Cardiovascular Health: Workflow Modifications

In Pennsylvania, heart disease is the leading cause of death, and stroke is the fifth leading cause of death. Providers and practices who are actively engaged in the Pennsylvania Department of Health's (DOH) National Cardiovascular Health Program have the opportunity to 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 as it relates to the management and prevention of cardiovascular disease and stroke.

The following list outlines solutions aimed at improving 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, please email Ashley Biscardi or call 1-800-642-8686, ext. 2137.

Electronic Health Record (EHR) Actions

	Monitor annual National Quality Forum (NQF) #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 EHR clinical decision support (CDS) 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 referral or via phone call, in structured data fields.

Protocol and Workflow Actions

	Implement policies and protocols to ensure utilization of standardized clinical quality measures to track blood pressure 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 CVD guidelines-based medical management and promote quality improvement.
	Implement annual staff training to review competencies and protocols for obtaining accurate BPs.

Practice and Clinical Solutions

Using the 2025 Cardiovascular Health Practice Module as a guide:

	Submit applications for Target: BP™ and/or Million Hearts® Hypertension Control Champion recognition programs.
	Implement a Self-Measured Blood Pressure (SMBP) Monitoring with Clinical Support program. Identify a staff member who can act as a program champion and assign roles to other members of the team.

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	Promote the use of telehealth for the management of HTN and HCL.
	Collaborate with Quality Insights in a portal message or text campaign for referrals to lifestyle change programs.
	Optimize relationships with Pennsylvania Pharmacists Care Network (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 (e.g., waiting room, patient portal, email, telehealth wait times, and text messaging).
	Promote SMBP monitoring, medication adherence, healthy diet, increased physical activity, and referrals to lifestyle change programs.
	Provide validation of home BP monitors and calibrate for accuracy with the BP machine in the office.
	Utilize a Quality Insights community health worker to contact patients regarding patient portal usage to receive education to help manage their health care.
	Initiate a closed-loop referral process for lifestyle change programs such as Weight Watchers, TOPS, and Curves, the YMCA's Blood Pressure Self-Monitoring (BPSM) program, Healthy Heart Ambassador BPSM program, PPCN, and National Diabetes Prevention Program, if eligible. Refer for application through PA Compass for low-income patients to receive Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). Consider referrals to SNAP Education and Expanded Food and Nutrition Education Programs for nutrition education.
	Document assessment and recommendations for tobacco use and cessation in the EHR. Leverage PPCN's no-cost patient tools for smoking cessation.

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 in 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 highest risk of CVD. Implement referrals for support services utilizing platforms such as PA NAVIGATE.
	Implement or optimize an SDOH screening tool such as the Protocol for Responding to & Assessing Patient's Assets, Risks & Experiences (PRAPARE) tool or an EHR template.

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