Quality Care Policies and Procedures Guide

Sample Policies, Procedures, and Resources to Assist in the Implementation of Quality Care and Healthy Living Practices in Primary Care Clinics and Pharmacies

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SALT LAKE COUNTY
HEALTH DEPARTMENT

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Introduction

This manual is intended to guide you in creating effective policies for your clinic that will help improve patient care. Implementing policies is a great way to create sustainability in your organization and to improve your patient's continuity of care. Included are helpful tools to provide ongoing education and training both annually and to newly hired staff. Overall policies improve an agency's processes, procedures, and long-term culture.

Policies should include a disclaimer statement reminding clinical staff to use their best judgement on whether the policy applies to that situation. An example of a disclaimer statement may be, "Policies are resources to assist staff in carrying out specific actions. Policies do not specify all circumstances to which they apply." For more information, please visit: https://www.psqh.com/analysis/policies-and-procedures-for-healthcare-organizations-a-risk-management-perspective/

Topics covered in this guide include hypertension, blood pressure management, cholesterol, prediabetes, establishing partnerships, nutrition and physical activity, and worksite wellness. Please use the fillable PDFs in your practice, if desired. We have included an *Additional Resources* section for each topic that include examples of workflows, models, and other helpful materials. If you require additional assistance in creating or implementing policies in your office, please contact us at healthpromotion@slco.org.

Hypertension

Elevated Blood Pressure Policy

Sample Policy

Purpose: To improve patient care through appropriate blood pressure monitoring and follow-up care.

Policy Statement:
If the patient is found to have a blood pressure value higher than the acceptable range **{systolic/diastolic measurement}**, when measured mechanically utilizing the Million Hearts accuracy criteria, **{Clinic or Agency Name}** is committed to providing the following:

- The blood pressure measurement will be circled on the chart and a heart will be drawn on the patient's assignment board to FLAG attention to this condition.
- The person's name and blood pressure reading will be written on the BP Monitoring roster and a sticker will be affixed to their chart to further identify them for education and possible follow up care.
- The blood pressure value is then added onto a designated spreadsheet for data collection purposes.
- The sticker will be used to identify the patient with elevated blood pressure measurement to FLAG the designated staff member to pull appropriate ***supporting activities.***
- During the visit the patient will be given instructions on how to use the blood pressure tracker, list of validated kiosks and list of free blood pressure opportunities outside the clinic.
- The patient will then be instructed to recheck their blood pressure up to twice a day for up to 14 days and record the findings on the BP tracker/log and instructions on when to return to schedule an appointment with the provider for follow up care.

Supporting Activities:

- Follow up and treatment include but are not limited to:
    - Laboratory blood test
    - Diet, physical activity, and lifestyle education and resources
    - Referral to Living Well with Chronic Conditions course
    - Medication regimen
    - When to call the provider

Signature of Approval: _____

Date of Implementation: _____

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Blood Pressure Accuracy Training

Sample Policy

Purpose: To improve patient care through accurate blood pressure measurement.

Policy Statement:
{Clinic or Agency Name} is committed to providing evidence-based blood pressure technique training to obtain an accurate measurement of blood pressure, for medical staff responsible for triaging and placing patients into exam room.

- Blood pressure measurement training will be conducted upon hire and annually for all staff.
- Blood pressure measurement trainings will include information on the process of maintaining and calibrating the equipment.
- Blood pressure measurement trainings will include demonstration/return demonstration of correct blood pressure measurement technique.
- Blood pressure measurement trainings will include information on the basics of blood pressure, the importance of accuracy and correct measurement including the following:
    - Patients will be reminded during visits and prior to scheduling future appointments that they should not drink alcohol, use tobacco, or exercise 30 minutes prior to their appointment.
    - Patients will be reminded to empty their bladder prior to blood pressure measurement.
    - Staff will remind patients to sit quietly for a few minutes prior to blood pressure measurement.
    - During blood pressure measurement, staff will ensure that the patient is sitting upright with back supported and both feet flat on the floor.
    - Staff will use an appropriately sized blood pressure cuff and fit the cuff snuggly around patient's upper arm approximately 1 inch above the elbow.
    - Staff will support the patient's arm, so the cuff is at heart level with the person's elbow slightly bent.
    - During the blood pressure reading, the patient and staff will refrain from speaking.

Scope: This policy applies to all employees, interns and volunteers of (Company Name) that perform blood pressure measurement on patients and walk-in clients.

This policy will ensure an accurate blood pressure reading for all patients regardless of age, gender or disability status.

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Hypertension Letter/Script for Patient

Sample Letter

Hello, my name is **{Name}** I'm calling from **{Clinic or Agency Name}**. I see that you came into the clinic within the last year and you were seen by one of our physicians. While you were here, they checked your blood pressure, and the results show that you may be at risk for becoming hypertensive.

I'm calling because your physician recommended you for a new program that will help reduce your risk of becoming hypertensive.

This program allows you to work one on one with a health coach. By attending these meetings, you will be able to:

- Set goals according to your needs
- Get information about nutrition, physical activity, and weight control
- Improve your blood pressure and make lifestyle changes

You would meet with a health coach weekly for 16 to 26 weeks and then monthly after. These sessions would be in person and over the phone. As you meet your goals you will earn incentives that you can take home and enjoy. We will also give you a free scale and a blood pressure monitor to help you reach your goals.

Would you be interested in signing up for this program?

1. If NO:

If you change your mind and decide that you want to receive this service, feel free to call us at **{clinical contact number}.**

Thank you for your time.

2. If YES:

Our next class is {provide class details}

Can I enroll you in our next class?

3. If NO, to #2

You will be contacted by your assigned health coach. What is the best day or time to reach you? Is this the best phone number to reach you at?

Thank you, your health coach will contact you to set up your first appointment.

Self-Measured Blood Pressure (SMBP) at Home

Sample Policy

Purpose: To improve patient care through correct measurement of blood pressure at home.

Policy Statement:
{Clinic or Agency Name} is committed to providing evidence-based blood pressure measurement technique training to patients referred for home blood pressure monitoring. This training shall include the following:

- Instruction on the basics of blood pressure
- Instruction with return demonstration on correct blood pressure measurement which includes:
    - Teaching the patient correct positioning during measurement
    - Teaching patient correct positioning of cuff during measurement
    - Ensuring the patient uses the correct cuff size for measurement
    - Teaching patient the importance of having an empty bladder, not talking, emailing, texting or watching television during measurement, not smoking, drinking alcohol or caffeine, or exercising 30 minutes prior to blood pressure measurement
- Instructing the patient on how to use the monitor correctly
- Instructing the patient on how often blood pressure should be monitored and for what period of time, including where to keep track of results and when to report back to provider
- Instruct patient on what to do in case of an out of range reading

Scope: This policy applies to all staff that give instruction to patients regarding measurement of blood pressure at home.

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Pharmacist Collaborative Practice Agreement

Sample Practice Agreement

Purpose: To enhance patient care and continuity of care, a pharmacist can initiate, modify, or discontinue medication therapy when appropriate; perform basic physical assessments for medication-related issues; participate in multidisciplinary reviews of patients' progress; order or renew medications; and provide information, education and counseling to patients or their caregivers. The pharmacist will adhere to approved Disease State Management Protocols and a signed collaborative practice agreement.

Policy Statement:
The pharmacist, pharmacy interns, and pharmacy students, completing rotations under the supervision of the pharmacist, will also adhere to this agreement.

Procedure:
A provider can refer a patient they feel would benefit from pharmacy services and document the referral in the patient medical record. Patients can also self-refer if they would like to receive medication therapy management services.

The pharmacist may perform the following functions in collaboration with physicians and other members of the primary care team:

1. Initiate or modify medication therapy care plans based on patient responses using cost-effective therapy and/or professionally recognized treatment guidelines (Appendix A).
2. Interpret data related to medication safety and effectiveness.
3. Provide information, education, and counseling to patients or patient's' caregiver about medication-related care.
4. Document the care provided in patients' records.
5. Identify any barriers to patient compliance.
6. Participate in multidisciplinary reviews of patients' progress.
7. Provide individualized or group classes on health promotion and disease prevention education.
8. Communicate with payers to resolve issues that may impede access to medication therapies.
9. Communicate relevant issues to physicians and other team members.
10. Verbally or electronically order or renew prescriptions for patients according to an established protocol or in consultation with the primary physician(s).
11. Perform limited physical assessment for medication-related factors.
12. Supervise medication therapy with appropriate collaborative medication therapy management authority.
13. Provide staff education and development.
14. Evaluate drug information resources and update as necessary.
15. Precept pharmacy students and pharmacy interns.

Collaborative physician(s) agrees to the following:
1. Availability of direct communication in person, by telephone or telecommunication between the supervised individual and the supervising physician.
2. Manage patients with more complex conditions.
3. In the absence of the collaborating physician, any other staff physician may be used for consultation.
4. The availability on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation, to review records, and to further educate the supervised individual in the performance of the individual's functions.
5. Review mutually developed clinical practice guidelines/standards annually.
6. A random sample of the medical records completed by the above mid-level provider will be regularly reviewed as part of the medical staff's clinical peer review.

Appendix A: Clinical Guidelines:

Anticoagulation

- The ACCP Conference on Antithrombotic and Thrombolytic Therapy, CHEST Supplement

Arthritis

- Pain in Osteoarthritis, Rheumatoid Arthritis, and Juvenile Chronic Arthritis, American Pain Society- Professional Association

Asthma

- National Asthma Education and Prevention Program Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma

Chronic Heart Failure

- ACC/AHA Guideline for the Diagnosis and Management of Chronic Heart Failure in the Adult

Cholesterol

- NCEP: Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adults Treatment Panel lll)

COPD

- The Global Initiative for Chronic Obstructive Lung Disease (GOLD)

Diabetes Prediabetes

- American Diabetes Association Clinical Practice Guidelines, Diabetes Care
- American Association of Clinical Endocrinologists/American College of Endocrinology Guidelines

Gastroesophageal Reflux Disorder

- AGC: American College of Gastroenterology
- GERD: American Gastroenterological Association

Hyperlipidemia

- NCEP: Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III)

Hypertension

- The Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure

Latent Tuberculosis

- Minnesota Department of Health Tuberculosis Prevention and Control Program
- CDC

Smoking Cessation:

- Treating Tobacco Use and Dependence. Quick Reference Guide for Clinicians. Utah Department of Health

Pharmacist Collaborative Practice Agreement:
The Pharmacy Practice Act allows pharmacists to practice under a Collaborative Practice Agreement with individual physicians. Pharmacists may participate in the practice of managing and modifying drug therapy according to a written protocol between the specific pharmacist and the individual physician(s) who is/are responsible for the patient's care and authorized to prescribe drugs.

By signing this document, the named physicians agree that the named pharmacist may enter a Collaborative Practice for their patients. As Medical Director and Residency Director of the clinic, all faculty and staff physicians, nurse practitioners, and resident physicians fall under this agreement.

Collaborative Agreement Approved By:

Pharmacist Clinician: _____ Date: _____

Medical Director, MD: _____ Date: _____

Residency Director, MD: _____ Date: _____

Date of Implementation: _____

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Additional Resources

Hypertension

Training

- Act rapidly – the importance of treating your patients' high blood pressure training
- Using SMBP to Diagnose and Manage HBP training (1-hour CME available)
- Measure Up, Pressure Down Hypertension Measurement Training Video

National Protocols

- Atherosclerotic Cardiovascular Disease (ASCVD) Risk Estimator
- Tobacco Cessation Protocol
- Hypertension Treatment Protocol
- National Million Hearts Protocols (Hypertension, Cholesterol, Tobacco)

Toolkits and Other Resources

- Hypertension Control Change Package
- Hiding in Plain Sight Consolidated Change Package
- Hypertension Prevalence Estimator Tool
- Measure Up, Pressure Down Toolkit
- Utah Million Hearts Hypertension Policy and Procedure and Training Resources
- Utah Million Hearts Clinician Resources
- National Million Hearts Clinician Resources
- National Million Hearts Toolkits, Protocols, Action Guides
- CDC Hypertension Tools and Trainings
- Pharmacists' Role in Controlling Hypertension
- Collaborative Practice Agreements:
    - Collaborative Practice Agreements and Pharmacists' Patient Care Services Decision Makers Resource
    - Advancing Team-Based Care Through CPAs

Cholesterol

Atherosclerotic Cardiovascular Disease (ASCVD) Risk Estimator

Sample Policy

Purpose: To estimate an adult patient's (age 20-79) 10-year ASCVD risk at an initial visit to establish a baseline reference point.

Policy Statement:
{Clinic or Agency Name} will implement the use of the 10-year ASCVD risk calculator for all adult patients, age 20-79, at initial visit to establish a baseline reference point.

Procedure:

- During team huddle or patient review, Medical Assistant (MA) will note patients that need to be screened using the ASCVD risk calculator
- During initial visit, patient will receive either a paper version of the ASCVD risk calculator to fill out or the MA will assist the patient in filling out the electronic version of the ASCVD risk calculator
- 10-year ASCVD risk will be noted and communicated to patient and provider
- If, after assessment, a risk-based treatment remains uncertain, the provider may integrate one or more of the following into the treatment decision making process:
    - Family history of premature CVD: Male <55 years or Female <65 years
    - High-sensitivity C-reactive protein (hs-CRP) level ≥300 Agostin units or 75th percentile for age, sex, and ethnicity
    - Ankle brachial index (ABI): <0.9
- Treatment will be prescribed according to protocol
- Education materials will be given to patient on ASCVD
- Education materials on lifestyle changes, risk factor management and pharmacologic treatment will be given to patient
- Follow-up will be scheduled as necessary

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Last Reviewed/Updated: _____

Cholesterol Medication Adherence

Sample Policy

Purpose: To assess medication adherence for patients currently taking cholesterol lowering medications (Statins, PCSK9 inhibitors, ezetimibe, bile acid sequestrants)

Policy Statement:
{Clinic or Agency Name} will identify patients currently taking cholesterol lowering medications and assess medication adherence.

Procedure:

- Assigned staff will run initial report to identify patients currently taking cholesterol lowering medications
- Assigned staff will develop a process for patient outreach
- Assigned staff will conduct questionnaire specific to medication adherence
- Assigned staff will develop a process to continue with monthly follow-up for newly prescribed cholesterol medications
- Assigned staff will report back to provider on a monthly basis the findings of medication adherence
- Assigned staff will provide appropriate follow-up to assist with adherence
- Assigned staff will make referral to a pharmacist to assist with medication adherence

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Additional Resources

Cholesterol

Trainings

- AMA Medication Adherence Patient Care Module (0.5 CME available)

National Protocols

- 2018 ACC/AHA Guideline on the Management of Blood Cholesterol
- Million Hearts Cholesterol Protocols
- Million Hearts 2018 ACC/AHA Cholesterol Guideline

Toolkits and Other Resources

- Cholesterol Management Guide for Health Care Practitioners
- American Heart Association (AHA) Infographic
- AHA ASCVD Risk Calculator
- AHA Consumer Risk Calculator
- AHA Tools and Resources
- Patient education materials
- Kaiser Permanente ASCVD Secondary Prevention Guide

Health Equity and Social Determinants of Health

Implementing Health Equity into Health Care

Healthy People 2020 defines health equity as, "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." Health Catalyst has a great article "Health Equity: Why it Matters and How to Achieve it" that provides resources and summarizes various steps health care can take to achieve health equity. Read the following excerpt from the article below:

> *The Health Equity Must Be a Strategic Priority article outlines five ways health systems can make health equity a core strategy:*
>
> 1. *Make health equity a leader-driven priority (healthcare leaders must articulate, act on, and build the vision into all decisions).*
> 2. *Develop structures and processes that support equity (health systems must dedicate resources and establish a governance structure to oversee the health equity work).*
> 3. *Take specific actions that address the social determinants of health (health systems must identify their health disparities and the needs and assets of people who face disparities, and then act to close the gaps). Some patient populations need additional support to achieve the same health outcomes as other patient populations (e.g., they need someone to drive them to appointments, they need home visits, etc.).*
> 4. *Confront institutional racism within the organization (health systems must identify, address, and dismantle the structures, policies, and norms that perpetuate race-based advantage).*
> 5. *Partner with community organizations.*
>
> *Making health equity a strategic priority is the first step. Next, healthcare organizations need to tackle the disparities with proven interventions designed for their disadvantaged populations. The RWJF outlines specific steps health systems can take to address disparities:*
>
> 1. *Adopt new vital signs to screen for the nonmedical factors influencing health.*
> 2. *Commit to helping low-income and non-English-speaking patients get the care they need.*
> 3. *Guard against the potential for bias to influence medical care.*
> 4. *Make sure elderly, women, and racial/ethnic minorities are adequately represented in clinical trials.*
> 5. *Understand the effects of adverse childhood experiences and use trauma-informed care.*
>
> *Healthcare organizations can broaden equity's scope to include more than the health outcomes of the patients they serve; they can use their resources and status as employers to address equity in myriad other ways:*
>
> - *Develop a diverse workforce by improving hiring practices.*
> - *Provide training and growth opportunities for all employees.*
> - *Pay employees living wages.*

- *Build facilities in underserved communities.*
- *Use a diverse pool of contractors and suppliers.*
- *Make healthcare investments beyond the required community benefit and invest back into the community.*

The Chronic Disease Quality Improvement Project Ideas document also outlines some steps to tackle health equity in your practice.

- First, utilize and analyze data to identify patient population experiencing health inequities. Data shows the health disparities between patient population groups, especially when stratified by race, ethnicity, and language. You can also uncover the health inequities through stratifying by income, insurance status, risk factors, comorbidities and so forth.
- Research the needs and barriers of identified patient populations experiencing health inequities.
- Learn and apply health equity principles to the clinic or agency's current processes.
- Implement interventions to improve the health outcomes of identified patient populations.
- Create and improve upon written policies and processes that reflect the changes made from previous activities.

There are many policies and protocols healthcare organizations can adopt to move health equity work forward. Below are some examples and a written sample policy on the following page:

- Linguistically Appropriate Health Care – may include language on health literacy
- Culturally Sensitive Health Care – may include language around interpretive and translation services, delivery of care, and patient education materials
- Equitable Hiring Practices and Diversity in the Workforce
- Workforce Training Around Health Equity – may include required trainings around health equity, implicit bias, anti-racism, and social determinants of health
- Identifying Health Inequities through Data – may include what data points around health equity will be included in EHR and how often data is analyzed

Identifying Health Inequities through Data Policy

Sample Policy

Purpose: To improve patient care of patient populations with highest health outcome disparities by identifying, collecting, analyzing, and reacting to data around health equity.

Policy Statement:
{Clinic or Agency Name} is committed to providing equitable healthcare to all patients. **{Clinic or Agency Name}** will collect appropriate data related to health equity, do regular analysis, and implement appropriate interventions to improve identified health outcome disparities among patient populations.

Procedure:

- The **{specific staff}** will decide what data should be collected and tracked in the EHR to understand what disparities exist in health outcomes. This will include demographic data such as race, ethnicity, and preferred language.
- **{Specified staff}** will build data reports that stratifies **{specified health outcomes}** by determined health equity measures such as race and ethnicity. Reports will be pulled and analyzed every **{specific timeframe}.**
- **{Specified staff}** will identify and collect other data and information to better understand health disparities identified. This may include looking at SDOH data, implementing further screenings, and/or patient surveys.
- **{Specified staff}** will meet every **{specific timeframe}** to review data analysis and decide on next steps to address identified health inequities. This may include staff training, improving clinical processes, improving materials, and/or other specific interventions.
- Provider will view health equity data in the EHR and take patient's cultural and socioeconomic perspectives into account when providing treatment plans.

Supporting Activities:

- **{Clinic or Agency Name}** will also work on supporting activities around health equity which include but are not limited to:
    - Implement health equity staff trainings, especially trainings specific to collecting and using health equity data
    - Create and work on data evaluation plan around health equity
    - Test, measure, and improve processes around health equity interventions
    - Become part of community coalitions and/or community strategic plans that address health inequities

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Implementing SDOH into Clinic

Social Determinants of Health (SDOH) are the economic and social conditions that influence individual and group differences in health status. Conditions in the places where people live, work, and play affect a wide range of health risks and outcomes. Addressing these conditions such as education, housing, income, access to healthy food, transportation and neighborhood safety can greatly impact the health of an individual and community and advance health equity.

There are many toolkits that can help your clinic implement SDOH. Below are a few:

- PRAPARE toolkit
- Iowa SIM toolkit
- Comagine 2-1-1- toolkit

The following is a summary of general steps to implement SDOH into your clinic:

1. *Understand the Communities Your Patients Live In*
    a. Identify zip codes and communities your patients live in
    b. Identify public health and community data
        i. http://www.healthysaltlake.org/; https://ibis.health.utah.gov/; GIS Map of public health data and community resources
2. *Gather Key Stakeholders and Clinic Champions*
    a. Consider all levels of staff and patients in the process
3. *Create a Data/Evaluation Plan*
    a. Set goals (i.e. number of patients screened, number of referrals, biggest barriers identified, number of interventions for identified barriers pre and post SDOH implementation)
    b. Use to identify high risk patients (risk stratification)
    c. Use to improve quality measures (30-day readmission, medication adherence, chronic disease control)
4. *Pick a SDOH Screening Tool* (Below are a few examples)
    a. PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences
    b. American Academy of Family Practice Short-Form Social Needs Screening Tool
    c. CMMI Accountable Health Communities Health-Related Social Needs (HRSN) Screening Tool
    d. Health Leads Social Needs (HLSN) Screening Toolkit
    e. Towncrest Pharmacy SDOH Screening (can be used verbally)
5. *Develop and Implement a Workflow for SDOH Screening and Referral*
    a. Integrate SDOH screening into EHR
    b. Can start with a pilot group such as clients with hypertension or diabetes and then expand to all patients

    c. Use ICD-10 Z codes to capture data (Also refer to Chapter 9 of the PRAPARE Toolkit)
6. *Create and Build Upon Referral Resources and Partnerships for SDOH Needs Identified*
    a. Utah 2-1-1
    b. Aunt Bertha
    c. Create own list or build off local community resource list
7. *Test and Assess*
    a. Test workflows, track referrals, assess data
8. *Continual Capacity Building and Improvements*
    a. Analyze and act on data through clinical, non-clinical, and community interventions
    b. Share data with other community stakeholders and/or coalitions

SDOH Workflow Models

The following framework and workflow models from the PRAPARE Toolkit are examples that can be applied to any screening tool and can help your clinic think through an appropriate workflow for implementing a SDOH screening tool. More detailed examples of each workflow model can be found in Chapter 5 of the PRAPARE Toolkit.

TABLE 3.2. Using Five Rights Framework to Plan Workflow for PRAPARE Data Collection and Response

5 RIGHTS	WORKFLOW CONSIDERATIONS	RESPONSE WORKFLOW CONSIDERATIONS
Right Information: WHAT	**What information in PRAPARE do you already routinely collect?** • Part of registration • Part of other health assessments or initiatives	**What information and resources do you have to respond to social determinants data?** • Update your community resource guide and referral list with accurate information • Track referrals, interventions, and time spent
Right Format: HOW	**How are we collecting this information and in what manner are we collecting it?** • Self-Assessment? • In-person with staff?	**How will intervention and community resource information be stored for use and presented to patients?** • Searchable database of resources (in-house or via partner)? • Printed resource for patients to take with them? • Warm hand-off for referrals?
Right Person: WHO	**Who will collect the data? Who has access to the EHR? Who has contact with the population of focus? Who needs to see the information to inform care?** • Providers and other clinical staff? • Non-Clinical Staff?	**Who will respond to social determinants data?** • By a dedicated staff person? • By any staff person who administers PRAPARE with the patients? • By the provider?
Right Channel: WHERE	**Where are we collecting this information? Where do we need to share and display this information?** • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?	**Where will referrals and/or resource provisions take place?** • In private office? • In the exam room?
Right Time: WHEN	**When is the right time to collect this information so as to not disrupt clinic workflow?** • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?	**When will referrals take place?** • Immediately after need is identified? • After the patient sees the provider? • At the end of the visit?

TABLE 5.2. Summary of PRAPARE Workflow Models and Response			
WHO	**WHERE**	**WHEN**	**HOW**
NON-CLINICAL STAFF (Patient Advocates, Patient Navigators, Community Health Workers, etc.)	In patient advocate's office	After clinical visit	Administered PRAPARE and responded to needs identified. Discussed needs with provider and care team.
NON-CLINICAL STAFF (outreach and enrollment staff, eligibility assistance staff, etc.)	In waiting room	Before provider visit	Administered PRAPARE with patients who would be waiting 30+ minutes for provider
CLINICAL STAFF (nurses, medical assistants, etc.)	In exam room	Before provider enters exam room	Administered PRAPARE after vitals and reason for visit. Provider reviews data to inform treatment plan
CARE COORDINATORS	In care coordinator's office	When completing Health Risk Assessments	Administered PRAPARE in conjunction with Health Risk Assessments to address similar needs in real time
CHRONIC DISEASE MANAGEMENT TEAM	In exam room	During the clinical visit	Administered PRAPARE with patients and discussed needs as a team to develop appropriate response and care management plan
INTERPRETERS	In waiting room or exam room	Before the clinical visit	Administered PRAPARE with patients requiring language assistance.
ANY STAFF (from front desk staff to providers)	"No Wrong Door" approach	"No Wrong Door" approach	"No Wrong Door" approach where any staff can ask PRAPARE questions at any time to paint fuller picture of patient
SELF-ASSESSMENT	In waiting room or at home	Before the clinical visit	Patient self-assesses using paper version of PRAPARE or Ipads, kiosks, tablets, email, patient portal, etc.

Social Determinants of Health (SDOH) Screening and Referral Policy

Sample Policy

Purpose: To improve patient care through identifying patient needs and connecting patients to appropriate resources.

Policy Statement:
{Clinic or Agency Name} is committed to provide screening around social determinants of health in order to provide quality care. All patients will be screened annually using the **{SDOH screening tool}** to identify patient needs and connect them to appropriate resources.

Procedure:

- The **{SDOH screening tool}** will be explained and administered to patient by **{specific staff}** as part of in-take form filled out in the waiting room.
- **{Specified staff}** will record and date the patient's answers and/or updates in EHR, using ICD-10 Z codes when possible.
- Provider will view SDOH data in the EHR and take patient's socioeconomic situation into account when providing treatment plans and prescriptions.
- **{Specified staff}** will discuss SDOH concerns and connect interested patients to available resources, either those available in-house or those available in the community. If no needs are identified, **{specified staff}** will flag next appointment for annual SDOH screening.
- **{Specified staff}** will follow up with patient to determine if resources were utilized and document responses in the EHR.

Supporting Activities:

- **{Clinic or Agency Name}** will also work on supporting activities around SDOH which include but are not limited to:
    - Understand patient population though identifying zip codes and community data
    - Create and work on data evaluation plan around SDOH
    - Test, measure, and improve processes around SDOH screenings and referrals
    - Identify high risk patients and implement appropriate SDOH interventions
    - Build capacity around SDOH interventions, referrals, and resources
    - Become part of community coalitions and/or community strategic plans that address SDOH

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Last Reviewed/Updated: _____

Community Health Needs Assessment Policy

Sample Policy

Purpose: To conduct regular community health needs assessments to better understand and respond to population health needs which improves overall patient care.

Policy Statement:
{Clinic or Agency Name} will conduct a community health assessment every **{specified timeframe}**.

Procedure:

- Develop a team of stakeholders to conduct the community health needs assessment
- Define the community the clinic will assess. (For example, the team may pull top zip codes that general patients or high-risk patients live in)
- Collect and analyze the data on the specified community. Data sources include but are not limited to:
    - Public health data (http://www.healthysaltlake.org/; https://ibis.health.utah.gov/; GIS Map of public health data and community resources)
    - Local city/community data (police, city and/or government agencies)
    - Surveys, interviews, focus groups with patients from that community or other community members
    - Information from SDOH screenings and other clinical data
- Select priority community health needs identified through assessment
- Create a report and communicate it to stakeholders and other community partners and community members
- Decide and implement a plan of action to respond to the identified needs which may include but is not limited to:
    - Set up goals
    - Create and implement clinical interventions
    - Create and/or update clinic strategic plan
    - Work with other community partners to develop a community strategic plan
    - Increase in-house resources or referrals to community resources
- Evaluate goals and interventions implemented
- Reassess plan of action and determine if changes and/or improvements are needed

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Examples of Clinical Interventions to Address SDOH

Many clinics and organizations have screened for, gathered, and responded to data through various interventions at the clinical level, non-clinical level, and community level. Chapter 9 of the PRAPARE Toolkit has examples of what can be done at each level when responding to cultural needs, education, employment, food insecurity, housing status, income, insurance status, language, legal needs, migrant/seasonal work, neighborhood conditions, safety and domestic violence, social integration, stress, transportation, and veteran status.

Here are a few examples of what health centers have done around food and transportation:

Food Insecurity

A health center in rural Massachusetts discovered that they had high food insecurity amongst their patients after administering PRAPARE. Their town did not have a food bank, but they called a food bank in Boston 70 miles away to see if they could help. Because the health center had data to demonstrate their need, the Boston food bank was happy to form a partnership where the Boston food bank delivers a truckload of food (both fresh and nonperishable) every week to the health center.

Marin Community Clinics in Novato, California partners with CalFresh to help make healthy foods affordable for their community. CalFresh and other community partners set up booths at Marin's weekly Health Hubs to bring more awareness about available community resources and services.

Transportation

A health center in Missouri calculated the number of missed appointments and how much money it was costing their organization. After they administered PRAPARE with their population, they found that 1 in 4 of their patients had transportation barriers. With that knowledge, they implemented a couple of transportation interventions and reduced their no-show rate by 50%, which led to a significant increase in revenue for the organization and better care for their patients.

A health center in Iowa found that 1 in 5 of their patients had transportation needs. This health center was able to use this data to form a partnership with local and regional transportation authorities to provide bus tokens and taxi vouchers as well as work to develop more bus routes to areas in need.

The Maine Primary Care Association (Maine PCA) joined state-wide transportation coalitions that included other organizations also interested in addressing transportation needs. The Maine PCA was able to share their PRAPARE data demonstrating the extent and location of needs with the coalition members while also benefiting from the resources and staff of the other partners to help address the transportation needs so that they didn't have to address them alone.

List of Community Coalitions in Salt Lake County

Joining a community coalition can connect your clinic to resources and supports for patient needs. It is also a way to share the data your clinic collects around community needs to other community partners. The list below are current coalitions in Salt Lake County your clinic may be interested in joining to further your work in SDOH.

Substance Use Prevention Coalitions: Salt Lake County

Community	Priorities	Contact
Kearns	Marijuana, e-cigarette, alcohol use	Mercedes Rodriguez: myrodriguez@slco.org
	Healthy Communities collaboration	Jason Cloward: jjcloward@slco.org
Magna	To be determined	Kellen Schalter: kschalter@slco.org
Murray	Substance use prevention, low commitment to school	Carol Anderson: canderson@murrayschools.org

Substance use prevention coalitions are community-driven groups that focus on preventing risk factors and encouraging protective factors in youth.

Community Coalitions: Salt Lake County		
Community	**Priorities**	**Activities**
Herriman	Physical Activity, Safety	Pedal Palooza— Bicycle safety and helmet distribution
	Mental Health	Community QPR Training
Holladay	Physical Activity	Walking Program
	Overall Health	Lecture Series, Fall Prevention, Pain Management
Magna	Prediabetes	Planning for 2020
Riverton	Suicide Prevention Prescription Drugs	Community QPR Training , Drug Take Back Box
	Overall Community Wellness	Community Workouts
South Jordan	Social Development Strategy	Planning Phases
West Jordan	Physical Activity, Nutrition, and Weight Loss	Way to a Better Life Contest—3 Month Health Contest
		Linda Buttars Memorial Fun Run—5k and 1 mile Family Fun Run
	Mental Health	Planning for 2020
Sandy	Overall Health	Promotes programs, activities, and strategies of partners created through Healthy Sandy. Partners are able to request funding from Healthy Sandy as well.

Healthy Community Coalitions are designed to be community driven groups, supported by businesses and organizations to identify community needs, strengths, and community solutions.

We have semi-active Healthy Community coalitions in Draper, Millcreek, Kearns, and West Valley City.

For meeting information and to join a coalition, please email healthycommunities@slco.org

Resources

Trainings

Health Equity

- NIHCM Webinar: Systemic Racism & Health: Solutions, Making Change Happen
- National Alliance Webinar: Race, Health & Equity Town Hall: The (Un)conscious Bias in Delivering Care
- National Alliance Other Race, Health & Equity Webinars and Resources
- AAFP Implicit Bias Resources and Trainings
- APCM Webinar: Reducing Hypertension in High-Risk Populations: Empowering Patients to Improve Blood Pressure
- APCM Webinar and Handouts: Reducing Hypertension in High-Risk Populations: Outreach to African-Americans before and during the COVID-19 Pandemic (Click the + on "Hypertension Learning Collaborative" to access)

Social Determinants of Health

- Putting the ethical guidelines for the use of SDOH into practice from LexisNexis
- SDOH Turns the Corner in 2019: Lessons Learned and Expectations for 2020 from LexisNexis
- How Utah 2-1-1 Can Help Address the Social Determinants of Health from Comagine
- Using Utah 2-1-1 to Address Patients' Social Needs: A Deeper Dive from Comagine
- Transforming Health with SDOH Coding from eHI
- Connecting Communities: HIEs and Social Determinants of Health from eHI
- FHN SDOH Webinar Series: Transportation, Housing, and Food Security (3 different webinars) from The Farmworker Health Network
- Integrating Clinical and Non-Clinical Care to Address the Social Determinants of Health from NACHC
- Various webinars specific to the PRAPARE tool

Toolkits and Other Resources

Health Equity

- NIHCM Systemic Racism Is a Public Health Crisis – includes resources for actionable ways to address disparities in healthcare
- Allina Health Advancing Health Equity – Data Driven Strategies Reduce Health Inequities
- AAFP How to Identify, Understand, and Unlearn Implicit Bias in Patient Care PRAPARE toolkit

Social Determinants of Health

- Iowa SIM toolkit

- Comagine 2-1-1- toolkit
- Intermountain's Care Process Model for Social Determinants of Health
- Screening tools:
    - PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences
    - American Academy of Family Practice Short-Form Social Needs Screening Tool
    - CMMI Accountable Health Communities Health-Related Social Needs (HRSN) Screening Tool
    - Health Leads Social Needs (HLSN) Screening Toolkit
    - Towncrest Pharmacy SDOH Screening (can be used verbally)

Community Health Workers (CHWs)

CHW Bi-directional Referral Policy

Sample Policy

Purpose: To implement a process for bi-directional referral to a community organization that employs CHWs to assist with patient education and resources around specific disease processes.

Policy Statement:
{Clinic or Agency Name} will implement a bi-directional referral process for patients with chronic disease conditions to appropriate organizations to engage CHWs with chronic disease management.

Procedure:

- Staff will identify community organizations that employ CHWs for potential patient referrals
- Staff will reach out to selected community organization to discuss potential partnership and referral of patients for education, outreach, and resources
- Staff will create a list of potential patients that could benefit from the assistance of a CHW
- The CHW will send a patient progress report at determined intervals/on a regular basis
- Progress reports can be added to the patient medical file
- At the next patient medical appointment, the healthcare provider reviews the update and continues to work with the patient as appropriate.

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

CHW Training Policy

Sample Policy

Purpose: To implement a policy for the annual and/or new hire training of CHWs on the basics of correct blood pressure measurement, cholesterol, diabetes and diabetes prevention.

Policy Statement:
{Clinic or Agency Name} is committed to providing staff evidence-based training and/or education to employed CHWs on correct blood pressure measurement, and the basics of blood pressure, cholesterol, diabetes and diabetes prevention. Providing excellent care and services in these areas requires regular training and re-training according to a standard process.

Procedure:

- Training on correct blood pressure measurement will be conducted upon hire and annually for all CHW staff. This training will consist of the following:
  - Staff will remind patients during visits and prior to scheduling future appointments that they should not drink alcohol, use tobacco or exercise 30 minutes prior to appointment
  - Staff will remind patients to empty their bladder prior to blood pressure measurement
  - Staff will remind patients to sit quietly for 5 minutes prior to blood pressure measurement
  - During blood pressure measurement, staff will ensure that the patient is sitting upright with back supported and both feet flat on the floor
  - Staff will use an appropriately sized blood pressure cuff and fit the cuff snuggly around patient's upper arm approximately 1 inch above the elbow
  - Staff will support the patients arm so the cuff is at heart level with the person's elbow slightly bent
  - During blood pressure reading, the patient and staff will refrain from speaking
- Training on correct blood pressure measurement will include return demonstration of correct process for measurement
- Training on blood pressure, cholesterol, diabetes and diabetes prevention will be conducted upon hire and annually for all CHW staff. Training on the basics of blood pressure, cholesterol, diabetes and diabetes will include:
  - Information on the basics of the disease
  - Lab values
  - Dietary guidelines
  - Physical activity guidelines

Signature of Approval: _____

Date of Implementation: _____ Last Reviewed/Updated: _____

Additional Resources

CHWs

- Utah Department of Health (UDOH) CHW Website
- 2018 Leavitt Partners white paper, "Driving Improvements in Utah's Health Outcomes: the community health worker solution" A summary page is also available.

Prediabetes

Prediabetes Screening and National DPP Referral Policy for Clinics

Sample Policy

Purpose: The purpose of the policy is to put into place measures for the healthcare team to identify patient eligibility for the National Diabetes Prevention Program (DPP) and provide referral to National DPP. **{Clinic or Agency Name}** believes in providing patient education and evidence-based lifestyle intervention programs to our patients.

Policy Statement:

1. Patients with prediabetes will be targeted for the program. To be eligible for referral, patients must be at least 18 years old and have a BMI ≥ 25 (≥ 23 if Asian) **AND** meet at least one of the following criteria:

- Have a blood test result in the prediabetes range within the past year:
  - Hemoglobin A1C: 5.7%–6.4% or
  - Fasting plasma glucose: 100–125 mg/dL or
  - Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL
- **OR** have a history of gestational diabetes

50% of participants can be considered eligible for the National DPP without a blood test or history of gestational diabetes if they screen positive for prediabetes based on the CDC Prediabetes Screening Test.

2. During in-person office visits, patients with prediabetes will be referred to DPP.

3. Patients will also be referred to the National DPP retroactively by identifying patients with prediabetes in the patient registry/portal within the A1C range of 5.7-6.4%. Other Electronic Health Record (EHR) filters will be used to refine patients with prediabetes. Patients with prediabetes from this registry report will be contacted via phone, email or letter to inform them of their risk of developing type 2 diabetes and will be referred to the National DPP. This report will be generated every **{desired frequency}**.

Staff can enroll patients by:
1. Calling 1-888-222-2542 OR
2. Registering for a National DPP workshop at http://livingwell.utah.gov/ws_find.php

Supporting Activities:

The National Diabetes Prevention Program is an evidence-based lifestyle change intervention that targets improving diet, increasing physical activity and achieving moderate weight loss. The program is founded on scientific research studies which showed that making modest behavior changes helped participants **lose 5% to 7% of their body weight and experienced a 58% lower incidence of type 2 diabetes.**

The goal for each participant is to lose 5-7% of their body weight by:

- Progressively reducing dietary intake of calories through improved food choices
- Gradually increasing moderate physical activity to ≥150 minutes per week

- Developing behavioral problem-solving and coping skills

Features include:

- A year-long structured program consisting of 16 sessions during the first six months followed by monthly sessions during the last six months
- Facilitation by a trained lifestyle coach using a CDC-approved curriculum
- Regular direct interaction between the lifestyle coach and other participants
- An emphasis on behavior modification, managing stress, and peer support

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Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Prediabetes Screening and National DPP Referral Policy for Pharmacies

Sample Template

Purpose: The purpose of the policy is to put into place measures for the healthcare team to identify patient eligibility for the National Diabetes Prevention Program (DPP) and provide referral to National DPP. **{Pharmacy Name}** believes in providing patient education and evidence-based lifestyle intervention programs to our patients.

Policy Statement:

1. Patients will be provided the prediabetes risk assessment and information about National DPP in the waiting area.
2. Patients will also be provided the risk assessment and National DPP information along with their medications.
3. Patients with a positive result on the prediabetes risk assessment will be educated about lifestyle modifications to reduce their risk for type 2 diabetes and will be referred to the National DPP. To be eligible for referral, patients must be at least 18 years old and have a BMI ≥ 25; ≥ 23 if Asian **AND** meet at least one of the following criteria:

- Have a blood test result in the prediabetes range within the past year:
  - Hemoglobin A1C: 5.7%–6.4% or
  - Fasting plasma glucose: 100–125 mg/dL or
  - Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL
- **OR** have a history of gestational diabetes

50% of participants can be considered eligible for the National DPP without a blood test or history of gestational diabetes if they screen positive for prediabetes based on the CDC Prediabetes Screening Test.

Staff can enroll patients by:

1. Calling 1-888-222-2542 OR
2. Registering for a National DPP workshop at http://livingwell.utah.gov/ws_find.php

Supporting Activities:

The National Diabetes Prevention Program is an evidence-based lifestyle change intervention that targets improving diet, increasing physical activity and achieving moderate weight loss. The program is founded on scientific research studies which showed that making modest behavior changes helped participants **lose 5% to 7% of their body weight and experienced a 58% lower incidence of type 2 diabetes.**

The goal for each participant is to lose 5-7% of their body weight by:

- Progressively reducing dietary intake of calories through improved food choices
- Gradually increasing moderate physical activity to ≥150 minutes per week
- Developing behavioral problem-solving and coping skills

Features include:

- A year-long structured program consisting of 16 sessions during the first six months followed by monthly sessions during the last six months
- Facilitation by a trained lifestyle coach using a CDC-approved curriculum
- Regular direct interaction between the lifestyle coach and other participants

- An emphasis on behavior modification, managing stress, and peer support

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Signature of Approval: _____

Date of Implementation: _____

Late Reviewed/Updated: _____

Annual Prediabetes Training Policy

Sample Policy

Purpose: {Clinic or Agency Name} is committed to providing the healthcare team/staff a yearly training on prediabetes processes and policies. Excellence in prediabetes identification and referral to the National Diabetes Prevention Program (DPP) requires regular training and re-training according to a standard process so our patients can be properly identified and referred.

Policy Statement:
{Clinic or Agency Name} prediabetes training will provide information on:

- Prediabetes, the National Diabetes Prevention Program, prediabetes identification, and National DPP referral
- Information about M.A.P. (Measure, Act, Partner) to review prediabetes roles and responsibilities for identifying patients with prediabetes and referring to DPP

All employees shall participate in the yearly prediabetes training during the month of **{month of annual training}**. Employee attendance at the training will be recorded.

Scope: This policy applies to all providers, staff, employees, interns and volunteers of **{Clinic or Agency Name}** regardless of age, cultural practices, sexual orientation, or disability status.

Supporting Activities/Information:
Why focus on diabetes prevention?

- Prediabetes is common and underdiagnosed. One out of 3 adults in America have prediabetes and 9 out of 10 don't know it.
- Without intervention, up to 30% of people with prediabetes develop type 2 diabetes within 3-5 years.
- Progression to diabetes can be prevented or delayed. Studies have shown that individuals in lifestyle interventions had a 58% reduction in the rate of conversion to diabetes. Those 60 and older had a 71% reduction.
- Diabetes prevention is cost effective.
- Diabetes prevention is a shared responsibility for promoting population health.

The National Diabetes Prevention Program is an evidence-based lifestyle change intervention that helps participants improve their diet, increase physical activity and achieve 5-7% of body weight loss to decrease the incidence of type 2 diabetes.

The following activities will be provided to employees to further support prediabetes trainings:

- Display prediabetes awareness posters and/or videos in the clinic
- Distribute information and studies regarding the evidence-base for the prevention of diabetes through lifestyle change interventions like National DPP
- Distribute the Prevent Diabetes STAT (Screen. Test. Act Today.) Toolkit by the AMA and CDC. This is a clinical guide to refer patients with prediabetes to an evidence-based diabetes prevention program

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Signature of Approval: _____

Date of Implementation: _____ Last Reviewed/Updated: _____

Letter/Email Follow-up National DPP Referral

Sample Letter

{Your Letterhead}
{Address}
{Phone Number}

{Date}

{Patient Name}
{Patient Address}

Dear **{Mr./Mrs.} {Patient Last Name}**,

Thank you for being a patient of the **{Clinic or Agency Name}**. We are writing to tell you about a service to help you make your health better.

Based on our review of your medical chart, you have a condition known as prediabetes. This means your blood sugar is higher than normal, which increases your risk of developing serious health problems including type 2 diabetes, as well as heart disease and stroke.

We have some good news. Our office wants you to know that you may be eligible for a diabetes prevention program run by our partners, **{Name of Program Provider}**. This program is proven to reduce your risk of developing diabetes and other health problems.

We have sent a referral to **{Name of Program Provider}** and someone will call you to discuss the program, answer any questions you may have and, if you are interested, enroll you in the program.

Please feel free to give **{Name of Program Provider}** a call at **{Phone Number}**.

OR

We have sent a referral to **{Name of Program Provider}** and we urge you to call **{Phone Number}** to learn more about the program and enroll.

We hope you will take advantage of this program, which can help prevent you from developing serious health problems.

Sincerely,

Dr. **{Physician Last Name}**

Phone Follow-up National DPP Referral

Sample Phone Script

Talking points for phone outreach:

- Hello **{Patient Name}**
- I am calling from **{Clinic or Agency Name}**.
- I'm calling to tell you about a program we'd like you to consider, to help you prevent some serious health problems.
- Based on our review of your medical chart, you have a condition known as prediabetes. This means your blood sugar is higher than normal, which makes you more likely to develop serious health problems including type 2 diabetes, stroke, and heart disease.
- We have some good news.
- You may be eligible for a diabetes prevention program run by our partners, **{Name of Program Provider}**.
    - Their program is based on research proven to reduce your risk of developing diabetes and other health problems.

Option A:

- We have sent a referral to **{Name of Program Provider}** and someone will call you to discuss the program, answer any questions you may have and, if you are interested, enroll you in the program.
- Please feel free to give **{Name of Program Provider}** a call at **{Phone Number}**.
- Do you have any questions for me?
- Thank you for your time and be well.

Option B:

- We have sent a referral to **{Name of Program Provider}** and we urge you to call **{Phone Number}** to learn more about the program and enroll.
- We hope you will take advantage of this program, which can help prevent you from developing serious health problems.
- Do you have any questions for me?
- Thank you for your time and be well.

National DPP & Community Resource Bi-directional Referral Policy

Sample Policy

Purpose:

The purpose of the policy is to put into place a process for the healthcare team/staff to implement a bi-directional referral policy between the clinical practice and the National Diabetes Prevention Program (DPP) and other community resources. **{Clinic or Agency Name}** is committed to directly referring patients to lifestyle intervention programs or community resources whenever possible to help patients achieve improved overall health.

Policy Statement:

1. Patients with prediabetes will be referred to the National DPP and other community resources through the EHR or other e-referral software.
2. The National DPP Program Coordinator will prepare and send a progress report for the healthcare provider at different times during the program.
3. The progress reports will be added to the patients EHR or medical records.
4. At the next patient medical appointment, the healthcare provider views the update and continues to work with the patient as appropriate.

{Clinic or Agency Name} has established a collaborative bi-directional referral relationship with the **{Name of National DPP Program Provider}**.

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Additional Resources

Prediabetes

Training

- Association of Gestational Diabetes with Maternal Disorders of Glucose Metabolism and Childhood Adiposity Training (1-hour CME available)

Toolkits and Other Resources

- CDC/AMA/ADA Prediabetes Risk Test (English and Spanish)
- Online Registration for a Utah National DPP
- National Diabetes Prevention Program CDC website
- AMA/CDC Prevent Diabetes STAT (Screen. Test. Act Today.) Website
- AMA/CDC Prevent Diabetes STAT (Screen. Test. Act Today.) Toolkit
    - This toolkit includes sample workflows, sample National DPP referral forms, and sample patient DPP handouts.
- Patient Education Prediabetes Awareness Posters/Infographics to Post:
    - CDC Infographics
    - Are you at risk? (English and Spanish)
- If you would like a local National DPP flyer to post at your clinic, contact the Salt Lake County Health Department at healthpromotion@slco.org
- Prediabetes Awareness Videos/Testimonials for Waiting Room TVs:
    - Risk Test Puppies :60
    - Tome la Prueba de Riesgo Prediabetes (Spanish)
    - Mike's Prediabetes Journey
    - Dionne's Prediabetes Journey
- The M.A.P. (Measure, Act, Partner) to Prevent Type 2 Diabetes
- Commonly Used Prediabetes CPT/ICD Codes
- CDC DPP Resources for Health Care Professionals
- Medicare Diabetes Prevention Program (MDPP) Expanded Model Healthcare Payment, Billing and Becoming an Enrolled Supplier
    - Payment and Billing Guide
    - MDPP Supplier Road Map
    - Become a MDPP Supplier Fact Sheet
    - Expanded Model Fact Sheet
- Rx for the National DPP: Action Guide for Community Pharmacists
- AMA Evidence and Research Supporting DPP

Diabetes

Type 2 Diabetes Screening and DSMES Referral Policy for Clinics

Sample Policy

Purpose: The purpose of the policy is to put into place measures for the healthcare team to identify patient eligibility for Diabetes Self-Management Education and Support (DSMES) and provider referral to DSMES.

Policy Statement:
{Clinic or Agency Name} believes in providing patient education and evidence-based lifestyle intervention programs to our patients.

- Patients with type 2 diabetes will be targeted for the program. To be eligible for referral, patients must meet the following criteria:
  - Have a blood test result in the diabetes range within the past year:
    - Hemoglobin A1C: ≥ 6.5% or
    - Fasting plasma glucose: ≥ 126 mg/dL or
    - Two-hour plasma glucose (after a 75 gm glucose load): ≥ 200 mg/dL
  - **OR** have a history of gestational diabetes
  - Been previously diagnosed with diabetes before meeting Medicare eligibility requirements and are now eligible for coverage **AND**
  - A written referral from a physician or mid-level provider
- During in-person office visits, patients diagnosed with type 2 diabetes will be referred to the DSMES
- Patients will also be referred to the DSMES retroactively by finding patients diagnosed with type 2 diabetes through the patient registry/portal with an A1C of 6.5% or higher. Other EHR filters will be used to refine patients with type 2 diabetes.
- Enroll by:
  - Using referral form provided at http://choosehealth.utah.gov/documents/pdfs/diabetes/dsme_referral_form.pdf
  - Register for a DSMES class at http://livingwell.utah.gov/ws_find.php

Supporting Information:
Diabetes Self-Management Education (DSME) is the active, ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. The overall objectives of DSME are to support informed decision-making and improved self-care behaviors, encourage effective problem-solving and active collaboration with the healthcare team, and improve clinical outcomes, health status, and quality of life.

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Diabetes Screening and Diagnosis

Sample Policy

Purpose: To provide criteria for diagnosing and screening for diabetes in adult patients.

Policy Statement:
{Clinic or Agency Name} is committed to providing patients with reliable diabetes screening and diagnosis. Laboratory procedure for two house oral glucose tolerance test includes:

- The two-hour oral glucose tolerance is done in the fasting state
- Prescribed medication may be taken and should be noted in the pretest interview. There are no specific medications that cannot be taken
- A glucose tolerance test should not be performed unless the patient has followed the proper preparatory procedures:
    - A carbohydrate intake of ≥ 150 grams/day for the three days prior to the OGGT
    - Fasting for ≥ 8 hours but ≤ 14 hours prior to the OGTT
- Procedure for the 2-hour OGTT:
    - Take a brief history to document the reason for the test. List medications.
    - Confirm that the patient had an adequate carbohydrate intake for three days prior to the test and is currently fasting.
    - Measure and record weight, blood pressure, and body temperature.
    - Instruct the patient to contact lab personnel during the test if she/he experiences any signs or symptoms that are uncomfortable or worrisome.
    - Inform patient that she/he is not allowed to eat, smoke, walk, or ingest any liquids, except water, during this test.
    - Phlebotomy laboratory testing procedure:
        - If the patient is febrile, contact supervising nurse or physician
        - Collect fasting plasma glucose level. To avoid unnecessary testing and patient risk, it is preferable to know the fasting glucose level before giving the oral glucose. *If the fasting plasma glucose value is ≥ 126 mg/dl, discontinue the OGTT.*
        - If the fasting glucose level is <126 mg/dl, administer the oral glucose solution.
        - Blood specimen collection times are fasting and 2 hours.
- Interpretation of OGTT Results: A diagnosis of diabetes (below) is made after diagnostic criteria have been confirmed on a subsequent day unless the patient has an unequivocally elevated glucose level with metabolic decompensation.

Supporting Information:
Criteria for the Diagnosis of Diabetes in Adult:
In the absence of unequivocally high glucose levels with metabolic decompensation, there are three ways to diagnose diabetes. An abnormal result must be confirmed on a subsequent day by any one of three methods:

- Random plasma glucose ≥ 200 mg/dl and symptoms of diabetes **OR**
- Fasting blood glucose (FBG) ≥ 126 mg/dl (fasting for ≥ 8 hours) **OR**

- 75 Gm Oral Glucose Tolerance Test (OGTT) 2-hour valve ≥200 mg/dl

[The FBG is the preferred screening method due to patient convenience and lower cost. If the FBG ≥ 126, re-test on a separate day. If the FBG < 126 and there is a high suspicion of diabetes, do an OGTT (see "Procedure" above)]

Screening for Diabetes in Adult:

Patients should be screened for diabetes as part of routine medical care starting at age 45 years. If the result is normal, it should be repeated every 3 years. Screen at a younger age if there are one or more of the following risk factors:

- Family history (parents or siblings with diabetes)
- Obesity (≥20% over desired body weight or BMI ≥25 kg/m^2)
- Race/ethnicity: African Americans, Hispanic-Americans, Native-Americans, Asian-Americans, Pacific Islanders
- Previously identified IFG or IGT
- Hypertension (≥140/90 mmHg)
- HDL cholesterol level ≤35 mg/dl or a triglycerides level ≥250 mg/dl
- History of GDM or delivery of a baby with a birth weight over 9 lb.
- Polycystic ovaries

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Chronic Kidney Disease Screening and Diagnosis

Sample Policy

Purpose: To provide criteria for screening and diagnosing of chronic kidney disease in patients with diabetes.

Policy Statement:
{Clinic or Agency Name} is committed to early detection of chronic kidney disease (CKD) among patients with diabetes and will follow the American Diabetes Association (ADA) recommendation for CKD screening and treatment.

Procedure:
{Clinic or Agency Name} will follow the following ADA recommendations for CKD screening in patients with diabetes:

- At least once a year, assess urinary albumin (e.g., spot urinary albumin-to creatinine ratio) and estimated glomerular filtration rate (eGFR) in patients with type 1 diabetes with duration of 5 years or more and in all patients with type 2 diabetes regardless of treatment.
- Patients with urinary albumin (ACR) >30 mg/g creatinine and/or an eGFR<60 mL/min/1.73 m² should be monitored twice annually to guide therapy

Patients will be diagnosed with CKD and assigned a GFR and/or Albuminuria category if the patient has an ACR >30 mg/g and/or eGFR<60 mL/min/1.73 m² for 3 months or more.

- ACR Category
  - <30 = normal or mild ↑
  - 30-299 = moderately ↑
  - >300 = severely ↑
- GFR Category
  - 45 – 59 = 3a
  - 30 – 44 = 3b
  - 15 – 29 = 4
  - <15 = 5

Provide CKD education to patients screened and have a normal or low risk level for CKD.
Patients will be referred to a nephrologist if:

- eGFR <30ml/min
- Marked proteinuria out of proportion with decreased GFR.
- Albumin-creatinine ratio>1000 mg/g
- Rapid decline in eGFR
- Abnormal urinalysis (persistent hematuria and/or
- proteinuria)
- Resistant hypertension: above target on 3 or more meds.
- Recurrent renal calculi
- PTH>100 or PO4>4.6
- Refractory Hyperkalemia K>5.5
- Transplant evaluation for eGFR <20

Provider will optimize glucose control and blood pressure control to reduce the risk or slow the progression of CKD.

- Target HbA1c ~7%
- Blood Pressure Goal <140/90
- Consider BP goal <130/80 only if ACR >300
  - ACE-I or ARB for HTN if ACR >30
  - Avoid ACE-I and ARB in general
  - Diuretic usually required
  - Dietary sodium <2000 mg/day

Provider will monitor CKD complications testing:

- Anemia – CKD 3+ Evaluation if Hb <13.0 for men and <12.0 for women. Treat iron deficiency first. Use ESA to treat Hb <10 g/dl (Target 9-11.5) or refer to nephrology.
- Acidosis – Bicarbonate goal >22-26 use sodium bicarbonate 650 mg thrice daily.
- CKD-MBD – CKD 3b+ calcium, phosphate, 25-OH vitamin D, and iPTH. Supplement vitamin D deficiency. If hyperphosphatemia or significant iPTH elevation refer to nephrology.

Provider will monitor unsafe medications to ensure patient safety:

- eGFR <60 = Patient Safety Risk
  - Drug dosing consider eGFR
  - Reduce risk of AKI volume depletion
  - Contrast-induced AKI prevention
    - Avoid contrast or minimize dose
    - Consider isotonic saline infusion before, during and after procedure
    - Withhold metformin, RAAS blockers and diuretics
- eGFR 45 - <60
  - Avoid prolonged NSAIDs
  - Continue metformin use
- eGFR 30 - <45
  - Avoid prolonged NSAIDs
  - Use metformin with close monitoring at 50% dose
- eGFR <30
  - Avoid any NSAIDs
  - Avoid bisphosphonates
  - Avoid metformin
  - Avoid PICC; lines use single and double lumen central catheters instead
  - Monitor PT INR closely given increased risk of warfarin anticoagulation bleeding

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Additional Resources

Diabetes and CKD

Training

- Expanding Quality Improvement: Data, Health Records, and Diabetes Reimbursement
- 2019 Diabetes Is Primary: Patient-Centered Care: What This Means for PCPs (.75 CE)
- National Kidney Foundation CME/CE Training Activity

National Protocols

- ADA Standards of Medical Care in Diabetes
- National Kidney Foundation CKD Change Package
- National Kidney Foundation CKD Algorithm

Toolkits and Other Resources

- CDC Diabetes Website
- Diabetes Report Card - most current information and data available about diabetes and prediabetes, along with diabetes-related preventive care practices, health outcomes, risk factors, and national and state trends
- Redesigning the Health Care Team – Clinic guide for diabetes prevention and management
- Intermountain CKD Best Practice Flashcard
- Intermountain CKD Care Process Model
- CKD Quick Reference Guide for Primary Clinician

Worksite Wellness

Worksite Nutrition Policy

Sample Policy

Purpose: {Clinic or Agency Name} is committed to providing a work environment that promotes healthy eating and supports employees in making healthy food choices in and outside of work.

Policy Statement:

Examples:

- **{Clinic or Agency Name}** will provide fruit and vegetable food choices that are low in fat at company meetings and functions. At company functions which offer food, one or more healthful entrees, side dishes, snacks, beverages or desserts will be served.
- Vending Machines: Vending machines will offer a variety of snack foods, including healthful alternatives. Drink machines will provide water and 100% fruit juices, as well as sugar-free and caffeine-free soda selections.
- Doughnuts, bars, giant muffins, pastries, sweet rolls, pies, cookies, sugared beverages (regular sodas, punch, etc.) will no longer be served to employees or clients during meetings or be paid for by **{Clinic or Agency Name}** funds.

Scope:

This policy applies to all employees, interns and volunteers of **{Clinic or Agency Name}**. **{Clinic or Agency Name}** will ensure that wellness opportunities are provided for all employees, regardless of age, cultural or religious practices, gender, sexual orientation or disability status.

Supporting Activities:

The following activities will be provided to employees to further support healthy food choices: [Select one or more activities]

- Refrigerators, microwaves and break areas will be offered for employee use.
- Access to free water will be available throughout the day. Vending machines and staff cafeteria(s) will:
    - Use competitive pricing to make healthier choices more economical.
    - Use signs or symbols to make healthy choices stand out and make nutrition information available for foods and beverages.

Local food initiatives will be supported:

- Employees will have access to a [discounted] on-site Community Supported Agriculture (CSA) program.

Signature of Approval: _____

Date of Implementation: _____ Last Reviewed/Updated: _____

Exercise and Health Activity Policy

Sample Policy

Purpose: To encourage employee participation in exercise and other health enhancing activities.

Policy Statement:

- **{Clinic or Agency Name}** encourages all its employees to engage in a regular program of exercise and health improvement (unless existing medical conditions make such a program inadvisable).
- This program is not an employee right and can be withdrawn by appropriate agency management at any time.
- Employees who wish to exercise during the workday may be granted thirty minutes per day, for a maximum of ninety minutes per week. Supervisors are encouraged to schedule working hours to allow employees to participate in an exercise program. The time shall be determined by agreement between the employee and his/her supervisor so as not to interfere with normal work requirements.
- Authorization to participate in this program may be revoked if the provisions of the program are violated or if the program interferes with the employee's ability to complete work assignments.
- Exercise time is not cumulative; time not used during the week cannot be carried over into the next week, nor can an employee use more than 30 minutes on a given day.
- It is not intended in any way to provide extra time for personal matters.
- The intent of this policy is to allow employees to utilize exercise in conjunction with an employee's work schedule and break periods. Exercise at the beginning or end of the workday must be taken on site.
- Exercise programs, such as structured aerobics, walking, jogging, swimming, bicycling, and weight control programs, are examples of programs that qualify for approval. However, other appropriate exercise programs may be approved.
- Modifications or variations to the original employee request for exercise and health activity release time must be approved by the supervisor.
- Renewal or continuation of approval to participate in exercise and/or health activities subject to this policy shall be reviewed annually, preferably during the employee's performance review.
- Employees shall participate at their own risk and agree to hold **{Clinic or Agency Name}** harmless.

Procedures:

An employee must request permission from his or her supervisor to participate in this program.

Exception:

Employees on formal corrective action are not eligible to participate in this program.

Signature of Approval: _____

Date of Implementation: _____ Last Reviewed/Updated: _____

Worksite Physical Activity Policy

Sample Policy

Purpose: {Clinic or Agency Name} encourages all **employees** to engage in regular physical activity during their workday and at home.

Policy Statement:
Employees are encouraged and supported through the following:

- **Active Meetings:** Staff organizing a full working day meeting will incorporate a set amount of time (i.e.15 or 30 minutes) for physical activity break(s) into the meeting. For example: a one-hour lunch break could have 30 minutes dedicated for physical activity, or two scheduled 15-minute breaks for physical activity throughout the day (i.e. stretching, walking).
- **Alternative Work Schedules**: Managers and supervisors encourage and support all staff to utilize breaks and lunch periods for physical activity during the workday. In addition, managers and supervisors are encouraged to allow flexible schedules to accommodate employee physical activity, while assuring primary work is accomplished (i.e. flexible work schedules to accommodate active transportation commuters or those that bike/walk to and from work or those that choose to be physically active over lunch periods).
- **Allotted Staff Planning Time:** Time will be dedicated for appropriate staff to organize and disseminate information about regular and special opportunities for physical activity engagement or for environmental enhancements to support physical activity.
- **Dedicated Physical Activity Time**: Outside of regularly scheduled breaks, employees will be allocated time to be active each day or week. For example, outside of regular break times, employees are allowed 30 minutes per week to engage in physical activity during paid time while assuring all primary job duties are accomplished.
- **Healthy Stairwells/Scenic Stairs**: Stairwells will be opened and encouraged for use during all business hours, especially during breaks throughout the day. Stairwells will be maintained, safe, visually appealing, well-lit and easily accessible to all employees.
- **Dedicated Walking Paths/Trails with Signage**: Outdoor or indoor walking areas will be identified with appropriate signage to indicate safe, accessible, and attractive areas for employees to walk and or walk/bike to and from work.
- **Bike Facilities and Amenities:** Bike storage, bike racks, and other biking amenities will be provided to encourage active transportation to work, or for use during dedicated physical activity time or regular break times.

Supporting Activities:
{Clinic or Agency Name} will create an environment that supports a physical activity culture in the workplace where all employees are encouraged and supported to be more physically active through:

- Support from leadership staff to enhance and promote physical activity.

- Encouraging regular physical activity both at the workplace and at home and recognizing the importance of work life balance.
- Making significant attempts to alter and enhance the workplace-built environment to increase and enhance physical activity opportunities for employees.
- Utilizing and implementing additional physical activity policy strategies from reliable and research-based sources.
- Supporting physical activity among all employees regardless of abilities.
- Providing various social support opportunities in the workplace to encourage physical activity.

Education and Implementation:

- The **{Clinic or Agency Name}** physical activity policy will be posted, discussed at employee meetings, promoted through multiple communication channels, and presented at new employee orientations to educate and inform all employees.
- Employees interested in engaging in physical activity may seek additional information from ***{human resources, worksite wellness coordinator or wellness champion}*** or access this policy at ***{insert website or building location}***.
- To support and enhance **{Clinic or Agency Name}** physical activity policy, additional evidenced-based physical activity workplace strategies will be implemented.
- Learning opportunities on various physical activity topics will be provided to employees to increase knowledge, skills, and attitudes on physical activity.
- Addressing barriers to implementation is key to a successful worksite physical activity policy. Conducting pre and post employee assessments as well as process evaluations will provides useful information on employee barriers to physical activity to plan and implement successful workplace policy.

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Policy for Supporting Breastfeeding Employees

Sample Policy

Purpose: In recognition of the well documented health advantages of breastfeeding for infants and mothers, **{Clinic or Agency Name}** provides a supportive environment to enable breastfeeding employees to express their milk during work hours. This includes a company-wide lactation support program administered by **{Clinic or Agency Name}** subscribes to the following worksite support policy. This policy shall be communicated to all current employees and included in new employee orientation training.

Policy Statement:

Company Responsibilities:

Breastfeeding employees who choose to continue providing their milk for their infants after returning to work shall receive:

- Milk Expression Breaks: Breastfeeding employees are allowed to breastfeed or express milk during work hours using their normal breaks and mealtimes. For time that may be needed beyond the usual break times, employees may use personal leave or may make up the time as negotiated with their supervisors.
- A Place to Express Milk**:** A private room (not a toilet stall or restroom) shall be available for employees to breastfeed or express milk. The room will be private and sanitary, located near a sink with running water for washing hands and rinsing out breast pump parts, and have an electrical outlet. If employees prefer, they may also breastfeed or express milk in their own private office, or in other comfortable locations agreed upon in consultation with the employee's supervisor. Expressed milk can be stored **{Company supplied refrigerator/ in the lactation room or other location in employee's personal cooler}**.
- Breastfeeding Equipment: **{Clinic or Agency Name} {provides/subsidizes/rents}** electric breast pumps to assist breastfeeding employees with milk expression during work hours. The company provides **{a hospital grade pump that can be used by more than one employee or a portable, personal use electric breast pump that the employee retains}** throughout the course of breastfeeding for the employee. **{If using a standard hospital grade pump, indicate whether the company provides/subsidizes personal attachment kit or where the employee can purchase the kit.} {Indicate whether breast pumps are also available for partners of male employees.}**
- Education: Prenatal and postpartum breastfeeding classes and informational materials are available for all mothers and fathers, as well as their partners.
- Staff Support: Supervisors are responsible for alerting pregnant and breastfeeding employees about the company's worksite lactation support program, and for negotiating policies and practices that will help facilitate each employee's infant feeding goals. It is expected that all employees will assist in providing a positive atmosphere of support for breastfeeding employees.

Employee Responsibilities

- Communication with Supervisors: Employees who wish to express milk during the work period shall keep supervisors informed of their needs so that appropriate accommodations can be made to satisfy the needs of both the employee and the company.
- Maintenance of Milk Expression Areas: Breastfeeding employees are responsible for keeping milk expression areas clean, using anti-microbial wipes to clean the pump and area around it. Employees are also responsible for keeping the general lactation room clean for the next user. This responsibility extends to both designated milk expression areas, as well as other areas where expressing milk will occur.
- Milk Storage: Employees should label all milk expressed with their name and date collected so it is not inadvertently confused with another employee's milk. Each employee is responsible for proper storage of her milk using **{company provided refrigeration/personal storage coolers}**.
- Use of Break Times to Express Milk: When more than one breastfeeding employee needs to use the designated lactation room, employees can use the sign-in log provided in the room to negotiate milk expression times that are most convenient or best meet their needs.

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Tobacco-Free Policy-General

Sample Policy

Purpose: Due to the acknowledged hazards arising from exposure to secondhand smoke, it shall be the policy of **{Clinic or Agency Name}** to provide a tobacco-free environment for all employees and visitors. This policy covers the use of any tobacco product and applies to both employees and nonemployee visitors of **{Clinic or Agency Name}**.

Policy Statement:

- There will be no use of tobacco products (i.e., cigarettes, pipes, cigars, spit tobacco, electronic cigarettes, and hookah) within the facilities of **{Clinic or Agency Name}** at any time.
  - All materials used for smoking, including cigarette butts and matches, will be extinguished and disposed of in appropriate containers. ***{The decision to provide or not provide designated smoking areas outside the building will be at the discretion of management or other decision-making body. For a policy that includes a designated smoking area, add the following information and clearly state where the designated smoking areas are located. The designated smoke areas will be located at least 25 feet from the main entrance, other exits and entrances, open windows, or air intakes. Supervisors will ensure periodic cleanup of the designated smoking area. If the designated smoking area is not properly maintained (for example, if cigarette butts are found on the ground), it may be eliminated at the discretion of management or other decision-making body.}***
- There will be no tobacco use in **{Clinic or Agency Name}** vehicles at any time. There will be no tobacco use in personal vehicles when transporting persons on **{Clinic or Agency Name}** authorized business.
- Breaks: Supervisors will discuss the issue of smoking breaks with their staff. Together they will develop effective solutions that do not interfere with the productivity of the staff.

Procedure:

- Employees will be informed of this policy through signs posted in **{Clinic or Agency Name}** facilities and vehicles, the policy manual, and orientation and training provided by their supervisors.
- Visitors will be informed of this policy through signs, and their host will explain it. **{Clinic or Agency Name}** will assist employees who wish to quit smoking by facilitating access to recommended smoking cessation programs and materials.
- Any violations of this policy will be handled through the standard disciplinary procedure.

Signature of Approval: _____

Date of Implementation: _____ Last Reviewed/Updated: _____

Tobacco-Free Policy-Comprehensive

Sample Policy

Purpose: The goal of this tobacco-free policy is to improve the health of **{Clinic or Agency Name}** employees and visitors by reducing exposure to secondhand smoke and promoting tobacco cessation.

Policy Statement:
Based on significant medical evidence and research documenting the health risks to users of all tobacco products, **{Clinic or Agency Name}** will provide a 100% tobacco-free environment for all employees, contractors and visitors. The use of tobacco products anywhere on **{Clinic or Agency Name}** property is prohibited.

Scope:
This policy applies to all **{Clinic or Agency Name}** employees, contractors and visitors.

Definitions:

- Tobacco products prohibited include cigarettes, pipes, cigars, spit tobacco, electronic cigarettes, and hookah.
- **{Clinic or Agency Name}** property includes all Company-owned and leased parking lots. It excludes public streets and street parking.

Procedure:

- Communication – "Tobacco-Free Workplace" signage is posted at all entrances. HR will advise all new hires of this policy, including the consequences of non-compliance, in writing.
- Responsibilities – Adherence to the tobacco-free policy is the responsibility of all **{Clinic or Agency Name}** employees, clients, and visitors. Employees who do not conform to this policy are subject to disciplinary action. **{Discipline process can be described below.}**
- Employees observing individuals not employed by **{Clinic or Agency Name}** violating this policy should courteously inform them of this policy and request their compliance.
- Tobacco Use Cessation Program - As tobacco cessation represents the single most important step users can take to enhance the length and quality of their lives, **{Clinic or Agency Name}** is committed to providing support to all employees who wish to stop using tobacco products. **{Clinic or Agency Name}** employees have access to several types of assistance, including:
    - The Utah Tobacco Quit Line (1.800.QUIT.NOW) provides telephone-based counseling, support materials, and referrals to local classes and additional assistance when appropriate. Callers may also qualify for free nicotine replacement therapy.
    - Utah QuitNet (*www.utahquitnet.com*) provides quitting guides, peer support through message boards and email, expert advice, and other services to help people quit using tobacco.

- Tobacco Free Resource Line (1-877-220-3466 or the TRUTH@utah.gov) provides materials including brochures, Quit Line cards, posters, and fact sheets.
- ***{Add specific information about your company's insurance benefits or company sponsored cessation classes here.}***

Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____

Fragrance-free Policy

Sample Policy

Purpose: A fragrance-free environment helps create a safe and healthy workplace. Fragrances from personal care products, air fresheners, candles and cleaning products have been associated with adversely affecting a person's health including headaches, upper respiratory symptoms, shortness of breath, and difficulty with concentration. People with allergies and asthma report that certain odors, even in small amounts, can cause asthma symptoms. **{Clinic or Agency Name}** will work with building management to ensure that products used to clean the workplace are fragrance-free and follow best practices to limit employee exposure to cleaning chemicals. **{Clinic or Agency Name}** recognizes the hazards caused by exposure to scented products and cleaning chemicals and we have a policy to provide a fragrance-free environment for all employees and visitors to keep a safe and healthy workplace environment. This policy applies to both employees and non-employee visitors of **{Clinic or Agency Name}.**

Policy Statement:

- **{Clinic or Agency Name}** expects that all offices and spaces used by the staff and their visitors remain free of scented products.
- Personal care products such as cologne, perfume, aftershave lotions, scented lotions, fragranced hair products and/or similar products are not to be worn in the facilities owned and operated by **{Clinic or Agency Name}** including company owned vehicles.
- Use of air fresheners and candles are prohibited from the facilities owned and operated by **{Clinic or Agency Name}** including company owned vehicles.
- Use of cleaning products other than those purchased by the **{Clinic or Agency Name or Building Management} a**re prohibited for cleaning personal workspaces.

Procedure:

- Employees will be informed of the **{Clinic or Agency Name}** Fragrance-free Policy through signs posted throughout properties owned and operated by **{Clinic or Agency Name}** including company-owned vehicles.
- Visitors will be informed of the **{Clinic or Agency Name}** Fragrance-free Policy by their hosts, the meeting invite, email correspondences and signs posted throughout the properties owned and operated by **{Clinic or Agency Name}**.
    - **Sample Email Signature for guests:** "*This is a fragrance-free workplace. Thank you for not wearing any of the following during your visit: cologne, after shave lotion, perfume, perfumed hand lotion, fragranced hair products, and/or similar products. Our chemically-sensitive co-workers and clients thank you.*"
- Any violations of this policy will be handled through the standard disciplinary procedure.

Signature of Approval: _____

Date of Implementation: _____ Last Reviewed/Updated: _____

Additional Resources

Worksite Wellness

Nutrition

- National Alliance for Nutrition and Activity: Healthy Meeting Toolkit
- Healthy Vending Guide
- American Heart Association: Healthy Workplace Food and Beverage Toolkit

Physical Activity

- CDC Recommendations for Worksite Physical Activity
- Utah Department of Health Worksite Physical Activity Success Story
- Deskercise! 33 Smart Ways to Exercise at Work

Breastfeeding

- Resources that Support the Business Case for Breastfeeding

Tobacco

- Helping Employees Stop Smoking
- WaytoQuit.org Healthcare Providers Resources
- WaytoQuit.org Quick Facts
- Truth Initiative How Employers Can Save Money and Help People Quit Smoking

Asthma

- Creating an Asthma-Friendly Work Environment
- Guide to Controlling Asthma at Work:

Park Rx

Park Rx Workflow

Sample Workflow

Purpose: Encourage patients to increase physical activity levels through a park prescription.

If the patient is found to be diagnosed with elevated or high blood pressure, diabetes, prediabetes, obesity, anxiety or depression, a park prescription should be utilized.

- Provider identifies Parks Rx eligible participants based on chronic disease or mental health diagnoses
    - Adults 18+
- Patient takes pre-assessment measurements
    - Height
    - Weight
    - Blood pressure
    - A1c (Most recent for Diabetics and Pre-Diabetics)
- Clinic personnel prescribes park to patient via PRXA.org
- Clinic personnel tracks weight and blood pressure as indicated below
    - Healthy Living Educator (or other personnel) follows up before 1st outing
    - Healthy Living Educator (or other personnel) follows up after 1st outing
    - Follow up questions to be recorded:
        - Have you visited a park since your last appointment?
        - How many times in the last 2 weeks have you visited a park?
        - How long (in minutes) did you spend in the park per visit?
        - Did you go to the park with another person? If so, with whom?
        - How did you get to the park?
        - What are your Healthy Living goals?
        - What helps motivate you to increase your physical activity?
        - What keeps you from being physically active?
        - How important is it for you to be physically active?
        - Do you think this parks prescription is something you will be able to follow long term?
- Patient receives $25 Amazon gift card after completing program. Gift cards are provided by SLCoHD.

Program Evaluation:

- Number of individuals prescribed to go to a park
- Number of individuals who followed through with a park prescription
- Number of times patients visited parks
- Changes in clinical measures

Signature of Approval: _____
Date of Implementation: _____
Last Reviewed/Updated: _____

Living Well

Living Well Class Referral Policy

Sample Policy

Purpose: To implement a policy for staff training, on identification of patients and referral to Living Well classes.

Policy Statement:
{Clinic or Agency Name} believes that providing excellent care and services to our patients includes referral to community programs or lifestyle change programs. We are committed to providing our staff with education and training on evidence-based self-management and physical activity programs to assist our patients in managing their chronic conditions.

- All providers and appropriate clinical staff will be trained upon hire and annually on the classes offered on the Living Well website: www.livingwell.utah.gov
- All providers and appropriate clinical staff will be trained upon hire and annually on the referral process to Living Well classes
- Assign a staff member to pull a registry report to identify patients with a specific chronic condition and refer them to Living Well classes
- Assign staff member to routinely query registry for newly diagnosed patients with a specific chronic condition and refer them to the Living Well classes
- During routine patient visit, providers will refer all patients with a chronic condition to appropriate Living Well classes
- Assigned staff member will provide patient education describing Living Well classes

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Signature of Approval: _____

Date of Implementation: _____

Last Reviewed/Updated: _____