United Hospital Fund
Improving Health Care for Every New Yorker

Advanced Primary Care (APC)

Quality Improvement Resource Compendium II

United Hospital Fund (UHF)

Quality Institute

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This document, Advanced Primary Care (APC) Quality Improvement Resource Compendium, was curated and produced by the United Hospital Fund (UHF) Quality Institute under its contract with the New York State Department of Health (DOH) for Award Year 3, February 1, 2017 to January 31, 2018.

I. Why This Resource?

The Advanced Primary Care (APC) program aims to improve primary care in New York through three strategies – a three-tiered system of practice capabilities/milestones, payment for transformation support, and the use of a Core Measure Set. The APC Core Measure Set assesses primary care performance for 28 measures that span six domains – prevention, chronic disease, behavioral health, patient-reported, appropriate use, and cost (see Section V for the list of measures). This set was developed through guiding principles and vetted by the APC Integrated Care Workgroup (ICW), a multi-stakeholder group of consumers, providers, payers and policymakers.

A practice's ability to collect, report, and improve on the Core Measure Set is a key component of practices' expected performance in the APC program. Primary care practices enrolled in the APC program may also receive value-based payments from payers based on their performance on the Core Measure Set.

The UHF Quality Institute compiled this Quality Improvement Resource Compendium II to support APC practices' quality improvement efforts related to the Core Measure Set. This compendium is a follow-up to *Quality Improvement Resource Compendium*, submitted by UHF to DOH in January 2017. That version comprised 13 measures that were mainly claims-based, a subset originally planned for a "Version 1" of the APC Scorecard. This compendium covers the remaining measures, many of which are outcome measures that require claims and medical record review.

We aimed to present a manageable number of resources, developed by reliable and trusted sources and based on the synthesis of scientific evidence. We included resources that provide practical guidance to primary care providers for patient management and for quality improvement efforts. We selected tools across various modes of communication, e.g., narratives, fact sheets, webinars, slide presentations, courses, social media.

DOH has included *Quality Improvement Resource Compendium* in the Practice Transformation Tracking System (PTTS) for use by Practice Transformation (PT) agents in their technical assistance work with APC practices; this follow-up compendium will also be uploaded to the PTTS. UHF posted the first compendium on its website and this second version will follow. The resources of the compendium can support the quality improvement efforts and broader practice transformation work of APC practices being facilitated by PT agents. UHF will work with DOH to identify other potential avenues for disseminating this product.

II. Who Is the Audience?

This compendium is intended for use by APC practices, specifically provider teams in primary care practices who will be working on activities to improve quality of care and their performance on the core

measures. The following staff might find this most useful: primary care providers, e.g., physicians, physician assistants, nurses, allied health professionals; care managers; quality improvement specialists; community health workers; and patient advocates.

Others who might find value in the Compendium include:

- PT agents working with practices to help them with practice transformation and movement through the gating and milestone system.
- Regional Oversight and Management Committees (ROMCs) as they identify regional priorities for quality improvement and opportunities for topic-specific quality collaboratives.
- The Statewide Steering Committee (SSC) in its ongoing stewardship of the APC Core Measure Set and oversight of quality monitoring and improvement in New York State's APC program.

III. How Were the Resources Compiled?

UHF scanned health care, clinical, and policy websites and literature databases to identify appropriate resources, which were defined broadly to include, but not be limited to, toolkits, research papers, resource websites, fact sheets, office-based tools, patient materials, videos, checklists, algorithms, flowcharts, courses, and webinars. The following criteria were used to identify a final set of resources for each measure:

- *Author/source:* the credibility of each resource was important, given the high volume of resources available in the health care literature. Only resources that were based on scientific evidence and authored by the following entities were included: federal health care agency (e.g., National Institutes of Health, Centers for Disease Control, Agency for Healthcare Research and Quality); state health care agency (e.g., state department of health); organization that either develops or endorses measures/clinical standards (e.g., National Committee for Quality Assurance, National Quality Forum); professional societies/disease-specific organizations (e.g., American College of Physicians, American Heart Association, primary care associations); quality improvement organization (e.g., Institute for Healthcare Improvement); group or coalitions of health care organizations (e.g., regional multi-stakeholder initiatives, provider learning collaboratives, health-plan performance improvement projects); or a reputed medical provider. Priority was given to New York-based sources.

- *Timeliness:* resources developed before the year 2000 were not included, to ensure scientific, technological, and cultural relevance to the present-day health care delivery system.

- *Content:* resources that were not directed to a primary care provider (i.e., quality improvement approaches for health plans) were given lower priority and excluded if other resources were available. Resources directed to providers in hospital or nursing home settings were excluded. The details of the measure specifications were taken into account to ensure that knowledge embedded in the resources spoke to the populations and specific care processes targeted by the measure. We also included resources that synthesize the evidence (vs. individual research publication) and that translated the evidence into practical application relevant to clinical management and quality improvement.

- *Presentation:* resources that were very lengthy, and/or used overly technical language were excluded. For each measure, UHF aimed to provide variety in the length and mode of the resources included, when possible. For example, both short (e.g. fact sheet) and long (e.g., research synthesis) pieces were included, as were written and non-written (e.g., webinars, interactive media) forms.

IV. How is the Compendium Organized?

The Resource Compendium comprises 10 tables. The tables are displayed in order of domain (see Section V) - prevention, chronic disease, behavioral health, patient-reported, and appropriate use – and contain the following measures:

Prevention:

- Table 1: Colorectal Cancer Screening
- Table 2: Influenza Immunization
- Table 3: Fluoride Varnish Application

Chronic Disease:

- Table 4: Tobacco Use Screening and Intervention
- Table 5: Controlling High Blood Pressure
- Table 6 (combined): Comprehensive Diabetes Care: HbA1C Control / Foot Exam
- Table 7: Weight Assessment and Counseling for nutrition and physical activity for children and adolescents/BMI Screening and Follow-up

Behavioral Health:

- Table 8: Screening for Clinical Depression and Follow-up Plan

Patient-Reported:[1]

- Table 9: CAHPS Access to Care, Getting Care Quickly

Appropriate Use:[2]

- Table 10 (combined): Inpatient Hospital Utilization / All-Cause Readmissions / Emergency Department Utilization

[1] Advance Care Plan (NQF #326/HEDIS) is not included in this resource compendium as it is more relevant to APC practices as a practice capability than as a quality measure. Resources for implementing and improving on this aspect of care can be obtained through practice transformation supports, including the technical assistance of the PT TA agents and DOH's Implementation Guide.

[2] Total Cost of Care is not included in this resource compendium. This measure is being assessed differently by each payer in the APC program.

At the top of each table is the measure name, endorsement number from the National Quality Forum (NQF), and the name of the measure developer (e.g., AMA - American Medical Association) or measure type (e.g., HEDIS, a product of NCQA, the National Committee for Quality Assurance). Each row of the tables is dedicated to a unique resource. Columns are used to display the name of the resource, author/developer, year of release, a brief description, and weblink. Resources are listed in alphabetical order within the following categories of author/developer:

- Federal Agencies
- New York State Agencies
- State Agencies, Other
- Professional Societies/Disease-Specific Organizations
- Provider Organizations
- Improvement Organizations/Multi-Stakeholder Coalitions/Networks
- Patient Organizations
- Academic Institutions
- Journal Articles

V. APC Core Measure Set

DOMAINS	DATA SOURCE	MEASURES / NQF# / DEVELOPER
Prevention	Claims/EHR. Claims-only possible.	**Cervical Cancer Screening** (32/HEDIS)
	Claims/EHR. Claims-only possible.	**Breast Cancer Screening** (2372/HEDIS)
	Claims/EHR	**Colorectal Cancer Screening** (34/HEDIS)
	Claims/EHR. Claims-only possible.	**Chlamydia Screening** (33/HEDI)S
	Claims/EHR/Survey	**Influenza Immunization (all ages)** (41/AMA)
	Claims/EHR/Survey. Claims-only possible.	**Childhood Immunization, Combo 3** (38/HEDIS)
	Claims	**Fluoride Varnish Application** (2528/ADA)
Chronic Disease	Claims/EHR	**Tobacco Use Screening and Intervention** (28/AMA)
	Claims/EHR	**Controlling High Blood Pressure** (18/HEDIS)
	Claims/EHR	**Comprehensive Diabetes Care: HbA1C Poor Control** (59/HEDIS)
	Claims	**Comprehensive Diabetes Care: HbA1C Testing** (57/HEDIS)
	Claims	**Comprehensive Diabetes Care: Eye Exam** (55/HEDIS)
	Claims	**Comprehensive Diabetes Care: Foot Exam** (56/HEDIS)
	Claims	**Comprehensive Diabetes Care: Medical Attention for Nephropathy** (62/HEDIS)
	Claims/EHR	**Persistent Beta Blocker Treatment after Heart Attack** (71/HEDIS)
	Claims/EHR. Claims-only possible.	**Medication Management for People With Asthma** (1799/HEDIS)
	Claims/EHR	***[Combined obesity measure]*** **Weight Assessment and Counseling for nutrition and physical activity for children and adolescents** (24/HEDIS)
	Claims/EHR	***[Combined obesity measure]*** **Body Mass Index (BMI) Screening and Follow-Up** (421/CMS)
Behavioral Health/ Substance Use	Claims/EHR	**Screening for Clinical Depression and Follow-up Plan** (418/CMS)
	Claims	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** (4/HEDIS)
	Claims/EHR. Claims-only possible.	**Antidepressant Medication Management** (105/HEDIS)
Patient-Reported	Claims/EHR	**Advance Care Plan** (326/HEDIS)
	Survey	**CAHPS Access to Care, Getting Care Quickly** (5/AHRQ)
Appropriate Use	Claims	**Use of Imaging Studies for Low Back Pain** (52/HEDIS)
	Claims	**Avoidance of Antibiotic Treatment in adults with acute bronchitis** (58/HEDIS)
	Claims	**Inpatient Hospital Utilization** (--/HEDIS)
	Claims	**All-Cause Readmissions** (1768/HEDIS)
	Claims	**Emergency Department Utilization** (--/HEDIS)
Cost	Claims	**Total Cost Per Member Per Month**

VI. RESOURCES

COLORECTAL CANCER SCREENING (NQF #34/HEDIS)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
Colorectal Cancer Screening	Health Resources & Services Administration (HRSA)	N/A	Myriad quality improvement resources on colorectal cancer screening.	Scroll down to Table 4: https://www.hrsa.gov/quality/toolbox/measures/colorectalcancer/ Appendix: https://www.hrsa.gov/quality/toolbox/measures/colorectalcancer/colorectalpathwayappendix.html#2C
How to Increase Preventive Screening Rates in Practice: An Action Plan for Implementing a Primary Care Clinician's Evidence-Based Toolbox and Guide*	National Colorectal Cancer Roundtable (NCCRT), co-funded by the American Cancer Society and the Centers for Disease Control and Prevention.		Practical, action-oriented assistance for use by clinicians in the office to improve colorectal cancer screening rates. "Clinician" includes Family Physicians, General Internists, Obstetrician-Gynecologists, Nurse Practitioners, Physician Assistants, and their Office Managers.	https://www.cancer.org/content/dam/cancer-org/cancer-control/en/reports/how-to-increase-preventive-screening-rates-in-practice.pdf Action plan, in slide deck or PDF format, with actionable tools/poster/forms to facilitate workflow: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/reports/slide-set-how-to-increase-preventive-screening-rates-in-practice.pdf
Resources for Health Professionals	National Cancer Institute	2014	Suite of resources for health professionals around colorectal cancer causes and prevention; screening; treatment; statistics; supportive and palliative care; and coping.	https://www.cancer.gov/types/colorectal/hp Similar set of resources for patients also available: https://www.cancer.gov/types/colorectal

New York State Organizations				
A Practical Guide to Increasing Screening Colonoscopy: Proven methods for health care facilities to prevent colorectal cancer deaths	New York City Department of Health and Mental Hygiene and New York Citywide Colon Cancer Control Coalition	2006	Five best practices for how health care facilities and endoscopy units can boost colonoscopy volume, reduce no-show rates and wait times, and improve quality of services.	https://www1.nyc.gov/assets/doh/downloads/pdf/cancer/cancer-colonoscopy-guide.pdf For up-to-date guidelines on colorectal cancer screening, see here: https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html
Improvement Organizations/Multi-stakeholder Coalitions/Networks				
Improving Colorectal Cancer Screening Rates	Wisconsin Collaborative for Healthcare Quality	2015	Toolkit that provides small, manageable set of improvement strategies that are evidence-based without requiring the purchase of expensive new technology or the hiring of additional staff. Based on experiences and recommendations of: University of Wisconsin Health, American Cancer Society, American College of Gastroenterology, and National Colorectal Cancer Roundtable	https://hipxchange.org/CRCScreening Free, upon registration.
Journal Articles				
Improving colon cancer screening rates in primary care: a pilot study emphasizing the role of the medical assistant	Quality and Safety in Healthcare	2009	An effective strategy to improve colorectal cancer screening rates using a redesigned primary care team.	https://www.ncbi.nlm.nih.gov/pubmed/19812097
Primary Care Collaboration to Improve Diagnosis and Screening for Colorectal Cancer	Center for Primary Care, Harvard School of Public Health, published in Joint Commission Journal on Quality and Patient Safety and	2017	Findings from an initiative to improve colorectal cancer screening diagnosis across 25 primary care practices in the greater Boston area.	http://www.sciencedirect.com/science/article/pii/S1553725017301058 Summary of findings available here: https://primarycare.hms.harvard.edu/primary-care-collaboration-improve-diagnosis-screening-colorectal-cancer/

INFLUENZA IMMUNIZATION (NQF #41/AMA)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
Digital Media Toolkit: 2016 – 2017 Flu Season	Centers for Disease Control (CDC)	2016	Communication and social media tools to increase knowledge of and facilitate flu prevention among patients. Includes: campaign events/activities, sample social media and newsletter content, website badges.	https://www.cdc.gov/flu/partners/digital-media-toolkit.htm
Free Resources (Patient Education)	CDC	2016	Variety of materials on seasonal influenza (flu) for providers to share with patients: ▪ Educational materials (fact sheets, posters, buttons, infographics) ▪ Interactive materials (videos, podcasts, social media tools) ▪ Links to resources/websites ▪ Answers to patients' FAQs ▪ Printable flyers for parents. Available in multiple languages.	https://www.cdc.gov/flu/freeresources/index.htm Patient education materials for vaccinations more broadly: https://www.cdc.gov/vaccines/ed/patient-ed.html
Influenza Vaccination Strategies	CDC/CMS Physician Group Practice Demonstration	2007	Methods used by 10 physician groups to increase influenza vaccination rates in the over 65 population.	https://innovation.cms.gov/Files/x/PGP-Flu-Vaccination.pdf
Seasonal Influenza Vaccination Resources for Health Professionals	CDC	2016	Myriad resources on 2016 – 2017 influenza season, including guidelines and recommendations for vaccination, information for health care professionals, and prevention strategies for influenza.	Guidelines and Recommendations: https://www.cdc.gov/flu/professionals/vaccination/index.htm Information for Health Care Professionals: https://www.cdc.gov/flu/about/season/health-care-professionals.htm Prevention Strategies for Seasonal Influenza in Healthcare Settings: https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm

New York State Agencies				
Seasonal Influenza Information for Health Care Providers	New York State Department of Health	2016	Information on vaccine supply, priority groups for immunizations, influenza activity and other timely alerts related to seasonal influenza immunization for health care providers.	https://www.health.ny.gov/diseases/communicable/influenza/seasonal/providers/
Professional Societies/Disease-Specific Organizations				
AAP Immunization Best Practices Making Flu Vaccine Accessible	American Academy of Pediatrics (AAP)	2013	Standards (best practices) from the National Vaccine Advisory Committee (NVAC) for primary care/pediatric providers to improve influenza immunization rates among children and adolescents.	https://www.aap.org/en-us/Documents/immunizations_nvac_standard1.pdf
Call to Action: Reinvigorating Influenza Prevention in US Adults Age 65 Years and Older	National Foundation for Infectious Diseases (NFID)	2016	Call to Action with information and best practice recommendations for focusing on improving influenza immunizations among the subset of adults age 65 years and older.	http://www.nfid.org/publications/cta/flu-65.pdf Infographic for use in clinics/websites/communications: http://www.adultvaccination.org/vpd/influenza/influenza-65-infographic
Immunization Social Media Toolkit	AAP	2016	Tools to help providers use social media to educate patients and parents on immunization, including sample tweets/posts, and guidance on developing social media accounts and creating videos.	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Practice-Management/Pages/Immunization-Social-Media-Toolkit.aspx

Improvement Organizations/Multi-Stakeholder Coalitions/Networks				
First STEPS—Change Package Toolkit for Improving Immunizations	Maine Quality Counts	2016	Change package toolkit with actionable tools to increase immunization rates, including checklists and action planning templates.	https://www.mainequalitycounts.org/image_upload/First%20STEPS%20Immunization%20Change%20Package%20Toolkit%20FINAL%20revised%2003.17.13.pdf
What Works: Real Life Examples of Ways to Increase Adult Vaccination Rates	National Adult and Influenza Immunization Summit. NAIIS is a public-private partnership focused on resolving adult and influenza immunization issues and improving the use of vaccines recommended by CDC's Advisory Committee on Immunization Practices.	2016	Posters from NAIIS meetings from 2012 – 2016 describing successful interventions to improve adult vaccination rates used by practices around the country.	Accomplishments of seven medical groups: https://www.izsummitpartners.org/content/uploads/2016/05/Seven-Medical-Groups.pdf Influenza Vaccination Resources: https://www.izsummitpartners.org/influenza-vaccination-resources/

Academic Institutions				
4Pillars™ Practice Transformation Program	University of Pittsburgh School of Medicine	2017	Step-by-step guide that uses quality improvement principles and evidence-based research to support providers in outpatient settings improve immunization rates. A self-guided or facilitated version is available.	http://www.4pillarstoolkit.pitt.edu/
Increasing Inner-City Adult Influenza Vaccination Rates: A Randomized Controlled Trial	University of Rochester Medical Center	2011	Results of a randomized controlled trial to improve influenza immunization rates In a population of seniors served by urban primary care centers. Results include an analysis of disparities in vaccination rates by race/ethnicity and insurance status.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3113429/
PROTECT™ (Supporting Appropriate Immunizations Across the Age Spectrum)	University of Nebraska Medical Center, Center for Continuing Education and Department of Family Medicine *Partners:* Nebraska AHEC Program, National Committee for Quality Assurance (NCQA), American Academy of Family Physicians (AAFP), American Osteopathic Association (AOA), CE City CE Outcomes, The France Foundation	N/A	CME learning content and systems improvement tools that support providers in multiple settings to increase immunization rates. Modules are provided for the following: ▪ Childhood immunizations ▪ Adolescent immunizations ▪ Adult immunizations ▪ PROTECT™ PI-CME – practice changes to streamline patient immunizations CME credit available.	http://www.protectcme.org/pi-cme.php Practice tools: http://www.protectcme.org/tools.php

FLUORIDE VARNISH APPLICATION (NQF #2528/ADA)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
A Health Professional's Guide to Pediatric Oral Health Management	National Maternal and Child Oral Health Resource Center, Georgetown University, funded by Health Resources and Services Administration (HRSA)	2010	A series of modules designed to assist health professionals in managing the oral health of infants and young children.	https://www.mchoralhealth.org/PediatricOH/index.htm
Bright Futures Oral Health Pocket Guide	National Maternal and Child Oral Health Resource Center, Georgetown University, funded by HRSA	2016	Pocket guide for health professionals around preventive oral health supervision, with information about risk assessment, a tooth eruption chart, a dietary fluoride supplementation schedule, a glossary, and a list of resources.	https://www.mchoralhealth.org/PDFs/BFOHPocketGuide.pdf Video demonstration: https://www.youtube.com/watch?v=zfdcjZ3ht9M Directory of resources (practical brochures, fact sheets, curricula): https://www.mchoralhealth.org/PDFs/ResGuideFlVarnish.pdf
New York State Agencies				
Primary Care Providers: What You Need to Know About Fluoride Varnish and How You Can Promote Early Childhood Oral Health	New York City Department of Health and Mental Hygiene	2010	Quick guide for New York state providers around conducting oral health examinations, assessing caries risk, applying fluoride varnish, ordering materials, and reimbursement.	https://www1.nyc.gov/assets/doh/downloads/pdf/hca/hca-fluoride-varnish.pdf Source page (oral health provider resources): https://www1.nyc.gov/site/doh/health/health-topics/oral-health-information-for-providers.page

Professional Societies/Disease-Specific Organizations				
Caries Risk Assessment, Fluoride Varnish and Counseling	Smiles for Life National Oral Health Curriculum, developed by the Society for Teachers of Family Medicine.	2016	Course on caries prevention for clinicians. Participants will learn about the importance of fluoride for children's oral health, appropriate dosing, and safety precautions, as well as how to apply fluoride varnish and perform adequate follow-up care. Endorsed by American Academy of Pediatrics and approved for continuing education credit.	http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=555&pagekey=62948&cbreceipt=0
Final Recommendation Statement *Dental Caries in Children from Birth Through Age 5 Years: Screening*	US Preventive Services Task Force (USPSTF)	2014	Grade B recommendation: the USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/dental-caries-in-children-from-birth-through-age-5-years-screening
Fluoride Use in Caries Prevention in the Primary Care Setting	American Academy of Pediatrics	2014	Clinical report clarifying the use of available fluoride modalities for caries prevention in the primary care setting. The report assists pediatricians in using fluoride to achieve maximum protection against dental caries while minimizing the likelihood of enamel fluorosis.	http://pediatrics.aappublications.org/content/134/3/626

Improvement Organizations/Multi-stakeholder Coalitions/Networks				
Oral Health: An Essential Component of Primary Care	QualisHealth, with support from the National Interprofessional Initiative on Oral Health, DentaQuest Foundation, REACH Healthcare Foundation, and Washington Dental Service Foundation	2015	White paper that makes the clinical and business case for including preventive oral health care in routine medical care. Includes five actions primary care teams can take and a practical model for enhancing partnerships between primary care and dentistry.	http://www.safetynetmedicalhome.org/sites/default/files/White-Paper-Oral-Health-Primary-Care.pdf
Resources to Integrate Early Pediatric Oral Health Into Well Child Visits	From the First Tooth (FTFT), funded by DentaQuest Foundation, Sadie & Harry Davis Foundation, Northeast Delta Dental, and HRSA. FTFT is a pediatric oral health initiative supporting primary care medical providers in providing preventive oral health interventions for young children. New York is not one of the featured states in the initiative.	2014	Practice-specific tools to support integration of pediatric oral health into primary care, including patient consent forms and questionnaires, brochures, fact sheets, waiting room flyers, and videos for provider training.	http://www.fromthefirsttooth.org/healthcare-providers/helpful-resources-medical-providers/additional-resources/
Tools for Integrating Pediatric Oral Health Into Well Child Care	FTFT	2014	Myriad resources to support effective oral health care in primary care/pediatric settings. Highlights: *Getting started*: planning and documentation (e.g., readiness assessment, workflow, EHR) to support fluoride varnish use. *Video demonstration:* A nurse practitioner applies fluoride varnish to the teeth of a two year old patient during a well child visit. *List of vendors that supply fluoride varnish materials.*	http://www.fromthefirsttooth.org/healthcare-providers/helpful-resources-medical-providers/ *Getting started*: http://www.fromthefirsttooth.org/healthcare-providers/helpful-resources-medical-providers/getting-started/ *Video demonstration:* https://www.youtube.com/watch?v=U2QRwoWAIpQ *List of Vendors:* http://www.fromthefirsttooth.org/wp-content/uploads/2014/12/3.2-10-Fluoride-Varnish-and-Toothbrush-Suppliers.pdf

TOBACCO USE SCREENING AND INTERVENTION (NQF #28/AMA)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
Improving Tobacco Use Screening and Smoking Cessation in a Primary Care Practice	HealthIT.gov	2013	Effort of 17-provider primary care practice, rural primary care practice to improve tobacco screening and cessation intervention rates.	https://www.healthit.gov/providers-professionals/improving-tobacco-use-screening-and-smoking-cessation-primary-care-practice
Resources for Health Professionals	National Institutes of Health, National Cancer Institute	N/A	Evidence-based tools created by the National Cancer Institute (NCI) that facilitate personalized approaches to quitting smoking, including the SmokefreeTXT text message program and the QuitGuide smartphone app. Medications approved by the Food and Drug Administration (FDA) to help patients who are trying to quit smoking, to be used by physicians to guide prescribing.	Evidence-based tools: https://smokefree.gov/sites/default/files/Smokefree_Overview_for_Physicians_508.pdf Medications: https://smokefree.gov/sites/default/files/Medications_Guide_for_Physicians_508.pdf
Smokefree.org	National Institutes of Health	N/A	Myriad of tools, tips, and supports to help individuals who want to quit smoking, have recently quit, and/or have quit for a while. Includes toolkits, apps, therapy programs, helplines, medication lists, and other resources, including those tailored for women, teens, vets, Spanish-speakers, and older adults. Guidance for health professionals is included as well.	https://smokefree.gov/ For health professionals: https://smokefree.gov/help-others-quit/health-professionals
Health Care Professionals: Help Your Patients Quit Smoking	Centers for Disease Control (CDC)	2017	Several tips to help providers facilitate smoking cessation among their patients, including resources from the *Tips From Former Smokers* campaign.	https://www.cdc.gov/tobacco/campaign/tips/partners/health/hcp/
New York State Agencies				
Talk to Your Patients	New York State Department of Health	N/A	Resources for providers and patients around smoking cessation medications, therapies, and supports (e.g., hotline).	https://talktoyourpatients.health.ny.gov/

State Agencies, Other				
Brief Interventions & 5 A's	*MDQuit.org, developed by the Maryland Resource Center for Quitting Use & Initiation of Tobacco, Maryland Department of Health and Hygiene*	N/A	Conceptual models for providers to implement brief interventions around substance use (e.g., tobacco) cessation among their patients.	http://mdquit.org/cessation-programs/brief-interventions-5
Professional Societies/Disease-Specific Organizations				
Tobacco and Nicotine Cessation Toolkit	*American Academy of* Family Physicians	2017	Office-based tools and best practices to help providers with facilitating tobacco screening and cessation, including practice manuals, effective use of EHRs, group visits, e-cigarettes, tobacco cessation medications, and coding/billing.	http://www.aafp.org/patient-care/public-health/tobacco-nicotine/toolkit.html?cmpid=_van_915
Improvement Organizations/Multi-Stakeholder Coalitions/Networks				
Tobacco Use in Children and Adolescents: Primary Care Interventions	*U.S. Preventive Services Task Force (USPSTF)*	2013	Guidelines on appropriate screening and referral for tobacco use cessation.	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions
Academic Institutions				
A Patient-Centered Tobacco Cessation Workflow for Healthcare Clinics	University of Colorado, School of Medicine	2015	A workflow for implementing cessation services, needed staffing and skills training.	https://www.bhwellness.org/fact-sheets-reports/A%20Patient-Centered%20Tobacco%20Cessation%20Workflow%20for%20Healthcare%20Clinics.pdf
Patient Perspectives on Tobacco Use Treatment in Primary Care	University of North Carolina at Chapel Hill, Department of Family Medicine	2015	Smokers' perspectives on their interactions with health care providers and the most helpful resources to support their quit attempts.	https://www.cdc.gov/pcd/issues/2015/14_0408.htm

CONTROLLING HIGH BLOOD PRESSURE (NQF #18/HEDIS)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
High Blood Pressure Educational Materials for Patients	Centers for Disease Control (CDC)	2015	Fact sheets and podcasts to educate patients on the control of high blood pressure. Special resources for specific communities, diets, and conditions.	https://www.cdc.gov/bloodpressure/materials_for_patients.htm
Hypertension Control: Change Package for Clinicians, a Million Hearts Action Guide.	CDC	2015	A menu of intervention or process improvement options for ambulatory care settings looking to improve blood pressure control.	https://millionhearts.hhs.gov/files/HTN_Change_Package.pdf
Professional Societies/Disease-Specific Organizations				
Controlling Hypertension in Adults	American Heart Association	2016	Pocket guide for providers on effective protocols for hypertension control in adults.	http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_461839.pdf
Improving Blood Pressure Control in Primary Care	Steps Forward, a practice transformation program of the American Medical Association.	2015	A continuing education module for primary care physicians to help primary care clinicians: 1. Measure blood pressure more accurately 2. Act rapidly to treat blood pressure that is not controlled 3. Use evidence-based communication strategies 4. Instruct patients to properly self-measure blood pressure 5. Instruct patients to follow evidence-based lifestyle changes to lower blood pressure Downloadable tools for providers and patients available. CME credit offered.	https://www.stepsforward.org/modules/hypertension-blood-pressure-control Tools: https://www.stepsforward.org/modules/hypertension-blood-pressure-control#downloadable

Professional Societies/Disease-Specific Organizations, continued				
Measure Up, Pressure Down: A Provider Toolkit to Improve Hypertension Control	American Group Medical Foundation. "Measure Up/Pressure Down" is a three-year effort/campaign created by the American Medical Group Foundation to reduce high blood pressure in populations across the country.	2013	A toolkit to help providers jumpstart their hypertension quality improvement initiatives. Organized around eight care processes, with action steps and case studies for each.	http://www.measureuppressuredown.com/hcprof/toolkit.pdf Success stories and best practices: http://www.measureuppressuredown.com/HCProf/Find/bestPractices_find.asp
Provider Organizations				
Quality Improvement in a Primary Care Practice	Meaningful Use Case Studies, healthit.gov	2013	Results from a quality improvement effort by Ellsworth Medical Clinic, WI to improve blood pressure control rates through team-based care, population management, and effective use of EHRs.	https://www.healthit.gov/providers-professionals/quality-improvement-primary-care-practice
Utilizing Lay and Clinical Community Health Workers to Address Untreated Hypertension: The University of Rochester Medical Center's HEART Initiative	University of Rochester Medical Center	2015	Toolkit from an effort to improve outcomes for underserved residents of Rochester's most underserved neighborhoods. Used a Blood Pressure Ambassador and Advocate program to increase community-clinic collaborations that effectively detect and treat hypertension.	https://www.cdc.gov/nccdphp/dch/pdfs/univ-rochester-heart-initiative.pdf Blood Pressure Advocate Program https://www.urmc.rochester.edu/community-health/programs-services/blood-pressure-advocate-program.aspx Overview video: https://www.youtube.com/watch?v=pHtolwj2jWo

Improvement Organizations/Multi-Stakeholder Coalitions/Networks				
High Blood Pressure Collaborative	High Blood Pressure Collaborative of the Greater Rochester Area (Monroe County), led by Rochester Chamber of Commerce and Finger Lakes Health Systems Agency.	2010 2016	Resources from a community-wide, multi-stakeholder effort to reduce high blood pressure in the Greater Rochester Area.	Overview of collaborative: https://www.commongroundhealth.org/initiatives/high-blood-pressure
Improving the Screening, Prevention, and Management of Hypertension: An Implementation Tool for Clinic Practice Teams	Washington State Department of Health	2013	Compilation of best practices and quality improvement resources for the management of hypertension by practice teams. The toolkit has been used to successfully address hypertension among the *Washington State Collaborative to Improve Health* and the University of Washington.	https://www.healthit.gov/sites/default/files/13_bptoolkit_e13l.pdf
Academic Institutions				
Medication Matters	Project ReDCHip, of Johns Hopkins University ReDCHip is Reducing Disparities and Controlling Hypertension in Primary Care.	2013	Web-based training tool that demonstrates communication approaches to address medication adherence among patients with hypertension.	http://www.projectredchip.com/
Journal Articles				
Improving Blood Pressure Control With Strategic Workflows	Family Practice Management	2016	Strategies used by primary care clinics in an integrated health system in San Diego to formulate a blood pressure control treatment algorithm and use team-based care to help high- and medium-risk patients improve their blood pressure control. Done through the Measure Up/Pressure Down campaign.	http://www.aafp.org/fpm/2016/0500/p23.html
Practical Lessons for Improving Care of Patients with High Blood Pressure in Urban Underserved Practices	Journal of Family Medicine	2016	Results of interventions to improve care of racially diverse and low-income hypertension patients at three clinics in the Greater Rochester New York area.	http://austinpublishinggroup.com/family-medicine/download.php?file=fulltext/jfm-v3-id1046.pdf

COMPREHENSIVE DIABETES CARE: HbA1c Poor Control (NQF #59/HEDIS) / Foot Exam (NQF #56/HEDIS)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
Health Care Professionals	National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health (NIH)	2016	Suite of resources, clinical practice tools, and patient education materials to help physicians and their health care teams to effectively meet the needs of people with or at risk of diabetes. Highlights: *Promoting Medication Adherence in Diabetics:* Resources for healthcare professionals and patients around improving adherence to diabetes medication. *Integrating Other Practitioners* Resources to help primary care providers work with other practitioners (e.g., pharmacists, podiatrists, optometrists, mental health practitioners, counselors) in addressing diabetes control. *Practice Transformation for Physicians and Health Care Teams* Quality improvement tools, care guidelines, and roadmaps for supporting practice improvement efforts around diabetes. *The Three Phases of the Diabetes Care: Pre-visit, Intra-visit, Post-visit* Resources to help providers optimize diabetes encounters by taking a planned, continuous improvement approach to visits.	https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/health-care-professionals/Pages/HealthCareProfessionals.aspx *Promoting Medication Adherence in Diabetics:* *https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/health-care-professionals/medication-adherence/Pages/default.aspx* *Integrating Other Practitioners* https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/health-care-professionals/practice-transformation/practice-changes/integrating-other-practitioners/Pages/default.aspx *Practice Transformation for Physicians and Health Care Teams* https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/Pages/index.aspx *The Three Phases of the Diabetes Care: Pre-visit, Intra-visit, Post-visit* https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/health-care-professionals/practice-transformation/practice-changes/phases-of-care/Pages/default.aspx

Federal Agencies, continued				
National Diabetes Education Program Online Resource Center	Centers for Disease Control (CDC)	2016	Culturally competent materials to help patients manage diabetes. Tools include fact sheets, toolkits, booklets, CDs, DVDs, and. Materials are developed using principles of plain language and health literacy. Searchable by patient diabetes risk status, age, race/ethnicity, language, literacy level; and available in multiple languages. Highlight: *Checklist/Tip Sheet:* Helps patients understand how to work with providers to successfully control their diabetes. Resources to also help providers follow recommended diabetes care guidelines and communicate with others on the provider team.	https://nccd.cdc.gov/DDT_DPR/ *Checklist/Tip Sheet:* https://www.cdc.gov/diabetes/ndep/pdfs/patient-care-sheet-and-patient-care-checklist-en.pdf

New York State Agencies				
Diabetes Action Kit	New York City Department of Health and Mental Hygiene (DOHMH).	N/A	Provider resources, clinical tools, and patient education materials to support and amplify providers' efforts to help patients with prediabetes and diabetes.	http://www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-diabetes.page
NYC REACH: Quality Improvement Projects	New York City Regional Electronic Adoption Center for Health (NYC REACH), New York City's Regional Extension Center	2017	Quality improvement initiatives facilitated by NYC REACH to improve diabetes control rates in New York City. NYC REACH assists New York City-based practices, independently owned community health centers, and hospital ambulatory sites with adopting and implementing health information systems, quality improvement, and practice transformation initiatives.	http://nycreach.org/qi-services/#qi-projects
Professional Societies/Disease-Specific Organizations				
Standards of Medical Care in Diabetes—2016 Abridged for Primary Care Providers	American Diabetes Association	2016	Formerly called Clinical Practice Recommendations, the Standards includes the most current evidence-based recommendations for diagnosing and treating adults and children with all forms of diabetes. This is an abridged version for primary care providers.	http://clinical.diabetesjournals.org/content/34/1/3

Provider Organizations				
Health Care Providers Improve Diabetes Care for Patients	New York State Health Foundation	2013	Provider testimonials (videos) from across New York State that share stories about earning national recognition for providing excellent diabetes care from the National Committee for Quality Assurance (NCQA) or Bridges to Excellence (BTE) programs.	http://nyshealthfoundation.org/our-grantees/grantee-stories/providing-excellent-diabetes-care#About this Initiative
New Yorkers at High Risk for Diabetes Find Help from YMCA Program	New York State Health Foundation	N/A	Patient testimonials (videos) from 10 regions in New York State that participated in a YMCA-run National Diabetes Prevention Program (NDPP). The NDPP has been shown to reduce the risk of adults with prediabetes from developing diabetes by 58%, and by 71% for adults over the age of 60.	http://nyshealthfoundation.org/our-grantees/grantee-stories/reducing-diabetes-risk-ymcas
Improvement Organizations/Multi-Stakeholder Coalitions/Networks				
Diabetes Mellitus in Adults, Type 2; Diagnosis and Management of. Guideline summary.	Institute for Clinical Systems Improvement (ICSI)	2014	A comprehensive approach to the diagnosis and management of type 2 diabetes mellitus in adults, with recommendations around therapies (e.g., nutrition, physical, pharmacologic), self-management, prevention, and diagnosis of complications and risk factors.	https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_endocrine_guidelines/diabetes/
Partnering in Self-Management Support: A Toolkit for Clinicians	Institute for Healthcare Improvement	2016	Practical, off-the-shelf tools to help practices support patients and families in the day-to-day management of diabetes and other chronic conditions. Login required (free).	http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx
Journal Articles				
Type 2 Diabetes Mellitus: Practical Approaches for Primary Care Physicians	*The Journal of the American Osteopathic Association*	2011	Practical strategies for primary care office staff to provide optimal diabetes care.	http://jaoa.org/article.aspx?articleid=2094165

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN AND ADOLESCENTS (NQF #24/HEDIS) BMI SCREENING AND FOLLOW-UP (NQF #418/CMS)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
New York State Agencies				
BMI Screening Tools	New York State Department of Health	2015	Sex-specific Body Mass Index (BMI)-for-age percentile growth charts.	https://www.health.ny.gov/prevention/obesity/bmi_screening_tools.htm
Professional Societies/Disease-Specific Organizations				
Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older	American Academy of Pediatrics	2016	Algorithm for clinical decision-making around BMI of children and appropriate interventions.	https://ihcw.aap.org/Documents/Assessment%20%20and%20Management%20of%20Childhood%20Obesity%20Algorithm_FINAL.pdf
Adolescent Obesity Time Tool	American College of Preventive Medicine	2011	Clinical guide on the chronology of patient visits to best address adolescent obesity, using the four stages of intervention recommended by the American Academy of Pediatrics.	http://www.acpm.org/?adobesity_clinicians
Provider Organizations				
Prevention, Intervention and Referral Pathway for Weight Management and T2DM	Healthy Weight Clinic, Akron Children's Hospital, OH	N/A	Algorithm to support clinical decision-making around weight assessment and management for children and adolescents.	https://www.akronchildrens.org/cms/resource_library/files/c3541947bb5383d2/weight_management_clinical_pathway.pdf
Improvement Organizations/Multi-Stakeholder Coalitions/Networks				
Adult Obesity Provider Toolkit *Child & Adolescent Obesity Provider Toolkit*	California Medical Association Foundation and California Association of Health Plans California Medical Association Foundation, California Association of Health Plans, California Office of Multicultural Health	2013 2011/ 2012	These two toolkits equip providers with strategies and tools across several areas – communication, workflow, patient/provider education, billing, cultural competency, community engagement - to assess, prevent and effectively manage adult and child/adolescent patients, respectively, who are overweight and obese. It also offers guidance around discussing healthy lifestyles and weight management with their patients, including those from diverse and underserved communities.	Adult Obesity Provider Toolkit: https://www.lacare.org/sites/default/files/adult-obesity-provider-toolkit-2013.pdf Child & Adolescent Obesity Provider Toolkit: https://www.lacare.org/sites/default/files/child-adolescent-obesity-toolkit.pdf

Academic Institutions				
Improving Obesity Management in Adult Primary Care	George Washington University School of Public Health and Health Services Department of Health Policy	2010	Paper developed by the Strategies to Overcome and Prevent (STOP) Obesity Alliance. Includes a summary of central themes from a literature review, STOP roundtable, and key informant interviews, to improve the integration of obesity screening, counseling and treatment into primary care practice.	http://stopobesityalliance.org/wp-content/assets/2010/03/STOP-Obesity-Alliance-Primary-Care-Paper-FINAL.pdf
Promoting Healthier Weight in Adult Primary Care	University of Vermont College of Medicine	2007	Toolkit, designed with extensive input from the primary care community, to improve prevention, identification, assessment and management of overweight and obese adult patients in primary care.	http://www.healthvermont.gov/sites/default/files/documents/2016/12/Promoting_Healthier_Weight_toolkit.pdf
Journal Articles				
An Evidence-based Guide for Obesity Treatment in Primary Care	The American Journal of Medicine	2016	Paper outlining a model for building a multidisciplinary team to maximize patients' success at weight management, using the 5A's Counseling Framework. Includes reimbursement guidelines and weight-management counseling strategies.	http://www.amjmed.com/article/S0002-9343(15)00691-9/fulltext

SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN (NQF #418/CMS)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration: Observations From Exemplary Sites	Agency for Healthcare Quality (AHRQ)	2015	Guidebook of organization-level and interpersonal/individual-level approaches that support integrated behavioral health care in the primary care setting. Guidebook developed through an expert panel, a literature review, and observations/interviews at eight high-performing primary care organizations.	https://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcademyGuidebook.pdf Synopsis of findings on page 10. Practice assessment worksheet on page 112.
Behavioral Health Treatment Services Locator	Substance Abuse and Mental Health Services Administration (SAMHSA)	2016	A national locator for individuals (and referring providers) to find treatment facilities for mental health and/or substance abuse issues.	https://findtreatment.samhsa.gov/
Final Recommendation Statement: Screening for Depression in Adults	U.S. Preventive Services Taskforce	2017	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1
Screening Tools	SAMHSA	N/A	Screening tools for depression, as well as drug and alcohol disorders, bipolar disorder, suicide risk, anxiety, and trauma.	https://www.integration.samhsa.gov/clinical-practice/screening-tools
New York State Agencies				
Depression	New York State Office of Mental Health	2016	A booklet for patients with simple and supportive messages about depression: ▪ Depression is a real illness. ▪ Depression affects people in different ways. ▪ Depression is treatable. ▪ If you have depression, you are not alone.	https://www.omh.ny.gov/omhweb/booklets/depression.pdf

Provider Organizations				
Collaborative Care for Depression in a Safety-Net Health System	New England Journal of Medicine (NEJM) Catalyst	2017	Description of and learnings from NYC Health + Hospitals' universal depression screening program for adults in primary care.	http://catalyst.nejm.org/collaborative-care-depression-safety-net-health-system/
Depression Medication Choice	Mayo Clinic Shared Decision Making National Resource Center	N/A	Resources to support shared decision-making between provider and patient around depression medication. Resources include: ▪ Decision aid cards and brochure, also available in Spanish ▪ Video and storyboard to demonstrate use of decision aids to providers	http://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/depression-medication-choice/
Improvement Organizations/Multi-Stakeholder Coalitions/Networks				
CCNC Adult Depression Toolkit for Primary Care	Community Care of North Carolina (CCNC)	2015	Toolkit of practical, evidence based tools to help primary care practitioners treat depression in adults. Includes implementation recommendations, algorithm for initial assessment, screening tools, treatment decision aids, medication recommendations, guidance on psychiatrist referrals, and suggestions for patient engagement.	https://www.communitycarenc.org/media/related-downloads/ccnc-depression-toolkit.pdf (Video) Screening for Depression Tools, Follow-Up, and Co-management https://vimeo.com/147902666 (Video) Rationale for Talking about Depression in Primary Care: https://vimeo.com/147903358 Provider Tools (e.g., flowcharts, self-care action plans, medication guides): https://www.communitycarenc.org/provider-tools/conditions/depression/
Implementation Guide for Depression Screening and Treatment	University of North Carolina at Chapel Hill, RTI International, and Carolina Collaborative Community Care	2016	A guide for practice facilitators that serves as a companion document to CCNC's Adult Depression Toolkit for Primary Care (above).	http://consortiumforis.org/wp-content/uploads/2016/10/Implementation-Guide-for-Depression-Screening-and-Treatment.pdf Especially useful for TA providers (e.g., PTA agents in APC).

Improvement Organizations/Multi-Stakeholder Coalitions/Networks, continued				
Integrating Depression Screening and Management with Primary Care in New York City: Lessons Learned from the Multi-Payer One Voice Initiative	Northeast Business Group on Health (NEBGH)	2014	Learnings from a multi-payer demonstration using a collaborative care model to screen and treat depression in NYC-based primary care practices.	http://nebgh.org/wp-content/uploads/2016/04/NEBGH_OneVoiceBriefFINAL-062014.pdf
PCMH Behavioral Health Integration - Screening for Depression	Patient-Centered Primary Care Collaborative (PCPCC)	2012	Webinar describing successful efforts to improve depression screening in the patient-centered medical home across a spectrum of patient populations (teens, adults, Medicare eligibles).	https://www.pcpcc.org/webinar/pcmh-behavioral-health-integration-screening-depression
Primary Care Team Guide: *- Behavioral Health Integration* *- Medication Management*	LEAP, developed by McColl Center for Health Care Innovation at Group Health Research Institute	2016	Myriad resources – learning modules, toolkits, publications, patient materials – on effective primary care teamwork in the areas of behavioral health integration and medication management.	http://www.improvingprimarycare.org/work/behavioral-health-integration#tab-2 http://www.improvingprimarycare.org/work/medication-management
Shared Decision-making and Depression Treatment in Primary Care	Six Minnesota health plans: Blue Cross, HealthPartners, Medica, Metropolitan Health Plan, Hennepin Health, and UCare, with project support from Stratis Health	2015	Recorded webinar for health care providers focusing on how to incorporate shared decision making into primary care when working with patients who experience depression.	http://www.stratishealth.org/documents/Shared-decision-making-20151112.wmv
Journal Articles				
Screening for Depression	American Family Physician	2012	Overview of depression symptoms, risk fact tools, screening tools, and population-specific approaches for screening.	http://www.aafp.org/afp/2012/0115/p139.html
Why Depression Screenings Should Be Part of Routine Check-Ups	The Atlantic	2016	A discussion of the importance of the U.S. Preventive Services Task Force guidelines on depression screening.	https://www.theatlantic.com/health/archive/2016/02/depression-screening-primary-care/462933/

CAHPS ACCESS TO CARE, GETTING CARE QUICKLY (NQF #5/AHRQ)				
Name	**Author**	**Year**	**Content/Mode**	**Link**
Federal Agencies				
CAHPS Ambulatory Improvement Guide	Agency for Healthcare Quality (AHRQ)	2017	Resource for providers around how to: ▪ Cultivate an environment that encourages and sustains improvements in patient-centered care. ▪ Analyze the results of CAHPS surveys and other forms of patient feedback to identify strengths and weaknesses. ▪ Develop strategies for improving CAHPS performance, in particular areas such as "Access to care, getting care quickly."	https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/improvement-guide.html How Two Provider Groups Are Using the CAHPS Survey for Quality Improvement: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/reports-and-case-studies/cgcahps-webcast-brief-2014.pdf
Improvement Organizations/Multi-Stakeholder Coalitions/Networks				
A Tale of Three Practices: How Medical Groups are Improving the Patient Experience	Aligning Forces for Quality	2011	An account of how three practices have achieved improvements in various domains of the CG-CAHPS survey, including access.	http://forces4quality.org/af4q/download-document/3214/Resource-A%20Tale%20of%20Three%20Practices.pdf.pdf
Engage, Collect, Partner: How to Use Patient Experience of Care Surveys in Your Practice	Patient-Centered Primary Care Institute	2014	Guidance on approaches and practical office-based tools to facilitate effective administration of patient experience surveys and application of the results.	http://oregon-pip.org/resources/May%2022_CAHPS_FINAL.pdf
Let's Talk: A guide for transforming the patient experience through improved communication	Minnesota Community Measurement	2013	A guide for providers that shows the importance of good provider-patient communication to patient experience. Includes patient stories of their experiences with providers, and case studies/strategies of medical groups that have made successful changes to enhance communication.	http://mncm.org/wp-content/uploads/2013/04/MNCM_LetsTalk_FNL_LoRes.pdf

Improvement Organizations/Multi-Stakeholder Coalitions/Networks, continued				
Listening to the Voice of the Patient: Using CAHPS® for Improving Care in Minnesota's Health Care Homes	Shaller Consulting Group	2013	A summary of CAHPS and examples of how patient experience survey scores can be used for improvement.	http://www.health.state.mn.us/healthreform/homes/outcomes/documents/ptexpresults/voiceofptshaller111313.pdf
Improving the Patient Experience: Change Package	California Quality Collaborative, Pacific Business Group on Health	2011	A guide to nine proven changes to support improvements in patient experience.	http://www.calquality.org/storage/Improving_Pt_Experience_Spread_Change_Pkg_Updated May2011.pdf
Patient Experience of Care Improvement: By Composite	John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital	2017	Practical tools to support improvement in every domain measured in patient experience surveys - Clinical Team Communication, Health Promotion, Integration of Care, Knowledge of the Patient, Office Staff, and Organizational Access.	http://www.massgeneral.org/stoecklecenter/programs/patient_exper/by_composite.aspx
Professional Societies				
Listening to the Voice of the Patient: Using CAHPS® for Improving Care in Minnesota's Health Care Homes	Shaller Consulting Group	2013	A summary of CAHPS and examples of how patient experience survey scores can be used for improvement.	http://www.health.state.mn.us/healthreform/homes/outcomes/documents/ptexpresults/voiceofptshaller111313.pdf

APPROPRIATE USE MEASURES (Hospitalization, Readmission, Emergency Department Utilization)				
INPATIENT HOSPITAL UTILIZATION (HEDIS)				
Integrating Primary Care and Hospital Care	Center for Care Innovations, University of California, San Francisco	2017	Myriad of strategies to improve coordination among primary care practices and hospitals using creative staffing models, co-location, EHRs, communication tools, and community engagement.	https://www.careinnovations.org/resources/facilitating-care-integrationintegrating-primary-care-and-hospital-care/ Report describing various models: https://www.careinnovations.org/wp-content/uploads/2017/10/BSCF_Facilitating_Care_Integration_Mar_2014.pdf#page=46
Strategies for Reducing Potentially Avoidable Hospitalizations for Ambulatory Care-Sensitive Conditions	Annals of Family Medicine	2013	Strategies for primary care physicians to reduce hospitalizations due to ambulatory care-sensitive conditions, including targeted after-hours care, intensified monitoring of high-risk patients, and initiatives to improve patients' medication adherence and ability to seek timely help.	http://www.annfammed.org/content/11/4/363.full

PLAN ALL-CAUSE READMISSIONS (NQF #1768/HEDIS)				
PRHI Readmission Reduction Guide: A Manual for Preventing Hospitalizations	Pittsburgh Regional Health Initiative	2011	Toolkit to help primary care practitioners and collaborating systems reduce readmissions. Based on learnings from a multi-year pilot with two large primary care physician practices and a community hospital focused on COPD.	http://www.chqpr.org/downloads/PRHI_Readmission_Reduction_Guide.pdf
Reducing hospital readmissions through primary care practice transformation	The Journal of Family Practice	2014	Study that found that multi-component interventions, particularly those that use a "culture of continuity" across outpatient-inpatient caregiver communication have higher changes of reducing readmissions.	http://www.mdedge.com/jfponline/article/80074/practice-management/reducing-hospital-readmissions-through-primary-care
Reducing Readmissions: A Focused Quality Improvement Project for Patient Centered Medical Home & Health Home Practices	Maine Quality Counts	2015	Results from a quality improvement project focused on reducing readmissions in select medical home and health home practices in Maine.	https://www.mainequalitycounts.org/image_upload/Reducing_Readmissions_PCMH_HH%20Intro_Webinar_10.15.15.pdf
The Post-Hospital Follow-up Visit: A Physician Checklist to Reduce Readmissions	California HealthCare Foundation	2019	A short issue brief summarizing key steps a primary care practice should take before and during a post-hospital visit to reduce the chance of readmission.	http://www.rarereadmissions.org/documents/PostHospital_FollowUp_Visit.pdf

EMERGENCY DEPARTMENT UTILIZATION (HEDIS)				
Reducing Avoidable Emergency Department Visits A Guide for Primary Care	Greater Detroit Area Health Council	N/A	Strategies successfully used in primary care settings in Detroit to reduce emergency department visits.	http://www.gdahc.org/sites/default/files/PCP%20Implementation%20Guide.pdf Paper describing further the strategies used: http://www.gdahc.org/sites/default/files/AJMC_13May185to196.pdf
Reducing Avoidable Emergency Department Use	Massachusetts General Hospital and Center for Primary Care Innovation	2011	Quality improvement framework and strategies in primary care for reducing avoidable emergency department use.	http://www.massgeneral.org/stoecklecenter/assets/pdf/patient_exper/ed_avoidance.pdf
Hotspotting: Data Toolkit	Camden Coalition of HealthCare Providers	2015	Strategies to improve care management and coordination for high-risk patients with disproportionate emergency and hospital use.	http://healthcarehotspotting.com/