**SCOPE OF WORK**

Care + Community + Equity

**Cardiovascular Disease Management and Prevention**

June 30th, 2022 – September 29th, 2023

This scope of work has been designed to:

* align with and support the current HRSA focus on data-driven prevention and treatment of cardiovascular disease by adopting CMS measures:
  + CMS 165v10: Controlling High Blood Pressure
  + CMS 347v5: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
* support the adoption and use of clinical quality measures to monitor cardiovascular disease health outcomes and reduce healthcare disparities at the clinic and/or provider- level

**Aims**

Through Care + Community + Equity (CCE), the Diabetes, Heart Disease and Stroke Program (DHDS) at the Rhode Island Department of Health (RIDOH) is seeking to improve health outcomes for people with or at risk for cardiovascular disease, and to improve their quality of care.

DHDS envisions a health care system where providers are connected to the communities they serve, and communities are connected to the providers within their neighborhood.

Within this scope of work, DHDS aims to:

* Improve blood pressure control in patients with hypertension
* Identify patients with uncontrolled hypertension (diagnosed and undiagnosed) and refer them to evidence-based lifestyle programs
* Identify patients with elevated cholesterol and refer them to evidence-based lifestyle programs
* Identify patients who are considered at high risk for cardiovascular events and have their cholesterol managed with statin therapy (CMS 347v5)
* Support the adoption and use of clinical quality measures at the clinic and/or provider-level to manage patients, monitor cardiovascular disease health outcomes, and reduce healthcare disparities
* Track improvements in blood pressure control and cholesterol management (based on implemented quality improvement (QI) activities)

**Scope of Work**

To effectively participate in this work, each practice must have the ability to:

* Generate reports from their electronic health records (EHRs) on:
  1. the percentage of patients with hypertension in control (CMS 165v10
  2. the percentage of patients who are considered at high risk for cardiovascular events and have their cholesterol managed with statin therapy (CMS 347v5)
  3. the number of patients with undiagnosed hypertension
* Develop and implement workflows that support screening and referrals to evidence-based lifestyle change programs and other treatment supports
* Track differences in blood pressure control and cholesterol management in priority populations compared to overall populations
* Track improvements in blood pressure control and cholesterol management (based on implemented QI activities)

The following deliverables outline in greater detail the responsibility of the practices.

Year 4 of CCE is designed to lead to improvements in cardiovascular disease management and prevention. The deliverables listed below are categorized as either “core” or “incentive.” Core deliverables will comprise up to 80% of the funding available to a practice or agency.

*Core Deliverables for Year 4 of Care+Community+Equity*

1. Meet with your CTC-RI practice facilitator quarterly or more, based on meeting performance and scope of work requirements to review progress, address barriers, and obtain support for cardiovascular disease management and prevention activities. Attendance of the Tobacco Cessation Champion is encouraged.
2. Identify members of the CCE project team, which should include clinical staff and, if applicable, a CHW, who will be involved in the QI project/PDSA.
3. Submit the following data quarterly by the 15th of October, January, April, and July to the CCE Portal (link and measure specifications to be provided). The final data submission will be due September 29, 2023 (data through September 15, 2023). 
   * **Adult Patient Panel**: Number of adult patients who are active (seen by a primary care provider for at least one medical visit) in the practice in the last 12 months
   * **Hypertension in Control (**CMS 165v10): Percent of patients whose blood pressure was adequately controlled during the measurement period (<140/90mmHg)
   * **Elevated Blood Pressure without Hypertension Diagnosis**: Number of patients who do not have a diagnosis of hypertension with two or more blood pressure readings > 140 mmHg SBP and/or >90 mmHg DBP, including the most recent visit, during the past 12 months.
   * **Statin Therapy for the Prevention and Treatment of CVD (**CMS 347v5): Percentage of patients considered at risk of cardiovascular events who were prescribed or were on a statin therapy during the measurement period
4. Revisit your Year 3 measures stratifications for CMS 165v9 and CMS 347v4. Propose ways in which disparities can be addressed, either independently or as part of your Year 4 CCE QI projects/PDSAs.

Example – Uncontrolled hypertension is higher in Hispanic females across our practices, compared to other demographics. To address this disparity, we will redesign our workflows to ensure Hispanic females with uncontrol hypertension (undiagnosed or diagnosed) meet with an on-site CDOE, CHW, etc. Measure stratifications for HTN Control will be pulled again in Year 4 (December 2022 and March 2023) to evaluate changes in HTN Control rates from the baseline pulled in Year 3.

1. Attend and participate at quarterly CCE best practice sharing meetings (dates TBD in September 2022, December 2022, March 2023, June 2023, and September 2023). Please come prepared to discuss best practices and progress on PDSAs, which will be incorporated into each meeting. Invite members of the care teams to participate in these meetings.
2. Meet with your CTC practice facilitator to draft and finalize your Year 4 QI projects/PDSA and aim statements. Your PDSA and aim statements must address improving outcomes for patients with uncontrolled hypertension (diagnosed and undiagnosed) **and** cholesterol. We strongly suggest using the PDSA template that will be provided by your practice facilitator.

While the completed QI project/PDSA will be submitted in June 2023, reporting on its components will take place throughout the year.

* During July and August, develop a timeline and due dates for each component of the QI project/PDSA
* Submit the Plan section of the PDSA and the aim statement(s) to RIDOH in September. Plans will be shared during the September best practice sharing meeting
* Summarize and present your test of change during the December and March best practice sharing meetings
* Present a final report during the June best practice sharing meeting

1. Complete a final evaluation survey, due September 29, 2023.

If deliverables cannot be completed by the due dates referenced in the CCE Year 4 Project Plan, practices must notify RIDOH’s Quality Improvement Consultant (Jayne Daylor) via email, preferably in advance. A plan of corrective action may need to be completed and submitted.

*Incentive Deliverables for Year 4 of Care+Community+Equity*

Incentive payments will be distributed annually if *three* of the following deliverables are met (up to 20% of funds allocated within each CCE scope of work). Incentive payments will be prorated for 1–3 deliverables achieved and will be dispersed as a lump sum at the end of the contract year.

By end of the Year 4 contract:

1. Complete a practice-designed incentive

With members of your care team, craft a project with target(s) consistent with the goals of this scope of work. Establish benchmarks to demonstrate achievement of the target by June 29th, 2023. Review and discuss with your practice facilitator and submit to RIDOH for approval by September 15th, 2022.

Options:

1. Craft a target that aligns with your PDSA; establish and monitor progress so that achievement of the agreed-upon target could be demonstrated by June 2023.
2. Participate in the Rhode to Equity initiative (July 1,2022 to June 30, 2023) to address hypertension and/or hyperlipidemia.
3. Participate in CTC’s Pharmacy Quality Improvement Initiative for ambulatory measurement of blood pressure, which is scheduled to begin in June 2022 or September 2022.
4. Utilize shared decision-making resources to help health care providers engage in shared decision-making conversations with patients about treating and preventing atherosclerotic cardiovascular disease (ASCVD)  [National Forum | Heart Disease & Stroke Prevention](https://www.nationalforum.org/)
5. Demonstrate that the percentage of patients with HTN in Control is at or above the goal of 65%. The target must be met and sustained each quarter.
6. Demonstrate that the percentage of patients considered at risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period is at or above the goal of 70%.
7. Participate in the American Heart Association’s Quality Improvement Initiatives

Apply and earn Participant, Silver or Gold Status recognition for AHA’s Target:BP® initiative

*and/or*

Apply and earn Participant or Gold Achievement recognition for AHA’s Check. Change. Control. *Cholesterol™* initiative

1. Identify members of your care team who refer patients to evidence-based programs within the CHN. Meet at least once with the CHN Manager in July, August, or September to develop or adapt existing workflows that support CHN referrals. Submit the finalized workflow to your practice facilitator in October or November. Strategies to support workflows for CHN referrals may include the following:
2. Identify and group patients based on defined criteria (i.e., clinical criteria for prediabetes) and submit a bulk referral to the CHN
3. Create an "always" event, standing order, or an EHR flag to support automatic referrals to the CHN
4. Implement the use of a fillable PDF CHN referral form that may be embedded into the EHR, mimicking referrals made to specialists or outside services
5. Implement the RIghtMoves Provider Toolkit for physical activity counseling and utilize its resources to generate CHN referrals
6. Incorporate CHN referrals into existing PDSA(s) or create and test a tailored 6-month PDSA for CHN referrals.
7. Refer patients to evidence-based programs within the Community Health Network throughout the contract year. Practices will receive the incentive if all three steps are achieved:

Step 1: Refer at least 25 patients by October 15th, 2022

Step 2: Refer an additional 25 patients by February 15th, 2023

Step 3: Refer an additional 25 patients by June 29th, 2023

1. Invite members of the clinical care team to a CCE Best Practice Sharing meeting scheduled for September, December, or March and present a practice or patient story that demonstrates successes and/or challenges in addressing cardiovascular disease (hypertension and/or hyperlipidemia).

The following deliverables outline in greater detail the responsibility of RIDHDS.

RIDHDS will:

* Provide practice facilitation and EHR technical assistance through existing contracts with CTC-RI and AHP
* In collaboration with the Rhode Island Health Center Association, provide training and technical assistance opportunities to FQHCs and free clinics serving vulnerable populations
* Provide technical assistance on RIDOH’s Community Health Network (CHN)
* Assist with evaluation of process measures and other analytical/data support (i.e., analyzing de-identified data, pre-post evaluations, etc.)
* Report quarterly on the number of CHN referrals made by each site
* Facilitate and strengthen connections between each health center and RIDOH programs (i.e., HEZs, CHN, DPP, WISEWOMAN)
* Distribute funds
* Alert practices to new resources and continuing education opportunities through regular programmatic updates