WISEWOMAN:
Lifestyle Medicine Provider Education
Systems Improvement
ACPM has a partnership with the Centers for Disease Control and Prevention (CDC) to create and deliver new lifestyle medicine education modules for providers in the CDC WISEWOMAN program.

The grant is administered through CDC’s Division for Heart Disease and Stroke Prevention (DHDSP).
SESSION REMINDERS

• The session is being recorded
• All participants are in listen only mode
• **We encourage questions and comments**
• Please enter questions into the question box in the GoToMeeting panel
• Questions will be addressed at the end of the presentation
Participants will:

• Increase understanding of ways to improve patient workflow.
• Identify best practices associated with quality improvement activities.
• Recognize public domain resources and funding opportunities available to assist in systems improvement.
TODAY’S MODERATOR AND SPEAKERS

Moderator:
Shaylona Kirk, MD, MPH
Health Promotion Physician (US Air Force)
ACPM Member

Speakers:
Ilan Shapiro, MD
Medical Director, Health Education and Wellness
AltaMed Health Services

Ayanna Buckner, MD, MPH, FACPM
Principal, Community Health Cooperative
ACPM Member
What is a patient workflow?
- A process involving a series of tasks—how tasks are accomplished, in what order, and by whom. In its simplest form, it can serve as a skeleton upon which the rest of patient care can be fleshed out.
PATIENT WORK FLOW AND WISEWOMAN

• **Strategic approach of today’s webinar**
  • The webinar will provide a view from an on-the-ground resource that treats a patient population that is similar to those in the WISEWOMAN program.
  • Present work flow models utilized by AltaMed Health Services
  • Focus on two examples
    • Hypertension Management
    • National Diabetes Prevention Program (evidence based program utilized by some WISEWOMAN providers)
PATIENT WORK FLOW AND WISEWOMAN

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Clinic Workflow Improvement with Innovative Approaches to Screening and Referring within a Community Healthcare Center

Dr. Ilan Shapiro, MD
Medical Director of Health Education & Wellness
(Presenter/ Co-author)
Jessica Solares, MPH-Director of Health Education & Wellness (Co-author)
August 18, 2017
Who is AltaMed?

• Founded in 1969, AltaMed Health Services Corporation is a network of federally qualified health centers.

• 44 service sites located in underserved communities (Los Angeles & Orange Counties).

• Our network provides +1 million encounters for primary care, behavioral health, dental services, senior care and other social services for 180K unique patients.

• Approximately 86-97% of our patient population self-identifying as Latino.
Improving Clinic Workflows

- AltaMed provides a variety of prevention services for patients
  - Health Education
  - Onsite Diabetes Prevention Classes
- AltaMed developed a **Hypertension Management Protocol (HMP)** to work collaboratively with hypertension patients and the primary care team to ensure the patient meets their blood pressure (BP) goals.
- AltaMed partnered with ACPM to identify and develop improved clinic workflow models for referral to the National Diabetes Prevention Program.
- Clinic strategies included
  - Establishing champions
  - Greater utilization of public domain materials (CDC, AMA, ADA),
  - Build of EMR queries
  - Development of registries of eligible patients
  - Establishing robust clinic communications / awareness
Clinic Workflow Improvement

• Success & Challenges Around 4 Key Strategies:
  • Incorporating a Champion Provider that is heavily involved in and serves as a staunch advocate;
  • Using staff exclusively dedicated to supporting recruitment, retention, and program implementation;
  • Utilizing a registry report/list to target outreach efforts;
  • Creating and refining an electronic referral and workflow in our electronic medical records system, NextGen, to refer patients.
Patient Awareness of Health Education Classes / Resources

<table>
<thead>
<tr>
<th>Promotion and Identification Across Clinic</th>
<th>Addition of New Resources</th>
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</table>
| • Community Health Worker (a.k.a. *Promotora de Salud*)  
  - Scrubbing e-charts  
  - Clinic huddling  
• ADA Risk Test  
• Presentations to Clinic Staff  
• Rapport building with Clinical Staff  
• Registry Report/List | • Electronic Medical Record Identification / E Referral for Patients with:  
  • Diabetes  
  • Hypertension  
  • Obesity  
  • High Cholesterol  
  • Prediabetes  
|                                               |  

- Use of public domain materials new promotional materials from AMA / CDC STAT Tool Kit
Funding Opportunities for Additional Resources (Staffing, Program Development)

State and National Health Plans

- Anthem
- United
- Aetna
- Cigna
- Humana

All have annual funding opportunities that support community clinics & prevention based initiatives

Americorps

- Placement of Americorp members in clinics to deliver classes/education

Links will be sent in follow up to all attendees & posted on website resources
Hypertension Management Protocol (HMP)

• HMP Goal: Work collaboratively with patients and the primary care team to ensure all patients meet their blood pressure (BP) goals

• Attainment of target BP requires a combination of:
  • Medication
  • Nutrition
  • Exercise
  • Education
  • Follow up interventions
The National Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program which has been demonstrated to delay or prevent the development of type 2 diabetes among people at high risk.

Year long program

Eligibility

- Be at least 18 years old and
- Be overweight (body mass index ≥24; ≥22 if Asian) and
- Have no previous diagnosis of type 1 or type 2 diabetes and
- Have a blood test result in the prediabetes range within the past year:
  - Hemoglobin A1C: 5.7%–6.4% or
  - Fasting plasma glucose: 100–125 mg/dL or
  - Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL or
- Be previously diagnosed with gestational diabetes
## Provider Engagement

<table>
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<tr>
<th><strong>Current State</strong></th>
<th><strong>Future State</strong></th>
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<tr>
<td>• Monthly all-staff meetings</td>
<td>• Task communication to health education team</td>
</tr>
<tr>
<td>• Electronic Medical Record (EMR) Referrals</td>
<td>• Pop-up window alert for provider</td>
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</tbody>
</table>

![Image of AM81 Health Ed Referral window](image-url)
• Enterprise analytics team developed a registry list of all active patients who have had a medical visit in 2016 + A1C test between 5.7 and 6.4.
• Total number of pre-diabetic patients who were identified via registry = 16,646
• Additional at risk patients can be identified through administration of DPP risk quiz or point of care testing.

The example above yielded patients eligible for a diabetes prevention intervention. Similar protocols could be developed to identify patients who would benefit from other health education interventions.
Developing Registry

• Run report with the following parameters:
  • Patients with recent visit
  • Recent A1c between 5.7 and 6.4, without prior diabetes diagnosis
  • BMI greater than / equal to 24

• Practice resources available at no charge:
  • Preventdiabetesstat.org
## Patient Identification

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
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<tbody>
<tr>
<td>• Risk Test</td>
<td>• Automated EMR alert</td>
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<tr>
<td>• Lab Values</td>
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<tr>
<td>• Other:</td>
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<tr>
<td>- Self-referral</td>
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<tr>
<td>- Provider Referral</td>
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<td>- <strong>Staff Referral</strong></td>
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</tbody>
</table>

*Image: AMI Health Ed Referral*

*Image: Diabetes Risk Test*
Example Workflow: Patient Profile

- Hispanic female patient
- Age 45
- BMI = 30.9
- A1c = 6.2
- Blood Pressure = 141/94 (Hypertensive)
Patient identified as possible candidate for DPP program (BMI+ A1c)

Assessment:
- Blood Pressure
- Ht / Weight
- BMI
- A1c

Wellness team talks to the patient in person

Health educator talks to pt about program

Assessment for Hypertension Management Program (HMP)

Eligible?

YES

Patient referred to HMP

NO

Patient referred to other programs

Patient presents for visit

Provider referral

Staff referral

Patient identified as hypertensive

Provider referral

Staff referral

Assessment:
- Blood Pressure
- Ht / Weight
- BMI
- A1c

Patient referred to other programs

Patient not considered enrolled until they attend first class

Screened for program readiness

HMP:
- Lifestyle interventions
- Medication management
- Regular follow up / monitoring

Patient referred to other programs

If ready, patient is scheduled

Patient referred to other programs

Patient referred to HMP
Patient Referral & Enrollment

**Retention Challenges**
- Transportation & parking issues
- Childcare needs
- Class day and time no longer convenient
- Took time off (vacation, surgery, illness) and unwilling to return
- Lack of Social Support
- Lack of Motivation (as observed by staff)
- Unwillingness to make health a priority (as observed by staff)

**Solutions**
- Adding virtual delivery options
- Strategies to address social determinants of health
Work Plan

• Quick Wins:
  • Launch of new e-referral process
  • Use of registry report
Best Practices

• Remove Provider from referral process
• Employing dedicated staff for recruitment and implementation
• Need to leverage technology
  • E-referrals
  • Data mining (i.e. registry list)
Thank You!

Class participants in movement!

Program flyer
Have Questions?

• Dr. Ilan Shapiro, MD
  • ishapirostrygler@altamed.org

• Jessica Solares, MPH
  • jsolares@altamed.org
QUALITY IMPROVEMENT PRIMER

Presenter:
Ayanna V. Buckner, MD, MPH, FACPM

Adapted from the HRSA Quality Series #3, Jan Wilkerson, RN, CPHQ, GAPHC and the Bureau of Primary Health Care Health Resources and Services Administration Department of Health and Human Services
WHY IS A QUALITY IMPROVEMENT (QI) PLAN NEEDED?

May serve as a roadmap for health center organization

- Leadership; focus/prioritization of improvement projects
- Efficient coordination of staff and resources
- Benchmarking
- Assess adherence to best practices and clinical guidelines
- Assess clinician/provider performance and competency
- Improve patient outcomes
WHY IS A QUALITY IMPROVEMENT (QI) PLAN NEEDED?

Satisfy external reporting requirements
  • State, funders (HRSA, IHS, etc.)
  • Third-party quality accreditation and recognition
WHERE TO START?

- Frequency – usually is an annual process
- Document QI policy and format
  - Include a summary description of mechanism
  - Explain who is responsible for developing, implementing, reviewing, and approving the plan
  - Outline the reporting process and recipients
POTENTIAL QUALITY COMMITTEE MEMBERS

Medical Director or Clinical designee (may serve as committee chair)

QI Coordinator, if applicable (may serve as facilitator)

Risk/ Compliance-Safety Coordinator, if applicable

Clinical staff

Finance staff

Front Office staff

Medical Records staff

In-house lab staff
POTENTIAL QUALITY COMMITTEE MEMBERS

- Make sure all departments and services are represented.
- For systems with multiple sites, make sure all sites are represented.
- Learners (students, residents – especially Preventive Medicine Residents)
- Faculty volunteers from partner academic institutions
- Board/health center governance members with expertise may also be helpful
EXPECTED QUALITY COMMITTEE

- Uphold a patient-driven philosophy and process that focuses on preventing problems and maximizing quality of care
- Prioritize quality initiatives and activities
- Quality assessment and planning/annual program evaluation
- Subcommittee and team chartering, with accountability and reporting followed up by the committee
- The ongoing monitoring, evaluation, and improvement of processes
EXPECTATIONS OF THE QUALITY COMMITTEE

• Attend committee meetings – monthly?
  • Join and participate in subcommittee and/or team meetings, with accountability & reporting followed up by the QC
• Complete tasks (assigned or voluntary tasks, as appropriate)
EXPECTATIONS OF THE QUALITY COMMITTEE

---

**Plan:**
Set goals, predict, plan data collection

**Do:**
Test the plan, document problems, reassess and revise

**Act:**
Implement, evaluate, decide next cycle

**Study:**
Complete data analysis, review lessons, decide action

---

Step 1:
- Develop the Quality Improvement Plan; development/revisions are based on:
  - The organization (system)
  - Population & services provided
  - External requirements [e.g., accreditation; reporting (HRSA, IHS, etc.)]
THE QUALITY IMPROVEMENT (PDSA) CYCLE

Step 2:
- Implement the QI Plan
- Use the QI Plan as the roadmap for implementing an integrated quality program system-wide
THE QUALITY IMPROVEMENT (PDSA) CYCLE

Step 3:
- Evaluate the QI Plan
- Did you do what you said you were going to do?
- Why? Why not?
- What were the results?
- How can next year be better?
THE QUALITY IMPROVEMENT (PDSA) CYCLE

Step 4:
- Act on the lessons learned to revise the QI plan for the next year.
CONFIDENTIALITY AND QI

- Protected & Privileged

- The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98.
  - Each state has legislation defining confidentiality and protection for individuals carrying out quality improvement activities

- Set specific requirements for maintaining confidentiality in your organization. Keep it simple. Attestation = Policy
  - Write your requirements. Have QI committee members sign the written requirements. Place in each member’s Human Resources file.
POTENTIAL MEASURES AND TOOLS

- Clinical measures
- Financial measures
- Patient experience surveys
- Staff satisfaction surveys
## QUALITY MEASURES WORK PLAN
### EXAMPLE CLINICAL MEASURES

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Measure</th>
<th>Data Gathering Plan</th>
<th>Goal</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling Blood Pressure</td>
<td>Percentage of women 40-64 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement period.</td>
<td>Numerator: Women 40-64 years of age whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure &lt; 140mm Hg and diastolic blood pressure &lt; mm Hg) during the measurement period. Denominator: Women 40-64 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period, excluding patients with evidence of end stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period. Also exclude patients who are pregnant during the measurement period.</td>
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<tbody>
<tr>
<td>Diabetes: HbA1c Poor Control</td>
<td>Percentage of women 40-64 years of age who had a diabetes who had hemoglobin A1c greater than 9.0% during the measurement period.</td>
<td>Numerator: Women 40-64 years of age whose most recent HbA1c level (performed during the measurement period) is greater than 9.0% or who had no test conducted during the measurement period. Denominator: Women 40-64 years of age with Type 1 or Type 2 diabetes with a medical visit during the measurement period, excluding patients with gestational diabetes. (Note: Patients with a diagnosis of secondary diabetes due to another condition should not be included.)</td>
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</table>
### QUALITY MEASURES WORK PLAN

#### EXAMPLE CLINICAL MEASURES

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</table>
| Tobacco Use: Screening and Cessation Intervention | Percentage of women 40-64 years of age who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. | Numerator: Women 40-64 years of age who were screened for tobacco use at least once within 24 months AND received tobacco cessation intervention if identified as a tobacco user.  

Denominator: Women 40-64 years of age seen for at least two medical visits or at least one preventive medical visit during the measurement period. | |
QUALITY MEASURES WORK PLAN
EXAMPLE CLINICAL MEASURES

<table>
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</thead>
<tbody>
<tr>
<td>Coronary Artery Disease: Lipid Therapy</td>
<td>Percentage of women 40-64 years of age with a diagnosis of coronary artery disease (CAD) who were prescribed a lipid-lowering therapy.</td>
<td>Numerator: Women 40-64 years of age who received a prescription for, were provided, or were taking lipid lowering medications. Denominator: Women 40-64 years of age who had an active diagnosis of coronary artery disease (CAD), were diagnosed as having a myocardial infarction (MI), or who had cardiac surgery in the past, excluding patients whose last LDL lab test during the measurement period was less than 130 mg/dl and individuals with an allergy to, or a history of, adverse outcomes from, or intolerance to LDL lowering medications.</td>
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<tr>
<td>Focus Area</td>
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<tr>
<td>Data from annual UDS report-data based on annual audit</td>
<td>Medical cost per medican visit</td>
<td>Numerator: Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray cost). Denominator: Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits).</td>
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## QUALITY MEASURES WORK PLAN
**EXAMPLE CLINICAL CALENDAR**

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<tr>
<th>Measure</th>
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<th>Oct</th>
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<tr>
<td>Percentage of women 40-62 years w/ BP control</td>
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<td>Percentage of women 40-62 years w/ poor diabetes control</td>
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<td>Percentage of women 40-62 years w/ tobacco screening &amp; intervention</td>
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<tr>
<td>Percentage of women 40-62 years w/ CAD and lipid-lowering therapy</td>
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<td>Medical cost per medical visit</td>
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<td>Satisfaction survey - Patient</td>
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<td>Satisfaction survey - Staff</td>
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<tr>
<td>Annual UDS measure collection</td>
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WITH WHOM SHOULD YOU SHARE YOUR QUALITY RESULTS?

• Staff (For systems with multiple sites, make sure to share with all sites.)
• Health center board (or governing body, as appropriate)
• Stakeholders (as appropriate)
  • Patients
  • Community partners
  • Potential funders (i.e., grant applications)
QUALITY IMPROVEMENT RESOURCES

The HRSA Quality Toolkit

The National Committee for Quality Assurance (NCQA) is an independent 501 non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. http://www.ncqa.org
QUALITY IMPROVEMENT RESOURCES

The Institute for Healthcare Improvement is a nonprofit organization focused on motivating and building the will for change, partnering with patients and health care professionals to test new models of care, and ensuring the broadest adoption of best practices and effective innovations. [http://www.ihi.org/](http://www.ihi.org/)

Each year, Health Center Program grantees and look-alikes report on their performance using the measures defined in the Uniform Data System (UDS). HRSA offers manuals, webinars, trainings online and at various state/regional/national meetings, and other technical assistance resources to assist health centers in collecting and submitting their data. [https://www.bphc.hrsa.gov/datareporting/reporting/index.html](https://www.bphc.hrsa.gov/datareporting/reporting/index.html)
QUALITY IMPROVEMENT RESOURCES MEASURES

Use nationally developed measures (standardized), rather than developing your own

- HRSA Clinical Quality Performance Measures
  - Clinical and Financial Performance Measures
  - Quality of Care
  - Health Outcomes and Disparities
  - Financial Viability/Costs
QUALITY IMPROVEMENT RESOURCES MEASURES

Use nationally developed measures (standardized), rather than developing your own

The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare. NQF measures and standards serve as a foundation for initiatives to enhance healthcare value, make patient care safer, and achieve better outcomes.

http://www.qualityforum.org/Home.aspx
Use nationally developed measures (standardized), rather than developing your own.

The **Agency for Healthcare Research and Quality (AHRQ)** is one the agencies within the US Department of Health and Human Services. It AHRQ creates materials to teach and train health care systems and professionals to put the results of research into practice. AHRQ generates measures and data used by providers and policymakers. [https://www.ahrq.gov](https://www.ahrq.gov)
QUALITY IMPROVEMENT RESOURCES MEASURES

Use nationally developed measures (standardized), rather than developing your own

NCQA HEDIS® Measures
The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an “apples-to-apples” basis.
ALTAMED QUALITY IMPROVEMENT

- Focused on continuous improvement
- Integrated quality measures that are focused on reducing rates of obesity, heart disease and stroke
- Goals are included in AltaMed’s corporate strategy and assessed monthly / annually
Altamed recognized a need to improve the quality of the process of referring patients to health education/wellness resources.

Pop up occurs in EHR if patient clinical measures indicate clinical measures that indicate patient would benefit from health education resources.
EHR alert asks physician / clinician if they want to place a health education referral order?

If yes, a Health Educator contacts patient

- AltaMed is currently working on analytics / processes to inform how the tool is being utilized
- AltaMed utilizes NextGen
- Many other systems have similar capabilities
ALTAMED QUALITY IMPROVEMENT

- New policies / workflows are evaluated by AltaMed’s Clinical Quality Council
- Utilization of EHR alerts are added to each clinics quality reports
QUESTIONS?
Module 1:
- Review of the latest studies on how lifestyle change can improve hypertension and CVD outcomes.
- This module will address the balance of lifestyle change and medication management in higher risk patients.

Module 2:
- Practical tips for implementing the lessons learned from these studies.
- Special considerations with regard to diet, physical activity, stress management, and sleep (e.g. salt and hypertension) for these conditions.

Module 3:
- Managing patients with cardiovascular disease on the spectrum of socioeconomic status, ethnicity/culture, readiness to change, and severity/complexity of common comorbid conditions (such as depression).

Module 4:
- Case studies of patients who represent typical populations.
NEXT STEPS

- Recording and slide will be posted to acpm.org/WISEWOMAN
- Instructions on how to access the WISEWOMAN Lifestyle Medicine Modules will be emailed to all attendees
- Questions?
  - Email Marissa Hudson – mhudson@acpm.org
THANK YOU!