

Developing, Testing and Adapting New Workflows

Million Hearts Learning Collaborative
October 19, 2022

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- ❖ The AAFP has reviewed DC Million Hearts Learning Collaborative Series, and deemed it acceptable for AAFP credit. Term of approval is from 02/08/2022 to 02/07/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- ❖ **If you would like to receive CME credit, the online evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar.
- ❖ Certificates of completion will be emailed within 10-12 business days of course completion.

Faculty	Margaret Kirkegaard, MD, MPH CME Reviewer	Mary Kate Brousseau, MPH Facilitator	Latrice Hughes, MPH Facilitator	Jeff Weinfeld, MD, MBI, FAAFP Presenter	Ricardo Fernandez, MD Presenter	Kristy McCarron, MPH Presenter
Company	No Financial Disclosures	No Financial Disclosures	No Financial Disclosures	No Financial Disclosures	No Financial Disclosures	No Financial Disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A	N/A



- ❑ Welcome and Introduction
- ❑ Facilitated Discussions with Grantees
 - MedStar Georgetown
 - La Clinica del Pueblo
- ❑ Prescribe the Y – Referrals into YMCA Health Programs
- ❑ Q and A throughout

- Define activities associated with developing, testing and implementing workflow to support Million Hearts activities.
- Employ new methods and ideas to improve existing workflows related to blood pressure monitoring and increased statin use for high-risk populations.
- Describe the Prescribe the Y program and identify opportunities for collaboration with the YMCA.

Poll: When thinking about workflow development and implementation, what is your biggest challenge?

- Provider engagement and buy-in
- Patient engagement or compliance issues
- EMR updates to support the workflow
- Evaluation of the workflow – does it "work"?
- Overall team time constraints
- Other (enter into chat)

Chatterfall:

- Name a project where you are really proud of your workflow.



MedStar Health

It's how we **treat people.**

Strategies to Improve Home Blood Pressure Use

Georgetown/MedStar DC Million Hearts Project

Jeff Weinfeld, MD, MBI, FAAFP
Project Director

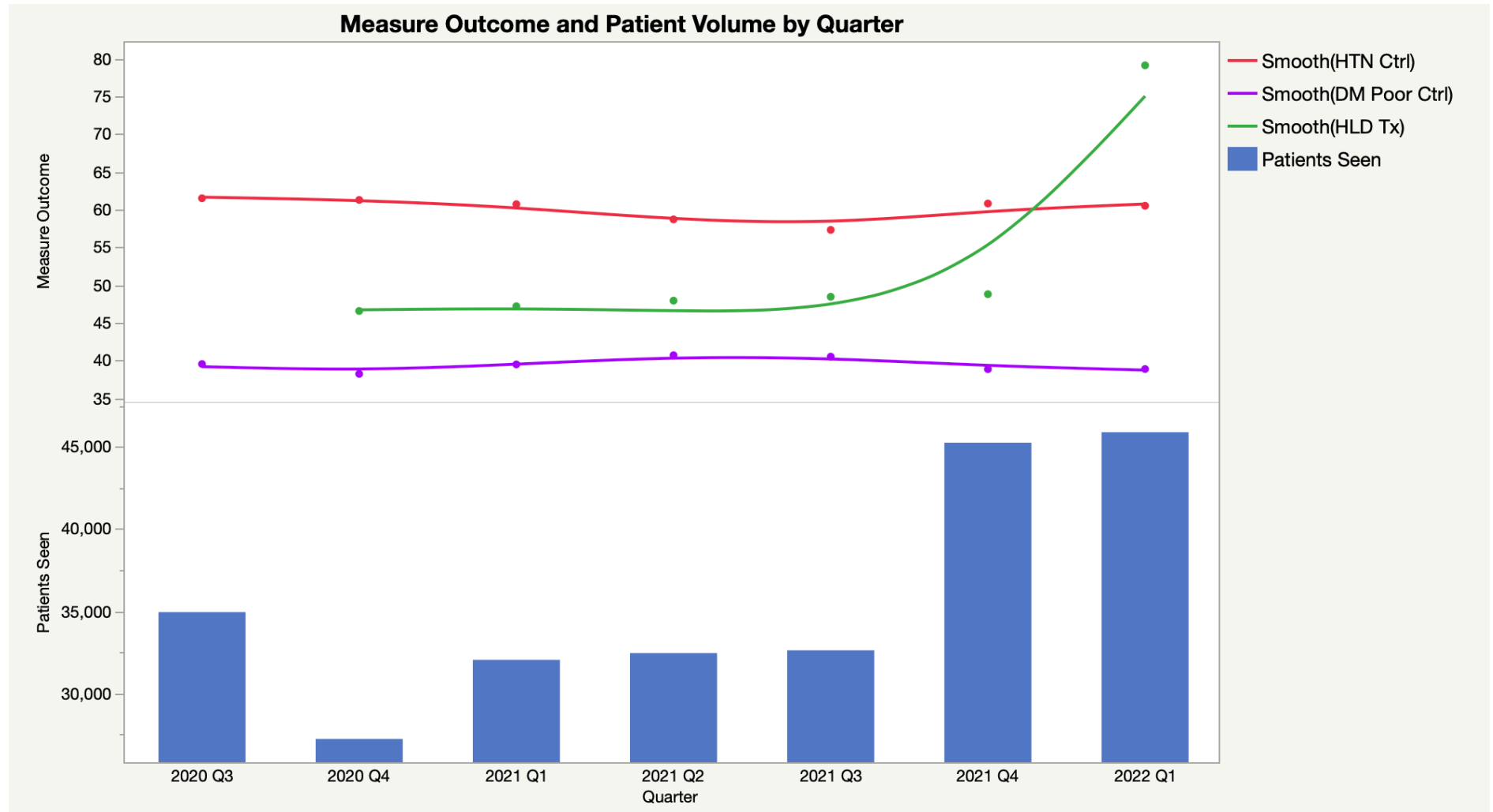
Objectives

- Understand the current home blood pressure (HBP) or self-measured (SMBP) workflow
- Describe EHR infrastructure
- Discuss lessons learned and challenges of this process

Goal

- Improve HTN Control metric (NQF 0018)
- Long stuck ~65% for the organization (~60% for DC patients)

Quality Outcomes



Jul-Sep '20

Jan-Mar '21

Jul-Sep '21




Background


- Project Scope
 - 7 DC Practices, 68 providers
- IT Infrastructure already in place
 - Common EHR with shared-chart model (2016)
 - Quality reporting – metrics go to site Medical Directors monthly (2017)
 - Registry that included HTN control metric (2019)
 - SAP Business Objects – ability to create custom EHR reports with limited programming (2020)

Strategy: Home Blood Pressure Monitoring

- Useful for diagnosis or management of HTN
- Supported by USPSTF, AHA/ACC guidelines, and adopted by MedStar guideline group
- Can diagnose white coat or masked HTN
- Monitors
 - paid for by some insurances
 - Should be upper arm, correct size
 - Educate patients on best practices for checking
- Can count towards quality measures

Vital Signs Repeat VS/Home Monitoring Form

Vital Signs + ▾ All Visits **Last 18 months** Last 3 years   

	NOV 29, 2021 11:13	MAR 15, 2021 10:36	OCT 05, 2020 15:18	OCT 02, 2020 14:00	12:58	11:29		
BP mmHg	118 / 84	--	--	--	109 / 72	117 /  55		09:18
HR bpm	81	--	--	--	75	67		106 / 67
Temp DegC	36.3	36.2	--	--	36.6	37.3		37.3
SpO2 %	--	--	--	98	98	--		97
Weight Dosing kg	74.5	--	--	--	70.7	--		70.2
Body Mass Index... kg/m2	24.13	--	--	--	24.75	--		24.23
Height/Length Dosing cm	175.7	--	--	--	169	--	170.2	170.2
BMI Exclusion Reason	--	System Reason	System Reason	--	--	--	--	--
Last Menstrual Period	--	DEC 01, 2020	OCT 03, 2020	--	AUG 19, 2020	--	--	--
Respiratory Rate BR/min	--	--	--	--	18	18	18	18
Home Height/Length... cm	--	172	172	--	--	--	--	--
Home Weight Estim... kg	--	71.36	70.90	--	--	--	--	--
Home BMI Estimated	--	24	24	--	--	--	--	--

Pediatric Ambulatory Care Intake and History

Ambulatory Vitals Height Weight

AMB in Office Repeat VS/Telehealth VS/Home Monitoring/Orthostatics

Adult Ambulatory Care Intake and History

In-Office Repeat/Telehealth VS/Home Monitoring

PC Quick Orders & Charges x PEDS Quick Orders & Char... x WH Quick Orders & Charges x Ambulatory Summary x Demographics x +

Vital Signs

		AUG 06, 2019 14:52
BP	mmHg	120 / 80
HR	bpm	66
Temp	DegC	37
Weight Dosing	kg	60
Body Mass Index...	kg/m2	15
Height/Length Dosing	cm	200
Respiratory Rate	BR/min	16

Imperial Conversion

		AUG 06, 2019 14:52
Temp		98.6 F - Oral
Weight Dosing		132 lbs 4 oz
Body Mass Index Dosing		15 kg/m2
Height/Length Dosing		6 ft 7 in

Patient Education

Quick Suggestions

All This Visit Problems	Suggestions based on all
Leg skin lesion, left	Excision of Skin Lesions
	Excision of Skin Lesions, C
	Hives
	Hives, Easy-to-Read
	Intertrigo
	Intertrigo, Easy-to-Read
	Juvenile Plantar Dermatosis

AMB in Office Repeat VS/Telehealth VS/Home Monitoring/Orthostatics - [REDACTED]

*Performed on: 12/02/2021 1123 EST By: Weinfeld, MD, Jeffrey M

Home Monitoring Blood Pressures

Systolic/Diastolic mmHg / mmHg Peripheral Pulse Rate bpm

Add Additional BP #2 Systolic/Diastolic /
 Add Additional Pulse Rate #2 Peripheral Pulse Rate

Add Additional BP #3 Systolic/Diastolic Repeat #3 /
 Add Additional Pulse Rate #3 Peripheral Pulse

In Progress

Recommendations – Self-Monitoring of Blood Pressure

RECOMMENDATIONS + ↺ ☰

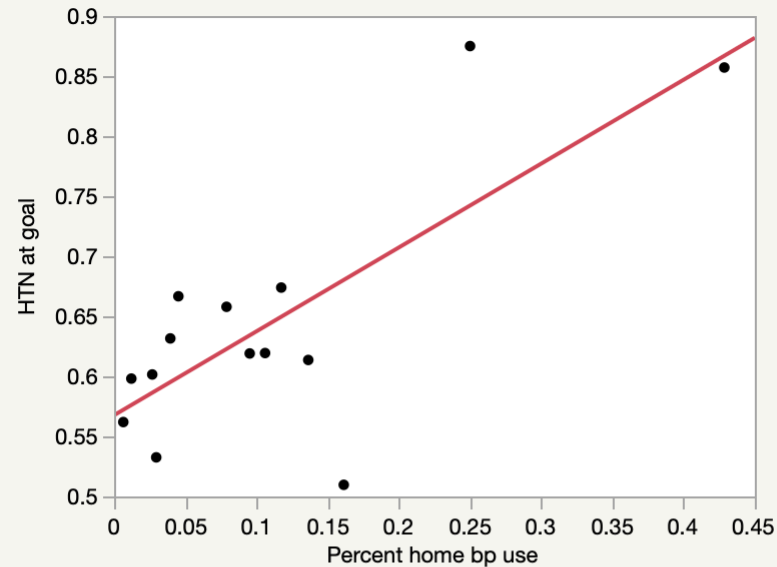
Pending Not Due / Historical HealthRegistries

Communication Preference: [Edit](#) My Role Only Group By Category

Recommendation	Next Due	Last Action	Recurrence	Orders
▼ Healthy Adult				
HCV Screening (One-Time) for Adults 18-79 years	Today	--	One-time only	Hepatitis C Virus - Order
Recombinant Zoster Vaccine Dose 1	Today	--	One-time only	Orders ▼
Tdap Vaccine	Today	--	One-time only	Orders ▼
Tetanus/TD Vaccine	Today	--	Every 10 years	Orders ▼
Alcohol Use Screening	In 3 weeks	Documented (Today) - Alcohol Use Singl...	Seasonal	
▼ Hypertention Maintenance				
Hypertension - Home Blood Pressure	Today		Seasonal	
Hypertension - Not Well Controlled	Today		Seasonal	
			Every 1 years	Orders ▼
			Variable	
▼ Medication Management				
Diuretic Monitoring: Monitor Creatinine	Overdue (13 months)	⬇ 1.50 mg/dL (2 years ago)	Every 1 years	Orders ▼
Diuretic Monitoring: Monitor Potassium	Overdue (13 months)	4.2 mmol/L (2 years ago)	Every 1 years	Orders ▼

BP control correlated with higher home BP use in a practice

Bivariate Fit of HTN at goal By Percent home bp use



— Linear Fit

Linear Fit

$$\text{HTN at goal} = 0.5676666 + 0.6983262 * \text{Percent home bp use}$$

Summary of Fit

RSquare	0.571559
RSquare Adj	0.535856
Root Mean Square Error	0.071653
Mean of Response	0.644151
Observations (or Sum Wgts)	14

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Ratio
Model	1	0.08219122	0.082191	16.0085
Error	12	0.06161055	0.005134	Prob > F
C. Total	13	0.14380177		0.0018*

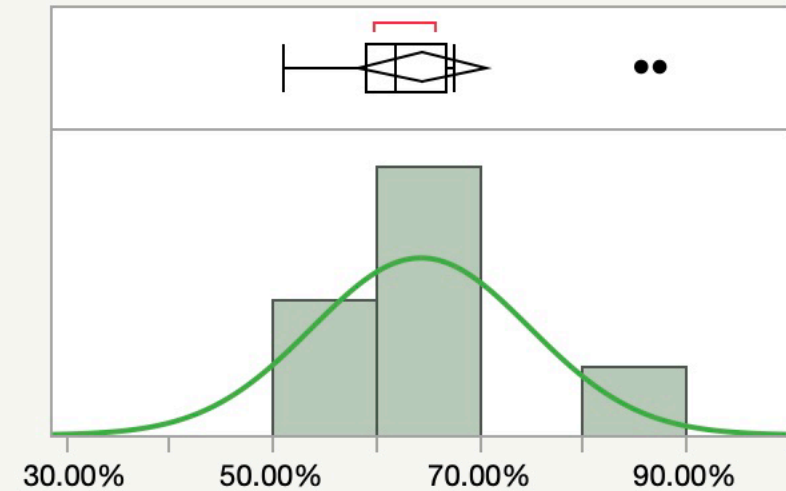
Patients with home BPs recorded skew higher for outcome measures

Median control
61.9%

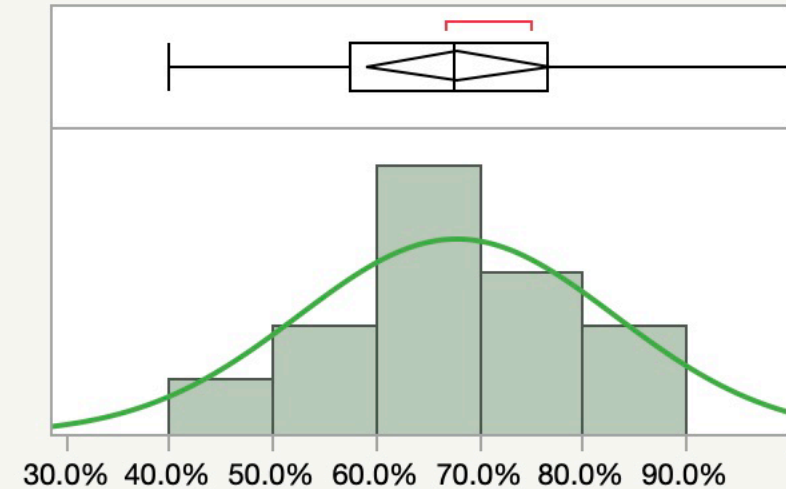
VS

76.7% using
home BPs only

HTN at Goal



Percent Met with HBP



MMG Navy Yard Success Story

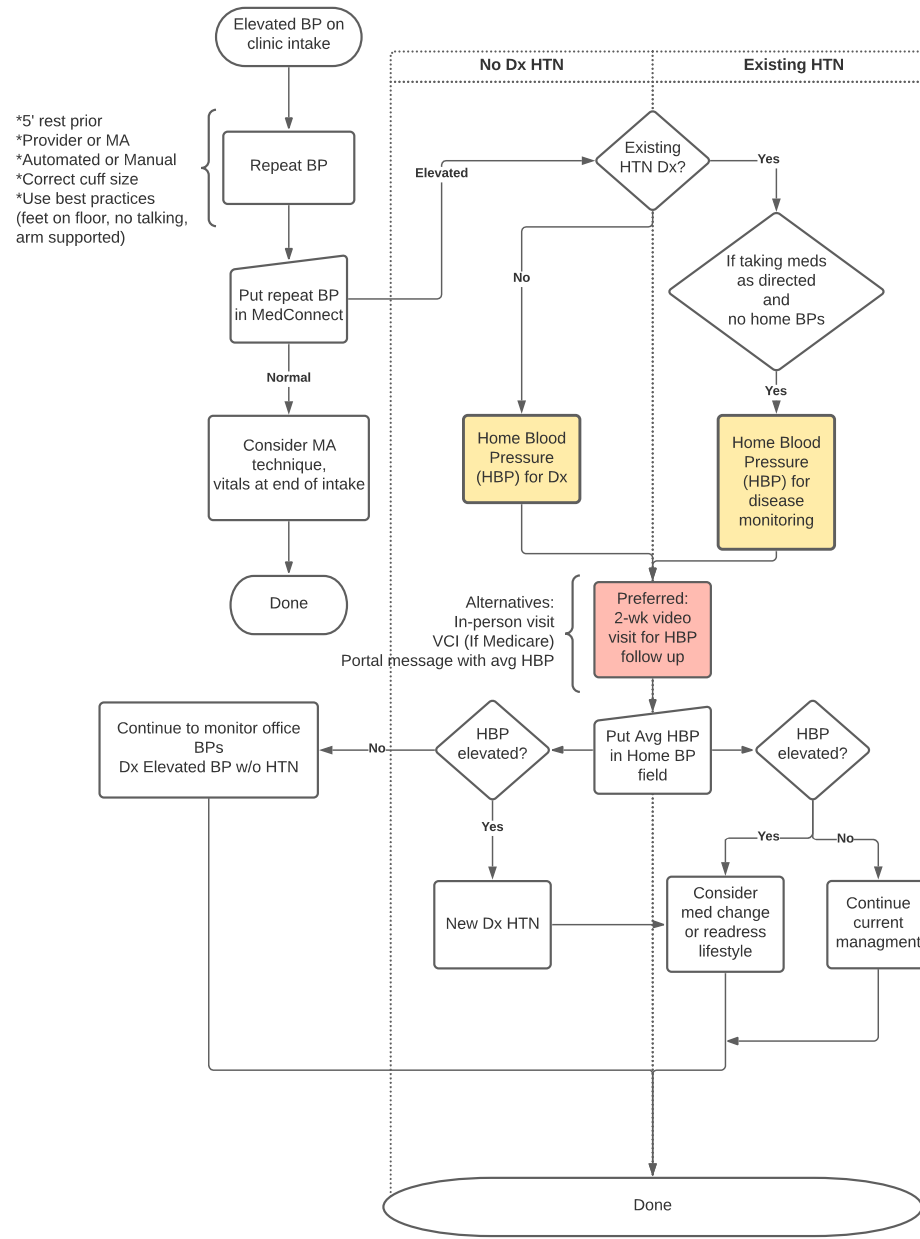
- Group decision among docs to use HBP more
- Plan to do 2-wk telehealth follow up to get HBP

	HBP Use	HTN Control
		62.48 (3/25)
4/1-6/30	0.66%	63.56 (5/27)
7/1-9/30	0.48%	66.44 (9/22)

Sylvia Medley, MD
MMG Navy Yard
Champion



HBP Workflow



Where are we now?

- Reporting HBP use to sites/champions quarterly
- Trying to work repeat into MA workflow
- Continuing to educate sites/providers
- HTN control seems to be gradually increasing across MedStar but not within DC

Lessons Learned

Infrastructure is needed for workflows	Be patient during this (often long) phase
Create a clear argument for your workflow	
Flexibility works	Use ideas of your providers and staff

Challenges

Quarterly numbers don't match 360-d look back	After several months of evaluation probably does match
Provider availability	Use RN visits or portal messages (phone calls another option)
Haven't addressed MA training	
We still may be early on the adoption curve	

Resources

- AMA HBP Ed <https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings/monitoring-your-blood-pressure-at-home>
- AFP Pt ed - <https://www.aafp.org/afp/2021/0900/p237-s1.html>
- Paper log AMA - <https://www.ama-assn.org/system/files/2020-05/tracking-your-bp-numbers.pdf>
- Link to AFP review article for providers - <https://www.aafp.org/afp/2021/0900/p237.html>

Thank you!

Contact information

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- Peter.Basch@Medstar.net



Activities to increase statin use in diabetics

Ricardo Fernandez, MD, Chief Medical Officer
October 2022



1st activity: Focus on clinician behavior

Ideas to influence clinician ordering behavior

- Education-review and emphasize current guidelines
- Create prompts/reminders in EHR (decision support)
- Recommend additional tools/web sites, provide info in EHR
- Review use of decision support features in EHR
- Discuss with clinicians to create buy-in

Limitations of ERH/alert

- Not possible to create “statin” alert specifically for diabetic or other high-risk patients
- Alert had to be activated for **all** patients, ages 40-75
- Providers were reminded to calculate/discuss/document cardiovascular risk annually, regardless of risk
- Provider feedback: alert fatigue, questioned utility in many patients

Promotion of current statin use guidelines and clinical decision support

- Reviewed guidelines on statin use: (ACC 2013, USPSTF) with clinicians during a meeting in 2021
- Introduced a customized clinical alert in EHR to remind clinicians to discuss/document cardiovascular risk with patients
- Alert was satisfied (turned off) by any documentation in a particular structured counseling field, annually
- A power point presentation was reviewed during a meeting and distributed to the providers

Excerpted from:

2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults
A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines

Originally published 12 Nov 2013 <https://doi.org/10.1161/01.cir.0000437738.63853.7a> Circulation. 2014;129:S1–S45

- **Four Statin Benefit Groups:**

1. Individuals with **clinical ASCVD**

2. Individuals with primary elevations of **LDL-C ≥ 190 mg/dL**

3. Individuals **40 to 75 years of age with diabetes and LDL-C 70 to 189 mg/dL without clinical ASCVD**

4. Individuals *without clinical ASCVD or diabetes* who are **40 to 75 years of age** and have **LDL-C 70 to 189 mg/dL** and an **estimated 10-year ASCVD risk of $\geq 7.5\%$** . This requires a **clinician-patient discussion**.

Findings after intervention

- No significant change in statin use among high-risk patients
- Diabetics-similar findings
- Provider feedback: preferable to focus on higher risk subgroups
- Due to the above, decision made to target diabetic patients with a team-based approach



2nd activity:
Team based care, pre-visit planning

Ideas for team-based care

- Involve medical assistants working with providers
- Pre-visit planning checklist for diabetes
- Include checking for current statin use, but
- Make the focus on diabetes standards of care generally

Questions for Diabetes Pre-Visit Checklist

- Diabetic eye exam in last year? Yes/No
- Foot exam in last year? Yes/No
- Microalbumin (urine) screening test, date
- Statin use for patients 40-75: Taking a statin? Yes/no
- When was your last A1C test? Result?



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Training of medical assistants

- Orientation on diabetes standards of care
- Focused on diabetic screenings and prevention of complications
- Introduced use of pre-visit planning checklist template in EHR
- Training on where to locate information in chart and how to document
- Training on recognition of statin medication
- Piloted with a subset of medical assistants first



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LCDP Diabetes Template / Diabetes Pre-visit Checklist

*Diabetes pre-visit checklist-completed by PCC before or during encounter

*Provider answers other questions beginning after pre-visit checklist, during patient encounter

The screenshot displays a medical chart interface for a patient with Diabetes Mellitus/Pre-Diabetes/At Risk. The 'HPI:' section contains a 'Diabetes pre-visit checklist' with the following items: Eye exam in last year? ..., Last Dilated Eye (retinal) Exam: ..., Diabetic foot exam in past year? ..., Last Foot Exam (with monofilament) or podiatry visit ..., Statin therapy (40-75 y.o.) ..., Urine microalbumin ..., Last A1C: ..., and A1C Result: Below this is 'Current Hyperglycemic symptoms' with the note 'denies polyuria, polydipsia.', followed by 'Diet ...', 'Exercise ...', 'Glucose monitoring schedule ...', and 'Blood Glucose ...'. Further down are sections for 'Current Medication:', 'Medical History:', 'Allergies/Intolerance:', 'Gyn History:', 'OB History:', and 'Surgical History:'. At the bottom of the chart area is a toolbar with buttons for Send, Print, Fax, Record, Lock, Details, Templates, Claim, Letters, Ink, Attachments, and PDMP. Two red arrows point from text boxes to the checklist items: one points to 'Diabetes pre-visit checklist' and another points to 'Current Hyperglycemic symptoms'.

Diabetes Mellitus/Pre-Diabetes/At Risk

Diabetes pre-visit checklist

- Eye exam in last year? ...
- Last Dilated Eye (retinal) Exam: ...
- Diabetic foot exam in past year? ...
- Last Foot Exam (with monofilament) or podiatry visit ...
- Statin therapy (40-75 y.o.) ...
- Urine microalbumin ...
- Last A1C: ...
- A1C Result: ...

Current Hyperglycemic symptoms denies polyuria, polydipsia.

Diet ...

Exercise ...

Glucose monitoring schedule ...

Blood Glucose ...

Current Medication:

Medical History:

Allergies/Intolerance:

Gyn History:

OB History:

Surgical History:

Send Print Fax Record Lock Details Templates Claim Letters Ink Attachments PDMP

Diabetes pre-visit checklist completed by PCC before provider sees patient

Provider answers remaining questions with patient

Using Diabetes Flowsheet to find Statin use

Diabetes/ Pre-DM/At Risk

Name	04/12/2022	12/20/2021	11/10/2021	11/09/2021	10/28/2021	09/07/2021	08/27/2021	08/18/2021
Retinopathy Check	05/2021							
Statin	(Taking) Lovastatin Tablet, 20 MG, 1 tablet with a meal, Orally, Once a day for 90 day(s), Dispense 90, 3 Refill(s).		(Taking) Lovastatin Tablet, 20 MG, 1 tablet with a meal, Orally, Once a day for 90 day(s), Dispense 90, 3 Refill(s).	(Taking) Lovastatin Tablet, 20 MG, 1 tablet with a meal, Orally, Once a day for 90 day(s), Dispense 90, 3 Refill(s).	(Taking) Lovastatin Tablet, 20 MG, 1 tablet with a meal, Orally, Once a day for 90 day(s), Dispense 90, 3 Refill(s).	(Refill) Lovastatin Tablet, 20 MG, 1 tablet with a meal, Orally, Once a day for 90 day(s), Dispense 90, 3 Refill(s). (Taking) Lovastatin Tablet, 20 MG, TAKE 1 TABLET BY MOUTH ONCE DAILY AFTER SUPPER FOR 90	(Stop) Lovastatin Tablet, 20 MG, 1 tablet after dinner, Orally, Once a day for 90 days, Dispense 90, 0 Refill(s). (Start) Lovastatin Tablet, 20 MG, TAKE 1 TABLET BY MOUTH ONCE DAILY AFTER SUPPER FOR 90	
Tobacco Use	never smoker						blat, Dispense 90 Tablet, 1 Refill(s).	
Renal Function(BMP)-								

Scroll down in flow sheet to look for "statin" to see if patient is taking a statin medication as of today's date



Alternative: Check List for Statin Medications

Medical Summary CDSS Rx Labs DI Procedures Growth Chart Imm T.Inj Encounters Patient Docs Flowsheets Notes Pat

Progress Note Scribe Orders Quick Order CP 04/20/2022 RF f/u BF

Immunizations Needed: Needs tetanus vaccine (q 10yr) , Zoster (>60-80), MMR.

Pending lab test Overdue.

Have you seen another provider or specialist? No.

Pending referrals No.

Pending Radiology No.

Diabetes Mellitus/Pre-Diabetes/At Risk

Diabetes pre-visit checklist

Eye exam in last year? No

Last Dilated Eye (retinal) Exam: ..., No eye exam in past year

Diabetic foot exam in past year? Due now for foot exam

Last Foot Exam (with monofilament) or podiatry visit ...

Statin therapy (40-75 y.o.) Taking a statin

microalbumin, urine 07-2021 ...

Last A1C: 11-2021 ...

A1C Result: 7-8%

Current Hyperglycemic symptoms denies polyuria, polydipsia.

Diet no real diet.

Exercise walks.

Glucose monitoring schedule occasionally.

! Current Medication:

Taking

- Tamsulosin HCl 0.4 MG Capsule 1 capsule Orally twice a day.
- Finasteride 5 MG Tablet COME UNA TABLETA TODOS LOS DIAS Orally Once a day.
- Atorvastatin Calcium 40 MG Tablet tome una tableta todos los dias orally daily.
- metFORMIN HCl 500 MG Tablet 1 tablet with meals Orally Twice a day.
- Chlorthalidone 50 MG Tablet 1 tablet in the morning with food Orally Once a day.
- amLODIPine Besylate 10 MG Tablet 1 tablet Orally Once a day.
- Glimepiride 2 MG Tablet 1 tablet with breakfast or the first main meal of the day Orally Once a day.
- Lisinopril 40 MG Tablet 1 tablet Orally Once a day.
- OneTouch Ultra - Strip as directed In Vitro three times a day.
- One Touch Ultra - Device as directed use to check blood sugar once a day.
- Dicyclomine HCl 10 MG Capsule TAKE 2 CAPSULESBY MOUTH FOUR TIMES A DAY ORALLY 90.
- Triamcinolone Acetonide 0.1 Cream 1 application Externally Twice a day, Notes: refills.

Not-Taking/PRN

- OneTouch Ultra

Statin (atorvastatin) found in medication list



Initial experience with diabetes pre-visit checklist template

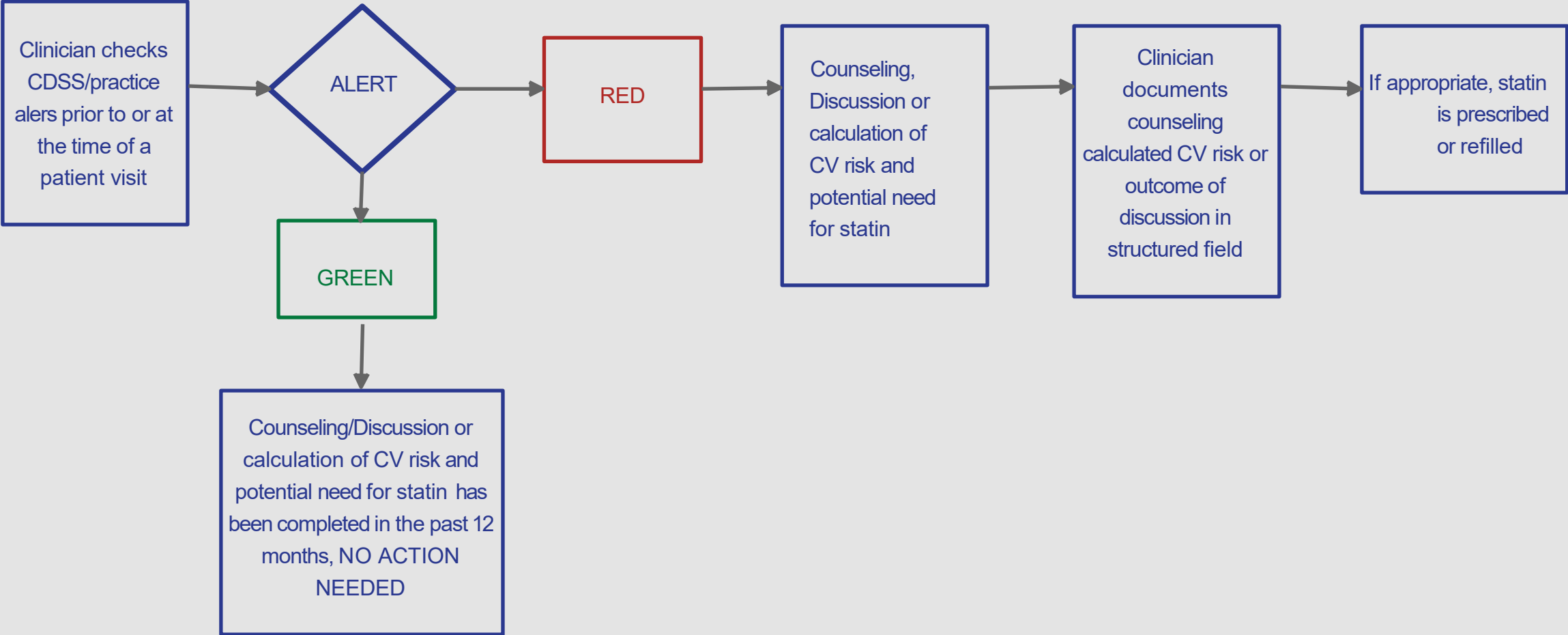
- Inconsistent use of template-some MAs use it consistently, others never
- In some cases, template loaded but some or all questions not answered
- Effect on provider behavior (conversation about statin, medication ordering, etc.) still unclear



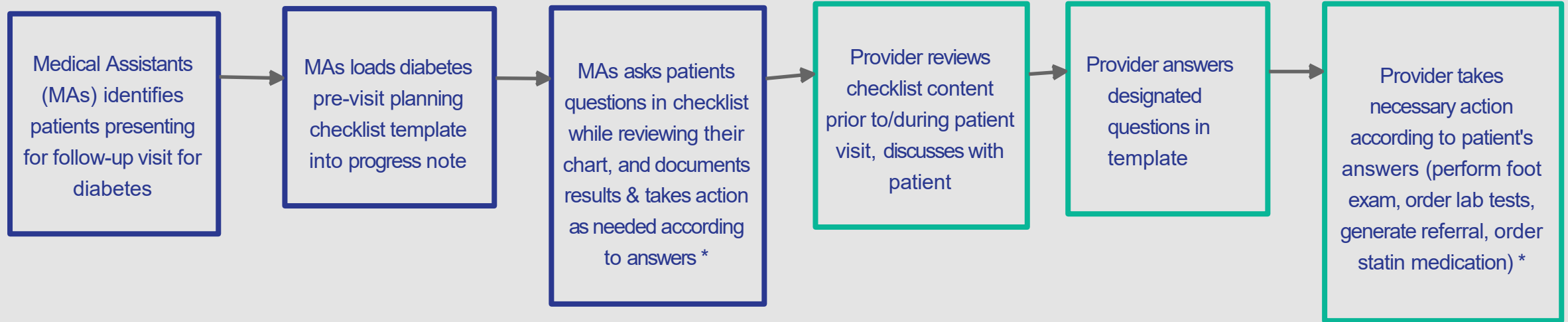
Next steps:

- Measure use of template/checklist over time
- Solicit feedback from medical assistants and providers
- Incorporate recommended changes in workflows
- Revise workflow, if necessary
- Present flow chart to team to clarify tasks and responsibilities of team members

Statin alert for clinicians - Workflow



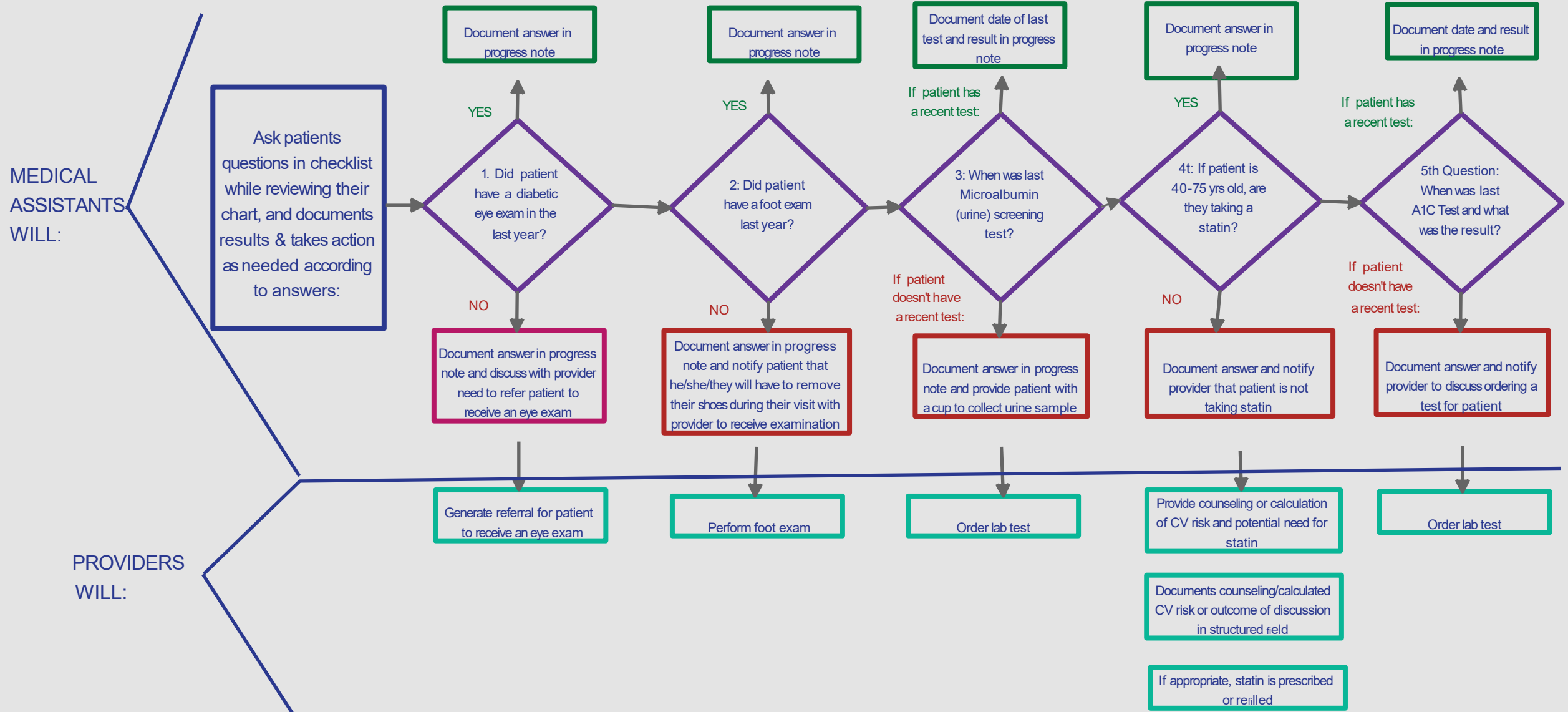
Diabetes pre-visit checklist workflow



*reference workflow: *Diabetes pre-visit checklist workflow:*

Actions to be taken by MAs & Clinicians according to patients' answers to questions

Diabetes pre-visit checklist workflow: Actions to be taken by MAs & Clinicians according to patients' answers to questions



Acknowledgements

- Monica Poujol, MSc Quality Improvement Manager
- Mariela Cabanillas, Grants and Contracts coordinator
- Genesis Cruz, Program Coordinator



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**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

PRESCRIBE THE Y

KRISTY MCCARRON, MPH
VICE PRESIDENT, COMMUNITY HEALTH AND WELLNESS
YMCA OF METROPOLITAN WASHINGTON

AGENDA

- YMCA programs
- YTD Outcomes
- Produce Rx: Medicaid Demonstration Project
- How to refer to the Y
- Q + A



PRESCRIBE THE Y PROGRAMS

Program	Condition Targeted	Program Format	Metrics Tracked
Blood Pressure Self-Monitoring English and Spanish	Hypertension prevention and management	4-month program where participants receive: <ul style="list-style-type: none"> • One-on-one coaching 2x/month • Monthly nutrition seminars • BP monitor 	<ul style="list-style-type: none"> • Pre and post blood pressure • Attendance
Diabetes Prevention Program English and Spanish	Type 2 diabetes prevention	1-year program where participants receive 25 small group supportive sessions	<ul style="list-style-type: none"> • Pre and post weight • Pre and post physical activity • Attendance
Dietetic Counseling	Prevention and management of common chronic diseases/conditions	One-on-one counseling with a Registered Dietitian Nutritionist	Dependent on individual's goals
Simple Cooking with Heart (SNAP-Ed) English and Spanish	Nutrition knowledge, kitchen confidence and cooking skills	4-week SNAP-Ed cooking and nutrition program, participants receive bags of groceries each week	Pre and post confidence, self-efficacy, meals cooked at home

YTD OUTCOMES

Blood Pressure Self-Monitoring

- 100% of participants have decreased BP
- Avg systolic change: -8.4
- Avg diastolic change: -2.4

Diabetes Prevention Program

- Weight change: -3.1
- BMI change: -0.6
- Retention: 75% attendance and 95% reporting weight

SNAP-Ed

- Participants noted feeling more confident in experimenting in the kitchen, in trying new recipes and new ingredients, and expressed newfound agency around taking ownership of their food procurement and preparation.

CONTINUUM OF CARE



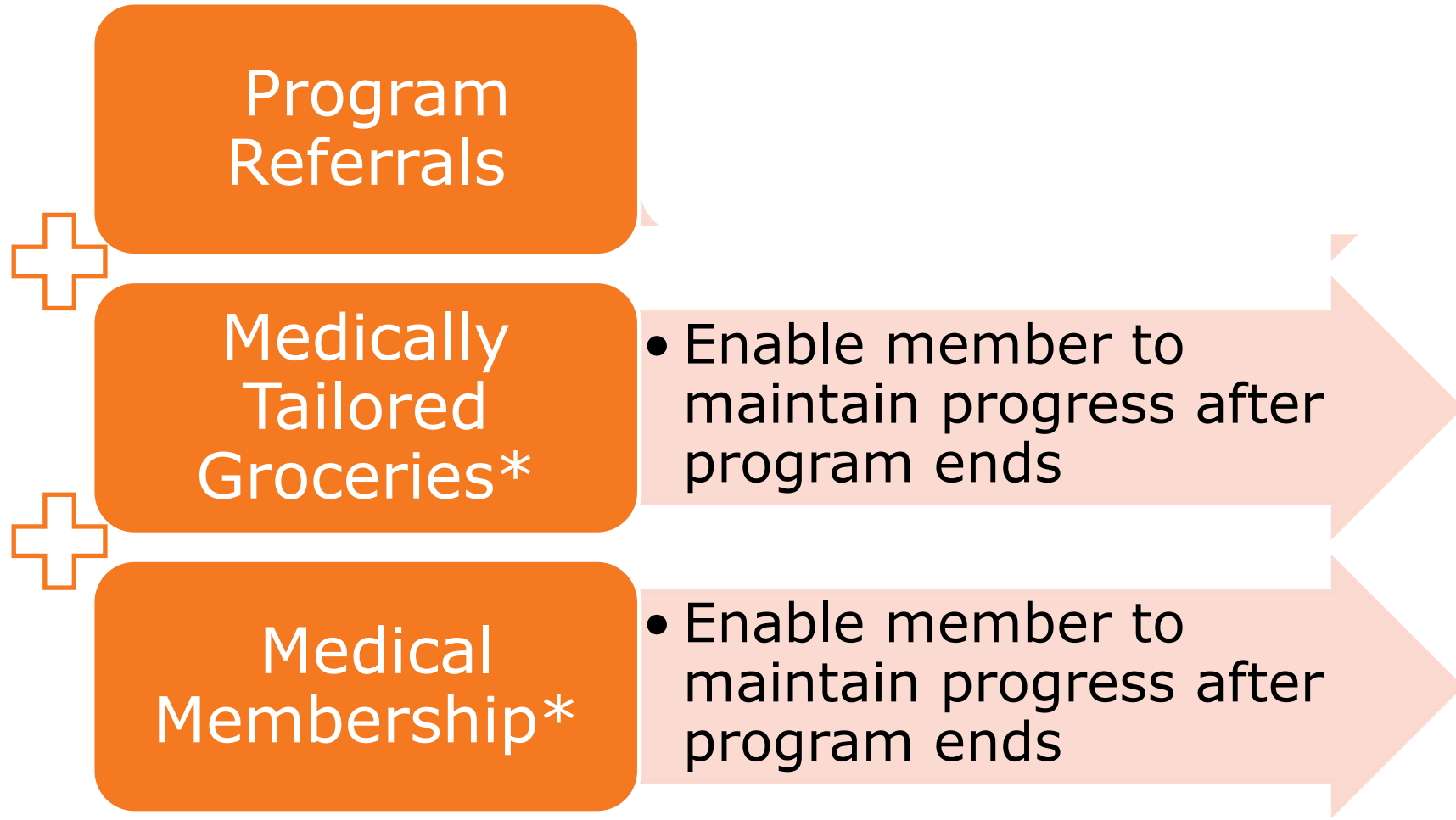
TRACKING OUTCOMES



HOW TO REFER TO THE Y: CLINICIANS

Referral System	Operations	Closed loop?
YMCA S Fax	Referrals directly to our S Fax # after patient has signed release form	Yes once patient has signed release form and BAA in place
YMCA HISP Email	Referrals directly to WELLD after patient has signed release form	Yes once patient has signed release form and BAA in place
CRISP	Referral sent via CRISP	Yes via the notes section
Aunt Bertha	Referral sent via Aunt Bertha	No

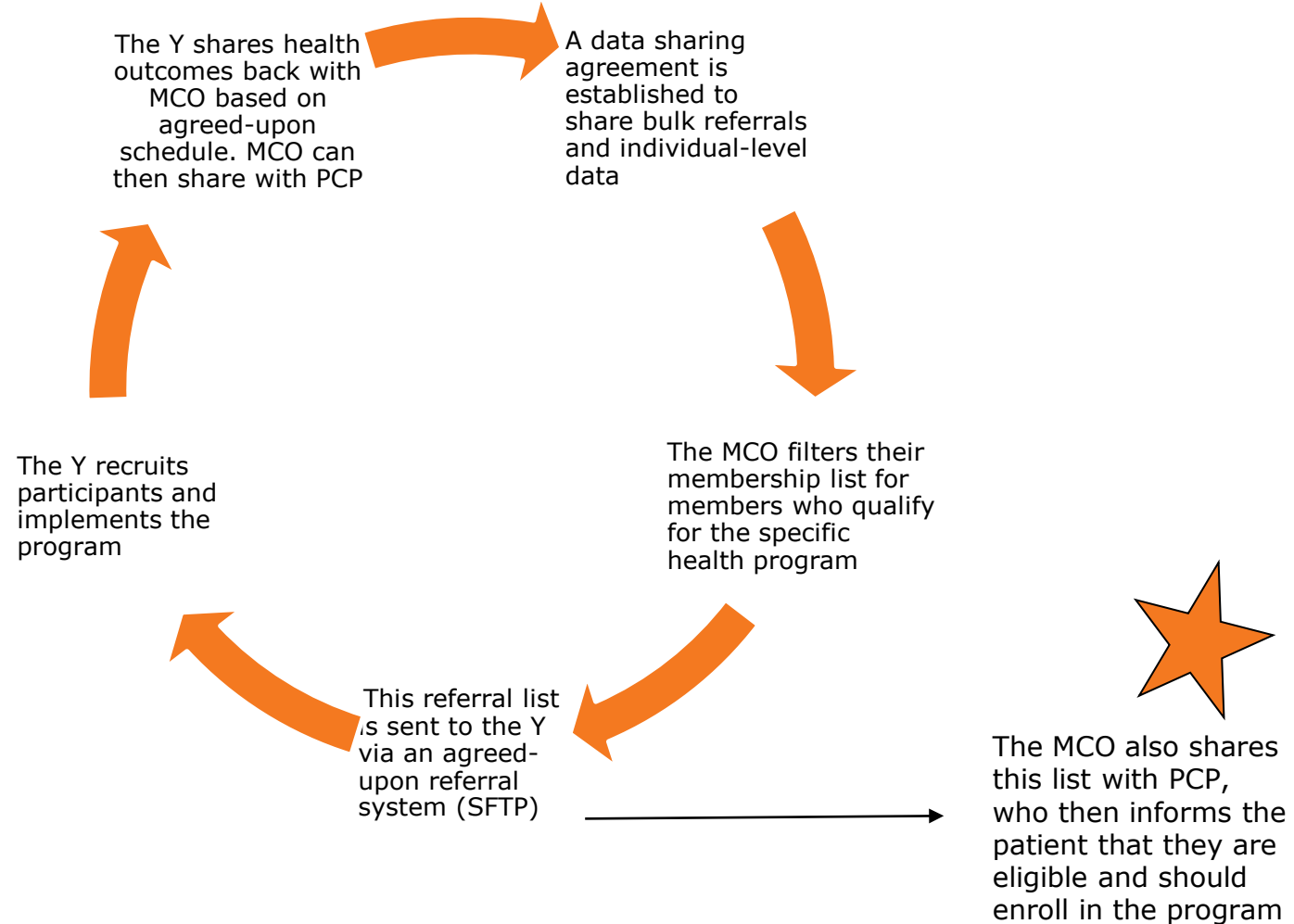
PRESCRIBE THE Y FORMATS: MEDICAID DEMONSTRATION PROJECT



*currently for Medicaid MCO referrals only

REFERRALS TO THE Y VIA MCOS

YMCA tracks individual health outcomes and shares back with MCO to evaluate cost-savings and HEDIS metrics





QUESTIONS?



THANK YOU

Kristy McCarron, MPH
Vice President, Community Health and Wellness
Kristy.McCarron@ymcadc.org

1. To what extent did the session meet the stated objectives?

(1 - not at all to 5 - met all objectives)

- Define activities associated with developing, testing and implementing workflow to support Million Hearts activities.
- Employ new methods and ideas to improve existing workflows related to blood pressure monitoring and increased statin use for high-risk populations.
- Describe the Prescribe the Y program and identify opportunities for collaboration with the YMCA.

2. How would you rate the session overall?

(1 - poor to 5 - excellent)

We are here to help you !

- ✓ For 1:1 site specific coaching, contact an HMA team member.
- ✓ To access previously recorded sessions and tools, visit <https://livingwell.dc.gov/page/million-hearts-providers> or see the technical assistance inventory document sent via email.



HEALTH
MANAGEMENT
ASSOCIATES



November

- Obesity Plan and Million Hearts Metrics Update
 - *Presented and facilitated by DC Health*

December and into 2023

- Facilitated Discussions with Grantees to share lessons learned, barriers encountered, and promising or best practices.
 - *Upcoming topics: SDOH, Sustainability*



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