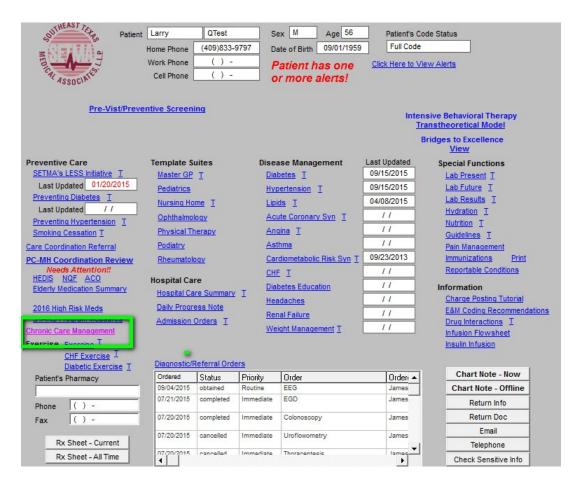
# James L. Holly, M. D.

#### The Chronic Care Management Code (CCM) Tutorial

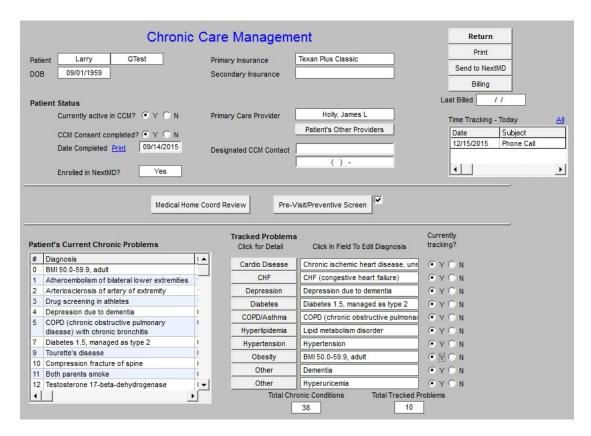
Current format of The Chronic Care Management (CCM) Code was instituted by CMS in January 2015. It was first proposed in 2013 with a projection of beginning in 2014, but the requirements were such that it would have been virtually impossible for a primary care provider to successfully use it.

When the final version was released, changes had been made such that it could be used. Because the compliance requirements were specific and significant, SETMA decided not to deploy it until we had built a tool so that we could efficiently fulfill the billing demands and so that we could internally audit those requirements to prove that we were meeting all of the demands. The tool would also allow us easily to respond to a CMS audit if one were initiated.

SETMA's deployment of Chronic Care Management can be found on the AAA Home template, as shown below outlined in green.



When the CCM button, outlined in green above, is deployed, the following Master CCM Template will appear. The master template is organized into five sections which will be explained individually.



The first section shown below is organized into three columns with a bottom section containing two functions.



The first column includes the patient's name and date of birth, which are automatically added to the template, followed by the **Patient Status** which includes the following information, which must be added by the provider:

- Currently active in CCM yes or no
   CCM Consent completed yes or no
- Date Consent completed
- Enrolled in NextMD? (this is SETMA's web portal)

The second section displays the following functions:

- **Primary Insurance** (for the CCM this will be Medicare Fee-for-Service)
- **Secondary Insurance** (this is important because the patient will have a co-pay for CCM, which cannot be waived, while most of our patients cannot afford to pay the co-pay.
- Primary Care Provider
- Patient's Other Providers this button interacts with a similar function in the EMR
- **Designated CCM Contact** with telephone number

The Third Column includes the following:

- **Return** button which takes you back to the main EMR
- **Print** this launches the printing of the current CCM document
- **Send to NextMD** this sends the current summary document to the web portal from which the patient can access the document
- **Billing** this launches the **CCM Billing Requirement Check** (Note: this automatically audits whether all required functions have been completed for the current contact to be billed)
- Last Billed this alerts the provider to when the CCM was last billed.
- Time Tracing Today see explanation below

#### **CCM Billing Requirement Check**

**Billing** -- launched when the Billing button, seen above, is deployed. When all requirements are met, the notice seen below in green will appear which states: "You may bill a Chronic Care Management (CCM code for this patient. You may select the code below and when you click "OK' the charge will be sent for billing."

riteria		
	ve two or more chronic conditions?	Yes
Total Chronic C		
death of the patient	the chronic conditions expected to last at least 12 months or until the t, and do they place the patient at significant risk of death, acute mposition or functional decline?	Yes
Total CCM-Eligib	ole/Tracked Chronic Conditions 9	
Has the patient met	with the provider and completed the consent form to initiate the CCM progr	am? Yes
this patient for CCM		Yes
Total Minutes TI	his Month 30	
Has a plan of care	been developed, reviewed and updated (at least monthly)?	Yes
Has a copy of that	care plan been provided to the patient?	Yes
Last Updated	10/29/2015	
clusions		
Has the patient had last 29 days?	a Transitions of Care Management (TCM) code billed within the	No
Is the patient currer	ntly under Home Health supervision?	No
Is the patient currer	ntly under Hospice Care supervision?	No
Does the patient ha	ve ESRD or is the patient on dialysis?	No
	may bill a Chronic Care Managemnt (CCM) code for this patient. elect the code below and when you click "OK" the code wil be sent	for billing.
	99490 - Chronic Care Management Services	

The template shows the requirements for CCM. The elements of this "Chronic Care Management Billing Requirement Check" are automatically and electronically audited. If the patient quantifies on the basis of all of the following, as per the above template, the provider will be alerted that a CCM Code can be billed. The provider can then click the box next to the 99490 CPT Code. Once the "OK" button has been clicked, the billing for the CCM Code will automatically be sent to SETMA's Central Billing Office.

#### The participation and billing requirements for the CCM are:

- 1. The patient must have two or more chronic conditions?
- 2. Are at least two of the chronic conditions expected to last for at least one year?
- 3. Do these chronic conditions place the patient and significant risk of exacerbation, decomposition or functional decline?
- 4. Has the patient met with the provider & completed a consent to initiate CCM program?
- 5. Has there been at least twenty minutes of documented clinical time spent this month spent in managing this patient for CCM services?

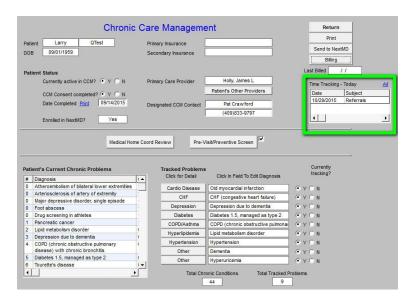
- 6. Has a plan of care been developed, reviewed and updated at least monthly?
- 7. Has a copy of that plan of care been provided to the patient?
- 8. Has the patient been hospitalized in the past twelve months?

#### The following excludes a patient from participating in or receiving CCM services:

- 1. Has the patient had a Transition of Care Management (TCM) code billed within the past 29 days?
- 2. Is the patient currently under Home Health supervision?
- 3. Is the patient currently under Hospice Care supervision?
- 4. Does the patient have ESRD or is the patient on dialysis?

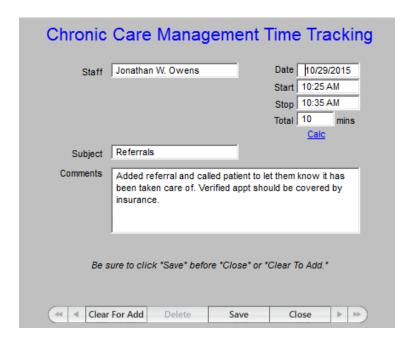
#### **Time Tracking**

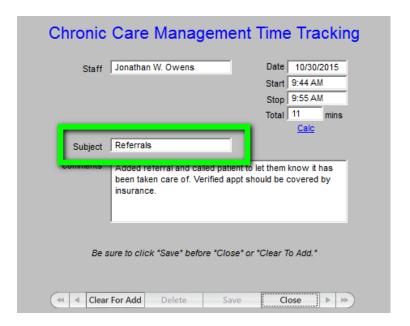
**The Time Tracking – Today** function is seen below outlined in Green. Because the payment for CCM is dependent upon the completion of a 20-minute telephone contact and/or a total of 20-minute time spent on the patient's care including a telephone contact each month, the ability to document and to audit the time spent is an important compliance issue.



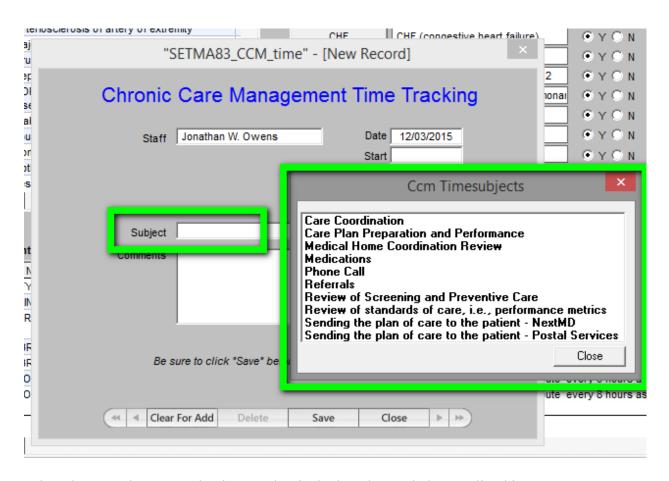
#### This is how the time tracker functions

The provider includes their name, date, start time and stop time of the activity being documented. The provider then documents the type of activity as seen in the "**subject**" below and then adds a descriptive note as to what was done for and with the patient. The "total" time is then automatically calculated. When this function is accessed multiple times during one month, such as completing referrals, or other care coordination functions, and a telephone call, the cumulative time will be noted on the last episode, once again allowing demonstration of compliance with the requirements for billing with this code.

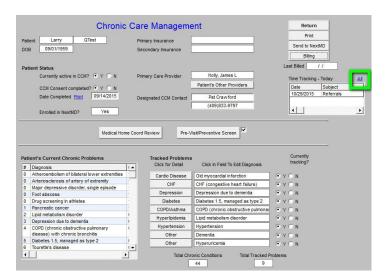




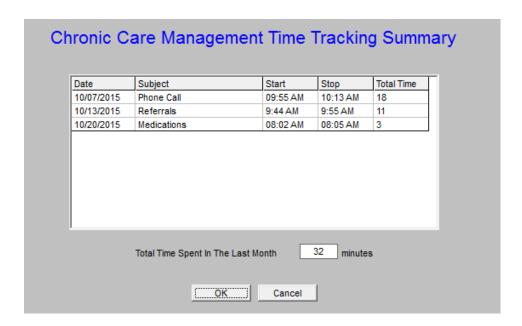
Outlined in green below are the options in a drop down menu for documenting the tasks which were performed in the current CCM call. Others will be added as we have more experience with this function.



When the "All" button on the time tracker is deployed – see below outlined in green – a summary of the time spent in the CCM Code functions is calculated. This will allow SETMA's provider to audit their own performance to make sure that we are remaining in compliance with CMS requirements.

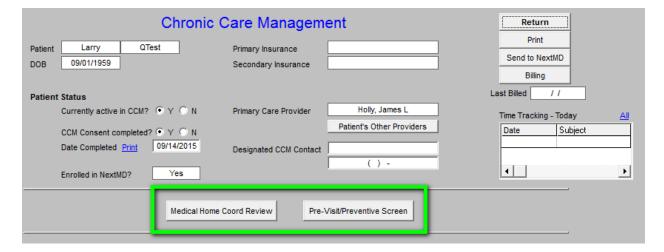


When the "All" button, seen above outlined in green, is clicked, the following summary of "time spent" will be displayed.



At least 20 minutes must be documented each month in order to support the charge for the CCM Code.

The last functions of the first section, which is seen below are the **Medical Home Coordination** Review and the **Pre-Visit/Preventive Screen**. They are outlined in green below.



**Medical Home Coordination Review** 

The details of this template are explained in pages 4-26 at the following link: <a href="http://www.jameslhollymd.com/EPM-Tools/pdfs/tutorial-medical-home-coordination-review-tutorial.pdf">http://www.jameslhollymd.com/EPM-Tools/pdfs/tutorial-medical-home-coordination-review-tutorial.pdf</a>. In relationship to the CCM Code, this template is deployed by clicking on the button seen above. In relationship to the CCM, it is important to assess: **Barriers to Care and Screening** and **Preventive Care**. This can be done as is described in the following two screens.

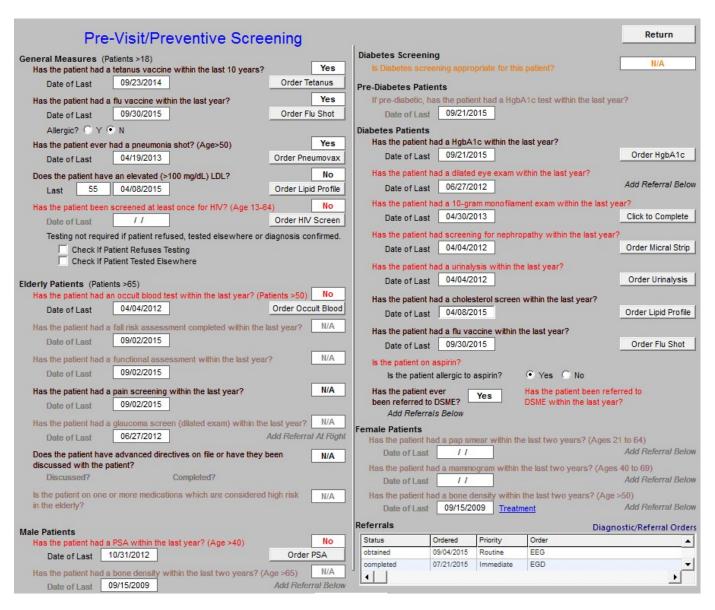
The Barriers to care can be documented with the following details: social, financial, assistive devices should be completed. In addition the following should be completed: the Medical Power of Attorney, Primary Care Giver, and Emergency Contact.

Med	ical Hon	ne Coordir	nation Revie	W		
Patient	And	illary Agencies		Medical Power of Attorney		
Larry QTest	Hom	e Health			()-	Return
Date of Birth 09/01/1959	9 Hosi	pice		Primary Caregiver		
Sex M Age 56 Years		isted Living			( ) -	Transtheoretical Model
COX		sing Home		Emergency Contact		Print Note
Troube Tribing		sical Therapy			( ) -	
Work Phone ( ) -	Fillys	sical filerapy j		Relation		
Language Spoken Chinese						Patient's E-mail Address
Coordination Review Completed	Inday?	Last Reviewe	d //	Compliance		F-1
C Yes C		Lust Novicire	•	Last H&P	11/10/2011	Enter only valid email address here. Do not enter
				Telephone Contact	11	"none" if the patient has no
Patient needs discussed today a	: Care	Last Reviewe	d //	Correspondence	11	email address.
Coordination Team Conference?				Birthday Card	11	Check here if patient does
○ Yes ○	No			Dianay Cara		not have email address or does
ronic Conditions	Care Coord	ination Team	Phone	Evacuation Options		not wish to share it.
Problem Description	Primary MD		( ) -		Contact Information	
Problem Description  Atheroembolism of bilateral I	CFNP		( ) -	Family Name		Student interns are
Arteriosclerosis of artery of	Coordinator		()-		) -	authorized to participate
Major depressive disorder, s	Г					and assist with office visit
Drug screening in athletes	Nurse		( ) -	Advanced Care Planning		and/or education? O Yes
Depression due to dementia	Unit Clerk		()-			○ No
COPD (chronic obstructive p	Seco	nday/Speciality Phy	sicians	Code Status   Full Code		
with chronic bronchitis	Evidence-Ba	sed Measures C	ompliance	Advanced Directives Discus	ssed?	Detail
Diabetes 1.5, managed as ty		Elderly Medication		Yes ○ No	02/25/2015	
Tourette's disease		-		Advanced Directives Comple	eted?	
Compression fracture of spi	_	HEDIS Measures C		● Yes C No Dat		
Both parents smoke		NQF Measures Co			ie	
Testosterone 17-beta-dehyd		Lipids Treatmer		Detail		
Acute confusion following in		Diabetes Physician	Consortium	_		
Yellow mutant oculocutaneo				Barriers to Care N	IONE	Patient Alerts
2 Purple toe syndrome				Social Final	ncial	
Red cell aplasia	Disease Ma	nagement Tools	Accessed		Co-Pays	
Alcohol dependence	Diabetes	Yes Vilo	Lipids @ Yes @ No	F 85-4	Medications	
Chronic ischemic heart disea	Hypertension	Yes 🔘 No	CHF C Yes C N		Nutrition Transportation	
Green monkey disease	Diagnostic/R	eferral Orders			Uninsured	
Two chambered right ventric	Status	Priority	Order -		None	
HIV (human immunodeficience	obtained	Routine	EEG	Language		
Dementia	completed	Immediate	EGD	✓ None		
AIDS	completed	Immediate	Colonoscopy	Assistive Devices	edicare Competitive B	la l
Establishing care with new ( >	completed	Routine	Colonoscopy	_	Splint/Brace	
Listabilishing care with new ( V	1		<b>b</b>	Crutches	Walker Wheelchair	
			Order Manageme		None Vyneeichair	
	Referral His	tory		1 Troductic Linio	none.	
	Status	Referral	Referring Provider			
	Completed	Abdominal U/S	Holly			
	Completed	SETMA Diabetes	Holly			
		Education	90			
	L					
	1		F			
			Click for Detail			
			GIIGK TOT DETAIL			

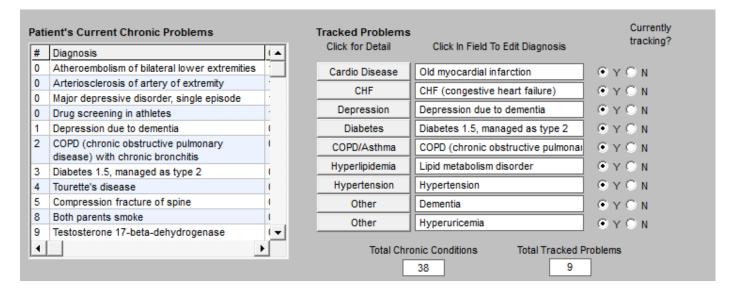
#### **Screening and Prevention**

To fulfill the CCM Code function, it is also necessary to evaluate the patient's screening and prevention care. This can easily be done by clicking the button entitled Pre-visit Screening and Preventive Care. This screen alerts you to assess the healthcare needs which are as yet unmet in the patient's care. During the CCM call, this should be reviewed and if the patient has unmet needs, they should be given an appointment or a referral made for the function to be completed.

When this button is deployed, the following screen appears which automatically alerts the provider to any unfulfilled screening or preventive health needs in the patients care. All elements in red apply to the patient and have not been done; all elements in black apply to the patient and have been done and all elements in grey, do not apply to the patient.



The second section of the Master CCM template is shown below. It has four columns and like the first section, two additional functions are displayed across the bottom of this section.



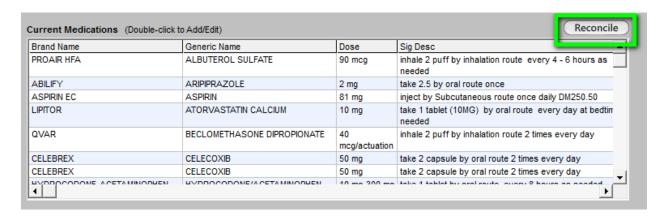
- Because the CCM interacts with the full EMR, the Patient's **Current Chronic Problem list** is automatically display in the first column.
- The second column has a list of **Tracked Problems**. When you click on any of the problems, the details of the tracking will display. There are eight problems (obesity has been added) which are structured with two other options for problems unique to a particular patient.
- The third column is entitled **Click in Field To Edit Diagnosis**. This will allow the provider to select the specific diagnoses from the patient's Current Chronic Problem List.
- The fourth column entitled **Currently Tracking?** allows the provider to denote whether or not a particular diagnosis is currently being tracked. If it is not, this will be left blank.

At the bottom of this section of the Master CCM Template are two boxes which display two numbers which enable SETMA to audit for compliance with the requirements of the CCM.

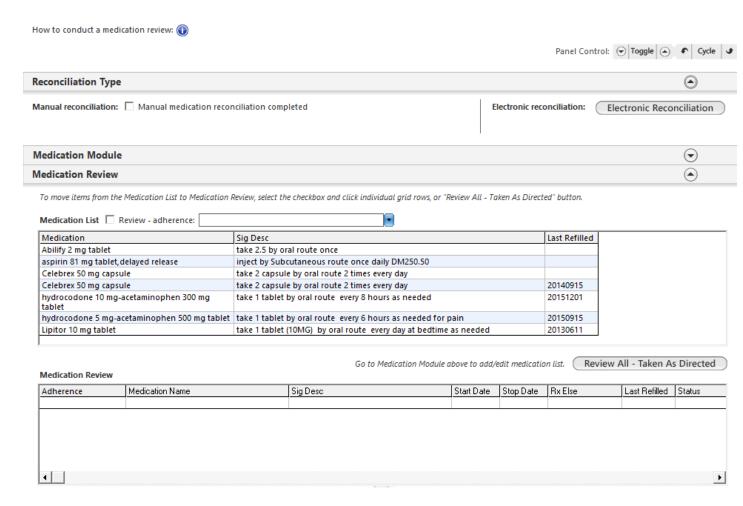
- **Total Chronic Conditions** this automatically displays the number of active diagnoses in the patient's care which meet the criteria for inclusion in the CCM.
- **Total Track Problems** this displays the number of conditions being tracked for this patient.

This allows for efficient auditing of the use of the CCM to make sure we remain compliant.

The third section of the Master CCM Template displays the patient's current, active medication list. The medication list can be reconciled during the call. If the **Reconcile button** outlined in green below is activated, a template appears which allows a medication reconciliation to be completed and documented.



At the top right, there is a button entitled **Reconcile**. When activated, this button launches the following template through which a formal medication reconciliation can be done. Below is what is launched when the button is clicked.



The use of this template is explain elsewhere and will not be repeated here.

The fourth section of the Master CCM Template displays:

- Current Allergies left handed window
- **Referrals** this shows the referrals that are currently outstanding with their status, priorities, content and ordering provider.



At the top right of this section of the template there are two functions which are hyperlinks in blue:

- Care Coordination Referral
- Diagnostic/Referral Orders

Across the bottom of this section there are two other functions:

- Allergies reviewed/updated today -- A check box for documenting that the allergies were reviewed on this day's telephone call.
- Community Resources a list of agencies which can provide services needed by patients.

These four functions are described below.

#### **Care Coordination Referral**

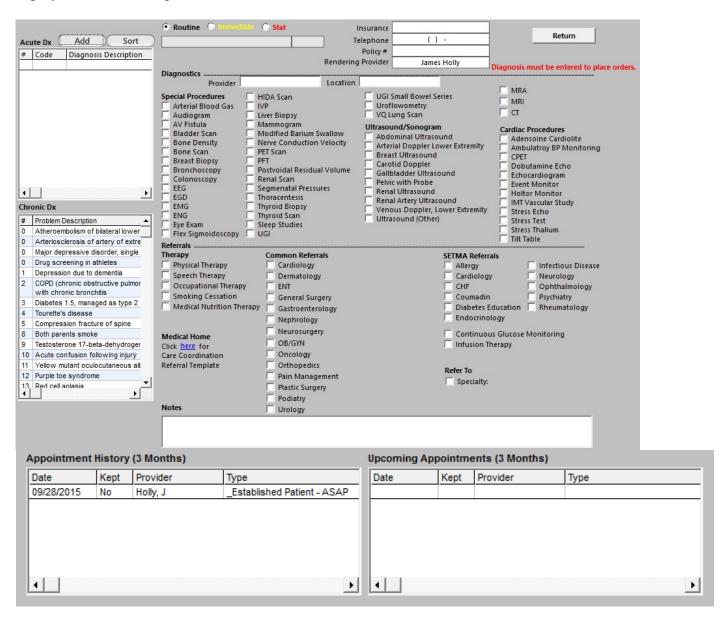
It is with this template that patients are referred for additional care and/or for financial asisstance from the SETMA foundation. All referrals are managed by SETMA Care Coordination Department. The options are directed by the template.

Patient Larry QTest  DOB 09/01/1959 Sex M  Please provide care coordination for this part of the provide care care care care care care care car	Home Phone (409)833-9797  Work Phone () -  patient in the areas selected below.  SETMA Foundation Dental Care DSME Living Expenses Medication MNT Procedures Transportation Other  Provider Comments
Protective Services, Child Tobacco Cessation	
Click to Send to Care Click once and the request	e Coordination Team t will be automatically sent.
	am Only) Click To Send Response

Once the needed services are noted by clicking in the box next to the functions in the first and second collumn and once any comments are placed in either of the comment boxes seen above, the button in red entitlled "Click to Send to Care Coordination Team" is deployed. The refferal is then sent to Care Coordination and the button's color is changed to green.

#### Diagnostic/Referral Orders

This is SETMA's Refferal tempaltetemplate. It works with SETMA's referral depatemnt and is deployed from this template and/or from our EMR.



This is a list of **Community Resources** which are available to our patients.



SETMAI - 2929 Calder, Suite 100

0 SETMA II - 3570 College, Suite 200 Lumberton - 137B LHS Drive Nederland/Port Arthur - 2400 Highway 365, Suite 201 Orange - 610 Strickland Drive, Suite 140

Mark Wilson Clinic - 2010 Dowlen

(409) 833-9797 www.setma.com

## Community Resources

**Alcoholics Anonymous** - 832-1107 Contact for locations and times of local meetings. There are many groups in the area and meetings daily.

**Alzheimer's Association** – local chapter 833-1613 24/7 Helpline 800/272-3900 Support groups, Morning Out Club, in-home care consultation, newsletters. Clarissa for referral to the association 291-2591.

APS – Adult Hotline 1-800-252-5400 For emergency situations, a case worker will be at the home within 24 hours. For non-emergency situations, a case worker will be at the home with in 2 weeks.

Area Agency on Aging – 409/924-3381ext 6277 Benefits Counseling, Care Coordination for assistance in securing temporary non-medical services such as personal care, home delivered meals, caregiver relief, homemaker/light housekeeping, health maintenance and emergency response devices. This agency has to be contacted by the person needing assistance or their family members. The agency is no longer permitted to accept information from any one else due to privacy issues.

Behavioral Health Center at Baptist Hospital (formerly the Fanning Pavilion) 409/212-7000. Direct line to admissions – 212-7019. Treatment programs for all ages including children, adolescents, young and mature adults and senior citizens. Their illnesses and emotional problems vary widely from mood disorders such as depression to alcohol or drug abuse/dependency. The scope of individual treatment ranges from acute inpatient care to day treatment and outpatient services.

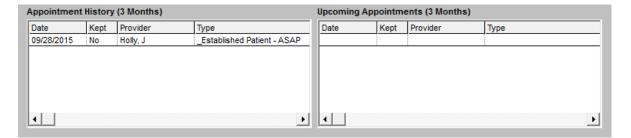
Best Years Center – 838-1902 Activities daily for seniors including dominoes, bridge, low impact aerobics, quilting, art projects, line dancing, computer classes and many others. Hot lunches are also served for a \$2.00 donation.

Caring Hearts 833-7062 – Provides in-home sitter services at a rate of \$10.00 per hour. Helpful to caregivers needing time to do errands or have a day out.

Family Services 409/833-2668 Family Services of Southeast Texas serves families and individuals in crises. Family Services Counseling Center provides healing to individuals and families who are facing a variety of issues that affect families, such as grief, stress, parenting challenges, marital difficulties, substance abuse and more. Family Services Women and Children's Shelter provides hope to all victims of domestic violence.

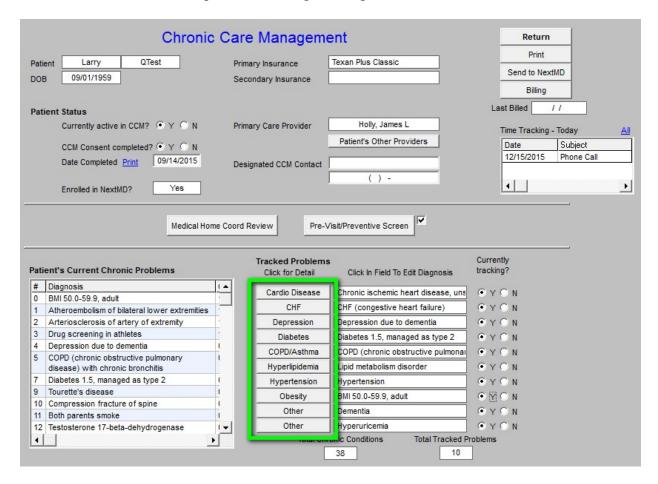
The fifth section of the CCM Master Template displays:

- Appointment History (3 Months)
- Upcoming Appointments (3 months)



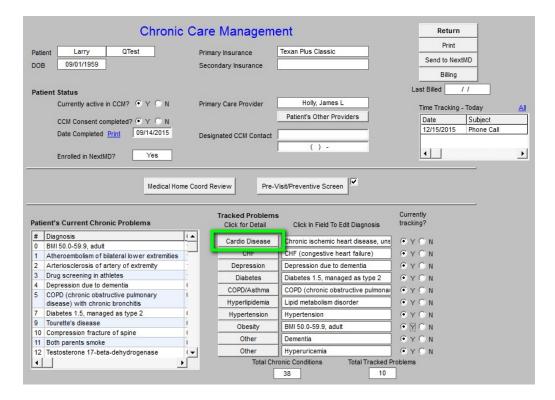
Structured Data for Following the Chronic Care Conditions

Structured data fields are provided for 8 conditions which are outlined in the green box below. These represent the most common Chronic Conditions examined in CCM. Other diagnoses can be added in the "other" fields. To the left of that box, there is a list of the patient's **Chronic Conditions**. This allows the provider making the telephone call to ask about other conditions.

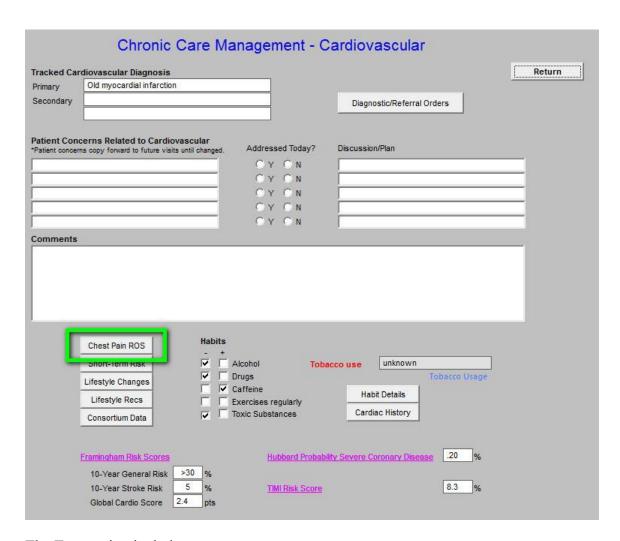


### The following are structured-data fields for the monitoring of needs and statuses of each of these conditions.

#### **Chronic Care Management for Cardiac Disease**

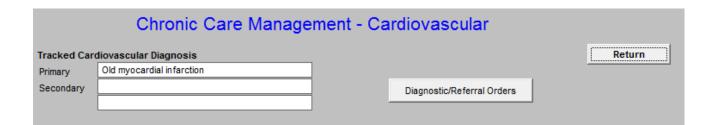


Below is the template which is deployed by clicking on Cardio Disease.



#### The Top section includes:

- Tracked Cardiovascular Diagnoses selected from the patient's Chronic Problem list
- Diagnostic/Referral Orders master referral template assessable from here



#### Middle section

- Patient's Concerns Related to Cardiovascular
- Addressed Today check boxes to note whether a condition was addressed or not.
- Discussion/Plan
- Comment box for free text additions

Patient Concerns Related to Cardiovascular *Patient concerns copy forward to future visits until changed.	Addressed Today?	Discussion/Plan
	OY ON	
Comments		
,		

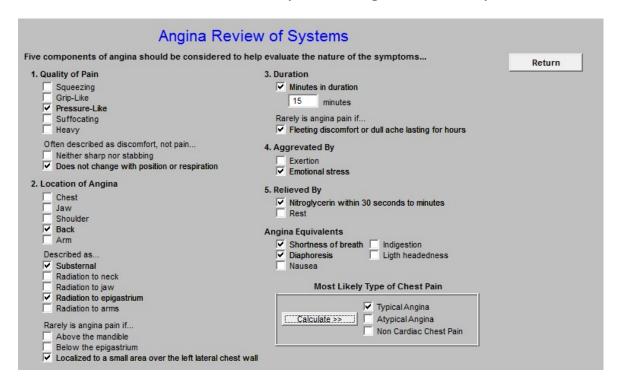
#### Third section

The first column in the third section includes (the details for each are presented below):

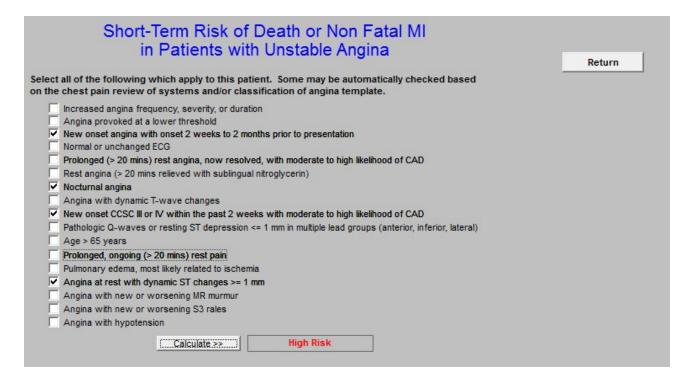
- Chest Pain ROS -- Angina Review of Systems
- Short Term Risk
- Life Style Changes
- Life Style Recommendations
- Consortium Data



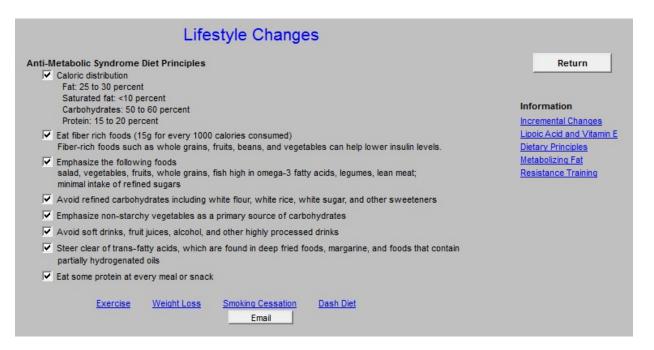
### Chest Pain Review of Systems - Angina Review of Systems



#### Short-Term Risk of Death or Non Fatal MI in Patients with Unstable Angina



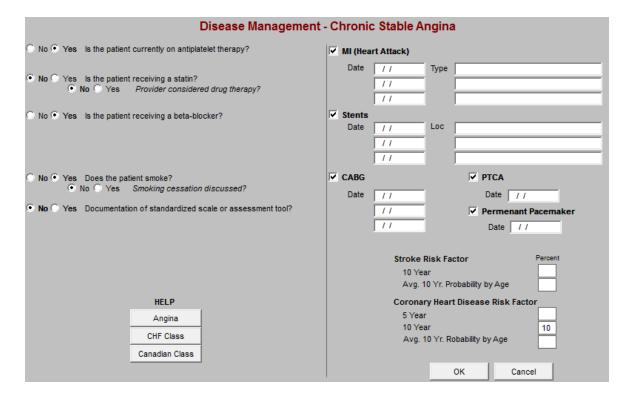
#### Life Style Changes



# Lifestyle Recommendations for cardiovascular risk factors.

Lifesty	le Recommendations
Click "Calculate" to view the I	recommended actions for the selected abnormalities.
Abdominal Obesity Hypertriglyceridemia Low HDL Cholesterol High Blood Pressure High Fasting Glucose Level	Reduce weight Reduce weight Reduce portion sizes to lower calorie intake.  Increase physical activity 30 minutes of moderate-intensity exercise daily.  Increase intake of low-glycemic-index foods Replace refined carbohydrates (white bread, potatoes,pasta) with legumes, whole grains, and monounsaturated fats (nuts, avocado, canola oil, olive oil).  Reduce carbohydrate intake Replace soda and juices with water, seltzer, and diet beverages.  Increase omega-3 fatty acids Eat fish at least once per week.  Increase intake of monosaturated fats Eat fish, nuts, and avocados. Use olive or canola oils in salad dressing and for cooking.  Reduce sodium intake Reduce sodium intake to no more than 2.4 g per day or 6 g per day of salt by using more herbs in cooking; read labels for sodium content; skip the salt shaker.  Increase intake of fruits and vegetables Consume more than five servings of fruits and vegetables every day.  Increase low-fat dairy products Consume three servings of low-fat dairy products daily.  Limit alcohol consumption Limit alcohol to no more than two drinks per day for men, or one drink per day for women.  Increase dietary fiber (more than 30 grams per day)  Add legumes and fruit for soluble fiber.  Reduce saturated fat intake Choose low-fat dairy products and reduce consumption of red meat, butter, and full-fat dairy products.

#### Physician Consortium for Performance Improvement (PCPI) Data Set



The second column in the third section includes Habits:

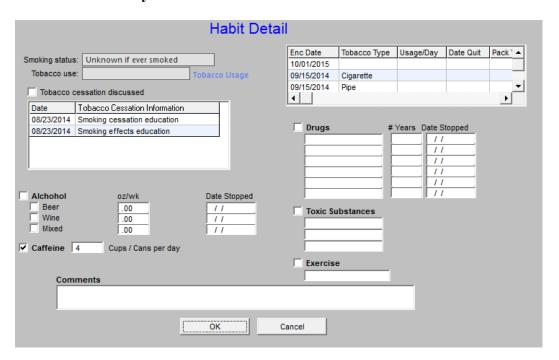


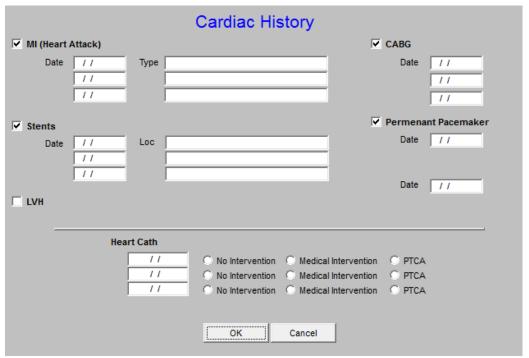
- Alcohol
- Drugs
- Caffeine
- Exercise Regularly
- Toxic Substances

These are all populated automatically from documents in the man EMR data base.

#### The third column in the third section includes:

- Tobacco Use
- Habit Details
- Cardiac History

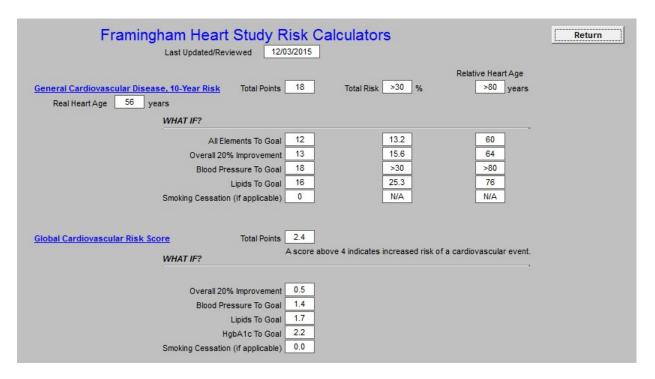




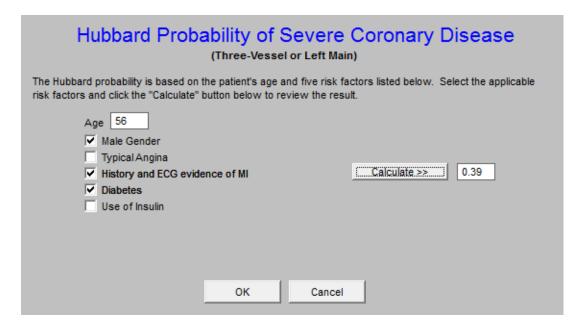
The fourth section includes hyperlinks to three functions related to cardiovascular disease (the details for each are presented below):

- Framingham Risk Score
- Hubbard Probability Severe Coronary Disease
- TIMI Risk Score

### Framingham Heart Study Risk Calculators



### **Hubbard Probability of Severe Coronary Disease**

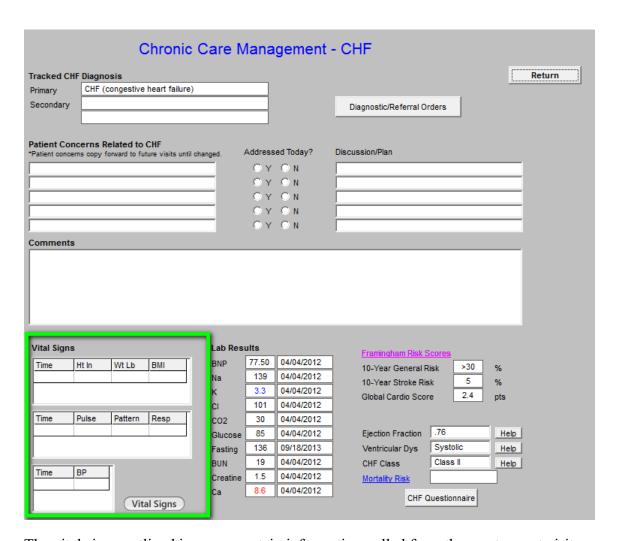


# TIMI Risk Score for Unstable Angina and Non-ST Elevated MI

TIMI Risk Score for UA/NSTEMI  UA = Unstable Angina, NSTEMI = Non-ST-Segment Elevation MI							
Risk Factors  Age > 65 years  Previous stenosis > 50%  Presence of ST-segment deviation  Occurrence of 2 anginal events within past 24 hours  Very Use of aspirin with past 7 days  Elevated cardiac biomarker levels  Smoking status:  Unknown  Tobacco Usage							
Calculate >>  One point is given for each of the seven major factors listed above.  2 points - TIMI Risk Score  8.3 % - Risk of death, nonfatal MI, urgent revascularization							
The TIMI risk score integrates historical factors, frequency of symptoms, electrocardiographic findings and cardiac biomarker levels.							
Higher scores are associated with an increased risk of adverse outcomes such as death, (re)infarction or recurrent ischemia requiring revascularization. The risk of these outcomes ranges from approximately 5 percent with a TIMI score of zero or one point to approximately 41 percent with a score of six or seven points.							
This score may be used to help guide therapuetic decisions. Patients with higher risk scores have been shown to derive greater benefit from specific pharmacologic therapies (enoxaparin [Lovenox], glycoprotein llb/lla inhibitor) and an early cardiac catheterization (invasive) strategy.							
OK Cancel Smoking							

# **Chronic Care Management – Congestive Heart Failure**

Chronic Care Management - CHF								
Tracked CHF Diagnosis					Return			
Primary CHF (congestive heart failure)					<u> </u>			
Secondary				Diagnostic/Referral Orders				
				Diagnostici (ciral cresis				
Patient Concerns Related to CHF *Patient concerns copy forward to future visits until cha	nned /	Address	ed Today?	Discussion/Plan				
Taken concerns copy formal to raise visits and one	gcu.		O N		_			
	-		ON		_			
	_	OY	O N		_			
	-		ON		_			
	-		O N		_			
Comments	-			,				
Comments					_			
Vital Signs	Lab Res	ults	1	Framingham Risk Scores				
Time Ht In Wt Lb BMI	BNP	77.50	04/04/2012	10-Year General Risk >30 %				
	Na	139	04/04/2012	10-Year Stroke Risk 5 %				
	K	3.3	04/04/2012	Global Cardio Score 2.4 pt	ts			
	CI	101	04/04/2012					
Time Pulse Pattern Resp	CO2	30	04/04/2012					
	Glucose	85	04/04/2012	Ejection Fraction .76	Help			
	Fasting	136	09/18/2013	Ventricular Dys Systolic	Help			
	BUN	19	04/04/2012	CHF Class   Class II	Help			
Time BP	Creatine	1.5	04/04/2012	Mortality Risk				
	Ca	8.6	04/04/2012					
Vital Signs				CHF Questionnaire				

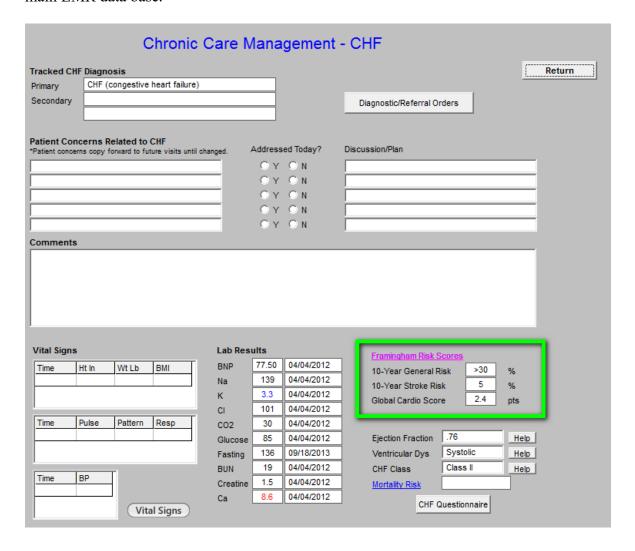


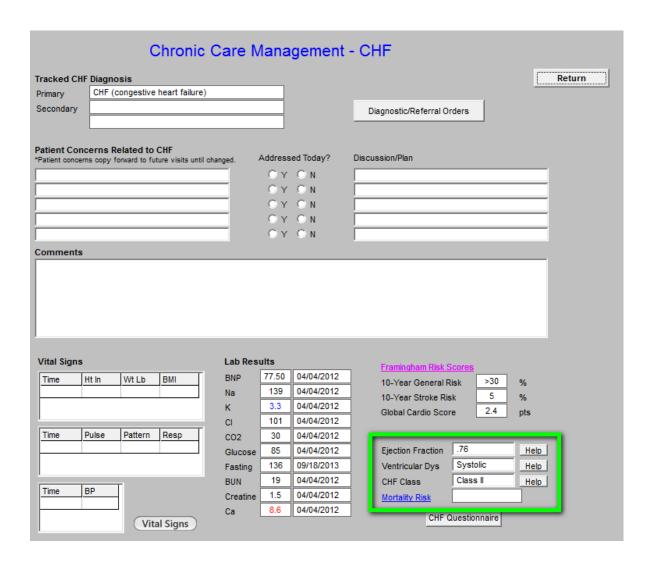
The vital signs outlined in green contain information pulled from the most recent visit.

Chroni	c Care M	lana	gement	- CHI	F	
Tracked CHF Diagnosis  Primary CHF (congestive heart failur Secondary	e)				Return	
Secondary				Diag	gnostic/Referral Orders	
Patient Concerns Related to CHF *Patient concerns copy forward to future visits un	til changed.	Address	ed Today?	Discussi	sion/Plan	
		ΟY	○ N			
		0 Y	○ N			
			O N			
			O N			
		O Y	○ N			
Comments						
Vital Signs	Lab Resi	ults			ramingham Risk Scores	
Time Ht In Wt Lb BMI	BNP	77.50	04/04/2012		0-Year General Risk >30 %	
	Na	139	04/04/2012		0-Year Stroke Risk 5 %	
	К	3.3	04/04/2012		Slobal Cardio Score 2.4 pts	
<u> </u>	CI	101	04/04/2012		pio	
Time Pulse Pattern Resp	CO2	30	04/04/2012			
	Glucose	85	04/04/2012		jection Fraction .76 Help	
	Fasting	136	09/18/2013		/entricular Dys Systolic Help	
, 	BUN	19	04/04/2012		HF Class II Help	
Time BP	Creatine	1.5	04/04/2012		Tortality Risk	
	Ca	8.6	04/04/2012		CHF Questionnaire	
Vital Signs					CHT QUESTIONNAILE	

The laboratory values outlined in green above are automatically pulled from the most recent data.

The data outlined in green below is from the Framingham Risk Scores and is pulled from the main EMR data base.





The information outlined in green above is pulled automatically from the main EMR; if it is not present, the echocardiogram should be ordered or documented in the EMR.

The CHF Questionnaire outlined below in green can be deployed by clicking on the button. In the course of CCM for CHF, this questionnaire should be completed annually.

Chronic Care Management - CHF								
Tracked CHF Diagnosis				Return				
Primary CHF (congestive heart failure)		]		<u>:</u>				
Secondary			Diagnostic/Referral Orders					
			2 agricultation at ordere					
Patient Concerns Related to CHF *Patient concerns copy forward to future visits until cha	nged. Addre	ssed Today?	Discussion/Plan					
		Y O N		_				
		Y O N		_				
		Y O N						
		Y O N		_				
		Y O N		_				
Comments								
Vital Signs	Lab Results		, Framingham Risk Scores					
Time Ht In Wt Lb BMI	BNP 77.50	04/04/2012	10-Year General Risk >30 %					
	Na 139	04/04/2012	10-Year Stroke Risk 5 %					
	К 3.3	04/04/2012	Global Cardio Score 2.4 pts					
	CI 101	04/04/2012	Joseph Gardio Coore					
Time Pulse Pattern Resp	CO2 30	04/04/2012						
	Glucose 85	04/04/2012	Ejection Fraction .76	elp				
	Fasting 136	09/18/2013	Ventricular Dys Systolic H	elp				
	BUN 19	04/04/2012	CHF Class Class II	elp				
Time BP	Creatine 1.5	04/04/2012	Mortal y russ					
	Ca 8.6	04/04/2012	CHF Questionnaire					
(Vital Signs			CIII QUUSUOIIII AII E					

#### **Chronic Care Management -- Depression**

This is the master template for **Chronic Care Management – Depression**. Like all of the Chronic Care Management, structured data templates there are the following in the Master Template below:

- 1. Tracked Depression Diagnosis, selected from the patient's Chronic Problem list.
- 2. Diagnostic/Referral Orders this allows the healthcare provider to complete referrals while making the monthly telephone call.
- 3. Document the Patient Concern Related to Depression
- 4. Document the Discussion/Plan

Chronic Ca	are Managemer	nt - Depressio	n	
Total and December Discussion			r	Dotum
Tracked Depressio Diagnosis			<u> </u>	Return
Primary Depression due to dementia		Discountin/Deferrel/	Nata	
Secondary		Diagnostic/Referral (	Draers	
Deticat Courses Deleted to December				
Patient Concerns Related to Depression *Patient concerns copy forward to future visits until changed.	Addressed Today?	Discussion/Plan		
	OY ON			
	OY ON			
	OY ON			
	OYON			
	OY ON			
		_		
Comments				
Signs and Symptoms of Depression				Last Updated
Anhedonia - absence of pleasure from the perform	mance of acts that would ord	finarily be pleasurable.	Stress Assessment	11
Depressed mood throughout the day		,	Wellness Assessment	11
Fatigue			Depression Screen	11
Significant change in weight, + / - 5% Insomnia or excessice sleep				
Loss of sense of self-value			Depression Risk Que	etionnaire
Loss of concentration			Depression Kisk Que	Stomale
Suicidal thoughts			Antipsychotic	cs
Other Factors That Can Cause Depressive Sym	ptoms			
Medication (beta blockers or corticosteroids)				
Endocrinopathies (hypothyroidism, Cushing's sync Neurological Disorders (Parkinson's disease, post		eorder)		
Connective Tissue Disease (lupus, polymyalgia rh		Jordon,		
Common Painful Symptoms Reported by Depre	ssed Patients			
Headaches, recurrent diffuse musculoskeletal pai		bdominal pain		
,	., sas.aono, ano rocarront o	a a a militar paint.		

**Signs and Symptoms of Depression** – seen below outlined in green. The caller can easy document the symptoms of depression being experienced by the patient. The following link is to

SETMA's Depression Tutorial: <a href="http://www.jameslhollymd.com/epm-tools/Tutorial-Depression">http://www.jameslhollymd.com/epm-tools/Tutorial-Depression</a>. This explains the below tools in more detail.

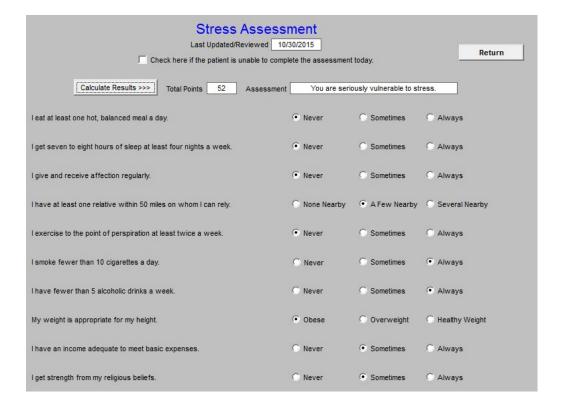
Chronic Car	e Managemer	nt - Depressio	n	
Primary Depression due to dementia Secondary		Diagnostic/Referral	Orders	Return
Patient Concerns Related to Diabetes *Patient concerns copy forward to future visits until changed.  Comments	Addressed Today?  O Y O N O Y O N O Y O N O Y O N O Y O N	Discussion/Plan		
Signs and Symptoms of Depression  Anhedonia - absence of pleasure from the performa Depressed mood throughout the day Fatigue Significant change in weight, + / - 5% Insomnia or excessice sleep Loss of sense of self-value Loss of concentration Suicidal thoughts  Other Factors That Can Cause Depressive Sympto Medication (beta blockers or corticosteroids) Endocrinopathies (hypothyroidism, Cushing's syndro Neurological Disorders (Parkinson's disease, post-st Connective Tissue Disease (lupus, polymyalgia rheur Common Painful Symptoms Reported by Depress Headaches, recurrent diffuse musculoskeletal pain, in	oms me, B12 Deficiency) roke, dementia, seizure di matica) sed Patients	sorder)	Stress Assessment Wellness Assessment Depression Screen  Depression Risk Qua Antipsychot	

In the right-hand column the following tools are accessible and each is explained below; they include the following. To the right of the first three are the dates of last completion of these screening tools.

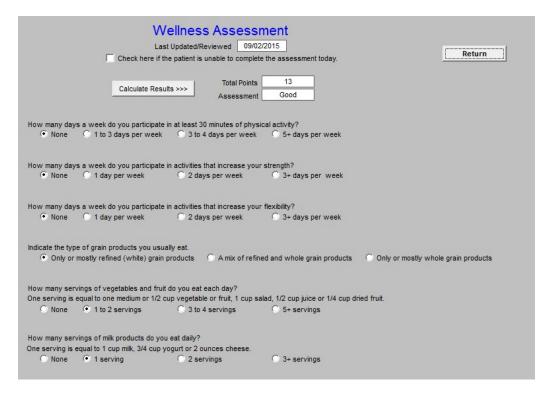
- Stress Assessment
- Wellness Assessment
- Depression Screen
- Depression Risk Questionnaire
- Antipsychotic Medication Tool

The above five tools are displayed in the following screen shots:

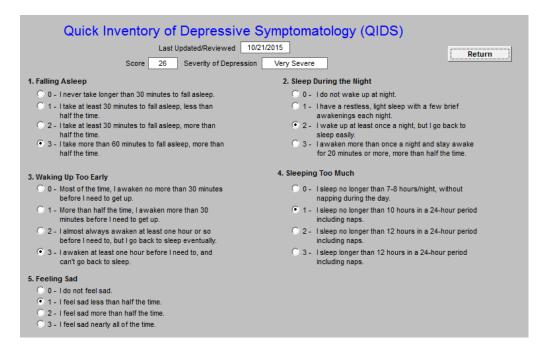
### **Stress Assessment**



#### **Wellness Assessment**



### **Quick Inventory of Depressive Symptomatology (QIDS)**



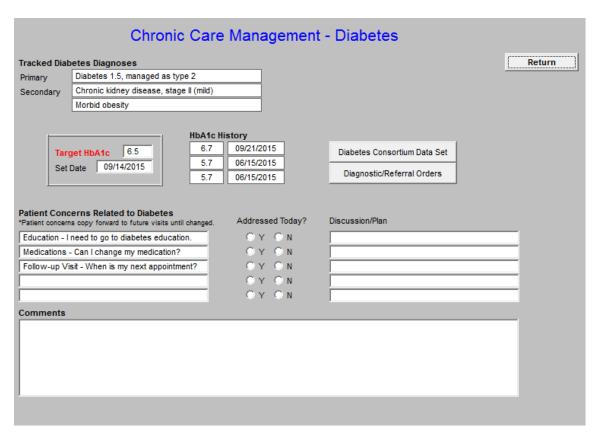
## **Geriatric Depression Scale**



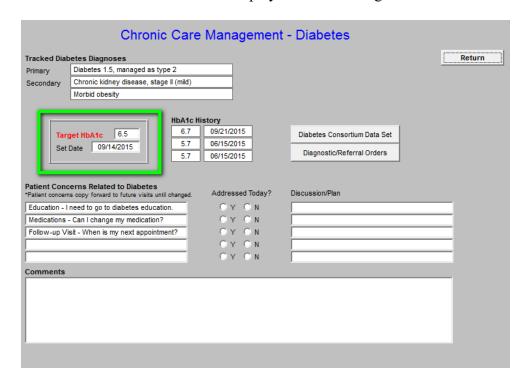
# **Tool for Reducing the Use of Antipsychotic Drugs**

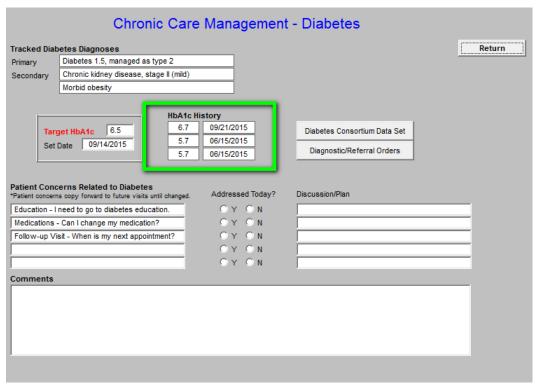
	Reduction	of Psychotro	ppic Medications		
Yes 1.	Is the patient on one	or more antipsychotic	: drugs?		Return
	Antipsychotic	Anxiolytic			Print
	ARIPIPRAZOLE				
	Hypnotic	Antidepressant	Anticonvulsant/Manic		AIMS Assessment
Yes 2.	Does the patient have	one or more adequa	te indications for an antipsyo	chotic drug?	
	Psychosis in the abs Medical illness with p e.g. neoplastic disea Tourette's disorder Hungtington's diseas Hiccups not induced by other Nausea and vomiting	sever depression refracence of dementia by by chotic symptoms see or delirium and/or treate			antipsychotics.
. 1110 101101	Wandering	_	n or indifference to surroundings		apojonosiooi
	Poor self care Restlessness Imparied memory	Sadness Fidgeting Nervousi	or crying alone that is not related	d to depression or other psychiatric	disorders
	Mild anxiety Insomnia	Uncoope	rative e.g. refusal of or difficult	y receiving care	

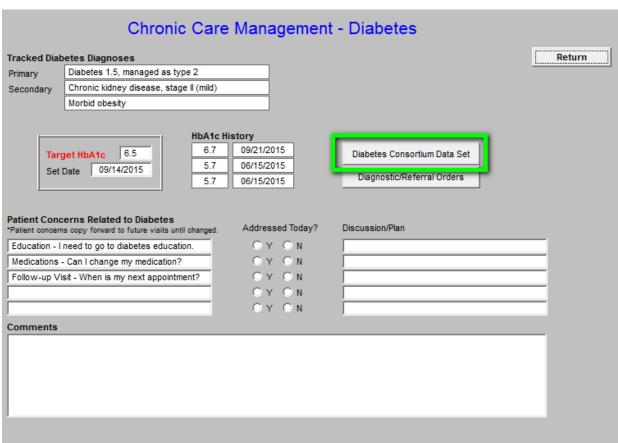
## **Chronic Care Management – Diabetes**



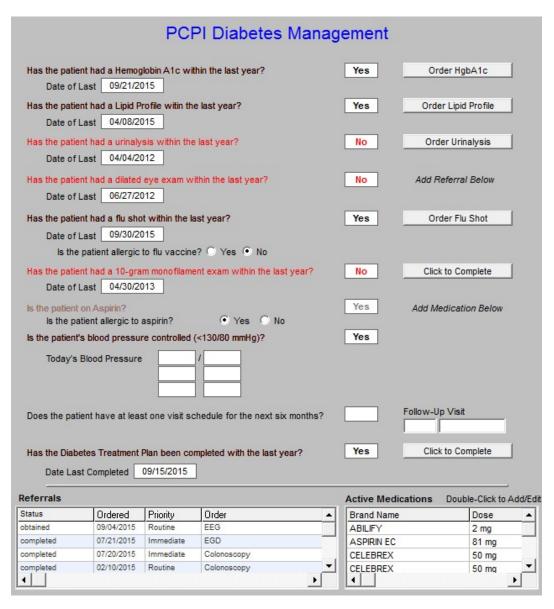
The last three HbA1c values are displayed with the Target A1c and the date the goal was set.



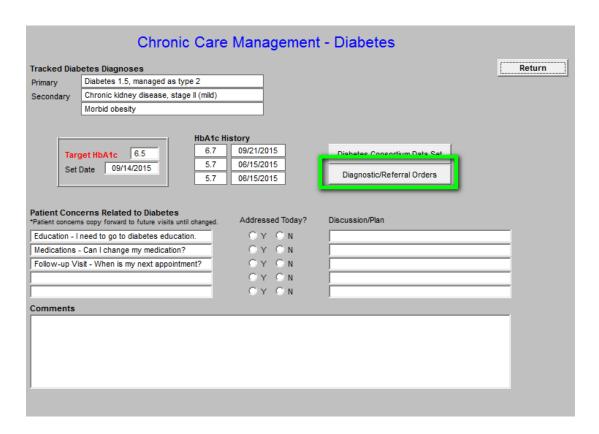




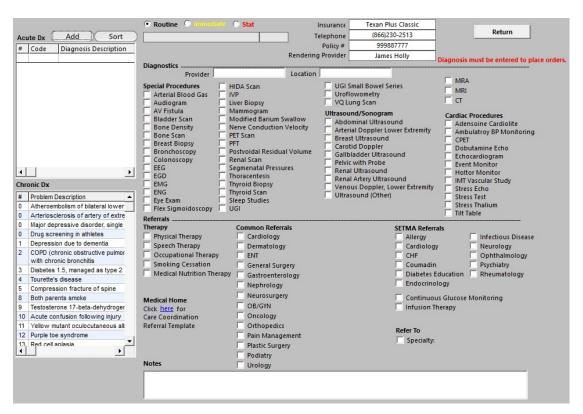
Quality Metric sets and standards of care for diabetes is deployed by clicking on the button outlined in green above. When that button is deployed, the following PCPI Diabetes Management measurement set is displayed. The legend is the same as in all SETMA disease management quality measurement tools: elements in black apply to the patient and have been done; elements in read apply to the patient and have not been done. If an element has not been completed, the provider can click the button in the right hand column and the function will be done. (**Note**: Because this interview will be done on the telephone, if an element is ordered the interviewer will have to be sure that the patient schedules an appointment or knows to come to the lab to have the testing done.)



If this review indicates that testing should be done, it can be done by clicking on the Diagnostic/Referral orders button outline in green below.



## The following is the referral template.



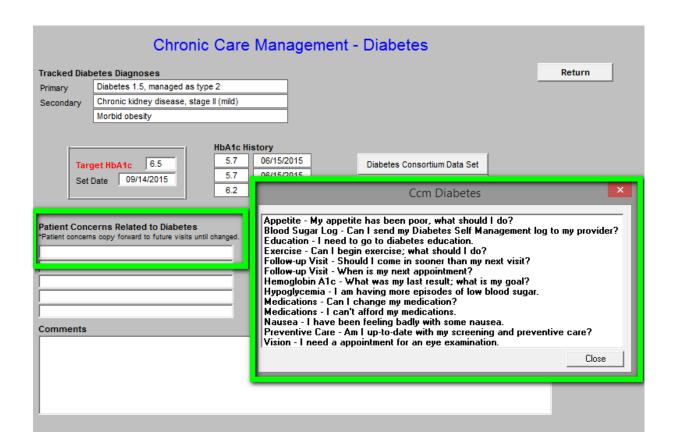
Below, outlined in green allows documentation f the Patient Concerns Related to Diabetes.

	Chroni	c Care Management	: - Diabetes	
Primary Secondary	Diabetes 1.5, managed as ty Chronic kidney disease, star Morbid obesity  Let HbA1c 6.5 Date 09/14/2015	·	Diabetes Consortium Data Set  Diagnostic/Referral Orders	Return
*Patient concerns  Education - I no  Medications - 0	erns Related to Diabetes s copy forward to future visits un need to go to diabetes educat Can I change my medication? sit - When is my next appointn	OYON	Discussion/Plan	

#### Patient Concerns Related to Diabetes -

As can be seen, the patient's diagnoses related to diabetes are automatically displayed. Also the patients current and last three Hemoglobin A1Cs are automatically displayed. The patient's target HbA1c is "set" and the date of that target being set is displayed. As can be seen just above the material outlined in green, there is a button entitled the Diabetes Consortium Data Set. This is the eight element data set published by the Physician Consortium for Performance Improvement. SETMA tracks this data, along with data audits for six other comprehensive data sets for diabetes. By provider name the results of these audits is published at <a href="https://www.jameslhollymd.com">www.jameslhollymd.com</a> under Public Reporting. Data from 2009 to date is published.

In the first column on this template is a tool for document **Patient Concerns Related to Diabetes.** A note indicates that these concerns "copy forward" to subsequent Chronic Care management calls. The larger box in the second column which is also outlined in green gives a set of options which can be easily added to the Patient Concerns list.

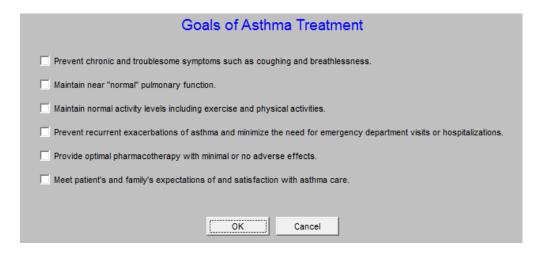


## **Chronic Care Management – Asthma/COPD**

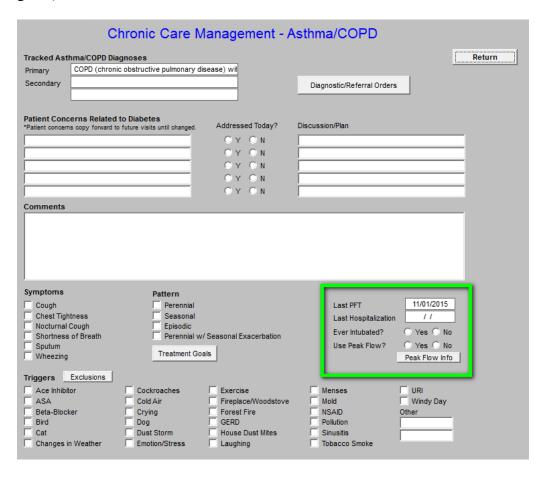
The following is the Master Template for the Chronic Care Management – Asthma COPD. The Tracked Asthma/COPD Diagnoses, Diagnostic/Referral Orders, Patient Concerns Related to Asthma/COPD, Discussion/Plan and Comments box are similar to all of the structure fields.

С	hronic Care N	Management - A	sthma/COPD		
Primary COPD (chronic Secondary	ignoses c obstructive pulmonary o	disease) wit	Diagnostic/Referral Orders		Return
Patient Concerns Related *Patient concerns copy forward to  Comments		Addressed Today?  O Y O N  O Y O N  O Y O N  O Y O N  O Y O N	Discussion/Plan		
Symptoms  Cough Chest Tightness Nocturnal Cough Shortness of Breath Sputum Wheezing  Triggers Exclusions Ace Inhibitor ASA Beta-Blocker Bird Cat Changes in Weather	Pattern Perennial Seasonal Episodic Perennial v Treatment Go  Cockroaches Cold Air Crying Dog Dust Storm Emotion/Stress	Exercise Fireplace/Woodstove Forest Fire GERD House Dust Mites Laughing	Last PFT Last Hospitalization Ever Intubated? Use Peak Flow?  Menses Mold NSAID Pollution Sinusitis Tobacco Smoke	11/01/2015 // C Yes C No C Yes C No Peak Flow Info  URI Windy Day Other	

The following allows for the efficient documentation of the goals of asthma and/or COPD treatment



If the patient has not had a PFT in the past two years (see documentation in the boxes outlined in green), one should be ordered.



The patient should be taught how to obtain and interpret the Peak Flow Meter.

Chronic Care	Management - /	Asthma/COPD
Tracked Asthma/COPD Diagnoses Primary COPD (chronic obstructive pulmonary Secondary	r disease) wil	Return  Diagnostic/Referral Orders
Patient Concerns Related to Diabetes *Patient concerns copy forward to future visits until changed	Addressed Today?  Y N Y N Y N Y N Y N Y N Y N	Discussion/Plan
Comments		
Symptoms Pattern  Cough Perennia Chest Tightness Seasona Nocturnal Cough Episodic Shortness of Breath Perennia Sputum Wheezing Treatment	w/ Seasonal Exacerbation	Last PFT Last Hospitalization  Ever Intubated?  Use Peak Flow?  Yes No Peak Flow Info
Triggers Exclusions Cockroaches  AsA Cold Air  Beta-Blocker Crying  Bird Dog  Cat Dust Storm  Changes in Weather Emotion/Stress	Exercise Fireplace/Woodstove Forest Fire GERD House Dust Mites Laughing	Menses URI Mold Windy Day NSAID Other Pollution Sinustis Tobacco Smoke



SETMAI - 2929 Calder, Suite 100

SETMAII - 3570 College, Suite 200

Mark Wilson Clinic - 2010 Dowlen

Lumberton - 137B LHS Drive Nederland/Port Arthur - 2400 Highway 365, Suite 201 Orange - 610 Strickland Drive, Suite 140

(409) 833-9797 www.setma.com

## Peak Flow Meter

### What are some signs that my asthma or COPD is getting worse?

In addition to measuring your or your child's peak flow on a daily basis, you need to look out for early warning signs of an asthma attack. Early warning signs of an asthma attack are:

Runny, stuffy nose Fatigue

Chin or throat itches

Headache

Moodiness

Cough with activity or laughing

Wheezing with activity

Waking up at night or early morning with a cough or wheeze

Faster breathing rate

Irritability

Outlined below in green are "triggers" for asthma and COPD exacerbation. During the course of the year, these should be addressed.

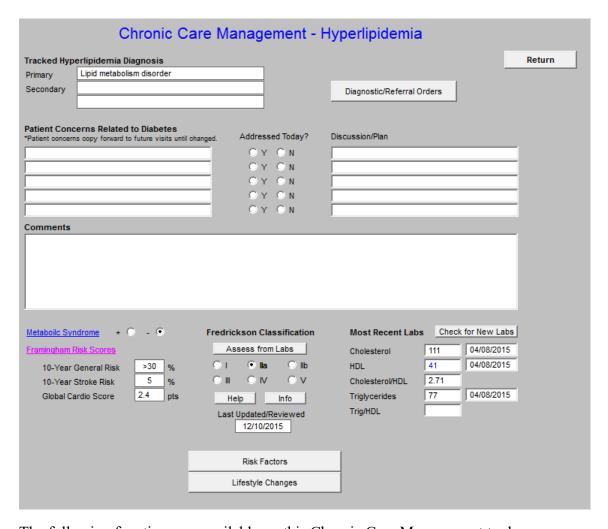
	Chror	nic Care Ma	anagement - A	sthma/COPD		
Primary	hma/COPD Diagnose		ase) wil			Return
Secondary	erns Related to Diab			Diagnostic/Referral Orders		
	is copy forward to future		Addressed Today?  O Y O N  O Y O N  O Y O N	Discussion/Plan		
Comments			OY ON OY ON			
Symptoms Cough Chest Tigh Nocturnal Shortness Sputum Wheezing	Cough of Breath	Pattern Perennial Seasonal Episodic Perennial w/ S	Seasonal Exacerbation	Last PFT Last Hospitalization Ever Intubated? Use Peak Flow?	11/01/2015  / /  Yes No Yes No Peak Flow Info	
Triggers  Ace Inhibit ASA Beta-Block Bird Cat Changes i	ker C	ockroaches   old Air rying   og   ust Storm   motion/Stress	Exercise Fireplace/Woodstove Forest Fire GERD House Dust Mites Laughing	Menses Mold NSAID Pollution Sinusitis Tobacco Smoke	URI Windy Day Other	

When the button outlined below in green entitled "Exclusions" is clicked, the following template is deployed. The "exclusions" are diagnoses which should be excluded in the diagnosis of asthma.

	Chro	onic Care N	Management - A	Asthma/COPD	
Tracked Asti	hma/COPD Diagnos	ses			Return
Primary		tructive pulmonary o	lisease) wit		
Secondary				Diagnostic/Referral Orders	s
Patient Conc	erns Related to Di	ahatae			
	s copy forward to futur		Addressed Today?	Discussion/Plan	
			OY ON		
			OY ON		
			OY ON		
			OY ON		
			OY ON		
Comments					
Symptoms		<b>.</b>			
Cough		Pattern Perennial		Last PFT	11/01/2015
Chest Tigh	itness	Seasonal		Last Hospitalization	
Nocturnal		Episodic			C Yes C No
Shortness	of Breath	Perennial v	// Seasonal Exacerbation	Ever Intubated?	
Sputum		Treatment Go	pals	Use Peak Flow?	C Yes C No
I WILLIAM					Peak Flow Info
Triggers	Exclusions				
☐ Ac Inhibit	tor [	Cockroaches	Exercise	Menses	□ URI
☐ ASA		Cold Air	Fireplace/Woodstove	Mold	☐ Windy Day
Beta-Block	ker	Crying	Forest Fire	☐ NSAID	Other
☐ Bird ☐ Cat		Dog Dust Storm	GERD House Dust Mites	Pollution Sinusitis	
Changes in	n Weather	Emotion/Stress	Laughing	Tobacco Smoke	
- Silangeon	,		, 20099	, , , , , , , , , , , , , , , , , , , ,	

<b>a</b>		
Conditions to b	e Excluded in the Diagno	sis of Asthma
Suspicions	Actions	
Allergic Rhinitis	2-D Echo	Pulmonary Function Test
Bronchopulmonary Aspergillosis	Arterial Blood Gases	Radioisotope Lung Perfusion Scan
Bronchopulmonary Dysplasia	☐ BNP	Serum Aspergillus Antibody Titer
Congenital Abnormality	Chest X-Ray	Serum Eosinophil Count
Congestive Heart Failure	CT of Chest	Serum IgE Level
Cystic Fibrosis	EGD	Serum Immunoglobin Assay
Foreign Body Aspiration	Esophageal Manometry	Spiromtery w/ Flow Volume Loops
Gastro Esophageal Reflux	Expiratory Chest X-Ray Films	Sweat Test
Immunodeficiency	Fluoroscopy of Chest	Ventilation Perfusion Lung Scan
Pulmonary Embolism	Methacholine Provocation	
Upper Airway Obstruction	History and Physical	
Vocal Cord Dysfunction	PA Inspiratory Chest X-Ray	
	OK Cancel	

### Chronic Care Management -- Hyperlipidemia

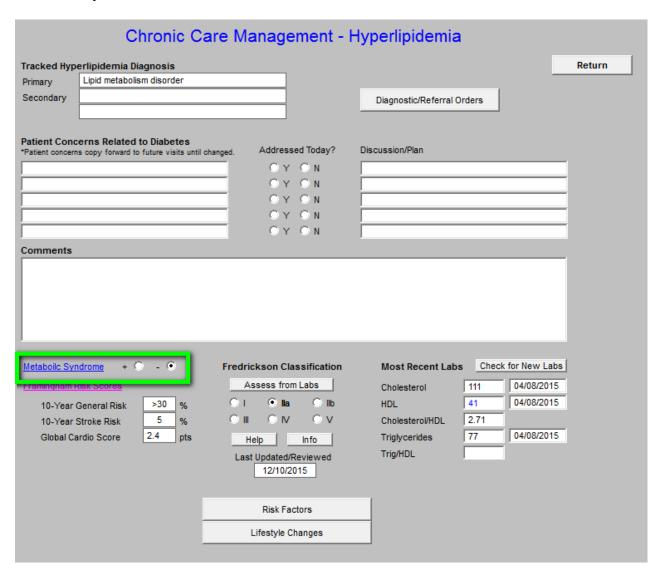


The following functions are available on this Chronic Care Management tool:

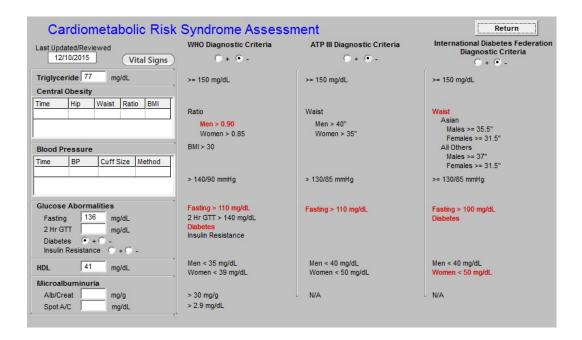
- 1. Metabolic Syndrome calculator and the designation of whether or not the patient has the Cardiometabolic Risk Syndrome.
- 2. Framingham Risk Scores
- 3. Fredrickson Classification for Dyslipidemia
- 4. Risk Factors for hyperlipidemia
- 5. Lifestyle changes for treating Dyslipidemia
- 6. In the right hand column, the follow values appear:
  - a. Most Recent Labs depress button to display most recent labs.
  - b. Cholesterol
  - c. HDL
  - d. Cholesterol/HDL Ratio optimally, this ratio should be below "4."
  - e. Triglycerides

f. Trig/HDL Ratio – optimally, this ratio should be below "2," a higher value indicates insulin resistance.

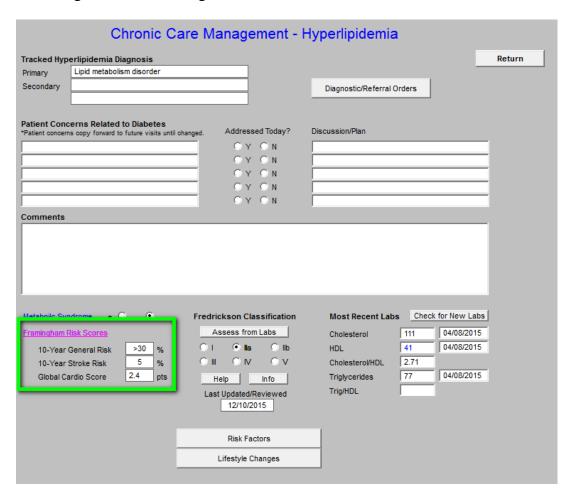
The aggressiveness of treatment of lipids is dictated by risk factors such as Framingham, Metabolic Syndrome, level of HDL and LDL.

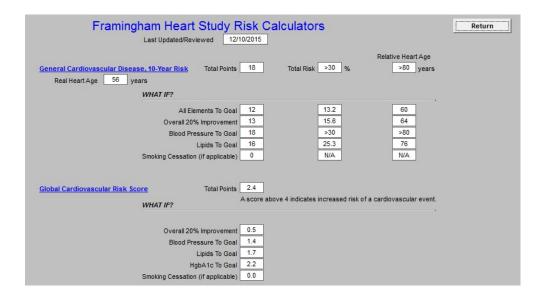


When the above button is clicked for "Metabolic Syndrome," the below assessment template is deployed.

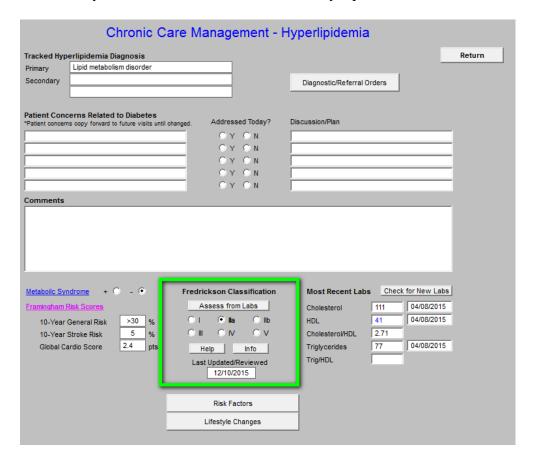


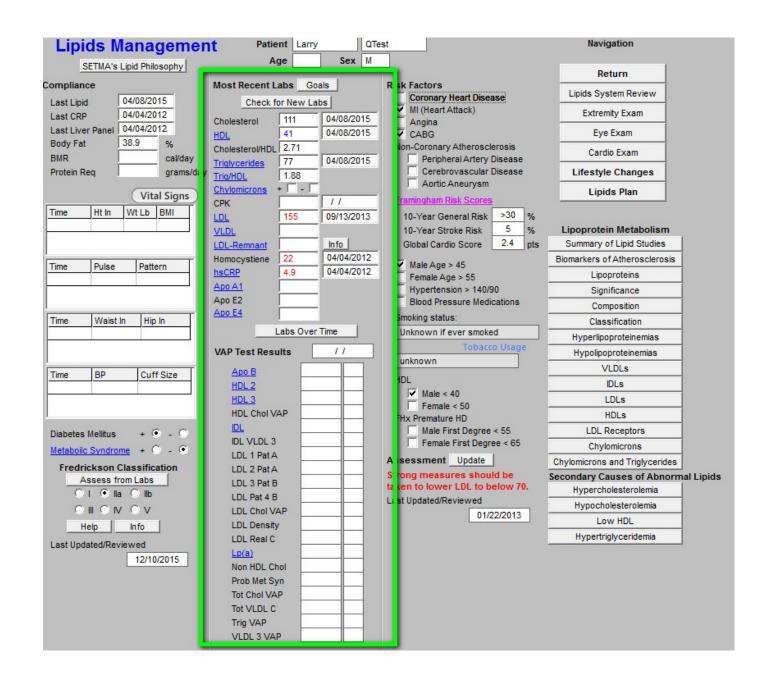
Following that is the Framingham Risk Score.

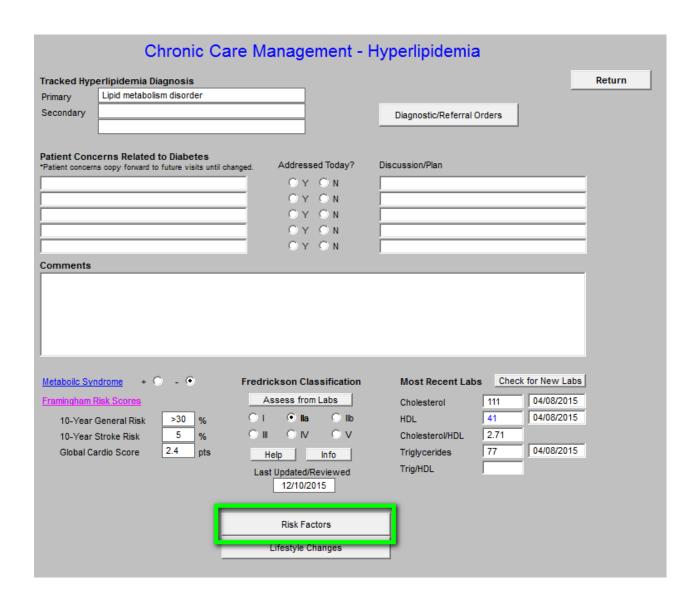


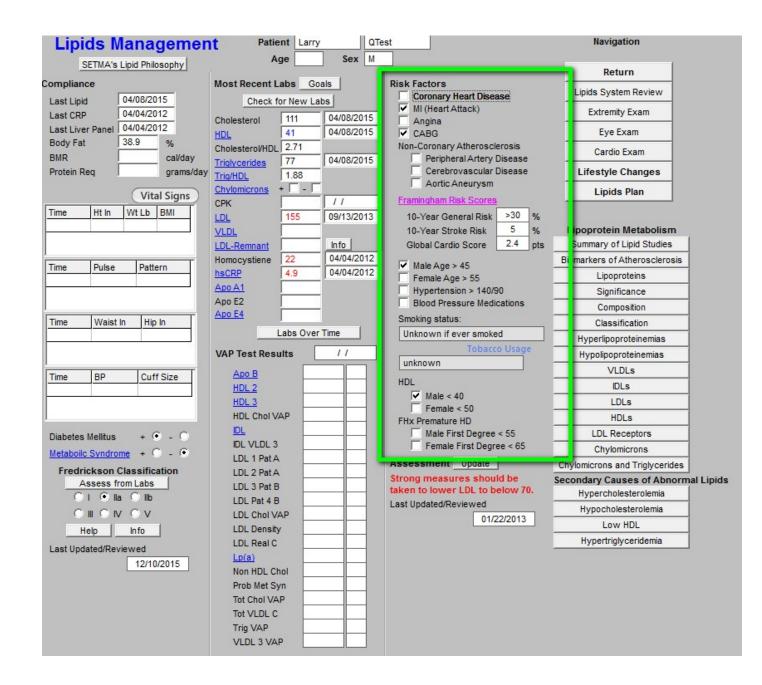


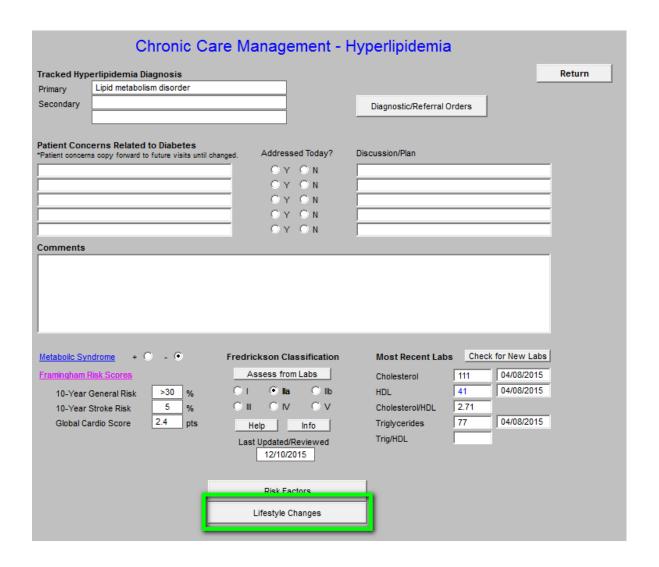
Followed by the Fredrickson Classification of Dyslipidemia.

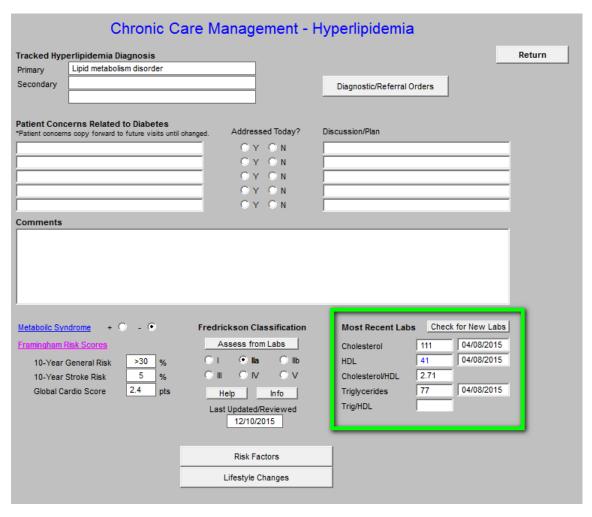


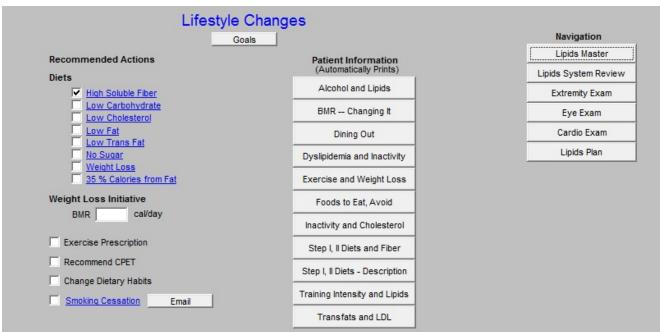








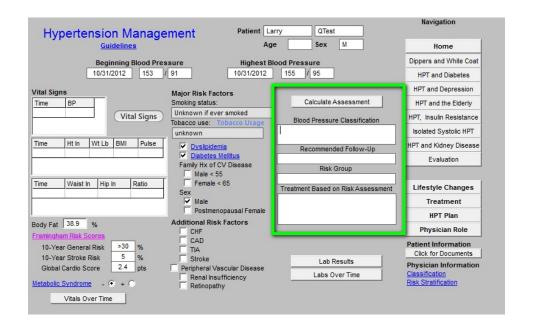


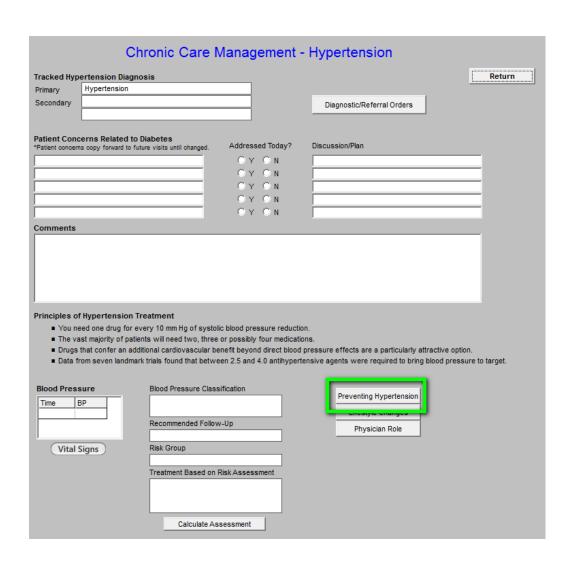


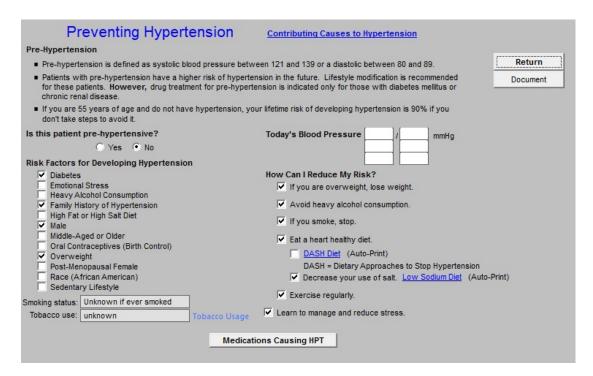
Lipids Treatment Aud	lit
Most Recent Values         Cholesterol         111         04/08/2015           Triglycercides         77         04/08/2015	HDL 41 04/08/2015 LDL 55 04/08/2015
Has the patient had a lipid profile within the last year?	Yes Click to Order
Has the Lipids Treatment Plan been completed within the last year?	Yes Click to Generate
Has the patient been assessed for Cardiometabolic Risk Syndrome within the last year?	Yes Click to Assess
If Cardiometabolic Risk Syndrome present, is it listed as a chronic condition?	No Click to Add
If most recent LDL > 100, is the patient on a statin?	N/A Click to Add Med
Is the patient allergic to statins? Yes No  Have the following lifestyle changes been recommended if applicable?  Stop Smoking, Exercise, Lose Weight, Low Cholesterol Diet, Low Carbohydrate Diet	No Click to Add
Has risk stratification for Lipids and Heart Disease been completed within the last year by using the Framingham Cardiovascular Risk Score AND one of the following?	Yes Click to Update
Global Cardiovascular Risk Score, Frederickson Classification of Dyslipidemia, Lipid Disease Management Risk Assessment	Order
If the most recent LDL > 100, has the patient been referred to Medical Nutrition Therapy at least once?	N/A EGD V
Does the patient have Diabetes? Yes Do	es the patient have Hypertension?
If most recent LDL > 70, is the patient on a statin?  Click to Add Med  Is the patient's HgbA1c below 7.0%?  Yes	Today's Blood Pressures  mmHg
Most Recent Result 6.7 09/21/2015  Click to Order	/ mmHg / mmHg

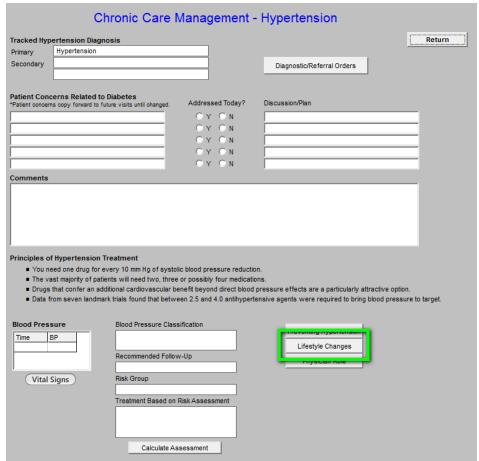
# **Chronic Care Management -- Hypertension**

	Chronic	Care Manag	gement -	Hypertension	
Tracked Hyp	ertension Diagnosis				Return
Primary	Hypertension				
Secondary				Diagnostic/Referral Orders	
Dationt Cons	erns Related to Hyperten				
	s copy forward to future visits ur		ssed Today?	Discussion/Plan	
		0.1	r ⊜ N		
		91	r ⊜ N		
		91	∕ © N		
		91	∕ ○ N		
		91	/ O N		
Comments					
Principles of	Hypertension Treatment				
	ed one drug for every 10 mm		essure reduction		
	st majority of patients will ne				
■ Drugs	that confer an additional card	liovascular benefit beyo	nd direct blood p	ressure effects are a particularly attractive of	ption.
■ Data fr	om seven landmark trials fou	nd that between 2.5 and	d 4.0 antihyperte	nsive agents were required to bring blood pre	essure to target.
Blood Press	sure Blood P	ressure Classification			
Time E	BP BP			Preventing Hypertension	
				Lifestyle Changes	
	Recomm	nended Follow-Up		Physician Role	
				Physician Role	
Vital 5	Signs Risk Gro	oup			
	Treatme	nt Based on Risk Asses	ssment		
		Calculate Assessment			

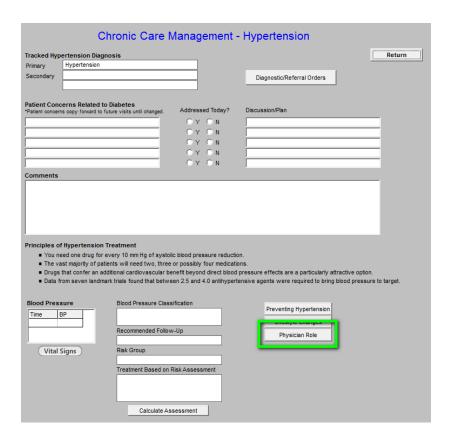








Lifestyle Char	nges	
Recommended Actions The numbers in parethesis indicate the approximate reduction in Sy		Return
Eliminate or reduce alcohol consumption to 2 drinks per day     (2-4 mmHg)      Eliminate or reduce caffiene intake      Take measures to reduce and control stress      If you are overweight, lose weight     (5-20 mmHg/20 lb wt. loss)      BMI     BMR calories/day      Exercise     (4-9 mmHg)      Smoking Cessation	✓ Change dietary habits     ✓ Increase potassium intake     ✓ Increase calcium intake     ✓ Maintain adequate magnesium intake     ✓ Increase fish oils      ✓ Reduce salt intake to no more than 2.4 grams/day     (2-8 mmHg)	Information Alcohol, Coffee, Cigarettes



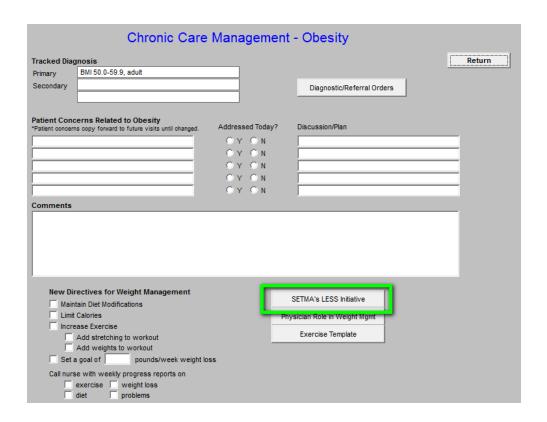
Physician Role in Hypertension Management
✓ Blood pressure measured at least once this visit
▼ Blood pressure measurement repeated if elevated
▼ Blood pressure classification determined
▼ Weight reduction discussed/recommended
Sodium intake discussed/changes recommended
✓ Alcohol intake discussed/changes recommended
Exercise discussed/recommended
Appropriate follow-up scheduled
Generate a follow-up document for the patient at least yearly  Date Last Generated 09/15/2015

Prospective Data Collection Flowsheet				
	No Yes			
Assessment of Clinical Symptoms of Volume Overload (Excess)	□ Dyspnea Return □ Fatique □ Orthopnea □ Standardized scale or assessment tool used Questionnaire Score			
Level of Activity	Standardized scale or assessment tool used			
Assessment of Clinical Signs of Volume Overload (Excess)	Peripheral Edema Rales Liver Enlarged (Hepatomegaly) Ascites Jugular Venous Pulse - Normal Jugular Venous Pulse - Distended			
Patient Education	Patient Education Given			
Beta-Blocker Therapy	Not Indicated Prescribed Not Prescribed (Medical Reasons) Not Prescribed (Patient Reasons)			
A Committee of the Comm	Patient refuses a B-blocker			
Ace Inhibitor Therapy	Not Indicated Prescribed  Not Prescribed (Patient Reasons) Patient Receiving Angiotensin Receptor Blocker  Patient refuses an ACE			
Warfarin Therapy Chronic Hx Paroxysmal Atrial Fib	Patient refuses an ARB  Not Indicated Prescribed Not Prescribed (Medical Reasons) Not Prescribed (Patient Reasons) Patient refuses Coumadin			

# **Chronic Care Management – Obesity**

Chronic Care Management - Obesity					
Tracked Diagnosis Primary BMI 50.0-59.9, adult Secondary	Diagnostic/Referral Orders				
	© N ON O				
New Directives for Weight Management  Maintain Diet Modifications Limit Calories Increase Exercise Add stretching to workout Add weights to workout Set a goal of pounds/week weight loss Call nurse with weekly progress reports on exercise weight loss diet problems	SETMA's LESS Initiative  Physician Role in Weight Mgmt  Exercise Template				

Chronic Care Management - Obesity					
Tracked Diagnosis Primary Secondary BMI 50.0-59.9, adult	Return   Diagnostic/Referral Orders				
	ressed Today? Discussion/Plan  Y C N				
Comments					
New Directives for Weight Management  Maintain Diet Modifications  Limit Calories  Increase Exercise  Add stretching to workout  Add weights to workout  Set a goal of pounds/week weight loss  Call nurse with weekly progress reports on  exercise weight loss  diet problems	SETMA's LESS Initiative Physician Role in Weight Mgmt Exercise Template				



Chronic Care Management - Obesity						
Tracked Diagnosis Primary BMI 50.0-59.9, adult Secondary		Diagnostic/Referral Orders				
Patient Concerns Related to Obesity *Patient concerns copy forward to future visits until changed.	Addressed Today?  C Y C N  C Y C N  C Y C N  C Y C N	Discussion/Plan				
Comments						
New Directives for Weight Management  Maintain Diet Modifications  Limit Calories  Increase Exercise  Add stretching to workout  Add weights to workout  Set a goal of pounds/week weight lo  Call nurse with weekly progress reports on  exercise weight loss  diet problems	<u> </u>	SFTMA's LFSS Initiative ysician Role in Weight Mgmt Exercise Template				

Chronic Care Management - Obesity					
Tracked Diagnosis Primary BMI 50.0-59.9, adult Secondary		Diagnostic/Referral Orders			
Patient Concerns Related to Obesity *Patient concerns copy forward to future visits until changed.	Addressed Today?  O Y O N  O Y O N  O Y O N  O Y O N  O Y O N	Discussion/Plan			
Comments					
New Directives for Weight Management  Maintain Diet Modifications  Limit Calories  Increase Exercise  Add stretching to workout  Add weights to workout  Set a goal of pounds/week weight locations  Call nurse with weekly progress reports on  exercise weight loss  diet problems		SETMA's LESS Initiative  Weician Pole in Weight Mont  Exercise Template			

#### Local Available Services Gulf Coast Health Care Center, Inc. Jefferson County Public Health Department Return 2548 Memorial Blvd. Health & Welfare Unit #1 Port Arthur, Texas 77640 1295 Pearl Print Complete List Beaumont, Texas 77701 (409) 983-1161 (409) 835-8530 601 Rev Dr Ransom Howard St Health & Welfare Unit #2 Pt Arthur, Texas 77642 246 Dallas (409) 983-1161 Port Arthur, Texas 77640 (409) 983-8380 1301 West Park Ave Ste C Orange, Texas 77630 (409) 886-4400 Ibn Sina Community Medical Center 8599 9th Ave Pt. Arthur, Texas 77642 710 Hwy 327 East (409) 724-7462 Silsbee, Texas 77656 (409) 386-1222 Legacy Community Health Services 4450 Highland 103 West Gibson Ste 110 Jasper, Texas 75951 Beaumont, Texas 77705 (409) 489-9103 (409) 242-2525