



Adirondack Health Institute

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# Practice Transformation Workgroup December 2020

PRESENTED BY:

*Louann Villani, RN, AHI*

*Brenda Stiles, RN, Adirondacks ACO*

Dec. 17, 2020



- I. Opening/Welcome – Louann Villani;
- II. PCMH: 2021 criteria, QPASS opportunities, Tracker Grid Updates;
- III. Hixny: Data Aggregator Update/Documentation Opportunities –  
RuthAnn Craven;
- IV. Future Topics:  
Risk Coding;  
  - I. Open Forum (10 minutes).



## Reminders and Updates

- Most NYS practices submitting for this year were due to submit 12/1/20;
- Practices may have less than a year to submit for 2021 due to the 2020 submission extension;
- Anyone with a reporting date in 2021 should be reviewing the v6 and 2021 annual reporting standards and guidelines publications;
- Major changes include the ability to use telehealth to meet certain requirements and an updated QI worksheet for annual reporting.



## Evidence Reminders

- Should be from within the past 12 months and after your last submission;
- Should be redacted so that it does not include PHI;
- Should follow the rules for site-specific vs. shared.



# PCMH Tracker Updates

In response to questions regarding what to do during annual reporting, the tracker has been updated to help guide the process.

Submission is due  
a month before your  
anniversary date.



2021 PCMH Annual Review Monthly Tracker	
Practice Name:	Sample Practice
Electronic Medical Record:	EMR
Anniversary Date:	8/1/2021
Submission Due Date:	7/1/2021
<b>Instructions:</b> The purpose of this tool is to provide guidance to help you proactively prepare for the NYS PCMH Annual Review. The tool lays out a timeline for the periodic review of policies and provides a place to identify/track information needed for annual review submission. <i>*This tracker is not meant to direct when to execute actions identified within your policies. IE: If your policy states your preventive reminders go out monthly then you must complete reminders monthly not just when it is listed for review in this workbook.</i>  Keep current on NCQA standards as new guidelines come out every July, and periodically as NCQA deems necessary. New guidelines can be downloaded from <a href="http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html">http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html</a> . <b>This tracker is meant to be used in conjunction with the most recent standards and guidelines and annual reporting publications.</b>	



## PCMH Tracker Updates

A new column has been added to help practices keep track of what to do once they have obtained or updated their evidence.

Core/ NYS/ Elective	AR	Concept	Can Combine with	Description	Documented Process/ Evidence	What to do with the Documented Process/Evidence	Shared/ Site-Specific	Person Responsible
Core		TC 01		PCMH Transformation Leads	<input type="checkbox"/> Detail about Clinician Lead <input type="checkbox"/> Detail about PCMH Manager	<u>Transforming Practices</u> : Upload to QPASS or share during virtual review <u>Annual Reporting</u> : Review, update if needed, and save with audit files	Shared	

What you do with your evidence may be different for each criteria. For example, some NYS criteria will be awarded as transfer credit after you submit them for the first time, and you will simply need to save the evidence in your own files thereafter. Others, like CC21A and QI19, will need to be **submitted each year**.



# PCMH Tracker Updates

Core/ NYS/ Elective	AR	Concept	Can Combine with	Description	Documented Process/ Evidence	What to do with the Documented Process/Evidence	Shared/ Site-Specific
Core	AR-CM 1  AR-SD 1 (D only)	CM 01		Identifying Patients for Care Management	<input type="checkbox"/> Documented Process OR CM 03	<u>Transforming Practices</u> : Upload to QPASS or share during virtual review <u>Annual Reporting</u> : Review, update, and save with audit files. Answer questions in QPASS.	Shared
Core	AR-CM 1: Data	CM 02*		Monitoring Patients for Care Management	<input type="checkbox"/> Report	<u>Transforming Practices</u> : Upload to QPASS or share during virtual review <u>Annual Reporting</u> : Review, update, and save with audit files. Answer questions in QPASS and provide report numbers.	Site-Specific
NYS (2)	AR-CM 1	CM 03*		Comprehensive Risk-Stratification Process	<input type="checkbox"/> Evidence of Implementation	<u>Transforming Practices and NYS year 1</u> : Upload to QPASS or share during virtual review (Transforming only) <u>Annual Reporting</u> : Review, update, and save with audit files	Shared
Core	AR-CM 2	CM 04*		Person-Centered Care Plans	<input type="checkbox"/> RRW or <input type="checkbox"/> Report AND <input type="checkbox"/> Patient Examples	<u>Transforming Practices</u> : Upload to QPASS or share during virtual review <u>Annual Reporting</u> : Review, update, and save with audit files. Answer questions in QPASS.	Shared- Patient Examples Only



- NCQA has some resources to help you navigate QPASS
  - What's new with the Q:
    - Free;
    - ~1.5 hours;
    - Upgrades to the system have occurred since the webinar/course was first developed, but much of the functionality remains the same.
  - Ask a question feature within QPASS:
    - Use if you are experiencing technical problems;
    - Can also be used for general program and content questions.
  - QPASS Q&A sessions:
    - Held periodically by NCQA via zoom when there are updates;
    - Come prepared with questions and a basic familiarity with the system.

<https://www.ncqa.org/education-training/webinars-and-seminars/patient-centered-medical-home-pcmh/?pg=2>



# Improving Quality Scores

(EHR Documentation Tips)

**RUTHANN CRAVEN, MS, PCMH CCE**

*Manager of Programs and Outreach*

Hixny®

# NCQA DAV “Lessons Learned”



# NCQA PSV Opportunities

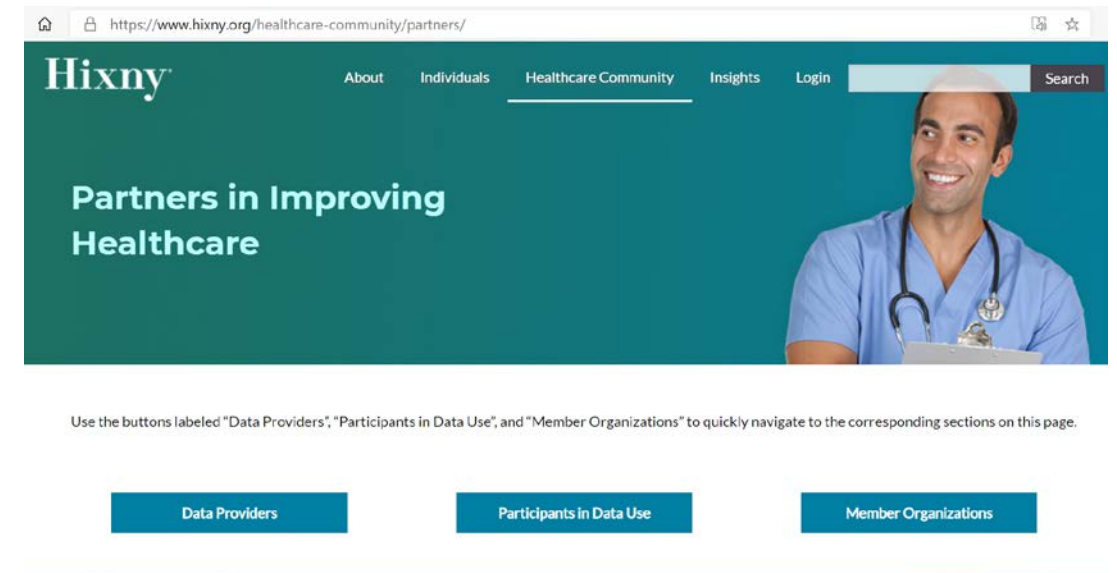
## Data Sources

- 118 Pass
- 102 Pass – Omission
- 8 Pass – Minor Error
- 14 Not Approved
- 31 Could Not Be Submitted
- 25 New Integrations (Since Validation)



# Data Contribution

- Must to connected to, and contributing data to Hixny
  - [Data Contributors](#)
  - [Participants in Data Use](#)
- CCD in C-CDA version R2.1 preferred
  - eCW upgrade
  - Athenahealth C-CDA version 1.1
  - C32 format cannot be validated



# EHR Documentation Basics

Structured Data Fields

Standard Codes

# PSV Validated Data

## Critical Data Elements – Always Reconciled

- Procedure, Assessment and / or Encounter section completed, depending on EMR and visit type
  - Procedure Code (Px) / Diagnosis Code (Dx)
  - Procedure Code (Px) / Diagnosis Code (Dx) Description
- Patient Name
- Patient DOB
- Provider Name
- Facility Name / OID
- Date of Service (DOS)

**NOTE:** All other data elements are considered non-critical

## Some Examples of Non-Critical Data Elements

- Smoking status
- Social History
- Allergies
- Medication list (not part of DAV program)

## Critical Data Elements – Reconciled When Applicable (depends on visit type)

- Admit Date
- Discharge Date
- Immunization Code / Description
- Lab Test
- Lab Results
- Blood Pressure
- Height
- Weight
- BMI



EHR at Practice / Hospital



Inbound Data (CCD or HL7) Sent to Hixny



Hixny Portal / Outbound CCD

# EHR Documentation



# Lab Results



- LOINC® codes rather than “local” codes
  - [LOINC®](#) (Logical Observation Identifiers Names and Codes) is a set of universal names and ID codes for identifying laboratory tests in electronic laboratory report messages.
  - It was designed to facilitate the exchange and correlation of results for clinical care, outcomes management, and research.
- Medent “Laboratory test code finding” not specific enough
- For medical record documentation submitted for PSV, include lab results if discussed with the patient on the date of service
  - if not in progress note, include screenshots from EHR – CCDs are NOT accepted as medical record documentation



# Vital Signs

- LOINC® codes rather than “local” codes
- Pull vitals into the CCD (for example, if a nurse rooms the patient and records vitals – how do they get into the CCD?)
  - Medent – pull nurse note into the progress note
- For medical record requests for PSV, provide documentation for ALL vital signs for the date(s) of the encounter



# Diagnoses

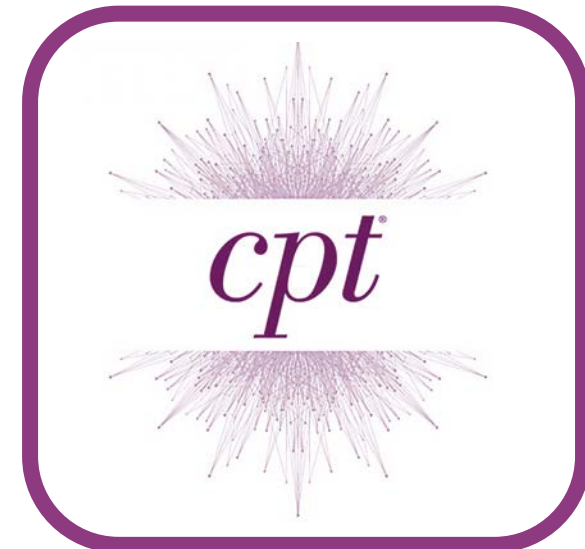
- [ICD10](#) (or [SNOMED](#)) codes and descriptions
- Diagnoses must be included in the CCD as either a) encounter diagnoses or b) problems
  - Medent assessments should be added to problem list

Acute conditions should be marked as “resolved” at a subsequent visit

- past illness vs. present illness; acute vs. chronic conditions
- All diagnoses included on CCD must also appear on progress note provided as medical record documentation for PSV
- Looking ahead: consider use of Z-codes for **social determinants of health**
  - Z59.0 Homelessness
  - Z59.4 Lack of food & safe drinking water

# Procedures

- [CPT](#) codes and descriptions
- Looking ahead: consider documenting **psycho social screenings** as procedures
  - [AIMS Center Basic Coding for Integrated Behavioral Health Care](#)
  - [CDPHP’s 2020 Effectiveness Tool for Providers](#)



# Smoking Status

## What should be included in a tobacco cessation EHR template?

Including tobacco use status as a vital sign provides an opportunity for office staff to begin the process. Status can be documented as:

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked

A complementary field can document secondhand smoke exposure: current, former, or never, and work, home, or social.

- Do not use default of “Unknown” (PointClickCare)
- Update status in progress note as applicable
- Record one status at a time (Medent – multiple statuses appearing)

# Medical Record Documentation

**John Smith**, 56 Y, Male, DOB: 4/13/1956, Acc. No: 503885

HE: (212) 509-8200  
Email: john.smith@yahoo.com

Allergy: NKDA

Primary Plan: Empire BCBS  
Plan Balance: \$ 540.00  
Patient Balance: \$0.00

Provider Notes | H&P Note | Attachments (1)

Save | Letters | Print | Fax | Email | Review | eSuperbill | Assign | Upload | Scan

Voice Record | Delete

Ariel

Mr. John Smith is a 56 years old Male with the following history

**Subjective**

**Family History:**  
Angina Pectoris (Mother)  
Alcohol Dependence (Father - Age at Onset: 61 years)

**Medical History:**  
Hepatitis A Inactive

**Objective**

**Vitals:**  
Wt: 155 lbs, Ht: 6', BSA: 1.91 m sq., BMI: 21.02kg/m sq., Obesity Scale: Normal Weight, Lean body Weight: 128.77lbs, Ideal body Weight: 171.00lbs, Temp: 98.60 F, Pulse: 80, Resp: 20 breaths/min, BP: 120/80  
Recorded on Wednesday, Dec 21, 2011 at 9:16 AM by John Smith

**Assessment and Plan**

**Diagnoses:**  
Established  
TYPHOID FEVER (ICD-002.0)  
CHRONIC INTESTINAL AMEBIASIS WITHOUT ABSCESS (ICD-008.1)

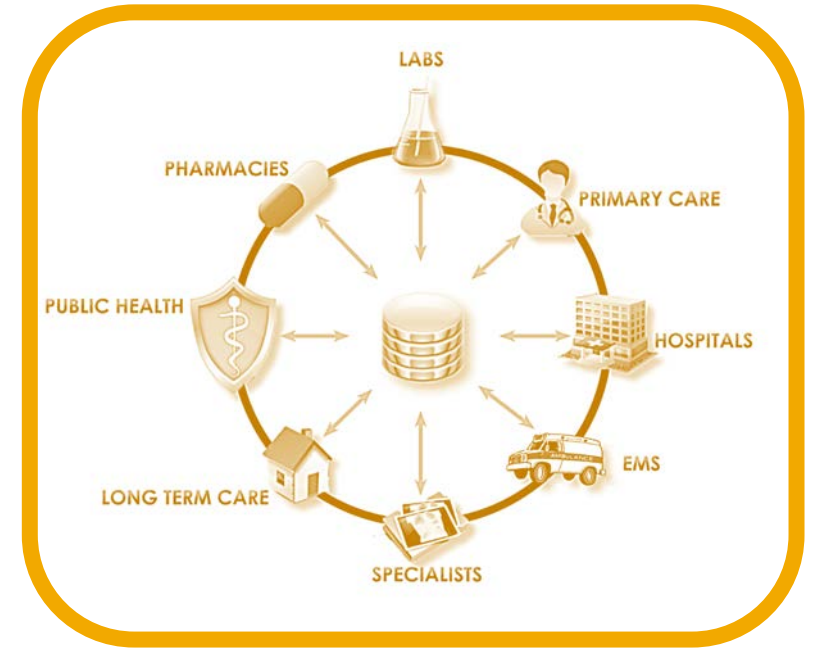
**Active Medication:**  
Amoxicillin Cap 500mg: 1 Tablet(s) QID/PRN PO-Orally, Start 02/07/2008, Qty 15 Tablet(s) Refill 2, DAW  
Follow Up in 5 days with Dr. Kelly Smith

# Progress Notes

- Practice name & address on progress note
- Provider e-signature matches CCD
- Medent family accounts
- Telehealth
  - Telehealth visits require both audio and visual
  - If vitals are self-reported by patient, progress note must indicate that
  - Rx renewal requires documentation, including appropriate diagnosis

The screenshot shows the eClinicalWorks EHR interface. The top navigation bar includes links for File, Patient, Schedule, EHR, Billing, Reports, CCD, Fax, ePayments, Tools, Community, Meaningful Use, Lock, and Help. The left sidebar contains icons for Admin, Practice, Resource Scheduler, DATA ENTRY/HISTORY, and a list of providers including Gandoff, Roy J, Hindle, Michael, Jackson, Easton D, Nelson, David C, and Pennington, Mar. The main content area displays a progress note for a patient named TEMPLATE, URGENTCARE. The patient information section includes a photo of a stethoscope, the patient's name, age (26 Y old Male), DOB (02/29/1990), Account Number (635667), address (3743 WEST 4100 SOUTH, WEST VALLEY CITY, UT 84149), phone number (Home: 801 963 3500), insurance (Guarantor: TEMPLATE, URGENTCARE Insurance: Self Pay), and appointment facility (Granger Medical WV). The progress note is dated 05/25/2016 and is signed by Easton D Jackson, MD. The note includes sections for Current Medications (None), Surgical History (appendectomy, back surgery, knee arthroscopy, tonsillectomy), Reason for Appointment (Sore throat), and History of Present Illness (Sore throat visit. The patient complains of Sore throat. The symptoms have been present for 2 days).

# Sharing Care Plans



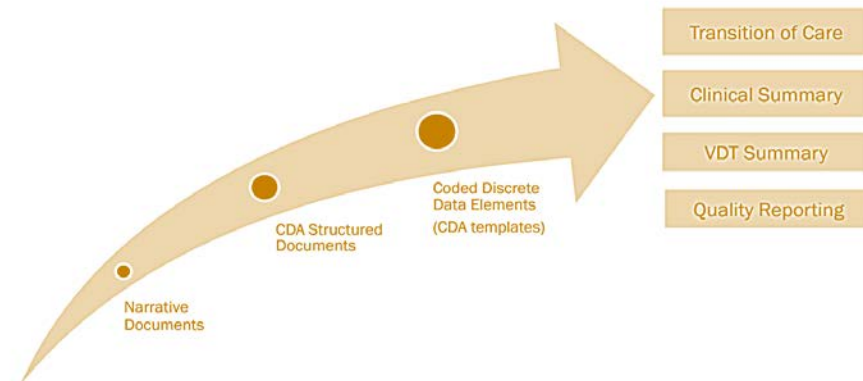
# Practices Send Data to Hixny Two Ways

## ■ Continuity of Care Document (CCD)

- HL7 Clinical Document Architecture (C-CDA) standard
- Core data set of the most relevant information for one healthcare practitioner to forward to another practitioner to support continuity of care
- Provides a “snapshot in time” containing clinical and demographic data for a specific patient

## ■ Unstructured Documents

- Progress notes
- Nurse notes
- Clinical visit summaries
- Care plans





# Practices Send Data to Hixny Two Ways

The screenshot displays the Hixny patient portal interface for a patient named Bill Brucker. The top navigation bar includes links for HealthShare Management, Administration Portal, Patient Search, View Summary, Send Summary, Download Summary, Messages (493), Subscriptions, My Account, Reports, eConsent Support, My Account, Switch User/Go To Dashboard, and Logout. The patient's name, BRUCKER, BILL, and date of birth, 07/04/1928, are shown. The left sidebar lists various patient record sections, with 'Documents' highlighted. The main content area is divided into several sections: Patient Record Snapshot, Allergies & Alerts, History, Documents (highlighted), Lab Results, Pathology Results, Radiology Results, Medications, Vaccinations, Conditions, Procedures, Physical Exams, Encounters, Appointments, Programs, and Pharmacy. The 'Documents' section lists several procedure notes and a discharge summary, including 'Consolidated CCDA R2.1 Structur...', 'Procedure Note 02-19-2020 AllScripts ProEHR', 'Procedure Note 09-20-2019 Saratoga Hospital', 'Procedure Note 09-10-2019 Saratoga Hospital', 'Procedure Note 09-10-2019 Saratoga Hospital', 'Procedure Note 09-03-2019 Saratoga Hospital', 'Procedure Note 07-18-2019 Saratoga Hospital', and 'DischargeSummary 08-09-2018 Albany Medical Center'.

- Some structured data from the CCD parses to various tabs of the portal (eg, problems, diagnoses, medications, lab results, etc.) or is integrated into your practice EHR.
- Care plans are unstructured and only available as documents – either the CCD or a separate unstructured document.

# CCDs and Unstructured Documents

Patient Record Snapshot	<b>Documents</b>					
Allergies & Alerts	<b>Document</b>	<b>Details</b>	<b>▲ Clinician</b>	<b>▲ Doc Type</b>	<b>▼ Activity Date</b>	<b>▲ Entered At</b>
History	transthoracic ECHO				12/09/2020 09:42	<a href="#">Download</a>
<b>Documents</b>	transthoracic ECHO			Consolidated CDA R2.1 Unstructured Document	10/30/2020 00:00	<a href="#">Download</a>
Lab Results	ED Provider Report			Emergency Department Report	10/07/2020 11:05	<a href="#">Download</a>
Pathology Results	ED Nurse Report			Nurse Note	10/07/2020 11:05	<a href="#">Download</a>
Radiology Results	Continuity of Care Document (CCD)			Continuity of Care Document (CCD)	01/27/2020 08:17	<a href="#">Download</a>
Medications	CHOLESTEROL RECHECK			Medical Summaries (XDS-MS)	01/20/2020 19:00	<a href="#">Download</a>
Vaccinations	CHOLESTEROL RECHECK, HTN RECHE			Medical Summaries (XDS-MS)	10/06/2019 20:00	<a href="#">Download</a>
Conditions	CHOLESTEROL RECHECK, HTN RECHE			Medical Summaries (XDS-MS)	10/06/2019 20:00	<a href="#">Download</a>
Procedures	CHOLESTEROL RECHECK			Medical Summaries (XDS-MS)	07/07/2019 20:00	<a href="#">Download</a>
Physical Exams	SUTURE REMOVAL-PLACED HERE			Medical Summaries (XDS-MS)	04/14/2019 20:00	<a href="#">Download</a>
Encounters	.ANNUAL PE MALE			Medical Summaries (XDS-MS)	03/31/2019 20:00	<a href="#">Download</a>
Appointments	CHOLESTEROL RECHECK			Medical Summaries (XDS-MS)	11/11/2018 19:00	<a href="#">Download</a>
Programs	Followup: CHOLESTEROL RECHECK,			Medical Summaries (XDS-MS)	08/12/2018 20:00	<a href="#">Download</a>
	Followup: CHOLESTEROL RECHECK,			Medical Summaries (XDS-MS)	05/13/2018 20:00	<a href="#">Download</a>
<b>Patient Entered Data</b>						
	<b>Document</b>	<b>Details</b>	<b>▲ Clinician</b>	<b>▲ Doc Type</b>	<b>▼ Activity Date</b>	<b>▲ Entered At</b>

# Care Plans in CCDs

- Update template & set preferences - contact your EHR vendor

**Create clinical document**

PATIENT NAME: Hannah Patient  
SEX: F  
DOB: 01/04/1986

DOCUMENT TYPE: Continuity of care document

SECTIONS TO INCLUDE [Unselect all](#)

<input checked="" type="checkbox"/> Allergies	<input checked="" type="checkbox"/> Immunizations	<input checked="" type="checkbox"/> Referrals
<input checked="" type="checkbox"/> Assessment & Plan	<input checked="" type="checkbox"/> Medical Equipment	<input checked="" type="checkbox"/> Results (Labs)
<input checked="" type="checkbox"/> Encounters	<input checked="" type="checkbox"/> Medications	<input checked="" type="checkbox"/> Social History
<input checked="" type="checkbox"/> Functional Status	<input checked="" type="checkbox"/> Mental (Cognitive) Status	<input checked="" type="checkbox"/> Vital Signs
<input checked="" type="checkbox"/> Goals	<input checked="" type="checkbox"/> Diagnoses	<input checked="" type="checkbox"/> Clinical Notes
<input checked="" type="checkbox"/> Health Concerns	<input checked="" type="checkbox"/> Procedures	

The patient's records will be exported into a continuity of care document which can be used to share the patient's chart with other providers. The export process can take a few minutes to complete. Once it is complete you can download the generated export file from the patient's timeline under "Exported patient records".

**Create**

Greenway CCD template preferences

**Care Plan Package Detail Setup (Documents)**

Start Dx: E08.00 End Dx: E08.9

Doctor: ☒ Cutterbuck, George T, M.D.

Package: Diabetes Plan Package

Documents: Pat Edu, Meds, Labs, X-rays, Orders, Therapy, Referral, Triage, Todo

Recom, Inst, Goals, GrChart, CPT, Immun/Inj

Code, Name, User, Status, Print

☐ Enter Document Distribution Screen

Medent care plan package preferences

# Example: Care Plan in CCD

## Goals Section

Goal	Start Date
Move out of the city of Albany	November 08, 2019
Support member in achieving the goals and objectives to reach overall health	September 05, 2019
Attend scheduled medical appointments	September 05, 2019
Take medications as prescribed	September 05, 2019
Keep chemical dependency service appointments/attend program as scheduled	June 25, 2019
Take medications as prescribed	June 25, 2019
Call doctor or care coordinator when symptoms return, flare up, or I feel worse	June 25, 2019
Keep mental health appointments/attend program as scheduled	June 25, 2019
Care Coordinator will provide assistance to member around identified needs	June 25, 2019

## Interventions Section

Planned Intervention	Status	Date
Work with HATAS to find new apartment	Active	November 08, 2019
Update CC on status of applications for apartments	Active	September 30, 2020
Request assistance from CC as needed with apartment applications	Active	September 30, 2020
Identify resources and link member with community supports	Active	September 05, 2019
assist and coordinate with any discharge planning	Active	September 05, 2019
coordinate and collaborate with care team and providers, as needed	Active	September 05, 2019
assist member in meeting needs that are unmet	Active	September 05, 2019
Request assistance from Care Coordinator if needed to schedule appointments	Active	September 05, 2019
Be sure to get all testing done prior to next appointment	Active	September 05, 2019
Prepare a list of questions and concerns prior to your appointment.	Active	September 05, 2019
Notify your Care Coordinator on the outcome of your appointment and when a follow up is scheduled .	Active	September 05, 2019
Be sure to get all ordered labs done prior to your next appointment.	Active	September 05, 2019
Request automatic refills from pharmacy	Active	September 05, 2019
Know your triggers	Active	June 25, 2019
Request assistance from Care Coordinator if needed to schedule appointments	Active	June 25, 2019
Arrange transportation in advance, if you need assistance contact your Care Coordinator	Active	June 25, 2019
Prepare a list of questions and concerns prior to your appointment.	Active	June 25, 2019
Review medications with Care Manager. ( ask about medication reconciliation)	Active	June 25, 2019
Request refill reminders form pharmacy.	Active	June 25, 2019
Know signs and symptoms of your chronic condition.	Active	June 25, 2019

Completed Intervention	Status	Date
Arrange transportation in advance, if you need assistance contact your Care Coordinator	Completed	March 27, 2020
Review medications with Care Manager. ( ask about medication reconciliation)	Completed	March 27, 2020
Request refill reminders form pharmacy.	Completed	March 27, 2020
complete plan of care	Completed	February 07, 2020
Care Coor will arrange transport	Completed	February 07, 2020

## Health Status Evaluations/Outcomes Section

Item	Outcome	Date
Take medications as prescribed	Completed	March 27, 2020





# Examples: Care Plan in Progress Note

**Assessment #1:** I25.10 Atherosclerotic heart disease of native coronary artery with

**Care Plan:**

**Comments:** Right now he appears to be stable he follows up with Dr. [redacted] will be seeing him in September will be having blood work at that time as well.

**Follow Up:** 6 months.

**Assessment #2:** E78.5 Hyperlipidemia, unspecified

**Care Plan:**

**Comments:** Pt is going to get blood work for Dr. [redacted] and continue on his atorvastatin 80 mg per day

**Assessment #3:** N40.0 Benign prostatic hyperplasia without lower urinary tract sym

**Care Plan:**

**Comments:** Patient has annual visits with his urologist, but he is not currently taking any medication for it at this time. He seems to avoid adequately.

**Assessment #4:** M48.00 Spinal stenosis, site unspecified

**Care Plan:**

**Comments:** Patient no longer is followed by Dr. [redacted] and he would not continue to prescribe the diclofenac for him so I did order it for him, 75 mg once a day but he only takes it on occasion when he gets a flare and doesn't use it on any routine basis.

The screenshot shows the PCC EHR interface for a patient named Pebbles Flintstone, PCC# 3336. The patient is 10 years, 1 month old, and was born on 1/07/04. The chart is for a 'Sick - (client v. I)' visit on 02/18/14. The left sidebar contains a menu with options like Medical Summary, Demographics, History, Prescriptions, and a 'Visit: 02/18/14' section with sub-options like Appointment Details, Chief Complaint, HPI, Past/Soc/Fam Hx, Review of Systems, Physical Exam, Lab, Diagnoses, Plan, and Immunizations. The main content area shows the 'Chief Complaint' as 'Asthma Recheck'. Below this is the 'Care Plan (Chart-wide)' section, which is highlighted with a red box. The Care Plan section includes a date of 02/13/14, a status of 'Active', and sections for Goals (Asthma Action Plan), Actions (Management of compliance with medication regimen, Asthma management), Next Steps (Pebbles was shown at her last visit how to use her inhaler...), Care Coordination Notes (internal use) (Pebbles has done very well being compliant...), and Team Members. At the bottom of the Care Plan section, it says 'Created by Douglas Beagley 02/13/14 10:42am' and 'Mark as Reviewed'. Below the Care Plan section is the 'Medications' section, which is currently empty. At the bottom of the interface are buttons for 'Previous', 'Next', 'Bill', 'Sign', 'Close', 'Save', and 'Save + Exit'. A red arrow points from the text below to the 'Mark as Reviewed' button.

If you add the Care Plan component to chart notes, you can review, update, print, and mark interventions as reviewed during a visit

# Example: Care Plan in Nurse Note

## Forest Family Practice – Nurse Note

Patient: **Samson Smith** Gender: **M** DOB: **11/14/1954** Acct. # **8765**

PCP: **Doctor Primary, MD**

Nurse Note: **3 Month Follow Up Call w Patient in Care Management**

AAFP Risk: **5**

Hospital Utilization in Past 6 Months: **No admissions; 2 ED visits**

Do you have any issues with getting to and from your doctor's appointments? ☒ No ☐ Yes

If "Yes" was selected, please select this button and check all that apply:

Date: 02/19/2020

Was the patient queried about smoking behavior? ☒ Yes ☐ No

**Does the patient currently smoke? Smoking:** Patient is a current smoker, smokes some days.

Nurse note completed by: **Jane Nurse, RN, CCM**

**Chronic conditions:** coronary artery disease & hypercholesterolemia

### Progress on Goals:

- Patient following low fat/low sodium diet, and walking routinely (joined a mall walking group 2x/week in winter; discussed this is only 120 min/week whereas goal is 150 min/week).
- Patient reports weight of 194 lbs. (up 2 lbs.)
- Patient not willing to consider smoking cessation at this time.
- Continuing to take statins; has adequate refills and no problem affording medication. Rx are delivered to home due to COVID pandemic.
- Lab results from 01/15/20 at Community Hospital: Total cholesterol 257 mg/dl (down from 263 mg/dl); LDL 143 mg/dl; HDL 38 mg/dl; Triglycerides 163 mg/dl
- Schedule next follow up call for 05/19/20.





**Thank You**

Hixny®





## 2021 Topics: Looking Ahead

- Risk coding
- Suggestions ?????





## Additional Resources

- AHI website: <https://ahihealth.org/>
  - \*Recordings and slides from meeting are posted on the site.
- AHI COVID newsletter – Mondays
- AHInformer newsletter – every other Thursday
- ADK ACO website: <https://www.adirondacksaco.com/>
- Adirondacks ACO newsletter - monthly

# Louann Villani, RN

[lvillani@ahihealth.org](mailto:lvillani@ahihealth.org)

# Brenda Stiles, RN

[bstiles@cvph.org](mailto:bstiles@cvph.org)



a·H·I

Adirondack Health Institute

