

CLINICAL GUIDELINE:

CHRONIC CONDITION FOLLOW-UP

Asthma, Depression, Diabetes, Hypertension, COPD, CAD, ESRD, CHF, and Lipid Disorders



Physician Clinical Integration
Network, LLC

Scope

Chronic disease management has become an increasing concern for primary care providers due to time constraints and the overall prevalence of chronic disease in the United States. A substantial number of follow-up visits are for routine care of a chronic disease. In 2009, of the approximately one billion office visits, 30% were for routine follow-up of a chronic problem and 42% were for the evaluation of a new problem or an exacerbation of a chronic condition [1].

Managing chronic disease and improving outcomes involves enhanced collaboration between patients and physicians. This involves goal setting, care-plan development, self-management training and support, and active follow-up [2].

Chronic illnesses are defined as illnesses lasting longer than one year, causing functional limitations and/or requiring ongoing monitoring and treatment [3]. Among these are asthma, depression, diabetes, hypertension, and lipid disorders.

Guidance

The PCIN Quality Committee and its designees reviewed the available information in the medical literature and societal guidelines on the evaluation and management of chronic illnesses in the primary care setting, as well as information derived from their clinical practice, to devise these guidelines.

Population Included

Patients ≥ 18 years of age with controlled chronic illnesses: asthma, depression, diabetes, hypertension, chronic obstructive pulmonary disorder (COPD), coronary artery disease (CAD), end stage renal disease (ESRD), congestive heart failure (CHF), and lipid disorders

Exclusions

Patients < 18 years of age with uncontrolled chronic disease

Recommendations

- ✓ All patients with a controlled chronic diagnosis of asthma, depression, diabetes, hypertension, COPD, CAD, ESRD, CHF, and/or lipid disorders will have a follow-up, at minimum, every six months.

Rationale

Follow-up frequency is dependent upon the severity of the illness and symptoms presented. Regardless of the condition, recommendations focus on a well-defined care plan, patient education, scheduled follow-ups, outcome and adherence monitoring, specialist consultations, and treatment according to diagnosis protocols [2].

Asthma

Long term asthma management is reliant upon reducing impairment and risk. Because asthma is highly variable over time, patients should be seen every two to six weeks while gaining control, every one to six months to monitor control, and every three months if a step down in therapy is anticipated [4].

Depression

Depression follow-up is based on the Patient Health Questionnaire (PHQ-9) score. The PHQ-9 should be repeated four to eight weeks after initiation of treatment, which is when the maximum response to treatment should occur. Patients should be followed monthly until remission, when a score of less than five is maintained for more than two months. At that time, follow-up visits should occur every six months [5]. Mayo Clinic considers three contacts within twelve weeks following the initial diagnosis ideal [6].

Diabetes

Management of diabetes focuses on assessment/management of glycemic control and prevention/management of diabetes complications (refer to PCIN's Clinical Guideline for [Comprehensive Diabetes Care and Statin Adherence Therapy](#)). For patients meeting treatment goals, an A1C should be repeated every six months, which correlates with the six-month follow-up recommendation [7].

Hypertension

Follow-up visits for hypertension are scheduled according to patients' responses to and adherence with treatment. Patients at low-risk with Stage I hypertension and low atherosclerotic cardiovascular disease (ASCVD) risk should have their blood pressure repeated after three to six months of nonpharmacologic therapy. At a minimum, patients should be seen every six months [8].

Lipid Disorders

According to the American Heart Association (AHA), patients should be reassessed at four to twelve weeks with lipid testing following initiation of therapy. Retesting/follow-up should occur every three to twelve months based on low-density lipoprotein cholesterol (LDL-C) control [8] to achieve a goal LDL 30-50% reduction or in high risk patients 50% or more.

Congestive Heart Failure

The recommendation for follow-up of chronic congestive heart failure patients is every three to six months and includes a plasma creatinine and urea (BUN). A complete blood count (CBC) should be completed annually. Upon clinical suspicion of acute symptoms, a chest x-ray, electrocardiogram, cardiac enzymes, and echocardiogram should be ordered [9]. Refer to PCIN's Clinical Guideline for [Evaluation and Management of Heart Failure in the Ambulatory Setting](#) for more detailed information regarding heart failure patients.

Chronic Obstructive Pulmonary Disease

Routine follow-up of chronic obstructive pulmonary disease (COPD) is essential. Symptoms, exacerbations and objective measures of airflow limitation should be monitored to determine when to modify treatment. Nonpharmacologic treatment should be based on the Refined ABCD Assessment Tool and the COPD severity level, per GOLD guidelines. The COPD Assessment Test (CAT) should be used and completed by patients to determine the level of impact the disease has on the patient. Smoking assessment and cessation should be provided at each visit if the patient is a tobacco user. Influenza and pneumococcal vaccinations should be administered to reduce the risk of vaccine preventable diseases. [10] Refer to PCIN's Clinical Guideline for [Potentially Avoidable Chronic Conditions: Chronic Obstructive Pulmonary Disease](#) for more detailed information regarding COPD patients.

Stage 3 and Stage 4 Renal Disease

Long term renal disease management is reliant on patient compliance with pharmacological and lifestyle changes. Changes in diet, exercise, pharmacological intervention, dialysis and management of comorbidities that negatively affect chronic kidney disease (CKD) are recommended. Optimal follow-up intervals are every six months for stage 3A, every three months for Stage 3B, and every two months for stage 4 [11].

Stable Coronary Artery Disease

Patients are considered stable if they are asymptomatic or their symptoms are controlled by medications or revascularization. Treatment involves risk factor management, antiplatelet therapy, and antianginal medications. Tobacco cessation, exercise, and weight loss are the most important lifestyle modifications. Treatment of comorbidities such as diabetes mellitus, hyperlipidemia, and hypertension should be optimized to reduce cardiovascular risk. All patients should be started on a statin unless contraindicated [12]. Refer to PCIN's Clinical Guideline for [Ischemic Heart Disease](#) for more detailed information regarding coronary artery disease patients.

References



1. Javorsky E, Robinson A, Kimball AB. Evidence-Based Guidelines to Determine Follow-Up Intervals: A Call for Action. *American Journal of Managed Care*. 2014;20(1):17-19
2. Von Korff, M., & Tiemens, B. (2000). Individualized stepped care of chronic illness. *The Western journal of medicine*, 172(2), 133–137. doi:10.1136/ewjm.172.2.133
3. Raghupathi, W., & Raghupathi, V. (2018). An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach. *International journal of environmental research and public health*, 15(3), 431. doi:10.3390/ijerph15030431
4. US Department of Health and Human Services. (2012). Asthma Care Quick Reference: Diagnosing and Managing Asthma. 2012;12-5075. Retrieved from: [file:///C:/Users/crdebold/Downloads/sites_default_files_publications_12-5075%20\(1\).pdf](file:///C:/Users/crdebold/Downloads/sites_default_files_publications_12-5075%20(1).pdf)
5. Berthold J. Manage diagnosis, follow-up of depression systematically. *ACP Internist and American College of Physicians*. 2011. Retrieved from: <https://acpinternist.org/archives/2011/06/depression.htm>
6. DeJesus RS, Vickers KS, Melin GJ, Williams MD. A System-Based Approach to Depression Management in Primary Care Using the Patient Health Questionnaire-9. *May Clin Proc*. 2007;82(11):1395-1402
7. American Diabetes Association. Standards of Medical Care in Diabetes. 2019; volume 42 issue Supplement 1
8. American Heart Association. Cholesterol Management Guide for Healthcare Practitioners. 2018. Retrieved from: https://www.heart.org/-/media/files/health-topics/cholesterol/chlstrmngmntgd_181110.pdf
9. Nicholls, M. G., Richards, A. M., & Christchurch Cardioendocrine Research Group (2007). Disease monitoring of patients with chronic heart failure. *Heart (British Cardiac Society)*, 93(4), 519–523. <https://doi.org/10.1136/hrt.2005.078519>
10. Bischoff EW, Akkermans R, Bourbeau J, van Weel C, Vercoulen JK, Shermer TR. Comprehensive self-management and routine monitoring in chronic obstructive pulmonary disease patients in general practice: randomized controlled trial. *BMJ* 2012; 345; e7642
11. Hirano, Keita et al. "Optimal follow-up intervals for different stages of chronic kidney disease: a prospective observational study." *Clinical and experimental nephrology* vol. 23,5 (2019): 613-620. doi:10.1007/s10157-018-01684-4
12. Fihn SD, Gardin JM, Abrams J, et al. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS guideline for the diagnosis and management of patients with stable ischemic heart disease: executive summary: a report of the American College of Cardiology Foundation/American Heart Association task force on practice guidelines, and the American College of Physicians, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons [published correction appears in *Circulation*. 2014;129(16):e462]. *Circulation*. 2012; 126(25):3097–3137

Approved: 9/11/2020

