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Hypertension Control Playbook

Purpose: The purpose of this document is to assist health centers with controlling blood pressure in patients with hypertension as it aligns with the HEDIS and CMS measures in Azara. This is not a comprehensive clinical guideline for hypertension; rather, it serves as a summary of selected quality improvement best practices based on experience from the High Impact Performance Program.

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INTRODUCTION

Overview: This section contains background information on hypertension and the importance of controlling blood pressure.

Background: Nearly half of all adults have high blood pressure, which is defined as a systolic blood pressure greater than 130mmHg or a diastolic blood pressure greater than 80mmHg [Cited]. Most of the time, high blood pressure has no obvious symptoms to indicate something is wrong. In most cases, damage from hypertension occurs over time and can lead to complications such as stroke, vision loss, heart failure, heart attack, kidney disease, and more [Cited]. This is why it is vital that primary care providers check blood pressure frequently and accurately for all of their patients. Consistent monitoring of blood pressure helps patients to understand their risk and have the information needed to address lifestyle modifications. This playbook outlines some of the quality improvement best practices and selected clinical guidelines that health centers can use to help their patients be aware of and educated on a hypertension diagnosis and address the population health of this group. For complete clinical guidelines, please see additional outside resources such as:

- The AAFP Hypertension Clinical Practice Guidelines,
- MQIC Guidelines
- 2020 International Society of Hypertension Global Hypertension Practice Guidelines
- The 2023 ESH Hypertension Guideline Update
- The USPSTF 2021 Recommendations for Screening for Hypertension in Adults
- The 2014 JNC8 Recommendations

Measure Definition: The definition of the Controlling High Blood Pressure (CBP) HEDIS Measure is "Members ages 18-85 years who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year." Note that a representative BP is defined as the most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled." See numerator and denominator details below.

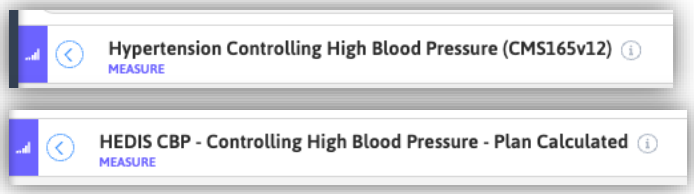
- Numerator: Members whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
  - A representative *systolic* BP <140 mm Hg

    AND
  - A representative *diastolic* BP of <90 mm Hg
- Denominator: Members 18-85 years of age who had visits that indicated a diagnosis of hypertension during the first six months of the measurement year or the year prior to the measurement year

POPULATION HEALTH MANAGEMENT

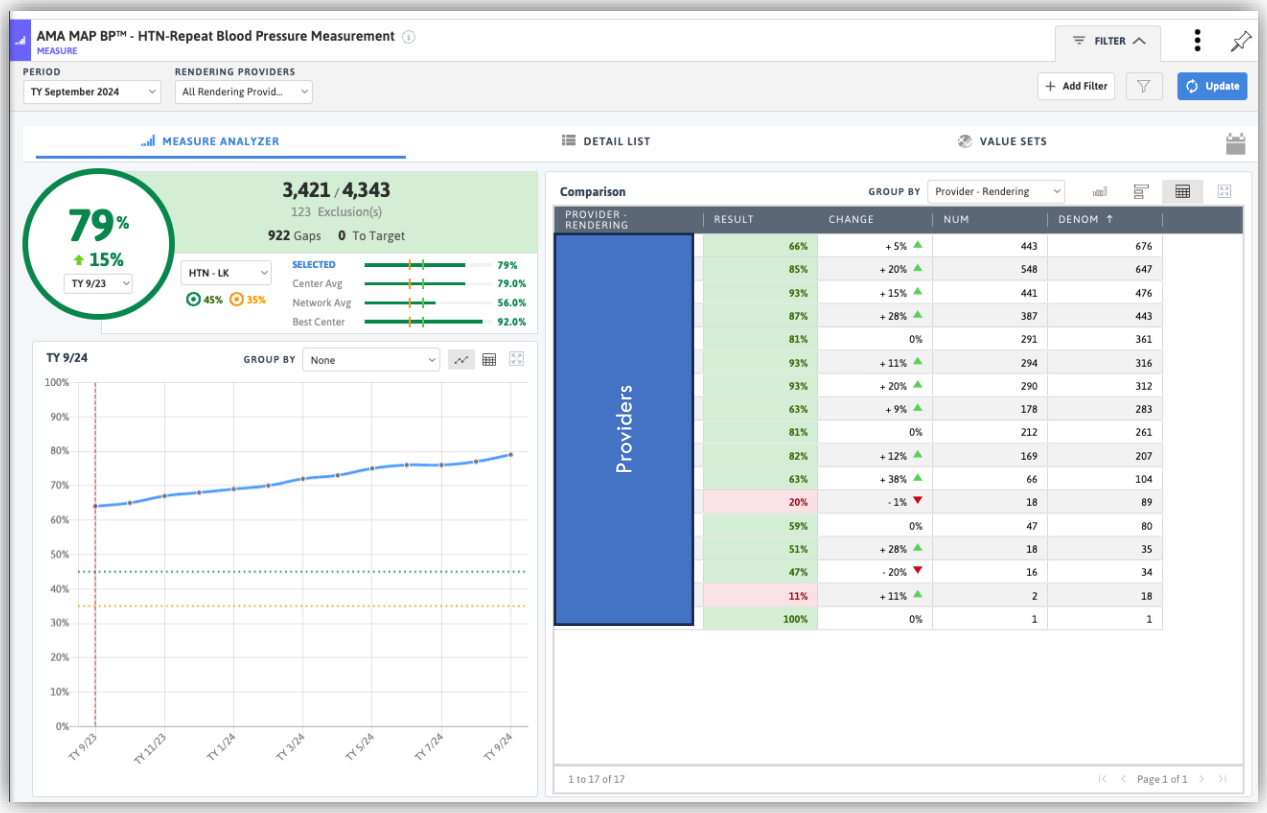
Obtaining Patient Lists: As a health center member of MCHN, Azara has many resources for managing the population health of patients with hypertension. There are various measures and reports that can produce patient lists for targeted blood pressure management. Two of the main

reports include the CMS and HEDIS measures for hypertension control and are screenshotted below for your reference:

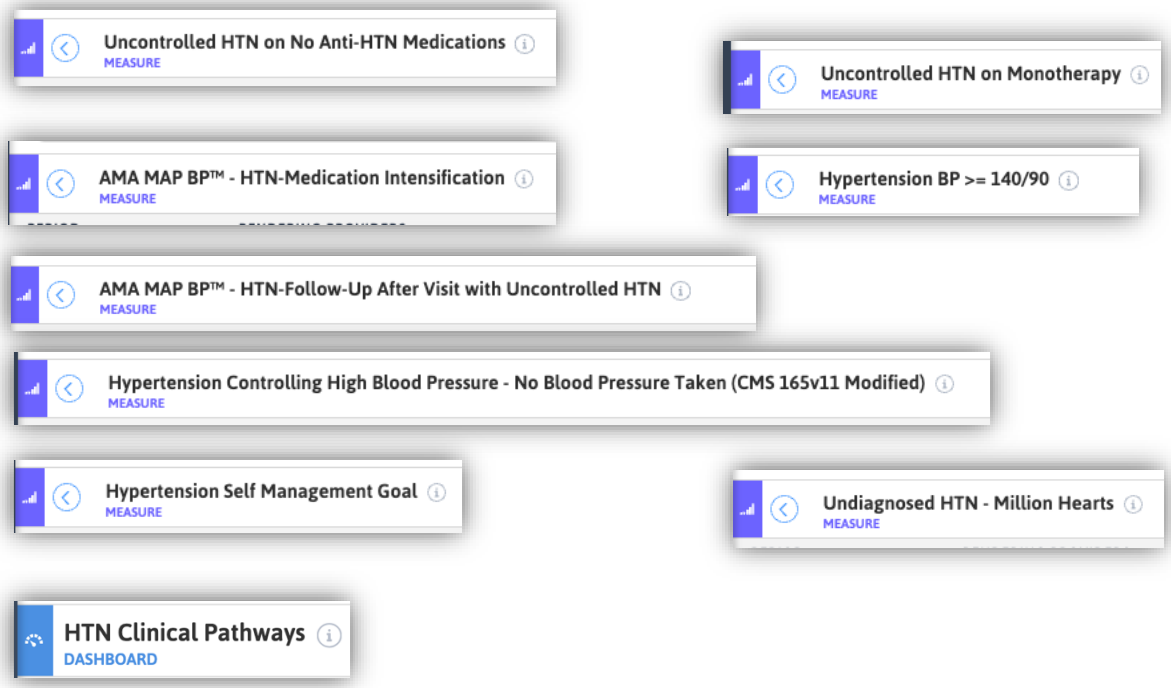


Both of these lists are able to provide patients with a diagnosis of hypertension and allocate those in the numerator who are in control (BP< 140/90) and the gap with uncontrolled patients. These lists can be used to determine which patients may need to be addressed with further clinical, nutritional, or behavioral health assistance. Additionally, one best practice was determined to be sorting these lists for targeted outreach by patients who have not had a visit in the measurement year to address those patients with the greatest need.

One of the known clinical best practices for hypertension includes taking a repeat blood pressure when the initial blood pressure reading at a visit is high [Cited]. Azara provides a measure that looks at this process, which can be helpful when sorting by provider to address any disparities in the workflow. Some health centers look at this measure on a monthly basis to address provider-specific needs in a timely manner. Below is an example screenshot of this measure for one health center:

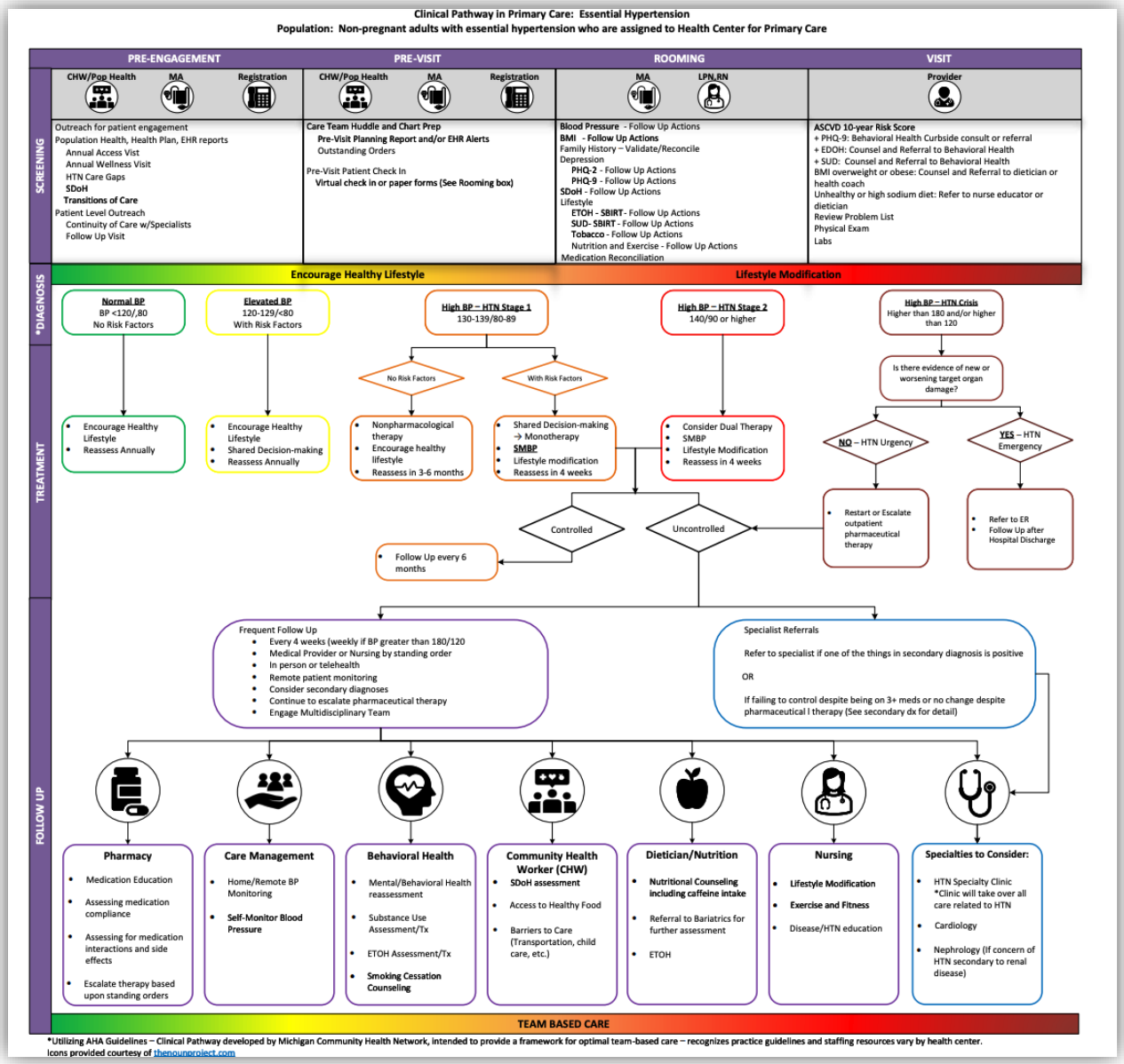


In addition to the Hypertension Control measures, Azara provides a variety of tools for the management of this population. Below are some screenshot examples of these measures. Please reach out to your MCHN or MPCA data team member for additional Azara measure questions that may arise.

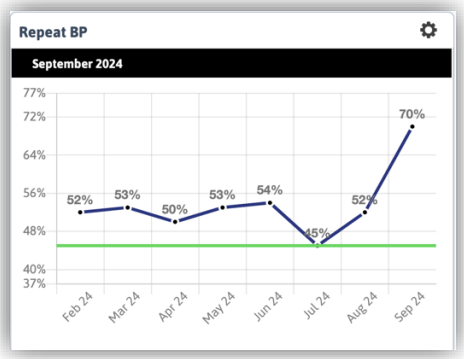


WORKFLOWS

MCHN Hypertension Clinical Pathway: MCHN's Clinical Pathway Subcommittee, comprised of member health center representatives and MCHN/MPCA staff, has been tasked with clinical pathway development for selected chronic diseases [Cited]. They created a standardized template utilizing team-based care to integrate existing clinical guidelines into a model of care for health centers to ensure its staff is working at the top of licensure. Their first chronic disease targeted for clinical pathway development was Hypertension and this pathway is available under the "Resources" section of the MPCA website. The pathway is also inserted below for your reference and is intended to be a "living" document that will be updated as needed. These pathways are intended to guide health center care teams through the development of their own specific workflows and should be modified to meet the specific needs and resources of each health center location. The following sections of this Workflow outline in the playbook will go into greater detail on specific areas of this MCHN Hypertension Clinical Pathway.



One way to measure the progress of process measures related to the HTN Clinical Pathway is to use the HTN Clinical Pathways Dashboard in Azara. This dashboard includes the Hypertension control quality measure, the AMA Repeat BP measure, the Medication Intensification measure, and an Undiagnosed HTN measure, in addition to a breakdown of performance by provider for hypertension control and repeat BP. One health center monitored the performance of each medical site every month to identify patterns and gaps that needed to be addressed. In doing so, they identified poor repeat BP performance which prompted staff education from their IT team on proper documentation in the EMR at monthly staff meetings. Following this, they saw a 37% improvement in their Repeat BP performance. They can now target specific sites or care teams for additional education and training as needed.

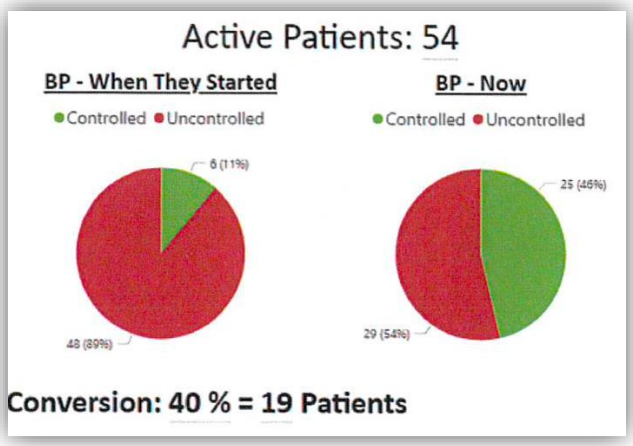


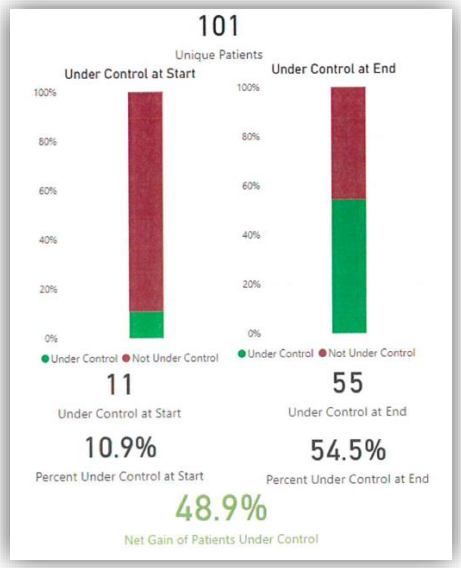
Standing Orders: Standing orders are written protocols that authorize designated members of the health care team (e.g., nurses or medical assistants) to complete certain clinical tasks without having to first obtain a physician order [Cited]. This can improve efficiency by freeing physicians to focus on more complex care. Several studies have demonstrated that standing orders can increase the delivery of routine preventive care services, leading the Centers for Disease Control and Prevention's Community Preventive Services Task Force to strongly recommend their use. Best practices for standing orders require support and adherence from all clinical staff at a health center. The Chief Medical Officer is responsible for signing off on standing orders, but all providers and clinical staff should be in agreement with the procedures and have the knowledge to act upon them as needed. Example hypertension standing orders can be found in Appendix Item 1, noting that BP ranges and other workflows should be tailored to health center needs and resources.

CDSS Alerts: A clinical decision support system (CDSS) informs or generates medical recommendations for healthcare practitioners. An alert is the most common way for a CDSS to interact with practitioners [Cited]. Studies have shown that alerts are an efficient way to prevent medication errors and streamline clinical workflow [Cited]. An alert may be for things like patients due for updated blood pressure, patients whose first BP was high and required a second reading at that visit, patients who may benefit from medication changes, and more. Each EMR will have different alerts that a health center may wish to turn on or off. In the Azara PVP report, there is an alert for "BP" which indicates that a patient is due for a blood pressure measurement and contains some of the most recent clinical information. An example screenshot can be seen below:

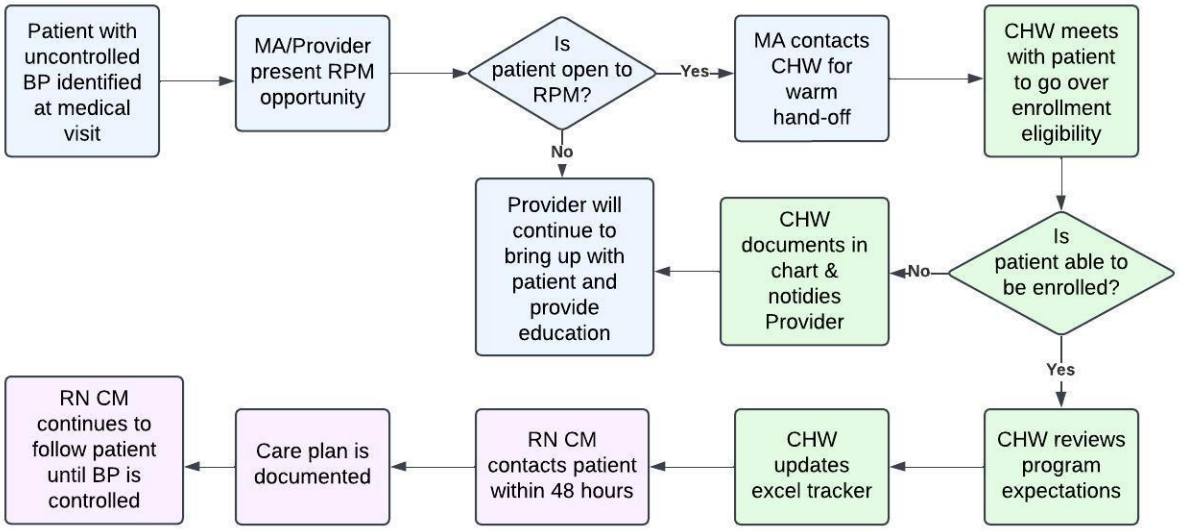
ALERT	MESSAGE	DATE	RESULT
LDL	Out of Range	6/20/2023	132
CKD Screening - HTN	Missing		
BP	Out of Range	2/29/2024	157/92
COVID-19 Adult	Due		Due: 2023–2024 Formula mRNA (Moderna, Pfizer-BioNTech) | Date: 09/12/2023 | Most Recent: None
Tetanus	Due 1		Due Date: 2003-09-10 | Most Recent: None

Remote Patient Monitoring: Monitoring patient blood pressure outside of the clinical setting can help patients see hypertension symptom improvement. Remote monitoring of blood pressure can improve patient self-management ability and quality of life [Cited]. RPM has also been shown to reduce treatment costs, improve adherence, and optimize medication dosages in patients with hypertension [Cited]. As an MCHN member, CareMindr is a remote monitoring platform that is available to health centers at a group rate. CareMindr allows the health center to create its own individualized app for patients to use when communicating with the care teams, which can help lead to longer-term adherence. This platform also has support for Medicare RPM reimbursement and coding best practices. CareMindr provides monthly reports for statistics including the number of enrolled patients, how many are actively engaged, and how many patients have achieved BP control since enrollment. Examples of data from these reports can be seen below:





Defining staff workflows for patient identification, enrollment, and engagement with RPM is critical for program and patient success. Example workflow:

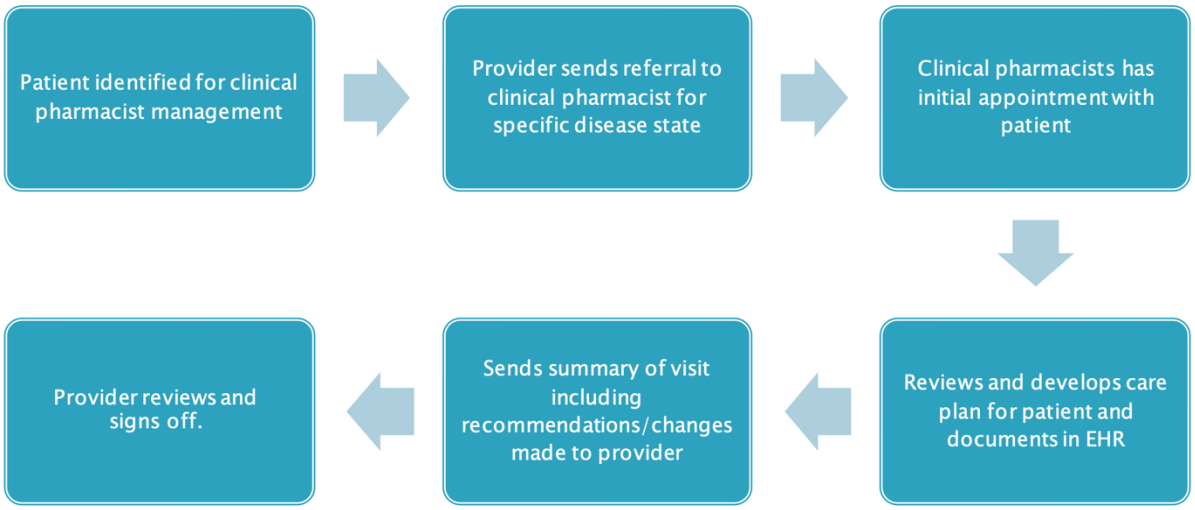


INTEGRATION OF ANCILLARY STAFF

Introduction: Team-based care is a known best practice for optimal primary care function and optimization of patient outcomes, such as blood pressure. One aspect of team-based care is the integration of staff outside of providers in the patient care process. These staff may include employees such as pharmacists, nurses, dietitians, MAs, behavioral health specialists, community health workers, and more.

Pharmacy: Pharmacy integration into primary care is one of the most impactful ways to lower patient blood pressure and improve population health outcomes. An example of a best practice resource for this integration is Michigan Medicine's implementation of the Pharmacists' Patient Care Process Framework, and a summary guide can be sent as supplemental material [Cited]. For FQHCs with clinical pharmacists, a Collaborative Practice Agreement (CPA) may be the most efficient way to integrate clinical pharmacists into primary care. A CPA is an agreement between the provider and a pharmacist that defines what services a pharmacist can provide autonomously [Cited]. For example, a pharmacist may be able to authorize refills, modify or initiate medication therapy, order or interpret labs, and more, depending on the agreement between the provider and pharmacist. When pharmacists can provide these services to patients it can reduce provider time, increase coordination of care for the patient, and improve team-based care workflows.

Below is an example workflow for how patients are referred to clinical pharmacists for management [cite – east Jordan slides]



One health center with engaged clinical pharmacists who have a CPA found that the average change in blood pressure after working with a clinical pharmacist and participating in an RPM program was a 23.3-point reduction in systolic blood pressure and an 8.3-point reduction in diastolic blood pressure [cite – east Jordan slides].

For more information about pharmacy integration, please contact Lindsay Sailor [lsailor@mpca.net] to join monthly office hours.

Community Health Workers: Community Health Workers (CHWs) can also play a pivotal role in assisting with blood pressure control in patients with hypertension. CHWs are trusted members of the community they serve and are certified to provide specific education and assistance to populations of focus [Cited]. In Michigan, CHWs have been shown to provide culturally competent care while improving health outcomes of populations with limited English proficiency and providing cost savings for healthcare organizations. For patients with hypertension, CHWs can perform targeted outreach and engagement using the outreach lists described above. Additionally, CHWs can assist at point-of-care during or after medical appointments with services such as health education, self-management strategies and goal setting, stress management strategies, helping a beneficiary with Medicaid coverage, addressing SDOH barriers, and more. All of these services can help to reduce patient blood pressure, improving patient outcomes, and HEDIS and CMS quality measure performance.

Behavioral Health: Behavioral Health integration into primary care can greatly improve patient outcomes and is another important aspect of team-based care. For health centers that have behavioral health specialists as part of their care team, developing the workflows to have those staff help address patients with uncontrolled hypertension is essential. A warm handoff can be key to this encounter. A warm handoff is a transition conducted in person between two members of the health care team in front of the patient (and family if they are present). The warm handoff engages the patient as a team member and partner in their care. In warm handoffs, patients hear what is discussed, reinforcing their understanding of the diagnosis and plan of care and allowing them to correct or clarify the information exchanged. Warm handoffs engage the patient through structured communication and improve patient safety by helping prevent communication

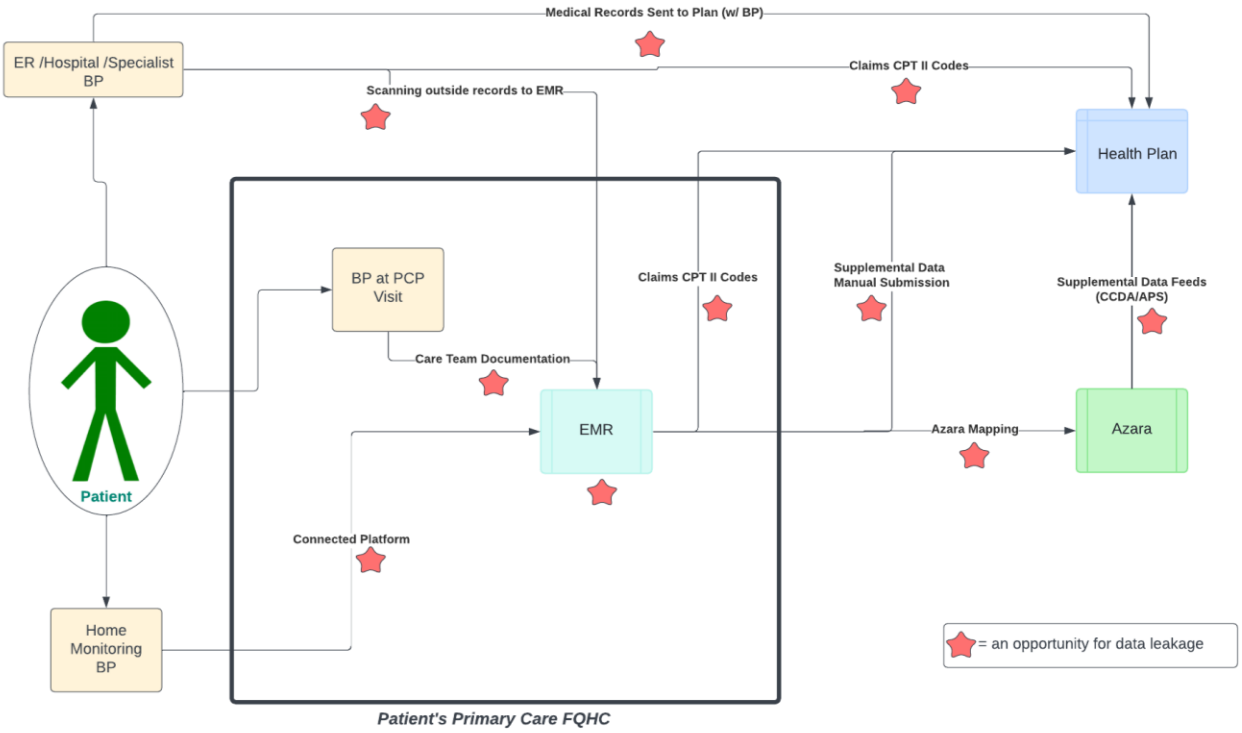
breakdowns [Cited]. Utilizing behavioral health specialists in chronic conditions like hypertension has been shown to improve patient outcomes, reduce costs, and improve provider well-being by reducing PCP burden [Cited]. For hypertension, a behavioral health specialist may be able to assist with positive screening on PHQ9 or PHQ2, lifestyle behavior change, medication adherence, weight management counseling, and more as needed.

Dental: Health centers may have patients who attend appointments with their dental staff who also have a diagnosis of hypertension. It is a known best practice to ensure that any staff member taking blood pressure is educated on the best practices required for that procedure, including repeat BP protocol, documentation in EMR, and more. This should be incorporated into the standing order language to include staff in any health center specialty area, including dental. Studies have determined an association between periodontitis and systolic blood pressure levels in a dose-response manner. This means the more severe periodontitis, the higher systolic blood pressure, and in those with hypertension, those with periodontitis had a 2.3-3 mm Hg higher systolic blood pressure compared to those without periodontitis. In those without hypertension, periodontitis was associated with a significantly higher risk of hypertension [Cite]. Some patients with hypertension may experience increased gingival bleeding, periodontitis, hyposalivation, and other oral health complications [Cite]. Patients who take medications for hypertension may be at an increased risk for poor oral health consequences as all major groups of these medications can cause oral side effects [Cite].
The appendix includes a blood pressure screening algorithm for oral health providers from the Hypertension Screening Guidance for Michigan Oral Health Professionals [Appendix Item 2]. The key to integration with primary care is to determine a referral and follow-up workflow between your dental department and primary care. If patients seen at a dental appointment have high blood pressure, scheduling a follow-up appointment with their PCP or seeing if they can be seen by a Care Manager or PCP same day is crucial to close the loop and work to lower the patient's blood pressure.

Huddles: Regardless of the care team members involved, optimal integration and team-based care require daily team huddles. Daily team huddles have been shown to boost productivity and improve communication within a primary care practice [Cited]. Huddles are an important time to discuss patients on the schedule for today and review any specific needs such as blood pressure education or re-check, medication needs, lifestyle education from CHWs, and more. Ideally, huddles should take no longer than 15 minutes, and it is recommended to have a "Huddle Checklist" or "Script" for teams to follow in order to streamline and standardize the process. An example huddle checklist can be seen in Appendix Item 3. Items covered during a huddle may include clinic capacity for the day, staffing levels and absences for the day, and patient needs for the day such as referrals, consults, care management, interpreter services, and more.

DOCUMENTATION AND CODING

Data Flow: There are a variety of ways that the health plan may become aware of a blood pressure reading for a patient and thus contribute to HEDIS data results. Below is an outline of the various paths that data can take from a home monitoring platform, an office visit, a specialist visit, etc., and how that data flows from the EMR to Azara to a Health Plan. Indicated by a red star are various opportunities for "data leakage" that should be investigated where there are discrepancies between health center data, Azara data, or health plan data. For questions regarding this flow, please reach out to the MCHN data team for more information.



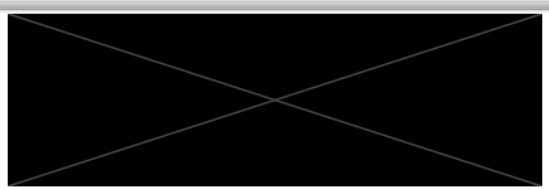
Coding: There are some CPT II codes that can be used to indicate whether a patient's blood pressure reading was controlled or not. CPT II codes are quality codes and not directly tied to reimbursement but are used for tracking purposes and to help ensure gap closure. Not all health centers currently use CPT II codes, but for those that do, below is a table of the qualifying CPT II codes for this measure. Of note, codes are often updated yearly and are always subject to change. Please refer to the Value Set list for each measurement year.

Description	Codes
Diastolic Less Than 80	CPT-CAT-II: 3078F
Diastolic 80-89	CPT-CAT-II: 3079F
Diastolic Greater Than/ Equal To 90	CPT-CAT-II: 3080F
Systolic Less Than 130	CPT-CAT-II: 3074F
Systolic 130-139	CPT-CAT-II: 3075F
Systolic Greater Than/ Equal To 140	CPT-CAT-II: 3077F

Documentation: When care teams document blood pressure results, the systolic and diastolic blood pressures must be documented in a discreet data section of the EMR and not only in a free text note. Often this occurs in the "vitals" section, but it may differ between EMRs. Additionally, when a repeat blood pressure is required, that second blood pressure should be documented in the discreet data section as well. For the HEDIS measure, when two blood pressures are taken at the same visit, the measure definition requires that the health plan take the lowest systolic and the lowest diastolic blood pressure reading from that visit as the official blood pressure, creating a 'representative blood pressure'. Thus, when an initial blood pressure reading is high, it is important to get that second blood pressure in case it may be lower and "in control". This is important not only for the correct HEDIS measure data but also for appropriate patient care, such as medication prescribing practices.

APPENDIX

Note, most appendix items can be sent as a separate document resource.
Item 1: Example Hypertension Standing Order



***Template*: Developing Nurse Standardized Procedure for Blood Pressure Management**

Clinical Protocol: Nurse Co-management in Uncomplicated Hypertension

Effective date:

Policy & Procedure:

Revision date:

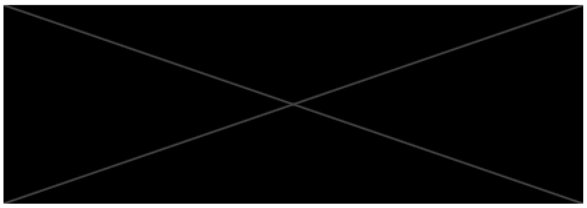
Last reviewed:

Policy
It is the policy of _____ Health Center to allow qualified RNs to co-manage patients ages 18 years and older with uncomplicated hypertension[1].

I. Procedure
A. Functions the RN may perform: collect subjective data (patient history), collect objective data (perform physical examinations), assess patient status, order and identify abnormal labs, develop and implement treatment and educational plan of care

B. Scope: under the following circumstances the RN may perform function
1. Setting – within the clinic site
2. Supervision – the RN may operate independently within the constraints and criteria of this policy in partnership with mentoring physician(s) and the designated primary care physician to provide care under the protocol.
3. Patient criteria:
   a. Patient has a designated primary care provider.
   b. The primary care physician has diagnosed the patient with Stage 1 or Stage 2 hypertension.
   c. The patient does not have the following co-morbidities: Stage 4 Chronic Kidney Disease, congestive heart failure or pregnancy.
   d. The patient's baseline labs are within normal limits (CBC, Cr, K, Na, Calcium (or CMP); U/A)
   d. The nurse has introduce her/himself utilizing correct title and explain role and the patient accepts RN co-management.

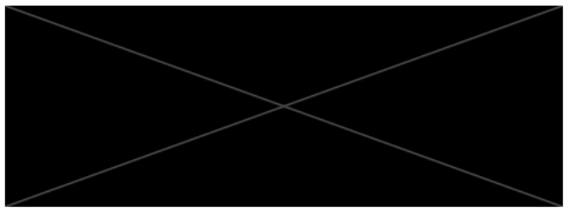
C. Definitions:
[1]Uncomplicated hypertension - systolic / diastolic blood pressure > 139/79 patients age 18-60 or patients with diabetes at any age; patients >60 years with new elevation of >149/89.
Resistant hypertension – asymptomatic patient who has not reached target goals for BP control.
Prehypertension – systolic blood pressure (SBP) 120-139 mm Hg or diastolic blood pressure (DBP) of 80-89 mm Hg.
Stage I hypertension - systolic blood pressure (SBP) ranging from 140 to 159 mm Hg or a diastolic blood pressure (DBP) ranging from 90 to 99 mm Hg.
Stage 2 hypertension - SBP ≥160 mm Hg or DBP ≥100 mm Hg.
Controlled blood pressure – Age <60 = BP<139/89; with diabetes = BP<139/89; Age ≥60 and does not have diabetes ≤149/89.



Stage 4 Chronic Kidney Disease – calculated glomerular filtration rate (eGFR) < 30 mls/min/1.73m^2
Champion – primary care mentoring physician

D. Procedure for Nurse Practice

1. Subjective assessment
   - Review relevant health history reported by the patient &/or documented in the EMR.
   - Conducted review of systems for complaints consistent with symptomatic hypotension (dizziness, syncope) and medication side effects (dizziness, persistent dry cough, fatigue, headache, or edema).
   - Review adherence with medications and lifestyle modifications.
2. Objective assessment
   - Check self-monitored blood pressure trends (average systolic and diastolic readings)
   - Measure blood pressure sitting; assess standing if systolic<110 or systolic is higher than target and patient ≥70 years old
   - Lab review to identify abnormal values:
     - Sodium <135 mEq/L
     - Potassium >5.5 mEq/L or < 3.5 on no diuretic treatment
     - Creatinine not >1.5 (eGFR not <40) or 10% increase in creatinine
   - Baseline EKG
3. Assessment – Stage 1 or Stage 2 hypertension;
4. Plan
   - Base treatment on patient's lowest BP in clinic
     - either sitting or standing for patients over 70 years old
       - if sitting BP elevated and patient is greater than 70 years old, standing BP after 2-5 minutes
   - Treatment goals = controlled BP without significant symptoms:
     - Age <60 BP<139/89;
     - With diabetes BP<139/89;
     - Age ≥60 and does not have diabetes ≤149/89.
   - Begin on single pill combination pharmacotherapy (see Appendix I); review for contraindications and consult accordingly
   - Patient education on self-monitoring blood pressures
     - Nurse orders BP cuff and instructs patient on how to obtain blood pressure measurement
       - Alternatively may refer to pharmacy for instruction
     - Patient reports BP to RN or primary care provider.
   - Lifestyle modifications should be addressed at every encounter:
     - Physical activity (30 minutes per day or 150 minutes a week)
     - Weight management (goal < 25 kg/m^2)
     - Reducing dietary sodium (1.8 to 2.4 gram sodium daily)
     - Limiting alcohol consumption (≤1 drink/day for women; ≤2 drinks for men)
     - DASH diet (low-fat, calcium, high fruit and vegetable diet)
     - Smoking cessation
5. Patient follow-up



- Follow up at regular intervals (2-4 weeks) and titrate as needed following clinical algorithm (Appendix I) until at goal, then reassess at 2-3 months and, if at goal, annually
- Asymptomatic patients with SBP 160 -179 and/or DBP 100-109 → refer to provider for evaluation; do NOT release patient prior to consultation with physician; schedule BP recheck.
- SBP >180 and /or DBP >100 diastolic → refer to provider for evaluation; do NOT release patient prior to consultation with physician; schedule recheck.
- BP≤ 125/75 and patient is implementing lifestyle changes, consider cutting back on most recently added medications; repeat in 2-4 weeks
- Symptomatic hypotension or asymptomatic with SBP<100: decrease medication dosage back to previous dosage and consult primary care provider; hold medication if new start and notify; recheck BP in one week, if hypotension continues, consult with physician again.
- Patient reports possible medication side effects – establish onset, severity and influencing factors then consult with physician (Appendix II).
- Abnormal laboratory results – consult with physician.

6. Record keeping of patient encounters – all patient care (BP, medications, lab work, and education) and verbal or telephone communications with the clinician, or patient/family shall be documented in the EMR.

II. Requirements for Registered Nurse

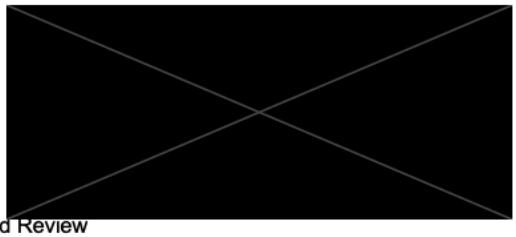
A. Preparation

1. Education/Licensure: nurse must be licensed as Registered Nurse in California and be in good standing with the Board of Registered Nursing (BRN).
2. Experience: a minimum of one year's experience (full-time or 2080 hours) as an RN is required.
3. Training: nurse must successfully complete advanced training on subjective and objective evaluation of patients including assessing mean blood pressure trends, hypertension medications, patient education and implementation of the protocol.
4. Nurse must demonstrate appropriate blood pressure measurement using both manual and automatic blood pressure instruments in both sitting and standing patient positions using appropriate positioning and cuff size (see Appendix IV).

B. Evaluation

Initial: Nurse must satisfactory complete training post-test. Three cases must be documented and reviewed with Champion each week for one month; followed by 3 cases per month for 3 months; then 6 cases per year. Nurse must demonstrate appropriate management of patients with hypertension. If primary care provider disagrees with management plan, cases will be reviewed with Champion. Evidence of successful completion will be documented and included in the nurse's personnel file

Ongoing Evaluation: Annual competency evaluations will be conducted documenting the RNs ability to function appropriately under the protocol including clinical knowledge, skills/ procedures, appropriate consultation and documentation.



C. Supervision and Review

Roles and responsibilities of Registered Nurses working under the protocol:

1. RN must verify that patients have a designated primary care provider and that the patient meets the criteria for standardized procedure.
2. RN will collaborate and work in partnership with individual patient's primary care physician to provide care under the protocol.
3. RN will introduce her/himself utilizing correct title and explain role
4. RN will collect subjective data (patient history), collect objective data (perform physical examinations), assess patient status, order and identify abnormal labs, develop and implement treatment and educational plan of care
5. Documentation - RN will maintain record of patient encounters (in person, group, telephone) patient ID, complaints, assessment of adherence to meds, diet, exercise, BP records (home, clinic), pertinent lab results, plan for med changes, follow-up labs and visits; physician notification if needed

Roles and responsibilities of the Champion & the primary care physician:

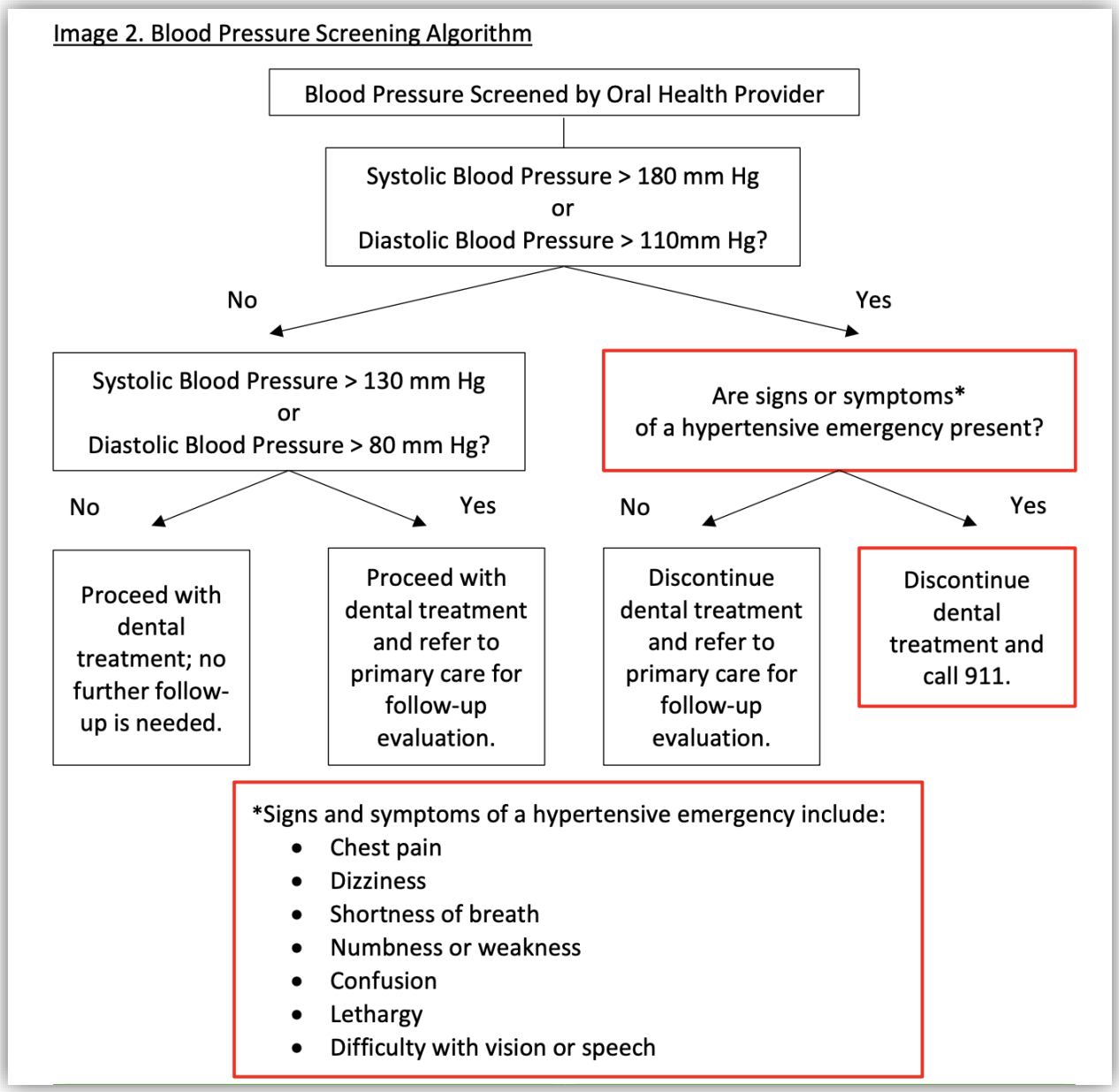
1. Champions should be identified for each site and meet with PHASE consultant prior to implementation.
2. The Champion will assure a physician will be available when the nurse consultation or for the physician to see the patient, the patient requests to see the physician, and/or there is an onsite emergency.
3. Primary care physician is responsible for patient management. He/she will be available for consultation and collaboration with RN.
4. The physician will see the patient or review the care of each patient at least once a year and renew the patient specific medication order on an annual basis.

III. Development and Approval of the Standardized Procedure

A. Method – this procedure was developed using the most current guidance from the Board of Registered Nursing, American Academy of Family Practice and technical references from the PHASE program.

B. Review schedule – the procedure shall be assessed at 3 and 6 months following implementation, and then annually.

Item 2: Hypertension Screening Guidance for Michigan Oral Health Professionals [cited] Blood Pressure Screening Algorithm for Oral Health Providers



Item 3: Example Huddle Checklist

AMA | STEPS forward

Team Huddle Checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:	End time:
Huddle leader:		
Check in with the team		
How is everyone doing?		
Are there any anticipated staffing issues for the day?		
Is anyone on the team out / planning to leave early / have an upcoming vacation?		
Huddle agenda		
Review today's schedule		
Identify scheduling opportunities		
Same-day appointment capacity Urgent care visits requested	Recent cancellations Recent hospital discharge follow-ups	
Determine any special patient needs for clinic day • Patients who are having a procedure done and need a particular exam room setup • Patients who may require a health educator, social work or behavioral health visit, or pharmacist consultation while at the practice		
Identify patients who need care outside of a scheduled visit		
Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled		
Share a shout-out and/or patient compliment		
Share important reminders about practice changes, policy implementation, or downtimes for the day		
End on a positive, team-oriented note • Thank everyone for being present at the huddle		

Source: AMA. Practice transformation series: Daily Team Huddles. 2022.