



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

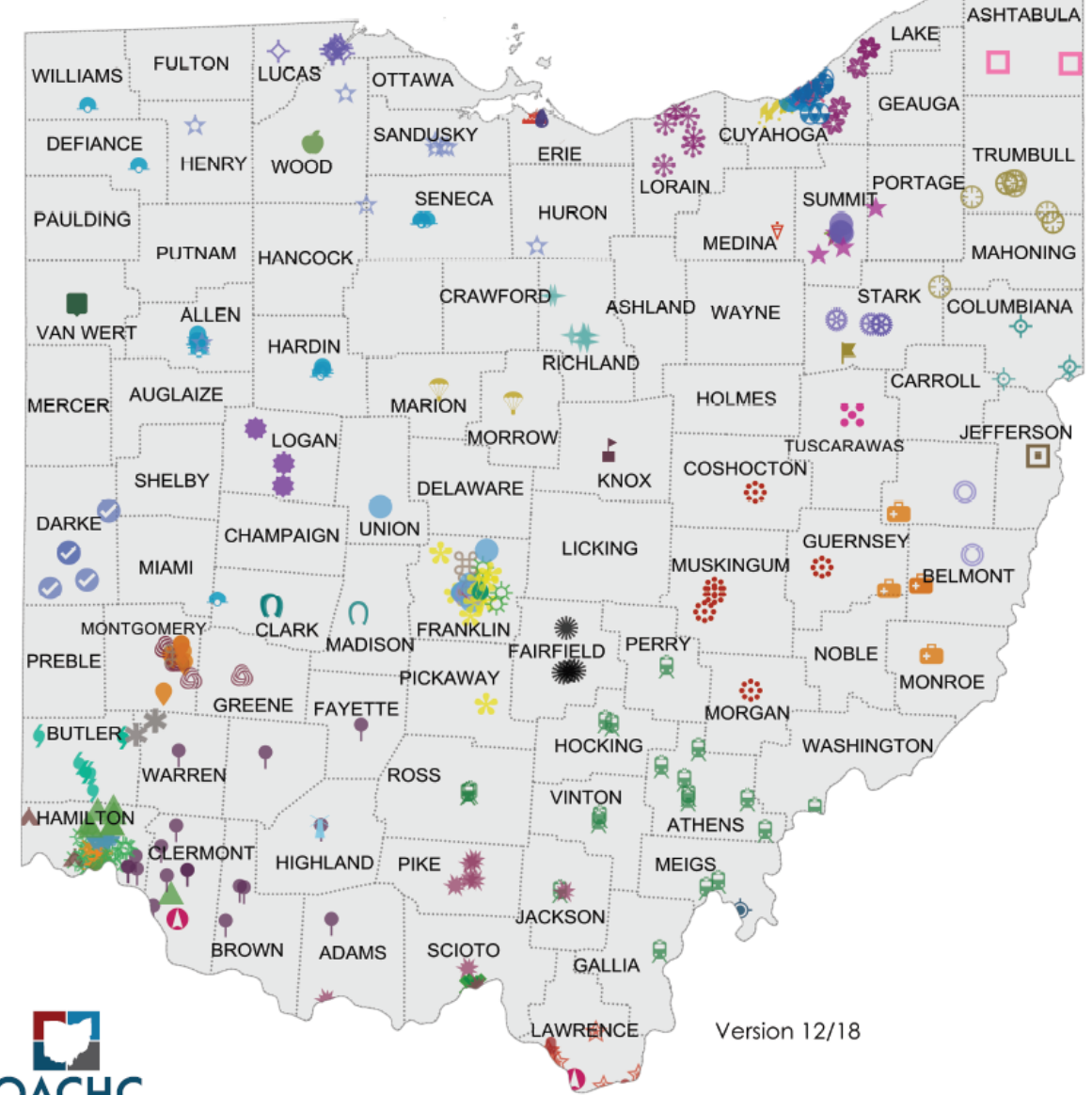
- ▶ **1815:** Support state investments in implementing and evaluating evidence-based strategies to prevent and manage cardiovascular disease (CVD) and diabetes in high-burden populations/communities
 - Funding period: September 30, 2018 - June 29, 2023
 - Prediabetes/diabetes/hypertension/blood cholesterol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

Ohio's Federally Qualified Health Centers



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



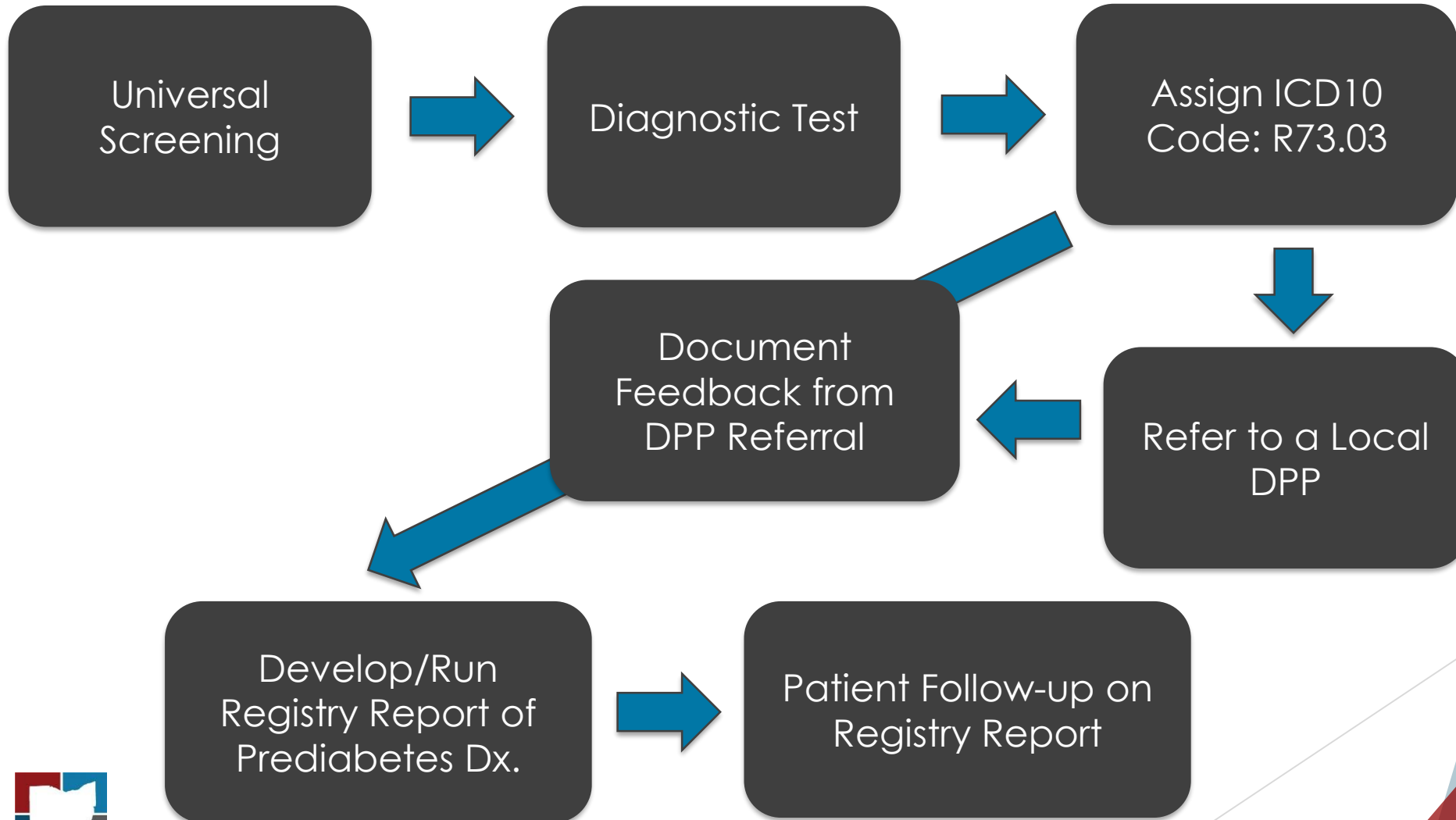
QI Project - Pathways

- ▶ 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



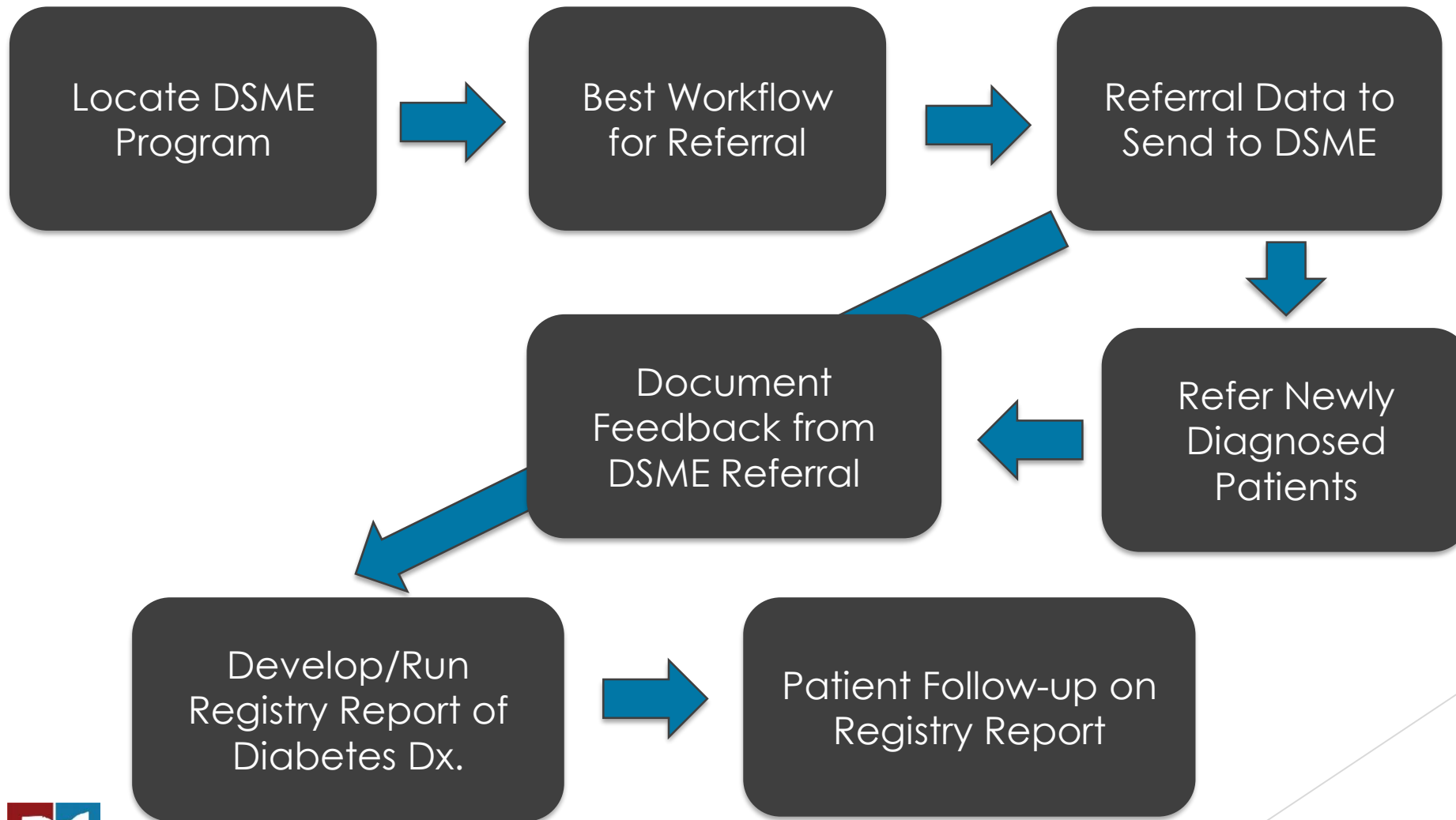
QI Project - Pathways

1. Screen, Test, and Refer for Prediabetes



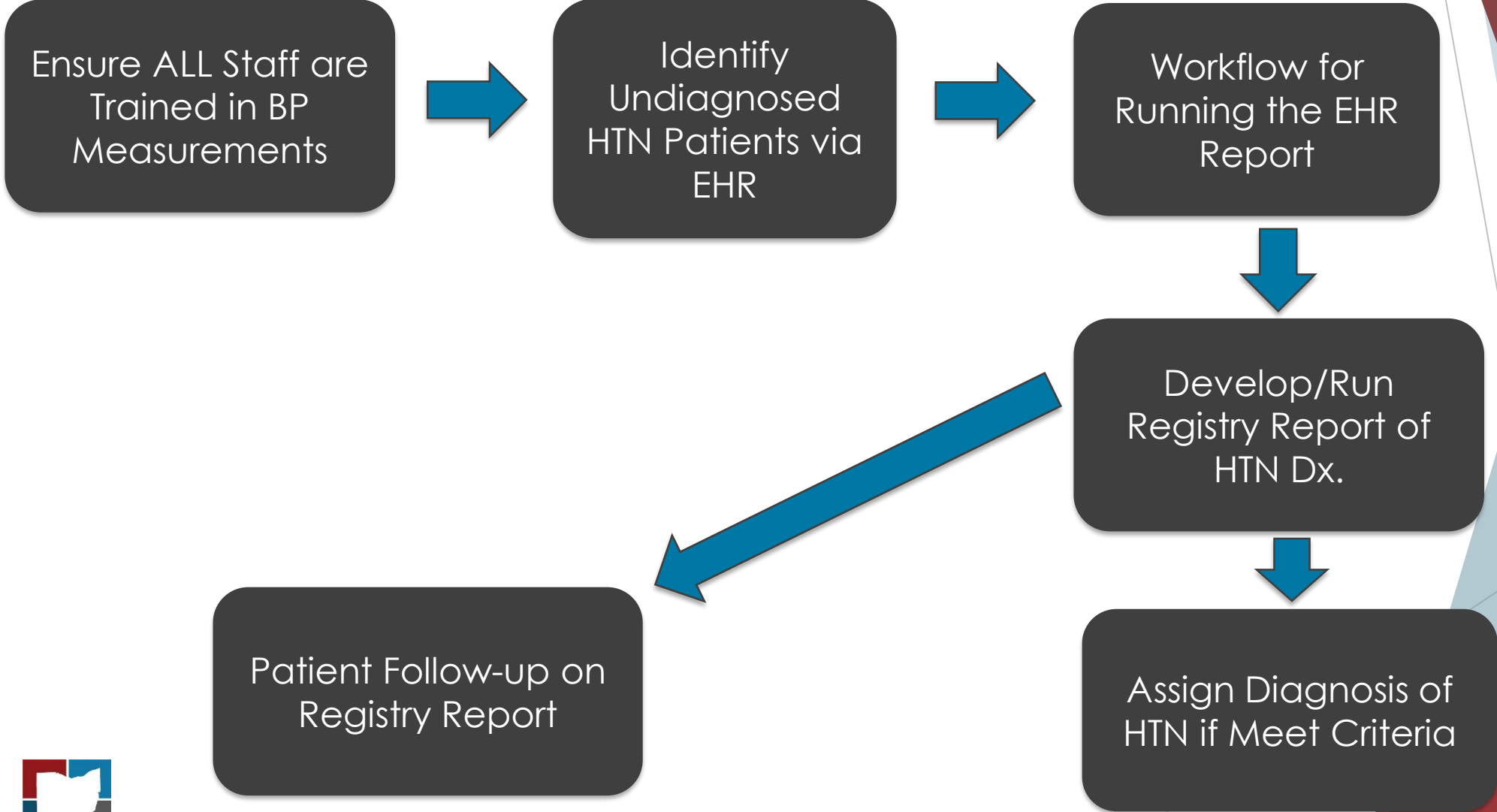
QI Project - Pathways

2. Management of Patients with Diabetes



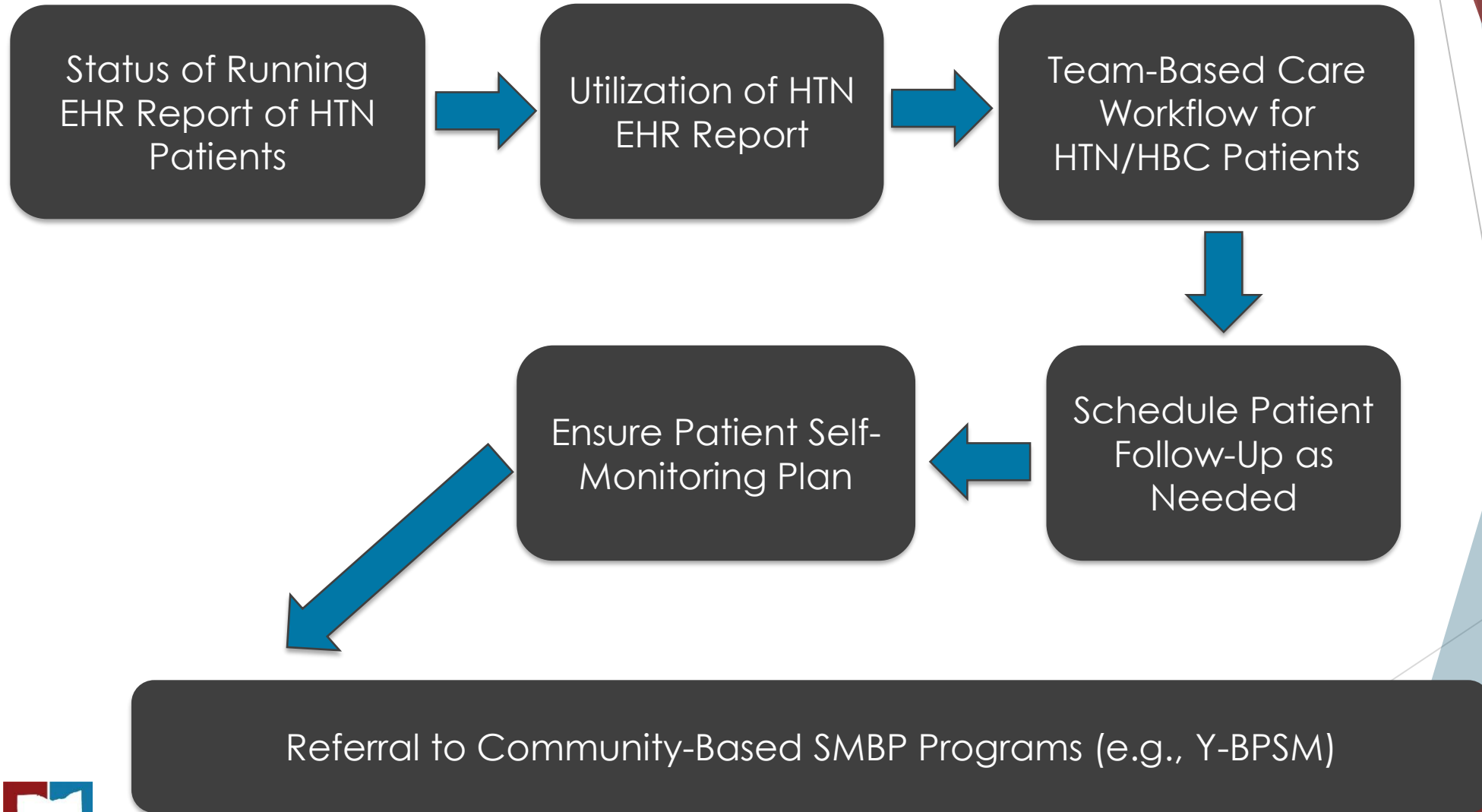
QI Project - Pathways

3. Identifying Undiagnosed Hypertension



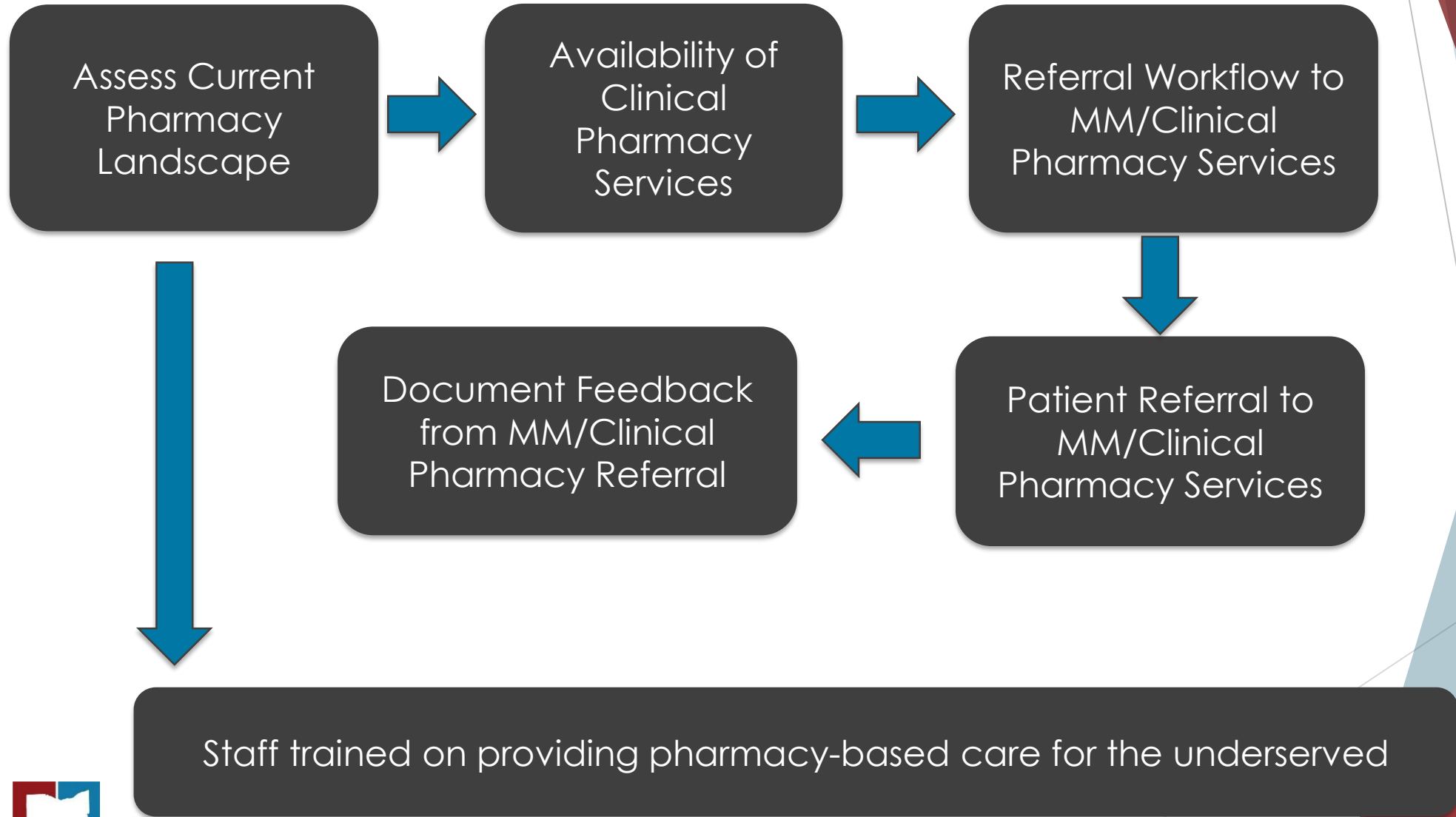
QI Project - Pathways

4. Management of Patients with HTN/High Blood Cholesterol



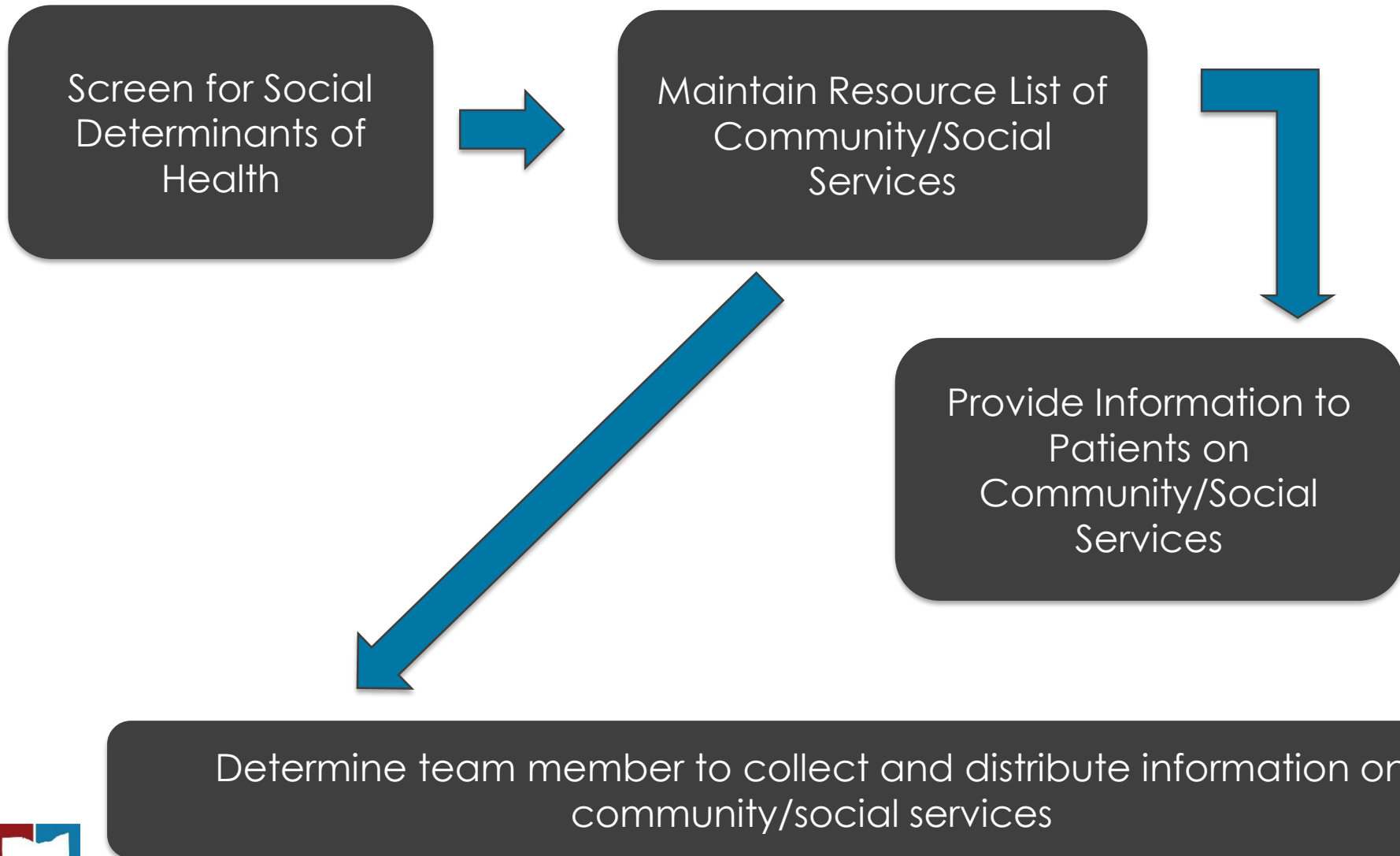
QI Project - Pathways

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

The screenshot shows the OACHC website with the following content:

- OACHC** Ohio Association of Community Health Centers
- Navigation: ABOUT, MEMBERSHIP, PUBLIC POLICY, CAREERS, OPERATIONS, RESOURCES, EVENTS
- Clinical Resources**
- Share icons: Facebook, Twitter, LinkedIn, Print
- PCMH Resources**
 - The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.
 - Ohio Learning Community
 - Grand Rounds
 - Medical Home
 - Quality Improvement
 - Patient Centered Primary Care Collaborative
 - NCQA
 - Ohio's PCPC
- FTCA Resources**
 - FTCA Deeming Application [Evaluation Self Checklist](#) for the CY 2016 Health Center FTCA Application
- EHR & Meaningful Use Resources**
 - Electronic health records can provide many benefits for providers and their patients, but the benefits depend on how they're used. Meaningful use is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria. For details about the incentive programs, visit the [CMS website](#). The goal of meaningful use is to promote the spread of electronic health records to improve health care in the United States.
- Ohio's Diabetes and Hypertension Quality Improvement Project**
 - This project will use quality improvement strategies to improve the health of Ohioans through prevention and management of Diabetes and Hypertension. Access the application [here](#).



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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