Attachment 1 - Questionnaire

Health Systems ScoreCard (HSSC) Assessment Tool for Primary Care Practices

Instructions for Completing the Assessment tool

1. We recommend that the person who completes the assessment tool is at the health systems level, and is someone most knowledgeable about the policies and protocols in place for all clinics or practices within the health system.

2. Answer “yes” or “no” for each question on the HSSC assessment tool. Consult the Glossary in Appendix A to help you understand some of the terms used in the questions. All questions should be answered consistently based on your health system’s policies or protocols that are currently in place or have occurred within the last 12 months.

3. For most questions, provide a response based on a typical practice in your health system, which manages patients with one or more of the following chronic diseases: high blood pressure, high cholesterol, diabetes, or obesity and is stable or relatively stable with a treatment regimen. There are a few questions that ask about follow-up when there is a chance that treatment can better control the disease.

4. There are 9 topic sections to the assessment tool. You may complete each section in separate sittings and in any order. Individual topic scores can be tallied for each section and combined for a total score once all sections are completed. The entire assessment tool will take approximately 45-60 minutes to complete.

Scoring Instructions

The CDC Healthcare Systems ScoreCard (HSSC) Assessment Tool scoring system was developed to reflect the relative impact of proven clinical and public health interventions in the management of chronic diseases. Each item on the assessment tool has been assigned a point value between 1 and 4 (1=good, 2=better, 3=best, and 4=exceptional). Each item is being rated in terms of the strength of scientific evidence available and the public health impact where measures for the effect size are considered. For more information about the evidence and impact rating systems, please see Appendix C. Also included, are the citations used as evidence to assign scores for each of the items on the assessment tool, please see *The Scoring Methodology: Evidence and Impact Ratings and Supporting Citations.*

The assessment tool below shows the point value that is assigned to each strategy. When scoring your completed assessment tool, you will be able to determine two scores—a total score and individual scores for each of the 9 topic sections. The individual section scores of the tool can be used for monitoring primary care practices, establishing best practice benchmarks, and to track improvements in the overall management of chronic diseases over time. One could also choose to limit the assessment of clinic policies for one or more diagnoses, such as diabetes only or diabetes and obesity, rather than all four common diseases.

- To calculate your total assessment tool score, add the point values of all the questions to which you responded YES.
- To calculate individual topic section scores, add the point values of all of the questions to which you responded YES in a particular section (e.g., clinical guidelines).
- Questions that are skipped are counted as “no,” whether or not the strategy is applicable to your practice. You will receive 0 points for skipped questions.
- When you review your total assessment tool score and individual topic scores, please keep in mind that your scores may be lower because of the questions that were not applicable to your practice.

HSSC Assessment Tool Modules

A. Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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 **multi-disciplinary team** to manage the care of patients? *If "Yes," continue to question A2.* *If "No," skip to question A3.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Have a multi-disciplinary team that includes <u>at least</u> a nurse or pharmacist in addition to the patient and their primary care provider? *Continue to question A5.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Refer patients to a **specialized clinic or center** to manage patient's care (e.g. a hypertension clinic or endocrinology clinic)? *If "Yes," skip to question A5.* *If "No," continue to question A4.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. Use the patient's **primary care provider** (physician, NP, or PA) to manage the patient's care?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
5. Have a **Collaborative Practice Agreement** (CPA) in place that incorporates pharmacists or CHWs?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

A. Multidisciplinary Team for Care Management Approach for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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. Have pharmacists provide **Collaborative Drug Therapy Management** (CDTM) or **Medication Therapy Management** (MTM)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
				Your Health System's Multidisciplinary Team Score:	
				Maximum Multidisciplinary Team Score:	

The following questions are for informational purposes only.				
If yes to A1, please indicate who else is on the multidisciplinary team for each specified medical condition:	**High Blood Pressure**	**High Cholesterol**	**Diabetes**	**Obesity**
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, Diabetes, or Obesity					
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, and national Diabetes Prevention Program)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Have all primary care providers follow the same evidence-based clinical guidelines to diagnose and treat adult patients with a specific condition?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	

	d. Obesity	☐	☐	☐	
3. Conduct **data-driven quality improvement initiatives** to improve provider adherence to clinical guidelines (i.e., the **Plan-Do-Study-Act model**)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
				Your Health System's Clinical Guidelines Score:	
				Maximum Clinical Guidelines Score:	

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…?	**High Blood Pressure**	**High Cholesterol**	**Diabetes**	**Obesity**
Follow evidence-based clinical guidelines issued by <u>your health system</u> for each specified medical condition?	☐	☐	☐	☐

C. Electronic Health Record (EHR) System			
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**Score**
1. Have an **EHR system** that was used by the practice? *If "No", skip to question D1* *If "Yes," continue to question C2.*	☐	☐	
2. Have and EHR system that follows the **Meaningful Use Objectives**? *If "Yes", answer questions in the A Path* *If "No," answer questions in the B Path*	☐	☐	

C. Electronic Health Record (EHR) System *A Path*			
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**Score**
3. Apply to the **Center for Medicare and Medicaid Services (CMS)** EHR Incentive "Meaningful Use" Program?	☐	☐	
4. Receive CMS incentives for the "meaningful use" of EHR technology?	☐	☐	
5. Have an EHR system that was **ONCHIT certified**?	☐	☐	
6. Have an EHR system that transmitted health data to <u>all</u> providers in the system?	☐	☐	

C. Electronic Health Record (EHR) System *B Path*			
During the past 12 months, did your health system have a policy/protocol in place that required your practices to…?	**Yes**	**No**	**Score**

3. Use provider prompts to order tests and imaging studies; notify when patient is due for screening; or notify when patients condition is not controlled	☐	☐	
4. Use patient prompts to notify patients with selected medical conditions who are overdue for office visits or to order tests and imaging studies	☐	☐	
5. Track key measures for the selected medical condition (e.g., blood pressure, lipid levels, and A1c); abnormal test or imaging results; referrals to specialists; or provider dashboards with appropriate goals and metrics	☐	☐	
6. Generate and transmit prescription orders	☐	☐	
7. Generate and transmit consultation requests	☐	☐	
8. View electronic results of lab/pathology reports or screening and diagnostic imaging results	☐	☐	
9. Have an EHR system that was ONCHIT certified?	☐	☐	
10. Have an EHR system (other than for billing) that was available to all providers in the practice?	☐	☐	
Your Health System's Electronic Health Record Score			
Maximum Electronic Health Record Score:			

D. Patient Tracking Systems for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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. Regularly use a **patient tracking system** to track management for patient populations (e.g., daily, weekly, or monthly)? *If "Yes," skip to question E1.* *If "No," continue to question D2.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Have an ONCHIT certified patient tracking system integrated within the practice's EHR system? *If "Yes," skip to question E1.* *If "No," continue to question D3.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Have a stand-alone patient tracking system that does not share information with an EHR system?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
Your Health System's Patient Tacking Systems Score:					
Maximum Patient Tracking Systems Score:					

E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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**	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Recommending, ordering, or viewing laboratory test(s) and results	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Recommendations for lifestyle modifications (i.e., diet and exercise)	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. Evidence-based **cardiovascular disease (CVD) risk calculator**	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
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)	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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**
6. Specified follow-up time period, including follow-up with primary care providers or other members of the **health treatment team**	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
7. Documentation in paper charts or electronic charts of positive or negative change in condition at follow-up	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
8. **Flags** in patients' paper charts or electronic prompts when a patient's medical condition <u>is uncontrolled</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
9. Flags in patients' paper charts or electronic prompts for determining <u>when tests should be done</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
10. Flags in patients' paper charts or electronic prompts for <u>medication adjustment</u>	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	

E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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**
11. Flags in patients' paper charts or electronic prompts for tobacco cessation	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
Your Health System's Clinical Decision Support and Protocols Score:					
Maximum Clinical Decision Support and Protocols Score:					

F. Patient Education for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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 telephone, email, or in group classes on-site? *Include diagnoses for which active interactions are used for educational purposes.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Provide any educational materials to the patient such as printed materials, DVDs/videos, self-study program, or referrals to community organizations or websites?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Communicate and provide specific goals regarding management of their medical condition either orally during the visit, written down on a piece of paper or other report for patient? *This may be orally during a visit, written on paper, or online through a patient portal.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. 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.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
5. Teach patients **problem-solving skills**?	a. High Blood	☐	☐	☐	

Include teaching patients what to do to maintain compliance with medications and lifestyle, especially during special circumstances like traveling, celebrations etc.	Pressure				
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
				Your Health System's Patient Education Score:	
				Maximum Patient Education Score:	

G. Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
2. Assess patient progress in meeting goals? *Include the review of logs from self-testing, weight control, food diary, exercise diary, etc.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
3. Record patients' self-monitored clinical values (e.g., blood pressure, glucose levels, weight, smoking diary, food diary etc.) and provide clinical staff advice, medication changes, and/or lifestyle modifications back to patients?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
4. Record patients' self-monitored clinical values (e.g., blood pressure, glucose levels, weight, smoking diary, food diary, etc.) and communicate those values to clinical staff?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
5. Refer patients to a professional (e.g., to pharmacists for consultation or Medication Therapy Management, nurses, registered dietitians, or certified diabetes educators, tobacco cessation quit line)?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	

	d. Obesity	☐	☐	☐	

G. Self-Management and Care Management for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity					
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. Provide **special follow up care**? *Include follow up by CHWs, staff nurses, or other clinical staff such as social worker or dietitian. review of logs from self-testing, weight control, food diary, exercise diary, etc.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
7. Provide **non-clinician case management**? *Include case management provided by nurses, as well as by CHWs and/ or patient navigators with nurse oversight.*	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
8. Refer patients to social support groups of others with the medical condition?	a. High Blood Pressure	☐	☐	☐	
	b. High Cholesterol	☐	☐	☐	
	c. Diabetes	☐	☐	☐	
	d. Obesity	☐	☐	☐	
Your Health System's Self-Management and Care Management Score:					
Maximum Self-Management and Care Management Score:					

H. AAR Guidelines on Tobacco Use Cessation			
During the past 12 months, did your health system have a policy/protocol in place that required your primary care providers to routinely implement the following Ask, Advise, Refer (AAR) guidelines on tobacco use?	**Yes**	**No**	**Score**
1. Ask every patient about tobacco use at every patient?	☐	☐	
2. Advise every tobacco user to quit?	☐	☐	
3. Refer patients to tobacco quitlines ((i.e. National Cancer Institute's Quitline), websites (i.e. smokefree.gov), and local programs?	☐	☐	
Your Health System's Ask, Advise, Refer (AAR) Score:			
Maximum Ask, Advise, Refer (AAR) Score:			

I. 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?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
2. Provide one-on-one education (e.g. phone or in-person education) about cancer screening, delivered by healthcare providers or staff, or by community health worker?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
3. Provide client reminders (e.g. messages advising people that they are due or overdue for screening. May include letter/postcard, phone call, email/text, or other reminder)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
4. Provide client incentives (e.g. financial or non-financial rewards given to patients for completing screening)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic	☐	☐	☐	

	Colorectal Cancer Screening				

I. 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**
5. Reduce **structural barriers** (non-economic obstacles that impede access to screening) such as: (1) modified hours of service when patients can receive screening (e.g. evening or weekend hours); (2) offering screening in alternative or non-clinical settings (e.g. mobile mammography vans at worksites or providing screening in residential communities); (3) simplifying administrative procedures or other scheduling obstacles?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
6. Reduce **patient out-of-pocket costs** for screening?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
7. Assess providers during screening delivery and offer feedback (e.g. evaluate provider or practice performance in screening patients and report to individual and/or groups of providers' information about their performance)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	
8. Provider 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)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	

	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	

I. 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**
9. Provider incentives (direct or indirect rewards to motivate providers to screen or refer patients for screening)?	a. Breast Cancer Screening	☐	☐	☐	
	b. Cervical Cancer Screening	☐	☐	☐	
	c. Colorectal Cancer Screening with FOBT or Colorguard	☐	☐	☐	
	d. Endoscopic Colorectal Cancer Screening	☐	☐	☐	

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**
10. Offer both stool blood testing and colonoscopy as options for colorectal cancer screening?	☐	☐	☐	
11. 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?	☐	☐	☐	
12. (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; percentage of exams with adequate bowel preparation quality?	☐	☐	☐	
13. (For endoscopy practices) Endoscopists report their colonoscopy performance on quality indicators such as their adenoma detection rates; cecal intubation rates; percentage of exams with adequate bowel preparation quality?	☐	☐	☐	
14. Collect and report any measures related to cancer screening to systems or entities such as Uniform Data System (UDS) or CMS / and or cancer registry?	☐	☐	☐	
Your Health System's Guidelines for Screening of Cancers Score:				
Maximum Guidelines for Screening of Cancers Score:				

Appendix A. Glossary

Module A. Multidisciplinary Team for the Care Management Approach for Adults with high Blood Pressure, High Cholesterol, Diabetes, or Obesity

Term	Definition	E-Version Definition	Source/Resources
Collaborative Practice Agreement (CPA)	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 provider to perform specific patient care functions.	A formal agreement that allows another provider to perform specific patient care functions.	Collaborative Practice Agreements and Pharmacists' Patient Care Services
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.	A collaborative practice agreement between one or more physicians and pharmacists.	Collaborative drug therapy management by pharmacists, 2003
Medication Therapy Management (MTM)	A distinct service or group of services that optimize therapeutic outcomes for individual patients, and 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, and 5) Documentation and follow-up.	A distinct service or group of services that optimize therapeutic outcomes for individual patients, and it represents one type of pharmacists' patient care services.	Medication therapy management in pharmacy practice: core elements of an MTM service model (version 2.0)
Community Health Workers (CHW)	Community health workers provide health education, referral and follow up, case management, and basic preventive health care and home visiting services to specific	Community health workers provide support and assistance to individuals and families in navigating the health and social services system.	International Standard Classification of Occupations: ISCO-08

communities.

Module B. Clinical Guidelines for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity

Term	Definition	E-Version Definition	Source/Resources
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 8 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; and 8) Updating. Guidelines can be found at the National Guideline Clearinghouse	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.	About Systematic Evidence Reviews and Clinical Practice Guidelines Standards for Developing Trustworthy Clinical Practice Guidelines Agency for Healthcare Research and Quality (AHRQ)
Data-driven quality improvement initiatives	Evidence-based interventions to refine care delivery systems to make sure patients get the right care at the right time, particularly among under-served populations.	Evidence-based interventions to refine care delivery systems to make sure patients get the right care at the right time.	NACDD DP13-1305 Domain 3 Resource Guide
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:** **Plan:** the change to be tested or implemented	A component of the Model for Improvement which involves testing changes on a small scale before full implementation.	NHS Institute for Innovation and Improvement: PDSA Institute for Healthcare Improvement PDSA

	Do: carry out the test or change **Study:** data before and after the change and reflect on what was learned **Act:** plan the next change cycle or full implementation		Worksheet NACDD DP13-1305 Domain 3 Resource Guide

Module C. Electronic Health Record (EHR) System

Term	Definition	E-Version Definition	Source/Resources
Meaningful Use Objectives	The Recovery Act specifies the following 3 components, established by CMS, of Meaningful Use for eligible providers to receive financial incentives for the use of certified EHRs: 1. Use of certified EHR in a meaningful manner 2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care 3. Use of certified EHR technology to submit clinical quality measures	3 components, established by CMS, for eligible providers to receive financial incentives for the use of certified EHRs.	Health IT Regulations: Meaningful Use Regulations CMS Electronic Health Records Incentive Programs NACDD DP13-1305 Domain 3 Resource Guide
Office of the National Coordinator Health Information Technology (ONC)	ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. It is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide health information exchange to improve health care.	ONC is a government organization that coordinates nationwide efforts to promote and implement the use of health information technology and electronic health records.	HealthIT.gov About ONC NACDD DP13-1305 Domain 3 Resource Guide

Module E. Clinical Decision Support and Protocols for Adults with High Blood Pressure, High Cholesterol, Diabetes, or Obesity

Term	Definition	E-Version Definition	Source/Resources
Clinical Decision-Support Systems (CDSS)	CDSS are computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care. CDSS use patient data to provide tailored patient assessments and evidence-based treatment recommendations for healthcare 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.	CDSS are computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care.	The Community Guide Cardiovascular Disease Prevention and Control: Clinical Decision-Support Systems
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.	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.	CVDD Risk Calculator

Module H. AAR Guidelines on Tobacco Use Cessation

Term	Definition	E-Version Definition	Source/Resources
Ask, Advise, Refer (AAR) guidelines	The three components of the AAR model includes: • **Ask** about tobacco use every encounter. • **Advise** patients to quit smoking using a clear, strong personalized message. • **Refer** patients willing to quit smoking in the next 30 days to external cessation services	The AAR guidelines follow a model for healthcare practices to follow in tobacco cessation interventions.	Clinician's Guide to Treating Tobacco Dependence AAR Poster

Term	Definition	E-Version Definition	Source/Resources
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.	The UDS is a core system of information appropriate for reviewing the operation and performance of health centers.	Uniform Data System Resources Uniform Data System Reporting Instructions

For more general terms, please refer to the CDC website using the link below:
http://www.cdc.gov/other/pdf/everydaywordsforpublichealthcommunication_final_11-5-15.pdf