Appendix D: ASTHO Community-Clinical Linkages Change Package Toolkit
Developed July 2015

Purpose: This toolkit is intended to help state teams identify potential strategies for their team's work in improving hypertension control by streamlining protocols for patients from the community to the clinical settings.

How to Use the Change Package Toolkit: Each applicant must identify *at least one* community-clinical strategy to implement *at least two* health system interventions. Once strategies are identified, state teams (which include partners at all levels of implementation from State Health Officials to clinical providers) will test the intervention steps using rapid cycle tests of change. The change strategies and implementation steps are overlapping and iterative and will likely be used in coordination with one another.

This toolkit is meant to offer a comprehensive array and consideration of a variety of evidence-based strategies and implementation steps. Each strategy will *not* be applicable to all sites. Intervention steps within each strategy might also differ from the examples listed. Please also note that this is one tool that applicants might use to design and plan strategies and implementation steps; other resources could be used.

All strategies related to supporting and enhancing community-clinical linkages will help state teams achieve the long-term goal of reducing the number of patients with uncontrolled hypertension at risk of adverse health outcomes and the following medium-term goals:

- Increasing reporting and monitoring of NQF 18.
- Improving identification of undiagnosed persons with high blood pressure.
- Improving the diagnosis, treatment, and follow up of persons with high blood pressure.

Content vs. Systems Strategies: In addition to the evidence-based strategies listed in the RFA, the change package toolkit also includes strategies and tests of change related to systems-level issues, such as vision and leadership, communication, and partnerships. These components can facilitate the ease with which interventions are adopted, implemented, and brought to scale, as well as how likely they are to be sustained over time.

Listing of Strategies: Each strategy is centered across all of the potential implementation steps and roles; if you are unable to see the text of the strategy in the column, scroll down the page until it is visible. Also, please note that many of the strategies and implementation steps are complementary and sometimes overlapping. For example, some of the linkage strategies between referring entities; these must also align with data systems that track patients' outcomes between community and clinical settings. ASTHO expects this to be a dynamic and iterative process, with changes and updates throughout, and teams applying lessons learned from ongoing tests of change.

Change Strategy	Implementation Steps	Responsible Entity	Resources, as available
Increase engagement of community-based health care professionals (including but not limited to community health workers, Medical Reserve Corps, public health or parish nurses, nutritionists, patient navigators, etc.) to promote linkages between clinical and community care for adults with high blood pressure.	Articulate and refine vision for strategy implementation, how it connects to other state initiatives and population health goals, and the vision for how it will be brought to scale across the state in different settings and with different populations than the ones in the test sites	State Leader/ Policymaker (including State Health Officials, Senior Deputies, Health Plan executive, Medicaid Director or senior level person, etc.)	
	Provide input on effectiveness of internal and external communication methods and messages about our strategy by assessing if vision, goals, and objectives, and actions are clearly articulated, publicly available, and clear to staff within the health department, as well as to state, regional/local, and community stakeholders		
	Develop and enhance partnerships to adopt, implement, and bring to scale the intervention at the state, local/regional, and community levels, including but not limited to professional membership associations, public/private insurers, hospital groups, community clinics/FQHC networks.	State Leader/ Policymaker State Implementer Local Implementer	ASTHO Case Study: Iowa's Million Hearts Initiative (highlights multi-sector partnerships) ASTHO Million Hearts Success Story: New York Develops Clinical Pathway to Identify and Manage Adult Hypertension Health Department-Federally Qualified Health Center Partnerships to Improve Hypertension Identification, Management, and Control (issue brief)
	Evaluate and build the evidence base or community-based health professionals in the state, including developing data systems and key questions for evaluation (e.g., Return on Investment)	State Implementers, including state health department,	Oklahoma's Return on Investment analysis (presentation)

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	Identify and evaluate strategies for reimbursement and/or payment models for community-based health care professionals.	QIO, health plans, medical professional associations, etc.	Minnesota's Provider Manual for reimbursement of Community Health Workers
	Develop an understanding of and coordinating the variety of care coordination efforts offered across the state, such as by private health insurers.		
	In coordination with local and community/clinical partners, create and/or disseminate standardized clinical-community linkage protocols, such as for referrals to clinical care from community screening and/or to community resources from clinical sites.		Oklahoma's Patient Flow into community resources Heartland OK patient flow to clinical care from community
	Organizing complementary state efforts to enhance coordination and reduce duplication, such as state Million Hearts efforts, chronic disease programs, Medical Reserve Corps, State Health Improvement Plans, etc.		
	Review available state data systems to assess the ability of state partners to determine the burden of hypertension in various areas across the state, such as BRFSS data, All Payers Claims Databases, Health Information Exchanges, GIS data, state quality measures, Medicaid data, hospital discharge data, UDS measures, etc.		Novel MDH study yields first statewide estimate of potentially preventable health care events (article) Policy for Quality Measures (Minnesota) (State Statute 62U.02, a standardized set of quality measures for health care providers of Minnesota). Using HIE Data to Evaluate Hypertension in Albany County (New York) (report) Working Across Federal Hypertension

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			Measures [peer group call recording] and Report (Pending)
	Use data to identify priority populations with high burdens of hypertension in state.		Using Data to Create Heat Maps: Examples from Alabama and Vermont [recording and slide deck)
	Assess the variety of different EMR systems used by large medical systems in state; work with vendors to understand how referral protocols are or could be integrated into EMRs and potentially shared outside clinical setting.		Kansas' EMR assessment tool (pending)
	In collaboration with local and community implementers, develop, test, and disseminate data sharing agreements and/or protocols between state, regional/local, and community levels to promote data-based decision-making at the population and patient levels.		Alabama's data sharing agreement (pending)
	Ensure that partners have a mechanism and forum for ongoing communication to discuss the project and how it intersects with other efforts.		
	In collaboration with state and community implementers, coordinate standardized clinical-community linkage protocols, such as for referrals to clinical care from community screening and/or to community resources from clinical sites.	Local Implementer (including Local Health Department leads, FQHC leaders, faith-based health ministries, fire department/EMS, community partners including YMCA or other, etc.)	Illinois' Blood Pressure Ministry Guidelines for Screening and Measurement (and Peoria's Immediate Referral Form) Arkansas' Community Team-Based Care Implementation Protocol for Hypertension Management Summit County, OH's Patient Referral Form

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			Oklahoma's Patient Referral Form for Care Coordination (tested in Pittsburg County, OK)
	Determine feasibility of providing care coordination from local health department AND/OR organize other care coordination efforts in the local area, such as through health ministries.		Summit County, OH's Care Coordination (webinar)
	Identify and facilitate relationships with specific clinical providers to test protocols for accepting new patients referred through community screening AND for referring patients from clinical site to community resources.		
	Coordinate with clinical and community providers to create and test bi-directional data exchange between community screening or service sites (such as fire halls) and clinical practices, ensuring accuracy, timeliness, and privacy.		Community-based Health Professionals Peer Group Call: Data Tracking and Outcomes [peer group call recording]
	Prioritize resources for by using regional/local data systems (such as hospital discharge, GIS, etc.) to create heat maps or determine hotspots.		Using Data to Create Heat Maps: Examples from Alabama and Vermont [recording and slide deck] ASTHO Million Hearts Success Story: Illinois Uses Hospital Discharge Data to Support Local Hypertension Control Efforts
	Test and refine blood pressure screening and referral protocols from community sites to clinical care for undiagnosed/at-risk or diagnosed/ uncontrolled patients with hypertension.	Clinical and Community Providers (including community-based health providers,	Illinois' Blood Pressure Ministry Guidelines for Screening and Measurement (and Peoria's Immediate Referral Form) Arkansas' Community Team-Based

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		such as public health or parish nurses, CHWs, Medical Reserve Corps members, YMCA health leaders, etc.)	Care Implementation Protocol for Hypertension Management Million Hearts Parish Nurse Program Materials (Maryland) Million Hearts Stories (The Association of Public Health Nurses)
	Test referral protocols from clinical sites to community care coordination and self-management resources.		Reducing Care Fragmentation: A Toolkit for Coordinating Care (from Improving Chronic Illness Care, for clinicians)
	Coordinate with local implementers to create and test bi-directional data exchange between community screening or service sites (such as fire halls) and clinical practices, ensuring accuracy, timeliness, and privacy.		Community-based Health Professionals Peer Group Call: Data Tracking and Outcomes [peer group call recording]
Increase engagement of community pharmacists in the provision of medication/self management for adults with high blood pressure.	Articulate vision and provide leadership for the implementation of the strategy, including how this will connect to other statewide efforts.	State Policymaker	Medication Adherence Webinar Series: Two States' Perspectives [webinar featuring CT and MN]
	Convene, facilitate, and coordinate partnerships at the state level to allow for enhanced implementation, such as between professional membership associations, public/private insurers, hospital groups, community clinics/FQHC networks.	State Leader/ Policymaker State Implementer Local Implementer	Partnering with Pharmacists in the Prevention and Control of Chronic Diseases: A Program Guide for Public Health
	Identify and disseminate resources and evidence base for using pharmacists as part of team-based care.	State Implementer	Team Up, Pressure Down The Hypertension Team: The Role of

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			the Pharmacist, Nurse, and Teamwork in Hypertension Therapy (CDC article) University of Maryland's Center for Innovative Pharmacy Solution's "Knowledge Enterprise" (online training) ASTHO Case Study: Maryland P^3 Program ASTHO Story: Iowa's Provider-Pharmacist Team Management of Hypertension
	Provide oversight of evaluation of efforts, including determining necessary evidence needed for scaling up efforts (i.e., cost effectiveness studies)		
	Identify and evaluate strategies for reimbursement and/or payment models for pharmacists for medication therapy management or other medication adherence efforts.		Washington's new law on pharmacist reimbursement
	In coordination with local and community/clinical partners, create and/or disseminate standardized linkage protocols for referral to pharmacists for medication therapy management, med adherence, or medication reconciliation from community and/or clinical settings.		
	Identify data systems to track medication-related population measures, such as through public data systems and/or private pharmacy databases.		Assessing and Addressing Medication Non-adherence at the Population and Clinic Level [slide deck]

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	Identify and facilitate relationships with specific pharmacists to test protocols for accepting counseling referrals AND for contacting providers regarding medication issues with specific patients.	Local Implementers	National Forum Learning Session: Working with Pharmacists to Increase Medication Therapy Management (podcast about the pharmacist's role in team-based care models).
	Assess resources available to community members to determine barriers to and support of medication adherence (including but not limited to ways to assess and measure social determinants of health) at client level.		Morisky Medication Adherence Scales
	Evaluate use of definitions for tracking medication adherence at the population level (such as PDC).		
	Facilitate assessment of methods for bi-directional data sharing of at-risk patient dashboards with providers to better jointly manage patients' medication adherence.		Assessing and Addressing Medication Non-adherence at the Population and Clinic Level [slide deck]
	Test protocols for pharmacy/clinician co-management of common hypertension patients.	Community/Clinical Providers	Morisky Medication Adherence Scales
	Test protocols for accepting referrals from providers and/or community-based health professionals to pharmacists for medication counseling and/or reconciliation.		
Implement systems to facilitate bi-directional referral between community resources and health systems, including lifestyle change programs (e.g. EHRs, 800 numbers,	In coordination with local and community/clinical partners, create and/or disseminate standardized linkage protocols for referral between community resources and health systems.	State Implementer	
	Assess feasibility of EMR systems and state-level data systems to exchange and share information about individual patients to inform patient care and population health.		

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211 referral systems, etc.).	Assess and disseminate information about array of self-management supports that are available in community.	Local Implementer	
	Assess and test methods for gather resource lists and frequency for updating these lists and who will be responsible for doing so.		
	Coordinate variety of community-based self-management support available to reduce duplication and allow for maximum access for patients.		
	In collaboration with state and community/clinical implementers, create, test, and disseminate protocols for referral to specific interventions, such as to health coaches, use of home BP monitors, classes, YMCA programs, etc.		American Heart Association's Check. Change. Control. Blood Pressure Monitoring Program
	Coordinate with community and clinical implementers to create and test bi-directional data exchange between community self-management efforts and clinical practices, ensuring accuracy, timeliness, and privacy.		American Heart Association's Heart360 Cardiovascular Wellness Center
	Develop, test, and implement referral protocols for specific interventions, including an algorithm for which patients should be referred and when, to both clinical care from the community and from community programs and resources to clinical care.	Clinical/Community Implementer	Health Care Access Hypertension FITT Program (Kansas) (Implementation guide and goal sheet for patients) Patient-Self Monitoring of Blood Pressure: A Provider's Guide (New York) Partnering in Self-Management: A Toolkit for Clinicians (McColl Center, Robert Wood Johnson Foundation, and the Institute for Healthcare Improvement)

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	Develop, test, and implement follow up procedures with patients to determine if referrals were followed through on and the results of those interventions.		
	Coordinate with state and local implementers to create and test bi-directional data exchange between community screening or service sites and clinical practices, ensuring accuracy, timeliness, and privacy, and ways to integrate data in patient EMRs.		American Heart Association's **Heart360 Cardiovascular Wellness Center** National Forum Learning Session: Linking Patient Data from the Community to Clinical Practice