



RURAL WISCONSIN
CHRONIC
DISEASE

TOOLKIT 2018

1. Introduction and Acknowledgments	Page 4
2. Resources for Effective Communication	Page 6
Team Based Communication	Page 7
Daily Huddles	
Team Based Communication - Sample Daily Huddle Workflow	
The Everett Clinic Huddle (Video)	
AM Huddle Communication Form – Memorial Hospital of Lafayette County	
All Clinic Morning Huddle - Cumberland Healthcare	
Therapeutic Communication	Page 13
Motivational Interviewing	
• <i>Rural Wisconsin Healthcare Cooperative Educational Offerings</i>	
• <i>MetaStar Educational Offerings & Resources</i>	
• <i>Agency for Healthcare Research and Quality (AHRQ) Coaching Video</i>	
• <i>AHRQ “My Action Plan” Example</i>	
Teach-back	
• <i>AHRQ Health Literacy Toolkit</i>	
• <i>Always Use Teach-back! Toolkit</i>	
3. Body Mass Index (BMI)	Page 18
Divine Savior Healthcare BMI Screening and Follow Up	Page 19
4. Resources for Diabetes Care	Page 20
Diabetes Facts and Figures	Page 21
National Overview	
• <i>A Snapshot: Diabetes In The United States</i>	
Wisconsin Overview	
Diabetes in Wisconsin Facts and Figures	
Map of Diabetes by County	
Reduce HgA1c Poor Control (NQF measure 0059)	Page 25
Diabetes-Focused Visit Every Six Months	
• <i>Standards of Medical Care in Diabetes</i>	
• <i>Approach to the Management of Hyperglycemia</i>	
• <i>Pharmacologic Therapy for Type 2 Diabetes</i>	
• <i>Antihyperglycemic Therapy in Type 2 Diabetes: General Recommendations</i>	
• <i>Combination Injectable Therapy for Type 2 Diabetes</i>	
• <i>Referrals to Diabetic Educator and/or Nutrition</i>	
• <i>Pre-Visit Chart Review</i>	
• <i>Visual Aid Graphs</i>	
• <i>Foot Exam</i>	
• <i>Wisconsin Diabetes Clinical Care Recommendations</i>	
• <i>Diabetes Planned Visit Algorithm</i>	
Diabetes Focused Visit	
• <i>Follow-up Within 30 Days</i>	
• <i>Registry</i>	
• <i>Referral for Diabetes Self-Management Education and Support</i>	
• <i>Follow-up with patients that are No Show for appointments</i>	
• <i>Communication</i>	
Diabetes Self-Management Education (DSMES) and Lifestyle Training	
• <i>Living with Diabetes</i>	
• <i>Diabetes Self-Management Education and Support (DSMES)</i>	
• <i>Living Well with Diabetes</i>	

- *Divine Savior Healthcare - Diabetes Support Group*
- *Blood Sugar Log*
- *Wisconsin Institute for Healthy Aging (WIHA): Healthy Living with Diabetes*
 - *Healthy Living with Diabetes (HLWA) Workshop*
 - *Healthy Living with Diabetes Fact Sheet*
- *DEEP: Diabetes Empowerment Education Program*

5. Resources for Blood Pressure Control	Page 48
Hypertension Overview – National	Page 49
Cardiac Disease Overview – Wisconsin	Page 51
Heart Health in Wisconsin	
Diagnosed Hypertension by County	
Blood Pressure Checks	Page 54
Online E-Learning	
• <i>MetaStar eLearning Modules & Resources - Taking an Accurate Blood Pressure Reading – Outpatient Adults</i>	
• <i>WNA Beyond the 50%: It Starts with Accurate Blood Pressure Measurement .</i>	
RWHC Resources	
• <i>BP Measurement Guideline</i>	
• <i>How to Take Patient’s BP Reading</i>	
• <i>BP Skills-Based Competency</i>	
• <i>References</i>	
Target: BP “7 Simple Tips to get an Accurate Blood Pressure Reading”	
Increase Percentage of Controlled BP	Page 62
Second Blood Pressure Process	
• <i>Visual Tools</i>	
• <i>Blood Pressure Workflow Example</i>	
Evidence-based Protocol for Hypertension Treatment	
Target: BP – AHA/ACC Blood Pressure Guideline	
Chronic Disease Huddles	
Chronic Disease Registry	
Nurse Visit Schedule	
Care Coordination	
• <i>Rural Wisconsin Health Cooperative Quarterly Care Coordination Roundtable</i>	
• <i>American Academy of Ambulatory Care Nursing: Care Coordination and Transition Management (CCTM)</i>	
• <i>National RN Case Manager Training Center LLC</i>	
Self-Management and Lifestyle Training	
• <i>Medication Adherence</i>	
• <i>AMA/Johns Hopkins Self-Measured BP Monitoring</i>	
• <i>Self-Measured BP Monitoring Fast Facts</i>	
• <i>Target: BP Self-Measurement Blood Pressure Program</i>	
• <i>Million Hearts - How to use Your Home Blood Pressure Monitor (Video)</i>	
• <i>Sauk Prairie Blood Pressure Log Book</i>	
• <i>American Heart Association My Blood Pressure Log</i>	
• <i>My Blood Pressure Wallet Card</i>	
• <i>Self-measurement of Blood Pressure Devices</i>	
6. Chronic Disease Management Resources	Page 81
UCSF Chronic Care Registry Information	Page 83
Standardized Rooming Guidelines.....	Page 84
Pre-Visit Planning Checklist.....	Page 86
No Show Follow Up Workflow	Page 88

01

SECTION ONE

INTRODUCTION & ACKNOWLEDGMENTS

RURAL WISCONSIN
CHRONIC DISEASE
TOOLKIT 2018

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.

02

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

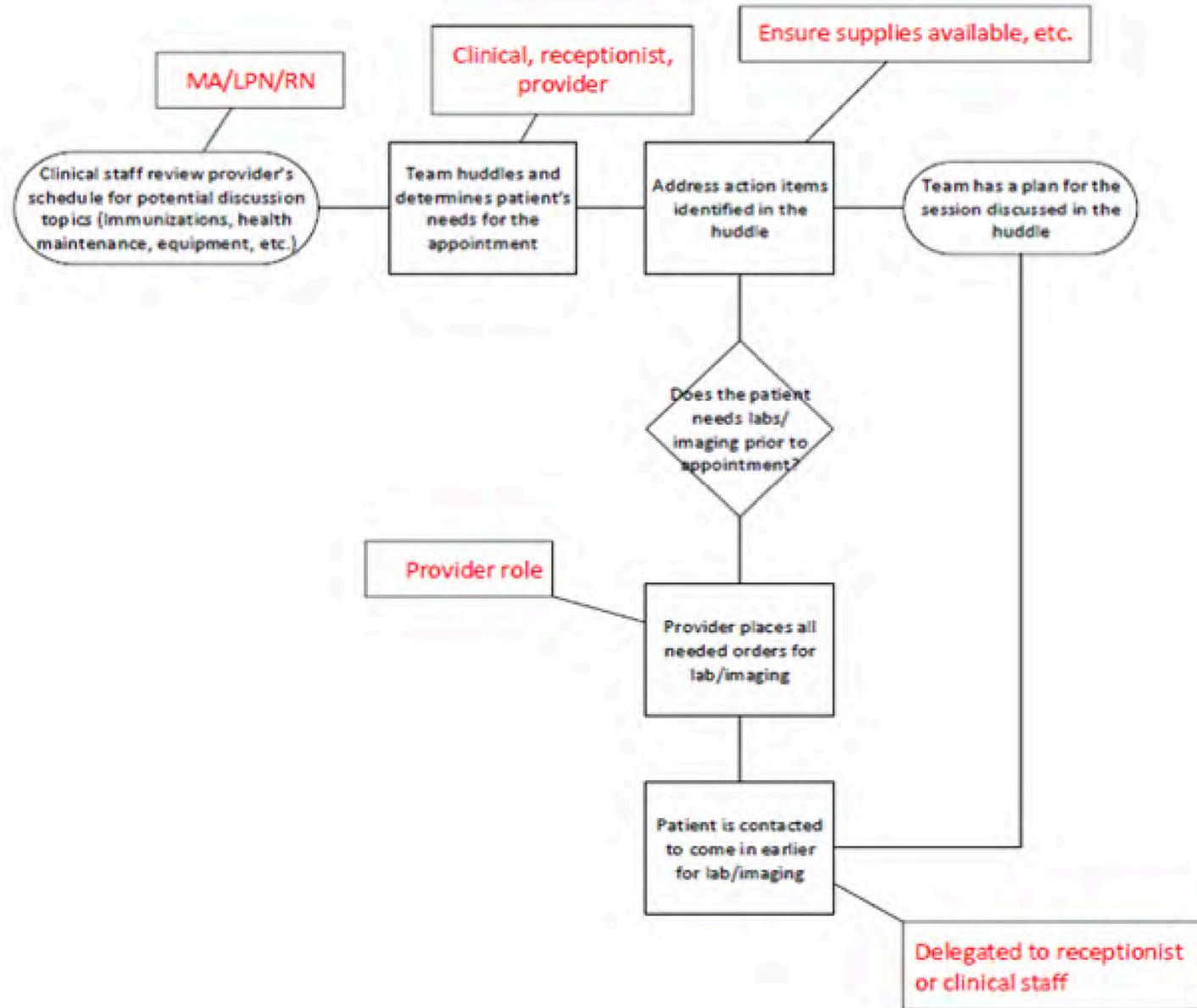
Daily huddles allow the team to briefly meet daily to discuss their patients' needs and determine what needs to be done and by whom. They are able to help increase efficiency and access within the clinic. It is a time to be proactive in the patients care instead of reacting throughout the day.

- 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



The Everett Clinic Huddle (Video)

MAXINE HALL HEALTH CENTER

SAN FRANCISCO, CALIFORNIA

Length of Huddles:

5 minutes

behaviorists, medical assistants, and registered nurses

and staff satisfaction.

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

Where does the Huddle take place?

The Huddle takes place near where the patients are seen.

What topics are addressed in the Huddle?

1 minute:

The whole clinic briefly reviews staffing issues (e.g. sick, on vacation).

How many days out of the week does the Huddle take place?

Every work day

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

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.



https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Spotlight_on_Huddles_12-1226.pdf

Video: <https://youtu.be/djrORZEiXpo>

AM Huddle Communication Form – Memorial Hospital of Lafayette County

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.



AM Huddle

Date:			
Phones:		Allergy Injections:	
Immunizations:		Lab:	
On Call Provider:		In basket/help:	
Meetings:			
FYI:			

Provider Name:	Clinical Staff	Location	Late Night

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

Date		
Time		
Huddle Lead		
Recorder		
Team Improvement Focus for the Day		
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.

<http://www.rwhc.com/Services/EducationalServices/LeadershipSeries.aspx>

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/>

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. 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

Action Plan Example: <https://www.chcf.org/wp-content/uploads/2017/12/PDF-MyActionPlanEnglish.pdf>

MY ACTION PLAN

Date: _____

I _____ and _____
 (Name) (name of clinician)

have agreed that to improve my health I will:

	_____ Work on something that's bothering me		_____ Improve my food choices
	_____ Stay more physically active		_____ Reduce my Stress
	_____ Take my Medications		_____ Cut down on smoking

Here is what I can do: _____

How much: _____
 When: _____
 How often: _____

This is how sure I am that I will be able to do this: circle a number)

Not sure										Very Sure
1	2	3	4	5	6	7	8	9	10	

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

<https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html>

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.

<http://www.teachbacktraining.org/assets/files/PDFS/Teach%20Back%20-%2010%20Elements%20of%20Competence.pdf>



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.
9. Use reader-friendly print materials to support learning.
10. Document use of and patient response to teach-back.

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



03

SECTION THREE

BODY MASS INDEX (BMI)

RURAL WISCONSIN
CHRONIC DISEASE
TOOLKIT 2018

BODY MASS INDEX (BMI)

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 to review 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

04

SECTION FOUR

RESOURCES FOR DIABETES CARE

RURAL WISCONSIN
CHRONIC DISEASE
TOOLKIT 2018

Resources for Diabetes Care

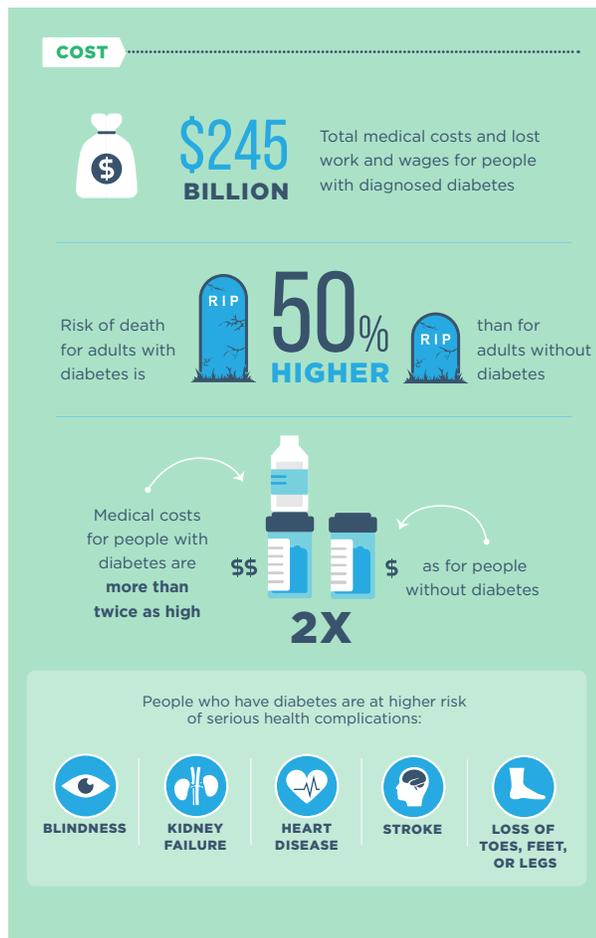
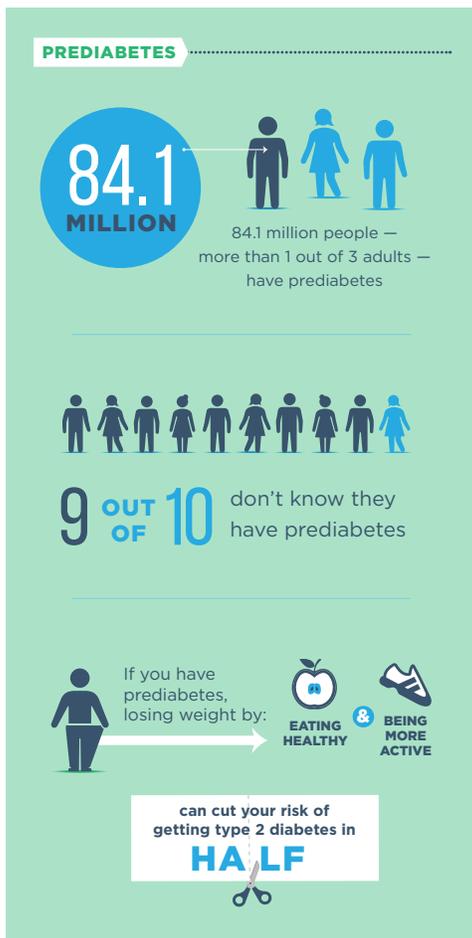
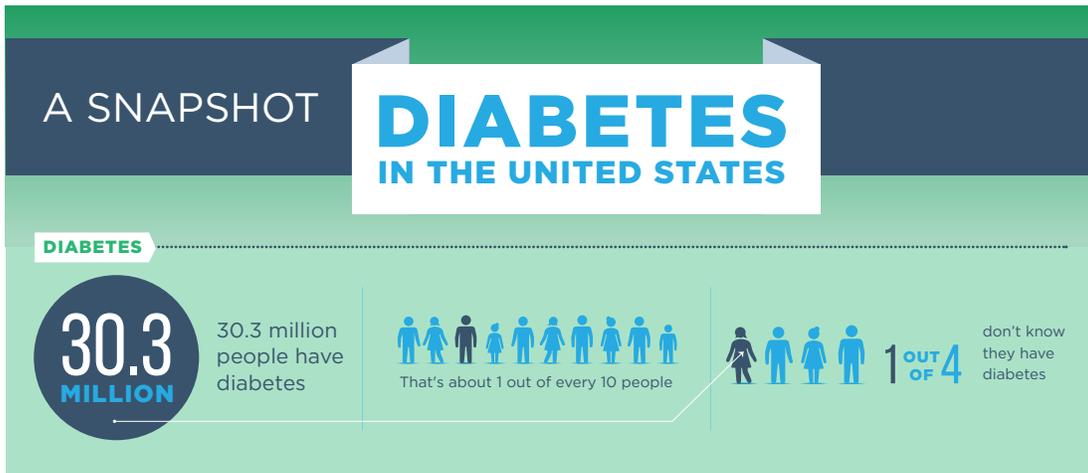
Diabetes Facts and Figures – National Overview

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>

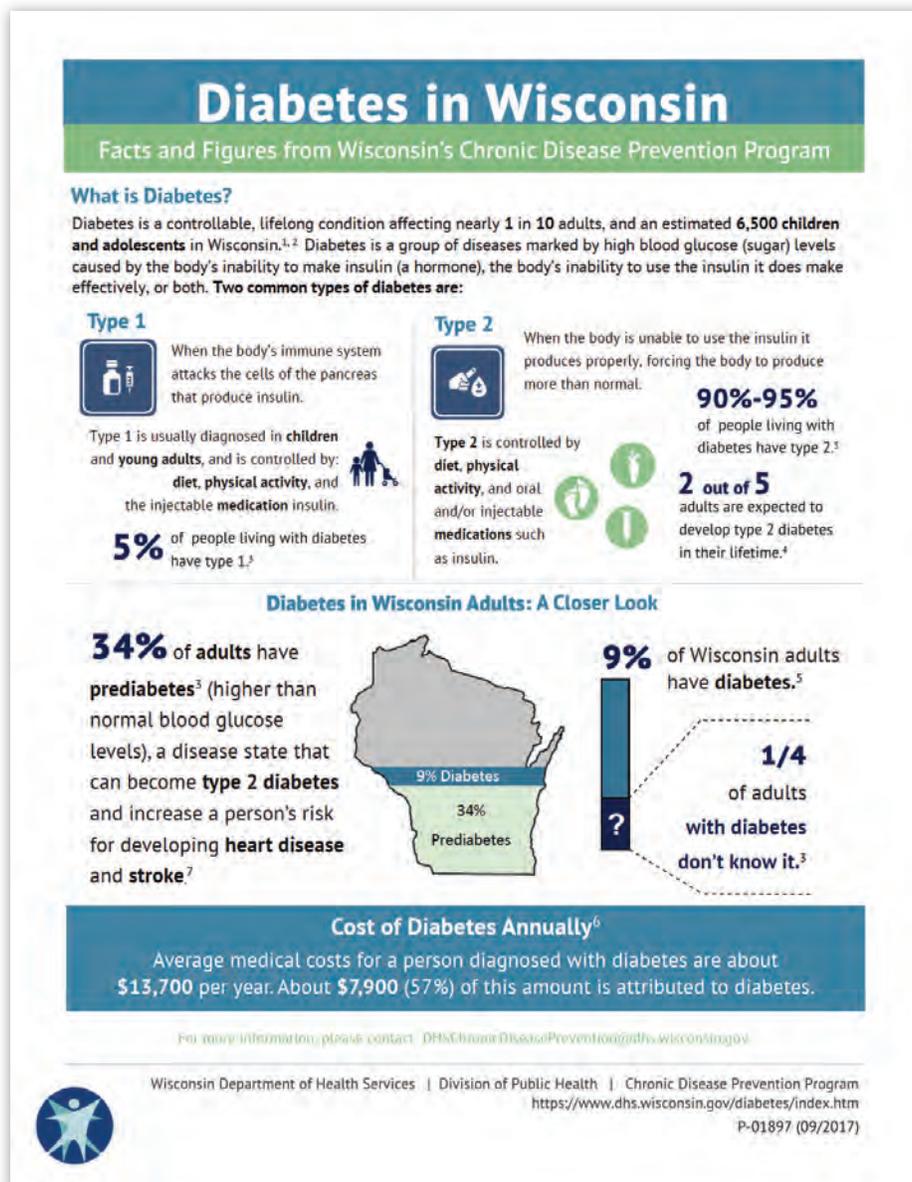


Diabetes – Wisconsin Overview

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>

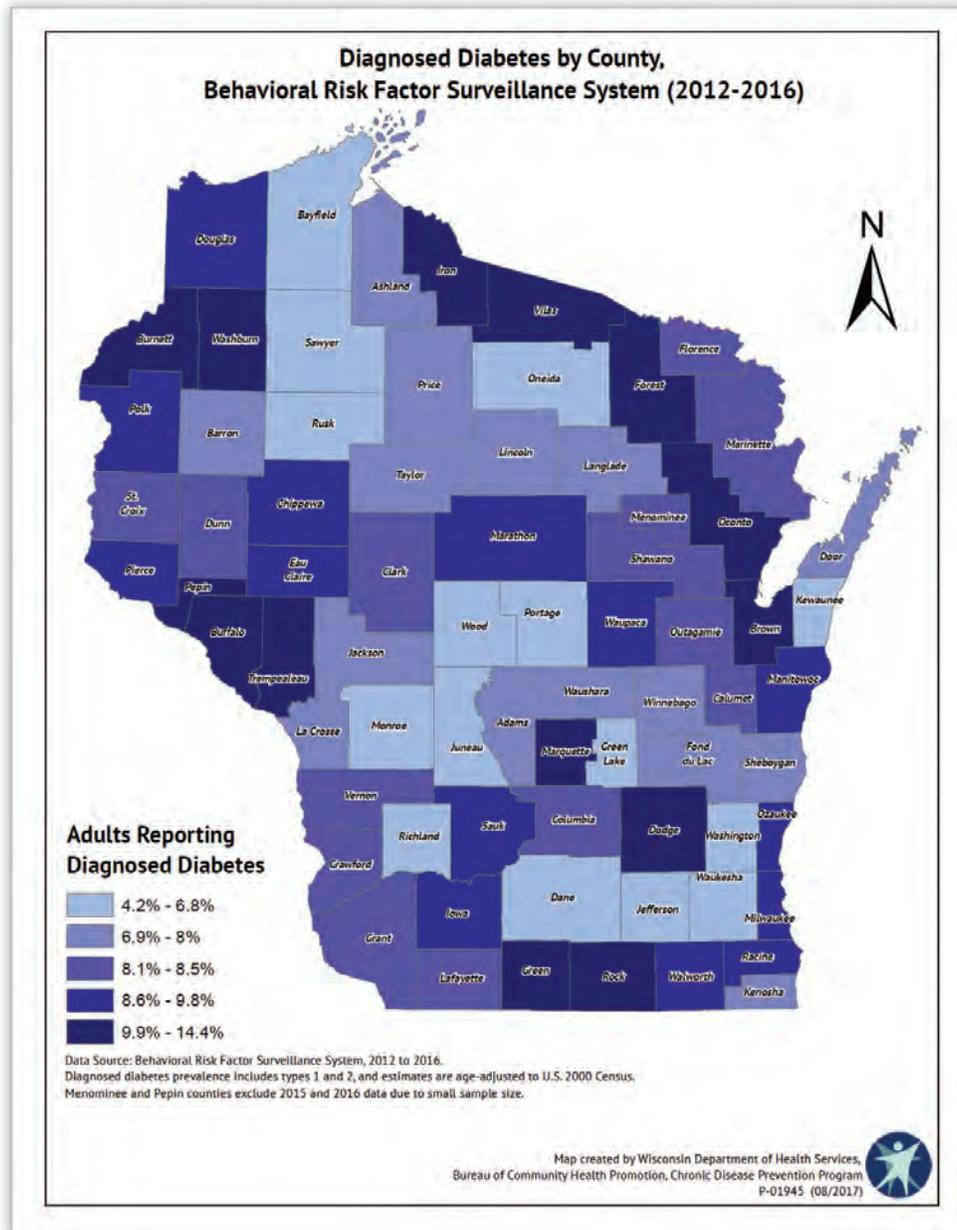
Diabetes in Wisconsin Facts and Figures

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 HgcA1c 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.

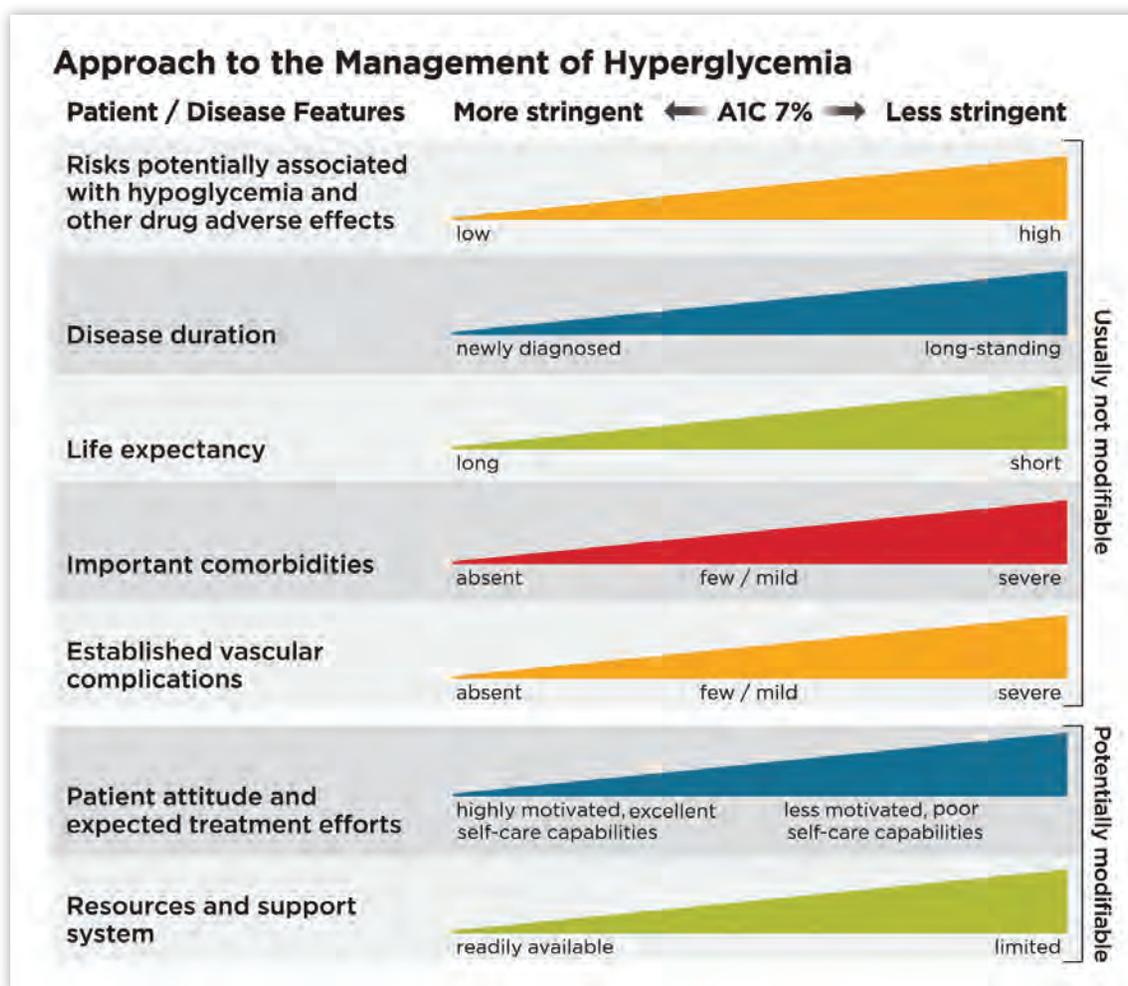
Standards of Medical Care in Diabetes

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>

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>

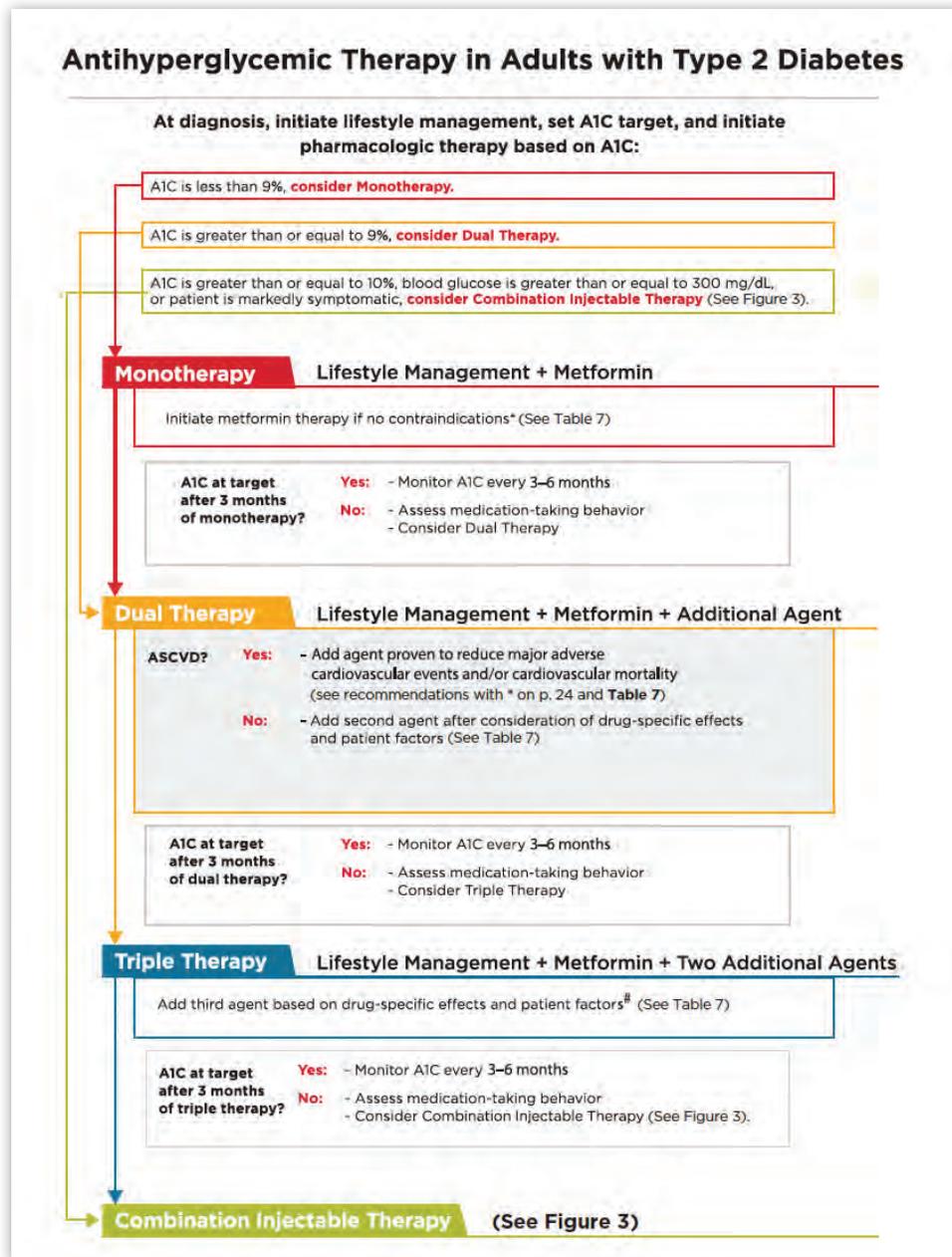
TABLE 7. Drug-Specific and Patient Factors to Consider When Selecting Antihyperglycemic Treatment in Adults With Type 2 Diabetes

	Efficacy*	Hypoglycemia	Weight Change	CV Effects		Cost	Oral/SQ	Renal Effects		Additional Considerations
				ASCVD	CHF			Progression of DKD	Dosing/Use considerations	
Metformin	High	No	Neutral (Potential for Modest Loss)	Potential Benefit	Neutral	Low	Oral	Neutral	<ul style="list-style-type: none"> Contraindicated with eGFR <30 	<ul style="list-style-type: none"> Gastrointestinal side effects common (diarrhea, nausea) Potential for B12 deficiency
SGLT-2 Inhibitors	Intermediate	No	Loss	Benefit: canagliflozin, empagliflozin†	Benefit: canagliflozin, empagliflozin	High	Oral	Benefit: canagliflozin, empagliflozin	<ul style="list-style-type: none"> Canagliflozin: not recommended with eGFR <45 Dapagliflozin: not recommended with eGFR <60; contraindicated with eGFR <30 Empagliflozin: contraindicated with eGFR <30 	<ul style="list-style-type: none"> FDA Black Box: Risk of amputation (canagliflozin) Risk of bone fractures (canagliflozin) DKA risk (all agents, rare in T2DM) Genitourinary infections Risk of volume depletion, hypotension ↑LDL cholesterol
GLP-1 RAs	High	No	Loss	Neutral: lixisenatide, exenatide extended release Benefit: liraglutide†	Neutral	High	SQ	Benefit: liraglutide	<ul style="list-style-type: none"> Exenatide: not indicated with eGFR <30 Lixisenatide: caution with eGFR <30 Increased risk of side effects in patients with renal impairment 	<ul style="list-style-type: none"> FDA Black Box: Risk of thyroid C-cell tumors (liraglutide, albiglutide, dulaglutide, exenatide extended release) Gastrointestinal side effects common (nausea, vomiting, diarrhea) Injection site reactions ?Acute pancreatitis risk
DPP-4 Inhibitors	Intermediate	No	Neutral	Neutral	Potential Risk: saxagliptin, alogliptin	High	Oral	Neutral	<ul style="list-style-type: none"> Renal dose adjustment required; can be used in renal impairment 	<ul style="list-style-type: none"> Potential risk of acute pancreatitis Joint pain
Thiazolidinediones	High	No	Gain	Potential Benefit: pioglitazone	Increased Risk	Low	Oral	Neutral	<ul style="list-style-type: none"> No dose adjustment required Generally not recommended in renal impairment due to potential for fluid retention 	<ul style="list-style-type: none"> FDA Black Box: Congestive heart failure (pioglitazone, rosiglitazone) Fluid retention (edema; heart failure) Benefit in NASH Risk of bone fractures Bladder cancer (pioglitazone) ↑LDL cholesterol (rosiglitazone)
Sulfonylureas (2nd Generation)	High	Yes	Gain	Neutral	Neutral	Low	Oral	Neutral	<ul style="list-style-type: none"> Glyburide: not recommended Glipizide & glimepiride: initiate conservatively to avoid hypoglycemia 	<ul style="list-style-type: none"> FDA Special Warning on increased risk of cardiovascular mortality based on studies of an older sulfonylurea (tolbutamide)
Insulin	Human Insulin	Yes	Gain	Neutral	Neutral	Low	SQ	Neutral	<ul style="list-style-type: none"> Lower insulin doses required with a decrease in eGFR; titrate per clinical response 	<ul style="list-style-type: none"> Injection site reactions Higher risk of hypoglycemia with human insulin (NPH or premixed formulations) vs. analogs
							High			

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

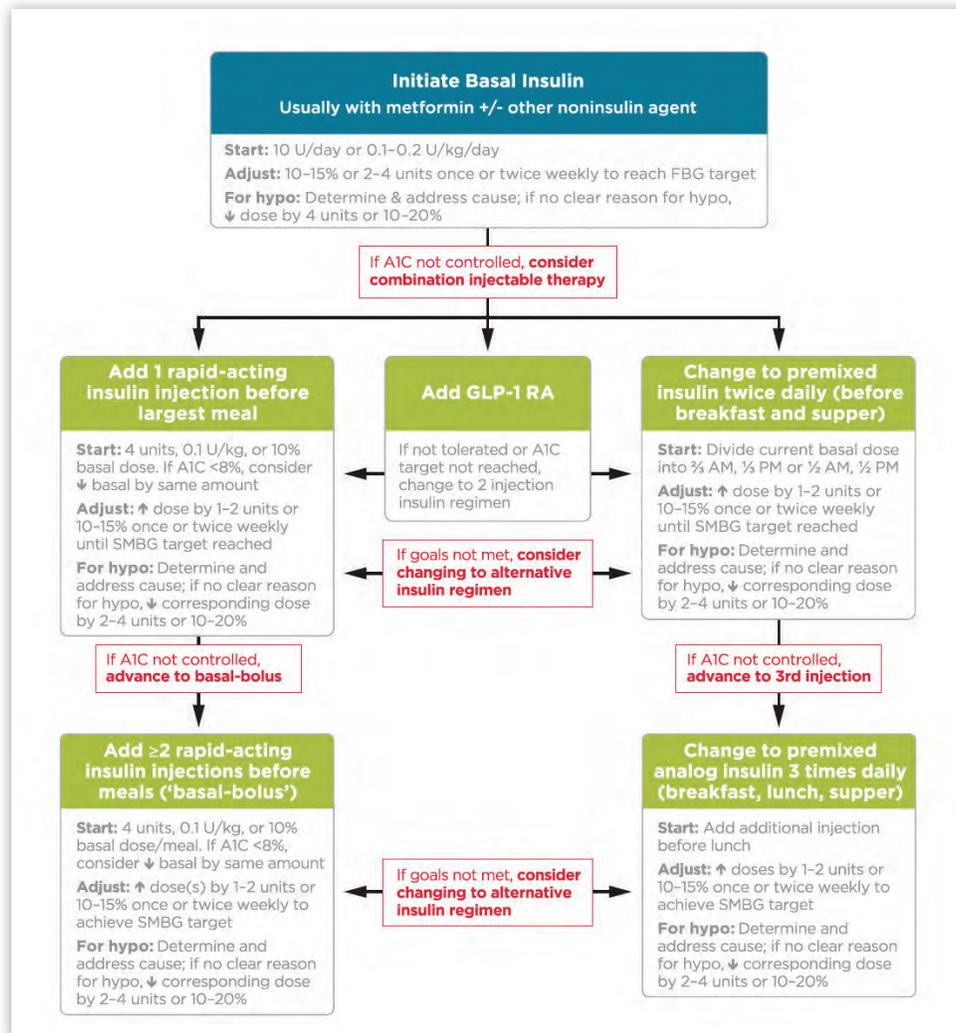
Antihyperglycemic Therapy in Type 2 Diabetes: General Recommendations

*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/algorithm_action_steps.pdf

Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes: ALGORITHM ACTION STEPS

Four critical times to assess, provide, and adjust diabetes self-management education and support

AT DIAGNOSIS	ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS	WHEN NEW COMPLICATING FACTORS INFLUENCE SELF-MANAGEMENT	WHEN TRANSITIONS IN CARE OCCUR
PRIMARY CARE PROVIDER/ENDOCRINOLOGIST/CLINICAL CARE TEAM: AREAS OF FOCUS AND ACTION STEPS			
<ul style="list-style-type: none"> <input type="checkbox"/> Answer questions and provide emotional support regarding diagnosis <input type="checkbox"/> Provide overview of treatment and treatment goals <input type="checkbox"/> Teach survival skills to address immediate requirements (safe use of medication, hypoglycemic treatment if needed, introduction of eating guidelines) <input type="checkbox"/> Identify and discuss resources for education and ongoing support <input type="checkbox"/> Make referral for DSME/S and medical nutrition therapy (MNT) 	<ul style="list-style-type: none"> <input type="checkbox"/> Assess all areas of self-management <input type="checkbox"/> Review problem-solving skills <input type="checkbox"/> Identify strengths and challenges of living with diabetes 	<ul style="list-style-type: none"> <input type="checkbox"/> Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals <input type="checkbox"/> Discuss impact of complications and successes with treatment and self-management 	<ul style="list-style-type: none"> <input type="checkbox"/> Develop diabetes transition plan <input type="checkbox"/> Communicate transition plan to new health care team members <input type="checkbox"/> Establish DSME/S regular follow-up care
DIABETES EDUCATION: AREAS OF FOCUS AND ACTION STEPS			
<ul style="list-style-type: none"> Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine which content to provide and how: <input type="checkbox"/> Medication – choices, action, filtration, side effects <input type="checkbox"/> Monitoring blood glucose – when to test, interpreting and using glucose pattern management for feedback <input type="checkbox"/> Physical activity – safety, short-term vs. long-term goals/recommendations <input type="checkbox"/> Preventing, detecting, and treating acute and chronic complications <input type="checkbox"/> Nutrition – food plan, planning meals, purchasing food, preparing meals, portioning food <input type="checkbox"/> Risk reduction – smoking cessation, foot care <input type="checkbox"/> Developing personal strategies to address psychosocial issues and concerns <input type="checkbox"/> Developing personal strategies to promote health and behavior change 	<ul style="list-style-type: none"> <input type="checkbox"/> Review and reinforce treatment goals and self-management needs <input type="checkbox"/> Emphasize preventing complications and promoting quality of life <input type="checkbox"/> Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands <input type="checkbox"/> Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes 	<ul style="list-style-type: none"> <input type="checkbox"/> Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications <input type="checkbox"/> Provide/refer for emotional support for diabetes-related distress and depression <input type="checkbox"/> Develop and support personal strategies for behavior change and healthy coping <input type="checkbox"/> Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change 	<ul style="list-style-type: none"> <input type="checkbox"/> Identify needed adaptations in diabetes self-management <input type="checkbox"/> Provide support for independent self-management skills and self-efficacy <input type="checkbox"/> Identify level of significant other involvement and facilitate education and support <input type="checkbox"/> Assist with facing challenges affecting usual level of activity, ability to function, health benefits and feelings of well-being <input type="checkbox"/> Maximize quality of life and emotional support for the patient (and family members) <input type="checkbox"/> Provide education for others now involved in care <input type="checkbox"/> Establish communication and follow-up plans with the provider, family, and others

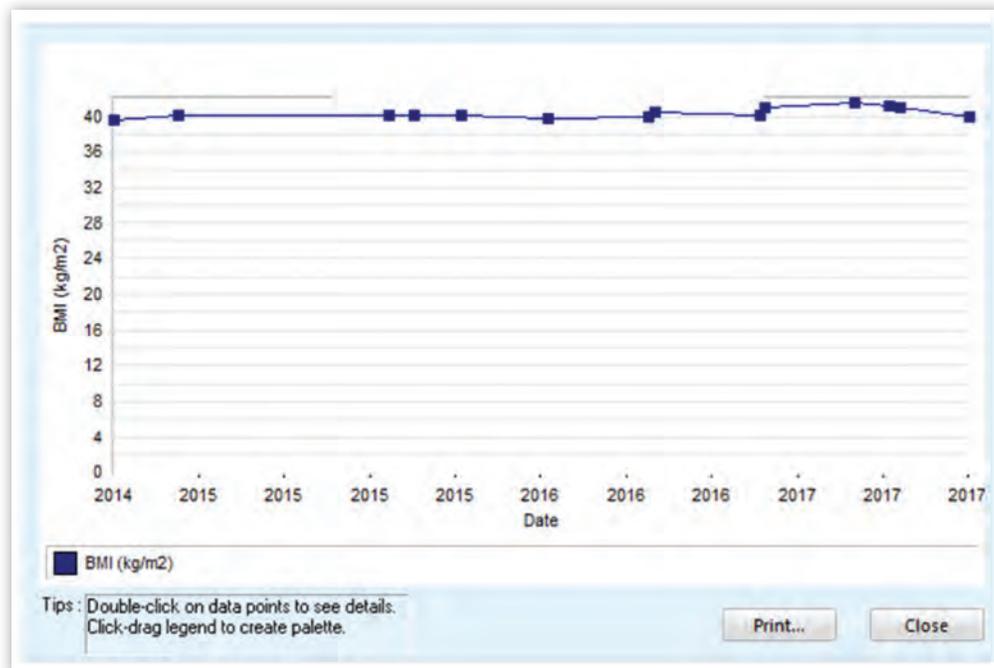
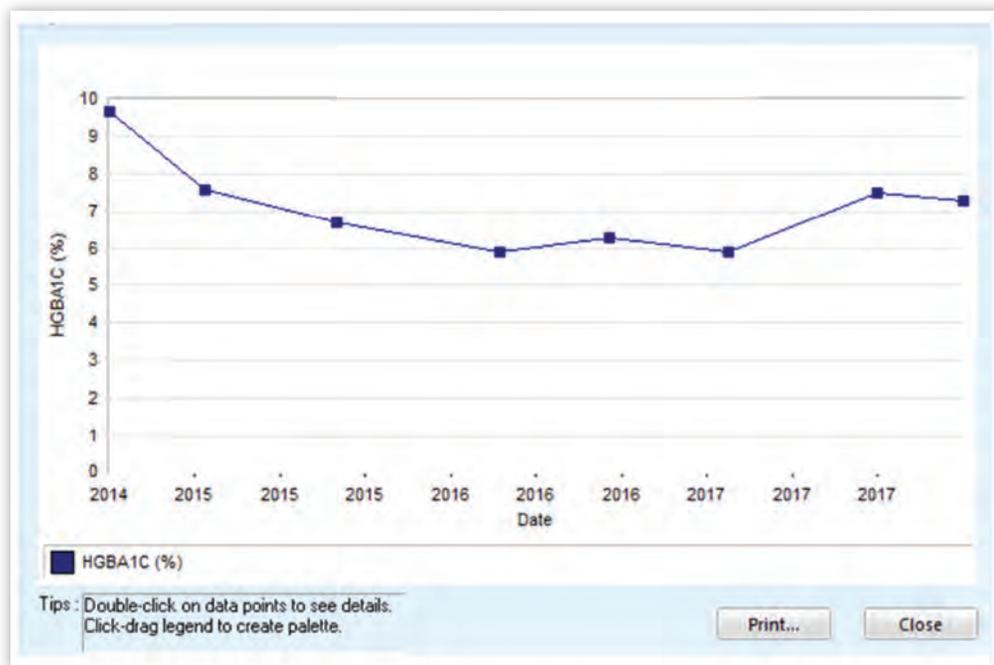
Flowers MA, Bardley L, Coyne M, Debar E, Farnell MM, Fajó AH, Mamyrok MD, Smeriero L, Vitoria E. Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. Diabetes Care 2015; 38(12):1392. The Diabetes Educator 2015;41:417-430. Journal of the Academy of Nutrition and Dietetics 2015;115:1323-1334. Modified August 2016

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)



Foot Exam

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>

revised 3/22/17

3-Minute Foot Exam

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>)

🕒 0:00 - 1:00 min.	🕒 1:01 - 2:00 min	🕒 2:01 - 3:00 min		
<h3 style="font-size: 2em; margin: 0;">ASK</h3> <p>DOES THE PATIENT HAVE A HISTORY OF:</p> <ul style="list-style-type: none"> • Previous leg/foot ulcer or lower limb amputation/surgery? • Prior angioplasty, stent, or leg bypass surgery? • Foot wound requiring more than 3 weeks to heal? • Smoking or nicotine use • Diabetes? (If yes, what are the patient's current control measures?) <p>DOES THE PATIENT HAVE:</p> <ul style="list-style-type: none"> • Burning or tingling in legs or feet? • Leg or foot pain with activity or at rest? • Changes in skin color, or skin lesions? • Loss of lower extremity sensation? <p>HAS THE PATIENT ESTABLISHED REGULAR PODIATRIC CARE?</p>	<h3 style="font-size: 2em; margin: 0;">LOOK</h3> <p>DERMATOLOGIC EXAM:</p> <ul style="list-style-type: none"> • Signs of fungal infection? • Discolored and/or hypertrophic skin lesions, calluses, or corns? • Open wounds or fissures? • Interdigital maceration? <p>NEUROLOGIC EXAM:</p> <ul style="list-style-type: none"> • Is the patient responsive to the Ipswich Touch Test? <p>MUSCULOSKELETAL EXAM:</p> <ul style="list-style-type: none"> • Full range of motion of the joints? • Obvious deformities? If yes, for how long? • Is the midfoot hot, red, or inflamed? <p>VASCULAR EXAM:</p> <ul style="list-style-type: none"> • Is the hair growth on the foot dorsum or lower limb decreased? • Are the dorsalis pedis and posterior tibial pulses palpable? • Is there a temperature difference? 	<h3 style="font-size: 2em; margin: 0;">Teach</h3> <p>RECOMMENDATIONS FOR DAILY FOOT CARE:</p> <ul style="list-style-type: none"> • Visually examine both feet, including soles and between toes. If the patient can't do this, have a family member do it. • Keep feet dry by regularly changing shoes and socks; dry feet after baths or exercise. • Report any new lesions, discolorations, or swelling to a health care professional. <p>EDUCATION REGARDING SHOES:</p> <ul style="list-style-type: none"> • The risks of walking barefoot, even indoors. • Avoiding shoes that are too small, tight or rub. • Replacing shoes regularly, at least once a year. <p>OVERALL HEALTH RISK MANAGEMENT:</p> <ul style="list-style-type: none"> • Recommend smoking cessation (if applicable). • Recommend appropriate glycemic control. 		
<p style="font-size: 1.2em; font-weight: bold;">✔ Follow up: Create a treatment plan</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <p>REFER TO SPECIALIST IMMEDIATELY FOR</p> <ul style="list-style-type: none"> • Open wound or ulcerative area • New neuropathic pain • Signs of active Charcot deformity • Vascular compromise • Chronic venous insufficiency </td> <td style="width: 50%; padding: 5px;"> <p>REFER TO SPECIALIST TIMELY FOR</p> <ul style="list-style-type: none"> • Peripheral artery disease • Presence of swelling or edema • Loss of protective sensation (LOPS) • Chronic venous insufficiency </td> </tr> </table>			<p>REFER TO SPECIALIST IMMEDIATELY FOR</p> <ul style="list-style-type: none"> • Open wound or ulcerative area • New neuropathic pain • Signs of active Charcot deformity • Vascular compromise • Chronic venous insufficiency 	<p>REFER TO SPECIALIST TIMELY FOR</p> <ul style="list-style-type: none"> • Peripheral artery disease • Presence of swelling or edema • Loss of protective sensation (LOPS) • Chronic venous insufficiency
<p>REFER TO SPECIALIST IMMEDIATELY FOR</p> <ul style="list-style-type: none"> • Open wound or ulcerative area • New neuropathic pain • Signs of active Charcot deformity • Vascular compromise • Chronic venous insufficiency 	<p>REFER TO SPECIALIST TIMELY FOR</p> <ul style="list-style-type: none"> • Peripheral artery disease • Presence of swelling or edema • Loss of protective sensation (LOPS) • Chronic venous insufficiency 			
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> <p>Everyone with Diabetes Counts</p> </div> <div style="font-size: 0.8em; text-align: center;"> <p><small>This material was prepared by Tetragen, the Quality Innovation Network National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 1150-WQI-WNCC-00273-d06/10/15.</small></p> </div> <div style="text-align: center;"> <p>Quality Improvement Organizations <small>Sharing Knowledge. Improving Health Care. CENTERS FOR MEDICARE & MEDICAID SERVICES</small></p> </div> </div>				

Wisconsin Diabetes Clinical Care Recommendations

The 2017 Wisconsin Diabetes Clinical Care Recommendations At-A-Glance is a useful resource that 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> or view sample below.

2017 Wisconsin Diabetes Clinical Care Recommendations At-A-Glance
 This document is an encapsulated overview of the 2017 American Diabetes Association Clinical Practice Recommendations. If you would like additional information about diabetes in Wisconsin, please refer to the Chronic Disease Prevention Unit webpage: <https://www.dhs.wisconsin.gov/diabetes/index.htm> or call: 608-261-8868.

Concern	Care/Test	Frequency																		
Pre Diabetes and Prevention of Type 2 Diabetes	Check A1C test, fasting plasma glucose test, or oral glucose tolerance test Testing for in Children and Adolescents *Age of initiation 10 years or at onset of puberty	Test all adults with BMI ≥ 25 kg/m ² (≥ 23 in Asian Americans) or \geq age 45 years. If normal, retest in 3 years or less. Overweight with 2 of the following: <ul style="list-style-type: none"> Family history of type 2 diabetes in 1st or 2nd degree relative Race/ethnicity Signs of insulin resistance or conditions associated with insulin resistance Maternal history of diabetes or gestational diabetes 																		
General Recommendations for Care	Perform diabetes-focused visit Review management plan; assess barriers and goals Assess physical activity level Assess lifestyle management and diabetes risk status Assess nutrition/weight/growth	Type 1: Every 3 months Type 2: Every 3-6 months Each focused visit; revise as needed Each focused visit At each visit; refer to evidence-based prevention resources as indicated Each focused visit																		
Self-Management Education	Refer to a Certified Diabetes Educator (CDE) in an American Diabetes Association (ADA) recognized or American Association of Diabetes Educators (AADE) accredited program	At diagnosis, then every 6-12 months, or more as needed																		
Medical Nutrition Therapy	Refer for medical nutrition therapy (MNT) provided by a Registered Dietitian (RD), preferably a CDE	At diagnosis or first referral to RD: 3-4 visits, completed in 3-6 months; then, 1-2 hours of routine RD visits annually. RD determines additional visits per needs/goals. Medicare Part B covers 3 hours per year of MNT when referred by a physician.																		
Glycemic Control	Check A1C, general goal: < 7.0% Review goals, change in lifestyle/meals pattern, medications, side effects, and frequency of hypoglycemia Assess self-blood glucose monitoring schedule	<ul style="list-style-type: none"> At least 2x annually in patients meeting treatment goals and have stable glycemic control Quarterly in patients with changed therapy or not meeting glycemic goals Each focused visit Continuous glucose monitoring (CGM) may be a supplemental tool to Self Monitored Blood Glucose (SMBG) in people with hypoglycemia unawareness and/or frequent hypoglycemic episodes Each focused visit. Patients on multiple-dose insulin or insulin pump therapy should perform self-monitored blood glucose (SMBG) prior to meals and snacks, at bedtime, prior to exercise, when they suspect low blood glucose, and prior to critical tasks. Continuous glucose monitoring (CGM) may be a supplemental tool to Self Monitored Blood Glucose (SMBG) in people with hypoglycemia unawareness and/or frequent hypoglycemic episodes Patients not on insulin should be treated on an individual basis, as the evidence is insufficient regarding when and how often to SMBG. 																		
Cardiovascular Care:	Check fasting lipid profile Start statin with ongoing lifestyle changes Check blood pressure. Adult goal: < 140/90 mmHg Assess smoking/tobacco use status	<p>Children: After age 2, then use American Academy of Pediatrics (AAP) guidelines Adults: At diagnosis, then every 5 years or more frequently as indicated</p> <table border="1"> <thead> <tr> <th>Age</th> <th>Risk Factors</th> <th>Statin Intensity</th> </tr> </thead> <tbody> <tr> <td rowspan="2">≥40 years</td> <td>None</td> <td>None</td> </tr> <tr> <td>ASCVD (no factors)</td> <td>Moderate to High</td> </tr> <tr> <td rowspan="2">40-75 years</td> <td>None</td> <td>None</td> </tr> <tr> <td>ASCVD (no factors)</td> <td>Moderate</td> </tr> <tr> <td rowspan="2">>75 years</td> <td>ASCVD (no factors)</td> <td>Moderate to High</td> </tr> <tr> <td>ASCVD (no factors)</td> <td>High</td> </tr> </tbody> </table> <p>For patients with diabetes: <ul style="list-style-type: none"> < 40 years with additional cardiovascular disease risk factors, consider using moderate or high intensity statin and lifestyle therapy 40-75 years without additional cardiovascular disease risk factors, consider high intensity statin and lifestyle therapy > 75 years without additional cardiovascular disease risk factors, consider using moderate intensity statin and lifestyle therapy </p> <p>Children: Each focused visit; follow National High Blood Pressure Education Program recommendations for children and adolescents Adults: Each office visit; weight loss if overweight, DASH-style diet, Moderation of alcohol intake, increased physical activity</p> <p>Each office visit; (5As: Ask, Advise, Assess, Assist, Arrange)</p>	Age	Risk Factors	Statin Intensity	≥40 years	None	None	ASCVD (no factors)	Moderate to High	40-75 years	None	None	ASCVD (no factors)	Moderate	>75 years	ASCVD (no factors)	Moderate to High	ASCVD (no factors)	High
Age	Risk Factors	Statin Intensity																		
≥40 years	None	None																		
	ASCVD (no factors)	Moderate to High																		
40-75 years	None	None																		
	ASCVD (no factors)	Moderate																		
>75 years	ASCVD (no factors)	Moderate to High																		
	ASCVD (no factors)	High																		

	Start aspirin therapy (unless contraindicated)	<ul style="list-style-type: none"> • Age ≥ 50 years for most men and women with diabetes and at least one other major risk factor • Men ≤ 50 years, and women ≤ 60 years, individualized based on risk • Consider adding 75-162 mg/day
Kidney Care	Test serum creatinine to estimate GFR and chronic kidney disease (CKD) stage	<p>Type 1: 5 years after diagnosis, then at least annually</p> <p>Type 2: At diagnosis, then at least annually</p>
	ACR: Check albumin/creatinine ratio for micro albuminuria using a random urine sample. Goal <30 mg/g	<p>Type 1: 5 years after diagnosis, then at least annually</p> <p>Type 2: At diagnosis, then at least annually</p> <p>*ACE inhibitors or angiotensin II receptor blockers reduce progression of CKD to ESRD and improve survival for hypertension with heavy albuminuria</p>
	Hypertension diagnosis or BP >140/90 mmHg AND albumin-creatinine ratio, urine ratio greater than or equal to 300mg/g creatinine (A evidence) or 30-299 mg/g creatinine (B evidence) use ACE inhibitor or angiotensin II receptor blocker	Assess at least annually
Eye Care	Dilated and comprehensive eye exam by an ophthalmologist or optometrist	<p>Type 1: ≥ 10 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)</p> <p>Type 2: At diagnosis, then annually, (or once every 2 years if no retinopathy found on LAST exam)</p> <p>Pregnant with pre-existing Type 1 or Type 2: within first trimester then second, third, and 1 year post-partum.</p> <p>Solely gestational diabetes: low-risk for retinopathy and not recommended for screening.</p>
Neuropathies and Foot Care	Assess/screen for neuropathy - autonomic and diabetic peripheral neuropathy (DPN)	<p>Type 1: Five years after diagnosis, then annually</p> <p>Type 2: At diagnosis, then annually</p> <p>Type 1 and Type 2: Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain in diabetes</p>
	Visual inspection of feet with shoes and socks off	Each focused visit; stress daily self-exam
	Perform comprehensive lower extremity/foot exam	At diagnosis, then annually
	Screen for peripheral artery disease (PAD) – consider ankle-brachial index (ABI)	At diagnosis, then annually
Oral Care	Simple inspections of gums and teeth for signs of periodontal disease	At diagnosis, then each focused visit
	Dental exam by general dentist or periodontal specialist	At diagnosis, then individualize based on an oral assessment and risk, as more frequent exams may be needed
Emotional and Sexual Health Care	Assess emotional health; screen for depression	Each focused visit
	Assess sexual health concerns	Each focused visit
Communicable Diseases Prevention	Provide influenza vaccine	Annually, if age ≥ 6 months
	Provide pneumococcal vaccine	Once; then per Advisory Committee on Immunization Practices
	Provide hepatitis B series	Once at diagnosis for age 19 -58 years of age; individualize for ≥ 60 years of age
	Screen for tuberculosis infection or disease	As needed
Preconception, Pregnancy and Postpartum Care	Ask about reproductive intentions/assess contraception	At diagnosis and then every visit ⇄
	Provide preconception counselling/assessment that addresses the importance of glycemic control as close to normal as safely possible, ideally <6.5% A1C to reduce the risk of congenital anomalies	3-4 months prior to conception
	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
	Screen for undiagnosed type 2 diabetes in women with known risk	At first prenatal visit ⇄
	Screen for gestational diabetes mellitus (GDM) in all women not known to have diabetes	At 24-28 weeks gestation ⇄
	Screen for type 2 diabetes in women who had gestational diabetes mellitus (GDM)	At 4-12 weeks postpartum then at least every 3 years lifelong, using OGTT

⇄ Consider more often if A1C 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 referring to provider experienced in care of women with diabetes during pregnancy

+ More or less stringent blood pressure goals must be individualized if < 140/90 is not reasonable to achieve



State of Wisconsin
Department of Health Services
Division of Public Health
P-49356A (5/2017)

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

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:

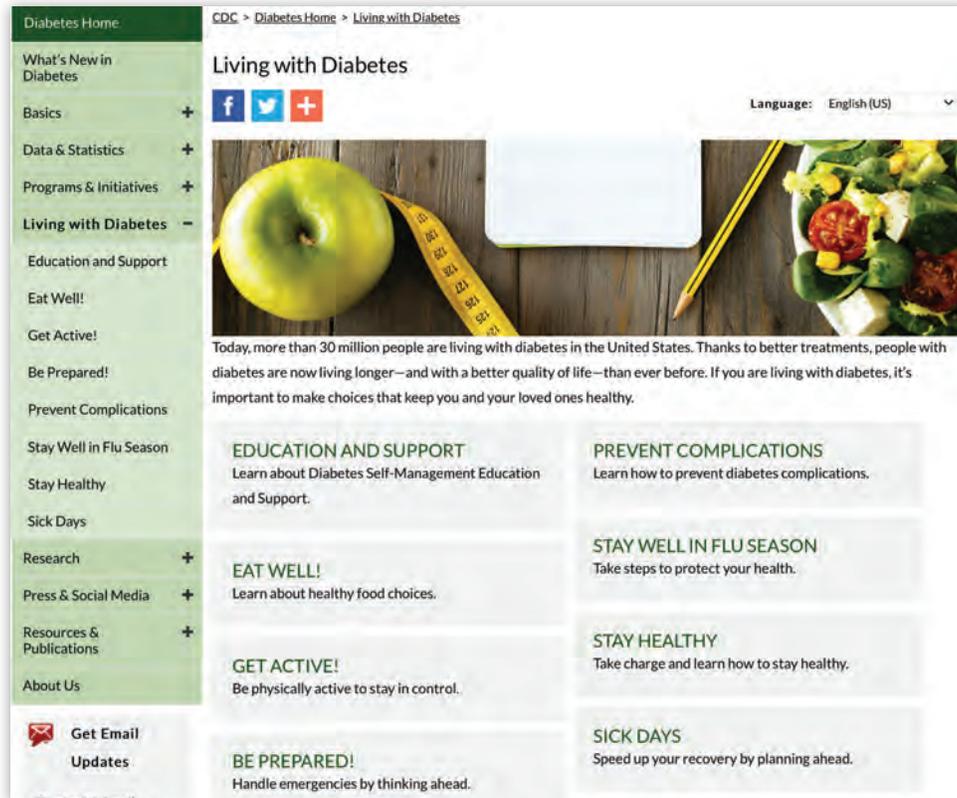
- Regular **A1C** test
- **B**lood pressure below 140/90 mm Hg
- Control **cholesterol**
- Stop/don't start **smoking**

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>



Diabetes Self-Management Education and Support (DSMES)

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

When Do You Need DSMES?	Why?
When you first find out that you have diabetes	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.
During yearly follow-up visits with your doctor	Check on your progress and get help to prevent complications.
When new situations affect the way you take care of yourself	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.
When other life changes occur that affect the way you take care of yourself	Major life changes can affect your diabetes. Examples of life changes include a change in your living situation, your doctors or insurance plan, or your job.

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>.

To find an accredited Diabetes Education Program in your area, visit: <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>

Divine Savior Healthcare - Diabetes Self-Management Support Group

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).



Join our group of medical professionals to partner with you to better manage your diabetes.

This support group does not replace your regular provider visits, but rather complements the care that your provider gives and provides participants with ongoing support and education to manage their disease.

Date: 3rd Wednesday of every month

From: 1:30 pm – 2:30 pm

Location:

Divine Savior Hospital

Lower Level of Hospital - Café A/B Conference Room

Who Should Attend?

- Adults with type 2 diabetes
- Adults with type 1 diabetes
- Adults with pre-diabetes
- Adults living with someone who has diabetes

Discussion Topics Include:

- Nutrition and Lifestyle
- Blood Sugar Monitoring
- Stress Management and Coping
- Medication Management
- Exercising with Diabetes
- Risk Reduction
- Healthy Coping

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

Toolkit No. 29

Blood Glucose Log

MAKE ONE (1) COPY OF THIS PAGE.

If you have **high blood glucose**, make notes in your log and talk with your health care team about whether you need to change your meal plan, physical activity, or diabetes medicines.

Having low blood glucose means that your blood glucose level is too low (below 70 mg/dl). Low blood glucose can be dangerous. Symptoms include being:

- hungry
- nervous and shaky
- light-headed or confused
- sleepy
- sweaty

If you think your blood glucose is too low, check it. If it's below 70 mg/dl, have 1 of these items right away to raise your blood glucose level:

- 3 or 4 glucose tablets
- 1 serving of glucose gel (the amount equal to 15 grams of carbohydrate)
- ½ cup (4 ounces) of fruit juice
- ½ cup (4 ounces) of a regular (not diet) soft drink
- 8 ounces of milk
- 5 or 6 pieces of hard candy
- 1 tablespoon of sugar or honey

After 15 minutes, check your blood glucose again. If it's still below 70 mg/dl, have another serving. Repeat these steps until your blood glucose is at least 70 mg/dl.

My Doctor
Name: _____
Phone: _____

My Diabetes Educator
Name: _____
Phone: _____

ADA Targets for Blood Glucose	My Usual Results	My Targets
Before meals: 80 to 130 mg/dl	_____ to _____	_____ to _____
2 hours after the start of a meal: below 180 mg/dl	below _____	below _____

TO MAKE MORE MONTHLY LOGS: Make one (1) copy of this page and two (2) copies of the next page. Cut the pages in half, placing this page on top. Staple in the upper left-hand corner and fold to fit in your pocket or purse.
©2012 by the American Diabetes Association, Inc. 1/15

CUT HERE ><

Date	Time	Breakfast	Medicine/Comment	Time	Lunch	Medicine/Comment	Time	Dinner	Medicine/Comment	Time	Snack/Other	Medicine/Comment

CUT HERE ><

American Diabetes Association 1-800-DIABETES (342-2383) www.diabetes.org ©2012 by the American Diabetes Association, Inc. 1/15

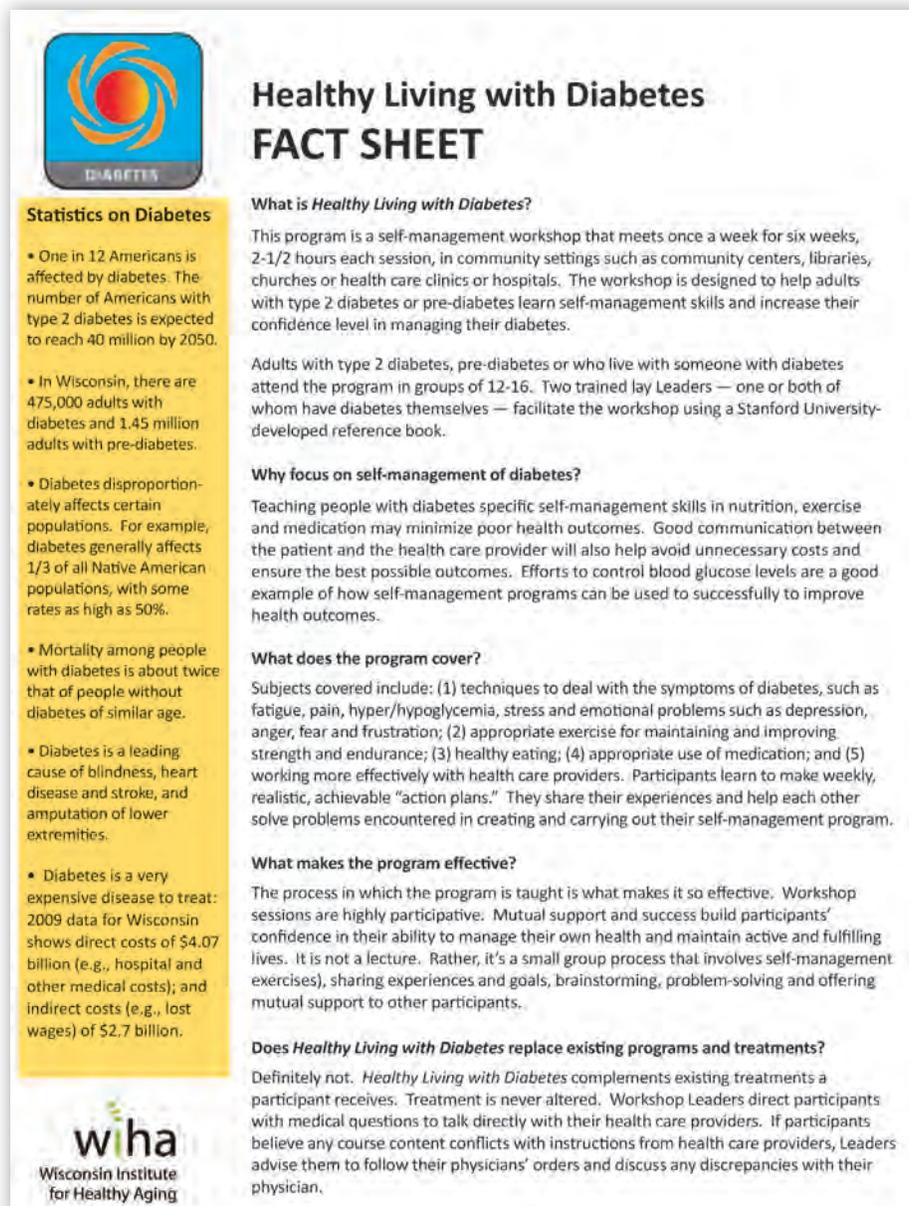
Wisconsin Institute for Healthy Aging: Healthy Living with Diabetes

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>

Healthy Living with Diabetes Fact Sheet

https://wihealthyaging.org/_data/files/HLWD/HLWD_FACT_sheet.pdf



The graphic is a fact sheet titled "Healthy Living with Diabetes FACT SHEET". It features a logo on the left with a stylized sun or flower icon and the word "DIABETES" below it. The content is organized into sections with bold headings and bullet points. A yellow sidebar on the left contains "Statistics on Diabetes". The main text includes sections for "What is Healthy Living with Diabetes?", "Why focus on self-management of diabetes?", "What does the program cover?", "What makes the program effective?", and "Does Healthy Living with Diabetes replace existing programs and treatments?". The Wisconsin Institute for Healthy Aging logo is at the bottom left.

Healthy Living with Diabetes FACT SHEET

Statistics on Diabetes

- One in 12 Americans is affected by diabetes. The number of Americans with type 2 diabetes is expected to reach 40 million by 2050.
- In Wisconsin, there are 475,000 adults with diabetes and 1.45 million adults with pre-diabetes.
- Diabetes disproportionately affects certain populations. For example, diabetes generally affects 1/3 of all Native American populations, with some rates as high as 50%.
- Mortality among people with diabetes is about twice that of people without diabetes of similar age.
- Diabetes is a leading cause of blindness, heart disease and stroke, and amputation of lower extremities.
- Diabetes is a very expensive disease to treat: 2009 data for Wisconsin shows direct costs of \$4.07 billion (e.g., hospital and other medical costs); and indirect costs (e.g., lost wages) of \$2.7 billion.

What is *Healthy Living with Diabetes*?

This program is a self-management workshop that meets once a week for six weeks, 2-1/2 hours each session, in community settings such as community centers, libraries, churches or health care clinics or hospitals. The workshop is designed to help adults with type 2 diabetes or pre-diabetes learn self-management skills and increase their confidence level in managing their diabetes.

Adults with type 2 diabetes, pre-diabetes or who live with someone with diabetes attend the program in groups of 12-16. Two trained lay Leaders — one or both of whom have diabetes themselves — facilitate the workshop using a Stanford University-developed reference book.

Why focus on self-management of diabetes?

Teaching people with diabetes specific self-management skills in nutrition, exercise and medication may minimize poor health outcomes. Good communication between the patient and the health care provider will also help avoid unnecessary costs and ensure the best possible outcomes. Efforts to control blood glucose levels are a good example of how self-management programs can be used to successfully to improve health outcomes.

What does the program cover?

Subjects covered include: (1) techniques to deal with the symptoms of diabetes, such as fatigue, pain, hyper/hypoglycemia, stress and emotional problems such as depression, anger, fear and frustration; (2) appropriate exercise for maintaining and improving strength and endurance; (3) healthy eating; (4) appropriate use of medication; and (5) working more effectively with health care providers. Participants learn to make weekly, realistic, achievable "action plans." They share their experiences and help each other solve problems encountered in creating and carrying out their self-management program.

What makes the program effective?

The process in which the program is taught is what makes it so effective. Workshop sessions are highly participative. Mutual support and success build participants' confidence in their ability to manage their own health and maintain active and fulfilling lives. It is not a lecture. Rather, it's a small group process that involves self-management exercises, sharing experiences and goals, brainstorming, problem-solving and offering mutual support to other participants.

Does *Healthy Living with Diabetes* replace existing programs and treatments?

Definitely not. *Healthy Living with Diabetes* complements existing treatments a participant receives. Treatment is never altered. Workshop Leaders direct participants with medical questions to talk directly with their health care providers. If participants believe any course content conflicts with instructions from health care providers, Leaders advise them to follow their physicians' orders and discuss any discrepancies with their physician.

wiha
Wisconsin Institute
for Healthy Aging



The imperative

Former Acting Surgeon General Rear Admiral (retired) Steven K. Galson, a Board-Certified physician in Preventive Medicine and Public Health, has endorsed this program with this statement:

“Community-based self-management programs will be particularly important in helping older adults manage their chronic conditions. [These] programs help individuals gain self-confidence in their ability to control symptoms and manage the progression of several long-term and chronic age-related illness.

... To obtain the best possible outcomes using self-management strategies in chronic conditions, patients must have access to information and services that can help them learn about and cope with their disease. Such information will also help them gain confidence in their ability to better manage their particular illness. “

PUBLIC HEALTH REPORTS
JULY-AUGUST 2009
VOLUME 124
pp. 478-480



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

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.

**Diabetes Empowerment Education Program (DEEP)
Curriculum Description**

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.

Program Goals

Goals of the DEEP curriculum include:

- Improving and maintaining the quality of life of persons with pre-diabetes and existing diabetes
- Preventing complications and incapacities
- Improving eating habits and maintaining adequate nutrition
- Increasing physical activity
- Developing self-care skills
- Improving the relationship between patients and health care providers
- Utilizing available resources

Class Guidelines

Classes incorporate the following guidelines:

- Evidence-based
- Eight learning modules, taught over six weeks
- Twelve to fifteen people per class
- Participatory teaching and learning
- Classes approximately one to two hours in length, depending on class size
- Can be taught by peer educators or community health workers (CHWs) who are usually lay people within the community
- Graduation after completion of at least 80 percent of the modules and completion of a pre and a post test

DEEP™ is copyrighted by UIC-Midwest Latino Health Research, Training and Policy Center. 6th edition.

The Lake Superior Quality Innovation Network represents Michigan, Minnesota and Wisconsin. | www.lsqin.org **EDC**
Everyone with Diabetes Counts

To learn more visit http://www.whcawical.org/files/2016/07/LSQIN_B2_DEEP_flier.pdf.
For support from a Wisconsin representative visit <https://www.metastar.com/communities-consumers/prevention/> or contact Mary Funseth mfunseth@metastar.com



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



05

SECTION FIVE

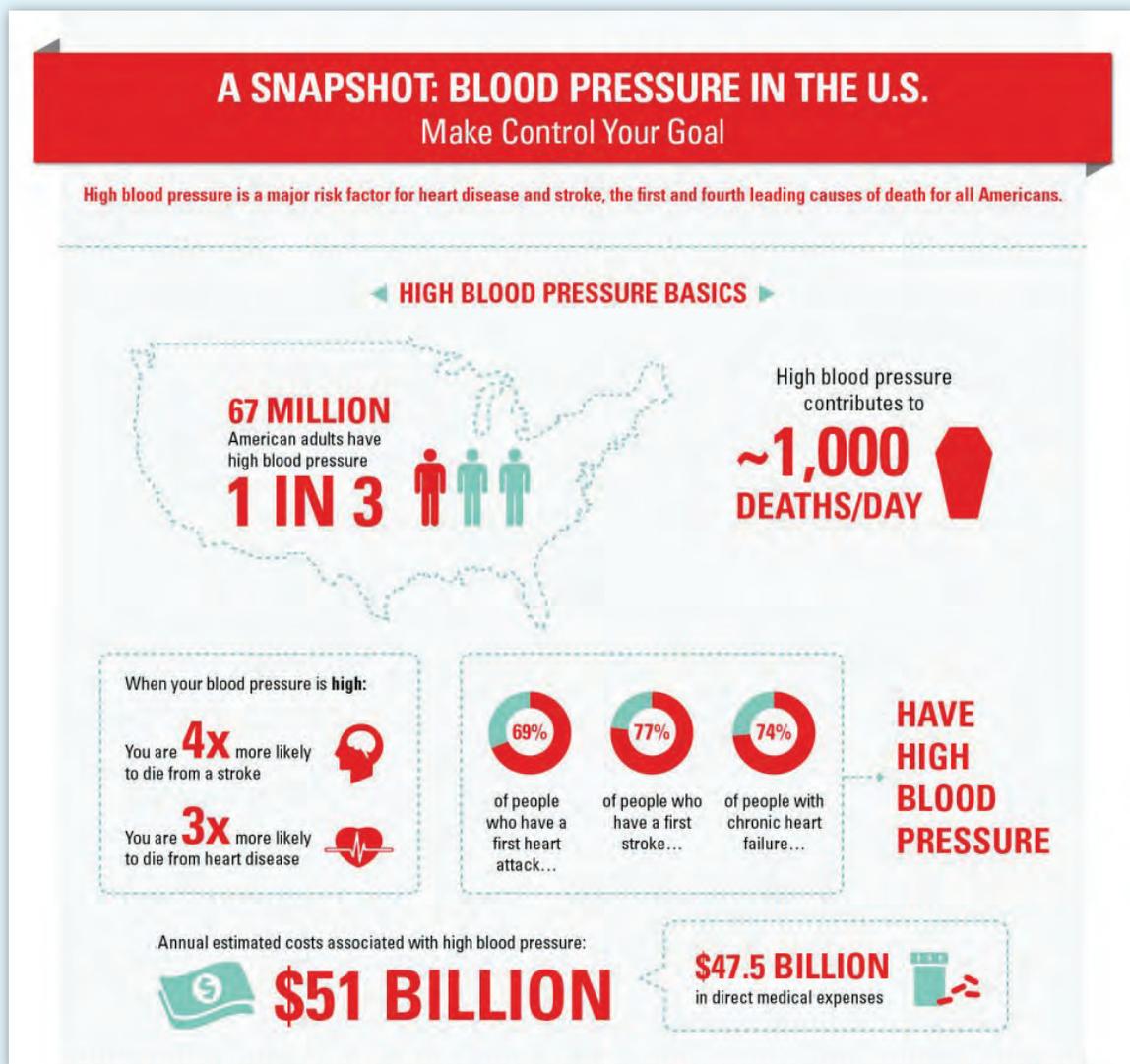
RESOURCES FOR BLOOD PRESSURE CONTROL

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>

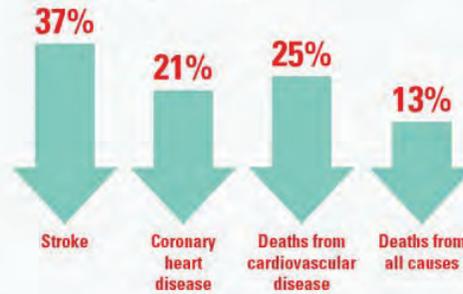


◀ **BLOOD PRESSURE CONTROL** ▶



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

Reducing average population systolic blood pressure by only 12–13 mmHg could reduce:



◀ **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:



Nutrition Facts



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



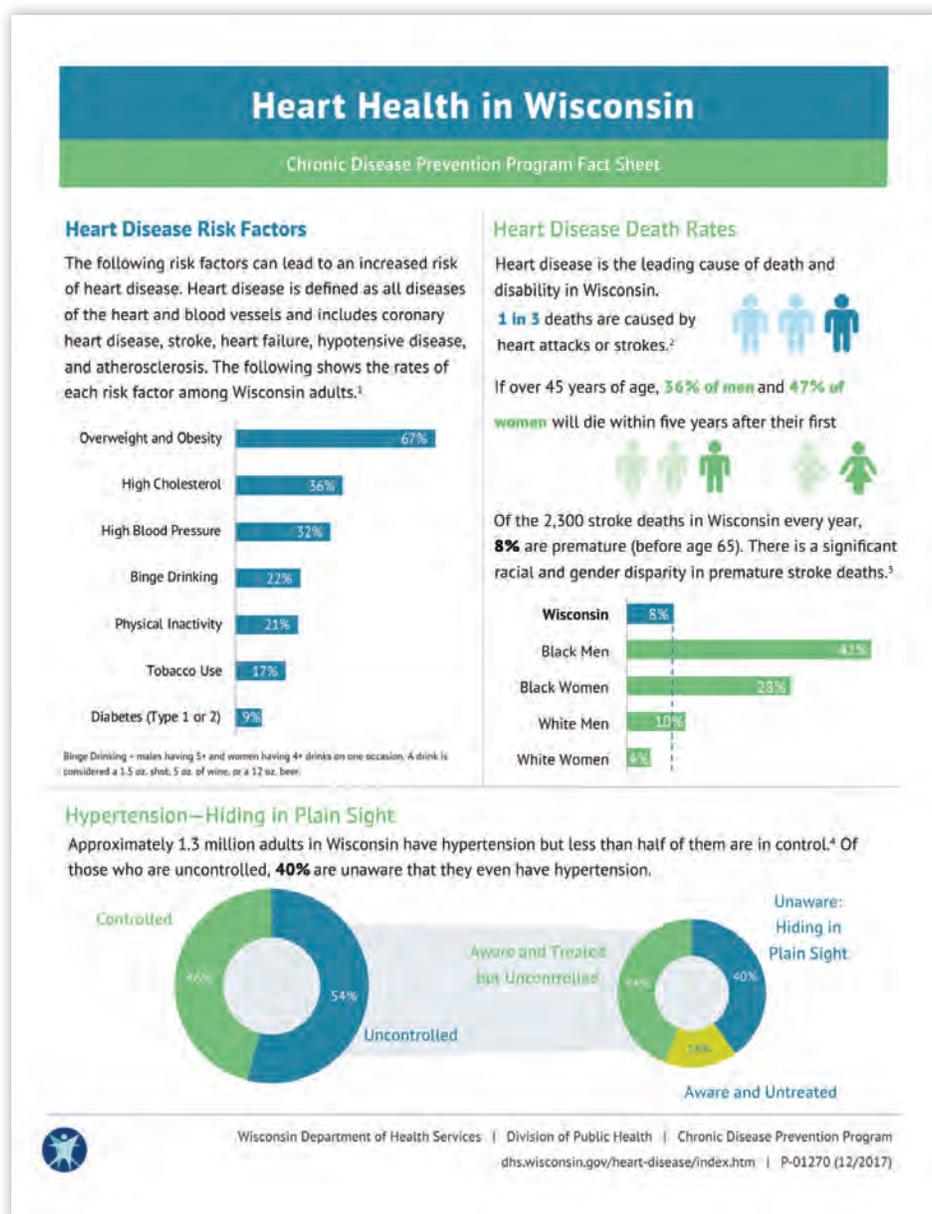
millionhearts.hhs.gov/about/hs/blood_pressure.html



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

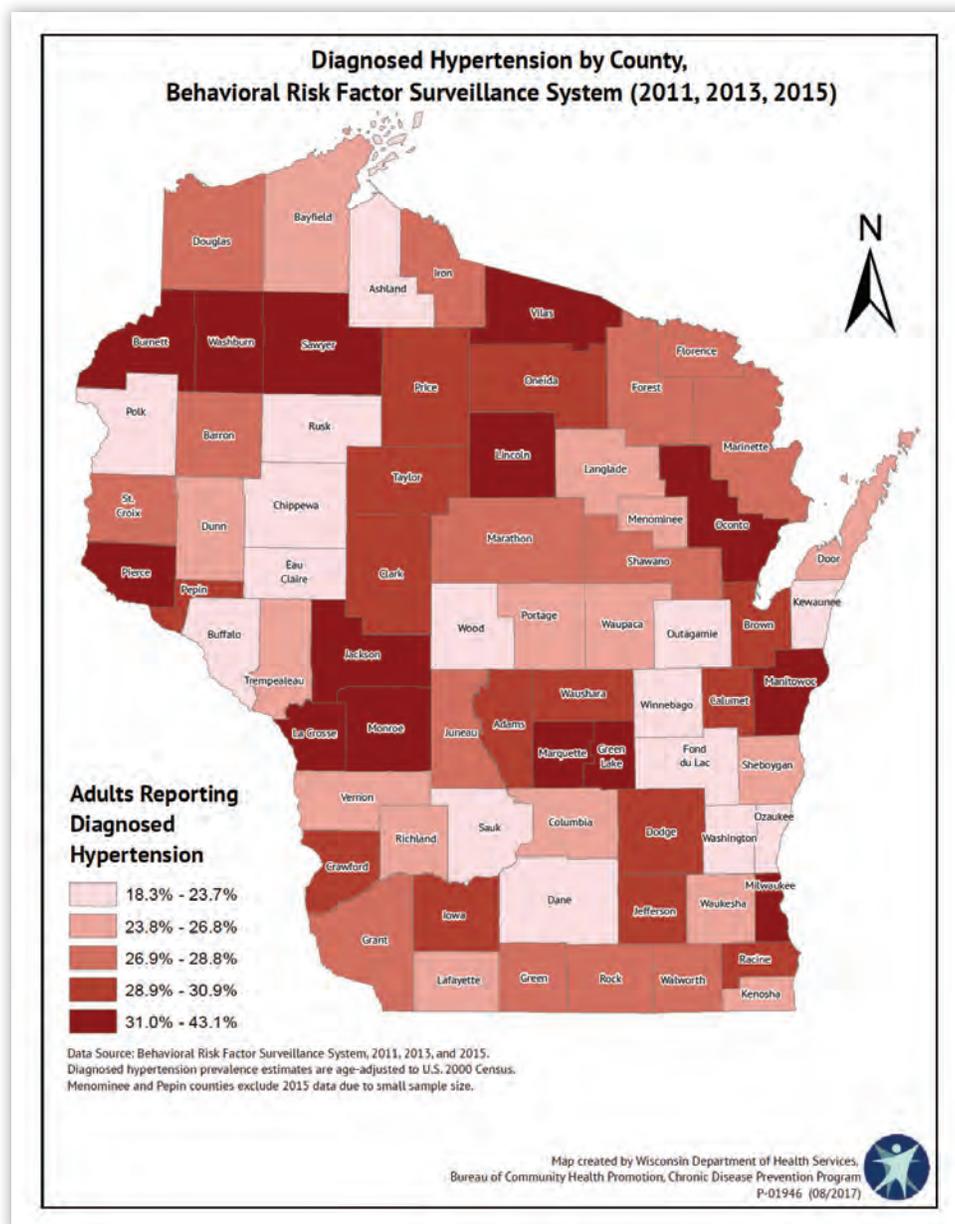


Diagnosed Hypertension by County

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>.



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/>

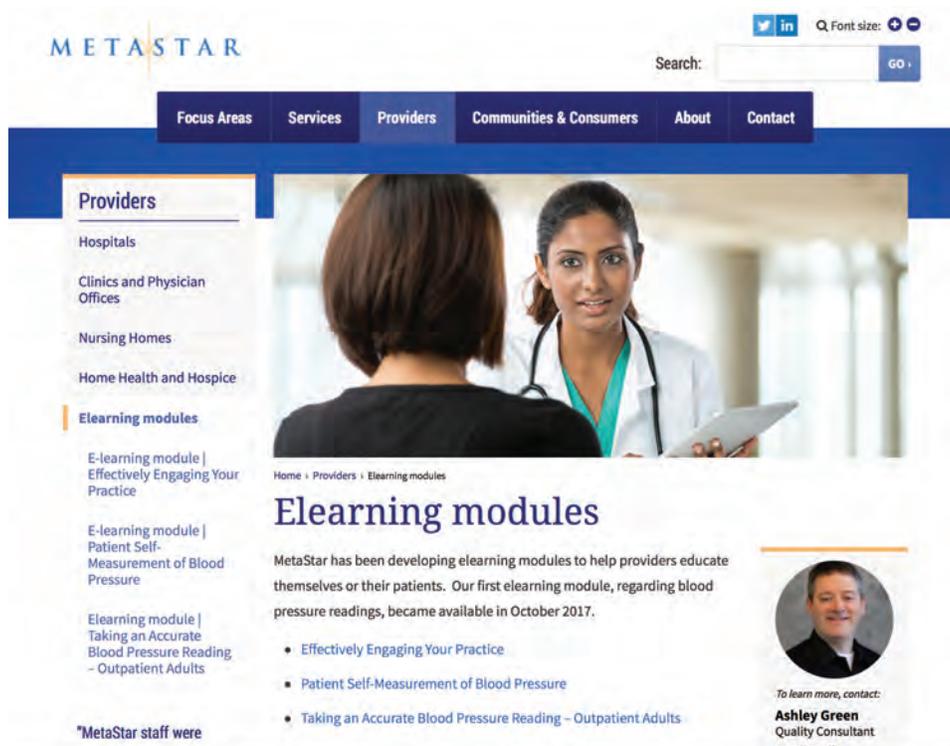


Taking an Accurate Blood Pressure Reading – Outpatient Adults:

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/>



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



ONLINE SELF-STUDY PROGRAM

*Did you know that 52% of people with hypertension in Wisconsin are not adequately controlled? **We can do better!** It starts with accurate blood pressure measurement.*

Beyond the 50%: Accurate Blood Pressure Measurement 2.0

Materials Developed and Posted September, 2017

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



Table Of Contents..... 1

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

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.

Participant's Name:	
Date:	
Patient MR Number:	

Criteria Assessed	Yes	No*
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.		
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.		
Participant will demonstrate appropriate cuff selection and placement on patient's 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		
Participant will accurately measure and record blood pressure in Electronic Medical Record		
If the initial BP is 140/90 or greater, repeats a BP measurement after 5 minutes of quietly waiting.		
Participant will record the second BP and will inform the provider if the second reading is 140/90 or above.		
Participant will verbalize the normal range of adult blood pressure and determine if reading is in a normal range for the individual		
Participant will verbalize techniques for measuring orthostatic blood pressure		
Reviewed e-module by MetaStar: Taking an Accurate Blood Pressure Reading		

**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/>
 Wisconsin Collaborative for Healthcare Quality Toolkit for Improving Hypertension Care & Outcomes:

Target: BP “7 Simple Tips to get an Accurate Blood Pressure Reading”

https://targetbp.org/wp-content/uploads/2017/11/Measuring_Blood_Pressure_In-Office.pdf

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/>

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:

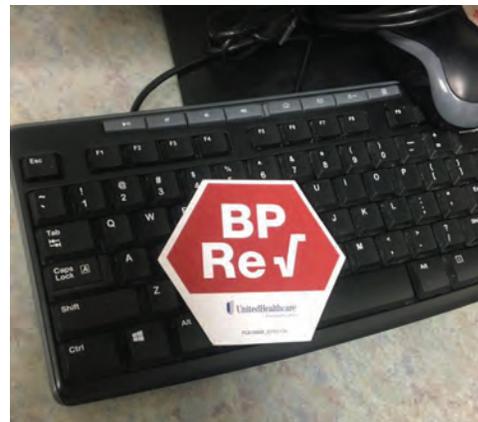
- Provider and clinical staff have a process defined and outlined on how and when to obtain a 2nd BP
- Standardized evidence-based protocol for treating hypertension that can be used as a clinical decision support to assist in achieving hypertension control
- Scheduled chronic disease huddles
- Self-management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

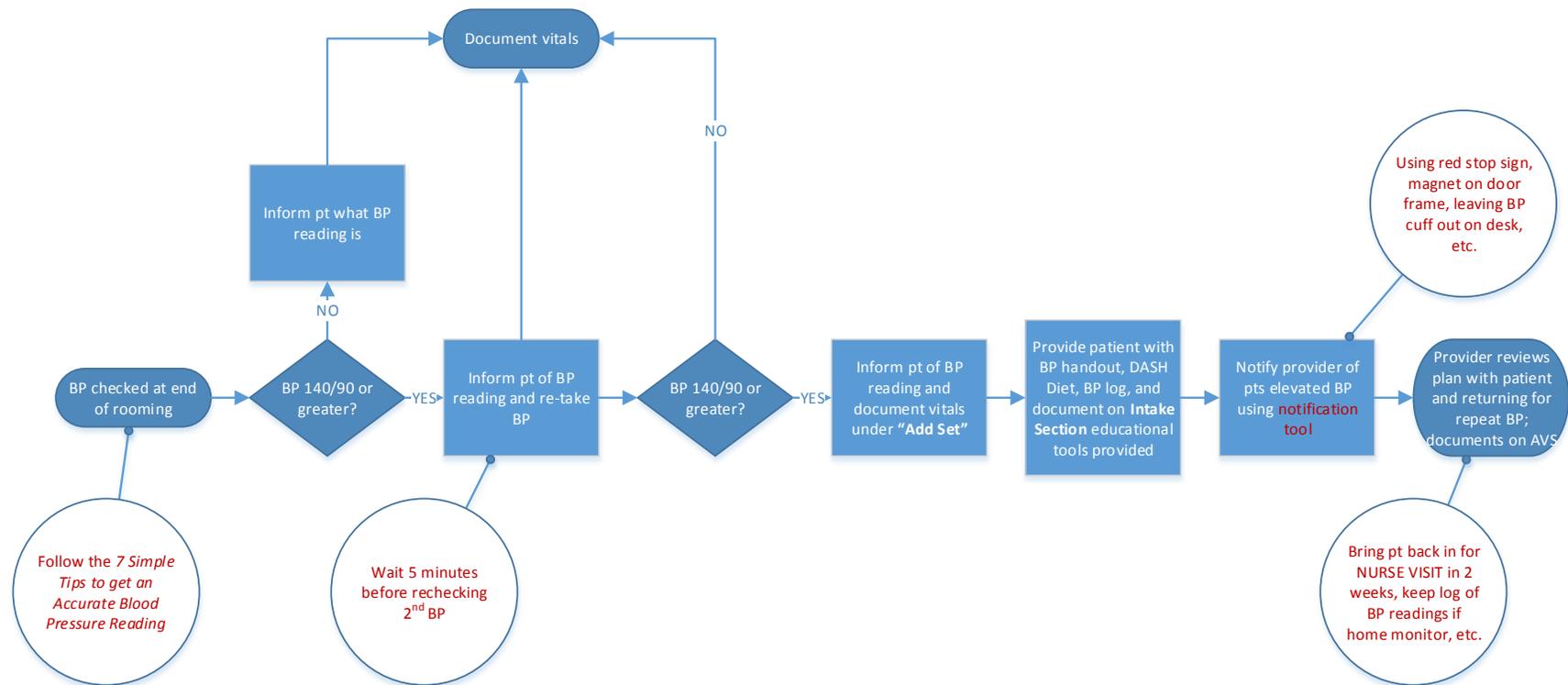
<https://www.stepsforward.org/modules/hypertension-blood-pressure-control>

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

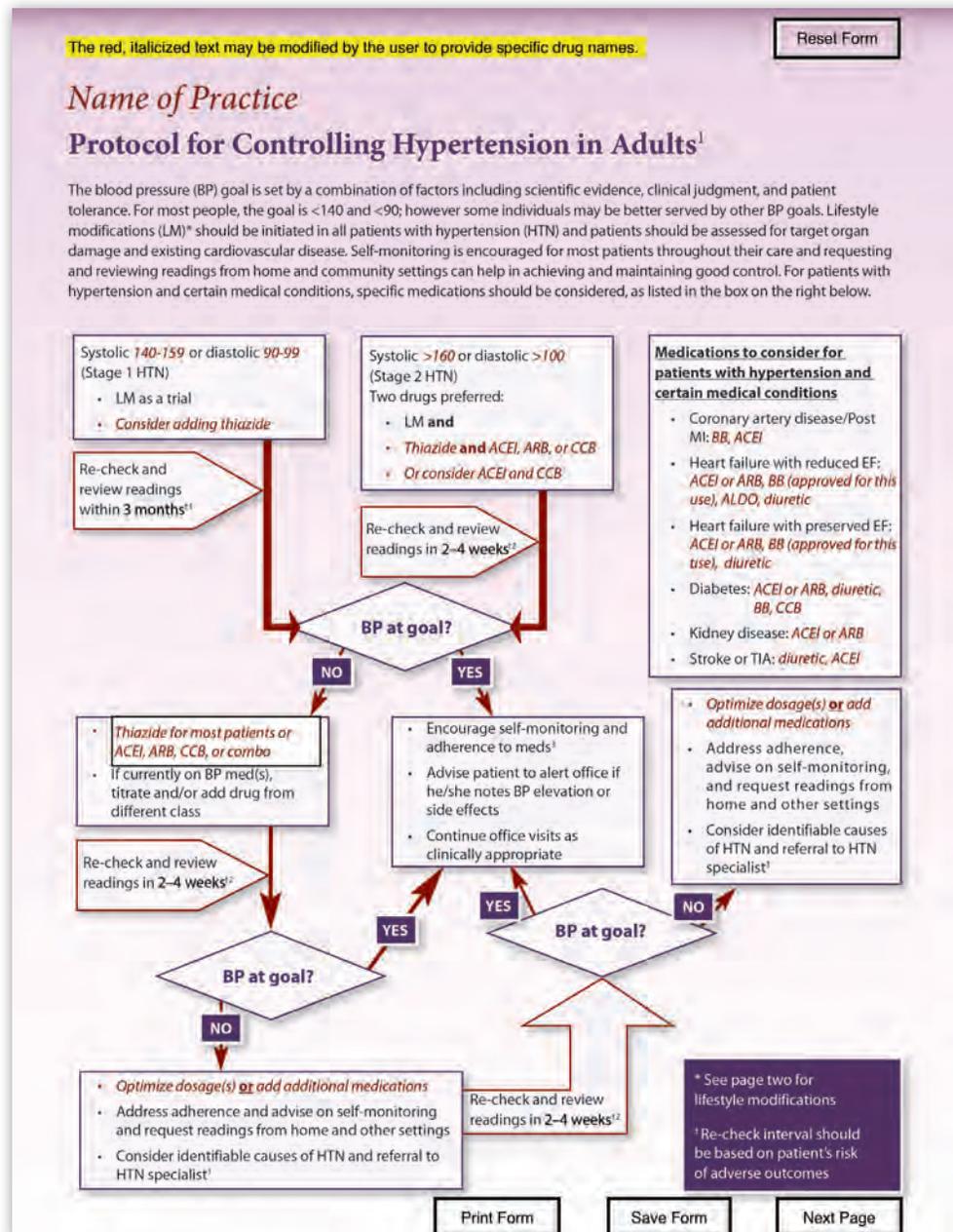
For Patients 18 and Older



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>



Previous Page

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

'Lifestyle Modifications' (LM)		
Modification	Recommendation	Approximate SBP** Reduction (Range)[†]
Weight reduction	Maintain normal body weight (body mass index 18.5–24.9 kg/m ²)	5–20 mm Hg/10kg
Adopt DASH ^{†††} eating plan	Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat	8–14 mm Hg
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride)	2–8 mm Hg
Physical activity	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)	4–9 mm Hg
Moderation of alcohol consumption	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	2–4 mm Hg

**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

- ¹ National Heart, Lung and Blood Institute, National Institutes of Health. *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure - Complete Report*. National Heart, Lung, and Blood Institute, National Institutes of Health. NIH Publication No. 04-5230, 2004.
- ² Jaffe MG, Lee GA, Young JD, Sidney S, Go AS. Improved Blood Pressure Control Associated with a Large-Scale Hypertension Program. *JAMA*. 2013;310(7):699-705.
- ³ Centers for Disease Control and Prevention. *Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.

Other Resources

Sacks FM, Svetkey LP, Vollmer WM, et al. Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. DASH-Sodium Collaborative Research Group. *N Engl J Med*. 2001;344:3-10.

US Department of Health and Human Services. 2008 physical activity guidelines for Americans. 2008. <http://www.health.gov/PAGuidelines>. Accessed November 4, 2013.

Suggested Citation

Centers for Disease Control and Prevention. *Protocol for Controlling Hypertension in Adults*. Atlanta, Georgia. 2013.

Print Form

Save Form

CS243702

Target: BP – AHA/ACC Blood Pressure Guideline

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/>**



Highlights

FROM THE 2017 GUIDELINE FOR THE PREVENTION, DETECTION, EVALUATION AND MANAGEMENT OF HIGH BLOOD PRESSURE IN ADULTS

A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

New blood pressure targets and treatment recommendations: For years, hypertension was classified as a blood pressure (BP) reading of 140/90 mm Hg or higher, but the updated guideline classifies hypertension as a BP reading of 130/80 mm Hg or higher. The updated guideline also provides new treatment recommendations, which include lifestyle changes as well as BP-lowering medications, as shown in Table 1

TABLE 1. Classification of BP

BP Category	Systolic BP		Diastolic BP	Treatment or Follow-up
Normal	<120 mm Hg	and	<80 mm Hg	Evaluate yearly; encourage healthy lifestyle changes to maintain normal BP
Elevated	120-129 mm Hg	and	<80 mm Hg	Recommend healthy lifestyle changes and reassess in 3-6 months
Hypertension: stage 1	130-139 mm Hg	or	80-89 mm Hg	Assess the 10-year risk for heart disease and stroke using the atherosclerotic cardiovascular disease (ASCVD) risk calculator <ul style="list-style-type: none"> • If risk is less than 10%, start with healthy lifestyle recommendations and reassess in 3-6 months • If risk is greater than 10% or the patient has known clinical cardiovascular disease (CVD), diabetes mellitus, or chronic kidney disease, recommend lifestyle changes and BP-lowering medication (1 medication); reassess in 1 month for effectiveness of medication therapy <ul style="list-style-type: none"> – If goal is met after 1 month, reassess in 3-6 months – If goal is not met after 1 month, consider different medication or titration – Continue monthly follow-up until control is achieved
Hypertension: stage 2	≥140 mm Hg	or	≥90 mm Hg	Recommend healthy lifestyle changes and BP-lowering medication (2 medications of different classes); reassess in 1 month for effectiveness <ul style="list-style-type: none"> • If goal is met after 1 month, reassess in 3-6 months • If goal is not met after 1 month, consider different medications or titration • Continue monthly follow-up until control is achieved

TABLE 2. Hypertensive Crises: Emergencies and Urgencies (See Section 11.2 of 2017 Hypertension Guideline)

Hypertensive Crises	Systolic BP		Diastolic BP	Treatment or Follow-up
Hypertensive urgency	>180 mm Hg	and/or	>120 mm Hg	Many of these patients are noncompliant with antihypertensive therapy and do not have clinical or laboratory evidence of new or worsening target organ damage; reinstitute or intensify antihypertensive drug therapy, and treat anxiety as applicable
Hypertensive emergency	>180 mm Hg + target organ damage	and/or	>120 mm Hg + target organ damage	Admit patient to an intensive care unit for continuous monitoring of BP and parenteral administration of an appropriate agent in those with new/progressive or worsening target organ damage (see Tables 19 and 20 in the 2017 Hypertension Guideline)

*Wilson PG, Chrys RM, Avenue WE, Chrys DE Jr, Collins GJ, Demissie Hirumelimb C, D'Palma SM, Golding S, Jamerson KA, Jones DW, MacLaughlin EJ, Maitner P, O'Vaughn B, Smith SC Jr, Spencer CC, Stoffel MJ, Taler SJ, Trogan RJ, Williams KA Sr, Williams JD, Wright JT Jr. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APLA/ASB/ASNC/AMA/PENA guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines [published online ahead of print November 13, 2017]. *Hypertension*. doi: 10.1161/HYP.0000000000000900
© 2017 American Heart Association

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>

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

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.



Improving Medication Adherence Among Patients with Hypertension

A Tip Sheet for Health Care Professionals



Medication adherence is critical to successful hypertension control for many patients. However, only 51% of Americans treated for hypertension follow their health care professional's advice when it comes to their long-term medication therapy.¹

Adherence matters. High adherence to antihypertensive medication is associated with higher odds of blood pressure control, but non-adherence to cardioprotective medications increases a patient's risk of death from 50% to 80%.¹

As a health care professional, you can empower patients to take their medications as prescribed. Effective two-way communication is critical; in fact, it doubles the odds of your patients taking their medications properly. Try to understand your patients' barriers and address them honestly to build trust.

Predictors of Non-Adherence

When discussing medications, be aware if your patient:

- ▶ Demonstrates limited English language proficiency or low literacy.
- ▶ Has a history of mental health issues like depression, anxiety, or addiction.
- ▶ Doesn't believe in the benefits of treatment.
- ▶ Believes medications are unnecessary or harmful.
- ▶ Has a concern about medication side effects.
- ▶ Expresses concern over the cost of medications.
- ▶ Says he or she is tired of taking medications.

These can all be predictors of a patient who may struggle with adherence to medication.

Medication Adherence by the Numbers¹



100	50-70	48-66	25-30	15-20
prescriptions written...	go to a pharmacy	come out of the pharmacy	are taken properly	are refilled as prescribed

*This data applies to all medication types, not only hypertension medication.
¹Ho PM, Bryson CL, Rumsfeld JS. Medication adherence: its importance in cardiovascular outcomes. *Circulation*. 2009;119:3028-3035.


Make control **your** goal.



As a health care professional, you can empower patients to take their medications as prescribed. Effective two-way communication is critical; in fact, it doubles the odds of your patients taking their medications properly.

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/?MedAdhereTTProviders>

Find and download additional materials to help your patients control hypertension at the Million Hearts® website.

Updated February 2017

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

https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/iho-bp-self-measured-blood-pressure-monitoring_0.pdf

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 patients¹
- 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 period²
- 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 data¹

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.^{2,3}

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 large 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.

¹ Self-measured blood pressure



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 Protocol⁶ 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

Dabl Educational Trust website: <http://bit.ly/1pLvucM>

British Hypertension Society website: bhsoc.org/index.php?cID=247

Additional information on home blood pressure monitors

Association for the Advancement of Medical Instrumentation website: aami.org

European Society of Hypertension website: eshonline.org

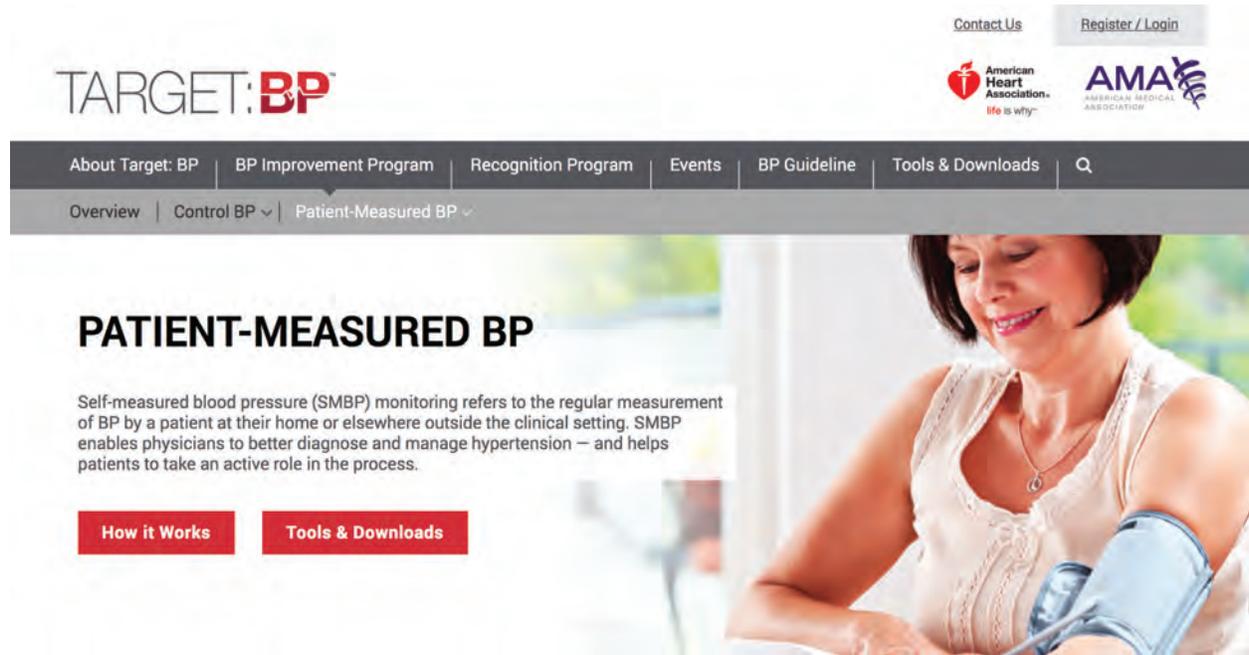
Article on wireless blood pressure cuffs and Smartphone applications: <http://bit.ly/1pLvFF4>

References

1. Centers for Disease Control and Prevention Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2013.
2. Pickering TG, Miller NH, Oggedge G, Krakoff LR, Artinian NT, Goff D. Call to action on use and reimbursement for home blood pressure monitoring: A Joint Scientific Statement from the American Heart Association, American Society of Hypertension, and Preventive Cardiovascular Nurses Association. *Hypertension*. 2008; 52:10-29.
3. Uhlig K, Balk EM, Patel K, Ip S, Kitsios GD, Obadan NO, et al. Self-Measured Blood Pressure Monitoring: Comparative Effectiveness. Comparative Effectiveness Review No. 45. (Prepared by the Tufts Evidence-based Practice Center under Contract No. HHS 290-2007-10055-1) AHRQ Publication No. 12-EHC002-EF. Rockville, MD: Agency for Healthcare Research and Quality, US Dept. of Health and Human Services; 2012. http://www.effectivehealthcare.ahrq.gov/ehc/products/193/293/CERA5_SMBP_20120131.pdf. Accessed July 9, 2014.
4. Nilranen TJ, Johansson JK, Reunanen A, Jula AM. Optimal Schedule for Home Blood Pressure Measurement Based on Prognostic Data: The Finn-Home Study. *Hypertension*. 2011; 57: 1081-1086. doi: 10.1161/HYPERTENSIONAHA.110.162123
5. Improving Health Outcomes: Blood Pressure. Murakami L, Astalas A, Boonyasai R, Wynia M, Rush C, Rakotz M. Fast Facts: Home Blood Pressure Monitoring. 1st ed. Daniel D and Prall M, eds. American Medical Association and the Johns Hopkins University School of Medicine; May 2014.

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



The screenshot shows the Target:BP website interface. At the top right, there are links for "Contact Us" and "Register / Login". Below these are logos for the American Heart Association (with the tagline "Life is why") and the American Medical Association (AMA). A navigation bar contains links for "About Target: BP", "BP Improvement Program", "Recognition Program", "Events", "BP Guideline", "Tools & Downloads", and a search icon. A secondary navigation bar shows "Overview", "Control BP", and "Patient-Measured BP". The main content area features the heading "PATIENT-MEASURED BP" and a descriptive paragraph: "Self-measured blood pressure (SMBP) monitoring refers to the regular measurement of BP by a patient at their home or elsewhere outside the clinical setting. SMBP enables physicians to better diagnose and manage hypertension – and helps patients to take an active role in the process." Below the text are two red buttons: "How it Works" and "Tools & Downloads". The background of the page shows a woman smiling while having her blood pressure measured with a cuff on her arm.

Million Hearts - How to Use Your Home Blood Pressure Monitor

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>



Blood Pressure Log Book

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



My Blood Pressure Log

Name- _____ **Date of Birth-** _____

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.



Date	AM	PM		Date	AM	PM

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 lowfat 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 Wallet Card



WISCONSIN COVERDELL STROKE PROGRAM
www.coverdellwi.org

Adapted from the U.S. Department of Health and Human Services NIH Publication No. 03-5068



WISCONSIN DEPARTMENT of HEALTH SERVICES
P-02102 (03/2018)

My Blood Pressure Diary

My Blood Pressure Goal:

/

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

Date/Time	Blood Pressure
	/
	/
	/
	/
	/
	/
	/
	/
	/
	/

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.

Upper Arm Devices for Self-measurement of Blood Pressure

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

[Printable version>>](#)

Device	Mode	AAMI	BHS	ESH 2002	ESH 2010	Circumstance	Recommendation ^{Ref}
--------	------	------	-----	-------------	-------------	--------------	-------------------------------

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

06

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

UCSF Center for Excellence in Primary Care Chronic Care Registry Information

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

Name	DOC SM	BP DATE	BP/s	BP/d	LDL Date	LDL	A1c DATE	A1c	DIABETIC	SMOKER	DATE ASKED IF SMOKES
Patient A	NO	3/5/2014	127	70	2/22/2013	135			NO	NO	12/15/2012
Patient B	YES	2/15/2014	110	55	1/2/2014	145	1/2/2014	11.3	YES	YES	7/25/2013
Patient C	NO	4/20/2014	158	87	4/12/2014	81	4/12/2014	6.7	YES	NO	6/28/2010
Patient D	YES	11/9/2013	148	95	10/30/2013	170	10/30/2013	8.9	YES	YES	4/2/2013
Patient E	NO	5/27/2014	129	72	5/17/2012	54	5/17/2014	9.6	YES	YES	6/28/2012
Patient F	NO	8/20/2013	155	88	8/20/2012	125			NO		
Patient G	YES	2/24/2012	149	85	3/16/2011	102			NO		3/16/2011
Patient H	NO	6/9/2014	147	90	5/19/2013	81	5/19/2013	12.1	YES	NO	8/15/2013
Patient I	NO	6/3/2013	120	64	1/3/2013	165			NO	NO	11/22/2004
Patient J	YES	10/13/2013	117	81	9/23/2013	112	9/13/2013	5.9	YES	YES	3/24/2013
Patient K	YES	12/10/2012	152	85	12/10/2012	157			NO		
Patient L	NO	5/14/2014	138	65	2/27/2014	111	12/3/2013	7.8	YES		
Patient M	NO	6/1/2014	119	71	3/2/2014	177			NO	NO	6/1/2014
Patient N	YES	1/4/2014	105	66	12/19/2014	108					
Patient O	NO	12/28/2013	132	67	11/8/2013	149	11/8/2013	14.3	YES	NO	12/28/2013
Patient P	YES	10/17/2013	114	87	9/27/2013	109	9/27/2013	10.1	YES	YES	1/25/2013

©2012, The Regents of the University of California. Created by UCSF Center for Excellence in Primary Care.

Self-Management and Lifestyle Training

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
 - α. **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
 - ι. Blood pressure measurements obtained using proper technique with manual and/or validated automated devices are acceptable, however automated devices are preferable
 - ιι. 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
 - α. **Height**: Yearly for adults
 - β. **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:
 - α. **Tobacco** history assessed for tobacco use and second-hand exposure at every visit
 - ι. Consider working with the Quit Line for further education and opportunities for improvement
 - β. **Medication** reconciliation at every clinic visit
 - ι. Ask patient if any refills needed and verify this request
 1. Pend medication renewal for provider
 - ιι. 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
 - χ. **Allergies** reviewed and documented at every clinic visit
 - δ. **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

- ι. 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

- ι. 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**

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

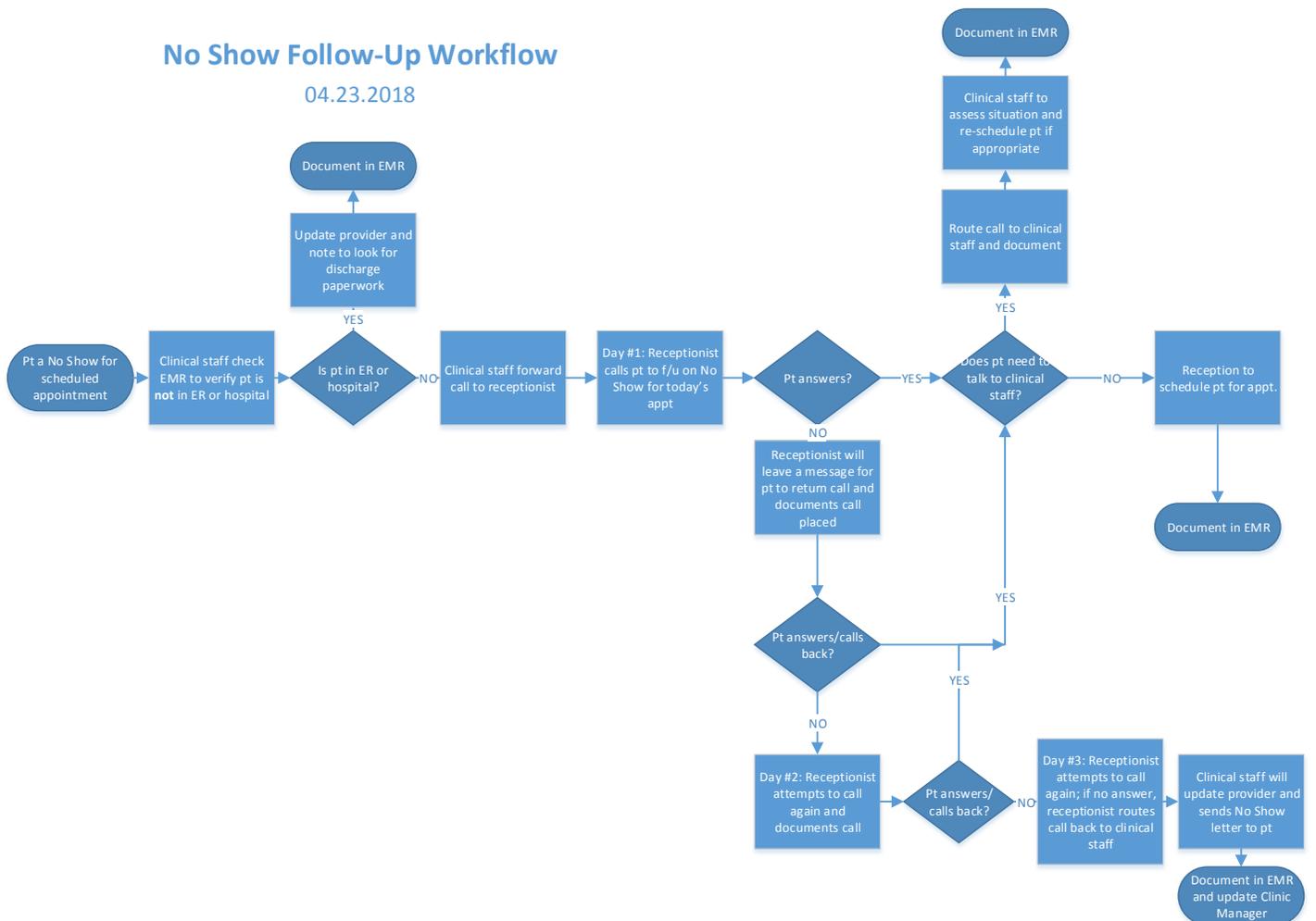
Diabetic Patients	
	Labs: Hgb A1c, CMP, creatinine, micro albumin, TSH, lipids NOTE: Organization may consider calling patient to come in and have labs drawn a few days prior to appointment so that lab results are available for the appointment
	Eye exam: annually—last appointment, where, results available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

Hypertension Patients	
	Labs: lipids, creatinine, potassium, BUN, fasting glucose 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
	Nutritionist
	Patient education material ready (smoking cessation, DASH diet, physical activity, etc.)
	Reminder phone call to bring in blood pressure log and cuff for calibration if needed

4/23/2018

No Show Follow-Up Workflow

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.

