2021 PRIMARY CARE CLINIC-
CHRONIC DISEASE QUALITY IMPROVEMENT PROJECTS APPLICATION
Access online: **https://tinyurl.com/SLCOClinicApplication**

The Healthy Living Program at the Salt Lake County Health Department works with primary care clinics to improve patient care and clinical practices in preventing and managing hypertension, high cholesterol, and diabetes. The overall goal of this funding opportunity is to improve hypertension control rates (NQF18), statin therapy rates (MIPS Measure #438; CMS 347), and uncontrolled diabetes rates (NQF59). **This funding opportunity is from January 1st through December 31st, 2021**. **Projects need to be implemented by July 15th, 2021 for reimbursement. Outcome evaluation needs to be turned in by January 15th, 2022.** Please read the following application instructions and funding requirements for more detail.

Application Instructions

- All clinics that offer primary care services in Salt Lake County are eligible to apply.
- Priority areas include Glendale, Rose Park, West Valley, South Salt Lake, Midvale, Kearns, Taylorsville, and Magna.
- Clinic can apply for a **maximum of $4,750.**
- Clinic CANNOT choose activities that are already implemented in the clinic.
- Application will be accepted on a first come, first served basis until funds are exhausted.
- Once submitted, application will only be approved after a staff member from the Healthy Living Program meets with the clinic to finalize project activities.
- Clinic must fully implement the projects by July 15, 2021 to receive reimbursement.
- Funding CAN pay for the time spent on planning, implementing, disseminating, and evaluating the projects. Funding CANNOT pay for research, equipment, incentives, or direct services such as patient care, co-pay fees, medication, or individual patient education.

Funding Requirements

- Meet with SLCoHD staff to go over the proposed projects and create a plan of how to execute the plan through a quality improvement Plan Do Study Act (PDSA) cycle.
- Fill out project planning templates including a timeline for data, implementation, and evaluation.
    - Complete project implementation and return required documentation by July 15th
    - Submit project outcome evaluation by January 15th of the following year
- Communicate regularly with assigned Healthy Living staff member including a kick-off meeting, mid-point meeting, and wrap-up meeting.
- When possible, stratify data and control rates by these high burden subpopulation categories; race/ethnicity and uninsured/low-income status. See the document "Evaluation for High Burden Subpopulations" for more information.
- Provide follow-up data for up to 5 years, upon request.
- Submit at least one success story of how a project(s) has improved your clinic.

CLINIC INFORMATION

Name of Clinic: _____

Clinic Address: _____

Applicant Name: _____

Applicant Job Title and Role in Application Projects:

_____

Applicant Phone Number: _____

Applicant Email: _____

Names and Roles of Other Staff Who Will Be Involved:

_____

_____

INSTRUCTIONS: **Each clinic can choose up to $4,750 in projects. Quality improvement projects under hypertension, cholesterol, and prediabetes/diabetes are worth $2,000 each. Living Well and Healthy Living projects at the bottom of the application are worth $250 each. Please mark the box of the projects your clinic would like to work on. You can choose two projects under the same topic area or choose one project from two different topic areas. There is no longer a specific list of activities each clinic needs to do for the project. Each clinic will create their own quality improvement project in the chosen area(s) with the guidance of a SLCoHD staff member. Once an application is submitted by the clinic, a SLCoHD staff member will meet with your clinic to tailor the chosen projects to your clinic's needs. Together we will come up with a quality improvement plan by using the Plan, Do, Study, Act (PDSA) tool and outline the project completion requirements based on the agreed upon project plan. The goal of this approach is to have meaningful quality improvement projects that improve quality measures and that are tailored to each clinic's individual priorities.**

Ideas of activities for each project can be found in the Chronic Disease Quality Improvement Project Ideas document. You can look at the ideas document ahead of meeting with SLCoHD to help you choose the projects your clinic will work on this year or you can wait to look at the document until you meet with SLCoHD staff to create your project plan.

Hypertension – $2,000 each

☐ **IMPROVE HEALTH EQUITY**

- **Project Goal:** To identify and improve the hypertension control rates of the clinic's disparate and/or high burden subpopulations. These are the patients that have higher rates of uncontrolled hypertension compared to the general clinic population.
- **Evaluation:** Hypertension control rate (NQF18) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).

- **Summary of activities:** Use data reports to identify disparate client populations, improve clinic staff training around health equity and implicit bias, and implement appropriate interventions to improve control rates of identified client populations.

☐ **TEAM-BASED CARE**

- **Project Goal:** To improve hypertension control through new or enhance approaches to team-based care. Team-based care is having multiple healthcare professionals working collaboratively with patients on shared goals in an effective, patient-centered, timely, efficient, and equitable way. It involves identifying who is part of your care team, who should be part of your care team, and ensuring all staff members are working to the highest level of their expertise and ability to meet the needs of your patient population.
- **Evaluation:** Hypertension control rate (NQF18) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
    - Number of non-physician team members included on care team for patients with hypertension
    - Pharmacy measures, if applicable:
        - Number of collaborative practice agreements implemented
        - Number of pharmacies and number of full-time equivalent pharmacists who provide Medication Therapy Management (MTM) services to promote medication self-management and lifestyle modification for patients with high blood pressure
    - Community Health Worker (CHW) measures, if applicable:
        - Number of CHWs
        - Number of patients referred to CHWs
        - Number of patients with hypertension that personally engaged with a CHW
- **Summary of activities:** Map out clinic workflows and roles of the care team, identify and improve gaps in team's care plan. Choose to incorporate other professional team members into the patient care model such as pharmacists and community health workers.

☐ **IMPROVE HYPERTENSION CARE**

- **Project Goal:** To improve and align hypertension standards of care including appropriate screening, measurement, diagnoses, and treatment of patients with high blood pressure.
- **Evaluation:** Hypertension control rate (NQF18) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
- **Summary of activities:** Implement or improve clinical processes and policies around hypertension care, use EHR alerts and registries, implement or improve Automated Office Blood Pressure or Self Monitor Blood Pressure programs, and improve educational materials.

☐ **UNDIAGNOSED HYPERTENSION**

- **Project Goal:** To use data to identify and diagnose current patients with undiagnosed hypertension.
- **Evaluation:** Hypertension control rate (NQF18) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
    - Other indictors depending on activities chosen such as number of community outreach events held, and people reached
- **Summary of activities:** Implement algorithms or protocols to identify undiagnosed hypertension, improve measurement and documentation, and expand screenings/opportunities for patients to check blood pressures.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing hypertension work in your clinic.

Cholesterol – $2,000 each

☐ **IMPROVE HEALTH EQUITY**

- **Project Goal:** To identify and improve the statin therapy rates of the clinic's disparate and/or high burden subpopulations. These are the patients that have higher rates of unmanaged high cholesterol compared to the general clinic population.
- **Evaluation:** Statin therapy rate (MIPS Measure #438; CMS 347) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
- **Summary of activities:** Use data reports to identify disparate client populations, improve clinic staff training around health equity and implicit bias, and implement appropriate interventions to improve statin therapy rates of identified client populations.

☐ **TEAM-BASED CARE**

- **Project Goal:** To improve cholesterol management through new or enhance approaches to team-based care. Team-based care is having multiple healthcare professionals working collaboratively with patient on shared goals in an effective, patient-centered, timely, efficient, and equitable way. It involves identifying who is part of your care team, who should be part of your care team, and ensuring all staff members are working to the highest level of their expertise and ability to meet the needs of your patient population.
- **Evaluation:** Statin therapy rate (MIPS Measure #438; CMS 347) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
    - Number of non-physician team members included on care team for patients with high cholesterol
    - Pharmacy measures, if applicable:
        - Number of collaborative practice agreements implemented

        - Number of pharmacies and number of full-time equivalent pharmacists who provide Medication Therapy Management services to promote medication self-management and lifestyle modification for patients with high cholesterol
    - Community Health Worker (CHW) measures, if applicable:
        - Number of CHWs
        - Number of patients referred to CHWs
        - Number of patients with high cholesterol that personally engaged with a CHW
- **Summary of activities:** Map out clinic workflows and roles of the care team, identify and improve gaps in team's care plan. Choose to incorporate other professional team members into the patient care model such as pharmacists and community health workers.

☐ **SCREENING AND TREATMENT**

- **Project Goal:** To improve the clinic's screening and treatment of high cholesterol, especially in patients with other chronic diseases. High cholesterol, specifically LDL-C, is a primary cause of atherosclerosis and major risk factor for heart disease and stroke. Statin therapy is the best treatment of high cholesterol depending on screening, comorbidities, and ASCVD risk of patients.
- **Evaluation:** Statin therapy rate (MIPS Measure #438; CMS 347) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
- **Summary of activities:** Assess and improve the ability to run statin therapy reports, implement clinical processes to screen for patient's10-year ASCVD risk, implement processes to identify, diagnosis, and treat high cholesterol, and improve patient education materials.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing cholesterol work in your clinic.

Prediabetes/Diabetes – $2,000 each

☐ **IMPROVE HEALTH EQUITY**

- **Project Goal:** To identify and improve the uncontrolled diabetes rates of the clinic's disparate and/or high burden subpopulations. These are the patients that have higher rates of uncontrolled diabetes compared to the general clinic population.
- **Evaluation:** Uncontrolled diabetes rate (NQF59) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
- **Summary of activities:** Use data reports to identify disparate client populations, improve clinic staff training around health equity and implicit bias, and implement appropriate interventions to improve uncontrolled diabetes rates of identified client populations.

☐ **TEAM-BASED CARE**

- **Project Goal:** To improve type 2 diabetes control through new or enhanced approaches to team-based care. Team-based care is having multiple healthcare professionals working collaboratively with patient on shared goals in an effective, patient-centered, timely, efficient, and equitable way. It involves identifying who is part of your care team, who should be part of your care team, and ensuring all staff members are working to the highest level of their expertise and ability to meet the needs of your patient population.
- **Evaluation:** Uncontrolled diabetes rate (NQF59) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
    - Number of non-physician team members included on care team for patients with type 2 diabetes
    - Pharmacy measures, if applicable:
        - Number of collaborative practice agreements implemented
        - Number of pharmacies and number of full-time equivalent pharmacists who provide Medication Therapy Management services to promote medication self-management and lifestyle modification for patients with diabetes
    - Community Health Worker (CHW) measures, if applicable:
        - Number of CHWs
        - Number of patients referred to CHWs
        - Number of patients with diabetes that personally engaged with a CHW
- **Summary of activities:** Map out clinic workflows and roles of the care team, identify and improve gaps in team's care plan. Choose to incorporate other professional team members into the patient care model such as pharmacists and community health workers.

☐ **IDENTIFY AND REFER**

- **Project Goal:** To identify patients with prediabetes and type 2 diabetes, provide education, and refer to the National Diabetes Prevention Program (NDPP) for patients with prediabetes, the Diabetes Self- Management Education and Support (DSMES) for patients with diabetes, and other behavior change services.
- **Evaluation:**
    - Diabetes uncontrol rate (NQF59)
    - Number of patients referred to DSMES
    - Number of patients identified in the prediabetic range
    - Number of patients referred to the National DPP
    - If applicable, number of patients that completed the National DPP
- **Summary of activities:** Screen for prediabetes, implement alerts and clinical workflows to flag patients with prediabetes and diabetes to refer to the National DPP or DSMES, and identify and provide referrals to other behavior change services.

☐ **BECOME A NATIONAL DIABETES PREVENTION PROGRAM SITE**

Refer to the separate National DPP application for $3,500
https://tinyurl.com/SLCONDPPApplication

☐ **BECOME A DIABETES SELF MANAGEMENT EDUACTION AND SUPPORT SITE**

Refer to the separate DSMES application for $2,500 (plus possible funding to pay $1,100 DSMES application fee)
https://tinyurl.com/SLCODSMESApplication

☐ **CARDIOVASCULAR DISEASE AND RISK MANAGEMENT**

- **Project Goal:** To prevent and reduce the risk of atherosclerotic cardiovascular disease (ASCVD) in patients with diabetes, which is the leading cause of morbidity and mortality for individuals with diabetes. Chronic conditions such as hypertension and dyslipidemia are clear risk factors for ASCVD.
- **Evaluation:**
  - Diabetes uncontrol rate (NQF59)
  - Hypertension control rate (NQF18) for diabetic patients
  - Statin therapy rate (MIPS Measure #438; CMS 347) for diabetic patients
- **Summary of activities:** Implement clinical process to screen for 10-year ASCVD risk in patients with diabetes, and implement clinical processes to screen and treat hypertension, lipid profiles, and cardiovascular disease according to ASCVD risk in patients with diabetes.

☐ **CHRONIC KIDNEY DISEASE**

- **Project Goal:** To increase appropriate screening, diagnosis, and treatment of chronic kidney disease (CKD) in patients with diabetes. CKD is a global public health problem most patients are unaware they have that leads to kidney failure, cardiovascular disease, and death. Early recognition and management of CKD allows providers more opportunities to protect kidney health.
- **Evaluation:**
  - Diabetes uncontrol rate (NQF59)
  - HEDIS Measure 2020: Kidney Evaluation for patients with Diabetes
    - Percentage of adults with diabetes (age 18-85) who have received both blood and urine kidney tests (ACR spot urinary albumin-to creatinine ratio and eGFR estimated glomerular filtration rate) within the last 12 months
- **Summary of activities:** Identify and define CKD metrics the clinic will use, educate/train staff on CKD, implement clinical processes to screen, diagnosis, and treat CKD, and improve educational materials for CKD.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing prediabetes/ diabetes work in your clinic.

Referral to Living Well Classes - $250

☐ **CHRONIC DISEASE POPULATION MANAGEMENT**

- **Project Goal:** To develop pathways to neighborhood/community-based resources that support patient health goals and maintain referral links to community-based chronic

disease self-management support programs, exercise programs, and other wellness resources.

- **Evaluation:** Number of referrals to community programs
- **Summary of activities:** Read the arthritis burden report, identify insurance reimbursement options for referrals, establish or improve referral processes to Living Well programs, and set goals to increase referrals.

Healthy Living – $250 each

☐ **BECOME A HEALTHIER WORKSITE FOR EMPLOYEES**

✓Fill out the CDC Worksite Wellness Scorecard and/or apply for the Utah Worksite Wellness Council's Healthy Worksite Award.

✓Choose at least 2 total activities to improve worksite wellness offerings in the areas of physical activity, nutrition, and/or breastfeeding.

☐ **BECOME A COMMUNITY PARTNER FOR IMPROVING HEALTHY FOOD ACCESS**

✓Choose a project or event that will increase access to healthy food such as holding a healthy food drive, creating a community garden, or partnering with a food pantry, farmer's market, or other organization.

☐ **IMPLEMENT PARK RX**

✓Use the Park Rx America database and your EHR to prescribe physical activity at a park with walking paths to combat chronic diseases. SLCoHD will train and assist with implementation.

☐ **BECOME A TOP STAR ENDORSED CENTER**

✓ Have your on-site childcare center become part of the TOP Star (Teaching Obesity Prevention in Childcare Settings) program by completing a pre- and post-assessment, work on policy improvement, and have staff participate in an online training good for 6 Continuing Education Credits.

Total Amount of Chosen Activities (CANNOT exceed $4,750) = $_____

By signing below, the clinic agrees to complete the chosen activities and submit the required documentation to healthpromotion@slco.org by July 15, 2021. To receive payment contingent upon ongoing federal government funding for this program, the clinic agrees to submit a supplier vendor form, if one is not already on file. The clinic agrees to contact SLCoHD staff by June 1, 2021 if the clinic will not be able to complete the chosen activities by the July 15th deadline.

Signature _____

Approved by SLCoHD _____