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Care Coordination
- Rural Wisconsin Health Cooperative Quarterly Care Coordination Roundtable
- American Academy of Ambulatory Care Nursing: Care Coordination and Transition Management (CCTM)
- National RN Case Manager Training Center LLC

Self-Management and Lifestyle Training
- Medication Adherence
- AMA/Johns Hopkins Self-Measured BP Monitoring
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Introduction

The Rural Wisconsin Chronic Disease Toolkit was developed as part of the Rural Wisconsin Health Cooperative (RWHC) Primary Care Improvement Project, which is a HRSA Network Development Grant-funded collaboration between RWHC, participating RWHC member hospitals, the Wisconsin Collaborative for Healthcare Quality (WCHQ), and other partner organizations.

The RWHC Primary Care Improvement Project’s overarching goal is to develop and implement a network approach to improving quality associated with diabetes and hypertensive disease care in rural primary care settings. The project’s initial focus is to reduce the percentage of the participant population’s diabetic patients with Hemoglobin A1C Poor Control (National Quality Forum measure 0059), and to increase the percentage of the population’s hypertensive patients with adequately controlled blood pressure (NQF 0018). These quality measure improvements are eventually expected to lead to reduced costs through decreased target population ED visits and inpatient admissions.

The Toolkit has been developed by WCHQ and RWHC in order to provide project participants with an up-to-date compendium of several rurally relevant best practices that have been shown to be effective in improving chronic disease outcomes. Depending on various factors—differences in size, demographics, internal processes, etc.—healthcare organizations may find some tools more useful than others. We intend to update this toolkit over time with additional resources as they become available.

Acknowledgments

Contributing Individuals and Organizations

• Cheryl DeVault, MS, RN, Primary Care Program Coordinator, RWHC
• Jill Lindwall, MSN, RN, Quality Improvement Specialist, WCHQ
• Anne Allen, MSN, RN, Clinical Quality Improvement Coordinator, Divine Savior Healthcare
• Carrie Chambers, BSN, RN, Memorial Hospital of Lafayette County
• Julie Hopkins, RN, Clinic Operations Lead RN, Sauk Prairie Healthcare
• Bridget Klingelhoets, Director of Quality Management, Clinic Manager, Cumberland
• Patti Ramsden, LPN, Clinic Supervisor, Upland Hills Health

Funding

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D06RH27788 through the Rural Health Network Development Program for $299,989. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
SECTION TWO

RESOURCES FOR EFFECTIVE COMMUNICATION

RURAL WISCONSIN CHRONIC DISEASE TOOLKIT 2018
**Daily Huddles**

**Resources for Effective Communication**
Communication in a healthcare setting is one of the most important tools we have for providing great patient care and improving patient satisfaction. Using tools available can improve effectiveness and can be key in overcoming communication barriers to provide excellent patient care. Included are tools to enhance the communication process between the care team such as daily huddles; and tools to use with your patients and families to foster therapeutic relationships and ensure they understand the information they have been given, such as motivational interviewing, and teach-back.

**Team Based Communication**
Just picture a football team not huddling before the play...confusion, lack of awareness, lack of preparation, not enough players on the field, and chaos!

**Why do a daily team huddle?** A practice team caring for patients must communicate and coordinate efforts among its members on a regular basis. Implementation of brief, in-person, scheduled meetings once or twice a day with relevant team members helps to ensure an efficient clinic day with fewer surprises.

Huddles provide an opportunity to anticipate patient needs and prepare for changes in staffing and logistics so the day runs more smoothly. Robust, routine huddles contribute to an interdependent team culture, improved relationships and the delivery of safe and reliable patient care. Over time they can serve as a platform for additional practice improvement and role expansion.
Team Based Communication - Daily Huddles

Daily huddles allow the team to briefly meet daily to discuss their patients’ needs and determine what needs to be done and by whom. They are able to help increase efficiency and access within the clinic. It is a time to be proactive in the patients care instead of reacting throughout the day.

- Need provider buy-in even if they do not show up—support is needed
- Set a time to meet consistently-this is an appointment that needs to be kept
- Experiment with who attends-providers, clinical staff, reception, lab, radiology, leadership
- Time limit for the huddle
- Central location-such as the nurses station
- Everyone stands- keeps the meeting short
- Designate a huddle leader and have an agenda
- Identify a huddle champion-physician, manager to keep on track to begin with

Consider:

- Review provider schedules/length of appointment for the day’s schedule. Are any changes necessary? Look at potential add-in or double book spots
- Communicate provider on call
- Discuss changes in staffing such as sick calls, needing to leave early, and meetings
- What are the team assignments for the day?
- Are rooms set up with needed supplies?
- Are needed reports and information available, such as hospital follow-ups, discharges, labs, consults?
- Check for patients on the schedule who may require more time and assistance due to age, disability, personality, or language barriers. Who is available to help?
Sample Daily Huddle Workflow

RESOURCES FOR EFFECTIVE COMMUNICATION
**The Everett Clinic Huddle (Video)**

**Maxine Hall Health Center**  
San Francisco, California

**Length of Huddles:**  
5 minutes

**When does the Huddle take place during the day?**  
Before morning visits from 8:00-8:05 AM and afternoon visits from 1:00-1:05 PM

**How many days out of the week does the Huddle take place?**  
Every work day

**Who attends the Huddle?**  
Front desk staff, clinicians, behaviorists, medical assistants, and registered nurses

**Where does the Huddle take place?**  
The Huddle takes place near where the patients are seen.

**What are some of the benefits of the Huddle?**  
A major benefit Maxine Hall has seen as a result of the Huddle is timeliness. All staff now show up on time, significantly reducing delays throughout the day. This results in smoother work flow and higher patient and staff satisfaction.

**What topics are addressed in the Huddle?**  
1 minute: The whole clinic briefly reviews staffing issues (e.g. sick, on vacation).

4 minutes: Clinicians and their medical assistants break up into their dyads and discuss patients who have appointments, patients who may be late, and patients who may have psychosocial or behavioral issues.

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[https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Spotlight_on_Huddles_12-1226.pdf](https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Spotlight_on_Huddles_12-1226.pdf)  
Video: [https://youtu.be/dJrORZEiXpo](https://youtu.be/dJrORZEiXpo)
Memorial Hospital of Lafayette County (MHLC) is a county-owned rural CAH with a primary care clinic in Darlington, Shullsburg and Argyle, WI, serving patients in Lafayette County. MHLC uses this daily forecast to provide a time to communicate on what is going on in the clinic so that everyone is on the same page for the day. It’s a quick check-in at the beginning of the day to promote teamwork. A forecast can be sent out via e-mail to all as a communication tool for the day for those that are not able to attend the morning check-in.

<table>
<thead>
<tr>
<th>AM Huddle</th>
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<tbody>
<tr>
<td><strong>Date:</strong></td>
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<tr>
<td><strong>Phones:</strong></td>
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<tr>
<td><strong>Immunizations:</strong></td>
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<tr>
<td><strong>On Call Provider:</strong></td>
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<tr>
<td><strong>Meetings:</strong></td>
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<td><strong>FYI:</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Clinical Staff</th>
<th>Location</th>
<th>Late Night</th>
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<tbody>
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</tbody>
</table>
All Clinic Morning Huddle Template – Cumberland Healthcare

Cumberland Healthcare is a rural CAH with primary care clinics in Cumberland and Turtle Lake WI, serving patients in Barron and Polk Counties. Why does Cumberland Healthcare Huddle? A practice team caring for patients must communicate and coordinate efforts among its members on a regular basis. Implementation of brief, in-person, scheduled meetings once or twice a day with relevant team members helps to ensure an efficient clinic day with fewer surprises. Huddles provide an opportunity to anticipate patient needs and prepare for changes in staffing and logistics so the day runs more smoothly. Robust, routine huddles contribute to an interdependent team culture, improved relationships and the delivery of safe and reliable patient care. Over time they can serve as a platform for additional practice improvement and role expansion.

### Daily Huddle Worksheet

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>Huddle Lead</td>
<td></td>
</tr>
<tr>
<td>Recorder</td>
<td></td>
</tr>
<tr>
<td>Team Improvement Focus for the Day</td>
<td></td>
</tr>
</tbody>
</table>

#### Staffing

| On Call - DOD |
| ED |
| Sick Calls |
| Schedule Slots Open |
| Lab Schedule |
| Scheduling – Front Desk |
| Clinical Assistants |
| Clinical Coverage/Special Concerns |

#### Other Work for Today

| Meetings or In-services |
| News, Urgent Updates |
| Staff Celebrations |
| Other |

**Note:**
- Stand up huddle begins promptly at 0815 for all clinic staff, including providers, social workers, managers
- Organization’s leadership attends when available
- Turtle Lake Primary Care Clinic calls in to participate in the huddle
- Hospital Supervisor attends to update on hospital, admission availability, and discharges
Therapeutic Communication – Motivational Interviewing

Motivational interviewing can help people improve their lifestyles and change their behavior. Engaging patients and establishing partnerships with the patient is an important step in changing behavior. Focusing on a specific direction, along with listening to the patient on what motivates them and how they are feeling about these changes helps towards working collaboratively together to create a plan with commitment to change. There are various opportunities to learn about Motivational Interviewing, such as the following links:

Rural Wisconsin Healthcare Cooperative Educational Offerings

**Empowering vs. Enabling** class offered through Rural Wisconsin Health Cooperative where participants learn that by asking the right questions, at the right time, you can move an individual away from a state of ambiguity and uncertainty, towards finding motivation to make positive decisions and accomplish established goals.


MetaStar Educational Offerings & Resources

MetaStar is a quality improvement organization that provides health care improvement and consulting services to address the need for system-wide innovation and consistent, evidence-based approaches across all settings of care, guided by their mission, to effect positive change in health and health care. MetaStar representatives work with communities, providers, and insurers to transform care with a vision of optimal health for all and is an independent nonprofit based in Madison and represents Wisconsin in the Lake Superior Quality Innovation Network.

**MetaStar - Motivational Interviewing**

Motivational interviewing (MI) is an evidence-based collaborative conversation style for strengthening a person’s own motivation for and commitment to change. To learn more about using Motivational interviewing, or to inquire about in-person training opportunities, contact Mary Funseth mfunseth@metastar.com, Mia Croyle mcroyle@metastar.com or visit [https://www.metastar.com/about/](https://www.metastar.com/about/)

Resources: *Motivational Interviewing in Diabetes* Care by Marc P. Steinberg and William R. Miller is a concise book that offers a relevant explanation of MI and is filled with examples of clinical conversations on the key topics in caring for people with diabetes or pre-diabetes. To order or view a sample chapter, go to: [www.guilford.com/p/steinberg](http://www.guilford.com/p/steinberg). You can use the promotional code 2E for a 20% discount.
Agency for Healthcare Research and Quality (AHRQ) Coaching Video

Coaching Patients for Successful Self-Management
http://www.chcf.org/publications/2008/08/video-on-coaching-patients-for-successful-selfmanagement

This video explains techniques that the physician or office staff can use to help motivate patients to better manage certain aspects of their disease. It demonstrates counseling a diabetic patient to improve their A1c levels by using an Action Plan. It also demonstrates how to increase compliance with medications by checking for understanding. This video emphasizes developing a common goal with the patient for success.

As much as 90% of the care needed to manage a chronic disease must come directly from the patient. These important self-management interventions, such as self-monitoring and healthy lifestyle changes, lead not only to improved health, but also to increased patient satisfaction and reductions in hospital and emergency room costs.
AHRQ “My Action Plan” Example

Therapeutic Communication – Teach-Back

Teach-back is another way to assess our patients understanding of information that we provide to the patient during their encounter whether it is in-person, via telephone, or through the EMR. It is an effective way to assess their understanding of what was discussed and ensuring the patient understands the information they have been given. There are various opportunities to learn about Teach-back such as through the following two resources:

AHRQ Health Literacy Toolkit
AHRQ--Agency for Healthcare Research and Quality: Advancing Excellence in Health Care
Health Literacy Universal Precautions Toolkit, 2nd Edition

Regardless of a patient’s health literacy level, it is important that staff ensure that patients understand the information they have been given. The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand. The related show-me method allows staff to confirm that patients are able to follow specific instructions (e.g., how to use an inhaler).

The teach-back and show-me methods are valuable tools for everyone to use with each patient and for all clinic staff to use. These methods can help you:

- Improve patient understanding and adherence
- Decrease call backs and canceled appointments
- Improve patient satisfaction and outcomes


Fact
Studies have shown that 40-80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect.
Always Use Teach-back! Toolkit

Always Use Teach-back! http://www.teachbacktraining.org/ the purpose of this toolkit is to help all health care providers learn to use teach-back—every time it is indicated—to support patients and families throughout the care continuum, especially during transitions between health care settings. The toolkit combines health literacy principles of plain language and using teach-back to confirm understanding, with behavior change principles of coaching to new habits and adapting systems to promote consistent use of key practices.


10 Elements of Competence for Using Teach-back Effectively

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.

What is Teach-back?

- A way to make sure you—the health care provider—explained information clearly. It is not a test or quiz of patients.
- Asking a patient (or family member) to explain in their own words what they need to know or do, in a caring way.
- A way to check for understanding and, if needed, re-explain and check again.
- A research-based health literacy intervention that improves patient-provider communication and patient health outcomes1.

1 Schillinger, 2003
SECTION THREE

BODY MASS INDEX (BMI)

RURAL WISCONSIN CHRONIC DISEASE TOOLKIT 2018
Regular BMI screening is one of the core metrics identified for needing improvement. Divine Savior Healthcare (DSH) has higher than average rates of BMI screenings completed. DSH has shared the practices that have made them successful in this area. DSH is a rural hospital with primary care clinics in Portage, Oxford, and Pardeeville WI, serving patients in Columbia and Marquette Counties.

**Divine Savior Healthcare BMI Screening and Follow Up**

Communication and education to the staff and providers are key factors to the success of this measure. Each quarter the leadership team meets with the provider and their care teams to review and update the provider dashboard and metrics. It was important to incorporate the care team into these meetings so that they understand the impact they have on the data collection. These meetings identify best practices amongst providers and their care teams, which are then rolled out to other teams.

Education included where the appropriate places to document BMI and the nutritional/exercise counseling follow-up plan was needed to meet these measures. The BMI was incorporated into the organizational rooming standards so it is an expectation of care delivery. This is not a one-time educational topic but instead, an ongoing conversation at the quarterly meetings and having the leadership team continue to train and educate.

**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current reporting period documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current reporting period.

**Normal Parameters:**
- Age 65 years and older BMI ≥ 23 and < 30
- Age 18-64 years BMI ≥ 18.5 and < 25

**Follow-Up Plan** – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up may include but is not limited to: documentation education, a referral (e.g., a registered dietitian, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.

**Not Eligible for BMI Calculation or Follow-Up Plan** – A patient is not eligible if one or more of the following reasons are documented:
- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient’s health status
Resources for Diabetes Care

Diabetes Facts and Figures – National Overview
Nationally, about 30.3 million people, or 9.4% of the US population, had diabetes in 2015. This total included 30.2 million adults aged 18 or older, or 12.2% of all US adults. About 7.2 million of these adults had diabetes but were not aware that they had the disease or did not report that they had it.

The Diabetes Report Card has been published by the Centers for Disease Control and Prevention (CDC) every 2 years since 2012 to provide current information on the status of diabetes and its complications in the United States. It includes information and data on diabetes, preventive care practices, health outcomes, and risk factors such as race, ethnicity, socioeconomic position, and prediabetes. For more information on the Diabetes Report Card go to this link: https://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2017-508.pdf
A Snapshot: Diabetes In The United States

To access this Infographic, visit https://www.cdc.gov/diabetes/library/socialmedia/infographics.html

30.3 million people have diabetes
That’s about 1 out of every 10 people

30.3 MILLION

1 out of every 4 don’t know they have diabetes

1 4 OUT

DIABETES COST

84.1 million people — more than 1 out of 3 adults — have prediabetes

84.1 MILLION

9 out of 10 don’t know they have prediabetes

9 OUT OF 10

If you have prediabetes, losing weight by:

EATING HEALTHY
BEING MORE ACTIVE

&

can cut your risk of getting type 2 diabetes in HALF

PREDIABETES

Total medical costs and lost work and wages for people with diagnosed diabetes

$245 BILLION

Risk of death for adults with diabetes is 50% higher than for adults without diabetes

RIP

50%

RIP

$2 as for people without diabetes

2X

Medical costs for people with diabetes are more than twice as high

$5

$5

People who have diabetes are at higher risk of serious health complications:

BLINDNESS
KIDNEY FAILURE
HEART DISEASE
STROKE
LOSS OF TOES, FEET, OR LEGS

RESOURCES FOR DIABETES CARE
Diabetes – Wisconsin Overview

Diabetes is a costly, complex, and devastating chronic illness that poses a major public health problem. Approximately 356,000 adults in Wisconsin have been diagnosed with diabetes. It is estimated that an additional 138,000 have diabetes but are undiagnosed. Diabetes is the seventh leading cause of death in Wisconsin, incurring an estimated $3.9 billion annually in health care and lost productivity costs. Each year, more than 1,300 Wisconsin residents die from diabetes and many more suffer disabling complications such as heart disease, kidney disease, blindness, and amputations. For more information on Diabetes in Wisconsin go to this link: https://www.dhs.wisconsin.gov/diabetes/index.htm

Diabetes in Wisconsin Facts and Figures
To access this Infographic, visit https://www.dhs.wisconsin.gov/publications/p01897.pdf
Diabetes Facts and Figures – Map of Diabetes by County

The Wisconsin Heart Disease Program has developed this map as a resource to assist partners and professionals visualize the significance of hypertension in Wisconsin.

To learn more about the effects of chronic disease in Wisconsin, visit the Wisconsin Department of Health Services Chronic Disease Prevention Program page https://www.dhs.wisconsin.gov/heart-disease/index.htm.

To access this detailed Map of Diabetes by County, visit https://www.dhs.wisconsin.gov/publications/p01945.pdf
Reduce HgbA1c Poor Control (NQF measure 0059)

To improve quality, increase population health, and reduce costs associated with diabetes in rural primary care settings, one of the goals identified was to reduce the percentage of population’s diabetic patients with Hemoglobin A1c Poor Control (NQF measure 0059). Three interventions were identified to help with this goal:

- Diabetes focused visit every 6 months
- Follow-up within 30 days if Hgb A1c is greater than or equal to 8 for a diabetes-focused visit
- Self-management and lifestyle training for patients with diabetes

Diabetes focused visit every 6 months

Optimal diabetes management requires an organized, standardized approach where the team of providers and clinical staff communicate and utilize the evidence and expectations for testing, provider visits, diabetes education, and lifestyle changes. The diabetes focused-visit will assist in addressing these issues and provide resources as needed for the patient to assist in improving their awareness and engagement. Patients who interact more frequently with their providers and care team are believed to have improved control of A1C, blood pressure, and LDL-D levels and improve their health and well-being.

Standards of Medical Care in Diabetes

The ADA offers an abridged version for primary care providers, Standards of Medical Care in Diabetes: Abridged for Primary Care Providers: [http://clinical.diabetesjournals.org/content/36/1/14](http://clinical.diabetesjournals.org/content/36/1/14)

This is a useful resource for providers that are looking for the most current evidence-based recommendations for diagnosing and treating adults and children with diabetes such as Antihyperglycemic Therapy in Adults with Type 2 Diabetes. Included are a sample of tables and figures that depict a summary of treatment recommendations.
Approach to the Management of Hyperglycemia

Depicted are patient and disease factors used to determine optimal A1C targets. Characteristics and predicaments toward the left justify more stringent efforts to lower A1C; those toward the right suggest less stringent efforts. Adapted with permission from Inzucchi et al. Diabetes Care 2015;38:140–149. http://clinical.diabetesjournals.org/content/36/1/14
Pharmacologic Therapy for Type 2 Diabetes

Drug-Specific and Patient Factors to Consider When Selecting Antihyperglycemic Treatment in Adults with Type 2 Diabetes – an outline monotherapy and combination therapy emphasizing drugs commonly used in the United States and/or Europe. http://clinical.diabetesjournals.org/content/36/1/14

![Table Image] (TABLE 7. Drug-Specific and Patient Factors to Consider When Selecting Antihyperglycemic Treatment in Adults With Type 2 Diabetes)

*See Inzucchi et al. Diabetes Care 2015;38:140–149 for description of efficacy. 1U.S. Food and Drug Administration–approved for CVD benefit. NASH, nonalcoholic steatohepatitis; RAs, receptor agonists; SQ, subcutaneous; T2DM, type 2 diabetes.
Antihyperglycemic Therapy in Type 2 Diabetes: General Recommendations

*If patient does not tolerate or has contraindications to metformin, consider agents from another class in Table 7. GLP-1 receptor agonists and DPP-4 inhibitors should not be prescribed in combination. If a patient with ASCVD is not yet on an agent with evidence of cardiovascular risk reduction, consider adding. http://clinical.diabetesjournals.org/content/36/1/14
Combination Injectable Therapy for Type 2 Diabetes

FBG, fasting blood glucose; hypo, hypoglycemia. Adapted with permission from Inzucchi et al. Diabetes Care 2015;38:140–149. http://clinical.diabetesjournals.org/content/36/1/14
Referrals to Diabetic Educator and/or Nutrition

Refer patients to a Registered Dietitian and/or Diabetes Educator for consult and then with reinforcement of education; consider using the Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes: Algorithm Action Steps [https://professional.diabetes.org/sites/professional.diabetes.org/files/media/algorith_action_steps.pdf](https://professional.diabetes.org/sites/professional.diabetes.org/files/media/algorith_action_steps.pdf)
Pre-Visit Chart Review

Clinical staff complete a pre-visit chart review to assess patient needs for labs, self-management goals, annual eye exam, health maintenance due, and smoking cessation. See Chronic Disease Management Resources section for Pre-Visit Planning Checklist.

Visual Aid Graphs

Provide a visual graph of patient’s A1C and weight for patients (courtesy of Divine Savior Health)
A comprehensive foot exam can be done in three minutes and reduces amputations among people with diabetes. The Medicare Quality Payment Program measure, Diabetes: Foot Exam, is for primary care providers from the National Committee for Quality Assurance. It must include a visual exam, monofilament, and pulse exam and is recommended at least annually on all adults with diabetes. See https://qpp.cms.gov
The 2017 Wisconsin Diabetes Clinical Care Recommendations At-A-Glance is a useful resource that an organization may consider using that discusses the diabetes concern, which care/test is recommended, and frequency. Please visit [https://www.dhs.wisconsin.gov/publications/p49356a.pdf](https://www.dhs.wisconsin.gov/publications/p49356a.pdf) or view sample below.
<table>
<thead>
<tr>
<th>Kidney Care</th>
<th><strong>Type 1:</strong> After diagnosis, then annually Type 2: At diagnosis, then annually Type 2: At diagnosis, then annually</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>ACE inhibitors or angiotensin II receptor blockers reduce progression of CKD to ESRD and improve survival for hypertension with heavy albuminuria</em></td>
</tr>
<tr>
<td>Hypertension diagnosis or BP &gt;140/90 mmHg AND albumin-creatinine ratio, urine ratio greater than or equal to 30mg/g creatinine (A evidence) or 30-329 mg/L creatinine (B evidence) use ACE inhibitor or angiotensin II receptor blocker</td>
<td></td>
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<tr>
<td></td>
<td>Assess at least annually</td>
</tr>
<tr>
<td>Eye Care</td>
<td><strong>Type 1:</strong> ≥ 12 years of age. Retinal exam within 5 years of diagnosis and then annually (or once every 2 years if no retinopathy found on LAST exam) Type 2: At diagnosis, then annually (or once every 2 years if no retinopathy found on LAST exam) Type 1 and Type 2: Diabetic retinopathy is a contraindication and not recommended for screening</td>
</tr>
<tr>
<td></td>
<td>Visual inspection of feet with shoes and socks off Each focused visit; stress sensory foot exam</td>
</tr>
<tr>
<td></td>
<td>Perform comprehensive lower extremity foot exam At diagnosis, then annually</td>
</tr>
<tr>
<td></td>
<td>Screen for peripheral artery disease (PAD) – consider ankle-brachial index (ABI) At diagnosis, then annually</td>
</tr>
<tr>
<td>Neuropathies and Foot Care</td>
<td><strong>Type 1:</strong> Five years after diagnosis, then annually Type 2: At diagnosis, then annually Type 1 and Type 2: Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain in diabetes</td>
</tr>
<tr>
<td></td>
<td>Visual inspection of feet with shoes and socks off Each focused visit; stress sensory foot exam</td>
</tr>
<tr>
<td></td>
<td>Perform comprehensive lower extremity foot exam At diagnosis, then annually</td>
</tr>
<tr>
<td></td>
<td>Screen for peripheral artery disease (PAD) – consider ankle-brachial index (ABI) At diagnosis, then annually</td>
</tr>
<tr>
<td>Oral Care</td>
<td><strong>Type 1:</strong> Five years after diagnosis, then annually Type 2: At diagnosis, then annually Type 1 and Type 2: Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain in diabetes</td>
</tr>
<tr>
<td></td>
<td>Simple inspection of gums and teeth for signs of periodontal disease At diagnosis, then each focused visit</td>
</tr>
<tr>
<td></td>
<td>Dental exam by general dentist or periodontal specialist At diagnosis, then individualized based on an oral assessment and risk, as more frequent exams may be needed</td>
</tr>
<tr>
<td>Emotional and Sexual Health Care</td>
<td><strong>Type 1:</strong> Five years after diagnosis, then annually Type 2: At diagnosis, then annually Type 1 and Type 2: Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain in diabetes</td>
</tr>
<tr>
<td></td>
<td>Assess emotional health; screen for depression Each focused visit</td>
</tr>
<tr>
<td></td>
<td>Assess sexual health concerns Each focused visit</td>
</tr>
<tr>
<td>Communicable Diseases Prevention</td>
<td><strong>Type 1:</strong> Five years after diagnosis, then annually Type 2: At diagnosis, then annually Type 1 and Type 2: Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain in diabetes</td>
</tr>
<tr>
<td></td>
<td>Provide influenza vaccine Annually, if age ≥ 6 months</td>
</tr>
<tr>
<td></td>
<td>Provide pneumococcal vaccine Once, then per Advisory Committee on Immunization Practices</td>
</tr>
<tr>
<td></td>
<td>Provide hepatitis B series Once at diagnosis for age 18–65 years of age; individualize for all 65+ years of age</td>
</tr>
<tr>
<td></td>
<td>Screen for tuberculosis infection or disease As needed</td>
</tr>
<tr>
<td>Preconception, Pregnancy and Postpartum Care</td>
<td><strong>Type 1:</strong> Five years after diagnosis, then annually Type 2: At diagnosis, then annually Type 1 and Type 2: Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain in diabetes</td>
</tr>
<tr>
<td></td>
<td>Ask about reproductive intentions/assess contraception At diagnosis and then every visit</td>
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<tr>
<td></td>
<td>Prevent preconception counseling/assessment that addresses the importance of glycemic control as close to normal as safely possible, ideally &lt;6.5% HbA1c to reduce the risk of congenital anomalies 3–4 months prior to conception</td>
</tr>
<tr>
<td></td>
<td>Counsel on the risk of development and/or progression of diabetic retinopathy Occur before pregnancy and then within first trimester then second, third, and 1 year post-partum as indicated by degree of retinopathy</td>
</tr>
<tr>
<td></td>
<td>Screen for undiagnosed type 2 diabetes in women with known risk At first prenatal visit</td>
</tr>
<tr>
<td></td>
<td>Screen for gestational diabetes mellitus (GDM) in all women not known to have diabetes At 24–28 weeks gestation</td>
</tr>
<tr>
<td></td>
<td>Screen for type 2 diabetes in women who had gestational diabetes mellitus (GDM) At 4–12 weeks postpartum then at least every 3 years thereafter, using OGTT</td>
</tr>
</tbody>
</table>

* Consider more often if FPG is above the patient's goal and/or individual risk and/or complications exist; or less often if at goal and individual risk and/or complication do not exist.

** Consider referral to provider for treatment in case of women with diabetes during pregnancy.

** More or less stringent blood pressure goals must be individualized if >140/90 is not less resistant to achieve
Diabetes Planned Visit Algorithm

Diabetes planned visits let patients become active participants in managing their diabetes. Patients set goals with their providers on what actions they will take to improve their health and manage their condition.

https://www.ahrq.gov/professionals/education/curriculum-tools/diabnotebk/diabnotebk1.html

Diabetes Planned Visit

Overview
Ultimately, it is important to control blood pressure, blood glucose and lipids, but the patient is in control of all daily decisions and actions required to reach these goals.

Success in managing diabetes requires patients to take control of the illness, set meaningful self-management goals, and become competent in diabetes management.

Traditional education, handouts, and cajoling do not promote patient competence. The greatest success has occurred when patients are encouraged to set the agenda of the visit and coached in setting attainable and meaningful self-management goals. Thus, the essential components of a planned visit for clinicians are to address the concerns of the patient and then to partner with the patient to create a self-management goal. If this process takes the entire 30 minutes of the visit time, the patient should receive additional appointments to address issues such as getting glucose, blood pressure, and lipids to goal and completing health maintenance.

Is the patient ready for a diabetes planned visit?
Determine if the patient is ready for diabetes planned visit or has another more pressing need.
If the patient is not ready for a diabetes planned visit, use regular a progress note and re-schedule the diabetes planned visit.

If the patient is ready for a diabetes planned visit:

Begin with Pre-Visit Questionnaire
Scan the pre-visit questionnaire for serious symptoms (e.g., chest pain, stroke/transient ischemic attack symptoms). Prioritize evaluation of potentially life- or limb-threatening symptoms.

If there are no serious symptoms, record on the progress note the patient’s answers to the following pre-visit questionnaire questions:
• What is the most important thing you hoped to get from this visit?
• What concerns you most about your diabetes?
Discuss and clarify the answers to these questions and address the patient’s concerns.

Review progress on previous self-management goal
Ask “At the last visit, you planned to … How did that go? Explore the patient’s insight into either “success” or “failure.”
Review new Self-Management Goal Sheet
If no goal is recorded:

- Review with the patient the importance and concept of self-management.
- Use the Self-Management Goal Sheet try to work with patient to create a meaningful self-management goal.
  - The goal should be an attainable small step to ensure success because effective self-management is more likely with cumulative small successes.
- Review side two of the Self-Management Goal Sheet and review and discuss barriers and coping strategies.
- Revise self-management goal, if needed, and give it to the patient to take home and use as a guide.
- Record the new self-management goal on the front side of the diabetes planned visit progress note.

Tip: If goal is related to weight, diet, or glucose control, consider a referral to a dietitian for help with setting dietary self-management goals.

Pre-Visit Questionnaire

- Review and confirm the patient’s medication list. Update the green continuity sheet as needed.
- Review, explore, and record pertinent “positives” on diabetes planned visit progress note.

If depression screening is positive, investigate and have the patient help prioritize. (Untreated depression and stress makes self-management more difficult.)

If not suicidal or homicidal, consider:

- Scheduling a medical evaluation as appropriate.
- Having the patient complete PHQ-9 Depression scale.
- Scheduling a follow up for depression discussion.
- Review educational needs recorded on the pre-visit questionnaire.

Pull educational handouts from the notebook and review then or near the end of the visit.

Physical Exam

- Re-check blood pressure. Consider intensification of regimen if the patient is not at goal (systolic < 130, diastolic < 70). (Use Nursing Blood Pressure Titration Protocol)
- Check heart and lungs.
- Examine feet.

Note deformities, calluses, skin breaks, vascular status, and any fungal infection. Ask the patient to show how he or she checks the feet and tell you what he or she is looking for. Follow up by asking the patient what he or she would do if redness, swelling, broken skin, or an ulcer were present.

- Perform and record monofilament if not done within 1 year. Monofilament is not necessary if neuropathy is already confirmed.
Diabetes Report Card

• Review and explain the Diabetes Report Card results.
• Fill out prescription for labs for medication monitoring for the next diabetes planned visit as appropriate. Fill out corresponding section on Diabetes Management Report Card.
• Agree on follow up. If blood pressure or glucose are not at goal, schedule more frequent, focused (15 minute) visits to get to goal. These do not need to be diabetes planned visits. Consider nurse blood pressure checks or blood pressure titration. Schedule the next diabetes planned visit in 3 to 4 months if blood pressure, glucose, and lipids are at goal. Write “Diabetes Planned Visit” on the return slip to ensure 30 minutes and lab date updates are scheduled.
• Confirm that health maintenance is up to date. If it is not up to date, give patient a Staying Healthy handout and either schedule or plan to discuss at next visit.

Close the Loop
Ask the patient:
• What they understand about how they are doing.
• New self-management goal.
• What will transpire before next visit.
Diabetes Focused Visit

**Follow-up within 30 days if Hgb A1c is greater than or equal to 8 for a diabetes-focused visit**
Scheduling an office visit with the provider within 30 days is critical part of the patient’s plan of care and helping the patient to understand you are committed to their health. Diabetes is one of the most costly conditions because of the serious complications that can result in increased emergency department visits and hospital admissions. Research has shown that patients with values of 9.0% or greater tend to utilize costly, intensive resources.

The specific follow-up visit will allow time to address diabetes education, address barriers, set up referrals to endocrinology, diabetes educator, and/or RN Care Coordinator. With the timely visit this will help the patient begin to gain control and lower their A1C, which will help reduce possible complications.

**Registry**
Identify a process for diabetic population identification, such as a registry and utilize the registry for outreaching patients that are in need of follow-up: See Other Resources to Support Chronic Disease Management, UCSF Chronic Care Registry Information for a Registry example

**Referral for Diabetes Self-Management Education and Support**
Refer patients to a Registered Dietitian and/or Diabetes Educator for consult and then with reinforcement of education: See *Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes: Algorithm Action Steps* in Referrals to Diabetic Educator and/or Nutrition section. Or, to access this algorithm, please visit: [https://professional.diabetes.org/sites/professional.diabetes.org/files/media/algorithm_action_steps.pdf](https://professional.diabetes.org/sites/professional.diabetes.org/files/media/algorithm_action_steps.pdf)

**Follow-up with patients that are No Show for appointments**
Having an office visit with the provider within 30 days is critical part of the patient’s plan of care. Proactive outreach for no shows in another step in the process to consider for comprehensive diabetes care. See Other Resources to Support Chronic Disease Management for Follow-up with patients that are No Show for appointments workflow sample
Communication

Engage patients using evidence-based communication strategies, such as motivational interviewing and teach-back. The way a provider communicates with the patient can influence a patient with medication adherence, lifestyle changes, and improve their motivation: See Resources for Effective Communication section for examples.

Diabetes Self-Management Education (DSMES) and Lifestyle Training
Self-management and lifestyle training for patients with diabetes and/or hypertension are necessary elements to help improve patient outcomes. Education in regard to nutrition, exercise, regular lab testing, medication adherence, checking blood sugars, working with a diabetic educator, and keeping regularly, scheduled appointments with their provider can help reduce costly Emergency Room visits and hospital admissions due to complications related to diabetes and/or hypertension. Engaged patients may seek out advice from their providers and clinical staff to take an active role in making treatment choices.

LIVING WELL WITH DIABETES
Are you one of the 30.3 million Americans with diabetes?
To be your healthiest and feel your best:

- Eat more fruits and vegetables, less sugar and salt.
- Get physically active—aim for at least 150 min/week.
- Take diabetes medicine as prescribed.
- Make and keep appointments with your health care team.
- Check blood sugar regularly.
- Know your ABCs:
  - Regular A1C test
  - Blood pressure below 140/90 mm Hg
  - Control cholesterol
  - Stop/don’t start smoking

DID YOU KNOW... making healthy lifestyle changes can greatly reduce your risk of diabetes-related health problems. It really works!
Living with Diabetes

Visit the CDC Living With Diabetes webpage for up to date information on Diabetes Self-Management and Support, as well as other key topics to support those living with diabetes. [https://www.cdc.gov/diabetes/managing/index.html](https://www.cdc.gov/diabetes/managing/index.html)

**Diabetes Self-Management Education and Support (DSMES)**

DSMES services help people with diabetes learn how to take the best care of themselves.

<table>
<thead>
<tr>
<th>When Do You Need DSMES?</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you first find out that you have diabetes</td>
<td>When you’re first diagnosed, you may not know where to begin. DSMES can give you the information and support to start managing your diabetes.</td>
</tr>
<tr>
<td>During yearly follow-up visits with your doctor</td>
<td>Check on your progress and get help to prevent complications.</td>
</tr>
<tr>
<td>When new situations affect the way you take care of yourself</td>
<td>New events or conditions in your life can affect your diabetes. Examples include diagnosis of a new health condition, a change in your mobility, depression, or money problems.</td>
</tr>
<tr>
<td>When other life changes occur that affect the way you take care of yourself</td>
<td>Major life changes can affect your diabetes. Examples of life changes include a change in your living situation, your doctor or insurance plan, or your job.</td>
</tr>
</tbody>
</table>
A doctor can make a referral to DSMES services to help PATIENTS manage their diabetes.

**Q:** Will insurance cover the cost of these services?

**A:** Most insurance plans, including Medicare and Medicaid, cover up to 10 hours of diabetes education the first year of diagnosis. After the first year, coverage may be different. Contact the insurance provider for more information. Visit the Centers for Disease Control and Prevention (CDC) Web Page – Diabetes Education and Support – to learn more about DSMES [https://www.cdc.gov/diabetes/managing/education.html](https://www.cdc.gov/diabetes/managing/education.html).

To find an accredited Diabetes Education Program in your area, visit: [https://www.diabeteseducator.org/living-with-diabetes/find-an-education-program](https://www.diabeteseducator.org/living-with-diabetes/find-an-education-program)

**Living Well with Diabetes**

The American Diabetes Association website offers free resources on ADA Recognized Programs and gives you access to free learning resources and tools. To learn more, visit [http://www.ada-ksw.com/LWT2DProgramOverview.php](http://www.ada-ksw.com/LWT2DProgramOverview.php)
Providing up-to-date resources that support self-management and lifestyle training that may include healthy diet information, medication adherence, and/or physical activity with goals that the patient is able to understand. Consider providing information about your organization’s Diabetic Support Group, such as Divine Savior Healthcare’s, or working with an outside organization such as Healthy living with Diabetes Wisconsin Healthy Aging, or the Diabetes Empowerment Education Program (DEEP).
Blood Sugar Log

It is important for patients to be educated on the reasons of why they should be checking, recording, and bringing their blood sugars in a log book to their appointments. Keeping a log book helps providers manage their diabetes. Helping the patient understand that by documenting their sugars will also help them to understand any patterns or trends that may be occurring. It can be difficult for patients to try and remember what their sugars have been and if not documenting, it can be inaccurate. For a free downloadable template, visit: https://professional.diabetes.org/sites/professional.diabetes.org/files/media/Blood_Glucose_Log.pdf
Wisconsin Institute for Healthy Aging: Healthy Living with Diabetes

Healthy Living with Diabetes (HLWD)
This is a high-level evidence-based workshop for people who have diabetes. Developed at Stanford University, the Healthy Living with Diabetes workshop meets for 2-1/2 hours once a week for six weeks. This community-based program is very interactive, where mutual support and success build participants’ confidence in their ability to manage their health condition and maintain active and fulfilling lives. It is facilitated by two trained leaders in a small group setting, and most of the learning comes from sharing and helping others in the workshop with similar challenges. Visit: [https://wihealthyaging.org/healthy-living-with-diabetes](https://wihealthyaging.org/healthy-living-with-diabetes)

Healthy Living with Diabetes Fact Sheet
Does Healthy Living with Diabetes replace or conflict with the work of Diabetes Educators?

No. Unlike appointments with a diabetes educator, Healthy Living with Diabetes is not an individualized program and does not consider any person’s individual health care needs or diabetes markers, nor provide individualized assessments, plans or medical advice. Rather, this complementary program provides assistance to participants in developing their “action plans” and group support in accomplishing them. Participants often report that the concepts they learn in the workshop are a reinforcement of what they had previously learned (and often forgot) years ago. Many participants report they have never had access to a diabetes educator because there are none in their community, their insurance doesn’t cover it or it only allows a very limited number of sessions. Experience across the country confirms that Healthy Living with Diabetes is an excellent program by itself, or as a complement to work with a diabetes educator.

How was Healthy Living with Diabetes developed?

Stanford University developed this program as a variation of its “Chronic Disease Self-Management Program” (Living Well with Chronic Conditions in Wisconsin). The original Diabetes Self-Management Program was developed in Spanish. After successful outcomes were found with that program, Stanford University conducted a randomized, controlled study to test the workshop’s effectiveness for English-speakers.

Does the program work? What are the outcomes?

Yes. Results from the Spanish program showed that the program participants, as compared with usual-care control subjects, demonstrated improved health status, health behavior and self-efficacy as well as fewer emergency room visits at four months. At six months, compared with control subjects, participants demonstrated improvements in blood sugar levels, health distress, symptoms of hypo- and hyperglycemia, and self-efficacy. At 18 months, all improvements persisted. Participants also demonstrated improvements in self-rated health and communication with physicians, had fewer emergency room visits and trended toward fewer visits to physicians.

Published studies are available upon request.

For more information, contact:
Wisconsin Institute for Healthy Aging | 1414 MacArthur Road, Suite B
Madison, WI 53714
Phone: 608/243-5690 | Fax: 866/341-1278 | info@wihealthyaging.org
Visit us online at: wihealthyaging.org
The Diabetes Empowerment Education Program, also known as DEEP™, is an education curriculum designed to help people with pre-diabetes, diabetes, relatives and caregivers gain a better understanding of diabetes self-care. Classes last a total of six weeks, providing participants with eight unique learning modules.

Class Descriptions

1: Beginning Sessions and Understanding the Human Body
   - Exercises to establish trust and solidarity among group members and to obtain the motivation and participation of all
   - Description of the functioning of the human body and its relation to diabetes
   - Strategies to manage and control diabetes with the goal of beginning to reinforce the importance of self-care principles

2: Understanding Risk Factors for Diabetes
   - The definition, classification and symptoms of diabetes
   - Risk factors and the Weekly Action Plan

3: Monitoring Your Body
   - The diagnosis of diabetes, hypoglycemia, hyperglycemia, and ways to control these
   - Diabetes management and the benefits of the glucose meter

4: Get up and Move! Physical Activity and Diabetes
   - Motivating participants to perform some physical activity on a regular basis and to incorporate exercise as a method to control diabetes

5: Controlling Diabetes through Nutrition
   - Concepts and basic nutritional terms that allow participants to make correct decisions when selecting foods, including using food labels
   - Portion control

6: Diabetes Complications: Identification and Prevention
   - The main complications of diabetes
   - The different specialists and health care team available for prevention and control

7: Learning about Medications and Medical Care
   - Medications available for the control of diabetes, hypertension, high cholesterol and triglycerides
   - Medications’ mechanisms of action, recommendations, cautions and side effects
   - How to improve communication with health care providers

8: Living with Chronic Disease: Mobilizing Family and Friends
   - Emotional aspects of chronic disease, such as stress and depression
   - Patients’ rights
   - How to involve family and friends in the self-care program
SECTION FIVE

RESOURCES FOR BLOOD PRESSURE CONTROL

RURAL WISCONSIN CHRONIC DISEASE TOOLKIT 2018
Resources for Blood Pressure Control

Hypertension Overview – National
High blood pressure is a common and dangerous condition. About 1 of 3 U.S. adults—or about 75 million people—have high blood pressure. Only about half (54%) of these people have their high blood pressure under control. This common condition increases the risk for heart disease and stroke, 2 of the leading causes of death for Americans. For more information from the Centers for Disease Control and Prevention, click on the following link: https://www.cdc.gov/bloodpressure/index.htm

A SNAPSHOT: BLOOD PRESSURE IN THE U.S.
Make Control Your Goal

High blood pressure is a major risk factor for heart disease and stroke, the first and fourth leading causes of death for all Americans.

HIGH BLOOD PRESSURE BASICS

67 MILLION
American adults have high blood pressure

1 IN 3

High blood pressure contributes to

~1,000 DEATHS/DAY

When your blood pressure is high:

You are 4x more likely to die from a stroke

You are 3x more likely to die from heart disease

89% of people who have a first heart attack...

77% of people who have a first stroke...

74% of people with chronic heart failure...

HAVE HIGH BLOOD PRESSURE

Annual estimated costs associated with high blood pressure:

$51 BILLION
in direct medical expenses

$47.5 BILLION
in lost productivity
RESOURCES FOR BLOOD PRESSURE CONTROL

BLOOD PRESSURE CONTROL

Reducing average population systolic blood pressure by only 12-13 mmHg could reduce:
- Stroke: 37%
- Coronary heart disease: 21%
- Deaths from cardiovascular disease: 25%
- Deaths from all causes: 13%

ONLY ABOUT HALF of people with high blood pressure have their condition under control

MAKE CONTROL YOUR GOAL, EVERY DAY

- Check your blood pressure regularly—at home, at a doctor’s office, or at a pharmacy
- Quit smoking—or don’t start 1-800-QUIT-NOW or Smokefree.gov
- Eat a healthy diet with:
  - More fruits, vegetables, potassium, and whole grains
  - Less sodium, saturated fat, trans fat, and cholesterol
- Adults should limit alcohol to no more than:
  - 1 drink per day for women
  - 2 drinks per day for men
- Read nutrition labels and lower your sodium intake
  - Most of the sodium we eat comes from processed and restaurant foods
  - About 90% of Americans eat too much sodium
- Get active and maintain a healthy weight
  - Aim for 2 hours and 30 minutes of moderate physical activity every week

millionhearts.hhs.gov/aboutds/blood_pressure.html

This infographic was developed by the Centers for Disease Control and Prevention’s Division for Heart Disease and Stroke Prevention in support of achieving the Million Hearts Initiative goal to prevent 1 million heart attacks and strokes by 2017.
Cardiac Disease Overview – Wisconsin

Each year, cardiovascular disease is responsible for one out of every three deaths in Wisconsin, affecting an increasing proportion of people under the age of 65. The good news is that many of the risk factors associated with heart disease and other cardiovascular conditions—hypertension, high cholesterol, smoking, overweight and obesity, and diabetes—are largely preventable. Approximately 1.3 million adults in Wisconsin have hypertension, and 2 out of 5 of them are unaware of their condition. To learn more about the Wisconsin Chronic Disease Prevention Program (CDPP) and the work that they do with health systems, health care providers, insurers, and professional organizations across the state to support a healthier Wisconsin by improving the prevention and management of heart disease, click on the following link: https://www.dhs.wisconsin.gov/heart-disease/index.htm
How is Wisconsin Addressing Heart Disease?

Chronic Disease Prevention Goals and Strategies

Chronic Disease Prevention Program Goals

- Healthier people living in healthier communities.
- Improved prevention and control of diabetes, heart disease, obesity, and associated risk factors.

Chronic Disease Prevention Program Strategies

In order to reach the Chronic Disease Prevention Program (CDPP) goals, the CDPP works with its partners on the following strategies to address heart disease.

1. Increase implementation of quality improvement processes and use of health information technology (HIT) in health systems for performance effectiveness.
2. Increase use of team-based care in health systems.
3. Increase use of lifestyle intervention programs in the community for the primary prevention of type 2 diabetes.
4. Increase use of diabetes and chronic disease self-management plans and programs in community settings.
5. Increase self-monitoring of blood pressure tied to clinical support.
6. Increase use of health-care extenders in the community to support self-management plans of high blood pressure and diabetes.

Medication Adherence

Medication adherence is the extent to which patients take medications as prescribed by their health care providers. High levels of medication adherence is associated with improved health outcomes and lower health care costs. In Wisconsin, both hypertension and diabetes medication adherence are close to 75%, or 3 in 4.

The CDPP is working with partners to find patients with low medication adherence and help them get back on track to improve their health.

Chronic Disease and Healthcare Systems

Increasing the use of electronic health records (EHR) across the state and nationally is a chronic disease prevention strategy.

93% of health care systems in Wisconsin have EHRs appropriate for treating patients with hypertension and/or diabetes which is 10% higher than the national average.

Team-Based Care

Team-based care is the provision of health services by at least two health professionals working collaboratively with patients, staff, and their caregivers on shared goals within and across settings to achieve high-quality care outcomes that are safe, effective, patient-centered, timely, efficient, and equitable.

The CDPP has limited team-based care outcome measurements that are only from FQHCs, which serve low socioeconomic populations. The CDPP continually works with partners to gain a better understanding of Wisconsin health systems that serve the general population.

The best data the CDPP currently has available on team-based care comes from Wisconsin’s 18 Federally Qualified Health Centers (FQHCs).

FQHCs with team-based care policies or systems in place regarding:

- 69% Blood Pressure Control
- 53% Self-Management of High Blood Pressure
- 53% Diabetes Control
Did you know?
Approximately 1.3 million adults in Wisconsin have hypertension? And of those 2 out of 5 are unaware of their condition?

To learn more about the effects of chronic disease in Wisconsin, find facts, figures, or additional resources, visit the Wisconsin Department of Health Services Chronic Disease Prevention Program page [https://www.dhs.wisconsin.gov/heart-disease/index.htm](https://www.dhs.wisconsin.gov/heart-disease/index.htm).
Blood Pressure Checks

Ensure that all clinical staff and providers have been educated on proper technique, clinical staff have ongoing evaluation and competency checks, and that staff have the equipment needed for proper blood pressure checks. Having a standardized method for taking patient’s blood pressure is important because an accurate measurement is the first step in the management of hypertension. In this section we have provided resources that your organization may find useful:

- Viewing an online e-learning module on how to check a blood pressure accurately
- Clinical staff complete yearly competency checklist with education as needed
- Standardized workflow for blood pressure checks during an office visit and nurse visit
- Signage posted in an acrylic frame that is on the patient counter for the patient to view with the poster titled “7 Simple Tips to get an Accurate Blood Pressure Reading”
Online E-Learning Modules

MetaStar eLearning Modules & Resources

MetaStar is a quality improvement organization that provides health care improvement and consulting services to address the need for system-wide innovation and consistent, evidence-based approaches across all settings of care, guided by their mission, to effect positive change in health and health care. MetaStar representatives work with communities, providers, and insurers to transform care with a vision of optimal health for all and is an independent nonprofit based in Madison and represents Wisconsin in the Lake Superior Quality Innovation Network. [http://www.lsquin.org/](http://www.lsquin.org/)

Taking an Accurate Blood Pressure Reading – Outpatient Adults:

**Purpose:** To provide an overview of proper blood pressure (BP) measurement technique for ambulatory patients using evidence-based research. As guidelines may change over time, this module does not address diagnosis or treatment of hypertension or other conditions. Ideally, this module would be used as part of a course that includes a skills-based competency check with an experienced trainer. It also serves as a valuable refresher course training for already experienced professionals. Please see Divines Savior Health’s story located within Strategy 1 of the toolkit.

**Intended Audience:** Healthcare professionals who take BP measurements for adult (18 years and older) patients in an ambulatory or community based setting

**Format:** The content of this 35-minute module is divided into five sections, with a sixth section devoted to test questions. To access the learning module, visit [https://www.metastar.com/providers/elearning-modules/](https://www.metastar.com/providers/elearning-modules/)
WNA Beyond the 50%

WNA Beyond the 50%: It Starts with Accurate Blood Pressure Measurement
This evidence-based self-study program available until September 30, 2019

Purpose: Protect and improve the health and safety of patients, families, and populations through accurate measurement each time a blood pressure is taken including by patients through self-measurement.

Objectives:
1. Understand the “M.A.P. Framework” as an evidence-based approach to prevention and control of hypertension developed by the American Medical Association and Johns Hopkins Medicine.
2. Learn the importance of accurate measurement and how to avoid common errors.
3. Explore how to partner with patients and engage their participation in accurate self-measurement.

Target Audience: All personnel measuring blood pressures or instructing patients in self-measurement, including nurses, other health professionals and assistant staff working in public/community health settings; also, students in technical college/university healthcare programs.

To access the learning module, visit https://wisconsinnurses.org/beyond-the-50/
RWHC Resources

It was identified that many of our organizations did not have a competency developed for blood pressure skills. The following tools were developed for our organizations to edit and use in their own organization:

- Blood Pressure Measurement Guideline
- How to Take Patient’s Blood Pressure Reading
- Blood Pressure Skills-Based Competency
- References for these tools

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- Blood Pressure Measurement Guideline ................................................. 2
- How To Take Patient’s Blood Pressure Reading ...................................... 4
- Blood Pressure Skills-Based Competency ............................................. 5
- References ............................................................................................... 6

For questions, please contact Cheryl DeVault

(o) 608.644.3243 | (m) 608.712.3706 | cdevault@RWHC.com
Blood Pressure Measurement Guideline

EFFECTIVE DATE: October 31, 2017

PURPOSE: To ensure accurate blood pressure measurement technique is utilized to produce consistent and reliable readings.

EQUIPMENT: Ensure that blood pressure equipment (stethoscopes, sphygmomanometers, cuffs, valves, etc.) are inspected on a regular basis for damage.

PROCEDURE
1. Position patient: Supported sitting or lying
   1.1. Remove clothing from arm
   1.2. Legs should be uncrossed and feet fully supported
   1.3. Arm supported at heart level
   1.4. Position arm with palmar surface facing up
   1.5. Back should be supported
   1.6. Patient has emptied their bladder
   1.7. Patient should be resting quietly (recommended that patient be resting for at least 5 minutes prior to taking blood pressure measurement)
   1.8. Neither the patient nor the clinical staff member should be talking during the procedure
2. Select appropriate cuff size
   2.1. Confirm appropriate size by looking at the index and range lines on the interior of the cuff
   2.1.1. A cuff without an index and range line should not be used
   2.2. Wrap cuff around the bare upper arm
   2.3. Ensure the index line along the short edge of the cuff falls within the range line along upper edge of cuff. If the index line falls outside of range, it is an incorrect size; remove cuff to obtain a different size
   2.4. Apply the cuff snugly to bare arm, allowing room for no more than two fingers
   2.5. Palpate arterial pulsation for stethoscope and cuff alignment
   2.6. Place the midline of the bladder of the cuff so that it is over the arterial pulsation of the patient’s bare arm utilizing the artery marker
   2.7. The lower end of the cuff should be 2 to 3 cm above the antecubital fossa to allow room for placement of the stethoscope
3. Blood pressure measurement using the palpation method
   3.1. Palpate the radial artery, inflate the cuff, noting the level at which the pulse disappears (systolic measurement)
   3.2. Place stethoscope over brachial artery and inflate cuff 30 - 40 mm Hg above level at which
   3.3. Deflate the cuff at a rate of 2 to 3 mm Hg per second
      3.3.1. The systolic blood pressure is noted on the manometer when the initial tapping sounds are heard
      3.3.2. The diastolic pressure should be noted when the sounds have gone silent
      3.3.3. The measurement should be read and recorded to the nearest 2 mm Hg
      3.3.4. If unable to auscultate, completely deflate cuff and wait one to two minutes before re-inflating cuff or use the other arm
   3.4. Deflate cuff per procedure and record blood pressure
   3.5. Document in the EMR

RESOURCES FOR BLOOD PRESSURE CONTROL

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Note: Use an automated blood pressure cuff to recheck the accuracy of a manual blood pressure reading, not the other way around.

Physically prepare the patient for the blood pressure measurement by utilizing the “7 Simple Tips to get an Accurate Blood Pressure Reading”:

1. Use the correct size cuff
2. Do not have a conversation
3. Ensure patient has emptied their bladder
4. Support the patient’s back and feet
5. Patient keeps legs uncrossed
6. Support the patient’s arm at heart level
7. Apply the blood pressure cuff on the patient’s bare arm

How to Take Patient’s Blood Pressure Reading

Before Beginning:
Ensure the following:

- Patient educated to sit quietly for a period of rest (5 minutes is best practice)
- Both feet flat on the floor and back supported
- Legs not crossed
- Ask the patient if they have been eating, smoking, had caffeine, exercised or consumed any alcohol within the last 30 minutes; if “yes” documents in vitals comment section and educates for future visits
- Appropriate cuff size is selected
- Place cuff on bare arm
- Patient’s arm totally supported at heart level
- Patient has an empty bladder
- Neither the patient nor the participant should be talking during the procedure

Steps:

1. Select the cuff size appropriate for the patient’s arm circumference
2. Wrap the cuff around the upper arm and ensure the index line along the short edge of the cuff falls within the range line along the upper edge of the cuff
3. Apply the cuff snugly to bare arm, allowing room for no more than two fingers
4. Inflate cuff rapidly to a level 30 mm Hg above estimated systolic pressure
5. Partially open the valve to allow deflation at a rate of 2 – 3 mm Hg per second. As the pressure falls, note systolic pressure and diastolic pressure detected with your stethoscope
6. Rapidly release the remaining pressure and record measurements immediately in the EMR
7. If blood pressure is >140/90, wait 5 minutes and repeat the above steps
# Blood Pressure Skills-based Competency

**Do it correctly, every time, for your patient.**

<table>
<thead>
<tr>
<th>Criteria Assessed</th>
<th>Yes</th>
<th>No*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant has educated the patient to sit quietly for a period of rest (5 minutes is best practice) with both feet flat on the floor and back supported. Takes the BP at the end of the rooming process to allow time for this rest.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants asks patient if they have been eating, smoking, had caffeine, exercised or consumed any alcohol within the last 30 minutes. If “yes” documents in vitals comment section and educates for future visits.</td>
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<tr>
<td>Participant will demonstrate appropriate cuff selection and placement on patient’s bare arm</td>
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<tr>
<td>Patient’s arm totally supported at heart level</td>
<td></td>
<td></td>
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<tr>
<td>Patient has an empty bladder</td>
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<td></td>
</tr>
<tr>
<td>Neither the patient nor the participant should be talking during the procedure</td>
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<tr>
<td>Participant will accurately measure and record blood pressure in Electronic Medical Record</td>
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<tr>
<td>If the initial BP is 140/90 or greater, repeats a BP measurement after 5 minutes of quietly waiting.</td>
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<tr>
<td>Participant will record the second BP and will inform the provider if the second reading is 140/90 or above.</td>
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<tr>
<td>Participant will verbalize the normal range of adult blood pressure and determine if reading is in a normal range for the individual</td>
<td></td>
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<tr>
<td>Participant will verbalize techniques for measuring orthostatic blood pressure</td>
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<tr>
<td>Reviewed e-module by MetaStar: Taking an Accurate Blood Pressure Reading</td>
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</table>

*If any of the criteria is missed, coaching will be completed privately and recommended education reviewed.

**Educational Recommendations at this time include:**

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Criteria assessed by (Legible Name Title):__________________________________________________

**References**

American Medical Association Blood Pressure Measurement: Measure Accurately
MetaStar: Taking an Accurate Blood Pressure reading: Evidence-based Competency
[https://www.metastar.com/providers/elearning-modules/](https://www.metastar.com/providers/elearning-modules/)
Wisconsin Collaborative for Healthcare Quality Toolkit for Improving Hypertension Care & Outcomes:
Placing signage in the exam room where both the patient and staff are able to view provides education and reminders on proper technique. Placing in an acrylic frame that can be easily moved is one idea for viewing.

Target: BP also provides the latest tools and resources for patients/providers and important recognition opportunities. To learn more about the Target BP program visit [https://targetbp.org/](https://targetbp.org/)
Increase the percentage of the population’s hypertensive patients with adequately controlled blood pressure (NQF 0018)

To improve quality, increase population health, and reduce costs associated with hypertension in rural primary care settings, one of the goals identified was to increase the percentage of the population’s hypertensive patients with adequately controlled blood pressure (NQF 0018). Interventions were identified to help with this goal:

- Provider and clinical staff have a process defined and outlined on how and when to obtain a 2nd BP
- Standardized evidence-based protocol for treating hypertension that can be used as a clinical decision support to assist in achieving hypertension control
- Scheduled chronic disease huddles
- Self-management and lifestyle training for hypertension
Second Blood Pressure Process

Provider and clinical staff have a process defined and outlined on how and when to obtain a 2nd BP. Small inaccuracies in blood pressure measurement can have considerable consequences to the patient. Before taking the 2nd blood pressure ensures the patient’s posture and arm positioning are correct; cuff size is accurate, and so forth. If the second blood pressure continues to be elevated, create a plan of care to address the issue, such as scheduled blood pressure visits with clinical staff. Blood pressure measurement needs to be done correctly and one blood pressure reading is not an appropriate way to diagnose hypertension.

Consider developing an action plan for your organization, or per provider where they can choose their process for obtaining a 2nd BP when it is elevated. Ideally this would be a shared decision between the provider and rooming staff. Implement a visual system to alert the provider that the patient’s BP is above goal, such as a sign or magnet outside the room or left on the keyboard (photos courtesy of Upland Hills Health and Cumberland Healthcare).

Visual Tools
Standardized Approaches the Treatment of Hypertension

You and your care team can improve the accuracy of blood pressure measurement through teamwork, improved communication and using standardized protocols. Measuring blood pressure accurately leads to reliable diagnosis and efficient and appropriate treatment.

Evidence–based treatment protocols encourage consistent delivery of care and help formalize the treatment plan, including reassessment schedules. Clinical teams with well-communicated plans will achieve greater success in improving blood pressure control.

Finally, patients who proactively participate in managing their hypertension tend to have better blood pressure control. By committing to lifestyle and behavior changes, taking medications as prescribed and participating in self-measurement of blood pressure, patients can make significant contributions to their overall health and well-being.

https://www.stepsforward.org/modules/hypertension-blood-pressure-control

A standardized treatment approach sends a strong message to the care team that hypertension control is a priority.
Blood Pressure Workflow Example

Blood Pressure Workflow
For Patients 18 and Older

BP checked at end of rooming

Inform pt what BP reading is

NO

Inform pt of BP reading and re-take BP

BP 140/90 or greater?

NO

Inform pt of BP reading and document vitals under “Add Set”

YES

BP 140/90 or greater?

YES

Inform pt of BP reading and document vitals

NO

Provide patient with BP handout, DASH Diet, BP log, and document on Intake Section educational tools provided

Notify provider of pts elevated BP using notification tool

Using red stop sign, magnet on door frame, leaving BP cuff out on desk, etc.

Provider reviews plan with patient and returning for repeat BP; documents on AVS

Follow the 7 Simple Tips to get an Accurate Blood Pressure Reading

Wait 5 minutes before rechecking 2nd BP

Bring pt back in for NURSE VISIT in 2 weeks, keep log of BP readings if home monitor, etc.

April 2018

RESOURCES FOR BLOOD PRESSURE CONTROL
Evidence-based Protocol for Hypertension Treatment

Standardized evidence-based protocol for treating hypertension can be used as a clinical decision support to assist in achieving hypertension control and provide transparent feedback for providers and clinical staff to view regarding hypertension control rates, including the number of patients on their panel, for both controlled and uncontrolled patients.

Consider utilizing a protocol such as this customizable the template below developed through Million Hearts that can be edited for your organization: https://millionhearts.hhs.gov/files/Hypertension-Protocol.pdf
Instructions for use of the template

1. Gather clinical staff to make consensus decisions about:
   - Specific medications to be prescribed for most patients with hypertension
   - Medications to consider for patients with hypertension and certain medical conditions
   - Starting dosages and dosage increases with each titration
   - Time intervals for follow-up and titration

2. Customize the template by accepting the variables in red or modifying them with other drug names, dosages, and titration
   - As needed, develop separate protocols for subpopulations with different treatment goals

3. Adopt the protocol across the practice or system and revise it over time to meet the needs of patients and staff

<table>
<thead>
<tr>
<th>'Lifestyle Modifications' (LM)</th>
<th>Modification</th>
<th>Recommendation</th>
<th>Approximate SBP** Reduction (Range)††</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight reduction</td>
<td>Maintain normal body weight (body mass index 18.5–24.9 kg/m²)</td>
<td>5–20 mm Hg/10kg</td>
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<tr>
<td>Adopt DASH*** eating plan</td>
<td>Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat</td>
<td>8–14 mm Hg</td>
<td></td>
</tr>
<tr>
<td>Dietary sodium reduction</td>
<td>Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride)</td>
<td>2–8 mm Hg</td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td>Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week which may be broken into shorter time intervals such as 10 minutes each of moderate or vigorous effort)</td>
<td>4–9 mm Hg</td>
<td></td>
</tr>
<tr>
<td>Moderation of alcohol consumption</td>
<td>Limit consumption to no more than 2 drinks (e.g. 24 oz. beer, 10 oz. wine, or 3 oz. 80-proof whiskey) per day in most men, and to no more than 1 drink per day in women and lighter weight persons</td>
<td>2–4 mm Hg</td>
<td></td>
</tr>
</tbody>
</table>

**SBP = systolic blood pressure
††The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals
***DASH = Dietary Approaches to Stop Hypertension

Abbreviations
- ACEI – Angiotensin-Converting Enzyme Inhibitor
- ALDO – Aldosterone Antagonist
- ARB – Angiotensin II Receptor Blocker
- BB – Beta Blocker
- CCB – Calcium Channel Blocker
- EF – Ejection Fraction
- MI – Myocardial Infarction
- TIA – Transient Ischemic Attack

References

Other Resources

Suggested Citation
The American Heart Association, American College of Cardiology and several other health organizations released a comprehensive new guideline with recommendations regarding the diagnosis, treatment and prevention of hypertension. The new guideline lowers the target for blood pressure treatment to 130/80 mmHg. This emphasizes the importance of early prevention, detection and treatment to reduce future cardiovascular risk. To see the top 5 takeaways for your practice visit https://targetbp.org/guidelines17/
Chronic Disease Huddles

Chronic disease huddles are team-based huddles that can be focused on patients with chronic diseases such as diabetes and/or hypertension. The huddles would take place once or twice a month and include the provider, MA/LPN, RN, RN Care Coordinator, Diabetes Educator, Pharmacist. The team would work off a registry of diabetic and/or hypertension patients that are empaneled to the provider. These huddles help with the process of continually outreaching to patients that have poorly controlled diabetes and/or hypertension to encourage the patient to schedule and complete office visits, lab testing, medication adherence, and self-care management. By proactively huddling, creating a plan of care with the team, and outreaching to the patient will help improve chronic care outcomes, improve relationships between the patient and team, and reduce costly Emergency Room visits and hospital admissions.

Chronic Disease Registry
Utilizing a registry to track patients with chronic diseases such as diabetes and hypertension, provides staff with a tool to work off from to see if patient is at goal, if there are care gaps, and for outreach for patients that are overdue for labs, appointment needed, or overdue for a follow up visit. See “Chronic Disease Management Resources” section for Registry example.

Nurse Visit Schedule
Having a designated schedule for Nurses provides time for 1:1 time with the patient to provide education, provide resources, diet and exercise counseling.
Care Coordination

It takes a coordinated approach / cohesive team working together to meet the health needs of patients in today’s healthcare environment. To ensure the right care is delivered at the right time, in the right place, by the right person. Care Coordination role would help to identify patients with chronic diseases and assist with facilitation, teaching, connecting resources, and plan of care for diabetic and hypertensive patients. The nurse-managed care coordination role could include ongoing patient education, medication planning and reconciliation, diet and exercise counseling, reviewing labs, diabetic foot exams, goal setting, and support. For more information on Care Coordination, consider the following opportunities:

**Rural Wisconsin Health Cooperative Quarterly Care Coordination Roundtable**
This is an opportunity for RWHC members to network with their peers, discuss topical issues, exchange ideas and implement special projects, such as Care Coordination. If you are interested in learning more, contact: office@rwhc.com or (608)643-2343.

**American Academy of Ambulatory Care Nursing: Care Coordination and Transition Management (CCTM)**
The Care Coordination and Transition Management (CCTM) online course and core define the integral role of the RN in the interprofessional team and apply to nurses in all settings from ambulatory care to hospitals. To learn more about this program go to: [https://www.aaacn.org/cctm](https://www.aaacn.org/cctm)

**National RN Case Manager Training Center LLC**
Registered Nurses enrolled in the Contemporary RN Case Manager Certificate Program will:

- Acquire the essential knowledge and skills needed to fill emerging roles in care coordination, transitions, and case management across patient care settings.
- Be prepared to practice to their full potential as members of a multidisciplinary healthcare team.
- Gain confidence in ability to perform and implement RN Case Manager and Advanced Care Coordination roles.
- Be positioned to meet CE eligibility requirements for specialty credentialing through ANCC and for recertification with both ANCC and CCMC.

To learn more about this program go to: [www.nationalrncm.com](http://www.nationalrncm.com)
Self-Management and Lifestyle Training

Self-management and lifestyle training for patients with hypertension are necessary elements to help improve patient outcomes. Education regarding nutrition, exercise, regular lab testing, medication adherence, checking blood pressure at home, and keeping regularly scheduled appointments with their provider can help reduce costly Emergency Room visits and hospital admissions due to complications related to hypertension. Engaged patients may seek out advice from their providers and clinical staff to take an active role in making treatment choices.

Medication Adherence

Medication adherence is an important part of our patient’s health; education to both patients and staff are needed. When patients are non-compliant with taking their medications, it can result in poor health care outcomes, such as unnecessary hospitalization admission and Emergency Room visits which increase costs to our patients and health care systems. It is important for the health care team to work with our patients to understand why they are not taking their medications while helping them to understand why it’s important for them to take their medication, and finding resources when issues are identified. The goal is to help our patients adhere to taking their medications and improve their overall health.
Use the SIMPLE method to help improve medication adherence among your patients

Simplify the regimen
- Encourage patients to use adherence tools, like day-of-the-week pill boxes or mobile apps.
- Work to match the action of taking medication with a patient’s daily routine (e.g., meal time or bed time, with other medications they already take properly).

Impart knowledge
- Write down prescription instructions clearly, and reinforce them verbally.
- Provide websites for additional reading and information—find suggestions at the Million Hearts® website.

Modify patients’ beliefs and behavior
- Provide positive reinforcement when patients take their medication successfully, and offer incentives if possible.
- Talk to patients to understand and address their concerns or fears.

Provide communication and trust
- Allow patients to speak freely. Time is of the essence, but research shows that most patients will talk no longer than 2 minutes when given the opportunity.
- Use plain language when speaking with patients. Say, “Did you take all of your pills?” instead of using the word “adherence.”
- Ask for patients’ input when discussing recommendations and making decisions.
- Remind patients to contact your office with any questions.

Leave the bias
- Understand the predictors of non-adherence and address them as needed with patients.
- Ask patients specific questions about attitudes, beliefs, and cultural norms related to taking medications.

Evaluate adherence
- Ask patients simply and directly whether they are sticking to their drug regimen.
- Use a medication adherence scale—most are available online:
  - Morisky-8 (MMAS-8)
  - Morisky-4 (MMAS-4 or Medication Adherence Questionnaire)
  - Medication Possession Ratio (MPR)
  - Proportion of Days Covered (PDC)

Source: http://www.acpm.org/IMedAdhereTTProviders

Find and download additional materials to help your patients control hypertension at the Million Hearts® website.
Self-Measured Blood Pressure Monitoring

Educate patients on how to accurately measure home BP and have the patient bring in cuff to ensure it is properly fitted and working properly; provide educational material for patient to reference; educate patient on when to call if BP is elevate

AMA/Johns Hopkins Self-Measured BP Monitoring

Employ a Self-measured blood pressure monitoring program and engage patients in self-measurement. These resources are designed for use by physician offices and health centers to engage patients in self-measurement of blood pressure. The Self-Measurement Blood Pressure Monitoring Program provides various resources for your practice or health center to establish a process for:

- Training staff on engaging patients in a self-measurement program
- Educating patients on hypertension
- Measuring blood pressure using proper positioning
- Suggestions for communicating blood pressure measurements back to the care team
- Guidance for instituting a blood pressure monitor loaner program
Self-Measured BP Monitoring Fast Facts

Measuring accurately:
Self-measured blood pressure monitoring

What is self-measured blood pressure monitoring?
Self-measured blood pressure (SMBP) monitoring, sometimes called home blood pressure monitoring, is a patient-performed measurement of their own blood pressure outside of a clinical setting. Research shows that SMBP:

- Can improve adherence and health outcomes for hypertensive patients
- Is different from, and more convenient than, ambulatory blood pressure monitoring, which requires a more specialized monitor to measure multiple blood pressures at set intervals over a 24-hour period
- Should always be accompanied by additional support, such as a one-time training session by a health care professional, during which patients should be observed to determine that they measure blood pressure readings correctly
- Is proven to improve blood pressure control when a patient/clinician feedback loop is used to provide personalized support and advice based on the patient’s data

Which SMBP device should patients use?
Most of the methods shown to improve patient outcomes have used an automated (oscillometric) device. With automatic devices, patients wrap a cuff around their arm and press a button to obtain a digital blood pressure reading.

When recommending an automated blood pressure measurement device for self-monitoring, take the following features into careful consideration.

Is the device valid? Automatic devices should be certified by one of three respected organizations:
- Association for the Advancement of Medical Instrumentation
- British Hypertension Society
- European Society of Hypertension

Does the device measure blood pressure from the upper arm? Only upper arm (not wrist) monitors produce reliable measures and these are the only type of monitors that reputable organizations recommend for home use.

Will patients find the device easy to use? Devices come in a range of models with varying features. For example, patients with visual, motor or hearing impairments may prefer devices with loud digital display and large buttons and/or that use voice commands to operate.

Does the device make it easy for patients to share results with their provider? Consider whether the device has the ability to:
- Store readings and report them back at a later time
- Calculate an average measure over multiple readings
- Transmit information to other devices, including to apps or to your electronic health record (EHR) system

Does your EHR permit the direct transmittal of blood pressure measurements via a patient portal? If so, you should establish a protocol to ensure that dangerously abnormal readings reported into the EHR receive timely responses.

How much does the device cost? Many public and private health insurance plans do not cover the cost of self-monitoring devices. Prices for a typical, high-quality device (available for purchase at most drug stores) can range between $50 and $150.
How should you and your patients use a home blood pressure monitor?

A universally accepted protocol for self-monitoring blood pressure does not exist. However, many patients and providers have found the following instructions useful. They are adapted from the Finn Protocol® by Michael Rakotz, MD, at Northwestern Medical Group.

- Ask your patients to find a space where they can position themselves appropriately: seated comfortably in a chair with their legs uncrossed, feet flat on the floor, and arm and back supported. The cuff should be wrapped snugly but not tightly around their upper arm.
- Ask your patient to take two blood pressure readings at one- to two-minute intervals, both in the morning and in the evening for seven consecutive days. This will provide four blood pressure measurements a day, totaling 28 measurements for the week, which is ideal. However, it is worth noting that even three days of measurements (i.e., 12 readings) also has prognostic value.
- Ask your patient to record each blood pressure measurement.
- When you receive these measurements calculate the average (mean) value of all the systolic and diastolic blood pressures. Use this single average value to determine if your patient has hypertension or if your patient’s blood pressure is controlled.
- It is important to note that self-monitored blood pressure values trend approximately 5mm Hg lower than those obtained by nurses in research settings. Thus a self-monitored systolic blood pressure of 135mm Hg is equivalent to a high-quality systolic blood pressure of 140mm Hg. The American Society of Hypertension recommends that when diagnosing or treating hypertension, providers and patients should consider a mean blood pressure >135/85 as the threshold for diagnosing hypertension or for treating high blood pressure.

Resources

List of validated home blood pressure monitors
British Hypertension Society website: bhsc.org/in dexa.php?id=247

Additional information on home blood pressure monitors
Association for the Advancement of Medical Instrumentation website: aaami.org
European Society of Hypertension website: e-shortingline.org

References

Make sure patients know what to do should they have a blood pressure measurement that is outside the pre-determined acceptable range, or if they experience any symptoms with a high or low blood pressure measurement, including seeking emergency treatment if appropriate. This guidance to the patient should be individualized by the clinician and reinforced by clinical staff at the initiation of any SMBP monitoring program.
Target: BP Self-Measurement Blood Pressure Program

One of the most accurate ways to measure your blood pressure is to do it yourself, outside of the doctor’s office, in a comfortable setting like your home. It’s called self-measured blood pressure monitoring (SMBP). This short video will teach you how to use your home blood pressure monitor so that you can share your readings with your provider and, together with your health care team, make better decisions about your health care. For more information, visit millionhearts.hhs.gov. http://bit.ly/millionheartssmbp
Providing log books for BP checks at home and educating patient to bring logs with them to their appointments such as the examples from Sauk Prairie Healthcare, and the American Heart Association:

**Sauk Prairie Healthcare My Blood Pressure Log**

Instructions for taking an accurate blood pressure at home:
- If you take a blood pressure medication, wait one hour after taking it before checking your blood pressure.
- Sit for 5 minutes with back supported before taking blood pressure.
  - Do not take with a full bladder
  - Sit for 30 minutes if you have exercised, including walking, ate, had caffeine or smoked a cigarette.
- Use an upper arm blood pressure machine.
  - Wrist machines are not recommended.
- Have feet flat on the floor and legs uncrossed.
- Rest your arm on a flat surface (such as a table) so your upper arm is at heart level.
- Apply the cuff to your bare skin and not over clothing.
- Bring these readings to your doctors appointments.
- Bring your BP machine to your visits.

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My Blood Pressure Log

Name __________________________

My Blood Pressure Goal __________ mm Hg

Instructions

• Take at least two blood pressure readings one minute apart - once in the morning before taking medications and in the evening before dinner.

• For best results, remain still for at least 5 minutes. Sit with your back straight and supported and your feet flat on the floor.

• When you measure your blood pressure, rest your arm on a flat surface (such as a table) so your upper arm is at heart level.

• Record your blood pressure on this sheet and show it to your doctor at every visit.

• You can also use AHA’s Check. Change. Control, Tracker (ccctracker.com/aha), a free online tool to help you track and monitor your blood pressure.

• You will need a campaign code to sign up for the CCC Tracker. Find the campaign code on the map for your state and sign up.

<table>
<thead>
<tr>
<th>Date</th>
<th>AM</th>
<th>PM</th>
</tr>
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<tbody>
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<th>Date</th>
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https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_305157.pdf
My Blood Pressure Wallet Card

To access please visit: https://www.dhs.wisconsin.gov/library/p-02102.htm

My Important Information:

Doctor's Name:

Doctor's Address:

Doctor's Telephone Number:

My Blood Pressure Medications:

Special Instructions:

Talk with your doctor about the lifestyle changes that are appropriate for you. Check off the lifestyle changes you are going to use to help lower your blood pressure.

My Lifestyle Changes

☐ Maintain a healthy weight.

☐ Do physical activity for 30 minutes most days of the week.

☐ Eat a diet high in fresh fruits and low-fat dairy products with reduced saturated and total fat.

☐ Choose foods lower in salt and other forms of sodium. Read food labels.

☐ If you drink alcohol, have no more than one drink/day for women, two drinks/day for men.

☐ Remember to take your blood pressure medicine.

My Blood Pressure Diary

My Blood Pressure Goal:

I take my blood pressure on the left / right arm. (circle one)

Date/Time	Blood Pressure

Questions to ask your doctor if you have high blood pressure:

• What is my blood pressure reading in numbers? And what does it mean?
• What is my goal blood pressure?
• Is there a healthy eating plan that I should follow to help lower my blood pressure and lose weight?
• Is it safe for me to do regular physical activity?
• What is the name of my medication?
• What is the generic name?
• What are the possible side effects of my medication?
• What time of day should I take my blood pressure medicine?
• Should I take it with or without food?
• What should I do if I forget to take my blood pressure medication at the recommended time?

If you think you are having a stroke or another medical emergency, CALL 911. Do NOT drive yourself to the hospital or ask a friend to drive you. CALL 911.
Self-measurement of Blood Pressure Devices

The following website contains a list of currently available Blood Pressure Devices for Self-measurement of Blood Pressure and Devices for Measuring Blood Pressure in the Community. Discontinued devices are shown on a separate table. A complete list of all devices is available on our Device Index.

http://dableducational.org/sphygmomanometers/devices_2_sbpm.html#ArmTable

<table>
<thead>
<tr>
<th>Device</th>
<th>Mode</th>
<th>AAMI</th>
<th>BHS</th>
<th>ESH 2002</th>
<th>ESH 2010</th>
<th>Circumstance</th>
<th>Recommendation</th>
<th>Ref</th>
</tr>
</thead>
</table>

FTS: Study evaluated prior to publication using the dabl® Educational Fast Track validation Service
SECTION SIX

CHRONIC DISEASE MANAGEMENT RESOURCES

RURAL WISCONSIN CHRONIC DISEASE TOOLKIT 2018
Additional Resources

Chronic disease management helps meet the diverse needs of our chronic disease patients. Designated members from the health care team can take action to address the needs of the patient. These huddles can help to:

- Enhance patient understanding of their own diagnosis, expectations, and discharge instructions
- Better awareness of prescription management
- Reduce hospital readmission
- Complete Transitional Care Management (TCM)
- Complete Chronic Condition Care Management (CCCM)
- Complete Preventive care (AWV, IPPE)
- Promote patient education
- Promote population health
A registry report helps organizations identify a specific panel of patients, such as diabetic or hypertensive patients. Running these reports through your EMR help to identify last blood pressure, date of last A1c, and other care gaps. Staff can be educated on the registry reports and work off the lists to identify patients that need labs ordered, appointments, and other follow-up. For more information on registries, you can refer to The 10 Building Blocks of Primary Care Sample Registry Exercise: https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/PM_Registry_Activity_14-0602.pdf

### Chronic Care Registry Report

<table>
<thead>
<tr>
<th>Name</th>
<th>DOC SM</th>
<th>BP DATE</th>
<th>BP/s</th>
<th>BP/d</th>
<th>LDL Date</th>
<th>LDL</th>
<th>A1c DATE</th>
<th>A1c</th>
<th>DIABETIC</th>
<th>SMOKER</th>
<th>DATE ASKED IF SMOKES</th>
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<tr>
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<td>NO</td>
<td>3/5/2014</td>
<td>127</td>
<td>70</td>
<td>2/22/2013</td>
<td>135</td>
<td>NO</td>
<td>NO</td>
<td>12/15/2012</td>
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<tr>
<td>Patient D</td>
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<td>11/9/2013</td>
<td>148</td>
<td>95</td>
<td>10/30/2013</td>
<td>170</td>
<td>10/30/2013</td>
<td>8.9</td>
<td>YES</td>
<td>YES</td>
<td>4/2/2013</td>
</tr>
<tr>
<td>Patient F</td>
<td>NO</td>
<td>8/20/2013</td>
<td>155</td>
<td>88</td>
<td>8/20/2012</td>
<td>125</td>
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<td>3/16/2011</td>
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<tr>
<td>Patient H</td>
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<td>6/9/2014</td>
<td>147</td>
<td>90</td>
<td>5/19/2013</td>
<td>81</td>
<td>5/19/2013</td>
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<td>YES</td>
<td>NO</td>
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<tr>
<td>Patient I</td>
<td>NO</td>
<td>6/3/2013</td>
<td>120</td>
<td>64</td>
<td>1/3/2013</td>
<td>165</td>
<td>NO</td>
<td>NO</td>
<td>11/22/2004</td>
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<td></td>
</tr>
<tr>
<td>Patient K</td>
<td>YES</td>
<td>12/10/2012</td>
<td>152</td>
<td>85</td>
<td>12/10/2012</td>
<td>157</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient M</td>
<td>NO</td>
<td>6/1/2014</td>
<td>119</td>
<td>71</td>
<td>3/2/2014</td>
<td>177</td>
<td>NO</td>
<td>NO</td>
<td>6/1/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient N</td>
<td>YES</td>
<td>1/4/2014</td>
<td>105</td>
<td>66</td>
<td>12/19/2014</td>
<td>108</td>
<td>NO</td>
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©2012, The Regents of the University of California. Created by UCSF Center for Excellence in Primary Care.
Standardized Rooming
Standardized rooming helps to efficiently direct the collection of important patient information to
help providers in their assessment of patients’ health. Benefits of standardized rooming may increase
patient satisfaction and helping the patient understand that these measurements are desired by the
provider to assist with the planning of their care. To enhance the rooming process, the provider and
clinical care team should huddle and review patient’s visit needs.

1. **Agenda setting** - Have the rooming staff set the agenda by asking “What is most
   important for you to accomplish during your visit today?”

2. **Assess vital signs** - to be a marker of chronic disease states such as hypertension
   - **Blood Pressure (BP)**: BP measured at every clinical visit by using appropriate
     sized cuff, patient has emptied their bladder, and have rested for 5 minutes
     - Blood pressure measurements obtained using proper technique with
       manual and/or validated automated devices are acceptable, however
       automated devices are preferable
     - If blood pressure elevated, follow 2nd BP workflow

3. **Measure growth** - to assist in determining medication dosing and identifying potential
   health concerns or conditions such as obesity
   - **Height**: Yearly for adults
   - **Weight**: At every clinical visit wearing one layer of light clothing and NO SHOES

4. **Perform screening assessments** - for pain and document

5. **Complete clinical documentation** - that includes:
   - **Tobacco** history assessed for tobacco use and second-hand exposure at every
     visit
     - Consider working with the Quit Line for further education and
       opportunities for improvement
   - **Medication** reconciliation at every clinic visit
     - Ask patient if any refills needed and verify this request
       1. Pend medication renewal for provider
       1. Verify and document preferred pharmacy
       1. Note: The updated medication list will appear on the After Visit
          Summary and Electronic Medical Record for patient to reference
   - **Allergies** reviewed and documented at every clinic visit
   - **Health Maintenance** reviewed at every clinic visit to ensure the patient is
receiving appropriate screening to prevent or attenuate the disease (diabetes, hypertension)

6. **Obtain information/Chart Prep** needed for visits that includes:

   α. **Eye exam** associated with diabetic patients

      1. If diabetic, patient should have a Retinal eye exam yearly to look for retinopathy

         1. If patient seeing an Optometrist, rooming staff will obtain name and location of optometrist, last visit, and authorization to obtain information

   β. **Foot care** associated with diabetic patients

      1. If diabetic, exam of the feet should be done at clinical visit

         1. Educate on the reason that this will be done and why

         2. If patient seeing a Podiatrist, rooming staff will obtain name and location of podiatrist, last visit, and authorization to obtain information

   χ. **Immunization records**

      1. Rooming staff will reconcile the Wisconsin Immunization Registry (WIR) prior to appointment if possible, or during the visit

      11. Rooming staff to address immunization needs and provide Vaccine Information Statement (VIS) to patient prior to provider going into the appointment so the patient has time to review the VIS

         1. If patient refuses vaccines, update provider and document on the Vaccine Refusal form, if applicable

   δ. **Release of Information**- Obtain Release of Information from the patient so that records needed can be obtained and uploaded into the Medical Record

   ε. **Authorization for Communication or Verbal Communication form**- If the reception staff did not obtain authorization for Communication, rooming staff to complete so that staff have authorization on file to communicate with the person(s) that the patient have designated

   φ. **Care Everywhere**- rooming staff to ask patient if they have received care anywhere outside of the last clinic visit elsewhere

      1. Rooming staff will ask the patient: “Have you had care outside of [ORGANIZATION NAME] since the last time you were seen in the clinic?”

         α. If yes, activate CARE EVERYWHERE, if applicable
Pre-Visit Planning Checklist

A Pre-visit checklist is a tool that clinical staff can use day(s) before the patient arrives for their office appointment. It addresses health maintenance and preventive and chronic care needs such as diabetic labs ordered and completed prior to the appointment, allowing proactive planning and coordination to efficiently take of the patients’ needs. Being prepared for the patient visit and looking at the patient as a whole will add value to the patient appointment. Pre-visit planning will help to:

• Understand why the patient is coming in for an office visit
• Be prepared for the patient’s visit
• Ensure patient’s lab tests and health screening results are available to address during the visit
• Address preventive and chronic care needs
• Address medication needs
# Pre-Visit Planning Checklist

## All Patients 18 and Older: Review Schedule

<table>
<thead>
<tr>
<th>Reason for appointment documented and visit type appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment time allotted appropriate for visit type</td>
</tr>
<tr>
<td>Special equipment needed (transfer board, oxygen, interpreter, etc.)</td>
</tr>
<tr>
<td>Health Maintenance that needs to be addressed and have handouts ready for appointment (mammogram, colonoscopy, bone density, labs, etc.)</td>
</tr>
<tr>
<td>Immunizations needed: Check WIR, reconcile, pull Vaccine Information Statements (VIS) that will be needed for appointment</td>
</tr>
<tr>
<td>Open Orders: Check to see if any tests that patient has not completed or for duplicate orders</td>
</tr>
<tr>
<td>Consults: notes available</td>
</tr>
<tr>
<td>Reminder phone call for chronic No Show patient</td>
</tr>
<tr>
<td>Height – annually; if not completed in last year ensure it is completed</td>
</tr>
<tr>
<td>Medication list: check for upcoming refills, duplicate meds, controlled substance medications</td>
</tr>
<tr>
<td>Controlled substance medications: Check PDMP, last urine drug screen (annually completed?), medication agreement (annually reviewed?)</td>
</tr>
<tr>
<td>Depression screening: last completed</td>
</tr>
<tr>
<td>My Chart, My Portal, or other EMR communication signed up</td>
</tr>
<tr>
<td>Verbal communication authorization to be able to leave voice mail or talk to another person that has been designated</td>
</tr>
</tbody>
</table>

## Diabetic Patients

<table>
<thead>
<tr>
<th>Labs: Hgb A1c, CMP, creatinine, micro albumin, TSH, lipids</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTE: Organization may consider calling patient to come in and have labs drawn a few days prior to appointment so that lab results are available for the appointment</td>
</tr>
<tr>
<td>Eye exam: annually—last appointment, where, results available</td>
</tr>
<tr>
<td>Foot exam: Podiatry consult? Does patient need a reminder that we will be checking their feet</td>
</tr>
<tr>
<td>Flow chart: A1c results</td>
</tr>
<tr>
<td>Diabetic educator: Last appointment; notes available</td>
</tr>
<tr>
<td>Nutritionist: Last appointment; notes available</td>
</tr>
<tr>
<td>Patient education material</td>
</tr>
<tr>
<td>Reminder phone call to bring in blood sugar readings</td>
</tr>
</tbody>
</table>

## Hypertension Patients

<table>
<thead>
<tr>
<th>Labs: lipids, creatinine, potassium, BUN, fasting glucose</th>
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<tbody>
<tr>
<td>NOTE: Organization may consider calling patient to come in and have labs drawn a few days prior to appointment so that lab results are available for the appointment</td>
</tr>
<tr>
<td>Nutritionist</td>
</tr>
<tr>
<td>Patient education material ready (smoking cessation, DASH diet, physical activity, etc.)</td>
</tr>
<tr>
<td>Reminder phone call to bring in blood pressure log and cuff for calibration if needed</td>
</tr>
</tbody>
</table>

4/23/2018
When patients miss their appointments, otherwise known as “No-Shows”, this can lead to poor disease control and may contribute to poor health outcomes, as well as it effects quality primary care. Having a process in place for timely outreach and follow-up to the patient for the clinic staff to follow is an important part of providing quality care and understanding the reason the patient did not show up for the scheduled appointment.
WCHQ publicly reports and brings meaning to performance measurement information that improves the quality and affordability of healthcare in Wisconsin, in turn improving the health of individuals and communities.