Improving Cardiovascular and Diabetes Care and Outcomes:

Change Package for Clinical Practice Teams

Kentucky Department for Public Health
Improving Cardiovascular and Diabetes Care and Outcomes

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Patient Self-Management

3. Equip Direct Care Staff to Facilitate Patient Self-Management Education and Support  
4. Support Patients In Hypertension or Diabetes Self-Management During Their Routine Daily Activities (e.g., Not Related to Any Specific Visit)

Data Driven Quality Improvement

1. Use Patient Registry to Identify, Track and Manage the Population of Patients with Hypertension and Diabetes  
2. Use Practice Data to Drive Improvement
Disclaimer
This toolkit provides general guidance and does not take into account the unique health issues of individual patients. It is not intended to be used as a substitute for the independent judgment of a medical provider.

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Kentucky Diabetes Prevention and Control Program

Kentucky Heart Disease and Stroke Prevention Program

HealthCare
Kentucky Regional Extension Center
Acknowledgments

Measure Up / Pressure Down™ Provider Toolkit
The American Medical Group Foundation and American Medical Group Association (AMGA) produced a toolkit for medical groups participating in Measure Up / Pressure Down™. The provider toolkit addresses many common challenges associated with effectively treating and managing hypertension. The comprehensive provider toolkit is available for download at: http://www.measureuppressuredown.com/HCPof.Find/provToolkit_find.asp.

Together2Goal®
Together 2 Goal® Planks used with permission from the American Medical Group Foundation. The AMGA Foundation produced the Together 2 Goal® Campaign Toolkit to help implement best practices and address many of the common challenges associated with effectively managing type 2 diabetes. The comprehensive toolkit is available for download at: http://www.together2goal.org/Improve/toolkit_improve.html.
Introduction
Medical practices see people with cardiovascular disease and type 2 diabetes on a daily basis. Management of these common health conditions is complex and quite challenging for both practitioners and their patients.

To help support medical practices focused on optimizing chronic disease management, the Kentucky Department for Public Health and the Kentucky Regional Extension Center (Kentucky REC) have developed this toolkit: Improving Cardiovascular and Diabetes Care and Outcomes: Change Package for Clinical Practice Teams. The resource contains quality improvement materials including change concepts, actionable change ideas and related best practice tools and resources that target both hypertension and diabetes management. The terms “change concept” and “change idea” are credited to the Institute for Healthcare Improvement (IHI). Change concept is a general evidence-based improvement principle while the related change ideas are specific actionable items. Evidence-based tools and resources are supporting materials for the change ideas.

Application of the toolkit concepts and ideas can help significantly improve process and outcomes related to hypertension and diabetes care management. The package contents are categorized in the following areas of focus:

- Operational Efficiency
- Evidence-Based Interventions
- Patient Self-Management
- Data Driven Quality Improvement
Focus Areas

**Operational Efficiency**

Targeted to streamline clinical operations to reduce variations in recordings and results, these change concepts build on information systems as well as human skills development. They are best implemented with team input and with physician champions leading the quality improvement efforts. Following the mantra of “every patient, every time”, can lead to sustained success.

**Evidence-Based Interventions**

Research has shown that application of evidence-based clinical protocols, clinical decision support tools, provider and patient reminder systems have dramatic impact on the quality of care and provide long-term improvements in chronic disease management.

**Patient Self-Management**

Patients with hypertension and diabetes are encouraged to be involved in self-care. Education and the right tools are essential care elements to develop the knowledge and skills needed for self-care. Some of the key change concepts offered in the change package focus heavily on patient education and engagement of patients and their families. Educating and empowering patients to take control is a critical step to improved patient outcomes. This change package offers opportunities at every step of the patient visit.

**Data Driven Quality Improvement**

Monitoring and measuring a change process is what helps to identify the success of the change itself. Reliable practice data that helps to understand the impact of the change is essential to drive improvement.

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How to Apply the Change Package
Building on the IHI’s Improvement Project Roadmap, this toolkit offers a number of options to achieve substantial improvement in chronic management of hypertension and diabetes. Practices can select change concepts and related actionable change ideas most suited to practice gaps and goals. The change ideas are paired with a sampling of tools and resources suggested by experts in the field from a variety of organizations. They can be adopted or adapted to support implementation of chosen change ideas. Clinicians and practices are encouraged to approach this change package as a tool to be addressed with a multidisciplinary team.

A stepwise improvement approach is highly encouraged by utilizing the simple, yet powerful model noted on the right. This Model for Improvement outlines an efficient way to plan, implement and test changes to see how they work in a particular clinic setting. Begin the process by answering the three model questions to set an aim, identify metrics to measure and determine the change idea for improvement. Once a change idea has been selected, work through the Plan-Do-Study-Act (PDSA) cycle to conduct a test of change on a small subset of the practice population. Utilization of the cycle is a “trial and learning” method to test changes quickly. Measure and monitor both the process and the outcomes as applicable. While outcomes could include improved blood pressure or A1C control, process measures such as newly diagnosed hypertensive patients educated on self-monitoring or newly diagnosed diabetes patients referred for Diabetes Self-Management Education and Support (DSMES) could be extremely valuable to the operational component of the change initiative. Effective utilization of multiple rapid PDSA cycles can greatly accelerate improvements as it allows for small tests of change to refine the process prior to system wide implementation.

The collection of concepts, ideas, tools and resources that follow have been shown to make improvement in chronic disease management. In your critical role to assist Kentuckians with chronic disease to live longer and have healthier lives, clinical practice teams are encouraged to utilize and take advantage of this improvement toolkit. It will be updated periodically and is easily accessible for electronic download on the Kentucky Diabetes Network website.
## Improving Cardiovascular and Diabetes Care and Outcomes

### Operational Efficiency

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<tr>
<td><strong>1. Use Clinical Information Systems to Collect Pertinent Patient Information</strong></td>
<td>A. Adopt a robust Electronic Health Record (EHR)</td>
<td>1) <strong>Practice Transformation Toolkit</strong>&lt;br&gt;Use to implement a new or upgraded electronic health record (EHR) <a href="https://www.healthit.gov/providers-professionals/implementation-resources/practice-transformation-toolkit?mc_cid=a3e211a6db&amp;mc_eid=497dbec33a">https://www.healthit.gov/providers-professionals/implementation-resources/practice-transformation-toolkit?mc_cid=a3e211a6db&amp;mc_eid=497dbec33a</a> 2) <strong>Contract Consultation and Technical Assistance Services for EHR Optimization</strong> <a href="http://kentuckyrec.com/">http://kentuckyrec.com/</a></td>
<td>1) Office of the National Coordinator for Health Information Technology 2) Kentucky Regional Extension Center (Kentucky REC)</td>
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<td><strong>2. Make Chronic Disease Management and Control a Practice Priority</strong></td>
<td>A. Designate a Chronic Disease Champion in the practice</td>
<td>1) <strong>Cardiovascular Physician Champion Role Description</strong> (Kaiser Permanente) Appendix A, page 13 <a href="https://millionhearts.hhs.gov/files/HTN_Change_Package.pdf">https://millionhearts.hhs.gov/files/HTN_Change_Package.pdf</a></td>
<td>1) Centers for Disease Control and Prevention/Million Hearts®</td>
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| 3) Implement practice-based screening to test high-risk patients and use EHR to identify those already meeting criteria for hypertension and/or type 2 diabetes but lack a diagnosis and/or problem list entry | 1) **Conduct Practice-Based Screening**  
Together 2 Goal® Campaign Toolkit, pages 49-54  
http://www.together2goal.org/assets/PDF/Toolkit/conductPracticeBasedScreening.pdf | 1) American Medical Group Association | |
| | | | |
| | | | |
| 4) **All Team Members Trained in Importance of BP Goals and Metrics**  
Measure Up Pressure Down Provider Toolkit: Plank 7, pages 65-66  
http://www.measureuppresuredown.com/HCPProf/Find/Toolkit/Plank7.pdf | 4) American Medical Group Association | |
| | | | |
| 5) **Team-Based Care to Improve Blood Pressure Control**  
Task Force Finding and Rationale Statement  
https://www.thecommunityguide.org/sites/default/files/assets/CVD-Team-Based-Care.pdf | 5) Community Preventive Services Task Force | |
| | | | |
| 6) **Create a Strong Team Culture**  
STEPSforward CME Module, Downloadable Tools and Implementation Support  
https://www.stepsforward.org/modules/create-healthy-team-culture | 6) American Medical Association | |
| | | | |
| 7) **Implementing Team-Based Care**  
STEPSforward, CME Module, Downloadable Tools and Implementation Support  
https://www.stepsforward.org/modules/team-based-care | 7) American Medical Association | |
### Operational Efficiency

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| D. Consider participating in an organized quality improvement initiative with other practices | **1) Chronic Disease Pilot on Hypertension and Diabetes Improvement**  
Contact the Kentucky REC for more information about this quality improvement project and resources at [http://kentuckyrec.com/contact/](http://kentuckyrec.com/contact/) | **2) Enroll in Together 2 Goal® Campaign**  
[http://www.together2goal.org/Involve/enroll_involv.html](http://www.together2goal.org/Involve/enroll_involv.html) | **1) Kentucky Regional Extension Center (Kentucky REC)**  
**2) American Medical Group Association** |
## Evidence-Based Interventions

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| 1. Use Evidence-Based Care Guidelines and Treatment Protocols in Systematic Ways | A. Utilize provider reminders or clinical decision support functions in EHRs to remind providers to consistently implement hypertension and diabetes guidelines for care | 1) **Embed Point-Of-Care-Tools**  
Together 2 Goal® Campaign Toolkit, pages 91-101  
[http://www.together2goal.org/assets/PDF/Toolkit/embedPointOfCareTools.pdf](http://www.together2goal.org/assets/PDF/Toolkit/embedPointOfCareTools.pdf)  
2) **Standards of Medical Care in Diabetes - 2017**  
3) **Comprehensive Type 2 Diabetes Management Algorithm - 2017**  
Pages 228-238  
4) **Clinical Decision Support (CDS)**  
How to Implement EHRs  
[https://www.healthit.gov/providers-professionals/clinical-decision-support-cds](https://www.healthit.gov/providers-professionals/clinical-decision-support-cds)  
5) **Perspectives on Hypertension**  
6) **Elements Associated with Effective Adoption and Use of a Protocol**  
Insights from Key Stakeholders  
2) American Diabetes Association  
3) American Association of Clinical Endocrinologists and American College of Endocrinology  
4) The Office of the National Coordinator for Health Information and Technology  
5) American College of Cardiology  
6) Centers for Disease Control and Prevention / Million Hearts® |
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|                 |                             | 10) Treatment Algorithm 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)  
|                 |                             | 11) 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)  
http://jamanetwork.com/journals/jama/fullarticle/1791497 | 11) American Medical Association |
|                 |                             | 12) Controlling Hypertension in Adults  
|                 |                             | 13) 24x18 Blood Pressure Treatment Algorithm  
https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_486133.pdf | 13) American Heart Association |
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| **B.** Proactively utilize Health Information Technology (HIT) to generate patient data report, registry summary or flow sheet reports for status of guideline implementation for individual patients on a single sheet for a planned visit | **1) Embed Point-of-Care-Tools**  
Together 2 Goal® Campaign Toolkit, pages 91-101  
[http://www.together2goal.org/assets/PDF/Toolkit/embedPointOfCareTools.pdf](http://www.together2goal.org/assets/PDF/Toolkit/embedPointOfCareTools.pdf)  

**2) Diabetes Care Tool**  
| **C.** Deploy detailed protocols and algorithms to facilitate treating to target and intensifying therapy for hypertension and diabetes | **1) Adopt Treatment Algorithm**  
Together 2 Goal® Campaign Toolkit, pages 55-70  
[http://www.together2goal.org/assets/PDF/Toolkit/adoptTreatmentAlgorithm.pdf](http://www.together2goal.org/assets/PDF/Toolkit/adoptTreatmentAlgorithm.pdf)  

**2) Pharmacologic Approaches to Glycemic Treatment**  
Diabetes Care, Standards of Medical Care in Diabetes – 2017, figures 8.1 and 8.2  
[http://care.diabetesjournals.org/content/40/Supplement_1/S64.figures-only](http://care.diabetesjournals.org/content/40/Supplement_1/S64.figures-only)  

**3) Glycemic Control Algorithm 2017**  
Page 236  
**2) American Diabetes Association**  
**3) American Association of Clinical Endocrinologists** |
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|                 | **Evidence-based Treatment Protocols**  
|                 | Cholesterol Management and Hypertension Treatment  
|                 | [https://millionhearts.hhs.gov/tools-protocols/protocols.html](https://millionhearts.hhs.gov/tools-protocols/protocols.html) | 4) Million Hearts® |
|                 | **New York Develops Clinical Pathway to Identify and Manage Adult Hypertension**  
|                 | Million Hearts® Success Story.  
|                 | [http://www.hcnny.org/WhitneyYoung_HTNProtocol.pdf](http://www.hcnny.org/WhitneyYoung_HTNProtocol.pdf) | 5) Centers for Disease Control and Prevention / Association of State and Territorial Health Officials |
| **D. Overcome treatment inertia** | **Blood Pressure Addressed for Every Hypertension Patient at Every Primary Care or Cardiology Visit**  
|                 | Measure Up Pressure Down Provider Toolkit: Plank 3, pages 35-36  
| **E. Manage resistant hypertension effectively** | **Resistant Hypertension**  
|                 | **Resistant Hypertension**  
| **F. Establish standing orders or diabetes order sets that can be initiated by non-physician staff members to facilitate A1C testing and** | **Measure HbA1c Every 3-6 Months**  
|                 | Together 2 Goal® Campaign Toolkit, pages 71-72  
|                 | [http://together2goal.org/assets/PDF/Toolkit/measureHbA1cEvery3To6Months.pdf](http://together2goal.org/assets/PDF/Toolkit/measureHbA1cEvery3To6Months.pdf) | 1) American Medical Group Association |
|                 | **Pre-Visit Laboratory Testing**  
|                 | STEPSforward, CME Module, Downloadable Tools and Implementation Support  
|                 | [https://www.stepsforward.org/modules/pre-visit-laboratory-testing](https://www.stepsforward.org/modules/pre-visit-laboratory-testing) | 2) American Medical Association |
|                 | **Diabetes Care Standing Orders**  
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| 2. Implement a Policy and Process to Measure and Address A1C Every 3-6 Months for Every Patient with Diabetes | other key standards of care                                                                                                                      | **4) Standing Orders for Type 2 Diabetes**  
| A. Develop a flowchart for how patients with diabetes will proactively be tracked and managed | **1) Critical Pathway Approach to A1C Control**  
Figure 4.2, page 31  
**2) Planned Care Visit Workflow**  
http://www.ihi.org/education/Documents/ProgramMaterials/CDCMillionHeartsBloodPressureProject/PaloAltoMed_PlannedCareVisitWorkflow.pdf | 1) Health Resources and Services Administration  
2) Institute for Healthcare Improvement and Palo Alto Medical Foundation |
| B. Incorporate educational interventions and tools on A1C and knowing the number | **1) My Diabetes Care Record**  
Aim for the Green Zone for Your A1C and Other Diabetes Care Goals  
http://www.kydiabetes.net/images/files/My%20Diabetes%20Care%20Record%20from%20Printer%202012%202015.pdf  
**2) Know Your A1C Number Poster**  
Companion piece to My Diabetes Care Record,  
2) Kentucky Diabetes Network |
| C. Provide blood pressure checks without appointment or co-pay | **1) Walk-in Medical Assistant Blood Pressure Check Protocol** (Kaiser Permanente)  
Measure Up Pressure Down Provider Toolkit: Plank 8, pages 81-84  
http://www.measureuppressedown.com/HCProf/Find/Toolkit/Plank8Tool3.pdf | 1) American Medical Group Association |
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| 3. Implement Policy and Processes to Measure and Address Blood Pressure at Every Patient Encounter | A. Develop hypertension control policy and procedures | 1) **Blood Pressure Addressed for Every Hypertension Patient at Every Primary Care or Cardiology Visit**  
Measure Up Pressure Down Provider Toolkit: Plank 3, pages 35-36  
2) **Blood Pressure Check Visit Policy and Procedure** (Kaiser Permanente)  
Measure Up Pressure Down Provider Toolkit: Plank 4, pages 1-4  
2) American Medical Group Association |
| | B. Leverage local Patient Centered Medical Home (PCMH) activities to help drive comprehensive approach to hypertension management | 1) **Improving the Screening, Prevention, and Management of Hypertension**  
An Implementation Tool for Clinic Practice Teams, pages 18-33  
The Eight Components of the PCMH  
[https://www.healthit.gov/sites/default/files/13_bptoolkit_e13l.pdf](https://www.healthit.gov/sites/default/files/13_bptoolkit_e13l.pdf)  
2) **Local Coaching and Technical Assistance**  
The Kentucky REC offers coaching and technical assistance to Kentucky practices and organizations interested in National Committee for Quality Assurance (NCQA) Patient Centered Medical Home and Specialty Practice Recognition. Contact the Kentucky REC for more information at  
2) Kentucky Regional Extension Center (Kentucky REC) |
| | C. Develop a flowchart for how hypertensive patients will be proactively tracked and managed | 1) **Critical Pathway for Hypertension Control**  
Figure 3.1  
2) **Planned Care Visit Workflow** (can be adapted for blood pressure control)  
2) Institute for Healthcare Improvement |
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| D.              | Contact patients to confirm upcoming appointments; instruct them to bring medications, medication list, and home blood pressure readings; tell them to take medications as instructed on day of visit; if possible, instruct them on submitting home blood pressure readings periodically via apps / portal | **1) Key Message #1: Building Trust is Critical**  
Improving the Screening, Prevention, and Management of Hypertension: An Implementation Tool for Clinic Practice Teams, page 49  
| E.              | Design workflows and use tools to ensure that indicated orders / actions occur during the visit | **1) Planned Care Visit Workflow**  
Partnering in Self-Management Support: A Toolkit for Clinicians  
http://www.ihi.org/education/Documents/ProgramMaterials/CDCMillionHeartsBloodPressureProject/PaloAltoMed_PlannedCareVisitWorkflow.pdf | 1) Institute for Healthcare Improvement / Palo Alto Medical Foundation |
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| F.              | Provide patient with tools to support their visit agenda and goal setting | 1) Action Plan Form  
|                 |                            | 2) My Life Check - Life's Simple 7  
http://www.heart.org/HEARTORG/Conditions/My-Life-Check---Lifes-Simple-7_UCM_471453_Article.jsp#.WOUAOIlzXbg | 2) American Heart Association |
|                 |                            | 3) CARE Collaborative  
Contact KHDSP@ky.gov | 3) Kentucky Heart Disease and Stroke Prevention Program |
|                 |                            | 4) Check. Change. Control. Community Partner Resources  
http://www.heart.org/HEARTORG/Conditions/More/ToolsForYourHeartHealth/Check-Change-iControli-Community-Partner-Resources_UCM_445512_Article.jsp#.WOUAsFlzXbg | 4) American Heart Association |
| G.              | Measure, document and repeat blood pressure correctly as indicated; flag abnormal readings | 1) Clinical Decision Supports (CDS)  
How to Implement EHRs  
https://www.healthit.gov/providers-professionals/clinical-decision-support-cds | 1) The Office of the National Coordinator for Health Information and Technology |
|                 |                            | 2) Improving Blood Pressure Control for Patients with Diabetes in 4 Community Health Centers  
Meaningful Use Case Studies  
https://www.healthit.gov/providers-professionals/improving-blood-pressure-control-patients-diabetes-4-community-health | 2) The Office of the National Coordinator for Health Information and Technology |
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| H. Use documentation templates to help capture key data such as patient treatment goals, barriers to adherence, etc. | **1) Clinical Decision Supports (CDS)**  
How to Implement EHRs  
[https://www.healthit.gov/providers-professionals/clinical-decision-support-cds](https://www.healthit.gov/providers-professionals/clinical-decision-support-cds)  

**2) Morisky Scale** (Mercy Clinics, Inc.)  
Measure Up Pressure Down Provider Toolkit: Plank 4, page 41  
[http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank4Tool1.pdf](http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank4Tool1.pdf) | 1) The Office of the National Coordinator for Health Information and Technology  
2) American Medical Group Association |
| I. Use protocols to cover proactive outreach or patient reminders driven by registry use and/or in response to patient submitted home blood glucose levels and blood pressure readings | **1) Protocol for Uncomplicated Hypertension**  
Registered Nurse Titration of Lisinopril, Hydrochlorothiazide, Atenolol, and Amlodipine  

**2) Standing Order**  
Antihypertensive Initiation and Titration  

**3) Blood Pressure Titration Protocol**  
Diabetes Planned Visit Notebook  

**4) Hypertension Standing Orders** (Mercy Clinics, Inc.)  
Measure Up Pressure Down Provider Toolkit: Plank 4, page 43  
[http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank4Tool2.pdf](http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank4Tool2.pdf) | 1) Kaiser Permanente  
2) University of North Carolina Health Care Center  
3) Agency for Healthcare Research and Quality  
4) American Medical Group Association |
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| 4. Use Clinician-Managed Protocols for Medication Adjustments and Lifestyle Recommendations | A. Use order sets (e.g., with prompts for medication titration; increase compliance via prescribing from patient insurance formulary, using once daily / fixed dose combinations when possible) and standing orders to support evidence-based and individualized care | 1) **Standing Orders Diabetes Care** (can be adapted for blood pressure control) [http://www.migrantclinician.org/toolsource/tool-box/standing-orders-diabetes-care.html](http://www.migrantclinician.org/toolsource/tool-box/standing-orders-diabetes-care.html)  
2) **All Patients Not at Goal or with New Hypertension Rx Seen within 30 Days**  
3) **Hypertension Standing Orders** (Mercy Clinics, Inc.)  
2) American Medical Group Association  
3) American Medical Group Association |
| B. Explore ways to incorporate community or onsite pharmacists on the healthcare team | 1) **The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide** [https://www.pcpcc.org/sites/default/files/media/medmanagement.pdf](https://www.pcpcc.org/sites/default/files/media/medmanagement.pdf)  
2) **Expert Practices in the Real World**  
Community Pharmacy and Patient-Centered Comprehensive Medication Management [https://ww04.elbowspace.com/secure/20160701102005942203](https://ww04.elbowspace.com/secure/20160701102005942203) | 1) Patient-Centered Primary Care Collaborative  
2) Community Pharmacy Foundation |
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</table>
| 5. Integrate Comprehensive Medication Management | A. Ensure team is skilled in identifying / promoting patient medication adherence | 1) **Actions to Improve Medication Adherence**  
Hypertension Control: Action Steps for Clinicians, Table 2  
https://millionhearts.hhs.gov/files/MH_HTN_Clinician_Guide.pdf | 1) Centers for Disease Control and Prevention / Million Hearts* |
| |  | 2) **Medication Adherence Time Tool**  
Medication Adherence - Improving Health Outcomes  
http://www.acpm.org/?MedAdhereTTProviders | 2) American College of Preventive Medicine |
| |  | 3) **Medication Adherence Action Kit**  
| |  | 4) **Medication Adherence**  
Tools and Tip Sheets  
https://millionhearts.hhs.gov/tools-protocols/medication-adherence.html | 4) Centers for Disease Control and Prevention / Million Hearts* |
| |  | 5) **Medication Adherence**  
STEPSforward, CME Module, Downloadable Tools and Implementation Support  
https://www.stepsforward.org/modules/medication-adherence | 5) American Medical Association |
| |  | 6) **Promoting Medication Adherence in Diabetes**  
| | B. Assess individual risk and counsel using motivational interviewing | 1) **ASCVD Risk Estimator**  
http://tools.acc.org/ASCVD-Risk-Estimator/ | 1) American College of Cardiology / American Heart Association |
## Evidence-Based Interventions

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<td>Reconcile medications patient is actually taking with the record’s medication list</td>
<td>1) <strong>Medication Reconciliation Form</strong>&lt;br&gt;<a href="http://www.ihi.org/education/Documents/ProgramMaterials/CDCMillionHeartsBloodPressureProject/BMHMemphis_MedReconciliationForm.pdf">http://www.ihi.org/education/Documents/ProgramMaterials/CDCMillionHeartsBloodPressureProject/BMHMemphis_MedReconciliationForm.pdf</a></td>
<td>1) Institute for Healthcare Improvement</td>
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<td></td>
<td>Support medication adherence by providing clear written and verbal instructions and encouraging patients to use medication reminders</td>
<td>1) <strong>Medication Adherence Action Kit</strong>&lt;br&gt;Provider Resources&lt;br&gt;<a href="https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-medication-adherence.page">https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-medication-adherence.page</a>&lt;br&gt;2) <strong>Pocket Medicine List</strong> (bulk order English and Spanish for free)&lt;br&gt;Various tools to keep track of medicines, how-to videos about taking medicine, and tips to help talk with doctors or pharmacists about health problems and medicine.&lt;br&gt;<a href="http://www.scriptyourfuture.org/tools/">http://www.scriptyourfuture.org/tools/</a></td>
<td>1) New York City Department of Health&lt;br&gt;2) Script Your Future</td>
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<tr>
<td>F. Implement frequent follow-ups (e.g., e-mail, phone calls, text messages) with patients to make sure they are continuing their medication</td>
<td>No resource or tool for actionable idea for change</td>
<td>Not Applicable</td>
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<td></td>
<td>blood pressure accurately</td>
<td>2) <strong>Correct Blood Pressure Measurement Technique Handout</strong> (Colorado Springs Health Partners) Measure Up Pressure Down Provider Toolkit: Plank 1, page 1 <a href="http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank1Tool5.pdf">http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank1Tool5.pdf</a></td>
<td>2) American Medical Group Association</td>
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| 6. Train and Evaluate Direct Care Staff on Accurate BP Measurement and Recording | A. Assess adherence to proper blood pressure measurement technique | 1) **Competency Checklist Blood Pressure Measurement** (Cleveland Clinic)  
Measure Up Pressure Down Provider Toolkit: Plank 1, page 1  
http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank1Tool3.pdf | 1) American Medical Group Association |
| | | 2) **Blood Pressure Spot Check** (Kaiser Permanente)  
Measure Up Pressure Down Provider Toolkit: Plank 4, pages 1-2  
http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank4Tool4.pdf | 2) American Medical Group Association |
| | | 3) **New Employee Blood Pressure Measurement Initial Competency Checklist**  
(HealthPartners)  
Measure Up Pressure Down Provider Toolkit: Plank 1, page 1  
http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank1Tool8.pdf | 3) American Medical Group Association |
| | | 4) **Quarterly Blood Pressure Auditing Tool** (HealthPartners)  
Measure Up Pressure Down Provider Toolkit: Plank 1, page 1  
http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank1Tool10.pdf | 4) American Medical Group Association |
## Patient Self-Management

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<td><strong>3) Diabetes Care Standing Orders</strong>&lt;br&gt;<a href="http://www.kydiabetes.net/uploads/pdf/Diabetes_Standing_Orders.pdf">Link</a></td>
<td>3) Kentucky Diabetes Network</td>
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<td></td>
<td><strong>4) Standing Orders for Diabetes Care</strong>&lt;br&gt;<a href="http://www.migrantclinician.org/toolsource/tool-box/standing-orders-diabetes-care.html">Link</a></td>
<td>4) Migrant Clinician’s Network</td>
</tr>
<tr>
<td>C. Identify nationally “recognized” or “accredited” DSMES programs or other DSMES classes offered in your service area and establish a DSMES program referral list</td>
<td><strong>1) Kentucky Diabetes Resource Directory</strong>&lt;br&gt;Listings of recognized or accredited or other Diabetes Self-Management Education and Support (DSMES) programs which can be queried by county and/or adjacent counties.&lt;br&gt;<a href="https://prd.chfs.ky.gov/KYDiabetesResources/Search.aspx">Link</a></td>
<td>1) Kentucky Diabetes Prevention and Control Program</td>
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<td><strong>3) Recognized Diabetes Education Programs Listing</strong>&lt;br&gt;<a href="http://professional.diabetes.org/erp_list_zip">Link</a></td>
<td>3) American Diabetes Association</td>
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<td><strong>1) Diabetes Services Order Form</strong> - Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services&lt;br&gt;Meets requirements set forth by Medicare and most insurance companies.&lt;br&gt;<a href="https://www.diabeteseducator.org/docs/default-source/default-document-library/diabetes-services-order-form7e32db36a05f68739c53ff0000b8561d.pdf?sfvrsn=0">Link</a></td>
<td>1) American Association of Diabetes Educators</td>
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<td>etc. (e.g., referral, prescription pad, referral forms, etc.)</td>
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<td>E. Assign a staff member to be a key contact to work with DSMES provider agencies</td>
<td>1) <strong>Refer to DSMES and Support Programs</strong>  Together 2 Goal® Campaign Toolkit, pages 45-48  <a href="http://www.together2goal.org/assets/PDF/Toolkit/referToDSMEAndSupportPrograms.pdf">http://www.together2goal.org/assets/PDF/Toolkit/referToDSMEAndSupportPrograms.pdf</a></td>
<td>1) American Medical Group Association</td>
<td></td>
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<tr>
<td>F. Explore ways to reduce or remove barriers to participation in DSMES classes such as lack of transportation, cost of service, language barriers, health literacy, etc.</td>
<td>1) <strong>Local Resources</strong>  Use resources within community to mitigate the obstacles.  2) <strong>Local Diabetes Self-Management Education and Support (DSMES) Providers</strong>  Check with local DSMES providers to see if there are sliding scale or scholarship options. Some local health departments offer the service without charge.</td>
<td>1) Not Applicable  2) Not Applicable</td>
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<td></td>
<td>DSMES can help</td>
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2. **Empower Patients with Knowledge and Skills for Self-Management – Refer for Self-Measured Blood Pressure Monitoring (SMBP).**

A. Support blood pressure self-monitoring: advise on choosing device / cuff size, check device for accuracy, train patient on use, provide BP logs (electronic / paper / portal)

1) **How to Check Your Blood Pressure**
   8.5x5.5 booklets come in English & Spanish
   [http://1.usa.gov/1nTAImf](http://1.usa.gov/1nTAImf)

2) **Blood Pressure Tracking Card and Action Plan**

3) **My Blood Pressure Wallet Card**

4) **Blood Pressure Tracking Card** (Arch Health Partners)
   Measure Up Pressure Down Provider Toolkit: Plank 4, pages 1-2

5) **Blood Pressure Measurement Instructions**

6) **Consequences of High Blood Pressure**

7) **Understanding and Managing High Blood Pressure**
   [https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_461840.pdf](https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_461840.pdf)

1) Washington State Department of Health
2) New York City Department of Health
3) National Heart, Lung, and Blood Institute / Million Hearts®
4) American Medical Group Association
5) American Heart Association
6) American Heart Association
7) American Heart Association
# Patient Self-Management

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| 3. Equip Direct Care Staff to Facilitate Patient Self-Management Education and Support | A. Facilitate access to opportunities to acquire the latest core cardiovascular / diabetes knowledge and to build / strengthen self-management support skills (e.g., professional education, motivational interviewing, setting self-management goals, etc.) | 1) **Licensed Health Professions**: ABCs of Diabetes Education and Facilitating Behavior Change  
| | | 2) **Health Educators and Certified Medical Assistants**: Diabetes Paraprofessional Level 2 Course  
https://www.diabeteseducator.org/education-career/career-path-certificate/associate-level-2 | 2) American Association of Diabetes Educators |
| | | 3) **Community Health Workers**: Diabetes Paraprofessional Level 1 Course  
https://www.diabeteseducator.org/education-career/career-path-certificate/associate-level-1 | 3) American Association of Diabetes Educators |
| | | 4) **Community Health workers and Chronic Disease Training**:  
www.chwtraining.mcdph.org | 4) Montgomery County District Public Health |
| | | 5) **Cardiovascular Assessment, Risk Reduction, and Education (CARE) Collaborative**  
Contact KHDSP@ky.gov | 5) Kentucky Heart Disease and Stroke Prevention Program |
| | | 6) **Partnering in Self-Management Support: A Toolkit for Clinicians**  
| | | 7) **Target: BP™ Fact Sheet**  
http://www.heart.org/idc/groups/heart-public/@wcm/@mwa/documents/downloadable/ucm_482030.pdf | 7) American Heart Association |
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| **B.** Consider attending Diabetes Self-Management Education and Support (DSMES) classes provided in your service area | **1) Kentucky Diabetes Resource Directory**  
| **C.** Identify a few patient educational materials and tools to help with key self-management information and setting self-management goals: blood pressure, salt intake, exercise, and smoking | **1) What is Diabetes?**  
A variety of low literacy materials on key self-care behaviors from various sources  
http://www.kydiabetes.net/what_is_diabetes.html | | 1) Kentucky Diabetes Network |
| | **2) Tools for Patients with Diabetes**  
Diabetes and nutrition basics booklets as well as other items (English and Spanish versions available).  
http://chfs.ky.gov/dph/info/dpqi/cd/PatTools.htm | | 2) Kentucky Diabetes Prevention and Control Program |
| | **3) Healthy Living with Diabetes Tool for Setting Self-Management Goals**  
| | **4) Patient Education Library**  
http://professional.diabetes.org/search/site?f%5B0%5D=im_field_dbp_ct%3A3A32&retain-filters=1 | | 4) American Association of Diabetes Educators |
| | **5) Diabetes Tip Sheets**  
https://www.diabeteseducator.org/patient-resources/tip-sheets-and-handouts | | 5) American Association of Diabetes Educators |
| | **6) 4 Steps to Manage Your Diabetes for Life**  
## Improving Cardiovascular and Diabetes Care and Outcomes

### Patient Self-Management

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|                 | 7) **Know Your Blood Pressure Numbers**  
|                 | 8) **What’s the Big Deal about Controlling My Blood Pressure?**  
|                 | 9) **Know the Facts About High Blood Pressure**  
https://www.cdc.gov/bloodpressure/docs/consumered_hbp.pdf | 9) Centers for Disease Control and Prevention |
|                 | 10) **Reducing Sodium in the Diet to Help Control Your Blood Pressure**  
|                 | 11) **Your Guide to Lowering Blood Pressure**  
| **D. Consider starting a recognized Diabetes Self-Management Education and Support (DSMES) program** | 1) **AADE Diabetes Education Accreditation Program**  
|                 | 2) **Education Recognition Program**  
| **E. Establish a program to support home blood pressure monitoring** | 1) **Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians**  
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<td><strong>4. Support Patients In Hypertension or Diabetes Self-Management During Their Routine Daily Activities (e.g., Not Related to Any Specific Visit)</strong></td>
<td><strong>A.</strong> Use an online patient portal or other approaches so that patients can access tools, information and practice staff outside face-to-face encounters to address home measured blood pressure readings and blood glucose monitoring values or trends and other needs</td>
<td><strong>1) What is a Patient Portal?</strong>  <a href="https://www.healthit.gov/providers-professionals/faqs/what-patient-portal">https://www.healthit.gov/providers-professionals/faqs/what-patient-portal</a></td>
<td>1) The Office of the National Coordinator for Health Information Technology and National Learning Consortium</td>
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</table>
| | | **B.** Ensure that the self-management support provided to patients is helpful in their daily routine (e.g. when making food and lifestyle choices) | **1) Diabetes Self-Management Support (DSMS) Plan**  [http://c.ymcdn.com/sites/www.ncchca.org/resource/resmgr/imported/DSMS.pdf](http://c.ymcdn.com/sites/www.ncchca.org/resource/resmgr/imported/DSMS.pdf)  
2) American Diabetes Association  
3) Institute for Health Care Improvement |
## Improving Cardiovascular and Diabetes Care and Outcomes

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<td>C. Establish linkages with community organizations delivering self-management education support programs</td>
<td>1) <strong>Kentucky Diabetes Resource Directory</strong>&lt;br&gt;Lists of diabetes support groups and other self-management support resources which can be queried by county and/or adjacent counties.&lt;br&gt;<a href="https://prd.chfs.ky.gov/KYDiabetesResources/Search.aspx">https://prd.chfs.ky.gov/KYDiabetesResources/Search.aspx</a></td>
<td>1) Kentucky Diabetes Prevention and Control Program</td>
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<td>D. Support medication adherence by providing clear written and verbal instructions and encouraging patients to use medication reminders</td>
<td>1) <strong>Medication Adherence Action Kit</strong>&lt;br&gt;Provider Resources&lt;br&gt;<a href="https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-medication-adherence.page">https://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-medication-adherence.page</a>&lt;br&gt;2) <strong>Pocket Medicine List</strong> (bulk order English and Spanish for free)&lt;br&gt;Various tools to keep track of medicines, how-to videos about taking medicine, and tips to help talk with doctors or pharmacists about health problems and medicine.&lt;br&gt;<a href="http://www.scriptyourfuture.org/tools/">http://www.scriptyourfuture.org/tools/</a>&lt;br&gt;3) <strong>Medicines to Help You: High Blood Pressure</strong>&lt;br&gt;<a href="https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM282311.pdf">https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM282311.pdf</a></td>
<td>1) New York City Department of Health&lt;br&gt;2) Script Your Future&lt;br&gt;3) Food and Drug Administration / Office of Women’s Health</td>
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<tr>
<td>E. Provide patients with a written self-management plan, visit summary, and follow-up guidance at the end of each visit</td>
<td>1) <strong>5As Encounter Form</strong> (Mercy Clinics, Inc.)&lt;br&gt;Measure Up Pressure Down Provider Toolkit: Plank 5, page 51&lt;br&gt;<a href="http://www.measureuppressuredown.com/HCPProf/Find/Toolkit/Plank5Tool3.pdf">http://www.measureuppressuredown.com/HCPProf/Find/Toolkit/Plank5Tool3.pdf</a>&lt;br&gt;2) <strong>Providing Patients in Ambulatory Care Settings with a Clinical Summary of the Office Visit</strong>&lt;br&gt;<a href="http://www.nihb.org/hitech/docs/08162013/Provider_Clinical_Summary_fact_sheet.pdf">http://www.nihb.org/hitech/docs/08162013/Provider_Clinical_Summary_fact_sheet.pdf</a></td>
<td>1) American Medical Group Association&lt;br&gt;2) The Office of the National Coordinator for Health Information and Technology</td>
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## Data Driven Quality Improvement

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<td>1. Use Patient Registry to Identify, Track and Manage the Population of Patients with Hypertension and Diabetes</td>
<td>A. Implement a hypertension and/or diabetes patient registry</td>
<td>1) Registry Used to Track Hypertension Patients Measure Up Pressure Down Provider Toolkit: Plank 6, pages 63-64 <a href="http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank6.pdf">Link</a></td>
<td>1) American Medical Group Association</td>
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<td>2) Use a Patient Registry Together 2 Goal® Campaign Toolkit pages 89-90 <a href="http://www.together2goal.org/assets/PDF/Toolkit/useAPatientRegistry.pdf">Link</a></td>
<td>2) American Medical Group Association</td>
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<td>3) Implementing a Point-of-Care Registry STEPSforward, CME Module, Downloadable Tools and Implementation Support <a href="https://www.stepsforward.org/modules/point-of-care-registry">Link</a></td>
<td>3) American Medical Association</td>
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<td>4) Provider Toolkit - Population Health Management &amp; Registries <a href="https://www.anthem.com/wps/portal/ahpprovider?content_path=provider/noapplication/f1/s0/t0/pw_e191222.htm&amp;label=Provider%20Toolkit%20%E2%80%93%20Population%20Health%20Management%20%E2%80%93%20Registries&amp;state=va">Link</a></td>
<td>4) Anthem BlueCross BlueShield</td>
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<td>7) Computerized Disease Registries <a href="https://healthit.ahrq.gov/key-topics/computerized-disease-registries">Link</a></td>
<td>7) Agency for Healthcare Research and Quality</td>
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| **B.** Identify patients due or overdue for tests and exams or have uncontrolled hypertension $\geq 140/90$ and/or diabetes (A1C $> 9\%$ may be starting point) | **1) Undiagnosed Hypertension**  
Find patients in your practice with undiagnosed hypertension who may be "hiding in plain sight".  
| | **2) Use a Patient Registry**  
Together 2 Goal® Campaign Toolkit pages 89-90  
[http://www.together2goal.org/assets/PDF/Toolkit/useAPatientRegistry.pdf](http://www.together2goal.org/assets/PDF/Toolkit/useAPatientRegistry.pdf) | 2) American Medical Group Association |
| | **3) Contact Patients Not at Goal and with Therapy Change within 30 Days**  
Together 2 Goal® Campaign Toolkit pages 85-88  
[http://www.together2goal.org/assets/PDF/Toolkit/contactPatientsNotAtGoalAndWithTherapyChangeWithin30Days.pdf](http://www.together2goal.org/assets/PDF/Toolkit/contactPatientsNotAtGoalAndWithTherapyChangeWithin30Days.pdf) | 3) American Medical Group Association |
| | **C. Use a defined process for outreach (e.g. via phone, mail, email, text) to patients with uncontrolled hypertension and/or diabetes, those who are not up-to-date on recommended tests, self-management knowledge / skills and otherwise** | | |
| | **1) Hypertension Recall Instructions** (Redwood Community Health Coalition)  
page 14, Appendix B, Hypertension Control Change Package for Clinicians  
| | **2) Quality Improvement in a Primary Care Practice**  
Meaningful Use Case Studies  
[https://www.healthit.gov/providers-professionals/quality-improvement-primary-care-practice](https://www.healthit.gov/providers-professionals/quality-improvement-primary-care-practice) | 2) The Office of the National Coordinator for Health Information Technology |
| | **3) Contact Patients Not at Goal and with Therapy Change within 30 Days**  
Together 2 Goal® Campaign Toolkit, pages 85-88  
[http://together2goal.org/assets/PDF/Toolkit/contactPatientsNotAtGoalAndWithTherapyChangeWithin30Days.pdf](http://together2goal.org/assets/PDF/Toolkit/contactPatientsNotAtGoalAndWithTherapyChangeWithin30Days.pdf) | 3) American Medical Group Association |
### Data Driven Quality Improvement

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| 2. Use Practice Data to Drive Improvement | A. Determine cardiovascular and diabetes clinical quality measures / metrics for the practice (A1C poor control of >9 and blood pressure control of <140/90 are a good starting point and align with multiple quality measurement sets) | **1)** 2017 Merit-based Incentive Payment System Quality Measures  
https://qpp.cms.gov/measures/quality  

**2)** Healthcare Effectiveness Data and Information Set (HEDIS) Comprehensive Diabetes Care  
http://www.ncqa.org/hedis-quality-measurement/hedis-measures  

**3)** Measures, Reports & Tools  
http://www.qualityforum.org/measures_reports_tools.aspx  

**4)** Specifications Hypertension Measures  
http://www.hcnny.org/HCNNY_HTNMeasureSpecs.pdf  

**5)** Reference Card From the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC7)  

**6)** 2014 Hypertension Guideline Management Algorithm  
From 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)  
2) National Committee for Quality Assurance  
3) National Quality Forum  
4) Health Center Network of New York  
5) U.S. Department of Health and Human Services  
6) American Medical Association |
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<td>B. Regularly provide assessment and feedback dashboard or scorecard for the practice and for individual providers as compared to other providers in practice with metric baseline, target and performance.</td>
<td>1) <strong>Physician Quality Report Card</strong> (Cleveland Clinic) Measure Up Pressure Down Provider Toolkit: Plank, page 73 <a href="http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank7Tool4.pdf">http://www.measureuppressuredown.com/HCProf/Find/Toolkit/Plank7Tool4.pdf</a></td>
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<td>2) <strong>Publish Transparent Internal Reports</strong> Together 2 Goal® Toolkit, pages 103-110 <a href="http://www.together2goal.org/assets/PDF/Toolkit/publishTransparentInternalReports.pdf">http://www.together2goal.org/assets/PDF/Toolkit/publishTransparentInternalReports.pdf</a></td>
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