James L. Holly, M. D.

Chronic Care Management

The Chronic Care Management payment is offered by CMS for the care of patients who have more than two chronic conditions and who are contacted each month for complex care management. The contact must result in an aggregate of 20 minutes of time spend in counseling with the patient by telephone or in person including time spent preparing a plan of care and treatment plan.

The tutorial for SETMA's preparation for this task includes documentation for:

1. Performed
2. Documented to meet all standards
3. Compared to exclusions such as nursing home admission, home healthcare and transitions of care charges being submitted.
4. Audited to prove that all elements of the Chronic Care Management being done.

SOUTHEAST TEXAS SETMA MEDICAL ASSOCIATES, L.L.P.

Patient Larry QTest Sex M Age 56 Patient's Code Status Full Code

Home Phone (409)833-9797 Date of Birth 09/01/1959

Work Phone ( ) -

Cell Phone ( ) -

Patient has one or more alerts! Click Here to View Alerts

Pre-Vist/Preventive Screening

Patient Eligible For Medicare Preventive Exam

Intensive Behavioral Therapy Transtheoretical Model

Bridges to Excellence View

Preventive Care
SETMA's LESS Initiative T
Last Updated 01/20/2015
Preventing Diabetes T
Last Updated / /
Preventing Hypertension T
Smoking Cessation T
Care Coordination Referral
PC-MH Coordination Review
Needs Attention!!
HEDIS NQF ACO
Elderly Medication Summary
STARS Program Measures
Chronic Care Management
CHF Exercise T
Diabetic Exercise T

Template Suites
Master GP T
Pediatrics
Nursing Home T
Ophthalmology
Physical Therapy
Podiatry
Rheumatology

Hospital Care
Hospital Care Summary T
Daily Progress Note
Admission Orders T

Disease Management	Last Updated
Diabetes T	08/11/2015
Hypertension T	05/21/2013
Lipids T	04/08/2015
Acute Coronary Syn T	/ /
Angina T	/ /
Asthma	/ /
Cardiometabolic Risk Syn T	09/23/2013
CHF T	/ /
Diabetes Education	/ /
Headaches	/ /
Renal Failure	/ /
Weight Management T	/ /

Special Functions
Lab Present T
Lab Future T
Lab Results T
Hydration T
Nutrition T
Guidelines T
Pain Management
Immunizations Print
Reportable Conditions

Information
Charge Posting Tutorial
E&M Coding Recommendations
Drug Interactions T
Infusion Flowsheet
Insulin Infusion

The CCM is found at the link surround in green above. The Chronic Care Management Master template is shown next. It includes:

1. Primary and Secondary Insurance designation
2. Patient Status in regard to CCM participation
3. Primary Care Provider and Designated CCM contact
4. Time Tracing function to document time spent monthly on CCM
5. Patient's Current Chronic Problems
6. Tracked Problems and whether or not they are currently being tracked.
7. Current Medications and whether or not they have been reconciled
8. Current Allergies
9. Referrals
10. Appointment History and Upcoming Appointments.

Chronic Care Management

Patient: Larry QTest
DOB: 09/01/1959

Primary Insurance:
Secondary Insurance:

Return | Print | Send to NextMD

Patient Status

Currently active in CCM? (•) Y ( ) N
CCM Consent completed? (•) Y ( ) N
Date Completed Print 09/14/2015
Enrolled in NextMD? Yes

Primary Care Provider: Holly, James L
Patient's Other Providers
Designated CCM Contact: ( ) -

Time Tracking - Today All

Date	Subject

Medical Home Coord Review | Pre-Visit/Preventive Screen

Patient's Current Chronic Problems

#	Diagnosis
1	Pancreatic cancer
2	Lipid metabolism disorder
3	Depression due to dementia
4	COPD (chronic obstructive pulmonary disease) with chronic bronchitis
5	Diabetes 1.5, managed as type 2
6	Tourette's disease
7	Compression fracture of spine
9	Discharge from ear
10	Both parents smoke
11	Testosterone 17-beta-dehydrogenase deficiency

Tracked Problems
Click for Detail

Tracked Problem	Diagnosis	Currently tracking?
Cardio Disease	Old myocardial infarction	(•) Y ( ) N
CHF	CHF (congestive heart failure)	(•) Y ( ) N
Depression	Depression due to dementia	(•) Y ( ) N
Diabetes	Diabetes 1.5, managed as type 2	(•) Y ( ) N
COPD/Asthma	COPD (chronic obstructive pulmonai	(•) Y ( ) N
Hyperlipidemia	Lipid metabolism disorder	(•) Y ( ) N
Hypertension	Hypertension	(•) Y ( ) N
Other	Dementia	(•) Y ( ) N
Other	Hyperuricemia	(•) Y ( ) N

Total Chronic Conditions: 40
Total Tracked Problems: 9

Current Medications (Double-click to Add/Edit)

Reconcile

Brand Name	Generic Name	Dose	Sig Desc
ABILIFY	ARIPIPRAZOLE	2 mg	take 2.5 by oral route once
ASPIRIN EC	ASPIRIN	81 mg	inject by Subcutaneous route once daily DM250.50
LIPITOR	ATORVASTATIN CALCIUM	10 mg	take 1 tablet (10MG) by oral route every day at bedtime a needed
CELEBREX	CELECOXIB	50 mg	take 2 capsule by oral route 2 times every day
CELEBREX	CELECOXIB	50 mg	take 2 capsule by oral route 2 times every day
HYDROCODONE-ACETAMINOPHEN	HYDROCODONE/ACETAMINOPHEN	5 mg-500 mg	take 1 tablet by oral route every 6 hours as needed for pa
HYDROCODONE-ACETAMINOPHEN	HYDROCODONE/ACETAMINOPHEN	10 mg-300 mg	take 1 tablet by oral route every 8 hours as needed

Current Allergies (Double-click to Add/Edit)

Allergy	Date of Onset
NO KNOWN DRUG ALLERGIES	01/10/2013

[ ] Allergies reviewed/updated today.

Referrals Care Coordination Referral Diagnostic/Referral Orders

Ordered	Status	Priority	Order	Ordered By
09/04/2015	obtained	Routine	EEG	James Holly
07/21/2015	completed	Immediate	EGD	James Holly
07/20/2015	completed	Immediate	Colonoscopy	James Holly
07/20/2015	cancelled	Immediate	Uroflowometry	James Holly
07/20/2015	cancelled	Immediate	Thoracentesis	James Holly

Community Resources

Appointment History (3 Months)

Date	Kept	Provider	Type

Upcoming Appointments (3 Months)

Date	Kept	Provider	Type
09/28/2015	No	Holly, J	_Established Patient - ASAP

The CCM requires the patient to have at least two chronic conditions and documentation for each condition being tracked is required. The following is taken from the above template and shows what conditions are being tracked.

Patient's Current Chronic Problems

#	Diagnosis
1	Pancreatic cancer
2	Lipid metabolism disorder
3	Depression due to dementia
4	COPD (chronic obstructive pulmonary disease) with chronic bronchitis
5	Diabetes 1.5, managed as type 2
6	Tourette's disease
7	Compression fracture of spine
9	Discharge from ear
10	Both parents smoke
11	Testosterone 17-beta-dehydrogenase deficiency

Tracked Problems
Click for Detail

Tracked Problems		Currently tracking?
Cardio Disease	Old myocardial infarction	Y
CHF	CHF (congestive heart failure)	Y
Depression	Depression due to dementia	Y
Diabetes	Diabetes 1.5, managed as type 2	Y
COPD/Asthma	COPD (chronic obstructive pulmonai	Y
Hyperlipidemia	Lipid metabolism disorder	Y
Hypertension	Hypertension	Y
Other	Dementia	Y
Other	Hyperuricemia	Y

Total Chronic Conditions: 40 Total Tracked Problems: 9

When the Diabetes button outlined in green above is clicked the following pick list will be deployed:

Chronic Care Management - Diabetes

Return

Tracked Diabetes Diagnoses
Primary: Diabetes 1.5, managed as type 2
Secondary: Chronic kidney disease, stage II (mild)
Morbid obesity

Target HbA1c: 6.5
Set Date: 09/14/2015

HbA1c History
5.7 06/15/2015
5.7 06/15/2015
6.2

Diabetes Consortium Data Set

Patient Concerns Related to Diabetes
*Patient concerns copy forward to future visits until changed.

Comments

Ccm Diabetes

Appetite - My appetite has been poor, what should I do?
Blood Sugar Log - Can I send my Diabetes Self Management log to my provider?
Education - I need to go to diabetes education.
Exercise - Can I begin exercise; what should I do?
Follow-up Visit - Should I come in sooner than my next visit?
Follow-up Visit - When is my next appointment?
Hemoglobin A1c - What was my last result; what is my goal?
Hypoglycemia - I am having more episodes of low blood sugar.
Medications - Can I change my medication?
Medications - I can't afford my medications.
Nausea - I have been feeling badly with some nausea.
Preventive Care - Am I up-to-date with my screening and preventive care?
Vision - I need a appointment for an eye examination.

Close

There are seven structured data fields for Chronic Conditions for the CCM function; they are:

1. Cardiac Disease
2. CHF
3. Depression
4. Diabetes
5. COPD/Asthma
6. Hyperlipdemia
7. Hypertension

There are several non-designated fields to be used for other chronic conditions.

When completed, each Tracked Problem will have a CCM template similar to the one below for diabetes. When the Diabetes tab above is clicked the CCM tool shown below will be deployed. For diabetes, there will be a HbA1c target with a date for that being achieved. The last three HbA1c will be document automatically. The Diabetes Consortium Data Set which includes targeted goals will be listed as is seen below and a referral tool will be deployable from this template as well.

In addition, there is a place to document the patient's expressed concerns about their diabetes care and a place to denote whether diabetes was discussed in the current CCM contact with the discussion and plan.

Chronic Care Management - Diabetes

Return

Tracked Diabetes Diagnoses

Primary: Diabetes 1.5, managed as type 2

Secondary: Controlled type 2 diabetes with renal manifestatio

Chronic kidney disease, stage II (mild)

Target HbA1c: 6.5

Set Date: 09/14/2015

HbA1c History

5.7	06/15/2015
5.7	06/15/2015
6.2	04/08/2015

Diabetes Consortium Data Set

Diagnostic/Referral Orders

Patient Concerns Related to Diabetes

*Patient concerns copy forward to future visits until changed.

Patient Concerns	Addressed Today?	Discussion/Plan
Follow-up Visit - When is my next appointment?	Y	Scheduled appt for next tuesday with PCP
Medications - Can I change my medication?	Y	No changes until seen by PCP
	Y / N	
	Y / N	
	Y / N	

Comments

Time Tracking

Chronic Care Management

Patient Larry QTest
DOB 09/01/1959

Primary Insurance
Secondary Insurance

Return
Print

Patient Status
Currently active in CCM? (•) Y ( ) N
CCM Consent completed? (•) Y ( ) N
Date Completed Print 09/14/2015
Enrolled in NextMD? Yes

Primary Care Provider Holly, James L
Patient's Other Providers
Designated CCM Contact
( ) -

Time Tracking - Today All

Date	Subject

Chronic Care Management Time Tracking

Staff Jayne A. Nurse

Date 09/14/2015
Start 11:18 AM
Stop 11:38 AM
Total 20 mins

Subject Phone Call

Comments Monthly phone call with patient. Addressed concerns related to diabetes. Patient states he is feeling well and does not need anything until his office visit next week.

Be sure to click "Save" before "Close" or "Clear To Add."

Clear For Add | Delete | Save | Close