Wisconsin Chronic Disease Prevention Program
Grant Funding Opportunity
**Reducing Chronic Disease Disparities through EHR/HIT and TBC Grant Application**

## Contact Information

| **Applicant Requesting Funds** | |
|---|---|
| Clinic Name: | |
| Contact Person: | |
| Address: | |
| City: | |
| State: | WI |
| ZIP: | |
| Phone: | |
| E-mail address: | |
| Web Site: | |
| Federal tax ID: | |
| DUNS # (if applicable): | |

| **Signatory/Business Official** | |
|---|---|
| Name: | |
| Address: | |
| City: | |
| State: | WI |
| ZIP: | |
| Phone: | |
| E-mail address: | |

| **Physician/Medical Provider Champion** | |
|---|---|
| Name: | |
| Address: | |
| City: | |
| State: | |
| ZIP: | |
| Phone: | |
| E-mail address: | |

## Narrative

### A. Patient Population within Your Clinic– 15 points

Describe your current patient population within your clinic by completing the following sections. This information informs the reach of your clinic and provides a better understanding of your patient population as it relates to specific hypertension (HTN), high blood cholesterol (HBC), and diabetes clinical quality measures (CQMs) as well as any needs within your community.

#### A.1. Hypertension (HTN)

**A.1.1.** Currently, do you have a system to report standardized clinical quality measures for the identification, management and treatment of patients with HTN?

☐ Yes [continue on A.1.2]

☐ No [skip to Patient Population Section A.2. High Blood Cholesterol]

**A.1.2.** What standardized clinical quality measures do you use for the identification, management and treatment of patients with HTN? Select all that apply.

☐ UDS or CMS 165 ☐ NQF 18 ☐ MIPS QPP 236 ☐ None ☐ Other, specify below.

If 'Other', please specify. Include systolic and diastolic measurement as well as CQM ID or criteria such as length of measurement period, diagnosis, number of visits, etc.

**A.1.3.**

- Number of patients in your clinic aged 18 to 85: _____
  - ↳ Of those, number of patients diagnosed with HTN: _____
    - ↳ Of those, number of patients whose last BP was <140/90: _____
- Timeframe data represents (ex: May 1, 2020 – May 1, 2021): _____

#### A.2. High Blood Cholesterol (HBC)

**A.2.1.** Currently, do you have a system to report standardized clinical quality measures for the identification, management and treatment of patients with HBC?

☐ Yes [continue on A.2.2]

☐ No [skip to Patient Population Section A.3. Diabetes]

**A.2.2.** What standardized clinical quality measures do you use for the identification, management and treatment of patients with HBC? Select all that apply.

☐ UDS or CMS 347 ☐ MIPS QPP 438 ☐ None ☐ Other, specify below.

If 'Other', please specify. Include cholesterol levels as well as CQM ID or criteria such as length of measurement period, diagnosis, number of visits, etc.

**A.2.3.**

- Number of patients in your clinic aged 21 and older: _____
  ↳ Of those, number of patients who meet one or more of the criteria that are considered at high risk for cardiovascular events, under ACC/AHA guidelines: _____
    ↳ Of those, number of patients who received at least one order (prescription) for statin therapy: _____
- Timeframe data represents (ex: May 1, 2020 – May 1, 2021): _____

## A.3. Diabetes

**A.3.1.** Currently, do you have a system to report standardized clinical quality measures for the identification, management and treatment of patients with diabetes?

☐ Yes [continue on A.3.2]

☐ No [skip to Patient Population Section A.4. Narrative]

**A.3.2.** What standardized clinical quality measures do you use for the identification, management and treatment of patients with diabetes? Select all that apply.

☐ UDS or CMS 122 ☐ NQF 59 ☐ MIPS QPP 1 ☐ None ☐ Other, specify below.
If 'Other', please specify. Include A1c level as well as CQM ID or criteria such as length of measurement period, diagnosis, number of visits, etc.

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**A.3.3.**

- Number of patients in your clinic aged 18 to 75: _____
  ↳ Of those, number of patients with diagnosed diabetes: _____
    ↳ Of those, number of patients whose most recent A1c level >9%: _____
- Timeframe data represents (ex: May 1, 2020 – May 1, 2021): _____

## A.4. Narrative

Provide a short narrative detailing any areas of need in your community related to chronic disease and health disparities. Highlight characteristics and populations where needs or gaps have been identified in your community health needs assessment or community health improvement plan. *(Limit 250 words)*

**B. Electronic Health Record/Health Information Technology (EHR/HIT) Dashboard and Report Capacity** – 20 points

The first step of the quality improvement project will be to utilize EHR/HIT to identify priority populations. Describe your clinic's EHR/HIT system(s), and your ability to analyze health record data utilizing targeted reports and dashboards. Share your current process for utilizing EHR/HIT to identify and address patient disparities (in chronic disease or another specialty). Please describe your capacity for generating reports and/or utilizing dashboards to identify your priority population(s) within the first 60 days of the grant period. Note: The capacity and plans you describe should complement your Work Plan activities in Section D. *(Limit 750 words)*

## C. Intent for Team-Based Care Innovation – 20 points

The second part of this quality improvement project will be to implement new or improved multi-disciplinary TBC approaches to reach priority populations. Select all of following multi-disciplinary TBC approaches your clinic currently has in place. Select at least one approach your clinic intends to implement or enhance to achieve maximum impact for and reach to identified priority populations.

### C.1. Current and Intended Multi-disciplinary TBC Approaches

Addressing social determinants of health (SDOH) by integrating data into an action plan to improve clinical access and patient engagement in care.

☐ Currently in place ☐ Intend to implement or enhance ☐ N/A (no current/intent to implement)

Standardized or structural integration of non-physician professionals, such as nurses, pharmacists, dietitians, social workers, patient navigators, and/or community health workers into the delivery of health services with established bi-directional feedback.

☐ Currently in place ☐ Intend to implement or enhance ☐ N/A (no current/intent to implement)

Structured or standardized pre-visit planning/anticipation and planning for upcoming patient visits including method (structured communication, dashboard in the EHR, checklist, appointment notes, etc.).

☐ Currently in place ☐ Intend to implement or enhance ☐ N/A (no current/intent to implement)

Structured communication process or regular care-team meetings for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow.

☐ Currently in place ☐ Intend to implement or enhance ☐ N/A (no current/intent to implement)

Integration and inclusion of the patient/family/caregiver as part of the team in identifying treatment goals and self-management plans.

☐ Currently in place ☐ Intend to implement or enhance ☐ N/A (no current/intent to implement)

Staff involvement in quality improvement that includes care team staff in the practice's performance evaluation and quality improvement activities.

☐ Currently in place ☐ Intend to implement or enhance ☐ N/A (no current/intent to implement)

**C.2. Narrative**

Describe how the selected multi-disciplinary TBC approach(es) you intend to implement or enhance will achieve maximum impact for and reach to identified priority populations. Note: This description should complement your Work Plan activities in Section D. (Limit 750 words)

**D. Work Plan – 20 points**

| **Activity**<br>[Ex: Build automated algorithm to identify priority populations and create 3 registries (HTN, HBC, diabetes) and a related dashboard for monitoring and continuous QI] | **Person(s) Responsible**<br>[Ex: QI Specialist, Jane Smith/Medical Provider Champion] | **How You'll Measure Progress**<br>[Ex: Process map, PDSA cycle, or Gap in HTN control rates between priority populations and overall population reduced] | **Start to End Date**<br>[Ex: 7/1/21-8/31/22] |
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## Supporting Documents *(to be submitted separately)*

**E. Budget and Justification –** 15 points

Complete the Budget and Justification form detailing anticipated program expenses.

**F. Administrator/Physician/Medical Provider Champion Letter of Support**– 10 points

This quality improvement project requires a strong leader who will gain buy-in and facilitate collaboration between the Quality Improvement Manager, IT support, and clinic team. In the Letter of Support, clinic leadership should display a commitment to engaging all members of the clinic team and the intention to navigate all necessary approvals for program implementation. *(Limit 500 words)*