# CARDIOVASCULAR DISEASE CARE PLAN

## Problems

1. Patient has Cardiovascular Disease

## Interventions

1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:
   - Importance of adherence to medication regimen
   - Importance of blood pressure control
   - Importance of diet
   - Importance of exercise
   - Importance of weight control
   - Importance of smoking cessation
   - Information of use of their Medical Home

2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence–based clinical guidelines:
   - AHA/ACC Guidelines for Secondary Prevention for patients with Coronary and Other Atherosclerotic Vascular Disease
     - [http://circ.ahajournals.org/content/124/22/2458](http://circ.ahajournals.org/content/124/22/2458)
   - Monitor timely and appropriate medication refills
   - Monitor laboratory data for compliance with above recommended testing
   - Monitor results to determine if further interventions need to be developed and addressed
   - Monitor Emergency Department visits and inpatient hospital admissions for the need for more frequent office visits and interventions

3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient’s current medications.

   At least annually, address the following with your patients and document in patients’ records:
   - Advance Care Planning
   - Medication Review
   - Functional Status Assessment
   - Comprehensive Pain Screening

## Goals

1. Maintain timely and appropriate medication refills
2. Primary care provider visit at least two (2) times a year
3. Obtain annual lipid profile LDL-C
4. Patient understands use of their Medical Home
5. Decrease use of hospital emergency department
6. Decrease inpatient admissions
**CONGESTIVE HEART FAILURE CARE PLAN**

<table>
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<tr>
<th>Problems</th>
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<tr>
<td>1. Patient has Congestive Heart Failure</td>
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<tr>
<td>1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:</td>
</tr>
<tr>
<td>• Importance of daily weights</td>
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<td>• Importance of blood pressure control</td>
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<td>• Importance of reducing salt intake</td>
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<tr>
<td>• Importance of smoking cessation</td>
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<tr>
<td>• Early signs of exacerbation of condition</td>
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<tr>
<td>• Importance of dietary compliance</td>
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<tr>
<td>• Information of use of their Medical Home</td>
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| 2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines: |
|   • Executive Summary: Heart Failure Society of America; Comprehensive Heart Failure Practice Guidelines |
|     - [http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.109.192064](http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.109.192064) |
|     • Monitor timely and appropriate medication refills |
|     • Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions |
|     • Monitor results to determine if further interventions need to be developed and addressed |

| 3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient’s current medications. |
|   At least annually, address the following with your patients and document in patients’ records: |
|   • Advance Care Planning |
|   • Medication Review |
|   • Functional Status Assessment |
|   • Comprehensive Pain Screening |

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<td>3. Obtain annual lipid profile LDL-C</td>
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<td>4. Primary care provider visit at least two (2) times a year</td>
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<td>5. Patient understands use of their Medical Home</td>
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<td>6. Decrease use of hospital emergency department</td>
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<tr>
<td>7. Decrease inpatient admissions</td>
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</tbody>
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## Problems

1. Patient has diabetes identified by HbA1c value

## Interventions

1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:
   - Importance of adhering to medication regimens
   - Importance of an annual eye exam, foot care, blood sugar, and blood pressure control
   - Importance of smoking cessation
   - Importance of dietary compliance
   - Information of use of their Medical Home

2. Physician monitoring of outcomes for compliance with regimen goals following guidelines:
   - Standards of Medical Care in Diabetes – American Diabetes Association
     - Monitor timely and appropriate laboratory data for compliance and recommended testing of HgbA1c, LDL-C level, and other profiles as needed
     - Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions
     - Monitor results to determine if further interventions need to be developed and addressed

3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient's current medications.

At least annually, address the following with your patients and document in patients’ records:
   - Advance Care Planning
   - Medication Review
   - Functional Status Assessment
   - Comprehensive Pain Screening

## Goals

1. Obtain HgbA1c at least two (2) times a year
2. Maintain HgbA1c at less than 7.0 percent
   a. HgbA1c poor control > 9.0%
   b. HgbA1c limited control ≥ 7.0% and ≤9.0%
   c. HgbA1c control < 7.0%
3. Maintain timely and appropriate medication refills
4. Primary care provider visit at least two (2) times a year
5. Obtain annual lipid profile, LDL-C
6. Maintain LDL-C level, < 100mg/dL
7. Obtain annual retinal exam, retinopathy
8. Obtain annual screen for micro albuminuria, nephropathy
9. Obtain annual foot exam, neuropathy
10. Patient understands use of their Medical Home
11. Decrease use of hospital emergency department
12. Decrease inpatient admissions/readmissions
Problems

1. Patient is socioeconomically disadvantaged which may negatively impact patient’s ability to access needed and preventive healthcare services.

Interventions

1. Plan will identify the chronic condition. When the condition is diagnosed, the plan will provide accessibility, via mail, point of contact (PCP, and service providers), and other communication methods, such as an educational packet four times a year and newsletters twice a year containing the following information:
   • Information of use of their Medical Home, which includes access and support to Social and Behavioral Services
   • Importance of smoking cessation
   • Importance of immunization
   • Importance of medication adherence
   • Early signs of exacerbation of condition
   • Importance of dietary compliance

2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based clinical guidelines:
   • **Prevention**: The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force
     - [http://www.ahrq.gov/clinic/pocketgd.htm](http://www.ahrq.gov/clinic/pocketgd.htm)
   • **Additional considerations**:
     - Monitor timely and appropriate medication refills
     - Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions
     - Monitor results to determine if further interventions need to be developed and addressed

3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient’s current medications.
   At least annually, address the following with your patients and document in patients’ records:
   • Advance Care Planning
   • Medication Review
   • Functional Status Assessment
   • Comprehensive Pain Screening

Goals

1. Maintain timely and appropriate medication refills
2. Primary care provider visit at least two (2) times a year
3. Obtain annual influenza immunization
4. Obtain pneumococcus immunization
5. Patient understands use of their Medical Home
6. Assist with Social Services and Behavioral Services
7. Educate patient on the program Eligibility requirements
8. Decrease use of hospital emergency department
9. Decrease inpatient admissions
## Problems

1. Patient has poor, intermediate, or at-risk pulmonary health

## Interventions

1. Plan will mail educational packet four times a year and newsletters twice a year containing the following information:
   - Importance of smoking cessation
   - Importance of immunization
   - Importance of medication adherence
   - Early signs of exacerbation of condition
   - Importance of dietary compliance
   - Information of use of their Medical Home

2. Physician monitoring of outcomes for compliance with regimen goals following the selected evidence-based guidelines:
   - Global Initiative for Chronic Obstructive Lung disease; Global Strategy for the diagnosis, management, and Prevention of Chronic Obstructive Pulmonary disease
     - [http://www.goldcopd.com](http://www.goldcopd.com)
   - Medical Therapy for Pulmonary Arterial Hypertension: Updated ACCP Evidence-Based Clinical Practice Guidelines
     - [http://chestjournal.chestpubs.org/content/](http://chestjournal.chestpubs.org/content/)
   - Monitor timely and appropriate medication refills
   - Monitor Emergency department and inpatient hospital admissions and encourage more frequent patient office visits and interventions
   - Monitor results to determine if further interventions need to be developed and addressed

3. Other important interventions: See your patient within 7 days of all inpatient hospitalizations. Complete medication reconciliation during follow-up visit. Include documentation that the medications prescribed/ordered at discharge were reconciled with the patient’s current medications.

At least annually, address the following with your patients and document in patients’ records:
   - Advance Care Planning
   - Medication Review
   - Functional Status Assessment
   - Comprehensive Pain Screening

## Goals

1. Maintain timely and appropriate medication refills
2. Primary care provider visit at least two (2) times a year
3. Obtain a baseline Spirometry measurement
4. Obtain annual influenza immunization
5. Obtain pneumococcus immunization
6. Patient understands use of their Medical Home
7. Decrease use of hospital emergency department
8. Decrease inpatient admissions