Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: Diabetes: Type 1 Type 2 IHD COPD													
Date of birth: Date(s) of Diagnosis: DM IHD COPD													
Co morbidities: HTN Dyslipidemia PAD Renal Disease A Fib TIA/Stroke Mental Health Diagnosis CHF Other:													
Interventions/Investigations: PCI/Stent Bare metal Drug-eluting Spirometry/PFT CABG Cardiac Cath Current Medication:													
REO	UIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD	Date	/	/	Date	/	/	Date	/	/	Date	/	/
ANNUALLY	Smoker Yes No If yes, discuss smoking cessation Immunizations Discussed and/or given Exercise/Activity												
REQ	UIRED COMMON INDICATORS FOR DIABETES and IHD	Date	/	/	Date	/	/	Date	/	/	Date	/	/
2/YR	Blood pressure												
ANNUALLY	Weight/Nutrition Counselling Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C												
REQ	JIRED INDICATORS FOR DIABETES ONLY												
2/YR	HbA1C												
ANNUALLY	Renal Function ACR and eGFR Foot Exam Use 10-g monofilament												
	Eye Exam Discuss and/or refer												
REQ	UIRED INDICATORS FOR IHD ONLY												
	Anti-platelet Therapy Review												
ANNUALLY	Beta-blocker Review	<u> </u>			<u> </u>								
NNN	ACEI/ARB Review	┼───											
A	Discuss Nitroglycerin												
REO	Consider further cardiac investigations UIRED INDICATORS FOR COPD ONLY	-											
1/YR	COPD Action Plan Develop. Review and complete annually												
RECOMMENDED ITEMS (Optional for CDM Incentive payment)													
Self Management Referrals: Diabetes Centre Cardiac Rehab Your Way to Wellness Pulmonary Rehabilitation Screen for: Depression/Anxiety Erectile Dysfunction Lifestyle: Alcohol Use Psychsocial Issues Economics: Pharmacare Third Party Insurance No Insurance Financial Issues End of Life: Care Discussion													
Date CDM Incentive Code Billed:													

SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

Atipidatelet Therapy ASA 81 to 325 mg OD ASA indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease ASA maximum dose 75-100 mg if of Ticagrelor Clopidogrel 75 mg OD Clopidogrel: STEMI - Only if had PCI Minimum 1 mo. post drug-eluting stent ASA maximum dose 75-100 mg if of Ticagrelor Clopidogrel 75 mg OD Clopidogrel: STEMI - Only if had PCI Minimum 1 mo. post drug-eluting stent Clopidogrel: STEMI Min. 12 mo. post drug-eluting stent Clopidogrel: STEMI Dependent on type of stent and rip profile Ticagrelor 90 mg BID Ticagrelor Ticagrelor 90 mg BID Ticagrelor Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended. Ticagrelor: Non-STEMI Dependent on risk of recurrent even & stent type Discuss Nitroglycerin Consider further cardiac investigations Comments COPD Indicators Target Comments COPD Indicators Ticagrelor Non-Stefful thereapy recommended. Copy given to patient. MILD Include medications and emergency instructions for patient. Copy given to patient. MILD MODERATE VERY SEVERE MILD Infrequent AECOPD (average of <1 per year) Frequent AECOPD (≥1 per year) Infrequent AECOPD (average of <1 per year) LAAC + ICS/LABA + SABA prn Persistent dyspnea LAAC + ICS/LABA + SABA prn Persistent dyspnea	Common Indicators: DM, IHD & COP	<u>D</u>	Target	Comments					
Immunications repeat at 65 yr, for COPD repeat every 5-10 year For CMR (HiD) 30 mim/day 5/ark plus restance served at Jvks. Service/Activity Discuss appropriate ever/sel/activity and possible referrance to the service of the	Smoking Cessation		Non-smoker						
Exercise/Activity Discuss appropriate overtise/activity and possible referrers in COM & 100:30 min/349 54/We plus restance exercise 3 3/We. Plus restance exercise 3 3/We plus restance exercise a 3/We plus restance ex	Immunizations								
Common Indicators: DM & HD Image: Trace Comments Used Pressure DM without DM CrCs: 140/90 DM: 140/926* *In DM with or and organ damage through the set of the s	Exercise/Activity			resistanc	esistance exercise 3 x/wk.				
Biod Pressure Bit Owthout DM or CKD: -130/90 DM and CKD: -210 DM or CKD: -210/90 DM and CKD: -210 For DM or LD C: -20550K reduction for IHD or IHD pkb DM DL C: -20550K reduction for IHD or IHD or IHD pkb DM DL C: -20550K reduction for IHD or IHD or IHD pkb DM DL C: -20550K reduction for IHD or IHD or IHD pkb DM DL C: -20550K reduction for IHD or IHD or IHD pkb DM DL C: -20550K reduction for IHD or IHD	Common Indicators: DM & IHD		Target	For COPE					
MinUb Pressure DM and CKD-si30/80** *** Where this case be achieved safely without Lipids For HID or HID pils DM LDL C: 20 *** Where this case be achieved safely without Upids For HID or HID pils DM LDL C: 20 SSR reduction Test every 1.3 years 0R as clinically indicated Weight/Wast circumference/ IbM: -25 & g(m) or IbM: -25 & g(m) or Test every 1.3 years 0R as clinically indicated Nutrition counseling IbM: -25 & g(m) or -9 & mo. In stable DM -9 & mo. In stable DM HBA1C -7% -9 & mo. In stable DM -9 & mo. In stable DM Renal Function ACR: -2.0 for males; -2.8 for females Ibm of months; IbGPR -20 mL/min Routine foot examination Annually DS are month monthight Ibg or month; Routine dilated eye examination Act: -2.0 for males; -2.8 for females Ibg or month; Ibg or month; Routine dilated eye examination At diagnosis then every 1.2 years based on expression recompatibility. Ibg or month; Routine of this foot administrate in the every 1.2 years based on expression. Comments MED Indicators STEM: Indefinitely unless low risk Commontine of this foot administrate in the every 1.2 years based on expression. Commontine foot administrate in the every 1.2 years based on expression. ACEI/ANB Indefinitely unless low risk Comonth monting it compandication on intheternate in the every 1.2 wea						<u>comments</u>			
Lipids For HD or HD pus DM LDLC : 2.0 > 50% reduction Test every 1-3 years OR as clinically indicated Point DM only DLC : 2.6 Multi Consoling Multi Consol	Blood Pressure		DM and CKD: <130/80**	** Where	* Where this can be achieved safely without				
Willight Walls Circumferency Number Counseling In children-35th Xiel for age Mast circumference: W-120 cm, Fr. 588 cm Diabetes Indicators Target Comments -9 Gross Table DM HBAIC < 7%	Lipids		For DM only LDL-C: < 2.6	Test every	t every 1-3 years OR as clinically indicated				
HBAIC < 7%			In children: <85th %ile for age						
HbA1C < <75 individual term to there individual term to the the set of the s	Diabetes Indicators				Comments				
Renal Function ACR: 42.0 for males: 42.8 for females eGFR: 320 for males: 42.8 for females eGFR: 320 for males: 42.8 for females eGFR: 320 mU/min In presence of COD, at least every 6 months. Referration apphrologist/memory 1.2 years based to degree of retinopativ. 03-6 mo. In moderate to high risk foot. Assess skin, neuropath (10 -g monofilament) and perfusion. Routine dilated eye examination At diagnosis, then every 1-2 years based on degree of retinopativ. By optimetrist or ophthalmologist HD Indicators Duration Comments Beta blocker Non STEMI: Indefinitely unless low risk ACE: Titrate to target dose. Consider ARB if contraindication o intolerance to ACE! Actipulatelet: Therapy AS & 10 325 mg OD ASA indefinitely -STEMI, Non-STEMI and Stable Coronary Artery Disease Clopidage: STEMI - Only if had PCI Minimum 1 mo. post bare metal stent Min. 12 mo. Post for uge eluting stent: 12 mo.; wery high risk ~>12 mo. MEC: Low risk & bare metal stent or complex PCI ->12 mo ASA maximum dose 75-100 mg. Transient dyspnea can be eard side effect. Usually mild and resolves with continued therapy. Titcagrelor 90 mg BID Titcagrelor Titcagrelor Precisibent on high risk Acute Coronary Syndrome patients, 12 months of therapy recommended. Titcagrelor 4000000000000000000000000000000000000	HbA1C		< 7%	-q 3 mo. For al	3 mo. For all others				
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SABD = Short-acting bronchodilator (e.g. ipatropium or SABA) LAAC = Long acting anticholinergic (e.g. tiotropium) LABA = Long acting beta agonist (e.g. salmeterol; formoterol) SABA = Short-acting beta agonist (e.g. salbutamol; terbutaline) ICS/LABA = inhaled corticosteroid/LABA (e.g. fluticasone/salmeterol; budesonide/formoteral)

Chronic Disease Management (CDM) Incentive fee billing rules

1. The CDM Incentive fee can be claimed by family physicians only.

2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic disease(s) for each qualifying disease.

3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.

4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.

5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.

6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.

7. The qualifying chronic diseases eligible for the CDM incentive payment are:

- Type 1 and Type 2 Diabetes defined as: FPG ³7.0 mmol/L or Casual PG ³11.1 mmol/L + symptoms or 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
- Ischaemic Heart Disease (IHD) characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
- Chronic Obstructive Pulmonary Disease (COPD), a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV₁ < 80% predicted and FEV₁/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.

9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:

- the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;
- the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
- the CDM indicators required for the CDM incentive payment have been addressed at the required frequency (see front of flow sheet) and documented in the clinical record or optional flow sheet at or before the time of billing.