The Accountable Community for Health of King County

Chronic Disease Prevention & Control

Workgroup: Diabetes/CVD

May 7, 2018
Chronic Disease Prevention - Diabetes

Project Goals

Immediate: Identification of Medicaid individuals with diabetes; risk-stratification based on high-risk comorbidities/conditions (e.g. chronic kidney disease, coronary disease, insulin use, polypharmacy, etc.). Verify medical home/PCP for each enrollee; assign high-risk patients to care coordinator.

Long-term: Improve utilization of HbA1c testing in patients with diabetes; Increase rates of screening for diabetes related complications and secondary prevention; Empower patients with diabetes to achieve successful self-management practices; Decrease rates of diabetes-related complications in those with the disease; improve HbA1c and LDL-c measures.

Focus Populations
Medicaid beneficiaries (adults and children) with or at risk for type 1 or type 2 diabetes and its complications.

Interventions
This project is based upon the Chronic Care Model which includes six core elements to optimize the care of patients with chronic disease: 1) Delivery system design – a proactive care delivery system where planned visits are coordinated through a team-based approach; 2) self-management support; 3) decision support based on evidence-based, effective care guidelines; 4) use of registries that provide patient-specific and population-based support to the care team; 5) connection to community resources to support healthy lifestyles; and 6) health systems that emphasizes quality.

The model includes the following elements:

- **Population identification and stratification:** Participating clinicians will assess patients with diabetes to identify those who are high-risk. For high-risk patients, providers should assess social context, including potential food insecurity, housing stability, and financial barriers, and apply that information to treatment decisions.

- **Care Team approach to treatment and management of diabetes:** Care teams may include physicians, nurse practitioners, physician assistants, nurses, dietitians, mental health providers, community health workers/peer support specialists and others. Providers should work with patients to formulate the management plan that also includes lifestyle management.

- **Care Management:** High-risk patients with diabetes will be assigned to care managers (CM), and Community Health Workers (CHWs). Care managers and community health workers should work with patients to assure access to appropriate diabetes self-management education and support, medical nutrition therapy, and behavioral health support as needed. Care managers and community health workers will also work with providers and patients to assure that patients receive recommended preventive care screenings.

- **Diabetes Education:** Providers should connect patients to an evidence-base program such as the Stanford Chronic Disease Self-Management Program or the NDDK-sponsored Diabetes Prevention Program. This project will increase access to evidence-based self-management programs by working with participating partners to expand existing DSMT resources in the county and offering the program in areas of highly prevalent high-risk disease by connecting
provider organizations to community-based organizations that can support community-based diabetes self-management programs.

Clinicians will be expected to adhere to the ADA Standards of Medical Care in Diabetes and obtain diabetes-specific clinical data and outcomes as noted in the Immediate and Long-term goals.

Innovations
- The incorporation of social context (including potential food insecurity, housing stability, and financial barriers) and application of that information (by the care team) to treatment decisions.
- Care managers and Community Health Workers to focus on high risk patients with diabetes.
- Comprehensive ‘care team’ approach (including physicians, nurse practitioners, physician assistants, nurses, dietitians, mental health providers, community health workers/peer support specialists and others) to support patients in managing their diabetes.

Metrics
- Child and Adolescents’ Access to Primary Care Practitioners
  - The percentage of members 12 months - 19 years of age who had a visit with a primary care provider. Report four separate rates: 12-24 months of age; 25 months - 6 years of age; 7-11 years of age; 12-19 years of age.
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
  - The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement period.
- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
  - The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement period, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.
- Inpatient Hospital Utilization
  - For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
- Medication Management for People with Asthma (5 – 64 Years)
  - The percentage of members 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.
- All Cause Emergency Department Visits per 1000 Member Months
  - The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder, reported for three age groups: 10-17 years, 18-64 years, and 65 years and older.
- Statin Therapy for Patients with Cardiovascular Disease
Percentage of males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: (1) Received statin therapy: Members who were dispensed at least one high or moderate-intensity statin medication.

- **Adult Access to Preventive/Ambulatory Care (AAP)**
  - Members age 20 years and older as of December 31st of the measurement year, who have one or more ambulatory or preventive care visits each year.

- **Adult Body Mass Index Assessment (ABA)**
  - The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

- **Diabetes control: Blood pressure control**
  - Percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure reading is <140/90 mm Hg.

- **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDC³)**
  - Percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c testing and results >9.0%.

- **Controlling High Blood Pressure (CBP)**
  - Percentage of Medicaid enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

- **All-Cause Readmission Rate (30 Days)**
  - Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days.

- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC¹)**
  - Percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:
    - BMI percentile documentation
    - Counseling for nutrition
    - Counseling for physical activity

- **Well-child visits in 3rd, 4th, 5th, 6th yrs of life**
  - Percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year.

- **Well-Child Visits in the First 15 Months of Life (W15)**
  - Percentage of members 0-15 months of age who received one or more well-child visits with a PCP during the measurement year.

*Metrics in addition to Healthier Washington pay for performance metrics for this project

References/Guidelines


Chronic Disease Prevention - Cardiovascular Wellness & Self-Management

Project Goal

Immediate: Integrate evidence-based strategies and clinical guidelines and patient education material; document at least 1 self-management goal identified by the patient and review at each visit.

Long-term: Improve access and management of hypertension and hypercholesterolemia in King County as demonstrated by: decreasing the admission rate for patients with a principal diagnosis of hypertension (PQI 7) and heart failure (PQI 8); adequately controlled blood pressure for patients with a diagnosis of hypertension.

Focus Populations

Medicaid adult beneficiaries with or at risk for chronic cardiovascular disease.

Interventions

Cardiovascular disease is a significant issue and a leading cause of avoidable admissions in King County. This project is based upon the Million Hearts Campaign and builds upon Healthy Hearts Northwest, which aims to help providers through practice transformation with the cardiovascular health of patients. The Project also relies on EvidenceNOW: Advancing Heart Health in Primary Care is an initiative of the Agency for Healthcare Research and Quality (AHRQ).

The goal is to enhance cardiovascular disease prevention by focusing on blood pressure control, cholesterol management, smoking cessation, and aspirin use for people at risk.

Providers will:

- Help patients adopt the:
  - Five A’s of tobacco control (optimally prompted in the EMR).
- Refer patients to the Washington Quitline (when appropriate).
- Identify patients with repeated elevated blood pressure readings but no diagnosis of hypertension for a hypertension visit.
- Document one patient self-management goal in the medical record (preferably an EMR) and reviewed at each visit.
- Integrate care management to follow up and coordinate patient care.

Innovations

- Advance team-based care in the treatment and management of cardiovascular disease.
- Utilize a shared-care plan that allows for coordinating care across multiple providers.
- Integrate interventions into routine clinic operations.
• Demonstrate the effectiveness of Community Health Workers in the prevention and management of cardiovascular disease.

Metrics

• Child and Adolescents’ Access to Primary Care Practitioners
  o The percentage of members 12 months - 19 years of age who had a visit with a primary care provider. Report four separate rates: 12-24 months of age; 25 months - 6 years of age; 7-11 years of age; 12-19 years of age.

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• *Adult Body Mass Index Assessment (ABA)
  o The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

• *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
Members age eighteen to sixty-four as of December 31st of the measurement year, with cardiovascular disease, including those with Schizophrenia, should have an LDL-C test at least annually.

*Controlling High Blood Pressure (CBP)
- Percentage of Medicaid enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

*Medical Assistance with Smoking and Tobacco Use Cessation
- Advising Smokers and Tobacco Users to Quit: Adults 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.
- Discussing Cessation Medications: Adults 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- Discussing Cessation Strategies: Adults 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.

*All-Cause Readmission Rate (30 Days)
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  - Counseling for nutrition
  - Counseling for physical activity

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References/Guidelines
2. Healthy Hearts NW; http://healthyheartsnw.org/


Evidence Based Approach: Chronic Care Model

The basic elements for improving care in health systems at the community, organization, practice, and patient levels.

<table>
<thead>
<tr>
<th>Elements of the Chronic Care Model</th>
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<tbody>
<tr>
<td><strong>Self-Management Support</strong></td>
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<tr>
<td>Empower and prepare patients to manage their health and health care.</td>
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<tr>
<td><strong>Delivery System Design</strong></td>
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<tr>
<td>Assure the delivery of effective, efficient clinical care and self-management support.</td>
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<tr>
<td><strong>Decision Support</strong></td>
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<tr>
<td>Promote clinical care that is consistent with scientific evidence and patient preferences.</td>
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<tr>
<td><strong>Clinical Information Systems</strong></td>
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<tr>
<td>Organize patient and population data to facilitate efficient and effective care (registries).</td>
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<tr>
<td><strong>Community-based Resources and Policy</strong></td>
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<tr>
<td>Activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care.</td>
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<tr>
<td><strong>Health Care Organization</strong></td>
</tr>
<tr>
<td>Create a culture, organization and mechanisms that promote safe, high quality care.</td>
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Chronic Disease Self-Management: Stanford CDSM

• Program Goal: Enable participants to build self-confidence to take part in maintaining their health and managing their chronic health conditions.

• CDSMP is a weekly 2.5 hour lay-led participant education program over six weeks for adults experiencing chronic health conditions such as hypertension, arthritis, heart disease, stroke, lung disease, and diabetes; their family members, friends and caregivers can also participate. The program provides information and teaches practical skills on managing chronic health problems. The CDSMP gives people the confidence and motivation they need to manage their challenges.

• Reasoning behind the program design and elements:
  o People with chronic conditions have similar concerns and problems;
  o People with chronic conditions must deal not only with their disease(s), but also with the impact on their lives and emotions;
  o Lay people with chronic conditions, when given a detailed leader's manual, can teach the CDSMP as effectively, if not more effectively, than health professionals (Lorig et al, 1999);
  o The process or the way the CDSMP is taught is as important, if not more important, than the subject matter that is taught.

• The CDSMP focuses on problems common to individuals suffering from chronic diseases. Coping strategies such as action planning and feedback, behavior modeling, problem-solving techniques, and decision making are applicable to all chronic diseases. Individuals are taught to control their symptoms through: Relaxation techniques; Healthy Eating; Managing sleep and fatigue; Manage Medications; Exercise; Communication with health providers.

• Desired Outcomes:
  o Increases in healthy behaviors (i.e., exercise and cognitive symptom management techniques, such as relaxation);
  o Positive changes in health status (less pain, fatigue, and worry; less health distress);
  o Increased self-efficacy;
  o Better communications with health providers;
  o Fewer visits to physicians and emergency rooms.

http://www.op.nysed.gov/surveys/mhpsw/sofa-att8.pdf
# Cardiovascular Wellness & Self Management: Million Hearts Campaign

## Hypertension Control – Action Steps for Clinicians

| Actions to Improve Delivery System Design | • Implement a standardized hypertension treatment protocol: Support titration of hypertension medications by clinical team members via a physician-approved protocol.  
• Designate hypertension champions within your practice or organization.  
• Proactively track and contact patients whose blood pressure is uncontrolled using an electronic health record (EHR)-generated list, patient registry, or other data source.  
• Create a blood pressure measurement station where all patients can rest quietly for 5 minutes before measurement and that is designed to support proper measurement techniques (e.g., feet on floor, proper arm position, multiple cuff sizes conveniently located).  
• Have care team members review a patient’s record before the office visit to identify ways to improve blood pressure control.  
• Proactively provide ongoing support for patients with hypertension through office visits or other means of contact until blood pressure is controlled.  
• Implement systems to alert physicians about patterns of high blood pressure readings taken by support staff: Place a sign or magnet on the outside of the examination room; build clinical decision supports into the EHR.  
• Provide feedback to individual clinicians and clinic sites on their hypertension control rates. Provide incentives for high performance, and recognize high performers.  
• Provide blood pressure checks without a copayment or appointment. Train clerical personnel in proper blood pressure measurement technique so they are capable of obtaining drop-in blood pressure readings.  
• Encourage clinicians to take continuing education on hypertension management and care of resistant hypertension. |
| --- | --- |
| Actions to Improve Medication Adherence | • Encourage patients to use medication reminders: Promote pill boxes, alarms, vibrating watches, and smartphone applications.  
• Provide all prescription instructions clearly in writing and verbally: limit instruction to 3–4 major points; use plain, culturally sensitive language; use written information or pamphlets and verbal education at all encounters.  
• Ensure patients understand their risks if they do not take medications as directed. Ask patients about these risks, and have patients restate the positive benefits of taking their medications.  
• Discuss with patients potential side effects of any medications when initially prescribed and at every office visit thereafter.  
• Provide rewards for medication adherence: praise adherence; arrange incentives, such as coupons, certificates, and reduced frequency of office visits.  
• Prescribe medications included in the patient’s insurance coverage formulary, when possible.  
• Prescribe once-daily regimens or fixed-dose combination pills.  
• Assign one staff person the responsibility of managing medication refill requests: create a refill protocol.  
• Implement frequent follow-ups (e.g., e-mail, phone calls, text messages) to ensure patients adhere to their medication regimen: Set up an automated telephone system for patient monitoring and counseling. |
| Actions to Optimize Patient Reminders and Supports | • Provide patients who have hypertension with a written self-management plan at the end of each office visit: encourage or provide patient support groups; use all staff interactions with patients as opportunities to assist in self-management goal-setting and practices; print visit summaries and follow-up guidance for patients.  
• Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.  
• Contact patients to confirm upcoming appointments, and instruct them to bring medications, a medication list, and home blood pressure readings with them to the visit.  
• Send a postcard to or call patients who have not had their blood pressure checked recently. Invite them to drop in to have their blood pressure checked by a medical assistant, nurse, or other trained personnel without an appointment and at no charge.  
• Send patients text messages about taking medications, home blood pressure monitoring, or scheduled office visits.  
• Encourage patients to use smartphone or Web-based applications to track and share home blood pressure measurements.  
• Encourage home blood pressure monitoring plus clinical support using automated devices with a properly sized arm cuff: Advise patients on choosing the best device and cuff size; check patients’ home monitoring devices for accuracy; train patients on proper use of home blood pressure monitors.  
• Implement clinical support systems that incorporate regular transmission of patients’ home blood pressure readings and customized clinician feedback into patient care: train staff to administer specific clinical support interventions (e.g., telemonitoring, patient portals, counseling, Web sites); incorporate regular transmission of patient home blood pressure readings through patient portals; telemonitoring, log books, etc., to clinicians and EHR systems; provide regular customized support and advice (e.g., medication titration, lifestyle modifications) based on patient blood pressure readings. |

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Cardiovascular Wellness & Self Management: Million Hearts Campaign
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### Million Hearts® 2022 Priorities

<table>
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<tr>
<th>Keeping People Healthy</th>
<th>Optimizing Care</th>
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<tr>
<td>Reduce Sodium Intake</td>
<td>Improve ABCS*</td>
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<tr>
<td>Decrease Tobacco Use</td>
<td>Increase Use of Cardiac Rehab</td>
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<tr>
<td>Increase Physical Activity</td>
<td>Engage Patients in Heart-healthy Behaviors</td>
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**Improving Outcomes for Priority Populations**

- Blacks/African Americans
- 35- to 64-year-olds
- People who have had a heart attack or stroke
- People with mental illness or substance use disorders

*Aspirin when appropriate, Blood pressure control, Cholesterol management, Smoking cessation
Cardiovascular Wellness & Self Management: Million Hearts Campaign

### Optimizing Care

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<tr>
<th>Goals</th>
<th>Effective Healthcare Strategies</th>
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<tr>
<td><strong>Improve ABCS</strong> 80% Targets</td>
<td>High Performers Excel in the Use of:</td>
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<td>• Technology – decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care</td>
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<td>• Teams – including pharmacists, nurses, community health workers, cardiac rehab professionals</td>
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<tr>
<td><strong>Increase Use of Cardiac Rehab</strong> 70% Target</td>
<td>• Processes – treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use</td>
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<tr>
<td><strong>Engage Patients in Heart-healthy Behaviors</strong> Targets TBD</td>
<td>• Patient and Family Supports – training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab</td>
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*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation*
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<th>Primary Prevention of Cardiovascular Disease – Action Steps for Clinicians</th>
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Diabetes Prevention Program (DPP)

- DPP works to make it easier for people with prediabetes to participate in affordable, high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.

- The CDC recognizes lifestyle change programs that meet certain standards and show they can achieve results. These standards include following an approved curriculum, facilitation by a trained lifestyle coach, and submitting data every 6 months to show that the program is having an impact. DPP Program Features:
  - Minimum of 22 in person sessions over the course of a year, some of which include: Get Active to Prevent T2, Track Your Activity, Eat Well to Prevent T2, Track Your Food, Get More Active, Burn More Calories than You Take In, Shop & Cook to Prevent T2, Manage Stress, Find Time for Fitness, Cope with Triggers, Keep Your Heart Healthy, Get Support, etc.
  - Participants track and report their activity and food daily
  - Weigh in at each session
  - Research shows that “people with prediabetes who take part in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old)”. For those completing the program, even 10 years later, were one third less likely to develop type 2 diabetes.

Chronic Disease Prevention: Project-specific Current State Assessment Results
All settings have interest in Diabetes and CVD.

- Pediatric asthma: Hosp (N=9) - 40%, FQHC (N=5) - 50%, BH (n=9) - 30%
- Adult asthma: Hosp (N=9) - 60%, FQHC (N=5) - 70%, BH (n=9) - 40%
- Diabetes: Hosp (N=9) - 100%, FQHC (N=5) - 100%, BH (n=9) - 100%
- CVD: Hosp (N=9) - 60%, FQHC (N=5) - 80%, BH (n=9) - 90%
BH agencies lag in use of registries

- Registry in EMR
- Registry in excel/access
- Asthma registry
- Diabetes registry

Hosp (N=9) | FQHC (N=5) | BH (n=9)
Care plan content: inconsistent - and coordination is a notable gap

- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and who is responsible
- Medication management
- Community/social services
- Description of how services will be coordinated
- Schedule for periodic review and revision

Legend: Hosp (N=9) – FQHC (N=5) – BH (n=9)
Chronic disease care team composition varies

- CHW
- Chronic care coord
- SW
- Pharmacists
- Registered dieticians

Legend:
- Hosp (N=9)
- FQHC (N=5)
- BH (n=9)
**Diabetes Wellness & Self Management Program (DWSP) Flow Chart**

1. **Primary care visit by patient**
   - **Does patient have diabetes?**
     - **YES**
       - **Education trigger:**
         - Is the patient not achieving adequate control or reaching their self-management goals?
         - Have new, complicating factors risen that influence self-management?
     - **NO**
       - **Does patient meet ADA criteria indicating they are at risk for diabetes?**
         - **YES**
           - **Stanford Self-Management Program/ Counseling by CDE/other pt. ed Resources provided via care coordination**
         - **NO**
           - **Process complete**

2. **Did patient have HbA1c test performed within last DSRIP year?**
   - **YES**
     - **PCP submit documentation of previously performed test to SCC**
   - **NO**
     - **Order HbA1c test (coordinate care to ensure test performed)**
     - **PCP submit documentation of performed test to SCC**

3. **Patient attends course led by Stanford workshop leaders**
   - **PCP receives feedback via care coordination from education provider**
   - **Patient receives education from clinician**

4. **Submit documentation of ongoing HbA1C testing to SCC**

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**Notes:**

- Determined by previous diagnosis or HbA1c results
- A1c test should be performed annually at minimum, however ADA recommends every 3-6 months
- Care coordination task assignments are dependent upon practice team composition, refer to 2ai.02 protocols for specific roles and responsibilities
- Reference: Protocols 2ai.01, 2ai.02, 2ai.03, 2ai.04, 2ai.05
Cardiovascular Wellness & Self-Management Program Flow Chart

**Clinical Guidelines**

**Care coordination task assignments are dependent upon practice team composition, refer to 2ai.02 protocols for specific roles and responsibilities**
- Reference: Protocols 2ai.01, 2ai.02, 2ai.03, 2ai.04, 2ai.05

- **Patient seen in PCP office**
  - **Vital Signs are measured and recorded in EMR**
    - **Is Systolic BP >140 &/or Diastolic BP>90?**
      - **NO**
        - **Does patient have other risk factors identified in the SCC clinical guideline summary?**
          - **NO**
            - No further action is needed for CWSP patients. Consider screening for 5 A’s of Tobacco Control to meet the goals of improving the health of the population.
          - **YES**
            - Work with patient via care coordination to identify self-management goal & document in EMR
    - **YES**
      - **Follow SCC 3bi clinical guidelines**
        - **Screen for 5 A’s of Tobacco Control**
          - **Does the patient smoke?**
            - **YES**
              - Refer Patient to NYS Smokers Quitline and/or other cessation resources via care coordination
            - **NO**
              - **Does the patient want to stop smoking?**
                - **YES**
                  - Refer Patient to NYS Smokers Quitline and/or other cessation resources via care coordination
                - **NO**
                  - No further action is needed for CWSP patients. Consider screening for 5 A’s of Tobacco Control to meet the goals of improving the health of the population.