Workflow Modifications: Actions Your Practice Can Take to Improve Cholesterol Management

Providers and practices who are actively engaged in the Delaware Division of Public Health Quality Improvement in Hypertension and Uncontrolled Diabetes Project have the benefit of scheduling a no-cost workflow assessment (WFA) with a local Quality Insights Practice Transformation Specialists (PTS). WFAs are completed **annually** and designed to initiate a future state of processes that will move the needle on clinical quality improvement activities.

The following list includes solutions aimed at achieving better patient outcomes in cooperation with the WFA. **We encourage you to partner with your Quality Insights PTS to discuss scheduling a WFA and implementing at least ONE of the recommendations listed below.**

Electronic Health Record (EHR) Actions

	Obtain an inventory of patients with low-density lipoprotein cholesterol (LDL-C) greater than 100 mg/dL to track over time.
	If EHR is capable, execute NQF reports at race and ethnicity levels. Partner with Quality Insights to conduct a pilot to report these quality measures.
	Activate a clinical decision support (CDS) reminder for LDL >100 mg/dL.
	Activate CDS reminders for patients with high cholesterol for referral to lifestyle change program such as Weight Watchers, TOPS, and University of Delaware Cooperative Extension.
	Report cholesterol/statin measure (CMS 347/MIPS 438) annually and quarterly.
	Review and implement the PRAPARE tool or other social determinants of health (SDOH) EHR templates.
	Evaluate EHR capabilities related to use of ICD-10-CM ("Z Codes") use. If already utilizing Z Codes, document use and report utilization.
	Partner with Quality Insights to mitigate barriers related to social determinants of health identification tools and ICD-10 coding.

Practice & Clinical Solutions

Using the 2022 Cholesterol Management Practice Module as a guide:

	Partner with Quality Insights to provide pharmacist-led Medication Therapy Management (MTM) at your clinic for individuals diagnosed with hypercholesterolemia and/or hypertension.
	Use the electronic PRAPARE/EHR tool or implement a paper form to identify your patients' social needs, such as housing status and stability, neighborhood safety, income, educational attainment, transportation needs, and employment. Consider assessing social and emotional health measures such as Social Support and Stress, as well as Substance Use Disorder.
	Educate all members of the care team on lifestyle change programs including the providers who are key in patients accepting the recommendations.
	Participate in Quality Insights Cholesterol Academic Detailing course. *(Coming Soon)*

Patient Education Actions

	Share community resources with patients promoting CDC-approved programs such as Weight Watchers and TOPS.
	Implement use of the Adherence Estimator® and suggested patient conversations to enhance medication adherence. Review Quality Insights' Medication Adherence learning module for more information.
	Plan and implement communications with your patients to help them understand why they are being asked about SDOH and ways in which they can benefit from the assessment.

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This publication was supported by the Cooperative Agreement Number NU58DP006516 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Publication number DEDPH-HD-091322