Updated 1/4/2018

# Sonoma Valley Community Health Center
# Diabetes HbA1c Control

*Redwood Community Health Coalition*
*Promising Practice*

## 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%.

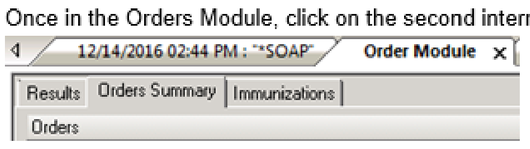
**In House Lab – Hemoglobin A1c PROCEDURE**

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)

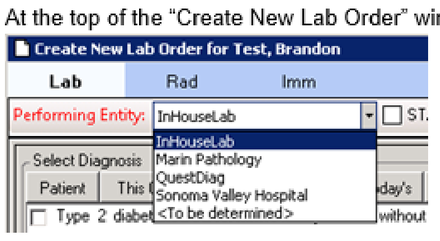
Once in the Orders Module, click on the second internal tab for the **Orders Summary**.



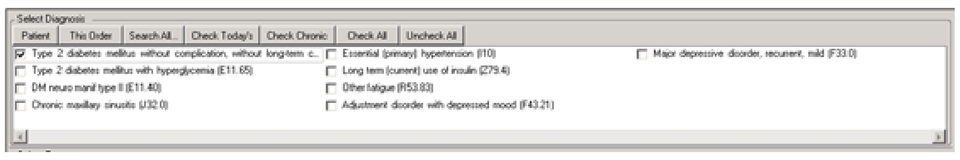

Now click **New** to order the test.



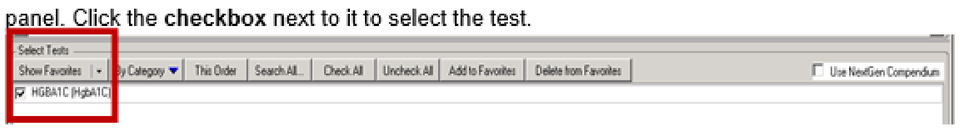
At the top of the "Create New Lab Order" window, select **InHouseLab** as the performing entity.




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

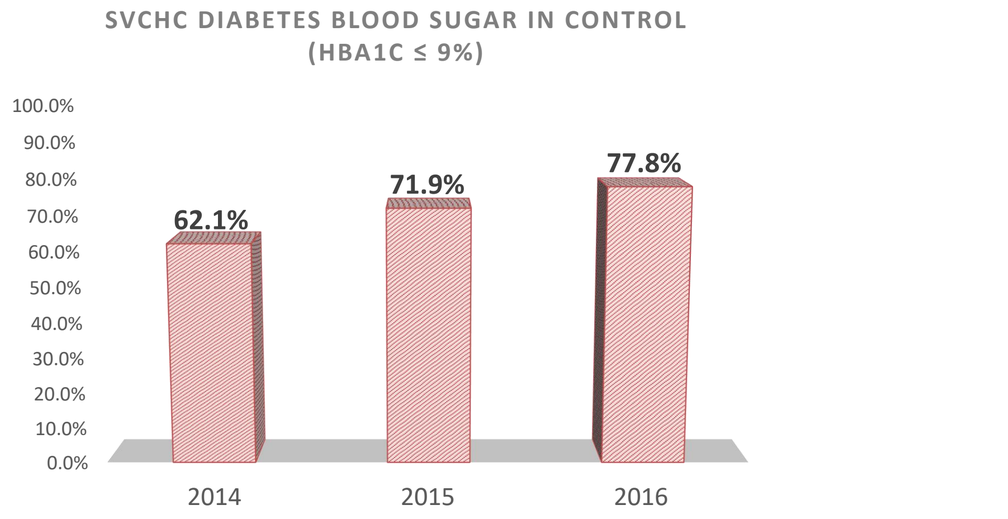
Between 2015 and 2016 SVCHC made the following changes that contributed to their improved performance:

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.

SONOMA VALLEY COMMUNITY HEALTH CENTER
*Your pathway to good health - Su camino a buena salud*

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|---|---|
| **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 |
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| **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 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 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 1/22/2013[iii], 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<=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-instrinsic 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
- 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 educ**a**tor 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 withType 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 funduscopic 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

[i] Executive 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 diabes: a patient-centered approach. Position statement of the American Diabes 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.

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|---|---|---|
| **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 | |
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| **Implementation Date: 04/16/2014** | **Revision Date:** | |
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- 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.
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.
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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<=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 1/22/2013[iii], 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<=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-instrinsic 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; UpTo Date website, www.uptodate.com, accessed 1/23/14.

**POLICY THIS PROCEDURE SUPPORTS:**

1. Implementation of Evidence-Based Guidelines Policy

[i] Executive 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 diabes: a patient-centered approach. Position statement of the American Diabes 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 devised 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 ( )**

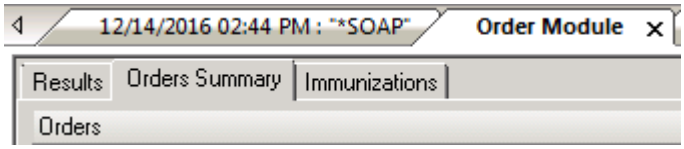
**PROCEDURES**:

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.

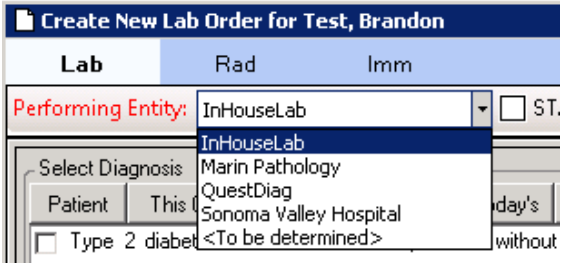
(The Medical Assistant will no longer be using Standing Orders/Office Diagnostic or Office Procedures when ordering or resulting the Hemoglobin A1c)

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

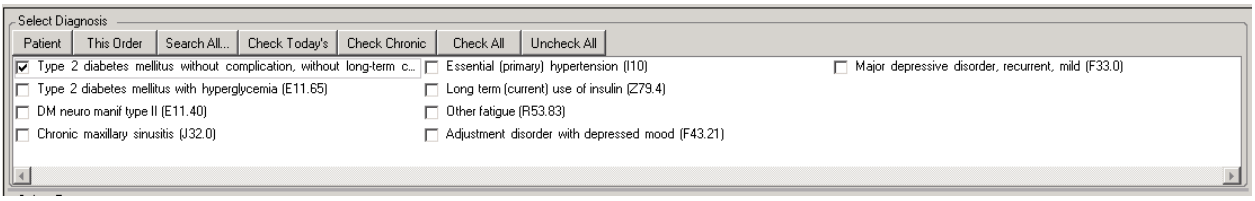



Now click **New** to order the test.

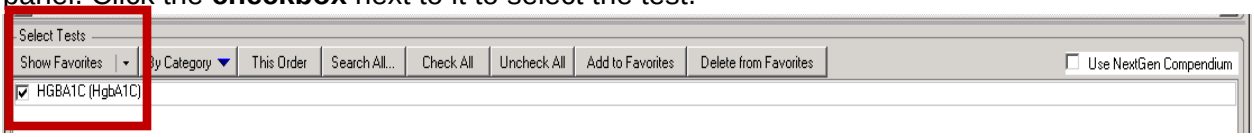

At the top of the "Create New Lab Order" window, select **InHouseLab** as the performing entity.




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)

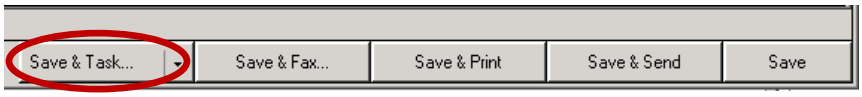



In the Select Tests section the Medical Assistant will see the **HGBA1C** test in the favorite's panel. Click the **checkbox** next to it to select the test.

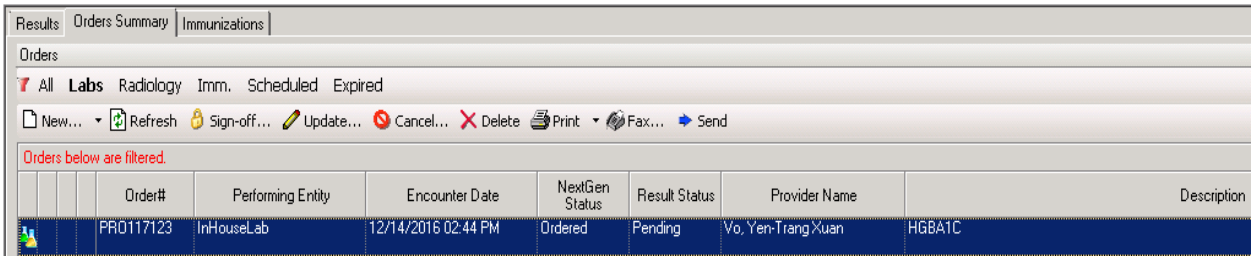


Click the **Save** button at the lower right of the window to **Save** the order.

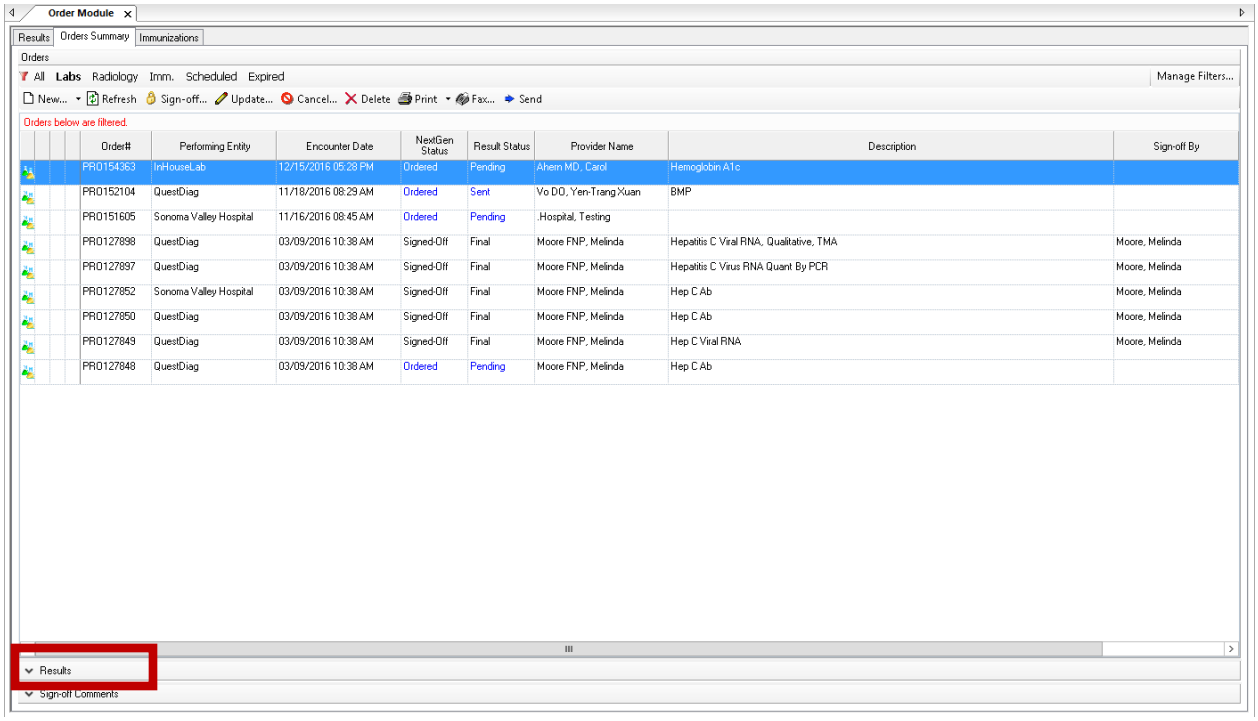
If the provider of record is ordering the test, they will need to task the Medical Assistant or Nurse to complete this test, please click **Save & Task** in order to task them.



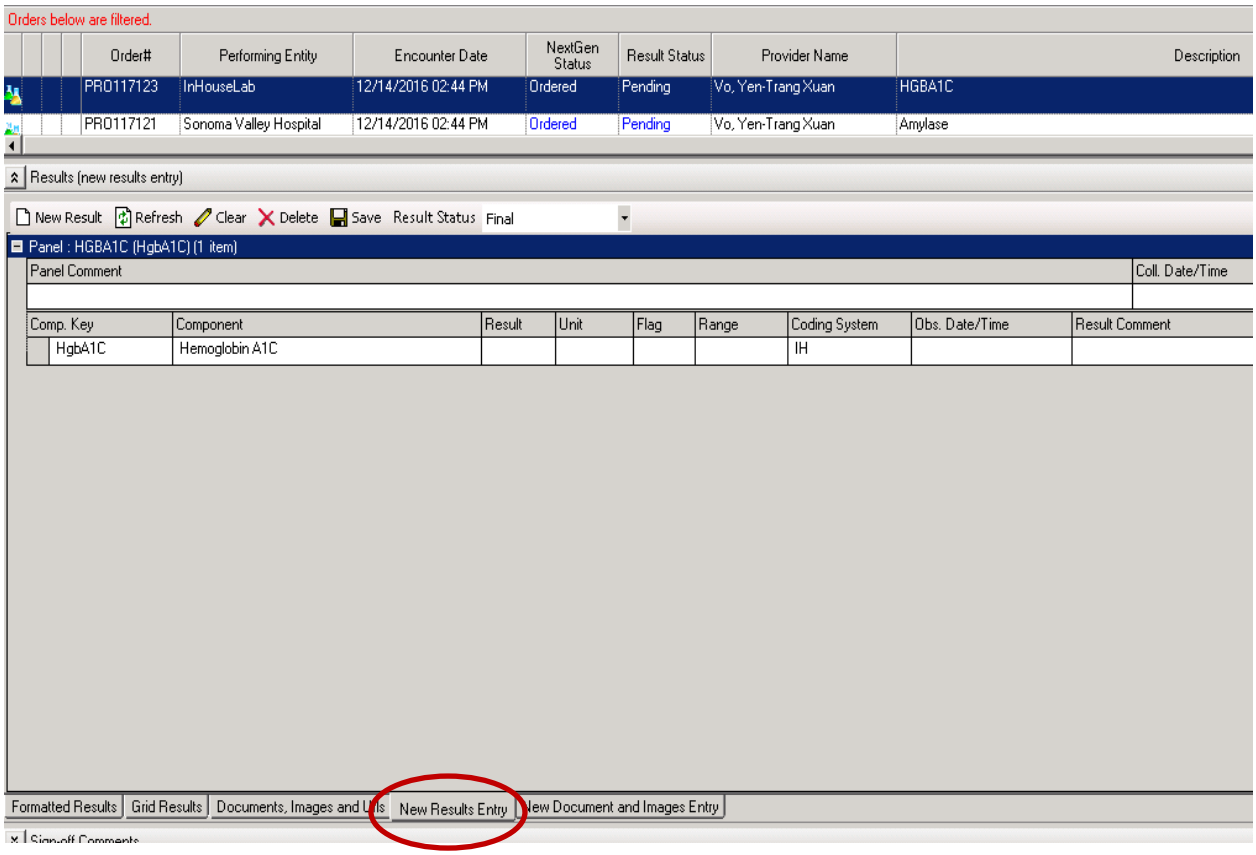

To Result the order, **click on the order in** the grid on the **Orders Summary** tab so that it is selected and highlighted in dark blue.



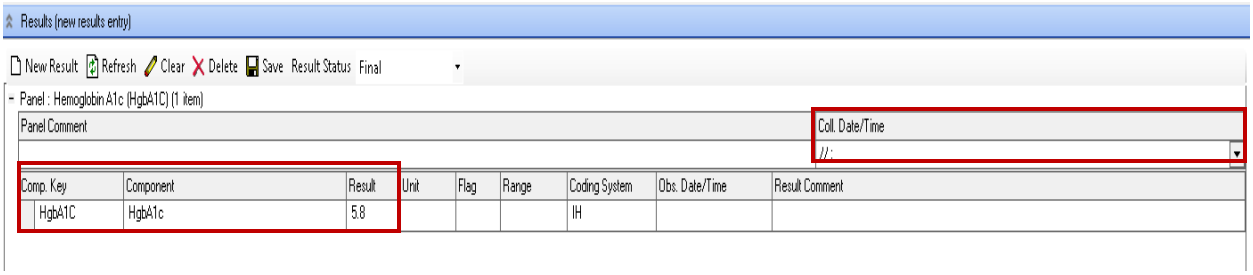

Now click on the **down arrow** next to the work **Results** at the bottom of the screen to expand that section.



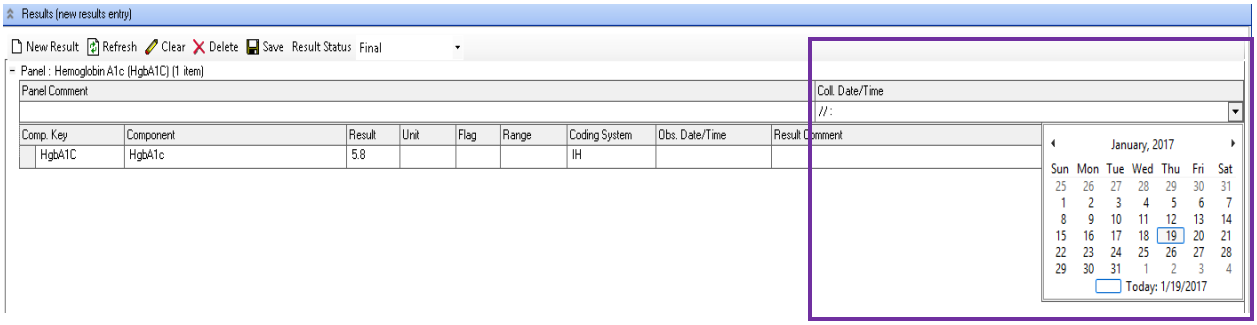
With the Results panel expanded click on the **New Results Entry** tab at the bottom of the panel.



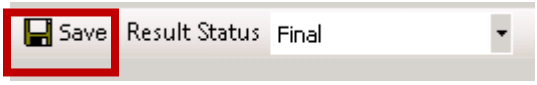

Finally click in the Result field and **type the result**, *make sure to **only use numbers and a decimal place when necessary. Do Not use:*** Letters *(HBA1C ) or Symbols(%,<,>)*



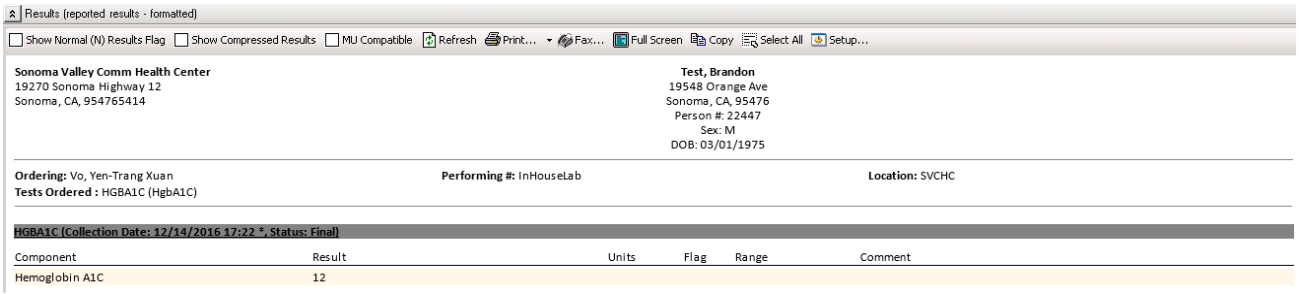

Then select **Coll Date /Time** to ensure the result will show on the Lab Module in the *result grid*. A calendar will appear with today's date highlighted. Please select the correct date of the test.




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**.

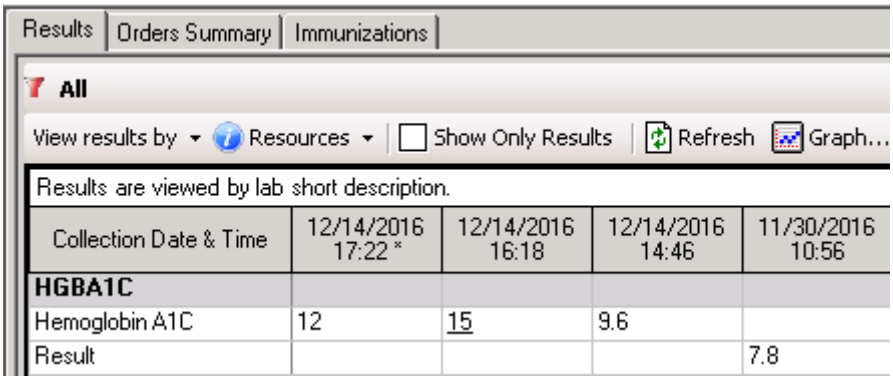



Along with being able to view the results in this results panel in the future as a **Formatted Result,**

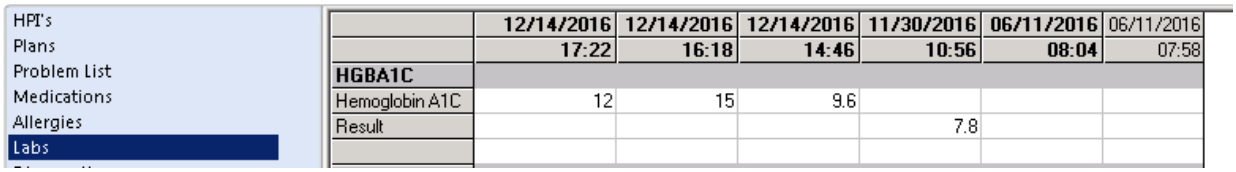



The Medical Assistant can see it on the **Results** tab in the Orders Module. The Provider or Medical Assistant has the ability to **graph** the results by clicking on the result component **row** (the row that spells out Hemoglobin A1C) and clicking the graph button.

**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.




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.




**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 12/22/216.

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 BITARTRATE | Vicodin |

**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 if shows patient education another area that will be monitored for the new Quality Measures that started actually 7/1/2016.

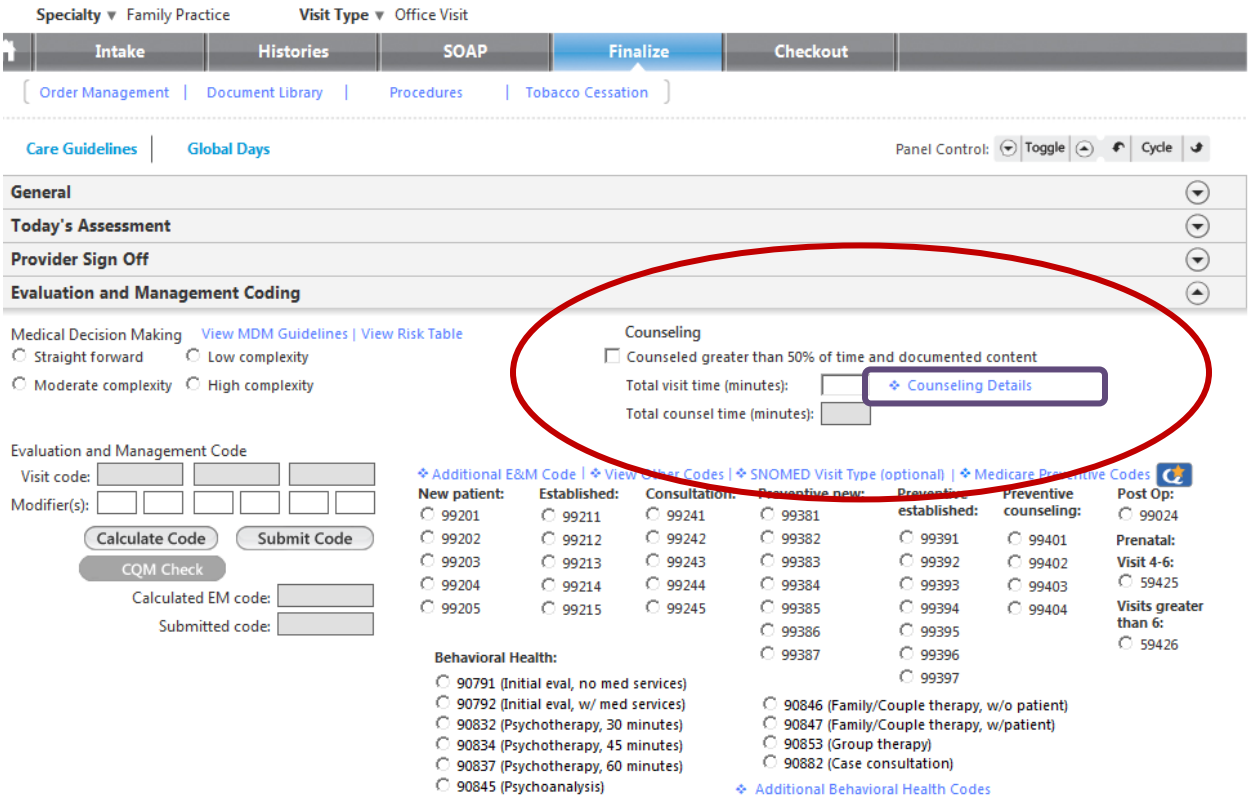
**ASSUMPTIONS:** n/a

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

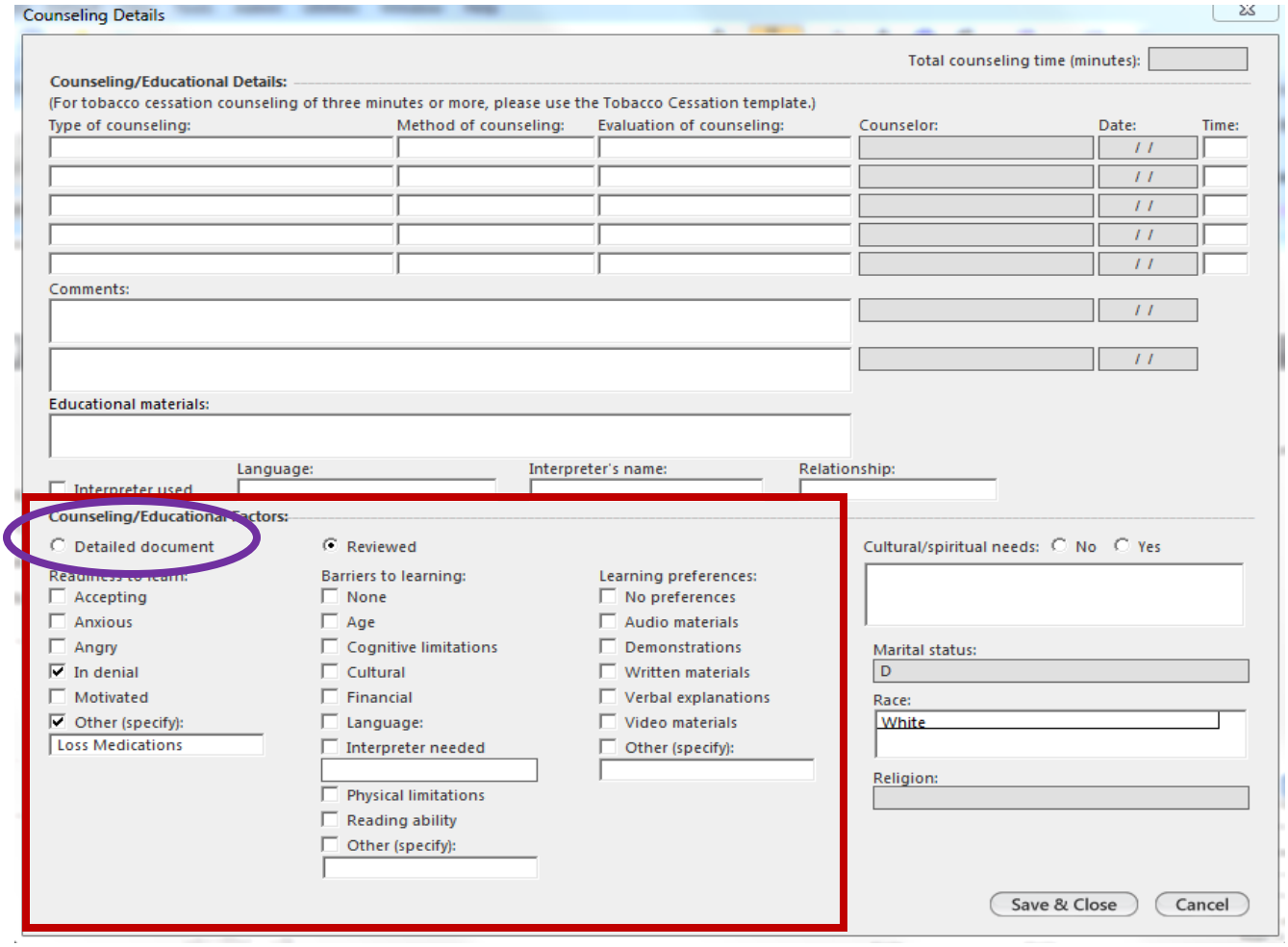
**NextGen EPM/EHR Procedure is needed for this Procedure: Yes ( ); No (X)**

**PROCEDURES**:
To document counseling details:

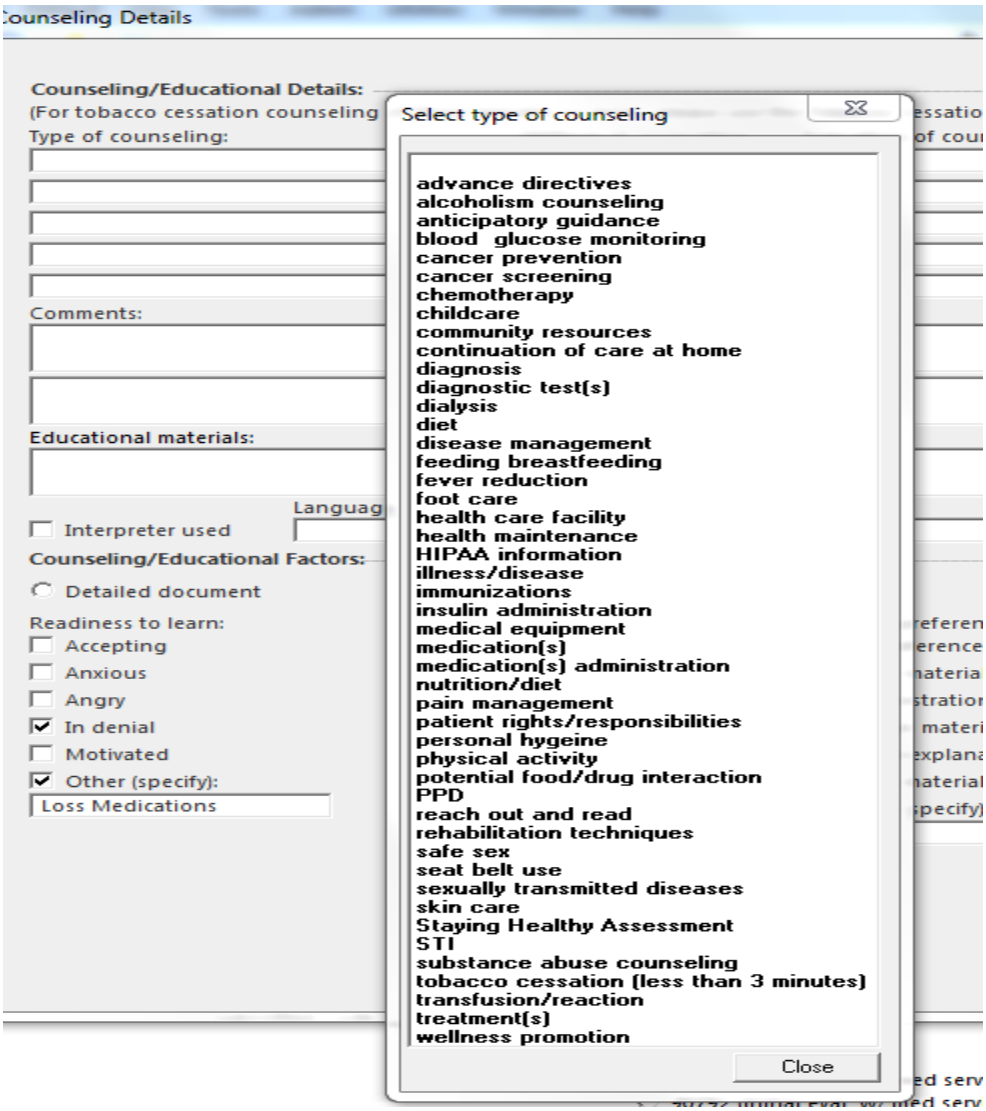
1. From the Finalize tab in NextGen:



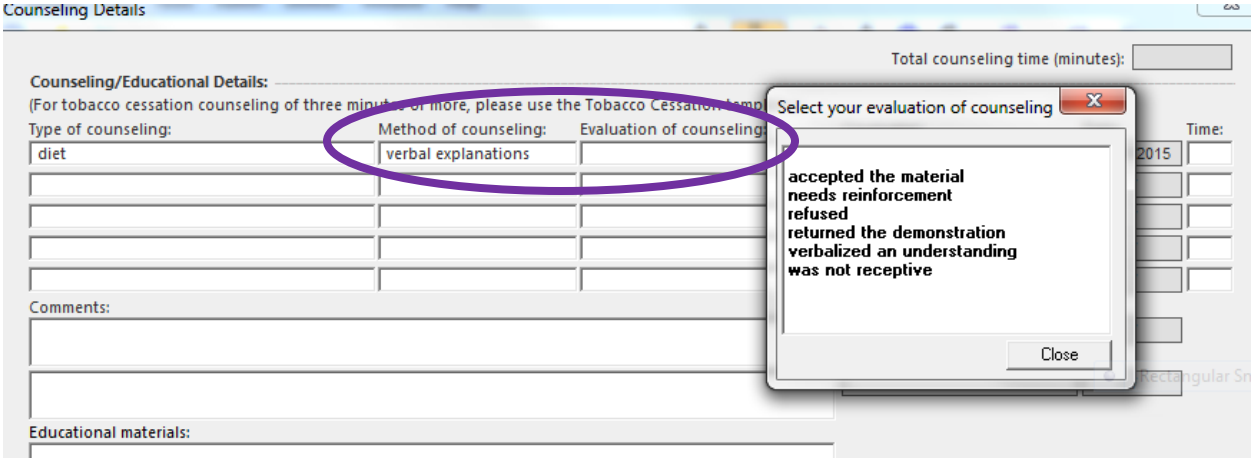

2. Select the Blue Counseling Details Button - *Please note you cannot add time without complete documentation.*
3. Select type of counseling from the drop down box.
4. **This is default for the last review** - please **make sure you change to detailed document** each time.




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

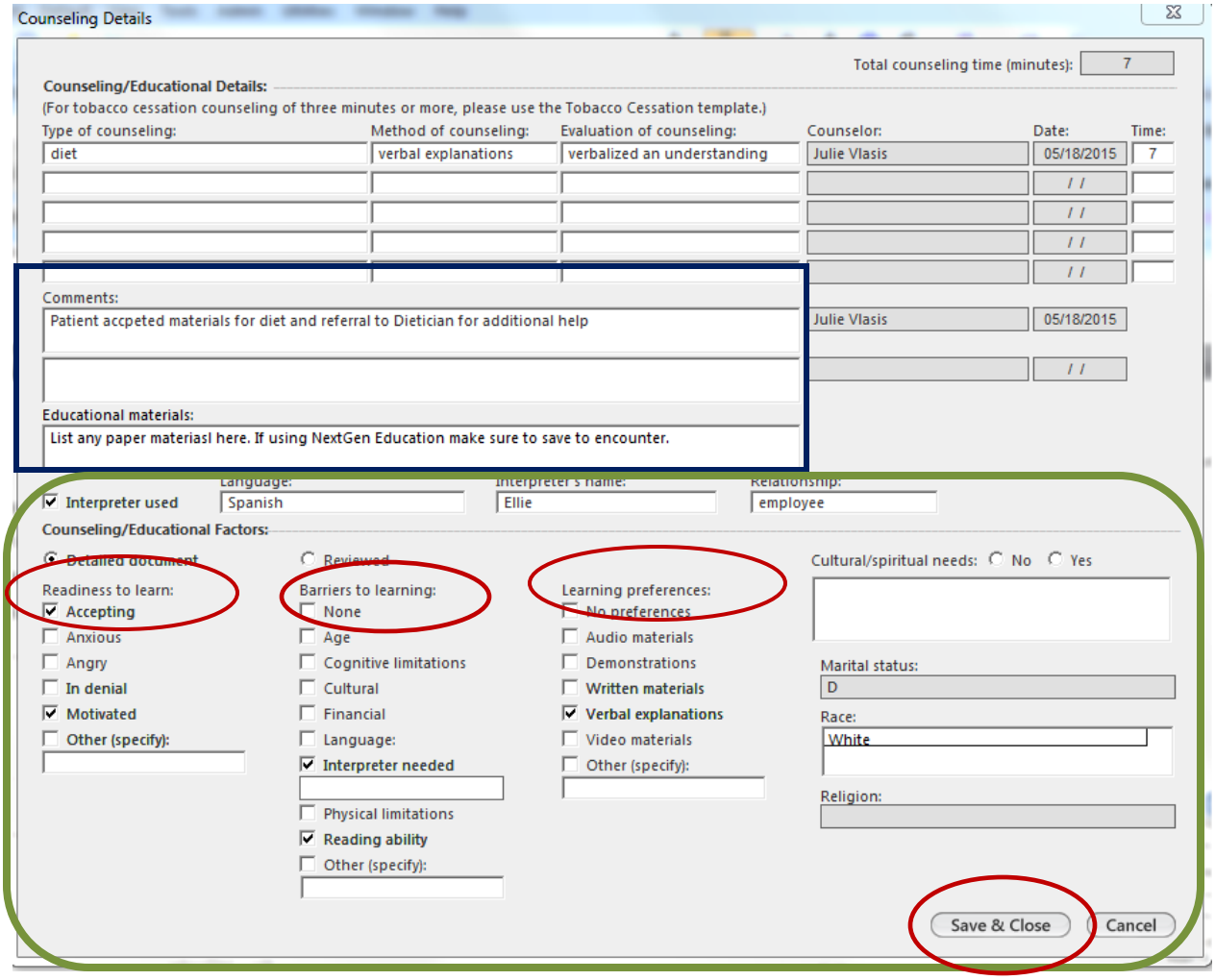



7. Identify the Method of Counseling and Evaluation of Counseling by using the drop down boxes for Method of Counseling and Evaluation of Counseling.




***8.*** The provider can add 5 different topics for each patient. ***Please note that each topic must have its own time.***

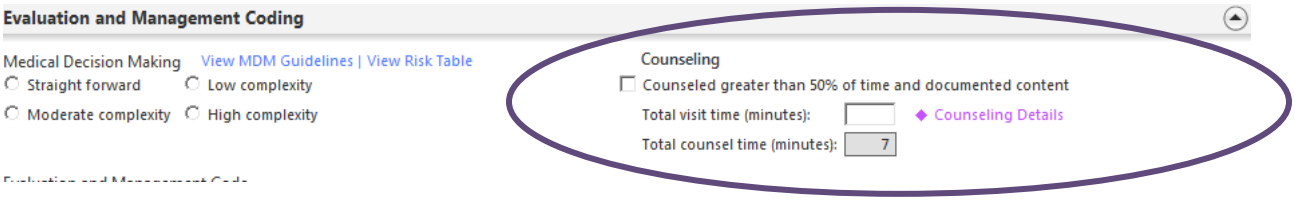
9. Place the number of minutes spent.
10. Please use the comment line for all additional information that you as a provider would like to add.
11. Make sure that you select **Detailed Document.**
12. If you used an interpreter (even if it is a member of our staff or if you are speaking to the patient 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.**




14. Remember to Save and Close when you are finished

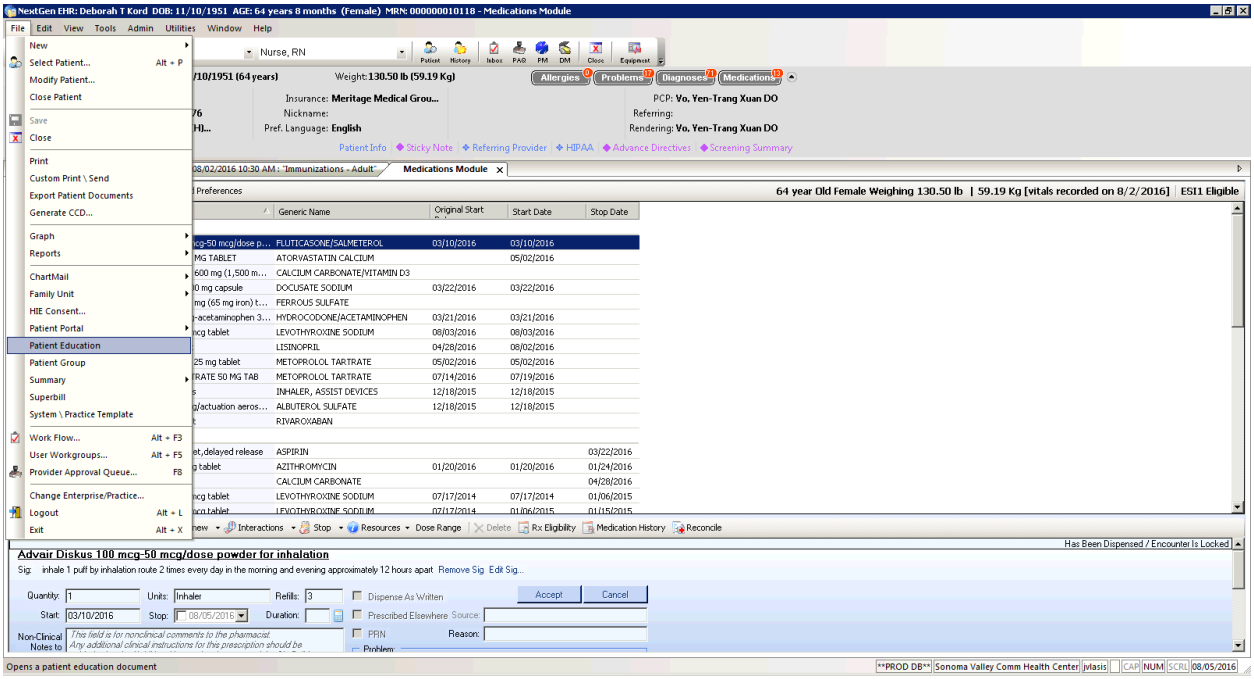
Patient Counseling Complete when Counseling Details turns pick and the total counsel time appears in the box (see below).

*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.*

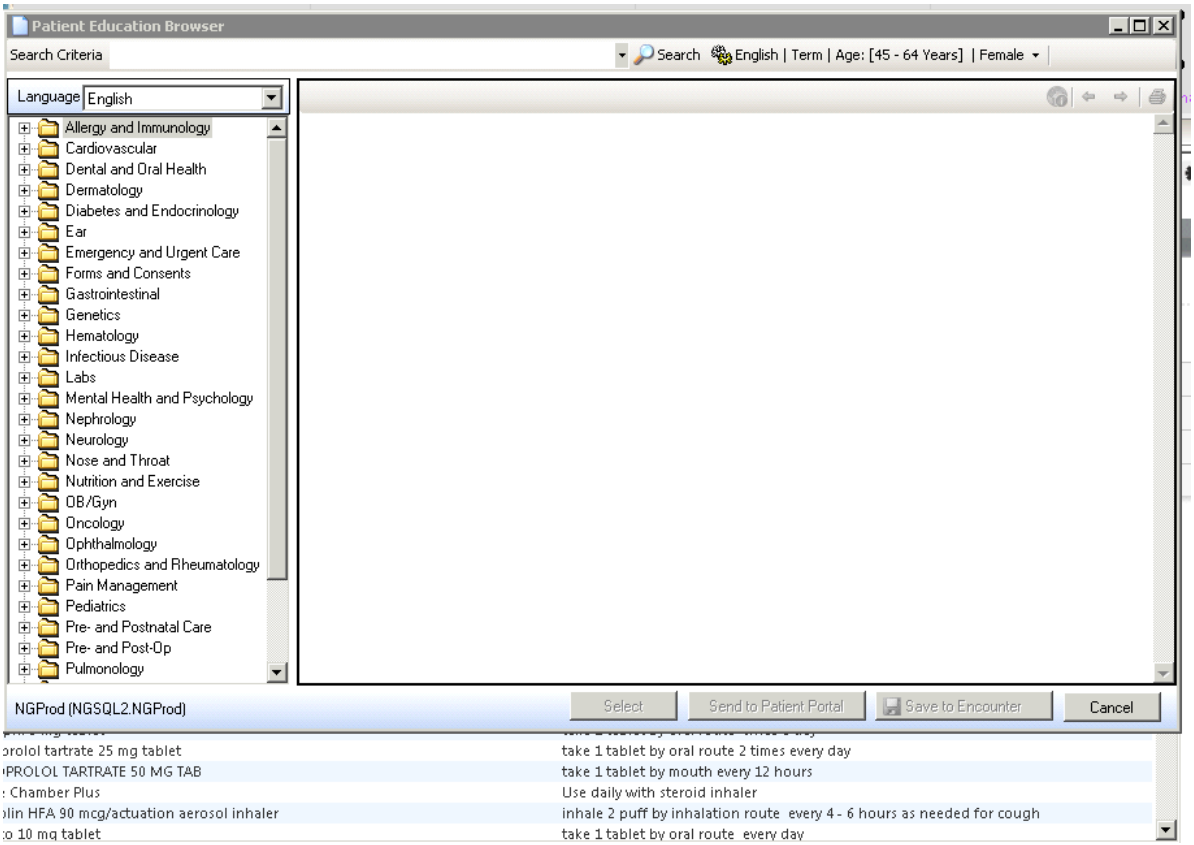


## Healthwise Information for Patient Education:

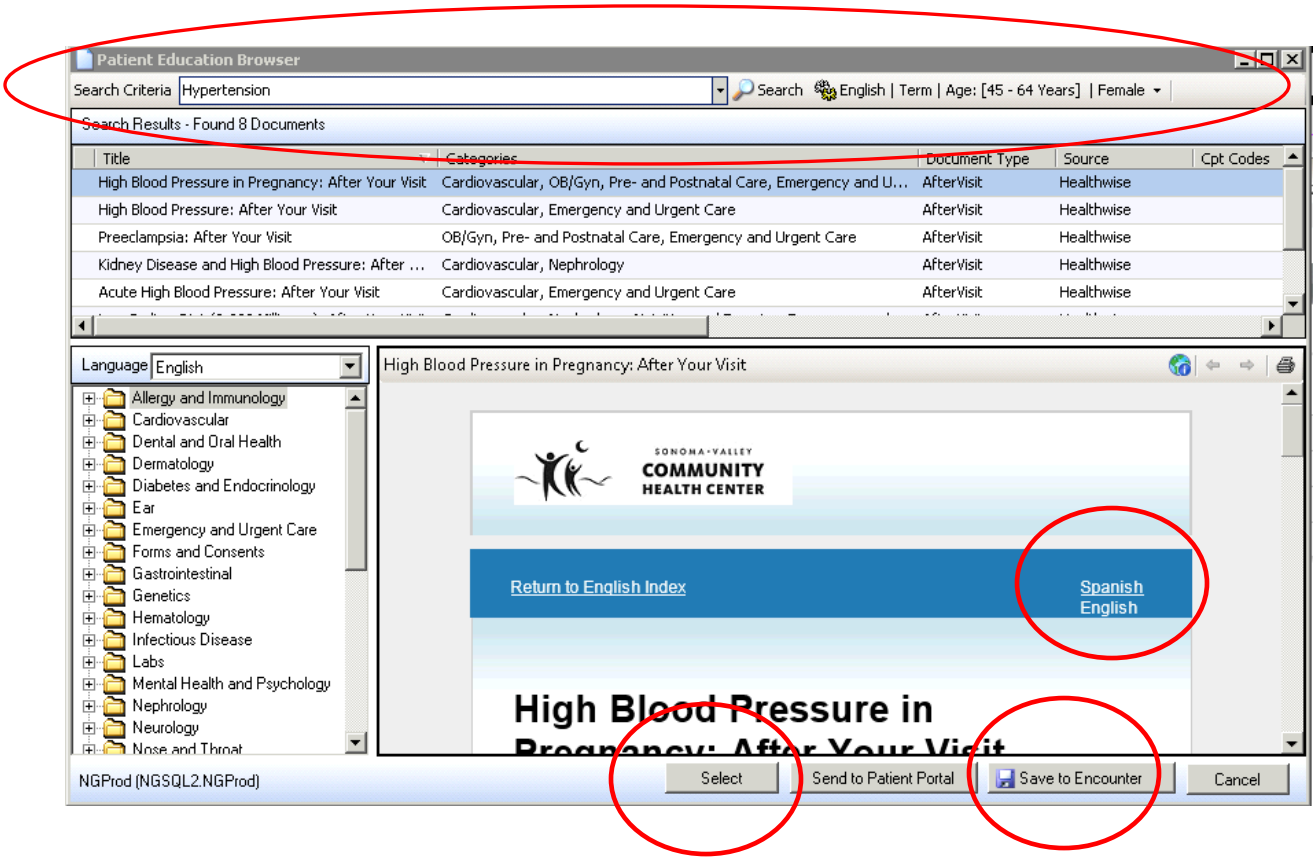
1. Go to file and review the drop down box. Find Patient Education.




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



3. For the specific search below, there were 8 documents found for the patient based on ***Search Criteria***, ***Age,*** and ***Gender***.
4. Select the document you want.
5. Please change language if appropriate.
6. 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.

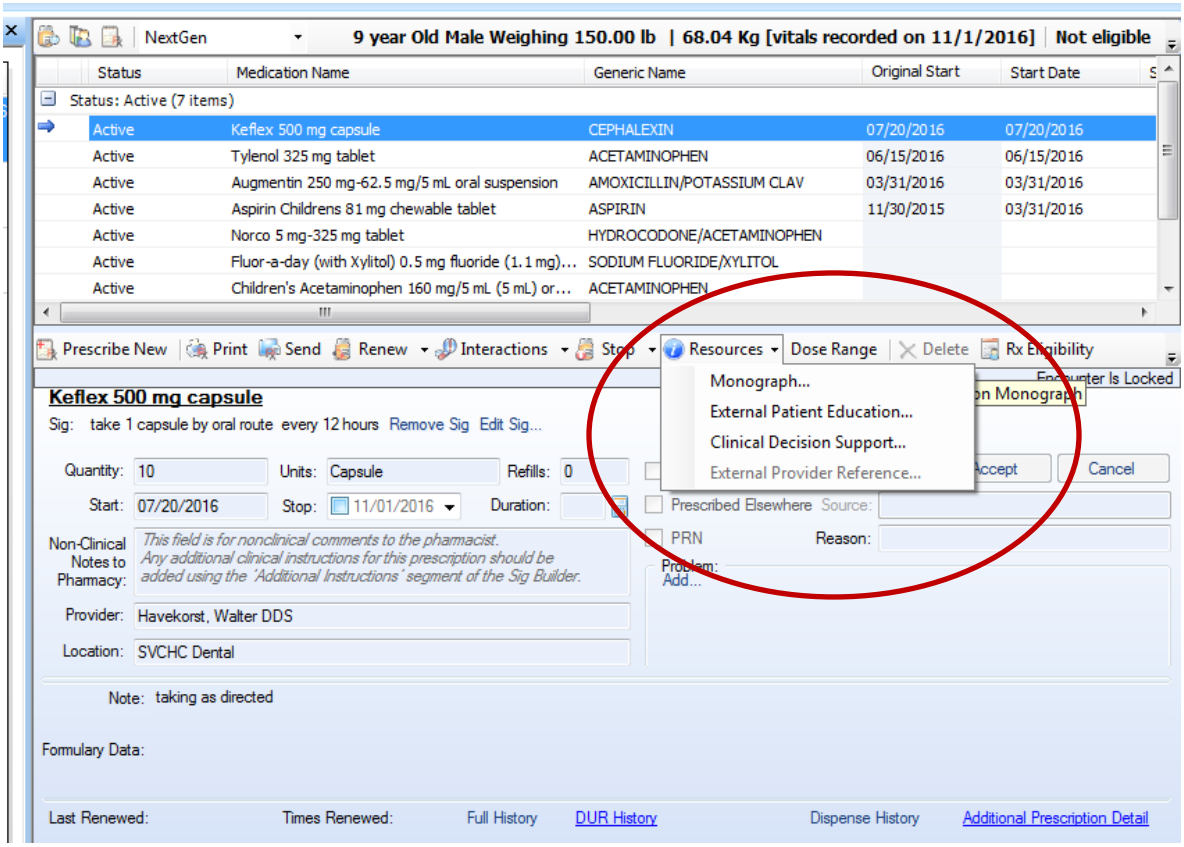
## New Medication Education

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.

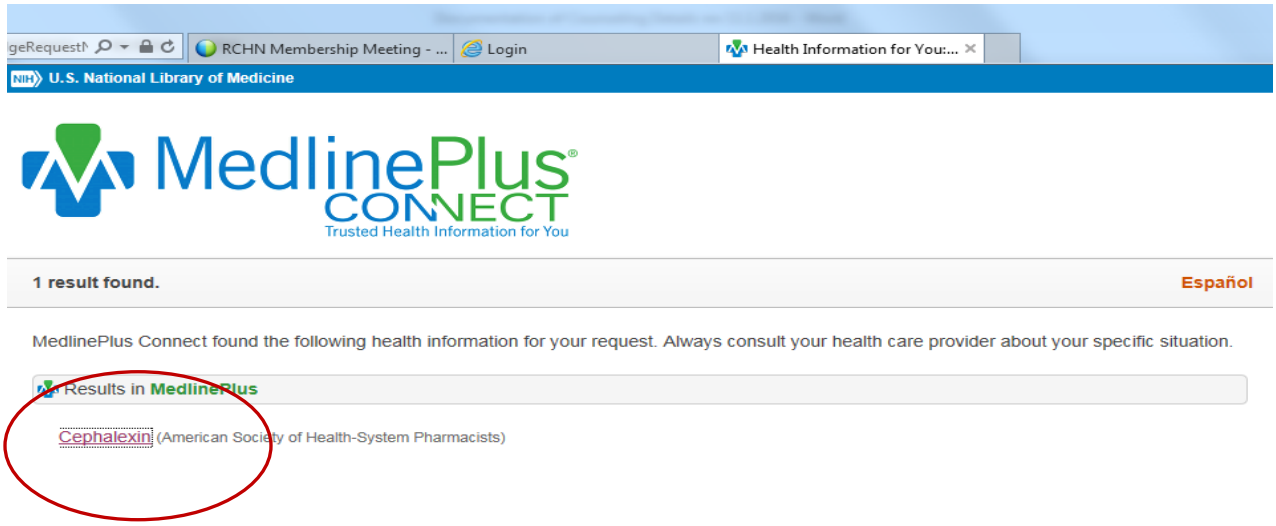
You will document this education as outlined above. The written materials for the patient, however, are located in the medication module.

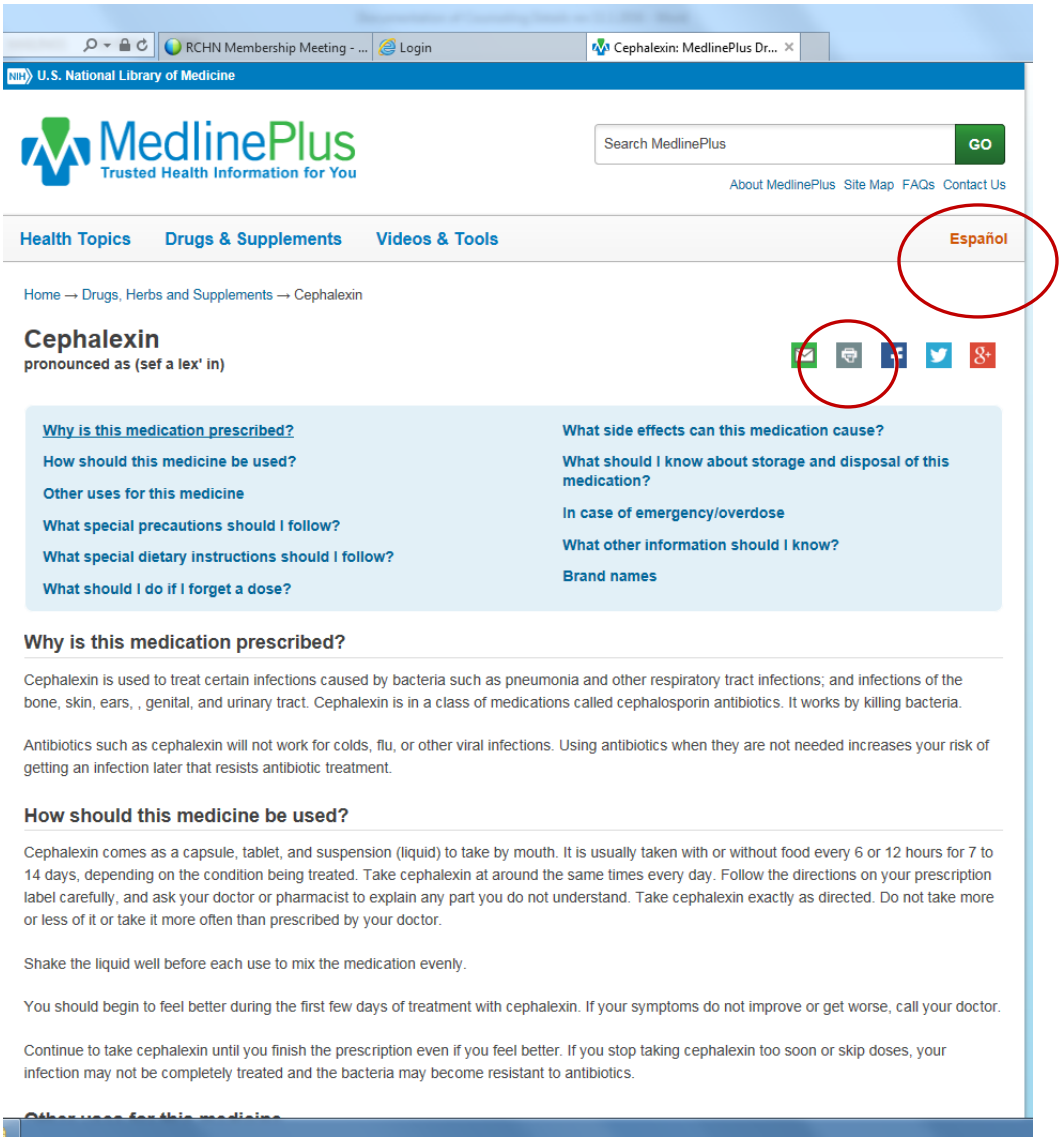
1. From the medication module and, after you have prescribed the medication, highlight the medication in question.

2. Go to Resources
3. Select External Patient Education




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.





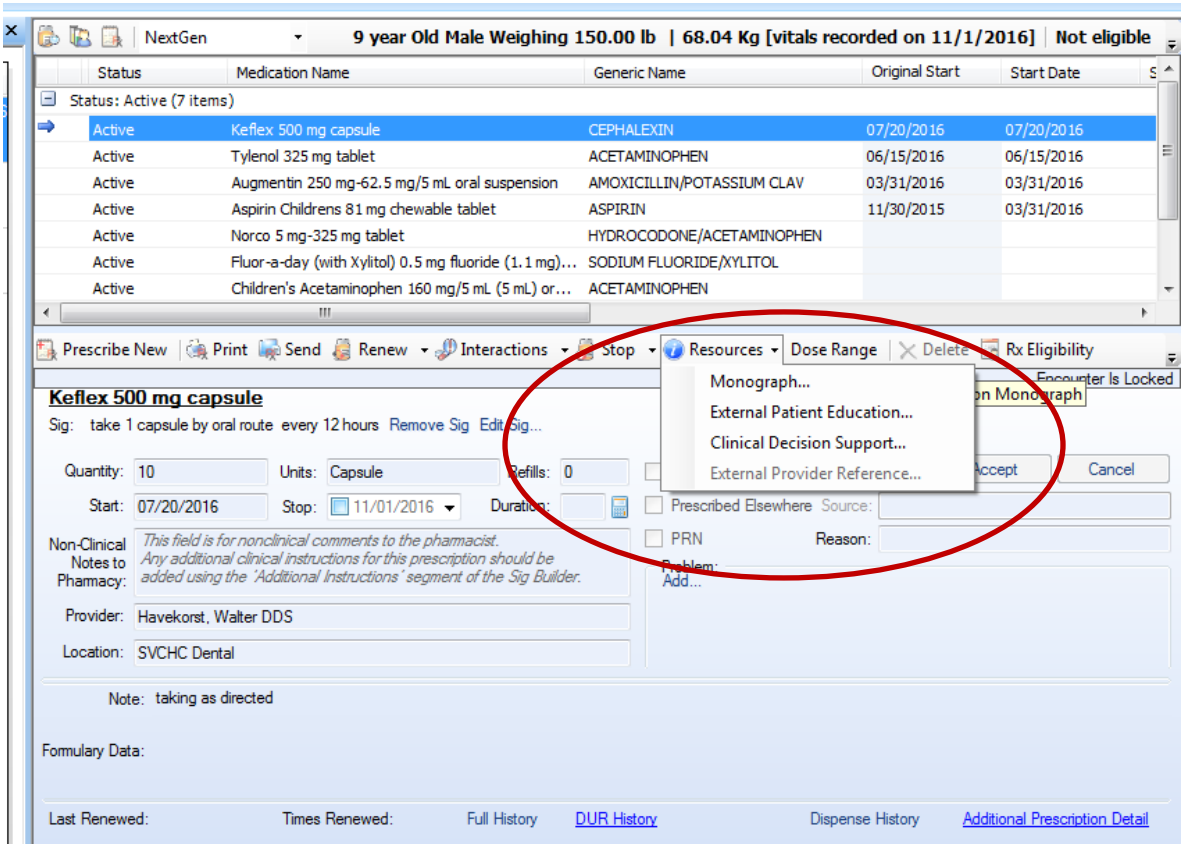

5. By clicking on the Espaňol hyperlink, this information will translate into Spanish.
6. You can print out this information by clicking on the print button.
7. Please note the following:
    a. This information **cannot** be saved into the patient chart
    b. This information **cannot** be printed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

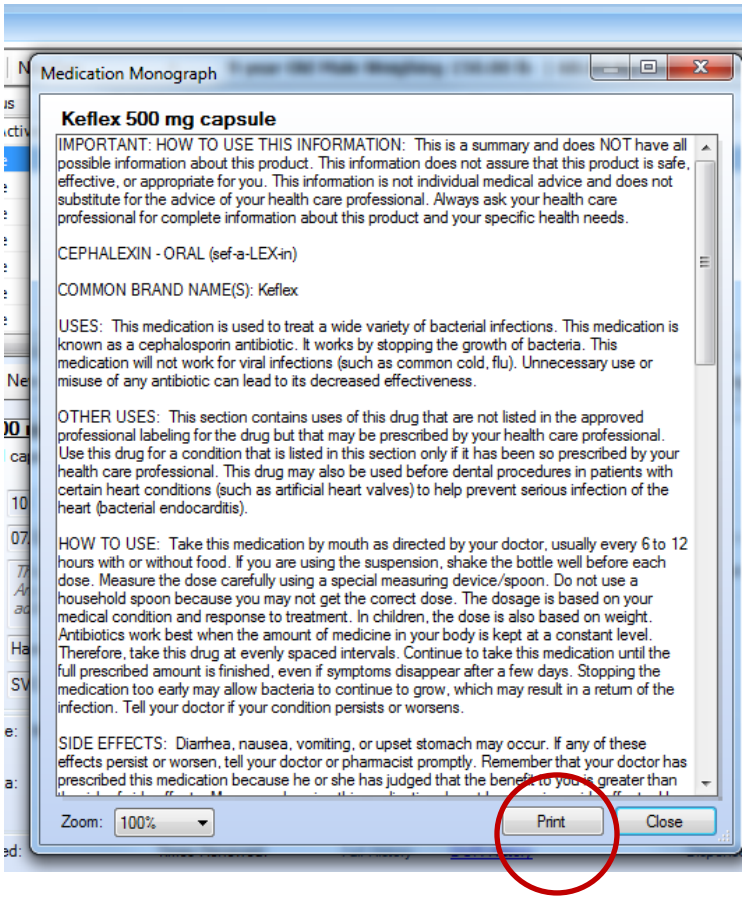
Alternately, you can use the monograph which can also be found in the medication module in NextGen, but this document is only available in English.

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

2. Go to Resources
3. Select Monograph




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




5. 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
    c. This information **cannot** be translated into Spanish.

## POLICY THIS PROCEDURE SUPPORTS:

1. 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 devised 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 18$^{th}$ 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 ( )**

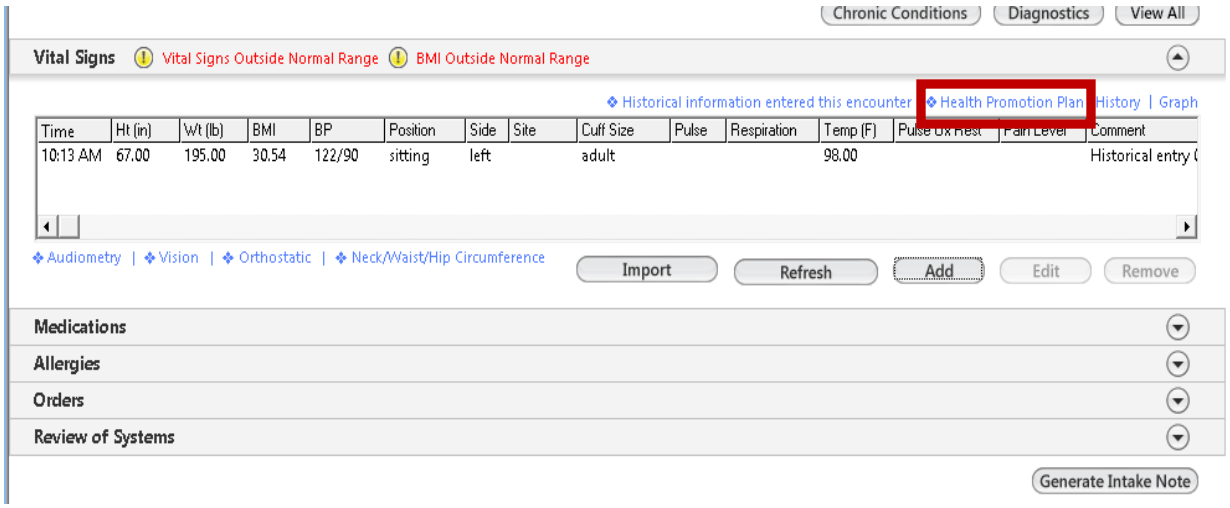
**PROCEDURES**:

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

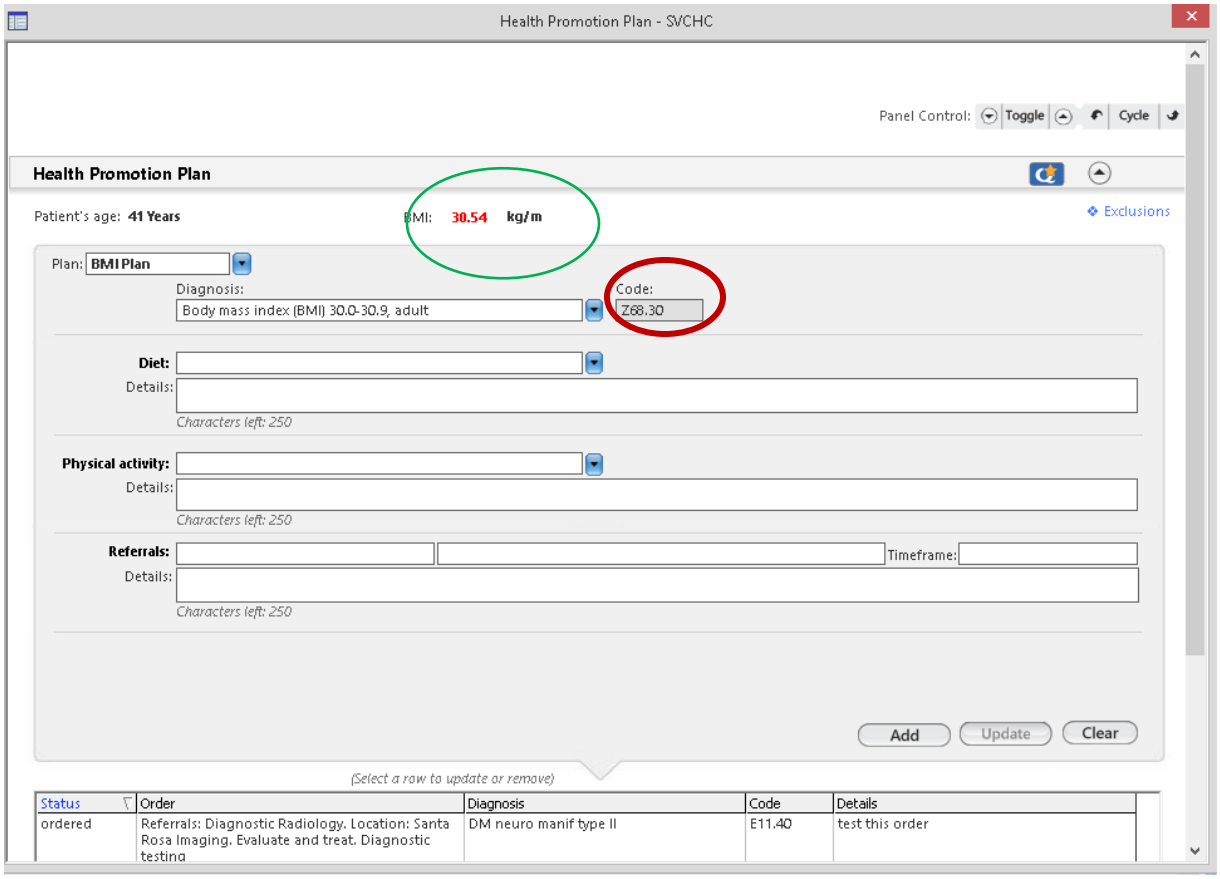
The only different is the BMI Code/ BMI Percentages

- 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.



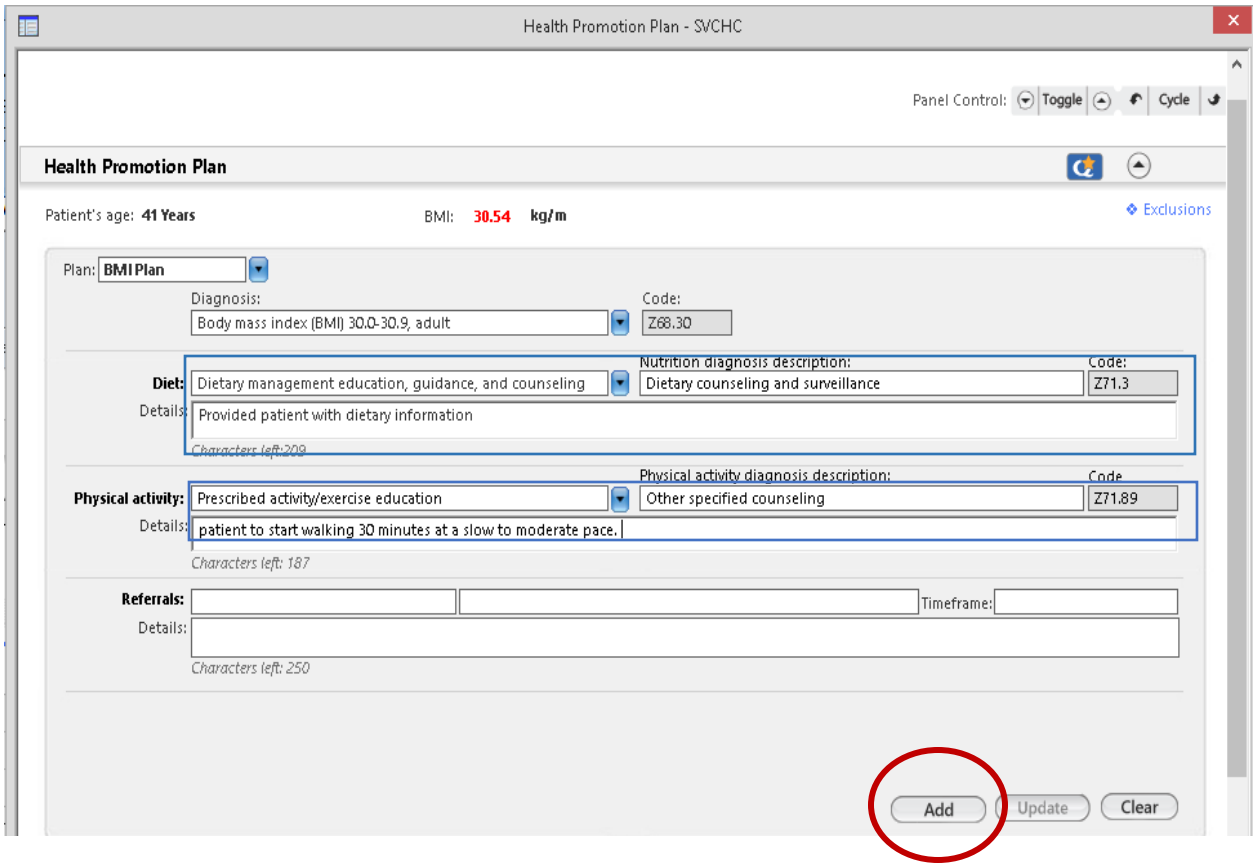

Select the **Health Promotion Plan**. Please note the BMI Plan is no longer available here.




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

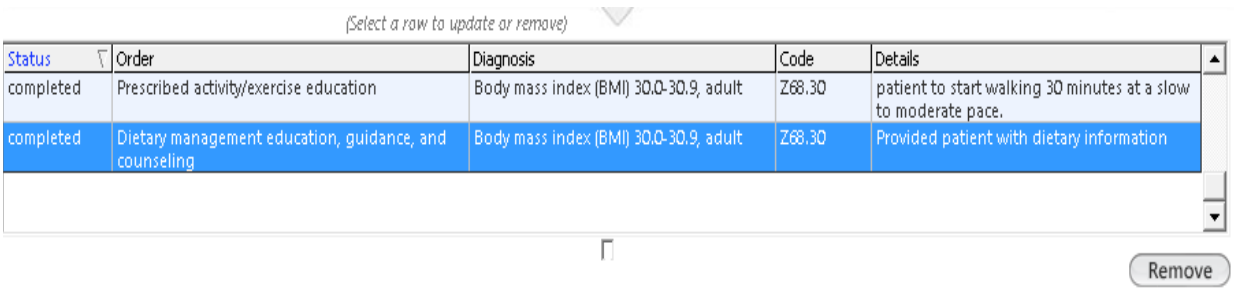
The Provider will no longer need to add each additional code individually. The provider will add Dietary Counseling and Activity Counseling as required for UDS reporting.

The screen will look as follows:

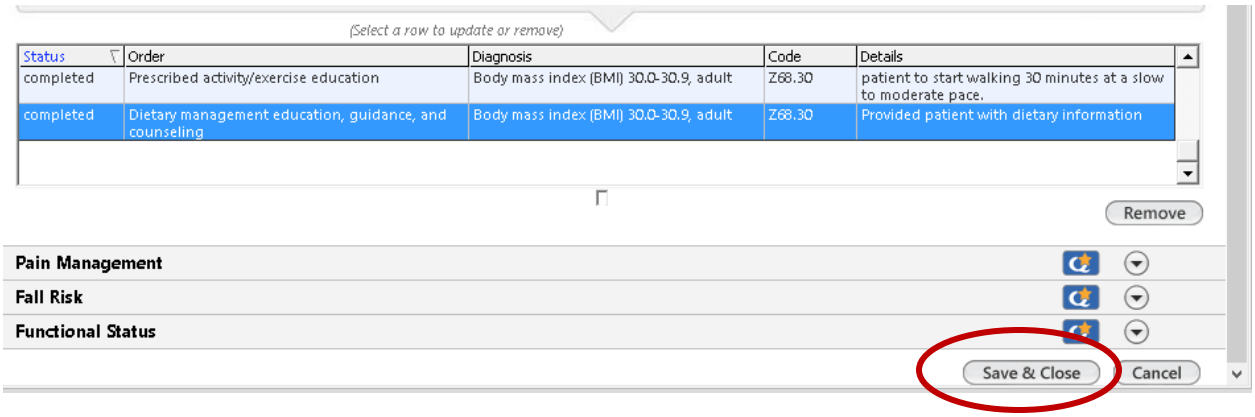



The Provider will select add and the information will fall into the grid below. The Required codes will automatically appear.

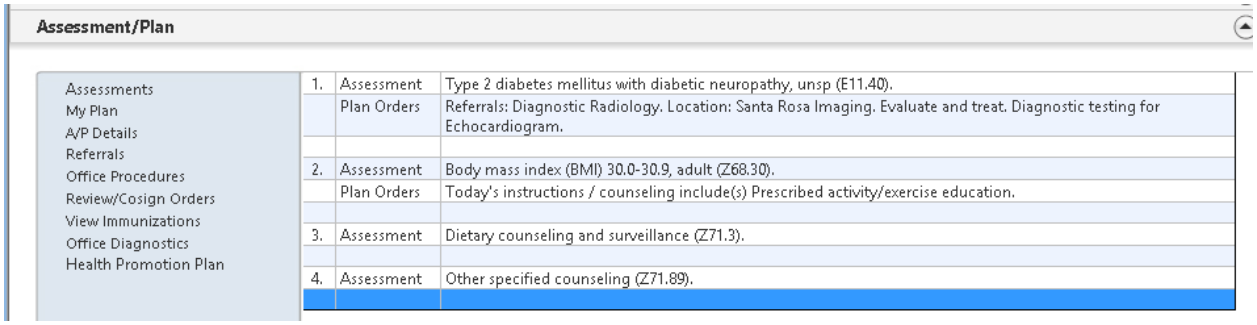
Please note that Z71.3 cannot be used without Z71.89 the correct BMI Z68.XX code. These codes as of 2017 ICD-10 Changes must all be used together for both Adults and Pediatrics. The provider will select add.



Remember to select **Save & Close**

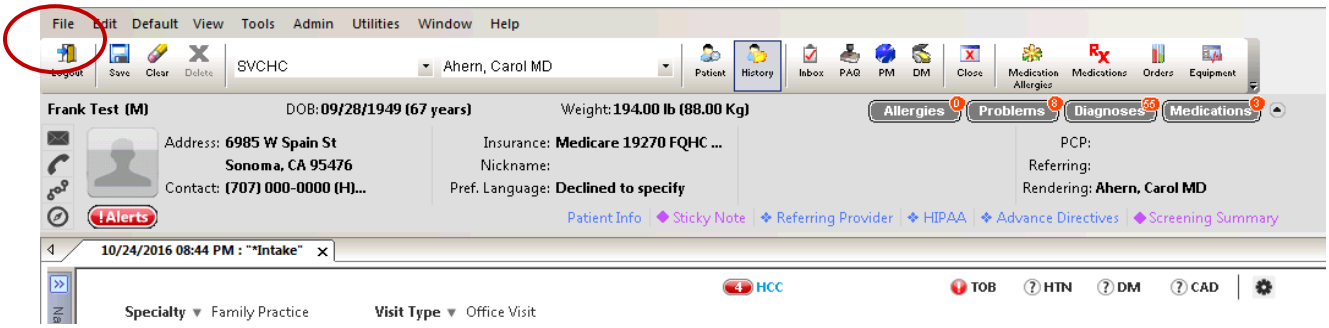


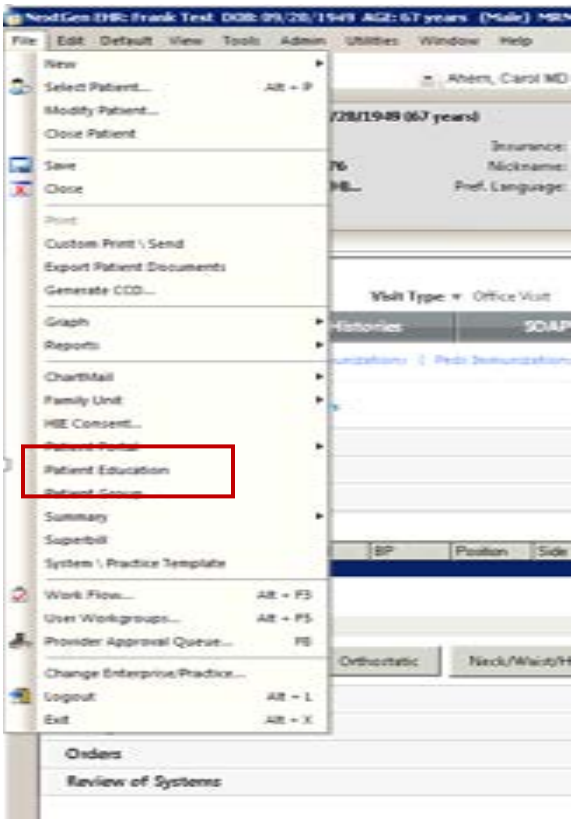

Please note that all of the additional information is under the BMI code this is for reporting. When you go to the Patient Assessment all of the Codes will show.



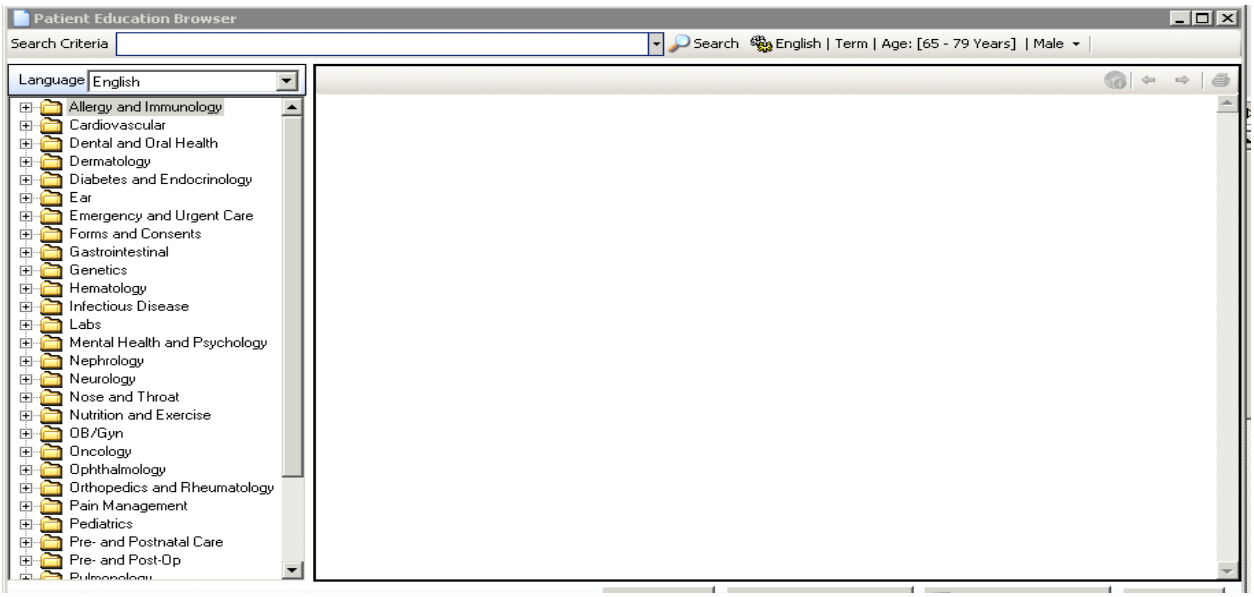

## Patient Education/ Health Wise

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.

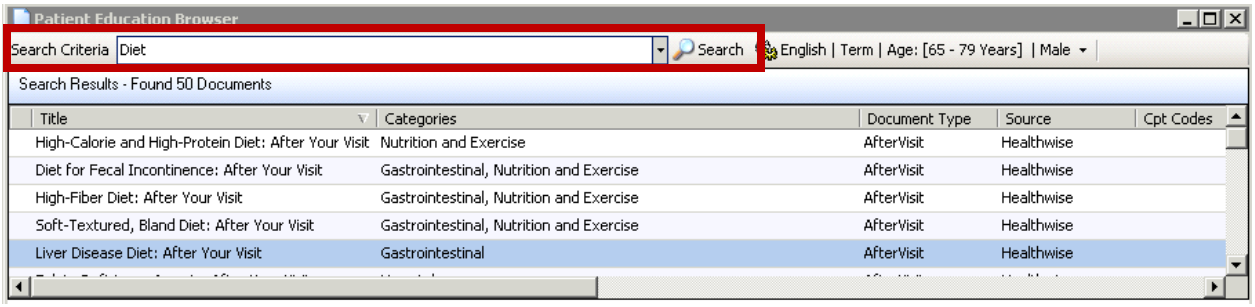


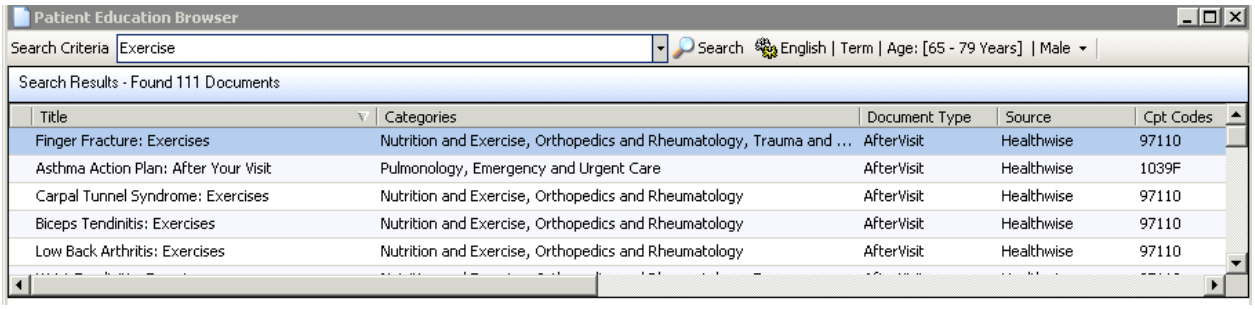


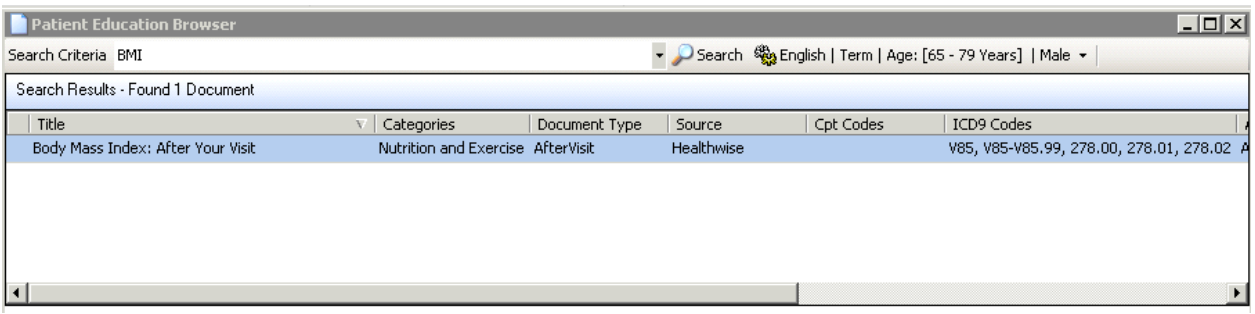

Select Patient Education from the drop down. This will take you to the Health Wise Information.



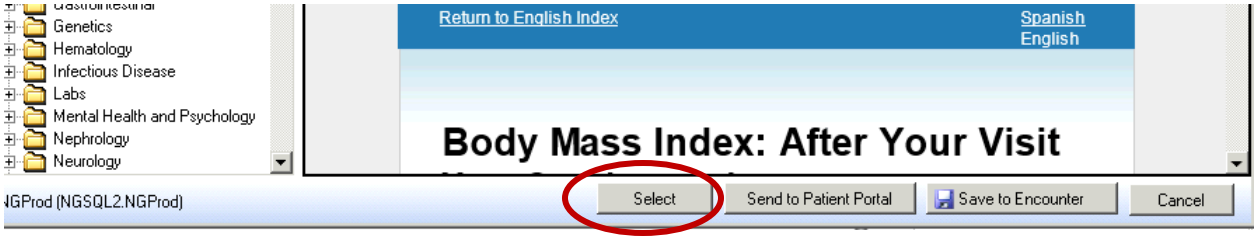
Use the **Search Criteria Box** to search for the information that you want to provide the patient. For this measure you can use Diet, Exercise, BMI or if they have a Chronic Condition that condition to search for the appropriate materials. Items are based on Age and Sex.

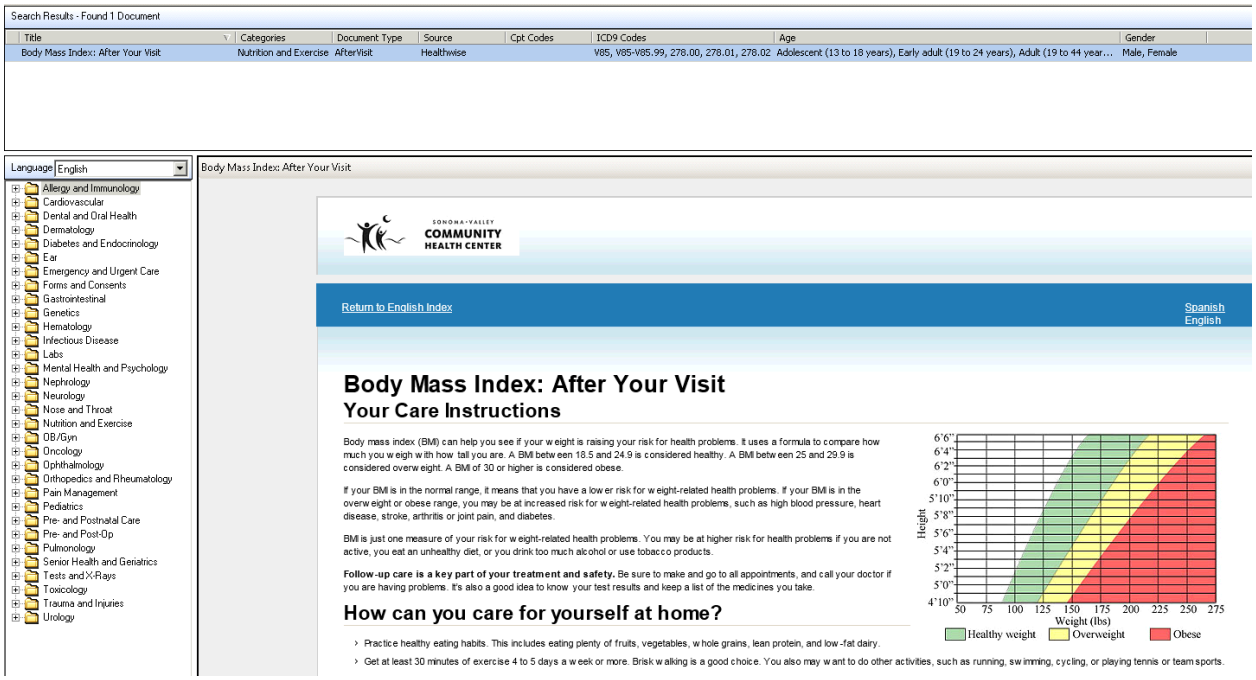


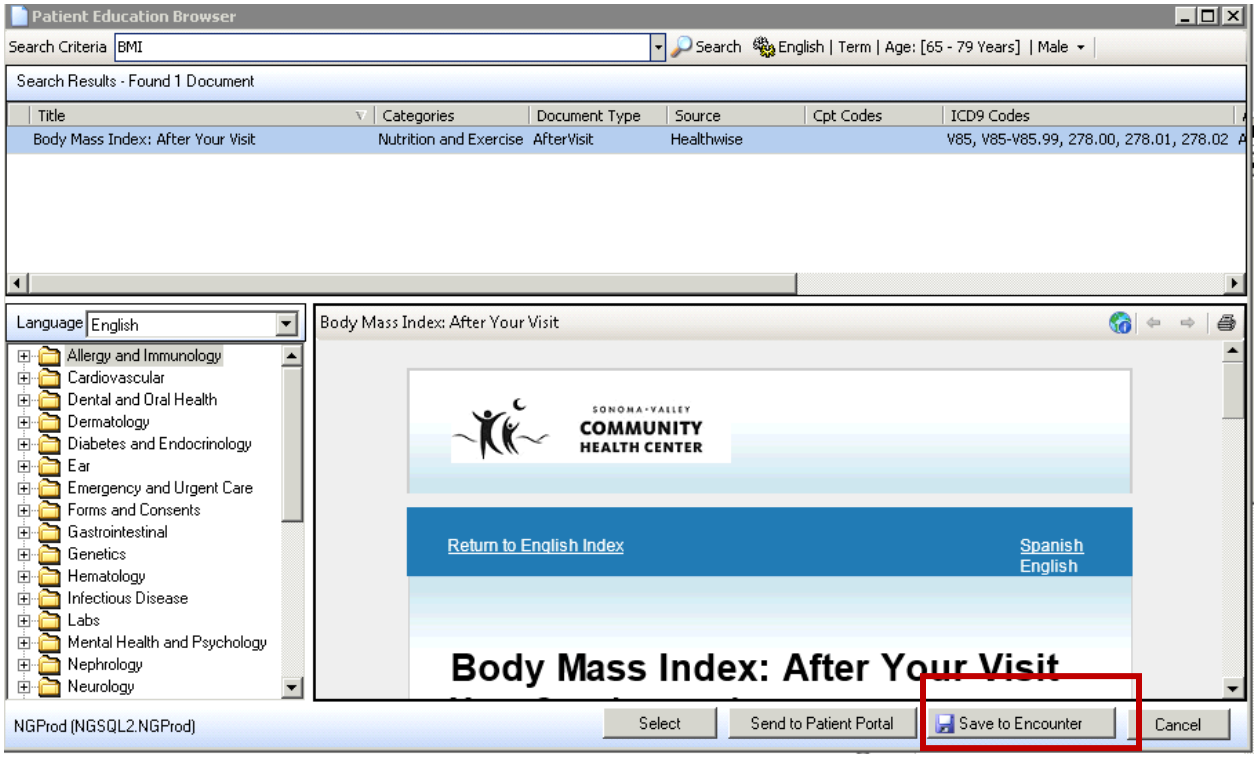



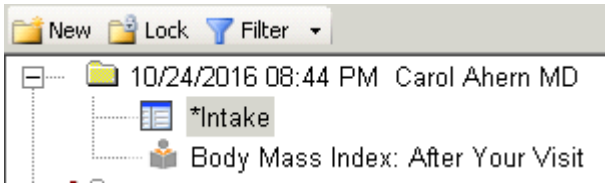

When you find the document that you want Highlight it and use the **Select** button and the document will fall in the view box for you to review with the patient.






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






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