Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: Type 1 ☐ Type 2 ☐ IHD ☐ COPD ☐

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy) COPD _____ (mm/yy)

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: _____

_____

REQUIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD		Date / /	Date / /	Date / /	Date / /
ANNUALLY	Smoker ☐ Yes ☐ No If yes, discuss smoking cessation				
ANNUALLY	Immunizations Discussed and/or given				
ANNUALLY	Exercise/Activity				
REQUIRED COMMON INDICATORS FOR DIABETES and IHD		**Date / /**	**Date / /**	**Date / /**	**Date / /**
2/YR	Blood pressure				
ANNUALLY	Weight/Nutrition Counselling				
ANNUALLY	Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C				
REQUIRED INDICATORS FOR DIABETES ONLY					
2/YR	HbA1C				
ANNUALLY	Renal Function ACR and eGFR				
ANNUALLY	Foot Exam Use 10-g monofilament				
ANNUALLY	Eye Exam Discuss and/or refer				
REQUIRED INDICATORS FOR IHD ONLY					
ANNUALLY	Anti-platelet Therapy Review				
ANNUALLY	Beta-blocker Review				
ANNUALLY	ACEI/ARB Review				
ANNUALLY	Discuss Nitroglycerin				
ANNUALLY	Consider further cardiac investigations				
REQUIRED 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

Common Indicators: DM, IHD & COPD	Target	Comments
Smoking Cessation	Non-smoker	
Immunizations	Influenza annually. Pneumococcal once, then for DM & IHD repeat at 65 yr.; for COPD repeat every 5-10 years..	
Exercise/Activity	Discuss appropriate exercise/activity and possible referrals	For DM & IHD: 30 mins/day 5x/wk plus resistance exercise 3 x/wk. For COPD: pulmonary rehab program
Common Indicators: DM & IHD	**Target**	**Comments**
Blood Pressure	IHD without DM or CKD: <140/90 DM: <140/80* DM and CKD: <130/80** In children: <95th %ile for age, gender and height	*In DM with no end organ damage ** Where this can be achieved safely without undue burden
Lipids	For IHD or IHD plus DM LDL-C: < 2.0 >50% reduction For DM only LDL-C: < 2.6	Test every 1-3 years OR as clinically indicated
Weight/Waist circumference/ Nutrition counseling	BMI: <25 kg/m^2 or In children: <85th %ile for age Waist circumference: M: <102 cm, F: <88 cm	

Diabetes Indicators	Target	Comments
HbA1C	< 7%	-q 6 mo. In stable DM -q 3 mo. For all others Individualize HbA1C based on age, DM duration & co-morbidity
Renal Function	ACR: <2.0 for males; <2.8 for females eGFR: >60 mL/min	In presence of CKD, at least every 6 months. Referral to nephrologist/internist if eGFR <30 mL/min
Routine foot examination	Annually	Q3-6 mo. In moderate to high risk foot. Assess skin, neuropathy (10 –g monofilament) and perfusion.
Routine dilated eye examination	At diagnosis, then every 1-2 years based on degree of retinopathy.	By optometrist or ophthalmologist

IHD Indicators	Duration	Comments
Beta-blocker	STEMI: Indefinitely Non-STEMI: Indefinitely unless low risk	
ACEI/ARB	Indefinitely unless low risk	ACEI: Titrate to target dose. Consider ARB if contraindication or intolerance to ACEI
Antiplatelet Therapy **ASA** 81 to 325 mg OD **Clopidogrel** 75 mg OD **Ticagrelor** 90 mg BID	**ASA** indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease **Clopidogrel: STEMI** - Only if had PCI Minimum 1 mo. post bare metal stent Min. 12 mo. post drug-eluting stent **Clopidogrel: Non-STEMI** No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo. PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo **Ticagrelor** Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended.	**ASA** maximum dose 75-100 mg if on Ticagrelor **Clopidogrel: STEMI** Dependent on type of stent and risk profile **Clopidogrel Non-STEMI** Depends on risk of recurrent event & stent type **Ticagrelor**: Reduce ASA to 75-100 mg. Transient dyspnea can be early side effect. Usually mild and resolves with continued therapy.
Discuss Nitroglycerin		
Consider further cardiac investigations		

COPD Indicators	Target	Comments
COPD Action Plan	Include medications and emergency instructions for patient.	Copy given to patient.

PHARMACOTHERAPY IN COPD

INCREASING DISABILITY AND LUNG FUNCTION IMPAIRMENT

MILD	MODERATE	VERY SEVERE
↓	↙ ↘	
	Infrequent AECOPD (average of <1 per year)	**Frequent AECOPD (≥1 per year)**
SABD prn	**LAAC *or* LABA + SABA prn**	**LAAC + ICS/LABA +SABA prn**
↓ Persistent dyspnea	↓ Persistent dyspnea	↓ Persistent dyspnea
LAAC + SABA prn	**LAAC + LABA + SABA prn**	**LAAC + ICS/LABA + SABA prn**
or	↓ Persistent dyspnea	±
LABA + SABD prn	**LAAC + ICS/LABA* + SABA prn**	**Theophylline**

*refers to lower dose ICS/LABA

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 FEV_1 < 80% predicted and FEV_1/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.