Utah Health Systems Assessment Report

2018 Results

An assessment of a sample of health systems in Utah to identify strengths, challenges, and possible opportunities for collaboration in the prevention and management of chronic conditions.

UTAH DEPARTMENT OF HEALTH

INTRODUCTION

From January to March of 2018, the Utah Department of Health Bureau of Health Promotion (UDOH BHP) conducted an assessment of a sample of health systems in Utah to identify strengths, challenges, and possible opportunities for collaboration in the prevention and management of chronic conditions.

Burden of Chronic Conditions in Utah

The rise in chronic conditions in Utah is putting an enormous burden on health systems, individuals, and families. Helping patients prevent the onset or the worst consequences of these conditions can save lives and reduce costs.[1] Rates below represent the Utah adult population defined as age 18 and older.

Arthritis

Arthritis is one of the most common chronic conditions and a leading cause of disability for Utah adults. In 2017, approximately 419,800 adults (19.3%) reported an arthritis diagnosis.[2] Among those with arthritis, 50.3% reported being limited in their activity[2] and one-third reported work limitations due to their arthritis.[3] In Utah, adults with arthritis are more likely to be physically inactive and obese than adults without arthritis.[2]

Asthma

Asthma is a common chronic condition contributing to high medical costs as well as losses in work productivity and school absences.[4] In Utah, 8.9% of adults and 6.0% of children currently have asthma.[5] Average asthma hospitalization charges have steadily increased from $6,924 in 2004 to $13,190 in 2014.[2] An estimated $28.1 million was charged for asthma-related emergency department visits and hospitalizations during 2014.[2]

Cancer

Cancer is the second leading cause of death in Utah, second only to diseases of the heart.[2] Regular screening, along with known preventive measures such as smoking cessation and sunscreen use, is the key to prevention and early detection.

Chronic Pain

In 2017, 25.3% of Utah adults reported suffering from chronic pain (pain that occurs constantly or flares up frequently).[6]

Cigarette Smoking

In 2017, approximately 193,600 Utah adults (8.9%) reported currently smoking cigarettes.[7] Cigarette smoking causes or worsens many chronic conditions including heart disease, respiratory disease, and cancer. Cigarette smoking rates are significantly higher in population groups with lower socioeconomic status.[2]

Depression

In 2017, 22.6% of Utah adults reported having ever been told they have a depressive disorder. Utah has consistently higher rates of self-reported lifetime depression than the U.S. rate (22.5% vs. 19.3% in 2017).[2] In Utah, adult women (29.0%) had significantly higher rates of doctor-diagnosed depression than men (16.1%).[2]

Diabetes

In 2017, approximately 154,000 Utah adults (7.1%), had a diagnosis of diabetes.[7] Nationally, approximately one in three adults age 20 and older had prediabetes in 2013.[8] Many of these individuals are unaware of their condition; only 8.1% of Utah adults have been told by a healthcare provider that they have prediabetes.[2]

Disability

Disability status is an important element to consider when caring for those with chronic conditions. Persons with disabilities are significantly more likely to have chronic conditions, such as heart disease, diabetes, asthma and to be physically inactive, obese, or smoke.[1] One in every five Utah adults has a disability (22.4%).[2]

Hypertension

As of 2017, 24.5% of adults in Utah were living with hypertension, a leading risk factor for heart attack and stroke.[2] Controlling high blood pressure is an important step in preventing heart attacks, strokes, kidney disease, and in reducing the risk of developing other serious conditions.

Methods

UDOH BHP staff identified a sample of 23 health systems† throughout Utah, based on a balanced representation from large and small systems, urban and rural systems, and systems that serve a higher proportion of patients with low socio-economic status. Staff created an online survey that was piloted with one health system. Staff then reached out to quality improvement professionals at each system by phone and email to complete the online survey. The Association for Utah Community Health (AUCH) partnered with the UDOH BHP to send the online survey to quality improvement professionals at each of the Federally Qualified Health Center systems. Several attempts were made to obtain complete responses from all systems in the sample.

Eighteen health systems submitted responses that were included in analysis. A complete list of the participating systems is included in Appendix A. For analysis purposes, responses included: "yes," "no," and "don't know."

A limitation of this assessment is the self-report format of the survey. While respondents were leaders of quality improvement within their health systems, questions were asked on a variety of areas and several respondents skipped questions or responded "don't know."

†Health systems in Utah were defined by a team of local experts and consulting national experts. UDOH BHP staff developed a list of 38 health systems that deliver primary care at multiple locations throughout the state. This list was reviewed by the Centers for Disease Control and Prevention (CDC) and multiple Utah healthcare leaders.

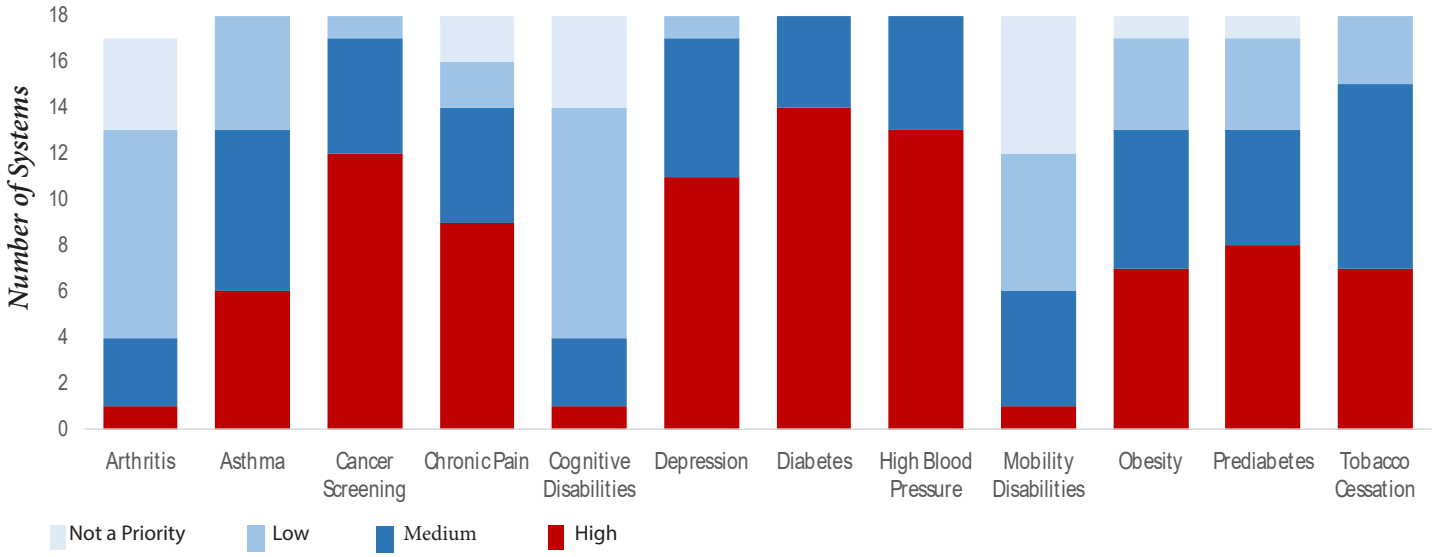
Utah Findings

The results of this assessment highlight the 18 Utah health systems' organizational priorities for quality improvement, as well as four priority areas for the UDOH BHP: electronic health records, organizational policies and systems, patient self-management, and community health worker utilizations for patients with chronic health conditions.

Organizational Priorities for Quality Improvement

Diabetes was high priority for 14 systems and high blood pressure was high priority for 13 systems. Cancer screening was high priority for 12 systems; depression was high priority for 11 systems. Arthritis, cognitive disabilities, and mobility disabilities were not high priorities for quality improvement among Utah health systems. Each of these conditions was considered a high priority by only one system each.

Figure 1. Diabetes, high blood pressure, cancer screening, and depression were the highest priorities for quality improvement among Utah health systems.



Electronic Health Records

Using Tools to Support Evidence-Based Protocols:

Electronic health records (EHRs) were most frequently used to support evidence-based protocols for cancer screening (94.4%), followed by high blood pressure (88.9%), depression (88.9%), obesity (83.3%), tobacco cessation (83.3%), and diabetes (83.3%). Only 66.7% of systems used EHRs to support evidence-based protocols for asthma and 38.9% for chronic pain. Only 27.8%, 22.2%, and 11.1% of systems used similar protocols for cognitive disabilities, arthritis, and mobility disabilities, respectively.

Running Reports to Identify Patients to Improve Care:

Almost all health systems (94.4%) reported using EHRs to run reports and identify patients with chronic conditions. Most commonly, these reports were run to identify patients with diabetes and in need of cancer screening (88.9% each). The least common conditions screened for in EHR reports were mobility disabilities (5.6%), cognitive disabilities (11.1%), and arthritis (11.1%). These are the same three conditions that were low priorities for quality improvement.

Using EHRs to Capture Patient Information:

All health systems surveyed collected information on ethnicity, race, sex, insurance type, and preferred language in EHRs. However, only 16.7% reported collecting information about fruit and vegetable intake. Only one system reported collecting information on food security status.

Using EHRs to Calculate Quality Indicators:

EHRs can also be used to calculate quality indicators. National Quality Forum (NQF) 59, the percentage of patients aged 18-85 with diabetes whose most recent HbA1c level was greater than 9%, was the most commonly calculated indicator within Utah health systems (88.9% of systems). Of indicators listed, the least-frequently calculated indicator was the percentage of patients aged 5-64 identified with persistent asthma who have a ratio of controller medications to total asthma medications of .50 or greater (NQF 1800), only 55.6% of systems reported calculating this. NQF 18, the percentage of patients aged 18-85 with hypertension whose blood pressure is controlled, was calculated by 77.8% of systems surveyed.

Organizational Policies and Systems

Policy to Treat Patients with a Multi-disciplinary Team Approach:

More than three-quarters of health systems (77.8%) had policies to ensure diabetes, asthma, and high blood pressure were treated with a multi-disciplinary team approach. Similar procedures for arthritis, cognitive disabilities, and mobility disabilities were in place for only 16.7% of systems.

Policy to Identify/Treat Patients with Certain Conditions:

Health systems in Utah did not commonly use EHRs to identify patients with undiagnosed hypertension, prediabetes, or food insecurity. Procedures to identify patients with undiagnosed high blood pressure were in place in 38.9% of systems and 44.4% had procedures to identify patients with prediabetes. Only 22.2% had procedures to identify patients with food insecurity. More than half of systems surveyed had workflows to ensure patients received education about at-home blood pressure monitoring (55.6%), but only one-third (33.3%) referred persons with prediabetes to a National Diabetes Prevention Program (DPP).

More than three-quarters of systems (77.8%) had policies or workflow procedures to ensure there are exam rooms and equipment that are accessible for use by patients with disabilities. However, only 38.9% had policies to ensure the same patients were receiving preventive services.

Only 33.3% of systems used the National Asthma Education and Prevention Program (NAEPP) guidelines for treating patients with asthma.

Systems to Improve Medication Adherence:

Policies and procedures to support medication adherence for diabetes were in place in 61.1% of health systems. The conditions with the lowest percentage of health systems with medication adherence policies in place were chronic pain and depression (38.9% each), followed by asthma (44.4%).

At-Home Visiting Programs:

Only 33.3% of health systems reported providing any home visiting service. The type of home visiting service provided was reported by 22.2% of systems; only one system reported providing an asthma home-visiting service. The format of the services varied by organization.

Health Care Financing Models:

More than one-third (38.9%) of health systems surveyed used health care financing models other than fee-for service, including sliding fee and shared savings.

Comfort with Planning and Implementing Quality Improvement Activities:

Most health systems were either extremely comfortable (44.4%) or moderately comfortable (27.8%) planning and implementing quality improvement activities. No system indicated a level of comfort below somewhat comfortable.

Self-Management

Policy to Document Self-Management Plans:

Some health systems in Utah had policies to document patient self-management plans so care teams could follow-up with patients. This was most commonly done for patients with asthma, high blood pressure, and tobacco cessation (55.6% each). Only 5.6% had a similar policy in place for patients with mobility disabilities and 11.1% had a policy to document arthritis self-management.

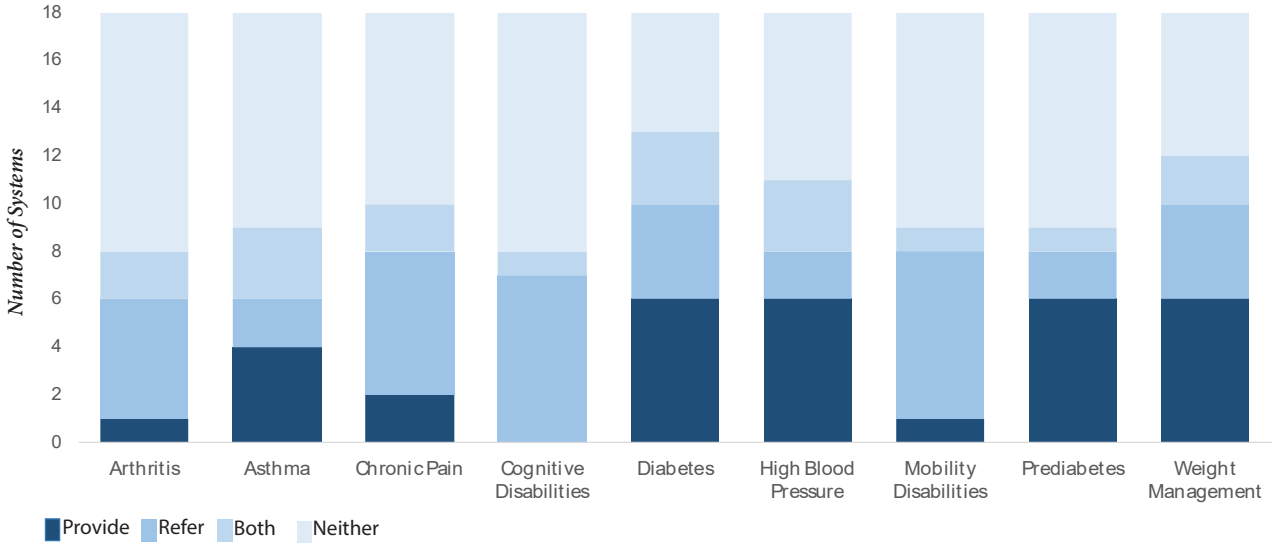
Provide Self-Management Programs:

Utah health systems provided diabetes and high blood pressure self-management programs most frequently (50.0% each) and most frequently referred patients with cognitive disabilities (38.9%) and mobility disabilities (38.9%) to programs outside of their system. Only one system provided self-management for patients with cognitive disabilities; however, this system also referred patients to outside resources. Despite NAEPP guidelines that recommend patients with asthma receive self-management education, only 50% of health systems provided and/or referred patients to asthma self-management programs (see Figure 2).

Community Health Workers

Half of health systems in Utah (50.0%) did not integrate community health workers (CHWs) into the clinical practice team. It was also not common for Utah health systems to engage CHWs to link patients to community resources that promote self-management. Patients in need of resources for diabetes (50.0%), tobacco cessation (44.4%), and food insecurity (44.4%) were the most likely to be connected with CHWs, while only 11.1% of systems reported connecting patients with arthritis with CHWs.

Figure 2. Number of Utah health systems that provide or refer to self-management programs by condition (n = 18).



Overall

Health systems in Utah have a good level of capacity and infrastructure to improve chronic disease management.

Electronic Health Records:
Health systems would benefit from implementing evidence-based care protocols for patients with chronic conditions. Additionally, systems would benefit from improved tracking of demographic information as this is an important way to appropriately target patients for needed care and follow up, as well as to identify and reduce health disparities.

Organizational Policies and Systems:
Organizational policies and workflow procedures such as patient identification and quality improvement tracking can result in earlier detection of chronic conditions and better disease management. In turn, this can decrease medical costs over time.[9]

Patient Self-Management:
Health systems should consider referring to and/or providing self-management programs for patients with various chronic conditions. Systems might also consider ways to track patient self-management plans in EHRs.

Community Health Workers:
Systems should consider using CHWs who can support patients in determining how best to adjust their lifestyles to manage their chronic conditions. CHWs have received considerable attention due to their potential to improve access to, and the quality of, health care.[10]

There are several areas where the UDOH BHP can collaborate with clinical health systems to improve health outcomes for Utahns.

Resource Table

Topic	What the UDOH BHP Can Offer Health Systems	Contact
Arthritis	• Free physician portal to refer patients with chronic conditions directly into evidence-based programs to improve their self-management skills and health • Online and worksite versions of the Chronic Disease Self-Management Program • Assistance to provide or refer patients with arthritis and other chronic conditions into the evidence-based programs	livingwell@utah.gov
Asthma	• Clinical quality improvement support around guidelines-based asthma care • Free asthma webinar series for continuing education for RNs and RTs • Refer uncontrolled asthma patients to the Utah Asthma Home Visiting Program • Asthma Task Force	Nichole Shepard nshepard@utah.gov
Breast & Cervical Cancer Screening	• Funding or technical experts to assist in implementing CDC recommended policies and evidence-based interventions to improve cancer screening rates • Free breast and cervical cancer screening for low to moderate income, underinsured, or uninsured women ages 40-64	Brenda Nelson brendanelson@utah.gov 1-800-717-1811
Chronic Pain	• Guidelines for all health care providers who prescribe opioids. http://www.health.utah.gov/vipp/pdf/RxDrugs/UtahClinicalGuidelinesOnPrescribing.pdf • Connect patients by recommending self-management workshops such as the Chronic Pain Self-Management Program http://livingwell.utah.gov/ • Access provider resources and tools at https://www.opidemic.org/providers/	Anna Fondario afondario@utah.gov
Depression and Suicide Prevention	• Suicide prevention and mental health training and patient resources • Training for health care professionals on how to help a person developing a mental health problem or experiencing a mental health crisis	Teresa Brechlin tbrechlin@utah.gov
Diabetes	• Become an accredited Diabetes Self-Management Education (DSME) provider • Learn how to refer patients with diabetes to DSME • Utah Diabetes Coalition	Brittany Ly bly@utah.gov
Disabilities	• Inclusive health care training and technical assistance for providers and staff • Evidence-based health promotion resources for persons with disabilities	Anna Braner abraner@utah.gov

Topic	What the UDOH BHP Can Offer Health Systems	Contact
High Blood Pressure	• Home blood pressure monitoring implementation support and education • Utilize EHRs to identify patients with undiagnosed hypertension and uncontrolled hypertension • Workflow processes and best practices for office blood pressure measurement and technique • Integrate non-physician team members in hypertension control and management	John Stuligross jstuligross@utah.gov
Obesity	• Learn how to integrate registered dietitians into outpatient care teams and referral processes to provide medical nutrition therapy and evidence-based lifestyle change counseling to improve dietary intake	Tessa Acker tacker@utah.gov
Prediabetes	• Learn how to become referral partners for the National Diabetes Prevention Program (DPP) • Become a National DPP provider • Train staff as lifestyle coaches for the National DPP	Natalie Rowe nrowe@utah.gov
Tobacco Cessation	• Training for healthcare professionals on how to connect patients to free tobacco cessation services • Free tobacco cessation materials for patients	Marci Nelson marcinelson@utah.gov
Additional Topics:		
Alzheimer's and Related Dementias	• Help finding local resources and Area Agencies on Aging • Dementia Dialogues courses for community and professional groups • Alzheimer's Association of Utah 24/7 helpline	http://www.agewell.health.utah.gov/ 1-800-272-3900
Cardiovascular Health Screenings	• Provide low-income clients with access to cardiovascular screening and health coaching for chronic disease management	Stephanie Wilkinson stephaniewilkinson@utah.gov
Community Health Workers	• Professional CHW trainings: Utah CHW Core Skills Training and other trainings available at https://livingwell.utah.gov/chwtrainings/ • UDOH Medical Interpreting Training Program	Tessa Acker tacker@utah.gov Edwin Espinel eespinel@utah.gov
Employee Wellness	• Worksite Chronic Disease Self-management Program	Livingwell@utah.gov
Falls Prevention	• Refer patientes to evidence-based falls prevention programs http://www.health.utah.gov/vipp/pdf/OlderAduts	Sheryl Gardner sagardner@utah.gov
Food Insecurity	• Algorithms for screening individuals for food insecurity: https://nopren.org/working_groups/food-security/clinical-linkages/	Natalie Loots nloots@utah.gov
Traumatic Brain Injury	• Resource facilitation for individuals with a traumatic brain injury • Neuropsychological testing	Health Resource Line 1-888-222-2542 health.utah.gov/tbi
Team Based Care	• Better utilize pharmacists, registered dietitians, and other non-physician providers in patient care	Ashley Rush arush@utah.gov

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Appendix A

Health systems included in final analysis:

Beaver Medical Clinic
Carbon Medical Service Association
Community Health Centers, Inc.
Enterprise Valley Medical Clinic
Family Healthcare
Fourth Street Clinic
Green River Medical Center
HCA Healthcare
Health Clinics of Utah
Intermountain Healthcare
Midtown Community Health Center
Mountainlands Community Health Center
Paiute Indian Tribe of Utah
Steward Health Care
Uintah Basin Healthcare
Utah Navajo Health System
University of Utah Health Community Physicians Group
Utah Partners for Health

Appendix B

Organizational Priorities for Quality Improvement

Table 1: Priority level for quality improvement, by condition (% systems, n = 18)

Condition	Priority Level			
	High	Medium	Low	Not
Arthritis	5.6	16.7	50.0	22.2
Asthma	33.3	38.9	27.8	-
Cancer Screening	66.7	27.8	5.6	-
Chronic Pain	50.0	27.8	11.1	11.1
Cognitive Disabilities	5.6	16.7	55.6	22.2
Depression	61.1	33.3	5.6	-
Diabetes	77.8	22.2	-	-
High Blood Pressure	72.2	27.8	-	-
Mobility Disabilities	5.6	27.8	33.3	33.3
Obesity	38.9	33.3	22.2	5.6
Prediabetes	44.4	27.8	22.2	5.6
Tobacco Cessation	38.9	44.4	16.7	-
Other	16.7	-	-	83.3

Electronic Health Records

Table 2: Systems using EHRs to support evidence-based protocols, by condition (% systems, n = 18)

Condition	Yes	No
Arthritis*	22.2	55.6
Asthma*	66.7	22.2
Cancer Screening	94.4	5.6
Chronic Pain*	38.9	50.0
Cognitive Disabilities*	27.8	61.1
Depression*	88.9	5.6
Diabetes	83.3	16.7
High Blood Pressure	88.9	11.1
Mobility Disabilities*	11.1	66.7
Obesity*	83.3	11.1
Prediabetes	55.6	44.4
Tobacco Cessation*	83.3	11.1

*Does not sum to 100% due to non-response

Table 3: Systems using EHRs to run reports to identify patients with condition (% systems, n = 18)

Condition	Yes	No
Arthritis*	11.1	77.8
Asthma	77.8	22.2
Cancer Screening	88.9	11.1
Chronic Pain	50.0	50.0
Cognitive Disabilities*	11.1	83.3
Depression	72.2	27.8
Diabetes	88.9	11.1
Hyperlidemia	50.0	50.0
High Blood Pressure	83.3	16.7
Mobility Disabilities*	5.6	83.3
Obesity*	61.1	33.3
Prediabetes*	50.0	44.4
Tobacco Cessation*	66.7	27.8
Undiagnosed Hypertension*	33.3	55.6

*Does not sum to 100% due to non-response

Electronic Health Records cont.

Table 4: Additional uses for EHRs

	Yes	No	Don't Know
Does your system routinely gather any of the following information? (% systems, n = 18)			
Ethnicity	100.0	-	-
Race	100.0	-	-
Sex	100.0	-	-
Income Level*	50.0	-	33.3
Insurance Type	100.0	-	-
Insurance or Self Pay	100.0	-	-
Language Preference	100.0	-	-
Cognitive Disabilities*	55.6	-	27.8
Mobility Disabilities*	33.3	-	44.4
Food Security Status*	5.6	-	66.7
Dietary Intake*	33.3	-	61.1
Fruit and Vegetable Intake*	16.7	-	72.2
Physical Activity*	44.4	-	44.4
Does your system use EHRs to calculate any of the following quality indicators**? (% systems, n = 18)			
NQF18	77.8	16.7	5.6
NQF32	83.3	11.1	5.6
NQF59	88.9	11.1	-
NQF2372	72.2	22.2	5.6
NQF1800*	55.6	22.2	16.7

*Does not sum to 100% due to non-response

** Quality indicators defined

NQF18: Percentage of patients aged 18-85 with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90).

NQF32: Percentage of women aged 21-64 screened for cervical cancer.

NQF59: Percentage of patients aged 18-85 with diabetes whose most recent HbA1c level was greater than 9%.

NQF2372: Percentage of women aged 50-74 who had a mammogram to screen for breast cancer.

NQF1800: Percentage of patients aged 5-64 who were identified as having persistent asthma and had a ratio of controlled medications to total asthma medications of 0.50 or greater.

Organizational Policies and Procedures

Table 5: Policy or workflow procedure in place to ensure a multi-disciplinary team approach, by condition (% systems, n = 18)

	Yes	No	Don't Know
Arthritis	16.7	66.7	16.7
Asthma	77.8	22.2	-
Chronic Pain	55.6	44.4	-
Cognitive Disabilities	16.7	66.7	16.7
Depression	66.7	27.8	5.6
Diabetes	77.8	22.2	-
High Blood Pressure	77.8	22.2	-
Mobility Disabilities	16.7	61.1	22.2

Table 6: Patient medication adherence by condition (%)

	Yes	No	Don't Know
Asthma	44.4	44.4	11.1
Cholesterol	55.6	38.9	5.6
Chronic Pain	38.9	50.0	11.1
Depression	38.9	50.0	11.1
Diabetes	61.1	33.3	5.6
High Blood Pressure	55.6	33.3	11.1

Organizational Policies and Procedures cont.

Table 7: Organizational Policies and Procedures (n = 18)			
	Yes	No	Don't Know
Percent of systems with policy to identify patients with:			
Undiagnosed hypertension	38.9	61.1	-
Prediabetes	44.4	50.0	5.6
Food insecurity	22.2	72.2	5.6
Percent of systems with policies or workflows for each of the following:			
Home blood pressure monitoring	55.6	44.4	-
Refer persons with prediabetes to CDC-recognized DPP	33.3	66.7	-
Accessible equipment	77.8	5.6	16.7
Preventive services for patients with disabilities	38.9	33.3	27.8
Percent of systems providing an at-home visiting service:			
	33.3	66.7	-
Percent of systems using model of financing other than fee-for-service*:			
	38.9	33.3	-

*Does not sum to 100% due to non-response

Table 8: Percent of systems using the NAEPP guidelines to treat patients with asthma (n = 18)		
Yes	No	Didn't Respond
33.3	5.6	61.1

Table 9: Comfort level with quality improvement (% of systems)	
Extremely Comfortable	44.4
Moderately Comfortable	27.8
Somewhat Comfortable	27.8
Slightly Comfortable	-
Not at all Comfortable	-

Self-Management

Table 10: Percent of systems with policy or workflow to document self-management plans, by condition

	Yes	No	Don't Know
Arthritis	11.1	66.7	16.7
Asthma	55.6	22.2	16.7
Chronic Pain	22.2	50.0	22.2
Cognitive Disabilities	11.1	61.1	22.2
Diabetes Care	50.0	33.3	11.1
Depression	50.0	33.3	11.1
High Blood Pressure	55.6	27.8	11.1
Mobility Disabilities	5.6	66.7	22.2
Obesity	50.0	33.3	11.1
Prediabetes	27.8	44.4	22.2
Tobacco Cessation	55.6	27.8	11.1

Table 11: Percent of systems providing or referring to self-management programs, by condition

	Provide	Refer	Both	Didn't Respond
Arthritis	5.6	27.8	11.1	55.6
Asthma	22.2	11.1	16.7	50.0
Chronic Pain	11.1	33.3	11.1	44.4
Cognitive Disabilities	-	38.9	5.6	55.6
Diabetes	33.3	22.2	16.7	27.8
High Blood Pressure	33.3	11.1	16.7	38.9
Mobility Disabilites	5.6	38.9	5.6	50.0
Prediabetes	33.3	11.1	5.6	50.0
Weight Management	33.3	22.2	11.1	33.3

Community Health Workers

Table 12: Use of CHWs to link patients with community resources that promote self-management by condition (%)

	Yes	No
Arthritis*	11.1	55.6
Asthma*	33.3	44.4
Cancer*	27.8	44.4
Chronic Pain*	22.2	50.0
Cognitive Disabilities*	27.8	38.9
Diabetes*	50.0	33.3
Food Insecurity*	44.4	38.9
High Blood Pressure*	38.9	44.4
Mobility Disabilities*	27.8	44.4
Obesity*	38.9	38.9
Prediabetes*	27.8	50.0
Tobacco Cessation*	44.4	38.9

*Does not sum to 100% due to non-response

Table 13: Integration of CHWs into clinical practice team* (%)

Yes	No
38.9	50.0

*Does not sum to 100% due to non-response