Prevention Forward

FREQUENTLY ASKED QUESTIONS (FAQS) RELATED TO SURVEYS AND OTHER DATA COLLECTION INSTRUMENTS

1. What is the difference between the Health System and the Partner Health Clinic/Participating Clinic in the Annual Health Capacity Survey?

    a. Questions referring to the ***Health System*** means we are asking for **'system-wide'** data e.g. Question 18: Number of patients, ages 18-85, uninsured in the health system/center/hospital. In this case you would collect data from your Electronic Health Records (EHR) system on ALL uninsured patients aged 18-85 within your health system.

    b. Questions referring to ***Partner Health Clinics/Participating Clinics*** relates to data collected from those **clinics that are involved in the 'Prevention Forward' program or proposed interventions**. A health system may have multiple clinics, but the data we are requesting relates ONLY to those clinics that are interested in "Prevention Forward" interventions. Thus, while you collect data on the same measures from both the health system and the participating clinic, the numbers you gather will be different.

2. Both the annual and quarterly surveys ask for almost identical information, are both surveys still due on October 30th, 2019?

    a. **Yes, both are due on October 30th, 2019.**

    b. The **Annual Health Capacity** Survey covers data collected **between 07/01/2018 through 06/30/2019 (1year period)** and represents the baseline data for the Prevention Forward Program. Thus, all data collected for the annual survey should relate to this one-year time period. Again, **ALL DATA** for the **Annual Health Capacity Survey** should be identified for the time period **07/01/2018 through 06/30/2019**. All data points/health measures requested should relate to this time period ONLY. **Do not provide information on any patient level data for any other time period in the Annual Health Capacity Survey.**

    c. The current **Quarterly Survey** period covers three months from **07/01/2019 through 09/30/2019 (3-month period)**. Thus, for the quarterly survey, please ensure that the data collected relates to this three-month time period. **ALL DATA** for the **Quarterly Survey** should be identified for the time period **07/01/2019 through 09/30/2019**. All data points/health measures requested should relate to this time period ONLY. **Do not provide information on any patient level data for any other time period in the Quarterly Survey.**

3. Our **Clinic Partners** are taking longer than expected to provide the data requested on the survey. Is there any way we can get an extension?

    a. All extension requests **must** be fielded to the CDPH Prevention Forward Team and they will determine whether an extension can be granted. Please contact the appropriate CDPH designated program Lead (please see attached Contractor Contact List) with regards to any questions concerning an extension or data collection delays.

4. Could you please clarify Q1, Q2 and Q5 in terms of how we to identify as a health clinic or health system?

    a. Q1 of the Annual Health Capacity Survey requires the name of the health organization (this means the name of the health system/system-wide e.g. UC Davis Health, Northridge etc).
    b. Q2 of the Annual Health Capacity Survey requires the name of the 'satellite clinic' within the health system that will participate or is participating in the intervention (i.e. the name of the Diabetes clinic you're working with).
    c. Q5 of the Annual Health Capacity Survey is what you consider your organization to be i.e. are you considered a health system (UC Davis Health System), a health center (i.e. Federally Qualified Health Center), or hospital? The answer to this question is up to you based on your perception of your organization.

5. With respect to questions about our clinics, do we report on data for just ONE clinic or for our Clinic Services Clinics?

    a. Please report data ONLY for the specific clinic you will be using for this program or the clinic you have identified to work with for this program. The clinic you have identified represents the 'Prevention Forward participating clinic'.

6. What are the definitions for different diseases for doing data pulls? We require ICD10 codes for cardiovascular disease, stroke, prediabetes, Diabetes (Type II) etc.

    a. We provided ICD10 Codes within the survey for those questions that we require specific ICD10 information.

7. **Quarterly Report Specific:** On **question 24** of the Quarterly Survey, what does A and B refer to?

    a. The letter A represents the CDC Category A strategy for the '1815 grant' which covers information about Prediabetes and Diabetes. The letter B represents the CDC Category B strategy for the '1815 grant' which covers cardiovascular disease, high blood pressure, high blood cholesterol, and stroke. This information is

for internal use only and was not shown in the final versions of the baseline/annual and quarterly health system surveys.

DEFINITIONS

1. **MTM - Medication Therapy Management:** Used by doctors or pharmacists to ensure that patients are receiving optimal therapeutic outcomes for the prescription medications they are taking. Management is used to cover a broad range of professional activities, such as:

   i. Performing patient assessments or a comprehensive review of prescriptions and their possible interactions or side effects.
   ii. Formulating both short- and long-term medication treatment plans.
   iii. Ensuring directional or instruction-based compliance through patient education.
   iv. Better documentation and communication between health providers in order to maintain a high standard of care across medical professionals.

2. **CMM - Comprehensive Medication Management:** An evidence-based, physician approved, pharmacist-led, preventive clinical service to ensure optimal use of medications to improve health outcomes for high-risk patients and decrease health care costs. More information can be found here: https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/CMMWhitePaperCDPH2015Dec23FINALrev.pdf CMM is used to cover a broad range of professional activities, such as:

   i. Conducting comprehensive medication therapy reviews.
   ii. Confirming medication-related problems via assessment, point of care testing, and medication-related labs.
   iii. Assessing all medications and medical conditions.
   iv. Developing individualized medication care plans.
   v. Modifying, adding, substituting, or discontinuing medication doses.
   vi. Provided follow-up care in accordance with treatment-related goals.
   vii. Establishing a collaborative practice agreement (CPA) between pharmacist and physician.

3. **Physician-Pharmacist Collaborative Practice Agreements (CPAs):** Collaborative practice agreements (CPAs) formalize practice relationships between prescribers and pharmacists. Pharmacists are often authorized to perform certain patient care functions, such as initiating, modifying or discontinuing medication therapy. However, CPAs can differ in scope and vary state to state. More information can be found at: https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf

4. **ADA – American Diabetes Association** https://www.diabetes.org/

5. **AADE – American Association of Diabetes Educators**
   https://www.diabeteseducator.org/

6. **DSMES – Diabetes self-management education and support:** DSMES programs facilitate the knowledge, skill, and ability necessary for diabetes self-management, and incorporate the needs, goals, and life experiences of the person with diabetes and are guided by evidence-based science. More information can be found at: https://www.cdc.gov/diabetes/dsmes-toolkit/index.html. DSMES programs can be formally ADA-recognized or AADE-accredited.

7. **Community Health Workers (CHWs):** CHWs are trusted individuals who live and work in communities where they share key elements of life experiences with the people they serve. CHWs may provide basic health and medical care as well as providing an advocacy bridge between communities and their healthcare system, provide culturally appropriate health education and prevention information, offer social support, informal counseling and coaching for self-management of chronic diseases, and also connect people with local resources and services they may need. CHWs may also be referred to as Promotoras, community care coordinator, community health aides, community health liaison, community outreach worker, health care extenders, health extension worker, community health advisors, patient navigators, lay health advocate, lay health worker, health volunteer, outreach educator, outreach worker, peer health workers and many other terms. More information on CHWs can be found here: https://www.cdc.gov/dhdsp/docs/chw_brief.pdf and here: https://www.apha.org/apha-communities/member-sections/community-health-workers

8. **Health Center Partner/Health Center Champion-** Health organization responsible for completing the baseline/annual health system capacity and quarterly health capacity surveys.

9. **Prevention Forward-** A public health program launched by CDPH that operates under the Chronic Disease Control Branch (CDCB). The focus of the program is to implement evidence-based interventions to prevent, manage, and treat cardiovascular disease, high blood pressure, high cholesterol, stroke, prediabetes, and diabetes among patients 18-85 years old. Prevention Forward objectives are as follows:
   a. Objective 1 addresses and assesses the use of health care reporting system to identify, report standard clinical quality measures, and/or refer patients with chronic conditions to nationally recognized lifestyle change programs (such as YMCA's blood pressure self–monitoring program, Weight Watchers, Supplemental Nutrition and Assistance program and Education [SNAP-ED], Expanded Food and Nutrition Education Program [EFNEP], Taking Off Pounds Sensibly [TOPS], Curve Complete, National DPP, and DSMES).

i. For the annual and quarterly capacity surveys we asked questions about clinics' Electronic Health Records systems (EHRs) and how they use them to gather this information. The questions in the annual and quarterly capacity surveys also address referrals to lifestyle change programs. It is possible that the clinic(s) identified by the local health departments or the other funded health systems or hospital may or may not have an EHR system. However, the clinic, health system or hospital should participate and utilize the technical assistance provided by Intrepid Ascent (our EHR expert/partner) to promote lifestyle change activities to address chronic conditions among patients who are between the ages of 18-85 years old. Any clinic, health system or hospital that ONLY target patients under the age of 18 years old would NOT be eligible to participate in the Prevention Forward program.

b. Objective 2 identify policies and procedures used within the clinic to identity, manage, and prevent chronic conditions within their target population.
   i. In the survey we have asked questions relating to these measures. The clinic(s) identified by the local health departments (the same clinic(s) described in Objective 1) and other funded health systems or hospital that participates in the Prevention Forward program may or may not have policies or procedures (as defined in the survey) for preventing, identifying, managing, treating patients with prediabetes, diabetes, hypertension, high blood cholesterol, stroke, and cardiovascular disease. Or policies and procedures for referring patients with these conditions to lifestyle modification program. In cases where the policies and procedures are not in place, the purpose of the Prevention Forward program is to encourage and provide supporting systems to develop and implement evidence -based policies and procedures to manage the specified health conditions.

c. Objective 3 assess the use of team-based models to manage, monitor, and refer patients with chronic conditions to nationally recognized lifestyle change programs.
   i. The survey asks about team-based models. Team-based care models engage more than one health care team member in

providing medical or health-related services to patients within clinic or health system or hospital settings. The clinic(s) identified by the local health departments (which should be the same clinic(s) described earlier in Objective 1 and 2) and other funded health systems or hospital that participates in the Prevention Program may or may not have team-based care model. However, the goal of the Prevention Forward program is to provide technical support necessary to promote or enhance the implementation of a team-based care model within the health system.

10. **Enrolled-** The term 'enrolled' used in this survey refers to patients who are screened by providers for preexisting or new cases of cardiovascular disease, high blood pressure, high cholesterol, stroke, prediabetes, and/or diabetes. Also, patients referred to lifestyle modification are considered enrolled or screened.

11. **Priority populations**- Includes those high burden populations affected disproportionately by high blood pressure, high blood cholesterol, diabetes, or prediabetes due to socioeconomic or other characteristics, including inadequate access to care, poor quality of care, or low income (CDC, 2019).

12. **Underserved population**- Priority population with high prevalence and incidence of chronic conditions above the state average or national average (measured by Healthy People 2020), low income (below state median), and those disproportionately affected by chronic conditions based on race, gender, insurance status, and other social or infrastructural-driven factors.

13. **High Blood Pressure (HBP)-** Systolic blood pressure (SBP) of 140 mmHg or higher or diastolic blood pressure (DBP) of 90 mm Hg or higher.

14. **Achieved Blood Pressure Control- Systolic blood pressure (SBP)/diastolic blood pressure (DBP) <140/90 mmHg during the measurement year**. If multiple readings were recorded for a single date, use the lowest SBP and lowest DBP on that date as the representative blood pressure. The systolic and diastolic results do not need to be from the same reading. Exclusions include 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 a pregnancy during the measurement year; or 3) who

had an admission to a non-acute inpatient setting during the measurement year. Adults: Patients aged 18-85 years old.

15. **Quarterly Report Values**- The EHR query for the quarterly reports covers only three-month timeline specified in each reporting period.

16. **Annual Report Values**- The EHR query for the annual reports covers 12 months or 1-year timeline specified in each reporting period.

Useful Links:

CDPH Prevention Forward:
https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/Prevention-Forward.aspx

UC Davis Technical Assistance:
https://preventionforward.ucdavis.edu/index.php

Contractor Contact List

ntractor Contact Summary Grid, 11/1/19—EXTERNAL Version

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