Patient-Centered Medical Home SETMA's Medical Home Coordination Review (MHCR) Tutorial

"The better the primary care, the greater the cost savings, the better the health outcomes, and the greater the reduction in health and health care disparities"

Because care coordination is the heart of the ideal of Medical Home, the hub of SETMA's Medical Home will be the **Medical Home Coordination Review** template. When the patient's care encounter is completed, the patient will be given a document which will summarize all of the Care Coordination issues which will be reviewed in this tutorial. The patient will be charged with the responsibility of directing their own care by requesting the points of care which the quality measures indicate they have not received and which are noted in this Care Coordination review document.

Accessing the Medical Home Coordination Review from AAA Home

There will be two possible alerts on the **AAA Home**, which address functions of the **Medical home Coordination Review**; they appear in red and are entitled:

- **Patient Has One or More Alerts** appears at the top of the **AAA template**. This alert refers to barriers to care such as hearing, seeing, reading, etc., which will impact the ability of the patient to receive and to direct their own care.
- Needs Attention -- appears under the Medical Home Coordination Review at the top right of the AAA template. This alert lets the provider know that an element of one or more of the six evidenced-based classes of quality measures which appear on the Medical Home Coordination of Care Review needs attention.

Pa Beneric Associates Pre-Vist/Pr	tient Chart Home Phone (Work Phone Cell Phone reventive Screening	QTest 409)833-9797 () - () -	Sex M Date of Birth Patient Bridges to Ex View	Age 43 06/30/1970 has one Clic cellence	Patient's C Or more al Ck Here to View A Inte	Code Status erts! Alerts ensive Behavioral Therapy franstheoretical 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 Referral PC-MH Coordination Referral PC-MH Coordination Referral Elderly Medication Summary STARS Program Measures Exercise Exercise I CHF Exercise I Diabetic Exercise I Diabetic Exercise I	Template Suite Master GP T Pediatrics Nursing Home Ophthalmology Physical There Podiatry W Rheumatology Hospital Care Hospital Care Daily Progress Admission Ord	ss I (<u>)</u> Summary I <u>Note</u> ers I	Disease Manag Diabetes I Hypertension Lipids I Acute Coronary Angina I Asthma Cardiometabolic CHF I Diabetes Educa Headaches Renal Failure Weight Manage	ement I <u>×Syn</u> I <u>×Risk Syn</u> I tion ment I	Last 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 Information
Patient's Pharmacy Phone () - Fax () - Rx Sheet - Active Rx Sheet - New Rx Sheet - New Rx Sheet - Complete Home Health	Pending Ref	Priority	Referral	Referrin	g Provider	Chart Note - Now Chart Note - Offline Return Info Return Doc Email Telephone Records Request Transfer of Care Doc

The first alert addresses special patient needs which are documented on the **Patient Alert popup** which normal launches from the GP Master Template. To the right of this notation, there is a button entitled "**click here to view alerts**." When this button is activated, the **Patient Alert** pop-up is launched.

 Patient is deaf Patient is hard of hearing, left ear Patient is hard of hearing, right ear Patient has hearing impairment Patient has vision impairment No information to family Spouse estranged Patient requires wheelchair Ambulance transit required No BP on left arm No BP on right arm CPS alert Adult Protective Services alert 	Substance alert Confidential labs Medical Power of Attorney Advanced Directives /// Patient speaks no English Literacy alert Patient name alert Nutritonal support Patient is mute Patient undergoes dialysis Allergen Injections
 Research participant Patient has been fired b 	у
Comments	
	- 1

The following are the communication issues which must be displayed:

- Identify and display in the record the language preference of the patient and family
- Assess both hearing and vision barriers to communication

These and other issues related to the patient's access to care are documented on SETMA's **Patient Alert pop-up** which can also be accessed from the GP Master template by clicking on the button entitled **Alert** which is found in the second column of the GP Master template. See the following screen shot:

PDM NURSE HISTORIES HE	EALTH QUIZES	HPI ROS P	E. X-RAY ASSESS PLAN PROCS	Home
Chart OTest	43 Years M	VISITIY	be raciily Payor	Nursing
Chief Complaints Comment	1.0.000		PCP	Histories
1			BP /	Health
2	Patient Goal	This Visit	Puise Pressure 0	Lab Basulta
3			Pulse	Lab Results
4			Resp	Questionnaires
5			Weight (lb)	HPI Chief
6			BMI Body Est	System Review
Chronic Conditions Archive Re-Order	HCC By Last Fr	relusted	BMR	Physical Exam
1		HPI-1,2	Cardiac Risk Ratio	Physical Exam
2	11		Fall Risk Assessment / /	Radiology
3	11	HPI-3,4	Functional Assessment / /	Assessment
4	11		Pain Assessment / /	Hydration
5	11	HPI-5,6	Stress Assessment / /	Nutrition
6	11		Wellness Assessment / /	
7		HPI-7,8	Nutrition Assessment //	Exercise
8	//		Sleep Questionnaire 77	Plan
9	//	HPI-9,10	Depression Screen //	Procedures
10			Pallistive Part Scale	Chart Note
11		HPI-11,12	Braden Scale //	Chart Hote
12		11014244	FAST Assessment	
14		HF1-13,14		1
15		HPI-15 16	Clinic Performance Measures	
16			X Alert	
17		HPI-17,18	Allergies	
18			Comments	
19	11	HPI-19,20	E-Mail Note HIPAA	
20	11		Telephone	
21	11		Vitals/Time	
22	11		Nursing Home Patient	
23			HCC Reviewed Today	
24			Last Reviewed / /	
25				

The second alert is found on the **AAA Home template** underneath the **Medical Home Coordination** button and is entitled "Needs Attention."



This alerts the provider that there is a deficiency in one or more of the following:

- 1. The Elderly Medication Summary (NCQA)
- 2. The HEDIS Measures (NCQA)
- 3. The NQF Measures (National Quality Forum)
- 4. The PQRS Measures (Centers for Medicare and Medicaid Services)
- 5. The PCPI Diabetes*
- 6. The PCPI Hypertension*

*Physician Consortium for Physician Performance Improvement Data Set

Each of these functions displays the evidence-based, quality measures published by the identified organization. The compliance of the patient's care with these measures is automatically displayed for quick and easy review by the provider. These functions will be described below.

Note: While there are six categories of evidenced-based measures which are tracked by SEMTA, numbers 5 and 6 appear only when a patient has diabetes and/or hypertension. If one or both of these buttons do not appear on the **Medical Home Coordination Review** template,, it is because the patient does not have that condition.

The **Medical Home Coordination Review** template is organized into three sections from top to bottom and into four columns left to right.

The first section from top to bottom has five lines in four columns and principally addresses demographic information about the patient. Each of the data points interact with all other elements of the EMR and are automatically filled when that information appears elsewhere in the EMR.

Patient Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-97 Work Phone () - Coordination Review Completed Yes Patient needs discussed today a Coordination Team Conference? C Yes	Image: Coordination Review Ancillary Agencies Home Health Hospice Assisted Living Yassisted Living Yassisted Living Physical Therapy Today? Last Reviewed It Care Last Reviewed No No	Medical Power of Attorney Medical Power of Attorney Primary Caregiver Primary Caregiver Relation Compliance Last H&P II Telephone Contact II Correspondence II Birthday Card II	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone () - Advanced Care Planning Code Status Advanced Directives Discussed? C Yes No 1/1 Advanced Directives Completed? C Yes No Date 1/1 Detail Barriers to Care NONE	€ No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes T Hypertension Yes No CHF Yes T Referral History Click for Detail Status Referral Referring Provider	Social Financial ✓ Deaf Co-Pays Hearing Medications Blind Vision Transportation Vision Transportation Literacy Uninsured Social Isolation None Assistive Devices Medicare Competitive Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair	Bid

The first column addresses the patient's personal information, which is automatically pulled from the EMR's enterprise practice management system:

- Name
- Date of Birth
- Sex and Age
- Home phone
- Work phone

Patient Chart QTest Date of Birth 06/30/197 Sex M Age 43 Years Home Phone (409)833-97 Work Phone () - Coordination Review Completed C Yes C Patient needs discussed today a Coordination Team Conference? C Yes C	Image: Second construction Ancillary Agencies Ancillary Agencies Home Health Home Health Hospice Assisted Living Home Health Yes Home Health Nursing Home Home Health Pysical Therapy Home Health Today? Last Reviewed 1 / I No Home Health Home Health Home Health Home Health Home Health Home Health Home Health Home Health Home Health Home Health Home Health	W Medical Power of Attorney Primary Caregiver Primary Caregiver Compliance Last H&P Telephone Contact Correspondence H Birthday Card //	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () CFNP () Coordinator () Nurse () Unit Clerk () Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Advanced Care Planning Code Status Advanced Directives Discussed? Yes No Advanced Directives Completed? Yes No Detail	○ No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes N Hypertension Yes No CHF Yes N Referral History Click for Detail Status Referral Referring Provider	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Usion Transportation Literacy Uninsured Social Isolation Language None Assistive Devices Medicare Competitive Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	Bid

The second column is entitled Ancillary Agencies from which and/or through which the patient is receiving services. The second and third column information will be principally gathered by a form given to each patient for completion and then will be entered by our staff. Once the data is entered on our current patients – this task should take six to twelve months, we will easily maintain the collection of that information on new patients.

- Home Health
- Hospice
- Assisted Living
- Nursing Home
- Physical Therapy

Patient Chart QTest Date of Birth 06/30/197 Sex M Age 43 Years Home Phone (409)833-97 Work Phone () - Coordination Review Completed C Yes Q Patient needs discussed today a Coordination Team Conference?	Ical Home Coordination Revie Ancillary Agencies Home Health 0 Assisted Living Assisted Living Nursing Home Physical Therapy Today? Last Reviewed Action No No	Medical Power of Attorney Primary Caregiver Primary Caregiver Compliance Last H&P Last H&P Telephone Contact Correspondence I Birthday Card	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or educating? Converting
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone () - Advanced Care Planning Code Status Advanced Directives Discussed? Yes No 11 Advanced Directives Completed? Yes No Date 11 Detail Barriers to Care NONE	C No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes N Hypertension Yes No CHF Yes N Referral History Click for Detail Status Referral Referring Provider	Social Financial ✓ Deaf Co-Pays Hearing Medications Bind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Language Medicare Competitive Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	Bid

The Third column addresses:

- Medical Power of attorney and telephone number Primary Care Giver and telephone number Emergency Contact and telephone number

Patient QTest Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-9 Work Phone () - Coordination Review Completed Yes Patient needs discussed today at Coordination Team Conference? "Yes	Ical Home Coordination Review Ancillary Agencies Home Health Hospice Assisted Living 797 Nursing Home Physical Therapy Today? Last Reviewed 1 No at Care Last Reviewed 1 No	Medical Power of Attorney Primary Caregiver Contact Co	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () CFNP () Coordinator () Nurse () Unit Clerk () Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status () - Advanced Care Planning - Code Status - Advanced Directives Discussed? / / Yes No / / Advanced Directives Completed? . Yes No Date Detail . .	⊂ No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes No Hypertension Yes No CHF Yes No Referral History <u>Click for Detail</u> Status Referral Referring Provider	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Assistive Devices Cane Splint/Brace Cane Splint/Brace Cane Splint/Brace Cane None Assistive Devices None Cane None None None None None None None None	Bid

The fourth column contains three navigation buttons:

- The first is entitled **RETURN** takes you back to AAA Home
- The second launches he **Transtheoretical Model Assessment** template
- The Third is entitled **Print note** and it prints the Medical home Coordination

Review document which is to be given to the patient.

Med Patient Chart QTest Date of Birth 06/30/197 Sex M Age 43 Years Home Phone (409)833-97 Work Phone () - Coordination Review Completed © Yes C Patient needs discussed today a Coordination Tame Conference?	ical Home Coordination Revious Ancillary Agencies Home Health Home Health Assisted Living Yange Service Home Health Assisted Living Yange Service Physical Therapy Today? Last Reviewed It Care Last Reviewed	Wedical Power of Attorney Primary Caregiver Emergency Contact Compliance Last H&P Telephone Contact Correspondence //	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate
C Yes C Chronic Conditions	No Care Coordination Team Phone Primary MD CFNP Coordinator Nurse C() Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance Lider Teactment and	Bithday Card // Evacuation Options Self Evacuation Contact Information Family Name Community Phone () - Advanced Care Planning Code Status Advanced Directives Discussed? Yes No 1/ Advanced Directives Completed? Yes No Date // Detail	and assist with office visit and/or education? O Yes O No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes Hypertension Yes No CHF Yes Referral Referring Provider	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None None Social Isolation Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	Bid

Clicking the Transtheoretical Model button launches the following pop-up.

Transtheoretical Mod Last Updated Reviewed	el Stages of Change	Return
Select Disease Diabetes		Transtheoretical Chart
Select Characteristic Clear • Unaware of Problem No Interest in Change • Aware of Problem Beginning to Think of Change • Realized Benefits of Making Change Thinking About How to Change • Actively Taking Steps Toward Change • Initial Treatment Goals Reached	Stage Precontemplation Appropriate Intervention Provide information about health risks and benefits of diabetes and Sample Dialogue Would you like to read some information about the health aspects of diabetes?	
OR-		
 Select Patient Verbal Cue Clear "I'm not really interested in my blood sugars. Its not a problem." "I know I need to control my sugar, but with all that's going on in my life right now, I'm not sure I can." "I have to get my diabetes under control, and I'm planning to do that." "I am doing my best. This is harder than I thought." "I've learned a lot through this process." 	Stage Precontemplation Appropriate Intervention Provide information about health risks and benefits of diabetes and Sample Dialogue Would you like to read some information about the health aspects of diabetes?	

This tool allows you to assess and document, the patient's current state of readiness to change their behavior. There are five, disease-specific options. Each option provides precise language for discussing with a patient their "readiness to change their behavior" of reach of the following conditions:

- CHF
- Diabetes
- Hypertension
- Lipids
- Weight Management

Transtheoretical Model Stages of Change 10/01/2013 Last Updated Reviewed Return Select Disease Diabetes Transtheoretical Chart Select Characteristic Clear Stage Precontemplation Unaware of Problem No Interest in Change Appropriate Intervention Aware of Problem Provide information about health risks Beginning to Think of Change and benefits of diabetes and Realized Benefits of Making Change С Sample Dialogue Thinking About How to Change Would you like to read some Actively Taking Steps Toward Change information about the health aspects of diabetes? C Initial Treatment Goals Reached --OR----Stage Select Patient Verbal Cue Clear "I'm not really interested in my Precontemplation blood sugars. Its not a problem." Appropriate Intervention "I know I need to control my sugar, Provide information about health risks but with all that's going on in my life and benefits of diabetes and right now, I'm not sure I can." Sample Dialogue C * I have to get my diabetes under Would you like to read some control, and I'm planning to do information about the health aspects of that." diabetes? "I am doing my best. This is harder than I thought." "I've learned a lot through this process."

You access these disease-specific options by selecting them from the disease field.

When you click in this field you will get a pop-up with the following options.



In that one of the goals of Medical Home is patient self-improvement and selfmanagement, it is important to be aware whether the patient is ready to make a change in his/her health and to have a recommendation as to how to address the patient's current state of readiness.

If a patient has not reached his/her goal in one of these conditions, or if the patient is not improving toward reaching that goal, the **Transtheoretical-Model Assessment** should be completed in order to assess where the patient is and what steps are required to encourage them to improve their health.

The results of this assessment will appear on the printed note which will be given to the patient and which will summarize the review of the Medical Home Coordination of Care. If more than one condition is assessed with this tool both will appear on the chart note.

Here is what the template would look like for a patient who has uncontrolled diabetes and who is not well motivated to change.

Select Disease Diabetes Transtheoretical Chart	Transtheoretical Model Stages of Last Updated Reviewed 10/01/2013	Change	urn
	ct Disease Diabetes	Transtheore	tical Chart
Select Characteristic Clear Stage • Unaware of Problem No Interest in Change Precontemplation • Aware of Problem Beginning to Think of Change Provide information about health risks and benefits of diabetes and • Realized Benefits of Making Change Thinking About How to Change Sample Dialogue • Actively Taking Steps Toward Change Would you like to read some information about the health aspects of diabetes?	ct Characteristic Clear Stage naware of Problem Precontemplation o Interest in Change Appropriate Interv ware of Problem Provide information eglized Benefits of Making Change Benefits of Making Change hinking About How to Change Sample Dialogue would you like to re Information about th diabetes? Mould you like to re	ention about health risks etes and ad some e health aspects of	
 Select Patient Verbal Cue Clear "I'm not really interested in my blood sugars. Its not a problem." "I know I need to control my sugar, but with all that's going on in my life right now, I'm not sure I can." "I have to get my diabetes under control, and I'm planning to do that." "I am doing my best. This is harder than I thought." "Tve learned a lot through this process." 	ct Patient Verbal Cue Clear 'm not really interested in my lood sugars. Its not a problem." Precontemplation Iknow I need to control my sugar, ut with all that's going on in my life ight now, I'm not sure I can." Appropriate Interv Provide information and benefits of diate I have to get my diabetes under ontrol, and I'm planning to do nat." Sample Dialogue Would you like to re information about th diabetes? Would you like to re wandoing my best. This is arder than I thought." Yve learned a lot through this process."	ention about health risks etes and ad some e health aspects of	

Under the heading "Select Characteristic", there are five choices which will display the patient's Stage of Change for the response they give. Depending upon which response a patient gives, one of the following stages will be displayed:

- 1. Pre-contemplation
- 2. Contemplation
- 3. Preparation
- 4. Action
- 5. Maintenance

Stage
Precontemplation
Appropriate Intervention
Provide information about health risks and benefits of diabetes and
Sample Dialogue
Would you like to read some information about the health aspects of
diabetes?

When a Stage of Change is selected, the following will be displayed:

- Stage of change
- Appropriate Intervention
- Sample dialogue

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Precontemplation

Appropriate Intervention

Provide information about health risks and benefits of diabetes and

Sample Dialogue

Would you like to read some information about the health aspects of diabetes?

Under the heading "**Select Patient Verbal cue**" there are five choices which are linked to the patients Stage of Change. Once the Stage of Change is selected, the patient's Verbal Cue should be noted.

Se	lect Patient Verbal Cue	Clear
۲	"I'm not really interested in r blood sugars. Its not a prob	ny lem."
0	"I know I need to control my but with all that's going on in right now, I'm not sure I can	r sugar, n my life ."
0	" I have to get my diabetes (control, and I'm planning to (that."	under do
0	"I am doing my best. This is harder than I thought."	
0	"I've learned a lot through th	is process."

Depending upon the Patient's "Verbal Cue" the following will appear:

- Stage of Change
- Appropriate Intervention
- Sample Dialogue

Stage

Precontemplation

Appropriate Intervention

Provide information about health risks and benefits of blood pressure control.

Sample Dialogue

Would you like to read some information about the health aspects blood pressure control?

To the right of these boxes, there is a button entitled **Transtheoretical Chart**.

Transtheoretical Moc Last Updated Reviewed	lel Stages of Change	Return
Select Disease Diabetes		Transtheoretical Chart
Select Characteristic Clear	Stage	
Unaware of Problem No Interest in Change	Precontemplation Appropriate Intervention	
 Aware of Problem Beginning to Think of Change 	Provide information about health risks and benefits of diabetes and	
C Realized Benefits of Making Change Thinking About How to Change	Sample Dialogue	
C Actively Taking Steps Toward Change	Would you like to read some information about the health aspects of disbates?	
OR Select Patient Verbal Cue <u>Clear</u>	Stage	
 "I'm not really interested in my blood sugars. Its not a problem." 	Precontemplation	
"I know I need to control my sugar, but with all that's going on in my life right now, I'm not sure I can."	Provide information about health risks and benefits of diabetes and	
C * I have to get my diabetes under	Sample Dialogue	
control, and I'm planning to do that."	Would you like to read some information about the health aspects of	
I am doing my best. This is harder than I thought."	diabetes?	
"Ive learned a lot through this process."		

When activated the entire chart for the condition chosen will appear. For instance if you had chosen "weight management," the following would appear.



SETMA I - 2929 Calder, Suite 100 SETMA II - 3570 College, Suite 200 SETMA W est, 2010 Dowlen (409) 833-9797 www.setma.com

Transtheoretical (Stages of Change) Model				
Stage	Characteristic	Patient verbal cue	Appropriate intervention	Sample dialogue
Precontemplation	Unaware of problem, no interest in change	"Im not really interested in weight loss. Its not a problem."	Provide information about health risks and benefits of weight loss	"Would you like to read some information about the health aspects of obesity?"
Contemplation	Aware of problem, beginning to think of changing	"I know I need to lose weight, but with all that's going on in my life right now, Im not sure I can."	Help resolve ambivalence; discuss barriers	"Let's look at the benefits of weight loss, as well as what you may need to change."
Preparation	Realizes benefits of making changes and thinking about how to change	" I have to lose weight, and Im planning to do that."	Teach behavior modification; provide education	"Let's take a closer look at how you can reduce some of the calories you eat and how to increase your activity during the day."
Action	Actively taking steps toward change	"I'm doing my best. This is harder than I thought."	Provide support and guidance, with a focus on the long term	"It's terrific that youre working so hard. What problems have you had so far? How have you solved them?"
Maintenance	Initial treatment goals reached	"I've learned a lot through this process."	Relapse control	"What situations continue to tempt you to overeat? What can be helpful for the next time you face such a situation?"

If you wish to use this tool to assess more than one condition in a visit, simply select as many of the options you wish and ALL of them will appear on your **Medical Home Coordination Review document**.

When you are through with this tool, click, **Return** and it will take you back to the **Medical Home Coordination Review template**.

Patient Otest Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-97 Work Phone () - Coordination Review Completed Yes Patient needs discussed today at Coordination Team Conference? ``Yes	ical Home Coordination Revie Ancillary Agencies Home Health Home Health Hospice Assisted Living YP7 Nursing Home Physical Therapy Today? Last Reviewed It Care Last Reviewed No	Wedical Power of Attorney Primary Caregiver Primary Caregiver Compliance Last H&P () Correspondence () Birthday Card () () Caregional () Correspondence () C	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Advanced Care Planning Code Status Advanced Directives Discussed? Yes No Yes No Orgen No Detail —	∽ No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes Yes No Hypertension Yes No CHF Yes T Referral History <u>Click for Detail</u> Status Referral Referring Provider	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Language None Assistive Devices Medicare Competitive Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	Bid

The button under the **Transtheoretical Model Assessment** is **Print Note**. Once the entire **Medical Home Coordination Review** has been completed, this button is launched in order to prepare a document which is given to the patient with the following instruction:

"This is a working tool. It is imperative that you review it for completeness, accuracy and usefulness to you. You should schedule a visit if any of your preventive health issues have not been completed and/or if there are issues raise with your review which require and explanation. You may choose to call your Nurse or Care Coordinator rather than scheduling a visit. The choice is yours."

The second section of the Medical Home Coordination Review only has four columns.

The first column tracks two events:

- Whether or not the coordination of care review was completed today -- if you reviewed this function on the current visit, you should click box next to this function.
- Whether or not the patient's care coordination needs were discussed at the team conference and if so what date and then the last time the team review was done is listed.

Patient Chart QTest Date of Birth 06/30/1970 Sex M Age Home Phone (409)833-9797 Work Phone () - Coordination Review Completed Today? Yes No Patient needs discussed today at Care Coordination Team Conference? Yes No	Home Coordination Review Ancillary Agencies Home Health Hospice Assisted Living Nursing Home Physical Therapy Last Reviewed / / Last Reviewed / /	Medical Power of Attorney Medical Power of Attorney Primary Caregiver () - Emergency Contact () - Relation Compliance Last H&P 1 1 Telephone Contact 1 1 Correspondence 1 1 Birthday Card 1 1	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? Or Yes
Chronic Conditions Care G Primary CFNP Coordi Nurse Unit Cl Eviden	Coordination Team Phone y MD () - nator () - () - () - () - () - () - () - () - () - erk () - Seconday/Speciality Physicians nce-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone () Advanced Care Planning Code Status Advanced Directives Discussed? Yes No /// Advanced Directives Completed? Yes No Date /// Detail	○ No
Disea Diabet Hyper Refer	se Management Tools Accessed es Yeb	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Cane Splint/Brace Cane Splint/Brace Cate Splint/Brace Cate Walker Hearing Aid Wheelchair Prosthetic Limb None]

In the second column of the second section, the following is captured. This will automatically be noted by the system and requires no action on your part.

- The last date the coordination of care review was completed
- The last date that the patient's coordination of care was discussed atteam conference

Patient QTest Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-97 Work Phone () - Coordination Review Completed Yes Patient needs discussed today as Coordination Team Conference? Yes	ical Home Coordination Ancillary Agencies Home Health Hospice Assisted Living Physical Therapy Today? Last Reviewed // No t Care Last Reviewed // No	Medical Power of Attorney Primary Caregiver () - Primary Caregiver () - Emergency Contact () - Relation Compliance Last H&P 1 Telephone Contact 1 Birthday Card	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C yes
Chronic Conditions	Care Coordination Team Phone Primary MD () CFNP () Coordinator () Nurse () Unit Clerk () Seconday/Speciality Physicians Evidence-Based Measures Compliance Evidence-Based Measures Compliance NQF Measures Compliance NGF Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Advanced Care Planning Code Status Advanced Directives Discussed? Yes No Advanced Directives Completed? Yes No Data / /	C No
	Disease Management Tools Accessed Diabetes Yee No Lipids Hypertension Yee Nto CHF Referral History Click for Detail Status Referral Referrin	Barriers to Care NONE Social Financial Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation Cane Splint/Brace Cane Splint/Brace Hearing Aid Wheelchair Prosthetic Limb None	aid

The third column documents four events which are related to the Medical Home and is entitled **Compliance**. This compliance relates to specific functions of the Medical Home. These are care-coordination issues and relate to the standards SETMA has established for communications with the Medical-Home patient beyond the contact time in the office. The one exception is the Last H&P which is a clinic-contact issue.

- Last H&P this will be captured automatically when you use the ICD-9 code V700 for Exam Well Adult, or V7231 for Exam GYN Gynecological Routine. It is important to use one of these codes as this is one HEDIS measure which requires that it be reported by the health plan through encounter data and not through a chart review or a report by the provider that they have done the examination.
- **Telephone contact** -- two times per year, the practice will contact the patient about their healthcare needs and/or about preventive care needs.
- **Correspondence** two times a year, the practice will contact the patient with education materials and/or with needed preventive care needs.
- **Birthday Card** each year, the practice will contact the patient via correspondence on his/her birth date both to acknowledge their birthday and to encourage them with needed preventive care measures.

Patient Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-97 Work Phone () - Coordination Review Completed	Ical Home Coordination F Ancillary Agencies Home Health Hospice Assisted Living Y97 Nursing Home Physical Therapy	Medical Power of Attorney Primary Caregiver Emergency Contact Relation Patient's E-mergency	urn stical Model Note
C Yes C Patient needs discussed today a Coordination Team Conference? C Yes C	No t Care Last Reviewed //	Last H&P // Student interr Telephone Contact // Student interr Correspondence // authorized to Birthday Card // and assist w and/or educa	is are participate th office visit tion? ○ Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Advanced Care Planning Code Status Advanced Directives Discussed? Yes No Yes No Directives Completed? Yes No Detail	[©] No
	Disease Management Tools Accessed Diabetes Yes No Lipids Hypertension Yes No CHF Referral History Click for Detail Status Referral Referring I	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Hearing Medications Hearing Medications Ution Usion Transportation Literacy Uninsured Social Isolation None Assistive Devices Assistive Devices Cane Splint/Brace Cane Splint/Brace Cane Splint/Brace Cane Splint/Brace Hearing Aid Wheelchair Prosthetic Limb None	

It is the intent of SETMA's Medical Home to contact the patient four times a year, other than at times the patient has an appointment, or comes to clinic. The contracts will be twice by correspondence and twice more by telephone calls. One of written correspondences will be a Medical-Home-birthday card which will acknowledge the patient's special day and include preventive health reminders to the patient and to their personal physician.

The fourth column has the patient's e-mail address

Patient QTest Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-97 Work Phone () - Coordination Review Completed () - Coordination Review Completed () Yes Patient needs discussed today as Coordination Team Conference? () Yes	ical Home Coordination Revie Ancillary Agencies Home Health Hospice Assisted Living '97 Nursing Home Physical Therapy Today? Last Reviewed I Care Last Reviewed No No	Wedical Power of Attorney Medical Power of Attorney Primary Caregiver Compliance Last H&P II Telephone Contact II Correspondence II Birthday Card II	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone () - Advanced Care Planning Code Status Advanced Directives Discussed? Yes No 11 Advanced Directives Completed? Yes No Date 11 Detail	○ No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes No Hypertension Yes No CHF Yes No Referral History Click for Detail Status Referral Referring Provider	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Language None Assistive Devices Cane Spint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	9 Bid

This is neither a secure nor an encrypted contact and cannot be used for communications with a patient of a confidential nature. For that capability, see the section on NextGen's web portal entitled NextMD.

The third section of the Medical Home Coordination Review has three columns.

The first column is a list of the patient's chronic conditions. This is essentially a **Patient Problem List**. While it is not displayed on the Medical Home Coordination Review, the patient's active medication list and medication allergies will appear on the **Medical Home Coordination Review document** which will be given to the patient each time it is reviewed.

Patient Chart QTest Date of Birth 06/30/1970 Sex M Age 43 Years Home Phone (409)833-979 Work Phone () -	Ancillary Agencies Ancillary Agencies Home Health Hospice Assisted Living Nursing Home Physical Therapy	Medical Power of Attorney Medical Power of Attorney Primary Caregiver Primary Caregiver Contact Relation	Return Transtheoretical Model Print Note
Coordination Review Completed To Yes 1 Patient needs discussed today at Coordination Team Conference? Yes 1	Iday? Last Reviewed // No Care Last Reviewed //	Compliance Last H&P / / / Telephone Contact / / Correspondence / / Birthday Card / /	Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - STNP () - Coordinator () - Iurse () - Iurse () - Init Clerk () - Seconday/Speciality Physicians Sidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status	© No
	Nisease Management Tools Accessed Nabetes Yes No Lipids Yes No typertension Yes No CHF Yes No Referral History Click for Detail Status Referral Referring Provider	Barriers to Care NONE Social Financial ✓ Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Language None Assistive Devices Medicare Competitive E Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	Bid

This provides the reviewer and/or physician a reminder of a patient's special and specific needs which should be considered in the Coordination of Care review.

The second column in the third section includes six elements

- Care Coordination Team
- Physician
- CFNP
- Care Coordinator
- Nurse
- Unit Clerk

Patient Chart QTest Date of Birth 06/30/197 Sex M Age 43 Years Home Phone (409)833-9 Work Phone () - Coordination Review Completed Yes Patient needs discussed today a Coordination Team Conference? Yes P	ical Home Coordination Revie Ancillary Agencies Home Health Hospice Assisted Living 797 Nursing Home Physical Therapy Today? Last Reviewed It Care Last Reviewed No	Medical Power of Attorney Medical Power of Attorney Primary Caregiver Compliance Last H&P // Telephone Contact // Correspondence // Birthday Card //	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () Primary MD () CFNP () Coordinator () Nurse () Unit Clerk () Secondary Provide any Physicians Ekderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status Advanced Care Planning Code Status Advanced Directives Discussed? Yes No 11 Advanced Directives Completed? Yes No Detail Detail Detail	℃ No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes N Hypertension Yes No CHF Yes N Referral History <u>Click for Detail</u> Status Referral Referring Provider	Barriers to Care J NONE Social Financial Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Assistive Devices Cane Splint/Brace Cane Splint/Brace Cane Splint/Brace Cane None Assistive Devices Prosthetic Limb None	Bid

The next element is a button entitled Secondary/Specialist Physicians.

Med	lical Home Coordination Revie	w	
Patient	Ancillary Agencies	Medical Power of Attorney	
Chart QTest	Home Health	() -	Return
Date of Birth 06/30/19	70 Hospice	Primary Caregiver	Taxaeth a santia al Mardal
Sex M Age 43 Year	s Assisted Living		Transtneoretical model
Home Phone (409)833-9	797 Nursing Home	Emergency Contact	Print Note
Work Phone () -	Physical Therapy		
		Relation	
Coordination Review Completed	Today? Last Reviewed / /	Compliance	Patient's E-mail Address
C Yes C	No	Last H&P	
Patient needs discussed today	at Care Last Reviewed //	Telephone Contact	Student interns are
Coordination Team Conference?		Correspondence //	authorized to participate
C Yes (No	Birthday Card 77	and assist with office visit
Chronic Conditions	Care Coordination Team Dhase	Evenuetion Options	and/or education? () Yes
		Evacuation Options	S NO
I		Family Name	
		Community Phone () -	
		Advanced Care Planning	
		Code Status	
	Seconday/Speciality Physicians		
	Evidence-based measures compliance	Advanced Directives Discussed?	
	Elderly Medication Summary	VYes VNo 177	
	HEDIS Measures Compliance	Advanced Directives Completed?	
	NQF Measures Compliance	◯ Yes ☉ No Date / /	
	PQRS Measures Compliance	Detail	
	Lipids Treatment Audit		
	1	Barriers to Care NONE	
	1	Social Financial	
	Disease Management Tools Accessed	✓ Deaf Co-Pays	
	Diabetes O Yes O No Lipids O Yes O N	Blind Nutrition	
	Hypertension C Yes C No CHF C Yes C N	Vision Transportation	
	Referral History Click for Detail	Literacy Uninsured	
	Status Referral Referring Provider	Social Isolation None	
		None	
L	-	Assistive Devices Medicare Competitive	Bid
		Cane Splint/Brace	
		Crutches Walker	
		Hearing Aid Wheelchair Drasthatia Limb Nana	
		None	

This button will launch the following template.

	Other D	octors	
	Last Updated/Review	ed //	
Cardiology Colorectal Surgery Dental Endocrinology Gastroenterology General Surgery		Nephrology Neurology Oncology Ophthalmology Orthopedics Podiatry	
Other MDs Seen	Specialty	Reason	_
			Ξ
		I	
	ОК	Cancel	

Because Medical-Home implies a **Medical Home Neighborhood**, it is important to know who other care gives are who participate in the care of this patient. As SETMA deploys NextGen's **Community Health Solutions** (interface engine, repository, physician portal), there will be a more seamless connectivity with the larger neighborhood. It will be the intent of SETMA's Medical Home to include each of the patient's specialist-care givers in the Community Health Solutions.

The next section is entitled **Evidenced-based Measures Compliance** and has six buttons**

- 1. The Elderly Medication Summary
- 2. The HEDIS Measures
- 3. The NQF Measures
- 4. The PQRS Measures
- 5. The PCPPI Diabetes*
- 6. The PCPPI Hypertension*

*(Physician Consortium for Physician Performance Improvement Data Sets) for:

**Remember, as previously noted, buttons 5 and 6 will ONLY appear in the records of patients with those diagnoses. If the patient has neither diabetes nor hypertension only four buttons will appear.

Mec Patient Chart QTest Date of Birth 06/30/19 Sex M Age 43 Year Home Phone (409)833-9 Work Phone () - Coordination Review Completed O Yes Q Patient needs discussed today Coordination Team Conference Q Yes Q	Ancillary Agencies Ancillary Agencies Home Health Hospice S Assisted Living Physical Therapy Today? Last Reviewed // No at Care Last Reviewed // No	Medical Power of Attorney Primary Caregiver Primary Caregiver () - Emergency Contact () - Relation Compliance Last H&P 1 Telephone Contact 1 Correspondence 1 Birthday Card 1	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Ekderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone () - Advanced Care Planning Code Status Advanced Directives Discussed? Yes No 1/1 Advanced Directives Completed? Yes No Date 1/1 Detail Barriers to Care NONE	© No
	Disease Management Tools Accessed Diabetes Yes Yes Info Lipids Yes Info Hypertension Yes Info CHF Yes Info Referral History Click for Detail Status Referral Referring Provider	Social Financial ✓ Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social isolation None Language Medicare Competitive E Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	id

These functions will be discussed below.

The next element is **Disease management Tools Accessed**.

- Diabetes
- Hypertension
- Lipids
- CHF

Patien	t Chart Home Phone (Work Phone Cell Phone (QTest 409)833-9797 () - () -	Sex M Date of Birth Patient I	Age <u>43</u> 06/30/1970 has one or <u>Click H</u>	Patient's Cod	e Status ts! ts
Pre-Vist/Prev	entive Screening		Bridges to Exc <u>View</u>	cellence	Intens <u>Trai</u>	ive Behavioral Therapy <u>istheoretical 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 NOF PORS ACO Elderly Medication Summary STARS Program Measures Exercise Exercise _T CHF Exercise _T Diabetic Exercise _T	Template Suitu Master GP T Pediatrics Nursing Home Ophthalmology Physical There Podiatry Rheumatology Hospital Care Hospital Care Daily Progress Admission Orc	es I Y apy Summary I tNote lers I	Diabetes I Hypertension I Lipids I Acute Coronary Angina I Asthma Cardiometabolic CHE I Diabetes Educate Headaches Renal Failure Weight Managen	Sym I Control	st Updated /// /// /// /// /// /// /// /// /// /	Special Functions Lab Present T Lab Future T Lab Results T Hydration T Nutrition T Guidelines T Pain Management Immunizations Reportable Conditions Information Charge Posting Tutorial Drug Interactions T E&M Coding Recommendations Infusion Flowsheet Insuin Infusion
Patient's Pharmacy	Pending Ret	ferrals T	Defend	Defension De		Chart Note - Now
	Status	Priority	Referral	Referring Pro	ovider	Chart Note - Offline
Phone () -						Return Info
rax j()-						Return Doc
Rx Sheet - Active						Email
Rx Sheet - New					an an an an an an 's come	Telephone
Rx Sheet - Complete	•				•	Records Request
Home Health						Transfer of Care Doc

From AAA Home, when a specific disease-management tool is:

- accessed and completed on any of these four conditions, and
- when the follow-up document is printed and given to the patient,

the radial button next to that condition will be highlighted on the **Medical Home Coordination Review** template.

Note: Because these radial buttons cannot be changed from the template and because they are in demographic fields which means they come forward at each visit, the highlighting is faded.

Patient QTest Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-9 Work Phone () - Coordination Review Completed Yes Patient needs discussed today of Coordination Team Conference? Yes	Iical Home Coordination Revie Ancillary Agencies Home Health 70 Hospice a Assisted Living 797 Nursing Home Physical Therapy Today? Last Reviewed 1 / No	W Medical Power of Attorney Primary Caregiver Compliance Last H&P Telephone Contact Correspondence I Birthday Card I I I I I I I I I I I I I	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education?
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status () - Advanced Care Planning () - Code Status () - Advanced Directives Discussed? () / / C Yes No / / Advanced Directives Completed? () / / Detail	No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes No Hypertension Yes No CHF Yes No Status Referral Referring Provider	Social Financial	id

The last element in this column is the **Referral History**. The most recent referrals are displayed in this window.

Patient Chart QTest Date of Birth 06/30/197 Sex M Age 43 Years Home Phone (409)833-9 Work Phone () - Coordination Review Completed Yes C Patient needs discussed today a Coordination Team Conference?	Item Coordination Review Ancillary Agencies Home Health Hospice Assisted Living Yes Physical Therapy	Medical Power of Attorney Medical Power of Attorney Primary Caregiver Emergency Contact Emergency Contact Compliance Last H&P I Telephone Contact I Correspondence I Birthday Card I I	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C vase
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PRS Measures Compliance	Evacuation Options Self Evacuation Contact Information Family Name Community Phone () - Advanced Care Planning Code Status Advanced Directives Discussed? Yes No 11 Advanced Directives Completed? Yes No Date 11 Detail	C No
	Lipids Treatment Audit Disease Management Tools Accessed Diabetes Yes No Lipids Yes The Hynertension Yes The Lipids Yes The Referral History Click for Detail Status Referral Referring Provider	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Literacy Uninsured Social Isolation None Language None Assistive Devices Cane Splint/Brace Cane Splint/Brace Cane Prosthetic Limb None	Bid

There is a button entitled **Click for Detail** beside the title **Referral History** which launches the following:

Patient Chart OTest Date of Birth Sex M Age 43 Years Home Phone (409)833-97 Work Phone () Coordination Review Completed T Cytes O Patient needs discussed today at Coordination Team Conference?	Coordination Review Ancillary Agencies Home Health	Medical Power of Attorney Primary Caregiver Primary Caregiver Compliance Last H&P Telephone Contact I Correspondence I Birthday Card I	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? Corves
Chronic Conditions	Care Coordination Team Phone Primary MD () CFNP () Coordinator () Nurse () Unit Clerk () Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status Advanced Directives Discussed? Yes No // Advanced Directives Completed? Yes No Date // Detail	C No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes No Hypertension Yes No CHF Yes No Referral History Click for Detail	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Language None Assistive Devices Cane Splint/Brace Cane Splint/Brace Cane Walker Hearing Aid Wheelchair Prosthetic Limb None	a

This will launch a list of all of the referrals which this patient has ever been given and will show their status. To make certain that no referral is not completed and/or no patient does not follow through, IT will run a query and will let SETMA operations know of patients whose referrals have either not been completed by our department or where we do not have a report from the referral source.

		Patien	t Referral History		Return
ate Si	tatus	Priority	Referral	Referred To	Referring Provider

The third column in this third section of the Medical Home Coordination Review template has the following elements:

- Evacuation Options
- Advanced Care Planning
- Barriers to Care

Patient Chart QTest Date of Birth 06/30/19 Sex M Age 43 Year Home Phone (409)833-9 Work Phone () - Coordination Review Completed C Yes Q Patient needs discussed today Coordination Team Conference?	Ical Home Coordination Revie Ancillary Agencies Home Health 0 Hospice a Assisted Living 797 Nursing Home Physical Therapy Today? Last Reviewed / / No at Care Last Reviewed / /	Medical Power of Attorney Primary Caregiver Primary Caregiver Compliance Last H&P I I Telephone Contact I I Correspondence I I Birthday Card I I	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit Disease Management Tools Accessed Diabetes Yes Yes No Referral History Click for Detail	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status	d

Each of the specific issues documented here are linked to other data points in the EMR where the same information is captured. This avoids redundancy in data entry and leverages the power of the EMR.

Evacuation Options allows the Medical Home to know who needs special help in the case of a mandatory evacuation being called by the local authorities. This function identifies who will be responsible for the patient's evacuation:

- Self
- Family
- Community

Patient Chart QTest Date of Birth 06/30/197 Sex M Age 43 Years Home Phone (409)833-97 Work Phone () - Coordination Review Completed © Yes C Patient needs discussed today a Coordination Team Conference?	ical Home Coordination Ancillary Agencies Home Health Hospice Assisted Living '97 Nursing Home Physical Therapy Today? Last Reviewed No t Care Last Reviewed No	Medical Power of Attorney Primary Caregiver Primary Caregiver Primary Contact Relation Compliance Last H&P / Telephone Contact / Correspondence Birthday Card //
Chronic Conditions	Care Coordination Team P Primary MD (CFNP (Coordinator (Nurse (Unit Clerk (Seconday/Speciality Physicians Evidence-Based Measures Complia HEDIS Measures Complian NQF Measures Complian PQRS Measures Complian Lipids Treatment Audit	Image: Self Evacuation Options Self Evacuation Contact Information Family Name Community Phone Advanced Care Planning Code Status Code Status Code Status Or Yes Or No Or Yes Or No Or Yes Or No Or Yes Or No Detail
	Disease Management Tools Acces Diabetes 7/25 16 Lipit Hypertension 7/25 16 CHF Referral History <u>Click for Detail</u>	Barriers to Care NONE Social Financial d Yes No Yes No Social Solation Hearing Medications Blind Nutrition Usion Transportation Literacy Uninsured Social Isolation Social Isolation None Assistive Devices Cane Splint/Brace Cane Splint/Brace Cane Hearing Aid Wheelchair Prosthetic Limb None

This function also provides a place to document the name and phone number of the family member or community agency which should be contacted to provide evacuation for this patient.

Advanced Care Planning is a HEDIS and a Medical Home requirement for older adults and it is a requirement of Medical Home. This function allows for the documentation of the patient's:

- Code status
- Whether Advanced Directive was discussed at the present encounter*
- Whether the patient has an Advanced Directive
- Advanced Care Directive details

Patient Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-97 Work Phone () - Coordination Review Completed Coordination Review Completed Coordination Team Conference? Patient needs discussed today a Coordination Team Conference?	Cal Home Coordination Reality Agencies Ancillary Agencies Home Health Assisted Living Assisted Living 97 Nursing Home Physical Therapy Today? Last Reviewed I Care Last Reviewed I No	Medical Power of Attorney Primary Caregiver Primary Caregiver Emergency Contact Compliance Last H&P /// Telephone Contact /// Correspondence // Birthday Card //	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or educatino? Correction
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance NQF Measures Compliance Lipids Treatment Audit Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Advanced Care Planning Code Status Advanced Directives Discussed? Yes No Yes No Advanced Directives Completed? Yes No Detail	C No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes Hypertension Yes No CHF Yes Referral History Click for Detail	Social Financial V Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Assistive Devices Cane Caruches Walker Hearing Aid Wheelchair Prosthetic Limb None	1

Whether Advanced Directive was discussed – one of the HEDIS measures for "care for older adults" requires that the advanced directive be on file, or that it be discussed at the current encounter. When you click the check box next to this function on the Medical Home Coordination Review template, it will automatically result in your receiving credit for this function.

If you check the box next to "Advanced Directive was discussed" or that "Whether the patient has an Advanced Directive", the following HEDIS Measure (see below) will be credited for this patient's Care for Older Adults record.

Care for Older Adults				
Routine care measures for patients 65 years of age and older.				
Patients should have advanced care planning in place.				
Advanced Directives Discussed? 🛛 Yes 🔘	No			
Advanced Directives Completed? ု Yes 📀	No			
Date Completed/Updated / /				
Comments/Detail				
	Date of Last Test			
Patients should have a medication assessment and reconciliation at least y	rearly. / /			
Patients should have a functional assessment evaluation at least yearly.	/ / Click to Complete			
Patients should have a pain screening evaluation at least yearly.	/ / Click to Complete			
OK Cancel				

The Barriers to Care section of the Medical Home Coordination Review template allows for the aggregation of data which is collected elsewhere. Three categories of barriers are reviewed:

- Social
- Financial
- Assistive Devices
| Patient
Chart QTest
Date of Birth 06/30/197
Sex M Age 43 Years
Home Phone (409)833-9
Work Phone () -
Coordination Review Completed
Yes Q
Patient needs discussed today a
Coordination Team Conference? | ical Home Coordination Review Ancillary Agencies Home Health Home Health Assisted Living Yara Assisted Living Pyro Nursing Home Physical Therapy Today? Last Reviewed It Care Last Reviewed No | Medical Power of Attorney Primary Caregiver Primary Caregiver Emergency Contact Compliance Last H&P I I Telephone Contact I I Correspondence I I Birthday Card I I | Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C vas |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Chronic Conditions | Care Coordination Team Phone Primary MD () - CFNP () - Cordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit | Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status Advanced Directives Discussed? Yes No Yes No Detail Co-Pays Hearing Medications Bind Uninsured Vision Transportation Literacy None None Splint/Brace None Splint/Brace Valker Hearing Aid None None | C No |

The Social Barriers of special interest to the Medical-Home-Coordination team are:

- Hearing
- Vision
- Literacy
- Social Isolation
- Language Preferred Language

Each of these data points is already collected in the EMR under Patient Alerts.

Financial Barriers identifies issues in the patient's care which prevents them from obtaining care due to financial limitations including their inability to pay for:

- Co-pays
- Medications
- Nutrition
- Transportation
- Uninsured

Med Patient Chart QTest Date of Birth 06/30/197 Sex M Age 43 Years Home Phone (409)833-9 Work Phone () - Coordination Review Completed Yes Patient needs discussed today a Coordination Team Conference? Yes C	Ical Home Coordination Review Ancillary Agencies Home Health 0 Hospice s Assisted Living 797 Nursing Home Physical Therapy Today? Last Reviewed 1 No No	Medical Power of Attorney Primary Caregiver Emergency Contact Compliance Last H&P I leiphone Contact Correspondence I i l Birthday Card I l	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status Advanced Directives Discussed? Yes No /// Advanced Directives Completed? Yes No Date // Detail	○ No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes No Hypertension Yes No CHF Yes No Referral History <u>Click for Detail</u> Status Referral Referring Provider	Barriers to Care Social Financial Co-Pays Hearing Blind Vision Literacy Social Solatio Language None Assistive Devices Cane Crutches Hearing Aid Wheelchair Prosthetic Limb None None	Bid

While SETMA's resources are limited, The SETMA Foundation has been established to assist in the obtaining of care by our patients who need financial help in obtaining care.

The final Barriers-to-Care is **Assistive Devices**. This is a list of devices which may be used by our patients, including:

- Cane
- Crutches
- Hearing Aid
- Prosthetic Limbs
- Spine/Brace
- Walker
- Wheelchair

The Medical Home Coordination Review will identify the use of these devices as they will affect the patients assess to care and often will limit the kinds of care which can be prescribed for the patient in regard to therapy and exercise.

Med	ical Home Coordina	tion Review	N	
Chart OTest	Home Health		Medical Power of Attorney	······
cliait diest			Primany Caregiver	Return
Date of Birth 06/30/197	0 Hospice			Transtheoretical Model
Sex M Age 43 Years	Assisted Living		Emergency Contact	Print Note
Home Phone (409)833-97	797 Nursing Home		()-	
Work Phone () -	Physical Therapy		Relation	
Oceantication Devices Convoluted	Today 2 Loost Devision of		Compliance	Patient's E-mail Address
Coordination Review Completed	Last Reviewed		Last H&P //	
U Yes U	NO		Telephone Contact	
Patient needs discussed today a	t Care Last Reviewed	11	Correspondence //	Student interns are
Coordination Team Conference?			Birthday Card / /	and assist with office visit
U Yes U	No			and/or education? () Yes
Chronic Conditions	Care Coordination Team	Phone	Evacuation Options	🔘 No
	Primary MD	() -	Self Evacuation Contact Information	
	CFNP	() -	Family Name	
	Coordinator	() -	Community Phone () -	
	Nurse	() -		
	Unit Clerk	() -	Advanced Care Planning	
	Seconday/Speciality Physic	ans	Code Status	
	Evidence-Based Measures Con	npliance	Advanced Directives Discussed?	
	Elderly Medication Su	immary	○ Yes ○ No / /	
	HEDIS Measures Com	nliance	Advanced Directives Completed?	
·	NOF Measures Com	pliance	◯ Yes ⊙ No Date //	
	PORS Measures Com	nliance	Detail	
	Lipids Treatment A	udit	Detail	
			Barriers to Care NONE	
			Social Financial	
	Disease Management Tools Ag	ressed	Deaf Co-Pays	
	Diabetes O Yes O No	Lipids O Yes O No	Hearing Medications	
	Hypertension 🔘 Yes 🔘 No	CHF O Yes O No	Blind Nutrition	
	Referral History Click for Deta	iil	Literacy Uninsured	
	Status Referral	Referring Provider	Social Isolation 🗌 None	
	Trefendi	issiening i rovider	Language	
L		1	Medicare Competitive	e Bid
			Assistive Devices	
			Crutches Walker	
		•	🗌 🗌 Hearing Aid 📄 Wheelchair	
			Prosthetic Limb None	

Evidenced-Based Measures for Quality of Care

The Following is the full detail of using the six categories which appear under the heading Evidenced-based Measures Compliance, in the second column of the Medical Home Coordination Review where there are 6 buttons:

- 1. The Elderly Medication Summary
- 2. The HEDIS Measures
- 3. The NQF Measures
- 4. The PQRS Measures
- 5. The PCPI Diabetes Data Set*
- 6. The PCPI Hypertension Data Set*

*These two buttons only appear when the patient is being treated for these conditions.

Patient QTest Chart QTest Date of Birth 06/30/197 Sex M Age Home Phone (409)833-97 Work Phone () - Coordination Review Completed () Yes QTest Patient needs discussed today at	Ical Home Coordination Revie Ancillary Agencies Home Health 0 Hospice a Assisted Living 797 Nursing Home Physical Therapy Today? Last Reviewed / / No at Care Last Reviewed / /	W Medical Power of Attorney Primary Caregiver Emergency Contact Compliance Last H&P Telephone Contact I	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are
Coordination Team Conference?	No	Birthday Card	authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance Lipids Treatment Audit	Evacuation Options Self Evacuation Contact Information Family Name Community Phone Code Status	© No
	Disease Management Tools Accessed Diabetes Yes No Lipids Yes N Hypertension Yes No CHF Yes N Referral History <u>Click for Detail</u> Status Referral Referring Provider	Barriers to Care NONE Social Financial Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Language None Assistive Devices Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	Від

The First button is the Elderly Medication Summary

Use of High-Risk Medications in the Elderly Avoidance of high-risk medications in patients ages 65 years of age and older. Listed below are the medications which are acitve in this patient and are condsidered high-risk for use in the elderly.			
Medication	Action	Discussed with patient?	
	ОК	Cancel	

This aggregates the material which is gathered automatically on the HEDIS Measures templates where there are six categories of medications which are potentially hazardous in older adults:

- High Risk Medications
- Medications which are contraindicated in the following conditions in older adults
 - 1. Arthritis
 - 2. COPD
 - 3. Dementia
 - 4. Depression
 - 5. Insomnia

When a medication is found which falls into these categories the name of that medication will appear in the appropriate list. The Alert under the **Medical Home Coordination** button on AAA entitled "**needs attention**," alerts that provider that this needs attention.

In the two columns beside the medication listed, the provider can document the action taken. When the provider clicks in the space entitled "**action**," the options on the pop-up are:

- Medication changed
- Medication stopped
- Reviewed, must be continued

When this is done, in the space entitled, "**Discussed with patient?**," the provider can designate whether this action was discussed with the patient with a "yes" or "no."

The second button is HEDIS Measures Compliance

What is HEDIS? -- Healthcare Effectiveness Data and Information Set published by he National Committee on Quality Assurance (NCQA) HEDIS measures are used by more than 90% of United States health plans to measure the effectiveness of care provided through their plans. HEDIS measures effectiveness of preventive care, acute care and chronic care based on the results of evident-based studies.

When this button I launched it displays the **HEDIS Measures Compliance template** which is entitled, "2009 HEDIS Technical Specifications for Physician Measurement."



This template lists all of the HEDIS measures for which providers are responsible. All of the activity and fulfillment of the HEDIS measures on this template are captured automatically.

In the course of the patient encounter, the provider will access this and other evidenced-based quality measures. Those which appear in **red** will be reviewed and the action required to fulfill that

measure will be taken, i.e., if the colorectal screening shows up in **red**, the provider will order a stool for occult blood, a colonoscopy, a double contrast barium enema or a flexible sigmoidoscopy. When the results of the study, or procedure is returned, the measure will be marked as met.

To the right of the HEDIS measures are the following buttons:

- Return this takes you back to the AAA Home screen
- **Tutorial** this makes it possible for you to review the content of all of the HEDIS measures whether or not they apply to the current patient or not. To revert back to the display of only those HEDIS measures which apply to the current patient, simply exit the template and then return.
- There are three Help buttons which display:
 - 1. NCQA this gives information about the National Committee on Quality Assurance.
 - 2. **CAHPS** this gives information about the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program.
 - 3. **HEDIS** this gives information about the Healthcare Effectiveness Data and Information Set.

At the top of the template is a section entitled, "LEGEND," which explains that:

*The measures which apply to the current patient and are not fulfilled appear in **RED**. The measures which apply to the current patient and are fulfilled appear in **BLACK**. The measures which do not apply to the current patient are grayed out.

	2012 HEDIS Technical Specifications for Physician Measurement				
Leger	nd Measures in red are measures which apply to this Measures in black are measures which apply to the	s patient that an his patient that	re not in compliance are in compliance.	Tutorial	
	Measures in gray are measures which do not app	bly to this patie	nt	Information	
Effect	iveness of Preventive Care	Effect	iveness of Chronic Care	NCQA	
<u>View</u>	Adult BMIAssessment Weight Assessment and Counseling for Nutrition and Physical Activity, for Children/Adolescents	<u>View</u> View	Persistence of Beta-Blocker Therapy After a Heart Attack Controlling High Blood Pressure	CAHPS HEDIS	
	Childhood Immunization Status Immunizations for Adolescents	View	Cholesterol Managment for Patients with Cardiovascular Disease		
	Lead Screening in Children		Comprehensive Adult Diabetes Care		
	Colorectal Cancer Screening Breast Cancer Screening Cervical Cancer Screening	<u>View</u> <u>View</u>	Use of Appropriate Medications for People with Asthma Use of Spirometry Testing in the Assessment and Diagnosis of COPD		
	Chlamydia Screening in Women Glaucoma Screening in Older Adults	<u>View</u> <u>View</u>	Pharmacotherapy Management of COPD Exacerbation Follow-Up After Hospitalization for Mental Illness		
	Use of High-Risk Medications in the Elderly Care for Older Adults	<u>View</u>	Antidepressant Medciation Management Follow-Up Care for Children Prescribed Attention_Deficit/Hymeractivity Disorder Medication		
Effect	iveness of Acute Care		Osteoporsis Management in Women		
<u>View</u>	Appropriate Treatment for Children with Upper Respiratory Infection		Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis		
View	Appropriate Testing for Children with Pharyngitis Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	<u>View</u>	Annual Monitoring for Patients on Persistent Medications Medication Reconciliation Post-Discharge		

Below this explanation is listed the three categories of HEDIS measures

1. Effectiveness of Preventive Care where there are 10 measures

Effectiveness of Preventive Care

Adult BMI Assessment
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Childhood Immunization Status
Lead Screening in Children
Colorectal Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women
Glaucoma Screening in Older Adults
Use of High-Risk Medications in the Elderly
Care for Older Adults

2. Effectiveness Acute Care where there are 5 measures

Effectiveness of Acute Care View Appropriate Treatment for Children with Upper Respiratory Infection View Appropriate Testing for Children with Pharyngitis View Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis View Use of Imaging Studies for Low Back Pain View Comprehensive Back Pain Care

3. Effectiveness of Chronic Care where there are 13 measures

Effectiveness of Chronic Care

<u>View</u>	Persistence of Beta-Blocker Therapy After a Heart Attack
View	Controlling High Blood Pressure
<u>View</u>	Cholesterol Managment for Patients with Cardiovascular Disease
<u>View</u>	Comprehensive Adult Diabetes Care
View	Use of Appropriate Medications for People with Asthma
<u>View</u>	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
<u>View</u>	Pharmacotherapy Management of COPD Exacerbation
View	Follow-Up After Hospitilization for Mental Illness
View	Antidepressant Medication Management
<u>View</u>	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication
<u>View</u>	Osteoporsis Management in Women
<u>View</u>	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
View	Annual Monitoring for Patients on Persistent Medications
View	Potentially Harmful Drug-Disease Interactions in the Elderly
View	Medication Reconciliation Post-Discharge

Screen shots of each of these 28 measures will now be displayed with:

- 1. The name of the measure listed first
- 2. Followed by a screen shot of the pop-up which defines the content of the measure launched. The content will typically define:
 - a. The age ranges to which the measure applies
 - b. The metric which the measure addresses, i.e., the blood pressure, LDL, etc.

*Remember, for any particular patient ONLY those HEDIS measures which apply to a particular patient will be in **red** or **black** according to the **LEGEND** above.

1. Effectiveness of Preventive Care

Adult BMI Assessment

Adult Body Mass Index		
Measurement of Body Mass Index (BMI) for patients 18 to 74 years of age.		
Patient Height 0.00 inches		
Patient BMI		
Please enter both the patient's height and weight to complete the calculation for Body Mass Index.		
OK Cancel		

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
Assessment of BMI percentile for children 2 to 17 years of age.		
Was the patient's BMI percentile assessed today? No		
Body Mass Index Value Percentile		
OK Cancel		

Childhood Immunization Status

Childhood Immunization Status			
Children should have each of the following	vaccinations by the time of their second birthday.		
Date of Birth	06/30/1970		
DTP/DTap 1	11		
DTP/DTap 2	11		
DTP/DTap 3	11		
DTP/DTap 4	11		
OPV/IPV 1	11		
OPV/IPV 2	11		
OPV/IPV 3	11		
MMR 1	11		
Hib 1	11		
Hib 2	11		
Varicella 1	11		
Prevnar 1	11		
Prevnar 2	11		
Prevnar 3	11		
Prevnar 4	11		
ОК	Cancel		

Lead Screening in Children

Lead Screening in Children			
Children 2 years of age who have had a lead screening by the time of their second birthday.			
Date of Birth Last Lead Screening	06/30/1970		
OK Cancel			

Colorectal Cancer Screening

Colorectal Cancer Scree Colorectal cancer screening for patients 50 to 80 ye	ning ears of age.
Patients should have at least one of the following	Date of Last Test
Fecal occult blood test within the last year.	11
Flexible sigmoidoscopy within the last four years.	11
Double contrast barium enema within the last four years.	11
Colonscopy within the last nine years.	11
OK Cancel	

Breast Cancer Screening

Breast Cancer Scre	ening
Breast cancer screening for women 40 to	69 years of age.
Patients should have mammogram yearly.	Date of Last Test
OK	

Cervical Cancer Screening

Cervical Cancer Screening
Cervical cancer screening in women 21 to 64 years of age.
Date of Last Test Patients should have Pap test at least every two years.
OK Cancel

Chlamydia Screening in Women



Glaucoma Screening in Older Adults

Glaucoma Screening in Older Adults	
Glaucoma screening for patients 65 years of age and older.	
Date of Last Test Patients should have a dilated eye exam yearly.	
OK Cancel	

Use of High-Risk Medications in the Elderly

Use of High	-Risk Medications	in the Elderly
Avoidance of high-risk medie	cations in patients ages 65 years of	age and older.
Listed below are the medications which are acitve in this patient and are condsidered high-risk for use in the elderly.		
Medication	Action	Discussed with patient?
	OK Cancel	

Care for Older Adults

Care for Older Adults	5
Routine care measures for patients 65 years of ag	ge and older.
Patients should have advanced care planning in place.	
Advanced Directives Discussed? 🔿 Yes 🔿 No	
Advanced Directives Completed? O Yes 💿 No	
Date Completed/Updated / /	
Comments/Detail	
	Date of Last Test
Patients should have a medication assessment and reconciliation at least yearly	<u>, //</u>
Patients should have a functional assessment evaluation at least yearly.	/ / Click to Complete
Patients should have a pain screening evaluation at least yearly.	/ / Click to Complete
OK	

2. Effectiveness of Acute Care

Appropriate Treatment for Children with Upper Respiratory Infection

Appropriate Treatment for Children with Upper Respiratory Infection		
Children 3 months to 17 years of age who were diagnosed with upper respiratory infection.		
Was the patient diagnosed with only an upper respiratory infection today? No Was the patient prescribed antibiotic therapy today? No		
OK Cancel		

Appropriate Testing for Children with Pharyngitis

Appropriate Treatment for Children with	h Pharyngitis	
Children 2 to 18 years of age who were diagnosed with pharyngitis.		
Was the patient diagnosed with acute pharyngitis today? No		
Was the patient given a strep test for the episode? Was the patient prescribed antibiotics today?	No	
]	
]	
OK Cancel		

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	
Avoidance of antibiotic treatment for acute bronchitis in patients 18 to 65 years of age.	
Did the patient have diagnosis of acute bronchitis this visit? Was the patient prescribed antibiotic therapy this visit? OK OK	

3. Effectiveness of Chronic Care

Persistence of Beta-Blocker Treatment After a Heart Attack

Persistence of Beta-Blocker Treatment A Patients 18 years of age and older who were hospitalized and discharged alive with a	fter a Heart Attack a diagnosis of acute myocardial infarction.
Has the patient had a history of acute myocardial infarction within the last 12 months?	No
Is the patient currently on beta-blocker therapy?	
OK	

Controlling High Blood Pressure

Controlling High Blood Pressure
Patients 18 to 85 years of age with a diagnosis of hypertension.
Does the patient have a chronic or recent diagnosis of hypertension? No Has the patient's blood pressure been well controlled for last three months (<140/90) ? Yes
Blood Pressure History (most recent first)
Date/Time Systolic Diastolic
OK Cancel

Cholesterol Management for Patients with Cardiovascular Disease

Cholesterol Management for Patie	nts
with Cardiovascular Conditions	
Does the patient have a history of	
acute myocardial infarction?	No
coronary artery bypass graft (CABG)?	No
percutaneous transluminal coronary angioplasty (PTCA)?	No
ischemic vascular disease (IVD)?	No
Most Recent LDL (Calculated) / / Most Recent LDL (Direct) / /]
Was the patient's most recent LDL screening with the last year?	No
Was the patient's most recent LDL screening controlled?	
OK Cancel	

Comprehensive Adult Diabetes Care

Comprehensive Adult Diabetes Care			
Patient with a diagnosis of Diabetes Mellitus ages 18 to 75 years of age.			
Does the patient have a diagnosis of diabetes? No			
Most Recent HgbA1c // Has the patient had HgbA1c screening with the last year? No Was the patient's last HgbA1c controlled? No			
Has the patient's blood pressure been controlled (< 130/80) within the last year? Yes			
Last Dilated Eye Exam / / Has the patient had a dilated eye exam within the last year? No			
Most Recent LDL //			
Has the patient had an LDL screening within the last year? No Was the patient's last LDL controlled? No			
Last Foot Exam / / Hast the patient had a foot exam within the last year? No			
Most Recent Micral Strip // Has the patient had a nephropathy screening within the last year? No			
OK Cancel			

Use of Appropriate Medications for People with Asthma

Use of Appropriate Medications for People with Asthma			
Patients with persistent asthma 5 to 56 years of age.			
Does the patient have a diagnosis of presistent asthma? No			
Does the patient have an active prescription for asthma medication? No			
OK Cancel			

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Patients 40 years of age and older with a diagnosis or newly active diagnosis of COPD.			
Does the patient have a chronic or acute diagnosis of COPD within the last year? No Has spirometry testing been used to confirm the diagnosis? O Yes O No			
OK			

Pharmacotherapy Management of COPD Exacerbation

Pharmacotherapy Management of COPD Exacerbation			
Patients ages 40 years of age and older with a discharge diagnosis of COPD exacerbation.			
Has the patient been discharged with COPD exacerbation? No			
Discharge Date			
Was the patient dispensed a systemic corticosteroid with 14 days of the event?			
O Yes O No			
Was the patient dispensed a bronchodilator within 30 days of the event?			
O Yes O No			
OK	cel		

Follow-Up After Hospitalization for Mental Illness

Follow-Up After Hospitalization for Mental Illness		
Patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders.		
Has the patient been hospitalized for mental illness within the last year? No Date of Discharge / /		
Did the patient have follow-up with a mental health care provdier within 7 days of discharge? Yes O No		
Did the patient have follow-up with a mental health care provdier within 30 days of discharge? Yes C No		
OK Cancel		

Antidepressant Medication Management

Antidepressant Medication Management		
Patients 18 years of age and older who were diagnosed with a new episode of depression.		
Was the patient diagnosed with depression today? No		
Is the patient on an antidepressant medication? No		
Acute Phase Treatment Has the patient been given medication to last at least 12 weeks? Yes O No		
Continuation Phase Treatment Has the patient been given medication to last at least 6 months? Yes O No		
OK Cancel		

Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication		
Children 6 to 12 years of age who are on one or more ADHD medications.		
Is the patient on one or more ADHD medications? No		
Initiation Phase Has the patient have a follow-up visit within 30 days of starting these medications?		
Continuation Phase		
Has the patient have a follow-up visit within 9 months of starting these medications?		
OK Cancel		

Osteoporosis Management in Women

Osteoporosis Management in Women Women 67 years of age and older who have history of a fracture.			
Does the patient have a history of fracture? No			
Has the patient BMD density test within the last year? No Date of Last Test / /			
OR			
Is the patient currently on prescription to treat or prevent osteoporosis? No			
OK			

Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis			
Proper medication management for patients with rheumatoid arthritis 18 years of age and older.			
Does the patient have a diagnosis of rheumatoid arthritis? No Has the patient been dispensed at least one disease-modifying No anti-rheumatic drug (DMARD)?			
OK Cancel			

Annual Monitoring for Patients on Persistent Medications

Annual Monitoring	for Patients on Persistent Medications	
Patients 18 years of ag	ge and older who are on one or more persistent medications.	
Is the patient on an ACE or ARB? No	For monitoring of an ACE, ARB, digoxin OR diuretic, any ONE of the following lab tests should be performed at least yearly.	
Is the patient on digoxin? No	Has the patient had a serum potassium test within the last year?	No
	Has the patient had a serum creatinine test within the last year?	No
Is the patient on a diuretic? No	Has the patient had a blood urea nitrogen test within the last year?	No
		No
Is the patient on an anticonvulsant? No	Hast the patient had a phenytoin level within the last year?	No
	Hast the patient had a valproic acid level within the last year?	No
	Hast the patient had a carbamazepine level within the last year?	NO
	OK Cancel	

Potentially Harmful Drug-Disease Interactions in the Elderly

The use of this template and its function is explained above. This is the only HEDIS measure which is presented twice – here and as a separate evidenced-based measure on the Medical Home Coordination Review template. See Above

Use of High-Risk Medications in the Elderly Avoidance of high-risk medications in patients ages 65 years of age and older. Listed below are the medications which are acitve in this patient and are condsidered high-risk for use in the elderly.				
	Madhantina	A	Discussed with	
	Medication	Action	Discussed with	n patient?
				_
				-
				-
				-
				-
				-
				-
				_
				_
			I	
		OK	Cancel	

Medication Reconciliation Post-Discharge

Medication Reconcilliation Post-Discharge Patients 65 years or age and older who were discharged from the hospital.			
Date of Last Hospital Discharge Date of Last Discharge Medication Reconcilliation			
Was the discharge medication reconcilliation completed within 30 days of discharge? No			
OK Cancel			

National Quality Forum (NQF) The next button is entitled NQF Compliance.

National Quality Forum (NQF) – In 1998, A report of the <u>President's Advisory</u> Commission on Consumer Protection and Quality in the Health Care Industry, proposed the formation of the Forum as a part of a national agenda for improvement in healthcare delivery. Formed in 1999, NQF's mission statement declared, "The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs."

NQF's vision is that "the NQF will be the convener of key public and private sector leaders to establish national priorities and goals to achieve the Institute of Medicine Aims—health care that is safe, effective, patient-centered, timely, efficient and equitable. NQF-endorsed standards will be the primary standards used to measure and report on the quality and efficiency of healthcare in the United States. The NQF will be recognized as a major driving force for and facilitator of continuous quality improvement of American healthcare quality." To achieve NCQA recognition as a Medical Home, SETMA must report on 10 measures endorsed by NQF. We have chosen to report on 43 for 2009.

Medical Home Coordination F Patient Ancillary Agencies Chart QTest Home Health Date of Birth 06/30/1970 Hospice Sex M Age 43 Years Home Phone (409)833-9797 Nursing Home Physical Therapy Work Phone () - Physical Therapy Ital Reviewed / / Coordination Review Completed Today? Last Reviewed / / / Coordination Team Conference? © Yes No Ital Reviewed / /	Medical Power of Attorney Return Primary Caregiver () - Primary Caregiver Transtheoretical Model Emergency Contact Print Note Compliance Patient's E-mail Address Last H&P / / Telephone Contact / / Birthday Card / / and/or education? Yes
Chronic Conditions Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Unit Clerk () - Evidence-Based Measures Compliance Elderly Medication Summary HEDS Measures Compliance NQF Measures Compliance NQF Measures Compliance NQF Measures Compliance Lipids Treatment Audit Lipids Treatment Audit	Evacuation Options No Self Evacuation Contact Information Family Name Community Phone Advanced Care Planning Code Status Advanced Directives Discussed? Yes No Yes No Detail
Disease Management Tools Accessed Diabetes Orge Orge Orge Orge Orge Orge Orge Orge	Barriers to Care NONE Social Financial Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Assistive Devices Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Provider Provider

This will launch the below template.



There are 7 categories of NQF-endorsed, evidenced-based measures which SETMA has chosen to report on for our NCQA recognition. The measures will be reviewed by category and by each individual measures.

General Health Measures

Body Mass Index Measurement

Body Mass Index Measurement
Body Mass Index measurement at least yearly for adults and at least every two years for children.
Was the patient's BMI measured at today's visit? No Today's BMI Measurement
OK Cancel

Smoking Cessation

Smoking Cessation	ו
Does the patient smoke?	No
Has smoking cessation been discussed with the patient?	No
Have smoking cessation strategies been discussed or implemented?	No
OK Cancel	

Proper Assessment for Chronic COPD

Proper Assessment for Chronic COPD	
Monitoring of oxygen saturation at least anually for patients with a chronic diagnosis of COPD.	
Does the patient have a chronic diagnosis of COPD? No	
Was the patient's oxygen saturation measured today? No	
Today's O2 Saturation	
OK Cancel	

Adult Immunization Status

Adult Immunization Status	
Immunization status for adults 50 years of age and older.	
Has the patient recieved a flu shot within the last year? No Last Flu Shot //	
Has the patient had a pneumonia vaccination? Yes	
Last PneumoVax / /	
OK Cancel	

Blood Pressure Measures

Blood Pressure Measurement

Blood Pressure Documentatio	n
Blood pressure measurement/documentation of patients 18 years of a	age and older.
Was the patient's blood pressure measured this visit?	10
Current Blood Pressure	
OK Cancel	

Blood Pressure Classification Control

Blood Pressure Classification/Control Appropriate plan of care for patients over 18 years of age with elevated blood pressure
Was the patient's most recent pressure over 140/90 mmHg? No Today's Blood Pressure // Is there a documented plan of care in place for elevated blood pressure? No (Hypertension Disease Management Plan)
OK Cancel

Medication Measures

Current Medication List

Current Medication List	
Were the patient's medications reviewed and updated today? Were one or more documents generated which contain the	No
patient's active medication list?	NO
OK Cancel	

Documentation of Allergies/Reactions

Documentation of Allergies/Reactions	
Were the patient's allergies reviewed/updated today? No	
OK Cancel	

Therapeutic Monitoring of Long Term Medications

Annual Monitoring for	or Patients on Persistent Medications
	Est monitoring of an ACE ARE dispute OR divertio any ONE
Is the patient on an ACE or ARB? No	of the following lab tests should be performed at least yearly.
	Has the patient had a serum potassium test within the last year? No
Is the patient on digoxin? No	Has the patient had a serum creatinine test within the last year?
Is the patient on a diuretic? No	Has the patient had a blood urea nitrogen test within the last year? No
Is the patient on an anticonvulsant? No	
	Hast the patient had a phenytoin level within the last year?
	Hast the patient had a valproic acid level within the last year? No
	Hast the patient had a carbamazepine level within the last year? No
	OK Cancel

Drugs to Avoid in the Elderly

Use of High-Risk Medications in the Elderly
Avoidance of high-risk medications in patients ages 65 years of age and older.
Listed below are the medications which are acitve in this patient and are condsidered high-risk for use in the elderly.
MedicationActionDiscussed with patient?
OK

Appropriate Medications for Asthma

Use of Appropriate Medications for People with Asthma	
Patients with persistent asthma 5 to 56 years of age.	
Does the patient have a diagnosis of presistent asthma? No	
Does the patient have an active prescription for asthma medication? No	
OK Cancel	

Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis Avoidance of antibiotic treatment for acute bronchitis in patients 18 to 65 years of age.
Did the patient have diagnosis of acute bronchitis this visit? No Was the patient prescribed antibiotic therapy this visit? No
OK Cancel

LDL Drug Therapy for Patients with CAD

Cholesterol Management for Patier with Cardiovascular Conditions	nts
Does the patient have a history of	
acute myocardial infarction?	No
coronary artery bypass graft (CABG)?	No
percutaneous transluminal coronary angioplasty (PTCA)?	No
ischemic vascular disease (IVD)?	No
Most Recent LDL (Calculated) / / Most Recent LDL (Direct) / /	
Was the patient's most recent LDL screening with the last year? Was the patient's most recent LDL screening controlled?	No
OK Cancel	

Care for Older Adults

Counseling on Physical Activity

Counseling on Physical Activity Physical activity counseling for patients 65 years of age and older.	
Has the patient been given physical activity counseling by means of the main Exercise template, the CHF Exercise template or the Diabetes No Exercise template?	
OK Cancel	

Colorectal Cancer Screening

Colorectal Cancer Screening	
Colorectal cancer screening for patients 50 to 80 years of age.	
Patients should have at least one of the following	Date of Last Test
Fecal occult blood test within the last year.	11
Flexible sigmoidoscopy within the last four years.	11
Double contrast barium enema within the last four years.	11
Colonscopy within the last nine years.	11
OK Cancel	

Fall Risk Management

Fall Risk Assessment
Regular fall risk assessment for patients 65 years of age and older.
Was a fall risk assessment completed on today's visit? No Last Fall Risk Assessment / /
OK Cancel

Diabetes Measures

Dilated Eye Exam

Comprehensive Adult Diabetes Care
Comprehensive Addit Diabetes Dare
Patient with a diagnosis of Diabetes Mellitus ages 18 to 75 years of age.
Does the patient have a diagnosis of diabetes? No
Most Recent HgbA1c // Has the patient had HgbA1c screening with the last year? No Was the patient's last HgbA1c controlled? No
Has the patient's blood pressure been controlled (< 130/80) within the last year? Yes
Last Dilated Eye Exam / / Has the patient had a dilated eye exam within the last year? No
Most Recent LDL
Most Recent LDL / / / Has the patient had an LDL screening within the last year? No
Most Recent LDL / / Has the patient had an LDL screening within the last year? No Was the patient's last LDL controlled? No
Most Recent LDL /// Has the patient had an LDL screening within the last year? No Was the patient's last LDL controlled? No Last Foot Exam // Hast the patient had a foot exam within the last year? No
Most Recent LDL /// Has the patient had an LDL screening within the last year? No Was the patient's last LDL controlled? No Last Foot Exam // Hast the patient had a foot exam within the last year? No Most Recent Micral Strip // Has the patient had a nephropathy screening within the last year? No

Foot Exam

Comprehensive Adult Diabetes Ca	are
Patient with a diagnosis of Diabetes Mellitus ages 18 to 75 years o	fage.
Does the patient have a diagnosis of diabetes? No	
Most Recent HgbA1c	
Has the patient had HgbA1c screening with the last year?	NO
Has the patient's blood pressure been controlled (< 130/80) within the last	year? Yes
Last Dilated Eye Exam / /	
Has the patient had a dilated eye exam within the last year?	No
Most Recent LDL	
Has the patient had an LDL screening within the last year?	No
Was the patient's last LDL controlled?	No
	_
Last Foot Exam / /	
Hast the patient had a foot exam within the last year?	No
-	
Most Recent Micral Strip	
Has the patient had a nephropathy screening within the last year?	No
······	
OK	

Hemoglobin A1c Testing Control

Comprehensive Adult Diabetes Care
Does the patient have a diagnosis of diabetes?
Most Recent HgbA1c // Has the patient had HgbA1c screening with the last year? No Was the patient's last HgbA1c controlled? No
Has the patient's blood pressure been controlled (< 130/80) within the last year? Yes
Last Dilated Eye Exam / / Has the patient had a dilated eye exam within the last year? No
Most Recent LDL // Has the patient had an LDL screening within the last year? No Was the patient's last LDL controlled? No
Last Foot Exam / / Hast the patient had a foot exam within the last year? No
Most Recent Micral Strip // Has the patient had a nephropathy screening within the last year? No OK Cancel
Blood Pressure

Comprehensive Adult Diabetes Care Patient with a diagnosis of Diabetes Mellitus ages 18 to 75 years of age.
Does the patient have a diagnosis of diabetes? No
Most Recent HgbA1c // Has the patient had HgbA1c screening with the last year? No Was the patient's last HgbA1c controlled? No
Has the patient's blood pressure been controlled (< 130/80) within the last year? Yes
Last Dilated Eye Exam / / Has the patient had a dilated eye exam within the last year? No
Most Recent LDL / / Has the patient had an LDL screening within the last year? No Was the patient's last LDL controlled? No
Last Foot Exam / / Hast the patient had a foot exam within the last year? No
Most Recent Micral Strip // Has the patient had a nephropathy screening within the last year? No OK Cancel

Lipid Screening

Comprehensive Adult Diabetes Care
Patient with a diagnosis of Diabetes Mellitus ages 18 to 75 years of age.
Does the patient have a diagnosis of diabetes? No
Most Recent HgbA1c / / Has the patient had HgbA1c screening with the last year? No Was the patient's last HgbA1c controlled? No
Has the patient's blood pressure been controlled (< 130/80) within the last year? Yes
Last Dilated Eye Exam / / Has the patient had a dilated eye exam within the last year? No
Most Recent LDL / /
Has the patient had an LDL screening within the last year?
Was the patient's last LDL controlled? No
Last Foot Exam / / Hast the patient had a foot exam within the last year? No
Most Recent Micral Strip // Has the patient had a nephropathy screening within the last year? No
OK Cancel

Physician Quality Reporting System (PQRS)

The 2006 Tax Relief and Health Care Act required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting System (PQRS). The 2009 PQRS Measures Specifications Manual for Claims and Registry Release Notes is a 442-page document which explains this program.

PQRS has identified 134 measures and requires that a practice report to report on at least 3 individual measures, or 1 Measures Group in order to be recognized by CMS. SETMA will report on three Measures Groups (Diabetes, Preventive Care, and Rheumatology, and the measures on Ophthalmology) which contain a total of 28 measures instead of the required 3. The program has been changed to PQRS.

The next button is entitled PQRS Compliance – those elements are described elsewhere.

Physician Consortium for Physician Performance Improvement Data Sets (PCPPI)

The Physician Consortium for Performance Improvement

The Physician Consortium for Physician Performance Improvement (Consortium) is a group of clinical and methodological experts convened by the AMA. The Consortium includes representatives from more than 60 national medical specialty and state medical societies, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services.

The Consortium's vision is to fulfill the responsibility of physicians to patient care, public health, and safety by:

- becoming the leading source organization for evidence-based clinical performance measures and outcomes reporting tools for physicians; and
- ensuring that all components of the medical profession have a leadership role in all national forums seeking to evaluate the quality of patient care.

The Consortium's mission is to improve patient health and safety by:

- Identifying and developing evidence-based clinical performance measures that enhance quality of patient care and that foster accountability;
- Promoting the implementation of effective and relevant clinical performance improvement activities; and
- Advancing the science of clinical performance measurement and improvement.

The Consortium works to develop evidence-based clinical performance measures and clinical outcomes reporting tools to support physicians in quality improvement efforts.

The Consortium has published a number of disease management data sets which established quality of care measures with which physicians and other healthcare providers can measure their own performance.

Physician Consortium for Performance Improvement – this measurement set for various conditions such as hypertension, diabetes, congestive heart failure and others have been developed by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Institute of Medicine (IOM) and the medical and surgical specialty societies. These data sets are intended as "open-book tests of provider performance, where the questions have been given to the provider." The hope is that as providers measure their own performance that quality of care will improve. SETMA has embedded some of the Consortium's data sets into our EMR and we will report on the results of these as well as HEDIS.

The next button on the Medical Home Coordination Review template is entitled **PCPPI Diabetes**

Patient Chart QTest Date of Birth 06/30/1 Sex M Age 43 Yea Home Phone (409)833 Work Phone () - Coordination Review Complete © Yes Patient needs discussed today Coordination Team Conference © Yes	dical Home Coordination Revie Ancillary Agencies Home Health 970 Hospice ars Assisted Living .9797 Nursing Home Physical Therapy ed Today? Last Reviewed // No y at Care 27 No	W Medical Power of Attorney Primary Caregiver Primary Caregiver Caregiver Relation Compliance Last H&P Telephone Contact // Correspondence // Birthday Card //	Return Transtheoretical Model Print Note Patient's E-mail Address Student interns are authorized to participate and assist with office visit and/or education? C Yes
Chronic Conditions Diabetes	Care Coordination Team Phone Primary MD () - CFNP () - Coordinator () - Nurse () - Unit Clerk () - Unit Clerk () - Seconday/Speciality Physicians Evidence-Based Measures Compliance Elderly Medication Summary HEDIS Measures Compliance NQF Measures Compliance PQRS Measures Compliance	Evacuation Options Self Evacuation Contact Information Family Name Community Phone () - Advanced Care Planning Code Status Advanced Directives Discussed? 11 Advanced Directives Completed? Yes () No Data 11 Detail	€ No
	Diabetes Physician Consortium Diabetes Physician Consortium Disease Management Tools Accessed Diabetes Yes No Lipids Yes Ni Hypertension Yes Nie CHF Yes Ni Referral History Click for Detail Status Referral Referring Provider	Barriers to Care NONE Social Financial ✓ Deaf Co-Pays Hearing Medications Blind Nutrition Vision Transportation Literacy Uninsured Social Isolation None Assistive Devices Medicare Competitive Cane Splint/Brace Crutches Walker Hearing Aid Wheelchair Prosthetic Limb None	Bid

Note: Remember, this button on shows up if the patient has the diagnosis of diabetes in their Chronic Problem list.

When launched this button automatically links the provider with the **Consortium Data Set** which is viewed from the **Plan Template** on the **Diabetes Disease Management Tool** which is launched from **AAA Home**

The following are the steps of how to access the **Consortium Data Set** via **AAA Home**. Of course, it can be launched as above from the **Medical Home Coordination Review** template.

Patient REAL FRI ASSOCIMENT	t Chart Home Phone (Work Phone Cell Phone	QTest 409)833-9797 () - () -	Sex M Date of Birth	Age 43 06/30/1970 has one o <u>Click</u>	Patient's Co	ode Status
Pre-Vist/Prev	entive Screening		Bridges to Ex <u>View</u>	cellence	Inter <u>Tr</u>	isive Behavioral Therapy anstheoretical 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 NOF PORS ACO Elderly Medication Summary STARS Program Measures Exercise Exercise I CHF Exercise I Diabetic Exercise I	Template Suit Master GP T Pediatrics Nursing Home Ophthalmolog Physical Ther Podiatry Rheumatology Hospital Care Hospital Care Daily Progress Admission Ord	es I Y apy Summary I & Note lers I	Diabetes I <u>Hypercension</u> Lipids I Acute Coronary Angina I Asthma Cardiometabolic CHF I Diabetes Educa Headaches Renal Failure Weight Manage	s Risk Syn I tion ment I	ast Updated /// /// /// /// /// /// /// /// /// /	Special Functions Lab Present T Lab Future T Lab Results T Hydration T Nutrition T Guidelines T Pain Management Immunizations Reportable Conditions Information Charge Posting Tutorial Drug Interactions T E&M Coding Recommendations Infusion Flowsheet Insulin Infusion
Patient's Pharmacy	Pending Re	ferrals <u>T</u>	D -f1	Defector		Chart Note - Now
	Status	Priority	Referral	Reterring	Provider	Chart Note - Offline
Phone () -						Return Info
Fax () -						Return Doc
Rx Sheet - Active						Email
Rx Sheet - New						Telephone
Rx Sheet - Complete	•				•	Records Request
Home Health						Transfer of Care Doc

The Diabetes Disease Management tool is launched from AAA Home.

Once the Diabetes Disease Management is launched the **Consortium Data Set for Diabetes** (entitled **PCPPI Diabetes** on the **Medical Home Coordination Review** template) is found by clicking on **Plan** in the list of navigational buttons on the **Diabetes Master template**

Diabetes Management Diabetes Sin	ICE Patient Chart QTest	Navigation
Joslin Treatment Goals Imp Diabetes Concepts Diagnostic Criteria Screening Criteria Evidenced-Based Recs	Current Frequency of SMBG	Diabetes O General Return
Adherence		Diab Sys Review
Dilated Eve Exam	Most Recent Labs Check for New Labs	Diabetic History
Flu Shot	Previous	Eye Exam
Foot Exam // Framingham Risk Scores		Nasopharynx
HobA1C // 10-Year General Risk %	eAG	Cardio Exam
Pneumovax // Global Cardio Score pts	C-Peptide	Foot Exam
Urinalysis // Weight Management Lipids Management	Fructosamine //	Neurological Exam
Statin C Yes C No HPT Management Immunizations	Cholesterol //	Complications/Education
Vital Signs Finger Stick	HDL //	Initiating Insulin
Height 0.00 Waist Glucose	Triglycerides //	Insulin Pump
BMI Chest Blood Pressure	Chucose	Lifectule Changes
Body Fat % Abdomen /	Fasting //	Diabetes Plan
Protein Req Ratio 0.00 BP In Diabetics		
BMR BER Vitals Over Time	HOMA-IR Na	11
Current SO Inculin Doce as of 11 Blood Supers	к //	Diabetes Education
Time of day Units Type Units Type mg/dl	Magnesium	Telephone Record
	Creatinine //	Last DE //
Diary	U Microalbumin	
	Albumin/Creat / //	
	Urinalysis Labs Over Time	Manual Lab Results

When the Diabetes Plan button is launched the following template appears.

On the **Diabetes Plan template** there is a button in the right hand upper part of the screen entitled **Consortium Data Set**

Meal Requirements Calc	Diabetes Plan		_	Return
Total Daily Dose Total Meal Dose	Pre-lunch 0	General Measures		
Basal Requirement Pre-breakfast	Pre-dinner	Help	L	Consortium Data Set
Laboratory & Procedures Patient	Goal This Visit			Patient Adherence
Ordering Provider Manage	ement			Comments
Cha	nge Self-Monitoring of Blood Glucose (S	SMBG) to		Follow IIp Document
	Phone alucase data into our office in 7 d	lavs		Tonow op bocament
<u>C-Peptide</u>	Refer to eve specialist	HgbA1C Tre	at Goals	Document
Elu Shot	Education a	nd Eye Referrals		
	Priority	Referring First Refe	erring Last Refe	rral
Hepatic Profile				
HqbA1C // Medica	tions 🔳			•
Lipid Profile w/LDL //	Continue present insulin and metformin/s	sulfonylurea/acarbos	e/pio/rosi/troglitaz	one regimen
Magnesium 🗌 🗌 🤇	Continue Aspirin			Deuble Click to MissulAdd Mede
Micral Strip	start Aspirin 325 mg			Double-Click to view/Add Meds
Pneumovax // O E	Begin 🔘 Increase 🔘 Decrease 🔘 Sto	op	to mg	Brand Name
Spot AC Ratio	Begin 🔘 Increase 🔘 Decrease 🔘 Sto	op	_	
TSH // 0 E	Begin 🔘 Increase 🔘 Decrease 🔘 Sto	op	_	
Venipuncture New SG	Insulin Dose Save Im	oort Current	Insulin Pump	
Assessment			modilin rump	Comparison of Human Insulin
Dx1	—			Conditions - Glycemic Control
Dx2	— — —			Drugs - Glucose Levels
Dx3				Basal/Bolus Insulin
Chronic Conditions				Incretins
You M	UST CIICK "Save" above after entering r	new insulin informatio	on.	Byetta
	noing scale	insuin over time		Actions: Byetta

When the **Consortium Data Set** button is launched the following pop-up appears, which is the same pop-up which appears when the **Medical Home Coordination Review PCPPI Diabetes** button is launched:

PCPI Diabete	s Management	
Has the patient had a Hemoglobin A1c within the last year? Date of Last / /	No	Order HgbA1c
Has the patient had a Lipid Profile witin the last year? Date of Last //	No	Order Lipid Profile
Has the patient had a urinalysis within the last year? Date of Last / /	No	Order Urinalysis
Has the patient had a dilated eye exam within the last year? Date of Last //	No	Add Referral Below
Has the patient had a flu shot within the last year? Date of Last / /	No	Order Flu Shot
Has the patient had a 10-gram monofilament exam within the Date of Last / /	last year? No	Click to Complete
Is the patient on Aspirin? Is the patient allergic to aspirin?	No	Add Medication Below
Is the patient's blood pressure controlled (<130/80 mmHg)?	Yes	
Today's Blood Pressure		
Does the patient have at least one visit schedule for the next	six months?	Follow-Up Visit
Has the Diabetes Treatment Plan been completed with the las	t year? Yes	Click to Complete
Date Last Completed / /		
Referrals Double-Click to Add/Edit	Active Medications	ouble-Click to Add/Edit
Referral Date	Brand Name	Dose
I I	•	Þ
ОК	Cancel	

The 9 data points which are automatically captured and documented by SETMA's Diabetes Suite of Templates, and, which are collected and displayed on the Consortium Data Set pop-up on the Diabetes Plan, are the quality measures for diabetes developed by the Consortium. These 9 data points are the basis along with several other data points of SETMA's Daily Diabetes Care Audit. These data points are:

- 1. Collected automatically
- 2. Provide a quick and easy review for the SETMA healthcare provider to evaluate his/her own Diabetes care.
- Provide a quick and easy way of completing the Diabetes measures required if they were not completed.
- Attention to these data points places in you line for additional reimbursement when CMS
- The Consortium material should be completed by the nursing staff and reviewed by the provider.

The Elements of the Consortium Data Set for Diabetes are listed on the pop-up.

(A complete tutorial for this function can be found in Appendix A below or on the Diabetes Disease Management tutorial)

The functioning of the Hemoglobin A1C element illustrates the above:

Hemoglobin A1C -

- The standard is that the patient has had a Hemoglobin A1C in the past three months or has one at this visit.
- The date of the last Hgb A1C is displayed on this template.
- If this data point is out of date, a button will appear to the right of the date box
- When you depress this button you will automatically order and charge post aHgb A1C, making it easier to do it right than not to do it at all.

PCPI Diabetes Management						
Has the patient had a Hemoglobin A1c within the last year? Date of Last //	No	Order HgbA1c				
Has the patient had a Lipid Profile witin the last year?	No	Order Lipid Profile				
Date of Last / /						
Has the patient had a urinalysis within the last year?	No	Order Urinalysis				
Date of Last / /						
Has the patient had a dilated eye exam within the last year?	No	Add Referral Below				
Date of Last / /						
Has the patient had a flu shot within the last year?	No	Order Flu Shot				
Date of Last //						
Has the patient had a 10-gram monofilament exam within the	last year? No	Click to Complete				
Date of Last / /						
Is the patient on Aspirin? Is the patient allergic to aspirin?	No	Add Medication Below				
Is the patient's blood pressure controlled (<130/80 mmHg)?	Yes					
Today's Blood Pressure						
Does the patient have at least one visit schedule for the next	t six months?	Follow-Up Visit				
Has the Diabetes Treatment Plan been completed with the last	st year? Yes	Click to Complete				
Date Last Completed //						
Referrals Double-Click to Add/Edit	Active Medications	Double-Click to Add/Edit				
Referral Date	Brand Name	Dose				
4	•	•				
ОК	Cancel					

When this Diabetes management tool is accessed from the Medical Home Coordination Review template, any elements which are incomplete will appear in **red** and the button to the right of that element will appear. Any incomplete element can be quickly completed by clicking on the button in the right hand column.

The next button is entitled PCPPI Hypertension

When launched this button takes the provider to the **Hypertension Disease Management** tool and to the template entitled **Physician Role.** This template automatically collects the information from the patient encounter and notes whether each element of the evidenced-based management, identified by the PCPPI has been met. Here are eight elements as they are listed on the pop-up below.

			Navigation
Hyperte	ension Management Patient Chart QTes	st	1
	Guidelines Ade 43 Sex	×	Return
_	Diff Hpt Check		Dippers and White Coat
	Physician Role in Hypertension Managem	nent	HPT and Diabetes
Vital Signs			HPT and Depression
Blood Press	Blood pressure measured at least once this visit		HPT and the Elderly
Trial 1	Blood pressure measurement repeated if elevated		HPT, Insulin Resistance
Trial 2	Blood pressure classification determined		Isolated Systolic HPT
Dulas	Weight reduction discussed/recommended		HPT and Kidney Disease
Height	Sodium intake discussed/changes recommended		Evaluation
Weight	Alcohol intake discussed/changes recommended		Diagnosis and Screening
BMI	Approprieto follour un acheduled	ment	Lifestyle Changes
Body Fat	Appropriate tollow-up scheduled		Treatment
Waist	Concrete a follow up desumant for the patient at least yearly		UDT Dian
Ratio	Date Last Generated //		Physician Role
10-Year 10-Year Global Ca	OK Cancel		Click for Documents Physician Information Classification
Metabolic Syndrom Vitals (ome - O + O Over Time		<u>New Construction</u>

As the provider progresses through SETMA's Hypertension Suite of Templates, this template automatically collects the data points for the **Physician Consortium for Performance Improvement Data Set for quality of care in hypertension management**. A review of this template will allow a provider to see "how he/she is doing," as measured against a national standard of care in hypertensive management.

The standard of excellence in the management of hypertension is measured on the following 8 data points.

- 1. Blood pressure measured at least once this visit
- 2. Blood pressure measurement repeated if elevated
- 3. Blood pressure classification determined
- 4. Weight reduction discussed/recommended
- 5. Sodium intake discussed/changes recommended
- 6. Alcohol intake discussed/changes recommended
- 7. Exercise discussed/recommended
- 8. Appropriate follow-up scheduled

The elements of evidenced-based measures for hypertension are met in SETMA's EMR:

- 1. Completed by performing a blood pressure check during the current encounter
- 2. Completed by repeating the blood pressure during the encounter if the initial pressure is above 140/90.
- 3. Completed by using the **Hypertension Disease Management** templates which automatically calculates the classification, follow-up recommendation, risk group and treatment recommendation when the **Calculate Assessment** button is depressed on the Hypertension Master template
- 4. Completed by accessing the Life-style changes template which is found on the Hypertension Master template and by completing the LESS Initiative
- 5. Completed by accessing the Life-style changes template which is found on the Hypertension Master template and by giving the patient the Hypertension Follow-up document which includes instructions on low sodium diets.
- 6. Completed by accessing the Life-style changes template which is found on the Hypertension Master template
- 7. Completed by using the LESS Initiative with its Exercise Prescription.
- 8. Completed by accessing the Life-style changes template this is found on the Hypertension Master template and by completing the LESS Imitative.