* Incentivize quality metrics
* Communicate between healthcare entities
* Transparent quality data
* Team roles/responsibilities defined
* Complex care case management
* Practice workflow
* Planned, evidence-based care
* Evidence-based guidelines
* Shared decision-making
* Specialist integration and accessibility
* Chronic disease registry
* Monitor performance of team
* Share inflow/patients
* Identify subpopulations
* Reminder system
* Patient e-tools
* Support strategies for patients
* Internal supports
* Community resources
* Form partnerships with community organizations
* Health policy advocacy
* Community involvement

[to be filled in]

**BHT Role**

**Change Idea**

* Passes to YMCA exercise class
* Sugar drinks in schools
* Local ADA or Asthma organizations
* ED reports to practices
* All clinics have a CM focused on the registry
* QI/team support
* Patient portal
* ID children and SPMI populations
* Staff MI Training
* Chronic disease self-management class
* Mayo clinic SDM tool
* Care Agreements with specialists

**Secondary Drivers**

Health System Coordination

The Community

Clinical Information Systems

**Aim**

**Primary Drivers**

Self-Management

Decision Support

Delivery System Design

**Populations:**

* Diabetes
* Asthma in children
* Chronic mental health disorders

**Outcomes:**

* Reduce number of preventable admissions for diabetes and asthma by 10%
* Reduce emergency department use by 6%
* Reduce hospital readmission by 2%
* Increase % of Medicaid residents who have mental health treatment needs by 10%

**Integrate health system and community approaches to improve chronic disease management and control.**

BHT Chronic Disease Driver Diagram

**BHT Role**

[to be filled in]

**QI Team Role**

**Change Idea**

*

**Secondary Drivers**

**Aim**

**Primary Drivers**

Driver Diagram Template

**BHT Role**

[to be filled in]