Chronic Care Model Components							
	Patient Flow Processes:	**CIS**	**DSD**	**DS**	**SMS**	**Assigned Roles: (DSD)**	**Ideas for goal setting**
1	**Check- in**	Registration DM identifier- EMR Provide SMS goal sheet Consolidate Gaps Alert appears on record-	Print out gap alerts- -Perhaps check in staff could also outreach to 1-5 patients daily with lapsed care, overdue, or due for care		Provide SMS goal sheet	**Administrative support**	1. Were all DM patients identified? 2. % of patients scheduled for planned care-
2	**Pre-visit**	Review and update care gap alerts	Perform and document: -- Foot exam - Vital signs - Documents eye exams -Smoking hx and cessation	Initiate SO: -Flu or pneumo Vacc prn -Recheck BP if BP > 130/80 - First line labs	Review SMS goal sheet with patient -Prepare education materials for physician use	**MA's / Nurses**	1.% of DM patients with documented foot exams, eye exams, tobacco hx, tobacco cessation? VS completion
3	**Provider/ Patient Visit**	In EMR task patient orders- to post visit	Patient assessment/ Treatment plan of care	Complete evidenced based DM template of care	Revise/ advise goals	**Physicians Providers**	1.A1C, 2.BP, 3. LDL control
4	**Post visit**	Referrals- eye exams, podiatry, labs Print of patient snap shot or report card summarizing their progress. Some have called this a progress report.	Arrange for community resource needs	Initiate provider orders	Close loop on goals- provide DM education materials Review Action Plan- for high risk patients(who to call and for what) Provide a copy of goals	**MA's / Nurses**	1. SMS documentation 2. Perhaps CM referrals 3. Follow-up care?
5	**Check -out**	Schedule F/U appt for all patients out of range Open access - tell patients when they should be seen again	Check out person confirms that the all care gaps have been attended to- and that the patient has scheduled/ or knows when to schedule a return planned visit	Provide print outs of med lists- Referrals- Lab slips needed for next visit		**Administrative support**	1. scheduled F/U care 2. Referrals mgt?
6	**Interim support**	Exception reporting- lapsed or over due care	Arrange planned visit	Previsit: Standing orders- lab orders- eye exams- populate data	Reinforce SMS goal activities	**Patient reminders: MA's / Administrative support**	1. # calls per month- 2. # of visits scheduled.
7		Exception reporting- High risk patients with multiple out of range values or A1C >9	Planned visit followed by Care Management services	Standing orders: Labs, med titration, BP checks	Exacerbation action plans SMS goals Customized Care plans	**Care Management: Nurses**	1. Case load volume 2. Percentage points improved?