Baseline Data: Health System Capacity Survey

PREVENTION FORWARD PROGRESS REPORT

INTRODUCTION

The California Department of Public Health (CDPH) Prevention Forward (1815) program is distributing this survey in an effort to assess the participating health system's capacity in implementing core measures to promote the program's objectives for the management and treatment of patients with prediabetes, diabetes, cardiovascular disease, hypertension, and high blood cholesterol. Your participation in completing this survey will help CDPH identify and create local and statewide resources that will support health systems/hospitals/clinics to improve the quality of life of patients with pre diabetes, diabetes, cardiovascular disease, hypertension, and high blood cholesterol and help them manage the conditions.

This survey has 124 questions and it will take approximately 63 minutes to complete. Please plan to complete the survey in one sitting, as responses may not be saved if you exit the survey before completion. Survey responses will be compiled into a state-level report to describe the organizational capacity of the California Prevention Forward health system partners. No identifiable information will be shared in this report or any future publication using this survey. Your responses will inform and guide CDPH's work on chronic disease management, control, prevention, and treatment. If you are interested in the health system capacity survey result, resources regarding the implementation approaches of the Prevention Forward program, and/or have any further questions or feedback, please contact Ndukaku Omelu at Ndukaku.Omelu@cdph.ca.gov or at (916) 552-9033.

SECTION I. PREVENTION FORWARD HEALTH SYSTEM CAPACITY SURVEY GOAL

This survey will be administered to the health system partners annually. The annual Health System Capacity Survey is a data collection tool that will be used to gather specific information about the partnering health system/hospital/center's characteristic profiles including baseline data and Prevention Forward performance measures. The survey results will be analyzed by the evaluation team and the program staff to advance meaningful technical assistance to the partnering health systems or hospitals or centers or clinics. The data analysis will provide information about each partner clinic's or health center's unique organizational capacity needs to help prevent and manage chronic conditions, increase monitoring and reporting of chronic conditions, and increase patient referrals to and participation in 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 Diabetes Prevention Program [National DPP], and Diabetes Self-Management Education and Support [DSMES]).

SECTION II. HEALTH SYSTEM/CENTER INFORMATION

Health System/Center/Hospital Name: click here to enter the organization Name
Participating Clinic Name: click here to enter the clinic Name
Clinic/hospital Address or Zip Code: click here to enter the clinics address

Program or clinic contact Person: click here to enter the program or clinic contact person

Progress Reporting Period (Check one):

- ☐ Y1: 07.01.2018-06.30.2019
- ☐ Y2: 07.01.2019-06.30.2020
- ☐ Y3: 07.01.2020-06.30.2021
- ☐ Y4: 07.01.2021-06.30.2022
- ☐ Y5: 07.01.2022-06.30.2023

SECTION III. HEALTH SYSTEM/CENTER ORGANIZATION CHARACTERISTICS

A. This section addresses and assesses the use of health care reporting system(s) within the health system in identifying and reporting standard clinical quality measures.

1. What type of health organization is your agency?

- ☐ Hospital
- ☐ Health System/Center
- ☐ Health Clinic

2. Has your health system/center/hospital/organization been open for less than a 1 year

- ☐ Yes
- ☐ No

3. Is your health system/center/hospital/organization a Federally Qualified Health Center (FQHC)?

- ☐ Yes
- ☐ No

4. Total number of physicians in the health system/center/hospital/organization?

- ➢ Click here to enter number of providers

5. Total number of pharmacists (including both in-house and pharmacists in the pharmacy network you have a collaborative partnership agreement) in the health system/center/hospital/organization?

- ➢ Click here to enter number of pharmacists

6. Total number of primary care clinics in health care system or center or hospital or organization

- ➢ Click here to enter number

7. Select the Electronic Health Record vendor used at the health system/center/hospital/organization

- ☐ eClinicalWorks
- ☐ Epic
- ☐ GE Centricity
- ☐ Greenway-Intergy

- ☐ Greenway-SuccessEHS
- ☐ NextGen
- ☐ Cerner
- ☐ Other ☐
- ☐ None

8. If 'other' health reporting system types are used in the health system/center/hospital/organization, please specify, if not applicable, enter 'not applicable'

- Click here to enter system used

9. If no Electronic Health Record is used, please specify what the health system/center/ hospital/organization uses, if not applicable, enter 'not applicable'

- Click here to enter

SECTION IV. PATIENT POPULATION CHARACTERISTICS WITHIN HEALTH SYSTEM/CENTER/ORGANIZATION

B. This section assesses the characteristics of the unit of analysis within health system/center.

10. Total number of patients in the health system/center/hospital

- Click here to enter number of patients

11. Number of patients ages 18-85 in the health system/center/hospital

- Click here to enter number of patients

12. Number of patients, ages 18-85 with prediabetes in the health system/center/hospital

- Click here to enter number of patients

13. Number of patients, ages 18-85 with diabetes in the health system/center/hospital

- Click here to enter number of patients

14. Number of patients, ages 18-85 with high blood pressure (ICD-10-CM:I10) in the health system/center/hospital (B1)

- Click here to enter number of patients

15. Number of patients, ages 18-85 with cardiovascular disease in the health system/center/hospital

- Click here to enter number of patients

16. Number of patients, ages 18-85 with stroke in the health system/center/hospital

- Click here to enter number of patients

17. Number of patients, ages 18-85 with high cholesterol in the health system/center/hospital

- Click here to enter number of patients

18. **Number of patients, ages 18-85, uninsured in the health system/center/ hospital**
    - Click here to enter number of patients

19. **Number of patients, ages 18-85 covered by Medicaid/Medi-Cal in the health system/center/ hospital?**
    - Click here to enter number of patients

20. **Number of Hispanic patients, ages 18-85, in the health system/center/hospital**
    - Click here to enter number of patients

21. **Number of White patients, ages 18-85, in the health system/center/hospital**
    - Click here to enter number of patients

22. **Number of Black or African American patients, ages 18-85, in the health system/center/hospital**
    - Click here to enter number of patients

23. **Number of Asian patients, ages 18-85, in the health system/center/hospital**
    - Click here to enter number of patients

24. **Number of Native Hawaiian or other Pacific Islander patients, ages 18-85, in the health system/center/ /hospital**
    - Click here to enter number of patients

25. **Number of American Indian or Alaska Native patients, ages 18-85, in the health system/center/hospital**
    - Click here to enter number of patients

26. **Number of bi- or multi-racial patients, ages 18-85, in the health system/center/hospital**
    - Click here to enter number of patients

SECTION V. PREVENTION FORWARD PARTICIPATING CLINIC CHARACTERISTICS

C. ***This section addresses and assesses the use of health care reporting system(s) used by the Prevention Forward participating clinics/hospitals to identify and report standard clinical quality measures*.**

27. **Is the participating clinic/hospital less than 1 year old?**
    - ☐ Yes
    - ☐ No

28. **Total number of physicians in participating clinic/hospital?**
    - Click here to enter number of providers

29. **Total number of pharmacists in participating clinic/hospital?**
    - Click here to enter number of pharmacists

30. **Select the Electronic Health Record vendor used at participating clinic/hospital (s)**
    - ☐ eClinicalWorks
    - ☐ Epic
    - ☐ GE Centricity
    - ☐ Greenway-Intergy
    - ☐ Greenway-SuccessEHS
    - ☐ NextGen
    - ☐ Cerner
    - ☐ Other ☐
    - ☐ None

31. **Other Health Information Technology (HIT) tools for data analytics and reporting used in participating clinic/hospital?**
    - ☐ Yes
    - ☐ No

32. **If 'other' health reporting system types are used in the clinic/hospital, please describe, if not applicable, enter 'not applicable'**
    - Click here to enter reporting system

33. **If, no Electronic Health Record is used, please specify what the Prevention Forward participating clinic/hospital uses, if not applicable, enter 'not applicable'**
    - Click here to specify the system used

34. **Does the Prevention Forward participating clinic/hospital have access to Health Information Technology (HIT) tools for data analytics and reporting?**
    - ☐ Yes
    - ☐ No
    - ☐ Not Applicable (please explain):_____

SECTION VI. PATIENT POPULATION CHARACTERISTICS WITHIN PARTICIPATING CLINIC(S)

D. This section assesses the characteristics of the unit of analysis within the Prevention Forward participating clinic(s).

35. **Total number of patients within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

36. **Number of patients, ages 18-85 within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

37. **Number of patients, ages 18-85 with prediabetes within the Prevention Forward participating clinic/hospital (A4)**
    - Click here to enter number of patients

38. **Number of patients, ages 18-85 with diabetes within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

39. **Number of patients, ages 18-85 with high blood pressure (ICD-10-CM:I10) within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

40. **Number of patients, ages 18-85 with cardiovascular disease within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

41. **Number of patients, ages 18-85 with stroke within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

42. **Number of patients, ages 18-85 with high cholesterol within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

43. **Number of uninsured patients, ages 18-85, within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

44. **Number of patients, ages 18-85 covered by Medicaid/Medi-Cal within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

45. **Number of Hispanic patients, ages 18-85 within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

46. **Number of White patients, ages 18-85 within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

47. **Number of Black or African American patients, ages 18-85 within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

48. **Number of Asian patients, ages 18-85 within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

49. **Number of Native Hawaiian or other Pacific Islander patients, ages 18-85 within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

50. **Number of American Indian or Alaska Native patients, ages 18-85 within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

51. **Number of bi- or multi-racial patients, ages 18-85, within the Prevention Forward participating clinic/hospital**
    - Click here to enter number of patients

SECTION VII. PATIENT POPULATION CHARACTERISTICS ENROLLED IN THE PREVENTION FORWARD PARTICIPATING CLINIC(S)/HOPITAL(S):

E. ***This section assesses the characteristics of the unit of analysis ENROLLED in the Prevention Forward participating clinic(s)/hospital(s).***

52. **Total number of patients enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

53. **Number of patients, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

54. **Number of patients, ages 18-85 with prediabetes enrolled in the Prevention Forward Program by partner clinic/hospital (A4)**
    - Click here to enter number of patients

55. **Number of patients, ages 18-85 with diabetes enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

56. **Number of patients, ages 18-85 with high blood pressure (ICD-10-CM:I10) enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

57. **Number of patients, ages 18-85 with cardiovascular disease enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

58. **Number of patients, ages 18-85 with stroke enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

59. **Number of patients, ages 18-85 with high cholesterol enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

60. **Number of uninsured patients, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

61. **Number of patients, ages 18-85 covered by Medicaid/Medi-Cal enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

62. **Number of Hispanics, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

63. **Number of Whites, ages 18-85 enrolled in the Prevention Forward Program by partner clinic/hospital**
    - Click here to enter number of patients

64. **Number of Blacks or African Americans, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

65. **Number of Asians, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

66. **Number of Native Hawaiian or other Pacific Islanders, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**

- Click here to enter number of patients

67. **Number of American Indians or Alaska Natives, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

68. **Number of bi- or multi-racial patients, ages 18-85 enrolled in the Prevention Forward Program within the partner clinic/hospital**
    - Click here to enter number of patients

SECTION VIII. ELECTONIC HEALTH RECORD OR OTHER HEALTH INFORMATION TECHNOLOGY OR POLICIES FOR IDENTIFYING AND REPORTING CHRONIC CONDITIONS WITHIN THE PREVENTION FORWARD PARTICIPATING CLINIC

F. ***This section assesses the promotion and adoption of health care reporting system or policies used in reporting standard clinical quality measures at the provider levels within the Prevention Forward participating clinic(s)*.**

69. **Does the clinic have the capability to use standardized clinical quality measures to track differences in blood pressure control in low-income patient population compared to overall populations within the Prevention Forward Participating health system/hospital/clinic (B2a)?**
    - ☐ Yes
    - ☐ No

70. **Does the clinic have the capability to use standardized clinical quality measures to track differences in cholesterol management in low-income patient population compared to overall populations within the Prevention Forward participating health system/ hospital/clinic (B2b)?**
    - ☐ Yes
    - ☐ No

71. **Does the Prevention Forward participating clinic/hospital have the capability to report standardized clinical quality measures for the management of cardiovascular disease?**
    - ☐ Yes
    - ☐ No

72. **Does the Prevention Forward participating clinic/hospital have the capability to report standardized clinical quality measures for the management of stroke?**
    - ☐ Yes
    - ☐ No

73. **Does the Prevention Forward participating clinic/hospital have the capability to report standardized clinical quality for the identification, management, and treatment of patients with hypertension (ICD-10:I10-15) (B1)?**
    - ☐ Yes
    - ☐ No

74. **Does the Prevention Forward participating clinic/hospital have the capability to report standardized clinical quality measures for the identification, management, and treatment of high cholesterol?**
    - ☐ Yes
    - ☐ No

75. **Does the Prevention Forward participating clinic/hospital have the capability to report standardized clinical quality measures for the management of diabetes?**
    - ☐ Yes
    - ☐ No

76. **Does the Prevention Forward participating clinic/hospital have the capability to report standardized clinical quality measures for the management and treatment of prediabetes?**
    - ☐ Yes
    - ☐ No

77. **The Prevention Forward participating clinic/hospital reports standardized clinical quality measures for which of the following conditions (check all that apply).**
    - ☐ Prediabetes
    - ☐ Diabetes (Type II)
    - ☐ Cardiovascular disease
    - ☐ High blood pressure (ICD-10-CM: I10)
    - ☐ Hypertension (ICD-10:I10-15)
    - ☐ High blood cholesterol (Total Cholesterol ≥200 mg/dL, LDL≥100mg/dL, HDL ≤60mg/dL, and Triglyceride ≥150mg/dL)
    - ☐ Stroke
    - ☐ Clinic/hospital does not report on any of these conditions

78. **What health condition(s) does the Prevention Forward participating clinic/hospital use electronic health record or health information exchange or health information technology to identify patients with (check all that apply)?**
    - ☐ Prediabetes
    - ☐ Diabetes (Type II)
    - ☐ Cardiovascular disease
    - ☐ High blood pressure (ICD-10-CM: I10)

- ☐ High blood cholesterol (Total Cholesterol ≥200 mg/dL, LDL≥100mg/dL, HDL ≤60mg/dL, and Triglyceride ≥150mg/dL)
- ☐ Hypertension (ICD-10:I10-15)
- ☐ Stroke

79. What health condition(s) does the Prevention Forward participating clinic/hospital use electronic health record or health information exchange or health information technology as a tool to manage (check all that apply)?

- ☐ Prediabetes
- ☐ Diabetes (Type II)
- ☐ Cardiovascular disease
- ☐ High blood pressure (ICD-10-CM: I10)
- ☐ High blood cholesterol (Total Cholesterol ≥200 mg/dL, LDL≥100mg/dL, HDL ≤60mg/dL, and Triglyceride ≥150mg/dL)
- ☐ Hypertension (ICD-10:I10-15)
- ☐ Stroke

80. Does the Prevention Forward participating clinic/hospital have policies to promote self-monitoring of blood pressure?

- ☐ Yes
- ☐ No
- ☐ Policies are under development

81. Does the Prevention Forward participating clinic/hospital implement team-based approaches or policies to address high blood pressure control in clinical settings (B3a)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

82. Does the Prevention Forward participating clinic/hospital implement team-based approaches or policies to address cholesterol management in clinical settings (B3b)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

83. Does the Prevention Forward participating clinic/hospital use an electronic health record or a health information exchange or health information technology to alert or prompt providers about patients with high blood pressure (ICD-10-CM:I10) to encourage self-monitoring blood pressure adherence (B6)?

- ☐ Yes

- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

84. Does the Prevention Forward participating clinic/hospital use an electronic health record or a health information exchange or health information technology to identify patients with diabetes (Type II) for referral to national CDC-recognized lifestyle change programs such as Diabetes Self-Management Education and Support (DSMES)?

- ☐ Yes
- ☐ No (skip to question 69)
- ☐ Don't Know (skip to question 69)
- ☐ Not Applicable (skip to question 69)

85. Annual number of patients with diabetes (Type II) ages 18-85 years old referred to Diabetes Self-Management Education and Support (DSMES) within this reporting period.

- ➢ Click here to enter number of patients

86. Does the Prevention Forward participating clinic/hospital use an electronic health record or a health information exchange or health information technology to identify patients with prediabetes for referral to a National Diabetes Prevention Program (National DPP)?

- ☐ Yes
- ☐ No (skip to question 71)
- ☐ Don't Know (skip to question 71)
- ☐ Not Applicable (skip to question 71)

87. Annual number of patients with prediabetes ages 18-85 years old referred to National DPP for diabetes (Type II) prevention within this reporting period.

- ➢ Click here to enter number of patients

88. Does the Prevention Forward participating clinic/hospital use an electronic health record or a health information exchange or health information technology to identify patients with high cholesterol or high blood pressure (ICD-10-CM:I10) for referral to national CDC-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], or Curve Complete)?

- ☐ Yes
- ☐ No (skip to question 72)
- ☐ Don't Know (skip to question 72)
- ☐ Not Applicable (skip to question 72)

89. **Annual number of patients ages 18-85 years old referred to National CDC-lifestyle change program [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], or Curve Complete) for cholesterol or high blood pressure (ICD-10-CM:I10) management within this reporting period.**
    - Click here to enter number of patients

90. **What system does the clinic/hospital use to identify patients with chronic conditions for referral to CDC-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, DSMES, or National DPP) (check all that apply)**?
    - ☐ Electronic health record
    - ☐ Health information exchange
    - ☐ Health information technology
    - ☐ Other system (please describe):_____
    - ☐ The clinic does not have a system in place to identify patients with diabetes (Type II) for referrals

91. **What electronic health record or health information exchange or health information technology reporting source(s) are used in the Prevention Forward participating clinic/hospital?**
    - ☐ HCCCP data warehouse
    - ☐ Clinic EHR
    - ☐ Health system EHR
    - ☐ EHR vendor
    - ☐ i2i population health
    - ☐ Other (specify:) _____

92. **What type of measure(s) are used in the Prevention Forward participating clinic/hospital?**
    - ☐ UDS
    - ☐ GPRA
    - ☐ HEDIS
    - ☐ NQF
    - ☐ Other (specify:) _____

SECTION IX. ACTIVITIES IN PLACE FOR MANAGEMENT/CONTROL PREDIABETES, DIABETES CADIOVASCULAR DISEASE, HIGH BLOOD PRESSURE, HIGH CHOLESTORAL, AND STROKE WITHIN THE PREVENTION FORWARD PARTICIPATING CLINIC/HOSPITAL

G. ***This section assesses the use of health care models and supportive activities within the Prevention Forward participating clinic(s)/hospital*.**

93. **Is the Prevention Forward participating clinic/hospital an American Diabetes Association (ADA)-recognized/American Association of Diabetes Educators (AADE)-accredited Diabetes Self-Management Education and Support (DSMES) program (A1)**?
    - ☐ Yes
    - ☐ No (skip to question 79)

94. **If 'no', is the Prevention Forward participating clinic/hospital interested in becoming an American Diabetes Association (ADA)-recognized/American Association of Diabetes Educators (AADE)-accredited Diabetes Self-Management Education and Support (DSMES) program (A1)**?
    - ☐ Yes
    - ☐ No

95. **Does the Prevention Forward clinic/hospital participating in or referring patients to the American Diabetes Association (ADA)-recognized or American Association of Diabetes Educators (AADE)-accredited Diabetes Self-Management Education and Support (DSMES) program or CDC-recognized lifestyle change programs such as the National Diabetes Prevention Programs [National DPP] (A1, A4, B4, & B6)?**
    - ☐ Yes
    - ☐ No

96. **Does the Prevention Forward clinic/hospital promote the use of Medi-Cal DPP benefits as means of payment among eligible patients for CDC-recognized lifestyle change programs such as the National Diabetes Prevention Programs [National DPP]?**
    - ☐ Yes
    - ☐ No

97. **In the past 12 months, how many persons ages 18-85 years old with diabetes (Type II) within the Prevention Forward participating clinic/hospital had at least one encounter at an American Diabetes Association (ADA)-recognized/American Association of Diabetes Educators (AADE)-accredited Diabetes Self-Management Education and Support (DSMES) program ?.**
    - ➢ Click here to enter number of patients

98. **Total number of persons ages 18-85 years old within the Prevention Forward participating clinic/hospital enrolled in CDC-recognized lifestyle change program (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) in the year prior to the implementation of the Prevention Forward (1815) Program (Baseline for A9).**
    - ➢ Click here to enter number of patients

99. Number of patients ages 18-85 years old with prediabetes within the Prevention Forward participating clinic/hospital referred to CDC-recognized lifestyle change program [such as the National DPP] (A4).

- Click here to enter number of patients

100. In the past 12 months, how many patients, ages 18-85 year old with high blood pressure (ICD-10-CM:I10) within the Prevention Forward participating clinic/hospital were referred to evidence-based 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], or Curve Complete)?(B7a).

- Click here to enter number of patients

101. Number of patients, ages 18-85 years old with high blood cholesterol within the Prevention Forward participating clinic/hospital referred to evidence-based 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], or Curve Complete) (B7b).

- Click here to enter number of patients

102. Number of patients, ages 18-85 years old seen in the Prevention Forward participating clinic/hospital with known hypertension (ICD-10-CM: I10) who have achieved blood pressure control (B8-Baseline).

- Click here to enter number

103. Number of patients, ages 21 and over seen in the Prevention Forward participating clinic/hospital, at high risk of cardiovascular events (B9-Baseline).

104. Number of patients, ages 21 and over seen in the Prevention Forward participating clinic/hospital, at high risk of cardiovascular events who have their cholesterol managed with statin therapy (B9-Baseline).

- Click here to enter number

105. Number of patients ages 18-75 years old with diabetes (Type II) within the Prevention Forward participating clinic/hospital (Denominator baseline).

- Click here to enter number of patients

106. Number of patients ages 18-75 years old with diabetes (Type II) with an A1C>9 within the Prevention Forward participating clinic/hospital (A10: numerator).

- Click here to enter number of patients with A1C >9

107. In the past 12 months, how many persons ages 18-75 years old with prediabetes within the Prevention Forward participating clinic/hospital participated in CDC-recognized lifestyle change programs [such as the National DPP] who have achieved 5-7% weight loss?.

- Click here to enter number of patients

108. Does the Prevention Forward participating clinic/hospital have policies or systems to encourage self-measured blood pressure monitoring (SMBP)? (B3 & B6)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

109. How many pharmacy locations are in a collaborative practice agreement with the Prevention Forward participating clinic/hospital (A3)?

- Click here to enter number of pharmacy locations

110. Which of the steps in your collaborative practice agreement with pharmacists across pharmacy locations are being implemented to improve and optimize patient's health and medication outcomes (A3)? (check all that apply)

- ☐ COLLECT: Collect information about patients to understand relevant medical history and clinical status of the patient.
- ☐ ASSESS: Assess the information collected and analyze it for the purpose of the context of improving the overall patient's health goals to achieve optimal care.
- ☐ PLAN: Plan and develop individualized cost-effective patient centered care plan in collaboration with the health care professionals and the patient or caregiver.
- ☐ IMPLEMENT: Implement the care plan in collaboration with other health care professionals and the patient or caregiver.
- ☐ FOLLOW UP: Follow up to monitor and evaluate the effectiveness of the care plan and, as needed, modify the plan in collaboration with other health care professionals and the patient or caregiver
- ☐ Don't Know
- ☐ Not Applicable/ no collaborative practice agreement in place

111. Which of the following core elements of medication therapy management [MTM] your pharmacists either in house or in a collaborative practice agreement implement?
(Check all that apply)

- ☐ Establish and utilize medication refill reminder system.
- ☐ Provide patient education, risk/screening/reduction, and brief intervention.
- ☐ Identify adherence issues.
- ☐ Educate patients about benefits of blood pressure medications.
- ☐ Increase blood pressure monitoring in the home and pharmacy settings.

- ☐ Encourage healthy lifestyle changes and pharmacy settings.
- ☐ Encourage healthy lifestyle changes.
- ☐ Don't Know
- ☐ Not Applicable/ Medication Therapy Management has not been adopted

112. How many pharmacists (in house or in a collaborative practice agreement) engage in the practice of medication therapy management (MTM) to promote <u>medication self-management</u> for hypertension?

- ➢ Click here to enter number of pharmacists

113. How many pharmacists (in house or in a collaborative practice agreement) engage in the practice of medication therapy management (MTM) to promote healthy <u>lifestyle changes</u> for hypertension) (B4a).

- ➢ Click here to enter number of pharmacists

114. How many pharmacists (in house or in a collaborative practice agreement) engage in the practice of medication therapy management (MTM) to promote medication self-management for high blood cholesterol (B4b).

- ➢ Click here to enter number of pharmacists

115. How many pharmacists (in house or in a collaborative practice agreement) engage in the practice of medication therapy management (MTM) to promote healthy lifestyle changes for high blood cholesterol (B4b).

- ➢ Click here to enter number of pharmacists

116. Does the Prevention Forward participating clinic/hospital have Community Health Workers (CHW) or promotores in chronic disease management programs?

- ☐ Yes
- ☐ No

117. Did Community Health Workers or promotores within the Prevention Forward participating clinic/hospital receive core competency training (A7 & B5)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

118. Did Community Health Workers or promotores within the Prevention Forward participating clinic/hospital receive certification (A7 & B5)?

- ☐ Yes
- ☐ No

- ☐ Don't Know
- ☐ Not Applicable

119. Does the medical billing for chronic condition management cover the salary of Community Health Workers or promotores' services offered to patients within the Prevention Forward participating clinic/hospital setting (A7 & B5)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

120. Does the Prevention Forward participating clinic/hospital need any technical assistance or support on any of the community health workers or promotores' activities?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

121. Does the Prevention Forward participating clinic/hospital offer opportunities for professional development or provider education?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

122. Does the Prevention Forward participating clinic/hospital use <u>patient reminder systems</u> to provide care?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

123. Does the Prevention Forward participating clinic/hospital use <u>provider reminder systems</u> to provide care?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Not Applicable

124. In the absence of the prevention forward funding, can your health systems/centers/hospitals/clinics sustain the activities of prevention forward mentioned above (Sustainability)

- ☐ Yes
- ☐ No
- ☐ Don’t Know
- ☐ Too early to measure

Thank you for your participation in this annual survey. Your work with CDPH-Prevention Forward is highly appreciated!