REVISED CDC Health Systems Scorecard (HSSC) Assessment Tool version 2.0 (Replication of Electronic Version)[1]

The CDC Health Systems Scorecard (HSSC) v2.0

US Department of Health and Human Services

Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Division for Heart Disease and Stroke Prevention

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[1] This document is not intended to be used for data collection. It is for documentation purposes only.

CDC Health Systems Scorecard (HSSC) v2.0

Introduction

No standard approach exists to assess the policies and strategies that health systems use to provide primary care to U.S. adults with preventable risk factors including high blood pressure, high cholesterol, prediabetes or diabetes, obesity, chronic obstructive pulmonary disease (COPD), cancer, or who smoke. The result is a lack of comparable data to assess the impact of health care policies and strategies on health outcomes. State and local public health programs can use the HSSC v2.0 to identify which policies are in place in primary care health systems to identify possible gaps in their use of evidence-based strategies to manage chronic conditions.

Purpose

The purpose of this tool is to provide a standardized approach in the assessment of evidence-based policies and strategies that healthcare organizations use to care for adults with chronic conditions and behavioral health risk factors. This tool can be used regularly to identify areas of primary care practice that might need to be refreshed or enhanced. Health care organizations can use the HSSC v2.0 to identify areas for targeted quality improvement activities by utilizing the resources the tool suggests. Tailored quality improvement resources are provided with scorecard results.

Instructions for completing the HSSC v2.0

- The HSSC v2.0 is intended for use by small (0-44,999 patients) to medium (45,000-49,999 patients) sized health systems. CDC recommends that the person who completes the HSSC v2.0 be knowledgeable about the policies and protocols in place at the health system level to guide the prevention, management, and care services provided to adult patients with chronic conditions.

- Each of the eight modules of the HSSC v2.0 is devoted to a specific topic. Some module questions focus on specific chronic conditions (high blood pressure, high cholesterol, prediabetes or diabetes, obesity, or chronic obstructive pulmonary disease [COPD]). The user can select the condition(s) of interest and may complete each section in separate sittings and in any order. Scores are calculated per section and can also be tallied and combined for a total score. Completing the entire HSSC v2.0 will take about 30 minutes.

- Answer “Yes,” “No,” or “not applicable” (“N/A”) for each HSSC v2.0 item. All questions should be answered consistently according to the policies or protocols that are currently in place or were established within the last 12 months in the health system.

- For most questions, provide a response based on typical practices in the health system for managing patients who have one or more of the following chronic conditions and who are stable or relatively stable with a treatment regimen: high blood pressure, high cholesterol, prediabetes or diabetes, obesity, or COPD. Questions about tobacco use cessation and cancer screening for eligible patients are also included.

- Navigate between modules by pressing the “Next” and “Previous” buttons at the bottom of each page. Answers will be saved between modules when using these buttons.

- Glossary terms are **bolded** throughout the HSSC v2.0. Click on the word to go to the Glossary for a more complete definition. At the top of each module, a Citations link will take the user to a list of all evidence used to develop the HSSC v2.0. All the Glossary and Citations links will open in new windows.

- The account holder (partner health department) can provide a username and password to the user (health system). Or the user can create a new username and password, if the account holder’s settings allow. If new login information is created, we recommend that the user contact their partnering health department so they may associate that username to the user’s Scorecard responses. Using the assigned, or a new, username and password will enable the user to save a partially completed Scorecard and return to it later to complete it. However, once the assessment is completed and closed, user responses to the HSSC v2.0 can only be accessed by the account holder. Please contact the partner state or local health department for assessment results if your health system needs to change any responses or would like access to the results after you have completed and closed the Scorecard.

- Upon completion of the HSSC v2.0, users will receive a customized report of suggested resources to refer to for more information for quality improvement. This report is unique to each user and is automatically generated based on the responses provided and scoring. The user should print or save the score report for their records. Users can contact their health department for their results and can access a complete list of resources on the CDC website.

Health System Information and Module Selection

Please provide the following information for your health system. Questions with asterisks (*) are required.

Please enter the name of your health system:*

Please enter the contact information of your health system's Point of Contact.*

First Name* Last Name*

Street Address*

Address Line 2

City* State*

Zip Code* Phone Number*

Email Address*

Please indicate your health system type (check all that apply):*

- ☐ Metropolitan/Urban Hospital
- ☐ Critical Access Hospital
- ☐ Small/Rural Hospital
- ☐ VA Hospital/Clinic
- ☐ Community Health Center (or similar)
- ☐ Federally Qualified Health Center
- ☐ Rural Health Center
- ☐ Provider Group/Practice
- ☐ Accountable Care Organization (ACO)
- ☐ Independent Physician Association (IPA)
- ☐ Health Maintenance Organization (HMO)
- ☐ Health Center Controlled Network (HCCN)
- ☐ Health Plan (private, public, or other)
- ☐ Multispecialty (psychology, OB/GYN, etc.)
- ☐ Individual primary clinic
- ☐ State or local government responsible for providing clinical care
- ☐ Other (please specify):

Please enter an approximate count of how many sites or clinics are a part of your health system:*

Please enter an approximate count of unique adult patients (18-85 years old) served by your health system for outpatient services (in the last calendar year):*

Please enter the name of the Electronic Health Record (EHR) system(s) that are currently in use (please list all):

What certification/recognition programs, quality measurement reporting, standards, and/or tools does your organization currently use? Please list all that apply for the following health conditions:

Refer to Glossary: General Terms for a list of common national programs.

1. High Blood Pressure:
2. High Cholesterol:
3. Prediabetes or Diabetes:
4. Obesity:
5. **Chronic obstructive pulmonary disease (COPD)**:
6. Tobacco Use and Dependence:
7. Cancer (Breast, Cervical, and/or Colorectal):

Which modules would you like to complete?

A. Multidisciplinary Team for the Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD
B. Clinical Guidelines for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD

   This module is disease-specific. Which of the following diseases would you like to score?
   - ☐ High Blood Pressure
   - ☐ High Cholesterol
   - ☐ Prediabetes or Diabetes
   - ☐ Obesity
   - ☐ COPD

C. Electronic Health Record (EHR) and Patient Tracking Systems for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD
D. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD

This module is disease-specific. Which of the following diseases would you like to score?

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Prediabetes or Diabetes
- ☐ Obesity
- ☐ COPD

E. Patient Education for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD

This module is disease-specific. Which of the following diseases would you like to score?

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Prediabetes or Diabetes
- ☐ Obesity
- ☐ COPD

F. Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD

G. Tobacco Use and Dependence Cessation

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

This module is disease-specific. Which of the following diseases would you like to score?

- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colorectal Cancer

A. Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD				
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**N/A**	**Score**
1. Use a **multidisciplinary team** to manage the care of patients? *If "Yes," continue to question A2.* *If "No," skip to question A4.*	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
2. Have a multidisciplinary team that includes at least a nurse or pharmacist in addition to the patient and their primary care provider? *Continue to A3.*	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
3. Have a multidisciplinary team approach that communicates regularly and coordinates patient care through team "huddles" or regularly scheduled meetings to discuss patient care, use of EHRs to promote communication between team members, etc.? *Continue to A6.*	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
4. Refer patients to a specialized clinic or center to primarily manage patient's care (e.g., a hypertension clinic or endocrinology clinic)? *If "Yes," skip to question A6.* *If "No," continue to question A5.*	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
5. Use the patient's primary care provider (physician, nurse practitioner, or physician assistant) to primarily manage the patient's care? *You have completed Module A.*	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
6. Have a **Collaborative Practice Agreement** (CPA) in place that incorporates pharmacists or **community health workers**? *Continue to A7.*	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
7. Have pharmacists provide **Collaborative Drug Therapy Management** (CDTM) or **Medication Therapy Management** (MTM)? *You have completed Module A.*	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
Your Health System's Multidisciplinary Team Score:				
Maximum Multidisciplinary Team Score:				

Note: This module includes a subset of unscored informational questions that were identified as helpful for health systems seeking to make healthcare improvements. These unscored items do not need to be completed for a module score to be generated.

The following question is for informational purposes only.		
8. If yes to A1, please indicate who else, in addition to the previously identified team members, is included on the multidisciplinary team:	**Yes**	**No**
Nurse Practitioner	☐	☐
Physician Assistant	☐	☐
Medical Assistant	☐	☐
Dietitian/Nutritionist	☐	☐
Community Health Worker	☐	☐
Social Worker	☐	☐
Health Educator/Nurse Educator	☐	☐
Other (please specify):_____	☐	☐

B. Clinical Guidelines for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Follow **evidence-based clinical guidelines** released by national organizations (e.g., National Heart, Lung, and Blood Institute; American Diabetes Association; American Association of Clinical Endocrinologists; American Heart Association; American College of Cardiology; National Diabetes Prevention Program)? *Continue to B2.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
2. Have all primary care providers follow the same evidence-based clinical guidelines to diagnose and treat adult patients with a specific condition? *Continue to B3.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		Yes	No	N/A	Score
3. Conduct **data-driven quality improvement initiatives** to improve provider adherence to clinical guidelines (e.g., the **Plan-Do-Study-Act model**)? *You have completed Module B.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
Your Health System's Clinical Guidelines Score:					
Maximum Clinical Guidelines Score:					

Note: This module includes a subset of unscored informational questions that were identified as helpful for health systems seeking to make healthcare improvements. These unscored items do not need to be completed for a module score to be generated.

The following question is for informational purposes only. *Checking the box indicates "yes" to the question.*

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	*High Blood Pressure*	*High Cholesterol*	*Diabetes*	*Obesity*	*COPD*
4. Follow evidence-based clinical guidelines issued by your health system for each specified medical condition? *Note: Please report health system–specific guidelines not captured by the first question in Module B.*	☐	☐	☐	☐	☐

C. Electronic Health Record (EHR) and Patient Tracking Systems

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	Yes	No	N/A	Score
1. Use an **EHR system** to manage and inform patient care? *If "Yes," continue to question C2.* *If "No," answer questions only in the B Path.*	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
2. Have an EHR system that qualifies for the **Promoting Interoperability Program**? *Continue to answer questions in the A Path.*	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

A Path					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
3. Use the EHR system to transmit health data to <u>all</u> providers in the system? *Continue to C4a.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
4. Use <u>provider prompts</u> to order tests and imaging studies, notify when patient is due for screening, or notify when patient's condition is not controlled? *Continue to C5a.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
5. Use <u>patient prompts</u> to notify patients with selected medical conditions who are overdue for office visits or to order tests and imaging studies? (These prompts can be external but linked to the EHR, such as a patient portal.) *Continue to C6a.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
6. Track key measures for the selected medical condition (e.g., blood pressure, lipid levels, A1c), abnormal test or imaging results, referrals to specialists, or provider dashboards with appropriate goals and metrics? *Continue to C7a.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
7. Use the EHR system to identify patients without a diagnosis of…?	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
Continue to C8a.					
8. Use the EHR system to report standardized clinical quality measures for the management and treatment of patients with…?	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
Continue to C9a.					
9. Use the EHR system and standardized clinical quality measures to track differences in **priority populations** compared to overall populations?	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
Continue to C10a.					
10. Generate and transmit prescription orders? *Continue to C11a.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
11. Generate and transmit consultation requests? *Continue to C12a.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
12. View electronic results of lab/pathology reports or screening and diagnostic imaging results? *You have completed Module C.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

B Path				
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**N/A**	**Score**
3. Regularly use a **patient tracking system** (e.g., a report or registry) to track management for patient populations (e.g., daily, weekly, or monthly)?	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
Your Health System's Electronic Health Record and Patient Tracking Score:				
Maximum Electronic Health Record and Patient Tracking Score:				

D. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD					
During the past 12 months, have the practices in your health system systematically used the following clinical decision supports and protocols?		**Yes**	**No**	**N/A**	**Score**
1. Cut-off points when making diagnostic or screening decisions? *Continue to D2.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
2. Functionality of recommending, ordering, or viewing laboratory test(s) and results? *Continue to D3.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
3. Recommendations for lifestyle modifications (i.e., diet and physical activity)? *Continue to D4.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, have the practices in your health system systematically used the following clinical decision supports and protocols?		**Yes**	**No**	**N/A**	**Score**
4. Evidence-based **cardiovascular disease (CVD) risk calculator**? *Continue to D5.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
5. Drug management protocol (e.g., prescribing first-line medications to initiate treatment, drug-dosing [titration] support, or second-line medication if the condition is not controlled)? *Continue to D6.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
6. Specified follow-up time period, including follow-up with primary care providers or other members of the health treatment team? *Continue to D7.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
7. Documentation in paper charts or electronic charts of positive or negative change in condition at follow-up? *Continue to D8.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
8. Flags in patients' paper charts or electronic prompts when a patient's medical condition is uncontrolled? *Continue to D9.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
9. Flags in patients' paper charts or electronic prompts for determining when tests should be done? *Continue to D10.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, have the practices in your health system systematically used the following clinical decision supports and protocols?		**Yes**	**No**	**N/A**	**Score**
10. Flags in patients' paper charts or electronic prompts for <u>medication adjustment</u>? *Continue to D11.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
11. Flags in patients' paper charts or electronic prompts for <u>tobacco cessation</u>? *You have completed Module D.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
Your Health System's Clinical Decision Support and Protocols Score:					
Maximum Clinical Decision Support and Protocols Score:					

E. Patient Education for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Educate patients via <u>telephone or e-mail or in group classes</u> on-site (e.g., for disease management)? *Indicate "Yes" for those disease states in which education is offered using active interaction (as opposed to education that is limited to printed and online material).* *Continue to E2.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
2. Provide any educational <u>materials</u> to the patient such as printed materials, DVDs/videos, self-study programs, or referrals to community organizations or websites? *Continue to E3.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
3. Teach patients problem-solving skills? *Include what to do to maintain compliance with medications and lifestyle, especially during special circumstances like traveling or celebrations.* *Continue to E4.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
4. Communicate and provide specific goals regarding management of their medical condition orally during the visit, written down on a piece of paper, or by other reporting method for patient? *This may be orally during a visit, written on paper, or online through a patient portal.* *Continue to E5.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
5. Employ evidence-based methods to increase patient **self-efficacy** and encourage them to feel in control of their condition(s)? *Include methods such as motivational interviewing, use of reminder techniques, and encouraging use of social support networks.* *You have completed Module E.*	a. High Blood Pressure	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(3 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
				Your Health System's Patient Education Score:	
				Maximum Patient Education Score:	

F. Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Prediabetes, Diabetes, Obesity, or COPD					
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Use any staff to work jointly with patients to develop their **self-management goals**? *For High Blood Pressure, if "Yes," continue to F2_HBP1.* *For High Blood Pressure, if "No," skip to F2.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
2_HBP1. Encourage **self-measured blood pressure monitoring** (SMBP) with clinical support for patients? *If "Yes," continue to F2_HBP2.* *If "No," skip to F2.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
2_HBP2. Document or receive electronic transmission of self-measured (i.e., home) blood pressure readings in the EHR? *Continue to F2_HBP3.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
2_HBP3. Provide blood pressure cuffs through a **loaner program**? *Continue to F2.*		☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
2. Assess patient progress in meeting health goals? *Include the review of logs from self-testing, weight control tracking, food diary, or physical activity diary.* *Continue to F3.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
3. Record patients' self-measured clinical values (e.g., blood pressure, glucose levels, weight, smoking diary, and food diary) and provide clinical staff advice, medication changes, or lifestyle modifications back to patients? *Continue to F4.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
4. Record patients' self-measured clinical values (e.g., blood pressure, glucose levels, weight, smoking diary, food diary) and communicate those values to clinical staff? *Continue to F5.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
5. Refer patients to a professional for specialized care (e.g., to pharmacists for consultation or **Medication Therapy Management** (MTM), nurses, registered dietitians, certified diabetes educators, or tobacco cessation quitline)? *Continue to F6.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
6. Refer patients to **evidence-based lifestyle change** and disease self-management programs (e.g., National Diabetes Prevention Program, Weight Watchers®, TOPS)? *If "Yes," continue to F7.* *If "No," skip to F8.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
7. Receive information back from referred evidence-based lifestyle change programs (e.g., report on attendance, participation or participant outcomes)? *Continue to F9.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
8. Have lifestyle referral information integrated with the EHR? *Continue to F9.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	e. COPD	☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
9. Provide follow-up care? *Include follow-up by community health workers (CHWs), patient navigators or coaches, or other **health care extenders** and review of logs from self-testing, weight control, food diary, or physical activity diary.* *Continue to F10.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
10. Provide non-clinician case management? *Include case management provided by nurses, as well as by CHWs or patient navigators with nurse oversight.* *Continue to F11.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
11. Refer patients to social support groups of others with the same medical condition? *Continue to F12.*	a. High Blood Pressure	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. High Cholesterol	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Prediabetes or Diabetes	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Obesity	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
12. Determine the patient's cognitive ability/capacity to engage in self-care or management? *Continue to F13.*		☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
13. Determine the availability of a caregiver to assist with self-care or management? *For High Blood Pressure and High Cholesterol, continue to F16.* *For all other conditions, you have completed Module F.*		☐ *(1 point)*	☐ *(0 points)*	☐ *(0 points)*	
Your Health System's Self-Management and Care Management Score:					
Maximum Self-Management and Care Management Score:					

Note: This module includes a subset of unscored informational questions that were identified as helpful for health systems seeking to make healthcare improvements. These unscored items do not need to be completed for a module score to be generated.

The following questions are for informational purposes only. *Checking the box indicates "yes" to the question.*

14. If "Yes" to F2_HBP1, please indicate who is referred for the self-measured blood pressure monitoring program. Please check all that apply.	**Yes**	**No**
Patients with diagnosed hypertension who have uncontrolled blood pressure	☐	☐
Patients without diagnosed hypertension who have elevated blood pressure	☐	☐
Patients changing blood pressure medication	☐	☐
Other, please describe:	☐	☐

15. If "Yes" to F6, to which evidence-based lifestyle change and disease self-management programs do you refer patients? Please check all that apply.	**Yes**	**No**
National Diabetes Prevention Program (DPP)	☐	☐
Diabetes Self-Management Education and Support (DSMES)	☐	☐
Weight Watchers®	☐	☐
Taking Off Pounds Sensibly (TOPS)	☐	☐
YMCA's Blood Pressure Self-Monitoring Program (BPSM)	☐	☐
Heart Health Ambassador BPSM (modeled after the Y's program)	☐	☐
Supplemental Nutrition and Assistance Program and Education (SNAP-ED)	☐	☐
Expanded Food and Nutrition Education Program (EFNEP)	☐	☐
Curves Complete	☐	☐
Other	☐	☐

Cardiac Rehabilitation Services

The following questions are for informational purposes only. *Checking the box indicates "yes" to the question.*			
During the past 12 months, did your health system…?	**Yes**	**No**	**N/A**
16. Incorporate referral to **cardiac rehabilitation services** into standardized processes of care for eligible patients? *Continue to F17.*	☐	☐	☐
17. Automate referrals to cardiac rehabilitation services for all eligible patients? *Continue to F18.*	☐	☐	☐
18. Use a **liaison** to help educate, refer, schedule, and enroll eligible patients in cardiac rehabilitation services? *For High Blood Pressure and High Cholesterol, you have completed Module F.*	☐	☐	☐

G. Tobacco Use and Dependence Cessation			
During the past 12 months, did your health system have a policy/protocol in place that required your primary care providers and staff to routinely implement the following clinical guidelines on tobacco use and dependence?	**Yes**	**No**	**Score**
1. Ask every patient about tobacco use at every visit. *Continue to G2.*	☐ *(3 points)*	☐ *(0 points)*	
2. Advise every patient who uses tobacco to quit at every visit. *Continue to G3.*	☐ *(3 points)*	☐ *(0 points)*	
3. Assess patients' current willingness to quit at every visit. *Continue to G4.*	☐ *(3 points)*	☐ *(0 points)*	
4. Assist patients making a quit attempt by providing evidence-based **tobacco cessation counseling**. *Continue to G5.*	☐ *(3 points)*	☐ *(0 points)*	
5. Assist patients making a quit attempt by offering FDA-approved **tobacco cessation medication**. *Continue to G6.*	☐ *(3 points)*	☐ *(0 points)*	
6. Arrange follow-up with patients to provide ongoing support, either in person or by phone. *Continue to G7.*	☐ *(3 points)*	☐ *(0 points)*	

During the past 12 months, did your health system have a policy/protocol in place that required your primary care providers and staff to routinely implement the following clinical guidelines on tobacco use and dependence?	**Yes**	**No**	**Score**
7. Refer patients to additional cessation supports, including tobacco quit lines (1-800-QUIT-NOW), websites (smokefree.gov), state- and community-based quit programs, or a tobacco treatment specialist. *Continue to G8.*	☐ *(3 points)*	☐ *(0 points)*	
8. Does your health system have a policy in place that requires all facilities be 100% tobacco free (including e-cigarettes), in both indoor and outdoor locations? *You have completed Module G.*	☐ *(3 points)*	☐ *(0 points)*	
Your Health System's Tobacco Use and Dependence Cessation Score:			
Maximum Tobacco Use and Dependence Cessation Score:			

H. Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients					
During the past 12 months, in order to increase the proportion of eligible patients screened for certain cancers, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
1. Make available small media products (e.g., videos/DVDs, letters, brochures, pamphlets, flyers, newsletters) to patients? *Continue to H2.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. Cervical Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Colorectal Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
2. Provide one-on-one education (e.g., phone or in-person education) about cancer screening, delivered by health care providers or staff or by lay persons? *Continue to H3.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. Cervical Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Colorectal Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
3. Provide group education (education about cancer and cancer screening delivered to 2 or more patients by health care providers or staff or by lay persons)? *Continue to H4.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

During the past 12 months, in order to increase the proportion of eligible patients screened for certain cancers, did your health system have a policy/protocol in place that required your practices to…?		**Yes**	**No**	**N/A**	**Score**
4. Provide client reminders (e.g., messages advising people that they are due or overdue for screening; may include letter/postcard, phone call, e-mail, text, or other reminder)? *Continue to H5.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. Cervical Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Colorectal Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
5. Reduce structural barriers (noneconomic obstacles that impede access to screening)? Examples include: (1) Modified hours of service when patients can receive screening (e.g., evening or weekend hours). (2) Screening offered in alternative or nonclinical settings (e.g., mobile mammography vans at worksites or providing screening in residential communities). (3) Simplified administrative procedures, scheduling, or other obstacles. *Continue to H6.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. Colorectal Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
6. Reduce patient out-of-pocket costs for screening? *Continue to H7.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
7. Assess provider delivery of or referral for screening and offer feedback (e.g., evaluate provider or practice performance in screening patients and report back about their performance)? *Continue to H8.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. Cervical Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Colorectal Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
8. Use reminder systems to notify providers when a patient is due or overdue for screenings (e.g., chart checklists/flow sheets, prompts such as stickers, flags, or other manual or electronic notices to providers)? *For Breast and Cervical Cancer, you have completed Module H.* *For Colorectal Cancer, continue to H9.*	a. Breast Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	b. Cervical Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	c. Colorectal Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
	d. Endoscopic Colorectal Cancer Screening	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	

For Colorectal Cancer				
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**N/A**	**Score**
9. Offer both stool blood testing and colonoscopy as options for **colorectal cancer screening**? *Continue to H10.*	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
10. Monitor provider recommendations for colorectal cancer screening intervals for consistency with published guidelines, taking into account personal and family history; AND/OR colorectal cancer or adenoma surveillance intervals for consistency with published guidelines? *Continue to H11.*	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
11. (For primary care practices) Refer only to endoscopists who provide high-quality exams as judged by quality indicators such as their adenoma detection rates, cecal intubation rates, and percentage of exams with adequate bowel preparation quality? *Continue to H12.*	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
12. (For endoscopy practices) Require that endoscopists report their colonoscopy performance on quality indicators such as their adenoma detection rates, cecal intubation rates, and percentage of exams with adequate bowel preparation quality? *For Colorectal Cancer, you have completed Module H.*	☐ *(2 points)*	☐ *(0 points)*	☐ *(0 points)*	
Your Health System's Guidelines for Screening of Cancers Score:				
Maximum Guidelines for Screening of Cancers Score:				

Note: This module includes a subset of unscored informational questions that were identified as helpful for health systems seeking to make healthcare improvements. These unscored items do not need to be completed for a module score to be generated.

The following question is for informational purposes only.			
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**N/A**
13. Collect and report any measures related to cancer screening to systems or entities such as the **Uniform Data System** (UDS) or the **Centers for Medicare & Medicaid Services** or cancer registries?	☐	☐	☐

All Selected Modules Have Been Completed

You have completed all selected modules of the HSSC v2.0. If you would like to complete additional modules, please use the “Previous” button below to navigate back to the Information and Module Selection page to select additional modules. If you have finished all the modules you would like to complete at this time, hit the “Next” button to view your HSSC v2.0 Score Report.

Appendix A: HSSC v2.0 Glossary

CDC Health Systems Scorecard (HSSC) v2.0 Glossary

The glossary provides definitions of terms used in some of the HSSC v2.0 modules. Evidence is based on literature published through June 2020.

General Terms

Term	Definition	Source/Resources
Chronic Obstructive Pulmonary Disease (COPD)	A group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis. COPD makes breathing difficult for the 16 million Americans who have this disease.	
Common national certification/recognition programs, quality measurement reporting, standards, and/or tools (this is not an exhaustive list)	• Accountable Care Organization (ACO) • American Medical Group Foundation Measure Up Pressure Down participant • CMS Million Hearts Risk Reduction Model • Community Health Center (or similar) • Comprehensive Primary Care Plus (CPC+) practice • Critical Access Hospital • Evidence NOW participant • Federally Qualified Health Center (FQHC) • Health Center Controlled Network (HCCN) • Health Department Lead QI initiative participant • Health Maintenance Organization (HMO) • Health Plan (private, public, or other) • Independent Physician Association (IPA)	

Term	Definition	Source/Resources
Common national certification/recognition programs, quality measurement reporting, standards, and/or tools (this is not an exhaustive list), continued	• Indian Health Service (IHS) provider • Individual primary clinic • Metropolitan/Urban Hospital • Medicare Shared Savings Program • Pioneer Accountable Care Organization (ACO) • Federally Qualified Health Center (FQHC) provider • CMS Million Hearts Risk Reduction Model • Transforming Clinical Practice Initiative participant (TCPI) • Quality Improvement Organization-Quality Innovation Network (QIO-QIN) participant • WISEWOMAN program participant Target: BP	
Health system	Health system refers to health care delivery organizations and may include health maintenance organizations (HMOs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and other clinical groups operating within the state.	

For more definitions of general terms used in the HSSC v2.0, see the CDC publication *Everyday Words for Public Health Communication*.

Module A: Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Term	Definition	Source/Resources
Collaborative Drug Therapy Management (CDTM)	A collaborative practice agreement between one or more physicians and pharmacists wherein qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments; ordering drug therapy-related laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens.	Collaborative Drug Therapy Management By Pharmacists, 2003
Collaborative Practice Agreement (CPA) (other related terms are Collaborative Care Agreement, Coordinated Care Agreement, Physician-Pharmacist Agreement, Collaborative Drug Therapy Management, Delegation of Authority by Physician, Physician Delegation, or Consult Agreement)	A formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patients to other providers under a protocol that allows the other providers to perform specific patient care functions.	Collaborative Practice Agreements and Pharmacists' Patient Care Services

Term	Definition	Source/Resources
Community health worker (CHW)	Community health workers (CHWs) provide health education, referral and follow-up, case management, and basic preventive health care and home visiting services to specific communities. Please note that a CHW may also be referred to as a lay health worker, *promotor*, *promotora*, community health advocate, lay health educator, community health representative, peer health promoter, community health advisor, patient navigator, lay health advisor, neighborhood health advisor, community care coordinator, community health educator, community health promoter, case work aide, community connector, community health outreach worker, family support worker, outreach specialist, peer educator, peer support worker, AND/OR public health aide.	CDC Community Health Worker Toolkit
Medication Therapy Management (MTM)	A distinct service or group of services that optimize therapeutic outcomes for individual patients; it represents one type of pharmacists' patient care services. The five core elements of the MTM service model include: 1. Medication therapy review (MTR). 2. Personal medication record (PMR). 3. Medication-related action plan (MAP). 4. Intervention and/or referral. 5. Documentation and follow-up.	Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model (Version 2.0)

Term	Definition	Source/Resources
Multidisciplinary team	A multidisciplinary team (MDT) includes the patient, the patient's primary care provider, and other professionals such as nurses, pharmacists, dietitians, social workers, and community health workers. Team members provide process support and share responsibilities of care to complement the activities of the primary care provider. Responsibilities include medication management, patient follow-up, and adherence and self-management support.	Multidisciplinary Teams (MDTs)

Module B: Clinical Guidelines for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Term	Definition	Source/Resources
Data-driven quality improvement initiatives	Evidence-based interventions designed to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations.	NACDD DP13-1305 Domain 3 Resource Guide Institute for Healthcare Improvement
Evidence-based clinical guidelines	Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Evidence-based guidelines should be those developed following the Institute of Medicine's eight Standards for Developing Trustworthy Clinical Practice Guidelines: 1. Establishing transparency. 2. Management of conflict of interest. 3. Guideline development group composition. 4. Clinical practice guideline–systematic review intersection. 5. Establishing evidence foundations for and rating strength of recommendations. 6. Articulation of recommendations. 7. External review. 8. Updating. Guidelines can be found at the National Guideline Clearinghouse.	About Systematic Evidence Reviews and Clinical Practice Guidelines Standards for Developing Trustworthy Clinical Practice Guidelines Agency for Healthcare Research and Quality

Term	Definition	Source/Resources
Plan-Do-Study-Act (PDSA) model	A tool used by the Institute for Healthcare Improvement to test an idea by temporarily trialing a change and assessing its impact. The four stages of the PDSA cycle: 1. **Plan:** develop the change to be tested or implemented 2. **Do:** carry out the test or change 3. **Study:** review data before and after the change and reflect on what was learned 4. **Act:** plan the next change cycle or full implementation	Institute for Healthcare Improvement PDSA Worksheet

Module C: Electronic Health Record (EHR) and Patient Tracking Systems for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Term	Definition	Source/Resources
Electronic Health Record (EHR) System	An electronic version of a patient's medical history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that person's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.	CMS Electronic Health Records NACDD DP13-1305 Domain 3 Resource Guide
Patient tracking system	A patient tracking system, also known as a registry, is an information system for tracking individual patients and populations of patients.	Institute for Healthcare Improvement: Clinical Information Systems
Priority Populations	Populations affected disproportionately by chronic disease due to socioeconomic or other characteristics, including inadequate access to care, poor quality of care, or low income. The specific patient population is often identified and defined based on disease and risk factor burden data.	

Term	Definition	Source/Resources
Promoting Interoperability Program Objectives	In 2019, CMS and ONCHIT established standards and other criteria for structured data that EHRs must meet in order to qualify for use in the Promoting Interoperability Programs. The 2019 objectives include electronic prescribing, health information exchange, provider to patient exchange, and public health and clinical data exchange.	Promoting Interoperability Program Fact Sheet

Module D: Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

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

Module E: Patient Education for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Term	Definition	Source/Resources
Self-efficacy	A concept of the Social Cognitive Theory by Albert Bandura. It is the personal judgment of "how well one can execute courses of action required to deal with prospective situations" (Bandura, 1982). Expectations of self-efficacy determine whether an individual will be able to exhibit coping behavior and how long effort will be sustained in the face of obstacles.	*Social Learning Theory* (Albert Bandura)

Module F: Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Term	Definition	Source/Resources
Cardiac Rehabilitation Services	Cardiac rehabilitation services are comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counselling. These programs are designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or re-infarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients.	Million Hearts® Cardiac Rehabilitation Change Package
Evidence-based lifestyle change programs	A structured lifestyle change program for people living with chronic conditions with a scientific base showing effectiveness. These programs may promote the following elements: reduce weight, adopt healthy eating, and engage in regular physical activity.	CDC-recognized Lifestyle Change Programs
Health care extenders	Non-physician health care professionals who help people take actions to prevent and manage their health conditions. They include nurse practitioners, medical assistants, community health workers, pharmacists, social workers, and registered dietitians.	National Association of Chronic Disease Directors Community Programs Linked to Clinical Services
Liaison *(for cardiac rehabilitation)*	Someone who assists in discharge, referrals, timely enrollment, and patient education.	Million Hearts® Cardiac Rehabilitation Change Package
Loaner program	A strategy to supporting self-measured blood pressure. Health care systems may choose to purchase monitors and loan them out to patients.	Million Hearts® Self-Measured Blood Pressure Monitoring

Term	Definition	Source/Resources
Medication Therapy Management (MTM)	A distinct service or group of services that optimize therapeutic outcomes for individual patients; it represents one type of pharmacists' patient care services. The five core elements of the MTM service model include: 1. Medication therapy review (MTR). 2. Personal medication record (PMR). 3. Medication-related action plan (MAP). 4. Intervention and/or referral. 5. Documentation and follow-up.	Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model (Version 2.0)
Self-measured blood pressure (SMBP)	The regular use of a personal blood pressure measurement device that is used by the patient outside a clinical setting.	Million Hearts® Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners
Self-management goals	Tailored, realistic, and achievable results from managing an individual's symptoms, treatment, physical and social consequences, and lifestyle change inherent in living with a chronic condition.	Self-management approaches for people with chronic conditions: a review

Module G: Tobacco Use and Dependence Cessation

Term	Definition	Source/Resources
5 A's Intervention Model	The five components of the 5 A's intervention model are: 1. **Ask** about tobacco use. *Identify and document tobacco use status for every patient at every visit.* 2. **Advise** to quit. *In a clear, strong, and personalized manner, urge every tobacco user to quit*. 3. **Assess** willingness to quit. *Is the tobacco user willing to make a quit attempt at this time?* 4. **Assist** in quit attempt. *For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional treatment to help the patient quit. For the patient unwilling to quit at the time, provide interventions designed to increase future quit attempts.* 5. **Arrange** follow up. *For the patient willing to make a quit attempt, arrange for follow-up contacts, beginning within the first week after the quit date. For the patient unwilling to make a quit attempt at the time, address tobacco dependence and willingness to quit at next clinic visit.* **Refer** patients to additional cessation supports, including tobacco quit lines (1-800-QUIT-NOW), websites (smokefree.gov), community-based quit programs, or a tobacco treatment specialist.	2014 CDC OSH's Best Practices for Comprehensive Tobacco Control Programs: III. Cessation Interventions 2008 AHRQ's Treating Tobacco Use and Dependence Clinical Practice Guideline
Tobacco Cessation Counseling	Tobacco Cessation Counseling programs provide information and resources to help tobacco users develop a quit plan, address specific barriers to quitting, seek support for their efforts, and manage withdrawal symptoms and stress to prevent relapse. The most effective counseling is tailored to meet individual needs and preferences. Methods and intensity will vary based on the type and amount of support needed.	An Overview of Tobacco Cessation Counseling 2008 AHRQ's Treating Tobacco Use and Dependence Clinical Practice Guideline 2014 CDC OSH's Best Practices for Comprehensive Tobacco Control Programs: III. Cessation Interventions
Tobacco Cessation Medication	The seven Food and Drug Administration (FDA)–approved cessation medications are bupropion, varenicline, and five forms of nicotine replacement therapy (NRT), including the patch, gum, lozenge, inhaler, and nasal spray.	2014 CDC OSH's Best Practices for Comprehensive Tobacco Control Programs: III. Cessation Interventions

Module H: Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients

Term	Definition	Source/Resources
Centers for Medicare & Medicaid Services (CMS)	A federal agency that runs the Medicare program. CMS also works with states to run the Medicaid program. CMS works to make sure that beneficiaries in these programs are able to get high-quality health care.	CMS.gov About CMS
Colorectal Cancer Screening	Screening types include colonoscopy, flexible sigmoidoscopy, computed tomography colonography, the guaiac-based fecal occult blood test, the fecal immunochemical test, the multitargeted stool DNA test, and the methylated SEPT9 DNA test.	Screening for Colorectal Cancer US Preventive Services Task Force Recommendation Statement
Uniform Data System (UDS)	The UDS is a core system of information appropriate for reviewing the operation and performance of health centers. UDS is a reporting requirement for Health Resources and Service Administration (HRSA) grantees, including community health centers, migrant health centers, health care for the homeless grantees, and public housing primary care grantees. The data are used to improve health center performance and operation and to identify trends over time. UDS data are compared with national data to review differences between the U.S population at large and those individuals and families who rely on the health care safety net for primary care.	Uniform Data System Resources Uniform Data System Reporting Instructions

Appendix B: HSSC v2.0 Reference List

Module A: Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

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Module H: Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients

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Appendix C: Screen Shot of HSSC v2.0 User Summary Report

HSSC Score Report

The HSSC Score Report includes your Overall Score, scores for each module and disease selected, considerations for improvement, and helpful resources. Considerations and resources are automatically generated according to your answers to the questions. Evidence is based on literature published through June 2020.

! After clicking "Exit" below or closing the browser window, you will not be able to return to this page. We recommend printing or saving this page for your records by clicking the "Print Results" button at the bottom of this page. This will not preserve the hyperlinked resources; however, you may copy and paste the short links (bit.ly) into your web browser to access the resource directly. You can also contact your health department for your results, and you can access a complete list of resources on the CDC website.

Overall HSSC Score: _____%

(____ out of ____ maximum total points for selected modules)

This Score Report and the scores were generated from the answers provided for the selected modules and diseases listed below.

Module A					
Module B:	Blood Pressure	Cholesterol	Diabetes	Obesity	COPD
Module C					
Module D	Blood Pressure	Cholesterol	Diabetes	Obesity	COPD
Module E	Blood Pressure	Cholesterol	Diabetes	Obesity	COPD
Module F	Blood Pressure	Cholesterol	Diabetes	Obesity	COPD
Module G					
Module H	Breast	Cervical	Colorectal		

Your overall score is calculated as a percentage of the maximum total possible points achievable based on the modules and diseases you selected to complete. Points are weighted by disease and module; therefore, the overall score may not equal the average of each Module Score.

Below are scores for each module and each disease selected. Overall module scores may not equal the average of the disease specific scores because questions are weighted by disease.

Module A: Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Module A Score: ___%

Considerations	Resources
Incorporate team-based care into your practice for patients with high blood pressure, high cholesterol, prediabetes or diabetes, obesity, and/or COPD.	2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i) CDC DDT's National Diabetes Education Program (https://bit.ly/3OXrwLF) 2020 CPSTF's Team-Based Care to Improve Blood Pressure Control (https://bit.ly/3DZkLTm) 2016 CPSTF's Team-Based Care for Patients with Type 2 Diabetes (https://bit.ly/31YPYJz) 2017 AMA's Patient Care Module: Managing Type 2 Diabetes: A Team-Based Approach (https://bit.ly/3shJmR4)
Include at least a nurse, pharmacist, or community health worker on the multidisciplinary health care team in your practice for patients with high blood pressure, high cholesterol, prediabetes or diabetes, obesity, and/or COPD.	2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i) 2018 CDC DDT's Recognized Lifestyle Program: How Pharmacists Can Participate (https://bit.ly/3bsALVB) 2021 CDC DDT's Rx for the National Diabetes Prevention Program: Action Guide for Community Pharmacists (https://bit.ly/3xWt3ux) 2020 CPSTF's Team-Based Care to Improve Blood Pressure Control (https://bit.ly/3DZkLTm) 2016 CPSTF's Team-Based Care for Patients with Type 2 Diabetes (https://bit.ly/31YPYJz)
Implement workflows and approaches to increase communication among members of the clinical care team to discuss patient care.	2017 AMA's Patient Care Module: Managing Type 2 Diabetes: A Team-Based Approach (https://bit.ly/3shJmR4)
Refer chronic disease patients to specialized clinics or centers (e.g., a hypertension clinic) when a team-based care approach is not available.	2020 CPSTF's Team-Based Care to Improve Blood Pressure Control (https://bit.ly/3DZkLTm) 2016 CPSTF's Team-Based Care for Patients with Type 2 Diabetes (https://bit.ly/31YPYJz)

Considerations	Resources
If feasible, implement a protocol for applying a team-based care approach for patients with high blood pressure, high cholesterol, prediabetes or diabetes, obesity, and/or COPD. Otherwise, consider including a nurse or pharmacist on a multidisciplinary health care team or referring chronic disease patients to specialized clinics or centers.	2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i) 2018 CDC DDT's Recognized Lifestyle Program: How Pharmacists Can Participate (https://bit.ly/3bsALVB) 2021 CDC DDT's Rx for the National Diabetes Prevention Program: Action Guide for Community Pharmacists (https://bit.ly/3xWt3ux) 2020 CPSTF's Team-Based Care to Improve Blood Pressure Control (https://bit.ly/3DZkLTm) 2016 CPSTF's Team-Based Care for Patients with Type 2 Diabetes (https://bit.ly/31YPYJz)
Use a Collaborative Practice Agreement to incorporate pharmacists or community health workers into your practice.	2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i) 2022 CDC DHDSP's Community Health Worker (CHW) Toolkit (https://bit.ly/3nyOtsV)
Arrange for pharmacists to provide Collaborative Drug Therapy Management or Medication Therapy Management to patients.	2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i) 2012 CDC DHDSP's Partnering with Pharmacists in the Prevention and Control of Chronic Diseases (https://bit.ly/3xPXhiM) 2021 CDC DDT's Rx for the National Diabetes Prevention Program: Action Guide for Community Pharmacists (https://bit.ly/3xWt3ux)

Module B: Clinical Guidelines for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Module B Score: ___%

Module B Blood Pressure Score: ___%
Module B Cholesterol Score: ___%
Module B Diabetes Score: ___%
Module B Obesity Score: ___%
Module B COPD Score: ___%

Considerations	Resources
Implement evidence-based clinical practice guidelines into your practice for patients with high blood pressure.	2021 AHRQ's Clinical Guidelines (https://bit.ly/3brhYKm) **For High Blood Pressure** • 2015 USPSTF's Screening for High Blood Pressure in Adults (https://bit.ly/3ypfPGH) • 2017 ACC/AHA's Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (https://bit.ly/3pZS2sN) • CDC Million Hearts® Hypertension Treatment Protocols (https://bit.ly/3P4BQBf)
Implement evidence-based clinical practice guidelines into your practice for patients with high cholesterol.	2021 AHRQ's Clinical Guidelines (https://bit.ly/3brhYKm) **For High Cholesterol** • 2018 AHA/ACC's Guideline on the Management of Blood Cholesterol (https://bit.ly/34iS0oA) • 2016 USPSTF's Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication (https://bit.ly/32UaNX2)
Implement evidence-based clinical practice guidelines into your practice for patients with prediabetes or diabetes.	2021 AHRQ's Clinical Guidelines (https://bit.ly/3brhYKm) **For Prediabetes or Diabetes** • 2015 USPSTF's Screening for Type 2 Diabetes Mellitus in Adults (https://bit.ly/3L2Kf5V) • 2019 ADA's Standards of Care (https://bit.ly/3F3v5KP)

Considerations	Resources
Implement evidence-based clinical practice guidelines into your practice for patients with obesity.	2021 AHRQ's Clinical Guidelines (https://bit.ly/3brhYKm) **For Obesity** • 2018 USPSTF's Behavioral Weight Loss Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults (https://bit.ly/3eY855q) • 2019 ACC/AHA's Guideline on the Primary Prevention of Cardiovascular Disease (https://bit.ly/3t4vU3J) • 2016 AACE/ACE's Comprehensive Clinical Practice Guidelines for Medical Care of Patients with Obesity (https://bit.ly/3JM5gCy)
Implement evidence-based clinical practice guidelines into your practice for patients with COPD.	2021 AHRQ's Clinical Guidelines (https://bit.ly/3brhYKm) **For COPD** • 2011 ACP/ACC's Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease: A Clinical Practice Guideline Update (https://bit.ly/3t3M2Ch) • 2020 GOLD's Global Strategy for Prevention, Diagnosis, and Management of COPD (https://bit.ly/31B0czI)
Conduct quality improvement initiatives to improve care provided to patients with high blood pressure.	IHI's PDSA Worksheet (https://bit.ly/3eYu107) **For High Blood Pressure** • 2013 AMCF's Measure Up Pressure Down Provider Toolkit to Improve Hypertension Control (https://bit.ly/3q08OJm) • 2020 Million Hearts® Hypertension Control Change Package, Second Edition (https://bit.ly/3u4MyQf)
Conduct quality improvement initiatives to improve care provided to patients with high cholesterol.	IHI's PDSA Worksheet (https://bit.ly/3eYu107) **For High Cholesterol** • 2013 AHA's Guide for Improving Cardiovascular Health at the Community Level (https://bit.ly/3OPPskr) • Million Hearts® Cholesterol Management Toolkit (https://bit.ly/3yfyo1g)
Conduct quality improvement initiatives to improve care provided to patients with prediabetes or diabetes.	IHI's PDSA Worksheet (https://bit.ly/3eYu107) **For Prediabetes or Diabetes** • 2022 AHRQ's Improving Diabetes Care Quality (https://bit.ly/3nij9y8) • 2017 Healthy People 2020's Improving Diabetes Screening and Referral to Prevention Programs (https://bit.ly/3xPY1o4)

Considerations	Resources
Conduct quality improvement initiatives to improve care provided to patients with obesity.	IHI's PDSA Worksheet (https://bit.ly/3eYu107) **For Obesity** • 2007 VDH's Promoting Healthier Weight in Adult Primary Care (https://bit.ly/3HYcOSg)
Conduct quality improvement initiatives to improve care provided to patients with COPD.	IHI's PDSA Worksheet (https://bit.ly/3eYu107) **For COPD** • 2014 Implementing clinical guidelines for chronic obstructive pulmonary disease: barriers and solutions (https://bit.ly/3A0lhlV)

Module C: Electronic Health Record (EHR) and Patient Tracking Systems for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Module C Score: ___%

Considerations	Resources
These resources can be used to find more information relevant to all questions asked in Module C. See below for more specific considerations.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)
Incorporate the functionality to transmit health data to all providers in your health care system via the EHR system.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)
Incorporate the protocol of provider prompts to order tests and imaging studies, notify when patient is due for screening, or notify when patient's condition is not controlled.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)

Considerations	Resources
Incorporate the protocol of patient prompts to notify patients with selected medical conditions who are overdue for office visits or to order tests and imaging studies.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)
Track key measures for a patient's medical condition, abnormal test or imaging results, and any referrals to specialists, or implementing the use of provider dashboards with appropriate goals and metrics.	• 2018 HealthIT.gov Learning the EHR Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)
Generate and transmit prescription orders electronically.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)
Generate and transmit consultation requests electronically.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)

Considerations	Resources
View lab/pathology reports or screening and diagnostic imaging results electronically.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)
Use an EHR system to manage and inform patient care.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2019 HealthIT.gov Meaningful Use (https://bit.ly/3ndmWwX) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir) • 2022 CMS EHR Incentive Programs (https://go.cms.gov/3OkrY6t) • 2020 Million Hearts® Hypertension Control Change Package for Clinicians (https://bit.ly/3u4MyQf)
Regularly use patient tracking systems to track patient management.	• 2018 Health IT and Health Information Exchange Basics (https://bit.ly/39X6rln) • 2021 HealthIT.gov ONC Health IT Certification Program (https://bit.ly/3OXntir)

Module D: Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Module D Score: ___%

Module D Blood Pressure Score: ___%
Module D Cholesterol Score: ___%
Module D Diabetes Score: ___%
Module D Obesity Score: ___%
Module D COPD Score: ___%

Considerations	Resources
These resources can be used to find more information related to all questions asked in Module D. See below for more specific considerations.	• 2017 HealthIT.gov Optimizing Strategies for Clinical Decision Support (https://bit.ly/39Tnrco) • AHRQ's Clinical Decision Support (https://bit.ly/3yko5cr) **For High Blood Pressure and High Cholesterol** • 2013 CPSTF's Cardiovascular Disease: Clinical Decision-Support Systems (CDSS) (https://bit.ly/36twajX) • 2017 NYC Health's ABCS Toolkit for the Practice Facilitator (https://bit.ly/3tL2qaQ) • 2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i) **For Prediabetes or Diabetes** • 2008 AHRQ's Trial of Decision Support to Improve Diabetes Outcomes (Ohio) (https://bit.ly/3HRmBJx) • CDC and AMA's Prevent Diabetes STAT (https://bit.ly/3Lq63c7)
Incorporate cut-off points in your clinical decision support system when making diagnostic or screening decisions for adult patients with high blood pressure, high cholesterol, prediabetes or diabetes, obesity, and/or COPD.	**For High Cholesterol** • CDC Million Hearts® Cholesterol Management Toolkit (https://bit.ly/3yfyo1g)
Incorporate the functionality of recommending, ordering, or viewing laboratory test(s) and results in your clinical decision support system for adult patients with high blood pressure, high cholesterol, prediabetes or diabetes, and/or obesity.	

Considerations	Resources
Incorporate recommendation statements on lifestyle modifications (e.g., diet and physical activity) in your clinical decision support system for adult patients with high blood pressure, high cholesterol, prediabetes or diabetes, obesity, and/or COPD.	• 2015 HHS's Step It Up! The Surgeon General's Call to Action to Promote Walking and Walkable Communities (https://bit.ly/3OEiiDQ) • 2014 ACSM's Exercise is Medicine: Healthcare Providers' Action Guide (https://bit.ly/3Lq47AK)
Incorporate a cardiovascular risk calculator in your clinical decision support system for adult patients with high blood pressure, high cholesterol, prediabetes or diabetes, obesity, and/or COPD.	• 2013 ACC/AHA's Guideline on the Assessment of Cardiovascular Risk (https://bit.ly/3DhJCTP) • ACC/AHA's Heart Risk Calculator (https://bit.ly/3DxCWRP) • ACC's CVD Risk Calculator (https://bit.ly/3IM16ZM) • 2013 NHLBI's Assessing Cardiovascular Risk: Systematic Evidence Review (https://bit.ly/3DkvZ6n)
Include drug management protocol in your clinical decision support system for adult patients with high blood pressure, high cholesterol, prediabetes or diabetes, and/or obesity.	
Include a specified follow-up time period with particular health care providers in your clinical decision support system for adult patients with high blood pressure, high cholesterol, prediabetes or diabetes, and/or obesity.	
Document positive or negative changes in condition at follow-up as a part of your clinical decision support system for adult patients with high blood pressure, high cholesterol, prediabetes or diabetes, and/or obesity.	
Incorporate the functionality in your clinical decision support system of flagging patient's charts when an adult patient has uncontrolled high blood pressure, high cholesterol, prediabetes or diabetes, and/or obesity.	
Incorporate the functionality in your clinical decision support system of flagging patient's charts when an adult patient needs testing for high blood pressure, high cholesterol, prediabetes or diabetes, and/or obesity.	
Incorporate the functionality in your clinical decision support system of flagging patient's charts when an adult patient needs medication adjustments for high blood pressure, high cholesterol, prediabetes or diabetes, and/or obesity.	

Considerations	Resources
Incorporate the functionality in your clinical decision support system of flagging patient's charts for tobacco cessation for an adult patient with high blood pressure, high cholesterol, prediabetes or diabetes, and/or COPD.	

Module E: Patient Education for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Module E Score: ___%

Module E Blood Pressure Score: ___%
Module E Cholesterol Score: ___%
Module E Diabetes Score: ___%
Module E Obesity Score: ___%
Module E COPD Score: ___%

Considerations	Resources
Implement patient education programs for patients with high blood pressure.	**For High Blood Pressure** • Million Hearts® Tools (https://bit.ly/3NiQKCD) • 2020 CDC's Hypertension Resources for Health Professionals (https://bit.ly/3QQJYay) • 2016 AHA/AMA's Target:BP™ (https://bit.ly/3IMLvJn) • YMCA's Blood Pressure Self-Monitoring (https://bit.ly/3qHMaWa)
Implement patient education programs for patients with high cholesterol.	**For High Cholesterol** • 2018 CDC's Cholesterol Resources for Health Professionals (https://bit.ly/3xNIZiu) • NHLBI's High Blood Cholesterol (https://bit.ly/3RijYFe) • AHA's Cholesterol Tools and Resources (https://bit.ly/3IOwkiS)
Implement patient education programs for patients with prediabetes or diabetes.	**For Prediabetes or Diabetes** • 2021 CDC DDT's Rx for the National Diabetes Prevention Program: Action Guide for Community Pharmacists (https://bit.ly/3xWt3ux) • ADA's Patient Education Materials (https://bit.ly/3qI0L4a) • NIDDK's Health Information For Health Professionals (https://bit.ly/3bozT4b)
Implement patient education programs for patients with obesity.	**For Obesity** • 2022 CDC's Defining Adult Overweight & Obesity (https://bit.ly/3QPcSHK) • 2022 NHLBI's Overweight and Obesity (https://bit.ly/3nfHPrb) • NIDDK's Weight Management & Healthy Living Tips (https://bit.ly/3NN8c2t)

Considerations	Resources
Implement patient education programs for patients with COPD.	**For COPD** • CDC's Chronic Obstructive Pulmonary Disease (https://bit.ly/3A8uWad) • ATS's Patient Education Resources (https://bit.ly/3uCO3Vc) • 2022 NHLBI's COPD (https://bit.ly/3buEKRy)

Module F: Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Prediabetes or Diabetes, Obesity, or COPD

Module F Score: ___%

Module F Blood Pressure Score: ___%
Module F Cholesterol Score: ___%
Module F Diabetes Score: ___%
Module F Obesity Score: ___%
Module F COPD Score: ___%

Considerations	Resources
Implement a self- and care-management protocol for staff to apply when treating patients with high blood pressure.	**For High Blood Pressure** • 2014 Million Hearts® Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians (https://bit.ly/3zZPUbb) • 2013 Million Hearts® Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners (https://bit.ly/3ngboc5) • 2022 CDC DHDSP's Community Health Worker Toolkit (https://bit.ly/3nyOtsV) • 2015 CPSTF's Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control - When Used Alone (https://bit.ly/3IQBH0O) • 2016 AHA/AMA's Target:BP™ (https://bit.ly/3IMLvJn) • Self-Management Resource Center (https://bit.ly/3iLfvuo) • 2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i) • YMCA's Blood Pressure Self-Monitoring (https://bit.ly/3IL85lp)

Considerations	Resources
Implement a self- and care-management protocol for staff to apply when treating patients with high cholesterol.	**For High Cholesterol** • 2018 CDC's Cholesterol Resources for Health Professionals (https://bit.ly/3xNIZiu) • AHA's Cholesterol Tools and Resources (https://bit.ly/3IOwkiS) • Self-Management Resource Center (https://bit.ly/3iLfvuo) • 2018 AHA's Cholesterol Management Guide for Health Care Practitioners (https://bit.ly/382iJYl) • U.S. NLM's MedlinePlus: Cholesterol (https://bit.ly/3HOy90e) • 2017 CDC DHDSP's Best Practices for Cardiovascular Disease Prevention Programs (https://bit.ly/3tWMq5i)
Implement a self- and care-management protocol for staff to apply when treating patients with prediabetes or diabetes.	**For Prediabetes or Diabetes** • CDC DDT's Information for Diabetes Professionals (https://bit.ly/3OXrwLF) • 2021 CDC DDT's Diabetes Self-Management Education and Support Toolkit (https://bit.ly/3bowq5G) • 2021 CDC DDT's Diabetes Prevention Recognition Program (https://bit.ly/3Ne6tTG) • ADA's Patient Education Materials (https://bit.ly/3qI0L4a) • NIDDK's Health Information for Health Professionals (https://bit.ly/3bozT4b) • Self-Management Resource Center (https://bit.ly/3iLfvuo)
Implement a self- and care-management protocol for staff to apply when treating patients with obesity.	**For Obesity** • 2022 CDC's Defining Adult Overweight & Obesity (https://bit.ly/3QPcSHK) • 2022 NHLBI's Overweight and Obesity (https://bit.ly/3nfHPrb) • NIDDK's Weight Management & Healthy Living Tips (https://bit.ly/3NN8c2t) • Self-Management Resource Center (https://bit.ly/3iLfvuo)
Implement a self- and care-management protocol for staff to apply when treating patients with COPD.	**For COPD** • CDC's Chronic Obstructive Pulmonary Disease (https://bit.ly/3A8uWad) • ATS's Patient Education Resources (https://bit.ly/3uCO3Vc) • 2022 NHLBI's COPD (https://bit.ly/3buEKRy) • Self-Management Resource Center (https://bit.ly/3iLfvuo)

Considerations	Resources
Implement a protocol to assess for patient cognitive ability and availability of caregiver assistance.	• 2013 Alzheimer's Association Recommendations for Detection of Cognitive Impairment in Primary Care (https://bit.ly/3qJh2pk) • AA's Cognitive Assessment (https://bit.ly/3JNFFJ9) • 2012 Practical Guidelines for the Recognition and Diagnosis of Dementia (https://bit.ly/3tKDfVN) • 2015 Information Sharing Preferences of Older Patients and Their Families (https://bit.ly/3tMCVGd) • Self-Management Resource Center (https://bit.ly/3iLfvuo) • 2017 GSA's Cognitive Impairment Detection and Earlier Diagnosis (https://bit.ly/3Lk0jAT)

Module G: Tobacco Use and Dependence Cessation

Module G Score: ___%

Considerations	Resources
Implement a protocol that requires primary care providers to follow the 5 A's intervention model when discussing tobacco use during patient visits.	• Million Hearts® Tobacco Cessation Change Package (https://bit.ly/3A1z63q) • Million Hearts® Tobacco Cessation Protocols (https://bit.ly/3P4ju45) • 2016 Million Hearts® Identifying and Treating Patients Who Use Tobacco: Action Steps for Clinicians (https://bit.ly/39RDkjv) • 2008 AHRQ's Treating Tobacco Use and Dependence Clinical Practice Guideline (https://bit.ly/3HRpKsP) • 2014 CDC OSH's Best Practices for Comprehensive Tobacco Control Programs: III. Cessation Interventions (https://bit.ly/3OIXoUa)
Implement a policy to require all facilities to be 100% tobacco-free (including e-cigarettes) in both indoor and outdoor locations.	• 2013 UCSF SCLC's Destination Tobacco-Free: A Practical Tool for Hospitals and Health Systems (https://bit.ly/37Yja60) • 2015 UC AMCSM's DIMENSIONS: Tobacco-Free Policy Toolkit (https://bit.ly/3qE3VFZ) • 2018 NBHN's How to Implement a Tobacco-Free Policy (https://bit.ly/35jwIZ1)

Module H: Guidelines for Screening for Breast, Cervical, and/or Colorectal Cancer of Eligible Patients

Module H Score: ___%

Module H Breast Cancer Screening Score: ___%
Module H Cervical Cancer Screening Score: ___%
Module H Colorectal Cancer Screening Score: ___%

Considerations	Resources
Implement policies that support evidence-based interventions to increase the proportion of eligible patients screened for cancers.	• CDC's DCPC's Resource Library (https://bit.ly/3OoweBW) • CPSTF's Cancer Prevention and Control Task Force Findings (https://bit.ly/3tOtzdc) • NCI's Evidence-Based Cancer Control Programs (https://bit.ly/3NfLShD) • Cancer Control PLANET (https://bit.ly/3HU8mE8) **For Breast Cancer** • 2020 CDC DCPC's Breast Cancer Screening Guidelines for Women (https://bit.ly/39MlgHH) **For Cervical Cancer** • CDC DCPC's Cervical Cancer Screening Guidelines for Average-Risk Women (https://bit.ly/3u0RWnq) **For Colorectal Cancer** • NCCR's How To Increase Colorectal Cancer Screening Rates In Practice: A Primary Care Clinician's Evidence-Based Toolbox And Guide (https://bit.ly/3uE0d04) • NCCR's Colorectal Cancer Screening Resources to Improve Quality (https://bit.ly/36CbyG7)
Monitor quality indicators for colorectal cancer screening and providing resources to health care providers on improving quality of colorectal cancer screening.	• CDC's DCPC's Resource Library (https://bit.ly/3OoweBW) • National Colorectal Cancer Screening Provider Education Resources (https://bit.ly/3JNJkGT) • NCCR's Colorectal Cancer Screening Resources to Improve Quality (https://bit.ly/36CbyG7) • CDC: CRC Screening and Surveillance: Optimizing Quality (https://bit.ly/3OG70yN) • American Society for Gastrointestinal Endoscopy Quality Indicators (https://bit.ly/36TCZee)

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