

Using Prediabetes and Hypertension Change Toolkits in the Context of Improving Quality of Care

Health Care Homes/Statewide Innovative Model Webinar
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Presenters



Sarah Nelson MD - Clinical Consultant Healthy Northland



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Objectives

1. Become familiar with prediabetes and hypertension practice change toolkits
2. Be able to list the components of the Model for Improvement
3. List 2 benefits of using practice change toolkits



Healthy Northland

Collaboration of the Aitkin Itasca Koochiching Community Health Board and
Carlton Cook Lake St Louis Community Health Board

Chronic Disease Prevention:

Statewide Health Improvement Partnership

Community Wellness Grant

ASTHO Million Hearts Learning Collaborative

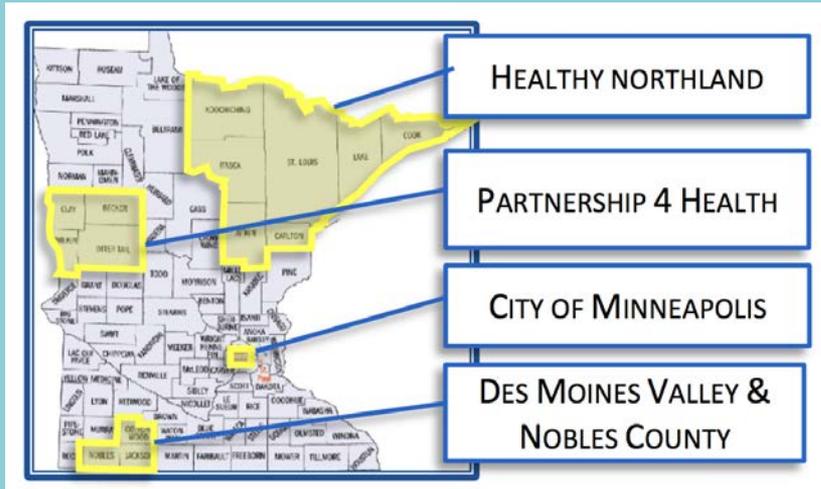
Community Transformation Grant



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Community Wellness Grant

Multi-year funding to prevent obesity, diabetes, heart disease and stroke.



Four Strategy Areas:

1. Environmental - healthy eating, active living
2. Lifestyle change support - Diabetes Prevention Program
3. Healthy systems quality care - focus on hypertension and prediabetes
4. Community-Clinic Linkages - Community Health Workers, Community Paramedics, Pharmacists



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Today's Agenda

Practice change and quality improvement

Prediabetes toolkit and resources

Hypertension control toolkits and resources

Successes and challenges of using toolkits in clinic practice

Questions and discussion



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Practice Change

Community Wellness Grant - “Health System Interventions to Improve the Quality of Health Care Delivery to Populations with the Highest Hypertension and Prediabetes Disparities”

- Improving performance through use of electronic health records and health information technology
- Expanding and monitoring system-wide, provider-focused quality measures
- Engaging non-physician health care professionals in hypertension management
- Increasing the use of self-measured blood pressure monitoring
- Systematically identifying patients with undiagnosed hypertension or prediabetes

MN Health Care Homes - “...focus on redesign of care delivery and meaningful engagement of patients in their care...”

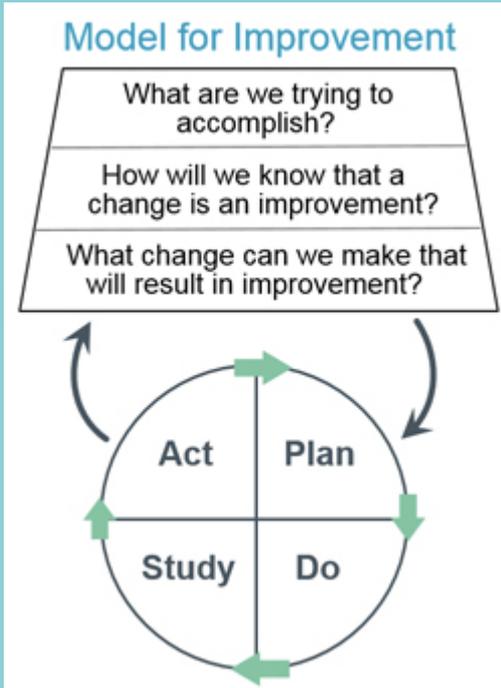
Quadruple Aim of Health Care

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care
- Improving work life of health care providers (clinicians and staff)



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Model for Improvement



Institute for Healthcare Improvement

Three Questions

1. What are we trying to accomplish? **Aim Statement**
2. How will we know that a change is an improvement? **Measurement**
3. What change can we make that will result in improvement? **Selecting Changes**



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Selecting Change Topics for PDSA Cycles

Ideas for change:

may come from the insights of those who work in the system

from change concepts or other creative thinking techniques

by borrowing from the experience of others who have successfully improved

Practice Change Toolkits have been developed to provide systematic change ideas and best practices



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KNOWLEDGE CHECK

Which of the following are ways to get ideas for quality improvement change?

- A. Insight from people working in the area/system you want to change
- B. Borrowing ideas from other people who have implemented change
- C. Change concepts and creative thinking
- D. A, B, C



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KNOWLEDGE CHECK

Which of the following are ways to get ideas for quality improvement change?

A. Insight from people working in the area/system you want to change

B. Borrowing ideas from other people who have implemented change

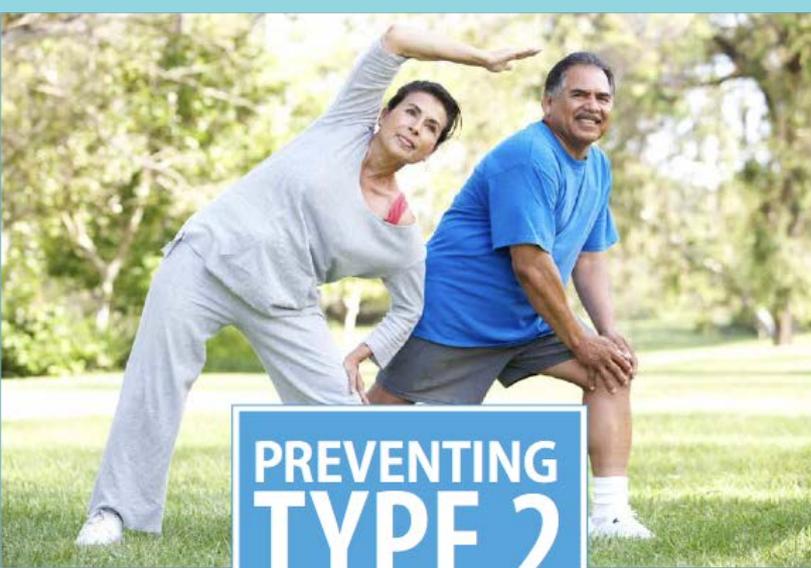
C. Change concepts and creative thinking

D. A, B, C



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Practice Change Toolkit for Prediabetes



PREVENTING
TYPE 2
DIABETES

**A guide to refer your patients with prediabetes
to an evidence-based diabetes prevention program**



Prevent Diabetes **STAT** | Screen / Test / Act Today™



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Overview of guide tools

Resource	Purpose
Engage clinicians	
You can prevent type 2 diabetes Health care provider fact sheet	Provides a brief overview of the evidence-based diabetes prevention program and a rationale for engaging with the program, such as improved patient outcomes. Also assists clinicians in advocating to their colleagues and leaders about the value of incorporating diabetes prevention screening and referral into their practices.
Engage patients	
Diabetes Risk Assessments CDC and American Diabetes Association (ADA) questionnaires	Offers an educational opportunity for patients to learn about their risk for prediabetes, and help physicians and care teams identify their patients at great risk.
Promoting prediabetes awareness to your patients 8" x 11" poster)	Helps practices increase patient awareness of prediabetes to pave the way for conversations with patients about screening and referral.
Are you at risk for type 2 diabetes? Patient handout	For use by physician practices in patient waiting areas to increase patient awareness and pave the way for conversations with patients about screening and referral.
So you have prediabetes ... now what? Patient handout	For use by physician practices in the exam room after screening has revealed that a patient has prediabetes. Helps the patient leave the office visit with concrete information for later reference.
Sample "Patient letter/email and phone script"	Enables physician practices to conduct efficient follow-up and referral with patients who have been identified as having prediabetes, informing them of their prediabetes status and referral to an evidence-based diabetes prevention program.
Incorporate screening, testing and referral into practice	
M.A.P. to diabetes prevention for your practice One-page overview	Offers practices a one-page roadmap to applying the elements of the diabetes prevention screening and referral guide.
Patient flow process Infographic	Provides a high-level overview of how office staff can facilitate point-of-care identification.
Point-of-care prediabetes identification algorithm Infographic and narrative	With a graphic on one side, and narrative on other, the document offers practices an option to adapt/ incorporate a prediabetes screening and referral process into their workflow.
Retrospective prediabetes identification algorithm Infographic and narrative	With a graphic on one side, and narrative on other, the document offers practices an option to adapt/ incorporate an identification and referral process into their electronic health records and generate a registry of patients at risk for type 2 diabetes.
Sample patient referral form/table for calculating body mass index	Makes the referral process easier for practices, helps engage the patient (particularly if they sign the optional patient signature box) and prepares diabetes prevention program providers to engage with the patient as well.
Commonly used CPT and ICD codes Table	Enables physician practices to obtain reimbursement for prediabetes screening.
Connect your clinic with diabetes prevention programs	
Link to sample "Business Associate Agreement" on AMA's website	Provides link to template agreement some practices have used to share information with diabetes prevention program providers.

Prevent Diabetes STAT toolkit components



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Engage Patients

So you have prediabetes ... now what?



Prediabetes means your blood glucose (sugar) level is higher than normal, but not high enough to be diagnosed as diabetes. This condition raises your risk of type 2 diabetes, stroke and heart disease.

What can you do about it?

The good news is that there's a program that can help you.

The National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC), uses a method proven to prevent or delay type 2 diabetes.

By improving food choices and increasing physical activity, your goal will be to lose 5 to 7 percent of your body weight—that is 10 to 14 pounds for a person weighing 200 pounds.

These lifestyle changes can cut your risk of developing type 2 diabetes by more than half.

How does the program work?

As part of a group, you will work with a trained diabetes prevention coach and other participants to learn the skills you need to make lasting lifestyle changes. You will learn to eat healthy, add physical activity to your life, manage stress, stay motivated and solve problems that can get in the way of healthy changes.

The program lasts one year, with 16 sessions taking place about once a week and six to eight more sessions meeting once a month. By going through the program with others who have prediabetes you can celebrate each other's successes and work together to overcome challenges.

Some insurance plans will cover the cost of the program. Check with your insurance provider to see if it is covered. Also, some places that provide the program will adjust the fee you pay based on your income.

Why should you act now?

Without weight loss and moderate physical activity, many people with prediabetes will develop type 2 diabetes within five years. Type 2 diabetes is a serious condition that can lead to health issues such as heart attack, stroke, blindness, kidney failure, or loss of toes, feet or legs. **NOW is the time to take charge of your health and make a change.**

Features of the program:

- o A trained coach to guide and encourage you
- o A CDC-approved program
- o Group support
- o Skills to help you lose weight, be more physically active and manage stress

What participants are saying ...

"I love having a lifestyle coach. She has given us great information, helped me stay on track and stay positive!"

—Bruce

"I'm so excited because I went to the doctor last week and all of my numbers were down and I officially no longer have prediabetes."

—Vivien

Sign up today for a program near you!

To find a program in our area that is part of the National Diabetes Prevention Program, visit cdc.gov/diabetes/prevention.



Prevent Diabetes **STAT** | Screen / Test / Act Today™



M.A.P. (Measure, Act, Partner)

THE M.A.P. (Measure, Act, Partner) to prevent type 2 diabetes—physicians and care teams can use this document to determine roles and responsibilities for identifying adult patients with prediabetes and referring to community-based diabetes prevention programs. “Point-of-Care” and “Retrospective” methods may be used together or alone.

Choose and check what works best for your practice

Step 1: Measure	When	Who	How (draw from AMA-CDC tools)
Point-of-care method <ul style="list-style-type: none"> o Assess risk for prediabetes during routine office visit o Test and evaluate blood glucose level based on risk status 	<ul style="list-style-type: none"> o At the front desk o During vital signs 	<ul style="list-style-type: none"> o Receptionist o Medical assistant o Nurse o Physician o Other _____ 	<ul style="list-style-type: none"> o Provide “Are you at risk for prediabetes?” patient education handout in waiting area o Use/adapt “Patient flow process” tool o Use CDC or ADA risk assessment questionnaire at check-in o Display 8 x 11” patient-facing poster promoting prediabetes awareness to your patients o Use/adapt “Point-of-care algorithm”
Retrospective method <ul style="list-style-type: none"> o Query EHR to identify patients with BMI ≥24* and blood glucose level in the prediabetes range 	<ul style="list-style-type: none"> o Every 6–12 months 	<ul style="list-style-type: none"> o Health IT staff o Other _____ 	<ul style="list-style-type: none"> o Use/adapt “Retrospective algorithm”
Step 2: Act			
Point-of-care method <ul style="list-style-type: none"> o Counsel patient re: prediabetes and treatment options during office visit o Refer patient to diabetes prevention program o Share patient contact info with program provider** 	<ul style="list-style-type: none"> o During the visit 	<ul style="list-style-type: none"> o Medical assistant o Nurse o Physician o Other _____ 	<ul style="list-style-type: none"> o Advise patient using “So you have prediabetes ... now what?” handout o Use/adapt “Health care practitioner referral form” o Refer to “Commonly used CPT and ICD codes”
Retrospective method <ul style="list-style-type: none"> o Inform patient of prediabetes status via mail, email or phone call o Make patient aware of referral and info sharing with program provider o Refer patient to diabetes prevention program o Share patient contact info with program provider** 	<ul style="list-style-type: none"> o Contact patient soon after EHR query 	<ul style="list-style-type: none"> o Health IT staff o Medical assistant (for phone calls) o Other _____ 	<ul style="list-style-type: none"> o Use/adapt “Patient letter/phone call” template o Use/adapt “Health care practitioner referral form” for making individual referrals o Use/adapt “Business Associate Agreement” template on AMA’s website if needed
Step 3: Partner			
With diabetes prevention programs <ul style="list-style-type: none"> o Engage and communicate with your local diabetes prevention program o Establish process to receive feedback from program about your patients’ participation 	<ul style="list-style-type: none"> o Establish contact before making 1st referral 	<ul style="list-style-type: none"> o Medical assistant o Nurse o Physician o Other _____ 	Use/adapt “ Business Associate Agreement ” template on AMA’s website if needed Refer to “Commonly used CPT and ICD codes”
With patients <ul style="list-style-type: none"> o Explore motivating factors important to the patient o At follow-up visit, order/review blood tests to determine impact of program and reinforce continued program participation o Discuss program feedback with patient and integrate into care plan 	<ul style="list-style-type: none"> o During office visit o Other _____ 	<ul style="list-style-type: none"> o Office manager o Other _____ 	<ul style="list-style-type: none"> o Advise patient using “So you have prediabetes ... now what?” handout and provide CDC physical activity fact sheet www.cdc.gov/physicalactivity

*These BMI levels reflect eligibility for the National DPP as noted in the [CDC Diabetes Prevention Recognition Program Standards and Operating Procedures](#). The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

Following the M.A.P. for Preventing Type 2 Diabetes can help your practice achieve [Patient Centered Medical Home \(PCMH\)](#) recognition, as well as [Meaningful Use](#) of your electronic medical record. (Supports PCMH recognition via Standard 4: Self-Care Support, B. Provide Referrals to Community Resources (3 points), [NCQA Facilitating PCMH Recognition, 2011](#).)

** To share patient contact information with a diabetes prevention program, you may need a Business Associate Agreement (BAA).

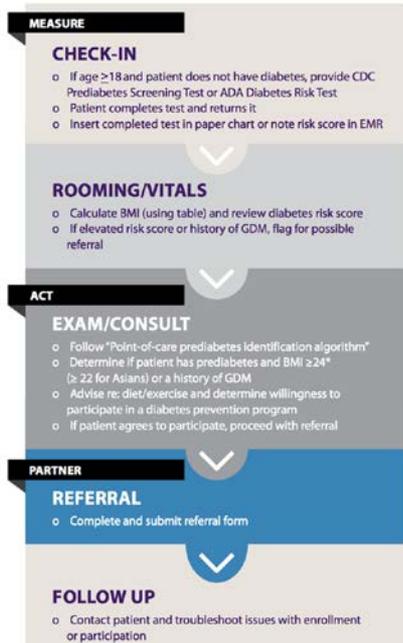
The American Medical Association and the Centers for Disease Control and Prevention have created a tool kit that can help physician practices screen and refer patients to evidence-based diabetes prevention programs. Visit preventdiabetesstat.org to learn more. Physicians and other health care providers should also use their independent judgment when referring to a diabetes prevention program.



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Incorporate screening, testing and referral into practice

Sample patient flow process



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Health care practitioner referral form to a diabetes prevention program

Send to: Fax: _____ Email: _____

PATIENT INFORMATION

First name	Address	
Last name		
Health insurance	City	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	State	
Birth date (mm/dd/yy)	ZIP code	
Email	Phone	

By providing your information above, you authorize your health care practitioner to provide this information to a diabetes prevention program provider, who may in turn use this information to communicate with you regarding its diabetes prevention program.

PRACTITIONER INFORMATION (COMPLETED BY HEALTH CARE PRACTITIONER)

Physician/NP/PA	Address	
Practice contact	City	
Phone	State	
Fax	ZIP code	

SCREENING INFORMATION

Body Mass Index (BMI)	Eligibility = >24* (>22 if Asian)	
Blood test (check one)	Eligible range	Test result (one only)
** Hemoglobin A1C	5.7-6.4%	_____
** Fasting Plasma Glucose	100-125 mg/dL	_____
** 2-hour plasma glucose (75 gm OGTT)	140-199 mg/dL	_____

Date of blood test (mm/dd/yy): _____

For Medicare requirements, I will maintain this signed original document in the patient's medical record.

OPTIONAL

Date	Practitioner signature	
By signing this form, I authorize my physician to disclose my diabetes screening results to the (insert program/organization name here) for the purpose of determining my eligibility for the diabetes prevention program and conducting other activities as permitted by law.	I understand that I am not obligated to participate in this diabetes screening program and that this authorization is voluntary.	
	I understand that I may revoke this authorization at any time by notifying my physician in writing.	
	Any revocation will not have an effect on actions taken before my physician received my written revocation.	
Date	Patient signature	

IMPORTANT WARNING: The documents accompanying this transmission contain confidential health information protected from unauthorized use or disclosure except as permitted by law. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted to do so by law or regulation. If you are not the intended recipient and have received this information in error, please notify the sender immediately for the return or destruction of these documents. Rev. 05/30/14

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Commonly Used CPT and ICD Codes

International Classification of Diseases (ICD-9 and ICD-10 for prediabetes and diabetes screening)			
ICD-10 code (effective 10-01-2015)	ICD-10 code description	ICD-9 code (effective through 9-30-2015)	ICD-9 code description
Z13.1	Encounter for screening for diabetes mellitus	V77.1	Diabetes screening
R73.09	Other abnormal glucose	790.29	Abnormal glucose
R73.01	Impaired fasting glucose	790.21	Impaired fasting glucose
R73.02	Impaired glucose tolerance (oral)	790.22	Impaired glucose tolerance (oral)
R73.9	Hyperglycemia, unspecified	790.29	Other abnormal glucose NOS
E66.01	Morbid obesity due to excess calories	278.01	Morbid Obesity
E66.09	Other obesity due to excess calories	278.00	Obesity (NOS)
E66.8	Other obesity	278.00	Obesity (NOS)
E66.9	Obesity, unspecified	278.00	Obesity (NOS)
E66.3	Overweight	278.02	Overweight
Z68.3x	Body mass indexes 30.0-39.9 (adult)	V85.30-V85.39	Body mass indexes 30.0-39.9 (adult)
Z68.4x	Body mass indexes ≥40.0 (adult)	V85.41-V85.45	Body mass indexes 30.0-39.9 (adult)

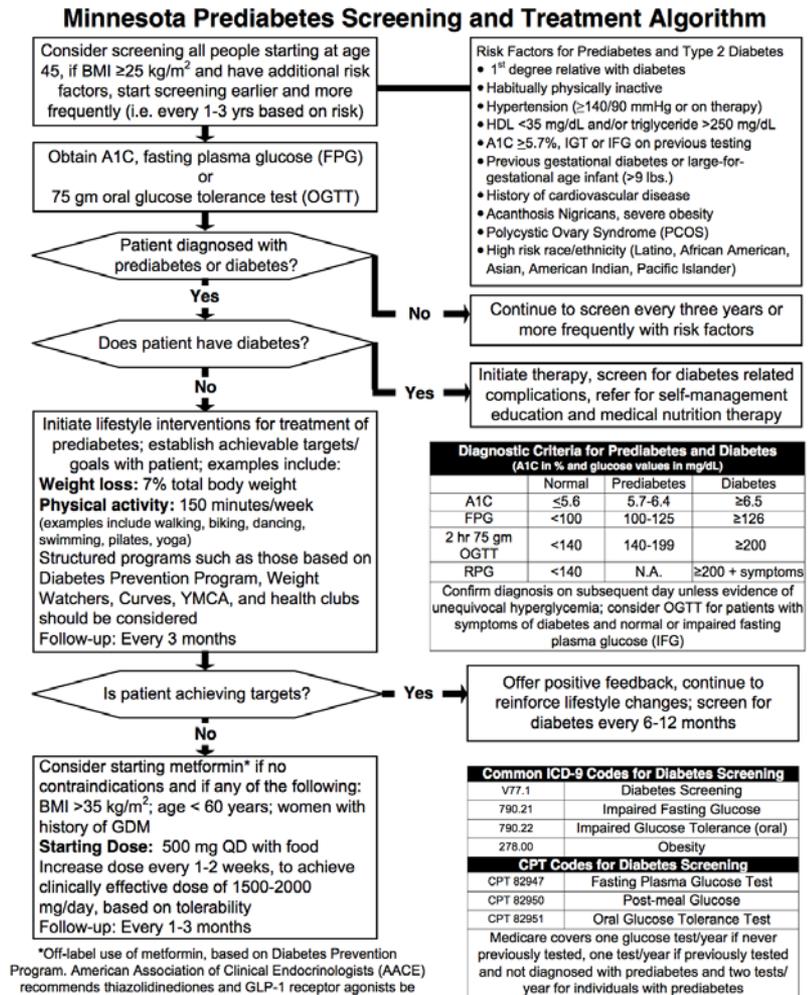
Current Procedural Terminology (CPT*) for diabetes screening tests		
CPT E/M codes for prevention-related office visits	CPT codes for office-based laboratory testing	CPT codes for office-based laboratory testing
Preventive Visit New Patient Commercial/Medicare	99381-99387	83036QW Office-based Hemoglobin A1C testing
Preventive Visit Established Patient Commercial/Medicare	99391-99397	82962 Office-based finger stick glucose testing
Annual Wellness Visit Initial Medicare	G0438	
Annual Wellness Visit Subsequent Medicare	G0439	

(Continued on next page)



Other Prediabetes Resources

Minnesota Prediabetes Screening and Treatment Algorithm



1. Hypertension Control Change Package for Clinicians - Million Hearts
1. Measure Up Pressure Down - Provider Toolkit to Improve Hypertension Control
1. Washington State Department of Health Hypertension Package
1. AMA Steps Forward - Improving Blood Pressure Control
1. AHA/AMA Target BP

Practice Change Toolkits for Hypertension





Hypertension Control

CHANGE PACKAGE for Clinicians

A MILLION HEARTS® ACTION GUIDE

Million Hearts Initiative - prevent 1 million heart attacks and strokes in 5 years.

Initial project - 2012 - 2017

Million Hearts 2022

Figure 1. Hypertension Control Change Package Focus Areas



Table 1. Hypertension Control Change Package—Key Foundations (continued)

Change Concepts	Change Ideas	Tools and Resources
Systematically Use Evidence-Based HTN Guidelines and Treatment Protocols	Implement HTN guidelines effectively, using the most appropriate information and recommendations	<ul style="list-style-type: none"> American College of Cardiology. Perspectives on Hypertension: http://bit.ly/1t0IPvI Centers for Disease Control and Prevention. Elements Associated with Effective Adoption and Use of a Protocol: Insights from Key Stakeholders: http://1.usa.gov/10qGr8R
	Deploy HTN protocols and algorithms	<ul style="list-style-type: none"> Centers for Disease Control and Prevention. Evidence-based Treatment Protocols for Improving Blood Pressure Control: http://1.usa.gov/10qGDFk Association of State and Territorial Health Officials. Million Hearts® Success Story. New York Develops Clinical Pathway to Identify and Manage Adult Hypertension: http://bit.ly/2Ivez5
	Overcome treatment inertia	<ul style="list-style-type: none"> American Medical Group Association. BP Addressed for Every Hypertension Patient at Every Primary Care or Cardiology Visit: http://bit.ly/1zdx7Vh*
	Manage resistant HTN effectively	<ul style="list-style-type: none"> New York City Health and Hospitals Corporation. Adult Hypertension Clinical Practice Guidelines: http://1.usa.gov/1z1qLXY Journal of the American Board of Family Medicine. Resistant Hypertension: http://bit.ly/10qIDx5 Family Practice Notebook. Resistant Hypertension: http://bit.ly/1pEONzs
Equip Direct Care Staff to Facilitate Patient Self-Management	Put a prevention, engagement and self-management program in place [†]	<ul style="list-style-type: none"> California Healthcare Foundation. Helping Patients Manage Their Chronic Conditions: http://bit.ly/1tOrpGZ Institute for Healthcare Improvement. Partnering in Self-Management Support: A Toolkit for Clinicians: http://bit.ly/1FJwBiz
	Ensure team is skilled in identifying/promoting patient medication adherence [†]	<ul style="list-style-type: none"> Centers for Disease Control and Prevention. Hypertension Control: Action Steps for Clinicians: Actions to Improve Medication Adherence (Table 2): http://1.usa.gov/1r183CZ American College of Preventative Medicine. Medication Adherence—Improving Health Outcomes: http://bit.ly/1rrMc1P New York City Department of Health. Medication Adherence Action Kit: Provider Resources: http://on.nyc.gov/1D2jUex Centers for Disease Control and Prevention. Medication Adherence Education Module: http://1.usa.gov/1kDzTJJ
	Establish a program to support home BP monitoring [†]	<ul style="list-style-type: none"> Centers for Disease Control and Prevention. Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians: http://1.usa.gov/1BkUI7b New York City Department of Health. Patient Self-Monitoring of Blood Pressure: A Provider's Guide: http://on.nyc.gov/1sUKJDE

Example page:

Change Concepts

Change Ideas

Tools and Resources

* Source: American Medical Group Foundation's Measure Up/Pressure Down® 2013 Provider Toolkit: www.measureuppressuredown.com/HCPof/Find/provToolkit_find.asp.

† For patient-facing tools, see Table 3. Use all Care Steps as Appropriate to Support Hypertension Control.



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Million Hearts Change Package

Key Foundations:

1. Make HTN Control a Practice Priority
2. Implement a Policy and Process to Address BP for Every Patient with HTN at Every Visit
3. Train and Evaluate Direct Care Staff on Accurate BP Measurement and Recording
4. Systematically Use Evidence-Based HTN Guidelines and Treatment Protocols
5. Equip Direct Care Staff to Facilitate Patient Self-Management



Million Hearts Change Package

Population Health Management:

1. Use a Registry to Identify, Track, and Manage Patients with HTN
2. Use Clinician Managed Protocols for Medication Adjustments and Lifestyle Recommendations
3. Use Practice Data to Drive Improvement



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Million Hearts Change Package

Individual Patient Supports:

1. Support Patients in HTN Self- Management During Their Routine Daily Activities (e.g., not related to any specific visit)
2. Prepare Patients and Care Team Beforehand for Effective HTN Management During Office Visits (e.g., via pre-visit patient outreach and team huddles)
3. Use Each Patient Visit Phase to Optimize HTN Management: Intake (e.g., check-in, waiting, rooming), Provider Encounter (e.g., documentation, ordering, patient education/ engagement), Encounter Closing (e.g., checkout)
4. Follow up to Monitor and Reinforce HTN Management Plans (i.e., after visits)





**Measure Up
Pressure Down**

PROVIDER TOOLKIT

TO IMPROVE HYPERTENSION CONTROL

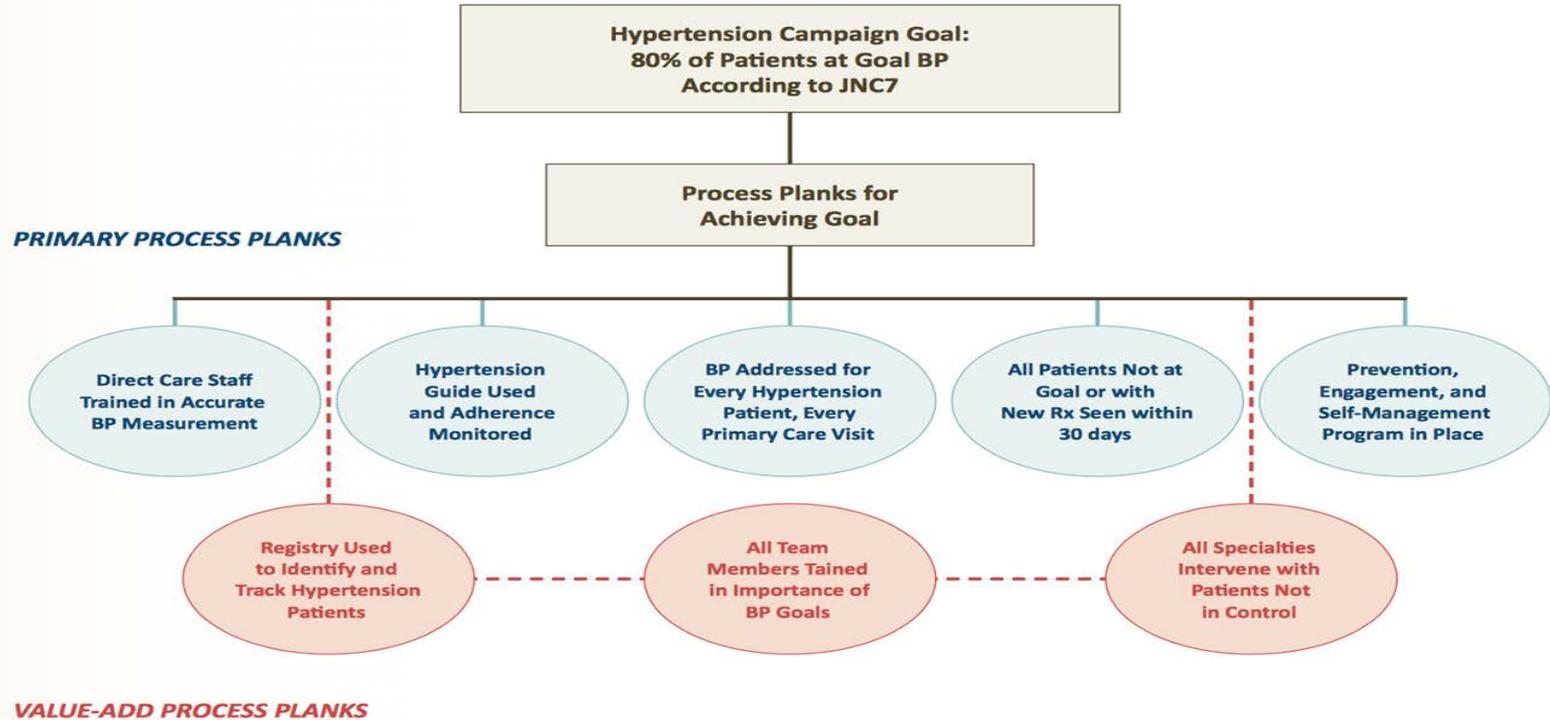
American Medical
Group Foundation
2013



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Measure Up Pressure Down



AMA's STEPS Forward

About the AMA's STEPS Forward™

Series of modules for practice transformation.

Includes CME for the modules and downloadable tools and resources

Helps practices achieve the **Quadruple Aim**: better patient experience, better population health and lower overall costs with **improved professional satisfaction**.

Modules include hypertension control and diabetes prevention



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STEPS *forward*[™]

PRACTICE SU

HOME

M

Measure, Act and Partner (M.A.P.) to help patients control blood pressure and ultimately prevent heart disease.

Improving blood pressure control

Michael Rakotz, MD, FAAFP
AMA

AMA IN PARTNERSHIP WITH



CME CREDITS: 1.0



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The 2015 M.A.P. checklists for improving BP control



Measure accurately

Screening checklist

When *screening* patients for high blood pressure:

- Use a validated, automated device to measure BP¹
- Use the correct cuff size on a bare arm²⁻¹⁰
- Ensure patient is positioned correctly^{2,3,11-19}

Confirmatory checklist

If screening blood pressure is $\geq 140/90$ mm Hg, obtain a *confirmatory* measurement:

- Repeat *screening* steps above
- Ensure patient has an empty bladder^{2,3,20}
- Ensure patient has rested quietly for at least five minutes^{2,3,21,22}
- Obtain the average of at least three BP measurements^{2,3,23}

Evidence-based tips for correct positioning

Ensure patient is seated comfortably with:

- Back supported
- Arm supported
- Cuff at heart level
- Legs uncrossed
- Feet flat on the ground or supported by a foot stool
- No one talking during measurement

Act rapidly

If patient has blood pressure $\geq 140/90$ mm Hg confirmed:

- Use an evidence-based protocol to guide treatment²⁴⁻²⁶
- Re-assess patient every 2–4 weeks until BP is controlled²⁷⁻²⁹
- Whenever possible, prescribe single-pill combination therapy³⁰⁻³²

Evidence-based protocols typically include

- Counsel on and reinforce lifestyle modifications
- Ensure early follow-up and add preferred medications in a step-wise fashion, until BP is controlled
- For most patients, give preference to:
 - Thiazide diuretics
 - *Dihydropyridine* calcium channel blockers
 - ACE inhibitors (ACEI) or
 - Angiotensin receptor blockers (ARB)
- Do not prescribe both ACEI and ARB to same patient
- If BP $\geq 160/100$ mm Hg, start therapy with two medications or a single pill combination

Partner with patients, families and communities

To empower patients to control their blood pressure:

- Engage patients using evidence-based communication strategies³³⁻³⁵
- Help patients accurately self-measure BP^{36,37}
- Direct patients and families to resources that support medication adherence and healthy lifestyles

Evidence-based communication strategies include

- Begin with *open-ended questions* about adherence, including recent medication use
- *Explore* reasons for possible non-adherence
- *Elicit patient views* on options and priorities to customize a care plan for each patient
- Remain *non-judgmental* at all times
- Use *teach-back* to ensure understanding of the care plan

Evidence-based tips for patient self-measurement of BP

- Instruct patient to measure BP accurately using a validated, automated device and correct positioning for measurement
- Ask patient to record ≥ 2 morning BP measurements and ≥ 2 evening BP measurements for ≥ 4 consecutive days between office visits
- Develop a systematic approach to ensure patients can act rapidly to address elevated BP readings between office visits
- Counsel patients that self-measured BP $\geq 135/85$ mm Hg is considered elevated

Evidence-based lifestyle changes to lower BP include

- Following the DASH diet, which is rich in fruits, vegetables and whole grains; low-fat dairy, poultry, fish and plant-based oils; and limits sodium, sweets, sugary drinks, red meat and saturated fats
- Engaging in moderate physical activity, such as brisk walking, for 40 minutes a day at least four days a week
- Maintaining a healthy body mass index (BMI)
- Limiting alcohol to ≤ 2 drinks/day in men, ≤ 1 drink/day in women

KNOWLEDGE CHECK

Of the following, which one is not a best practice in hypertension control change?

- A. Train staff in accurate measurement of blood pressure
- B. Take blood pressure right after a patient has coffee and a cigarette
- C. Engage patients in self-management
- D. Adopt and use an evidence based hypertension treatment protocol



KNOWLEDGE CHECK

Of the following, which one is not a best practice in hypertension control change?

A. Train staff in accurate measurement of blood pressure

B. Take blood pressure right after a patient has coffee and a cigarette

C. Engage patients in self-management

D. Adopt and use an evidence based hypertension treatment protocol



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Rainy Lake Clinic

Small Rural Health clinic in International Falls, MN.

Part of Rainy Lake Medical Center

Primary Care includes 1 physician, 1 physician assistant, 2 nurse practitioners

Nancy Lee RN BSN



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Prediabetes Toolkit

Rainy Lake Medical
Center Annual
Wellness Event:

Prediabetes display:

**86 MILLION
AMERICAN
ADULTS
have prediabetes**

You could be one of them.

Having prediabetes means you are at increased risk for developing serious health problems such as type 2 diabetes, stroke and heart disease.

You could have prediabetes if you have:

- High cholesterol **or**
- High blood pressure **or**
- A parent, brother or sister with diabetes

Your risk goes up if you are also overweight, and/or over age 45.

If you have prediabetes, we can help!

Ask your doctor how you can stop diabetes before it starts.

AMA
Prevent Diabetes **STAT** | Screen / Test / Act Today™
CDC

AMA/CDC “You Could be
One of Them” information
sheet

MDH Minnesota
Department of Health
DIABETES UNIT

Prediabetes in Minnesota

What is Prediabetes?

Prediabetes occurs when blood sugar (glucose) levels are higher than normal, but not high enough to be diabetes. Prediabetes may be called borderline diabetes, impaired fasting glucose or impaired glucose tolerance.

How many people in Minnesota have prediabetes?

Around 1 in 3 (37 percent) of American adults have prediabetes.¹ Using this number, as many as 1.5 million adult Minnesotans may have prediabetes.

In 2014 only 7.4% percent of adults in Minnesota (Source: 3/12/2015) said their health care team told them they had prediabetes.²

These numbers suggest that most Minnesotans with prediabetes do not know they have it.

Why is it important?

People with prediabetes are at higher risk of developing type 2 diabetes, heart disease, and stroke.³ Between 15-30% of people with prediabetes will develop type 2 diabetes within 5 years.⁴

However, 165,000,000 with prediabetes will develop type 2 diabetes.

There are steps people with prediabetes can take to lower their chances of developing diabetes, such as losing weight.

People with prediabetes can develop health problems usually associated with diabetes. These include early kinds of kidney disease, nerve damage, and damaged blood vessels. The risk of stroke is also higher in people with prediabetes.⁵

A 2014 study estimated that 2012 medical costs for US adults with prediabetes were \$510 higher each year as compared to adults without prediabetes. Costs were higher due to treatment of conditions like high blood pressure, kidney problems, hormonal problems and general medical issues.⁶ This means up to \$162 million dollars may be spent each year on additional medical services for adults with prediabetes in Minnesota.

Who is at risk for prediabetes?

Older adults

Prediabetes is more common among older adults. Around 25 percent of 18-44 year-olds have prediabetes. This nearly doubles for adults 45 and older.⁷

Overweight or obese adults

Nearly two out of three adults in Minnesota were overweight or obese in 2015.⁸ People who are overweight or obese are more likely to have prediabetes than people who are normal weight.

Adults who get little physical activity

In 2015, around 1 in 3 adult Minnesotans said they did not participate in any physical activity in the last month.⁹ Physical activity is associated with maintaining a healthy weight and lowering risk of prediabetes and type 2 diabetes.

Who should get tested for prediabetes?

Who should get tested for prediabetes varies by age, weight and other factors:

10/24/2016
Diabetes in Minnesota/english

MDH “Prediabetes
in Minnesota”



Prediabetes Toolkit

Point of Care Screening for Prediabetes

American Diabetes Association Patient Risk Assessment

Developed a process for identification of prediabetes in clinic patients.

Patients 30 and older coming to the clinic for an annual physical.

- Registration Staff
- LPN (rooming staff)
- Providers
- Lab
- HIM
- Nurse Educator



ARE YOU AT RISK FOR

TYPE 2 DIABETES?



Diabetes Risk Test

- 1 How old are you?
Less than 40 years (0 points)
40—49 years (1 point)
50—59 years (2 points)
60 years or older (3 points)
- 2 Are you a man or a woman?
Man (1 point) Woman (0 points)
- 3 If you are a woman, have you ever been diagnosed with gestational diabetes?
Yes (1 point) No (0 points)
- 4 Do you have a mother, father, sister, or brother with diabetes?
Yes (1 point) No (0 points)
- 5 Have you ever been diagnosed with high blood pressure?
Yes (1 point) No (0 points)
- 6 Are you physically active?
Yes (0 points) No (1 point)
- 7 What is your weight status?
(see chart at right)

Write your score in the box.

Height	Weight (lbs.)		
4' 10"	119-142	143-190	191+
4' 11"	124-147	148-197	198+
5' 0"	128-152	153-203	204+
5' 1"	132-157	158-210	211+
5' 2"	136-163	164-217	218+
5' 3"	141-168	169-224	225+
5' 4"	145-173	174-231	232+
5' 5"	150-179	180-239	240+
5' 6"	155-185	186-246	247+
5' 7"	159-190	191-254	255+
5' 8"	164-196	197-261	262+
5' 9"	169-202	203-269	270+
5' 10"	174-208	209-277	278+
5' 11"	179-214	215-285	286+
6' 0"	184-220	221-293	294+
6' 1"	189-226	227-301	302+
6' 2"	194-232	233-310	311+
6' 3"	200-239	240-318	319+
6' 4"	205-245	246-327	328+
	(1 Point)	(2 Points)	(3 Points)

You weigh less than the amount in the left column (0 points)

If you scored 5 or higher:
You are at increased risk for having type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanics/Latinos, American Indians, and Asian Americans and Pacific Islanders.

For more information, visit us at www.diabetes.org or call 1-800-DIABETES

Visit us on Facebook
[Facebook.com/AmericanDiabetesAssociation](https://www.facebook.com/AmericanDiabetesAssociation)



Lower Your Risk

The good news is that you can manage your risk for type 2 diabetes. Small steps make a big difference and can help you live a longer, healthier life.

If you are at high risk, your first step is to see your doctor to see if additional testing is needed.

Visit diabetes.org or call 1-800-DIABETES for information, tips on getting started, and ideas for simple, small steps you can take to help lower your risk.

Hypertension Toolkit

AMA STEPS Forward Controlling Hypertension

At nursing meeting gave LPN staff the AMA/John Hopkins sheet on steps for **Blood Pressure Measurement**

Have developed a **process for rechecking blood pressure** if the first reading is greater than 140/90

Blood pressure measurement: Measure accurately

Screening for high blood pressure

- Use a validated, automated device to measure BP
- Use the correct cuff size on a bare arm
- Ensure the patient is positioned correctly

If initial blood pressure is $\geq 140/90$ mm Hg, obtain a confirmatory measurement

- Repeat above steps
- Ensure the patient has an empty bladder
- Ensure the patient has rested quietly for at least five minutes
- Obtain the average of at least three BP measurements

Evidenced-based tips for correct positioning

- Ensure the patient is seated comfortably with:
 - 1 Back supported
 - 2 Legs uncrossed with feet flat on the floor/ supported with a stool
 - 3 Arm supported with the BP cuff at heart level
- Remain quiet: No one should be talking during the measurement



Hypertension Toolkit

AMA STEPS Forward

Controlling Hypertension

Providers discussing using the **High Blood Pressure Self-Care Plan**



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High Blood Pressure Self-Care Plan

Date _____

At your appointment today you and your healthcare team discussed your high blood pressure (also called hypertension) and made a plan for what to do next. These are notes on what you did and decided.

Goal. The goal you have set for your high blood pressure is: _____

Current blood pressure: _____ / _____

Treatment guidelines

Borderline high blood pressure = 120–139 / 80–89

High blood pressure = 140 and above / 90 and above

Yearly lab test. Write the most recent date you had the following:

- Comprehensive/Basic metabolic panel (CMP/BMP): _____

Self management. We discussed some changes you can make that will help you manage your high blood pressure and reach your goals.

How **important** are these changes to you? (1-10): _____

What would help you move from a _____ to a _____?

How **confident** are you that you can make these changes? (1-10): _____

What would help you move from a _____ to a _____?

Local resources:

Care manager or health educator: _____

Local clinic phone and website: _____

Other consultants or providers: _____

Self-care goals and monitoring

Check the goals that you most want to work on now.

- Take medication daily.
- Complete yearly lab tests. (See left panel)
- Monitor blood pressure at home at least one time a week and write results in the BP Tracker.
- Increase physical activity.
 - Aim for 30 to 45 minutes of moderate-intensity aerobic activity (such as a brisk walk), most days of the week
- Manage weight to reach a BMI between 18.5 and 24.9.
- Follow the DASH diet (Dietary Approaches to Stop Hypertension).
 - Eat a diet rich in fruits, vegetables, and low-fat dairy products and low in saturated and total fat.
 - Reduce dietary sodium to below 1500 mg per day.
 - Limit alcohol to 2 drinks per day for most men, and 1 drink per day for most women and lighter weight men.
- Stop smoking.

- Manage stress. Identify 3 ways to reduce stress.

- Sign up for and use Intermountain MyHealth to review lab results and health records, and to communicate with healthcare providers as needed.

Patient education resources

Write the date you received each resource.

- BP Basics booklet:
- High Blood Pressure and the DASH diet:
- BP Tracker:

Online resources

- www.intermountainhealthcare.org/BP
- Hypertension and Your Heart from AHA www.heart.org/HEARTORG/Conditions/HighBloodPressure
- www.hearthishighway.org/bp.html
- Heartwise Blood Pressure Tracker app for smart phone
- Blood Pressure Companion app for smart phone

Hypertension Toolkit (continued)

Home BP Monitoring Program

Developed protocols and using the Omron monitors supplied by grant funds

Provider identifies patient with potential hypertension

Referral to Nurse Educator

Education on proper technique of taking blood pressure

Tracking sheet given to patient

Follow up with provider



Referral for Home Blood Pressure Monitor

Patient Sticker

Ordering Provider _____

Length of time for home monitoring:

Days _____

Week(s) _____

Time of day to take BP:

Morning _____

Afternoon _____

Evening _____



Home Blood Pressure Monitoring Agreement

Name _____

Date _____

DOB _____

Phone _____

This Omron Blood pressure monitor is the property of Rainy Lake Clinic

To keep this digital monitor in the best condition and protect the unit from damage follow the directions listed below.

1. Make sure the AC adapter is placed under the main unit so that it does not damage the display. Avoid kinking or sharply bending the AC adapter cord.
2. Do not forcefully bend the arm cuff or air tube. Do not fold the cuff tightly.
3. Clean the monitor with a soft dry cloth. Do not use abrasives or volatile cleaners.
4. Do not attempt to clean the cuff.
5. Do not submerge the device or any of the components in water.
6. Do not subject the monitor to extreme hot or cold temperatures, humidity or direct sunlight.
7. Store the device and the components in a clean safe location.
8. Do not subject the monitor to strong shocks such as dropping the unit on the floor.

RETURN THIS MONITOR TO RAINY LAKE CLINIC

You are to use this blood pressure monitor from _____ to _____.

Signature _____

Date _____

Benefits of using practice change toolkits

1. Benefit from knowledge and work of others
2. Based on best practices and tested protocols
3. Downloadable templates for letters, forms, workflows and other resources
4. Many resources can be customized for your practice
5. Helps your team to develop and follow a step-by-step approach to change



KNOWLEDGE CHECK

Which of the following, are benefits of using a practice change toolkit?

- A. Not having to “reinvent the wheel”.
- B. Having access to tested protocols
- C. Having an stepwise approach to change
- D. A, B, and C



KNOWLEDGE CHECK

Which of the following, are benefits of using a practice change toolkit?

- A. Not having to “reinvent the wheel”.
- B. Having access to tested protocols
- C. Having an stepwise approach to change
- D. A, B, and C**



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RESOURCES

PREDIABETES

[Prevent Diabetes STAT](#) - AMA/CDC prediabetes toolkit

[Preventing Diabetes in at risk patients](#) - AMA's STEPS Forward

Minnesota Prediabetes Screening and Treatment Algorithm



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RESOURCES

HYPERTENSION

[Hypertension Control Change Package for Clinicians](#) - Million Hearts

[Measure Up Pressure Down](#) - Provider Toolkit to Improve Hypertension Control

[Washington State Department of Health Hypertension Package](#)

[AMA Steps Forward - Improving Blood Pressure Control](#)

[AHA/AMA Target BP](#)



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QUESTIONS

COMMENTS



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