HEART DISEASE AND STROKE PREVENTION & INNOVATIVE HEART HEALTH LEARNING COLLABORATIVES

NOVEMBER 2024

Copyright 2024 DC Health | Government of the District of Columbia

Agenda

1. Welcome and Introductions
2. Program Updates
3. Best Practices to Support Care Plans and Shared Decision Making
4. AmeriHealth Caritas DC Tools to Support Care Planning
5. Q & A and Next Steps

Welcome!

Come on Video

Introduce Yourself:

Name, Title, Organization/Affiliation

Vote Your Favorite:

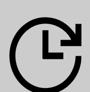
1789
Ben's Chili Bowl
Florida Avenue Grill
Iron Gate
Martin's Tavern
Old Ebbitt Grill
Old Europe
Monocle

Program Updates

Bonny Nunez, Public Health Analyst, DC Health

Heart Disease and Stroke Prevention Learning Collaborative: *September 2024-August 2025*

Learning Collaborative Structure



Quarterly Cycles:
Informed by Strategic Plan and participant-identified priorities based on the HIT/EHR Assessment

Capacity Building Calls:
- *Framed in data*
- *Health equity focus*
- *Focus on building and applying knowledge*

Work Plan Report-Out:
- *Health system grantees selected to report*
- *Identify share problem solving, best practices, innovative approaches, and partner engagement*

Bi-Annual In-Person Strategic Planning:
To foster shared vision and progress toward goals

Collaboration and Engagement:

All virtual and in-person events focused on participatory engagement and collaboration, include team members where relevant

Current Cycle

HIT to Support Care Management in Alignment with Evidence-Based Guidelines

- **September 25**: HIT to Support Care Management

- **October 16**: HIT in Care Management – Pre-Visit Planning; featuring CRISP DC

- **November 20**: HIT in Care Management - Care Plan Development

- **December 18**: Workplan/Action Cycle Report Out

SAVE THE DATE: Next In-Person: Feb 19, 2025

Best Practices to Support Care Plans and Shared Decision-Making

Jodi Pekkala, HMA

Team-Based Care: Your "High Priorities" for Ongoing Support

	OCTOBER:	NOVEMBER:
BEST PRACTICE	1 Team-Based Visit Planning	2 Care Plans and Shared Decision-Making
	HIT Assessment Results: • Low use of EHR- and/or PHM tool-based chart prep tools and reviews of gaps in care • Variations within a clinic on chart prep based on provider	**HIT Assessment Results:** • Low systematic development of care plans, unless in defined (funding-based) populations • Care plans not routinely reviewed by providers/care team huddles

Best Practices: Care Plans and Shared Decision-Making

BEST PRACTICE

Person-Centered

- Care Plan focused on chronic condition(s)
- Developed through a collaborative process where the patient actively participates in the development of goals and interventions
- Focused on individual capacities, preferences and goals
- Includes caregiver in shared decision-making as relevant
- Respects individuals cultural, linguistic, social and environmental needs
- *Individual is core participant in development of their plan of care*

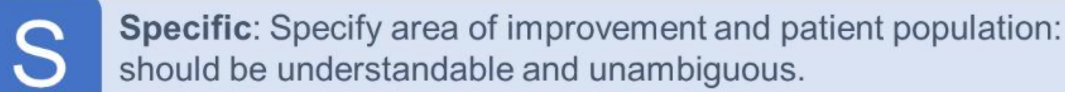
Best Practices: Care Plans and Shared Decision-Making

BEST PRACTICE

Shared SMART(IE) Goals Developed and Tracked

- Developed by CC and RN CM, with patient, based on physical, mental, cognitive, psychosocial, functional, and environmental information obtained
- Includes documented SMART(IE) (specific, measurable, achievable, realistic, timely, equitable, inclusive) goals
- Care plan is shared with the patient, care giver and care team (HIT support: portal)
- Updated at each patient encounter (supported by the EHR)

Developing SMART(IE) Goals



M — **Measurable**: Select measure to track change: numeric goals.

A — **Achievable:** But a stretch; **Actionable:** Including the who, what, where, when; and **Assignable**: Consider who is accountable.

R — **Realistic**: Within available resources and change concepts; **Relevant:** To stakeholders and organization.

T — **Timely**: Within a specific and realistic timeframe.

I — **Inclusive:** Brings impacted and traditionally marginalized people into processes and activities in a way that shares power.

All content was created and delivered by HMA.

E — **Equitable:** Seeks to address systemic injustice, inequity, or oppression.

SMARTIE goals help guide goal development to increase patients' chances of success.

Key Questions for SMARTIE goals:

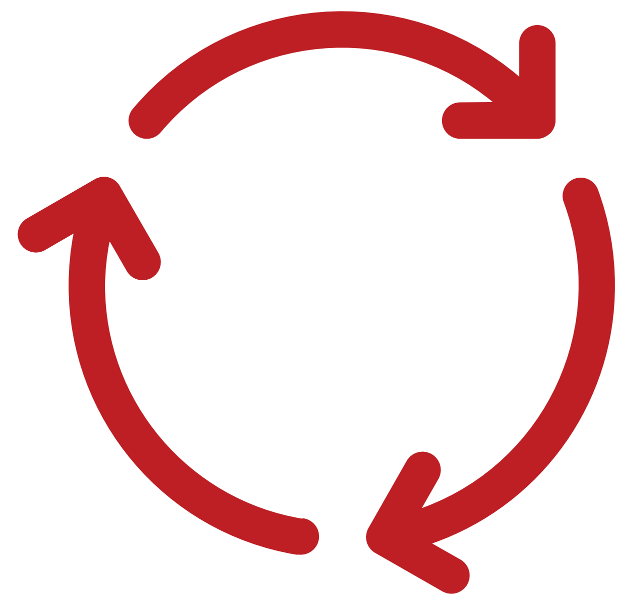
- Exactly *what* are you going to do?
- *How much* will you do?
- *When* will you do this?
- *How often* will you do the activity?
- *Anticipate barriers* and include:
  - Potential solutions for barriers
  - Follow-up plan
  - Confidence rating

Best Practices: Care Plans and Shared Decision-Making

BEST PRACTICE

HIT and Workflows to Support Follow-Up

- Reviewed in huddles/care team meetings
- Care coordinators work with providers to identify and support patients in need of follow-up (HIT to support communication when needed)
- Workflow to provide patient education on lifestyle management and that identifies role/department responsible; person incorporated into care team planning
- Care management dashboards to support care team activities; filterable by provider



Best Practice: RN Interventions for HTN Care Plan

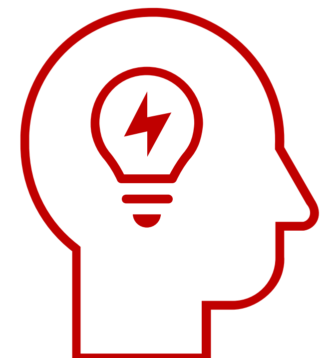
BEST PRACTICE

- **Monitor Blood Pressure:** Regularly monitor to assess for changes; adjust medication dosages as needed.
- **Medication Management/Adherence:** Educate the patient on the importance of medication compliance and taking medicine as prescribed, and potential side effects. Should also monitor for adverse reactions.
- **Education:** Educate the patient on hypertension, potential complications, and the importance of regular medical check-ups.
- **Lifestyle Changes:** Educate the patient on lifestyle changes such as dietary approaches (DASH guidelines, reducing sodium intake) and exercise.
- **Stress Management:** Teach stress management techniques such as deep breathing exercises, meditation, and progressive muscle relaxation.
- **Home Blood Pressure Monitoring:** Educate patient on how to monitor BP at home; provide BP cuff.
- **Risk Factor Identification:** Assess the patient for risk factors such as obesity, smoking, and a sedentary lifestyle and educate the patient on the importance of managing these risk factors.
- **Referral to a Specialist:** Refer the patient to a specialist, such as a cardiologist or an endocrinologist, for further evaluation and management.

https://drkumo.com/nursing-care-plan-and-diagnosis-for-hypertension/#:~:text=Lifestyle%20modifications,-Patients%20diagnosed%20with&text=Emphasize%20the%20consumption%20of%20fruits,the%20treatment%20plan%20if%20needed.

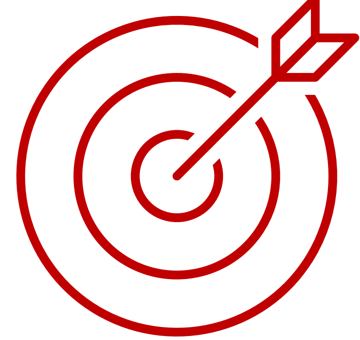
Basics of a Care Plan

1 Problem



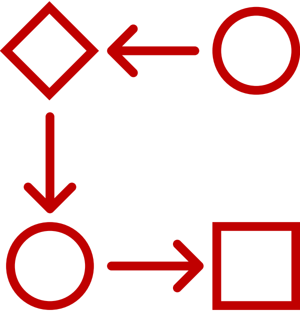
What is the concern identified during the engagement?

2 Goal



What is the person's goal for this specific problem?

3 Interventions



What action steps will the person and care team take to reach the goal?

Care Plan Scenario: Meet Mr. Green

Mr. Green is 55-year-old male with a diagnosis of **Hypertension** and **obesity** and he is a smoker. During the assessment, Mr. Green states, “I walk around my house when I need to. **I only leave my house if I need to, I am embarrassed of the way I look and I don’t want people staring at ‘how big I am**.’ I don’t really exercise, but **I would like to lose some weight**.” PHQ-9 score of 12, indicating depression. He recently became a grandfather and per patient “would love to be around and see him grow up.” Despite being aware of his hypertension, he **does not actively monitor** his blood pressure and only checks it “when I feel dizzy.” He also states he **forgets to take his medicine some days**. Recently, he faced a critical health episode, being **hospitalized for uncontrolled blood pressure and acute kidney injury**. His favorite food is Chinese and eats it several times a week. He also **smokes a pack a day** has tried to quit before, but per patient “I always goes back to it.”

What problems were identified during the engagement with Mr. Green?

- Mr. Green has hypertension and does not take his medication daily or check his blood pressure daily. He also has a recent acute kidney injury.
- Mr. Green is obese with minimal daily physical activity and eats a sodium-rich diet.
- Mr. Green verbalizes feeling bad about himself and has a PHQ-9 of 12.

Care team helps Mr. Green develop goals for these specific problems.

Mr. Green's Care Plan

PROBLEM	GOAL	INTERVENTIONS
Mr. Green has hypertension and does not take his medication daily or check his blood pressure daily. He also has a recent acute kidney injury.	I will take my medication daily to manage my blood pressure. I will check my blood pressure daily before taking my medication.	**Patient Interventions** • I will take my blood pressure before my breakfast every day and record it. • I will go to my nephrology appointment. • I will put a sticky note on my fridge to remind me to take my blood pressure before breakfast. • I will take my medication with breakfast and dinner as prescribed. **Care Team Interventions** • CC will check in with patient twice a week over the next month to provide support and encouragement • Nurse to provide education high blood pressure on following medication regiment. • Provide resources and education on smoking cessation. • Arrange transportation for nephrology appointment.

Mr. Green's Care Plan

<table>
<tr><th>PROBLEM</th><th>GOAL</th><th>INTERVENTIONS</th></tr>
<tr>
<td>Mr. Green is obese with minimal daily physical activity and eats a sodium-rich diet.</td>
<td>I will exercise three times per week.

I will lose two pounds this month.</td>
<td>Patient Interventions
• I will get a step counting watch and get 6,000 steps daily.
• I will walk to my mailbox daily.
• I will walk to the end of the block 3 times a week.
• I will spend 15 min 3 times a week lifting small weights (5-10lb).
• I will ask my family to join me in my walks and exercise.
Care Team Interventions
• Nurse will provide education to patient and family regarding obesity and hypertension.
• Dietician to contact Mr. Green to discuss diet specific to his cultural preferences.
• CC will check in with patient twice a week over the next month to provide support and encouragement.</td>
</tr>
</table>

Mr. Green's Care Plan

PROBLEM	GOAL	INTERVENTIONS
Mr. Green verbalizes feeling bad about himself and has a PHQ-9 of 12.	I will complete my positive reflection exercise daily. I will complete one pleasant activity daily. I will engage in conversation with psychologist 2x per month.	**Patient Interventions** • I will reflect on my positive achievement daily (such as exercise completed that day, healthy food choices made, new things learned, etc.). • I will look at the pleasant activities sheet from my CC and pick out something different every day that I could do. • I will call my friend Marilyn tomorrow night and see if she still plays cards and wants to set up a time to play. • I will meet with psychologist via virtual visit every other Thursday at 3:00PM. **Care Team Interventions** • CC will provide patient with a list of pleasant activities they can engage in. • RN will educate patient on how to recognize and when to report escalating symptoms to the doctor or care manager. • CC will check in with patient twice a week over the next month to provide support and encouragement.

Care Planning Discussion

- How aligned are these best practices with current practices in your office?
- What best practices not currently implemented feel the most feasible to try?
  - What are the barriers to the others?
- What would it look like implementing this in your practice?
- Can this be incorporated into your workplan?
- Where would you need technical assistance?

DC Spotlight: AmeriHealth Care Planning Processes and Resources

Rosalyn Carr Stephens, Corporate Clinical Director,
Population Health Clinical Operations

AmeriHealth Caritas DC

- To support better health for Mr. Green and others with chronic conditions:
- Smoking cessation benefits
- BP cuffs (with prescription)
- OTC benefit which includes items such as reminder pill boxes
- Home delivered meals (Mom's Meals and Food &Friends)
- Healthy cooking classes at our Wellness Center in S.E. DC
- Depression screening (PHQ9/PHQ9A) with referral to BH services
- In-person Heart Health Wellness Circles facilitated by an RN Case Manager
- Medication delivery and prescription mail order options
- Virtual Wellness Circles – (S.H.I.R.E. Health) 6-8 sessions over 3 months
- CM Consultations as well as Online Health Library ($\leq 5^{th}$ grade reading level)
- Transportation, Interpreter and translation services

AmeriHealth Caritas DC

AmeriHealth Caritas
District of Columbia

How are community members connected to services?
What efforts does your organization make to improve access and utilization for community members with hypertension and high cholesterol?

Get Connected to Services

- https://www.amerihealthcaritasdc.com/member/eng/index.aspx
- Call our Enrollee Services Dept. at 1-202-408-4720 or 1-800-408-7511, 24 hrs./day, seven days/week
- Stop by our Enrollee Wellness Center at 1209 Marion Barry Ave. SE, Washington, DC 20020, from 9 a.m. to 4:30 p.m., Monday through Friday.
- AmeriHealth Caritas enrollee portal / AmeriHealth Caritas mobile app

Improving Access to Services

- Self-referral for all primary and specialist care - No out-of-pocket costs for Medicaid/Alliance benefits
- Broad network including telemedicine and urgent care options, as well as and transportation benefit
- Outreach team assists with navigation of health systems, use of Medicaid/Alliance benefits
- Pharmacy Help Desk 1-888-452-3647 (TTY 1-888-989-0073)

AmeriHealth Caritas DC

How can partners make referrals to your organization? Who can partners contact for more information?

We welcome collaboration with our partners via:

- Let Us Know Program – referrals to our services which support the health of your patients/clients
  - https://www.amerihealthcaritasdc.com/pdf/provider/resources/let-us-know-flyer.pdf
  - https://www.amerihealthcaritasdc.com/pdf/provider/resources/let-us-know-intervention-form.pdf
  - Rapid Response and Outreach Team 1-877-759-6224 Fax: 1-888-607-6405 are available from 8 a.m. to 5:30 p.m., Monday – Friday, for support with care coordination and enrollee access to services as well as referrals to a Care Manager
  - Ryan Auerbach, RN, Manager, Population Health rauerbach1@amerihealthcaritasdc.com
  - Dashawn Anderson, Manager, Community Outreach danderson3@amerihealthcaritasdc.com

Next Steps and Q&A

DC Health

Quick Evaluation Poll

1. **To what extent did the session meet objectives?**
   (1 - not at all to 5 - met all objectives)

2. **How would you rate the session overall?**
   (1 - poor to 5 - excellent)

2201 Shannon Place SE, Washington, DC 20020