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Million Hearts® Model Promising Practice Case Study

Participant Spotlight

Holmes Family Medicine
Millersburg, OH

This Million Hearts® Model participant, **Holmes Family Medicine** provides preventive services and treatments to a rural patient population, which includes a culturally diverse Amish and Mennonite community, as well as many geriatric patients.

Their patients primarily face cultural and age barriers to accessing care through digital health technology and their online patient portal. Holmes Family Medicine has the following practices in place designed to address these barriers:

- **Maximize available communication avenues with patients** via telephone and mail. They partner with a local hospital to ensure a provider is always available outside of operating hours and use an automated phone call service to encourage follow-up care. They also send lab and diagnostic results through the mail for patients without consistent telephone or internet access.
- Reserve acute and same-day appointments daily to **accommodate patients' transportation and financial limitations.** Patients from the Amish community often share transportation costs and combine appointments and errands within a single trip.

In the future, Holmes Family Medicine plans to adopt a **new at-home blood pressing monitoring program** to serve their rural patient population.

Since their patients also face additional barriers to accessing care, including lower socio-economic status and healthcare coverage, Holmes Family Medicine plans to purchase at-home blood pressure monitors that patients can reserve to improve their cardiovascular health.

> "We always make sure to have a substantial amount of acute and same-day appointments available on our schedule. Keeping acute appointments open allows [patients] **greater access to their provider** within financial and transportation limitations."
>
> *~ Gillian Vanaman, Holmes Family Medicine*

Million Hearts® Model
Innovative health care for every heart

The aim of the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Million Hearts ® Cardiovascular Disease Risk Reduction Model (Million Hearts® Model or MH Model) is to prevent first time heart attack and stroke in high risk Medicare beneficiaries. The model aim was supported by primary model drivers. This case study spotlights one of our participant organizations' innovative implementation of the "Establishing a Team-Based Care" model driver.

Promising Practice: Million Hearts® Model Individualized Care Planning to Address Social Determinants of Health Barriers to Care

Social Determinants of Health (SDOH) are conditions in places where people live, learn, work, and play that affect a range of health and quality-of-life-risks and outcomes.[1] Inequities in social, economic, and environmental conditions needed for health have been associated with greater hypertension risk among minority groups.[2]

SDOH factors that can affect cardiovascular health include:[3]

- Socioeconomic position
- Race and ethnicity
- Social support and networks
- Culture and language
- Access to medical care
- Residential environment

To reduce the risk of cardiovascular disease, increase awareness of SDOH factors and incorporate actional resolutions within a patient's individualized care plan.[4]

Million Hearts® Model Developing Sustainable Tactics to Incorporate SDOH in Individualized Care Planning

Consider using data sources to measure or track SDOH factors to identify potential health inequities in your patient population and inform care planning and identification of patients who may have greater cardiovascular disease risk.

Use team-based care to develop processes and an organizational culture that addresses and promotes incorporating SDOH into individualized care planning and chronic care management.

Understand and discuss your patient's community and the barriers they may face to accessing care.

Million Hearts® Model Practical Tools to Consider when addressing Social Barriers to Care

You can use the following tools to inform individualized care planning with patients' SDOH in mind:

Neighborhood Navigator: Community-based resources can support patients to resolve or address barriers to care. Use the Neighborhood Navigator from the American Academy of Family Physicians to search available social services related to health, food, transportation, and financial aid by your zip code.

Social Needs Screening: Screen patients to determine what SDOH factors may impact their access to health by using Social Needs Screening forms. Develop an action plan with your patient, incorporating SDOH factors and how to address them into discussions with your patient about their individualized care planning for cardiovascular health.

Health Equity in Tobacco Prevention and Control User Guide: Check out this user guide from the Centers for Disease Control and Prevention (CDC) to tailor care planning for patients with this co-morbidity factor.

Reference Links: 1. Social Determinants of Health 2. Controlling Hypertension 3. Circluation - An Article by the AHAA 4. Measures of SES 5. Advancing Health Equity