

# HEART DISEASE AND STROKE PREVENTION & INNOVATIVE HEART HEALTH LEARNING COLLABORATIVES

---

OCTOBER 2024

# Agenda

- 1. Welcome and Introductions**
- 2. Program Updates: Learning Collaborative Format**
- 3. Best Practices to Support Team-Based Visit Planning**
- 4. CRISP DC Tools to Support Team-Based Visit Planning**
- 5. Q & A and Next Steps**

# Welcome!

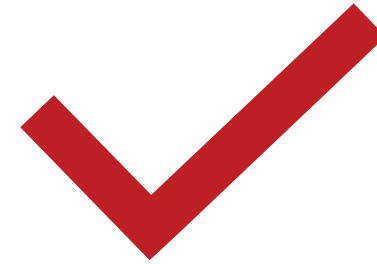


## Come on Video



## Introduce Yourself:

Name, Title,  
Organization/Affiliation



## Vote Your Favorite:

Capitals  
Commanders  
DC United  
Mystics  
Nationals  
Spirit  
Wizards

# Program Updates

---

Latrice Hughes, 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

# Best Practices to Support Pre-Visit Planning

---

Jodi Pekkala, HMA

# Team-Based Care: Your “High Priorities” for Ongoing Support

BEST PRACTICE  
IN ACTION



OCTOBER:

## 1 Team-Based Visit Planning



A multi-disciplinary care team structure, with routine chart preparation and huddle review, supported by EHR/HIT systems

### 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

NOVEMBER:

## 2 Care Plans and Shared Decision-Making



Documented care plans, with outcomes and shared SMART goals developed with the patient, shared with the patient and care team. Updated and acted upon to support follow up and education needs. Supported by the EHR.

### 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 Practice: Team-Based Visit Planning Overview

A multi-disciplinary care team structure, with routine chart preparation and huddle review, supported by EHR/HIT systems



## BEST PRACTICE

- Pre-visit planning starts with the prior visit:
  - Schedule next visit and any other follow-up appointments at the end of each visit
  - Arrange lab tests to be completed before the next visit
- One week in advance of visit:
  - Confirm appointments (starting one week in advance, with subsequent reminders up to the day prior); **confirm transportation needs**



## MAXIMIZING HIT

- Scheduling platforms allowing visits to be scheduled out at relevant intervals to support patient need **★ CRISP DC**
- EHR interface for ordering/resulting of labs **★ CRISP DC**
- Automated reminder letters, emails, phone calls or text messages to reduce no-show rates

# Best Practice: Team-Based Visit Planning Overview (cont'd)

A multi-disciplinary care team structure, with routine chart preparation and huddle review, supported by EHR/HIT systems



## BEST PRACTICE

- 1-2 days before the visit:
  - Staff (typically an RN or MA) reviews the list of scheduled patients and pulls charts:
  - Review the provider notes from last visit
  - Ensure notes from any other visits in the interim are in the patient's record (specialists)
  - Ensure lab results, X-rays, other tests ordered are entered
  - Confirm reason for visit/any info needed
  - Identify gaps in care (missing preventive and chronic care needs), **HRSN** needs



## MAXIMIZING HIT

- EHR- or PHM-enabled chart prep tools
- EHR interface for ordering/resulting of labs
  - ★ **CRISP DC**
- HIE to identify visits/services that may have occurred
  - ★ **CRISP DC**
- EHR/PHM gaps in care alerts
- Pre-appointment questionnaires sent through portals

# Best Practice: Team-Based Visit Planning Overview (cont'd)

A multi-disciplinary care team structure, with routine chart preparation and huddle review, supported by EHR/HIT systems



## BEST PRACTICE

- Day of visit/morning:
  - Multi-disciplinary team huddles to review and share knowledge for the day ahead, including:
    - What to expect with patients



- Supporting key needs (e.g., pre-flagging patients for potential BH, CC, **HRSN** support)
- Time of visit:
  - Pre-appointment questionnaire



- MA/RN handoff: additional concerns identified by patients, including **HRSN**



## MAXIMIZING HIT

- EHR- or PHM-enabled chart prep tools

- Pre-appointment questionnaires electronically through tablets

- LinkU to support **HRSN**  **★ CRISP DC**

# Best Practice: Team-Based Visit Planning for HTN and Hyperlipidemia



## BEST PRACTICE

- Flagging key patient populations for upcoming week:
  - Hypertension:
    - Uncontrolled HTN and no anti-HTN medication
    - Uncontrolled HTN and on monotherapy
    - Last BP above target (and number of consecutive visits above target)
    - Link to order set/patient treatment algorithm based on patient specifics (e.g., American Heart Association clinical practice guidelines/treatment algorithm)
  - Hyperlipidemia:
    - No lipids recheck in past 12 months
    - No 10-year risk for a cardiovascular event recalculated in the past 12 months



## MAXIMIZING HIT

- EHR- or PHM-enabled gaps in care
- Order sets, electronic clinical decision support



# Team-Based Visit Planning Discussion

---



- Alignment of best practices with current practices: thoughts on this exercise.
  - What surprised you (about your own practice and others)?
  - What inspired you (about your own practice and others)?
- What best practices not currently implemented feel the most feasible to try?
- What would it look like implementing this in your practice?
- Can this be incorporated into your Million Hearts workplan?
- Where would you need technical assistance?

# DC Spotlight: Using CRISP DC to Support Pre-Visit Planning

---

Corey Main, Account Manager



**The District Designated  
Health Information  
Exchange**

# District-Wide Data Sharing for Whole Person Care

**Regional Health Information Exchange** (HIE) serving Maryland, West Virginia, and the District of Columbia.

CRISP's main goal is to securely deliver the right health information to the right place at the right time to **enable safe, timely, effective, equitable, and patient-centered care.**

CRISP DC is a **non-profit organization** advised by a wide range of stakeholders who are responsible for public health throughout the District.

CRISP DC has been serving the District since 2016 and became the **District Designated Health Information Exchange** in April 2020 through a competitive process governed by DHCF.



1k+

Organizations Accessing and Contributing Data



15,000+

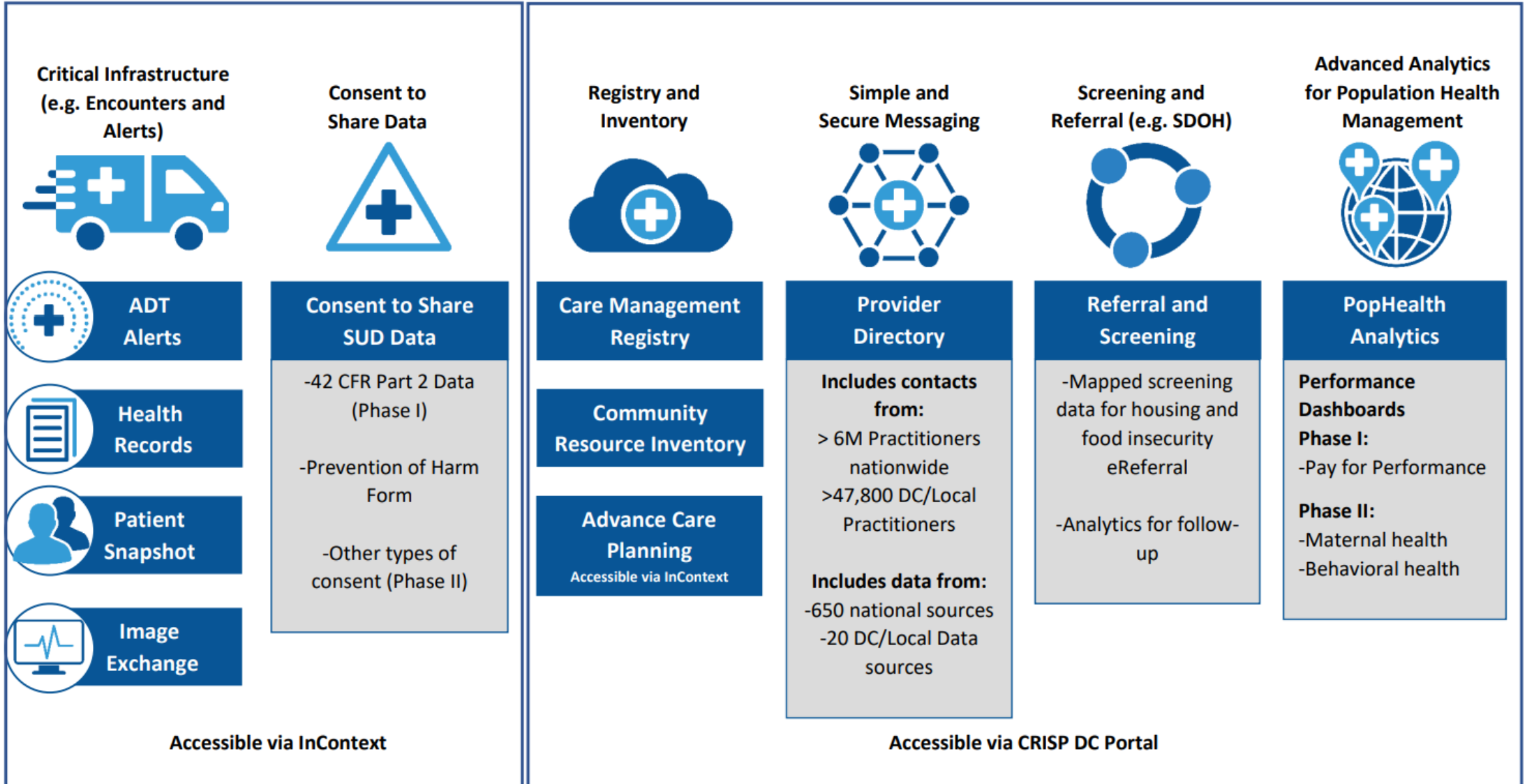
DC Healthcare Professionals Utilizing the HIE



1,400,000+

Patients Served Through the HIE

# The DC HIE is a Health Data Utility with Six Core Capabilities for Providers





# CRISP DC HIE Network

CRISP DC Participants:

**1075**

Sending Admission, Discharge  
and Transfer Data (ADTs):

**395**

Sending Continuity of Care  
Documents/Visit Summary (CCD):

**331**

Total Patient Population:

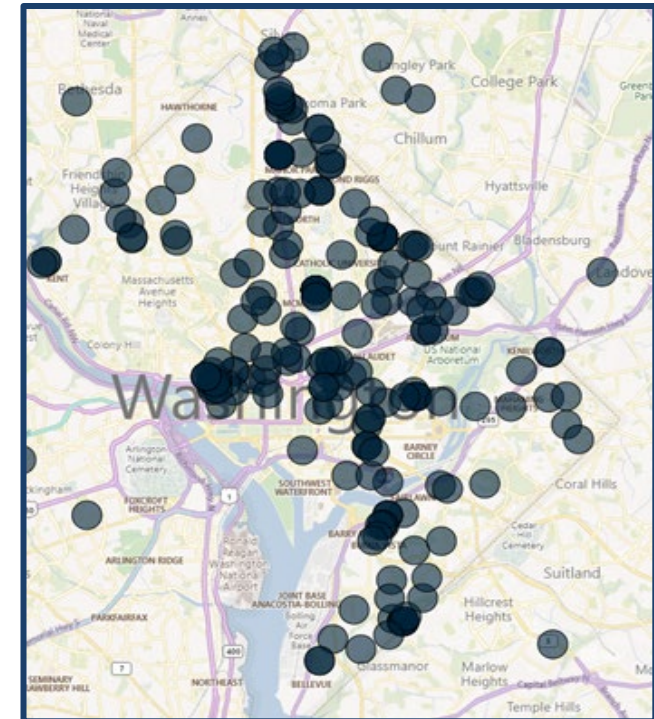
**46M+**

## Connected DC Providers and Health Systems

- 8 Hospitals (all)
- 8 Federally Qualified Health Centers (all)

## CRISP DC receives real-time ER visit details and more from the region; plus, data from national networks

- All DC, Maryland, Virginia, Delaware, and West Virginia acute care hospitals
- 5100 data sources and growing across entire CRISP network





# Highlighted CRISP Tools and Services

## Event Notification System via Population Explorer

- A free service which enables medical personnel to receive real-time alerts that can be customized through filtering capabilities.
  - Care Managers and Programs, Diagnosis Codes (Encounter and Primary), Chronic Conditions, Follow-up Status, and Insurance

## Patient Care Snapshot

- Information is presented from a compilation of care management data alongside real-time encounters, up-to-date demographics, patient to care provider attribution, and clinical summaries.

## Image Exchange

- Participant organizations can share all common Radiology and Cardiology imaging modalities including X-Rays, CT scans, MRI, Ultrasound, PET-CT, and Cardiac Angio. These become viewable within the patient's health record.

## Upcoming: LinkU

- CRISP users will soon be able to access to LinkU, DC Health's screening and referral platform powered by FindHelp! New user onboards will begin soon allowing them to login via the CRISP DC HIE Portal. Launching from the EHR InContext application is planned for future development. The LinkU platform will allow users to:
  - Conduct a social needs screening assessment
  - Send closed loop referrals to community-based organizations
  - Search for community resource information available in the District



# Live Demonstration

---





# Connectivity/Timeliness & Completeness



## Goal of 48 Hour Discharge Turnaround

Reduction from the current average of 5 days, up to 30

### Priority Elements

- Discharge Diagnosis
- Reason for Visit
- Discharge Medications
- Medication Allergies

### Level 2 Elements

- Immunizations
- Laboratory Results
- Vital Signs

### Pending Definition

- Discharge Appointments
- Consult Notes
- Procedure Notes
- Plan of Care
- Point of Contact
- Goal progress



For CRISP DC related inquiries please contact outreach at [dcoutreach@crisphealth.org](mailto:dcoutreach@crisphealth.org).

For support contact [support@crisphealth.org](mailto:support@crisphealth.org) or call 833.580.4646.

1140 3<sup>rd</sup> Street NE  
Washington, DC 20002  
833.580.4646 | [www.crispdc.org](http://www.crispdc.org)  
[dcoutreach@crisphealth.org](mailto:dcoutreach@crisphealth.org)

# 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)*



# DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

2201 Shannon Place SE, Washington, DC 20020

 [dchealth.dc.gov](https://dchealth.dc.gov)

 [@\\_DCHealth](https://twitter.com/_DCHealth)

 [dchealth](https://www.instagram.com/dchealth)

 [DC Health](https://www.facebook.com/DCHealth)

 [dchealth](https://www.tiktok.com/@dchealth)

 [DCHealth](https://www.youtube.com/DCHealth)