OACHC
Ohio Association of Community Health Centers

Ohio's Diabetes and Hypertension Quality Improvement Project

Kick-Off Webinar

April 1st, 2019

11:00am – 12:00pm

Ashley Ballard, RN, BSN, Director of Clinical Quality

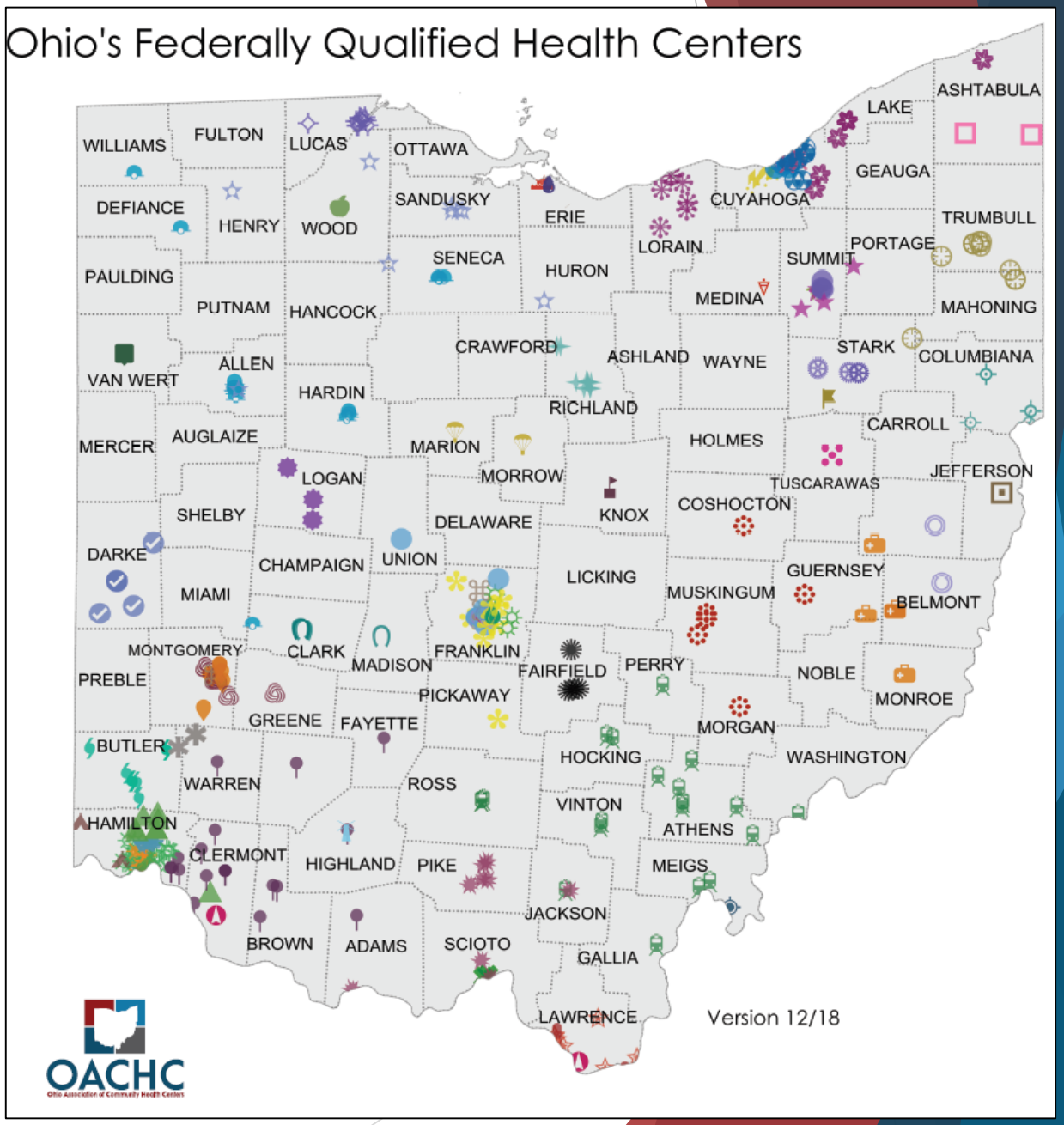
Erica Brown, Chronic Disease Program Manager

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

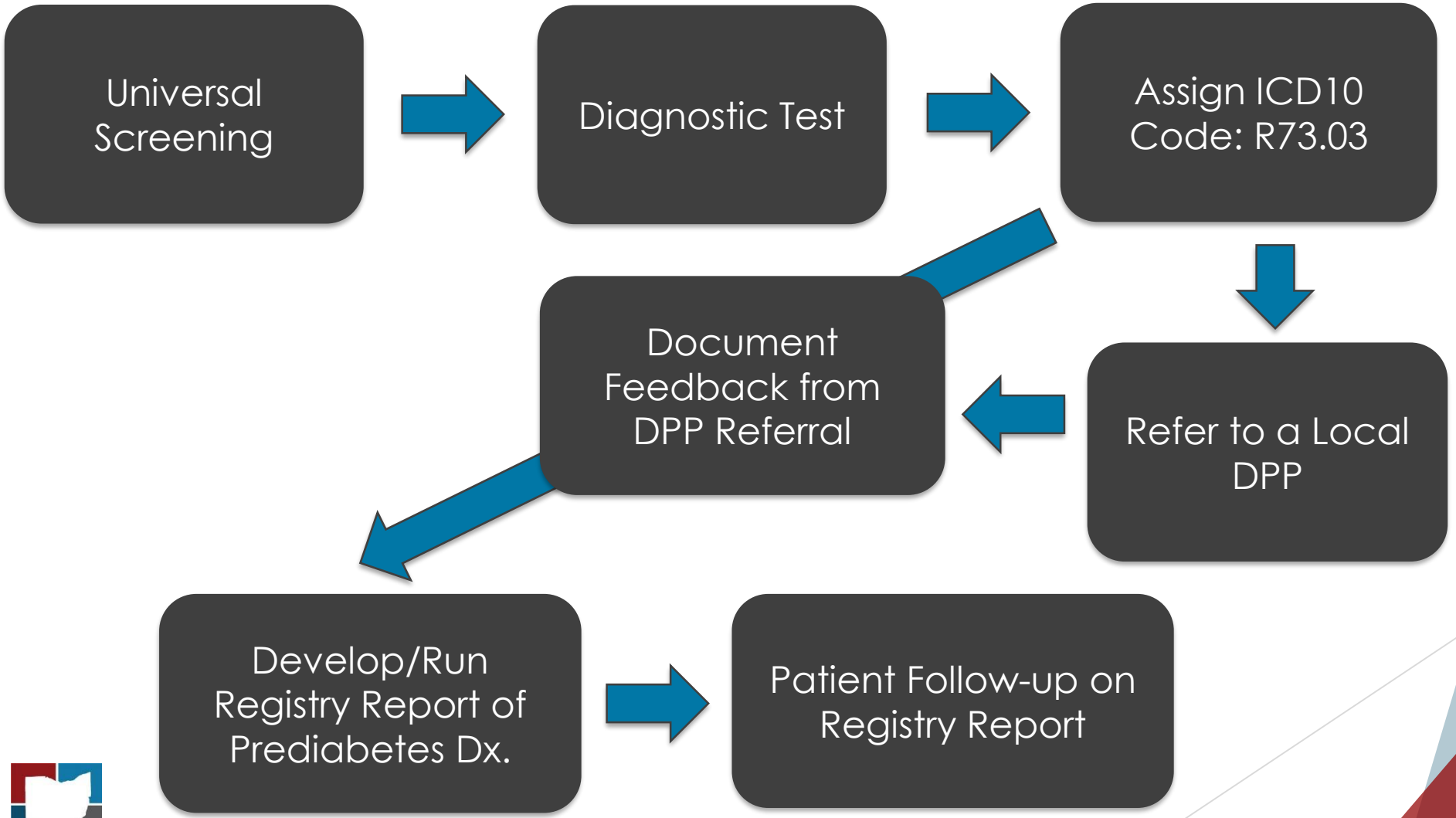
- Decrease the number of adults with diabetes with a hemoglobin A1c >9
- Increase the number of adults with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved a 5-7% weight loss
- Increase control among adults with known high blood pressure and high cholesterol
- Identify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

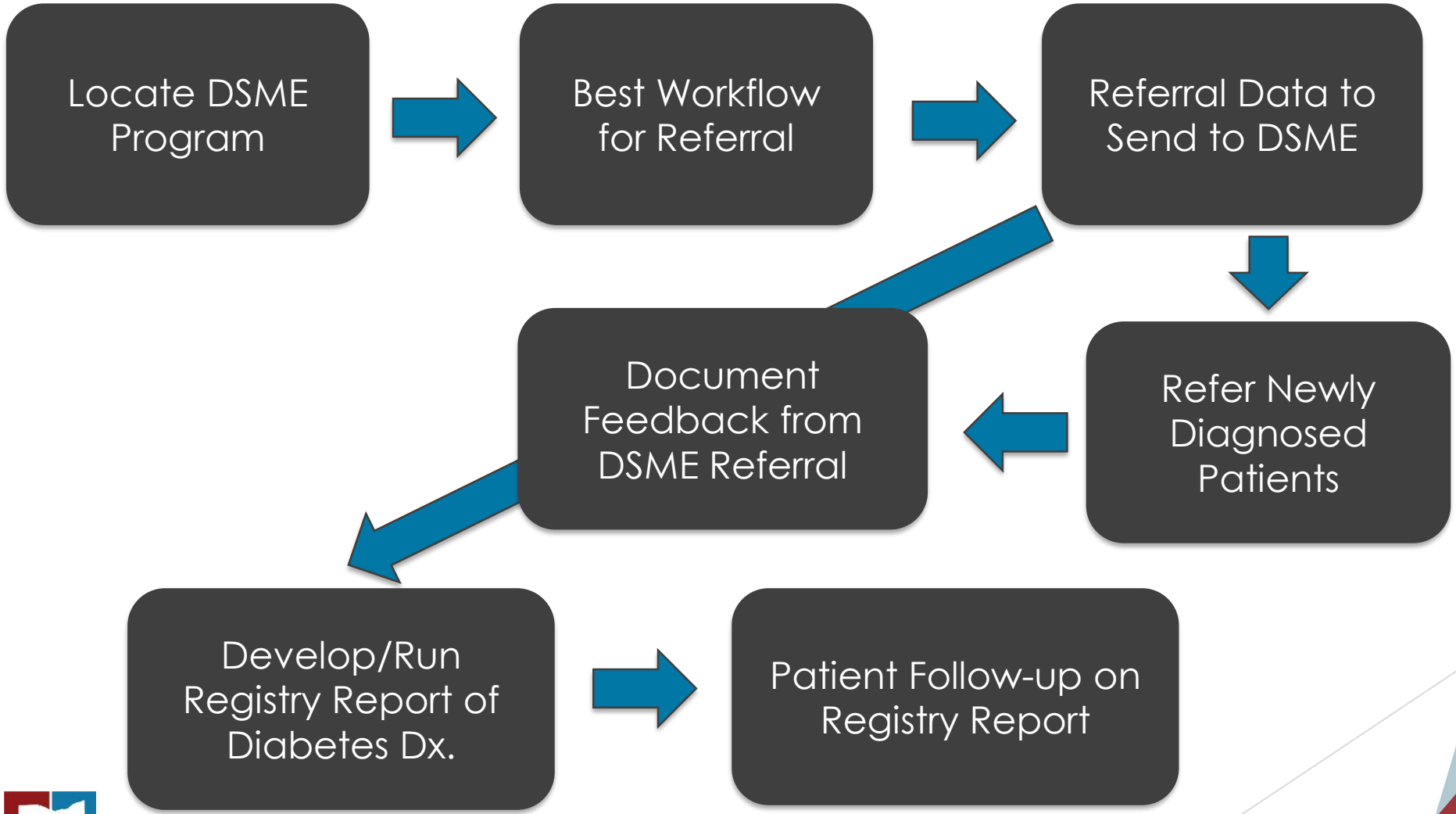
QI Project - Pathways

1. Screen, Test, and Refer for Prediabetes



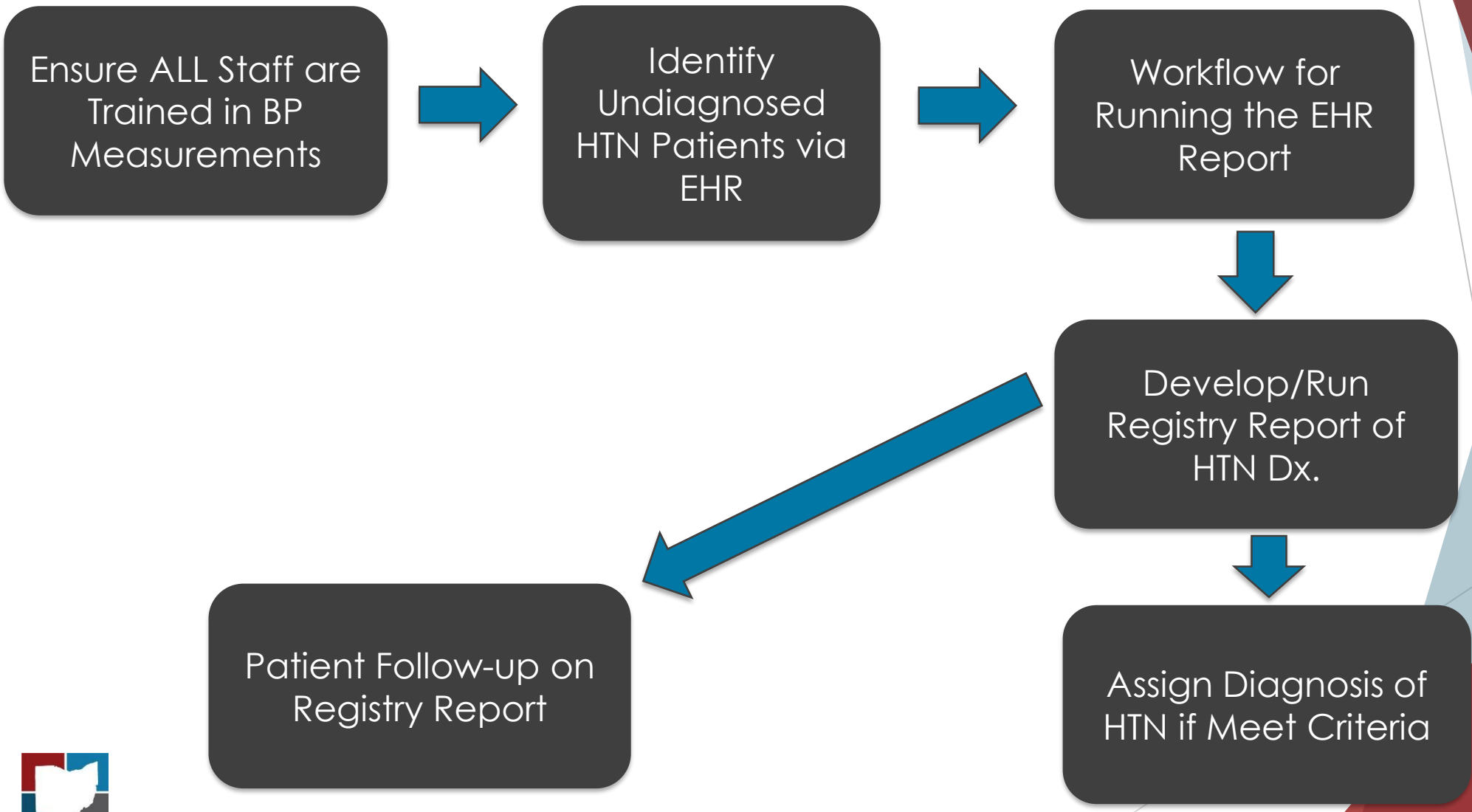
QI Project - Pathways

2. Management of Patients with Diabetes



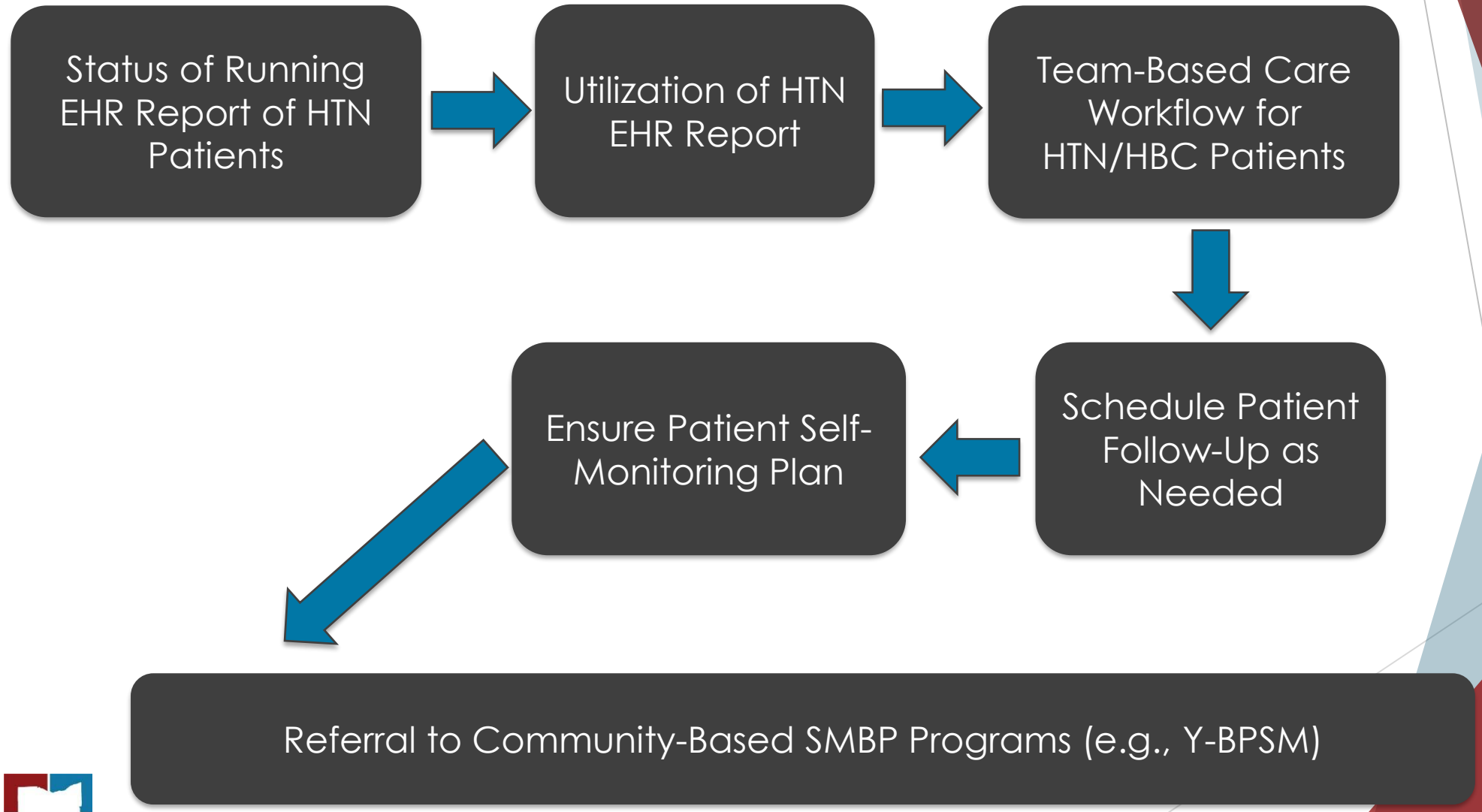
QI Project - Pathways

3. Identifying Undiagnosed Hypertension



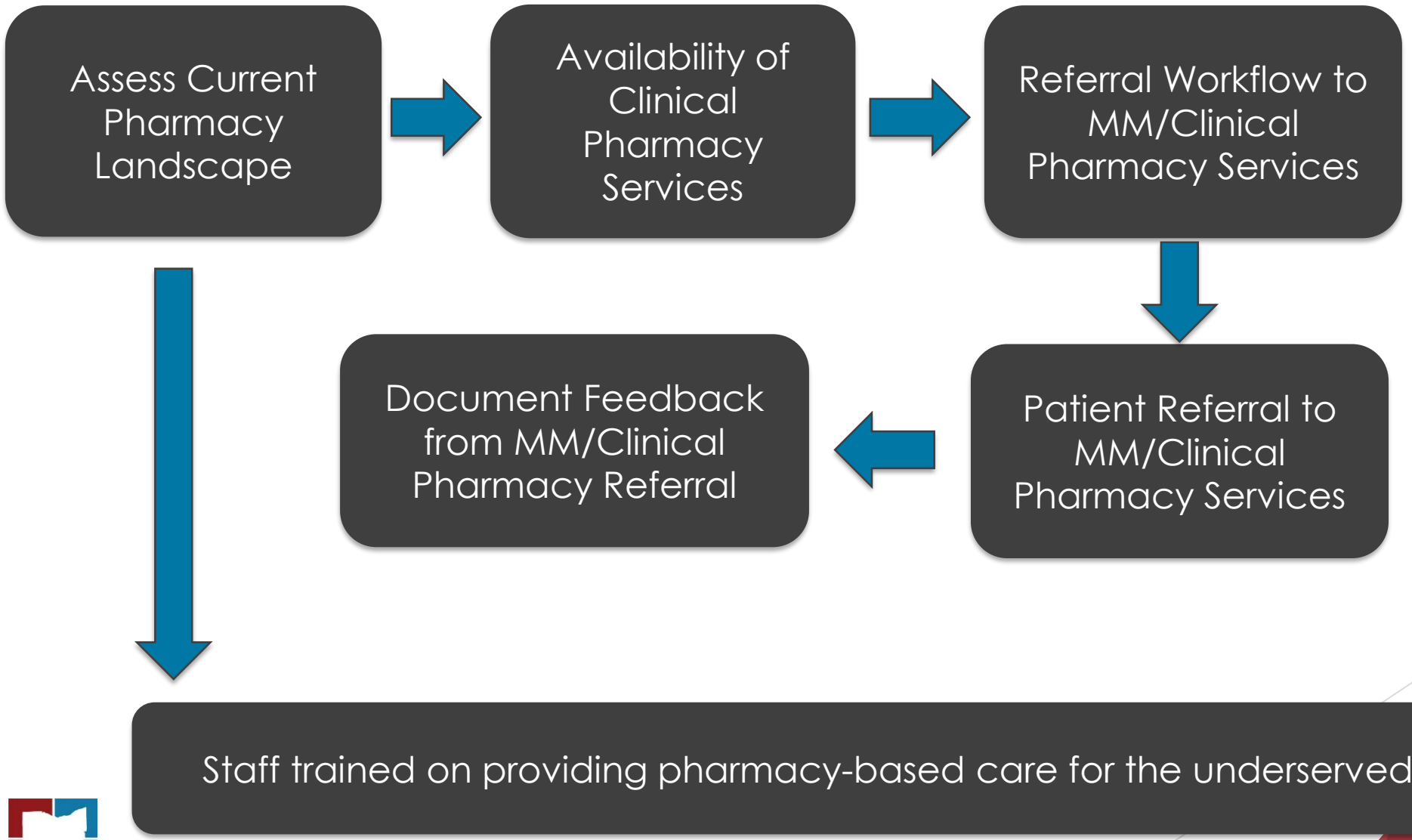
QI Project - Pathways

4. Management of Patients with HTN/High Blood Cholesterol



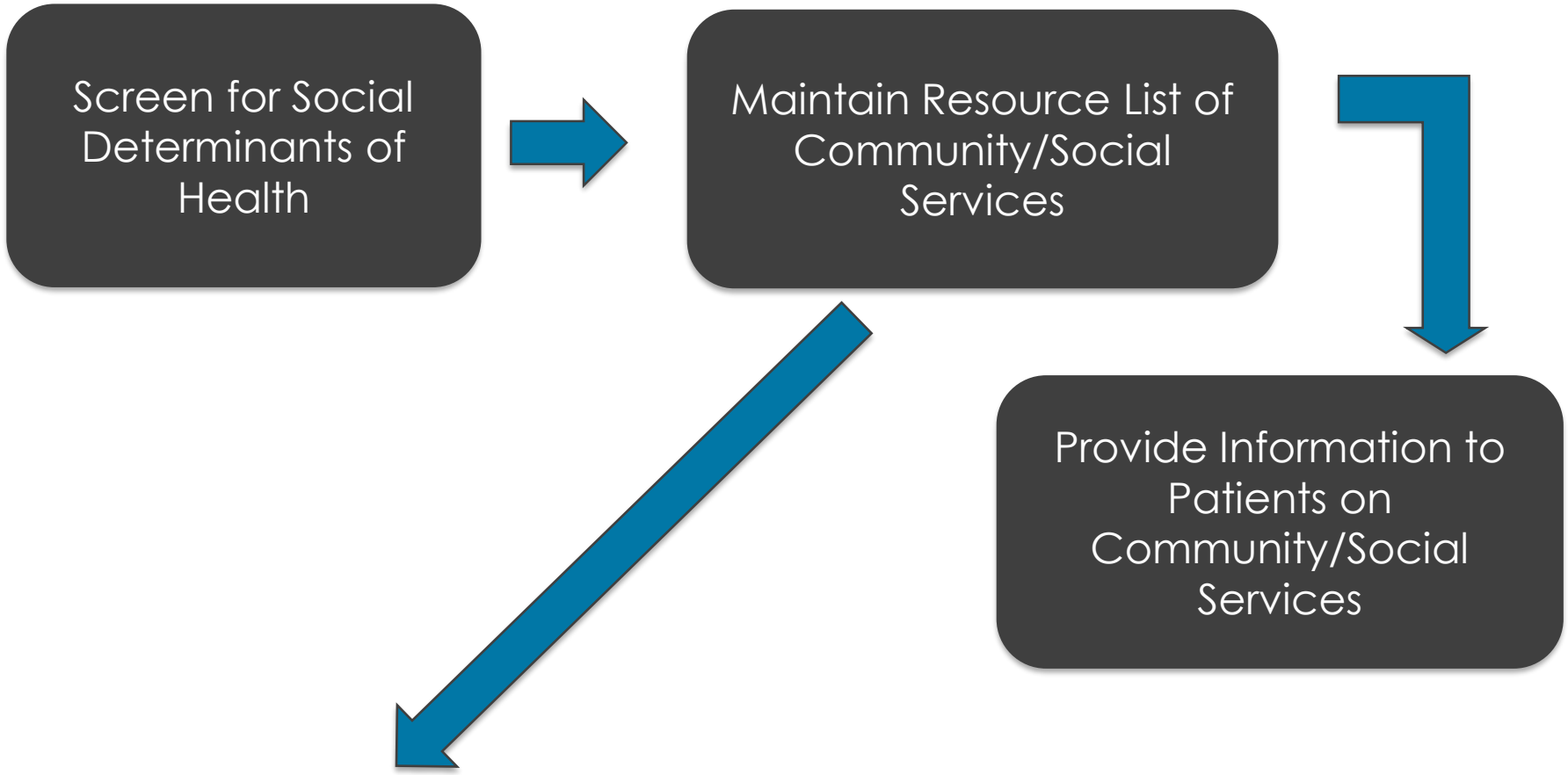
QI Project - Pathways

5. Establishing or Expanding MTM Services



QI Project - Pathways

6. Linking to Community Resources



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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