UTAH COUNTY
HEALTH DEPARTMENT

# 2025 PRIMARY CARE CLINIC-
# CHRONIC DISEASE QUALITY IMPROVEMENT PROJECTS APPLICATION

The Chronic Disease Prevention Program at the Utah County Health Department would like to collaborate with primary care clinics on quality improvement projects that improve outcomes for the residents of Utah County specific to diabetes, chronic kidney disease, hypertension, and social drivers of health.

## Program Goals

- Identify and improve Hypertension Control Rates (NQF 18) by using a team-based care approach.
- Identify and improve detection of prediabetes, type 2 diabetes and refer to diabetes prevention and management programs.
- Identify and improve detection of chronic kidney disease (CKD) in patients with Diabetes (NQF 59)
- Implement and improve screenings for social drivers of health and refer patients to community resources to address their needs.

## Application Instructions

- Select one (1) chronic disease quality improvement project for $2,500.
- Review our standard terms and conditions
- Email completed application form to katej@utahcounty.gov
- Applications are due **January 31st, 2025.**

## Project Expectations

- The goal of this approach is to have meaningful quality improvement projects that improve quality measures and are tailored to each clinic's individual priorities.
- Each clinic will create their own quality improvement project in the chosen area(s) using the PDSA (Plan, Do, Study, Act) process or other QI processes of their choice with support from a UCHD staff member. Ideas of activities for each project can be found here: https://docs.google.com/document/d/1LCcIr6TcAkFxWrvE5k_V3JmpXclcln1PlBxi3X7OSl0/edit?usp=sharing
- UCHD staff will create an outline of the project completion requirements and deliverables based on the agreed upon project plan.

**Eligibility and Selection Criteria**

a. All clinics that offer primary care services in Utah County are eligible to apply.
b. Priority areas include Eagle Mountain, Elberta, Goshen, Payson, Provo, Orem, Santaquin, Spanish Fork, Springville, and Utah County South.
c. Clinics can apply for a maximum of $2,500.
d. Clinics CANNOT choose practices that are already implemented in the clinic but may develop, revise, or strengthen policies and workflow processes to address barriers identified through process evaluation.
e. Once submitted, the application will only be approved after a staff member from the Utah County Health Department meets with the clinic to finalize project activities.
f. Funding CAN pay for the time spent on planning, implementing, disseminating, and evaluating projects. Funding CANNOT pay for research, equipment, incentives, or direct services such as patient care, co-pay fees, medication, or individual patient education.

**Timeline and Due Dates**

- After submitting the application meet with UCHD staff to go over the proposed projects.
    - **February 28th:** Submit baseline data for projects and start project implementation.
    - **June 30th:** Submit mid-point project data.
- Communicate regularly with assigned staff member including a minimum of a kick-off meeting, mid-point emails, and annual follow-up.
- Provide follow-up data through **February 28th, 2026**
- Submit at least one success story of how a project(s) has improved your clinic.

**CLINIC INFORMATION**

Name of Clinic:

Clinic Address:

Applicant Name:

Applicant Job Title and Role in Application Project:

Applicant Phone Number:

Applicant Email:

Names and Roles of Other Staff Who Will Be Involved (ex: Project Champion):

## Chronic Disease Quality Improvement Project

Through UCHD, the CDC will provide $2,500 for completion of one (1) chronic disease quality improvement project.

In addition to the selected quality improvement project, clinics will assess their current screening workflow process for social drivers of health (SDOH) and either implement or improve upon screening and referral processes. Social drivers of health are the conditions in which people are born, grow, work, live, and age. These are nonmedical conditions that influence health outcomes and quality of life, such as: transportation, food insecurity, housing, education, employment and working conditions, income, etc. Screening for this is important as it helps identify social needs of patients and direct them to resources. Addressing social drivers of health within a primary care setting can improve patient health. Clinics will work with UCHD staff to review their current processes for SDOH screenings and create a plan, specific to their clinic, to implement or improve screenings and refer patients to community resources.

## Hypertension

☐ **TEAM-BASED CARE**

- **Project Goal:** To improve hypertension control through new or enhanced approaches to team-based care. Team-based care is having multiple healthcare professionals working collaboratively with patients on shared goals in an effective, patient-centered, timely, efficient, and equitable way. It involves identifying who is part of your care team, who should be part of your care team, and ensuring all staff members are working to the highest level of their expertise and ability to meet the needs of your patient population.
- **Evaluation:** Hypertension control rate (NQF18) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
    - Number of non-physician team members included on care team for patients with hypertension
    - Number of patients referred to non-physician team members included on care team

    - Number of patients with hypertension that personally engaged with a non-physician team member included on care team
- **Summary of activities:** 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 social workers, pharmacists, registered dieticians, chiropractors, community health workers, RNs, and other health specialists.

☐ **UNDIAGNOSED HYPERTENSION**

- **Project Goal:** To use data to identify and diagnose current patients with undiagnosed hypertension.
- **Evaluation:** Hypertension control rate (NQF18) – overall rate and stratified by disparate (i.e., race/ethnicity, insurance status, income, zip code, age, other risk factors) and/or high burden subpopulations (Black/African American, American Indian/Native Alaskan, low income/insurance status).
    - Other indictors depending on activities chosen such as number of community outreach events held, and people reached
- **Summary of activities:** Implement algorithms or protocols to identify undiagnosed hypertension, improve measurement and documentation, and expand screenings/opportunities for patients to check blood pressures at the clinic or in the community.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing hypertension work in your clinic

## Prediabetes/Diabetes

☐ **IDENTIFY AND REFER**

- **Project Goal:** To identify patients with prediabetes and type 2 diabetes, provide education, and refer to diabetes prevention and support programs (i.e. the National Diabetes Prevention Program (NDPP), Diabetes Self- Management Education and Support (DSMES), Prediabetes 101, etc.).
- **Evaluation:**
    - Diabetes uncontrol rate (NQF59)
    - Number of patients identified in the prediabetic range
    - Number of patients referred to the diabetes prevention and support programs (i.e. National DPP, DSMES, Prediabetes 101, etc.)
- **Summary of activities:** Screen for prediabetes, implement alerts and clinical workflows to flag patients with prediabetes and diabetes. Refer those patients to diabetes prevention and support programs and other behavior change services.

☐ **CHRONIC KIDNEY DISEASE**

- **Project Goal:** To increase appropriate screening, diagnosis, and treatment of chronic kidney disease (CKD) in patients with diabetes. CKD is a global public health problem most patients are unaware they have the leads to kidney failure, cardiovascular disease, and death. Early recognition and management of CKD allows providers more opportunities to protect kidney health.
- **Evaluation:**
    - Diabetes uncontrol rate (NQF59)
    - HEDIS Measure 202: 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
- **Summary of activities:** Identify and define CKD metrics the clinic will use, educate/train staff on CKD, implement clinical processes to screen patients with diabetes, diagnosis, and treat CKD, and improve educational materials for CKD.

☐ **INDIVIDUAL QI/PDSA CYCLE PROJECT**

- Create and implement a quality improvement project to build upon existing prediabetes/diabetes work in your clinic

For the project you selected, please provide a brief description of what your clinic would like to focus on:

**Total Amount of Chosen Activities (CANNOT exceed $2,500) = $** _____

By signing below, the clinic agrees to complete the chosen activities, and submit the application to katej@utahcounty.gov by **January 31st, 2025**. To receive payment contingent upon ongoing federal government funding for this program, the clinic agrees to submit a W-9 supplier vendor form, if one is not already on file. If you have any questions or need assistance with the application process, contact Kate Jenkins.

Signature: _____

Approved by UCHD: _____

*Adopted from the Salt Lake County Healthy Living Program