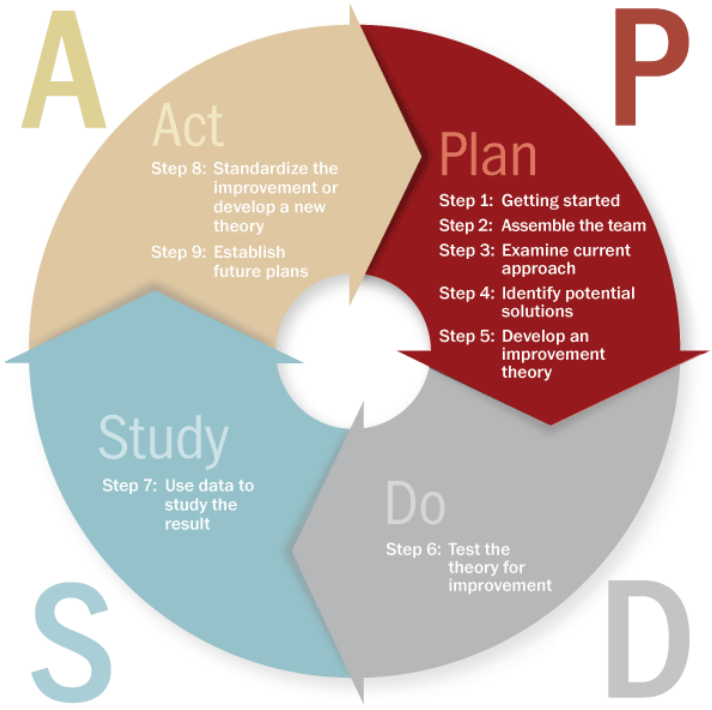

2021 Primary Care Clinic Chronic Disease Quality Improvement Project Ideas

Access online: https://tinyurl.com/SLCOClinicIdeas

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SALT LAKE COUNTY
HEALTH DEPARTMENT

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Introduction

This document provides ideas to the projects presented on the 2021 Primary Care Clinic Chronic Disease Quality Improvement Project Application. Each project below includes a list of activities that are the main building blocks around a successful quality improvement project for each topic. **The intent is not that each clinic must do all the activities listed, but to give an idea of all the places for quality improvement processes.** A SLCoHD staff member will sit down with the clinic to talk through the quality improvement Plan, Do, Study, Act (PDSA) cycle, assist in creating a tailored plan of activities, and outline the requirements based on that plan. Our goal is to have more meaningful quality improvement projects that improve quality measures and are tailored to the clinic's priorities.

Definitions

Automated Office Blood Pressure (AOBP): a blood pressure machine that provides multiple sequential measurements when staff is not present to reduce "white-coat hypertension"

Collaborative Practice Agreement (CPA): a formal practice relationship between a pharmacist and a prescriber. The agreement specifies what functions (in addition to the pharmacist's typical scope of practice) can be delegated to the pharmacist by the collaborating prescriber. CPA's increase the efficiencies of team-based care and formalize practice relationships between pharmacists and prescribers.

Community Health Worker (CHW): The jobs and roles of CHWs are as varied as their titles (promotora, patient advocate, health navigator, peer support specialist, etc.). All CHWs, however, share trust and a connection with their communities. Community Health Workers are trained lay people who provide education and social support, while serving as a liaison with health care providers and social services. CHWs offer interpretation, provide culturally appropriate health information, assist people in receiving the care they need, help overcome barriers, give informal counseling and guidance on health behaviors, and advocate for individual and community health needs.

Diabetes Self-Management Education Support (DSMES): Diabetes Self-Management Education (DSME) is the cornerstone of care for all individuals with diabetes who want to achieve successful health outcomes and avoid complications. The ten-week program is conducted in health care settings, such as physicians' offices and clinics, pharmacies and hospital outpatient settings. DSME is the active, ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. The overall objectives of DSME are to support informed decision-making and improved self-care behaviors, encourage effective problem-solving and active collaboration with the healthcare team, and improve clinical outcomes, health status, and quality of life.

Electronic Health Record (EHR): a digital version of a patient's paper chart; they are real-time, patient centered records that make information available instantly and securely to authorized users

Medication Therapy Management (MTM): a distinct service or group of services that optimize therapeutic outcomes for individual patients. These services are independent of, but can occur in conjunction with, the provision of a medication product. MTM encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's scope

of practice. These services include but are not limited to the following: performing or obtaining necessary assessments of the patient's health status, formulating a medication treatment plan, selecting, initiating, modifying, or administering medication therapy, monitoring and evaluating the patient's response to therapy, performing a comprehensive medication review, communicating essential information to the patient's primary care providers, providing verbal education and training to enhance patient understanding and appropriate use of medications, providing services designed to enhance patient adherence to therapeutic regimens.

National Diabetes Prevention Program (National DPP): The National DPP is a structured, evidence-based, year-long lifestyle change program to prevent or delay onset of type 2 diabetes in adults with prediabetes or at risk of developing type 2 diabetes. The National DPP lifestyle change program is founded on randomized controlled research studies which showed that making realistic behavior changes helped people with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58% (71% for people over 60 years old). The program is group-based, facilitated by a trained lifestyle coach, and uses a CDC-approved curriculum. The curriculum supports regular interaction between the lifestyle coach and participants; builds peer support; and focuses on behavior modification through healthy eating, increasing physical activity, and managing stress. The program may be delivered in-person, online, via distance learning, or through a combination of these delivery modes.

NQF18: The measure of the percentage of patients 18-85 years of age who had a diagnosis of Hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

NQF59: The measure of the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

2019 MIPS Clinical Quality Measure #438:**Statin Therapy for the Prevention and Treatment of CVD-** Percentage of the following patients-all considered at high risk of cardiovascular events-who were prescribed or were on statin therapy during the measurement period: Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR Adults aged >=21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

Social Determinants of Health (SDOH): The economic and social conditions that influence individual and group differences in health status. Conditions in the places where people live, work, and play affect a wide range of health risks and outcomes. Addressing these conditions such as education, housing, income, access to healthy food, and neighborhood safety and greatly impact the health of an individual and community and advance health equity.

Hypertension

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).
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
  1. Analyze data - Stratify hypertension control rate report by disparate and/or high burden subpopulations to identify patient populations with highest uncontrolled hypertension rates.
  2. Research the needs and barriers of identified under resourced patient populations to achieving hypertension control. Activity options may include:
     - Implement or improve upon SDOH (social determinants of health) screening and referral process
     - Implement or improve upon risk stratification scoring of patients
     - Implement or improve upon a way to receive input from the identified patient populations on needs, barriers, and ideas for interventions (i.e. questionnaire, focus groups, patient boards, etc.)
     - Utilize existing community and public health data to research key neighborhoods and/or communities' needs, resources, etc.
  3. Learn and apply health equity principles to the clinic's current processes.
     - Train staff on health equity and implicit bias
     - Review clinic policies and processes to see how certain races, ethnicities, languages, and/or communities are adversely affected or at a disadvantage due to existing policies. Make policy revisions where indicated.
     - Review and update health education materials so they are culturally appropriate and/or fit the health literacy levels of common patient demographics.
     - Review and update hiring practicing so that the clinic is hiring staff that reflects the patients/communities it serves.
  4. Implement interventions to improve the hypertension control rates of identified patient populations.
     - Offer behavior and community program referrals related to SDOH such as Parks Rx (prescribing physical activity outside in parks/green space), Produce Rx (prescribing fruits and vegetables), affordable housing, etc.
     - Improve coordination and integration of social services and healthcare. Consider referral processes, bi-directional feedback, policies and systems in place.
     - Incorporate Community Health Workers (CHWs) or patient navigators into connecting patients with resources and education to improve hypertension control.
     - Improve team-based care that will improve the care of identified disparate populations and will increase health equity. Consider working with pharmacists, nutritionists, CHWs, health coaches, peer educators, nurses, mental health

professionals and others to provide the needed culturally appropriate coordination and support that affects hypertension control.
    - Improve patient trust and access to culturally appropriate care for hypertension. Consider hiring health professionals and trusted staff from the communities the clinic serves, assessing and addressing health literacy, screen for and meet the barriers and needs of patients, etc.
    - Invest and partner with other organizations and coalitions that works on social determinants of health and health equity such as investing in community infrastructure, access to resources, and increasing patient and community advocacy.
5. Create and improve upon written clinic policies and processes that reflect the changes made from previous activities.

Team-Based Care

- **Project Goal:** To improve hypertension control through new or enhanced 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 in order 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 the 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 Workers (CHWs) measures, if applicable:
        - Number of CHWs
        - Number of patients referred to CHWs
        - Number of patients with hypertension that personally engaged with a CHW
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
    1. Identify and make improvements to the care team that works with patients with hypertension. Ensure all staff members are working to the highest level of their expertise and ability. This may include changing workflows, roles of care team, and hiring or contracting with other healthcare professionals.
    2. Improve communication and trust among the care team. This may include regular team huddles, improved utilization of the EHR and alerts for communication, identifying and matching strengths of each team member to their duties, and staff training.
    3. Identify gaps and weaknesses in hypertension management and care. Implement new processes to improve care such as assigning specific team members to pulling reports, screening, following up, educating, and referring to services.
    4. Activities specific to integrating pharmacists into care team:

i. Identify internal or community pharmacists who can become part of the clinic team for hypertension control.
ii. Establish a Collaborative Practice Agreement with a pharmacist for Medication Therapy Management (MTM) with patients on hypertension medications with the goal of increasing medication adherence rates, improving hypertension-related health outcomes, and providing lifestyle modification counseling.
iii. Pull reports and create registries of patients diagnosed with hypertension that are not well controlled and review medication adherence; then refer to a pharmacist for MTM.
iv. Work with a pharmacy to implement a Self-Monitored Blood Pressure program tied with clinical support either through offering monitors at cost or through a lending program.

5. Activities specific to integrating Community Health Workers (CHWs) into care team:
   i. Identify internal or external CHWs who can become part of the clinic team for hypertension control.
   ii. Create or improve a workflow process to integrate the internal or external CHWs into the care team to help with hypertension control which may include assessing SDOH and other needs, referring to services, and providing education.
   iii. Train the CHWs appropriately on the duties they will provide. Possible trainings include the CHW Core Skills/Competency Training (offered by Utah Department of Health), high blood pressure and other chronic disease management training, and motivational interviewing/health coaching training.
   iv. Have CHWs or supervisor join the Utah CHW Coalition.
   v. Utilize the CHWs as a patient advocate and allow them to provide input to the care team on patient needs, barriers, and possible solutions to improve hypertension control.
6. Add other healthcare professionals and staff to the care team for hypertension control – dieticians/nutritionists, health coaches, behavioral health specialists, patient navigators, community partners (stronger referral relationships).
7. Create and improve upon written clinic policies and processes that reflect the changes made from previous activities.

Improve Hypertension Care

- **Project Goal:** To improve 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).
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:** (Refer to Hypertension Control Change Package)
  1. Train and evaluate direct patient care staff on accurate blood pressure measurement and documentation.
  2. Implement a clinical process to appropriately screen, diagnosis, and treat patients with hypertension which may include the use of EHR and other types of alerts, protocols, and algorithms.

i. Implement a protocol for correctly diagnosing hypertension through Automated Office Blood Pressure (AOBP), Self-Monitored Blood Pressure (SMBP), and/or 24-hour ambulatory monitoring.

3. Implement a clinical process to proactively track and manage patients with hypertension which may include the use of registries, dashboards, and quality measure reports
   i. Create a registry and use a defined process for outreach (e.g., via phone, mail, email, text message) to patients with uncontrolled hypertension and those otherwise needing follow-up.
4. Implement or improve Self-Monitored Blood Pressure tied to clinical support through a home blood pressure machine lending library, providing regular, free, walk-in blood pressure check opportunities for patients, or another method (i.e. using existing community resources such as senior centers, pharmacies, etc.).
5. Implement or improve the use of after-visit summaries and patient educational materials on nutrition ("DASH" diet), physical activity, medication adherence, etc.
6. Provide other patient education and referrals for comorbidities and other risk factors (i.e. create registries of patients diagnosed with hypertension that are also smokers and provide follow-up education including offering a referral to the Utah Tobacco Quit Line and other resources).
7. Create or update a written policy(ies) to reflect changes made from previous activities.

Undiagnosed Hypertension

- **Project Goal:** To use current 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).
  - Number of community outreach events held
  - Number of people reached during community outreach events
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:** (Refer to Hiding in Plain Sight Consolidated Change Package)
  1. Compare your clinic's hypertension prevalence to national or local estimates to determine if you might be missing patients with undiagnosed hypertension (Hypertension Prevalence Estimator Tool).
     - Establish clinical criteria to define potentially undiagnosed hypertension.
  2. Implement a clinical process to screen every patient for elevated blood pressure and undiagnosed hypertension at every visit which may include screening protocols, EHR or physical alerts when blood pressure is out of range, registries, and algorithms.
  3. Search EHR data for patients who meet criteria for undiagnosed hypertension.
     - Implement evidence-based algorithms (clinical criteria) to identify patients with potentially undiagnosed hypertension.
     - Implement a protocol for identifying undiagnosed hypertension by regularly pulling reports from the EHR of patients who have had high blood pressure readings in the past year including a workflow process to contact patients for follow up care.
  4. Train and evaluate direct care staff on accurate blood pressure measurement and documentation.

        - Prepare patients and care team effective blood pressure measurement and hypertension identification during office visits (i.e. via pre-visit patient outreach and team huddles)
5. Systematically use evidence-based hypertension diagnosis guidelines and protocols to diagnose those identified with undiagnosed hypertension.
    - Implement a protocol for correctly diagnosing hypertension through AOBP, SMBP, and/or 24-hour ambulatory monitoring.
    - Pull reports and create registries of patients with high blood pressure readings (without a formal hypertension diagnosis) to identify those with undiagnosed hypertension and then provide a follow-up workflow process including enrolling the patient in SMBP program.
6. Work with community partners (such as existing NDPP sites) and stakeholders to conduct community screening(s) to identify people with undiagnosed and/or uncontrolled hypertension and connect them to a clinic for follow up care.
7. Create or update a written policy(ies) to reflect changes made from previous activities.

Individual QI/PDSA Cycle Project

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

Cholesterol

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).
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
    1. Analyze data - Stratify statin therapy rate report by disparate and/or high burden subpopulations to identify patient populations with lowest statin therapy rates.
    2. Better understand the needs and barriers of identified patient populations to improve ASCVD risk and cholesterol management. Activity options may include:
        i. Implement or improve upon SDOH (social determinants of health) screening and referral process
        ii. Implement or improve upon risk stratification scoring of patients
        iii. Implement or improve upon a way to receive input from the identified patient populations on needs, barriers, and ideas for interventions (i.e. questionnaire, focus groups, patient boards, etc.)
        iv. Utilize existing community and public health data to better understand certain neighborhoods and/or communities
    3. Learn and apply health equity principles to clinic's current processes and implicit bias.

- Review clinic policies and processes to see how certain races, ethnicities, languages, and/or communities are adversely affected or at a disadvantage due to existing policies. Make revisions where indicated.
- Review and update health education materials so they are culturally appropriate and/or fit the health literacy levels of common patient demographics.
- Review and update hiring practicing so that the clinic is hiring staff that reflects the patients/communities it serves.

4. Implement interventions to improve the statin therapy rates and cholesterol management of identified patient populations. Activity options may include:
   - Offer behavior and community program referrals related to SDOH such as Parks Rx (prescribing physical activity outside in parks/green space), Produce Rx (prescribing fruits and vegetables), affordable housing, etc.
   - Improve coordination and integration of social services and healthcare. Consider referral processes, bi-directional feedback, policies and systems in place.
   - Incorporate Community Health Workers (CHWs) or patient navigators into connecting patients with resources and education to improve cholesterol.
   - Improve team-based care that will improve the care of identified disparate populations and will increase health equity. Consider working with pharmacists, nutritionists, CHWs, health coaches, peer educators, nurses, mental health professionals and others to provide the needed culturally appropriate coordination and support that affects cholesterol.
   - Improve patient trust and access to culturally appropriate care for high cholesterol. Consider hiring health professionals and trusted staff from the communities the clinic serves, assessing and addressing health literacy, screen for and meet the barriers and needs of patients, etc.
   - Invest and partner with other organizations and coalitions that works on social determinants of health and health equity such as investing in community infrastructure, access to resources, and increasing patient and community advocacy.
5. Create and improve upon written clinic policies and processes that reflect the changes made from previous activities.

Team-Based Care

- **Project Goal:** To improve cholesterol management 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 in order 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 the 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 (MTM) services to promote medication self-management and lifestyle modification for patients with high cholesterol
    - Community Health Workers (CHWs) measures, if applicable:
        - Number of CHWs
        - Number of patients referred to CHWs
        - Number of patients with high cholesterol that personally engaged with a CHW
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
    1. Identify and make improvements to the care team that works with patients with high cholesterol. Ensure all staff members are working to the highest level of their expertise and ability. This may include changing workflows, roles of care team, and hiring or contracting with other healthcare professionals.
    2. Improve communication and trust among the care team. This may include regular team huddles, improved utilization of the EHR and alerts for communication, identifying and matching strengths of each team member to their duties, and staff training.
    3. Identify gaps and weaknesses in cholesterol management and care. Implement new processes to improve care such as assigning specific team members to pulling reports, screening, following up, educating, and referring to services.
    4. Activities specific to integrating pharmacists into care team:
        i. Identify internal or community pharmacists who can become part of the clinic team for cholesterol management.
        ii. Establish a Collaborative Practice Agreement with a pharmacist for Medication Therapy Management (MTM) with patients on cholesterol medications with the goal of increasing medication adherence rates, improving cholesterol-related health outcomes and providing lifestyle modification counseling.
        iii. Pull reports and create registries of patients diagnosed with high cholesterol that are not well controlled and review medication adherence; then refer to a pharmacist for MTM.
        iv. Work with a pharmacy to implement a Self-Monitored Blood Pressure program tied with clinical support either through offering monitors at cost or through a lending program.
    5. Activities specific to integrating Community Health Workers (CHWs) into care team:
        i. Identify internal or external CHW who can become part of the clinic team for cholesterol management.
        ii. Create or improve a workflow process to integrate the internal or external CHWs into the care team to help with cholesterol management which may include assessing SDOH and other needs, referring to services, and providing education.
        iii. Train the CHWs appropriately on the duties they will provide. Possible trainings include the CHW Core Skills/Competency Training (offered by Utah Department of Health), cholesterol and other chronic disease management training, and motivational interviewing/health coaching training.
        iv. Have CHWs or supervisor join the Utah CHW Coalition.
        v. Utilize the CHWs as a patient advocate and allow them to provide input to the care team on needs, barriers, and possible solutions to improve cholesterol management.
    6. Add other healthcare professionals and staff to the care team for cholesterol management – dieticians/nutritionists, health coaches, behavioral health specialists, patient navigators, community partners (stronger referral relationships).

7. Create and improve upon written clinic policies and processes that reflect the changes made from previous activities.

Screening and Treatment

- **Project Goal:** To improve 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).
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
  Activities: (Refer to Overview and Full 2018 Cholesterol Guideline)
  1. Assess EHR's capability to run the statin therapy report (MIPS Measure #438; CMS 347) and ability to stratify by certain patient populations such as race/ethnicity. Run a baseline report.
  2. Implement clinical processes to screen for high cholesterol and other heart disease risk factors such as:
     i. A cholesterol checked every 4 to 6 years, starting at age 20 and more often for those with higher risk.
     ii. 10-year ASCVD risk evaluated by using a tool such as The College of Cardiology/American Heart Association ASCVD risk calculator.
     iii. Coronary Artery Calcium (CAC) scoring among patients ≥ 40 years with an uncertain risk status.
  3. Identify patients with or at risk for high cholesterol and assess diagnosis and treatment plans by running patient registries (such as a registry report of patients with LDL >100).
  4. Implement appropriate alerts or other electronic decision supports in the EHR system to help with screening, identification, diagnosis, and treatment of high cholesterol.
  5. Implement clinical processes to appropriately treat high cholesterol including creating lifestyle behavior goals and utilizing statin therapy (Refer to 2018 Cholesterol Guideline).
  6. Provide or improve educational materials on topics such as nutrition, physical activity, and medication adherence for patient with high cholesterol.
  7. Create or update a written policy(ies) to reflect changes made from previous activities.

Individual QI/PDSA Cycle Project

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

Prediabetes/Diabetes

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).
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
  1. Analyze data - Stratify the uncontrolled diabetes rate report by disparate and/or high burden subpopulations to identify patient populations with highest uncontrolled diabetes rates.
  2. Better understand the needs and barriers of identified patient populations to achieving diabetes control. Activity options may include:
     i. Implement or improve upon SDOH (social determinants of health) screening and referral process
     ii. Implement or improve upon risk stratification scoring of patients
     iii. Implement or improve upon a way to receive input from the identified patient populations on needs, barriers, and ideas for interventions (i.e. questionnaire, focus groups, patient boards, etc.)
     iv. Utilize existing community and public health data to better understand certain neighborhoods and/or communities
  3. Learn and apply health equity principles to the clinic's current processes.
     - Review clinic policies and processes to see how certain races, ethnicities, languages, and/or communities are adversely affected or at a disadvantage due to policies. Make revisions where indicated.
     - Review and update health education materials so they are culturally appropriate and/or fit the health literacy levels of common patient demographics.
     - Review and update hiring practicing so that the clinic is hiring staff that reflects the patients/communities it serves.
  4. Implement interventions to improve the uncontrolled diabetes rate of identified patient populations. Activity options may include:
     - Offer behavior and community program referrals related to SDOH such as Parks Rx (prescribing physical activity outside in parks/green space), Produce Rx (prescribing fruits and vegetables), affordable housing, etc.
     - Improve coordination and integration of social services and healthcare. Consider referral processes, bi-directional feedback, policies and systems in place.
     - Incorporate Community Health Workers (CHWs) or patient navigators into connecting patients with resources and education to improve diabetes control.
     - Improve team-based care that will improve the care of identified disparate populations and will increase health equity. Consider working with pharmacists, nutritionists, CHWs, health coaches, peer educators, nurses, mental health professionals and others to provide the needed culturally appropriate coordination and support that affects hypertension control.
     - Improve patient trust and access to culturally appropriate care for diabetes. Consider hiring health professionals and trusted staff from the communities the clinic serves, assessing and addressing health literacy, screen for and meet the barriers and needs of patients, etc.
     - Invest and partner with other organizations and coalitions that works on social determinants of health and health equity such as investing in community infrastructure, access to resources, and increasing patient and community advocacy.

5. Create and improve upon written clinic policies and processes that reflect the changes made from previous activities.

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 in order to meet the needs of your patient population.
- **Evaluation:** Diabetes uncontrol 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 the 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 (MTM) services to promote medication self-management and lifestyle modification for patients with diabetes
    - Community Health Workers (CHWs) measures, if applicable:
        - Number of CHWs
        - Number of patients referred to CHWs
        - Number of patients with diabetes that personally engaged with a CHW
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
    1. Identify and make improvements to the care team that works with patients with type 2 diabetes. Ensure all staff members are working to the highest level of their expertise and ability. This may include changing workflows, roles of care team, and hiring or contracting with other healthcare professionals.
    2. Improve communication and trust among the care team. This may include regular team huddles, improved utilization of the EHR and alerts for communication, identifying and matching strengths of each team member to their duties, and staff training.
    3. Identify gaps and weaknesses in diabetes management and care. Implement new processes to improve care such as assigning specific team members to pulling reports, screening, following up, educating, and referring to services.
    4. Activities specific to integrating pharmacists into care team:
        i. Identify internal or community pharmacists who can become part of the clinic team for diabetes control.
        ii. Establish a Collaborative Practice Agreement with a pharmacist for Medication Therapy Management (MTM) with patients on diabetes medications with the goal of increasing medication adherence rates, improving diabetes-related health outcomes and providing lifestyle modification counseling.
        iii. Pull reports and create registries of patients diagnosed with type 2 diabetes that are not well controlled and review medication adherence; then refer to a pharmacist for MTM.

iv. Work with a pharmacy to implement a Self-Monitored Blood Pressure program tied with clinical support either through offering monitors at cost or through a lending program.

5. Activities specific to integrating Community Health Workers (CHWs) into care team:
    i. Identify internal or external CHWs who can become part of the clinic team for diabetes control.
    ii. Create or improve a workflow process to integrate the internal or external CHWs into the care team to help with diabetes control which may include assessing SDOH and other needs, referring to services, and providing education.
    iii. Train the CHWs appropriately on the duties they will provide. Possible trainings include the CHW Core Skills/Competency Training (offered by Utah Department of Health), diabetes and other chronic disease management training, and motivational interviewing/health coaching training.
    iv. Have CHWs or supervisor join the Utah CHW Coalition.
    v. Utilize the CHWs as a patient advocate and allow them to provide input to the care team on needs, barriers, and possible solutions to improve diabetes control.
6. Add other healthcare professionals and staff to the care team for diabetes control – dieticians/nutritionists, health coaches, endocrinologist, eye doctor, nephrologist, podiatrist, behavioral health specialists, patient navigators, community partners (stronger referral relationships).
7. Create and improve upon written clinic policies and processes that reflect the changes made from previous activities.

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:**
    - Uncontrolled diabetes 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
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
    1. Screen patients for prediabetes (through glucose or risk test), diabetes, and/or uncontrolled diabetes regularly.
    2. Implement alerts in the EHR to flag/identify patients with prediabetes or diabetes.
    3. Create clinical workflow to identify patients with prediabetes, refer to National DPP, and follow-up on patients with prediabetes during in-office visits OR retrospectively. Retrospective method: every 6-12 months collect a list of patients with prediabetes through EHR/patient database query and refer/follow-up.
        i. If applicable, integrate screening and referral into annual wellness exam
        ii. If applicable, integrate a screening during the post-partum visit and/or follow-up visits with women who had gestational diabetes
    4. If applicable, implement a bi-directional referral system to exchange information with organizations implementing National DPP.

5. Create a clinical workflow to identify patients with diabetes, refer to Diabetes Self-Management Education and Support (DSMES), and follow-up with patients with diabetes during in-office visits OR retrospectively. Retrospective method: every 6-12 months collect a list of patients with diabetes through EHR/patient database query and refer/follow-up.
    i. Four critical time points have been defined when the need for DSMES is to be evaluated by the medical care provider and/or multidisciplinary team, with referrals made as needed (2): 1. At diagnosis 2. Annually for assessment of education, nutrition, and emotional needs 3. When new complicating factors (health conditions, physical limitations, emotional factors, or basic living needs) arise that influence self-management 4. When transitions in care occur.
6. Create a clinical workflow to provide or refer to other behavior change services and goals such as medical nutrition therapy (MNT), physical activity (refer to Parks Rx, Living Well Utah classes), smoking cessation, and mental health services.
7. Provide culturally appropriate and tailored diabetic education materials to patients.
8. Work with community partners and stakeholders to conduct a community screening to identify people with elevated blood glucose and connect them to a clinic for follow-up for management and diagnosis.
9. Create or update a written policy(ies) to reflect changes made from previous activities.

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:**
    - Uncontrolled diabetes rate (NQF59)
    - Hypertension control rate (NQF18) for diabetic patients
    - Statin therapy rate (MIPS Measure 38; CMS 347) for diabetic patients
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
- **Activities:**
    1. Implement a clinical process where patients with diabetes have their 10-year ASCVD risk evaluated by using a tool such as The College of Cardiology/American Heart Association ASCVD risk calculator.
    2. Implement a clinical process to screen, diagnosis, and appropriately treat hypertension according to ASCVD risk in patients with diabetes. Refer to ADA Standards of Medical Care in Diabetes for appropriate blood pressure goals, lifestyle therapy and medication therapy.
    3. Implement a self-monitoring blood pressure (SMBP) program so all patients with diabetes and hypertension regularly monitor their blood pressure at home.
    4. Implement a clinical process to screen, diagnose, and appropriately treat lipid profile (dyslipidemia) according to ASCVD risk in patients with diabetes. Refer to ADA Standards of Medical Care in Diabetes for appropriate lipid goals, lifestyle therapy and statin therapy.
    5. Implement a clinical process to screen, diagnosis, and appropriately treat cardiovascular disease in patients with diabetes. Refer to ADA Standards of Medical Care in Diabetes for appropriate treatment of cardiovascular disease, including heart failure.
    6. Create or update a written policy(ies) to reflect changes made from previous activities.

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:**
  - Uncontrolled diabetes 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
- **Training Resources & Templates:** Refer to Quality Care Policies & Procedures Guide
  Activities: (Refer to CKD Change Package for details on strategies)
  1. Identify and define the CKD metrics to be evaluated in primary care (i.e. testing rates, blood pressure control, A1c control, use of specific medications, and referrals).
  2. Educate and train staff about CKD, the importance of testing and treating, and how to make it a priority in the clinic.
  3. Implement a CKD screening process and workflow according to the ADA recommendations that includes risk stratification and needed follow-up.
  4. Implement a clinical workflow to diagnosis and treat CKD appropriately. (Example of Clinical Algorithm for CKD)
  5. Establish a CKD registry within the EHR system to identify and notify providers of the need for intervention.
  6. Implement appropriate alerts or other electronic decision supports in EHR system to help with screening, identification, diagnosis, and treatment of CKD.
  7. Identify and collaborate with those who are part of CKD care and improve team-based care. This may include appropriate referrals and collaboration with nephrology.
  8. Improve CKD patient education which may include developing tailored educational materials.
  9. Create or update a written policy(ies) to reflect changes made from previous activities.

Individual QI/PDSA Cycle Project

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

Referral to Living Well Classes

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

- **Training:** A clinic champion will meet with a SLCo staff member to learn about Living Well workshops for asthma, diabetes, prediabetes, falls prevention, arthritis, and pain management
- **Activities:**
  1. Read the Arthritis Burden report
  2. Work with SLCoHD staff to determine if Providers can bill through the reimbursement referral process. Options may include:
     - Glycemic management services
     - Chronic care and preventive care management for empaneled patients
     - Practice improvements that engage community resources to support patient's health goals
     - Engagement with QIN-QIO to implement self-management training programs
     - Participation in a QCDR, that promotes use of patient engagement tools
     - Implementation of condition-specific chronic disease self-management support programs
     - Improved practices that disseminate appropriate self-management materials
  3. Establish or improve a patient referral method for Living Well Programs.
  4. Pull a registry report to identify patients who have been diagnosed with specific chronic diseases (such as arthritis, prediabetes, or diabetes) and refer them to the Living Well self-management and physical activity programs.
  5. Establish or update a policy with workflow to routinely query registry for newly diagnosed patients with specific chronic conditions (such as arthritis, prediabetes, or diabetes) and refer them to the Living Well self-management and physical activity programs.
  6. Track and set goals for patient referrals.

Healthy Living

Healthy Worksite

☐ **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.

Food Access

☐ **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.

Park Rx

☐ **IMPLEMENT PARK RX**

- ✓ Use Parks 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.

TOP Star

☐ **BECOME A TOP STAR ENDORSED CENTER**

- ✓ Have your on-site child care 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.