Cardiovascular Health: Workflow Modifications Guide

Providers and practices actively engaged in the Delaware Division of Public Health's National Cardiovascular Health Program can benefit from a no-cost workflow assessment (WFA) with a Quality Insights Practice Transformation Specialist (PTS). WFAs are designed to initiate processes to improve the quality of care related to the management and prevention of cardiovascular disease and stroke.

The following list outlines solutions aimed at achieving improved patient outcomes in cooperation with a completed WFA. These solutions are to be implemented with the assistance of a Quality Insights PTS. If you are not currently working with a PTS and would like to, email Ashley Biscardi or call 1-800-642-8686, ext. 2137.

Electronic Health Record (EHR) Actions

	Monitor annual National Quality Forum #0018: Controlling High Blood Pressure (BP) clinical quality measures. Collaborate with a PTS to create reports on patient race/ethnicity and patient population disparities.
	Develop clinical decision support alerts for patients with hypertension (HTN) and/or hypercholesterolemia (HCL) for proactive outpatient management.
	Implement a process for documenting all referrals (including lifestyle change programs) through multidirectional electronic referrals or via phone calls in structured data fields.

Protocol and Workflow Actions

	Implement policies and protocols to ensure the utilization of standardized clinical quality measures to track BP control measures by race, ethnicity, and other populations of focus.
	Update and implement team-based care protocols, focusing on disparate populations, to share and discuss HTN control and HCL management among providers. Create monthly reports to explore gap closures in cardiovascular disease (CVD) guidelines-based medical management and promote quality improvement.
	Implement annual staff training to review competencies and protocols for obtaining accurate BP measurements.

Practice and Clinical Solutions

Using the **2024 Cardiovascular Health Practice Module** as a guide:

	Implement self-measured blood pressure (SMBP) monitoring with a clinical support program. Identify a staff member who can act as a program champion and assign roles to other members of the team.
	Promote the use of telehealth for the management of HTN and HCL.
	Collaborate with Quality Insights to launch a portal message or text campaign for referrals to lifestyle change programs.
	Optimize relationships with PPCN pharmacy services and utilize services related to CVD, such as medication adherence, home visits, smoking cessation, and social determinants of health (SDOH) support services.

Patient Education Actions

	Utilize and share SMBP instructional videos with patients through the practice's preferred method (i.e., waiting room, patient portal, email, telehealth wait times, and text messaging).
	Provide validation of home BP monitors and calibrate for accuracy with the BP machine in the office.
	Initiate a closed-loop referral process for lifestyle change programs such as WW® (formerly Weight Watchers), Taking Off Pounds Sensibly (commonly referred to as TOPS), and the Healthy Heart Ambassador Blood Pressure Self-Monitoring Program, if eligible.
	Refer for application through Delaware ASSIST for low-income patients to receive Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP).
	Consider referring to the Supplemental Nutrition and Assistance Program Education and Expanded Food and Nutrition Education Program for nutrition education.

SDOH Actions

	Utilize SDOH ICD-10 Z-Codes and referrals to community-based organizations for reporting and tracking purposes. Explore opportunities to close the gaps for the highest needs of the patient population.
	Optimize standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at the highest risk of CVD. Implement referrals for support services utilizing platforms such as Unite Delaware or Findhelp.org.
	Implement or optimize an SDOH screening tool, such as the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) tool, or an EHR template.

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