Cognitive Interview Evaluation of CDC Healthcare Systems Scorecard Assessment Tool

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Background of the Study

The staff of the NCHS Center for Questionnaire Design and Evaluation Research conducted an evaluation of scorecard items on the forthcoming 2016 CDC Healthcare Systems Scorecard (HSSC) Assessment Tool for Primary Care Practices. The purpose of the HSSC will be to assess the extent to which health systems have implemented evidence-based policies, practices, and systems to guide the delivery of care for adult patients with high blood pressure, high cholesterol, obesity, diabetes, cancer, and who use tobacco. The HSSC was developed by CDC's Division for Heart Disease and Stroke Prevention (Applied Research and Evaluation Branch) in collaboration with a workgroup from other parts of CDC's National Center for Chronic Disease Prevention and Health Promotion and external partners and stakeholders, such as state health department representatives and the National Association of Chronic Disease Directors. Using a scorecard approach, this quality improvement assessment tool will help CDC-funded state and local public health programs to better understand the implementation of evidence-based policies and protocols in health systems and to assess the current state of primary care management for adult patients with high blood pressure, high cholesterol, obesity, diabetes, cancer, and who use tobacco. It will also assist health systems to identify possible gaps and prioritize strategies with the highest impact to better manage chronic disease conditions. The HSSC consists of approximately 70 weighted binary questions about evidence-based health system policies that will be completed by ambulatory facilities to assess their own policies. Domains of inquiry include policies that support use of multi-disciplinary care teams, clinical decision supports, clinical guidelines, electronic functions for managing patient health and follow-up, and patient self-management.

Evaluation Method

Recruitment

The original goal was to conduct twenty 60-minute cognitive interviews with healthcare administrators who work in primary care or ambulatory care practices of small to medium size (less than 500 employees). However, recruitment posed a significant challenge.

It was difficult initially tracking down the appropriate individuals, as many of them worked at different offices during different days and times. It took between 5-10 calls and 6-10 emails or faxes to establish a relationship with the respondent. Even with extensive communication, respondents were hesitant to participate. Some said they simply did not have an hour to devote to the study. Many also act as physicians when their office is short of staff, which was the case most of the time, but especially during the summer. With many patients in the middle of summer vacation, practices experienced a high volume of appointments during this time. Even completing the telephone screener (to establish study eligibility) was difficult to accomplish because of respondent time constraints. Others would not participate unless it was mandatory for their job, some thought it was some sort of scam, and others were worried that their supervisor would frown up their participation.

Difficulties with recruitment made it impossible to meet the study deadline, so fewer interviews were conducted in order to meet that goal. A total of 13 interviews were conducted. Table 1 summarizes the types of organizations included in the study.

Table 1: Summary of Organizations in Interview Sample

Type of Organization	Number
HMO	2
Physician or Physician Group	6
FQHC	1
State or Local Clinic	1
Hospital or Hospital System	3

Each type of organization was represented at least once, but a fuller sample would have provided richer detail and thicker description of findings.

Data Collection

As the HSSC collection mode is self-administered, interviewers instructed respondents to first complete the assessment tool on their own (in paper-and-pencil format). It took respondents between 15 and 20 minutes to complete the form, without going through the scoring instructions. Because the cognitive interview was limited to one hour, it focused on respondents' understandings of the questions themselves and not on the scoring process. Once respondents completed the form, interviewers used retrospective probing to explore how respondents understood the items and discuss any difficulties they had in completing the form. There was not time in a one-hour interview to cover every individual item, so probing focused on general concepts and terms, as well as any issues raised by respondents.

General Findings

1. Mode of administration is important: Most respondents missed skip instructions and simply answered every question. Additionally, many needed help with acronyms and jargon. While some used the glossary, many did not take the time to do so. The on-line mode of administration will help eliminate or minimize problems associated with these issues. One respondent, for example, specifically commented that while she did not take the time to use the printed glossary, she would click on a term for clarification if she were taking this on-line and knew the definition would pop up on the screen.
2. Respondents need an option when they do not know the answer (such as a 'don't know' column). This is especially important when the most appropriate person is not filling the assessment tool out, which is likely to happen on occasion. Respondents who did not know the answer to a question either left the item blank or answered 'no'.
3. There was minimal substantive difference between answers of 'no' and 'n/a'. When a practice did not engage in a particular activity, some respondents understood that question as not applicable while others simply answered no. For example, one respondent answered the entire assessment tool with either 'yes' or 'n/a'. To her, if the practice did not engage in an activity, the question was not applicable. But other respondents did make a distinction. One respondent explained her answers of 'n/a'. She said, "It's not something that's offered in our office. If it was offered and we didn't do it, then I would say 'no'. But it's not offered at all." In the end, the lack of differentiation between 'no' and 'n/a' may not matter in terms of the scoring system, since only answers of 'yes' add point value to the total score.

Findings by Section (The entire assessment tool can be found starting on page 7.)

Section A

A1:

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		***Yes***	***No***	***N/A***	***Score***
1. Use a **multi-disciplinary team** to manage the care of patients? *If "Yes," continue to question A2.* *If "No," skip to question A3.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

The term "multidisciplinary team" was not understood the same way by all respondents. The central issue was the manner in which respondents thought of "team". To some this concept included essentially all co-workers in the office. One respondent said she was thinking about, "My physicians, my MAs [medical assistants], an RN that does dietary and holistic medicine stuff…so we're pretty much a one-stop shop." In a similar vein, another said, "It typically consists of the physicians, any residents, social worker, case managers, a dietician is usually involved, the floor managers, the charge nurse, and I think that's about it."

To others the team involved only those who make clinical decisions about patient care (i.e., physicians), regardless of where they are employed. For example one respondent who answered 'yes' to A1a-A1d was thinking of physicians outside the practice who were not co-workers or even necessarily part of the organizational network. She included, "People that we work with…the physicians that we work with, not just limited to our office." Another person said, "There's a network to it in the sense that these doctors [in her practice] have been in this community a long time. So a lot of their colleagues are here that are in different specialties that they have worked with over the years. So they refer to them."

Still others included in the team *anyone* involved with patient care, regardless of where they were employed. For example, one respondent answered 'yes' to A1 and said, "I think about the patient's PCP and if they see a cardiovascular doctor, if they see a nephrologist, endocrinologist, a nurse, it can be a home health aide, physical therapist. I'm thinking about the whole health team."

Because of the variations in how respondents interpreted 'multidisciplinary team,' perhaps the question could provide more guidance about whom a respondent should think.

A4:

4. Use the patient's **primary care provider** (physician, NP, or PA) to manage the patient's care?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

It was unclear how to answer this question when the respondent's office is the PCP. For example, one respondent left this item blank. When asked why, she said, "Because we *are* the provider." During probing she

decided that n/a may have been the best choice, but while completing the form her confusion caused her to simply leave it blank. This pattern is likely to be a greater problem for offices that provide only primary care than it is for offices that provide other services as well.

A5:

5. Have a **Collaborative Practice Agreement** (CPA) in place that incorporates pharmacists or CHWs?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

Many respondents had to consult the glossary to understand what was meant by Collaborative Practice Agreement. Even then, there was some variation in understandings. For example, some understood this as a formal or legal agreement. In explaining her understanding of a CPA, one respondent said, "In terms of medical legal issues, we are now having these agreements done with entities that we're sharing patient information with." Another person had to refer to glossary for this term and arrived at a similar understanding. She said, "It's not a familiar term. I felt like I could figure it out. If you have an agreement, it feels like a formal agreement." Both respondents answered 'no' to this question.

Others focused solely on CPA part of the sentence and missed the fact that it was referring to pharmacists or CHWs. One respondent, for example, answered 'yes' to A5a-A5d because she was thinking of how the doctors in her practice work with doctors outside the practice. She said, "A doctor could collaborate with another doctor on how to proceed." But when asked specifically if an agreement existed with pharmacists or CHWs, she said no. "Pharmacists, they don't really get involved. The health workers, the only time they get involved is if it's a social worker or a case like that."

Additionally, some respondents did not know the CHW acronym.

Team box:

If yes to A1, please indicate who else is on the multidisciplinary team for each specified medical condition:	**High Blood Pressure**	**High Cholesterol**	**Diabetes**	**Obesity**
Nurse Practitioner	☐	☐	☐	☐
Physician Assistant	☐	☐	☐	☐
Medical Assistant	☐	☐	☐	☐
Dietitian/nutritionist	☐	☐	☐	☐
Community health worker	☐	☐	☐	☐
Social worker	☐	☐	☐	☐
Health educator/Nurse Educator	☐	☐	☐	☐
Other (please specify):_____	☐	☐	☐	☐

Because respondents had differing ideas about what and who constituted the multidisciplinary team (see discussion for A1), the box asking respondents to include all members of the multidisciplinary team did not always accurately capture the team. This was sometimes because respondents did not know how to classify them. For example, one respondent said, "Where does my RN fall in there? Because I put her under 'nurse educator', as a nurse. But people use the word 'nurse' as a catchall. I have providers that call my MAs nurses. And I say they're not a nurse. And there's so many levels of nurses." She thought there should be more options for specific types of nurses. Another person similarly did not include the physical therapist that works in the office because she did not know how to classify them and did not think to include them in the "other-specify" box.

Other times the box captured people who do not work in the same office as the respondent, or even in the same organization. One respondent included nutritionist for diabetes, but this was not a nutritionist employed by the same organization. She said, "We send them [patients] to a diabetes clinic at the hospital." Another respondent included nurses in other practices who manage "less complicated" cases and refer patients to the respondent's practice when appropriate. She said in other offices "the PCP now has the nurse practitioners work with them, so that's what I thought."

Section B

B1:

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Follow **evidence-based clinical guidelines** released by national organizations (e.g., National Heart, Lung, and Blood Institute, American Diabetes Association, American Association of Clinical Endocrinologists, American Heart Association, and national Diabetes Prevention Program)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

Respondents were generally familiar with the concept of evidence-based guidelines. One respondent defined it as "basically trials that have been proven and tested to serve as good references and resources for specific diseases, protocols, procedures that you may use…they serve as the forefront of how we should deliver care." Another respondent said this was "bringing together surveys, studies, different types of clinical information brought together and then they put it out. Different groups put it out." When asked for an example she said, "When the American Cancer Society comes out and says you should be doing different screenings for lung cancer every 2 years instead of every 5 years. Then we would change to 2 years."

Respondents also included the appropriate organizations in their answers, even if not in the list of examples. For example, GYNs included The American Congress of Obstetricians and Gynecologists (ACOG). When asked why she answered 'yes' to B1a-B1d, one respondent said, "You have the guidelines from your laboratories. When you get test results it shows you what is high cholesterol. So you have your protocols from your labs. And then you also have them from the American Heart Association and your diabetes center. And we also follow ACOG recommendations."

Section C

C5:

5. Have an EHR system that was **ONCHIT certified**?	☐	☐	

The ONCHIT acronym was known by only a couple respondents. One respondents said, "I only know [the acronym] because I needed to answer it for meaningful use every year. I have to make sure that we are…you have to test for Medicare – download stuff from Medicare. So I only know that because I talk to Medicare. Medicare does ask that question. They give us a certification number and everything." However, most respondents were not at all familiar with it. Sometimes they left the item blank as a result. One respondent wrote in the margin, "Not sure what this is." Another similarly left the item blank and said, "I don't know what that is."

Section D

D1:

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Regularly use a **patient tracking system** to track management for patient populations (e.g., daily, weekly, or monthly)? *If "Yes," skip to question E1.* *If "No," continue to question D2.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

The term 'patient tracking system' was a source of some confusion and understandings of the term varied by respondent. A couple respondents were thinking of physically tracking a patient. For example, one respondent said, "What are you actually talking about? Because we have a surgery center here. I have a patient tracking system that shows on a tracking board a patient number and whether they're in surgery, recovery, post-op, pre-op. So that's what I consider a patient tracking system." As a result she answered 'yes' to D1a-D1d. Another person had the same interpretation and said, "Our tracking system is basically on the patient."

However, other respondents were thinking about tracking a patient's conditions and whether those conditions were controlled or not. As one respondent explained, "Electronically we can pull people out of…given this criteria of high blood pressure, you can pull them out. It depends how you want to track them. Have they been here in the past 6 months or whose high blood pressure was uncontrolled in the last reading, in the last 3 months have they been back? So that's what I thought of. Basically you can pull data for those conditions in your EMR."

Other respondents remained somewhat confused and answered 'no' as a result. For example, one respondent said, "I have never seen a patient tracking system. I think it could be maybe where you sign in and see…which a lot of places do have access to. Because all of our patients are older, we don't do that." This respondent was thinking the question was asking whether they had a system whereby patients create their own account on-line and can log-in to see their personal medical chart and appointment information.

Section E

E1:

During the past 12 months, have the practices in your health system systematically used the following clinical decision supports and protocols?		**Yes**	**No**	**N/A**	**Score**
1. Cut-off points when making **diagnostic or screening decisions**	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

Many respondents were confused by the meaning of "cut off points." One respondent left the item blank and wrote question marks in the margin. When asked why she said, "I don't understand what that means. I'm really puzzled. Does it mean that as OB/GYNs who have a patient with one of these four diagnoses, at what point…if my blood pressure is 200/90 then you refer me out? Is that my cut-off for care? I don't understand the cut-off points." Another respondent also left it blank and explained, "I haven't seen that. Cut-off points. Not sure what that is meaning. I haven't seen that wording before. I could be just not understanding it." Another respondent seemed to figure it out, but had to think about it. "I was interpreting it as, does your system send you alerts when something happens like this – their blood pressure is out of range or something. That was hard to know what that meant." More clarity could be offered on that item.

E8-11:

8. **Flags** in patients' paper charts or electronic prompts when a patient's medical condition <u>is uncontrolled</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
9. Flags in patients' paper charts or electronic prompts for determining <u>when tests should be done</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
10. Flags in patients' paper charts or electronic prompts for <u>medication adjustment</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
11. Flags in patients' paper charts or electronic	a. High Blood	☐	☐	☐	

8. **Flags** in patients' paper charts or electronic prompts when a patient's medical condition <u>is uncontrolled</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
prompts for <u>tobacco cessation</u>	Pressure				
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

There was some confusion and varying definitions of "flags." Some respondents were uncertain what to count as a flag. Some considered this strictly to be an automated process in the EHR and did not think about paper charts. For example, one respondent who answered 'yes' to these questions said, "We primarily use the EHR and if something is abnormal, one of two things will happen. If it's an abnormal result that's not critical, it flags red in the chart. And then we get a little alert thing under the patient's chart. If it's something critical, before it pops up in the chart, the lab will call us and let us know, and then they'll post it in the chart." In fact, even though the question includes 'paper charts *or* electronic prompts', some did not consider flags in paper charts. For example, one respondent answered 'no' to these items. When asked why she said, "It's the flags. The doctor puts in her notes – what she decided to do." But this is in the paper chart only so the respondent did not include it. Similarly, another respondent marked 'no' to the questions and explained, "Our system doesn't flag. [The doctor] will make a reminder [in the patient chart], but our system doesn't flag it – our system flags medicine interactions." The respondent did not include reminders added by physicians. Others were not sure what counted. One respondent put a question mark for E10 (medication adjustment). When asked why she said, "It's in there, but I don't know about *prompting* for medication adjustment. Because generally medication adjustments happen because a patient lets you know that, 'Hey, I'm not getting better,' and then an adjustment is made. It's not like the system is saying…like something flashes for doctors saying, 'You need to adjust this patient's medication.'" Overall, paper charts and electronic prompts were different enough concepts that respondents were uncertain about the intent of the question. But most focused on the electronic aspect of flags.

E11:

11. Flags in patients' paper charts or electronic prompts for <u>tobacco cessation</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

The intent of this question was not clear to some respondents. One respondent answered 'yes' but wrote in the margin 'all patients.' When asked why, she said, "Every single patient, when they come in, that is one of the questions that we ask them directly." It does not matter if they have those conditions, but the respondent answered 'yes' because the smoking question is asked of all patients regardless of their conditions – not because they have those conditions. Another respondent with the same confusion left the item blank. She said, "If the

patient has those diagnoses AND we're screening for tobacco? It could be worded differently. It does ask if they're a smoker. BUT, are they a smoker *with those things*? That's what I was unsure about. It comes up with everyone, it doesn't just come up for certain diagnoses."

Section F

F1:

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Educate patients via <u>telephone, email, or in group classes</u> on-site? *Include diagnoses for which active interactions are used for educational purposes.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

The word "required" caused confusion for one respondent. She answered 'yes' to all items, but circled the word required. When asked why she said, "I just wondered, is it required? This is where I was getting stuck. Because I don't know if anything is 'required'. It's what you do, but I'm not sure what they mean by 'required' as opposed to standard of care. I think that's the term we would use more. It's not required, but it is our standard of care." When asked why she answered 'yes' she said, "Because you feel bad saying you don't do any of this stuff. [To say it's not required], it makes it seem like you don't do any of that stuff. So I don't know what's the point of what they're getting at." When she got to Section H, she felt more comfortable with the language, "routinely implement."

Section I

I10:

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**N/A**	**Score**
10. Offer both stool blood testing and colonoscopy as options for colorectal cancer screening?	☐	☐	☐	

Respondents understood the word "offer" to mean different things. Most respondents thought the question was asking whether they *performed* blood stool testing or colonoscopies. In those cases, some respondents answered on the basis of whether they perform both tests, while most answered on the basis of whether they perform at least one of those tests (but not both). For example, several respondents answered 'yes' because they performed blood stool tests but not colonoscopies. It is unclear what the intent of the question is.

Others thought it was asking whether they *refer* patients out to get these procedures done when it's time. One respondent answered 'yes', not because they perform the tests, but because they make sure to refer patients to get them done at the appropriate time intervals. She said, "When it said 'offer,' I'll offer my patients a choice between the two. And if they choose colonoscopy, then I refer them out. I offer both, you choose what you want. But when someone says, 'do you offer,' well, of course I'm going to offer that to them. Just because you don't do it…" This respondent answered on the basis of offering to give patients a referral to get the procedure

done. Other respondents were also not sure. For example, one respondent said, "I didn't understand. We ask the question – everybody over 50 – 'have you had your colonoscopy?' If not, we refer them to where they need to go. But we don't actually do the whole screening. So that's why I was, like, what are you asking here?"

I12:

12. (For primary care practices) Refer only to endoscopists who provide high quality exams as judged by quality indicators such as their adenoma detection rates; cecal intubation rates; percentage of exams with adequate bowel preparation quality?	☐	☐	☐	

One respondent thought this was an oddly worded question. She said, "We do refer out. But we're not going to refer out to someone we don't believe it!" She wondered what physician would refer a patient to a provider they believed to be sub-par.

Test Instrument: HSSC Assessment Tool Modules

A. Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		***Yes***	***No***	***N/A***	***Score***
1. Use a **multi-disciplinary team** to manage the care of patients? *If "Yes," continue to question A2.* *If "No," skip to question A3.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Have a multi-disciplinary team that includes <u>at least</u> a nurse or pharmacist in addition to the patient and their primary care provider? *Continue to question A5.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Refer patients to a **specialized clinic or center** to manage patient's care (e.g. a hypertension clinic or endocrinology clinic)? *If "Yes," skip to question A5.* *If "No," continue to question A4.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. Use the patient's **primary care provider** (physician, NP, or PA) to manage the patient's care?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
5. Have a **Collaborative Practice Agreement** (CPA) in place that incorporates pharmacists or CHWs?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

A. Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
6. Have pharmacists provide **Collaborative Drug Therapy Management** (CDTM) or **Medication Therapy Management** (MTM)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
Your Health System's Multidisciplinary Team Score:					
Maximum Multidisciplinary Team Score:					

The following questions are for informational purposes only.				
If yes to A1, please indicate who else is on the multidisciplinary team for each specified medical condition:	**High Blood Pressure**	**High Cholesterol**	**Diabetes**	**Obesity**
Nurse Practitioner	☐	☐	☐	☐
Physician Assistant	☐	☐	☐	☐
Medical Assistant	☐	☐	☐	☐
Dietitian/nutritionist	☐	☐	☐	☐
Community health worker	☐	☐	☐	☐
Social worker	☐	☐	☐	☐
Health educator/Nurse Educator	☐	☐	☐	☐
Other (please specify):_____	☐	☐	☐	☐

B. Clinical Guidelines for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Follow **evidence-based clinical guidelines** released by national organizations (e.g., National Heart, Lung, and Blood Institute, American Diabetes Association, American Association of Clinical Endocrinologists, American Heart Association, and national Diabetes Prevention Program)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Have all primary care providers follow the same evidence-based clinical guidelines to diagnose and treat adult patients with a specific condition?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Conduct **data-driven quality improvement initiatives** to improve provider adherence to clinical guidelines (i.e., the **Plan-Do-Study-Act model**)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
				Your Health System's Clinical Guidelines Score:	
				Maximum Clinical Guidelines Score:	

The following question is for informational purposes only.				
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**High Blood Pressure**	**High Cholesterol**	**Diabetes**	**Obesity**
Follow evidence-based clinical guidelines issued by <u>your health system</u> for each specified medical condition?	☐	☐	☐	☐

C. Electronic Health Record (EHR) System			
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**Score**
1. Have an **EHR system** that was used by the practice? *If "No", skip to question D1* *If "Yes," continue to question C2.*	☐	☐	
2. Have and EHR system that follows the **Meaningful Use Objectives**? *If "Yes", answer questions in the A Path* *If "No," answer questions in the B Path*	☐	☐	

C. Electronic Health Record (EHR) System *A Path*			
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**Score**
3. Apply to the **Center for Medicare and Medicaid Services (CMS)** EHR Incentive "Meaningful Use" Program?	☐	☐	
4. Receive CMS incentives for the "meaningful use" of EHR technology?	☐	☐	
5. Have an EHR system that was **ONCHIT certified**?	☐	☐	
6. Have an EHR system that transmitted health data to <u>all</u> providers in the system?	☐	☐	

C. Electronic Health Record (EHR) System *B Path*			
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**Score**
3. Use <u>provider prompts</u> to order tests and imaging studies; notify when patient is due for screening; or notify when patients condition is not controlled	☐	☐	
4. Use <u>patient prompts</u> to notify patients with selected medical conditions who are overdue for office visits or to order tests and imaging studies	☐	☐	
5. Track key measures for the selected medical condition (e.g., blood pressure, lipid levels, and A1c); abnormal test or imaging results; referrals to specialists; or provider dashboards with appropriate goals and metrics	☐	☐	
6. Generate and transmit prescription orders	☐	☐	
7. Generate and transmit consultation requests	☐	☐	
8. View electronic results of lab/pathology reports or screening and diagnostic imaging results	☐	☐	
9. Have an EHR system that was ONCHIT certified?	☐	☐	
10. Have an EHR system (other than for billing) that was available to <u>all</u> providers in the practice?	☐	☐	

Your Health System's Electronic Health Record Score	
Maximum Electronic Health Record Score:	

D. Patient Tracking Systems for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Regularly use a **patient tracking system** to track management for patient populations (e.g., daily, weekly, or monthly)? *If "Yes," skip to question E1.* *If "No," continue to question D2.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Have an ONCHIT certified patient tracking system integrated within the practice's HER system? *If "Yes," skip to question E1.* *If "No," continue to question D3.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Have a stand-alone patient tracking system that does <u>not</u> share information with an EHR system?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
Your Health System's Patient Tacking Systems Score:					
Maximum Patient Tracking Systems Score:					

E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, have the practices in your health system systematically used the following clinical decision supports and protocols?		**Yes**	**No**	**N/A**	**Score**
1. Cut-off points when making **diagnostic or screening decisions**	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Recommending, ordering, or viewing laboratory test(s) and results	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Recommendations for lifestyle modifications (i.e., diet and exercise)	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. Evidence-based **cardiovascular disease (CVD) risk calculator**	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
5. Drug management protocol (e.g., prescribing first-line medications to initiate treatment, drug-dosing [titration] support, or second-line medication if the condition is not controlled)	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, have the practices in your health system systematically used the following clinical decision supports and protocols?		**Yes**	**No**	**N/A**	**Score**
6. Specified follow-up time period, including follow-up with primary care providers or other members of the **health treatment team**	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
7. Documentation in paper charts or electronic charts of positive or negative change in condition at follow-up	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
8. **Flags** in patients' paper charts or electronic prompts when a patient's medical condition <u>is uncontrolled</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
9. Flags in patients' paper charts or electronic prompts for determining <u>when tests should be done</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
10. Flags in patients' paper charts or electronic prompts for <u>medication adjustment</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, have the practices in your health system systematically used the following clinical decision supports and protocols?		**Yes**	**No**	**N/A**	**Score**
11. Flags in patients' paper charts or electronic prompts for <u>tobacco cessation</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
Your Health System's Clinical Decision Support and Protocols Score:					
Maximum Clinical Decision Support and Protocols Score:					

F. Patient Education for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Educate patients via telephone, email, or in group classes on-site? *Include diagnoses for which active interactions are used for educational purposes.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Provide any educational materials to the patient such as printed materials, DVDs/videos, self-study program, or referrals to community organizations or websites?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Communicate and provide specific goals regarding management of their medical condition either orally during the visit, written down on a piece of paper or other report for patient? *This may be orally during a visit, written on paper, or online through a patient portal.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. Employ evidence based methods, to increase **patient self-efficacy** and encourage them to feel in control of their condition(s)? *Include methods such as motivational interviewing, use of reminder techniques and encouraging use of social support networks.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
5. Teach patients **problem-solving skills**? *Include teaching patients what to do to maintain compliance with medications and lifestyle, especially during special circumstances like traveling, celebrations etc.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
				Your Health System's Patient Education Score:	
				Maximum Patient Education Score:	

G. Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Use any staff to work jointly with patients to develop their self-management goals?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Assess patient progress in meeting goals? *Include the review of logs from self-testing, weight control, food diary, exercise diary, etc.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Record patients' self-monitored clinical values (e.g., blood pressure, glucose levels, weight, smoking diary, food diary etc.) and provide clinical staff advice, medication changes, and/or lifestyle modifications back to patients?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. Record patients' self-monitored clinical values (e.g., blood pressure, glucose levels, weight, smoking diary, food diary, etc.) and communicate those values to clinical staff?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
5. Refer patients to a professional (e.g., to pharmacists for consultation or Medication Therapy Management, nurses, registered dietitians, or certified diabetes educators, tobacco cessation quit line)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

G. Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
6. Provide **special follow up care**? *Include follow up by CHWs, staff nurses, or other clinical staff such as social worker or dietitian. review of logs from self-testing, weight control, food diary, exercise diary, etc.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
7. Provide **non-clinician case management**? *Include case management provided by nurses, as well as by CHWs and/ or patient navigators with nurse oversight.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
8. Refer patients to social support groups of others with the medical condition?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
Your Health System's Self-Management and Care Management Score:					
Maximum Self-Management and Care Management Score:					

H. AAR Guidelines on Tobacco Use Cessation			
During the past 12 months, did your health system have a policy/protocol in place that required your primary care providers to routinely implement the following Ask, Advise, Refer (AAR) guidelines on tobacco use?	**Yes**	**No**	**Score**
1. Ask every patient about tobacco use at every patient?	☐	☐	
2. Advise every tobacco user to quit?	☐	☐	
3. Refer patients to tobacco quitlines ((i.e. National Cancer Institute's Quitline), websites (i.e. smokefree.gov), and local programs?	☐	☐	
Your Health System's Ask, Advise, Refer (AAR) Score:			
Maximum Ask, Advise, Refer (AAR) Score:			

I. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients					
During the past 12 months, in order to increase the proportion of eligible patients screened for certain cancers, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Make available small media products (e.g. videos/DVDs, letters, brochures, pamphlets, flyers, newsletters) to patients?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
2. Provide one-on-one education (e.g. phone or in-person education) about cancer screening, delivered by healthcare providers or staff, or by community health worker?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
3. Provide client reminders (e.g. messages advising people that they are due or overdue for screening. May include letter/postcard, phone call, email/text, or other reminder)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	

I. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients					
4. Provide client incentives (e.g. financial or non-financial rewards given to patients for completing screening)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	

I. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients					
During the past 12 months, in order to increase the proportion of eligible patients screened for certain cancers, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
5. Reduce **structural barriers** (non-economic obstacles that impede access to screening) such as: (1) modified hours of service when patients can receive screening (e.g. evening or weekend hours); (2) offering screening in alternative or non-clinical settings (e.g. mobile mammography vans at worksites or providing screening in residential communities); (3) simplifying administrative procedures or other scheduling obstacles?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
6. Reduce **patient out-of-pocket costs** for screening?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal	☐	☐	☐	

I. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients					
	Cancer Screening				
7. Assess providers during screening delivery and offer feedback (e.g. evaluate provider or practice performance in screening patients and report to individual and/or groups of providers' information about their performance)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
8. Provider reminder systems to notify providers when a patient is due or overdue for screenings (e.g. chart checklists/flow sheets, prompts such as stickers, flags, or other manual or electronic notices to providers)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	

I. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients					
During the past 12 months, in order to increase the proportion of eligible patients screened for certain cancers, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
9. Provider incentives (direct or indirect rewards to motivate providers to screen or refer patients for screening)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	

I. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients					
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	

For Colorectal Cancer…				
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**N/A**	**Score**
10. Offer both stool blood testing and colonoscopy as options for colorectal cancer screening?	☐	☐	☐	
11. Monitor provider recommendations for colorectal cancer screening intervals for consistency with published guidelines, taking into account personal and family history; AND/OR colorectal cancer or adenoma surveillance intervals for consistency with published guidelines?	☐	☐	☐	
12. (For primary care practices) Refer only to endoscopists who provide high quality exams as judged by quality indicators such as their adenoma detection rates; cecal intubation rates; percentage of exams with adequate bowel preparation quality?	☐	☐	☐	
13. (For endoscopy practices) Endoscopists report their colonoscopy performance on quality indicators such as their adenoma detection rates; cecal intubation rates; percentage of exams with adequate bowel preparation quality?	☐	☐	☐	
14. Collect and report any measures related to cancer screening to systems or entities such as Uniform Data System (UDS) or CMS / and or cancer registry?	☐	☐	☐	
Your Health System's Guidelines for Screening of Cancers Score:				
Maximum Guidelines for Screening of Cancers Score:				

Appendix A. Glossary

Module A. Multidisciplinary Team for the Care Management Approach for Adults with high Blood Pressure, High Cholesterol, Diabetes, or Obesity

Term	Definition	E-Version Definition	Source/Resources
Collaborative Practice Agreement (CPA)	A formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patients to other providers under a protocol that allows the other provider to perform specific patient care functions.	A formal agreement that allows another provider to perform specific patient care functions.	Collaborative Practice Agreements and Pharmacists' Patient Care Services
Collaborative Drug Therapy Management (CDTM)	A collaborative practice agreement between one or more physicians and pharmacists wherein qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments; ordering drug therapy–related laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens.	A collaborative practice agreement between one or more physicians and pharmacists.	Collaborative drug therapy management by pharmacists, 2003
Medication Therapy Management (MTM)	A distinct service or group of services that optimize therapeutic outcomes for individual patients, and it represents one type of pharmacists' patient care services. The five core elements of the MTM service model include: 1) Medication therapy review (MTR) 2) Personal medication record (PMR), 3) Medication-related action plan (MAP), 4) Intervention and/or referral, and 5) Documentation and follow-up.	A distinct service or group of services that optimize therapeutic outcomes for individual patients, and it represents one type of pharmacists' patient care services.	Medication therapy management in pharmacy practice: core elements of an MTM service model (version 2.0)
Community Health	Community health workers provide health education, referral	Community health workers provide support and assistance to	International Standard

Workers (CHW)	and follow up, case management, and basic preventive health care and home visiting services to specific communities.	individuals and families in navigating the health and social services system.	Classification of Occupations: ISCO-08

Module B. Clinical Guidelines for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity

Term	Definition	E-Version Definition	Source/Resources
Evidence based clinical guidelines	Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Evidence based guidelines should be those developed following the Institute of Medicine's 8 Standards for Developing Trustworthy Clinical Practice Guidelines: 1) Establishing transparency; 2) Management of conflict of interest; 3) Guideline development group composition; 4) Clinical practice guideline–systematic review intersection; 5) Establishing evidence foundations for and rating strength of recommendations; 6) Articulation of recommendations; 7) External review; and 8) Updating. Guidelines can be found at the National Guideline Clearinghouse	Statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.	About Systematic Evidence Reviews and Clinical Practice Guidelines Standards for Developing Trustworthy Clinical Practice Guidelines Agency for Healthcare Research and Quality (AHRQ)
Data-driven quality improvement initiatives	Evidence-based interventions to refine care delivery systems to make sure patients get the right care at the right time, particularly among under-served populations.	Evidence-based interventions to refine care delivery systems to make sure patients get the right care at the right time.	NACDD DP13-1305 Domain 3 Resource Guide
Plan-Do-Study-Act (PDSA) model	A tool used by the Institute for Healthcare Improvement to test an idea by temporarily trialing a change and assessing its impact. **The four stages of the PDSA cycle:**	A component of the Model for Improvement which involves testing changes on a small scale before full implementation.	NHS Institute for Innovation and Improvement: PDSA Institute for Healthcare

Plan: the change to be tested or implemented
Do: carry out the test or change
Study: data before and after the change and reflect on what was learned
Act: plan the next change cycle or full implementation

Improvement
PDSA Worksheet

NACDD DP13-1305
Domain 3
Resource Guide

Module C. Electronic Health Record (EHR) System

Term	Definition	E-Version Definition	Source/Resources
Meaningful Use Objectives	The Recovery Act specifies the following 3 components, established by CMS, of Meaningful Use for eligible providers to receive financial incentives for the use of certified EHRs: 1. Use of certified EHR in a meaningful manner 2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care 3. Use of certified EHR technology to submit clinical quality measures	3 components, established by CMS, for eligible providers to receive financial incentives for the use of certified EHRs.	Health IT Regulations: Meaningful Use Regulations CMS Electronic Health Records Incentive Programs NACDD DP13-1305 Domain 3 Resource Guide
Office of the National Coordinator Health Information Technology (ONC)	ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. It is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide health information exchange to improve health care.	ONC is a government organization that coordinates nationwide efforts to promote and implement the use of health information technology and electronic health records.	HealthIT.gov About ONC NACDD DP13-1305 Domain 3 Resource Guide

Module E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity

Term	Definition	E-Version Definition	Source/Resources
Clinical Decision-Support Systems (CDSS)	CDSS are computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care. CDSS use patient data to provide tailored patient assessments and evidence-based treatment recommendations for healthcare providers to consider. CDSS are often incorporated within EHR systems and integrated with other computer-based functions that offer patient-care summary reports, feedback on quality indicators, and benchmarking.	CDSS are computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care.	The Community Guide Cardiovascular Disease Prevention and Control: Clinical Decision-Support Systems
Cardiovascular disease (CVD) risk calculator	A risk assessment tool that uses information from the Framingham Heart Study to predict a person's chance of having a heart attack in the next 10 years. This tool is designed for adults aged 20 and older who do not have heart disease or diabetes.	A risk assessment tool that uses information from the Framingham Heart Study to predict a person's chance of having a heart attack in the next 10 years.	CVDD Risk Calculator

Module H. AAR Guidelines on Tobacco Use Cessation

Term	Definition	E-Version Definition	Source/Resources
Ask, Advise, Refer (AAR) guidelines	The three components of the AAR model includes: • **Ask** about tobacco use every encounter. • **Advise** patients to quit smoking using a clear, strong personalized message. • **Refer** patients willing to quit smoking in the next 30 days to external cessation services	The AAR guidelines follow a model for healthcare practices to follow in tobacco cessation interventions.	Clinician's Guide to Treating Tobacco Dependence AAR Poster

Module I. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients

Term	Definition	E-Version Definition	Source/Resources
Uniform Data System (UDS)	The UDS is a core system of information appropriate for reviewing the operation and performance of health centers. UDS is a reporting requirement for Health Resources and Service Administration (HRSA) grantees, including community health centers, migrant health centers, health care for the homeless grantees, and public housing primary care grantees. The data are used to improve health center performance and operation and to identify trends over time. UDS data are compared with national data to review differences between the U.S population at large and those individuals and families who rely on the health care safety net for primary care.	The UDS is a core system of information appropriate for reviewing the operation and performance of health centers.	Uniform Data System Resources Uniform Data System Reporting Instructions

For more general terms, please refer to the CDC website using the link below:
http://www.cdc.gov/other/pdf/everydaywordsforpublichealthcommunication_final_11-5-15.pdf