1815/1817 Assessment for Population Health and Chronic Disease Management

In an effort to align quality improvement efforts in Kansas, the Kansas Department of Health and Environment Bureau of Health Promotion has partnered with the Kansas Healthcare Collaborative to enhance partnerships between providers and community-based individuals and organizations to reduce the impact of chronic disease in Kansas.

To participate,

- Review the CDC | KDHE 1815/1817 Collaborative Strategies.

- Complete this 1815/1817 Assessment with your KHC Quality Improvement Advisor. If you do not have an assigned Quality Improvement Advisor, contact KHC.

- Review your custom report. This report celebrates top performers of the 1815/1817 Collaborative by name. Your practice information is only included in YOUR custom report; all other practice information is masked (unless you are in top 25% of submitted assessments).

- Review work plan instructions contained in the report. Consider submitting an optional 1815/1817 Work Plan to focus improvement efforts on specific, designated CDC|KDHE strategies.

- Engage in quality improvement to address areas of opportunity.

* Practice/Health System Name

Practice Name	
Street Address	
City, State	
Zip	

* Contact Information

Point of Contact	
Phone	
Email	
KHC QIA	

Questions? Contact the Kansas Healthcare Collaborative
Amanda Prosser, MPH
(785) 231-1336
aprosser@khconline.org

All assessments are due by July 15, 2019. Practices will receive notification of awards and instructions for reimbursement prior to receiving their custom reports.

To download a blank assessment, use this link: https://www.khconline.org/files/Clinical__Community_Linkages/PDF_Assessment.pdf

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* Does the practice/health system. . .

	Not yet.	Getting Started, Partially Operating.	Functioning, Performing.	Performing, sustainable, and documented in writing (e.g. policy, EHR capability, written workflow).
1) Routinely screen patients using the CDC Prediabetes Screening Test or the ADA Type 2 Diabetes Risk Test?	○	○	○	○
2) Include identification of prediabetes as part of the standard clinical assessment?	○	○	○	○
3) Routinely use EHR or other technology to generate lists of patients with **prediabetes** for follow up care management and/or education?	○	○	○	○
4) Routinely use EHR or other technology to generate lists of patients diagnosed with **diabetes** for follow up care management and/or education?	○	○	○	○
5) Routinely use EHR or other technology to identify patients with potentially undiagnosed hypertension?	○	○	○	○
6) Use EHR or other technology to report NQF 0018 (Controlling High Blood Pressure) to the Quality Payment Program, another payment model or program?	○	○	○	○

Please describe how your practice uses data to identify specific priority populations and/or identify disparities in care for patients with hypertension.

Comments/Notes on questions 1-6:

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* Does the practice/health system. . .

	Not yet.	Getting Started, Partially Operating.	Functioning, Performing.	Performing, sustainable, and documented in writing (e.g. policy, EHR capability, written workflow).
7) Encourage self-measured blood pressure monitoring among patients with hypertension or who are at risk for hypertension.	○	○	○	○
8) Train patients on proper measurement techniques to self-measure blood pressure.	○	○	○	○
9) Monitor patient blood pressure readings obtained outside of the office visit.	○	○	○	○
10) Provide timely advice on needed medication titrations based on patient self-measured blood pressure readings.	○	○	○	○
11) Provide timely advice on lifestyle changes based on patient self-measured blood pressure readings.	○	○	○	○
12) Use smart apps, mobile health technology, or remote patient monitoring tools to promote the management of patients with high blood pressure.	○	○	○	○

	Not yet.	Getting Started, Partially Operating.	Functioning, Performing.	Performing, sustainable, and documented in writing (e.g. policy, EHR capability, written workflow).
13) Use smart apps, mobile health technology, or remote patient monitoring tools to promote the management of patients with high blood cholesterol.	○	○	○	○

Comments/Notes on questions 7-13:

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* Does the practice/health system routinely refer patients, as applicable to any of the following programs and/or community resources?

	No; program is not locally available.	No; practice/health system does not routinely refer patients.	**Yes**; practice/health system routinely refers patients.	**Yes**; practice/health system routinely refers patients and receives feedback from the program.
14) National Diabetes Prevention Program (DPP)	○	○	○	○
15) ADA recognized or AADE accredited Diabetes Self-Management Education and Support Services (DSMES)	○	○	○	○
16) YMCA Blood Pressure Self-Monitoring Program	○	○	○	○
17) AHA Programs (Check. Change. Control. OR Check. Change. Control. Cholesterol.)	○	○	○	○
18) Chronic Disease Self-Management Program (CDSMP) and/or Tomando Control de su Salud.	○	○	○	○
19) Diabetes Self-Management Program (DSMP) and/or Programa de Manejo Personal de la Diabetes.	○	○	○	○
20) Other lifestyle modification program	○	○	○	○

If other lifestyle modification program, please list program:

If **YES**, to questions 14-20, estimate the number of patients referred during 2018. (please enter number into box for corresponding program)

14a) National Diabetes Prevention Program (DPP)

15a) ADA recognized or AADE accredited Diabetes Self-Management Education and Support Services (DSMES)

16a) YMCA Blood Pressure Self-Monitoring Program

17a) AHA Programs (Check. Change. Control. OR Check. Change. Control. Cholesterol)

18a) Chronic Disease Self-Management Program (CDSMP) and/or Tomando Control de su Salud

19a) Diabetes Self-Management Program (DSMP) and/or Programa de Manejo Personal de la Diabetes.

20a) Other lifestyle modification program

Comments/Notes for questions 14-20:

* Has the practice/health system. . .

	No	Yes - In Progress	Yes - Completed
21) Pursued ADA recognition or AADE accreditation for a diabetes education program?	○	○	○
22) Pursued CDC recognition for the National Diabetes Prevention Program?	○	○	○

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The following questions assess team-based care at multiple levels, showing the various stages in improving chronic illness care. Answer each question regarding how your organization is doing with respect to care for patents with hypertension, then high cholesterol.

* 23) **For Hypertension** - Staff other than primary care providers. . .

- ◯ are not employed by the practice.
- ◯ play a limited role in providing clinical care.
- ◯ are primarily tasked with managing patient flow and triage.
- ◯ provide some clinical services such as assessment or self-management support.
- ◯ perform key clinical service roles that match their abilities and credentials.

* 23a) **For High Cholesterol** - Staff other than primary care providers. . .

- ◯ are not employed by the practice.
- ◯ play a limited role in providing clinical care.
- ◯ are primarily tasked with managing patient flow and triage.
- ◯ provide some clinical services such as assessment or self-management support.
- ◯ perform key clinical service roles that match their abilities and credentials.

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The following questions assess team-based care at multiple levels, showing the various stages in improving chronic illness care. Answer each question regarding how your organization is doing with respect to care for patents with hypertension, then high cholesterol.

* 24) **For Hypertension** - Workflows for clinical teams. . .

- ◯ have not been documented and/or are different for each person or team.
- ◯ have been documented, but are not used to standardize workflows across the practice.
- ◯ have been documented and are utilized to standardize practice.
- ◯ have been documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.

* 24a) **For High Cholesterol** - Workflows for clinical teams. . .

- ◯ have not been documented and/or are different for each person or team.
- ◯ have been documented, but are not used to standardize workflows across the practice.
- ◯ have been documented and are utilized to standardize practice.
- ◯ have been documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.

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The following questions assess team-based care at multiple levels, showing the various stages in improving chronic illness care. Answer each question regarding how your organization is doing with respect to care for patents with hypertension, then high cholesterol.

* 25) **For Hypertension** - Standing orders that can be acted on by staff other than primary care providers under protocol. . .

- ◯ do not exist for this practice.
- ◯ have been developed for some conditions but are not regularly used.
- ◯ have been developed for some conditions and are regularly used.
- ◯ have been developed for many conditions and are used extensively.

* 25a) **For High Cholesterol** - Standing orders that can be acted on by staff other than primary care providers under protocol. . .

- ◯ do not exist for this practice.
- ◯ have been developed for some conditions but are not regularly used.
- ◯ have been developed for some conditions and are regularly used.
- ◯ have been developed for many conditions and are used extensively.

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The following questions assess team-based care at multiple levels, showing the various stages in improving chronic illness care. Answer each question regarding how your organization is doing with respect to care for patents with hypertension, then high cholesterol.

* 26) **For Hypertension** - MAs and/or CNAs in our practice. . .

- ◯ are not employed by the practice.
- ◯ mostly take vital signs and room patients.
- ◯ perform a few clinical tasks beyond rooming patients such as reviewing medication lists or administering a PHQ.
- ◯ perform a few clinical tasks and collaborate with the provider in managing the panel (reviewing exceptions reports, making outreach calls, etc.)
- ◯ collaborate with the provider in managing the panel and play a major role in providing preventive services and services to chronically ill patients such as self-management coaching or follow-up phone calls.

* 26a) **For High Cholesterol** - MAs and/or CNAs in our practice. . .

- ◯ are not employed by the practice.
- ◯ mostly take vital signs and room patients.
- ◯ perform a few clinical tasks beyond rooming patients such as reviewing medication lists or administering a PHQ.
- ◯ perform a few clinical tasks and collaborate with the provider in managing the panel (reviewing exceptions reports, making outreach calls, etc.)
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The following questions assess team-based care at multiple levels, showing the various stages in improving chronic illness care. Answer each question regarding how your organization is doing with respect to care for patents with hypertension, then high cholesterol.

* 27) **For Hypertension** - RNs and/or LPNs in our practice. . .

- ◯ are not employed by the practice.
- ◯ are not a part of the core practice team.
- ◯ mostly triage phone calls and do injections or other procedures.
- ◯ manage transitions within and across levels of care (home, hospital, specialists). RNs provide specific intensive care coordination and management to highest risk patients.
- ◯ provide care management for high risk patients and collaborate with providers in teaching and managing patients with chronic illness, monitoring response to treatment, and titrating treatment according to delegated order sets in independent nurse visits.

* 27a) **For High Cholesterol** - RNs and/or LPNs in our practice. . .

- ◯ are not employed by the practice.
- ◯ are not a part of the core practice team.
- ◯ mostly triage phone calls and do injections or other procedures.
- ◯ manage transitions within and across levels of care (home, hospital, specialists). RNs provide specific intensive care coordination and management to highest risk patients.
- ◯ provide care management for high risk patients and collaborate with providers in teaching and managing patients with chronic illness, monitoring response to treatment, and titrating treatment according to delegated order sets in independent nurse visits.

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The following questions assess team-based care at multiple levels, showing the various stages in improving chronic illness care. Answer each question regarding how your organization is doing with respect to care for patents with hypertension, then high cholesterol.

* 28) **For Hypertension** - Community Health Workers (CHWs) and/or patient navigators in our practice. . .

- ◯ are not employed by the practice.
- ◯ are not involved.
- ◯ provide non-clinical patient facing roles such as reception or referral management.
- ◯ include individuals who do one or more of the following: provide self management coaching, coordinate care, help patients navigate the health care system, or access community services.
- ◯ perform the functions listed above, and are key members of the core practice team.

* 28a) **For High Cholesterol** - Community Health Workers (CHWs) and/or patient navigators in our practice. . .

- ◯ are not employed by the practice.
- ◯ are not involved.
- ◯ provide non-clinical patient facing roles such as reception or referral management.
- ◯ include individuals who do one or more of the following: provide self management coaching, coordinate care, help patients navigate the health care system, or access community services.
- ◯ perform the functions listed above, and are key members of the core practice team.

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The following questions assess team-based care at multiple levels, showing the various stages in improving chronic illness care. Answer each question regarding how your organization is doing with respect to care for patents with hypertension, then high cholesterol.

* 29) **For Hypertension** - A pharmacist(s). . .

- ◯ is not involved in our practice.
- ◯ oversees our dispensary but is not involved in clinical care.
- ◯ is available to answer medication-related questions from providers and staff both directly and electronically.
- ◯ works closely with the core practice team to review prescribing practices and proactively assist patients with medication related problems such as non-adherence, side effects, and mediation management challenges.

* 29a) **For High Cholesterol** - A pharmacist(s). . .

- ◯ is not involved in our practice.
- ◯ oversees our dispensary but is not involved in clinical care.
- ◯ is available to answer medication-related questions from providers and staff both directly and electronically.
- ◯ works closely with the core practice team to review prescribing practices and proactively assist patients with medication related problems such as non-adherence, side effects, and mediation management challenges.

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CDC defines a multi-disciplinary team approach to care as team-based care that is established by adding new staff or changing the roles of existing staff to work with a primary care provider. Each team includes the patient, the patient's primary care provider, and other non-physician professionals such as nurses, pharmacists, dieticians, social workers, patient navigators, and/or community health workers. Team members also provide support such as team huddles and share responsibilities of care to complement the activities of the primary care provider. These responsibilities include medication management, patient follow-up, medication adherence, and self-management support.

* 30) Thinking about a typical patient with hypertension, how does the practice team (clinical and nonclinical) coordinate services and resources to help the patient manage their blood pressure?

* 31) How is this process different for a patient with high cholesterol or other concerns regarding lipid levels?

PLEASE COMPLETE THE FOLLOWING: Please indicate number of staff employed by the practice, including part-time and PRN. For example, 1 full time MD, 1 part-time MD, and 2 MDs on call would equal 4 physicians.

Physicians (MD or DO)	
Advanced Practice Registered Nurses (APRN)	
Physician Assistants (PA)	
Registered Nurses (RN)	
Licensed Practical Nurse (LPN)	
Medical Assistants	
Certified Nursing Assistants	
Pharmacists	
Dietitians	
Social Workers	
Patient Navigators	
Community Health Workers	

If other personnel are involved, please provide the title, number of personnel, and description of their role on the care team.

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Practice Demographics and Clinical Quality Measures

Instructions: Please provide result values for each of the demographic measures and clinical quality measures below. For all measures, use the following time period:

1/1/2018 through 12/31/2018 (CY2018)

Patient demographics and payer source are collected to describe the population reached through this project.

Ideally, the sum of patient counts for each demographic factor and payer source will equal the total number of patients seen by the clinic. If this is not the case, or if the data is not available, briefly describe the reasons in the space below:

Clinic Demographics

Total Patients (18 years and older)	

Primary Payer - *a count is preferred. But if a count is not available, the percentage may be provided (use "%" sign).*

Medicare	
Medicaid	
Private (including HMO)	
Self-Pay or No Insurance	
Other or Unknown	

Race - *a count is preferred. But if a count is not available, the percentage may be provided (use "%" sign).*

American Indian or Alaska Native	
Asian or Pacific Islander	
Black	
White	
Other	

Ethnicity - *a count is preferred. But if a count is not available, the percentage may be provided (use "" sign).*

Hispanic Origin	
Not of Hispanic Origin	

Primary Language - *a count is preferred. But if a count is not available, the percentage may be provided (use "" sign).*

English	
Language other than English	

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Clinical Quality Measure

Please provide result values for each of the clinical quality measures below. For all measures, use the following time period:

1/1/2018 through 12/31/2018 (CY2018)

If it is not possible to provide the CQM, please use NA

Controlling High Blood Pressure (Measure: NQF0018 / CMS165v6)

Numerator	
Denominator	
Exclusions	

Diabetes: Hemoglobin A1c Poor Control (>9%) (Measure: NQF0059 / CMS122v6)

Numerator	
Denominator	

Statin Therapy for the Prevention and Treatment of CVD(Measure: No NQF / CMS347v2)

Numerator	
Denominator	
Exclusions	
Exceptions	

Additional CDC Measure Requested (B.10; measure: none) See details below.

Numerator	
Denominator	

Numerator: Number of adult patients (age 20-75) who have received a diagnosis of Dyslipidemia AND have a prescription for statin therapy(s).

Denominator: Number of adult patients (age 20-75) with a diagnosis of Dyslipidemia.

- Dyslipidemia: a patient with abnormal levels of lipids in the blood, diagnosed by a provider or clinician. Examples of IDC-10 codes used are: E78.00, E78.1, E78.2, E78.4, E78.5, and E78.6.

- Statin Medication Therapy list (generic name is listed first followed by brand or trade name in parenthesis): Atorvastatin (Lipitor), Fluvastatin (Lescol XL or Lescol), Lovastatin (Mevinolin), Pitavastin (Livalo), Pravastatin Sodium (Pravachol, Rosuvastin Calcium (Crestor)), Simvastatin (Zocor), Amiodipine Besylate/Atorvastatin Calcium (Caudet), Ezetimibe/Simvastatin (Vytorin).

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Please review all answers before clicking "Submit". All assessments are due by July 15, 2019. Practices will receive notification of awards and instructions for reimbursement prior to receiving their custom reports.