

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.

Patient Alert

<input type="checkbox"/> Patient is deaf	<input type="checkbox"/> Substance alert
<input type="checkbox"/> Patient is hard of hearing, left ear	<input type="checkbox"/> Confidential labs
<input type="checkbox"/> Patient is hard of hearing, right ear	<input type="checkbox"/> Medical Power of Attorney
<input type="checkbox"/> Patient has hearing impairment	<input type="checkbox"/> Advanced Directives <input type="text"/>
<input type="checkbox"/> Patient is legally blind	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> Patient has vision impairment	<input type="checkbox"/> Patient speaks no English
<input type="checkbox"/> No information to family	<input type="checkbox"/> Literacy alert
<input type="checkbox"/> Spouse estranged	<input type="checkbox"/> Patient name alert
<input type="checkbox"/> Patient requires wheelchair	<input type="checkbox"/> Nutritional support <input type="text"/>
<input type="checkbox"/> Ambulance transit required	<input type="checkbox"/> Patient is mute
<input type="checkbox"/> No BP on left arm	<input type="checkbox"/> Patient undergoes dialysis
<input type="checkbox"/> No BP on right arm	<input type="checkbox"/> Allergen Injections
<input type="checkbox"/> CPS alert	
<input type="checkbox"/> Adult Protective Services alert	

<input type="checkbox"/> Research participant	<input type="text"/>
<input type="checkbox"/> Patient has been fired by	<input type="text"/>

Comments

Do NOT enter HIPAA information here!!
All HIPAA information should be added to the "HIPAA" box at the bottom of the MASTER GP.

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:

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.

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney		Return	
Chart	QTest	Home Health		Primary Caregiver	() -	Transtheoretical Model	
Date of Birth	06/30/1970	Hospice		Emergency Contact	() -	Print Note	
Sex	M Age 43 Years	Assisted Living		Relation	() -		
Home Phone	(409)833-9797	Nursing Home					
Work Phone	() -	Physical Therapy					

Coordination Review Completed Today?	Last Reviewed	//	Last H&P	//	Patient's E-mail Address	
<input type="radio"/> Yes <input type="radio"/> No			Telephone Contact	//		
Patient needs discussed today at Care Coordination Team Conference?	Last Reviewed	//	Correspondence	//	Student interns are authorized to participate and assist with office visit and/or education? <input type="radio"/> Yes <input type="radio"/> No	
<input type="radio"/> Yes <input type="radio"/> No			Birthday Card	//		

Chronic Conditions	Care Coordination Team		Phone	Evacuation Options	
	Primary MD		() -		<input type="checkbox"/> Self Evacuation Contact Information
	CFNP		() -		<input type="checkbox"/> Family Name
	Coordinator		() -		<input type="checkbox"/> Community Phone () -
	Nurse		() -		
	Unit Clerk		() -		
	Secondary/Specialty 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	<input type="radio"/> Yes <input type="radio"/> No	Lipids	<input type="radio"/> Yes <input type="radio"/> No		
Hypertension	<input type="radio"/> Yes <input type="radio"/> No	CHF	<input type="radio"/> Yes <input type="radio"/> No		
Referral History Click for Detail					
Status	Referral	Referring Provider			

Advanced Care Planning	
Code Status	
Advanced Directives Discussed?	<input type="radio"/> Yes <input type="radio"/> No //
Advanced Directives Completed?	<input type="radio"/> Yes <input checked="" type="radio"/> No Date //
Detail	
Barriers to Care <input type="checkbox"/> NONE	
Social	Financial
<input checked="" type="checkbox"/> Deaf	<input type="checkbox"/> Co-Pays
<input type="checkbox"/> Hearing	<input type="checkbox"/> Medications
<input type="checkbox"/> Blind	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Vision	<input type="checkbox"/> Transportation
<input type="checkbox"/> Literacy	<input type="checkbox"/> Uninsured
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> None
<input type="checkbox"/> Language	
<input type="checkbox"/> None	
Assistive Devices	Medicare Competitive Bid
<input type="checkbox"/> Cane	<input type="checkbox"/> Splint/Brace
<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Prosthetic Limb	<input type="checkbox"/> None

The fourth column contains three navigation buttons:

- The first is entitled **RETURN** takes you back to AAA Home
- The second launches the **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.

Transtheoretical Model Stages of Change

Last Updated Reviewed 10/01/2013

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

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

The screenshot shows a web interface titled "Transtheoretical Model Stages of Change". At the top, it says "Last Updated Reviewed" with a date field containing "10/01/2013". On the right, there is a "Return" button and a "Transtheoretical Chart" button. The main content is divided into two sections, separated by "-----OR-----".

Top Section:

- Select Disease:** A dropdown menu with "Diabetes" selected. This field is highlighted with a red border.
- Select Characteristic:** A "Clear" button and a list of radio buttons:
 - 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:** A text box containing "Precontemplation".
- Appropriate Intervention:** A text box containing "Provide information about health risks and benefits of diabetes and".
- Sample Dialogue:** A text box containing "Would you like to read some information about the health aspects of diabetes?".

Bottom Section:

- Select Patient Verbal Cue:** A "Clear" button and a list of radio buttons:
 - "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:** A text box containing "Precontemplation".
- Appropriate Intervention:** A text box containing "Provide information about health risks and benefits of diabetes and".
- Sample Dialogue:** A text box containing "Would you like to read some information about the health aspects of diabetes?".

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

Transtheoretical Model Stages of Change

Last Updated Reviewed 10/01/2013

Return
Transtheoretical Chart

Select Disease Diabetes

Select Characteristic

- Unaware of Problem**
No Interest in Change
- Aware of Problem
Beginning to Think of
- Realized Benefits of
Thinking About How
- Actively Taking Step
- Initial Treatment Goal

Transtheo Disease ×

CHF
Diabetes
Hypertension
Lipids
Weight Management

Close

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?

In that one of the goals of Medical Home is patient self-improvement and self-management, 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.

The screenshot shows a web-based interface titled "Transtheoretical Model Stages of Change". At the top, it indicates "Last Updated Reviewed" as "10/01/2013". There is a "Return" button in the top right corner. The main content is organized into two columns. The left column contains two sections: "Select Disease" with a dropdown menu set to "Diabetes", and "Select Characteristic" with a "Clear" button and five radio button options. The first option, "Unaware of Problem No Interest in Change", is selected. The right column contains three sections: "Stage" with a dropdown menu set to "Precontemplation", "Appropriate Intervention" with a text box containing "Provide information about health risks and benefits of diabetes and", and "Sample Dialogue" with a text box containing "Would you like to read some information about the health aspects of diabetes?". Below these sections is a separator line with "OR" in the center. The bottom section mirrors the top one, with "Select Patient Verbal Cue" and a "Clear" button, followed by five radio button options. The first option, "I'm not really interested in my blood sugars. Its not a problem.", is selected. The right column for this section also shows "Stage" set to "Precontemplation", "Appropriate Intervention" with the same text as above, and "Sample Dialogue" with the same text as above.

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

Select Disease

Select Characteristic

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

Appropriate Intervention

Sample Dialogue

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

- Stage of change
- Appropriate Intervention
- Sample dialogue

Stage

Appropriate Intervention

Sample Dialogue

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.

Select Patient Verbal Cue

"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."

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 Model Stages of Change

Last Updated Reviewed

Select Disease

Select Characteristic

- 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

-----OR-----

Select Patient Verbal Cue

- "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

Appropriate Intervention

Sample Dialogue

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



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 SETMA II - 3570 College, Suite 200
 SETMA West, 2010 Dowlen
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 www.setma.com

Transtheoretical (Stages of Change) Model				
<i>Stage</i>	<i>Characteristic</i>	<i>Patient verbal cue</i>	<i>Appropriate intervention</i>	<i>Sample dialogue</i>
<i>Precontemplation</i>	Unaware of problem, no interest in change	"I'm 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?"
<i>Contemplation</i>	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, I'm 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."
<i>Preparation</i>	Realizes benefits of making changes and thinking about how to change	"I have to lose weight, and I'm 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."
<i>Action</i>	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 you're working so hard. What problems have you had so far? How have you solved them?"
<i>Maintenance</i>	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**.

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.

Medical Home Coordination Review

Patient
 Chart: QTest
 Date of Birth: 06/30/1970
 Sex: M Age: 43 Years
 Home Phone: (409)833-9797
 Work Phone: () -

Ancillary Agencies
 Home Health: _____
 Hospice: _____
 Assisted Living: _____
 Nursing Home: _____
 Physical Therapy: _____

Medical Power of Attorney
 _____ () -
 Primary Caregiver: _____ () -
 Emergency Contact: _____ () -
 Relation: _____

Compliance
 Last H&P: //
 Telephone Contact: //
 Correspondence: //
 Birthday Card: //

Coordination Review Completed Today?
 Yes No

Patient needs discussed today at Care Coordination Team Conference?
 Yes No

Last Reviewed //

Last Reviewed //

Chronic Conditions

Care Coordination Team

Role	Name	Phone
Primary MD		() -
CFNP		() -
Coordinator		() -
Nurse		() -
Unit Clerk		() -

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 No Lipids: Yes No
 Hypertension: Yes No CHF: Yes No

Referral History [Click for Detail](#)

Status	Referral	Referring Provider

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: _____

Barriers to Care NONE

Social
 Deaf
 Hearing
 Blind
 Vision
 Literacy
 Social Isolation
 Language
 None

Financial
 Co-Pays
 Medications
 Nutrition
 Transportation
 Uninsured
 None

Assistive Devices

Cane Splint/Brace
 Crutches Walker
 Hearing Aid Wheelchair
 Prosthetic Limb None

Medicare Competitive Bid

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 at team conference

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney		<input type="button" value="Return"/> <input type="button" value="Transtheoretical Model"/> <input type="button" value="Print Note"/>	
Chart	QTest	Home Health			() -		
Date of Birth	06/30/1970	Hospice		Primary Caregiver	() -		
Sex	M Age 43 Years	Assisted Living		Emergency Contact	() -		
Home Phone	(409)833-9797	Nursing Home			() -		
Work Phone	() -	Physical Therapy		Relation		Patient's E-mail Address <input type="text"/>	
Coordination Review Completed Today? <input type="radio"/> Yes <input type="radio"/> No		Last Reviewed		//			
Patient needs discussed today at Care Coordination Team Conference? <input type="radio"/> Yes <input type="radio"/> No		Last Reviewed		//		Student interns are authorized to participate and assist with office visit and/or education? <input type="radio"/> Yes <input type="radio"/> No	

Chronic Conditions	Care Coordination Team	Evacuation Options	Advanced Care Planning						
<input type="text"/>	Primary MD <input type="text"/>	<input type="checkbox"/> Self	Code Status <input type="text"/>						
<input type="text"/>	CFNP <input type="text"/>	<input type="checkbox"/> Family	Advanced Directives Discussed? <input type="radio"/> Yes <input type="radio"/> No						
<input type="text"/>	Coordinator <input type="text"/>	<input type="checkbox"/> Community	Advanced Directives Completed? <input type="radio"/> Yes <input type="radio"/> No						
<input type="text"/>	Nurse <input type="text"/>	Evacuation Contact Information Name <input type="text"/>	Date <input type="text"/>						
<input type="text"/>	Unit Clerk <input type="text"/>	Phone <input type="text"/>	Detail <input type="text"/>						
<input type="text"/>	<input type="button" value="Secondary/Specialty Physicians"/>								
<input type="text"/>	Evidence-Based Measures Compliance								
<input type="text"/>	<input type="button" value="Elderly Medication Summary"/>								
<input type="text"/>	<input type="button" value="HEDIS Measures Compliance"/>								
<input type="text"/>	<input type="button" value="NQF Measures Compliance"/>								
<input type="text"/>	<input type="button" value="PQRS Measures Compliance"/>								
<input type="text"/>	<input type="button" value="Lipids Treatment Audit"/>								
<input type="text"/>	Disease Management Tools Accessed								
<input type="text"/>	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Lipids <input type="radio"/> Yes <input type="radio"/> No							
<input type="text"/>	Hypertension <input type="radio"/> Yes <input type="radio"/> No	CHF <input type="radio"/> Yes <input type="radio"/> No							
<input type="text"/>	Referral History Click for Detail								
<input type="text"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Status</th> <th>Referral</th> <th>Referring Provider</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Status	Referral	Referring Provider			
Status	Referral	Referring Provider							
<input type="text"/>	Barriers to Care <input type="checkbox"/> NONE								
<input type="text"/>	Social	Financial							
<input type="text"/>	<input checked="" type="checkbox"/> Deaf	<input type="checkbox"/> Co-Pays							
<input type="text"/>	<input type="checkbox"/> Hearing	<input type="checkbox"/> Medications							
<input type="text"/>	<input type="checkbox"/> Blind	<input type="checkbox"/> Nutrition							
<input type="text"/>	<input type="checkbox"/> Vision	<input type="checkbox"/> Transportation							
<input type="text"/>	<input type="checkbox"/> Literacy	<input type="checkbox"/> Uninsured							
<input type="text"/>	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> None							
<input type="text"/>	<input type="checkbox"/> Language								
<input type="text"/>	<input type="checkbox"/> None								
<input type="text"/>	Assistive Devices	<input type="checkbox"/> Medicare Competitive Bid							
<input type="text"/>	<input type="checkbox"/> Cane	<input type="checkbox"/> Splint/Brace							
<input type="text"/>	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker							
<input type="text"/>	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Wheelchair							
<input type="text"/>	<input type="checkbox"/> Prosthetic Limb	<input type="checkbox"/> 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 contacts 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

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney		<input type="button" value="Return"/> <input type="button" value="Transtheoretical Model"/> <input type="button" value="Print Note"/>
Chart	QTest	Home Health			() -	
Date of Birth	06/30/1970	Hospice		Primary Caregiver	() -	
Sex	M Age 43 Years	Assisted Living		Emergency Contact	() -	
Home Phone	(409)833-9797	Nursing Home			() -	
Work Phone	() -	Physical Therapy		Relation		

Coordination Review Completed Today? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed //	Compliance	
Patient needs discussed today at Care Coordination Team Conference? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed //	Last H&P	//
		Telephone Contact	//
		Correspondence	//
		Birthday Card	//

Chronic Conditions	Care Coordination Team	Phone
	Primary MD	() -
	CFNP	() -
	Coordinator	() -
	Nurse	() -
	Unit Clerk	() -
	<input type="button" value="Secondary/Specialty Physicians"/>	
	Evidence-Based Measures Compliance	
	<input type="button" value="Elderly Medication Summary"/>	
	<input type="button" value="HEDIS Measures Compliance"/>	
<input type="button" value="NQF Measures Compliance"/>		
<input type="button" value="PQRS Measures Compliance"/>		
<input type="button" value="Lipids Treatment Audit"/>		
Disease Management Tools Accessed		
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Lipids <input type="radio"/> Yes <input type="radio"/> No
Hypertension	<input type="radio"/> Yes <input type="radio"/> No	CHF <input type="radio"/> Yes <input type="radio"/> No
Referral History Click for Detail		
Status	Referral	Referring Provider

Evacuation Options	Advanced Care Planning
<input type="checkbox"/> Self Evacuation Contact Information	Code Status
<input type="checkbox"/> Family Name	Advanced Directives Discussed? <input type="radio"/> Yes <input type="radio"/> No //
<input type="checkbox"/> Community Phone () -	Advanced Directives Completed? <input type="radio"/> Yes <input checked="" type="radio"/> No Date //
	Detail
Barriers to Care <input type="checkbox"/> NONE	
Social	Financial
<input checked="" type="checkbox"/> Deaf	<input type="checkbox"/> Co-Pays
<input type="checkbox"/> Hearing	<input type="checkbox"/> Medications
<input type="checkbox"/> Blind	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Vision	<input type="checkbox"/> Transportation
<input type="checkbox"/> Literacy	<input type="checkbox"/> Uninsured
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> None
<input type="checkbox"/> Language	
<input type="checkbox"/> None	<input type="button" value="Medicare Competitive Bid"/>
Assistive Devices	
<input type="checkbox"/> Cane	<input type="checkbox"/> Splint/Brace
<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Prosthetic Limb	<input type="checkbox"/> None

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.

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney		Return		
Chart	QTest	Home Health			() -	Transtheoretical Model		
Date of Birth	06/30/1970	Hospice		Primary Caregiver	() -	Print Note		
Sex	M Age 43 Years	Assisted Living		Emergency Contact	() -			
Home Phone	(409)833-9797	Nursing Home			() -			
Work Phone	() -	Physical Therapy		Relation				
Coordination Review Completed Today?		Last Reviewed //		Compliance		Patient's E-mail Address		
<input type="radio"/> Yes <input type="radio"/> No				Last H&P //		Patient's E-mail Address		
Patient needs discussed today at Care Coordination Team Conference?		Last Reviewed //		Telephone Contact //		Student interns are authorized to participate and assist with office visit and/or education? <input type="radio"/> Yes <input type="radio"/> No		
<input type="radio"/> Yes <input type="radio"/> No				Correspondence //				
				Birthday Card //				
Chronic Conditions	Care Coordination Team			Evacuation Options				
	Primary MD		Phone	<input type="checkbox"/> Self Evacuation Contact Information				
	CFNP		() -	<input type="checkbox"/> Family Name				
	Coordinator		() -	<input type="checkbox"/> Community Phone () -				
	Nurse		() -					
	Unit Clerk		() -					
	Secondary/Specialty Physicians							
	Evidence-Based Measures Compliance			Advanced Care Planning				
	Elderly Medication Summary			Code Status				
	HEDIS Measures Compliance			Advanced Directives Discussed?				
	NQF Measures Compliance			<input type="radio"/> Yes <input type="radio"/> No //				
	PQRS Measures Compliance			Advanced Directives Completed?				
	Lipids Treatment Audit			<input type="radio"/> Yes <input checked="" type="radio"/> No Date //				
				Detail				
	Disease Management Tools Accessed			Barriers to Care <input type="checkbox"/> NONE				
	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Lipids	<input type="radio"/> Yes <input type="radio"/> No	Social			
	Hypertension	<input type="radio"/> Yes <input type="radio"/> No	CHF	<input type="radio"/> Yes <input type="radio"/> No	<input checked="" type="checkbox"/> Deaf			
					<input type="checkbox"/> Hearing			
					<input type="checkbox"/> Blind			
					<input type="checkbox"/> Vision			
					<input type="checkbox"/> Literacy			
					<input type="checkbox"/> Social Isolation			
					<input type="checkbox"/> Language			
					<input type="checkbox"/> None			
					Assistive Devices			
					<input type="checkbox"/> Cane		Medicare Competitive Bid	
					<input type="checkbox"/> Crutches		<input type="checkbox"/> Splint/Brace	
					<input type="checkbox"/> Hearing Aid		<input type="checkbox"/> Walker	
					<input type="checkbox"/> Prosthetic Limb		<input type="checkbox"/> Wheelchair	
							<input type="checkbox"/> None	

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

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney			
Chart	QTest	Home Health		Primary Caregiver	() -	<input type="button" value="Return"/>	
Date of Birth	06/30/1970	Hospice		Emergency Contact	() -	<input type="button" value="Transtheoretical Model"/>	
Sex	M Age 43 Years	Assisted Living		Relation	() -	<input type="button" value="Print Note"/>	
Home Phone	(409)833-9797	Nursing Home					
Work Phone	() -	Physical Therapy					

Coordination Review Completed Today? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed	//	Compliance	Patient's E-mail Address
Patient needs discussed today at Care Coordination Team Conference? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed	//	Last H&P	
			Telephone Contact	
			Correspondence	
			Birthday Card	

Chronic Conditions	Care Coordination Team	Phone	Evidence-based measures compliance		
	Primary MD	() -		Elderly Medication Summary	
	CFNP	() -		HEDIS Measures Compliance	
	Coordinator	() -		NQF Measures Compliance	
	Nurse	() -		PQRS Measures Compliance	
	Ux/Clk	() -		Lipids Treatment Audit	
	Secondary/Specialty Physicians				
	Disease Management Tools Accessed				
	Diabetes	<input type="radio"/> Yes <input type="radio"/> No		Lipids	<input type="radio"/> Yes <input type="radio"/> No
	Hypertension	<input type="radio"/> Yes <input type="radio"/> No		CHF	<input type="radio"/> Yes <input type="radio"/> No

Evacuation Options	Advanced Care Planning
<input type="checkbox"/> Self Evacuation Contact Information	Code Status
<input type="checkbox"/> Family Name	Advanced Directives Discussed?
<input type="checkbox"/> Community Phone () -	<input type="radio"/> Yes <input type="radio"/> No //
	Advanced Directives Completed?
	<input type="radio"/> Yes <input type="radio"/> No Date //
	Detail

Barriers to Care	<input type="checkbox"/> NONE
Social	Financial
<input checked="" type="checkbox"/> Deaf	<input type="checkbox"/> Co-Pays
<input type="checkbox"/> Hearing	<input type="checkbox"/> Medications
<input type="checkbox"/> Blind	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Vision	<input type="checkbox"/> Transportation
<input type="checkbox"/> Literacy	<input type="checkbox"/> Uninsured
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> None
<input type="checkbox"/> Language	
<input type="checkbox"/> None	

Assistive Devices	<input type="checkbox"/> Medicare Competitive Bid
<input type="checkbox"/> Cane	<input type="checkbox"/> Splint/Brace
<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Prosthetic Limb	<input type="checkbox"/> None

This button will launch the following template.

Other Doctors

Last Updated/Reviewed //

Cardiology		Nephrology	
Colorectal Surgery		Neurology	
Dental		Oncology	
Endocrinology		Ophthalmology	
Gastroenterology		Orthopedics	
General Surgery		Podiatry	

Other MDs Seen	Specialty	Reason

Because Medical-Home implies a **Medical Home Neighborhood**, it is important to know who other care givers 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.

Medical Home Coordination Review

Patient
 Chart: QTest
 Date of Birth: 06/30/1970
 Sex: M Age: 43 Years
 Home Phone: (409)833-9797
 Work Phone: () -

Ancillary Agencies
 Home Health:
 Hospice:
 Assisted Living:
 Nursing Home:
 Physical Therapy:

Medical Power of Attorney
 () -
Primary Caregiver
 () -
Emergency Contact
 () -
 Relation:

Compliance
 Last H&P:
 Telephone Contact:
 Correspondence:
 Birthday Card:

Coordination Review Completed Today?
 Yes No
 Last Reviewed:

Patient needs discussed today at Care Coordination Team Conference?
 Yes No
 Last Reviewed:

Chronic Conditions

Chronic Conditions	Care Coordination Team	Phone
	Primary MD	() -
	CFNP	() -
	Coordinator	() -
	Nurse	() -
	Unit Clerk	() -
	Secondary/Specialty 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 No Lipids: Yes No
 Hypertension: Yes No CHF: Yes No

Referral History [Click for Detail](#)

Status	Referral	Referring Provider

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:

Barriers to Care NONE

Social
 Deaf
 Hearing
 Blind
 Vision
 Literacy
 Social Isolation
 Language
 None

Financial
 Co-Pays
 Medications
 Nutrition
 Transportation
 Uninsured
 None

Assistive Devices
 Cane
 Crutches
 Hearing Aid
 Prosthetic Limb

Medicare Competitive Bid
 Splint/Brace
 Walker
 Wheelchair
 None

Buttons: Return, Transtheoretical Model, Print Note

Patient's E-mail Address:

Student interns are authorized to participate and assist with office visit and/or education? Yes No

These functions will be discussed below.

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

- Diabetes
- Hypertension
- Lipids
- CHF

SOUTHEAST TEXAS MEDICAL ASSOCIATES, L.L.P.

Patient: Chart [] QTest [] Sex: M Age: 43 Patient's Code Status []
 Home Phone: (409)833-9797 Date of Birth: 06/30/1970
 Work Phone: () - []
 Cell Phone: () - []

Patient has one or more alerts!
[Click Here to View Alerts](#)

[Pre-Vist/Preventive Screening](#) [Bridges to Excellence View](#) [Intensive Behavioral Therapy Transtheoretical Model](#)

Preventive Care	Template Suites	Disease Management	Last Updated	Special Functions								
SETMA's LESS Initiative I	Master GP I	Diabetes I	//	Lab Present I								
Last Updated //	Pediatrics	Hypertension I	//	Lab Future I								
Preventing Diabetes I	Nursing Home I	Lipids I	//	Lab Results I								
Last Updated //	Ophthalmology	Acute Coronary Syn I	//	Hydration I								
Preventing Hypertension I	Physical Therapy	Angina I	//	Nutrition I								
Smoking Cessation I	Podiatry	Asthma	//	Guidelines I								
Care Coordination Referral	Rheumatology	Cardiometabolic Risk Syn I	//	Pain Management								
PC-MH Coordination Review	Hospital Care	CHF I	//	Immunizations								
<i>Needs Attention!!</i>	Hospital Care Summary I	Diabetes Education	//	Reportable Conditions								
HEDIS NQF PQRS ACO	Daily Progress Note	Headaches	//	Information								
Elderly Medication Summary	Admission Orders I	Renal Failure	//	Charge Posting Tutorial								
STARS Program Measures		Weight Management I	//	Drug Interactions I								
Exercise Exercise I				E&M Coding Recommendations								
CHF Exercise I				Infusion Flowsheet								
Diabetic Exercise I				Insulin Infusion								
Pending Referrals I												
<table border="1"><thead><tr><th>Status</th><th>Priority</th><th>Referral</th><th>Referring Provider</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td></tr></tbody></table>	Status	Priority	Referral	Referring Provider								
Status	Priority	Referral	Referring Provider									
Patient's Pharmacy				Chart Note - Now								
[]				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								

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 Referral History					
Date	Status	Priority	Referral	Referred To	Referring Provider

[Return](#)

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

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney		<input type="button" value="Return"/>	
Chart	QTest	Home Health			() -	<input type="button" value="Transtheoretical Model"/>	
Date of Birth	06/30/1970	Hospice		Primary Caregiver	() -	<input type="button" value="Print Note"/>	
Sex	M Age 43 Years	Assisted Living		Emergency Contact	() -		
Home Phone	(409)833-9797	Nursing Home			() -		
Work Phone	() -	Physical Therapy		Relation			

Coordination Review Completed Today? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed //	Compliance	Patient's E-mail Address
Patient needs discussed today at Care Coordination Team Conference? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed //	Last H&P //	Student interns are authorized to participate and assist with office visit education? <input type="radio"/> Yes <input type="radio"/> No
		Telephone Contact //	
		Correspondence //	
		Birthdays Card //	

Chronic Conditions	Care Coordination Team	Phone
	Primary MD	() -
	CFNP	() -
	Coordinator	() -
	Nurse	() -
	Unit Clerk	() -
	<input type="button" value="Secondary/Specialty Physicians"/>	
	Evidence-Based Measures Compliance	
	<input type="button" value="Elderly Medication Summary"/>	
	<input type="button" value="HEDIS Measures Compliance"/>	
<input type="button" value="NQF Measures Compliance"/>		
<input type="button" value="PQRS Measures Compliance"/>		
<input type="button" value="Lipids Treatment Audit"/>		
Disease Management Tools Accessed		
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Lipids <input type="radio"/> Yes <input type="radio"/> No
Hypertension	<input type="radio"/> Yes <input type="radio"/> No	CHF <input type="radio"/> Yes <input type="radio"/> No
Referral History Click for Detail		
Status	Referral	Referring Provider

Evacuation Options	
<input type="checkbox"/> Self	Evacuation Contact Information
<input type="checkbox"/> Family	Name
<input type="checkbox"/> Community	Phone () -
Advanced Care Planning	
Code Status	
Advanced Directives Discussed?	<input type="radio"/> Yes <input type="radio"/> No //
Advanced Directives Completed?	<input type="radio"/> Yes <input checked="" type="radio"/> No Date //
Detail	
Barriers to Care <input type="checkbox"/> NONE	
Social	Financial
<input checked="" type="checkbox"/> Deaf	<input type="checkbox"/> Co-Pays
<input type="checkbox"/> Hearing	<input type="checkbox"/> Medications
<input type="checkbox"/> Blind	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Vision	<input type="checkbox"/> Transportation
<input type="checkbox"/> Literacy	<input type="checkbox"/> Uninsured
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> None
<input type="checkbox"/> Language	
<input type="checkbox"/> None	<input type="button" value="Medicare Competitive Bid"/>
Assistive Devices	
<input type="checkbox"/> Cane	<input type="checkbox"/> Splint/Brace
<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Prosthetic Limb	<input type="checkbox"/> None

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

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney		Return																														
Chart	QTest	Home Health		Primary Caregiver	() -	Transtheoretical Model																														
Date of Birth	06/30/1970	Hospice		Emergency Contact	() -	Print Note																														
Sex	M Age 43 Years	Assisted Living		Relation	() -																															
Home Phone	(409)833-9797	Nursing Home																																		
Work Phone	() -	Physical Therapy																																		
Coordination Review Completed Today? <input type="radio"/> Yes <input type="radio"/> No		Last Reviewed //		Compliance		Patient's E-mail Address																														
Patient needs discussed today at Care Coordination Team Conference? <input type="radio"/> Yes <input type="radio"/> No		Last Reviewed //		Last H&P //		Student interns are authorized to participate and assist with office visit and/or education? <input type="radio"/> Yes <input type="radio"/> No																														
				Telephone Contact //																																
				Correspondence //																																
				Birthday Card //																																
Chronic Conditions		Care Coordination Team		Evacuation Options <input type="checkbox"/> Self Evacuation Contact Information <input type="checkbox"/> Family Name _____ <input type="checkbox"/> Community Phone () - _____																																
		Primary MD () -																																		
		CFNP () -																																		
		Coordinator () -																																		
		Nurse () -																																		
		Unit Clerk () -																																		
		Secondary/Specialty Physicians																																		
		Evidence-Based Measures Compliance																																		
		Elderly Medication Summary																																		
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		PQRS Measures Compliance																																		
		Lipids Treatment Audit																																		
		Disease Management Tools Accessed																																		
Diabetes <input type="radio"/> Yes <input type="radio"/> No		Lipids <input type="radio"/> Yes <input type="radio"/> No																																		
Hypertension <input type="radio"/> Yes <input type="radio"/> No		CHF <input type="radio"/> Yes <input type="radio"/> No																																		
Referral History Click for Detail																																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Status</th> <th>Referral</th> <th>Referring Provider</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		Status	Referral	Referring Provider																																
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				Code Status _____																																
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				<input type="checkbox"/> Blind		<input type="checkbox"/> Nutrition																														
				<input type="checkbox"/> Vision		<input type="checkbox"/> Transportation																														
				<input type="checkbox"/> Literacy		<input type="checkbox"/> Uninsured																														
				<input type="checkbox"/> Social Isolation		<input type="checkbox"/> None																														
				<input type="checkbox"/> Language																																
				<input type="checkbox"/> None																																
				Assistive Devices Medicare Competitive Bid																																
				<input type="checkbox"/> Cane <input type="checkbox"/> Splint/Brace																																
				<input type="checkbox"/> Crutches <input type="checkbox"/> Walker																																
				<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Wheelchair																																
				<input type="checkbox"/> Prosthetic Limb <input type="checkbox"/> 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

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

Patients should have a medication assessment and reconciliation at least yearly.

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](#)

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

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.**

Medical Home Coordination Review

Patient		Ancillary Agencies		Medical Power of Attorney		<input type="button" value="Return"/> <input type="button" value="Transtheoretical Model"/> <input type="button" value="Print Note"/>
Chart	QTest	Home Health		Primary Caregiver	() -	
Date of Birth	06/30/1970	Hospice		Emergency Contact	() -	
Sex <input type="radio"/> M <input type="radio"/> F	Age 43 Years	Assisted Living		Relation	() -	
Home Phone	(409)833-9797	Nursing Home				
Work Phone	() -	Physical Therapy				

Coordination Review Completed Today? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed //	Compliance	Patient's E-mail Address
Patient needs discussed today at Care Coordination Team Conference? <input type="radio"/> Yes <input type="radio"/> No	Last Reviewed //	Last H&P //	Student interns are authorized to participate and assist with office visit and/or education? <input type="radio"/> Yes <input type="radio"/> No
		Telephone Contact //	
		Correspondence //	
		Birthday Card //	

Chronic Conditions <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td> </td></tr> </table>												Care Coordination Team <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>Primary MD</th><th>Phone</th></tr> <tr><td> </td><td>() -</td></tr> <tr><td>CFNP</td><td>() -</td></tr> <tr><td>Coordinator</td><td>() -</td></tr> <tr><td>Nurse</td><td>() -</td></tr> <tr><td>Unit Clerk</td><td>() -</td></tr> </table> <p style="text-align: center;"><input type="button" value="Secondary/Specialty Physicians"/></p>	Primary MD	Phone		() -	CFNP	() -	Coordinator	() -	Nurse	() -	Unit Clerk	() -	Evacuation Options <input type="checkbox"/> Self Evacuation Contact Information <input type="checkbox"/> Family Name <input type="checkbox"/> Community Phone () -					
Primary MD	Phone																													
	() -																													
CFNP	() -																													
Coordinator	() -																													
Nurse	() -																													
Unit Clerk	() -																													
Evidence-Based Measures Compliance <div style="border: 2px solid green; padding: 5px; text-align: center;"> <input type="button" value="Elderly Medication Summary"/> <input type="button" value="HEDIS Measures Compliance"/> <input type="button" value="NQF Measures Compliance"/> <input type="button" value="PQRS Measures Compliance"/> <input type="button" value="Lipids Treatment Audit"/> </div>		Advanced Care Planning Code Status Advanced Directives Discussed? <input type="radio"/> Yes <input type="radio"/> No //																												
Disease Management Tools Accessed Diabetes <input type="radio"/> Yes <input type="radio"/> No Lipids <input type="radio"/> Yes <input type="radio"/> No Hypertension <input type="radio"/> Yes <input type="radio"/> No CHF <input type="radio"/> Yes <input type="radio"/> No		Advanced Directives Completed? <input type="radio"/> Yes <input checked="" type="radio"/> No Date //																												
Referral History Click for Detail <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Status</th><th>Referral</th><th>Referring Provider</th></tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		Status	Referral	Referring Provider										Barriers to Care <input type="checkbox"/> NONE <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><input checked="" type="checkbox"/> Deaf</td> <td><input type="checkbox"/> Co-Pays</td> </tr> <tr> <td><input type="checkbox"/> Hearing</td> <td><input type="checkbox"/> Medications</td> </tr> <tr> <td><input type="checkbox"/> Blind</td> <td><input type="checkbox"/> Nutrition</td> </tr> <tr> <td><input type="checkbox"/> Vision</td> <td><input type="checkbox"/> Transportation</td> </tr> <tr> <td><input type="checkbox"/> Literacy</td> <td><input type="checkbox"/> Uninsured</td> </tr> <tr> <td><input type="checkbox"/> Social Isolation</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Language</td> <td></td> </tr> <tr> <td><input type="checkbox"/> None</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> Deaf	<input type="checkbox"/> Co-Pays	<input type="checkbox"/> Hearing	<input type="checkbox"/> Medications	<input type="checkbox"/> Blind	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Vision	<input type="checkbox"/> Transportation	<input type="checkbox"/> Literacy	<input type="checkbox"/> Uninsured	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> None	<input type="checkbox"/> Language		<input type="checkbox"/> None	
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<input type="checkbox"/> None																														
Assistive Devices <input type="checkbox"/> Cane <input type="checkbox"/> Medicare Competitive Bid <input type="checkbox"/> Crutches <input type="checkbox"/> Splint/Brace <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Walker <input type="checkbox"/> Prosthetic Limb <input type="checkbox"/> Wheelchair <input type="checkbox"/> None																														

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 active in this patient and are considered high-risk for use in the elderly.

Medication	Action	Discussed with patient?

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 the 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.”

**2012 HEDIS Technical Specifications
for Physician Measurement**

Legend Measures in red are measures which apply to this patient that are not in compliance
 Measures in black are measures which apply to this patient that are in compliance.
 Measures in gray are measures which do not apply to this patient.

Return
Tutorial

Information
[NCQA](#)
[CAHPS](#)
[HEDIS](#)

Effectiveness of Preventive Care

- [View](#) **Adult BMI Assessment**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Childhood Immunization Status
- Immunizations for Adolescents
- 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

Effectiveness of Acute Care

- [View](#) Appropriate Treatment for Children with Upper Respiratory Infection
- [View](#) Appropriate Testing for Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Effectiveness of Chronic Care

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

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**

Legend Measures in red are measures which apply to this patient that are not in compliance
Measures in black are measures which apply to this patient that are in compliance.
Measures in gray are measures which do not apply to this patient.

Return

Tutorial

Information

[NCQA](#)

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[HEDIS](#)

<p>Effectiveness of Preventive Care</p> <p>View Adult BMI Assessment Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</p> <p>Childhood Immunization Status Immunizations for Adolescents</p> <p>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</p> <p>Effectiveness of Acute Care</p> <p>View Appropriate Treatment for Children with Upper Respiratory Infection</p> <p>View Appropriate Testing for Children with Pharyngitis Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</p>	<p>Effectiveness of Chronic Care</p> <p>View Persistence of Beta-Blocker Therapy After a Heart Attack</p> <p>View Controlling High Blood Pressure</p> <p>View Cholesterol Management for Patients with Cardiovascular Disease</p> <p>Comprehensive Adult Diabetes Care</p> <p>View Use of Appropriate Medications for People with Asthma</p> <p>View Use of Spirometry Testing in the Assessment and Diagnosis of COPD</p> <p>View Pharmacotherapy Management of COPD Exacerbation</p> <p>View Follow-Up After Hospitalization for Mental Illness</p> <p>View Antidepressant Medication Management</p> <p>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication Osteoporosis Management in Women Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</p> <p>View Annual Monitoring for Patients on Persistent Medications Medication Reconciliation Post-Discharge</p>	
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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	
View	Adult BMI Assessment
View	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
View	Childhood Immunization Status
View	Lead Screening in Children
View	Colorectal Cancer Screening
View	Breast Cancer Screening
View	Cervical Cancer Screening
View	Chlamydia Screening in Women
View	Glaucoma Screening in Older Adults
View	Use of High-Risk Medications in the Elderly
View	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	
View	Persistence of Beta-Blocker Therapy After a Heart Attack
View	Controlling High Blood Pressure
View	Cholesterol Management for Patients with Cardiovascular Disease
View	Comprehensive Adult Diabetes Care
View	Use of Appropriate Medications for People with Asthma
View	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
View	Pharmacotherapy Management of COPD Exacerbation
View	Follow-Up After Hospitalization for Mental Illness
View	Antidepressant Medication Management
View	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication
View	Osteoporosis Management in Women
View	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 inches

Patient Weight pounds

Patient BMI

Please enter both the patient's height and weight to complete the calculation for Body Mass Index.

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?

Body Mass Index Value

Percentile

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	//
DTP/DTap 2	//
DTP/DTap 3	//
DTP/DTap 4	//
OPV/IPV 1	//
OPV/IPV 2	//
OPV/IPV 3	//
MMR 1	//
Hib 1	//
Hib 2	//
Varicella 1	//
Prevnar 1	//
Prevnar 2	//
Prevnar 3	//
Prevnar 4	//

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	06/30/1970
Last Lead Screening	//

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...

Fecal occult blood test within the last year.	Date of Last Test
Flexible sigmoidoscopy within the last four years.	
Double contrast barium enema within the last four years.	
Colonscopy within the last nine years.	

Breast Cancer Screening

Breast Cancer Screening

Breast cancer screening for women 40 to 69 years of age.

Patients should have mammogram yearly.

Date of Last Test

Cervical Cancer Screening

Cervical Cancer Screening

Cervical cancer screening in women 21 to 64 years of age.

Patients should have Pap test at least every two years.

Date of Last Test

Care for Older Adults

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

Patients should have a medication assessment and reconciliation at least yearly. [Click to Complete](#)

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](#)

Date of Last Test

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?

Was the patient prescribed antibiotic therapy today?

Appropriate Testing for Children with Pharyngitis

Appropriate Treatment for Children with Pharyngitis

Children 2 to 18 years of age who were diagnosed with pharyngitis.

Was the patient diagnosed with acute pharyngitis today?

Was the patient given a strep test for the episode?

Was the patient prescribed antibiotics today?

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?

3. Effectiveness of Chronic Care

Persistence of Beta-Blocker Treatment After a Heart Attack

Persistence of Beta-Blocker Treatment After a Heart Attack

Patients 18 years of age and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction.

Has the patient had a history of acute myocardial infarction within the last 12 months?

Is the patient currently on beta-blocker therapy?

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?

Has the patient's blood pressure been well controlled for last three months (<140/90)?

Blood Pressure History (most recent first)

Date/Time	Systolic	Diastolic

Cholesterol Management for Patients with Cardiovascular Disease

Cholesterol Management for Patients 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?

Most Recent HgbA1c

Has the patient had HgbA1c screening within the last year?

Was the patient's last HgbA1c controlled?

Has the patient's blood pressure been controlled (< 130/80) within the last year?

Last Dilated Eye Exam

Has the patient had a dilated eye exam within the last year?

Most Recent LDL

Has the patient had an LDL screening within the last year?

Was the patient's last LDL controlled?

Last Foot Exam

Has the patient had a foot exam within the last year?

Most Recent Micral Strip

Has the patient had a nephropathy screening within the last year?

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 persistent asthma?

Does the patient have an active prescription for asthma medication?

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?

Has spirometry testing been used to confirm the diagnosis? Yes No

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?

Discharge Date

Was the patient dispensed a systemic corticosteroid with 14 days of the event?
 Yes No

Was the patient dispensed a bronchodilator within 30 days of the event?
 Yes No

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?

Date of Discharge

Did the patient have follow-up with a mental health care provider within 7 days of discharge?
 Yes No

Did the patient have follow-up with a mental health care provider within 30 days of discharge?
 Yes No

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?

Is the patient on an antidepressant medication?

Acute Phase Treatment
Has the patient been given medication to last at least 12 weeks?
 Yes No

Continuation Phase Treatment
Has the patient been given medication to last at least 6 months?
 Yes No

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?

Initiation Phase
Has the patient have a follow-up visit within 30 days of starting these medications?
 Yes No

Continuation Phase
Has the patient have a follow-up visit within 9 months of starting these medications?
 Yes No

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?

Has the patient BMD density test within the last year?

Date of Last Test

-- OR --

Is the patient currently on prescription to treat or prevent osteoporosis?

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?

Has the patient been dispensed at least one disease-modifying anti-rheumatic drug (DMARD)?

Annual Monitoring for Patients on Persistent Medications

Annual Monitoring for Patients on Persistent Medications

Patients 18 years of age and older who are on one or more persistent medications.

Is the patient on an ACE or ARB?

Is the patient on digoxin?

Is the patient on a diuretic?

Is the patient on an anticonvulsant?

For monitoring of an ACE, ARB, digoxin OR diuretic, any ONE of the following lab tests should be performed at least yearly.

Has the patient had a serum potassium test within the last year?

Has the patient had a serum creatinine test within the last year?

Has the patient had a blood urea nitrogen test within the last year?

Has the patient had a phenobarbital level within the last year?

Has the patient had a phenytoin level within the last year?

Has the patient had a valproic acid level within the last year?

Has the patient had a carbamazepine level within the last year?

This will launch the below template.

**National Quality Forum (NQF)
National Voluntary Consensus Standards**

Legend Measures in red are measures which apply to this patient that are not in compliance.
Measures in black are measures which apply to this patient that are in compliance.
Measures in gray are measures which do not apply to this patient.

General Health Measures View Body Mass Index Measurement View Smoking Cessation Proper Assessment for Chronic COPD Adult Immunization Status	Care for Older Adults View Counseling on Physical Activity View Urinary Incontinence in Older Adults Colorectal Cancer Screening Fall Risk Management
Blood Pressure Measures View Blood Pressure Measurement View Blood Pressure Classification/Control	Diabetes Measures Dilated Eye Exam Foot Exam Hemoglobin A1c Testing/Control Blood Pressure Urine Protein Screening Lipid Screening
Medication Measures View Current Medication List View Documentation of Allergies/Reactions View Therapeutic Monitoring of Long Term Medications Drugs to Avoid in the Elderly View Appropriate Medications for Asthma View Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis View LDL Drug Therapy for Patients with CAD	Female Specific Measures Breast Cancer Screening Cervical Cancer Screening Chlamydia Screening Osteoporosis Management
Chronic Conditions Measures Comprehensive CHF Care Osteoarthritis Care	Pediatric Measures Appropriate Screening for Children with Pharyngitis Childhood Immunization Status

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?

Today's BMI Measurement

Smoking Cessation

Smoking Cessation

Does the patient smoke?	<input type="text" value="No"/>
Has smoking cessation been discussed with the patient?	<input type="text" value="No"/>
Have smoking cessation strategies been discussed or implemented?	<input type="text" value="No"/>

Proper Assessment for Chronic COPD

Proper Assessment for Chronic COPD

Monitoring of oxygen saturation at least annually for patients with a chronic diagnosis of COPD.

Does the patient have a chronic diagnosis of COPD?	<input type="text" value="No"/>
Was the patient's oxygen saturation measured today?	<input type="text" value="No"/>

Today's O2 Saturation

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 Documentation

Blood pressure measurement/documentation of patients 18 years of age and older.

Was the patient's blood pressure measured this visit?

Current Blood Pressure /

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?

Today's Blood Pressure /

Is there a documented plan of care in place for elevated blood pressure?
(Hypertension Disease Management Plan)

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 patient's active medication list?

Documentation of Allergies/Reactions

Documentation of Allergies/Reactions

Were the patient's allergies reviewed/updated today?

Therapeutic Monitoring of Long Term Medications

Annual Monitoring for Patients on Persistent Medications

Patients 18 years of age and older who are on one or more persistent medications.

<p>Is the patient on an ACE or ARB? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr></table>					<p><i>For monitoring of an ACE, ARB, digoxin OR diuretic, any ONE of the following lab tests should be performed at least yearly.</i></p> <p>Has the patient had a serum potassium test within the last year? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px; text-align: center;">/ /</td></tr></table>		/ /
	/ /						
<p>Is the patient on digoxin? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr></table>					<p>Has the patient had a serum creatinine test within the last year? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px; text-align: center;">/ /</td></tr></table>		/ /
	/ /						
<p>Is the patient on a diuretic? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr></table>					<p>Has the patient had a blood urea nitrogen test within the last year? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px; text-align: center;">/ /</td></tr></table>		/ /
	/ /						
<hr/>							
<p>Is the patient on an anticonvulsant? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr></table>					<p>Has the patient had a phenobarbital level within the last year? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px; text-align: center;">/ /</td></tr></table>		/ /
	/ /						
	<p>Has the patient had a phenytoin level within the last year? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px; text-align: center;">/ /</td></tr></table>		/ /				
	/ /						
	<p>Has the patient had a valproic acid level within the last year? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px; text-align: center;">/ /</td></tr></table>		/ /				
	/ /						
	<p>Has the patient had a carbamazepine level within the last year? <input type="checkbox"/> No</p> <table border="1" style="width: 100%;"><tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px; text-align: center;">/ /</td></tr></table>		/ /				
	/ /						
<p><input type="button" value="OK"/> <input type="button" value="Cancel"/></p>							

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 active in this patient and are considered high-risk for use in the elderly.

Medication	Action	Discussed with patient?

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 persistent asthma?

Does the patient have an active prescription for asthma medication?

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?

Was the patient prescribed antibiotic therapy this visit?

LDL Drug Therapy for Patients with CAD

Cholesterol Management for Patients with Cardiovascular Conditions

Does the patient have a history of...

acute myocardial infarction?

coronary artery bypass graft (CABG)?

percutaneous transluminal coronary angioplasty (PTCA)?

ischemic vascular disease (IVD)?

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?

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 Exercise template?

No

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.	//
Flexible sigmoidoscopy within the last four years.	//
Double contrast barium enema within the last four years.	//
Colonoscopy within the last nine years.	//

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?

Last Fall Risk Assessment

Diabetes Measures

Dilated Eye Exam

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?

Most Recent HgbA1c

Has the patient had HgbA1c screening with the last year?

Was the patient's last HgbA1c controlled?

Has the patient's blood pressure been controlled (< 130/80) within the last year?

Last Dilated Eye Exam

Has the patient had a dilated eye exam within the last year?

Most Recent LDL

Has the patient had an LDL screening within the last year?

Was the patient's last LDL controlled?

Last Foot Exam

Has the patient had a foot exam within the last year?

Most Recent Micral Strip

Has the patient had a nephropathy screening within the last year?

Foot Exam

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?

Most Recent HgbA1c

Has the patient had HgbA1c screening with the last year?

Was the patient's last HgbA1c controlled?

Has the patient's blood pressure been controlled (< 130/80) within the last year?

Last Dilated Eye Exam

Has the patient had a dilated eye exam within the last year?

Most Recent LDL

Has the patient had an LDL screening within the last year?

Was the patient's last LDL controlled?

Last Foot Exam

Has the patient had a foot exam within the last year?

Most Recent Micral Strip

Has the patient had a nephropathy screening within the last year?

Hemoglobin A1c Testing Control

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?

Most Recent HgbA1c

Has the patient had HgbA1c screening with the last year?

Was the patient's last HgbA1c controlled?

Has the patient's blood pressure been controlled (< 130/80) within the last year?

Last Dilated Eye Exam

Has the patient had a dilated eye exam within the last year?

Most Recent LDL

Has the patient had an LDL screening within the last year?

Was the patient's last LDL controlled?

Last Foot Exam

Has the patient had a foot exam within the last year?

Most Recent Micral Strip

Has the patient had a nephropathy screening within the last year?

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?

Most Recent HgbA1c

Has the patient had HgbA1c screening with the last year?

Was the patient's last HgbA1c controlled?

Has the patient's blood pressure been controlled (< 130/80) within the last year?

Last Dilated Eye Exam

Has the patient had a dilated eye exam within the last year?

Most Recent LDL

Has the patient had an LDL screening within the last year?

Was the patient's last LDL controlled?

Last Foot Exam

Has the patient had a foot exam within the last year?

Most Recent Micral Strip

Has the patient had a nephropathy screening within the last year?

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?

Most Recent HgbA1c

Has the patient had HgbA1c screening with the last year?

Was the patient's last HgbA1c controlled?

Has the patient's blood pressure been controlled (< 130/80) within the last year?

Last Dilated Eye Exam

Has the patient had a dilated eye exam within the last year?

Most Recent LDL

Has the patient had an LDL screening within the last year?

Was the patient's last LDL controlled?

Last Foot Exam

Has the patient had a foot exam within the last year?

Most Recent Micral Strip

Has the patient had a nephropathy screening within the last year?

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**

Medical Home Coordination Review

Patient
 Chart: QTest
 Date of Birth: 06/30/1970
 Sex: M Age: 43 Years
 Home Phone: (409)833-9797
 Work Phone: () -

Ancillary Agencies
 Home Health: () -
 Hospice: () -
 Assisted Living: () -
 Nursing Home: () -
 Physical Therapy: () -

Medical Power of Attorney
 () -
Primary Caregiver
 () -
Emergency Contact
 () -
 Relation: () -

Compliance
 Last H&P: () -
 Telephone Contact: () -
 Correspondence: () -
 Birthday Card: () -

Chronic Conditions
 Diabetes

Care Coordination Team
 Primary MD: () -
 CFNP: () -
 Coordinator: () -
 Nurse: () -
 Unit Clerk: () -
 Secondary/Specialty Physicians: () -

Evidence-Based Measures Compliance
 Elderly Medication Summary
 HEDIS Measures Compliance
 NQF Measures Compliance
 PQRS Measures Compliance
 Lipids Treatment Audit
Diabetes Physician Consortium

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

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: () -

Barriers to Care NONE

Social
 Deaf
 Hearing
 Blind
 Vision
 Literacy
 Social Isolation
 Language
 None

Financial
 Co-Pays
 Medications
 Nutrition
 Transportation
 Uninsured
 None

Assistive Devices Medicare Competitive Bid
 Cane
 Crutches
 Hearing Aid
 Prosthetic Limb
 Splint/Brace
 Walker
 Wheelchair
 None

Return
 Transtheoretical Model
 Print Note

Patient's E-mail Address: () -
 Student interns are authorized to participate and assist with office visit and/or education? Yes No

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.

The Diabetes Disease Management tool is launched from AAA Home.

SOUTHEAST TEXAS MEDICAL ASSOCIATES, L.L.P.

Patient: Chart [] QTest [] Sex: M Age: 43 Patient's Code Status: []
 Home Phone: (409)833-9797 Date of Birth: 06/30/1970
 Work Phone: () - []
 Cell Phone: () - []

Patient has one or more alerts!
[Click Here to View Alerts](#)

[Pre-Vist/Preventive Screening](#) [Bridges to Excellence View](#) [Intensive Behavioral Therapy Transtheoretical Model](#)

Preventive Care	Template Suites	Diagnosis	Last Updated	Special Functions								
SETMA's LESS Initiative [] Last Updated: []	Master GP []	Diabetes []	[]	Lab Present []								
Preventing Diabetes [] Last Updated: []	Pediatrics	Hypertension []	[]	Lab Future []								
Preventing Hypertension []	Nursing Home []	Lipids []	[]	Lab Results []								
Smoking Cessation []	Ophthalmology	Acute Coronary Syn []	[]	Hydration []								
Care Coordination Referral	Physical Therapy	Angina []	[]	Nutrition []								
PC-MH Coordination Review	Podiatry	Asthma	[]	Guidelines []								
Needs Attention!!	Rheumatology	Cardiometabolic Risk Syn []	[]	Pain Management								
HEDIS [] NQF [] PQRS [] ACO []	Hospital Care	CHF []	[]	Immunizations								
Elderly Medication Summary	Hospital Care Summary []	Diabetes Education	[]	Reportable Conditions								
STARS Program Measures	Daily Progress Note	Headaches	[]	Information								
Exercise Exercise []	Admission Orders []	Renal Failure	[]	Charge Posting Tutorial								
CHF Exercise []		Weight Management []	[]	Drug Interactions []								
Diabetic Exercise []				E&M Coding Recommendations								
Patient's Pharmacy	Pending Referrals []			Infusion Flowsheet								
[]	<table border="1"><thead><tr><th>Status</th><th>Priority</th><th>Referral</th><th>Referring Provider</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td> </td></tr></tbody></table>	Status	Priority	Referral	Referring Provider							Insulin Infusion
Status	Priority	Referral	Referring Provider									
Phone: () - []					Chart Note - Now							
Fax: () - []					Chart Note - Offline							
Rx Sheet - Active					Return Info							
Rx Sheet - New					Return Doc							
Rx Sheet - Complete					Email							
Home Health					Telephone							
					Records Request							
					Transfer of Care Doc							

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 Since: Patient Chart QTest
 Type I Type II GDM Pre-Diabetes Other Month Year Age 43 Sex M

Navigation: Diabetes General
 Return
 Diab Sys Review
 Diabetic History
 Eye Exam
 Nasopharynx
 Cardio Exam
 Foot Exam
 Neurological Exam
 Complications/Education
 Initiating Insulin
 Insulin Pump
 Lifestyle Changes
Diabetes Plan
 Diabetes Education
 Telephone Record
 Last DE
 Manual Lab Results

Adherence: Dental Care, Dilated Eye Exam, Flu Shot, Foot Exam, Monofilament, HgbA1C, Pneumovax, Urinalysis, Aspirin, Statin

Vital Signs: Height, Weight, BMI, Body Fat %, Protein Req, BMR, Waist, Hips, Chest, Abdomen, Ratio, BER, Finger Stick Glucose, Pulse, Blood Pressure, BP In Diabetics, Vitals Over Time

Current SQ Insulin Dose as of: Time of day, Units, Type, mg/dl, Diary

Most Recent Labs: HoA1C, Previous, eAG, Mean Plasma Glucose, C-Peptide, Fructosamine, Cholesterol, LDL, HDL, Triglycerides, Trio/HDL Ratio, Glucose, Fasting, Insulin, HOMA-R, Na, K, Magnesium, BUN, Creatinine, U Microalbumin, Albumin/Creat

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**

Diabetes Plan

Meal Requirements: Total Daily Dose, Basal Requirement, Total Meal Dose, Pre-lunch, Pre-breakfast, Pre-dinner, General Measures, Help

Laboratory & Procedures: BMP, C-Peptide, Creatinine, EKG, Flu Shot, Fructosamine, Hepatic Profile, HgbA1C, Lipid Profile w/LDL, Magnesium, Micral Strip, Pneumovax, Spot AC Ratio, TSH, Venipuncture

Assessment: Dx1, Dx2, Dx3, Chronic Conditions, EM Coding

Management: Change Self-Monitoring of Blood Glucose (SMBG) to, Phone glucose data into our office in 7 days, Refer to eye specialist, HgbA1C Treat Goals

Follow Up Visit: Priority, Referring First, Referring Last, Referral

Medications: Continue present insulin and metformin/sulfonylurea/acarbose/pio/ros/vitrogliatzone regimen, Continue Aspirin, Start Aspirin 325 mg, Begin/Increase/Decrease/Stop [] to [] mg

New SQ Insulin Dose: Save, Import Current, Insulin Pump

Navigation: Return, Consortium Data Set, Patient Adherence, Comments, Follow Up Document, Document

Comparison of Human Insulin: Conditions - Glycemic Control, Drugs - Glucose Levels, Basal/Bolus Insulin, Incretins, Byetta, Actions: Byetta

You MUST click "Save" above after entering new insulin information.

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 Diabetes Management

Has the patient had a Hemoglobin A1c within the last year?
 Date of Last

Has the patient had a Lipid Profile within the last year?
 Date of Last

Has the patient had a urinalysis within the last year?
 Date of Last

Has the patient had a dilated eye exam within the last year? *Add Referral Below*
 Date of Last

Has the patient had a flu shot within the last year?
 Date of Last

Has the patient had a 10-gram monofilament exam within the last year?
 Date of Last

Is the patient on Aspirin? *Add Medication Below*
 Is the patient allergic to aspirin? Yes No

Is the patient's blood pressure controlled (<130/80 mmHg)?
 Today's Blood Pressure /

Does the patient have at least one visit schedule for the next six months?

Has the Diabetes Treatment Plan been completed with the last year?
 Date Last Completed

Referrals	Active Medications
Double-Click to Add/Edit	Double-Click to Add/Edit
Referral	Brand Name
Date	Dose
◀ ▶	◀ ▶

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.

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.

The screenshot displays the 'Hypertension Management' interface. At the top, there are fields for 'Patient Chart' and 'QTest', and 'Age 43' and 'Sex M'. A 'Dm Hpt Check' window is open, titled 'Physician Role in Hypertension Management'. This window contains a checklist of eight items, each with an unchecked checkbox:

- Blood pressure measured at least once this visit
- Blood pressure measurement repeated if elevated
- Blood pressure classification determined
- Weight reduction discussed/recommended
- Sodium intake discussed/changes recommended
- Alcohol intake discussed/changes recommended
- Exercise discussed/recommended
- Appropriate follow-up scheduled

Below the checklist, there is a checkbox for 'Generate a follow-up document for the patient at least yearly' and a 'Date Last Generated' field with the value ' / /'. At the bottom of the pop-up are 'OK' and 'Cancel' buttons. On the right side of the main interface, a 'Navigation' pane lists various options, with 'Physician Role' highlighted in a green box. Other options include 'Return', 'Dippers and White Coat', 'HPT and Diabetes', 'HPT and Depression', 'HPT and the Elderly', 'HPT, Insulin Resistance', 'Isolated Systolic HPT', 'HPT and Kidney Disease', 'Evaluation', 'Diagnosis and Screening', 'Lifestyle Changes', 'Treatment', and 'HPT Plan'. Below these are sections for 'Patient Information' (with a 'Click for Documents' button) and 'Physician Information' (with links for 'Classification' and 'Risk Stratification').

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 Initiative.