The Development of an NP Led Interprofessional Collaborative Practice

The Ohio State University College of Nursing

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Workshop Purpose

- Discuss the development of an NP-led interprofessional collaborative practice that integrates mental health services with primary care.

Workshop Objectives

- Explore opportunities for NP faculty in the development of an interprofessional health care center.
- Analyze the advantages of managing mental health disorders in primary care.
- Discuss the benefits of the TEAMcare model in management of chronic disease.
- Describe management of chronic disease through group visits in primary care.
- Discuss critical components of the COPE Program and its implications for use in primary care settings.
- Discuss the use of the IPCP competencies in developing clinic based curriculum for health care professionals.

Funding Sources

- HRSA - *Nurse Education Practice, Quality and Retention (NEPQR)*
- MEDTAPP - Medicaid Technical Assistance and Policy Program (MEDTAPP) Project

Determine Center Location

- Community Needs Assessment
  - Need for Primary Care Providers
  - Over Use of ED
  - Diabetes death rate from diabetes is 2X higher in the Near East population
  - Chronic Disease – Hypertension, Hyperlipidemia
  - Need for general mental health and substance abuse services
    - Serious mental illness and addiction
    - Basic counseling and support services

Goal of the HRSA Project

- Sustain a NP-led interprofessional collaborative practice (IPCP) clinic that integrates primary care and mental health services to improve health outcomes in an at-risk underserved population located in East Columbus, Ohio to: 1) increase the number of nurses and other health professional students skilled in interprofessional collaborative practice, and 2) strengthen nursing's capacity to improve the health outcomes of high-risk patients.

Objective 1 HRSA

- Objective I: Establish a healthcare delivery team implementing the Core Competencies for Interprofessional Collaborative Practice.
- Competency Domain 1: Values/Ethics for Interprofessional Practice
- Competency Domain 2: Roles/Responsibilities
- Competency Domain 3: Interprofessional Communication
- Competency Domain 4: Teams and Teamwork
- http://www.aacn.nche.edu/education-resources/ipecreport.pdf

Objective 2 HRSA

- Objective II: Implement and sustain an IPCP model incorporating:
- TeamCare
- Million Hearts
- USPSTF Depression Screening and
- COPE (Creating Opportunities for Personal Empowerment)

Goal of MEDTAPP Training, Attraction and Retention

The training activities, which overlap with attraction and retention to some extent, are intended to produce the outcomes listed below. We will assess these as part of the evaluation activities.

1) Health professional trainees prepared to more effectively provide service to Medicaid patients (Training Goal)
2) Health professional students prepared to work in integrated, interdisciplinary team settings (Training)
3) Increased number of health professional students pursuing graduate level training in high need areas, such as primary care and mental health specialty areas (Attraction)
4) Increased number of students pursuing post-graduation employment at high volume Medicaid sites (Attraction)
5) Increased number of health professional graduates who sign Medicaid provider agreements and serve Medicaid patients in their private practice settings, for those disciplines where private practice is a likely work option (Attraction)
6) Educated health professionals more aware and better prepared for what it takes to work in high volume Medicaid sites, thus reducing staff attrition (Retention)
7) Culture within each discipline that results in more graduates volunteering their services at sites that assist Medicaid and other low income populations (Retention)

MEDTAPP Related to NP Led Clinic

- Increase number of APNs in primary care
- Develop an IPCP Course with clinicals at NP Clinic
- Develop an online educational curriculum for providing mental health services in primary care settings
  - OSU primary care residents/fellows
  - OSUCON Primary care APN students
  - Masters level social work students

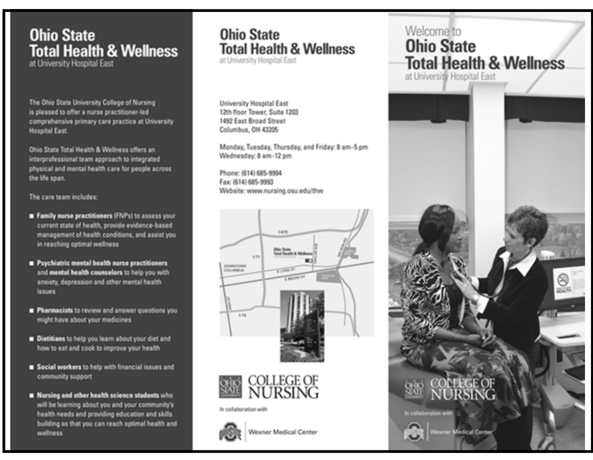
  Participants will receive a certificate upon completion of this curriculum

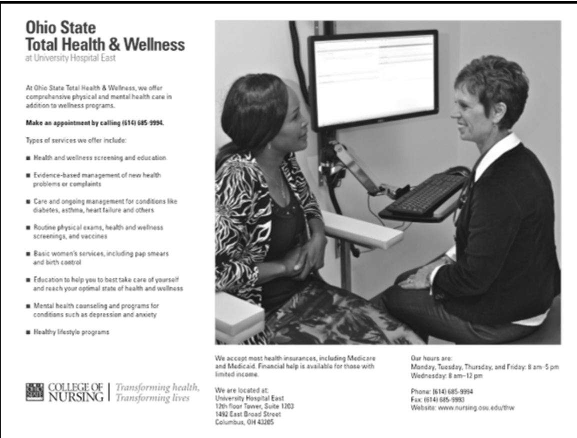
Planning the NP led Clinic

- Collaboration with the major health system in the area
  - EMR
  - Resources
  - Collaborating Physician
- Timeline to Accomplish Tasks
  - Individual to be in charge of the task list
  - Clinical person oversee the clinical aspect
  - Marketing

Start Up Tasks

- Building
- Office Space
- Financial Systems
- IT Services
- Marketing and Communication
- Service Contracts/Purchasing
- Staffing
- Licenses
- Other





Planning for Opening

- Ohio State Launches First NP Led Interprofessional Collaborative Clinic
- WOSU NPR story
- 10 TV news spot
- Open Houses

Putting together the IPCP Team

- When possible, IPC members Faculty VS Staff
- Facilitates IPCP education
- Credentialing Issues with Institution
- Credentialing with Medicare/Medicaid and Third-Party Payors
- Billing
- Malpractice

TEAMcare Model

- Patient Centered Focus
- Collaborative Goal Setting
- Practical Care Planning
- Consistent targeted multidisciplinary healthcare team management

(Katon, Lin, Von Korff, Ciechanowski, Ludman, Young, Rutter, Oliver, McGregor, 2010).

Program Integration

- Million Hearts ABCS(S)
  - Aspirin for people at risk (baseline 47%, 2017 goal 65%)
  - • BP control (baseline, 46%; 2017 goal 65%)
  - • Cholesterol management (low-density lipoprotein cholesterol [LDL-C]) (baseline 33%; 2017 goal 65%),
  - Cessation of smoking (prevalence 19%, 2017 goal 17%).
  - Screening for Anxiety and Depression with each patient using PHQ-9 and GAD-7.
- USPSTF Recommendations
- Group Visits
- COPE

- **Healthcare Maintenance - MALE*:** Age today: 45-64
- Td / TdaP (Td q 10 yrs, Pertussis once as adult): **{YES(DEF)/NO:22152}**
- Influenza (anually <49 if presence of other risk factors; >49 anually):
- **{YES(DEF)/NO:22152}**
- Hepatitis A immunization (at risk based on life-style, medical hx, occupational exposure, etc.) : **{YES(DEF)/NO:22152}**
- Hepatitis B immunization (at risk based on life-style, medical hx, occupational exposure, etc): **{YES(DEF)/NO:22152}**
- Pneumovax (at risk <65): **{YES(DEF)/NO:22152}**
- Zoster vaccine (60 and older): **{YES(DEF)/NO:22152}**
- ALCOHOL MISUSE: **{YES(DEF)/NO:22152}**
- **C {YES/NO (DEF):19694}**
- **A {YES/NO (DEF):19694}**
- **G {YES/NO (DEF):19694}**
- **E {YES/NO (DEF):19694}**
- ASA to prevent CVD: **{Yes/No-Ex:120004}**
- High Blood Pressure Screening: @VS@
- Cholesterol Screening:
- **@LASTLABOSU(CHOLESTEROL,LDLcalc,HDL,TRIG)@**
- Colonoscopy/Fecal Occult Blood/Flexible Sig (**age 50**, q 1-10 yrs until age 75): **{YES(DEF)/NO:22152}**
- Depression Screening: **{YES/NO (DEF):19694}** PHQ9 score: *** GAD score ***
- **{MONTH:19319} {YEAR:19320}**
- Glucose (if sustained BP>135/80; screen at least Q3yrs): **@LASTBP(3)@** **@LASTLABOSU(GLUCOSE)@**
- Healthy Diet Counseling for HDL, or other risk factors for CVD: **{Yes/No-Ex:120004}**
- Obesity Screening and counseling if at risk (BMI: 25-29.9=overweight, BMI>30=obesity; waist circm.
- Men> 40 in, Women > 35 in= inc risk for CVD) @BMI@
- **Counseling done: {Yes/No-Ex:120004}**
- Assessment for risk for STIs, counseling done, and testing for HIV, syphilis, chlamydia and gonorrhea as appropriate:
  - **{Yes/No-Ex:120004}**
- Tobacco Use: @TOBHX@ Tobacco Cessation Counseling: **{Yes/No-Ex:120004}**

Group Visits

Self-Care: Take Control of Your Heart Disease Risk Factors

HeartHealth

A Community Program for Life

Reduce risk factors for heart disease

Support lifestyle changes, Improve quality of life

Debra K. Moser, DNSc, RN, FAAN

University of Kentucky, College of Nursing

HeartHealth Group Visits Topics

Facilitated by different disciplines

- Self-Care: Take Control of Heart Disease Risk Factors
- Heart Healthy Eating
- Prescription Medication and Why You Should Take Them
- Physical Activity
- Blocking Out Stress
- Preventing and Managing Multiple Risk Factors
- Quitting Tobacco

The Rationale for Integrating Mental Health Services into Primary Care

The Epidemiology of Depression

Affects 5% Children, 10-20% Adolescents and approximately 10% of Adults, yet less than 25% receive treatment

Higher incidence in minority populations

Detection LOW, < 20% of cases

Average length of untreated episode of major depressive disorder is 7-9 months

Recurrence rate is approximately 70%

Affects adherence to management of physical health problems

Children, Teens and Adults are Stressed

The prevalence of anxiety disorders is climbing and now affects approximately 29% of individuals over their lifetime, with the most common age of onset being 11 years

COPE for Children, Adolescents and Adults

A Cognitive-Behavioral Skills Building Manualized Intervention Designed for Delivery in Multiple Formats:
1:1 in-person sessions; Group sessions; and an on-line self-paced program

Cognitive Theory Guides COPE

- CBT principles apply to everyone. We all have cognitive distortions and negative thoughts at times
- In COPE, children, teens and adults are taught why changing their thoughts from negative to positive impacts their feelings and behaviors in a positive way
- CBT is the “gold standard” treatment for depression and anxiety disorders yet few individuals receive it

The 7 Session COPE Content

1. Thinking, Feeling, and Behaving: What is the connection?
2. Positive Thinking and Forming Healthy Thinking Habits
3. Coping with Stress
4. Problem Solving & Setting Goals
5. Dealing with Emotions in Healthy Ways through Positive Thinking and Effective Communication
6. Coping with Stressful Situations
7. Pulling it all together for a Healthy You

The ABCs are Taught in COPE

STRESSOR (Antecedent Event)

↓

NEGATIVE THOUGHT TO STOP (Belief)

↓

REPLACE THE NEGATIVE WITH A POSITIVE THOUGHT

↓

POSITIVE EMOTION & BEHAVIOR (Consequence)

COPE
Goal Setting & Self-Monitoring Log

Goal: Write Two Positive Self-Statements

____
____

Goal for Number of times per day to say the positive self statements ___________

Number of Times You Said Your Positive Self-Statements

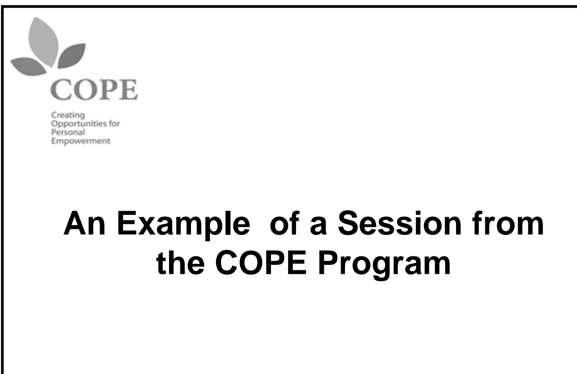
Thinking Day #1__ Day #2___ Day #3___ Day #4___ Day #5___ Day#6___ Day #7__

***Emotions* (How have you felt this week?)**

Rate your emotions on a scale from 0 “not at all” to 10 “a lot”

Worried ______
Stressed ______
Happy ______
Sad ______

COPE
Creating Opportunities for Personal Empowerment



The 15 Session COPE Healthy Lifestyles Program

A 15-session program that incorporates the 7 cognitive behavioral skills building sessions from COPE, plus nutrition education and physical activity

Findings from Prior Studies Testing COPE with Adolescents and College Students

(Melnyk et al, 2007; Melnyk et al., 2009; Melnyk et al., in press; Lusk & Melnyk, 2011)

Adolescents and college students who have received COPE had:

- A decrease in depressive symptoms
- A decrease in anxiety symptoms
- An increase in self-concept
- Enhanced social skills
- Higher grade performance
- Less alcohol use
- Improvements in healthy lifestyle behaviors and BMI

The KySS Mental Health Online Fellowship Program for Children/Teens and Adults

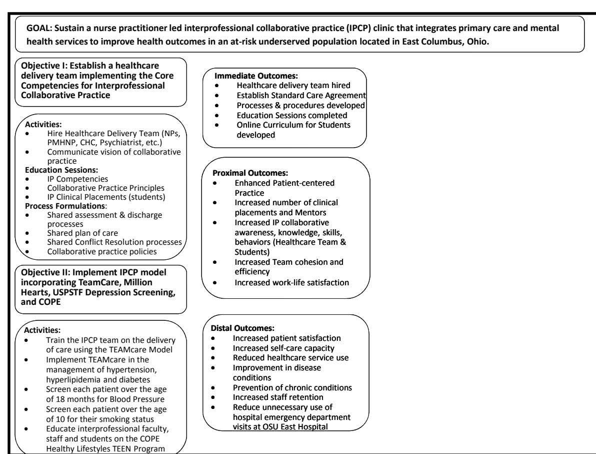
- Tracks for Children/Teens and Adults
- 12 on-line self-paced modules covering the most common mental health problems seen in primary care settings
- Skills building activities to assist providers to implement the knowledge gained
- Mentorship by a mental health specialist

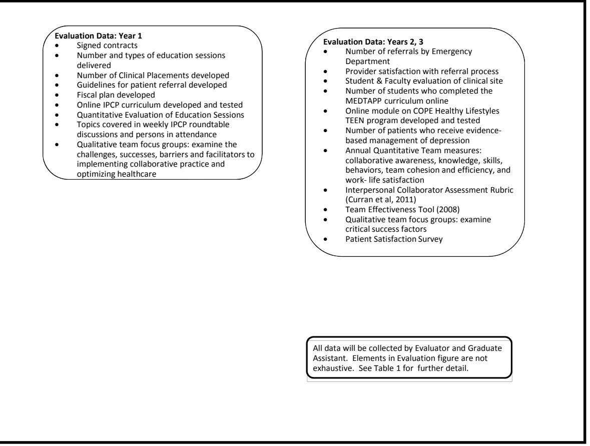
Interprofessional Collaborative Practice Competency Domains

- Values Ethics
- Roles/ Responsibilities
- Interprofessional Communication
- Teams and Teamwork

American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Dental Education Association
Association of American Medical Colleges
Association of Schools of Public Health

Interprofessional Education Collaborative Expert Panel. (2011). Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative.





Challenges

- Use of EMR
- Credentialing Time
- Seeing patients across the age span
- Reimbursement for all services
- CMS Published New Rule Nov 6, 2012

Allows Physicians to receive increased reimbursement for preventive services. APNs will not receive the increased reimbursement unless we are billing “incident to”.

Assistance for Challenges

- CMS Published New Rule Nov 6, 2012
  - Allows Physicians to receive increased reimbursement for preventive services
  - APNs will not receive the increased reimbursement unless we are billing “incident to”

Acknowledgement

We acknowledge the support of the Division of Nursing Bureau of Health Professions (BHPr), and the Health Resources Services Administration Department of Health and Human Services (DHHS). Funding for this project was received through the grant titled: Promoting Total Health and Wellness in Underserved Populations with IPCP.

The content and conclusions presented are those of the authors and not the position, policy or endorsement of the Division of Nursing, BHPr, DHHS or the US Government.

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Tasks for Opening NP Led Clinic – Total Health & Wellness Clinic at University Hospital East

Building

- Rent Negotiation
- Janitorial Services
- Who pays for Renovations

Office Space

- Space for each professional on team

Financial Systems

- Billing Systems
- Fee Schedules
- Scheduling patients in Advance of Opening
- Downtime Processes
- Cash Drawer/Armour Service/Deposits
- Credit Card Machine
- Safe

Credentialing

- Providers/Professional required to be credentialed for practice/reimbursement

IT Services

- Ordering and Purchasing
- Installation
- Phone and Fax
- Phone Tree
- Plan for emergency
- Back up system for IT if no power

Marketing/Communications

- Letterhead, envelopes, business cards
- Website
- Office Policies
- New patient Packet

Service Contracts/Purchasing

Eye Wash Station
Vendor Services
Office cleaning
Copy machine delivery and contract
Stericycle
MEDICAL SUPPLY ORDERING
After-hours coverage
Vaccine Program/Refrigerator(s)
Hand Rub/Paper Towel Dispensers/Soap etc.
Emergency Cart/AED

Staffing

Manager & Support Staff
Write job descriptions & Post
Interviews
Orientations including training for EMR
Ensure licensed staff have appropriate license and skills for the position
Work schedules, coverage, cross-training, ill and vacation time
Process for time keeping, time-off requests, approval, etc.

Licenses

CLIA –submit early
Pharmacy – submit early –Terminal Distributor's License (Ohio)
Must have to purchase supplies from particular suppliers – EKG electrodes, speculums!
DEA change of address for providers transferring sites

Other

Clinical and lab equipment inventory and evaluation for appropriate operation
Event Reporting System
Complaint System/Satisfaction Surveys
Staff mailboxes/communication system (encryption?)

Initial	Age/Sex	Visit Date	Last BP Value	Last A1c Dt	Last A1c Value	Last LDL Dt	Last LDL Value	Last TRIG Dt	Last TRIG Value	Last Creatinine	Last Microalbumin	Last BMI	Tobacco Use Status	Next Appt Date by Dept
V.C.	46 y.o. / M	04/08/2013	116/82	02/06/2013	>14					0.80		29.02 kg/m^2	Never	03/25/2013
MR	48 y.o. / M	06/24/2013	136/74	02/25/2013	9.7%	03/04/2013	133	03/04/2013	112	1.19	30mg/L	36.29 kg/m^2	Never	06/24/2013
C.F.	54 y.o. / M	06/18/2013	118/64	03/07/2013	6.8	03/21/2013	81	03/21/2013	33	0.82	3.2	20.22 kg/m^2	Yes	04/08/2013
R.C.	30 y.o. / M	04/22/2013	138/62	02/20/2013	4.9	02/20/2013	140	02/20/2013	180	0.55		41.24 kg/m^2	Never	04/22/2013
T.A.	51 y.o. / F	04/09/2013	137/77			12/30/2008	138	12/30/2008	125	0.86		36.78 kg/m^2	Yes	03/27/2013
D.J.	39 y.o. / M	03/20/2013	156/100			01/30/2013	184	01/30/2013	88	0.91		30.02 kg/m^2	Quit	
CH	73 y.o. / F	05/22/2013	122/78	11/16/2012	5.2	02/20/2013	83	02/20/2013	95	0.65		38.19 kg/m^2	Yes	03/26/2013
AH	38 y.o. / F	06/14/2013	126/78	02/21/2013	10.6	02/21/2013	108	02/21/2013	100	0.55	80	29.15 kg/m^2	Never	03/25/2013
L.M.	56 y.o. / F	06/04/2013	126/82	01/23/2013	6.5	01/23/2013	102	01/23/2013	55	0.60		29.99 kg/m^2	Quit	03/28/2013
M.B.	69 y.o. / F	03/29/2013	136/76	03/01/2013	6.3%	03/01/2013	129	03/01/2013	121	1.03	80mg/l	43.55 kg/m^2	Never	03/29/2013
G.T.	50 y.o. / M	04/12/2013	128/82	03/20/2013	6.2%	03/18/2013	102	03/18/2013	113	0.90		23.79 kg/m^2	Yes	04/12/2013
L.S.	33 y.o. / F	04/04/2013	130/82	02/27/2013	6.6%	03/21/2013	72	03/21/2013	41	0.87	80mg/L	42.65 kg/m^2	Never	03/25/2013
CO	65 y.o. / F	07/22/2013	134/82	03/22/2013	6.8%	03/11/2013	160	03/11/2013	116	0.65	10mg/L	34.59 kg/m^2	Never	03/25/2013
W.S.	55 y.o. / M	04/02/2013	122/80	03/11/2013	7.7%	03/11/2013	67	03/11/2013	109	0.84	80mg/L	33.18 kg/m^2	Yes	03/29/2013
M.S.	40 y.o. / F	03/28/2013	128/76							0.76		48.63 kg/m^2	Yes	03/28/2013
M.W.	76 y.o. / F	04/22/2013	148/86	02/20/2010	7.0	02/19/2010	132	02/19/2010	132	1.19		31.75 kg/m^2	Never	03/28/2013
D.W.	27 y.o. / M	03/04/2013	148/72	02/07/2013	6.4	02/07/2013	193	02/07/2013	150	0.83		57.62 kg/m^2	Yes	
RJ	50 y.o. / M	05/13/2013	140/73	02/14/2013	6.3	02/14/2013	35	02/14/2013	55	1.85	202.0	32.85 kg/m^2	Never	03/25/2013
DH	62 y.o. / F	04/04/2013	118/78								10mg/L	34.19 kg/m^2	Never	03/27/2013
D.P.	49 y.o. / M	05/23/2013	148/80	02/22/2013	5.8					0.87	150mg/L	31.23 kg/m^2	Yes	03/28/2013

20 Patient(s)

Supervision Action List

Case Manager: EH	**Date:3.21.13**
Patient: TA– 51y/o F Status: New Last Contact: 3/20/13 PHQ-9 baseline: 3 Next contact:	1. Referred to neurosurgeon in ER 2. Make sure she can get medications (HCTZ = $4, amlodipine = $20) 3. Lori to talk to her about getting into Medicaid
Patient: MB - 69y/o F Status: Active Last Contact: 3/13 PHQ-9: baseline = 2 Next contact: 3/15 (Kristie)	1. TLC (diet and exercise) x 3 months, then re-evaluate 2. Scheduled with Julie on 4/11
Patient: VC - 46y/o M Last THW Contact: 3/7/13 Status: Active PHQ-9: Next contact: 3/21 (Tiffany)	1. Give 2nd Hep B shot in April (after 4/7) 2. Tell him CXR results at next visit 3. Microalbumin at next visit 4. Lipids at following visit 5. Bring W2 to finish enrolling in Lantus MAP
Patient: RC – 30y/o M Last THW contact: 3/19 LM Status: New PHQ-9: 1 Next Contact: Ericia to call	1. Check home BP 2. Recheck Chem 6 next week (can get done at work, orders in IHIS) 3. See Julie for nutrition education on lipids
Patient: CF - 54y/o M Last THW Contact: Status: NEW PHQ-9: baseline= 14	1. Start Cymbalta, available at pharmacy now 2. Schedule appt for first TEAMcare visit
Patient: DH 62 y/o Last THW Contact: 3/20 Status: New PHQ-9: Baseline = 4 Next Contact: 3/28 (Ericia and Tiffany)	1. Lori to call her about dentist resources 2. Finding out about Hep B immunization 3. Check BG readings, titrate Lantus 4. Getting enrolled with MAP for Lantus
Patient: CH -73y/o F Last Contact: 2/28/13 Status: Maintenance, monthly contact PHQ-9: baseline = 2 Next Contact: phone call re: appts	1. Scheduled for Echo and ABI 2. Scheduled phone appt with Julie on 4/11 3. F/u with smoking cessation and use of patch 4. F/u with starting ASA 5. F/u with change from Zantac from Tagamet
Patient: AH - 37y/o F Last Contact: 3/6 Status: Active PHQ-9: basline = 6 Next Contact: 3/21/13	1. Lisinopril 2.5mg daily, if BP is low may consider d/c and monitor microalbumin 2. Check BP at pharmacy when possible 3. Go to optometry and dentist appointment

Patient	Notes
Patient: DJ - 38y/o M Last Contact: Status: Active- PHQ-9 baseline: 8 Next Contact:	1. Letter sent 3/20/13, 2. No contact for 2 weeks 3. Check if he started lisinopril and pick up chlorthalidone 4. To see Caroline & Julie for 3/28 (has no show x 2) 5. Get PHQ-9 and GAD at next contact
Patient: RJ - 50y/o M Last Contact: 3/19 Status: Monitoring PHQ-9 baseline: Next Contact: 3/25	1. Doing better on lower dose Cymbalta 2. Consider adding Wellbutrin to augment therapy 3. Get updated PHQ-9 4. Check Vitamin D level 5. Recheck microalbumin at next visit; Microalbumin elevated in the past – good reason to consider an ARB in the future
Patient: LM - 56y/o F Last THW Contact: Status: active PHQ-9 baseline: Next Contact:	1. Follow-up BP and BG 2. Discuss weight watchers with her again
Patient: DP – 49y/o M Last THW Contact: 3/14/13 Status: **New** PHQ-9 Baseline: 11 Next Contact: Phone contact may be issue Intolerant to ACE (n/v)	1. Proteinuria – intolerant to ACEi (n/v) – start losartan 50mg daily 2. Recurrent gout – Rheumatologist recommends colchicine; look into why not allopurinol 3. Stop HCTZ 4. Reinforce diet with gout
Patient: MR - 48y/o M Last Contact: 3/11 Status: Monitoring PHQ-9 baseline: 6 Next Contact:	1. Adjust Toprol dose as needed 2. Try to go back up on metformin dose when he feels better 3. Will be out of town for 2 months 4. Check BG and BP 5. Recommend he see Julie for nutrition education upon return
Patient: MS - 40y/o F Status: Active Last Contact: 3/4 PhQ-9: 18, GAD-7: 14 Next Contact:	1. F/u with MRI results (taken 3/20) 2. See Caroline after appt on 3/28 3. Ask her to come fasting to her next appt. Needs to have additional endocrine labs drawn to with TSH being so high and T3 and T4 low normal range
Patient: LS- 33y/o F Last Contact: 3/11 Status: Monitoring PHQ-9 Baseline: Next Contact: 3/21/13	1. To come in today, discuss following: 2. Want to get off OCP due to HTN – looking into IUD. 3. Give her a meter at visit to check BS Fasting and 2 hr post-prandial to determine if we want to start Metformin 4. Obtain urine microalbumin and lipids at next visit
Patient: WS – 55y/o M Last Contact: 3/15 Status: Active PHQ-9 baseline:16 Next contact: 3/18 (Ericia-phone) MAP patient	1. Increase Cymbalta to 30mg – Tiffany to call Ellen to find out how to increase dose with MAP 2. Seeing Caroline 4/2 3. F/u about sleep study – not yet scheduled 4. Discuss smoking cessation further – pt not ready to quit

<table>
<tr><td>Patient: GT 50 y/o M
Status: Active
Last Contact: 3/20/13
PHQ-9 Baseline:</td><td>1. Add 555-5555 as a contact number for him
2. Determine appropriate contact person for him
3. Check BP and BG readings
4. Start Vitamin D 2000 units daily
5. Start ASA 81mg
6. Check if he restarted his inhalers; cough ACE related or not?</td></tr>
<tr><td>Patient: MW - 75y/o F
Status: Active
Last Contact: 3/5
PhQ-9 baseline: 7, increased to 11
GAD-7 baseline: 10
Next Contact:</td><td>1. Add ASA 81 mg
2. F/u Ambien for insomnia
3. Recheck PHQ-9
4. To see Caroline for counseling
5. Needs to have reinforced diabetic teaching at some point with Julie (get through grieving process first)
6. See if she has seen rheumatology yet
7. Waiting on ROR from physician at other facility</td></tr>
<tr><td>Patient: DW - 27y/o M
Status: Inactive
Last Contact: 2/13</td><td>1. Patient has not returned CM calls
2. Letter sent 3/5/13, if no contact within 14 days, discharge from TEAMcare</td></tr>
</table>

Healthcare Maintenance - MALE*: Age today: @AGE@

Td / TdaP (Td q 10 yrs, Pertussis once as adult): **{YES(DEF)/NO:22152}**

Influenza (annually <49 if presence of other risk factors; >49 annually):
{YES(DEF)/NO:22152}

Hepatitis A immunization (at risk based on life-style, medical hx, occupational exposure, etc.) : **{YES(DEF)/NO:22152}**

Hepatitis B immunization (at risk based on life-style, medical hx, occupational exposure, etc): **{YES(DEF)/NO:22152}**

Pneumovax (at risk <65): **{YES(DEF)/NO:22152}**

Zoster vaccine (60 and older): **{YES(DEF)/NO:22152}**

ALCOHOL MISUSE: **{YES(DEF)/NO:22152}**
C {YES/NO (DEF):19694}
A {YES/NO (DEF):19694}
G {YES/NO (DEF):19694}
E {YES/NO (DEF):19694}

ASA to prevent CVD: **{Yes/No-Ex:120004}**

High Blood Pressure Screening: @VS@

Cholesterol Screening:
@LASTLABOSU(CHOLESTEROL,LDLcalc,HDL,TRIG)@

Colonoscopy/Fecal Occult Blood/Flexible Sig (**age 50**, q 1-10 yrs until age 75):
{YES(DEF)/NO:22152}

Depression Screening: **{YES/NO (DEF):19694}** PHQ9 score: *** GAD score ***
{MONTH:19319} {YEAR:19320}
Glucose (if sustained BP>135/80; screen at least Q3yrs): **@LASTBP(3)@**
@LASTLABOSU(GLUCOSE)@

Healthy Diet Counseling for HDL, or other risk factors for CVD: **{Yes/No-Ex:120004}**

Obesity Screening and counseling if at risk (BMI: 25-29.9=overweight, BMI>30=obesity; waist circm. Men> 40 in, Women > 35 in= inc risk for CVD) @BMI@

Counseling done: {Yes/No-Ex:120004}

Assessment for risk for STIs, counseling done, and testing for HIV, syphilis, chlamydia and gonorrhea as appropriate: **{Yes/No-Ex:120004}**

Tobacco Use: @TOBHX@ Tobacco Cessation Counseling: **{Yes/No-Ex:120004}**