2023 CHRONIC DISEASE QUALITY IMPROVEMENT PROJECT

REQUEST FOR APPLICATIONS (RFA)

PRIMARY CARE CLINICS

1.0 Introduction:

The Chronic Disease Prevention Team at Salt Lake County Health Department (SLCoHD) would like to collaborate with primary care clinics to improve patient care and clinical practices. Through quality improvement projects, clinics will implement interventions that improve outcomes for the residents of Salt Lake County specific to diabetes, cholesterol levels, hypertension, and related risk factors. Funding will be granted upon completion of these projects and as described throughout the RFA and resulting contract. Funding is provided by the Centers for Disease Control and Prevention (CDC).

2.0 Program Goals – Prevent, identify, and manage chronic diseases:

a. Identify and Improve Hypertension Control Rates (NQF18)
b. Identify and Improve Statin Therapy Rates (MIPS Measure #438; CMS 347)
c. Identify and Decrease uncontrolled Diabetes (NQF59)

3.0 Application Instructions:

a. Select One (1) Chronic Disease Focus Project for $3,000
b. Select One (1) Smaller/Community Project for $500
c. Email completed application form to healthpromotion@slco.org
    i. Application Due Date: January 15, 2023

4.0 General Expectations for Clinics:

a. Complete an improvement plan, using the PDSA (Plan, Do, Study, Act) worksheet.
b. Implement improvement plan, evaluate effectiveness of strategies, and adapt accordingly.
c. Have regular contact (in person, virtual, phone, or email correspondence) with a member of Salt Lake County Chronic Disease Prevention Team, typically at least monthly.
d. Submit at least one success story of how your project has improved your clinic.
e. Provide pre and post data corresponding to your chosen project, including control rates broken down by race/ethnicity and where possible, low-income and/or insurance status.
f. Provide follow-up data for up to 5 years, upon request.
g. Follow Timeline as listed in this application.
h. See project-specific details for additional requirements.

5.0 Eligibility and Selection Criteria:

a. All clinics that offer primary care services in Salt Lake County are eligible to apply.
b. We are eager to support and work with several clinics in Salt Lake County and to the extent that is feasible we will accept and work with all clinics that apply, however, funding is limited. If more applications/funding requests are submitted than can be accommodated by funding, recipients will be chosen primarily based on clinic location and populations served, with some consideration given to potential impact and feasibility of projects chosen. The funding request may also be reduced to a single project proposed in the application.
    i. Priority areas include Glendale, Rose Park, West Valley, South Salt Lake, Midvale, Kearns, Taylorsville, and Magna.
    ii. Priority populations include those who are low income, Native American, Black/African American, or do not speak English as their primary language.
c. Once submitted, applications will only be approved after a staff member from the Salt Lake County Chronic Disease Prevention Team meets with the clinic to finalize project activities.
d. If received, funding CAN pay for time spent on planning projects, implementing projects, disseminating projects, evaluating projects.
e. Funding CANNOT pay for research, equipment, incentives, direct services such as patient care, co-pay fees, medication, patient education.

6.0 Timeline/Due Dates:

a. January 15, 2023: Complete and email 2023 Application to SLCoHD
b. By February 15, 2023: Meet with the SLCoHD Chronic Disease Prevention Team

Applicants will be notified of the funding decision no later than February 24, 2023

c. February 28, 2023: Complete and email formal contract to SLCoHD
d. March 15, 2023: Baseline Data Due (For the year 2022)
e. April 15, 2023: PDSA Cycle Worksheet Complete
f. April 15 - September 15, 2023: PDSA Cycle in Progress
g. Between April 15 - August 15, 2023: Midpoint Meeting (Specific Date: _____)
h. September 30, 2023: Success story collected and given to Health Department

Payment will start being processed upon satisfactory progress of improvement plan implementation, utilizing the PDSA process.

i. Between November 1- December 15, 2023: Final Meeting (Specific Date: _____)
j. January 15, 2024: Post Data Due (For the year 2023)

2023 CHRONIC DISEASE QUALITY IMPROVEMENT PROJECTS APPLICATION

PRIMARY CARE CLINICS

Clinic Information:

Name of Clinic:

Clinic Address:

Applicant Name:

Applicant Job Title and Role in Projects:

Applicant Phone Number:

Applicant Email:

Name and Roles of Other Staff Who Will Be Involved:

Additional Staff Contact:

Name:

Role:

Email:

Phone:

Specific Populations Served:

If applicable, please provide a brief explanation of any of the priority populations you serve. This includes Native American, Black/African American, those who do not speak English as their primary language, or those who are low income.

Do you serve those covered by Medicaid? Select Medicare? Select

Chronic Disease Focus Project

Please select one (1) chronic disease to focus on for this quality improvement project.

Hypertension ~ Cholesterol ~ Prediabetes/Diabetes

Through SLCoHD, the CDC will provide **$3,000** for completion of one (1) chronic disease focus project.

HYPERTENSION (HTN)

☐ IMPROVE HEALTH EQUITY

- **Project Goal:** Identify and work to 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.
- **Project Activity Options:**
  - Use data reports to identify disparate client populations
  - Research the needs and barriers of under-resourced patient populations
  - Improve clinic staff training around health equity and implicit bias
  - Implement appropriate interventions to improve control rates of identified client populations
  - Create and improve upon written clinic policies and processes to improve health equity
- **Evaluation Expectations:**
  - This project requires the Core Evaluation Measures for Hypertension (see below)

☐ TEAM-BASED CARE

- **Project Goal:** Improve hypertension control through new or enhanced approaches to team-based care.
- **Project Activity Options:**
  - 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, health coaches, behavioral health specialists, and/or community health workers (CHWs).
  - Improve communication and trust among care team and/or patients
  - Create and improve on written clinic policies and processes that improve team-based care resulting in better managed hypertension
- **Evaluation Expectations:**
  - This project requires the Core Evaluation Measures for Hypertension (see below)
  - This project has additional evaluation questions:
    - Count of team members of patient care team: The total number of pharmacies, CHWs, and/or non-physician team members involved in care team for patients with hypertension
    - Count of referrals to CHWs: Number of patients referred to CHWs; Number of hypertensive patients that engaged with CHWs

☐ IMPROVE HYPERTENSION CARE

- **Project Goal:** Improve and align hypertension standards of care including appropriate screening, measurement, diagnoses, and treatment of patients with high blood pressure.
- **Project Activity Options:**
    - Train and evaluate direct patient care staff on accurate blood pressure measurements and documentation
    - Implement a clinical process to appropriately screen, diagnose, and treat patients with hypertension
    - Use electronic health records alerts and registries
    - Implement or improve Automated Office Blood Pressure or Self Monitor Blood Pressure programs
    - Improve patient education and/or sending referrals for comorbidities and other risk factors
    - Create or update written policies that implement improvement on diagnosing hypertension
- **Evaluation Expectations**:
    - This project requires the Core Evaluation Measures for Hypertension (see below)

☐ UNDIAGNOSED HYPERTENSION

- **Project Goal:** Use data to identify and diagnose current patients with undiagnosed hypertension.
- **Project Activity Options:**
    - Implement algorithms or protocols to identify undiagnosed hypertension
    - Improve measurement and documentation
    - Expand screenings/opportunities for patients to check blood pressures
    - Use community partners and stakeholders to conduct community hypertension screenings
    - Compare and gather data of your clinic's hypertension prevalence to national and local estimates to determine if you might be missing diagnosing patient
    - Search electronic health record (EHR) data for patients who meet criteria for undiagnosed hypertension
    - Train and evaluate direct care staff on accurate blood pressure measurements and documentation
    - Set up lending library to give blood pressure monitors to patients
    - Create or update written policies to improve diagnosing patients with hypertension
- **Evaluation Expectations:**
    - This project requires the Core Evaluation Measures for Hypertension (see below)

EVALUATION EXPECTATIONS FOR ALL HYPERTENTION PROJECTS

Core Evaluation Measures for Hypertension:

The following will be required as part of baseline and post data submitted: (1) Total number of patients; (2) Number of patients with an essential hypertension diagnosis; and (3) Number of patients with Essential Hypertension diagnosis with their blood pressure controlled (under 140/90 mm/Hg), for your entire patient population, within required racial/ethnic patient sub-populations, and within other optional patient sub-populations.

- Required patient sub-populations: Black/African American, American Indian/Alaska Native, Asian, Pacific Islander or Other Pacific Islander, White, Other Race/2+ Races, Hispanic/Latino
- Optional patient sub-populations: income status/level, insurance status, zip code, age, sex/gender, etc.
- Baseline Data: Required numbers for January 1- December 31, 2022
- Post Data: Required numbers for January 1- December 31, 2023

A fillable data table will be provided to assist with gathering these specific data measures; this will be given at the beginning of the project.

CHOLESTEROL

☐ IMPROVE HEALTH EQUITY

- **Project Goal:** 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.
- **Project Activity Options:**
  - Use data reports to identify disparate client populations
  - Improve clinic staff training around health equity and implicit bias
  - Implement appropriate interventions to improve statin therapy rates of identified client populations.
  - Better understand the needs and barriers of identified patient populations
  - Learn and apply health equity principles to clinic's current processes and identified implicit bias(es)
  - Create or improve upon written clinic policies and processes that reflect change
- **Evaluation Expectations:**
  - This project requires the Core Evaluation Measures for Cholesterol (see below)

☐ TEAM-BASED CARE

- **Project Goal:** Improve cholesterol management through new or enhanced approaches to team-based care.
- **Project Activity Options:**
  - Map out clinic workflows and roles of the care team
  - Identify and improve gaps or weaknesses in team's care plan
  - Choose to incorporate other professional team members into the patient care model
  - Find a way to increase integration with pharmacies
  - Improve communication and trust among the care team
  - Create and improve upon written clinic policies and processes
- **Evaluation Expectations:**
  - This project requires the Core Evaluation Measures for Cholesterol (see below)
  - This project has additional evaluation questions:
    - Count of team members of patient care team: The total number of pharmacies, CHWs, and/or non-physician team members involved in care team for patients with high cholesterol
    - Count of referrals to CHWs: Number of patients referred to CHWs; Number of patients with high cholesterol that engaged with CHWs

☐ SCREENING AND TREATMENT

- **Project Goal:** 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 atherosclerotic cardiovascular disease (ASCVD) risk of patients.
- **Project Activity Options:**
    - Assess and improve the ability to run statin therapy reports
    - Implement clinical processes to screen for patients' 10-year ASCVD risk
    - Implement processes to identify, screen, and diagnose
    - Improve patient education materials
    - Implement clinical processes to treat high cholesterol including lifestyle behavior goals and utilizing statin therapy
    - Create or update a written policy
- **Evaluation Expectations:**
    - This project requires the Core Evaluation Measures for cholesterol (see below)

EVALUATION EXPECTATIONS FOR ALL CHOLESTEROL PROJECTS

Core Evaluation Measures for Cholesterol:

The following will be required as part of baseline and post data submitted: (1) Total number of patients; (2) Number of patients who receive at least one order (prescription) for statin therapy at any point during the measurement period; and (3) Number of patients at the beginning of the measurement period with a clinical ASCVD diagnosis, for your entire patient population, within required racial/ethnic patient sub-populations, and within other optional patient sub-populations.

- Required sub-populations: Black/African American, American Indian/Alaska Native, Asian, Pacific Islander or Other Pacific Islander, White, Other Race/2+ Races, Hispanic/Latino
- Optional patient sub-populations: income status/level, insurance status, zip code, age, sex/gender, etc.
- Baseline Data: Required numbers for January 1- December 31, 2022
- Post Data: Required numbers for January 1- December 31, 2023

A fillable data table will be provided to assist with gathering these specific data measures; this will be given at the beginning of the project.

PREDIABETES/DIABETES

☐ IDENTIFY AND REFER

- **Project Goal:** Identify patients with prediabetes and type 2 diabetes, provide education, and refer to the National Diabetes Prevention Program (NDPP) or the Diabetes Self-Management Education and Support (DSMES).
- **Project Activity Options:**
    - Screen for prediabetes
    - Implement alerts and clinical workflows to flag patients with prediabetes and diabetes
    - Refer diabetic patients and prediabetic patients to the National DPP or DSMES
    - Identify and provide referrals to other behavior change services
    - Create a workflow to provide or refer to other behavior change services
    - Provide culturally appropriate and tailored diabetic education materials to patients
    - Create or update a written policy
- **Evaluation Expectations:**
    - This project requires the Core Evaluation Measure for diabetes (see below)
    - This project has additional evaluation questions:
        - The number of patients referred to DSMES
        - The number of patients in your clinic identified within the prediabetic range, which is a HbA1c of 5.7 - 6.4 (or use FPG/OGTT ranges if preferred)
        - Number of patients referred to the National DPP
        - If applicable, the number of patients that completed the National DPP

☐ IMPROVE HEALTH EQUITY

- **Project Goal:** Identify and improve the uncontrolled diabetes rates of the clinic's disparate and/or high burden subpopulations.
- **Project Activity Options:**
    - Use data reports to identify disparate client populations
    - Improve clinic staff training around health equity and implicit bias
    - Implement appropriate interventions to improve uncontrolled diabetes rates of identified client populations
    - Better understand the needs and barriers of identified patient populations
    - Learn and apply health equity principles to the clinic's current processes
    - Create and improve upon written clinic policies and processes
- **Evaluation Expectations:**
    - This project requires the Core Evaluation Measures for diabetes (see below)

☐ TEAM-BASED CARE

- **Project Goal:** Improve type 2 diabetes control through new or enhanced approaches to team-based care.
- **Project Activity Options:**
    - 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 community health workers (CHWs), health coaches, or nephrologists
    - Improve communication and trust among the care team
    - Combine efforts with pharmacies to treat those with diabetes
    - Create and improve upon written clinic policies and processes
- **Evaluation Expectations:**
    - This project requires the Core Evaluation Measures for diabetes (see below)
    - This project has additional evaluation questions:
        - Count of team members of patient care team: The total number of pharmacies, CHWs, and/or non-physician team members involved in care team for patients with diabetes
        - Count of referrals to CHWs: Number of patients referred to CHWs; Number of patients with diabetes that engaged with CHWs

☐ CARDIOVASCULAR DISEASE AND RISK MANAGEMENT

- **Project Goal:** Prevent and reduce the risk of atherosclerotic cardiovascular disease (ASCVD) in patients with diabetes.
- **Project Activity Options:**
    - Implement clinical process to screen for 10-year ASCVD risk in patients with diabetes
    - Implement clinical processes to screen, diagnose, and treat hypertension, lipid profiles, and cardiovascular disease according to ASCVD risk in patients with diabetes
    - Implement a self-monitoring blood pressure program in your clinic
    - Create or update a written policy
- **Evaluation Expectations**
    - This project requires the Core Evaluation Measure for diabetes (see below)
    - This project has additional evaluation questions:
        - Hypertension control rate for diabetic patients
        - Statin therapy rate (MIPS Measure #438; CMS 347) for diabetic patients

☐ CHRONIC KIDNEY DISEASE

- **Project Goal:** Increase appropriate screening, diagnosis, and treatment of chronic kidney disease (CKD) in patients with diabetes.
- **Project Activity Options:**
    - Identify and define CKD metrics the clinic will use
    - Educate/train staff on CKD
    - Implement clinical processes to screen, diagnose, and treat CKD
    - Improve educational materials for CKD
    - Establish a CKD registry within the electronic health record (EHR) system to identify and notify providers of the need for intervention
    - Collaborate with those who are part of CKD care and improve team-based care
    - Create or update a written policy
- **Evaluation Expectations**
    - This project requires the Core Evaluation Measure for diabetes (see below)
    - This project has an additional evaluation question:
        - 2020 HEDIS Measure (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

EVALUATION EXPECTATIONS FOR ALL DIABETES PROJECTS

Core Evaluation Measures for Diabetes:

The following will be required as part of baseline and post data submitted: (1) Total number of patients; (2) Number of patients with diabetes (type 1 or type 2); and (3) Number of diabetic patients with poor control (HbA1C greater than 9.0%, was missing a result, NQF #59), for your entire patient population, within required racial/ethnic patient sub-populations, and within other optional patient sub-populations.

- Required sub-populations are: Black/African American, American Indian/Alaska Native, Asian, Pacific Islander or Other Pacific Islander, White, Other Race/2+ Races, Hispanic/Latino
- Optional patient sub-populations: income status/level, insurance status, zip code, age, sex/gender, etc.
- Baseline Data: Required numbers for January 1- December 31, 2022
- Post Data: Required numbers for January 1- December 31, 2023

A fillable data table will be provided to assist with gathering these specific data measures; this will be given at the beginning of the project.

Smaller/Community Projects

Please select one (1) smaller/community project

Through SLCoHD, the CDC will provide **$500** for completion of one (1) smaller/community project

The Chronic Disease Prevention Team will get you in contact with individuals at the Salt Lake County Health Department that will help with these projects.

☐ 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 (provided specifically for your workplace at the end of filling out the application) to improve worksite wellness offerings.

☐ BECOME A COMMUNITY PARTNER FOR IMPROVING HEALTHY FOOD ACCESS

- ✓ Choose a project or an event that will increase access to healthy foods. Projects could include holding a healthy food drive, creating a community garden, promoting awareness of local food resources, partnering with a food pantry, farmer's market, or other organization.

☐ IMPLEMENT PARK RX

- ✓ Participate in Park Rx (prescribing outdoor activity as medicine) by using the Park Rx America database and your electronic health record (EHR) to prescribe physical activity outdoors to combat chronic diseases. Salt Lake County Health Department will train and assist with implementation.

☐ REFER TO LIVING WELL CLASSES

- ✓ Set up or refine the process to refer patients to Living Well classes to address certain chronic conditions, especially arthritis. This includes identifying insurance reimbursement options for referrals, establishing or improving referral processes, setting goals, tracking referrals, and reporting the number of referrals to SLCoHD.

☐ IMPLEMENT TOBACCO CESSATION PROGRAMMING

***<u>This project offers up to an additional $500 (for a possible total of $1,000) for completion of the following</u>:

- ✓ Invite the Salt Lake County Tobacco Education Program to present to your clinic staff about cessation best practices.
- ✓ Assess tobacco use status for each patient annually and offer those who report tobacco use a referral to the Utah Tobacco Quitline (made by the provider at waytoquit.org).
- ✓ Track referrals made by the clinic through the electronic health record/reports from the Utah Tobacco Quitline and provide an annual tally in grant reporting.