WELLCARE DIABETES MANAGEMENT

PATIENT NAME: DATE OF BIRTH: PHONE NUMBER:

MONTH 1: *INITIAL ASSESSMENT*	BUILD RAPPORT MEDICATION SYNCHRONIZATION COLLECT DATA: HBA1C, BP, WEIGHT, HEIGHT	☐ ASSESS ADHERENCE & ENROLL PATIENT IN MEDSYNC ☐ PROVIDE INITIAL ASSESSMENT & CREATE A PROBLEM LIST ☐ DOCUMENT ADHERENCE AND LABS ☐ EDUCATION ON HYPOGLYCEMIA PLAN	**REQUIRED SNOMED CODES** NONCOMPLIANCE WITH MEDICATION REGIMEN: **129834002** MEDICATION SYNCHRONIZATION: **415693003**
MONTH 2	GAPS IN CARE - HEALTHY EATING	☐ ASSESS ADHERENCE & FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA & BG PATTERN ASSESSMENT ☐ EDUCATION ON FOOD CHOICES ☐ PATIENT HANDOUT ON HEALTHY EATING ☐ DOCUMENT ADHERENCE & CREATE SMART GOALS	DIABETES MEDICATION REVIEW: **394725008** DIABETIC EDUCATION: **6143009** CONTRACT REQUIREMENTS: • ACTIVELY ENGAGE IN THE PROGRAM BY SUBMITTING AT LEAST 1 eCARE PLAN PER QUARTER • DOCUMENT AT LEAST 2 HbA1C MEASUREMENTS PER ENGAGED PATIENT PER PROGRAM YEAR • SUBMIT AT LEAST ONE PATIENT SUCCESS STORY PER QUARTER (ONLINE FORM)
MONTH 3	GAPS IN CARE - IMMUNIZATIONS	☐ ASSESS ADHERENCE & FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA & BG PATTERN ASSESSMENT ☐ IMMUNIZATION SCREENING ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS	
MONTH 4	GAPS IN CARE - PREVENTATIVE SERVICES/REDUCING RISK	☐ ASSESS ADHERENCE & FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA & BG PATTERN ASSESSMENT ☐ SCHEDULING FOR LABS, EYE, FOOT, DENTAL CARE ☐ PATIENT HANDOUT ON REDUCING RISK ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS	
MONTH 5	GAPS IN CARE - TAKING MEDICATION STATIN USE IN DIABETES	☐ ASSESS ADHERENCE & FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ STATIN USE IN PATIENTS WITH DIABETES ☐ PATIENT HANDOUT ON TAKING MEDICATION ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS	
MONTH 6	GAPS IN CARE - BLOOD PRESSURE & A1C CHECK	☐ ASSESS ADHERENCE AND FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ A1C CHECK, SCHEDULE LAB OR PROVIDE AT PHARMACY ☐ MONITOR/ASSESS BLOOD PRESSURE ☐ PATIENT HANDOUT ON BLOOD PRESSURE/LOG SHEET (DOCUMENT IN LABS) ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS	

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MONTH 7	GAPS IN CARE - SDOH	☐ ASSESS ADHERENCE AND FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ SCREENING TO ASSESS SDOH ISSUES ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS
MONTH 8	GAPS IN CARE - BEING ACTIVE	☐ ASSESS ADHERENCE AND FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ EDUCATION ON PHYSICAL ACTIVITY OF CHOICE ☐ PATIENT HANDOUT BEING ACTIVE ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS
MONTH 9	GAPS IN CARE - HEALTHY COPING	☐ ASSESS ADHERENCE AND FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ ASSESS DIABETES DISTRESS: PHQ-9/GAD-7/DDS/PAID ☐ PATIENT HANDOUT HEALTHY COPING ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS
MONTH 10	GAPS IN CARE - MONITORING	☐ ASSESS ADHERENCE AND FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ PATIENT HANDOUT ON MONITORING ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS
MONTH 11	GAPS IN CARE - PROBLEM SOLVING	☐ ASSESS ADHERENCE AND FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ ASSESS & ASSIST WITH PROBLEM SOLVING ☐ PATIENT HANDOUT ON PROBLEM SOLVING ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS
MONTH 12	GAPS IN CARE - A1C CHECK	☐ ASSESS ADHERENCE AND FOLLOW-UP ASSESSMENT ☐ HYPOGLYCEMIA AND BG PATTERN ASSESSMENT ☐ ADDRESS ANY OTHER GAPS IN CARE OR PROBLEMS THAT HAVE YET TO BE ADDRESSED ☐ A1C CHECK, SCHEDULE LAB OR PROVIDE AT PHARMACY ☐ DOCUMENT ADHERENCE & REVIEW SMART GOALS

DIABETES MEDICATION REVIEW:
394725008

DIABETIC EDUCATION:
6143009

CONTRACT REQUIREMENTS:

- ACTIVELY ENGAGE IN THE PROGRAM BY SUBMITTING AT LEAST 1 eCARE PLAN PER QUARTER
- DOCUMENT AT LEAST 2 HbA1C MEASUREMENTS PER ENGAGED PATIENT PER PROGRAM YEAR
- SUBMIT AT LEAST ONE PATIENT SUCCESS STORY PER QUARTER (ONLINE FORM)