumption (no more than 2 drinks per day)	Glycemic Information			
Poor dental hygiene is associated with complications in diabetic patients	Importance of Glycemic Index			
I ✓ Encourage patient to clean teeth with flossing daily	Applying the Glycemic Index			
I ← Encourage annual dental examination and teeth cleaning	Glycemic Load			
Evercise Weight Management Smoking Cessation	Processing and Glycemic Level			

This returns you to the Diabetes Management template.



Now, click on **Diabetes Plan.** This launches the Diabetes Plan template.

Meal Requirements Calc	Diabetes Plan
Total Daily Dose	Total Meal Dose Pre-lunch General Measures
Basal Requirement	Pre-breakfast Pre-dinner Help Consortium Data Set
Total Daily Dose         Basal Requirement         Laboratory & Procedures         Ordering Provider         BMP         Creatinine         Creatinine         Flu Shot         Flu Shot         Hepatic Profile         Hepatic Profile         Micral Strip         Micral Strip         Micral Strip         TSH         Venipuncture         Assessment         Dx1         Dx2	Diabletes       Tell       Perture         Total Meal Dose       Pre-lunch       General Measures       Consortium Data Set         Pre-breakfast       Pre-dinner       Help       Consortium Data Set         Patient Goal This Visit       Comments       Comments         Patient Goal This Visit       Comments       Follow Up Document         Phone glucose data into our office in 7 days       HgbA1C Treat Goals       Document         Phone glucose data into our office in 7 days       Refer to eye specialist       Education and Eye Referrals         Follow Up Visit       Education and Eye Referrals       Priority Referring First Referring Last Referral         Medications       4       Image: Start Aspirin 325 mg       Double-Click to View/Add Meds         Begin © Increase © Decrease © Stop       to       mg       Brand Name         Begin © Increase © Decrease © Stop       to       mg       Brand Name         Begin © Increase © Decrease © Stop       to       mg       Brand Name         Begin © Increase © Decrease © Stop       Insulin Pump       Comparison of Human Insulin         Conditions - Glycemic Control       Drugs - Glucose Levels       Bean@lepu.lepu.lepu.lepu.lepu.lepu.lepu.lepu.
Dx3   Chronic Conditions EM Cod	You MUST click "Save" above after entering new insulin information.     Incretins       Ing     Sliding Scale     Insulin Over Time

You may review the **Consortium Data Set** from this template or from the **Medical Home Coordination Review** template. Once you review the Consortium Data Set to make sure that your comprehensive diabetes measures have been met, click on **Follow-up Document**. This creates the Follow-up document which has all of the elements of a written Treatment Plan and a written Plan of Care.

- Print this document and give it to the patient. (You should review one of these documents so that you can tell your patient what this document contains and what you want them to do with it.)
- Make sure they receive the Follow-up Document before they leave the clinic.
- If you do significant modifications to the Treatment Plan and/or Plan of Care after reviewing the patent's lab work, re-create the Follow-up Document and have it mailed to the patient.

You are through. You have produced a document which is educational to the patient and which meets a standard of care of which you can be proud.

# Lipid Treatment Plan and Plan of Care

You will find the Lipid Diabetes Disease management Tool by going to AAA Home

Patien	t Chart Home Phone ( Work Phone Cell Phone	QTest 409)833-9797 ( ) - ( ) -	Sex M Date of Birth ( <b>Patient h</b>	Age 43 06/30/1970 as one or n <u>Click Herr</u>	Patient's Code	Status
<u>Pre-visuprev</u>	entive screening		Bridges to Exce <u>View</u>	ellence	Intensiv <u>Trans</u>	e Behavioral Therapy atheoretical Model
Preventive Care SETMA's LESS Initiative I Last Updated // Preventing Diabetes I Last Updated // Preventing Hypertension I Smoking Cessation I Care Coordination Referral PC-MH Coordination Review Needs Attention!! HEDIS NGF PQRS ACO Elderly Medication Summary STARS Program Measures Exercise Exercise I CHF Exercise I Diabetic Exercise I	Template Suite Master GP T Pediatrics Nursing Home Ophthalmology Physical Thera Podiatry Rheumatology Hospital Care Hospital Care Daily Progress Admission Ord	I ( ABPY Summary I Note lers I	Disease Manager Diabetes I Lipids I House coronal S Angina I Asthma Cardiometabolic R CHE I Diabetes Educatio Headaches Renal Failure Weight Managemet	nent Lasti in isk Syn I isk Syn I in in in in in in in in in in	Updated ( / / ) (	Special Functions Lab Present I Lab Future I Lab Results I Hydration I Nutrition I Guidelines I Pain Management Immunizations Reportable Conditions Information Charge Posting Tutorial Drug Interactions I E&M Coding Recommendations Infusion Flowsheet Insulin Infusion
Patient's Pharmacy	Pending Ref	errals <u>T</u> Priority	Referral	Referring Provi	ider	Chart Note - Now
Phone () - Fax () - Rx Sheet - Active Rx Sheet - New Rx Sheet - Complete Home Health	1				Þ	Return Info Return Doc Email Telephone Records Request Transfer of Care Doc

Click on the button entitled Lipids and the Lipids Disease Management tool is launched.



All of the evaluation and documentation which you have done on GP Master will populate this tool. While this tool can be used as a complete guide to the treatment of lipids, it may also be used for our current purpose. In order to make use the Fredrickson Classification function, click on the **Check for New Labs button**.

To use the tool for Treatment Plan and Plan of Care, click on **Assess from Labs** button at the lower left hand corner of the template.



If the patient's lipid pattern matches one of the phenotypes in the Fredrickson Classification, it will be automatically denoted and an education document on that type will be added to the patient's Lipid Follow-up Document. This will be done automatically.

If you want to review this patient's specific lipid-phenotype document, click on the button entitled **Info** at the bottom left of the template. If no type is automatically selected but you wish to assign one, just check the appropriate box.

If you wish to review the six phenotypes in the Frederickson Classification click on the button entitled **Help** also at the bottom left of the template.

Next click on the navigation button entitled Lifestyle Changes.



On the Lifestyle template, check the box by any of the diets which apply to your patient. You can click as many as apply. All of the diets which are checked will appear on your Lipid Follow-up Note.

Lifestyle Chang	ges	
Goals		Navigation
Recommended Actions	Patient Information	Lipids Master
Diets	(Automatically Prints)	Lipids System Review
High Soluble Fiber	Alcohol and Lipids	Extremity Exam
Low Carbohydrate	BMR Changing It	Eye Exam
Low Fat	Dining Out	Cardio Evam
No Such	Dyslipidemia and Inactivity	Lipids Plan
35 % Calories from Fat	Exercise and Weight Loss	_
Weight Loss Initiative	Foods to Eat, Avoid	
BMR Cavday	Inactivity and Cholesterol	
Exercise Prescription	Step I, II Diets and Fiber	
Recommend CPET	Step I, II Diets - Description	
Change Dietary Habits	Training Intensity and Lipids	
	Transfats and LDL	
Creating an Electronic Tickler File 1. Open Microsoft Outlook by clicking on the e-mail button 2. Address the e-mail to your unit clerk, your nurse and yourself 3. Click on the "options" button at the top, right of the Microsoft Outlook 4. Find "delivery options" on the "options" pop-up 5. Click on "do not deliver before" 6. Select a date, preferably a Monday, one month hence 7. Close the "option" pop-up 8. Send your e-mail, its delivery will be delayed for one month, at whic The unit clerk will be responsible for calling the patient to seet they haven't admonish them. If they fail to quit in two to three them from the program.	tool bar h time it will appear on your unit clerk's e if they have quit smoking. If the e months, serious consideration s	s, your nurse's and you own desktop. y have, congratulate them; if should be given to removing

Click on the Lipid Plan navigation button. (see above Lipid Plan button in green)

	Linids Management Plan	Navigation
		Lipids Master
Cholesterol	Patient Goal This Visit	Lipids System Review
	Medications	Extremity Exam
LDL-Remnant	Continue Current Medications Choosing A Drug Interactions	Eve Exam
Lp(a)	O Begin O Increase O Decrease O Stop to mg	Cardio Exam
	O Begin O Increase O Decrease O Stop	
LDL Pattern B	O Begin O Increase O Decrease O Stop	
VLDL	O Begin O Increase O Decrease O Stop	Treatment Audit
Triglycerides	Double-click to Order Meds Deced Verse	Document
HDL2	Brand Name	Follow Up Document
hsCRP	Assessment	
Summary of Orders	Laboratory Ordering Provider	Information
	CPK Dx1	Recommended Measures
	Lipio Panel W/LDL Dx2	Tx Methods, New Evidence
	Dx3	Brand, Generic Drug Names
	Lipoproteins Dx4	Comparison of Lipid Drugs
1	hsCRP	Bile Acid Sequestrants
	Homocystiene	Lipid Statins
	Triglycerides	FIDRIC ACID DERIVATIVES
	Follow In	Zetia
	Acute Routine	Omage 2 Eatty A sid=
		Omega-5 Fatty Acids
		Rolaxiterie

Note any changes in medications or note to "**continue current medications**". Then click on the **Follow-up Document**. Print this document and give it to your patient. You are done.

# Hypertension Treatment Plan and Plan of Care

You will find the Hypertension Disease management Tool by going to AAA Home

Patie	ent Chart Home Phone ( Work Phone Cell Phone	QTest 409)833-9797 () - () -	Sex M Date of Birth Patient	Age 43 06/30/1970 has one o Click	Patient's C	ode Status
Pre-Vist/Preventive Screening			Bridges to Excellence Intensive Behavioral Therapy <u>View</u> <u>Transtheoretical Model</u>			
Preventive Care SETMA's LESS Initiative T Last Updated // Preventing Diabetes T Last Updated // Preventing Hypertension T Smoking Cessation T Care Coordination Referral PC-MH Coordination Review Needs Attention!! HEDIS NQF PQRS ACO Elderly Medication Summary STARS Program Measures Exercise Exercise T CHF Exercise T Diabetic Exercise T	Template Suit <u>Master GP</u> <u>T</u> <u>Pediatrics</u> <u>Nursing Home</u> <u>Ophthalmolog</u> <u>Physical Ther</u> <u>Podiatry</u> <u>Rheumatology</u> <b>Hospital Care</b> <u>Hospital Care</u> <u>Daily Progress</u> <u>Admission Ord</u>	es : I Y apy : Summary I s Note ders I	Hypertension Hypertension Acute Coronary Acute Coronary Angina I Asthma Cardiometabolic CHF I Diabetes Educa Headaches Renal Failure Weight Manage	ement L I Syn I Risk Syn I tion	ast Updated / / / / / / / / / / / / / / / / / / /	Special Functions Lab Present I Lab Future I Lab Results I Hydration I Nutrition I Guidelines I Pain Management Immunizations Reportable Conditions Information Charge Posting Tutorial Drug Interactions I E&M Coding Recommendations Infusion Flowsheet Insulin Infusion
Patient's Pharmacy	Pending Re	ferrals <u>T</u>				- Chart Note - Now
	Status	Priority	Referral	Referring F	Provider	Chart Note - Offline
Phone () -	-					Return Info
Fax () -	1					Return Doc
Rx Sheet - Active						Email
Rx Sheet - New						Telephone
Rx Sheet - Complete	•				)	Records Request
Home Health						Transfer of Care Doc

Click on the button entitled **Hypertension** and the Hypertension Disease Management tool is launched.

Hypertension Management Patient Chart	QTest
Guidelines Age	43 Sex M Return
Reginning Blood Pressure Highest Blood F	Dippers and White Coat
	/ 0 HPT and Diabetes
Vital Signs Major Disk Factors	HPT and Depression
Blood Pressure Pulse Pressure Tobacco Use	Calculate Assessment HPT and the Elderly
Trial 1 / 0 Dyslipidemia	Blood Pressure Classification HPT, Insulin Resistance
Trial 2 / Diabetes Mellitus Family Hx of CV Disease	Isolated Systolic HPT
Male < 55	Recommended Follow Un
Pulse Female < 65	Evaluation
Weight pounds Vale	Risk Group Diagnosis and Screening
BMI Postmenopausal Female	tment Based on Disk Assessment Lifestyle Changes
Body Fat % Additional Risk Factors	Treatment
Waist inches CAD	HPT Plan
Ratio 0.00	Physician Role
Framingham Dink Sooren	
10-Year General Risk 6.7 % Renal Insufficiency	Patient Information
10-Year Stroke Risk 1 %	Lab Results Physician Information
Global Cardio Score43.1 pts	Labs Over Time Classification
Metabolic Syndrome - O + O	Risk Stratification
Vitals Over Time	

All of the evaluation and documentation which you have done on GP Master will populate this tool as well. While this tool can be used as a complete guide to the treatment of hypertension, it may also be used for our current purpose.

In order for this to fulfill all of the NCQA requirements for hypertension, you must click the button entitled **Calculate Assessment** 

			-	c					Navigation
Hyperte	nsion Manage	ement Pa	tient	Chart		QTest			
	Guidelines		A	Age	43	Sex	М		Return
	Beginning Blood Pres	sure Hi	inhest	Blood	Press	ure			Dippers and White Coat
			/ /		0 /	0			HPT and Diabetes
Vital Signs		Major Risk Factors						_	HPT and Depression
Blood Pressure	Pulse Pressure	Tobacco Use			C	alculate /	Assessmen	t	HPT and the Elderly
Trial 1 /	0	Dyslipidemia			Blood	Pressur	e Classifica	ation	HPT, Insulin Resistance
Trial 2 /		Family Hx of CV Diseas	se	T					Isolated Systolic HPT
Dulas		Male < 55			Re	commenc	ed Follow-	Un	HPT and Kidney Disease
Height 0.00	inches	Sex			100				Evaluation
Weight	pounds	Male				Risk	Group		Diagnosis and Screening
BMI		Postmenopausal I	Female	_		Decede	- Distriction		Lifestyle Changes
Body Fat	%	Additional Risk Factors	s		reatmen	t Based o	IN RISKASS	essment	Treatment
Waist	inches	CHF							ireatment
Hips	inches	T TA							HPT Plan
Ratio 0.00		Stroke							Physician Role
Framingham Risk S	COTES	Peripheral Vascular Di Renal Insufficiency	sease						Patient Information
10-Year Stroke	Risk 1 %	Retinopathy				Lab F	esults	1	Physician Information
Global Cardio S	core -43.1 pts					Labs O	ver Time		Classification
Metabolic Syndrom Vitals O	ne - O + O verTime				345				KISK Strauncation

This displays the:

- Blood Pressure Classification,
- Risk Group,
- Recommendation and Treatment Plan based on the Risk Group.

All of these are elements of quality measures for hypertension.

Now, in order to use the tool for Treatment Plan and Plan of Care, click on the navigation button entitled **Lifestyle Changes**.

This will display a template which addresses the major lifestyle changes which will significantly influence blood pressure, along with the potential reduction in systolic pressure which can be achieved by each. All of these will be automatically selected and they will also appear on your Treatment Plan and Plan of Care for hypertension.

Lifestyle Char	nges	· · · · · · · · · · · · · · · · · · ·
Recommended Actions The numbers in parethesis indicate the approximate reduction in Sy	ystolic Blood Pressure for each lifestyle change.	Return
<ul> <li>Eliminate or reduce alcohol consumption to 2 drinks per day (2-4 mmHg)</li> <li>Eliminate or reduce caffiene intake</li> <li>Take measures to reduce and control stress</li> <li>If you are overweight, lose weight (5-20 mmHg/20 lb wt. loss)</li> <li>BMI</li> <li>BMR</li> <li>calories/day</li> <li>Exercise (4-9 mmHg)</li> <li>Smoking Cessation</li> <li>Email</li> </ul>	<ul> <li>Change dietary habits</li> <li>Increase potassium intake</li> <li>Increase calcium intake</li> <li>Maintain adequate magnesium intake</li> <li>Increase fish oils</li> <li>Reduce salt intake to no more than 2.4 grams/day (2-8 mmHg) What Is A Low Sodium Diet?</li> <li>DASH Diet (8-14 mmHg)</li> <li>Monitor your blood pressure and keep a record</li> <li>Be sure to take your medications as indicated</li> </ul>	Information Alcohol, Coffee, Cigarettes

You ought to review the information on this template. There is also the ability for documenting Exercise and Smoking Cessation on this template. Click on **Return**, which will display the Hypertension Master template.

Hyperte	nsion Manage	ment Patient	Chart QTest	Navigation
	Guidelines	· · · · · · · · · · · · · · · · · · ·	Age 43 Sex M	Return
	Beginning Blood Pres	sure Highest	t Blood Pressure	Dippers and White Coat
[	// 0 /			HPT and Diabetes
Wital Signa		Major Dick Fastore		HPT and Depression
Blood Pressure	Pulse Pressure		Calculate Assessment	HPT and the Elderly
Trial 1 /	0	Dyslipidemia	Right Property Classification	HPT, Insulin Resistance
Trial 2 /		Diabetes Mellitus	Dibbe Pressure classification	Isolated Systolic HPT
Trial 3 / /		Male < 55	Deserves ded Fellow He	HPT and Kidney Disease
Pulse	inches	Female < 65	Recommended Follow-up	Evaluation
Weight	pounds	Male	Risk Group	Diagnosis and Screening
вмі	•	Postmenopausal Female	Treatment Based on Disk Assessment	Lifestyle Changes
Body Fat	%	Additional Risk Factors		Trestment
Waist Hips	inches	CAD		HPT Plan
Ratio 0.00		TIA Stroke		Physician Role
Framingham Risk S	icores	Peripheral Vascular Disease		Patient Information
10-Year Genera	al Risk 6.7 %	Renal Insufficiency		Click for Documents
10-Year Stroke	Risk 1 %	Reunopauty	Lab Results	Physician Information
Global Cardio Se	core -43.1 pts		Labs Over Time	Classification Risk Stratification
Metabolic Syndrom	<u>1e</u> - O + O			
Vitals O	ver Time			

Now click on the button entitled HPT Plan. You need to do three things on this template:

- Complete the section on whether to "continue current medication" or "add or change a medication"
  - Then click on the button entitled **Follow-up Note**.
  - Then click on
  - Return.

Laboratory	Hypertension Plan		
Ordering Provider	Patient Goal This Visit		Return
CBC BMP Uric Acid Urinalysis Micral Strip Spot A/C Ratio Lipid Profile w/LDL Plasma Renin Activity Thyroid Profile Venipuncture Procedures EKG Echocardiogram Renal Artery Ultrasound	Medications         Continue current medications         Begin       Increase         Decrease       Discontinue         General/Dosing Information       General/Dosing Information         Double-click to Order Meds       Double-click for Referring         Priority       Referring First         Image: State S	ng Last Referral	Comments Follow-Up Doc Document Information (Auto-Print) HPT Medications Antihistamines Cautions About OTC Meds OTC Meds and Hypertension
Ambulatory BP Monitoring Assessment Dx1 Dx2 Dx3	Follow Up     Call Your       Acute     Take Care       Routine     OTC Me	Doctor If of Yourself	
	EM Coding OTC Me	dications	

When you click on the Follow-up note, this creates note which you should give to the patient. It will also have material on the DASH diet and a low sodium diet.

This note will fulfill all of the requirements for a written Template Plan and for a written Plan of Care. When you click **Return**, it will take you back to the Hypertension Master template.

Hyperte	nsion Manage	ement Patient Cr	art QTest	Navigation
	Guidelines	Ag	e 43 Sex M	Return
	Peginning Plead Dree	Nouro Highoot Pl	lood Brossure	Dippers and White Coat
				HPT and Diabetes
Witel Ciene		Major Diak Fastara		HPT and Depression
Blood Pressure	Pulse Pressure		Calculate Assessment	HPT and the Elderly
Trial 1 /	0	Dyslipidemia	Right Brassure Classification	HPT, Insulin Resistance
Trial 2 /		Eamily Hy of CV Disease		Isolated Systolic HPT
Trial 3 / /		Male < 55		HPT and Kidney Disease
Pulse		Female < 65	Recommended Follow-Up	Evaluation
Height 0.00	inches	Sex Male	Risk Group	
Weight	pounds	Postmenopausal Female		Diagnosis and Screening
BMI			Treatment Based on Risk Assessment	Lifestyle Changes
Body Fat	%	Additional Risk Factors		Treatment
VValst	inches	CAD		HDT Dian
Ratio 0.00	inches			Physician Pole
Francisco Pictor		Stroke		Physician Role
rramingnam Risk a	cores	Penal Insufficiency		Patient information
10-Year Genera	al Risk 0.7 %	Retinopathy		Click for Documents
10-Year Stroke	Risk 1 %		Lab Results	Physician Information
Global Cardio S	core -43.1 pts		Labs Over Time	Classification Risk Stratification
Metabolic Syndrom	<u>1e</u> - O + O			
Vitals 0	ver Time			

You may assess whether you have completed all of the appropriate measures for hypertension by clicking on the navigation button at the right of the template entitled **Physician Role**.

Physician Role in Hypertension Management
<ul> <li>Blood pressure measured at least once this visit</li> <li>Blood pressure measurement repeated if elevated</li> <li>Blood pressure classification determined</li> <li>Weight reduction discussed/recommended</li> <li>Sodium intake discussed/changes recommended</li> <li>Alcohol intake discussed/changes recommended</li> <li>Exercise discussed/recommended</li> <li>Appropriate follow-up scheduled</li> </ul>
Generate a follow-up document for the patient at least yearly Date Last Generated // OK Cancel

This same material can be reviewed from the Medical Home Coordination Review Template. Once you have reviewed this template, click **OK**. You are done.

To use these three disease management tools to create robust, personalized, specific and complete Treatment Plans and Plans of Care not only meets NCQA requirements, but improves the quality of care which you will be giving to the members of your Medical Home. Even if your patient has diabetes, hypertension and dyslipidemia, as many of our patients do, it takes only a couple of minutes to complete these tasks and to produce the documents which fulfill one of the most complex NCQA requirements. Once you give these documents to your patient, instruct them to read them and at their next visit review anything they do not understand, you have taken another step toward excellence.