Workflow Modifications for the Prevention and Management of Cardiovascular Disease and Stroke

In Pennsylvania, heart disease is the leading cause of death and stroke is the fifth leading cause of death. The following list includes workflow modifications to help in the management of hypertension (HTN) and hypercholesterolemia (HCL).

Quality Insights is a partner with the Pennsylvania Department of Health (PA DOH) in the Centers for Disease Control and Prevention (CDC) National Cardiovascular Health Program.

Electronic Health Record (EHR) Actions

	Monitor annual and quarterly National Quality Forum (NQF) #0018: Controlling High Blood Pressure (BP) and Centers for Medicare and Medicaid Services (CMS) #347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CVD) clinical quality measures. Create reports at race/ethnicity level and utilize the CMS Disparities Impact Statement to address disparities.
	Execute and add clinical decision support (CDS) alerts for patients with HTN and/or HCL. Refer patients to a lifestyle change program during the next visit. For HTN - schedule follow-up appointments every 2-3 weeks until HTN is in control and then every six months thereafter. For HCL - review prescription status for statin therapy according to guidelines-based recommendations and monitor labs.
	Implement and utilize a social determinants of health (SDOH) screening tool such as the Protocol for Responding to & Assessing Patient's Assets, Risks & Experiences (PRAPARE) tool or an EHR template. Document ICD-10-CM Z codes and referrals to community-based organizations for positive responses. Work with Quality Insights to mitigate barriers related to use of SDOH identification tools and ICD-10-CM coding.
	Implement a process for documenting all referrals (including lifestyle change programs) in structured data fields.
	Document assessment and recommendations for tobacco use and cessation in EHR. Order and provide free PA DOH Tobacco Cessation print materials and referral to the PA Free Quitline.

Protocol & Workflow Actions

	Update and implement team-based multidisciplinary care protocols with a focus on disparate populations for sharing and discussing HTN control and HCL management among providers. Create monthly provider reports to explore gap closures in CVD guidelines-based medical management and promote quality improvement.
	Update and implement prevention and management of HTN and HCL guidelines-based medical management protocol. Include evaluation of patients with HTN and elevated low-density lipoprotein cholesterol (LDL-C) >100 milligrams/deciliter(mg/dl). Promote team-based care, updated appointment processes (including follow-up), self-measured blood pressure (SMBP) monitoring, medication adherence, healthy diet, increased physical activity, and referrals to lifestyle change programs.
	Implement annual staff training to review competencies and protocol for obtaining accurate BPs.

Practice & Clinical Solutions

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

	Partner with Quality Insights to submit an application for Target: BP™ (4-6 HTN evidence-based interventions and/or NQF # 0018 ≥ 70 %*) and/or Million Hearts® Hypertension Control Champion (NQF #0018 ≥ 80 %*) recognition programs.
	Implement a Self-Measured Blood Pressure (SMBP) Monitoring program. Identify a staff member who can act as a program champion and roles for other members of the team.
	Promote use of telehealth for the management of HTN and HCL.
	Utilize apps, Bluetooth, and patient portals to improve SMBP results reporting to providers.
	Schedule HCL follow-up appointments with EHR-identified patients with LDL-C >100 mg/dl. Assess need for statin therapy and/or referral to lifestyle change programs.
	Initiate referrals to lifestyle change programs such as Weight Watchers, TOPS, and Curves, YMCA's Blood Pressure Self-Monitoring (BPSM) program, PA DOH Healthy Heart Ambassador BPSM (HHA-BPSM) program, Pennsylvania Pharmacists Care Network (PPCN), and National Diabetes Prevention Program, if eligible. Refer for application through PA Compass to low income patients for Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). Consider referrals to SNAP Education (SNAP-Ed) and Expanded Food, and Nutrition Education Programs (EFNEP) for nutrition education.
	Establish a multidisciplinary closed-loop referral process with CDC-recognized lifestyle change programs.
	Collaborate with Quality Insights in a referral letter, portal message, or text campaign for referrals to programs and community partners to provide support for SDOH positive responses.

** Represents controlling BP rates of adults at or above 70% or 80% within the populations served.*

Patient Education Actions

	Utilize and share SMBP instructional videos with patients through the practice's preferred method (e.g., waiting room, patient portal, email, telehealth wait times, and text messaging).
	Provide validation of home BP monitors with the practice BP machine.

We encourage you to partner with your Quality Insights Practice Transformation Specialist (PTS) and implement at least ONE of the recommendations listed above. If you are not currently working with a PTS and would like assistance, email Ashley Biscardi or call **1.800.642.8686, Ext. 137**.

Funding provided by the Pennsylvania Department of Health as part of the National Cardiovascular Health Program federal grant from the Centers for Disease Control and Prevention (CDC-RFA-DP-23-0004). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Publication number PADOH-CV-022024

Quality Insights