



Sonoma Valley Community Health Center

Diabetes HbA1c Control

Redwood Community Health Coalition
Promising Practice

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H2QCS30258, Health Center Controlled Networks, for \$1,500,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

PROMISING PRACTICE OVERVIEW

Sonoma Valley Community Health Center (SVCHC) is achieving high performance on diabetes HbA1c control < 9% with a 6% improvement from 2015 to 2016 according to UDS reporting. SVCHC made several workflow changes in 2015 that have led to continued improvements. SVCHC re-wrote their clinical care guidelines, documented workflows and regularly trained staff on the changes. They also focused on data validation and making sure i2i reports were accurately mapped and started sharing care team level reports with providers. SVCHC’s QI Director meets with providers when data demonstrates that adherence to the guidelines/workflow is not being followed and provides one-on-one assistance to improve the clinical quality measures for the provider’s panel. Diabetic patients with A1Cs over 9 are brought in monthly for provider visits where their in-house lab is used to measure A1C monthly. An endocrinologist consultant was temporarily used as a resource for provider education about the new generation of medications. They have had success using the GLP-1 receptor antagonists for some patients.


AIM

Population for focused improvement: adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes. Goal is reduce the number of patients with HbA1c>9 from 21% to 18% (82% Diabetes A1c Controlled <9).

MEASURES

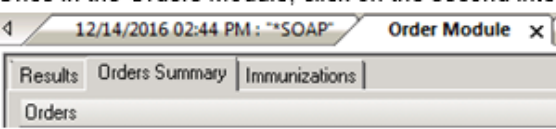
For UDS reporting to HRSA for diabetes A1c blood sugar in control, SVCHC improved from 72% in 2015 to 78% in 2016 and they have continued to improve in 2017. Sonoma Valley is close to meeting their goal of 82%.

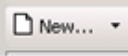
In House Lab – Hemoglobin A1c PROCEDURE

From anywhere within the current encounter (The medical assistant always completes the 5 point check) click on the icon for the **Orders Module**  on the top tool bar or at the bottom of the History bar.

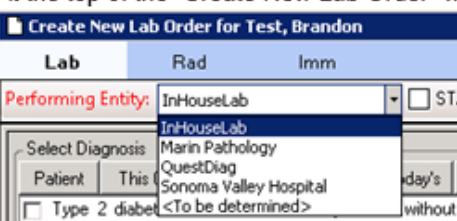
(The Medical Assistant will no longer be using Standing Orders/Office Diagnostic or Office Procedures when ordering or resulting the Hemoglobin A1c)

Once in the Orders Module, click on the second internal tab for the **Orders Summary**.

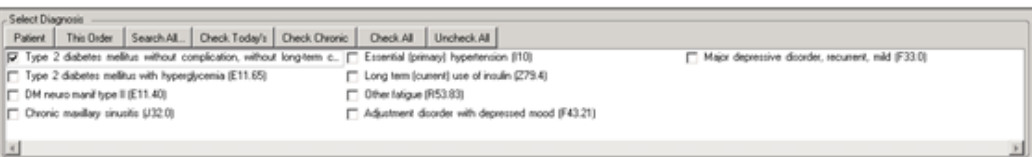


Now click **New** to order the test. 

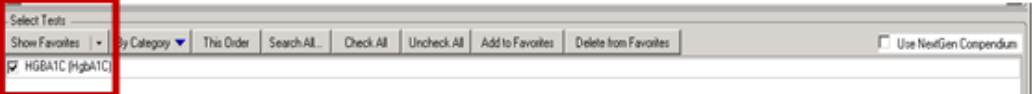
At the top of the "Create New Lab Order" window, select **InHouseLab** as the performing entity.



From the top Select Diagnosis section select the appropriate **diabetes diagnosis** by clicking the **checkbox** next to it. The diagnoses that the Medical Assistant will see are the patient's current and chronic diagnoses. (**Please Note:** If there is **not a diabetes diagnosis or screening for diabetes diagnosis** the Medical Assistant will need to ask the provider to add the appropriate diagnoses to the patient Assessment and, if a Chronic Condition, to the Patient Problem list)



In the Select Tests section the Medical Assistant will see the HGBA1C test in the favorite's panel. Click the **checkbox** next to it to select the test.



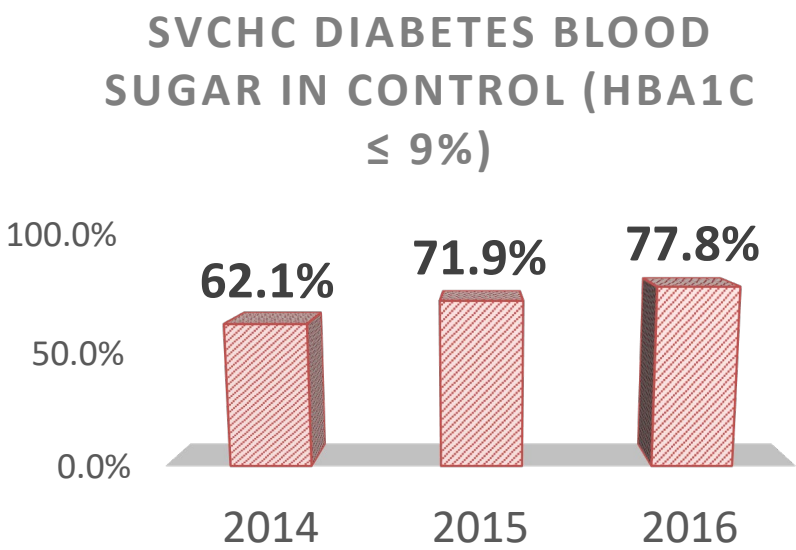
ACTIONS TAKEN

- Between 2015 and 2016 SVCHC made the following changes that contributed to their improved performance:
- 1) SVCHC rewrote their clinical care guidelines for management of diabetic patients to support their care team model. The roles and responsibilities for managing diabetic patients with HbA1cs over 9 are documented as a procedure which outlines responsibilities for care team managers, MAs and providers. Huddle sheets printed from i2i are used by care teams during huddles and include last A1c, BMI and preventive screenings. Diabetic patients are flagged in the EHR with big red letters so their chronic condition is not missed. According to the workflow, diabetic patients with A1Cs >9 are recommended to come into the health center for monthly visits with phone calls in-between visits. HbA1cs are performed using their in-house lab monthly (in-house lab launched in January 2015).
 - 2) Training of the new clinical care guidelines and workflow occur during staff meetings and ongoing. Data is used to facilitate conversations about what isn't happening and why so adherence to the guideline/workflow is improved.
 - 3) SVCHC upgraded their EHR system (NextGen) template for management of diabetes and started to work on re-mapping i2i and validation of reports.
 - 4) SVCHC contracted with a endocrinologist who served as a resource for one year from 2016 to 2017 and trained providers on medication management for the new generation of medications. The GLP-1 receptor antagonists have been helpful in managing patients struggling to get their A1cs under control.
 - 5) SVCHC’s QI Director e-mails reports of each provider’s panel on a quarterly basis and if data shows that a provider is not following the standard procedure for management of diabetes, she will schedule an appointment on the provider’s clinic schedule and bring the data in for a more in-depth review and discussion in-person. The QI Director has conducted these conversations with about 50% of the providers.
 - 6) SVCHC increased referrals to their certified diabetic educator (CDE) and registered dietitian who is on staff two days a week. They also have access to a podiatrist and they do retinography in-house. LVN/case managers have a caseload of about 25 patients at a time and ensure that A1c are completed every visit.

WORKFLOWS

See attachments for documented workflows

RESULTS TO DATE



LESSONS LEARNED

SVCHC has learned that while monthly A1c tests are expensive, it helps to make sure patient progress on glucose control is regularly documented and engages the patient in discussions about their lab values with their provider and nurse case manager.



Document Title: Chronic Conditions Diabetes, HbA1C >9		Page 1 of 8
Document Type: Procedure	Document ID Number:	
Department: Medical		
Author: Marianne Clinton, MD CMD	Implementer/Owner: Marianne Clinton, MD CMD	
Approval Date:04/16/2014	Training Date:04/16/2014	
Implementation Date: 04/16/2014	Revision Date:	
Effective Date: 04/16/2014	Next Review Date: 04/01/2016	

STATEMENT OF PURPOSE:

- It is the policy of Sonoma Valley Community Health Center (SVCHC) that we provide excellent care of diabetic patients by standardizing our care processes based on recommendations of the American Diabetes Association. Work flows and policies are modeled on those of Kaiser Permanente.
- To this end, SVCHC has selected improvement in diabetes management as one of the chronic conditions for focused attention within the construct of Patient Centered Medical Home (PCMH). Specifically, goal is to reduce the number of patients with HbA1C>9 from 21% to 18%.
- Population for focused improvement – adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes.

DEFINITIONS:

Diabetes Mellitus (DM) or simply Diabetes, is a group of metabolic diseases in which a person has an elevated serum glucose. Symptoms include frequent urination, increased thirst, and increased hunger. Untreated, diabetes can cause many complications. Acute complications include diabetic ketoacidosis and nonketotic hyperosmolar coma. Long-term complications include heart disease, kidney failure, damage to the eyes, and damage to the nervous system and circulation.

- Type I DM results from the body's failure to produce insulin. This form was previously referred to as "insulin-dependent diabetes mellitus" (IDDM) or "juvenile diabetes".
- Type 2 DM results from insulin resistance, a condition in which cells fail to use insulin properly, sometimes also with an absolute insulin deficiency. This form was previously referred to as noninsulin-dependent diabetes mellitus (NODDM) or "adult-onset diabetes".
- Gestational diabetes, is the third main form and occurs when pregnant women without a previous diagnosis of diabetes develop a high blood glucose level.

Evidence Based Guidelines: Clinical Practice guidelines based on scientific evidence; or in the absences of scientific evidence, professional standards, or in the absences of professional standards, an expert opinion.

Practice Guidelines: Systematically developed descriptive tools or standardized procedures for care to support clinician and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

Important Condition: A condition including an unhealthy behavior, substance abuse or mental health issue, with evidence –based clinical guidelines that affect a large number of people or consumes a disproportionate amount of health resources.

NextGen Enterprise Practice Management (EPM): NextGen EPM is the application used primarily for billing and is also used to manage appointments. Other functions of EPM include, but are not limited to, storing patient demographics, posting transactions, and processing charges.

NextGen Electronic Health Records (EHR): NextGen EHR is the application used to store and maintain a patient's electronic chart. Clinical information such as lab results, health history, and diagnosis history are located in EHR.

History of Present Illness (HPI): The HPI is a chronological description of the development of the patient's present illness including the following elements: Location, Quality, Severity, Duration, Timing, Context, Modifying factors and associated signs and symptoms. Brief and Extended HPI's are distinguished by the amount of detail needed to accurately characterize the clinical problem or problems:

_____ Brief – consist of 1 to 3 elements.

_____ Extended - consists of 4 or more elements.

BACKGROUND:

Diagnostic criteria for diagnosis of diabetes – at least one of the following:ⁱ

- A1C ≥ 6.5%
- Fasting serum glucose ≥ 126. Fasting is defined as no caloric intake for at least 8 hours.
- Oral glucose tolerance test (OGTT), 2-hour plasma glucose ≥ 200 after 75g glucose load.
- Random plasma glucose ≥ 200 in a patient with classic symptoms of hyperglycemia.
- In the absence of unequivocal hyperglycemia, result should be confirmed by repeat testing.

ASSUMPTIONS: None

PCMH (Patient Care Medical Home) Related: Yes (X); No ()

PCMH 2, Element G: The Practice Team, Factor 3: the practice has written standing orders. PCMH Element 3, and PCMH 4.

NextGen EPM/EHR Procedure is needed for this Procedure: Yes (X); No ()

PROCEDURE:

The Care Manager/Care Team Manager is responsible for

1. Running and reviewing NextGen report weekly for patients with type 1 and type 2 diabetes with HgA1c >9.0.
2. Identifying patients due for lab and other testing, and patients with failed appointments. In addition, providers may identify other patients with co-morbidities and psychosocial risk factors that warrant closer monitoring.
3. Contacting patients in need of services, ordering needed tests/services per protocol, tasking the patient's Primary Care Provider (PCP) with any other needed orders, scheduling follow up appointments, and follow-up on patients who failed to keep their appointments.
4. Activation of patient recall for Diabetes based on diagnosis, date of last visit, and date of last recorded HbgA1C . (This responsibility may eventually be re-assigned to other staff members.)
5. Responding to requests from the providers.

The Medical Assistant is responsible to:

1. Complete review of patient's Health History ensuring past medical, family and social histories are complete and updated appropriately.
2. Update any recent hospitalizations/ ER visits
3. Obtain any appropriate medical records for the providers review
4. Complete tobacco assessment.
5. Complete full set of vitals (height, weight, blood pressure, pulse, respiratory rate, temperature).
6. Make sure that patient has removed their shoes and socks at each visit to facilitate completion of the foot examination.
7. Select Diabetes HPI as the reason for visit. (Never select Diabetes Follow-up HPI.)
8. Determine if patient brought a record of home glucose monitoring. If not, perform random glucose.
9. Review chart, obtain results, and place into the Diabetes Protocol (optimally at time of pre-visit chart preparation) the following:
 - a. Consultation report of dilated fundoscopic eye examination and/or retinal photography.
 - b. Date of last dental exam, name of dental provider, and consultation report.
 - c. Date of most recent monofilament foot exam.
 - d. Dates of most recent A1C, lipid panel, metabolic panel, and microalbumin.
10. Complete monofilament foot exam if not completed within last 12 months.
11. Provide assistance in completion of Patient Self Management Tool.
12. Review patient's medications.
13. Using a standing order, perform A1C if not done in the last 3 months (or 6 months for Medicare patients).
14. Provide any needed immunizations, utilizing the CAIR registry. Enter all immunization data and patient information into CAIR registry.
15. Perform a PHQ2 depression screen annually. If PHQ2 is positive, administer the PHQ9 depression screen.

16. Provide information regarding available education classes and community resources.

The Provider is responsible to:

1. Complete the Diabetes HPI (Required MU and PCMH).
2. Assure that diagnosis is on problem list.
3. Review of history information (past, family, social) at each patient visit
4. Perform appropriate physical examination for the diabetic patient.
5. Perform foot inspection at every visit with monofilament exam at least yearly. Monofilament exam may be performed by MA, and documentation reviewed by the provider.
6. Refer for dental examination every 6 months.
7. Refer for eye examination annually.
8. Hemoglobin A1C every 3 months (in most cases). (Medicare only pays for this service twice a year starting 1/1/2014.)
9. Lipid screening annually and as indicated.
10. Micro-albumin annually and as indicated
11. Complete Metabolic Panel annually and as indicated.
12. Immunizations – up to date influenza and Pneumovax immunizations.
13. All patients will be referred to the SVCHC Certified Diabetes Educator for diabetes education, home glucose monitoring instruction, diet and exercise counseling.
14. Diabetic patients to have 2 focused visits per year with the exception of patients that have not achieved optimal blood glucose range below 8 they will be brought back for additional focused visits by the PCP on a monthly basis.

Provider identified treatment goals by current A1C level:

- A1C level >9%
 - Drug naïve
 - With symptoms – insulin +/- other agents
 - No symptoms – combination therapy (metformin + another oral hypoglycemic medication).
 - Under treatment – insulin +/- other agents
- Recommended medication regimens:ⁱⁱ
 - Monotherapy – metformin. If needed to reach individualized A1C target after 3 months, proceed to two-drug combination.
 - Two drug combinations – metformin plus (listed in random order):
 - Sulfonylurea (SU)
 - Thiazolidinedione (TZD)
 - DPP-4 inhibitor (DPP-4-I)
 - GP-1 receptor agonist (GLP-1-RA)
 - Insulin (usually basal – i.e. NPH, glargine, detemir)
 - Three drug combinations – metformin plus (listed in random order):
 - ☐ Sulfonylurea + thiazolidinedione or SPP-4-1 or GP-1 receptor agonist or
 - Thiazolidinedione = (sulfonylurea or DPP-4 inhibitor or GP-1 receptor agonist or insulin)
 - DPP-4 inhibitor = (sulfonylurea or thiazolidinedione or insulin)
 - GP-1 receptor agonist + (sulfonylurea or thiazolidinedione or insulin)
 - Insulin + (thiazolidinedione or DPP-4 inhibitor or GP-1 receptor agonist)

Treatment Goals:

- HbA1C
 - For all patients, A1C≤8
 - Target for many patients is A1C< 7 %.
 - A more stringent A1C goal of <6.5% may be reasonable for selected patients, if this can be achieved without hypoglycemia or other adverse effects of treatment
 - A less stringent goal of A1C< 9% may be appropriate for patients with a history of hypoglycemia, limited life expectancy, advanced microvascular and macrovascular complications, or extensive comorbid conditions.
 - Minimum of HbA1C testing every 6 months. This frequency is more reliably achieved by testing every 3 months during focused diabetes visits. Patients with variable control will continue to be best managed with A1C testing every 3 months. Patients who maintain excellent control can be managed with less frequent testing, but for best care and auditing purposes, frequency must never fall below twice yearly.
- Glucose
 - Fasting glucose <110
 - Postprandial glucose <140
 - Home glucose monitoring is a key component of optimal diabetes management. Frequency of testing depends on patient's current diabetic control, use of insulin (especially short-acting sliding scale), symptoms, etc.
- Blood Pressure target – optimal blood pressure which balances benefit and risk, continues to be studied. Based on Up-to-date literature review of 1/22/2013ⁱⁱⁱ, and specifically the UDPDS, HOT, and ADVANCE trials, the following treatment goals are recommended:
 - All patients with diabetes mellitus have a goal blood pressure less than 140/90 mmHg.
 - Attempt to lower the systolic pressure below 130 to 135 mmHg (preferably less than 130 mmHg) if it can be achieved without producing significant side effects (weaker recommendation).
 - Goal blood pressure of less than 130/80 mmHg in patients with diabetic nephropathy and proteinuria (500 mg/day or more). Patients with moderately increased albuminuria (formerly "microalbuminuria") are treated similarly to diabetic patients without proteinuria.
- Lipid Management
 - An LDL goal of <100, with an optional goal of <70, is recommended for all patients with diabetes.
 - See separate section on lifestyle management.
 - Statin therapy
 - Statin therapy is recommended for all patients with diabetes and coronary artery disease (CAD).
 - Statin therapy is recommended for all patients with diabetes who are 40 years of age and older.
 - Statin therapy, age 39 or younger.
 - With ≥1 risk factor, statin therapy is RECOMMENDED when LDL≥100. Statin therapy is OPTIONAL when LDL<100.

- Without risk factors, statin therapy is RECOMMENDED with LDL \leq 130. Statin therapy is OPTIONAL when LDL $<$ 130.
 - Risk factors include: duration of diabetes \geq 10 years, HDL $<$ 40, current smoker, or family history of premature CAD (clinical CAD or sudden death in a first-degree relative aged $<$ 55[men] and $<$ 65 [women]).
- Drug Therapy for Primary and Secondary Prevention of Cardiovascular Events
 - ACE Inhibitor Therapy – drug therapy with ACE inhibitors is recommended for patients with diabetes aged \geq 55 years with one or more cardiovascular risk factors:
 - Total cholesterol $>$ 200
 - HDL cholesterol \leq 35
 - Hypertension
 - Microalbuminuria
 - Current smoking
 - History of cardiovascular disease (coronary artery disease, stroke, or peripheral vascular disease).
 - Beta-Blocker Therapy
 - For patients with coronary artery disease, non-intrinsic sympathomimetic activity beta-blocker therapy is recommended, unless contraindicated.
 - Aspirin Therapy
 - For patients \geq 40 years old with diabetes, treatment with at least 81mg/day aspirin is recommended unless contraindicated.
- Screening for Complications
 - Retinal screening – diabetic patients with background retinopathy, or more severe disease, should be monitored at least annually. Those without retinopathy should be screened every one to two years.
 - Foot screening
 - Visual foot inspection every visit.
 - Monofilament testing at least once per year.
 - Patients with an abnormal monofilament test are at a high risk for lower limb complications and are candidates for entry into a podiatry population-based foot care program, or equivalent.
- Lifestyle Management
 - Healthy diet – The American Diabetes Association (ADA) recommends decreased calorie intake, increased physical activity to promote weight reduction, and monitoring carbohydrate intake as the primary considerations in achieving glycemic control. ADA nutritional guidelines do not give specific total dietary compositional targets, except for the following recommendations, which are in large part similar to the recommendations for the general population:
 - A diet that includes carbohydrates from fruits, vegetables, whole grains, legumes, and low-fat milk is encouraged.
 - A variety of eating patterns (low fat, low carbohydrate, Mediterranean, vegetarian) are acceptable.
 - Fat quality is more important than fat quantity. Saturated fat and trans fat contribute to coronary heart disease, while monounsaturated fats are relatively protective. Saturated fats (e.g. in meats, cheese, ice cream) can be replaced with monounsaturated and polyunsaturated fatty acids

(e.g. in fish, olive oil, nuts). Trans-fatty acid consumption should be kept as low as possible.

- A reduced sodium intake of 2300mg per day or less is prudent. For individuals with hypertension, further reduction in sodium may be necessary.
- Activity – moderate exercise (e.g. walking), at least 30 minutes daily is encouraged.
- Tobacco Cessation
- Psychosocial Risk Factors

Patient Education:

- Encourage patient to make/keep appointment with diabetic educator/registered dietician and to attend available diabetes and nutrition classes. Family members are encouraged to attend as well.
- Stress the importance of healthy diet, exercise, home blood glucose monitoring, hypoglycemia signs and symptoms, and foot care.
- When insulin therapy is initiated, refer to the diabetic educator or RN for education.
- Establish and review 3 patient self-management goals.

Physician Consultation/Referral – Mid-Level Provider:

- Patients who have difficulty controlling blood glucose as well as patients who have significant co-morbidities, refer to physician provider at the health center.
- Patients with suspected diabetic ketoacidosis or hyperosmolar, nonketotic syndrome (blood glucose 500mg/dL, ketones negative), refer to the Emergency Department.
- Most patients with Type 1, insulin-dependent diabetes should be referred to an endocrinologist, if feasible. Otherwise refer to a health center physician provider.

Physician Consultation/Referral – External:

- Referral to an endocrinologist when diabetic control is difficult to achieve.
- Referral to an endocrinologist for most patients with Type I diabetes.

Monitoring:

Quarterly chart audits will be performed to assure that providers are following best practices. It is acknowledged that diabetes care is nuanced, with goals individualized as noted above. At a minimum, the following measures will be monitored:

A1C \geq 9%

Blood pressure < 140/90.

LDL cholesterol performed annually.

Referral for fundoscopic eye exam at least every 2 years.

Tobacco cessation counseling.

Optimally, monitoring will be performed via the electronic health record quality reports. In absence of this capability, a sampling of charts of patients with diabetes will be reviewed for each primary care provider.

References:

1. Executive Summary: Standards of Medical Care in Diabetes – 2014; volume 37, Supplement S5-S13. Accessed from the American Diabetes Association website, www.diabetes.org, 1/16/14.
2. Overview of Medical Medical Care in Adults with Diabetes, updated 12/19/13; UpTo Date website, www.uptodate.com, accessed 1/23/14.
3. Clinical Practice Guidelines – Diabetes, Kaiser Permanente Medical Group, 2010.

POLICY THIS PROCEDURE SUPPORTS:

1. Implementation of Evidence-Based Guidelines Policy

ⁱExecutive Summary: Standards of Medical Care in Diabetes – 2014; Diabetes Care; January 2014; volume 37, no. Supplement 1 S5-S13. Accessed from American Diabetes Association website, www.diabetes.org, 1/16/14.

ⁱⁱInzucchi SE, Bergenstal RM, Buse JB, et al; Management of hyperglycemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). Diabetologia 2012; 55(6): 1577-1596.

ⁱⁱⁱUp to Date website, www.uptodate.com, Overview of Medical Care in patients with Diabetes, updated 12/18/13; accessed 1/23/14.



Document Title: Chronic Condition Diabetes		Page 1 of 8
Document Type: Procedure	Document ID Number:	
Department: Medical Department		
Author: Marianne Clinton, MD, CMO	Implementer/Owner: Marianne Clinton, MD, CMO	
Approval Date: 04/16/2014	Training Date: 04/16/2014	
Implementation Date: 04/16/2014	Revision Date:	
Effective Date: 04/16/2014	Next Review Date: 04/01/2016	

STATEMENT OF PURPOSE:

It is the policy of Sonoma Valley Community Health Center that we provide excellent care of diabetic patients by standardizing our care processes based on recommendations of the American Diabetes Association. Work flows and policies are modeled on those of Kaiser Permanente.

DEFINITIONS:

Evidence Based Guidelines: Clinical Practice guidelines based on scientific evidence; or in the absences of scientific evidence, professional standards, or in the absences of professional standards, an expert opinion.

Practice Guidelines: Systematically developed descriptive tools or standardized procedures for care to support clinician and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed though a formal process and are based on authoritative sources that include clinical literature and expert consensus.

Important Condition: A condition including an unhealthy behavior, substance abuse or mental health issue, with evidence –based clinical guidelines that affect a large number of people or consumes a disproportionate amount of health resources.

NextGen Enterprise Practice Management (EPM): NextGen EPM is the application used primarily for billing and is also used to manage appointments. Other functions of EPM include, but are not limited to, storing patient demographics, posting transactions, and processing charges.

NextGen Electronic Health Records (EHR): NextGen EHR is the application used to store and maintain a patient's electronic chart. Clinical information such as lab results, health history, and diagnosis history are located in EHR.

History of Present Illness (HPI): The HPI is a chronological description of the development of the patient's present illness including the following elements: Location, Quality, Severity, Duration, Timing, Context, Modifying factors and Associated signs and symptoms.

Brief and Extended HPI's are distinguished by the amount of detail needed to accurately characterize the clinical problem or problems:

Brief – consist of 1 to 3 elements.

Extended - consists of 4 or more element

BACKGROUND:

Diagnostic criteria for diagnosis of diabetes – at least one of the following: ⁱ

- A1C \geq 6.5%
- Fasting serum glucose \geq 126. Fasting is defined as no caloric intake for at least 8 hours.
- Oral glucose tolerance test (OGTT), 2-hour plasma glucose \geq 200 after 75g glucose load.
- Random plasma glucose \geq 200 in a patient with classic symptoms of hyperglycemia.
- In the absence of unequivocal hyperglycemia, result should be confirmed by repeat testing.

ASSUMPTIONS: None

PCMH (Patient Care Medical Home) Related: Yes (X); No ()

PCMH 2, Element G: The Practice Team, Factor 3: the practice has written standing orders. PCMH Element 3, and PCMH 4.

NextGen EPM/EHR Procedure is needed for this Procedure: Yes (X); No ()

PROCEDURE:

The Care Manager/Care Team Manager is responsible for

1. Running and reviewing NextGen report weekly for patients with type 1 and type 2 diabetes.
2. Identifying non compliant patients, patients with poorly controlled diabetes and/or co-morbidities, patients due for lab and other testing, and patients with psychosocial risk factors.
3. Initiating action plan for patients determined to be high risk and/or in need of more intensive care.
4. Contacting patients in need of services, ordering needed tests/services per protocol, tasking the patient's Primary Care Provider (PCP) with any other needed orders, and scheduling follow up appointments.
5. Activation of patient recall for Diabetes using diagnosis and HbgA1C last recorded value.
6. Responding to requests from the providers.

The Medical Assistant is responsible to:

1. Complete review of patient's Health History ensuring past medical, family and social histories are complete and updated appropriately.
2. Update any recent hospitalizations/ ER visits
3. Obtain any appropriate medical records for the providers review
4. Complete tobacco assessment and, if a tobacco user make sure provider is made aware
5. Complete full set of vitals.
6. Make sure that patient has removed their shoes and socks at each visit to facilitate completion of the foot examination and inspection.
7. Select Diabetes HPI as the reason for visit. (Never select Diabetes Follow-up HPI)
8. Determine if patient brought a record of home glucose monitoring. If not, perform random glucose.
9. Perform urine dip if random blood sugar > 300.
10. Review chart and obtain results/ consultation report of dilated fundoscopic eye examination/ retinal photography if not already present.
11. Review chart/ask patient date of last dental exam.
12. Review chart for monofilament foot exam completion.
13. Complete monofilament foot exam if not completed within last 12 months.
14. Provide assistance in completion of Patient Self Management Tool.
15. Review patient's medications.
16. Review chart for dates of most recent A1C, lipid panel, metabolic panel, and microalbumin.
17. Using a standing order perform A1C if not done in the last 3 months.
18. Provide any needed immunizations. Use and enter all immunization data and patient information into CAIRS registry.
19. Perform a PHQ2 depression screen annually. If PHQ2 is positive, administer the PHQ9 depression screen.
20. Provide information regarding available education classes and community resources.

The Provider is responsible to:

1. Complete the Diabetes HPI (Required MU and PCMH).
2. Assure that diagnosis is on problem list.
3. Review of history information (past, family, social) at each patient visit
4. Perform appropriate physical examination for the diabetic patient.
5. Perform foot inspection at every visit with monofilament exam at least yearly.
6. Refer for dental examination every 6 months.
7. Refer for eye examination annually.
8. Hemoglobin A1C every 3 months (in most cases). (Medicare only pays for this service twice a year starting 1/1/2014.)
9. Lipid screening at initial visit, then annually and as indicated.
10. Micro-albumin at initial visit, then annually and as indicated
11. Complete Metabolic Panel at initial visit, then annually and as indicated.
12. Immunizations – up to date influenza and Pneumovax immunizations.
13. All patients will be referred to the SVCHC Certified Diabetes Educator for diabetes education, home glucose monitoring instruction, diet and exercise counseling.

Provider identified treatment goals by current A1C level:

- A1C level 6.5% to 7.5%:
 - Refer to Diabetes Educator
 - Provider information on healthy diet and exercise.
 - Initiate Monotherapy or Combination Medication Therapy.
 - Continue current therapy if all treatment goals are met
 - Monitor/adjust therapy as needed to meet treatment goals
- A1C level 7.6% to 9.0%:
 - Initiate Combination Therapy (if not already started)
 - Monitor/adjust Rx to meet treatment goals.
 - Maximize Combination Therapy.
 - Maximize Insulin Therapy
 - If elevated fasting blood sugar (FBS), add Basal
 - If elevated post-prandial glucose (PPG), add Bolus
 - If elevated FBS and PPG, add Basal-Bolus therapy or Pre-mixed insulin analogs
 - Monitor/adjust to meet treatment goals.
- A1C level >9.1%:
 - Drug naïve
 - With symptoms – insulin +/- other agents
 - No symptoms – combination therapy (metformin + another oral hypoglycemic medication).
 - Under treatment – insulin +/- other agents
- Recommended medication regimens:ⁱⁱ
 - Monotherapy – metformin. If needed to reach individualized A1C target after 3 months, proceed to two-drug combination.
 - Two drug combinations – metformin plus (listed in random order):
 - Sulfonylurea (SU)
 - Thiazolidinedione (TZD)
 - DPP-4 inhibitor (DPP-4-I)
 - GP-1 receptor agonist (GLP-1-RA)
 - Insulin (usually basal – i.e. NPH, glargine, detemir)
 - Three-drug combinations – metformin plus (listed in random order):
 - SU + (TZD or SPP-4-I or GLP-1-RA or insulin)
 - TZD + (SU or DPP-4-I or GLP-1-RA or insulin)
 - DPP-4-I + (SU or TZD or insulin)
 - GLP-1-RA+ (SU or TZD or insulin)
 - Insulin + (TZD or DPP-4-I or GLP-1-RA)

Treatment Goals:

- HbA1C
 - For all patients, $A1C \leq 8$
 - Target for many patients is $A1C < 7\%$.
 - A more stringent A1C goal of $<6.5\%$ may be reasonable for selected patients, if this can be achieved without hypoglycemia or other adverse effects of treatment
 - A less stringent goal of $A1C < 9\%$ may be appropriate for patients with a history of hypoglycemia, limited life expectancy, advanced microvascular and macrovascular complications, or extensive comorbid conditions.

- Minimum of HbA1C testing every 6 months. This frequency is more reliably achieved by testing every 3 months during focused diabetes visits. Patients with variable control will continue to be best managed with A1C testing every 3 months. Patients who maintain excellent control can be managed with less frequent testing, but for best care and auditing purposes, frequency must never fall below twice yearly.
- Glucose
 - Fasting glucose <110
 - Postprandial glucose <140
 - Home glucose monitoring is a key component of optimal diabetes management. Frequency of testing depends on patient's current diabetic control, use of insulin (especially short-acting sliding scale), symptoms, etc.
- Blood Pressure target – optimal blood pressure which balances benefit and risk, continues to be studied. Based on Up-to-date literature review of 1/22/2013ⁱⁱⁱ, and specifically the UDPDS, HOT, and ADVANCE trials, the following treatment goals are recommended:
 - All patients with diabetes mellitus have a goal blood pressure less than 140/90 mmHg.
 - Attempt to lower the systolic pressure below 130 to 135 mmHg (preferably less than 130 mmHg) if it can be achieved without producing significant side effects (weaker recommendation).
 - Goal blood pressure of less than 130/80 mmHg in patients with diabetic nephropathy and proteinuria (500 mg/day or more). Patients with moderately increased albuminuria (formerly "microalbuminuria") are treated similarly to diabetic patients without proteinuria.
- Lipid Management
 - An LDL goal of <100, with an optional goal of <70, is recommended for all patients with diabetes.
 - See separate section on lifestyle management.
 - Statin therapy
 - Statin therapy is recommended for all patients with diabetes and coronary artery disease (CAD).
 - Statin therapy is recommended for all patients with diabetes who are 40 years of age and older.
 - Statin therapy, age 39 or younger.
 - With ≥ 1 risk factor, statin therapy is RECOMMENDED when $LDL \geq 100$. Statin therapy is OPTIONAL when $LDL < 100$.
 - Without risk factors, statin therapy is RECOMMENDED with $LDL \leq 130$. Statin therapy is OPTIONAL when $LDL < 130$.
 - Risk factors include: duration of diabetes ≥ 10 years, $HDL < 40$, current smoker, or family history of premature CAD (clinical CAD or sudden death in a first-degree relative aged < 55 [men] and < 65 [women]).
- Drug Therapy for Primary and Secondary Prevention of Cardiovascular Events
 - ACE Inhibitor Therapy – drug therapy with ACE inhibitors is recommended for patients with diabetes aged ≥ 55 years with one or more cardiovascular risk factors:
 - Total cholesterol > 200
 - HDL cholesterol ≤ 35
 - Hypertension

- Microalbuminuria
 - Current smoking
 - History of cardiovascular disease (coronary artery disease, stroke, or peripheral vascular disease).
- Beta-Blocker Therapy
 - For patients with coronary artery disease, non-intrinsic sympathomimetic activity beta-blocker therapy is recommended, unless contraindicated.
- Aspirin Therapy
 - For patients ≥ 40 years old with diabetes, treatment with at least 81mg/day aspirin is recommended unless contraindicated.
- Screening for Complications
 - Retinal screening – diabetic patients with background retinopathy, or more severe disease, should be monitored at least annually. Those without retinopathy should be screened every one to two years.
 - Foot screening
 - Visual foot inspection every visit.
 - Monofilament testing at least once per year.
 - Patients with an abnormal monofilament test are at a high risk for lower limb complications and are candidates for entry into a podiatry population-based foot care program, or equivalent.
- Lifestyle Management
 - Healthy diet – The American Diabetes Association (ADA) recommends decreased calorie intake, increased physical activity to promote weight reduction, and monitoring carbohydrate intake as the primary considerations in achieving glycemic control. ADA nutritional guidelines do not give specific total dietary compositional targets, except for the following recommendations, which are in large part similar to the recommendations for the general population:
 - A diet that includes carbohydrates from fruits, vegetables, whole grains, legumes, and low-fat milk is encouraged.
 - A variety of eating patterns (low fat, low carbohydrate, Mediterranean, vegetarian) are acceptable.
 - Fat quality is more important than fat quantity. Saturated fat and trans fat contribute to coronary heart disease, while monounsaturated fats are relatively protective. Saturated fats (e.g. in meats, cheese, ice cream) can be replaced with monounsaturated and polyunsaturated fatty acids (e.g. in fish, olive oil, nuts). Trans-fatty acid consumption should be kept as low as possible.
 - A reduced sodium intake of 2300mg per day or less is prudent. For individuals with hypertension, further reduction in sodium may be necessary.
 - Activity – moderate exercise (e.g. walking), at least 30 minutes daily is encouraged.
 - Tobacco Cessation

Patient Education:

- Encourage patient to make/keep appointment with diabetic educator/registered dietician and to attend available diabetes and nutrition classes. Family members are encouraged to attend as well.

- Stress the importance of healthy diet, exercise, home blood glucose monitoring, hypoglycemia signs and symptoms, and foot care.
- When insulin therapy is initiated, refer to the diabetic educator or RN for education.
- Establish and review 3 patient self-management goals.

Physician Consultation/Referral – Internal (Mid-Level Provider):

- Patients who have difficulty controlling blood glucose as well as patients who have significant co-morbidities.
- Patients with suspected diabetic ketoacidosis or hyperosmolar, nonketotic syndrome (blood glucose 500mg/dL, ketones negative)
- All Type 1 Insulin-Dependent Diabetics.
-

Physician Consultation/Referral – External:

- Referral to an endocrinologist when diabetic control is difficult to achieve.
- Referral to an endocrinologist for most patients with Type I diabetes.

Monitoring:

Quarterly chart audits will be performed to assure that providers are following best practices. It is acknowledged that diabetes care is nuanced, with goals individualized as noted above. At a minimum, the following measures will be monitored:

A1C < 9%

Blood pressure < 140/90.

LDL cholesterol performed annually.

Referral for fundoscopic eye exam at least every 2 years.

Tobacco cessation counseling.

Optimally, monitoring will be performed via the electronic health record quality reports. In absence of this capability, a sampling of charts of patients with diabetes will be reviewed for each primary care provider.

References:

1. Executive Summary: Standards of Medical Care in Diabetes – 2014; volume 37, Supplement S5-S13. Accessed from the American Diabetes Association website, www.diabetes.org, 1/16/14.
2. Overview of Medical Medical Care in Adults with Diabetes, updated 12/19/13; UpToDate website, www.uptodate.com, accessed 1/23/14.

POLICY THIS PROCEDURE SUPPORTS:

1. Implementation of Evidence-Based Guidelines Policy

ⁱExecutive Summary: Standards of Medical Care in Diabetes – 2014; Diabetes Care; January 2014; volume 37, no. Supplement 1 S5-S13. Accessed from American Diabetes Association website, www.diabetes.org, 1/16/14.

ⁱⁱ Inzucchi SE, Bergenstal RM, Buse JB, et al; Management of hyperglycemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetologia* 2012; 55(6): 1577-1596.

ⁱⁱⁱ Up to Date website, www.uptodate.com, Overview of Medical Care in patients with Diabetes, updated 12/18/13; accessed 1/23/14.



Document Title: In-House Lab - Hemoglobin A1c		Page 1 of 8
Document Type: Procedure	Document ID Number:	
Department: Medical Department		
Author: Julie Laird, IT Manager	Implementer/Owner: Phiroze Kazi, MD, CMO	
Approval Date: 12/1/2013	Training Date: 12/20/2016	
Implementation Date: 12/1/2013	Revision Date: 12/15/2016	
Effective Date: 12/01/2013	Next Review Date: 12/1/2017	

STATEMENT OF PURPOSE:

This procedure provides guidelines for the In-House Hemoglobin A1c testing resulting and submission of charges. This procedure does not change the Back Office procedure for obtaining and completing the individual patient test.

DEFINITIONS:

NextGen Enterprise Practice Management (EPM): NextGen EPM is the application used primarily for billing and is also used to manage appointments. Other functions of EPM include, but are not limited to, storing patient demographics, posting transactions, and processing charges.

NextGen Electronic Health Records (EHR): NextGen EHR is the application used to store and maintain a patient's electronic chart. Clinical information such as lab results, health history, and diagnosis history are located in EHR.

Provider Approval Queue (PAQ): The PAQ contains all items that need a provider's approval/signature. These items include but are not limited to the following:

- Lab Orders

- Scanned images from NextGen ICS: consultation reports, outside provider records, hospital record, diagnostic report, specialty OB lab, other lab results, other specialty lab, Health Risk Assessment, CMR/suspected child abuse report

- Documents generated within NextGen EHR: Master IM, PHQ9, specialty-specific chart notes (OB Master, BH Master)

Master IM: Patient progress note generated within NextGen EHR which includes information from the selected encounter. The Master IM includes vitals, patient history, physical exam findings, and orders.

EHR Tasks /Tasking: Tasks are a user's to-do items. The EHR Workflow window (also referred to as Inbox) lists tasks assigned to the current user. Tasks can be sent to another user, a group

of users, or one's own inbox. Delegates will also have the option to view tasks assigned to the provider they are a delegate for.

NextGen Image Control System (ICS): An application that is used to import, file, and view scanned images into the NextGen system. ICS images can also be opened in NextGen Electronic Health Record (EHR) and NextGen Electronic Practice Management (EPM).

Scanning: Is defined as a process in which a device is used that optically scans images such as reports, results and other pertinent health documents and converts it to a [digital image](#) that is placed into specific categories for identification into the Patient Electronic Health Record in NextGen.

Order Management: Order Management is a template in NextGen EHR that shows all orders that have been placed for the patient. This template is not encounter-based and will show orders from any encounter in the patient's chart.

Provider Test Action: Provider Test Action is a template that is used by providers to document actions that need to be taken outside of face-to-face encounters. Providers may use this template to place orders and also to send tasks to other staff. A Provider Test Action document can also be generated from this template.

High Risk Patients: See Definition of High Risk Patient procedure.

Electronic Summary-of-Care Record: this consist of the last two patient progress notes, medications list, current problem list, last laboratory results (not more than 3 months old) and Diagnostic testing (not more than 3 months) as appropriate for the Specialty Care provider selected. (See Specialty Care Referral Requirements Grid)

BACKGROUND:

As of January 1, 2017, the in-house HgbA1c workflow will change to accommodate revisions NextGen made to the software. This procedure modifies a previous workflow and ensures proper documentation and reporting of testing completed at the Health Center's In-House Laboratory.

The Medical Assistant will no longer be using Standing Orders/Office Diagnostic or Office Procedures when ordering or resulting the in-house HgbA1c test.

ASSUMPTIONS:

PCMH (Patient Care Medical Home) Related: Yes (); No (X)

NextGen EPM/EHR Procedure is needed for this Procedure: Yes (X); No ()

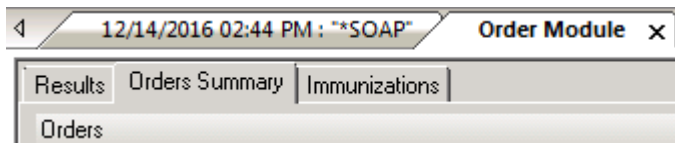
PROCEDURES:

From anywhere within the current encounter (The medical assistant always completes the 5

point check) click on the icon for the **Orders Module**  on the top tool bar or at the bottom of the History bar.

(The Medical Assistant will no longer be using Standing Orders/Office Diagnostic or Office Procedures when ordering or resulting the Hemoglobin A1c)

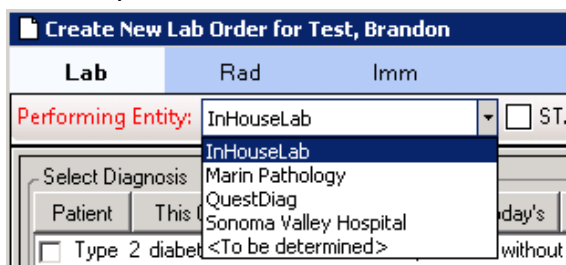
Once in the Orders Module, click on the second internal tab for the **Orders Summary**.



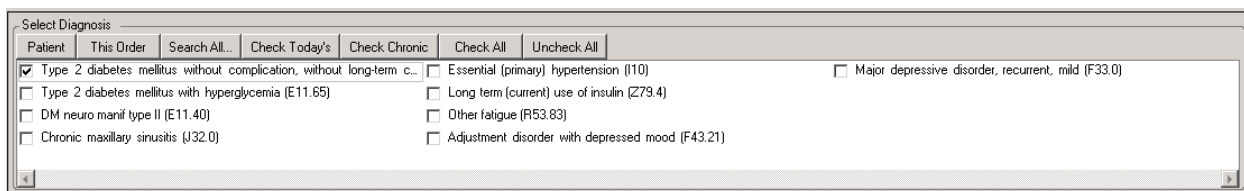
Now click **New** to order the test.



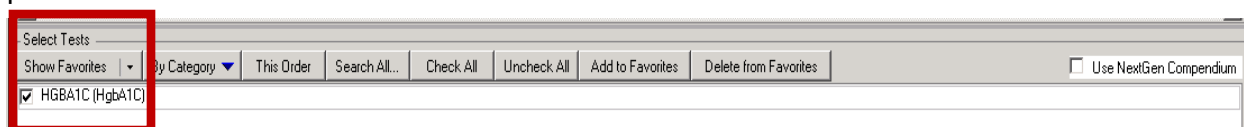
At the top of the "Create New Lab Order" window, select **InHouseLab** as the performing entity.



From the top Select Diagnosis section select the appropriate **diabetes diagnosis** by clicking the **checkbox** next to it. The diagnoses that the Medical Assistant will see are the patient's current and chronic diagnoses. **(Please Note: If there is not a diabetes diagnosis or screening for diabetes diagnosis the Medical Assistant will need to ask the provider to add the appropriate diagnoses to the patient Assessment and, if a Chronic Condition, to the Patient Problem list)**



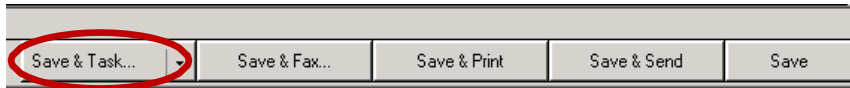
In the Select Tests section the Medical Assistant will see the **HGBA1C** test in the favorite's panel. Click the **checkbox** next to it to select the test.



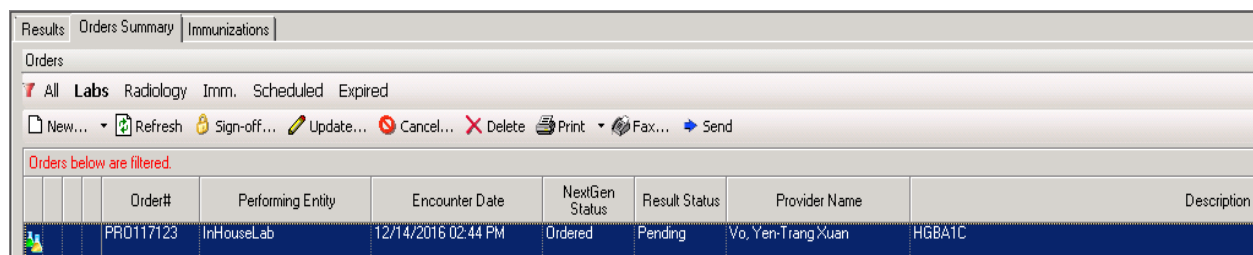
Click the **Save** button at the lower right of the window to **Save** the order.



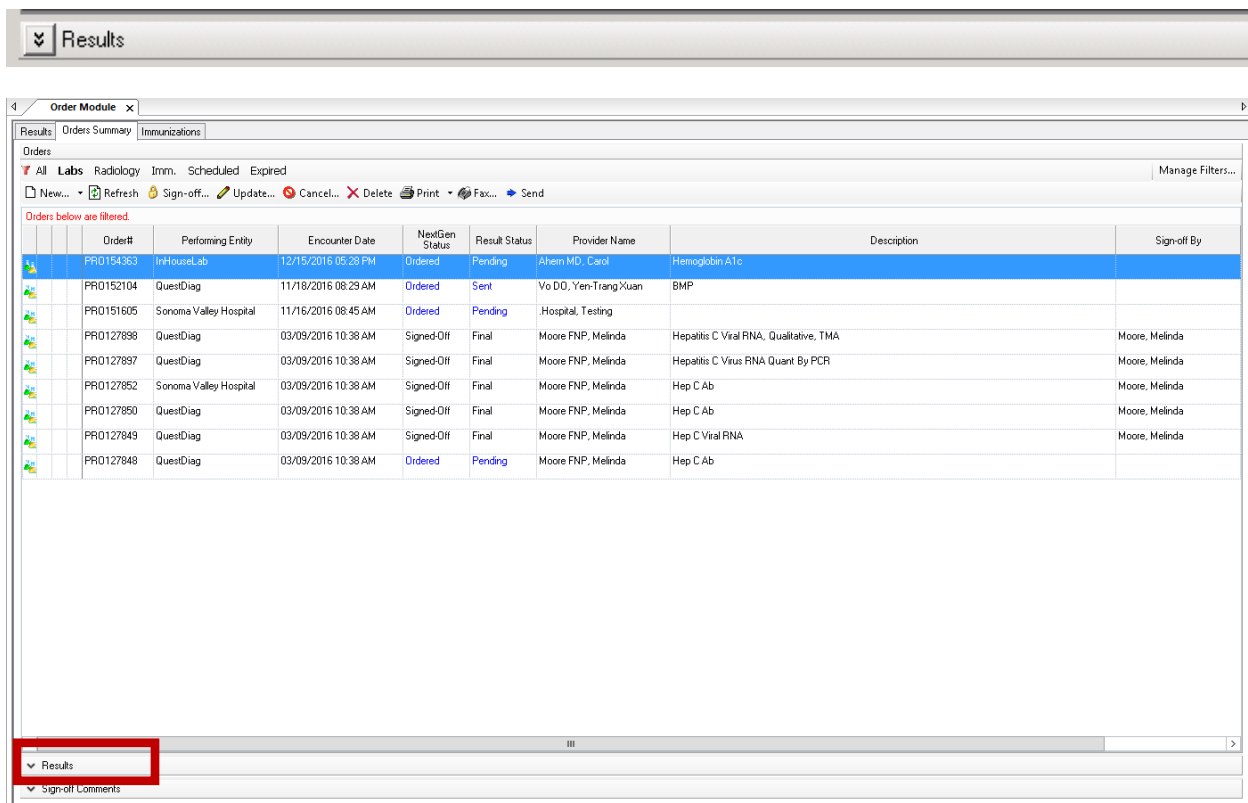
If the provider of record is ordering the test, they will need to task the Medical Assistant or Nurse to complete this test, please click **Save & Task** in order to task them.



To Result the order, **click on the order in the grid on the Orders Summary tab** so that it is selected and highlighted in dark blue.



Now click on the **down arrow** next to the work **Results** at the bottom of the screen to expand that section.



With the Results panel expanded click on the **New Results Entry** tab at the bottom of the panel.

Orders below are filtered.

	Order#	Performing Entity	Encounter Date	NextGen Status	Result Status	Provider Name	Description
	PR0117123	InHouseLab	12/14/2016 02:44 PM	Ordered	Pending	Vo, Yen-Trang Xuan	HGBA1C
	PR0117121	Sonoma Valley Hospital	12/14/2016 02:44 PM	Ordered	Pending	Vo, Yen-Trang Xuan	Amylase

Results (new results entry)

New Result Refresh Clear Delete Save Result Status Final

Panel: HGBA1C (HgbA1C) (1 item)

Panel Comment Coll. Date/Time

Comp. Key	Component	Result	Unit	Flag	Range	Coding System	Obs. Date/Time	Result Comment
HgbA1C	Hemoglobin A1C					IH		

Formatted Results Grid Results Documents, Images and Links **New Results Entry** New Document and Images Entry

Sign-off Comments

Finally click in the Result field and **type the result, make sure to only use numbers and a decimal place when necessary. Do Not use: Letters (HBA1C) or Symbols(%,<,>)**

Results (new results entry)

New Result Refresh Clear Delete Save Result Status Final

Panel: Hemoglobin A1c (HgbA1C) (1 item)

Panel Comment Coll. Date/Time

Comp. Key	Component	Result	Unit	Flag	Range	Coding System	Obs. Date/Time	Result Comment
HgbA1C	HgbA1c	5.8				IH		

Then select **Coll Date /Time** to ensure the result will show on the Lab Module in the result grid. A calendar will appear with today's date highlighted. Please select the correct date of the test.

Results (new results entry)

Result Status: Final

Panel: Hemoglobin A1c (HgbA1C) (1 item)

Panel Comment

Comp. Key	Component	Result	Unit	Flag	Range	Coding System	Obs. Date/Time	Result Comment
HgbA1C	HgbA1c	5.8				IH		

Coll. Date/Time
//:

January, 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
25	26	27	28	29	30	31
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4

Today: 1/19/2017

Now click **Save** in the row just a little above where the Medical Assistant entered the result. This **submits** the **CPT code for billing** as well **saves** the result into the Orders Module of the **chart** and for display into the **master document**.

Result Status: Final

Along with being able to view the results in this results panel in the future as a **Formatted Result**,

Results (reported results - formatted)

☐ Show Normal (N) Results Flag
 ☐ Show Compressed Results
 ☐ MU Compatible

Sonoma Valley Comm Health Center
 19270 Sonoma Highway 12
 Sonoma, CA, 954765414

Test, Brandon
 19548 Orange Ave
 Sonoma, CA, 95476
 Person #: 22447
 Sex: M
 DOB: 03/01/1975

Ordering: Vo, Yen-Trang Xuan
 Tests Ordered: HGBA1C (HgbA1C)

Performing #: InHouseLab

Location: SVCHC

HGBA1C (Collection Date: 12/14/2016 17:22 *, Status: Final)

Component	Result	Units	Flag	Range	Comment
Hemoglobin A1C	12				

The Medical Assistant can see it on the **Results** tab in the Orders Module. The Provider or Medical Assistant has the ability to **graph** the results by clicking on the result component **row** (the row that spells out Hemoglobin A1C) and clicking the graph button.

Please Note: This will only graph the In House Hemoglobin A1Cs, although Quest, and SVH results that are in a row can be graphed separately.

Results | Orders Summary | Immunizations

All

View results by Resources ☐ Show Only Results Refresh Graph...

Results are viewed by lab short description.

Collection Date & Time	12/14/2016 17:22 *	12/14/2016 16:18	12/14/2016 14:46	11/30/2016 10:56
HGBA1C				
Hemoglobin A1C	12	15	9.6	
Result				7.8

In addition, results of the In-House Hemoglobin A1C's will show on the Home Page in the Labs section rather than the Office Labs section.

HPI's		12/14/2016	12/14/2016	12/14/2016	11/30/2016	06/11/2016	06/11/2016
Plans		17:22	16:18	14:46	10:56	08:04	07:58
Problem List							
Medications							
Allergies							
Labs							

Please Note: When completing huddle sheets, staff must still look at Office Labs on the Home Page to see in-house HgA1c results prior to 12/22/2016.

This procedure must be completed by the medical Assistant or Nurse before the provider finalizes the encounter in order for the test results to show on the patient's Master IM under the **In-House Module Labs section**.

SODIUM
LATEX
OXYCODONE HCL Percocet
HYDROCODONE Vicodin
BITARTRATE

Assessment/Plan

#	Detail Type	Description
1.	Other Orders	Orders not associated to today's assessments.
	Plan Orders	Hemoglobin A1c to be performed.

In-House Module Labs *(resulted today)*

Lab Description	Result	Comments
HgbA1c	10.5	

Medications *(Added, Continued or Stopped today)*

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
03/11/2015	acyclovir 200 mg capsule	take 1 capsule by oral route every 4 hours 5 times per day	N			
08/25/2014	antipyrine-benzocaine 5.4 %-1.4 % ear drops	instill by otic route 3 times every day into affected ear(s) enough drops to fill	N			

Please Note: If the procedure is not completed prior to the provider finalizing the encounter the Master IM will need to be re-generated to include the results.

POLICY THIS PROCEDURE SUPPORTS:

1. SVCHC Evidence- based Guidelines.



Document Title: Documentation of Counseling Details		Page 1 of 12
Document Type: Procedure	Document ID Number:	
Department: Medical		
Author: J. Vlasis	Implementer/Owner: X. Perez, CMO	
Approval Date: n/a	Training Date: 11/1/2016 (retrain)	
Implementation Date: 8/5/2016	Revision Date: 11/1/2016	
Effective Date: 8/5/2016	Next Review Date: 11/1/2018	

STATEMENT OF PURPOSE: This procedure provides guidelines for documenting counseling details, providing patient education materials and ensuring that the patient is able to comprehend information (verbal and/or written) provided to them.

DEFINITIONS:

NextGen Electronic Health Records (EHR): NextGen EHR is the application used to store and maintain a patient's electronic chart. Clinical information such as lab results, health history, and diagnosis history are located in EHR.

Healthwise: Healthwise is a helper software embedded in NextGen that provides patient education material on a variety of different medical concerns. Health education materials are presented based on age and gender and can be saved to the patient's encounter.

BACKGROUND: This is a critical measure for the New Quality Measure that we will be required to meet starting 7/1/2016 to 12/1/2017. We are in the process of setting out baseline for MACRA/MIPS which will be a payment methodology for FQHC's based solely on quality indicators and health education provided to patients.

Providers must clearly identify that they have assessed the patients: **Learning Preference, Potential Barriers, and Preference for Materials**. This is especially important for patients and families that have literacy issues. This is considered a quality measure that all payers will begin assessing for baseline starting 7/1/2016.

Counseling Details must be documented providing any type of Counseling to Patients. This is critical for proof of management of the patient's chronic condition or any education you are providing a patient. The simple documentation (texting) of provided instructions and counseling on the diagnosis code is no longer adequate. Providers must use counseling details and document the time spent with the patients.

This is also to be used when providing patients with information from Health Wise in NextGen. Providers must document the patients understanding and using this information for all patients is important as it shows patient education another area that will be monitored for the new Quality Measures that started actually 7/1/2016.

ASSUMPTIONS: n/a

PCMH (Patient Care Medical Home) Related: Yes (): No (X)

NextGen EPM/EHR Procedure is needed for this Procedure: Yes (): No (X)

PROCEDURES:

To document counseling details:

1. From the Finalize tab in NextGen:

Specialty ▼ Family Practice Visit Type ▼ Office Visit

Intake Histories SOAP **Finalize** Checkout

[Order Management | Document Library | Procedures | Tobacco Cessation]

Care Guidelines | Global Days Panel Control: [Toggle] [Cycle]

General Today's Assessment Provider Sign Off Evaluation and Management Coding

Medical Decision Making View MDM Guidelines | View Risk Table

☐ Straight forward ☐ Low complexity
☐ Moderate complexity ☐ High complexity

Evaluation and Management Code

Visit code: [] [] []
 Modifier(s): [] [] [] [] [] []

Calculate Code Submit Code

CQM Check

Calculated EM code: []
 Submitted code: []

Counseling

☐ Counseled greater than 50% of time and documented content

Total visit time (minutes): []

Total counsel time (minutes): []

Additional E&M Code | View Other Codes | SNOMED Visit Type (optional) | Medicare Preventive Codes

New patient:	Established:	Consultation:	Preventive new:	Preventive established:	Preventive counseling:	Post Op:
<input type="radio"/> 99201	<input type="radio"/> 99211	<input type="radio"/> 99241	<input type="radio"/> 99381	<input type="radio"/> 99391	<input type="radio"/> 99401	<input type="radio"/> 99024
<input type="radio"/> 99202	<input type="radio"/> 99212	<input type="radio"/> 99242	<input type="radio"/> 99382	<input type="radio"/> 99392	<input type="radio"/> 99402	<input type="radio"/> 99425
<input type="radio"/> 99203	<input type="radio"/> 99213	<input type="radio"/> 99243	<input type="radio"/> 99383	<input type="radio"/> 99393	<input type="radio"/> 99403	<input type="radio"/> 59426
<input type="radio"/> 99204	<input type="radio"/> 99214	<input type="radio"/> 99244	<input type="radio"/> 99384	<input type="radio"/> 99394	<input type="radio"/> 99404	
<input type="radio"/> 99205	<input type="radio"/> 99215	<input type="radio"/> 99245	<input type="radio"/> 99385	<input type="radio"/> 99395		
			<input type="radio"/> 99386	<input type="radio"/> 99396		
			<input type="radio"/> 99387	<input type="radio"/> 99397		
Behavioral Health:						
<input type="radio"/> 90791 (Initial eval, no med services)			<input type="radio"/> 90846 (Family/Couple therapy, w/o patient)			
<input type="radio"/> 90792 (Initial eval, w/ med services)			<input type="radio"/> 90847 (Family/Couple therapy, w/patient)			
<input type="radio"/> 90832 (Psychotherapy, 30 minutes)			<input type="radio"/> 90853 (Group therapy)			
<input type="radio"/> 90834 (Psychotherapy, 45 minutes)			<input type="radio"/> 90882 (Case consultation)			
<input type="radio"/> 90837 (Psychotherapy, 60 minutes)						
<input type="radio"/> 90845 (Psychoanalysis)						

Additional Behavioral Health Codes

2. Select the Blue Counseling Details Button - Please note you cannot add time without complete documentation.
3. Select type of counseling from the drop down box.
4. **This is default for the last review - please make sure you change to detailed document** each time.

Counseling Details

Total counseling time (minutes):

Counseling/Educational Details:
(For tobacco cessation counseling of three minutes or more, please use the Tobacco Cessation template.)

Type of counseling:	Method of counseling:	Evaluation of counseling:	Counselor:	Date:	Time:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	//	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	//	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	//	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	//	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	//	

Comments:

Educational materials:

Language: Interpreter's name: Relationship:

☐ Interpreter used

Counseling/Educational Factors:

☐ Detailed document ☒ Reviewed

Readiness to learn:

☐ Accepting ☐ Anxious ☐ Angry ☒ In denial ☐ Motivated ☒ Other (specify):

Barriers to learning:

☐ None ☐ Age ☐ Cognitive limitations ☐ Cultural ☐ Financial ☐ Language: ☐ Interpreter needed ☐ Physical limitations ☐ Reading ability ☐ Other (specify):

Learning preferences:

☐ No preferences ☐ Audio materials ☐ Demonstrations ☐ Written materials ☐ Verbal explanations ☐ Video materials ☐ Other (specify):

Cultural/spiritual needs: ☐ No ☐ Yes

Marital status:

Race:

Religion:

5. The information on this template defaults from the last time it; **please make sure you change to detailed document each time.**
6. Select the Type of Counseling

Counseling Details

Counseling/Educational Details:
(For tobacco cessation counseling)

Type of counseling:

Comments:

Educational materials:

☐ Interpreter used

Language:

Counseling/Educational Factors:

☐ Detailed document

Readiness to learn:

☐ Accepting

☐ Anxious

☐ Angry

☒ In denial

☐ Motivated

☒ Other (specify):
Loss Medications

Select type of counseling

advance directives
alcoholism counseling
anticipatory guidance
blood glucose monitoring
cancer prevention
cancer screening
chemotherapy
childcare
community resources
continuation of care at home
diagnosis
diagnostic test(s)
dialysis
diet
disease management
feeding breastfeeding
fever reduction
foot care
health care facility
health maintenance
HIPAA information
illness/disease
immunizations
insulin administration
medical equipment
medication(s)
medication(s) administration
nutrition/diet
pain management
patient rights/responsibilities
personal hygiene
physical activity
potential food/drug interaction
PPD
reach out and read
rehabilitation techniques
safe sex
seat belt use
sexually transmitted diseases
skin care
Staying Healthy Assessment
STI
substance abuse counseling
tobacco cessation (less than 3 minutes)
transfusion/reaction
treatment(s)
wellness promotion

Close

7. Identify the Method of Counseling and Evaluation of Counseling by using the drop down boxes for Method of Counseling and Evaluation of Counseling.

Counseling Details

Total counseling time (minutes):

Counseling/Educational Details:
(For tobacco cessation counseling of three minutes or more, please use the Tobacco Cessation form.)

Type of counseling:	Method of counseling:	Evaluation of counseling:
diet	verbal explanations	

Comments:

Educational materials:

Select your evaluation of counseling

accepted the material
needs reinforcement
refused
returned the demonstration
verbalized an understanding
was not receptive

Close

8. The provider can add 5 different topics for each patient. ***Please note that each topic must have its own time.***
9. Place the number of minutes spent.
10. Please use the comment line for all additional information that you as a provider would like to add.
11. Make sure that you select **Detailed Document.**
12. If you used an interpreter (even if it is a member of our staff or if you are speaking to the patient directly using another language), please check the Interpreter Used box and document who provided the interpretation.
13. Please select the appropriate boxes in each of the three categories listed:
 - a. **Readiness to Learn.**
 - b. **Barriers to Learning; and**
 - c. **Learning Preference.**

Counseling Details

Total counseling time (minutes): 7

Counseling/Educational Details:
(For tobacco cessation counseling of three minutes or more, please use the Tobacco Cessation template.)

Type of counseling:	Method of counseling:	Evaluation of counseling:	Counselor:	Date:	Time:
diet	verbal explanations	verbalized an understanding	Julie Vlasis	05/18/2015	7
				//	
				//	
				//	
				//	

Comments:
Patient accepted materials for diet and referral to Dietician for additional help

Julie Vlasis 05/18/2015

Education materials:
List any paper materials here. If using NextGen Education make sure to save to encounter.

Language: Spanish Interpreter's name: Ellie Relationship: employee

☒ Interpreter used

Counseling/Educational Factors:

☒ Detailed document ☐ Reviewed

Readiness to learn:
☒ Accepting
☐ Anxious
☐ Angry
☐ In denial
☒ Motivated
Other (specify):

Barriers to learning:
☐ None
☐ Age
☐ Cognitive limitations
☐ Cultural
☐ Financial
Language:
☒ Interpreter needed
☐ Physical limitations
☒ Reading ability
Other (specify):

Learning preferences:
☐ No preferences
☐ Audio materials
☐ Demonstrations
☐ Written materials
☒ Verbal explanations
☐ Video materials
Other (specify):

Cultural/spiritual needs: ☐ No ☐ Yes

Marital status: D

Race: White

Religion:

Save & Close Cancel

14. Remember to Save and Close when you are finished

Patient Counseling Complete when Counseling Details turns pick and the total counsel time appears in the box (see below).

This also increased the level of visit provided automatically as the system has a built in points score that is used for all Medicare Audits.

Evaluation and Management Coding

Medical Decision Making [View MDM Guidelines](#) | [View Risk Table](#)

☐ Straight forward ☐ Low complexity
☐ Moderate complexity ☐ High complexity

Counseling
☐ Counseled greater than 50% of time and documented content

Total visit time (minutes):
Total counseling time (minutes): 7

[Counseling Details](#)

Healthwise Information for Patient Education:

1. Go to file and review the drop down box. Find Patient Education.

NextGen EHR: Deborah T Kord DOB: 11/10/1951 AGE: 64 years 8 months (Female) MRN: 00000010118 - Medications Module

File Edit View Tools Admin Utilities Window Help

New Select Patient... Alt + P Modify Patient... Close Patient Save Close Print Custom Print \ Send Export Patient Documents Generate CCD...

Graph Reports ChartMail Family Unit HIE Consent... Patient Portal Patient Education Patient Group Summary Superbill System \ Practice Template Work Flow... User Workgroups... Provider Approval Queue... Change Enterprise/Practice... Logout

64 year Old Female Weighing 130.50 lb | 59.19 Kg [vitals recorded on 8/2/2016] | ES11 Eligible

Generic Name	Original Start	Start Date	Stop Date
ca 50 mcg/dose p...	PLUTICASON/SALMETEROL	03/10/2016	03/10/2016
MG TABLET	ATORVASTATIN CALCIUM	05/02/2016	
600 mg (1,500 m...	CALCIUM CARBONATE/VITAMIN D3	03/22/2016	03/22/2016
10 mg capsule	DOXILATE SODIUM	03/22/2016	03/22/2016
mg (65 mg iron) t...	FERROUS SULFATE	03/21/2016	03/21/2016
acetaminophen 3...	HYDROCODONE/ACETAMINOPHEN	08/03/2016	08/03/2016
mg tablet	LEVOTHYROXINE SODIUM	04/28/2016	08/02/2016
25 mg tablet	METOPROLOL TARTRATE	05/02/2016	05/02/2016
RATE 50 MG TAB	METOPROLOL TARTRATE	07/14/2016	07/19/2016
g/actuation aeros...	ALBUTEROL SULFATE	12/18/2015	12/18/2015
	RIVAROXABAN	12/18/2015	12/18/2015
delayed release	ASPIRIN	01/20/2016	01/20/2016
tablet	AZITHROMYCIN	01/20/2016	01/24/2016
tablet	CALCIUM CARBONATE	07/17/2014	07/17/2014
mg tablet	LEVOTHYROXINE SODIUM	07/17/2014	01/06/2015
mg tablet	LEVOTHYROXINE SODIUM	07/17/2014	01/06/2015

Advair Diskus 100 mcg/50 mcg/dose powder for inhalation

Sig: inhale 1 puff by inhalation route 2 times every day in the morning and evening approximately 12 hours apart Remove Sig Edit Sig...

Quantity: 1 Units: Inhaler Refills: 3 Dispense As Written Accept Cancel

Stat: 03/10/2016 Stop: 08/05/2016 Duration: Prescribed Elsewhere Source: PRN Problem: Reason:

Non-Clinical Notes to: This field is for nonclinical comments to the pharmacist. Any additional clinical instructions for the prescription should be entered here.

Opens a patient education document

PROD DB Sonoma Valley Comm Health Center \maxis CAP NUM SCRL 08/05/2016

2. Search for the Educational Materials that you are looking for in the Search Criteria:

Patient Education Browser

Search Criteria English | Term | Age: [45 - 64 Years] | Female

Language English

- Allergy and Immunology
- Cardiovascular
- Dental and Oral Health
- Dermatology
- Diabetes and Endocrinology
- Ear
- Emergency and Urgent Care
- Forms and Consents
- Gastrointestinal
- Genetics
- Hematology
- Infectious Disease
- Labs
- Mental Health and Psychology
- Nephrology
- Neurology
- Nose and Throat
- Nutrition and Exercise
- OB/Gyn
- Oncology
- Ophthalmology
- Orthopedics and Rheumatology
- Pain Management
- Pediatrics
- Pre- and Postnatal Care
- Pre- and Post-Op
- Pulmonology

NGProd (NGSQL2.NGProd)

Select Send to Patient Portal Save to Encounter Cancel

PROLOL TARTRATE 50 MG TAB take 1 tablet by oral route 2 times every day

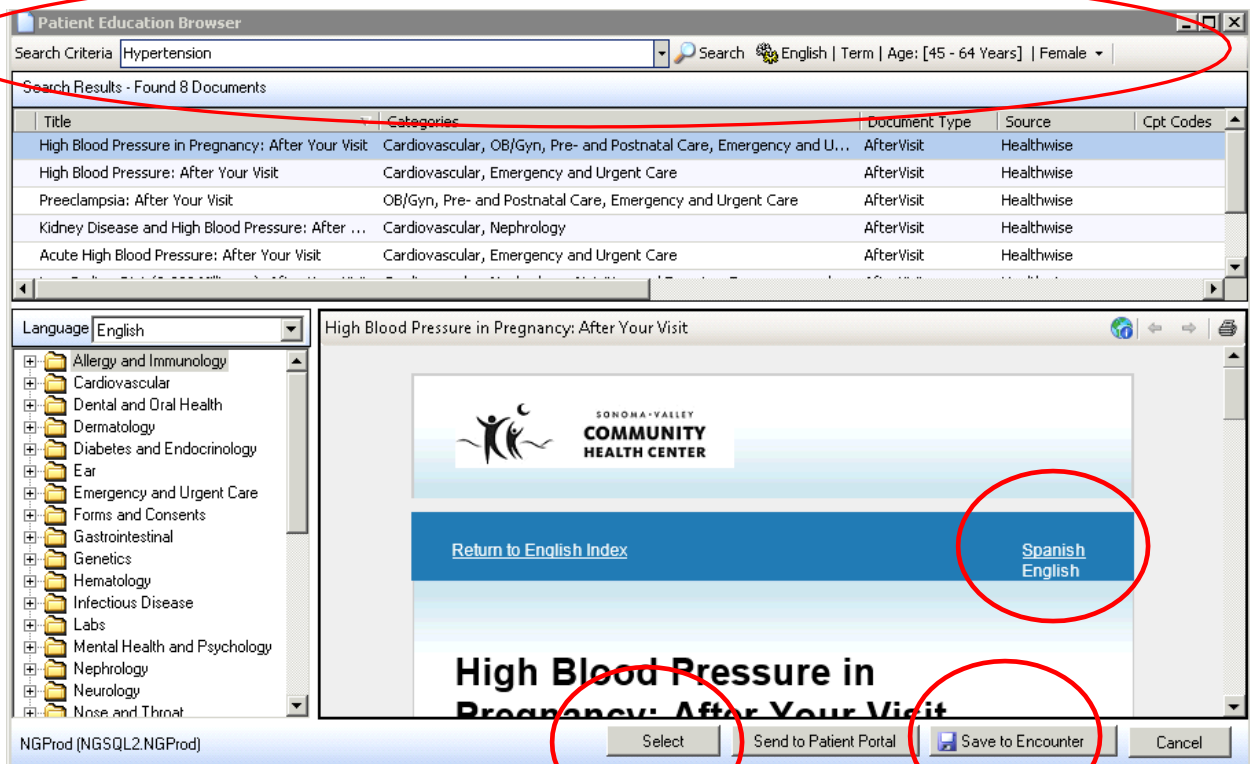
Chamber Plus take 1 tablet by mouth every 12 hours

ilin HFA 90 mcg/actuation aerosol inhaler Use daily with steroid inhaler

10 mg tablet inhale 2 puff by inhalation route every 4 - 6 hours as needed for cough

take 1 tablet by oral route every day

- For the specific search below, there were 8 documents found for the patient based on **Search Criteria**, **Age**, and **Gender**.
- Select the document you want.
- Please change language if appropriate.
- Save to the Encounter. It will show in the Encounter for the day and Front Desk will print if you have not.



If you talk to the patient following the information outlined within Healthwise's health education materials, you will have touched upon most of the expected key points.

New Medication Education

Please note that you are required to provide the patient with health education and/or written materials each time a new medication is prescribed. This is over and beyond the information that the pharmacist may provide.

You will document this education as outlined above. The written materials for the patient, however, are located in the medication module.

- From the medication module and, after you have prescribed the medication, highlight the medication in question.

2. Go to Resources
3. Select External Patient Education

NextGen 9 year Old Male Weighing 150.00 lb | 68.04 Kg [vitals recorded on 11/1/2016] Not eligible

Status	Medication Name	Generic Name	Original Start	Start Date
Status: Active (7 items)				
Active	Keflex 500 mg capsule	CEPHALEXIN	07/20/2016	07/20/2016
Active	Tylenol 325 mg tablet	ACETAMINOPHEN	06/15/2016	06/15/2016
Active	Augmentin 250 mg-62.5 mg/5 mL oral suspension	AMOXICILLIN/POTASSIUM CLAV	03/31/2016	03/31/2016
Active	Aspirin Childrens 81 mg chewable tablet	ASPIRIN	11/30/2015	03/31/2016
Active	Norco 5 mg-325 mg tablet	HYDROCODONE/ACETAMINOPHEN		
Active	Fluor-a-day (with Xylitol) 0.5 mg fluoride (1.1 mg)...	SODIUM FLUORIDE/XYLITOL		
Active	Children's Acetaminophen 160 mg/5 mL (5 mL) or...	ACETAMINOPHEN		

Keflex 500 mg capsule
Sig: take 1 capsule by oral route every 12 hours Remove Sig Edit Sig...

Quantity: 10 Units: Capsule Refills: 0
Start: 07/20/2016 Stop: 11/01/2016 Duration:
☐ Prescribed Elsewhere Source:
☐ PRN Reason:
Problem: Add...

Non-Clinical Notes to Pharmacy: This field is for nonclinical comments to the pharmacist. Any additional clinical instructions for this prescription should be added using the 'Additional Instructions' segment of the Sig Builder.

Provider: Havekorst, Walter DDS
Location: SVCHC Dental

Note: taking as directed

Formulary Data:

Last Renewed: Times Renewed: Full History [DUR History](#) Dispense History [Additional Prescription Detail](#)

4. This will take you to the US National Library of Medicine's Medline Plus Connect and to the information for the selected medication.
 - a. Please note that it may take you to the generic name of the medication and that you may need to click on the hyperlink to get the med info sheet.

geRequest® RCHN Membership Meeting - ... Login Health Information for You...

U.S. National Library of Medicine

MedlinePlus[®] CONNECT
Trusted Health Information for You

1 result found. Español

MedlinePlus Connect found the following health information for your request. Always consult your health care provider about your specific situation.

Results in **MedlinePlus**

[Cephalexin](#) (American Society of Health-System Pharmacists)

U.S. National Library of Medicine

MedlinePlus
Trusted Health Information for You

Search MedlinePlus GO

About MedlinePlus Site Map FAQs Contact Us

Health Topics Drugs & Supplements Videos & Tools **Español**

Home → Drugs, Herbs and Supplements → Cephalexin

Cephalexin

pronounced as (sef a lex' in)

[Why is this medication prescribed?](#)
[How should this medicine be used?](#)
[Other uses for this medicine](#)
[What special precautions should I follow?](#)
[What special dietary instructions should I follow?](#)
[What should I do if I forget a dose?](#)

[What side effects can this medication cause?](#)
[What should I know about storage and disposal of this medication?](#)
[In case of emergency/overdose](#)
[What other information should I know?](#)
[Brand names](#)

Why is this medication prescribed?

Cephalexin is used to treat certain infections caused by bacteria such as pneumonia and other respiratory tract infections; and infections of the bone, skin, ears, , genital, and urinary tract. Cephalexin is in a class of medications called cephalosporin antibiotics. It works by killing bacteria.

Antibiotics such as cephalexin will not work for colds, flu, or other viral infections. Using antibiotics when they are not needed increases your risk of getting an infection later that resists antibiotic treatment.

How should this medicine be used?

Cephalexin comes as a capsule, tablet, and suspension (liquid) to take by mouth. It is usually taken with or without food every 6 or 12 hours for 7 to 14 days, depending on the condition being treated. Take cephalexin at around the same times every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take cephalexin exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.

Shake the liquid well before each use to mix the medication evenly.

You should begin to feel better during the first few days of treatment with cephalexin. If your symptoms do not improve or get worse, call your doctor.

Continue to take cephalexin until you finish the prescription even if you feel better. If you stop taking cephalexin too soon or skip doses, your infection may not be completely treated and the bacteria may become resistant to antibiotics.

Other uses for this medicine

5. By clicking on the Español hyperlink, this information will translate into Spanish.
6. You can print out this information by clicking on the print button.
7. Please note the following:
 - a. This information **cannot** be saved into the patient chart
 - b. This information **cannot** be printed out by the Front Desk

If you talk to the patient following the information outlined within Medline Plus Connect's health education materials, you will have touched upon most of the expected key points.

Alternately, you can use the monograph which can also be found in the medication module in NextGen, but this document is only available in English.

1. From the medication module and, after you have prescribed the medication, highlight the medication in question.

2. Go to Resources
3. Select Monograph

NextGen 9 year Old Male Weighing 150.00 lb | 68.04 Kg [vitals recorded on 11/1/2016] Not eligible

Status	Medication Name	Generic Name	Original Start	Start Date
Active (7 items)				
Active	Keflex 500 mg capsule	CEPHALEXIN	07/20/2016	07/20/2016
Active	Tylenol 325 mg tablet	ACETAMINOPHEN	06/15/2016	06/15/2016
Active	Augmentin 250 mg-62.5 mg/5 mL oral suspension	AMOXICILLIN/POTASSIUM CLAV	03/31/2016	03/31/2016
Active	Aspirin Childrens 81 mg chewable tablet	ASPIRIN	11/30/2015	03/31/2016
Active	Norco 5 mg-325 mg tablet	HYDROCODONE/ACETAMINOPHEN		
Active	Fluor-a-day (with Xylitol) 0.5 mg fluoride (1.1 mg)...	SODIUM FLUORIDE/XYLITOL		
Active	Children's Acetaminophen 160 mg/5 mL (5 mL) or...	ACETAMINOPHEN		

Keflex 500 mg capsule

Sig: take 1 capsule by oral route every 12 hours Remove Sig Edit Sig...

Quantity: 10 Units: Capsule Refills: 0

Start: 07/20/2016 Stop: 11/01/2016 Duration:

Non-Clinical Notes to Pharmacy: This field is for nonclinical comments to the pharmacist. Any additional clinical instructions for this prescription should be added using the 'Additional Instructions' segment of the Sig Builder.

Provider: Havekorst, Walter DDS

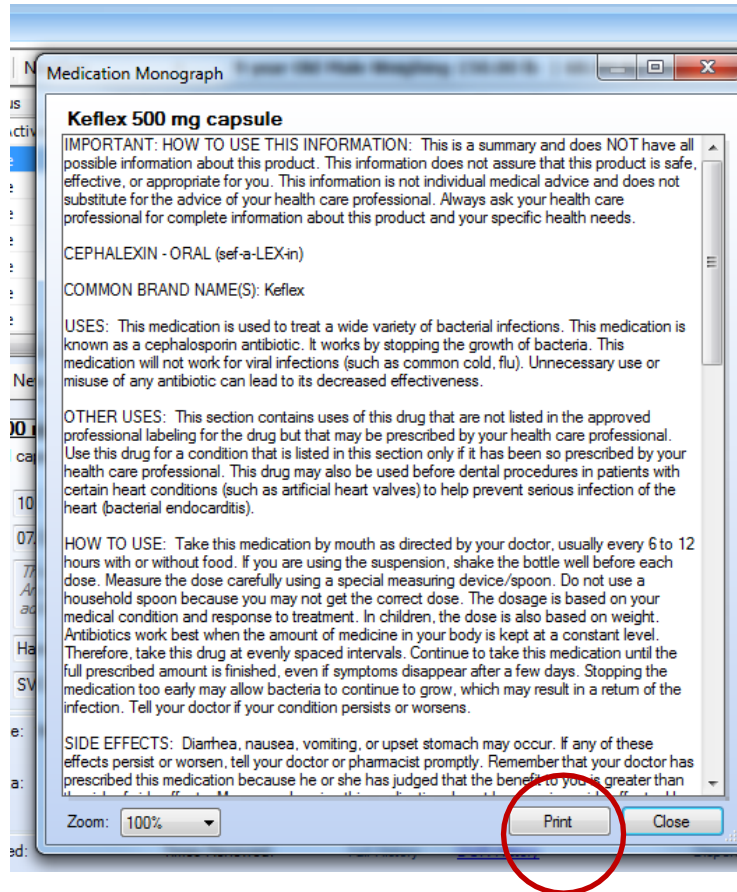
Location: SVCHC Dental

Note: taking as directed

Formulary Data:

Last Renewed: Times Renewed: Full History [DUR History](#) Dispense History [Additional Prescription Detail](#)

4. You can print out this information by clicking on the print button.



5. Please note the following:
- This information **cannot** be saved into the patient chart
 - This information **cannot** be printed out by the Front Desk
 - This information **cannot** be translated into Spanish.

POLICY THIS PROCEDURE SUPPORTS:

- Clinical Protocols



Document Title: BMI Documentation Requirements		Page 1 of 11
Document Type: Procedure	Document ID Number:	
Department: Clinic Operations, Medical Department, Behavioral Health Department		
Author: Julie Vlasis, Consultant CQI/Risk Manager	Implementer/Owner: Xavier Perez, MD, CMO	
Approval Date: 04/14/2014	Training Date: 04/14/2014	
Implementation Date: 04/14/2014	Revision Date: 10/01/2015	
Effective Date:	Next Review Date: 10/01/2017	

STATEMENT OF PURPOSE:

It is the policy of Sonoma Valley Community Health Centers that all patients one time per year have their BMI recorded in their electronic health record. SVCHC required BMI with Dietary and Physical Activity counseling during the Comprehensive Health Assessment for adult patient 18+ years of age and all CHDP visits for children 3-17. BMI Documentation is required for all Chronic Condition Care Guidelines, i.e.: Hypertension, Diabetes, CAD, IVD and Hyperlipidemia.

DEFINITIONS:

NextGen Enterprise Practice Management (EPM): NextGen EPM is the application used primarily for billing and is also used to manage appointments. Other functions of EPM include, but are not limited to, storing patient demographics, posting transactions, and processing charges.

NextGen Electronic Health Records (EHR): NextGen EHR is the application used to store and maintain a patient's electronic chart. Clinical information such as lab results, health history, and diagnosis history are located in EHR.

Provider Approval Queue (PAQ): The PAQ contains all items that need a provider's approval/signature. These items include but are not limited to the following:

- Lab Orders

- Scanned images from NextGen ICS: consultation reports, outside provider records, hospital record, diagnostic report, specialty OB lab, other lab results, other specialty lab, Health Risk Assessment, CMR/suspected child abuse report

- Documents generated within NextGen EHR: Master IM, PHQ9, specialty-specific chart notes (OB Master, BH Master)

Master IM: Patient progress note generated within NextGen EHR which includes information from the selected encounter. The Master IM includes vitals, patient history, physical exam findings, and orders.

EHR Tasks /Tasking: Tasks are a user's to-do items. The EHR Workflow window (also referred to as Inbox) lists tasks assigned to the current user. Tasks can be sent to another user, a group of users, or one's own inbox. Delegates will also have the option to view tasks assigned to the provider they are a delegate for.

NextGen Image Control System (ICS): An application that is used to import, file, and view scanned images into the NextGen system. ICS images can also be opened in NextGen Electronic Health Record (EHR) and NextGen Electronic Practice Management (EPM).

Scanning: Is defined as a process in which a device is used that optically scans images such as reports, results and other pertinent health documents and converts it to a [digital image](#) that is placed into specific categories for identification into the Patient Electronic Health Record in NextGen.

Order Management: Order Management is a template in NextGen EHR that shows all orders that have been placed for the patient. This template is not encounter-based and will show orders from any encounter in the patient's chart.

Provider Test Action: Provider Test Action is a template that is used by providers to document actions that need to be taken outside of face-to-face encounters. Providers may use this template to place orders and also to send tasks to other staff. A Provider Test Action document can also be generated from this template.

i2iTracks: is a population management system that securely integrates clinical data from practice management, systems, electronic health records, labs, pharmacies and other providers, into a single unified view, with reports to identify subpopulations that require follow-up actions. I2iTracks manages the workflow and specific patient follow up actions, to ensure that both staff and patients complete the required tasks.

Electronic Summary-of-Care Record: this consist of the last two patient progress notes, medications list, current problem list, last laboratory results (not more than 3 months old) and Diagnostic testing (not more than 3 months) as appropriate for the Specialty Care provider selected. (See Specialty Care Referral Requirements Grid)

Body Mass Index, BMI: Body mass index (BMI) is an estimate of body fat based on height and weight. It doesn't measure body fat directly, but instead uses an equation to make an approximation. BMI can help determine whether a person is at an unhealthy or healthy weight. A high BMI can be a sign of too much fat on the body, while a low BMI can be a sign of too little fat on the body. The higher a person's BMI, the greater their chances of developing certain serious conditions, such as heart disease, high blood pressure, and diabetes. A very low BMI can also cause health problems, including bone loss, decreased immune function and anemia.

Bureau of Primary Care Uniform Data System, (UDS): Each year, Health Center Program grantees and look-alikes report on their performance using the measures defined in the Uniform Data System (UDS). HRSA offers manuals, webinars, trainings online and at various

state/regional/national meetings, and other technical assistance resources to assist health centers in collecting and submitting their data.

BACKGROUND:

The following are the actual measures that SVCHC is required to report to UDS

Pediatric Measure

Performance Measure: The performance measure is “Percentage of patients aged 3 -17 years of age who had evidence of BMI *percentile* documentation **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement year.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement year
- **Denominator:** Number of patients who were 3 years of age through adolescents who were aged 17 at some point during the measurement year, who had at least one medical visit during the reporting year, and were seen by the health center for the first time prior to their 18th birthday; for measurement year 2017, this includes patients with a date of birth between January 1, 2000, and December 31, 2014.

Total Number of Patients 3 through 17 Years of Age, Criteria:

- Were born between January 1, 2000, and December 31, 2014, **and**
- Were first seen ever by the health center prior to their 18th birthday, **and**
- Had at least one medical visit in a clinical setting during 2017.

Exclusions: Pregnant patients

Adult Measure

Performance Measure: The performance measure is “Percentage of patients aged 18 and older (no outer age limit) with a documented BMI during the most recent visit or within the 6 months prior to that visit **and** when the BMI is outside of normal parameters a follow-up plan is documented.” This is calculated as follows:

- **Numerator:** Number of patients in the denominator who had their BMI (not just height and weight) documented during their most recent visit **or** within 6 months of the most recent visit **and** if the most recent BMI is outside of normal parameters, a follow-up plan is documented
- **Denominator:** Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year; for measurement year 2017 this includes patients with a date of birth on or before December 31, 1999.

**Total Number of Patients Age 18 and Over,
Criteria:**

- Were born on or before December 31, 1999 **and**
- Were last seen by the health center after their 18th birthday, **and**
- Had at least one medical visit in a clinical setting during 2017.

Exclusions:

- Pregnant women
- Terminally ill patients - end of life palliative care

BMI Defined by Age

- Were under age 65 **and** their BMI was greater than or equal to 25, **or**
- Were age 65 or older **and** their BMI was greater than or equal to 30, **or**
- Were under age 65 **and** their BMI was under 18.5, **or**
- Were age 65 or older **and** their BMI was under 23.

ASSUMPTIONS:

Assisting Patients in reaching and maintaining a healthy weight is important for overall health and can help a patient prevent and control many diseases and conditions. If a patient is overweight or obese, they are at higher risk of developing serious health problems, including heart disease, high blood pressure, type 2 diabetes, gallstones, breathing problems, and certain cancers.

Maintaining a healthy weight is so important: It helps the patient lower their risk for developing these problems, helps them feel good about them self, and gives them more energy to enjoy life.

PCMH (Patient Care Medical Home) Related: Yes (X); No () PCMH

NextGen EPM/EHR Procedure is needed for this Procedure: Yes (X); No ()

PROCEDURES:

The BMI Documentation pattern is exactly the same for both Adults and Pediatrics.

The only different is the BMI Code/ BMI Percentages

- ICD-10 code Z68.5- are for recording BMI percentile. Presence is required
- Codes 97802-97804 are for 15 minutes or more of nutritional counseling. Their presence is sufficient but not necessary. (RD Codes)
- ICD-10 code Z71.89 is required for physical activity counseling.

- ICD-10 Code Z71.3 is required for dietary and nutrition counseling.

Chronic Conditions Diagnostics View All

Vital Signs ⚠ Vital Signs Outside Normal Range ⚠ BMI Outside Normal Range

Historical information entered this encounter **Health Promotion Plan** History | Graph

Time	Ht (in)	Wt (lb)	BMI	BP	Position	Side	Site	Cuff Size	Pulse	Respiration	Temp (F)	Pulse O ₂ Rest	Pain Level	Comment
10:13 AM	67.00	195.00	30.54	122/90	sitting	left		adult			98.00			Historical entry (

[Audiometry](#) | [Vision](#) | [Orthostatic](#) | [Neck/Waist/Hip Circumference](#)

Medications
Allergies
Orders
Review of Systems

Select the **Health Promotion Plan**. Please note the BMI Plan is no longer available here.

Health Promotion Plan - SVCHC

Panel Control:

Health Promotion Plan

Patient's age: 41 Years BMI: 30.54 kg/m Exclusions

Plan: BMI Plan

Diagnosis: Body mass index (BMI) 30.0-30.9, adult Code: Z68.30

Diet:

Details:
Characters left: 250

Physical activity:

Details:
Characters left: 250

Referrals: Timeframe:

Details:
Characters left: 250

(Select a row to update or remove)

Status	Order	Diagnosis	Code	Details
ordered	Referrals: Diagnostic Radiology, Location: Santa Rosa Imaging. Evaluate and treat. Diagnostic testing	DM neuro manif type II	E11.40	test this order

Please note that the BMI Code that is connected to the patient's current weight and height is shown.

The Provider will no longer need to add each additional code individually. The provider will add Dietary Counseling and Activity Counseling as required for UDS reporting.

The screen will look as follows:

Health Promotion Plan - SVCHC

Panel Control: Toggle Cycle

Health Promotion Plan

Patient's age: 41 Years BMI: 30.54 kg/m Exclusions

Plan: BMI Plan

Diagnosis: Body mass index (BMI) 30.0-30.9, adult Code: Z68.30

Diet: Dietary management education, guidance, and counseling Code: Z71.3
Details: Provided patient with dietary information
Characters left: 209

Physical activity: Prescribed activity/exercise education Code: Z71.89
Details: patient to start walking 30 minutes at a slow to moderate pace.
Characters left: 187

Referrals: Timeframe: Characters left: 250

Add Update Clear

The Provider will select add and the information will fall into the grid below. The Required codes will automatically appear.

Please note that Z71.3 cannot be used without Z71.89 the correct BMI Z68.XX code. These codes as of 2017 ICD-10 Changes must all be used together for both Adults and Pediatrics. The provider will select add.

(Select a row to update or remove)

Status	Order	Diagnosis	Code	Details
completed	Prescribed activity/exercise education	Body mass index (BMI) 30.0-30.9, adult	Z68.30	patient to start walking 30 minutes at a slow to moderate pace.
completed	Dietary management education, guidance, and counseling	Body mass index (BMI) 30.0-30.9, adult	Z68.30	Provided patient with dietary information

Remove

Remember to select **Save & Close**

(Select a row to update or remove)

Status	Order	Diagnosis	Code	Details
completed	Prescribed activity/exercise education	Body mass index (BMI) 30.0-30.9, adult	Z68.30	patient to start walking 30 minutes at a slow to moderate pace.
completed	Dietary management education, guidance, and counseling	Body mass index (BMI) 30.0-30.9, adult	Z68.30	Provided patient with dietary information

Remove

Pain Management

Fall Risk

Functional Status

Save & Close Cancel

Please note that all of the additional information is under the BMI code this is for reporting. When you go to the Patient Assessment all of the Codes will show.

Assessment/Plan

Assessments	1.	Assessment	Type 2 diabetes mellitus with diabetic neuropathy, unsp (E11.40).
My Plan	Plan Orders	Referrals: Diagnostic Radiology. Location: Santa Rosa Imaging. Evaluate and treat. Diagnostic testing for Echocardiogram.	
A/P Details			
Referrals			
Office Procedures	2.	Assessment	Body mass index (BMI) 30.0-30.9, adult (Z68.30).
Review/Cosign Orders	Plan Orders	Today's instructions / counseling include(s) Prescribed activity/exercise education.	
View Immunizations			
Office Diagnostics	3.	Assessment	Dietary counseling and surveillance (Z71.3).
Health Promotion Plan			
	4.	Assessment	Other specified counseling (Z71.89).

Patient Education/ Health Wise

Please remember that NextGen has a wide array of health education documents in English and Spanish. These can be saved to the encounter and printed for the patient to take with them. Patient Education Documentation can be found by selecting File.

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Delete SVCHC Ahern, Carol MD Patient History Inbox PAQ PM DM Close Medication Allergies Medications Orders Equipment

Frank Test (M) DOB: 09/28/1949 (67 years) Weight: 194.00 lb (88.00 Kg)

Address: 6985 W Spain St Sonoma, CA 95476 Insurance: Medicare 19270 FQHC ...

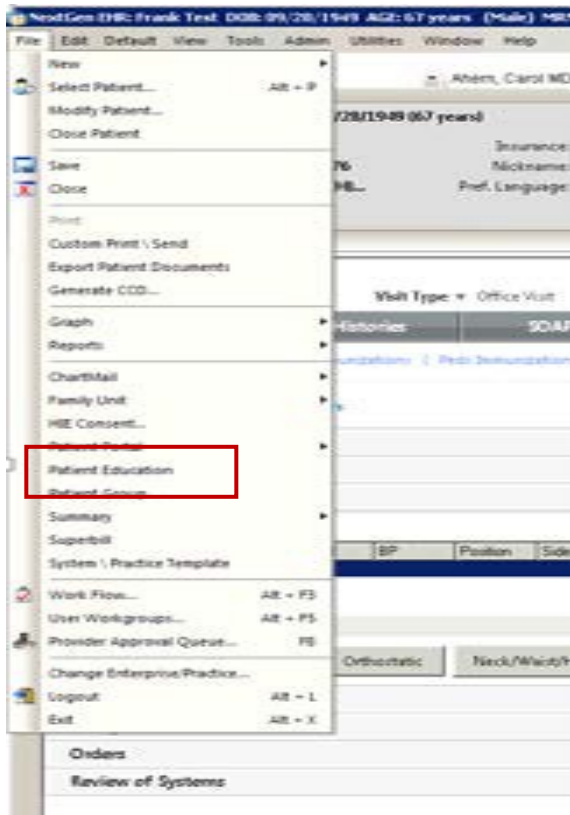
Contact: (707) 000-0000 (H)... Nickname: Pref. Language: Declined to specify

PCP: Referring: Rendering: Ahern, Carol MD

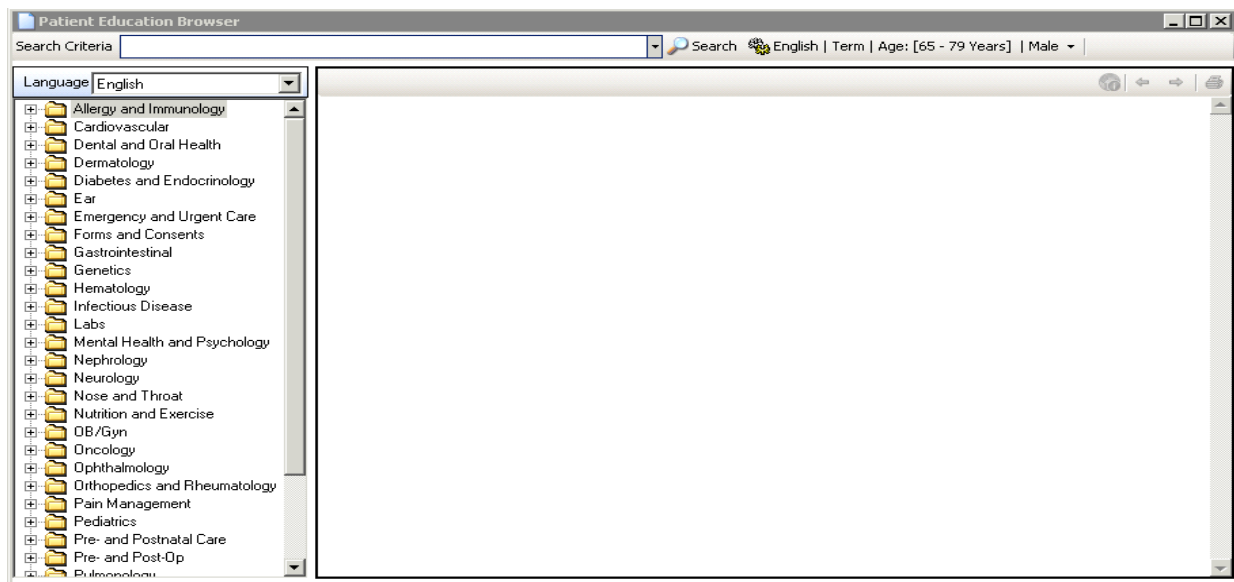
Alerts Patient Info Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

10/24/2016 08:44 PM: "Intake"

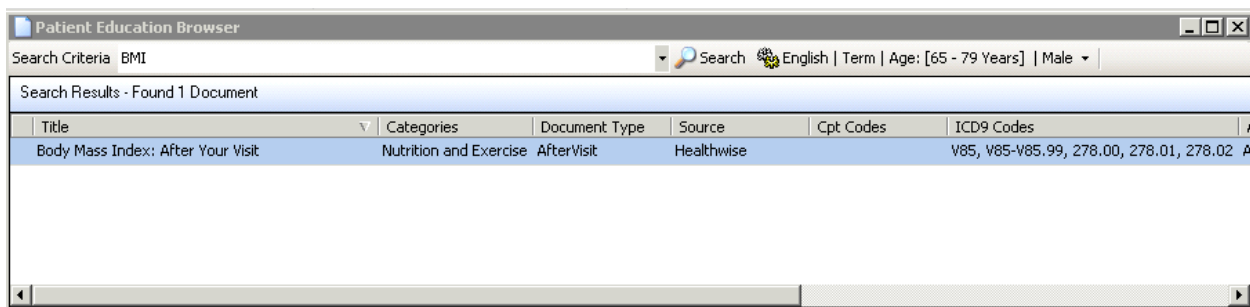
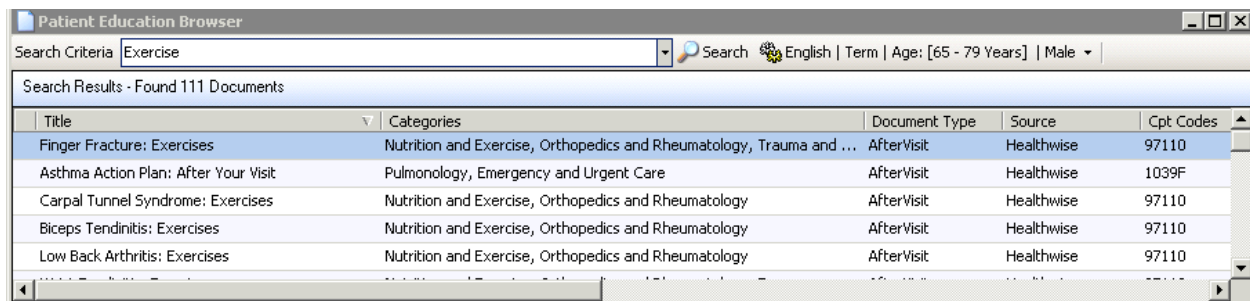
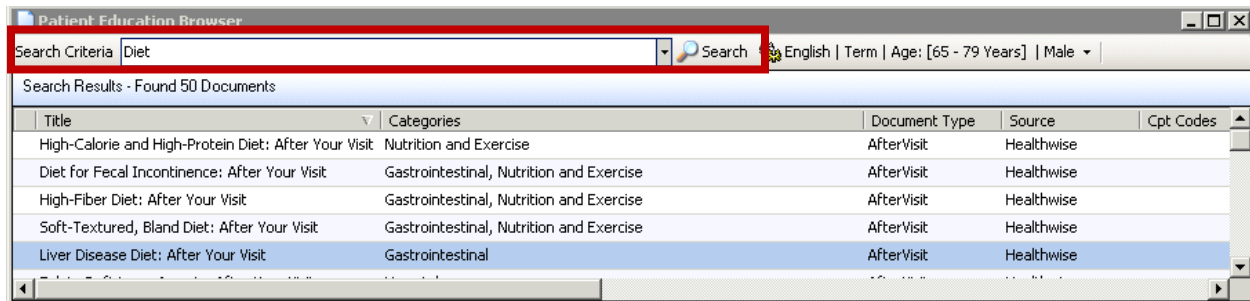
Specialty: Family Practice Visit Type: Office Visit



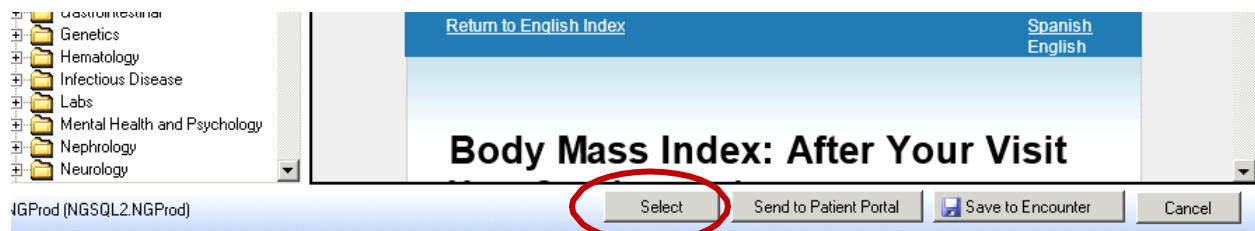
Select Patient Education from the drop down. This will take you to the Health Wise Information.



Use the **Search Criteria Box** to search for the information that you want to provide the patient. For this measure you can use Diet, Exercise, BMI or if they have a Chronic Condition that condition to search for the appropriate materials. Items are based on Age and Sex.



When you find the document that you want Highlight it and use the **Select** button and the document will fall in the view box for you to review with the patient.



Search Results - Found 1 Document

Title	Categories	Document Type	Source	Cpt Codes	ICD9 Codes	Age	Gender
Body Mass Index: After Your Visit	Nutrition and Exercise	AfterVisit	Healthwise		V85, V85-V85.99, 278.00, 278.01, 278.02	Adolescent (13 to 18 years), Early adult (19 to 24 years), Adult (19 to 44 year...	Male, Female

Language: English

Body Mass Index: After Your Visit

Body Mass Index: After Your Visit
Your Care Instructions

Body mass index (BMI) can help you see if your weight is raising your risk for health problems. It uses a formula to compare how much you weigh with how tall you are. A BMI between 18.5 and 24.9 is considered healthy. A BMI between 25 and 29.9 is considered overweight. A BMI of 30 or higher is considered obese.

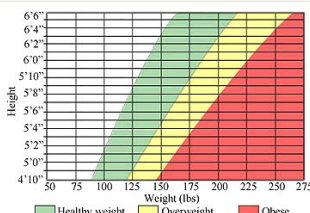
If your BMI is in the normal range, it means that you have a lower risk for weight-related health problems. If your BMI is in the overweight or obese range, you may be at increased risk for weight-related health problems, such as high blood pressure, heart disease, stroke, arthritis or joint pain, and diabetes.

BMI is just one measure of your risk for weight-related health problems. You may be at higher risk for health problems if you are not active, you eat an unhealthy diet, or you drink too much alcohol or use tobacco products.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

How can you care for yourself at home?

- Practice healthy eating habits. This includes eating plenty of fruits, vegetables, whole grains, lean protein, and low-fat dairy.
- Get at least 30 minutes of exercise 4 to 5 days a week or more. Brisk walking is a good choice. You also may want to do other activities, such as running, swimming, cycling, or playing tennis or team sports.



Remember to **Save to Encounter** so that it can be printed at checkout for the patient.

Patient Education Browser

Search Criteria: BMI

Search Results - Found 1 Document

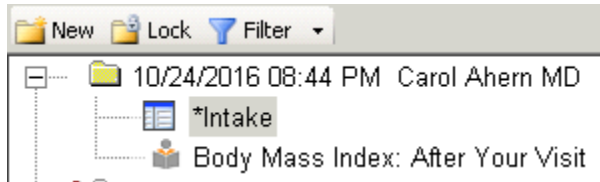
Title	Categories	Document Type	Source	Cpt Codes	ICD9 Codes
Body Mass Index: After Your Visit	Nutrition and Exercise	AfterVisit	Healthwise		V85, V85-V85.99, 278.00, 278.01, 278.02

Language: English

Body Mass Index: After Your Visit

Body Mass Index: After Your Visit

Select Send to Patient Portal **Save to Encounter** Cancel



Once the information is saved to the encounter it is a permanent part of the patient electronic health record.

This Procedure support the following Policy:

SVCHC Evidence-based Guideline Development