

# CATAPUL



A Model for Diagnosis and Management  
of Chronic Diseases in Georgia Health Systems



**CATAPULT** is a framework created by the Georgia Department of Public Health (DPH) for health systems to support Georgia in improving the diagnosis and control of chronic disease and reduce disparities.



**C**ommit To Participating  
**A**ssess Your Practice or System  
**T**raining  
**A**ctivate Your Community Resources  
**P**repare Your Action Plan  
**U**timize Your Plan  
**L**everage Your Data  
**T**est and Implement Your Approach

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# Defining CATAPULT

## AIMS

The Georgia Department of Public Health (DPH) is seeking to improve population health outcomes for patients with hypertension (HTN) and type 2 diabetes mellitus (DM), and improve the quality of care for chronic conditions in health systems in Georgia. Specifically, DPH is seeking to do the following—

- Reduce hospitalizations for type 2 diabetes by 25% by 2020;
- Reduce hospitalizations for hypertension by 10% by 2020;
- Improve hospital and health system performance on National Quality Forum (NQF) 18 & 59 and corresponding Physician Quality Reporting System (PQRS) and Uniform Data System (UDS) measures; and
- Build a community of health systems and health care providers engaged in continuous quality improvement.

## Defining Health Systems – Who Can Participate?

Any health system is encouraged to utilize the CATAPULT framework. DPH is especially interested in engaging with any health system setting that has an adult patient population with hypertension and/or diabetes from the following health systems (health care delivery organization):

- Federally Qualified Health Centers (FQHC)
- Public Health Districts (Health Districts)
- Hospital-based health system with affiliated primary care practices (HPCP)
- Health Plans and Health Maintenance Organizations (HMO)
- Accountable Care Organizations (ACO)
- Care Management Organizations (CMO)
- Rural Health Centers (RHCs)

DPH will first focus on those practices that use an electronic health record (EHR). Click [here](#) to determine if your EHR has been certified by the Office of the National Coordinator for Health Information Technology (ONC).

## Benefits of Participation

Health Systems can make significant improvements in their systems of care for all patients in their practice relative to hypertension identification and control and diabetes management.

Contact DPH at [chronic.disease@dph.ga.gov](mailto:chronic.disease@dph.ga.gov) if you are interested in learning more.

# Commit

## Commit to Participating

### WHY?

Hypertension and diabetes are very common chronic conditions that if left untreated can lead to costly complications that greatly reduce the quality of life for the individual. Committing to address these conditions within the clinic setting—and looking closely at the data over time—can improve the health of the population, as well as improve the systems in place to provide better care. Benefits of participating in CATAPULT include:

- Tailored quality improvement support designed to optimize chronic disease registries and build more effective practice teams;
- Support to strengthen delivery of evidence-based, team-based care for chronic disease management and increased patient engagement;
- Health Information Technology (HIT) support to assist in identifying current strengths, opportunities, and challenges;
- Opportunities for collaborative learning activities with other practices and providers;
- Access to educational support and tools, including disease registries, team-based care, patient self-management and community resources and tools;
- Assistance with reporting hypertension and diabetes-related measures to quality systems, including NQF and the CMS PQRS;
- Access to virtual learning platforms to support access to practice improvement resources and sharing of best practices;
- Support in collecting and reporting data; and,
- Recognition as you progress through the CATAPULT process.

**Incentive #1 - Once you complete the statement of commitment, DPH will provide you with a pledge certificate.**

### WHAT DO I NEED TO DO?

Sign the Statement of Commitment (Appendix A) and commit to promoting systems change and improving quality of care by addressing hypertension or diabetes in your health system. If you feel your practice is ready to address both conditions, DPH can offer support to complete both.

Ensure you have identified a team who will support this work at the practice level. At a minimum, you will need a provider champion, a nurse, health IT support, and a quality improvement director.

### HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

DPH will provide training on areas of interest and technical assistance through webinars, conference calls, in-person meetings, and electronic/hard copy resources. DPH will work with health systems and provider groups to improve care through the implementation of quality improvement (QI) processes and the use of EHR and HIT at the provider and system level to ensure reliable systems of care.

The purpose of CATAPULT is to assist health systems in thinking systematically about what is needed to implement best practices in chronic disease care that will result in improvements in HTN and DM outcomes among their patients. DPH is committing to provide practice level coaching that will support your practice as you move along each step of CATAPULT.

DPH is available to speak with your practice/organization in more detail about the CATAPULT process. Contact DPH at [chronic.disease@dph.ga.gov](mailto:chronic.disease@dph.ga.gov).

# A Assess

## Assess your practice using Georgia's Health System Assessment Tool

### WHY?

The purpose of the assessment is to understand how your system/practice currently operates. The assessment establishes a baseline and helps your team better understand which clinic flows and processes support quality improvement as well as those that may need to change.

### WHAT DO I NEED TO DO?

- Request and complete the online Georgia Health Systems Assessment. You will be asked to answer questions regarding EHRs, your patient population, follow-up and management of patients with high blood pressure, diabetes and pre-diabetes programs and referrals, ambulance services (for hospitals), medication adherence, communication, and current challenges addressing patients with diabetes and hypertension. DPH will provide the link once your team is ready to assess.
- Complete the data use agreement, provided by DPH.
- Consider developing a logic model to identify short and long-term intended outcomes, and steps your team will take to achieve those outcomes.
- Define your main project objectives, and use DPH-developed tools to ensure the objectives are specific, measurable, achievable, relevant, and time-bound.



## HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

- DPH staff will review your health systems and data assessments.
- DPH will provide you with a summary, including training recommendations and highlighting areas for more focused work.
- DPH staff have developed a logic model template to help you think through your project goals. See the Tools/Resources section.
- DPH staff have developed a SMART objective worksheet to help you identify objectives that are specific, measurable, achievable, relevant, and time-delineated. See the Tools/Resources section.

## TOOLS / RESOURCES (DATA)

- Health Systems Assessment Tool provided by DPH after commitment form received.
- Logic Model Development – Use a logic model to help [guide](#) the work you will be doing. The Centers for Disease Control and Prevention (CDC) has developed a guide to help walk people through each step of developing a logic model. DPH has developed a logic model template you can use – See Appendix B.
- Developing SMART objectives – Create meaningful objectives for your project. DPH has developed a SMART goals and objectives guide to assist you – See Appendix C.
- Federally Qualified Health Center (FQHC)/Health Center Program Grantee Data Trends: this [data](#) is available for FQHCs to monitor their trends on a number of indicators, including hypertension and diabetes prevalence.
- Public Health Districts: Utilize the [OASIS](#) website to monitor trends on a number of indicators, including heart disease and diabetes quality measures. Data do not include hypertension quality measures, and they only go through 2014, so individual public health districts will have more recent data.
- Hospitals: The [Guideline Advantage](#) is a qualified clinical data registry that uses data collection, analysis, and feedback to translate guidelines into practice.
- The [National Cardiovascular Disease Registry](#) is a suite of registries designed for the inpatient and outpatient setting to address patients with diabetes and hypertension.
- Health Management Organization (HMO): The National Committee for Quality Assurance (NCQA) provides a [list](#) of the current Healthcare Effectiveness and Data Information Set (HEDIS) data; more than 90% of health plans—public and commercial—report HEDIS data annually. Measures include blood pressure control and comprehensive diabetes management.
- Accountable Care Organizations (ACO): Center for Medicaid and Medicare Services (CMS) provides a [repository](#) of quality measures for Medicare fee-for-service. Measures of interest include 17, 18, 21-28.
- Care Management Organizations (CMO) - this includes Amerigroup, Peach State Health Plan, and WellCare. Data can be obtained through [Quality Compass](#), developed by the NCQA.
- [Healthcare Effectiveness Data and Information Set \(HEDIS\)](#).
- Data use agreement – this document will be reviewed and signed by DPH and the health system.

# T Training

## Training

### WHY?

Based on the findings from your data and health systems assessments, your team and DPH will have identified areas where focused training may be beneficial. Potential training areas include:

- Standardizing blood pressure measurement
- Coaching patients for successful self-management
- Implementing protocols for population management of hypertension
- Motivating change

### WHAT DO I NEED TO DO?

- Review assessment results and training recommendations with your team.
- Work with DPH staff to identify existing training opportunities in the needed areas.

### HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

The tools listed here are just a few of the examples available to you. DPH staff can assist in identifying additional resources to help your team. DPH also offers training opportunities in hypertension control and diabetes management—send an email to DPH at [chronic.disease@dph.ga.gov](mailto:chronic.disease@dph.ga.gov) if you are interested in learning more. DPH can also help connect you with experts who offer the kind of training your team is seeking.

### TOOLS / RESOURCES (TRAINING)

- DPH has developed treatment protocols for HTN and DM to be used by public health districts. For more information, contact [chronic.disease@dph.ga.gov](mailto:chronic.disease@dph.ga.gov).
- The National Association of Chronic Disease Directors (NACDD) has developed a [comprehensive resource](#) on many topics related to DM self-management, including accreditation, training, and reimbursement.
- Hypertension treatment protocol information is also available from the national [Million Hearts® Initiative](#).
- [Improving the Screening, Prevention, and Management of Hypertension: An Implementation Tool for Clinical Practice Teams](#), developed by Washington State Department of Health.
- [Team Up. Pressure Down](#), developed by Million Hearts®, promotes a team-based approach to addressing hypertension and provides health professionals with resources to promote medication adherence.
- [Hiding in Plain Sight resources from Million Hearts®](#)
  - [Hypertension Prevalence Estimator Tool](#)
  - Compilation of [resources](#) for identifying patients with undiagnosed hypertension from National Association of Community Health Centers.
- [Check. Change. Control.](#), developed by American Heart Association (AHA) and American Stroke Association (ASA), is designed to empower people to learn about, monitor, and manage their blood pressure.
- Self-management [support resources](#) available from the Agency for Healthcare Research and Quality (AHRQ).

# A Activate

## Activate your Community Resources

### WHY?

Recognize that patients may spend but a small fraction of their lives in the clinic setting. The remainder of time is spent in the broader community—where they live, learn, work, pray, and play. It's also in this broader community that your patient population must navigate to help manage their conditions—this is where they engage in physical activity, where they eat, and where they receive their medications.

### WHAT DO I NEED TO DO?

- Identify a team member who understands what community resources are available for the patient population you serve. This could be a community health worker (CHW), medical assistant, or a care coordinator.
- Identify how you can gather information from your patient population as to what community resources they need. This could be documented in a self-management plan.
- Clinic leadership should examine this information to see what community resource gaps exist. This information can be shared with DPH.
- Work with community-based organizations to determine whether the needed resources already exist in the community. This could include the local health departments, the hospital association, local pharmacies, area agencies on aging, and area health education centers.

**Incentive #2 -  
Recognition during  
the in-person  
orientation meeting**

### HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

DPH supports a Chronic Disease Council, which helps guide chronic disease-related work across the state. Members include Georgia Medical Association, Employers Like Me, local pharmacies, Georgia Association for Primary Care, Alliant GMCF and Georgia Health Information Technology Extension Center (GA-HITEC). The Chronic Disease Council may be able to connect your team with resources you need for your area. For more information, contact [chronic.disease@dph.ga.gov](mailto:chronic.disease@dph.ga.gov).



## TOOLS AND RESOURCES FOR COMMUNITY ACTIVATION

- Does your region have a non-profit hospital that has completed a community health needs assessment (CHNA)? Thirty-eight nonprofit hospitals' CHNAs in Georgia were reviewed and the results are compiled here. Compare the results of their assessment with the needs identified for your patient population to identify areas of opportunity and greatest need.
- [Georgia Health Information Technology Extension Center](#) (GA--HITEC). This is Georgia's regional extension center, and offers training and technical assistance in implementing electronic health records and attaining meaningful use.
- [Area Agencies on Aging](#) (AAAs). The Georgia Division of Aging Services coordinates with twelve AAAs, which coordinate all community--based services for older Georgians.
- [Area Health Education Centers](#) (AHECs). These centers are networks of colleges and universities, along with federally--qualified and migrant health centers serving rural and underserved populations. The goal of the six AHECs in Georgia is to recruit, train, and retain qualified health professionals to improve access to quality primary care in medically underserved areas of the state.
- Georgia Hypertension Collaborative. The Georgia Hypertension Collaborative, established by the Georgia Department of Public Health in 2014, was created to convene public health practitioners, clinicians, partners and stakeholders across the state with the goal of reducing the prevalence of hypertension and heart disease among the population. This collaborative provides a platform for partners and stakeholders to share information on programs, initiatives, interventions and evidence-based practices in addition to providing guidance and assistance on hypertension, heart disease and its associated risk factors.
- Georgia Diabetes Advisory Council. The Georgia Diabetes Advisory Council consists of diabetes stakeholders identified to share opportunities and ideas for planning and implementation of interventions that support the prevention and management of diabetes. This Advisory Council is a way for all the organizations within the state working on diabetes prevention and management—public and private sector clinics, worksites, and community settings—to coordinate their efforts and broaden their reach.
- [Georgia Clinical Transformation Team](#). The Georgia Clinical Transformation Team (GCT2) is a unique interdisciplinary collaboration among groups of various healthcare professionals within Georgia. GCT2 was created to collaborate on practice quality improvement and facilitation efforts around cardiac care, obesity, tobacco use and diabetes among Georgia adults through efficient use of healthcare technology and team-based care to improve the health and wellbeing of the population. Fundamental to this collaborative is the use of public health practices to implement health systems change through: 1) policies on the reporting of national quality measures, 2) adoption of systems change practices and 3) encouraging education on the prevention of chronic diseases using the Triple Aim Model. GCT2 partners include Alliant Quality, DCH Medicaid, GA--HITEC, GAFF, Georgia DPH, GAPHC, Georgia Chapter of ACP, GHA, GPHA and MAG. The GCT2 offers 30-minute webinars each month on topics that may be relevant to your teams. Click [here](#) for archived webinars and to sign up for future events.
- [Georgia Hospital Association](#).
- [Medical Association of Georgia](#).
- [American Heart Association](#).
- [American Diabetes Association](#).

# P Plan

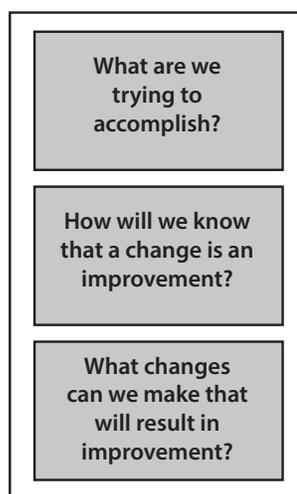
## Plan of Action

### WHY?

You have committed to participating. You have assessed your practice. You have identified areas where you would like more training. Now it is time to develop your action plan for implementation.

### WHAT DO I NEED TO DO?

- Develop a practice aim statement and goals for your project. The aim should be time-specific and measurable, and it should define your population of interest. See the Plan of Action resources for an example.
- Select the Plans (Appendix D) your team wants to implement. For each plan, your health system will need to address multiple components: system redesign, EHR/clinical information system, decision support, self-management and community resources.
  - Plan of Action A: Improve management of patients with hypertension
  - Plan of Action B: Identify patients with undiagnosed hypertension
  - Plan of Action C: Improve management of patients with diabetes
  - Plan of Action D: Identify patients at risk for pre-diabetes
- Select changes you'd like to make in your practice that will address your plan of action. See the Plan of Action resources for examples of evidence-based changes you could make around either hypertension or diabetes.
- For each change, consider using the [Institute for Healthcare Improvement Model for Improvement](#) to guide your work. The model poses three questions that support the team when implementing small tests of change through the Plan-Do-Study-Act (PDSA) cycle:
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What changes can we make that will result in an improvement?



#### Setting Aims

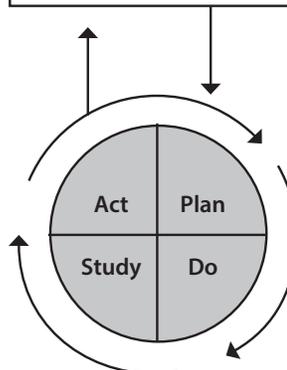
Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

#### Establishing Measures

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

#### Selecting Changes

All improvement require making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.



#### Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the result, and acting on what is learned. This is the scientific method used for action-oriented learning.

## HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

- Provide technical support for each of the Plans of Action, how to implement the change package you select.
- Connect you with a regional extension center (REC) or quality improvement organization (QIO) for further assistance
- Offer opportunities for provider teams to network and communicate goals, objectives, strategies, sustainability plans, as well as to evaluate progress.
- Assist you if your team is interested in becoming Certified Diabetes Educator (CDE) certified or in obtaining Diabetes Self-Management Education (DSME) accreditation.

## TOOLS / RESOURCES (IMPLEMENTATION)

- Million Hearts® developed the Hypertension Control Change Package for Clinicians in 2015 and focused their change concepts and ideas around three major areas:
  1. Key Foundations – how to establish a quality improvement foundation for effective hypertension control efforts. This could include identifying a clinical champion as well as making hypertension control a priority for the health system.
  2. Population Health Management – how to both monitor and manage hypertension across the patient population. This could include implementing treatment protocols and using data to drive improvement.
  3. Individual Patient Supports – how to better manage hypertension for individual patients. This includes examples from each step of patient care: pre-visit, check-in, during the visit, checkout, and post-visit.
- California Academy of Family Physicians Diabetes Change Package (CAFP). CAFP developed a change package using the Chronic Care Model as a framework. Developed by the MacColl Institute, the Chronic Care Model as originally developed frames systems and quality improvement around six core components:
  - Delivery system design
  - Decision support
  - Clinical information systems
  - Self-management support
  - Community resources and policies
  - Health system organization of health care
- [Implementing Practice Protocols](#) – the Million Hearts® protocol website includes resources and protocol templates and examples for tobacco cessation and hypertension control.
- [Million Hearts® Hypertension Control Change Package](#).
- [National Association of Community Health Centers Undiagnosed Hypertension Change Package of Tools](#).
- [Improving the Screening, Prevention, and Management of Hypertension: An Implementation Tool for Clinic Practice Teams](#).
- [Ten Steps for Improving Blood Pressure Control in New Hampshire: A Practical Guide for Clinicians and Community Partners](#).
- [California Academy of Family Physicians Diabetes Change Package](#).
- [AMA/CDC Diabetes Toolkit](#).

## Hypertension AIM Statement Example

### THREE MONTH AIM STATEMENT:

By July 2011, Neighborhood Health Clinic will implement proactive changes to improve the management of hypertension based on the Hypertension Change Package. This will provide measurably improved care for our patients with hypertension.

### OUR POPULATION IS DEFINED AS:

Patients of participating health care providers who have diagnosis of essential (primary) hypertension as defined by the clinic, over 18 years of age, and who have been seen at the clinic at least two times in the last year.

### WE EXPECT THAT:

- The percentage of patients with a most recent blood pressure of less than 140/90 will be **five percent** above baseline within three months.
- The percentage of patients with diabetes or CKD with blood pressure of less than 130/80 will be five percent above baseline withing three months.
- The percentage of patients with documentation of self-management goal will be **20 percent above baseline within three months.**
- The percentage of patients who use tobacco – who have been offered tobacco-cessation counseling in the past 12 months – will be 20 percent above baseline **within three months.**

realistic goals

clear numerical target, measurable

time-specific

### WE WILL ACHIEVE THIS BY:

Starting with small steps of change in two areas of the Change Package and progressing to performing small steps of change in all eight components of the Change Package. Changes that have been shown to be effective will then be implemented.

The team will meet weekly to track what is being learned and to monitor progress.

# Utilize

## Utilize your Plan of Action

### WHY?

Ideally, your team has been involved in developing your action plan. Your plan will work best when all team players support the action steps and what their role will be in carrying out these action steps. Every team member should have a clear role in implementing the action plan.

### WHAT DO I NEED TO DO?

- [Determine the role of each team members.](#)
- Incorporate the action steps into your regular team huddle. Discuss plans for action each day—who will be providing outreach to patients to bring them back for a follow-up appointment, have the data been reviewed to look for signs of improvement or increased attention, are there new community resources available that the team should be aware of?
- Create a Performance Improvement Plan Committee (PIP) – the committee should include representatives of the team and the quality improvement director. The PIP should focus on the areas of greatest need for your health system, and could include:
  - Clinical practice guidelines
  - Risk management (reduce waste, misuse, resource overuse)
  - Reporting and compliance
  - Evaluation
  - Pharmacy and therapeutics

### HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

- DPH staff can provide you with a team-based care member role form that can help you determine the role of each person on your team.
- Quarterly network call – DPH staff will coordinate a phone or virtual meeting to discuss what is working, what challenges teams are facing and how they can be addressed, as well as provide a forum to discuss any issues teams are having with implementation.
- DPH can help the PIP committee identify resources that will help them address the results of the needs assessment.
- DPH can provide technical assistance on how best to utilize and begin to implement your Plan of Action. Complete the online CATAPULT Technical Assistance Request Form.

### TOOLS / RESOURCES

- [Improving the Screening, Prevention, and Management of Hypertension: An Implementation Tool for Clinical Practice Teams, developed by Washington State Department of Health](#) addresses each step of the quality improvement process, including how to think about clinic flows, systems design and redesign, as well as considerations for implementing clinical decision support tools.
- [Million Hearts® Hypertension Control Change Package.](#)
- [AMA/CDC Diabetes Toolkit.](#)
- [National Association of Community Health Centers Undiagnosed Hypertension Change Package of Tools.](#)
- [California Academy of Family Physicians Diabetes Change Package.](#)
- [PDSA Cycle Overview.](#)
- Technical Assistance Request Form (Available in Appendix E.)
- Team Member Role / Member Assignment Form (Available in Appendix E.)

# Leverage

## Leverage your Data System

### WHY?

Data and data systems are critical to any quality improvement process. In addition to tracking outcomes data, it is important to also examine data that can reflect changes in the processes involved in delivering care. In addition to gathering baseline data, you will be responsible for submitting monthly data reports on a set of core and outcome measures. The importance of running monthly data reports is to assess whether the changes you are testing are resulting in improvement of your defined measures.

### WHAT DO I NEED TO DO?

- Identify the person from your team who will be responsible for running data reports.
- Determine if you can report on NQF 18 and NQF 59
  - NQF 18 – Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
  - NQF 59 – Percentage of patients 18-75 years of age with type 1 and type 2 diabetes whose most recent HbA1c level during the measurement year was greater than 9.0 (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
- Collect data on chart review measures. Reporting form Appendix F.
- Report your data to DPH – some measures will be collected monthly, some will be collected quarterly, and some will be collected annually.

**Incentive #3 - Your health system will be highlighted in the Chronic Disease monthly newsletter.**

### HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

- Review your monthly reports and provide you with feedback.
- Provide you with your own practice data and see the aggregate rates for all the practices in the project.
- Connect you with the QIO or REC if you need help getting this data from your EHR
- Provide technical assistance on how best to leverage your data. Complete the online CATAPULT Technical Assistance Request Form. (Appendix E.)

## TOOLS / RESOURCES

- List of measures to report on each month
  - Monthly required EHR measures
    - ♦ Proportion of patients ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year
    - ♦ Proportion of patients ages 18-75 with either Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year was >9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
  - Monthly required chart review measures for patients with diabetes
    - ♦ Percentage of patients diagnosed with diabetes (Type 1 or Type 2) in your practice/organization
    - ♦ Percentage of patients with diabetes (Type 1 or Type 2) who are in adherence to medication regimens
    - ♦ Percentage of patients with diabetes with documented presence (including frequency and severity) of hypoglycemic episodes
    - ♦ Percentage of patients with diabetes with documented absence (including frequency and severity) of hypoglycemic episodes
    - ♦ Percentage of patients with diabetes having an HbA1c greater than 9
    - ♦ Percentage of patients with HbA1c greater than 9 who have not previously completed diabetes self-management education program and were referred to a CDE or DSME program
  - Monthly chart review measures for patients with hypertension
    - ♦ Percentage of patients diagnosed with hypertension in your practice/organization
    - ♦ Percentage of patients with high blood pressure who are in adherence to medication regimens
    - ♦ Percentage of patients with high blood pressure who have achieved blood pressure control (<140/90)
    - ♦ For identifying undiagnosed hypertension: percentage of patients ages 18-84 who do not have a diagnosis of hypertension, and have 2 blood pressure readings in the last year >140/90
- PDSA reporting – DPH will provide you with the Monthly CATAPULT PDSA Reporting Form. (Appendix F.)
- [GA-HITEC](#)
- [Wide River Healthcare IT Consulting](#) offers a help desk and can support health systems in their work related to meaningful use, PQRS reporting, chronic care management and more.



# Test

## Test and Spread your Approach

### WHY?

You will find that small, rapid tests of change will allow you to quickly determine if your action plan will help you to achieve your goals for the project. According to the Institute for Healthcare Improvement, you test changes to:

- Increase your belief that the change will result in improvement
- Decide which of several proposed changes will lead to the desired improvement
- Evaluate how much improvement can be expected from the change
- Decide whether the proposed change will work in the broader health system

### SPREAD/SCALING AND SUSTAINABILITY

Spread is the process of taking a successful implementation process from a pilot unit or pilot population and replicating that change or package of changes in other parts of the organization or other organizations. During implementation, teams learn valuable lessons necessary for successful spread, including key infrastructure issues, optimal sequencing of tasks, and working with people to help them adopt and adapt a change.

### WHAT DO I NEED TO DO?

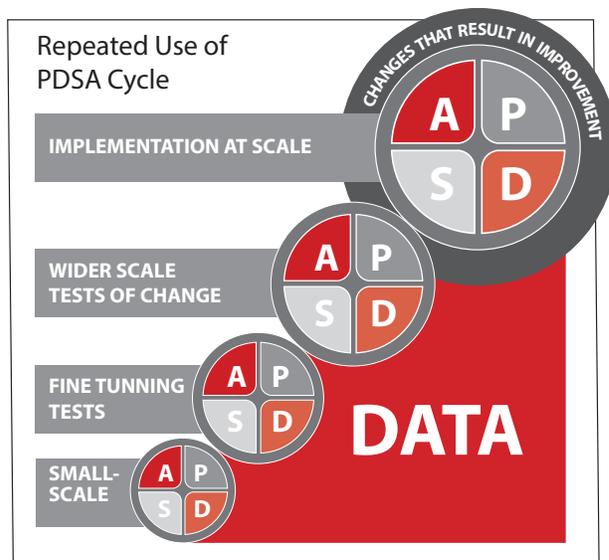
- Test small changes by following the Plan-Do-Study-Act cycle:
  - Plan the change and how you will collect data
  - Do – try out the test on a small scale
  - Study the results – did the change make the improvement you were intending?
  - Act – refine the change based on what was learned before
- Begin to test the changes at a gradually larger scale, repeating the PDSA cycle. Over time, you will scale those changes that have consistently led to an improvement across your health system.

### HOW CAN THE GEORGIA DEPARTMENT OF PUBLIC HEALTH HELP?

- Technical support around how to do the PDSA.
- Training webinar on PDSA.

### TOOLS / RESOURCES

- PDSA reporting – DPH will provide you with the Monthly CATAPULT PDSA Reporting Form. (Appendix F.)
- [IHI Spread and Sustainability](#)



#### Incentive #4 -

- Recognition at the GA Board of Public Health
- Platinum CATAPULT Award

## GLOSSARY

### DIABETES

A metabolic disease in which the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood

The following websites provide definitions of diabetes and pre-diabetes and diagnosis guidelines:

[http://care.diabetesjournals.org/content/37/Supplement\\_1/S81.full](http://care.diabetesjournals.org/content/37/Supplement_1/S81.full)

<http://www.diabetes.org/are-you-at-risk/prediabetes/>

### DIABETES SELF-MANAGEMENT EDUCATION (DSME) PROGRAM

Programs offering diabetes self-management education with American Association of Diabetes Educators (AADE) accreditation, American Diabetes Association (ADA) recognition, State accreditation/certification, and/or Stanford licensure. A DSME program includes satellite sites established by the above programs.

### HEALTH SYSTEM

A health system can be categorized as either:

- Federally Qualified Health Centers
- Public Health Districts
- Hospital-based health system with affiliated primary care practices
- Health Maintenance Organizations
- Accountable Care Organizations
- Care Management Organizations

### HIGH BLOOD PRESSURE/HYPERTENSION

Systolic blood pressure (SBP) of 140 mm Hg or higher and/or diastolic blood pressure (DBP) of 90 mm Hg or higher (CDC, 2013).

### MEDICATION ADHERENCE

The World Health Organization defines adherence as "the extent to which a person's behavior – taking medications, following a diet and/or executing lifestyle changes – corresponds with agreed recommendations from a health care provider."

Medication adherence can further be distinguished as primary adherence (prescription initially filled within a specified time period) and secondary adherence (i.e., prescription refilled within a specified time period) (Raebel 2013).

Resources available for hypertension medication adherence:

<https://www.cdc.gov/vitalsigns/blood-pressure/>

Resources available for diabetes medication adherence:

<http://www.niddk.nih.gov/health-information/health-communication-programs/ndep/health-care-professionals/medication-adherence/resources-health-care-teams/Pages/index.aspx>

## **MULTI-DISCIPLINARY TEAM APPROACH (OR ALSO REFERRED TO AS TEAM-BASED CARE)**

Team-based care is established by adding new staff or changing the roles of existing staff to work with a primary care provider. Each team includes the patient, the patient's primary care provider, and other non-physician professionals such as nurses, pharmacists, dietitians, social workers, patient navigators, and/or community health workers. Team members provide process support such as team huddles and share responsibilities of hypertension care to complement the activities of the primary care provider. These responsibilities include medication management; patient follow-up; and adherence and self-management support (Guide to Community Preventive Services, 2012).

## **NATIONAL QUALITY FORUM (NQF) MEASURE 18**

Clinical quality measure endorsed by National Quality Forum since 2009. The National Committee for Quality Assurance (NCQA) is the data steward for this measure. NQF 0018/PQRS 236 is defined as "The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year." This measurement excludes all patients: 1) with evidence of end-stage renal disease on or prior to the end of the measurement year; 2) with a diagnosis of pregnancy during the measurement year; 3) who had an admission to a non-acute inpatient setting during the measurement year. Various health care systems are required or incentivized to report this clinical measure to funders/quality improvement entities annually.

## **NATIONAL QUALITY FORUM (NQF) MEASURE 59**

Clinical quality measure is endorsed by National Committee for Quality Assurance (NCQA) since 2009. NQF 59 is defined as "The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year." This definition excludes all patients: 1) with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement; 2) with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.

## **PATIENT SELF-MANAGEMENT**

The systematic provision of education and supportive interventions by staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting and problem-solving support (IOM, 2001).

## **POLICY OR SYSTEM**

Includes laws, regulations, procedures, protocols, quality improvement processes, structures, arrangements, administrative actions, incentives, or voluntary practices of governments and other institutions to encourage things such as multi-disciplinary team approach to blood pressure control/A1C control, patient self-management of high blood pressure. For example, these may be set by the provider, payer, Accountable Care Organization, Medicaid or Medicare.

## **PRE-DIABETES**

Pre-diabetes is a condition in which blood glucose levels are higher than normal, but not high enough to be classified as diabetes. Those with pre-diabetes are at increased risk of developing type 2 diabetes within a decade unless they adopt a healthier lifestyle that includes weight loss and more physical activity (Joslin Diabetes Center, 2016).

## **SELF-MANAGEMENT PLAN TO MANAGE HIGH BLOOD PRESSURE**

Documentation or notation by a health care provider, non-physician team member, or community health care extender (physician, other members of a clinic practice team, community health worker, community pharmacist) in a patient's medical record or client file confirming that the patient has developed a self-management plan to manage their high blood pressure. The plan may include goals related to any of the following:

- Medication adherence
- Self-monitoring of blood pressure levels
- Increased consumption of nutritious food and beverages
- Increased physical activity
- Maintaining medical appointments

Evidence of a patient self-management plan could include forms, tools or resources such as goal setting tools, action planning documents, self-management support patient planning worksheets, referral confirmation from a community resource, etc.

## **SELF-MEASURED BLOOD PRESSURE MONITORING TIED TO CLINICAL SUPPORT**

Self-measured blood pressure monitoring differs from clinic-based and ambulatory blood pressure monitoring; and refers to the regular use of a personal blood pressure measuring device outside of a clinical setting to monitor one's own blood pressure.

## **TEAM-BASED CARE (SEE MULTIDISCIPLINARY TEAM APPROACH)**

## **UNDIAGNOSED HYPERTENSION**

Patients ages 18-85 who do not have a diagnosis of hypertension, and have two blood pressure readings in the last year >140/90. Can be measured using searches of electronic health records.

## References

Centers for Disease Control and Prevention. *Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2013

Guide to Community Preventive Services. Cardiovascular disease prevention and control: team-based care to improve blood pressure control.

[www.thecommunityguide.org/cvd/teambasedcare.html](http://www.thecommunityguide.org/cvd/teambasedcare.html). Last updated: April 2012

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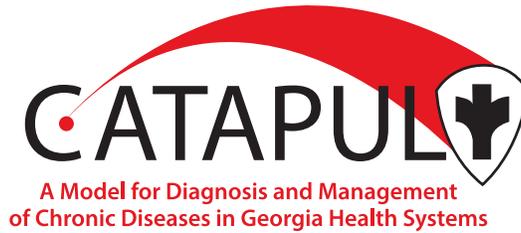
Nau DP. Proportion of Days Covered (PDC) as a Preferred Method of Measuring Medication Adherence. Pharmacy Quality Alliance. Accessed on January 22, 2014 at:

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Raebel MA, Schmittiel J, Karter AJ, Konieczny JL, Steiner JF. 2013. Standardizing Terminology and Definitions of Medication Adherence and Persistence in Research Employing Electronic Databases. *Medical Care* 51(8) Suppl 3, S11-S21.

Uhlig K, Balk EM, Patel K, Ip S, Kitsios GD, Obadan NO, et al. *Self-Measured Blood Pressure Monitoring: Comparative Effectiveness*. Comparative Effectiveness Review No. 45. Rockville, MD: Agency for Healthcare Research and Quality, US Dept. of Health and Human Services; 2012.

## APPENDIX A – Statement of Commitment



### CATAPULT STATEMENT OF COMMITMENT

By signing below, I acknowledge my understanding of the goals and expectations of CATAPULT, and commit to full participation in the initiative as defined by agreement to fulfill the expectations outlined in the CATAPULT Manual.

**PRACTICE NAME:** CLICK HERE TO ENTER TEXT.

**PRACTICE ADDRESS:** CLICK HERE TO ENTER TEXT.

#### PROVIDER LEADER

Signed: \_\_\_\_\_ Email: \_\_\_\_\_  
Name: \_\_\_\_\_ Date: \_\_\_\_\_

#### PROJECT MANAGER OR LEAD ADMINISTRATOR

Signed: \_\_\_\_\_ Email: \_\_\_\_\_  
Name: \_\_\_\_\_ Date: \_\_\_\_\_

#### HEALTH INFORMATION TECHNOLOGY (HEALTH IT) CONTACT

Name: \_\_\_\_\_ Email: \_\_\_\_\_

#### QUALITY IMPROVEMENT DIRECTOR

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Please return to: Health Systems Project Manager

2 Peachtree Street, NW

Atlanta, GA 30303

Fax: 404-657-4338

Email: [chronic.disease@dph.ga.gov](mailto:chronic.disease@dph.ga.gov)

## APPENDIX B – Logic Model

Inputs	Activities	Outputs	Outcomes -- Impact		
			<i>Short</i>	<i>Medium</i>	<i>Long</i>
			Learning	Action	Conditions
Time:					
Funding:					
Partners:					
Research:					
Outlets for Marketing:					
Technology:					
Facility:					
Volunteers/ Staff:					
Participants:					

**ENVIRONMENTAL CONSTRAINTS**

**ASSUMPTIONS**

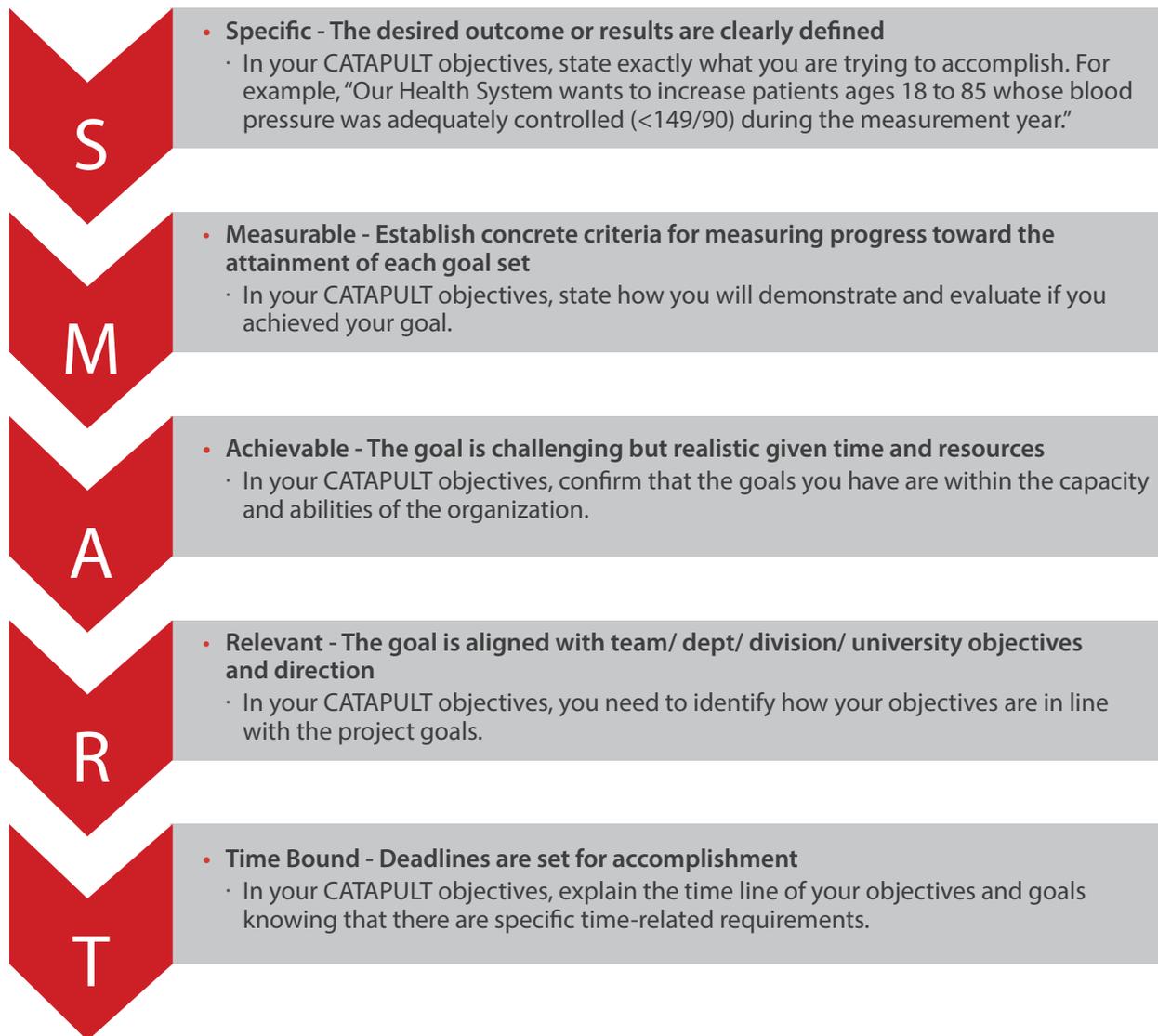
Outcome	Target	Data Method Collection
<b>Short</b>		
<b>Medium</b>		
<b>Long</b>		

## Appendix C – Creating Objectives and AIM Statements

### SMART OBJECTIVES

#### GUIDELINES FOR WRITING EFFECTIVE GOALS USING SMART OBJECTIVES

Use the SMART goal model, as outlined on the Goal Worksheet on the next page, to assist with writing more effective goals for CATAPULT. Below is a brief explanation of SMART and all of the components that need to be included or considered when writing a SMART objective statement:



## CATAPULT SMART GOAL WORKSHEET

Name:	Position:

Step 1: List your goal(s) for CATAPULT. Step 2: In the table below, identify how your goals are SMART.

**GOALS:**

Goal 1:

S - Specific	M – Measurable	A – Achievable	R - Relevant	T – Time Bound
What specifically are you interested in impacting? For example: “Increasing the number of patients who have achieved blood pressure control”	How are you going to determine if a change occurred? For example: “Increasing the number of patients who have achieved blood pressure control by 5%”	The goal / objective has to be realistic. For example, you can briefly explain how increasing the number of patients from the previous example by 5% is achievable for you.	The goal/objective has to be relevant. How is this objective related to both your organization’s mission and to CATAPULT?	What are the deadlines for this goal? For example, are you setting your own deadline to see the increase in the previous example, or are you going to use the time line set by DPH for data reviews?

**CDC Hypertension Control Change Package for Clinicians – refer to this document for tools and resources to support each of the change concepts listed.**

**Key Foundations**

<b>Change Concepts</b>	<b>Change Ideas</b>
Make hypertension control a practice priority	<ul style="list-style-type: none"> <li>• Designate a hypertension champion in the practice</li> <li>• Ensure care team engagement in hypertension control</li> <li>• Provide blood pressure checks without appointment or co-pay</li> </ul>
Implement a policy and process to address blood pressure for every patient with hypertension at every visit	<ul style="list-style-type: none"> <li>• Develop hypertension control policy and procedures</li> <li>• Leverage local patient centered medical home activities to help drive comprehensive approach to hypertension management</li> <li>• Develop a flowchart for how hypertensive patients will be proactively tracked and managed</li> </ul>
Train and evaluate direct care staff on accurate blood pressure measurement and recording	<ul style="list-style-type: none"> <li>• Provide guidance on measuring blood pressure accurately</li> <li>• Assess adherence to proper blood pressure measurement technique</li> </ul>
Systematically use evidence-based guidelines and treatment protocols	<ul style="list-style-type: none"> <li>• Implement hypertension guidelines effectively, using the most appropriate information and recommendations</li> <li>• Deploy hypertension protocols and algorithms</li> <li>• Overcome treatment inertia</li> <li>• Manage resistant hypertension effectively</li> </ul>
Equip direct care staff to facilitate patient self-management	<ul style="list-style-type: none"> <li>• Put a prevention, engagement, and self-management program in place</li> <li>• Ensure team is skilled in identifying/promoting patient medication adherence</li> <li>• Establish a program to support home blood pressure monitoring</li> </ul>

**Population Health Management**

Use a registry to identify, track, and manage patients with hypertension	<ul style="list-style-type: none"> <li>• Implement a hypertension registry</li> <li>• Identify patients with elevated blood pressure yet without a hypertension diagnosis; diagnose hypertension as appropriate</li> <li>• Use a defined process for outreach (e.g., via phone, mail, email, text message) to patients with uncontrolled hypertension and those otherwise needing follow-up</li> </ul>
Use clinician-managed protocols for medication adjustments and lifestyle recommendations	<ul style="list-style-type: none"> <li>• Use protocols to cover proactive outreach driven by registry use and respond to patient-submitted home blood pressure readings</li> </ul>
Use practice data to drive improvement	<ul style="list-style-type: none"> <li>• Determine hypertension control metrics for the practice</li> <li>• Regularly provide a dashboard with blood pressure goals, metrics, and performance</li> </ul>

Individual Patient Supports	
Support patients in hypertension self-management during their routine daily activities (e.g., not related to any specific visits)	<ul style="list-style-type: none"> <li>• Use an online patient portal or other approaches so that patients can access tools, information, and practice staff outside face-to-face encounters to address home blood pressure readings and other needs</li> <li>• Ensure that the self-management support provided to patients is helpful in their daily routine (e.g., when making food and lifestyle choices)</li> </ul>
Prepare patients and care team beforehand for effective hypertension management during office visits (e.g., via previsit patient outreach and team huddles)	<ul style="list-style-type: none"> <li>• Contact patients to confirm upcoming appointments; instruct them to bring medications, medication list, and home blood pressure readings; tell them to take medications as instructed on the day of the visit; if possible, instruct them on submitting home blood pressure readings periodically via apps/portal</li> <li>• Use a flowchart or dashboard with care gaps highlighted to support team huddles</li> <li>• Design workflows and use tools to ensure that indicated orders/actions occur during the visit</li> </ul>
Use each patient visit phase to optimize hypertension management: intake (e.g., check-in, waiting, rooming)	<ul style="list-style-type: none"> <li>• Provide patients with educational materials to help them understand hypertension and its implications</li> <li>• Provide patient with tools to support their visit agenda and goal setting</li> <li>• Measure, document, and repeat blood pressure correctly as indicated; flag abnormal readings</li> <li>• Reconcile medications patient is actually taking with the record's medication list</li> </ul>
Use each patient visit phase to optimize hypertension management: provider encounter (e.g., documentation, ordering, patient education/engagement)	<ul style="list-style-type: none"> <li>• Use documentation templates to help capture key data such as patient treatment goals, barriers to adherence, etc.</li> <li>• Use order sets (e.g., with prompts for med titration; increase compliance via prescribing from patient insurance formulary, using once daily/fixed dose combinations when possible) and standing orders to support evidence-based and individualized care</li> <li>• Assess individual risk and counsel using motivational interviewing techniques; agree on a shared action plan</li> <li>• Support blood pressure self-monitoring: advise on choosing device/cuff size, check device for accuracy, train patient on use, provide blood pressure logs (electronic/paper/portal)</li> <li>• On the patient portal, provide educational materials to support a low-sodium diet and exercise and links to community resources or support groups</li> <li>• Support medication adherence by providing clear written and verbal instructions and encouraging patients to use medication reminders</li> </ul>
Use each patient visit phase to optimize hypertension management: encounter closing (e.g., checkout)	<ul style="list-style-type: none"> <li>• Provide patients with a written self-management plan, visit summary, and follow-up guidance at the end of each visit</li> </ul>

**California Academy of Family Physicians Diabetes Initiative Care Model Change Package**  
**Refer to this document for tools and resources to support each of the change concepts listed.**

Chronic Care Model Component	Change Concept
Delivery System Design	<ul style="list-style-type: none"> <li>• Identify your diabetes patient population</li> <li>• Use standardized procedures for routine referral and care</li> <li>• Bring multidisciplinary services together to promote continuity of care through individual or group planned visits</li> <li>• Cross-train staff and expand capabilities to improve diabetes case management</li> <li>• Incorporate case management, promotora, and other programs to help with managing patients and follow-up</li> </ul>
Clinical Information System	<ul style="list-style-type: none"> <li>• Implement electronic tracking system for proactive management of your diabetes patient population</li> <li>• Use clinical information systems to provide protection against errors</li> <li>• Develop flow sheets for provider/patient interaction and care management</li> </ul>
Decision Support	<ul style="list-style-type: none"> <li>• Embed current evidence-based guidelines into daily clinical care</li> <li>• Provide ongoing care management feedback to providers and team</li> <li>• Integrate specialist expertise into primary care settings through increased communication</li> <li>• Use proven provider education modalities</li> <li>• Use care management, or team conferences/huddles to raise patient issues</li> <li>• Educate patients about guideline recommendations</li> </ul>
Self-Management Support	<ul style="list-style-type: none"> <li>• Train providers and other key staff to help patients set self-management goals</li> <li>• Empower patients to manage their health by involving them in all goal setting and health care decisions, and by emphasizing their central role in this process</li> <li>• Emphasize the patient's role in managing his/her diabetes</li> <li>• Offer group visits to educate and provide support</li> <li>• Use culturally-appropriate, standardized educational materials</li> <li>• Identify and utilize community resources to achieve patient self-management goals</li> </ul>
Community Resources and Policies	<ul style="list-style-type: none"> <li>• Identify and address socioeconomic barriers to care: lack of knowledge about resources; under or uninsured patient populations; inability to access or finance care</li> <li>• Identify cultural and linguistic opportunities/resources to improve diabetes care and management</li> <li>• Improve access and participation in community-offered educational classes and support groups</li> <li>• Raise community awareness through networking, education, and utilization of lay workers as a link/resource between community and your practice</li> </ul>
Organization and Health Systems	<ul style="list-style-type: none"> <li>• Define and communicate priorities and progress to relevant practice members, senior leaders, and staff on a regular basis</li> <li>• Integrate chronic disease management into the strategic, business, and quality improvement plans for your practice</li> <li>• Develop and promote the business case for your project as it relates to clinical, operational, and financial goals and outcomes</li> <li>• Create strategies to spread successful changes to other clinical conditions, sites, providers, and teams</li> <li>• Empower teams to create and sustain systems changes</li> <li>• Actively participate in the development of community health policies to improve diabetes</li> </ul>

## Appendix D - CATAPULT Plans of Action

Plan of Action 1: Improve management of patients with hypertension

**Option A- Hypertension Management Program:** The health system will collaborate with physician practices to focus on the control of undiagnosed hypertension using self-management plans in their patient population.

- a. Practices will identify and designate a healthcare provider lead
- b. Practices will use their EHR to identify undiagnosed hypertensive patients to enroll in the Hypertension Management Program
- c. Each hypertensive patient recruited will be evaluated and treatment will be recommended based on the Joint National Committee
- d. Practices will identify a case manager to encourage appointment retention and medication therapy management and a case management strategy (to include self-management plans). Self-management plans may include:
  - i. Medication Adherence
  - ii. Self-Monitoring of blood pressure levels
  - iii. Increased consumption of nutritious foods and beverages
  - iv. Increased physical activity
  - v. Maintaining medical appointments
- e. Practices will follow the enrolled patients for nine months to monitor their hypertension status and determine if the disease is being controlled
- f. To the extent possible, based on their EHR system, practices will also report on NQF 18 and 59
- g. Tools and resources will be developed and protocols will be recommended by DPH
- h. DPH will provide technical assistance to include education and training. Best practices, successful strategies and lessons learned will be reported to DPH

### PLAN OF ACTION 2: IDENTIFY PATIENTS WITH UNDIAGNOSED HYPERTENSION

**Option A- Hypertension Improvement Initiative:** The health system will partner with 4 provider practices to do the following:

1. Identify patients with undiagnosed hypertension:
  - A. Search an electronic medical record or clinical data system to identify patients not diagnosed with hypertension with two or more elevated blood pressures, and recall those patients using telephonic, written or email reminders to be rescreened for hypertension, and provide: a) an aggregate number of patients identified for recall based on the search of the records system; b) the percentage of those patients who return to be rescreened; and c) the total number of those patients diagnosed with hypertension, if available; and d) a plan detailing how the patients will be recalled and the health system's strategy on enrolling the patients in a hypertension management plan for disease management.
2. Use a Plan-Do-Study-Act approach to test at least three (3) changes in practice, policy, patient management, and/or patient education in an existing panel of patients to improve control over hypertension. Tests of change may include, but are not limited, to the following:
  - Standardizing practice across all providers within a clinical setting to a single recognized algorithm or guideline for the control of hypertension (e.g., JNC8);
  - Adding provider reminders in an electronic medical records system to schedule referrals or follow-up appointments with patients with single elevated blood pressures;
  - Providing patients with written or electronic blood pressure tracking tools to record blood pressures taken between appointments and in clinical settings, such as fire departments, Walgreens or CVS pharmacies;
  - Providing patients with home blood pressure monitors to facilitate self-monitoring of blood pressure between appointments;
  - Standardizing patient education provided regarding hypertension and the risks of hypertension and medication adherence.
3. Report best practices, successful strategies and lessons learned to DPH.

### **Option B- Health Information Technology Improvement:**

Identify 5 health systems to do the following:

- i. Conduct an initial organizational capacity/readiness assessment of the providers to determine: electronic record capacity, functionality, electronic health record certification status and existing organizational workflows (using a DPH created assessment tool)
- ii. Offer educational sessions about electronic health record adoption, certification and meaningful use criteria (includes National Quality Forum (NQF) measure 18 and NQF 59 reporting) with the providers
- iii. Identify and share “Best Practices” tools, protocols and processes for Hypertension control that promote system changes with the providers
- iv. Assist the providers with developing protocols for retrieving healthcare quality measures data from reports to identify patients with undiagnosed hypertension, diagnosed hypertension (controlled/poorly controlled) and diagnosed diabetes (Controlled/poorly controlled)
- v. Incorporate into EHR systems content such as: treatment protocols, algorithms, workflow templates, electronic health record prompts and reminders, and Hypertension and Diabetes (where applicable) Clinical Decision Support alerts (to alert the provider of any abnormal or significant values and prompt provider to implement a protocol utilizing the most current guidelines approved by his/her organization)
- vi. Enroll in American Heart Association Target BP initiative

### **PLAN OF ACTION 3: IMPROVE MANAGEMENT OF PATIENTS WITH DIABETES**

**Option A- Diabetes Management Program:** The health system will collaborate with physician practices to focus on the primary goal of managing diabetes in patients.

- a. Practices will identify and designate a healthcare provider lead
- b. Practices will use their EHR to identify undiagnosed pre-diabetic or undiagnosed diabetic patients to enroll in the Diabetes Management Program
- c. Each diabetic patient recruited will be evaluated and treatment will be recommended based on the Joint National Committee
- d. Practices will identify a case manager to encourage appointment retention and medication therapy management and a case management strategy (to include self-management plans). Self-management plans may include:
  - i. Medication Adherence
  - ii. Self-Monitoring of blood glucose levels
  - iii. Increased consumption of nutritious foods and beverages
  - iv. Increased physical activity
  - v. Maintaining medical appointments
- e. Practices will follow the enrolled patients for nine months to determine if their A1C is controlled
- f. Each provider will refer patients to a CDC-recognized lifestyle change program (if available in their area)
- g. To the extent possible, based on their EHR system, practices will also report on NQF 18 and 59
- h. Tools and resources will be developed and protocols will be recommended by DPH
- i. DPH will provide technical assistance to include education and training. Best practices, successful strategies and lessons learned will be reported to DPH

## PLAN OF ACTION 4: IDENTIFY PATIENTS AT RISK FOR PREDIABETES

**Option A- Diabetes Prevention Lifestyle Change Programs (DPP):** A CDC-recognized lifestyle change program is a structured program—in person or online—developed specifically to prevent type 2 diabetes. It is designed for people who have prediabetes or are at risk for developing type 2 diabetes, but who do not already have diabetes.

A lifestyle change program is a year-long program led by a trained Lifestyle coach. The program focuses on healthy eating choices, increasing physical activity, coping skills, stress management, and problem solving. During the first 6 months of the program participants meet on a weekly basis and transition to monthly meetings in the last 6 months. Goals of this program should focus on moderate changes in both diet and physical activity to achieve modest weight loss in the range of 5% to 10% of baseline body weight.

Key components of the program include:

- The health system representative(s) will be trained as a *lifestyle coach and receive special training to lead the program*. This will help the participants learn new skills, encourage them to set and meet goals, and keep them motivated. The coach will facilitate discussions and help make the program fun and engaging.
- *CDC-approved curriculum* with lessons, handouts, and other resources to help the participant make healthy changes and reduce their risk of developing diabetes will be provided in the lifestyle coach training.
- A support group of people with similar goals and challenges. Together, participants can share ideas, celebrate successes, and work to overcome obstacles. In some programs, participants interact with one another on a weekly basis. It may be easier to make changes when working with group members.

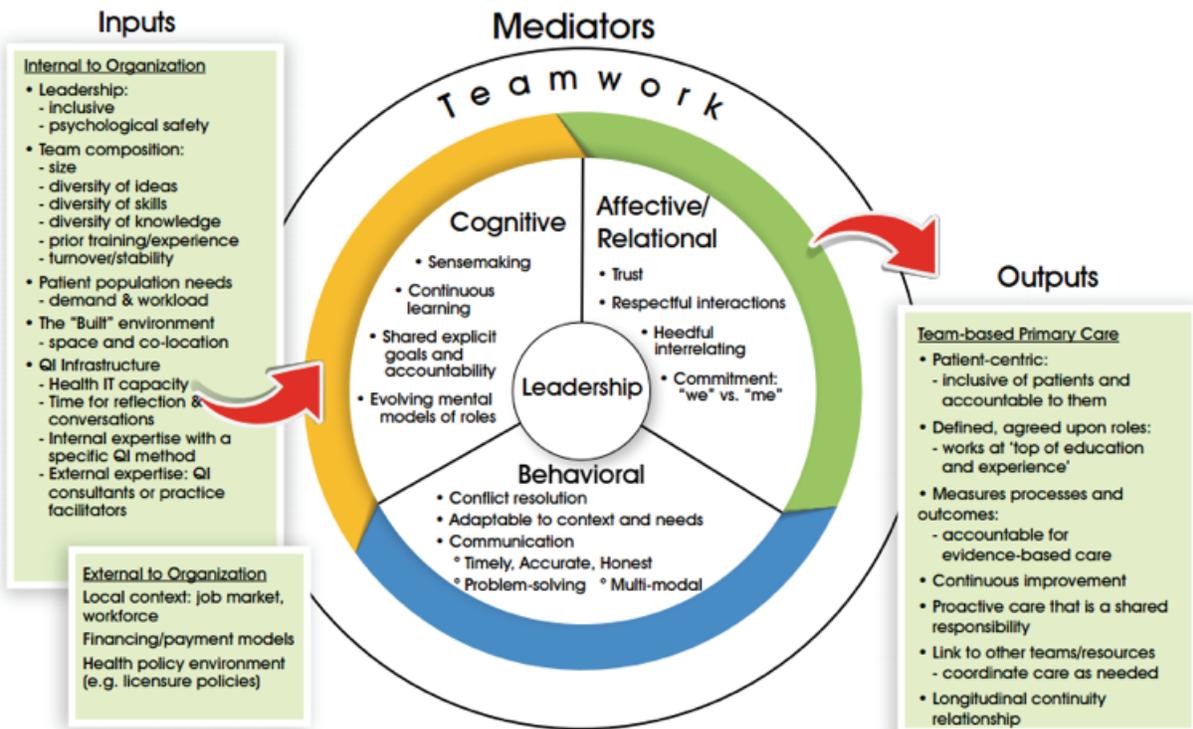
If your organization is interested in delivering the lifestyle change program, preparations can begin with:

- Reading the CDC recognition program standards and operating procedures at [www.cdc.gov/diabetes/prevention](http://www.cdc.gov/diabetes/prevention)
- Assessing your organization's capacity to offer the program using the CDC capacity assessment in the standards and operating procedures document on CDC's website
- Reviewing the application form and applying for CDC recognition on CDC's website
- Identifying individuals affiliated with your organization who can be trained to serve as [Lifestyle Coaches](#)
- Finding a lifestyle coach training program through [Emory University](#). This training incorporates two days of programmatic instruction and one half day of implementation instruction

## Appendix E – CATAPULT Technical Assistance Request Form

CATAPULT Technical Assistance Request Form	
Health System:	
Funding Year:	Report Completed By: <i>(Name)</i>
<b>Technical Assistance Topic:</b> <i>Describe in two-three sentences the specific technical assistance need you have that DPH can assist you with. Please include challenges/barriers you are experiencing.</i>	
<b>Progress:</b> <i>Describe what you have been able to achieve thus far in this area.</i>	

## Appendix F – Selecting Your Team / Team-based Care



### Team-Based Care Member Role Form

**Dietician**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

**Social Worker / Case Manager**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

**Primary Care Provider**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

**Specialist**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

**Nurse**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

**Medical Assistant**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

**Pharmacist**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

**Community Health Worker**

Name: \_\_\_\_\_  
Activity: \_\_\_\_\_

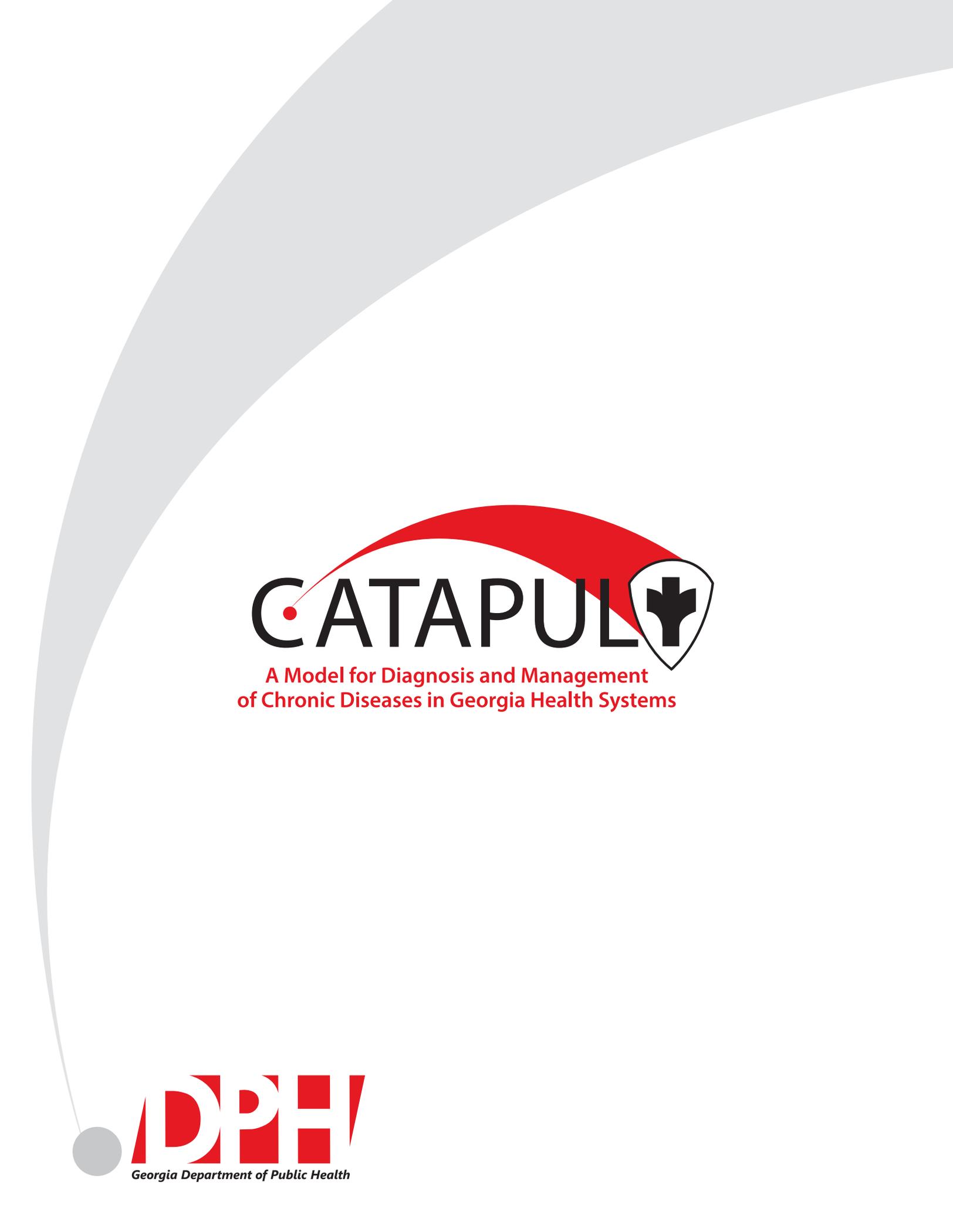


## Appendix G – CATAPULT Monthly PDSA Progress Report

CATAPULT Monthly PDSA Progress Report	

PDSA Cycle/Quality Improvement Progress Form					
Test of Change	(In Progress/ On-Track)	(Delayed/ Pending)	(Critical/ Off-Track)	Implementation Status	
				Date Implemented	Date Suspended
Selected Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Selected Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Selected Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Selected Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Please provide details for any activity/ test identified as Yellow or Red:					
Please provide strategy for getting activity/ test back on track:					
Please provide details for any changes in scope, resource or due dates for each activity/ test:					
Identified Barriers: Practice Level, Hospital System, State:					
# of HTN/DIAB patients in the Health System: _____					
# of HTN/DIAB patients enrolled in a self-management program: _____					
# of HTN/DIAB patients with controlled blood pressure/ blood glucose: _____					





# CATAPUL

A Model for Diagnosis and Management  
of Chronic Diseases in Georgia Health Systems