HEALTH MANAGEMENT ASSOCIATES

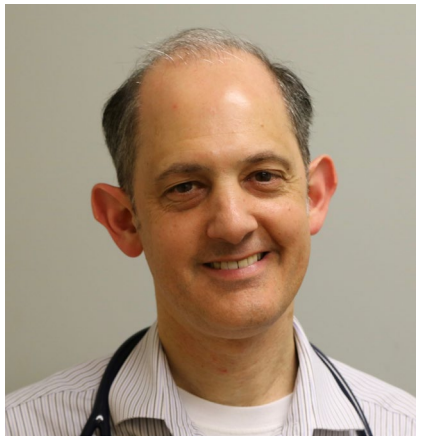
Developing, Testing and Adapting New Workflows

Million Hearts Learning Collaborative

October 19, 2022

DC | HEALTH

PRESENTERS



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CME

- 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

AGENDA

- 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

LEARNING 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.

DISCUSSION QUESTION

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

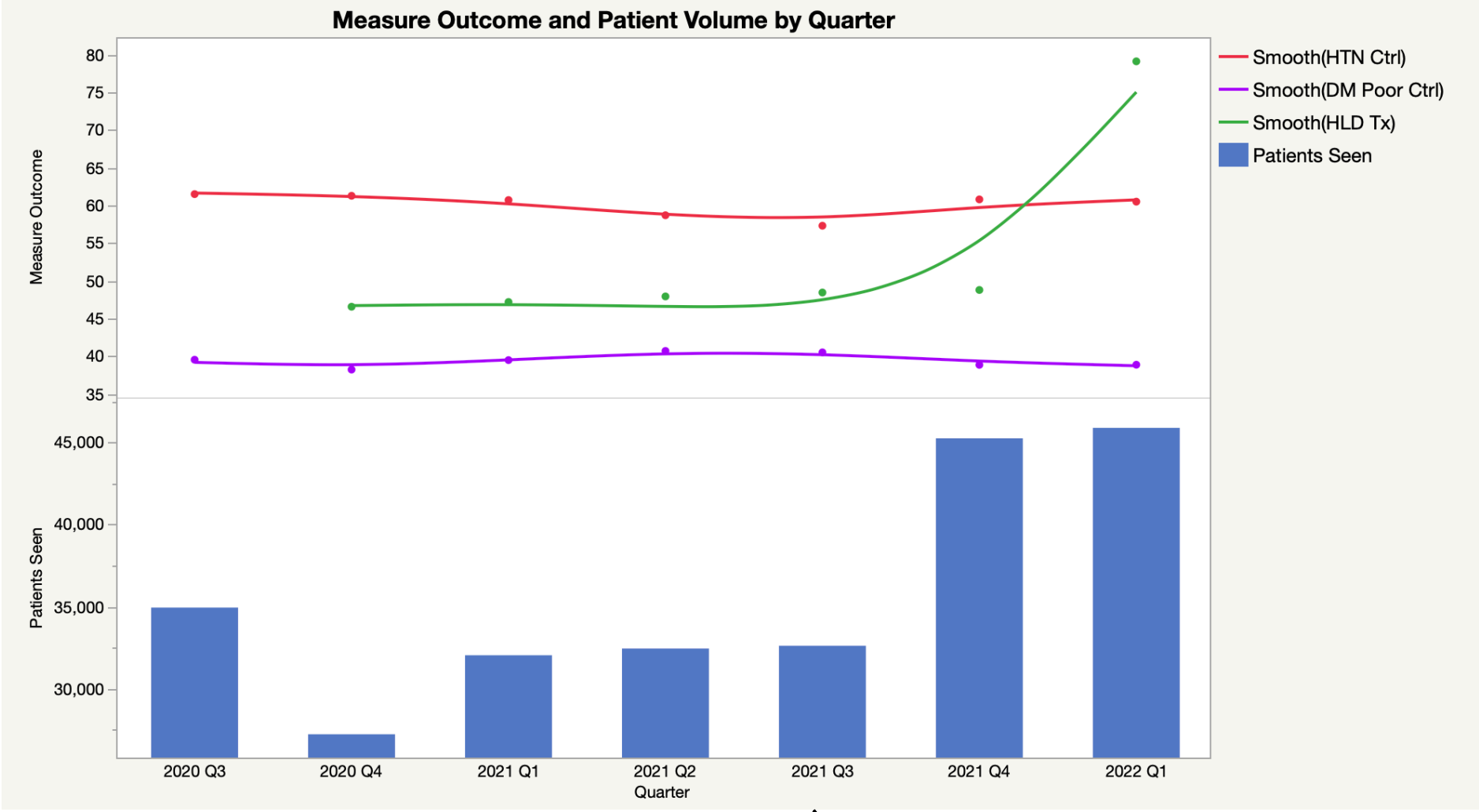
Objectives

- 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

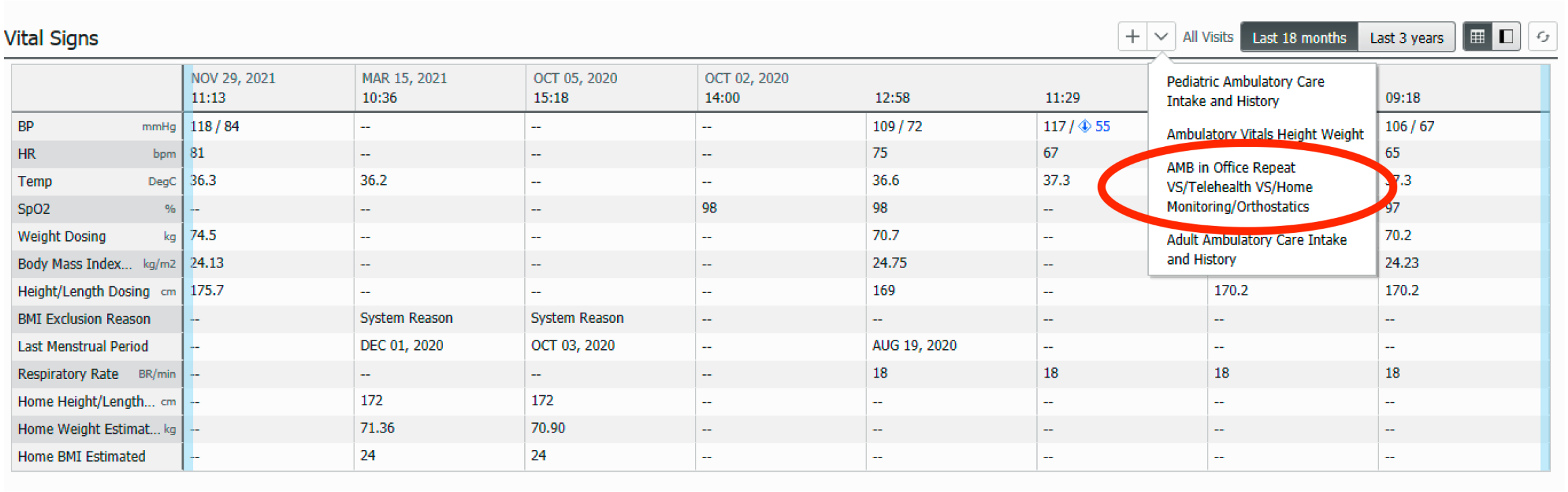
Background

- 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

Pediatric Ambulatory Care Intake and History

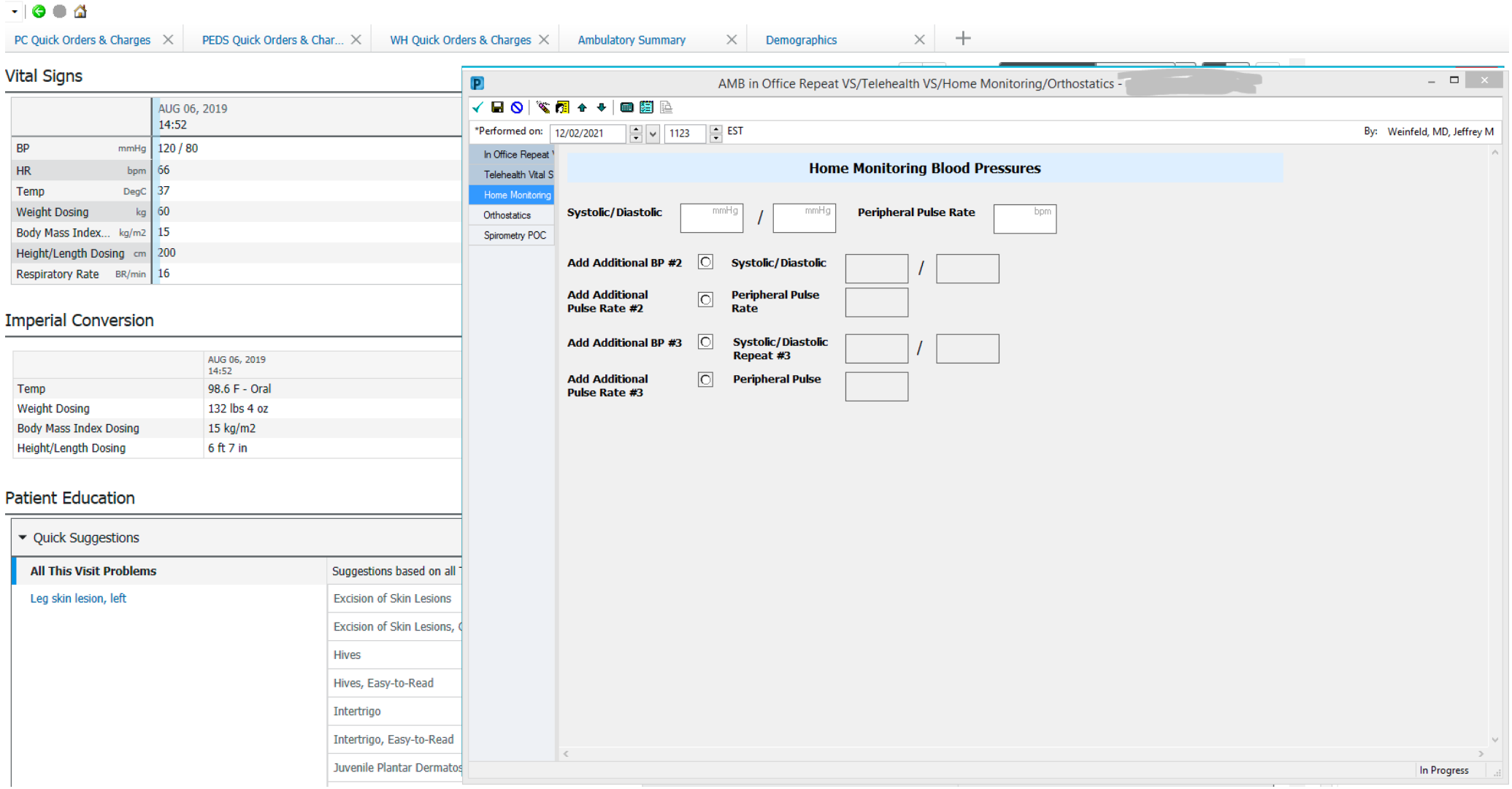
Ambulatory Vitals Height Weight

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

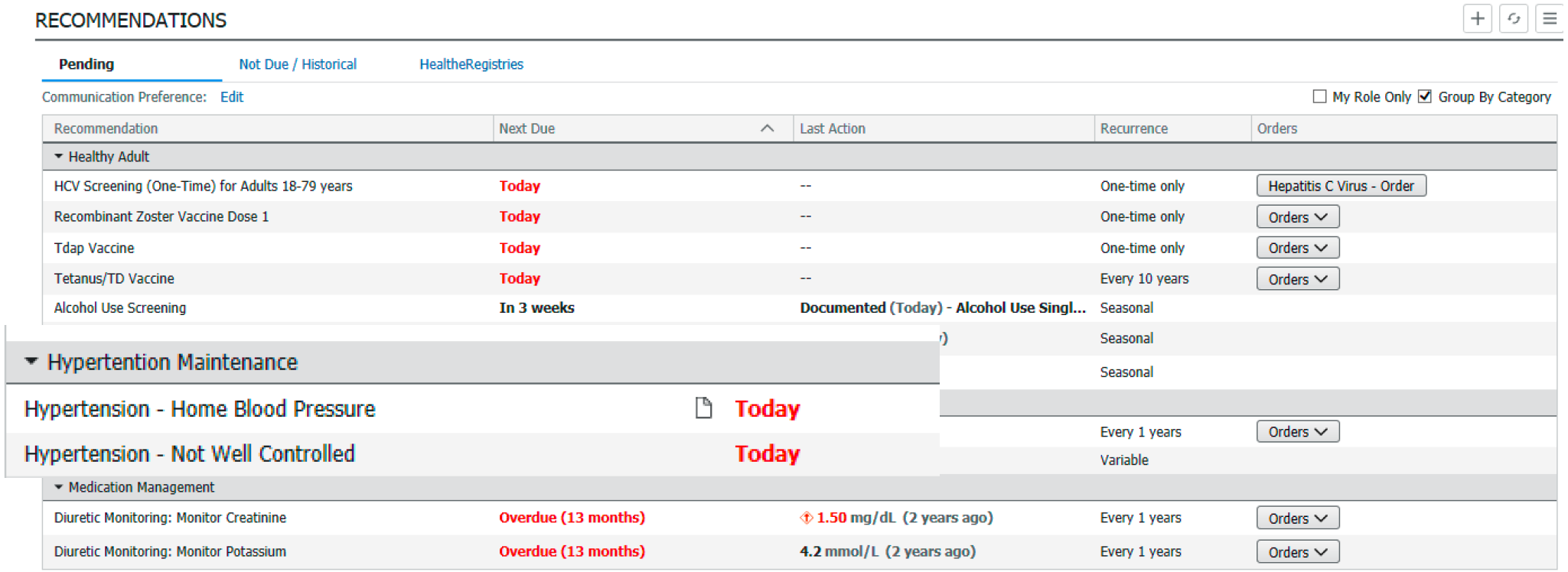
Adult Ambulatory Care Intake and History

	NOV 29, 2021 11:13	MAR 15, 2021 10:36	OCT 05, 2020 15:18	OCT 02, 2020 14:00	12:58	11:29		09:18
BP mmHg	118 / 84	--	--	--	109 / 72	117 / 55		106 / 67
HR bpm	81	--	--	--	75	67		65
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 Estimat... kg	--	71.36	70.90	--	--	--	--	--
Home BMI Estimated	--	24	24	--	--	--	--	--

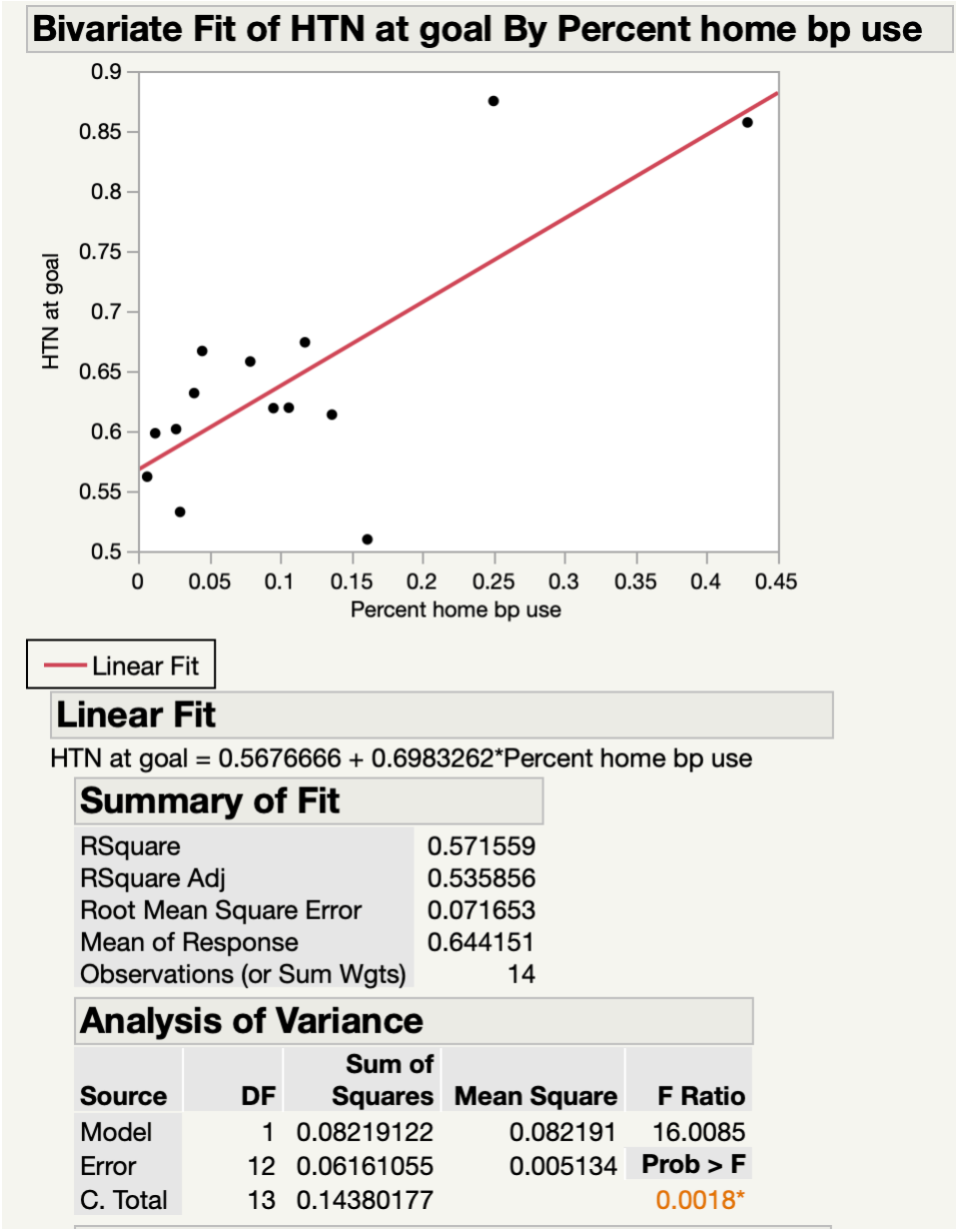
In-Office Repeat/Telehealth VS/Home Monitoring



Recommendations – Self-Monitoring of Blood Pressure



BP control correlated with higher home BP use in a practice

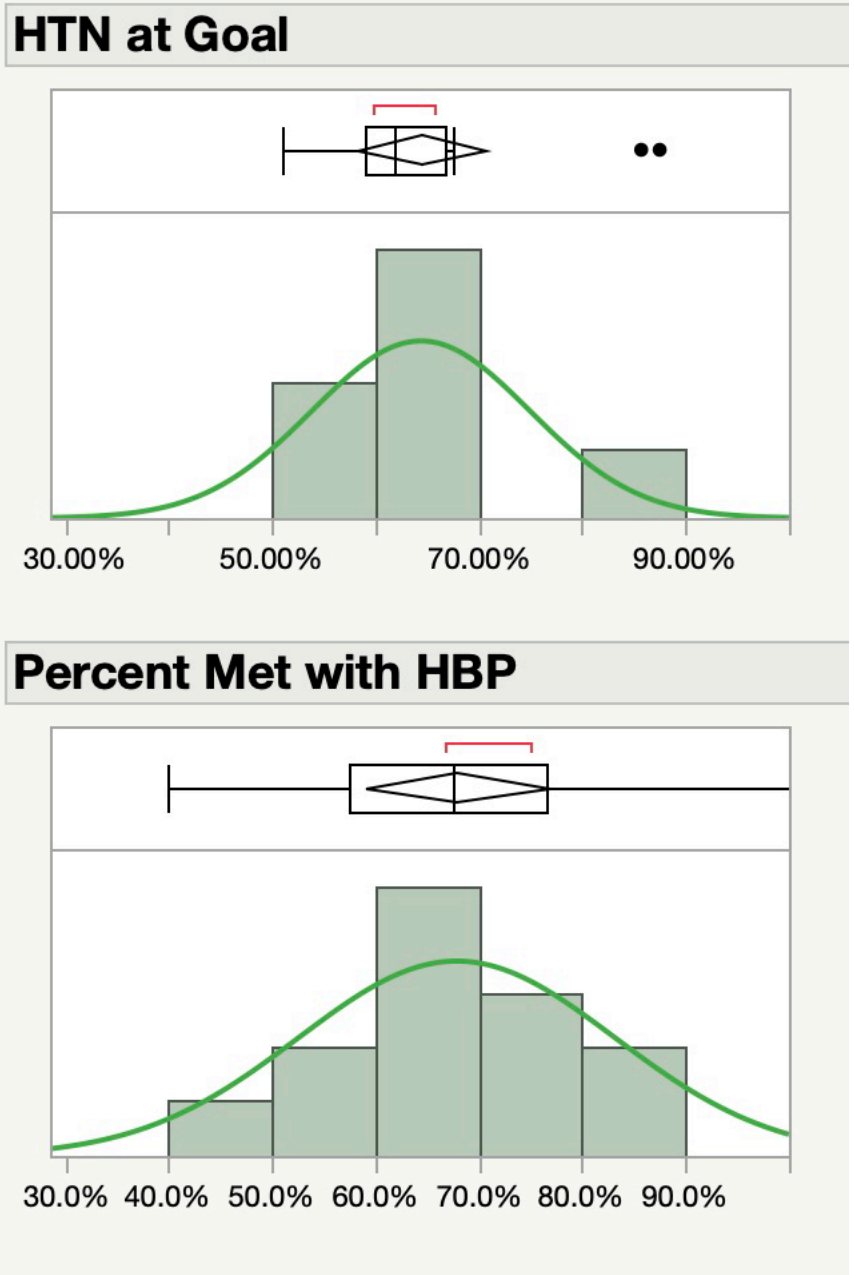


Patients with home BPs recorded skew higher for outcome measures

Median control
61.9%

vs

76.7% using
home BPs only



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)

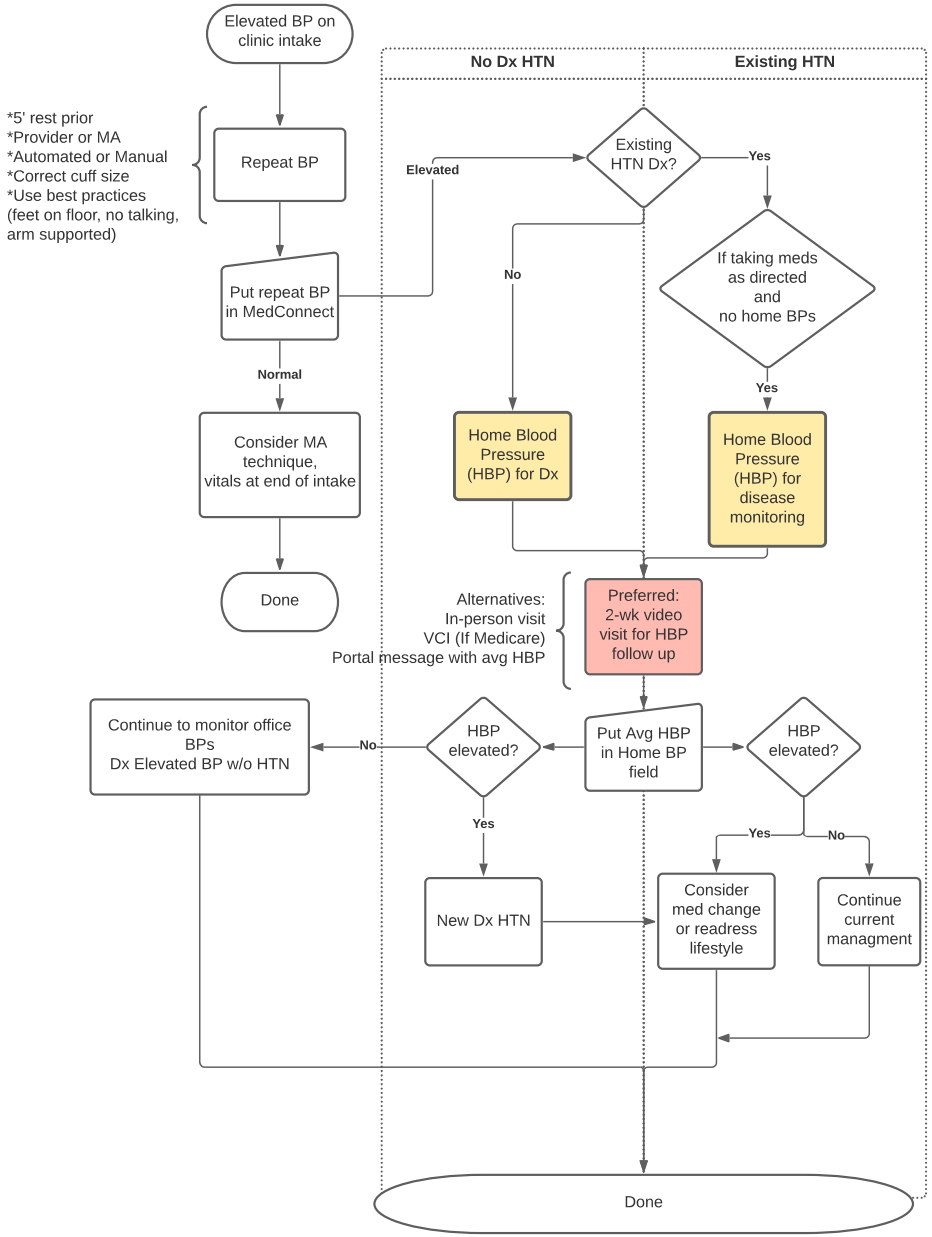
MedStar Health

Knowledge and Compassion
Focused on You

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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LA CLÍNICA DEL PUEBLO

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

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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

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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

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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 published12 Nov 2013https://doi.org/10.1161/01.cir.0000437738.63853.7aCirculation. 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 **≥7.5%. This requires a clinician-patient discussion.**

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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

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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

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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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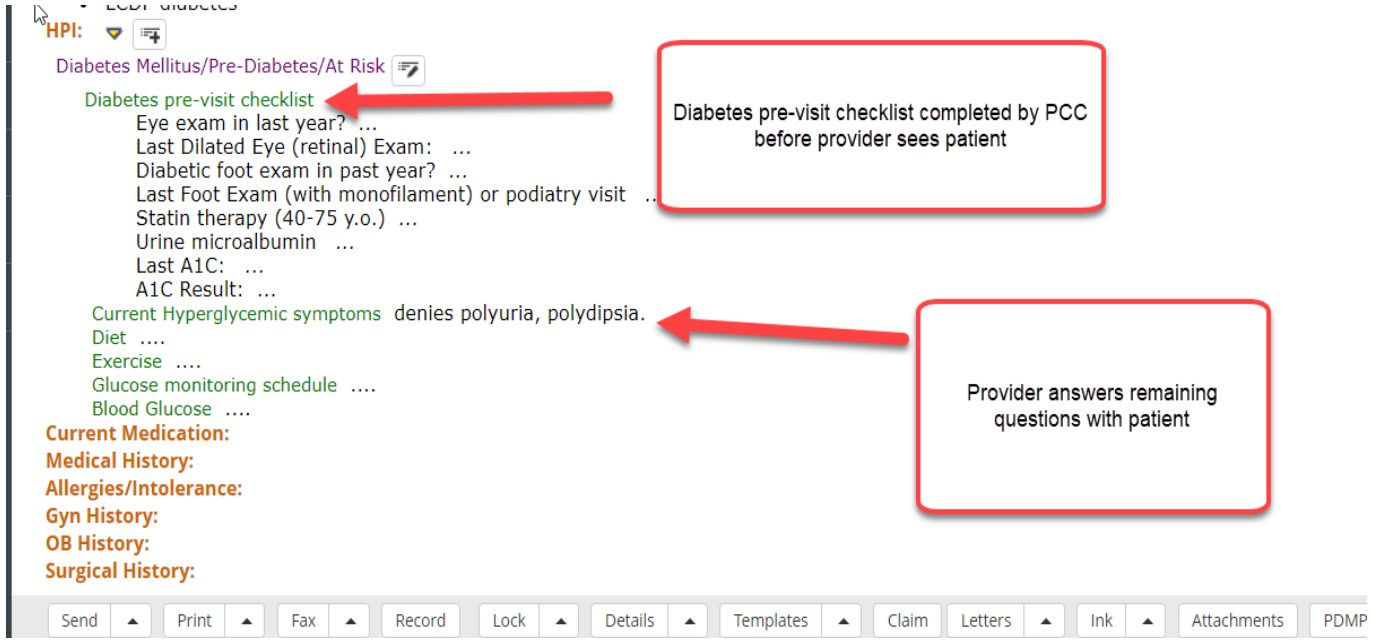
LCDP Diabetes Template / Diabetes Pre-visit Checklist

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

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



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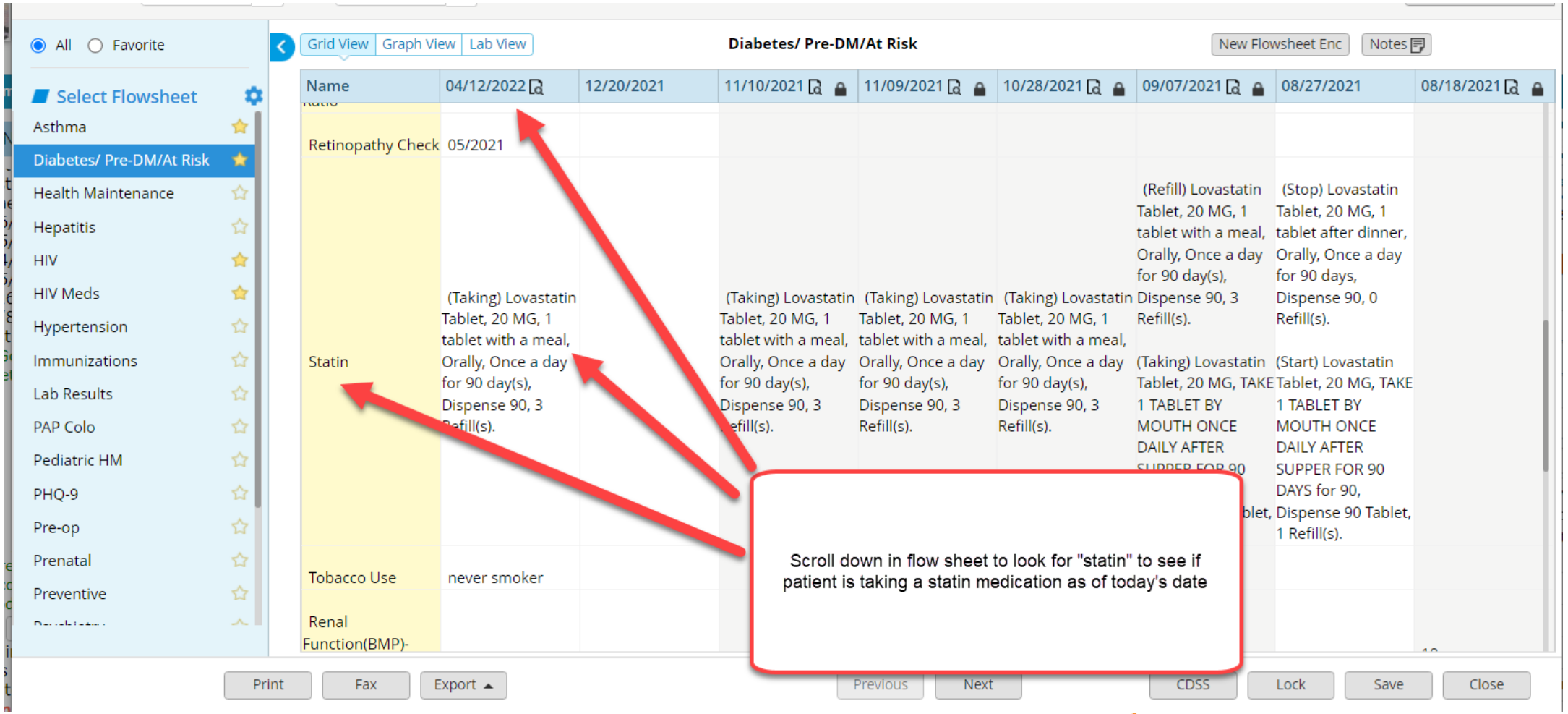
Using Diabetes Flowsheet to find Statin use



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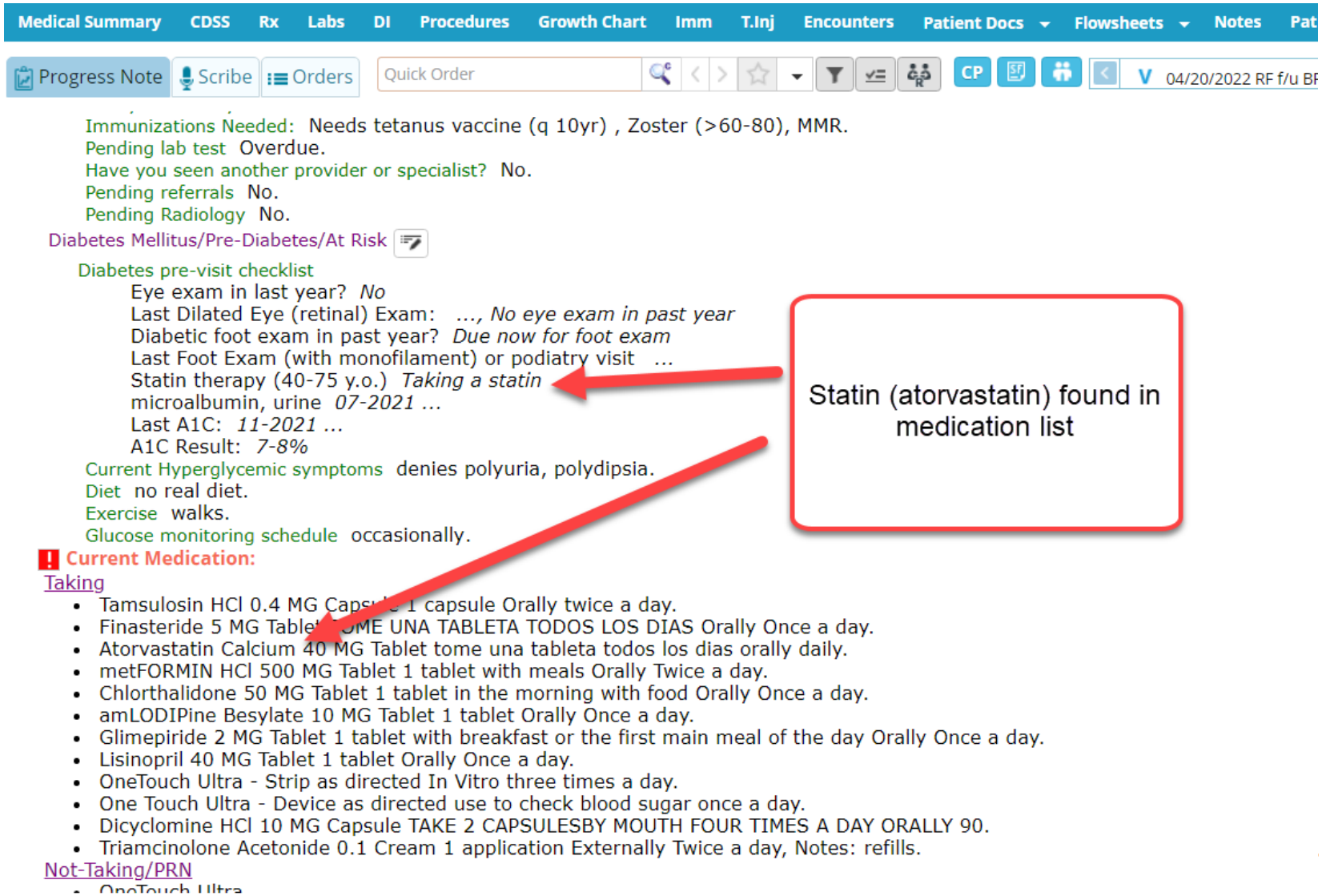
Alternative: Check List for Statin Medications



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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

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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

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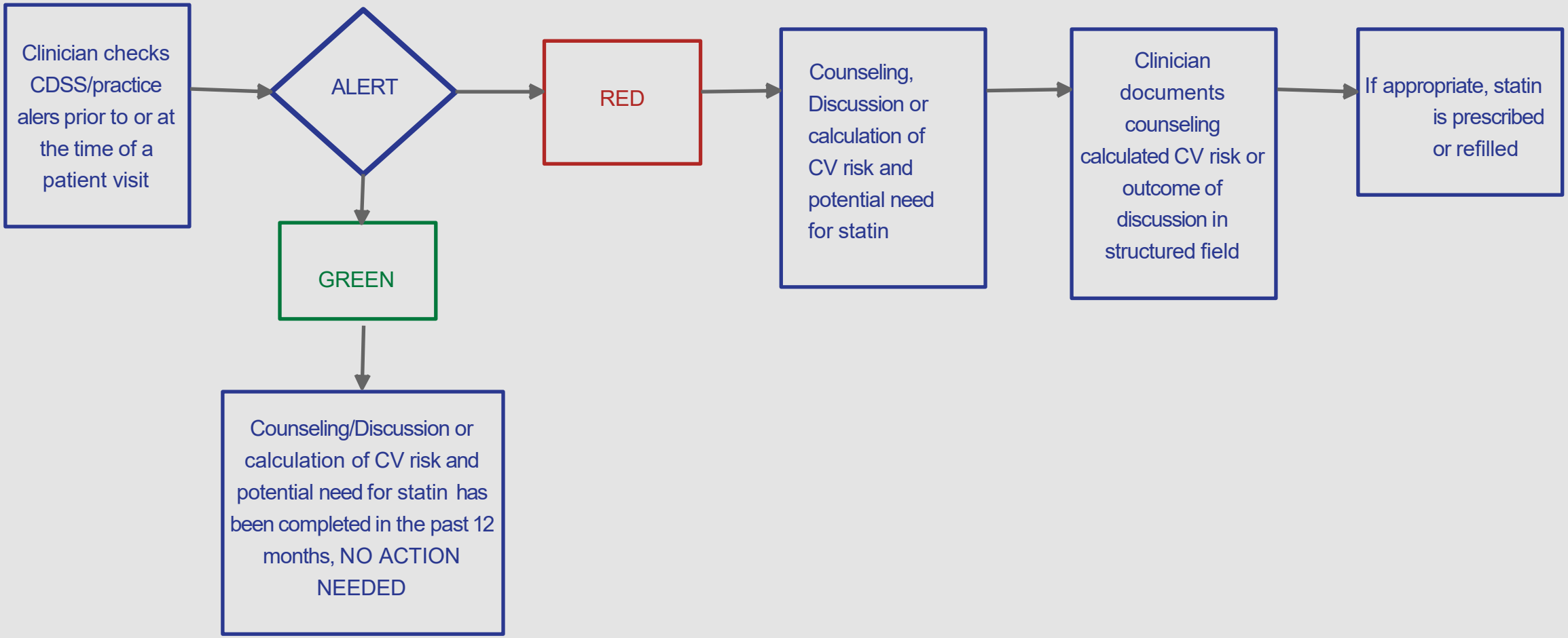
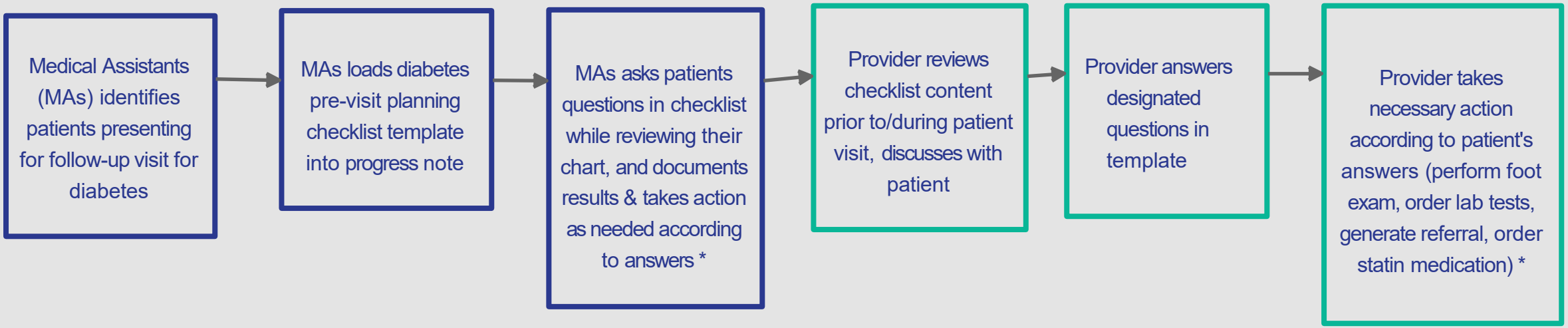
Statin alert for clinicians - Workflow



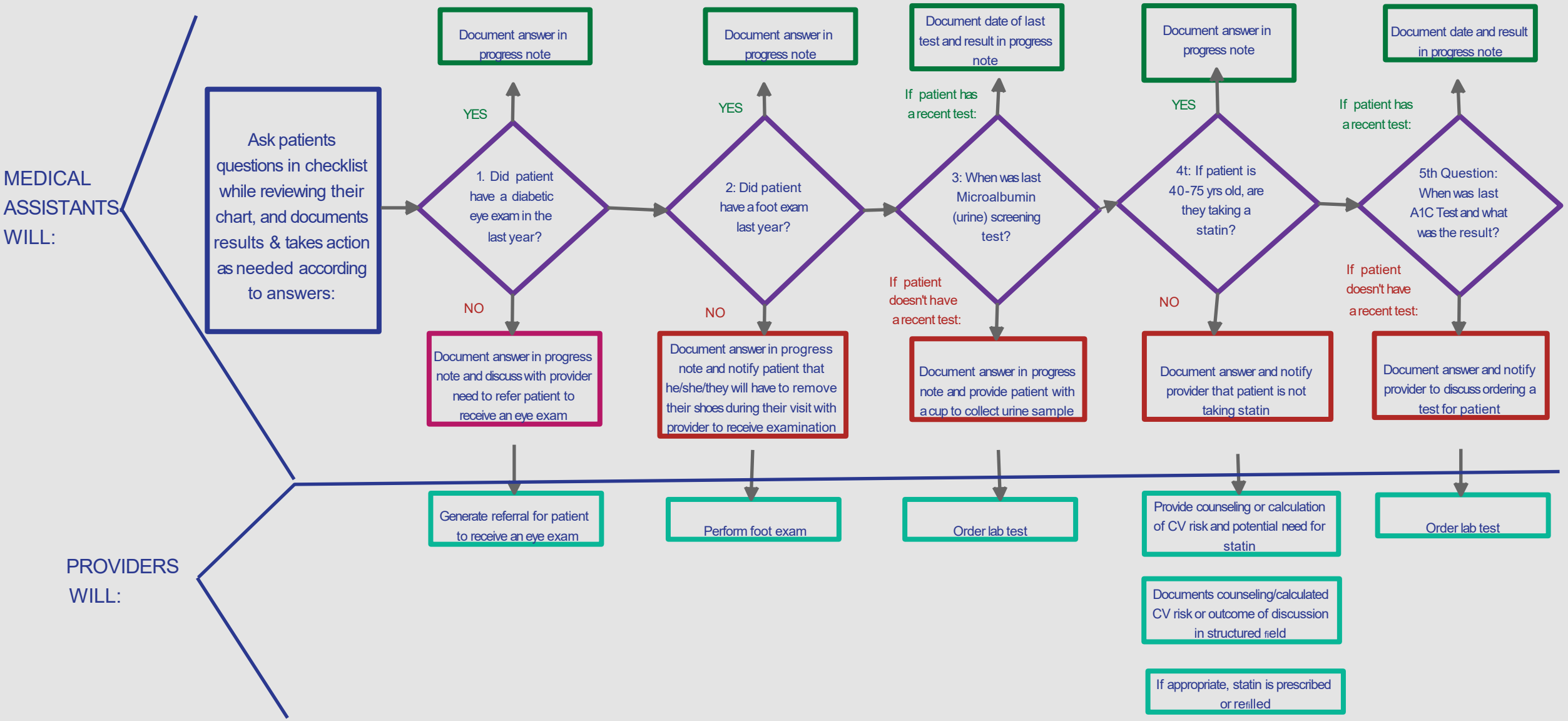
Diabetes pre-visit checklist workflow



*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



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Acknowledgements

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

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PRESCRIBE THE Y

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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: • One-on-one coaching 2x/month • Monthly nutrition seminars • BP monitor	• 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	• 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.

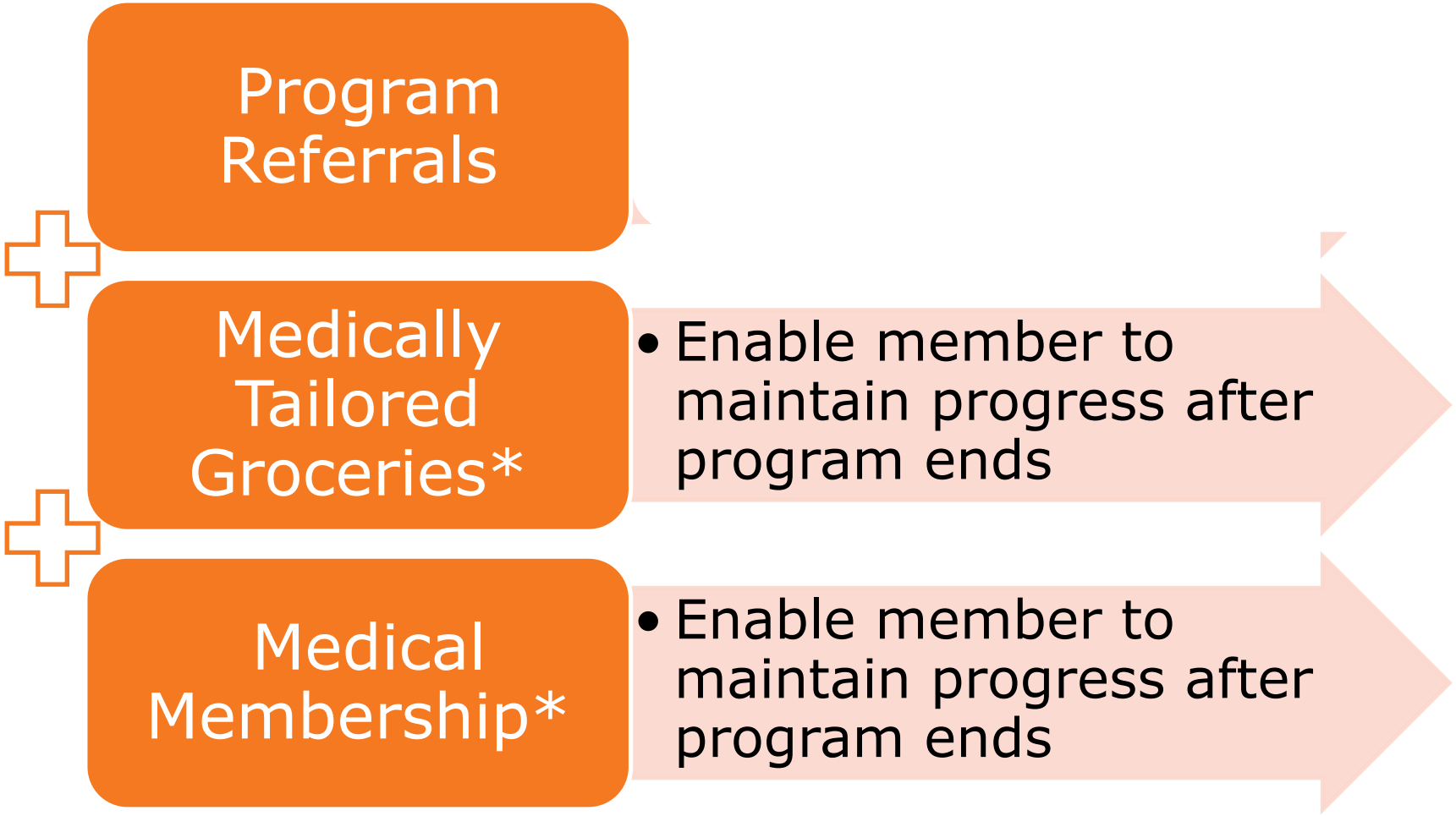
CONTINUUM OF CARE

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

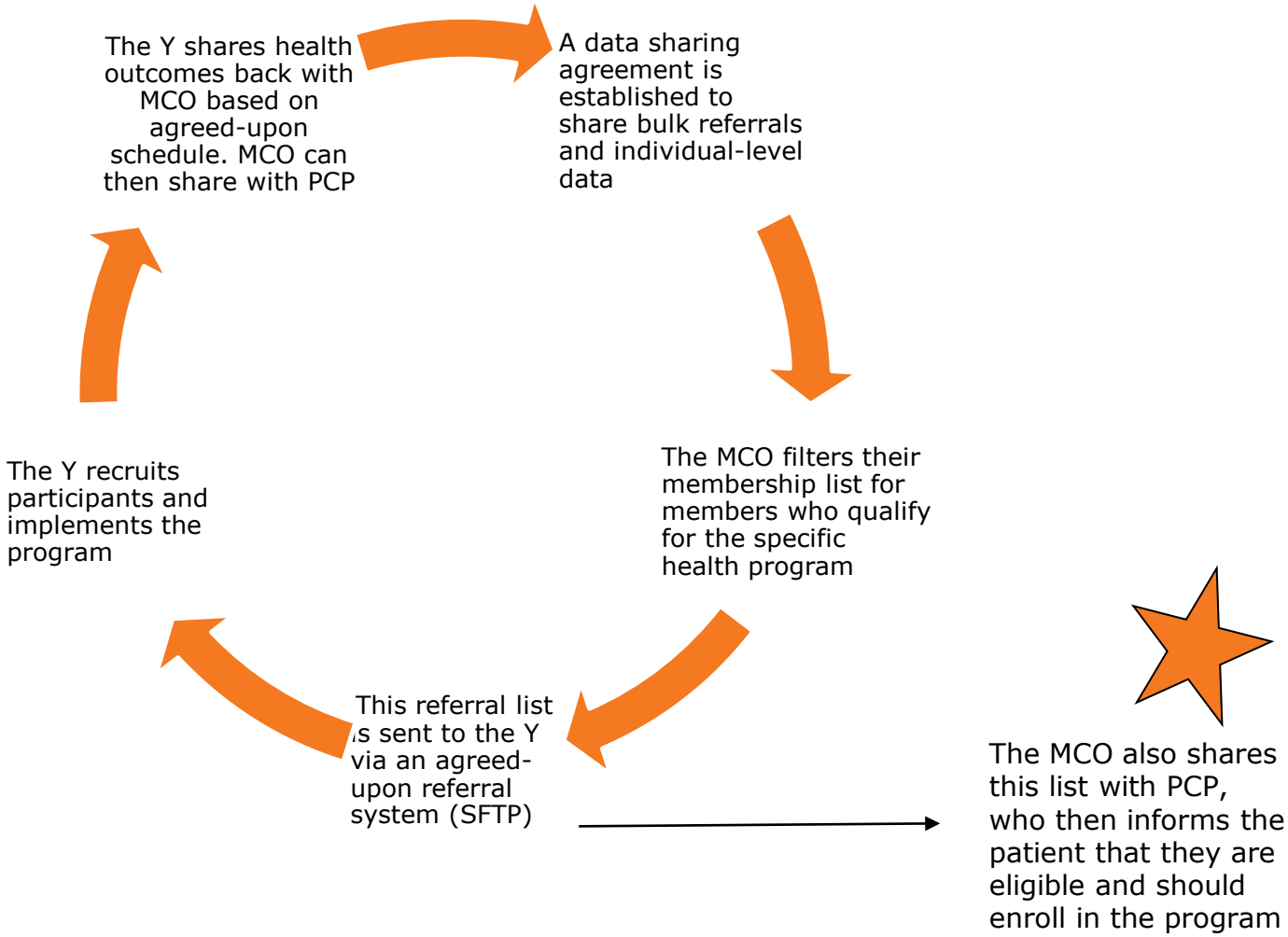
PRESCRIBE THE Y FORMATS: MEDICAID DEMONSTRATION PROJECT



*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

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DC | HEALTH HMA

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)

TECHNICAL ASSISTANCE AVAILABLE

DC | HEALTH HMA

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*

PLEASE CONTACT US!

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