Ohio’s Diabetes and Hypertension Quality Improvement Project

Kick-Off Webinar
April 1st, 2019
11:00am – 12:00pm

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CDC Chronic Disease Funding

- **1815**: Support state investments in implementing and evaluating evidence-based strategies to prevent and manage cardiovascular disease (CVD) and diabetes in high-burden populations/communities
  - Funding period: September 30, 2018 - June 29, 2023
  - Prediabetes/diabetes/hypertension/blood cholesterol
  - Statewide efforts with focus on high-burden populations
QI Project

- Contract Start: April 2019
  - Year 1: Planning & FQHC Recruitment
  - Years 2-3: Implementation – Cohort #1
  - Years 4-5: Implementation – Cohort #2

- QI Project will address:
  - Prediabetes
  - Diabetes
  - Hypertension
  - High blood cholesterol
QI Project - Objectives

► Decrease the number of adults with diabetes with a hemoglobin A1c >9
► Increase the number of adults with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved a 5-7% weight loss
► Increase control among adults with known high blood pressure and high cholesterol
► Identify patients with undiagnosed hypertension
QI Project - Pathways

- Implement a diabetes and hypertension/high blood cholesterol QI project with FQHCs utilizing six pathways:
  1. Screening, testing, and referring for prediabetes
  2. Management of patients with diabetes including referral to DSMEs
  3. Identifying undiagnosed HTN
  4. Management of patients with HTN/high blood cholesterol
  5. Establishing or expanding MTM services
  6. Linking patients to community resources to improve management
QI Project - Pathways

1. Screen, Test, and Refer for Prediabetes

Universal Screening ➔ Diagnostic Test ➔ Assign ICD10 Code: R73.03

Document Feedback from DPP Referral ➔ Refer to a Local DPP

Develop/Run Registry Report of Prediabetes Dx. ➔ Patient Follow-up on Registry Report

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2. Management of Patients with Diabetes

- Locate DSME Program
- Best Workflow for Referral
- Referral Data to Send to DSME
  - Refer Newly Diagnosed Patients
  - Document Feedback from DSME Referral
  - Patient Follow-up on Registry Report
  - Develop/Run Registry Report of Diabetes Dx.
QI Project - Pathways
3. Identifying Undiagnosed Hypertension

1. Ensure ALL Staff are Trained in BP Measurements
2. Identify Undiagnosed HTN Patients via EHR
3. Workflow for Running the EHR Report
5. Assign Diagnosis of HTN if Meet Criteria
6. Patient Follow-up on Registry Report
QI Project - Pathways

4. Management of Patients with HTN/High Blood Cholesterol

- Status of Running EHR Report of HTN Patients
- Utilization of HTN EHR Report
- Team-Based Care Workflow for HTN/HBC Patients
- Schedule Patient Follow-Up as Needed
- Ensure Patient Self-Monitoring Plan

Referral to Community-Based SMBP Programs (e.g., Y-BPSM)
5. Establishing or Expanding MTM Services

- Assess Current Pharmacy Landscape
- Availability of Clinical Pharmacy Services
- Referral Workflow to MM/Clinical Pharmacy Services
- Document Feedback from MM/Clinical Pharmacy Referral
- Patient Referral to MM/Clinical Pharmacy Services

Staff trained on providing pharmacy-based care for the underserved
QI Project - Pathways
6. Linking to Community Resources

- Screen for Social Determinants of Health
- Maintain Resource List of Community/Social Services
- Provide Information to Patients on Community/Social Services
- Determine team member to collect and distribute information on community/social services
QI Project - Benefits of Participation

- Contribute to Ohio’s efforts to improve the management of adult patients with hypertension, find adult patients with undiagnosed hypertension, and identify adult patients with prediabetes

- Increased engagement of non-physician team members in hypertension management

- Increased the patient use of self-monitoring blood pressure

- Increased screening to all adults patients for prediabetes using a universal screening tool

- Optimized workflows for ensuring all diabetic patients are referred to a DSME

- Ensure all team members are fully trained in accurate BP measurement
QI Project - Application Considerations

- Geographic distribution (urban, rural/Appalachian, suburban)
- Patient demographics
- Patient population size
- Proximity to DPPs, DSMEs, YMCA BPSM programs
- UDS performance quartile ranking
- FQHC Capacity
- EMR vendor/reporting capabilities
- Population health management tool
- Use and understanding of improvement methodology
- Current initiatives
QI Project - Selected Site Expectations

- Participation in quality improvement (QI) practice coaching plans
- Designation of internal project lead in a clinical and/or quality role
- Participation in on-site trainings and discussions, monthly webinars and/or conference calls, and face-to-face meetings
- Quarterly data collection and entry
- Ensure adequate staff training on diabetes and hypertension
- Update policies and procedures to reflect evidence-based clinical operation
QI Project - OACHC & ODH Deliverables

- Monthly calls
- Webinars, articles, education opportunities, trainings (DPP, DSME, BPSM, HTN)
- QI project development and implementation plan
- Practice coaching plan
- Quarterly data collection
- MTM collaborative
- EHR Technical Assistance
- Year-end reports
Data Collection – Prediabetes/DM

- Number of adult patients identified as having prediabetes or at high risk of developing type 2 diabetes
- Number of adult patients referred to a DPP
- NQF Measure #59- percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
- Number of adult patients referred to a DSME
Data Collection – Hypertension/High Cholesterol

- Number of adult patient with a diagnosis of HTN
- Number of adult patients meeting criteria for having undiagnosed HTN
- Number of previously undiagnosed adult patients diagnosed with HTN as a result of algorithm implementation
- Number of previously undiagnosed adult patients diagnosed with HTN as a result of implementing the algorithm that have their blood pressure controlled to <140/90mmHg.
- Number of adult patients referred to a community-based organization for HTN management
- Number of adult patients screened for high cholesterol using the Framingham (ASCVD risk calculator) assessment
Data Collection – MTM/Community Resources

- Number of adult patients who were referred to MTM services
- Number of active adult patients
- Number of adult patients referred to community/social services
Application Instructions

- www.ohiochc.org > Resources > Clinical > Ohio's Diabetes and Hypertension Quality Improvement Project

Accepting Applications from 4/1/19 to 4/15/19
Opportunities for Impact

- Apply for the FQHC QI Project

- Referrals…Referrals…Referrals
  - Healthcare team outreach
  - DSME/DSMP/DEEP/DPP/YMCA BPSM
Resources

- CDC Prediabetes Awareness Campaign
- AMA/CDC Prevent Diabetes STAT
- CDC Division of Diabetes
- Million Hearts Initiative
- OACHC Website
- HSAG Integrating Diabetes Self-Management Education in Your Community Health Centers- Webinar 3/22/19 12pm-1pm
QUESTIONS?

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