Indicators Spotlight

HEALTH CARE PRACTICE REDESIGN

Background for Health Care Practice Redesign

Health care practice redesign initiatives, such as the Patient-Centered Medical Home model or the Planned Care Model, are emerging approaches to improve the quality of primary health care delivery. These models are comprehensive, multifaceted, and seek to provide high-quality care and continuity while involving patients, communities, health care teams, and policy makers. Funded programs can play a role in health care practice redesign by partnering with state community health center organizations or medical associations to implement these models and promote quality improvement, use of evidence-based guidelines, and data collection.

Purpose of the Indicators Spotlight

The purpose of this document is to give funded programs working in health care practice redesign a list of potential indicators to explore for evaluation purposes. Multiple indicators can be chosen as outcomes for logic models and measures for companion evaluation plans. This Indicators Spotlight should be used in conjunction with the Expert Panel Indicator Ratings Table and Indicator Profiles found in *Outcome Indicators for Policy and Systems Change: Controlling High Blood Pressure* or *Controlling High Cholesterol*.

**Using Indicators for Planning**

When implementing comprehensive health care practice redesign initiatives, it is important to monitor complete implementation of model components. These components include: 1) use of evidence-based guidelines; 2) multidisciplinary teams; 3) electronic health records with clinical decision supports, registries, and e-prescribing; 4) continuous quality improvement; 5) patient follow-up mechanisms; 6) patient treatment adherence supports; and 7) patient self-management supports.

Step 1

Select pertinent short-term policy/systems change indicators. For comprehensive health care practice redesign initiatives, *all* indicators related to policy, systems, or environmental changes for *Health Care Systems* listed on the next page should be monitored for blood pressure and/or cholesterol. It also may be helpful for program improvement purposes to choose one or more indicators related to policy, systems, or environmental changes for *Health Care Providers* as well.

Step 2

Map outcomes of interest over time. It is advantageous to determine the logic model pathway of one or more intermediate outcomes. Measuring short-term and intermediate outcomes along a logic model pathway allows programs to identify gaps in program implementation before completing a comprehensive evaluation that focuses on long-term outcomes related to death and disability.
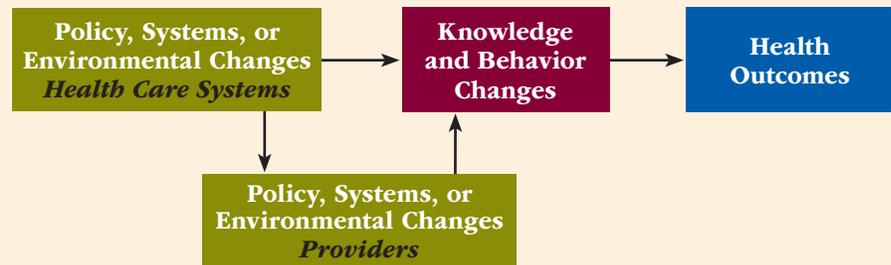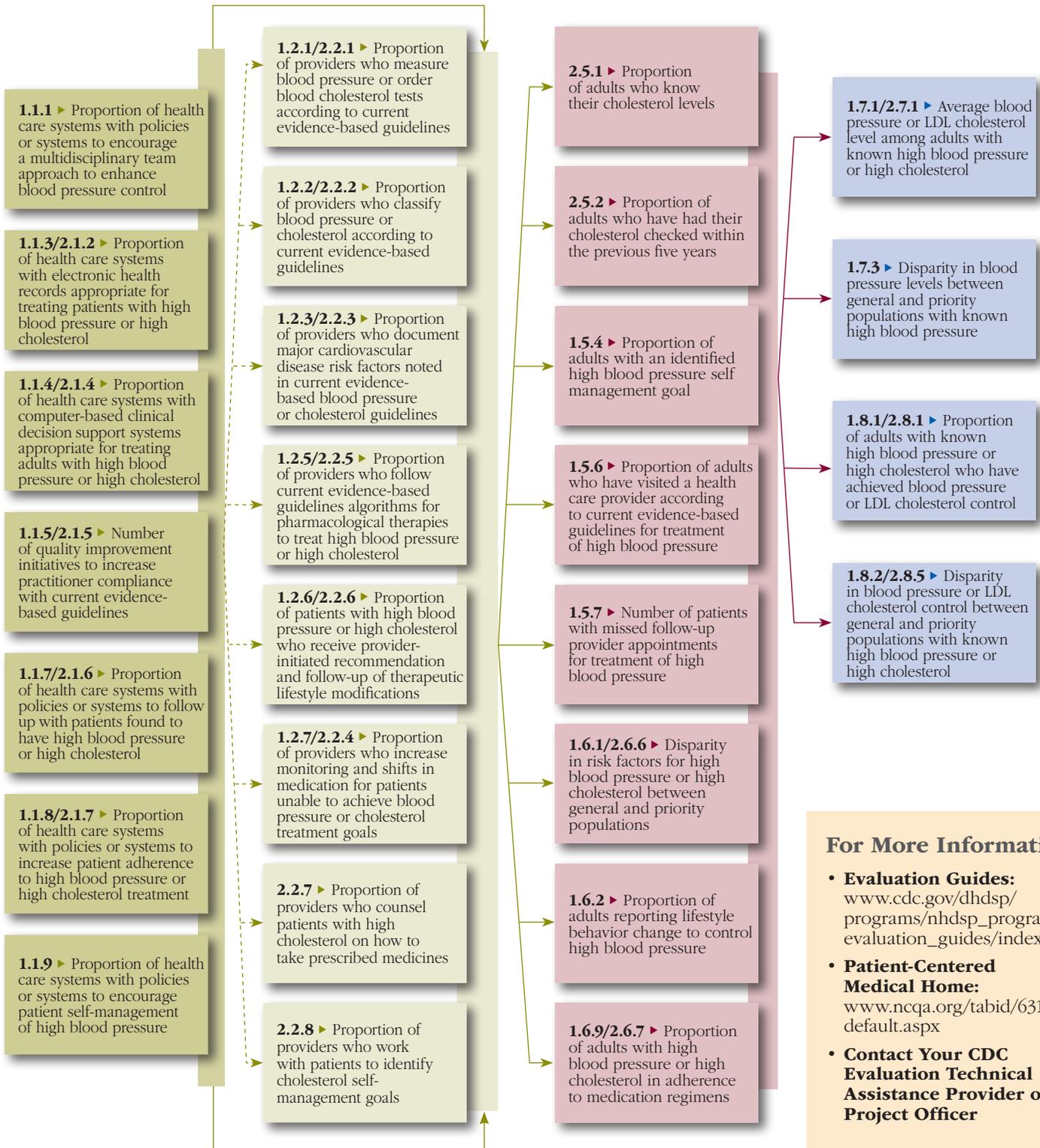

Step 3

Enhance the evaluation with other outcomes of interest. Round out the evaluation plan by including other pertinent outcomes that meet programmatic needs or the needs of decision makers.

Evaluation

Short-Term		Intermediate	
Policy/Systems Change		**Knowledge/Behavior Change**	**Health Outcomes**
Health Care Systems *(All)*	Health Care Providers *(May choose one or more)*	*(Choose one or more)*	*(Choose one or more)*

Policy/Systems Change — Health Care Systems (All)

1.1.1 ▸ Proportion of health care systems with policies or systems to encourage a multidisciplinary team approach to enhance blood pressure control

1.1.3/2.1.2 ▸ Proportion of health care systems with electronic health records appropriate for treating patients with high blood pressure or high cholesterol

1.1.4/2.1.4 ▸ Proportion of health care systems with computer-based clinical decision support systems appropriate for treating adults with high blood pressure or high cholesterol

1.1.5/2.1.5 ▸ Number of quality improvement initiatives to increase practitioner compliance with current evidence-based guidelines

1.1.7/2.1.6 ▸ Proportion of health care systems with policies or systems to follow up with patients found to have high blood pressure or high cholesterol

1.1.8/2.1.7 ▸ Proportion of health care systems with policies or systems to increase patient adherence to high blood pressure or high cholesterol treatment

1.1.9 ▸ Proportion of health care systems with policies or systems to encourage patient self-management of high blood pressure

Policy/Systems Change — Health Care Providers (May choose one or more)

1.2.1/2.2.1 ▸ Proportion of providers who measure blood pressure or order blood cholesterol tests according to current evidence-based guidelines

1.2.2/2.2.2 ▸ Proportion of providers who classify blood pressure or cholesterol according to current evidence-based guidelines

1.2.3/2.2.3 ▸ Proportion of providers who document major cardiovascular disease risk factors noted in current evidence-based blood pressure or cholesterol guidelines

1.2.5/2.2.5 ▸ Proportion of providers who follow current evidence-based guidelines algorithms for pharmacological therapies to treat high blood pressure or high cholesterol

1.2.6/2.2.6 ▸ Proportion of patients with high blood pressure or high cholesterol who receive provider-initiated recommendation and follow-up of therapeutic lifestyle modifications

1.2.7/2.2.4 ▸ Proportion of providers who increase monitoring and shifts in medication for patients unable to achieve blood pressure or cholesterol treatment goals

2.2.7 ▸ Proportion of providers who counsel patients with high cholesterol on how to take prescribed medicines

2.2.8 ▸ Proportion of providers who work with patients to identify cholesterol self-management goals

Knowledge/Behavior Change (Choose one or more)

2.5.1 ▸ Proportion of adults who know their cholesterol levels

2.5.2 ▸ Proportion of adults who have had their cholesterol checked within the previous five years

1.5.4 ▸ Proportion of adults with an identified high blood pressure self management goal

1.5.6 ▸ Proportion of adults who have visited a health care provider according to current evidence-based guidelines for treatment of high blood pressure

1.5.7 ▸ Number of patients with missed follow-up provider appointments for treatment of high blood pressure

1.6.1/2.6.6 ▸ Disparity in risk factors for high blood pressure or high cholesterol between general and priority populations

1.6.2 ▸ Proportion of adults reporting lifestyle behavior change to control high blood pressure

1.6.9/2.6.7 ▸ Proportion of adults with high blood pressure or high cholesterol in adherence to medication regimens

Health Outcomes (Choose one or more)

1.7.1/2.7.1 ▸ Average blood pressure or LDL cholesterol level among adults with known high blood pressure or high cholesterol

1.7.3 ▸ Disparity in blood pressure levels between general and priority populations with known high blood pressure

1.8.1/2.8.1 ▸ Proportion of adults with known high blood pressure or high cholesterol who have achieved blood pressure or LDL cholesterol control

1.8.2/2.8.5 ▸ Disparity in blood pressure or LDL cholesterol control between general and priority populations with known high blood pressure or high cholesterol

For More Information

- **Evaluation Guides:** www.cdc.gov/dhdsp/ programs/nhdsp_program/ evaluation_guides/index.htm
- **Patient-Centered Medical Home:** www.ncqa.org/tabid/631/ default.aspx
- **Contact Your CDC Evaluation Technical Assistance Provider or Project Officer**

For more information please contact Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov **Web:** www.cdc.gov

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