



HealthierHere

The Accountable Community for Health of King County

Integration Workgroup: Chronic Disease Prevention & Control – Diabetes/CVD

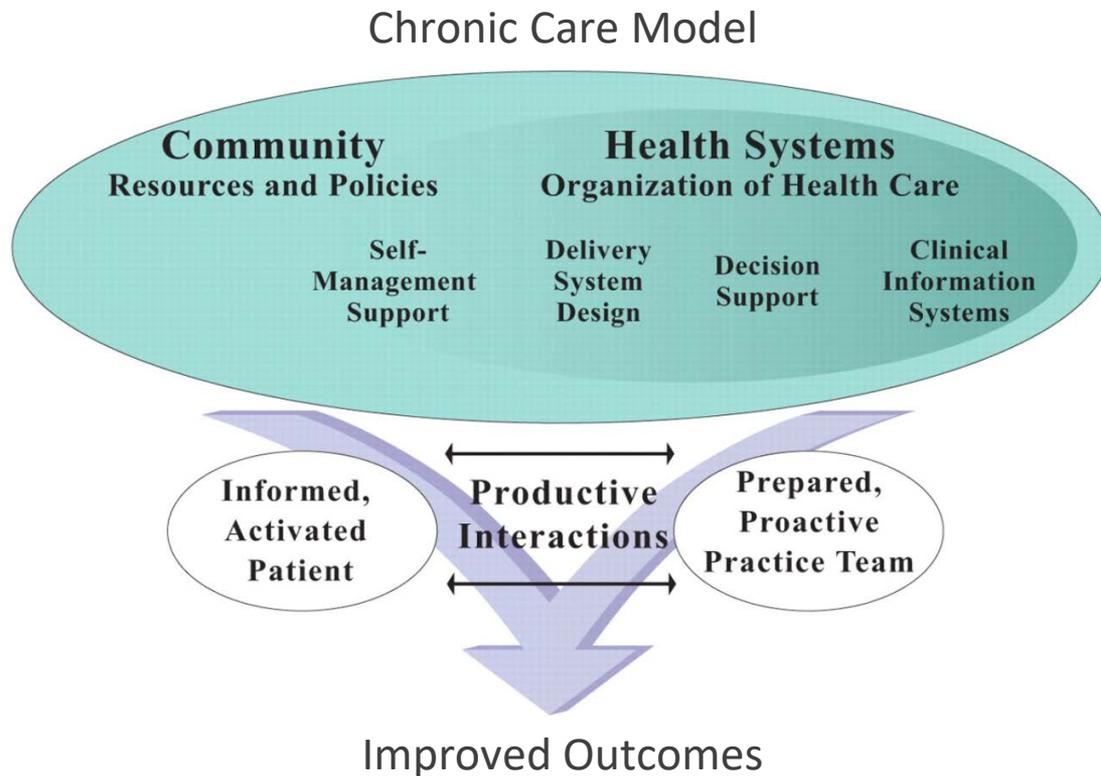
May 7, 2018





Evidence Based Approach: Chronic Care Model

The basic elements for improving care in health systems at the community, organization, practice, and patient levels.



Elements of the Chronic Care Model	
<u>Self-Management Support</u>	Empower and prepare patients to manage their health and health care.
<u>Delivery System Design</u>	Assure the delivery of effective, efficient clinical care and self-management support.
<u>Decision Support</u>	Promote clinical care that is consistent with scientific evidence and patient preferences.
<u>Clinical Information Systems</u>	Organize patient and population data to facilitate efficient and effective care (registries).
<u>Community-based Resources and Policy</u>	Activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care.
<u>Health Care Organization</u>	Create a culture, organization and mechanisms that promote safe, high quality care.



Chronic Disease Self-Management: Stanford CDSM

- Program Goal: Enable participants to build self-confidence to take part in maintaining their health and managing their chronic health conditions.
- CDSMP is a weekly 2.5 hour lay-led participant education program over six weeks for adults experiencing chronic health conditions such as hypertension, arthritis, heart disease, stroke, lung disease, and diabetes; their family members, friends and caregivers can also participate. The program provides information and teaches practical skills on managing chronic health problems. The CDSMP gives people the confidence and motivation they need to manage their challenges.
- Reasoning behind the program design and elements:
 - People with chronic conditions have similar concerns and problems;
 - People with chronic conditions must deal not only with their disease(s), but also with the impact on their lives and emotions;
 - Lay people with chronic conditions, when given a detailed leader's manual, can teach the CDSMP as effectively, if not more effectively, than health professionals (Lorig et al, 1999);
 - The process or the way the CDSMP is taught is as important, if not more important, than the subject matter that is taught.
- The CDSMP focuses on problems common to individuals suffering from chronic diseases. Coping strategies such as action planning and feedback, behavior modeling, problem-solving techniques, and decision making are applicable to all chronic diseases. Individuals are taught to control their symptoms through: Relaxation techniques; Healthy Eating; Managing sleep and fatigue; Manage Medications; Exercise; Communication with health providers.
- Desired Outcomes:
 - Increases in healthy behaviors (i.e., exercise and cognitive symptom management techniques, such as relaxation);
 - Positive changes in health status (less pain, fatigue, and worry; less health distress);
 - Increased self-efficacy;
 - Better communications with health providers;
 - Fewer visits to physicians and emergency rooms.

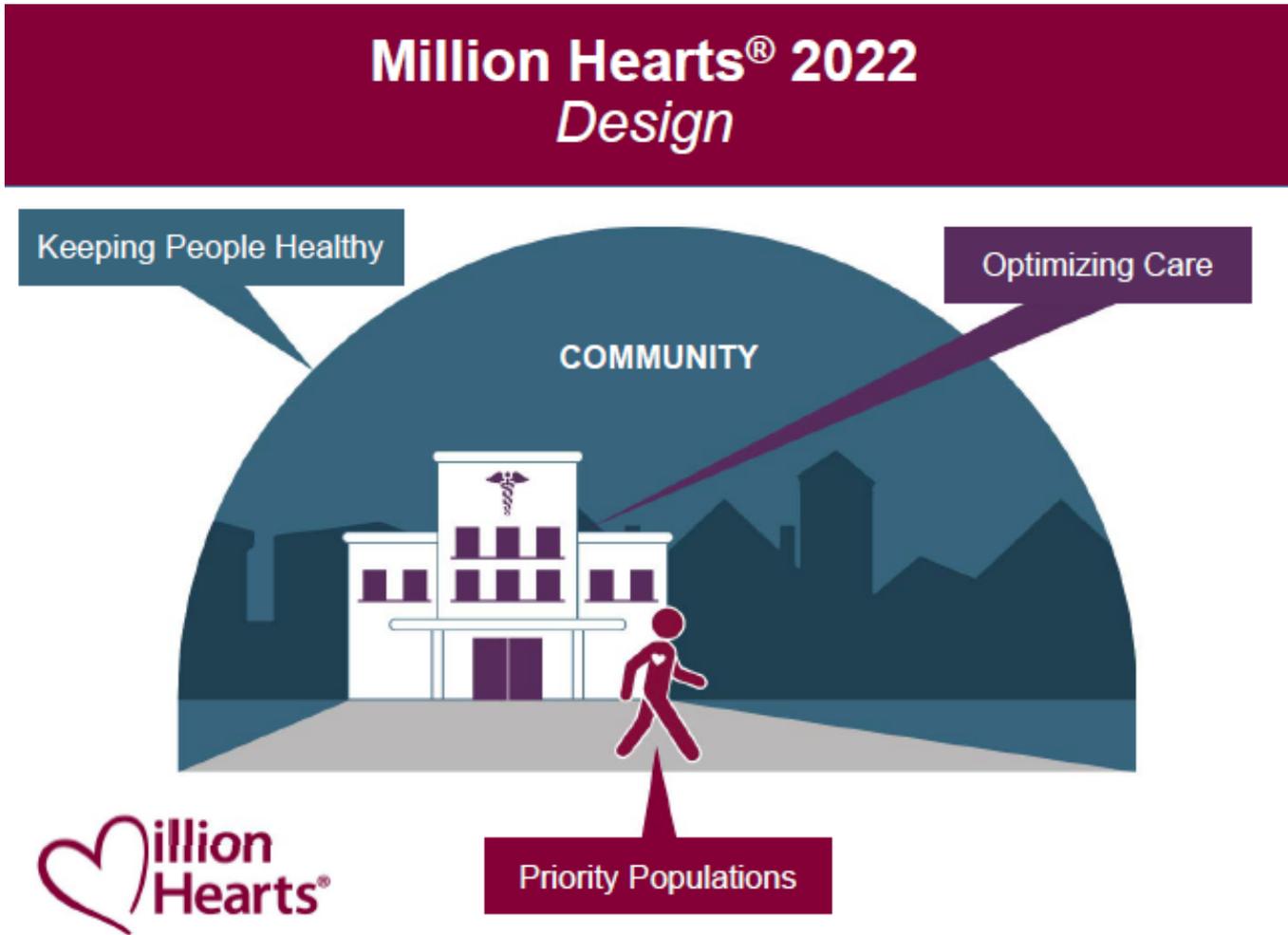


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Hypertension Control – Action Steps for Clinicians

Actions to Improve Delivery System Design	<ul style="list-style-type: none">• Implement a standardized hypertension treatment protocol: Support titration of hypertension medications by clinical team members via a physician-approved protocol.• Designate hypertension champions within your practice or organization.• Proactively track and contact patients whose blood pressure is uncontrolled using an electronic health record (EHR)-generated list, patient registry, or other data source.• Create a blood pressure measurement station where all patients can rest quietly for 5 minutes before measurement and that is designed to support proper measurement techniques (e.g., feet on floor, proper arm position, multiple cuff sizes conveniently located).• Have care team members review a patient’s record before the office visit to identify ways to improve blood pressure control.• Proactively provide ongoing support for patients with hypertension through office visits or other means of contact until blood pressure is controlled.• Implement systems to alert physicians about patterns of high blood pressure readings taken by support staff: Place a sign or magnet on the outside of the examination room; build clinical decision supports into the EHR.• Provide feedback to individual clinicians and clinic sites on their hypertension control rates. Provide incentives for high performance, and recognize high performers.• Provide blood pressure checks without a copayment or appointment. Train clerical personnel in proper blood pressure measurement technique so they are capable of obtaining drop-in blood pressure readings.• Encourage clinicians to take continuing education on hypertension management and care of resistant hypertension.
Actions to Improve Medication Adherence	<ul style="list-style-type: none">• Encourage patients to use medication reminders: Promote pill boxes, alarms, vibrating watches, and smartphone applications.• Provide all prescription instructions clearly in writing and verbally: limit instruction to 3–4 major points; use plain, culturally sensitive language; use written information or pamphlets and verbal education at all encounters.• Ensure patients understand their risks if they do not take medications as directed. Ask patients about these risks, and have patients restate the positive benefits of taking their medications.• Discuss with patients potential side effects of any medications when initially prescribed and at every office visit thereafter.• Provide rewards for medication adherence: praise adherence; arrange incentives, such as coupons, certificates, and reduced frequency of office visits.• Prescribe medications included in the patient’s insurance coverage formulary, when possible.• Prescribe once-daily regimens or fixed-dose combination pills.• Assign one staff person the responsibility of managing medication refill requests: create a refill protocol.• Implement frequent follow-ups (e.g., e-mail, phone calls, text messages) to ensure patients adhere to their medication regimen: Set up an automated telephone system for patient monitoring and counseling.
Actions to Optimize Patient Reminders and Supports	<ul style="list-style-type: none">• Provide patients who have hypertension with a written self-management plan at the end of each office visit: encourage or provide patient support groups; use all staff interactions with patients as opportunities to assist in self-management goal-setting and practices; print visit summaries and follow-up guidance for patients.• Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.• Contact patients to confirm upcoming appointments, and instruct them to bring medications, a medication list, and home blood pressure readings with them to the visit.• Send a postcard to or call patients who have not had their blood pressure checked recently. Invite them to drop in to have their blood pressure checked by a medical assistant, nurse, or other trained personnel without an appointment and at no charge.• Send patients text messages about taking medications, home blood pressure monitoring, or scheduled office visits.• Encourage patients to use smartphone or Web-based applications to track and share home blood pressure measurements.• Encourage home blood pressure monitoring plus clinical support using automated devices with a properly sized arm cuff: Advise patients on choosing the best device and cuff size; check patients’ home monitoring devices for accuracy; train patients on proper use of home blood pressure monitors.• Implement clinical support systems that incorporate regular transmission of patients’ home blood pressure readings and customized clinician feedback into patient care: train staff to administer specific clinical support interventions (e.g., telemonitoring, patient portals, counseling, Web sites); incorporate regular transmission of patient home blood pressure readings through patient portals, telemonitoring, log books, etc., to clinicians and EHR systems; provide regular customized support and advice (e.g., medication titration, lifestyle modifications) based on patient blood pressure readings.

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Million Hearts[®] 2022 *Priorities*

Keeping People Healthy

Reduce Sodium Intake

Decrease Tobacco Use

Increase Physical Activity

Optimizing Care

Improve ABCS*

Increase Use of Cardiac Rehab

Engage Patients in
Heart-healthy Behaviors

Improving Outcomes for Priority Populations

Blacks/African Americans

35- to 64-year-olds

People who have had a heart attack or stroke

People with mental illness or substance use disorders

*Aspirin when appropriate, Blood pressure control, Cholesterol management, Smoking cessation





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Optimizing Care

Goals	Effective Healthcare Strategies
Improve ABCS* 80% Targets	<i>High Performers Excel in the Use of.....</i> <ul style="list-style-type: none">• Technology – decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care• Teams – including pharmacists, nurses, community health workers, cardiac rehab professionals• Processes – treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use• Patient and Family Supports – training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab
Increase Use of Cardiac Rehab 70% Target	
Engage Patients in Heart-healthy Behaviors Targets TBD	



*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation



Cardiovascular Wellness & Self Management: EvidenceNOW - ABCS of Heart Health

Primary Prevention of Cardiovascular Disease – Action Steps for Clinicians

Aspirin Use by high-risk individuals	<p>Patients with heart disease or who have had a stroke in the past are at high risk for having a heart attack or another stroke. Substantial PCOR evidence shows that taking an aspirin every day can help these patients lower their risk. For patients with heart disease, including those who have angina or have been treated for blocked arteries, taking aspirin can prevent them from having a heart attack. For people who have already had a heart attack or stroke, aspirin use can prevent another heart attack or stroke.</p> <ul style="list-style-type: none">• Long-term low-dose aspirin therapy (75 to 100 mg daily) for patients with heart disease. For patients intolerant or allergic to aspirin, clopidogrel (75 mg daily) can be used as an alternative.
Blood pressure control	<p>High blood pressure is a major risk factor for heart attack, heart failure, stroke, and chronic kidney disease. Doctors and nurses should screen all adults for high blood pressure. Blood pressure categories in the 2017 American College of Cardiology/American Heart Association guideline are:</p> <p>Normal: Less than 120/80 mm Hg; Elevated: Systolic between 120-129 <i>and</i> diastolic less than 80; Stage 1: Systolic between 130-139 <i>or</i> diastolic between 80-89; Stage 2: Systolic at least 140 <i>or</i> diastolic at least 90 mm Hg; Hypertensive crisis: Systolic over 180 and/or diastolic over 120, with patients needing prompt changes in medication if there are no other indications of problems, or immediate hospitalization if there are signs of organ damage.</p> <ul style="list-style-type: none">• Lifestyle interventions (weight management, exercise, sodium restriction); minimum yearly BP checks• Pharmacotherapy may be started with lifestyle changes
Cholesterol management	<p>PCOR evidence supports a combined approach of promoting healthy lifestyle behaviors and use of statins as the main treatment for managing blood cholesterol and decreasing the risk of heart attack or stroke.</p> <ul style="list-style-type: none">• Prevention begins with a healthy lifestyle—following a heart-healthy diet, being physically active, avoiding tobacco, and maintaining a healthy weight.• Unless contraindicated or not tolerated, all patients at high risk should receive a high- or moderate-intensity statin.
Smoking cessation	<p>In 2015, the U.S. Preventive Services Task Force released evidence-based recommendations for behavioral and pharmacological interventions to help people quit smoking. The recommendations are based on a systematic review of literature on the effectiveness of these interventions (Siu, 2015).</p> <ul style="list-style-type: none">• PCOR evidence strongly supports the use of behavioral interventions alone or in combination with pharmacotherapy. All pregnant women who smoke should receive behavioral interventions.



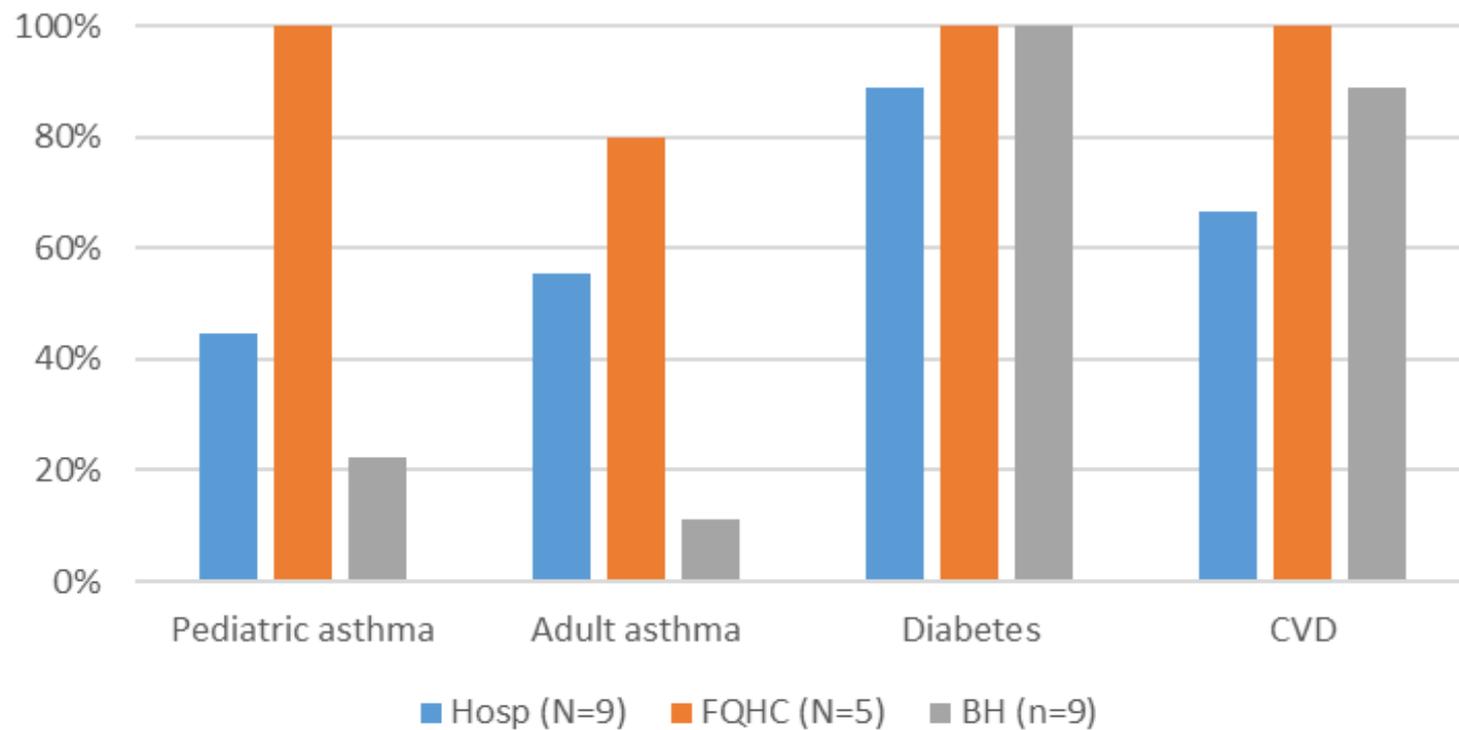
Diabetes Prevention Program (DPP)

- DPP works to make it easier for people with prediabetes to participate in affordable, high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.
- The CDC recognizes lifestyle change programs that meet certain standards and show they can achieve results. These standards include following an approved curriculum, facilitation by a trained lifestyle coach, and submitting data every 6 months to show that the program is having an impact. DPP Program Features:
 - Minimum of 22 in person sessions over the course of a year, some of which include: Get Active to Prevent T2, Track Your Activity, Eat Well to Prevent T2, Track Your Food, Get More Active, Burn More Calories than You Take In, Shop & Cook to Prevent T2, Manage Stress, Find Time for Fitness, Cope with Triggers, Keep Your Heart Healthy, Get Support, etc.
 - Participants track and report their activity and food daily
 - Weigh in at each session
- Research shows that “people with prediabetes who take part in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old)”. For those completing the program, even 10 years later, were one third less likely to develop type 2 diabetes.

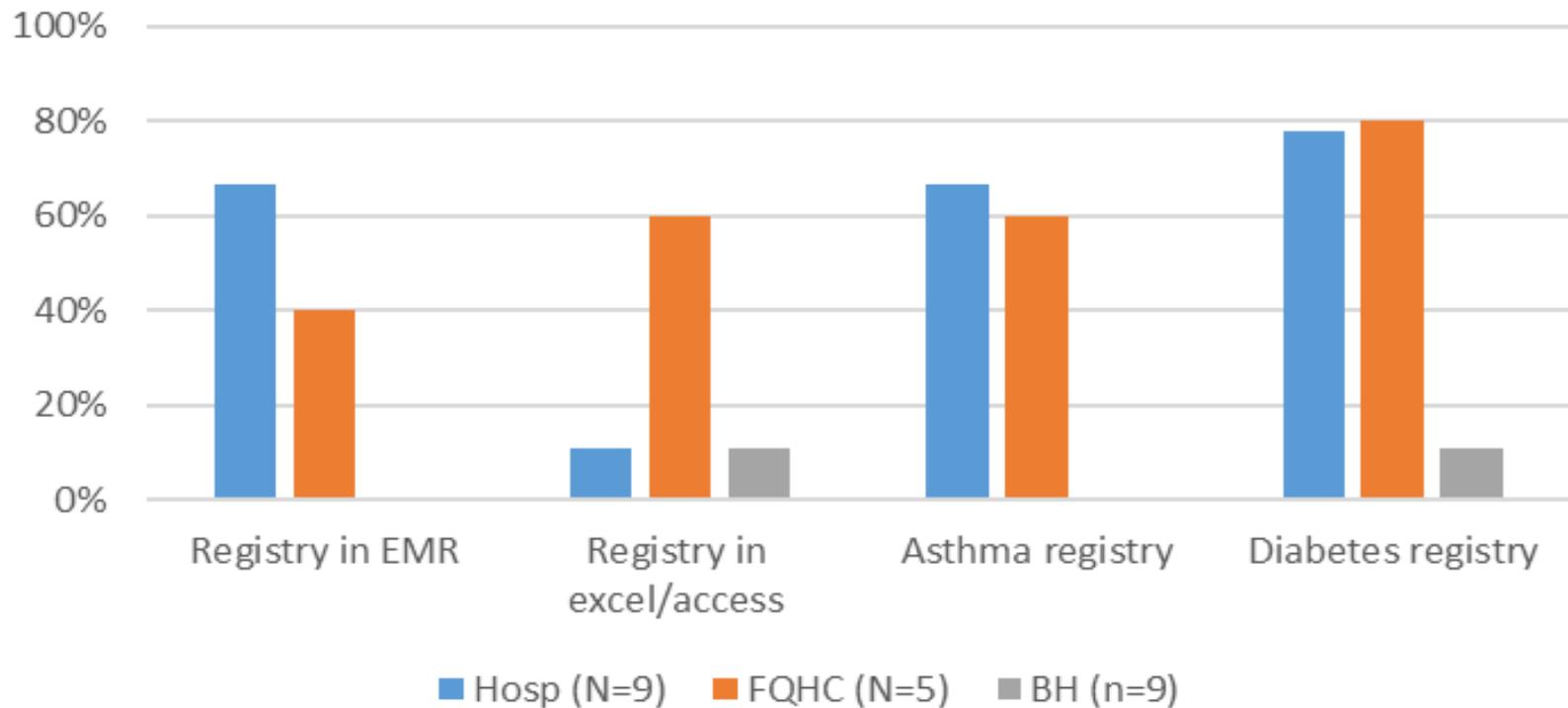
Chronic Disease Prevention: Project-specific Current State Assessment Results



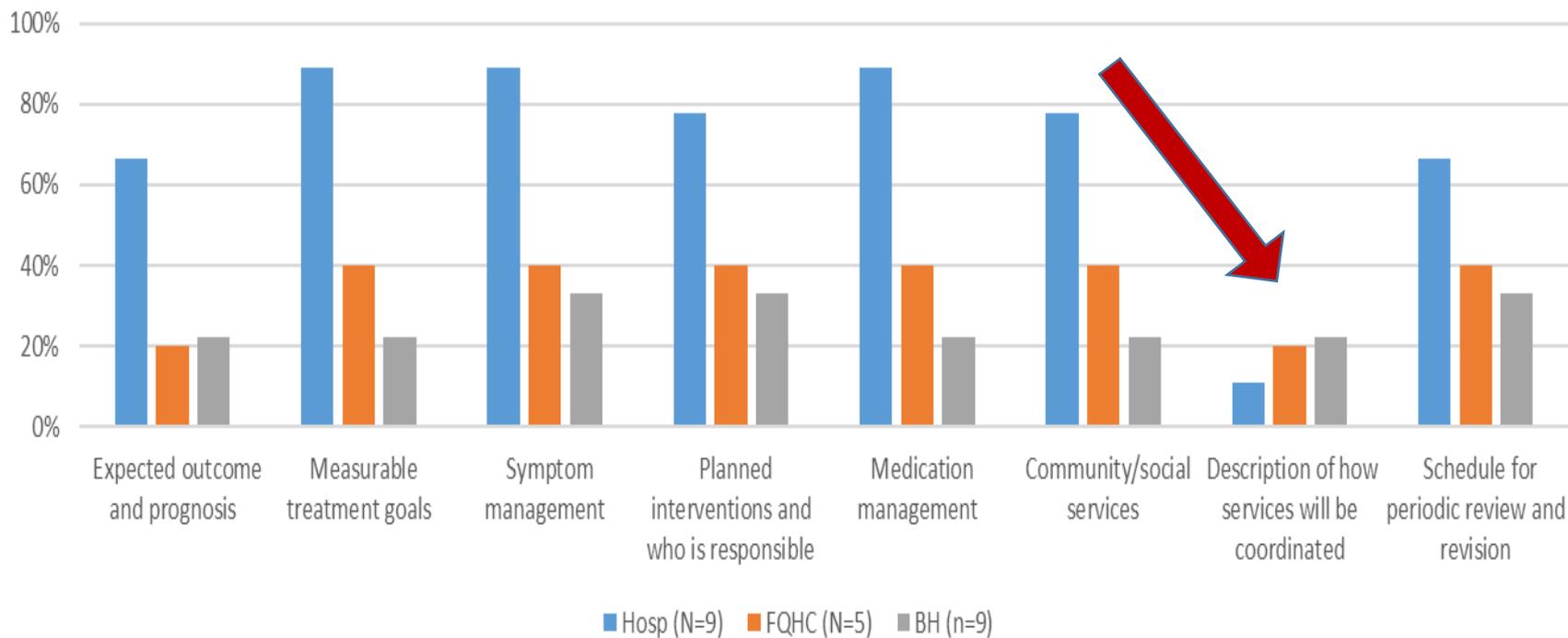
All settings have interest are Diabetes and CVD



BH agencies lag in use of registries



Care plan content: inconsistent - and coordination is a notable gap



Chronic disease care team composition varies

