Care + Community + Equity Best Practice Sharing Meeting

Type Name & Organization in the Chat

March 29th, 2023

AGENDA – March 29, 2022

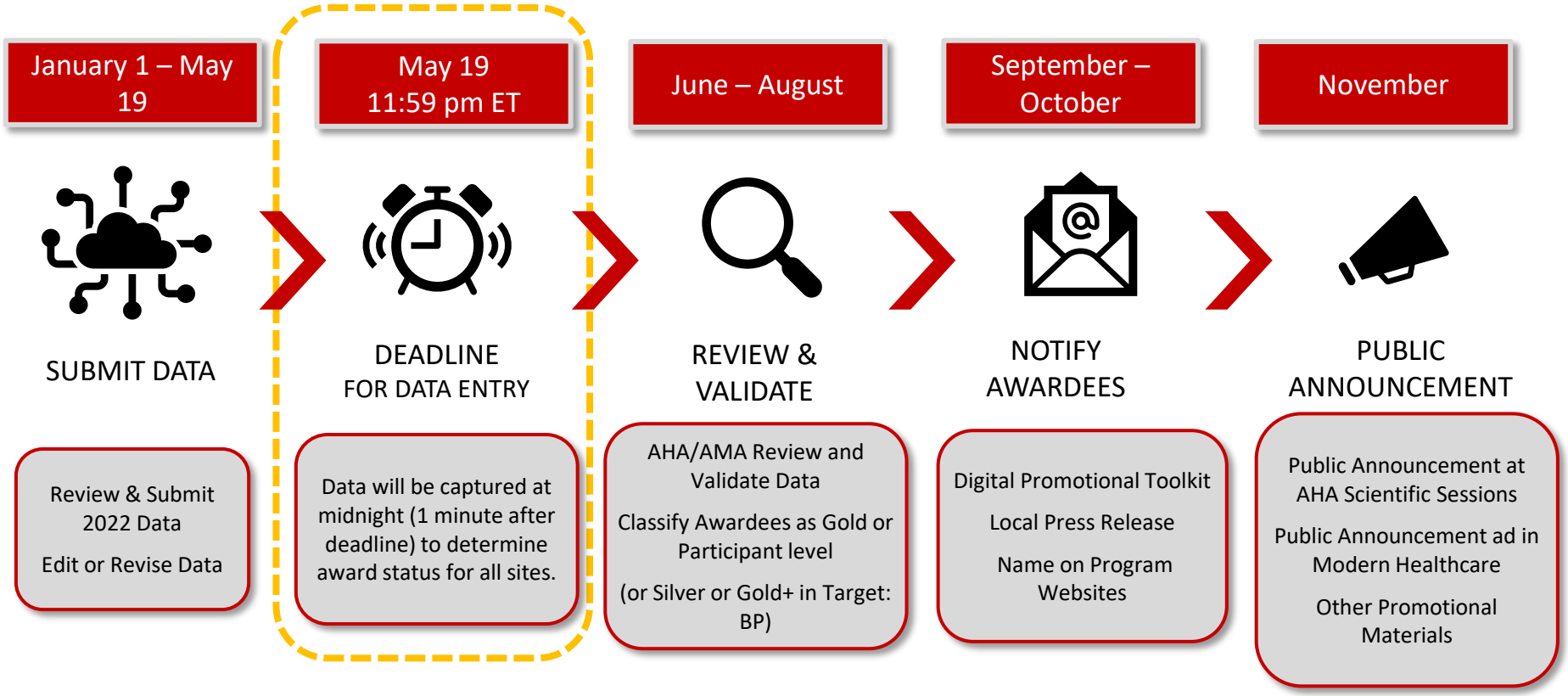
- Welcome and Introductions
- Albert Whitaker Upcoming AHA Initiatives
- QRS Stratification Updates
- Year 4 Quality Improvement Project Presentations

1. WellOne Primary Medical and Dental
2. Wood River Health Services
3. Thundermist Health Centers
4. Tri-County Community Action Program
5. Rhode Island Free Clinic
6. Comprehensive Community Action Program
7. Clinica Esperanza, Hope Clinic

- Closing thoughts and evaluation *(link in chat)*

American Heart Association
Upcoming Initiatives and Deadlines

Recognition Timeline



Important Dates

May 19 at 11:59 PM – all data must be submitted to review for recognition

April 27 5:30 -7:00 PM – Tobacco/Vaping Summit – Providence College

June 1, 2023 – Attestation to evidence-based activities for measuring blood pressure

Target BP Office Hours – April 13 at noon OR April 17 at 3:00pm

Evidence-based Activities

Target: BP

Requirements for 2023 Data Submission

Attest* to completing evidence-based BP activities

In 2022, did your organization…

1. Calibrate all regularly used BP measurement devices (including both manual and/or automated BP devices) per recommended timelines?
2. Check to see if BP measurement devices are validated for clinical accuracy (such as ValidateBP.org), and if so, what percentage?
3. Strengthen staff knowledge of accurate BP measurement every 6-12 months?
4. Test staff skills in accurate BP measurement every 6-12 months?
5. Use a BP measurement protocol to perform initial and confirmatory measurements via repeat in-office, SMBP, or 24-hr ambulatory blood monitoring (ABPM)?
6. Post a visual reminder of proper patient positioning next to every BP device?

Thank you!

Albert Whitaker
Community Impact Director
albert.whitaker@heart.org

WellOne PDSA

ADVANCING INTEGRATED HEALTHCARE

Increasing the use of 90-day prescriptions for long-term medications for hypertension and cholesterol management

- Background/Goal of Project
  - 30-day prescriptions with low refill counts are more likely to lead to non-adherence to a medication regimen and are less efficient for the health center and providers. Increasing the use of 90-day prescriptions and higher refills will ensure that our patients are less likely to run out of medications and decrease workload of our clinical and pharmaceutical staff.
- **Aim:** Our overall goal is to increase the number of <90 prescriptions written for our patients by Sept. 2023 by 5%. We will have to run the necessary reports in order to determine a numeric goal.
- **Baseline Data**
  - 65% of providers issued a script for 90 days or more (5 month period – April-August 2022)
  - 1 provider was at 17% - New providers tended to provide fewer 90-day scripts
  - 24% percent of scripts for hypertensives and lipid meds had 3 or more refills
  - Number of phone calls to front desk for all meds, except controlled substances – 9791 (Jan. 1, 2021-Dec. 31, 2021). Estimate of 2 minutes/call. 326 hours, eight weeks of work.

Outline your patient engagement strategy:			
Every goal will require multiple smaller tests of change			
Describe your first (or next) test of change:	**Person responsible**	**When to be done**	**Date completed**
Increase the number of 90 day + prescriptions written for our patients.	Andrea, Patty, Kendra		

WellOne PDSA

Plan:			
List the tasks needed to set up this test of change	**Person responsible**	**When to be done**	**Date completed**
Run a report to determine baseline data (number of >90-day and <90 day rx) per site	Andrea	By 10/31	complete
Run a report to determine number of refills being written per script	Andrea	By 10/31	complete
Review and set goals	Andrea/Patty/Dierdre	By 10/31	complete
Determine providers to pilot the project	Andrea/Patty/Dierdre	By 11/15	Complete Worked with providers one on one and as a group
Review pts to see if there is a reason to not provide a longer script			Complete. Became too cumbersome. Assuming relatively similar pt populations, the percentages should be roughly the same.
Address misconceptions – some providers thought that health plans wouldn't fill 90 day scripts		complete	
Meet with providers to discuss barriers		complete	Myths: Fear that insurance wouldn't cover, Some pharmacies won't fill. Worry that pts won't follow up and something will be missed
Review at clinical meeting		complete	One of the providers with a high rate of 90 scripts and high number of refills presented, and Andrea provided information on benefits from a pt perspective, including not skipping days of a med, not having to call the office or the pharmacy

WellOne PDSA

- **Measures to determine if prediction succeeds**
  - Percentage of 90 day prescriptions and percent of prescriptions for 3 or more refills
- **Do**
  - Describe what actually happened when you ran the test
  - We exceeded our goal for 90 day prescriptions and 3 or more refills.
- **Study**
  - Describe the measured results and how they compared to the predictions
  - 71% of providers wrote any scripts for 90 or more days (baseline 65%) for hypertensives and lipid meds
  - 31% of prescriptions for hypertensives and lipid meds had 3 or more refills (baseline 24%)
- **Act**
  - Describe what modifications to the plan will be made for the next cycle from what you learned

WellOne PDSA

ADVANCING INTEGRATED HEALTHCARE

New Test of Change			
Describe your next test of change:	**Person responsible**	**When to be done**	**Where to be done**
Run the data to see if providers have improved	Andrea	End of January/ beginning of Feb.	
Provide education to new provider and to those with lower rates of 90 day prescriptions			
Review those providers who are doing well and schedule another clinical meeting.			

Wood River Health Diabetes Incentive

Aim Statement: To improve the diagnosis of patients at risk for diabetes by using evidence-based criteria to increase the percentage of patients diagnosed as pre diabetic by 10% and decreasing the patients uncontrolled by 5% by September 29, 2023

Data

- Baseline data as of June 2022 uncontrolled diabetes A1C 22%
- December 2022 uncontrolled diabetes A1C 13%

- **Progress to date**
- We are working with Genoa pharmacy (on site) to review the medications for our diabetic patients with the goal of assuring patients are on the adequate medications and that they are taking them as directed.
- The Pharmacist is a CDOE and will be contacting the patient to help educate them on their medications and the diabetes control
- We are focusing on patients with A1C greater than 7.5 and less than 9
- Providers will be trained on this in April/ May
- The patient navigator will also be contacting patients that need to be seen and making appointments
- We have created a report for our pre-diabetics to assure better capture of that group of patients

Wood River Health-CVD Incentive

Aim Statement: To improve the patients with elevated cholesterol by using evidence-based criteria to increase the patients prescribed statin therapy by 10% and increase the patients with controlled hypertension by 10% by September 29, 2023

Data

- Baseline data as of June 2022: Controlled Hypertension 68.3%; Statin therapy 64.5%
- December 2022: Controlled Hypertension 69.8%; Statin Therapy 62.7%

Progress to date

- We are working with Genoa pharmacy (on site) to review the medications for our patients on Statins with the goal of assuring patients are on the adequate medications and that they are taking them as directed.
- The Pharmacist will be contacting the patient to help educate them on their medications
- Providers will be trained on this in April/ May
- The patient navigator will also be contacting patients that need to be seen and making appointments

Wood River Health- Successes and Challenges

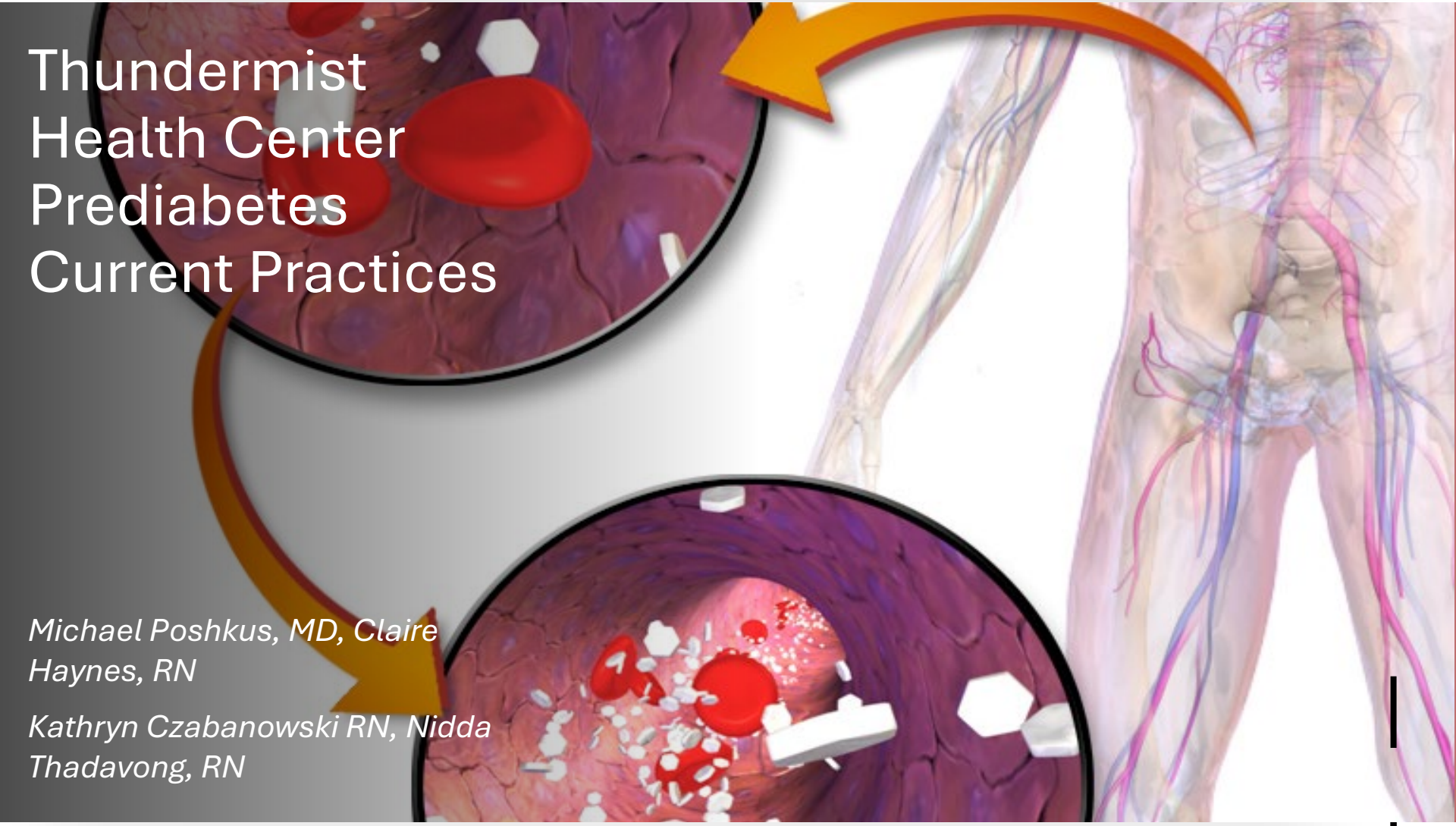
Challenges

- Medical staffing shortages
- Change in Medical Leadership: Director of Nursing left in October position is still not filled New Chief Medical Officer started in January
- With new leadership there brings a new focus on these measures which requires some change in our original PDSA
- New Patient Care Navigator started in January
- New Data Analysts

Successes

- Pre-Diabetic Report Created
- Reduction in uncontrol diabetics
- Collaboration with pharmacy

Thundermist Health Center Prediabetes Current Practices



Michael Poshkus, MD, Claire Haynes, RN

Kathryn Czabanowski RN, Nidda Thadavong, RN

Objectives

Prediabetes

Defining Criteria

Identify

Screening Criteria and Frequency

Education and Support

Activities to support patient with Prediabetes

Diabetes – defining criteria

Fasting Plasma Glucose: 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmol/L) (IFG)

OR

2-h Plasma Glucose during 75-g Oral Glucose Tolerance Test 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) (Impaired Glucose Tolerance)

OR

A1C 5.7–6.4% (39–47 mmol/mol)

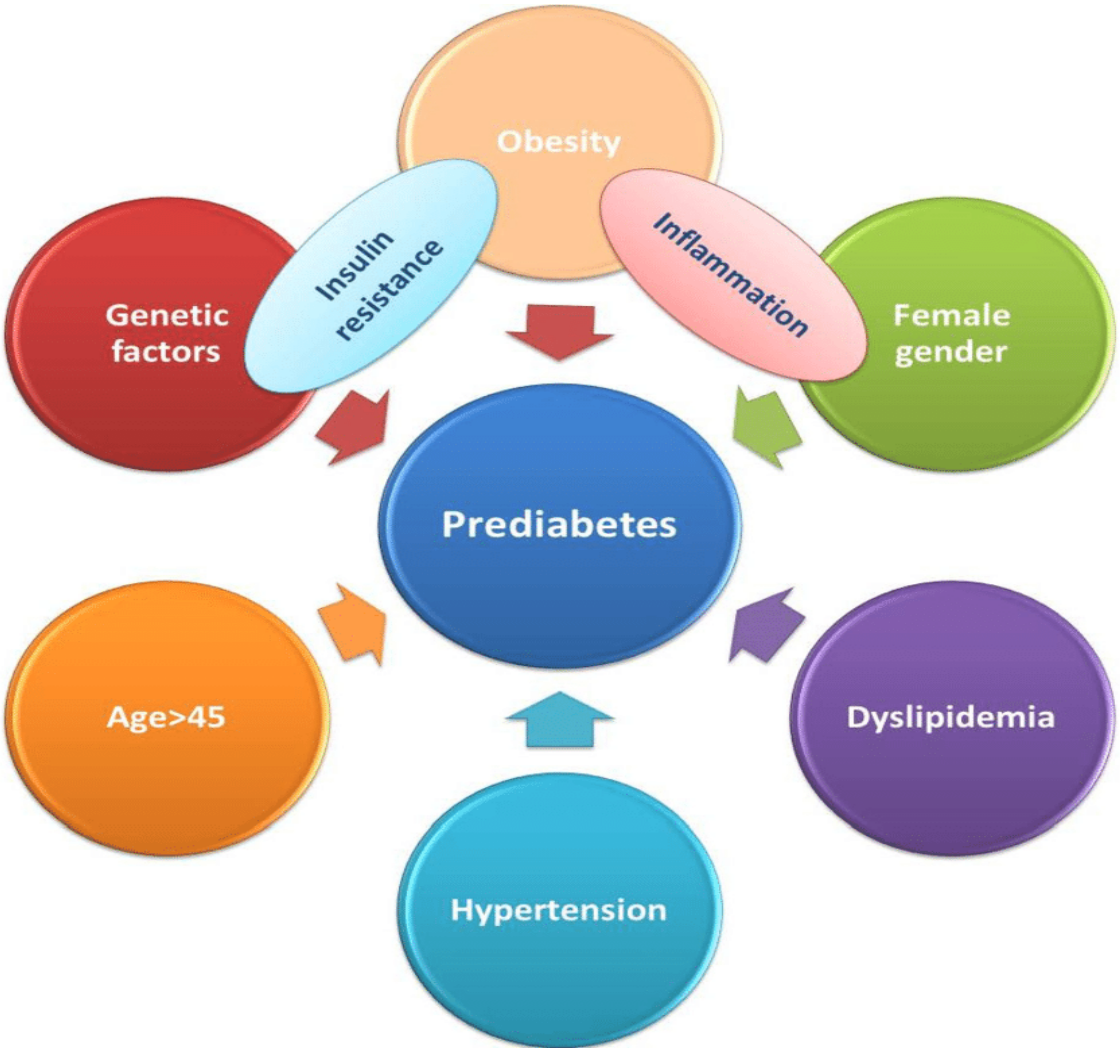
In a systematic review of 44,203 individuals from 16 cohort studies with a follow-up interval averaging 5.6 years:

A1C between 5.5% and 6.0% (between 37 and 42 mmol/mol) had a substantially increased risk of diabetes (5-year incidence from 9% to 25%).

A1C range of 6.0–6.5% (42–48 mmol/mol) had a 5-year risk of developing diabetes between 25% and 50% and a relative risk 20 times higher compared with A1C of 5.0% (31 mmol/mol)

As A1C rises the risk of diabetes rises disproportionately.!

(Diabetes Care Volume 46, Supplement 1, January 2023)


Obesity
Insulin resistance
Inflammation
Genetic factors
Female gender
Prediabetes
Age>45
Dyslipidemia
Hypertension

Criteria for screening for diabetes or prediabetes in asymptomatic adults

Testing should be considered in adults with overweight or obesity (BMI ≥25 kg/m^2 or ≥23 kg/m^2 in Asian American individuals) who have one or more of the following risk factors:
First-degree relative with diabetes
High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander
History of CVD
Hypertension (≥130/80 mmHg or on therapy for hypertension)
HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
Physical inactivity
Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans, polycystic ovary syndrome)
People with HIV

(Diabetes Care Volume 46, Supplement 1, January 2023)

Screening frequency

People with prediabetes (A1C ≥5.7% [39 mmol/mol], IGT, or IFG) should be tested yearly.

People who were diagnosed with GDM should have lifelong testing at least every 3 years.

For all other people, testing should begin at age 35 years.

If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status

(Diabetes Care Volume 46, Supplement 1, January 2023)

CCE: Prediabetes Measure (5.7% ≤ A1c ≤ 6.4%)

Percentage of patients 18+ that do not have DM on their PL who had their HbA1c tested and whose results fell between 5.7% and 6.4% indicating prediabetes

Rationale: Internal measure criteria decided by medical directors and the Chief Medical Officer

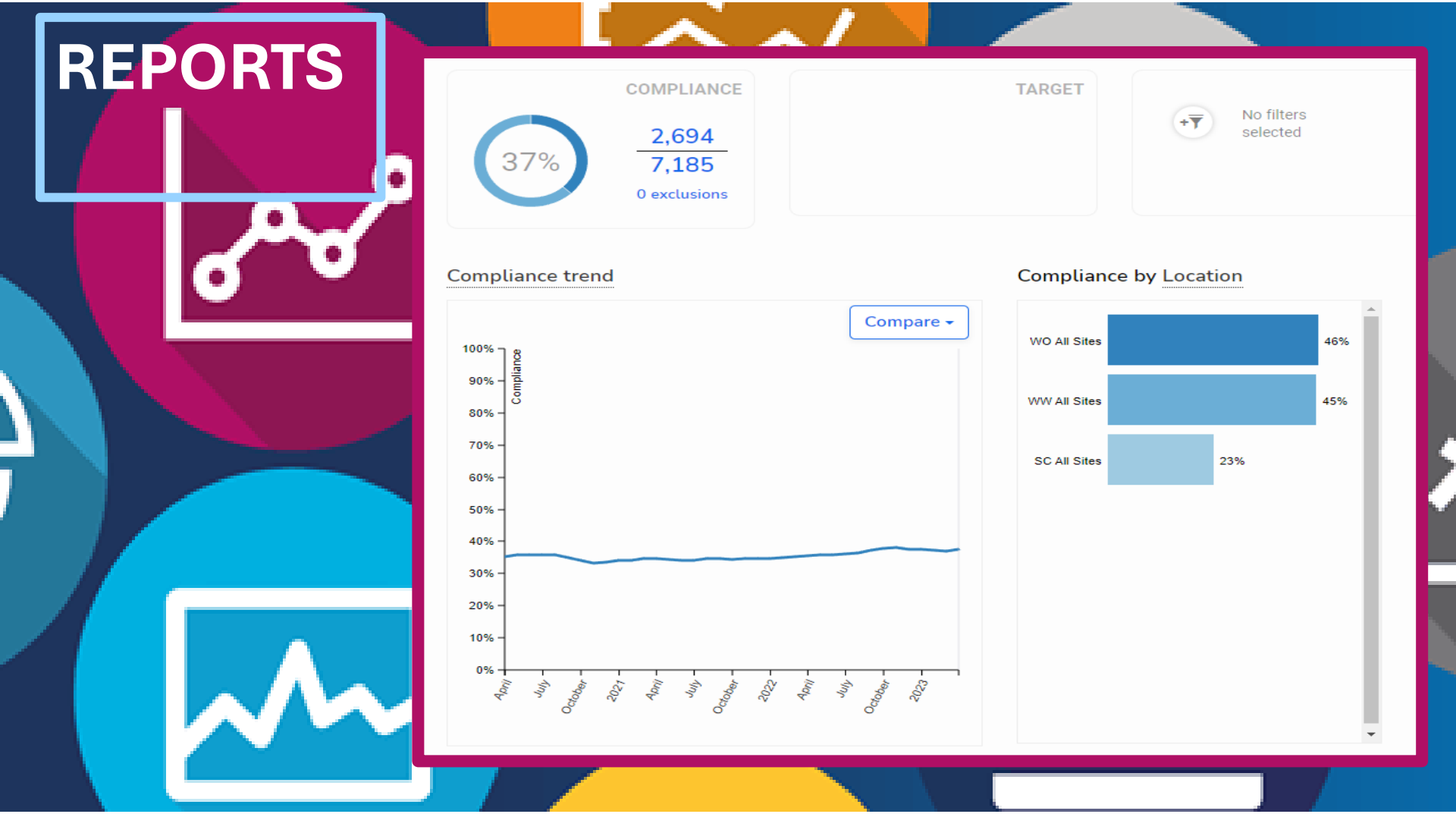
Denominator: Patients 18+ who had an HbA1c test completed in the measurement period and do not have DM on their Problem List

Numerator: Patients from the denominator whose most recent HbA1c in the measurement period was between 5.7% and 6.4% indicating prediabetes

Exclusions: None

Measure type: Outcome

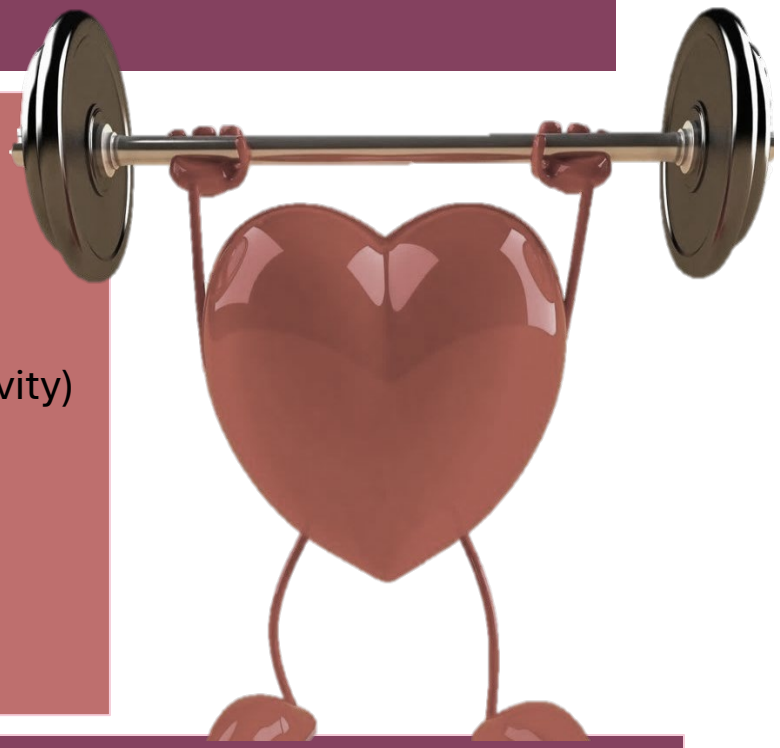
REPORTS


COMPLIANCE
37%
2,694
7,185
0 exclusions
TARGET
No filters selected
Compliance trend
Compare
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Compliance
April
July
October
2021
April
July
October
2022
April
July
October
2023
Compliance by Location
WO All Sites
46%
WW All Sites
45%
SC All Sites
23%

Management of Prediabetes

Primary goal is to decrease the progression of Prediabetes to Diabetes and reduce the risk of complications of Diabetes through:

- Lifestyle education (nutrition and physical activity)
- Pharmacotherapy
- Surgery
- Combination of the above

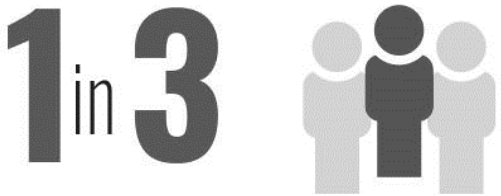


- Antihyperglycemic medications (e.g., metformin, semaglutide) can reduce future risk
  - May also provide cardiovascular benefits (prediabetes increase the risk for developing atherosclerotic cardiovascular disease (ASCVD)

Thundermist helps prevent the progression of prediabetes to diabetes by:
Provider's add Prediabetes to the Problem List
Nurses provide telephonic and onsite education. Many nurses are Certified Diabetic Outpatient Educators (CDOE)
Pharmacists work with providers and patients (medication management, lifestyle changes)
Social Determinates of Health Food Insecurities: access to nutritious foods and physical activity Financial Barriers Healthcare Access
Farmers Markets (Woonsocket open year-round, West Warwick July – October) Accept WIC, senior coupons, EBT/SNAP accepted at higher value than regular cash Healthy Foods, Healthy Families Program participants may receive $20 for regularly visiting the market
size Inclusive Health: removes bias and focus on the health and wellness of people of all sizes.
Referral to Dietician and/or Nutritionist

Identified Areas for Improvement:

Improve testing and screening rates
Offer Prediabetes Groups
Continue to identify biases and remove/reduce stigma associated with body size.
Improve collaboration with external entities offering lifestyle coaching.
Encourage more nurses to obtain Certified Diabetic Outpatient Educator certification (CDOE)



According to the RIDOH 1 in 3 Rhode Islanders has prediabetes

Tri-County PDSA

- **<u>Improving the continuity of care for patients with diabetes</u>**
- **Background/Goal of Project**
  - The percentage of patients with diabetes in poor control or who haven't had their A1c checked in >12 months continues to be high (>30%).
  - Tri-County continues to strive to ensure that patients with diabetes are followed up with on a consistent basis by either their PCPs or the CDOE team.
  - Tri-County also strives to screen for diabetes and prediabetes according to ADA guidelines and our own clinical practice guidelines.
- **Aim:** (overall goal you wish to achieve) (Specific, Measurable, Attainable, Relevant, Time-bound)
  - Tri-County Health Center aims to decrease the number of patients with diabetes in poor control from 45% of patients to 30% (or lower) and screen at least 75% of patients at risk for preDM (according to our clinical practice guidelines) by September 29,2023.

- **Baseline** data indicates that ~45% of Tri-County patients diagnosed with diabetes have and A1c >9% or have not had an A1c check in >12 months.

Tri-County PDSA

- **Outline your patient engagement strategy:**
  - The HIT team will send reports to the Patient Engagement Specialist so they may outreach to patients for diabetes follow up visits, to follow up on endocrinology referrals, etc.
  - The Referral Coordinators also follow up on endocrinology referrals.
  - The Patient Engagement Specialist will schedule patients with their PCP or the CDOE team.
  - The CDOE team and primary care providers will complete either point of care or venous A1c's, will review medication management and will make/follow up on medication changes accordingly.
  - The RN and provider team will also help to identify patients in the pre-diabetic range or with A1c's >9% and refer for PCP follow up or MNT if desired or to the CHN (prediabetes).

Tri-County PDSA

ADVANCING INTEGRATED HEALTHCARE

Describe your first (or next) test of change:	Person responsible	When to be done	Date completed
Check percentage of patients with uncontrolled diabetes or a missing A1c every quarter.	Casey and Corey/Cindy	Quarterly	Y3 Q1-Q4
Track number of patients outreached to for diabetes-related visits and associated outcomes.	Danielle and Casey	Quarterly	Y3 Q1-Q4
Track total number of patients diagnosed with prediabetes/w/ A1c's of 5.7-6.4%.	Casey and Corey/Cindy	Quarterly	Y3 Q1-Q4
Plan:			
List the tasks needed to set up this test of change	**Person responsible**	**When to be done**	**Date completed**
Reports need to be created to track metrics.	Corey	ASAP	Completed August 2022
Workflows for PES to outreach to patients with diabetes needs to be revised.	Casey	ASAP	Completed August 2022
Revised workflows/schedules need to be completed so CDOE co-visits may resume.	Casey and Amanda D,	By April 2023	
Predict what will happen when the test is carried out			
- Patients will have better glucose control. - Patients will have routine follow up appointments for diabetes management. - The percentage of patients with A1c >9% or missing A1c's will reduce from ~45% to 30% or less. - Patients at risk for prediabetes and diabetes will be identified and connected with appropriate resources.			

Tri-County PDSA

ADVANCING INTEGRATED HEALTHCARE

- **Do:**
  - Describe what actually happened when you ran the test
  - The percentage of patients with uncontrolled diabetes or with a missing A1c remains ~45% of all patients with diagnosed diabetes.
- **Study**
  - Describe the measured results and how they compared to the predictions
  - Measures are worse than prediction, but we still have 6+ months to work on this.
- **Act**
  - Describe what modifications to the plan will be made for the next cycle from what you learned
  - We will be working with Karen L. and the rest of the care team to refine practices and improve the care of patients in this population.

Describe your next test of change:	**Person responsible**	**When to be done**	**Where to be done**
Check percentage of patients with uncontrolled diabetes or a missing A1c every quarter.	Casey and Corey/Cindy	Quarterly	Y3 Q1-Q4
Track number of patients outreached to for diabetes-related visits and associated outcomes.	Danielle and Casey	Quarterly	Y3 Q1-Q4
Track total number of patients diagnosed with prediabetes/w/ A1c's of 5.7-6.4%.	Casey and Corey/Cindy	Quarterly	Y3 Q1-Q4
List the tasks needed to set up this test of change	**Person responsible**	**When to be done**	**Where to be done**
Reports tracking metrics will continue.	Corey	Ongoing	
Outreach for appointments will continue.	Casey and Daniella	Ongoing	
MNT and CDOE patient education will continue.	Casey and Kim	Ongoing	

RHODE ISLAND FREE CLINIC

PDSA Update
March 2023

25TH ANNIVERSARY
RHODE ISLAND FREE CLINIC

Presented By : Eileen Ruiz

25TH ANNIVERSARY
RHODE ISLAND **FREE CLINIC**

Eileen Ruiz

Project Lead
Health Impact Programs
eruiz@rifreeclinic.org
401-274-6347 ext 210

Forrest Daniels, MPA, DSc, FACHE

CEO

Cruz Martinez, MHA

Practice Manager

Rhode Island Free Clinic made tremendous progress over the past year in engaging providers in entering billing codes for the first time at this organization. Preliminary data on patients with a1C >9 or missing and patients with HTN > 140/90 was able to be obtained with the use of systematic EMR reporting. Since Q4 of 2022, we have added to our reporting data on pre-diabetes, patients with ASCVD who are on a statin, and are currently working to report on patients with undiagnosed HTN using our EMR.

RHODE ISLAND **FREE CLINIC**

Project Summary

Presented By : Eileen Ruiz

Goals

By September 29, 2023, RIFC will be able to report accurately on measures related to HTN, DM, Prediabetes and CVD. Our measures will include the following.

Goal 1

A1c ≥ 9 or missing
CMS 122

Goal 2

Prediabetes
A1c: 5.7-6.4
ICD10- R73.01

Goal 3

HTN control with the use of Statin
CMS 347v4

Goal 4

HTN control
CMS 165*

25TH ANNIVERSARY RHODE ISLAND FREE CLINIC

Progress Report 2022

Using eCW, the following is the data compiled from 1/1/2022 to 12/31/2022.

Goal 1: A1c ≥ 9

DENOMINATOR	NUMERATOR
242	91 - 37.60%

Goal 2: Prediabetes

DENOMINATOR	NUMERATOR
924	404 - 43.72%

Goal 3: HTN control + Statin

DENOMINATOR	NUMERATOR
53	37 - 69.81%

Goal 4: HTN control

DENOMINATOR	NUMERATOR
425	199 - 46.82%

Projects 2023

- Self Measuring Blood Pressure Program- AHA RI
- Brown Medicine Pharmacists Pilot Program
  Will offer Diabetes Management Visits for patients to be enrolled in Continuous Glucose Monitoring Program
- Diabetes Management Group Classes

American Heart Association.

BROWN MEDICINE
BROWN PHYSICIANS, INC.

RHODE ISLAND FREE CLINIC

25TH ANNIVERSARY
RHODE ISLAND FREE CLINIC

Contact us to get more info

info@rifreeclinic.org

655 Broad St Providence RI 02907

401-274-6347

www.riFreeClinic.org

CCAP

1. CVD PDSA

Aim Statement:

- Our Aim is to reach 80% for CMS 165 (Controlling Blood Pressure) and CMS 347 (Statin Therapy) by the end of CCE year 4.

Process:

- Create a flow of information from Quality Department to Care Teams.

Goal:

- Have better outcomes for our patient population by sharing data more regularly to staff on the frontlines.

CCAP

Successes:

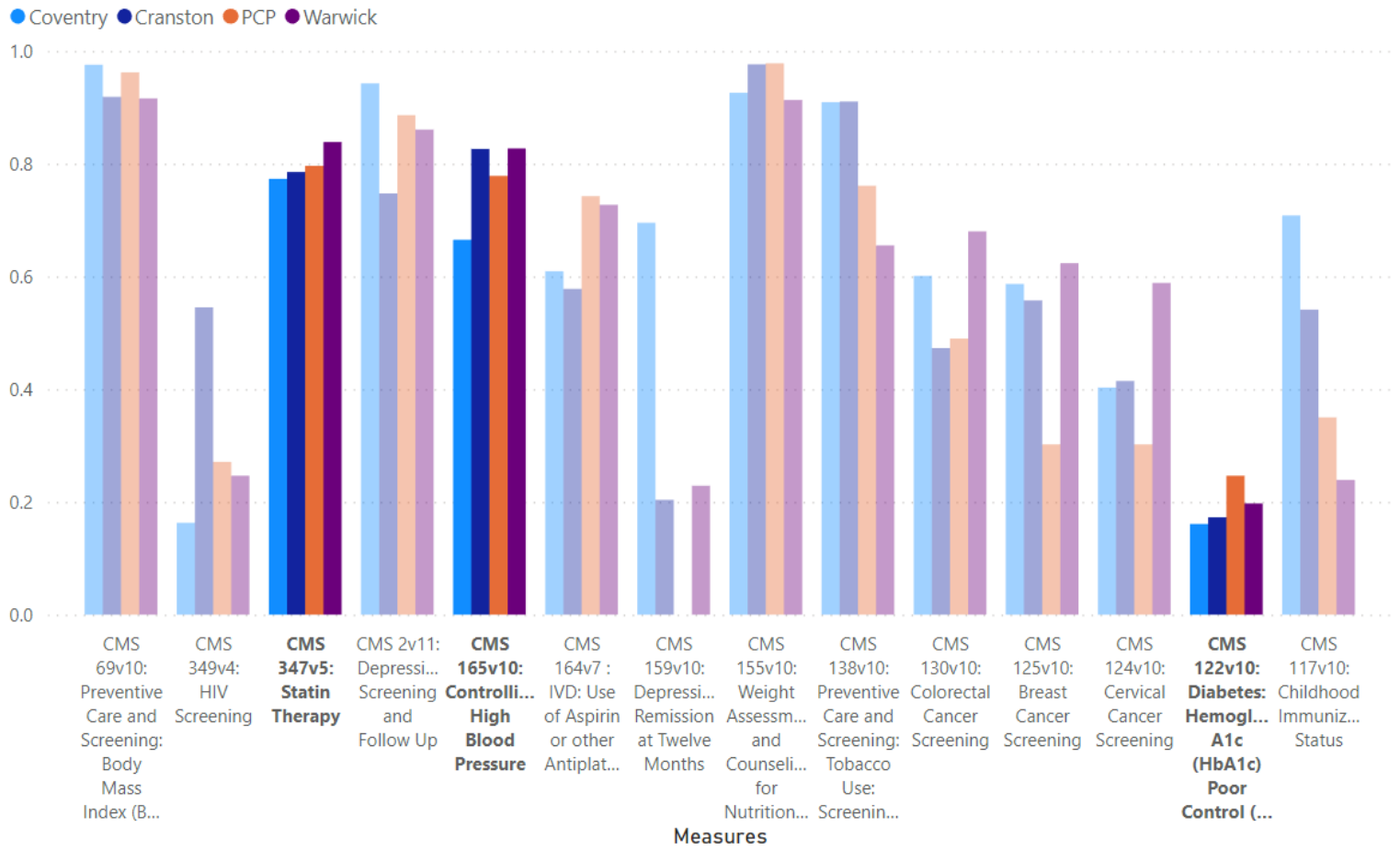
- Used Nextgen Population Health Tool to generate reports that were shared and presented at Provider Meetings.
- Providers engaged Quality Department in process improvement versus Quality Department "assigning" work. (As evidenced by Providers requesting Treatment Opportunity Lists to close gaps).

Challenges:

- Data presented from Pop. Health was still "messy" and I believe that caused less Providers to engage.

Next Steps for practice:

- Our new data analyst is doing work in a program called Power BI, which is a great data visualization tool. This will allow staff across multiple areas see the information relevant to them in clear and concise way. Providers can have Care Team level data, while Site Managers can have Site specific data. All of this can be presented relative to goals (either CCAP specific or by stakeholder).


Coventry
Cranston
PCP
Warwick
1.0
0.8
0.6
0.4
0.2
0.0
CMS 69v10: Preventive Care and Screening: Body Mass Index (B...
CMS 349v4: HIV Screening
CMS 347v5: Statin Therapy
CMS 2v11: Depressi... Screening and Follow Up
CMS 165v10: Controlli... High Blood Pressure
CMS 164v7 : IVD: Use of Aspirin or other Antiplat...
CMS 159v10: Depressi... Remission at Twelve Months
CMS 155v10: Weight Assessm... and Counseli... for Nutrition...
CMS 138v10: Preventive Care and Screening: Tobacco Use: Screenin...
CMS 130v10: Colorectal Cancer Screening
CMS 125v10: Breast Cancer Screening
CMS 124v10: Cervical Cancer Screening
CMS 122v10: Diabetes: Hemogl... A1c (HbA1c) Poor Control (...
CMS 117v10: Childhood Immuniz... Status
Measures

CCAP

	Measure Year	
	2022	2021
Patients with Hypertension Controlled	78%	75%
Hispanic or Latino/a	83%	81%
Non-Hispanic or Latino/a	76%	72%

CLINICA ESPERANZA/HOPE CLINIC

JULIA TESTA

MORGAN LEONARD

SHARON FARRAR

Self-Measured Blood Pressure Success!

SMBP at CEHC

- SMBP patients are identified by providers during visits, chart reviews, EMR reports, one-on-one visits with Navegantes
- Rosa Roman, CCHW, Navegante Coordinator works with patients before, during, and after the cuffs go out
  - Calls and texts patients to remind them about using and returning the cuffs
- When patients return, a provider goes over their results with them and determines next steps

Changes Made

- Shorter loaner periods
  - 2 weeks
  - Originally 1 month
- Fewer cuffs going out at once
  - 6-10 now
  - 10+ in previous years
- Better follow-up system

Impacts

- 100% cuff return rate
  - 2023 patients engaged: 13
  - Total patients engaged (2022-2023): 19
- Improved medication adherence
- Better understanding of how BP medications are helping specific patients

Drawbacks

- Not all patients return for their appointment with the provider
- Don't always get 2 full weeks of readings
  - But, we get enough information to get an understanding of patient's BP and the factors that influence it: mediation adherence, diet changes, etc.

Going Forward

- Continue to send out BP cuffs for 2 weeks to small groups
- Continue having Rosa work and follow up with SMBP participants
- Better communicate SMBP program with volunteer providers to get more patients involved

CLÍNICA ESPERANZA
HOPE CLINIC

Thank you!

Closing Thoughts & Evaluation

Next Meeting TBD:

June 2023

Next data submissions due:
April 15, 2023

Please leave us feedback on your overall participation in CCE and indicate your availability for the next ***meeting.*** Closing thoughts and evaluation *(link inchat)*