Figure I: ACO Chronic Care Clinical Process

ACO Population Health Chronic Disease Program: Diabetes Pilot

Inputs	Process Step	Outputs
Nurse reminder calls to patient - Assessment- review diet, labs, activity, guidelines - Provide tracking sheet- food, meds, Instructions- My Chart, Urgent care information, Cancellation Policy - Review medications, glucometer (patient	**Phase I: Patient Visit: Intake**	Assessment paper worksheet completed - EMR checklist checked complete - Pharmacy notified- dispense glucometer, set up account
Nurse reminder calls to patient -Set 2-3 goals such as adhere to PCP visits, Labwork, diet, Endocrinologist, Med Compliance	**Phase II: 1st Follow up to Patient Visit Intake**	Goal: Improve compliance - Monitor progress, roadblocks, mitigate inappropriate ED and hospital use
Nurse reminder calls to patient Schedule every 2-4 weeks Offer customized telephonic, home and satellite visits	**Phase III: Patient Visits for Ongoing Follow Up**	Continue with customized goal management
Continue above process	**3 Month Goal: Optimal Wellness**	Transition to maintenance plan for optimal wellness