



# Quality Improvement Initiative Sample PDSA Health Equity Interventions CATEGORY 3 - MEASURES 3.1, 3.2 AND 3.3

**PCH and Champion:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Target Measure:** Promoting health equity across one or more selected Category 3 measures

**Team Members:** Interdisciplinary team of clinical and LINK members partnering together within a Partnership for Community Health (PCH); some measures are catered to physician offices as well

## Plan/Goal Setting: Describe the Problem to be Solved

<p><b>State the problem.</b> ex., who, what, when, where, and how long</p>	<p>PCH efforts do not have a foundation to support health equity. An infrastructure needs to be developed to advance health equity standards and best practices in the populations we serve.</p>
<p><b>Category 3: Chronic Disease Self-Management</b></p>	<p>Measures 3.1, 3.2, and 3.3</p>
<p><b>What exactly will be done?</b> e.g., initial intervention(s), expected outcome for each intervention, goal(s), and expected overall outcome goal rate in a percentage format</p>	<p><b>What will be done:</b></p> <ol style="list-style-type: none"> <li>1. Clinical facilities in the PCH will identify a health equity champion and form a team to review the following document to select <u>at least one</u> specific health equity intervention to work on in the below Category 3 measures.</li> <li>2. Depending on which health equity intervention facilities select, they will either work on promoting health literacy OR developing a partnership with a LINK in their PCH or existing network to address the social determinant of health (i.e., food insecurity or transportation) noted in the action step.</li> <li>3. Implementation topics and updates should be tracked on a monthly basis concerning progress on achieving action steps and overall improvement in the key health equity indicators for that PCH measure.</li> </ol> <p><b>Expected outcome:</b> The key to this project is to promote a community and clinical engagement model that supports health equity partnership and addresses the social determinants of health (SDOH) across Category 3 measures. This work ensures that beneficiaries with the greatest need have access to services to align with the CMS, HHS and White House priorities on reducing health disparities.</p>

**Measure 3.1: Increase percentage of adequately controlled (<140/90 mmHg) blood pressure in Medicare beneficiaries with a hypertension diagnosis by 15%**

DO: Intervention/Improvements:		STUDY Results		Act
Action Step	Start Date/ End Date	Person Responsible	Analysis of Results	Outcome and Decisions
<p><b><u>OPTION #1: SDOH INTERVENTION ON FOOD INSECURITY</u></b></p> <p>Health equity champion and leadership will 1) identify and meet with community leaders who promote food security for patients to better understand the needs of the community they serve, and 2) identify what healthy food resources are available for pick up or for home delivery to patients in need.</p> <p><i>Example LINKS/community organizations include food banks, food pantries, and local food programs. Here's a list of state-based anti-hunger organizations:</i>  <a href="https://frac.org/about/1303-2">https://frac.org/about/1303-2</a></p>		Health equity champion, DON, ADON Administrator, or physician office leader/ staff and food security LINK/ community organizations	Team will work with the community entities to compile a list of low-cost or no-cost healthy food delivery services and/or food banks for use when a patient has a food insecurity issue. The groceries will be balanced as part of the healthy eating plan, a.k.a. the DASH (Dietary Approaches to Stop Hypertension) diet, known to be high in important nutrients and low in sodium.	<p>Outcome:</p> <p>Discharge planners have an updated resource/referral list to adequately address food insecurity challenges for patients post-discharge.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>
<p><b><u>OPTION #2: SDOH INTERVENTION ON HEALTH LITERACY</u></b></p> <p>Address gaps by providing resources on chronic disease management and medical nutrition therapy (MNT).</p> <p><i>Below are good resources to share:</i>  <a href="#">Take a Closer Look at Cholesterol in Your Lipid Profile</a>  <a href="#">What You Need to Know About Meeting with a Registered Dietitian Nutritionist</a>  <a href="#">Healthy Eating Tips to Fight Chronic Disease</a></p>		Health equity champion and team	<p>Resources shared and discussed in a staff meeting and adapted into patient discharge process.</p> <p>Provided resources in multiple languages when possible (Spanish resources available on AHS website).</p> <p>Use of language interpretation services</p>	<p>Outcome:</p> <p>Resources are adopted and rolled out to all discharge planners for full use.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>

<p><b><u>OPTION #3: SDOH INTERVENTION ON TRANSPORTATION</u></b></p> <p>Health equity champion and leadership will identify and meet with community leaders who offer resources to increase support for transportation to clinics and pharmacies, especially in rural or isolated settings.</p> <p><i>Example LINKS/community organizations include State Area Medicaid Reps, non-emergency medical transport, United Way 211, churches with vans, etc.</i></p>		<p>Health equity champion and team and transportation LINKS/ community organizations</p>	<p>Team will work with the community entities to compile a list of low-cost or no-cost transportation/ van services for use when a patient has a transportation issue.</p>	<p>Outcome:</p> <p>Discharge planners have an updated resource/referral list to adequately address patient transportation challenges post-discharge.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>
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**Measure 3.2: Increase percentage of outpatient Medicare beneficiaries who experienced a Medicare coverable cardiac event/diagnosis and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were enrolled in a CR program, by 15%**

DO: Intervention/Improvements:		STUDY Results		Act
Action Step	Start Date/End Date	Person Responsible	Analysis of Results	Outcome and Decisions
<p><b><u>OPTION #1: SDOH INTERVENTION ON HEALTH LITERACY</u></b></p> <p>Address gaps by providing resources to effectively express the purpose and process of early outpatient cardiac rehabilitation/secondary prevention (CR) programs at the health literacy level of Medicare patients.</p> <p><i>Below are good resources to share:</i>  <a href="#">Clinical Guide for Addressing Patient Barriers to Cardiac Rehab Services &amp; Coding for Social Determinants of Health (SDoH Z Codes)</a>  <a href="#">Do It For You! Do It For Your Heart! Say Yes to Cardiac Rehabilitation (Cardiac Rehab) Flyer</a>  <a href="#">AHS Cardiac Rehab Guide</a>  <a href="#">Connect Patients to Cardiac Rehab or ICR</a></p>		<p>Health equity champion and team</p>	<p>Resources shared and discussed in a staff meeting and adapted into patient discharge process.</p> <p>Provided resources in multiple languages when possible (Spanish resources available on AHS website).</p> <p>Use of language interpretation services</p>	<p>Outcome:</p> <p>Resources are adopted and rolled out to all discharge planners for full use.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>

<p><b><u>OPTION #2: SDOH INTERVENTION ON TRANSPORTATION</u></b></p> <p>Health equity champion and leadership will identify and meet with community leaders who offer resources to increase support for transportation to cardiac rehab, especially in rural or isolated settings.</p> <p><i>Example LINKS/community organizations include State Area Medicaid Reps, non-emergency medical transport, United Way 211, churches with vans, etc.</i></p>		<p>Health equity champion and team and transportation LINKS/ community organizations</p>	<p>Team will work with the community entities to compile a list of low-cost or no-cost transportation/ van services for use when a patient has a transportation issue.</p> <p>Discussed this resource with the team on transportation barriers to cardiac rehab: <a href="#">What's Holding You Back from Going to Cardiac Rehab?</a></p>	<p>Outcome:</p> <p>Discharge planners have an updated resource/referral list to adequately address patient transportation challenges post-discharge.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>
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**Measure 3.3: Decrease percentage of Medicare beneficiaries with diabetes who had hemoglobin A1c > 9.0%, by 9%**

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Action Step	Start Date/ End Date	Person Responsible	Analysis of Results	Outcome and Decisions
<p><b><u>OPTION #1: SDOH INTERVENTION ON FOOD INSECURITY</u></b></p> <p>Health equity champion and leadership will 1) identify and meet with community leaders who promote food security for patients to better understand the needs of the community they serve, and 2) identify what healthy food resources are available for pick up or for home delivery to patients in need.</p> <p><i>Example LINKS/community organizations include food banks, food pantries, and local food programs. Here's a list of state-based anti-hunger organizations: <a href="https://frac.org/about/1303-2">https://frac.org/about/1303-2</a></i></p>		<p>Health equity champion, DON, ADON Administrator, or physician office leader/ staff and food security LINK/ community organizations</p>	<p>Team will work with the community entities to compile a list of low-cost or no-cost healthy food delivery services for use when a patient has a food insecurity issue. The groceries will be balanced as part of the healthy eating plan, a.k.a. the DASH (Dietary Approaches to Stop Hypertension) diet, known to be high in important nutrients and low in sodium.</p>	<p>Outcome:</p> <p>Discharge planners have an updated resource/ referral list to adequately address food insecurity challenges for patients post-discharge.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>

<p><b><u>OPTION #2: SDOH INTERVENTION ON HEALTH LITERACY</u></b></p> <p>Address gaps by providing resources on chronic disease management MNT.</p> <p><i>Below are good resources to share:</i>  <a href="#">Diabetes Self-Management Training (DSMT) Provided by Diabetes Care and Education Specialist (CDCES)</a>  <a href="#">Initiate Timely Referrals to Registered Dietitian Nutritionists (RDNs) To Slow the Progression of CKD and Diabetes</a>  <a href="#">Take a Closer Look at Cholesterol in Your Lipid Profile</a>  <a href="#">Everything You Need to Know About Meeting with a Registered Dietitian Nutritionist</a>  <a href="#">Healthy Eating Tips to Fight Chronic Disease</a></p>		<p>Health equity champion and team</p>	<p>Resources shared and discussed in a staff meeting and adapted into patient discharge process.</p> <p>Provided resources in multiple languages when possible (Spanish resources available on AHS website).</p> <p>Use of language interpretation services</p>	<p>Outcome:</p> <p>Resources are adopted and rolled out to all discharge planners for full use.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>
<p><b><u>OPTION #3: SDOH INTERVENTION ON TRANSPORTATION</u></b></p> <p>Health equity champion and leadership will identify and meet with community leaders who offer resources to increase support for transportation to clinics and pharmacies for diabetes check-ups, especially in rural or isolated settings.</p> <p><i>Example LINKS/community organizations include State Area Medicaid Reps, non-emergency medical transport, United Way 211, churches with vans, etc.</i></p>		<p>Health equity champion and team and transportation LINKS/ community organizations.</p>	<p>Team will work with the community entities to compile a list of low-cost or no-cost transportation/ van services for use when a patient has a transportation issue.</p>	<p>Outcome:</p> <p>Discharge planners have an updated resource/referral list to adequately address patient transportation challenges post-discharge.</p> <p><input type="checkbox"/> Adopt  <input type="checkbox"/> Adapt  <input type="checkbox"/> Abandon  <input type="checkbox"/> N/A</p>

**Communication/Notes:**