Advancing Million Hearts®

AHA and Heart Disease and Stroke Prevention Partners Working Together in Montana

September 17, 2020
Virtual Event
Meeting Summary

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Meeting Summary

Goal: The goal of the meeting was to develop a coordinated and integrated strategy for managing blood pressure and cholesterol to prevent and control co-morbidities in Montana.

Objectives:

1. Increase awareness of Million Hearts® strategies and activities for 2020
2. Increase stakeholder awareness of the links between hypertension/hypercholesterolemia and co-morbidities such as dementia
3. Develop strategies to increase community supports for patient management of hypertension and hypercholesterolemia
4. Identify strategies to increase patient engagement in managing hypertension and hypercholesterolemia

Outcome:
Attendees will initiate plans to align and sustain efforts to manage hypertension and hypercholesterolemia in Montana.

Overview
On September 17, 2020, 48 representatives from 22 health organizations devoted to reducing the prevalence of heart disease met to develop a coordinated and integrated strategy for managing blood pressure and cholesterol to prevent and control co-morbidities in Montana. This was the 12th Advancing Million Hearts® and the second to be held virtually.

The meeting was designed to help participants increase their knowledge of existing hypertension efforts, initiate opportunities for collaboration and share success and lessons learned with peers. Speakers provided national, state, and local perspectives on preventing and managing cardiovascular disease risk factors and co-morbidities. This included tools and resources available through the Million Hearts® initiative; hypertension initiatives through the Montana Department of Public Health and Human Services, the American Heart Association and Mountain-Pacific Quality Health; and the link between hypertension and dementia. Clinic staff also shared their successes and lessons learned through implementing strategies in their settings.

Participants separated into breakout groups to share information about their organizations' hypertension management efforts and identify potential alignments to (1) increase patient engagement in managing hypertension and hypercholesterolemia and (2) increase community supports for patient management of hypertension and hypercholesterolemia. Approximately 58% of meeting attendees participated in the first breakout group, and 42% participated in the second.

Participants concluded the breakout sessions by sharing key takeaways and next steps. The following themes emerged for overcoming challenges and guiding next steps:

- Using videos to educate patients how to take their own blood pressure
- Using team-based care
- Using clinic hotspots and devices to provide telehealth services to patients who might not have broadband or a cellphone

- Exploring remote patient monitoring; establishing protocol for pharmacists and care team members; and sharing the results statewide
- Implementing peer education strategies for providers
- Purchasing accurate blood pressure devices
- Educating patients on proper device usage
- Engaging with payers to demonstrate successes to implement change/movement towards value-based care

Montana will continue moving hypertension and cholesterol improvement efforts forward in a coordinated manner. Potential avenues include:

- Mountain-Pacific Quality Health will collaborate with interested health systems on remote patient monitoring options.
- The MT DPHHS will highlight successful primary care interventions at Montana's Million Hearts Workgroup meetings.
- Primary care clinics are encouraged to participate in Mountain-Pacific Quality Health's Learning and Action Network on topic-specific chronic disease management.

Approximately 25 of the 48 participants responded to the post meeting evaluation survey. Overall, respondents indicated the presentations and discussions were very useful or somewhat useful in meeting the day's objectives. Approximately 67% of survey respondents identified new organizations with which to partner and feedback reflected an appreciation to hear from partners working in the field. A Post-Meeting Evaluation Summary is provided later in the document.

What excites you about your work in heart disease and stroke prevention?

The following responses were shared by meeting participants:

- *Educating patients on lifestyle changes*
- *Decreasing preventable deaths in Montana*
- *Offering evidenced-based care to my patients*
- *Working with our partners on stroke and blood pressure efforts, we can improve and save lives*
- *Patient engagement*
- *I love having direct patient care to improve medication adherence and medication regimens for chronic disease states*
- *Having the resources and contacts to help cardiac rehabilitation programs optimize their capacity and reach and providing science translational tools to improve the quality of cardiovascular care services*
- *The ability to have proactive and upstream impacts on outcomes*
- *The opportunity to learn and then to guide community pharmacists in helping people lead healthier lives*
- *The opportunity to assist patients with health lifestyle change and use medication management to help patients reach their personal health goals*
- *Meeting communities where they are and supporting community efforts to address overall health and well-being while advancing health equity*
- *Ability to improve the quality of life of people*
- *Working with our clinical team on ways to promote self-management and optimal outcomes for our patients*
- *Help organizations and individuals magnify their collective impact*
- *Driving changes to policies and systems to reduce cardiovascular health disparities*
- *Bringing partners together across various sectors and finding synergies*
- *I love empowering patients and helping them activate their own role in improving their health*
- *Helping people live healthier lives*
- *Broad statewide initiatives to better improve cardiovascular care in rural and underserved communities*
- *Getting to design and disseminate tools whose implementation can impact the health trajectories for thousands of people. Small changes have a big effect when applied across the U.S. population*
- *Being able to look back and see the progress we are making in treatments and prevention*
- *Partnership we have with our cardiovascular group and the overlap of work we have for both diabetes and CVD*
- *The potential to create positive behavior change among individuals that lead to better choices and improved physical and mental well-being*
- *Reducing death and disability from CVD*
- *Finding innovative ways to improve patient care and engagement*
- *Making an impact in our communities for healthier lives*
- *The ability to intervene sooner and prevent serious complications from poorly treated hypertension and hypercholesteremia*
- *The ability to help people live healthier lives*
- *Enabling medical facilities to provide the best possible care*
- *Cardiovascular prevention is a key piece for population health and healthier communities. I am excited to learn more of the steps we can take for our community to prevent heart disease and stroke both within the Health System and innovative partnerships within the community*

Agenda

Time	Agenda Item/Topic	Speaker/Facilitator
8:15 – 8:45 am	**Pre-meeting Partner Networking** Participants connect/meet in a few rounds of randomly assigned virtual rooms to network	**John Bartkus, PMP, CPF** Principal Program Manager, Pensivia
8:45 – 9:00 am	**Please Join no later than 8:50 am** Verify Zoom Audio/Video working, and Vevox App setup on your phone	
9:00 – 9:10 am	**Welcome** **Overview of the Day**	**John Clymer** Executive Director, National Forum for Heart Disease and Stroke Prevention **Sharon Nelson, MPH** Program Initiatives Manager, Million Hearts® Collaboration
9:10 – 9:35 am	**Engagement & Introductions** Introduction to key materials, engagement process (polls and Q&A), and Introductions	**John Bartkus**
9:35 – 10:05 am	**Million Hearts® 2022 Update** **Q&A**	**Laurence Sperling, *MD*** Executive Director, Million Hearts® **Lauren Owens, MPH** Public Health Analyst, Million Hearts® **Haley Stolp, MPH** Public Health Analyst, Million Hearts®
10:05-10:40 am	**Montana Hypertension Initiatives and Resources** • Montana Department of Public Health & Human Services • American Heart Association • Mountain-Pacific Quality Health **Q&A**	**Crystelle Fogle, *MBA, MS, RD*** Manager, Cardiovascular Health Program **Jessica Newmyer** Community Impact Consultant **Patty Kosednar, PMP, CPHIMS** Account Manager
10:40-10:45 am	**Stretch Break**	**Jen Childress,** *MS, MCHES* Jenspiration, Inc. Senior Public Health Consultant, National Forum for Heart Disease & Stroke Prevention
10:45-11:05 am	**Hypertension and Dementia** **Q&A**	**Jim Richards**, **MD** St. Vincent Healthcare
11:05-11:40 am	**Managing Chronic Conditions in a Changing Healthcare Environment**	**Laurence Sperling, MD** Executive Director, Million Hearts® **Eduardo Sanchez, MD, MPH** Chief Medical Officer, American Heart Association

Time	Agenda Item/Topic	Speaker/Facilitator
11:40 – 12:00 pm	**Patient engagement in hypertension and cholesterol management** **Q&A**	**Angela Jennings, RN-BC** Primary Care Nurse Manager, Bozeman Health
12:00 – 12:20 pm	**Community Supports for self-management of hypertension and hypercholesterolemia** **Q&A**	**Aimee Grose, RN,** Clinical Care Leader **Libby Kyllo, BS, RRT,** Community Health Worker Bridging Health and Home Program Sanford Health, Mayville Medical Center
12:20-12:50 pm	**Lunch**	
12:50-12:55 pm	**Activity Break**	**Jen Childress**
12:50 – 2:05 pm	**Breakout Sessions** • Patient Engagement • Community Supports	**John Bartkus**
2:05 - 2:15 pm	**Break**	
2:15 – 2:35 pm	**Group Report Outs**	**John Bartkus**
2:35 - 2:45 pm	**Summary of Common Themes/Strategies**	**Julie Harvill, MPA, MPH** Operations Manager, Million Hearts® Collaboration
2:45-2:55 pm	**Next Steps**	**Crystelle Fogle**
2:55-3:00 pm	**Adjourn**	**Laura King** Director of Public Health, American Heart Association

What does Success Look Like?

Presentations:

The following are highlights of presentations shared by meeting participants. The full presentations can be found at the end of the report.

Million Hearts® 2022 Update

- *Laurence Sperling, Executive Director, Million Hearts®*
  Division for Heart Disease and Stroke Prevention, CDC
- *Lauren E. Owens, Public Health Analyst, Million Hearts®*
  IHRC, Inc.
- *Haley Stolp, Public Health Analyst, Million Hearts®*
  IHRC, Inc.

Million Hearts®
Executive Director Update

- **Our hearts are focused on Millions across the Nation**
- Cardiovascular Health and Prevention Remain a Priority
- Million Hearts® in Action
  - Updates and Priorities
- Discussion / Q & A- following update on HCCP

Use vevox.app ID: 136-377-847

Impact of Pandemic on Cardiovascular Care

Emergency physicians are seeing declines in the number of patients arriving with cardiac problems.

Current Challenges/Concerns

- 118 million Americans living with Hypertension
- Disruption of Ambulatory care
- Need for Medication Access and Adherence
- Impact on lifestyle implementation
- Disruption of cardiac rehabilitation

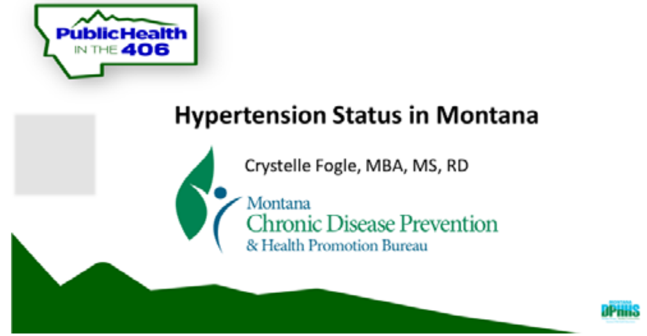
Million Hearts® Updates

- CDC Foundation Campaign
- Million Hearts 1.0 Addendum
- Hypertension Control Champions
- Cardiac Rehabilitation Think Tank
- AMA/ AHA Scientific Statement SMBP
- AMA validatebp.org

- JCRP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control Change Package
  - Includes 253 tools from 87 organizations
  - Capitalizes on 7 years of MH Hypertension Control Champions
  - Features more self-measured blood pressure monitoring (SMBP) resources
  - Explores potentially undiagnosed hypertension
  - Added new strategies that focus on chronic kidney disease (CKD) testing and identification
  - Provides more patient supports for lifestyle modifications
- Million Hearts® Cardiac Rehab Collaborative
  - Joining efforts to reach 70% CR participation by 2022
  - Quarterly calls of reps from ~200 organizations
  - CR professionals, health care team members, QI specialists, hospital and health system administrators, public health professionals, payers, and innovators
  - Shared 'action plan' of objectives; report progress
    1. Increase awareness of the value of CR among health systems, clinicians, patients and families, employers, payers
    2. Increase use of best practices for referral, enrollment, and participation
    3. Build equity in CR referral, participation, and program staffing
    4. Increase sustainability, affordability, and accessibility through innovations in program design, delivery, and payment
    5. Measure, monitor, and report progress toward the CRC aim

Montana Department of Public Health and Human Services

Crystelle Fogle
Cardiovascular Health Program Manager



Key Blood Pressure Focus of Grants

- Undiagnosed Hypertension
- BP Quality Improvement
- Team-Based Care
- Medication Therapy Management
- Self-Measured Blood Pressure Monitoring

American Heart Association

Jessica Newmyer, Community Impact Consultant

Target: BP

- Customize a plan using MAP Framework
    - Measure accurately
    - Act rapidly
    - Partner with patients, families, and Communities to promote self-management and monitor progress
- Measure Improvement and Report Result
- Strive for Recognition at 70% or higher

Mountain Pacific Quality Health

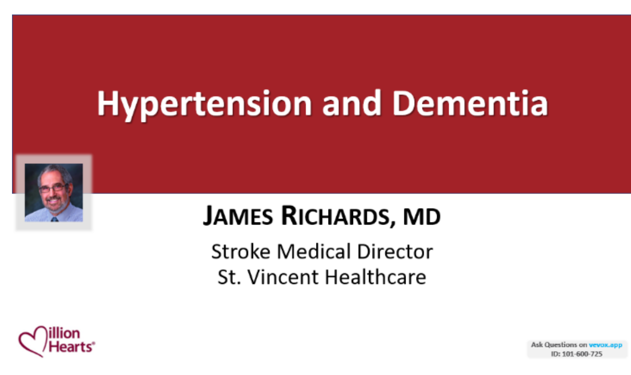
Patty Kosednar
Account Manager

Current Initiatives

1. Improve Behavioral health outcomes, including opioid misuse
2. Increase patient safety
3. Improve chronic disease outcomes/self-management
4. Improve care transitions
5. Improve nursing home quality
6. Implement age-friendly health care systems
7. Transition from fee-for-service (FFS) to value-based payment models
8. Assist quality reporting
9. (Quality Payment Program's Merit-based Incentive Payment System [MIPS] and Alternative Payment Model [APM])

Hypertension and Dementia

James Richards, MD, Stroke Medical Director
St. Vincent Healthcare

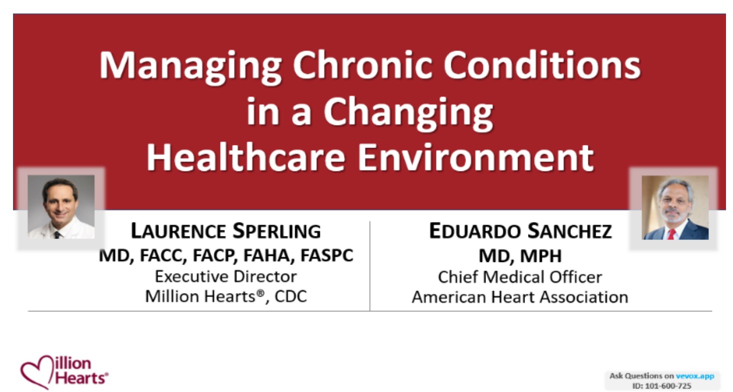


Dementia Risk Factors

- Age
- Race (higher in African American populations)
- APOE status e4
- Traumatic Brain Injury, CTE
- Stroke

<u>Managing Chronic Conditions in a Changing Healthcare Environment</u>

- *Eduardo Sanchez, Chief Medical Officer*
  American Heart Association
- *Laurence Sperling, Executive Director, Million Hearts®*
  Division for Heart Disease and Stroke Prevention, CDC



People of any age with certain underlying conditions are at increased risk of severe COVID-19

- Chronic kidney disease
- COPD
- Immunocompromised from solid organ transplant
- Obesity (BMI ≥ 30)
- Serious heart conditions (HF, CAD, cardiomyopathies)
- Sickle cell disease
- Type 2 DM

COVID-19 Mortality

Compared to White people, the age-adjusted COVID-19 mortality rate for:

- Black people is 3.8 times as high
- American Indian/Alaska Native people is 3.2 times as high
- Pacific Islander people is 2.6 times as high
- Hispanic/Latino people is 2.5 times as high
- Asian people is 1.5 times as high.

Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management

Angela Jennings
Primary Care Nurse Manager, Bozeman Health

- The RN-Pharmacist Hypertension Clinic started in January 2019
- The team consists of 8 RNs and 8 Clinical Pharmacists
- 38 Practitioners have signed the compact agreement
- Year to date: 240 patients have participated in the program
- 82% of the patients are at goal within 9 weeks
- After graduating, patients receive a follow up phone call every 3 months for the first year
- Continue to expand the program

Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia

Aimee Grose, Clinical Care Leader
Libby Kyllo, Community Health Worker
Sanford Health, Mayville Medical Center

The Bridging Health and Home program (BHH)
Model of Care

- Nurse-led community-based clinic
- Faith community nursing principles of intentional care of the spirit
- Evidenced-based self-management workshops, “Better Choices, Better Health”

Funding and locations

- Mayville, ND
- Webster, SD

Breakout Group Discussions:

Meeting participants selected one of the following discussion sessions in which to participate.

Group	Topic	Co-Facilitators	Notetakers
1	**Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management**	**Patty Kosednar**	
2	**Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia**	**Mike McNamara** **Amber Rogers**	**Kristen Range**

The following notes were taken during each discussion.

Group 1: Increasing Patient Engagement in Hypertension and Hypercholesterolemia Management

BREAKOUT GROUP QUESTIONS

What is each organization doing? What's working? What isn't? What can be shared? What Next?

Facilitator(s):	***Marilyn McLaury, Patty Kosednar***	*Notetaker:*	***Courtney Buys***

Group Questions: (~60 mins total)

What are you doing now? What are the results? (~15 mins)
What did you learn today that might influence your direction or support you? (~10 mins)
How does patient engagement change as a result of Covid-19? (~10 mins)
What challenges/barriers do we have to overcome? (~10 mins)
How can we address those challenges? (~15 mins)

Individual Take-aways: (~5 mins)

- What new partners have I identified today with whom I can work to further my/their goals?
- What two actions will I take based on what I learned today?

KEY TAKE-AWAYS TO SHARE IN REPORT-OUT

What are you doing now? What are the results?

Pre-COVID engagement with fitness facilities. Currently trying to get people who are in pods to go for walks and other physical activity. Can get people there for a week to two weeks but challenging to get folks to buy in long-term. (KRMC)

Maintained need for wellness visits throughout pandemic; providing patient education on why wellness visits are safe and necessary. Older patients are willing to go virtual. Finding ways to encourage activity including Medicare Advantage exercise videos. "Staff is relentless" educating patients about the different ways and places patients can be seen. Tap into care managers as needed. (Providence)

Care management is very involved in calling patients and follow-up. Financial piece is even more seen during pandemic. Less virtual visits and more in-person visits recently at request of patients. Important to have many different "touch points" for patients who can offer different expertise and experience. (Billings)

Piloting "Welldoc" for diabetes self-management services. (DPHHS)

Carehere hypertension program has seen a decrease in enrollment, but still good engagement. The program is already online and engaged remote monitoring.

You cannot have patient engagement without meeting the patient where they are at. E.g. having patient use their own blood pressure monitor for self-monitoring.

What did you learn today that might influence your direction or support you?

Innovative ways to engage with nontraditional community groups

Providers refer patients to allied health people (pharmacist, dieticians, care team) who have more time to spend with patient

Care management and motivational interviewing. Medicare annual wellness visits for PCPs, NPs have a full 45 minutes to spend with patients to talk through wellness and prevention.

Virtual peer learning and education as a long-term solution to transportation barriers.

High touch, quick return, model in Bozeman hypertension clinic, to create change quickly.

How does patient engagement change as a result of Covid-19?

Increased telehealth, decreased in person visits

What challenges/barriers do we have to overcome?

Finding the additional time for someone to spend with the patient.

Broadband, cell service, connectivity with telehealth.

Remote patient monitoring- devices, Bluetooth, takes forever to interface devices into EHR. Hard to separate good and bad.
Creating a common language. Not using clinical speak, translating the important information to language that is universally understandable.

How can we address those challenges?

Using videos to educated patients how to take their own blood pressure.

Team care!

Using clinic hotspots and devices to provide telehealth services to patients who might not have broadband or a cellphone.

Communicating or working as a group around remote monitoring and sharing the results statewide.

Utilize resources that might have more bandwidth / expertise to create a common language

Key takeaways

- Better understand if there is any tracking of post COVID complications.
- Bring takeaways back to organization about Bozeman health hypertension successes
- Write up of recommendations from Patient and Family Advisory Council
- Connect with folks doing all of these innovative things to share with frontline folks.
- Think outside of traditional boxes to connect with patients to make health changes
- CDC may be able to provide assistance in connecting folks with other organizations that are not traditional partners; and identify ways to connect best practices both inside and outside of Montana
- AHA excited about collective QI work

The following individuals registered to participate in the breakout discussion:

Aimee Grose
Alona Jarmin
Amber Rogers
Amy Emmert
Cheryl Stensrud
Courtney Buys
Crystal Menick
Cynthia Armstrong
Debbie Butz
Erica Hoversland
Haylie Wisemiller
James Bennett
James DeFoe
Jeff Redekopp
Jessie Fernandes
John Clymer
Julia Schneider
Kamesha Ellis
Kristen Range
Laura King
Libby Kyllo
Lisa Jones Barker
Marilyn McLaury
Melissa House
Mike Lionbarger
Mike McNamara
Molly Wendland
Patricia Kosednar
Rebecca Atkinson
Roberta Wagner
Sang-Mi Oh
Sarah Elliott
Sarah Leake
Sharon Nelson
Susan Morgan
Tessa Tatsey
Trina Filan
Trish Gilliam

Group 2: Increasing Community Supports for Self-Management of Hypertension and Hypercholesterolemia

BREAKOUT GROUP QUESTIONS *What is each organization doing? What's working? What isn't? What can be shared? What Next?*			
Facilitator(s):	***Mike McNamara, Amber Rogers***	*Notetaker:*	***Kristen Range***

Facilitator guidance:
Lead the group through these five key questions. The group has 65 mins from 1:00 – 2:05pm MDT.
Capture your group's notes on the following section (KEY TAKE-AWAYS TO SHARE IN REPORT-OUT).
Those following page(s) will be shared on-screen during group reports back to the main group.
Tip - have the person capturing the conversation share their screen (in Zoom) – using this document like a visual flip chart.
Leave at least 5 minutes at end for individual take-aways.

Group Questions: (~60 mins total)

1. What are you doing now? What are the results? (~15 mins)
2. What did you learn today that might influence your direction or support you? (~10 mins)
3. How does community support change as a result of Covid-19? (~10 mins)
4. What challenges/barriers do we have to overcome? (~10 mins)
5. How can we address those challenges? (~15 mins)

Individual Take-aways: (~5 mins)

- What new partners have I identified today with whom I can work to further my/their goals?
- What two actions will I take based on what I learned today?

KEY TAKE-AWAYS TO SHARE IN REPORT-OUT

1. **What are you doing now? What are the results?**
   Susan Morgan: Has worked with DPHHS for a couple years. Room for improvement in quality metrics and would like to focus on team-based care. Utilized lunch and learns to work with the team to try and decrease the "silos" that occur. Worked on hypertension with the medical director that believes in hypertension algorithms and created a BP program. Worked with DPHHS to create a QI project to reach target BP to improve outcomes for patients. Ongoing education is moving this project forward. Building a report in to the Health IT platform for undiagnosed HTN (a patient seen in the last year with 2+ BP readings of 140/90 or greater). Goals include, establishing a blood pressure clinic. Barriers include provider buy-in, concerns that it may cause more work. Began CCM about a year ago and that is gaining buy-in from providers.

   Amy Emmert: Significant work with TBC this includes, pharmacist, behavioral health specialists, clinical nutritionist support, and care management. Beginning in October there will be training for consistent accurate BP readings across all care team members. Incorporating automated BP readings with manual readings as the cost allows. Community paramedic program will go to patients' homes to take BP readings for patients with transportation barriers. Areas of opportunity include culinary arts as a prescription to incorporate healthy foods. Potential partners include the Helena Food Share.

   Jimmy Bennett: The most effective thing with BP program was starting with a daylong seminar for primary care providers across the state. 20-30 people attend the sessions to focus on teaching people how to do accurate BP readings with the most up-to-date technology. This increased awareness of hypertension through the accurate readings. Community pharmacy program (3rd year) this uses a smart phone app to order meds through the app and includes med adherence, education, and reminders. Areas of opportunity include TBC to establish a way for a clinic and community pharmacist to improve outcomes for patients with DM and HTN. Aiming to work with local providers and the community pharmacists that share patients to work together to be able to have a full medication review for the shared patient panel.

   Haylie Wisemiller: Community paramedic team can go to the patient's homes for wound care, immunizations, and food delivery. Utilizing EMTs to address needs for patients that are frequently in the ER to reduce the EDU rates.

2. **What did you learn today that might influence your direction or support you?**
   Billing codes BP checks, access to self-monitored BP cuffs, how social determinants of health play a large role in managing patients with chronic conditions, telehealth opportunities, provider engagement and role, outreach the Sanford practices are doing, how do we get to the community as a whole and make the population healthier, use the talents across the entire healthcare and community system (utilize TBC!), patient motivation, community

pharmacist establishing talking points to support patients, creating relationships with resources outside the healthcare system (senior centers, churches, food banks, etc.), AHA resources, utilize technology to connect even during COVID-19

3. **How does community support change as a result of Covid-19?**
   Things are difficult but utilizing telehealth has been a big win for patients in a rural setting or with health-related social needs. Community paramedicine program was moved forward quickly due to Covid-19. This allowed for greater outreach to patients.

4. **What challenges/barriers do we have to overcome?**
   Challenges/Barriers: Providers do not feel the at-home BP readings are accurate (can you diagnose based on those readings?), standardization and proactive identification of patients, workload for care team, reimbursement

5. **How can we address those challenges?**
   Provider education (establish a provider champion to start a pilot project and share ideas to spread the change throughout the organization), physician to physician education, utilize remote patient monitoring, purchase accurate devices, patient education on proper device usage, establish a protocol for remote patient monitoring for pharmacists and care team members to follow, data transparency, engaging with payer partners to demonstrate successes to implement change/movement towards value-based care.

Individual Take-aways: (~5 mins)

- What new partners have I identified today with whom I can work to further my/their goals?

Bozeman Health BP clinic and Sanford Health

- What two actions will I take based on what I learned today?

The following individuals registered to participate in this breakout discussion:

Courtney Buys
Crystal Menick
Erica Hoversland
James DeFoe
Jessie Fernandes
Julia Schneider
Libby Kyllo
Lisa Jones Barker
Marilyn McLaury
Melissa House
Mike Lionbarger
Molly Wendland
Patricia Kosednar
Rebecca Atkinson
Trish Gilliam
Angela Jennings
Chandala Curtiss
Crystelle Fogle
Haley Stolp
Jessica Newmyer
Jill Swenson
Joe Tabler
Joel Allen
Julie Harvill
Karen Gray-Leach
Katelin Conway

Kim Pullman
Melissa Brummell
Rachael Zins
Victoria Cech

Post Meeting Evaluation:
Advancing Million Hearts: American Heart Association and Heart Disease and Stroke Prevention Partners Working Together in Montana
September 17, 2020

Meeting Attendees: 48
Survey Responses: 25

100% of survey respondents thought the meeting was very useful or somewhat useful in meeting its objectives of:

- *Increase awareness of Million Hearts® strategies and activities for 2020*
    - Very useful: 91%
    - Somewhat useful: 9%
- *Increase stakeholder awareness of the links between hypertension/ hypercholesterolemia and co-morbidities such as dementia*
    - Very useful: 82%
    - Somewhat useful: 18%
- *Develop strategies to increase community supports for patient management of hypertension and hypercholesterolemia*
    - Very useful: 91%
    - Somewhat useful: 9%
- *Identify strategies to increase patient engagement in managing hypertension and hypercholesterolemia*
    - Very useful: 86%
    - Somewhat useful: 14%

67% of survey respondents plan to connect with new organizations as a result of this meeting. Including:

- Bozeman Clinic (6)
- AHA (4)
- Hospital systems
- St. Vincent's
- CDC
- MT Primary Care Association
- KRMC

100% of survey respondents participated in the Q&A polling. The majority of respondents liked the polling platform and said it was "*easy and straightforward to use.*" However, one participant noted that there was a delay in the questions and another participant did not like the split between Vevox and zoom. One participant preferred the chat function and polling in Zoom to Vevox.

After attending the meeting, respondents said they plan to explore CVH resources related to:

- SMBP (3)
- Flu shot promotion (3)
- Non-traditional partners and new relationships (2)
- Remote patient monitoring (2)
- Share information within organization
- BP dashboard activity
- Change packet
- Home monitoring
- Identify hidden hypertension
- BP Clinics

Participants felt the most valuable part of the meeting was:

- Presenters (5)
- Updated information (3)
- Information sharing/networking (3)
- Liked remote option (2)
- Bozeman and N Dakota (2)
- Breakout sessions (2)
- Resources
- Information about different interventions

Participants felt the least valuable part of the meeting was:

- Pre-networking (2)
- Breakout sessions
- Technology
- Presentation on dementia
- Lunch break
- No handouts
- Less time from CDC and state speakers
- Lost in some of the medical terminology

Attendee List:

First Name	Last Name	Organization	Job Title	Email
Aimee	Grose	Sanford Health	RN Clinical Care Leader	aimee.grose@sanfordhealth.org
Alona	Jarmin	Mountain-Pacific Quality Health (MPQHF)	Senior Account Manager	ajarmin@mpqhf.org
Amber	Rogers	Mountain-Pacific Quality Health (MPQHF)	Account Manager	arogers@mpqhf.org
Amy	Emmert	St. Peter's Health	Senior Director of Population Health	aemmert@sphealth.org
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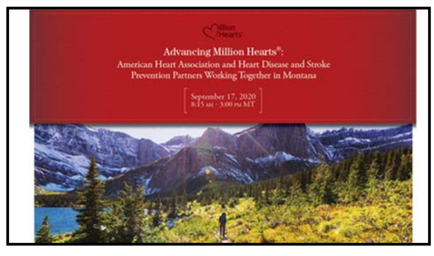

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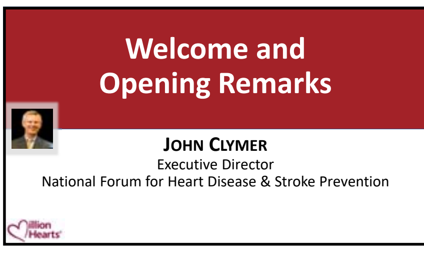

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Objectives for Today

1. Identify strategies to increase patient engagement in managing hypertension and hypercholesterolemia
2. Increase awareness of Million Hearts® strategies and activities for 2020
3. Increase stakeholder awareness of the links between hypertension/ hypercholesterolemia and co-morbidities such as diabetes and dementia
4. Develop strategies to increase community supports for patient management of hypertension and hypercholesterolemia

Million Hearts

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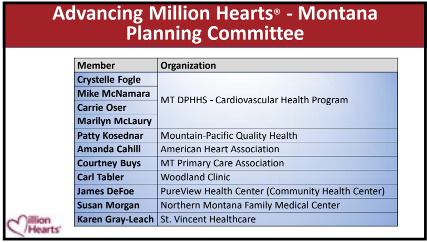

Member	Organization
Crystelle Fogle	MT DPHHS - Cardiovascular Health Program
Mike McNamara	
Carrie Oser	
Marilyn McLaury	
Patty Kosednar	Mountain-Pacific Quality Health
Amanda Cahill	American Heart Association
Courtney Buys	MT Primary Care Association
Carl Tabler	Woodland Clinic
James DeFoe	PureView Health Center (Community Health Center)
Susan Morgan	Northern Montana Family Medical Center
Karen Gray-Leach	St. Vincent Healthcare

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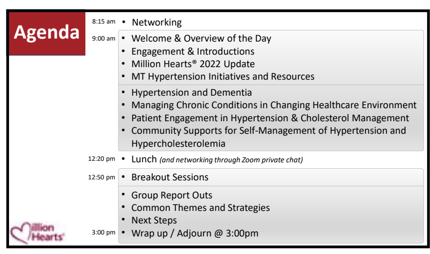

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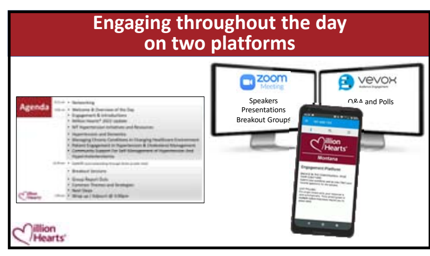

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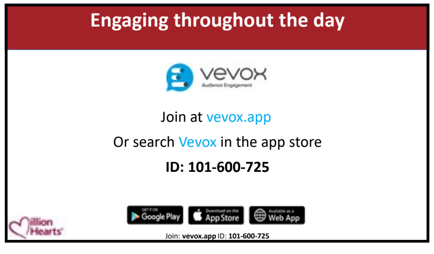

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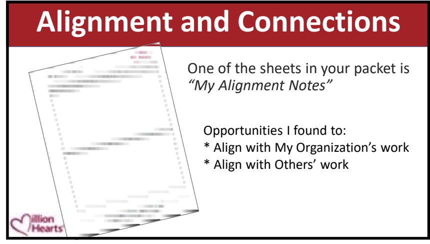

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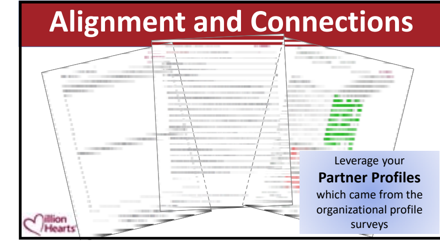

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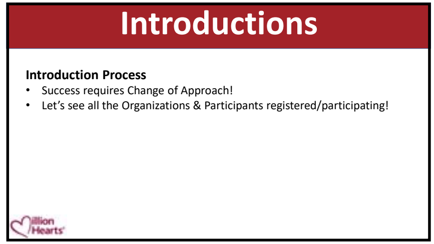

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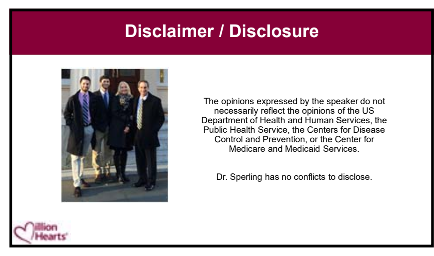

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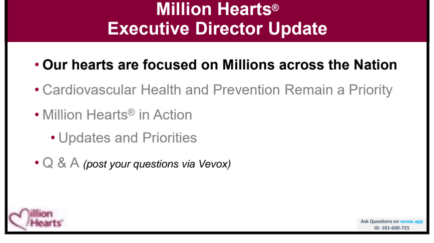

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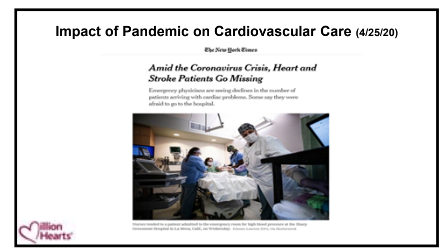

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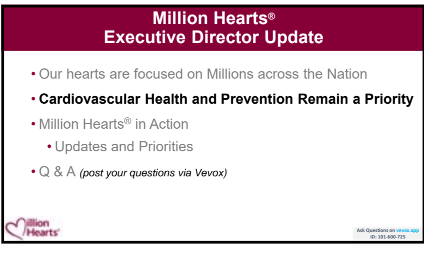

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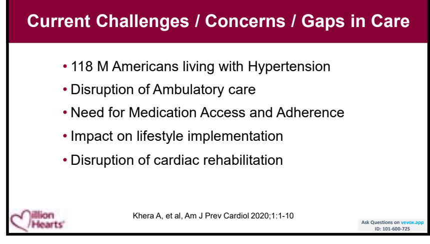

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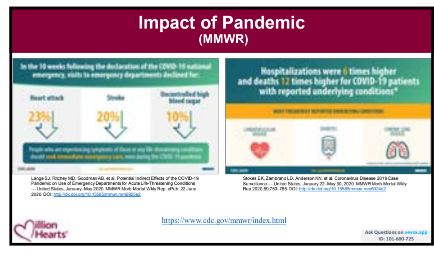

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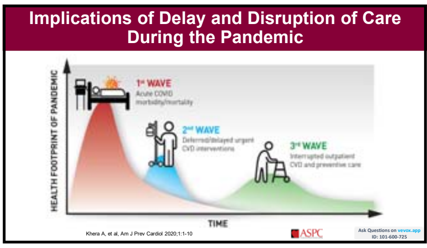

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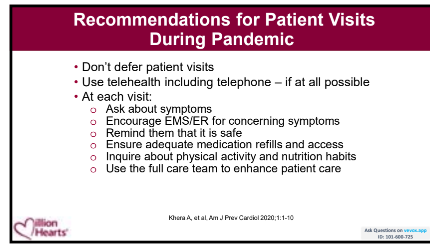

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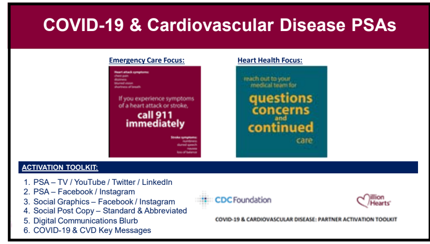

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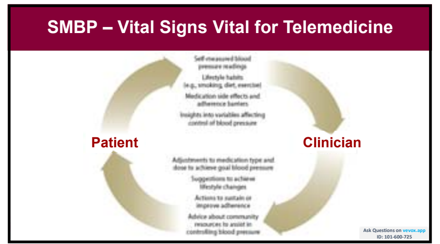

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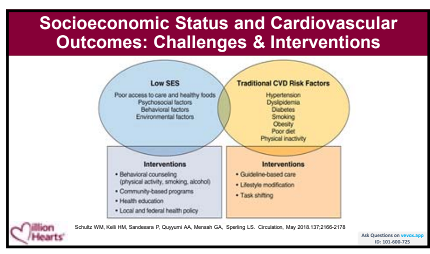

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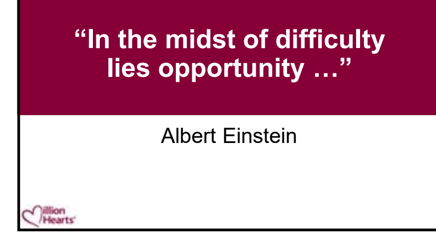

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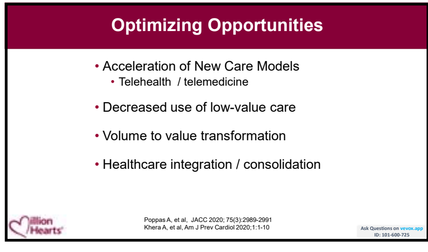

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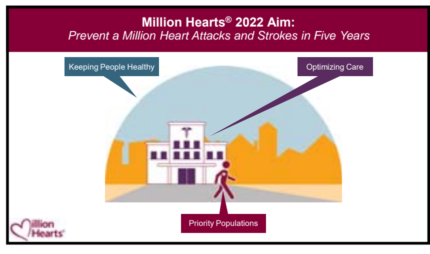

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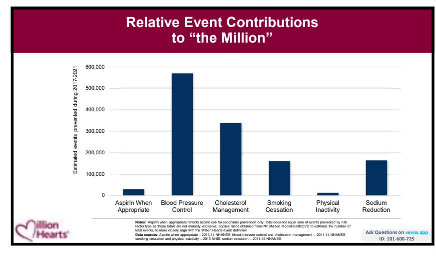

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County-level Heart Disease Mortality Across Age Groups, 2017

These data are updates of estimates previously published in Vaughan AS, et al. Widespread recent increases in county-level heart disease mortality across age groups. Ann Epidemiol. 2017;27(12):796-800.

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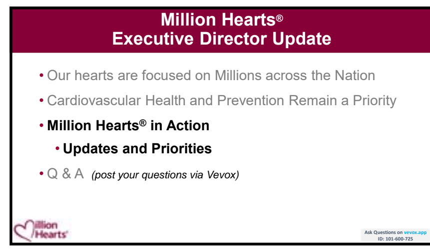

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Million Hearts® Hospitals & Health Systems Recognition Program

- A new program to recognize institutions working to improve the cardiovascular health of the population & communities they serve by:
  1. Keeping People Healthy
  2. Optimizing Care
  3. Improving Outcomes for Priority Populations
  4. Innovating for Health
- Applicants apply online by **October 31, 2020** for the third quarter.
- Million Hearts® will publicly recognize top-performing Million Hearts® Hospitals and Health Systems

Apply today at https://millionhearts.hhs.gov/partners-progress/hospitals-health-systems/index.html

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MH® Updates

- CDC-F Campaign (PSA's & beyond)
- Million Hearts 1.0 Addendum ($5.6 B savings; 135K events)
- Hypertension Control Champions (118; 15M / 5 M)
- Cardiac Rehabilitation Think Tank
- AMA/ AHA Scientific Statement SMBP
- AMA validatebp.org
- JCRP & JAMA Cardiology invited commentaries
- CMS promotes V-BID in Final Payment Notice for 2021
- Reinvigorating 100 Congregations
- Updated Hypertension Control Change Package

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MH® Priorities

- Strategic Planning given current realities – Impact Document /
- Hypertension Control / Priority Populations (SG CTA / Hypertension Roundtable)
- National Association of Community Health Centers Hypertension Control / Cholesterol Management- statin videos (1400 / 24 M)
- Initiative focused on Nursing Partnerships (ORISE fellow)
- Increase uptake and implementation of evidence-based strategies
- Enhance existing internal/external relationships and partnerships (Maintain strong partnership with CMS & CMMI) ****Growth of new partnerships

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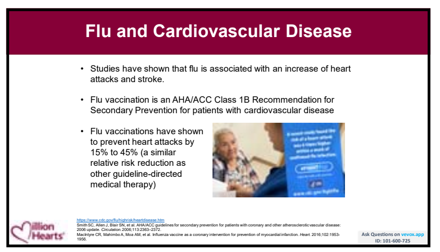
Flu and Cardiovascular Disease

- Studies have shown that flu is associated with an increase of heart attacks and stroke.
- Flu vaccination is an AHA/ACC Class 1B Recommendation for Secondary Prevention for patients with cardiovascular disease
- Flu vaccinations have shown to prevent heart attacks by 15% to 45% (a similar relative risk reduction as other guideline-directed medical therapy)



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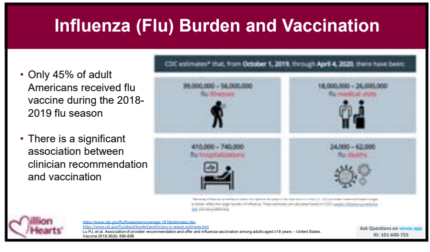

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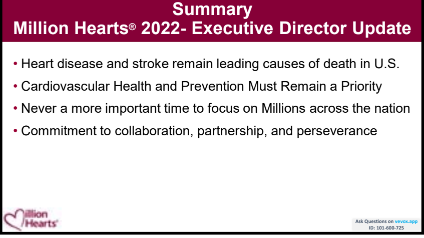

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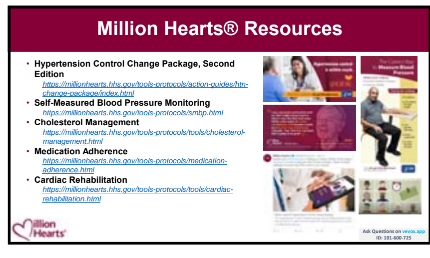

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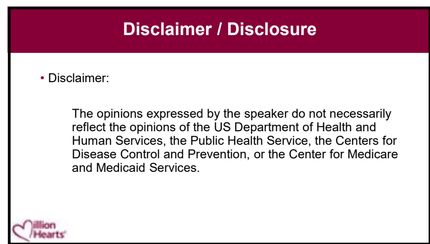

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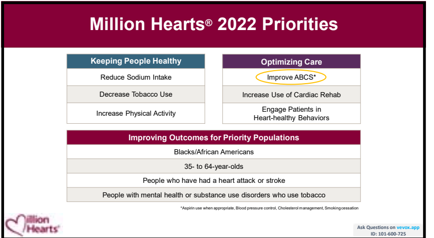

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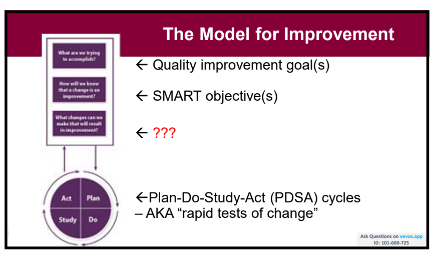

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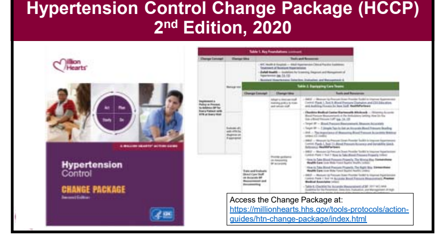

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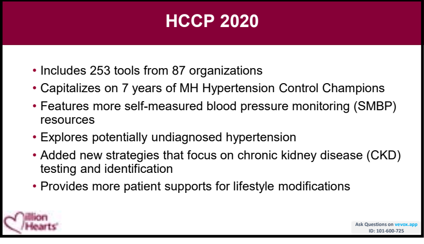

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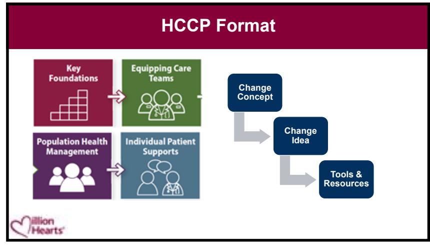

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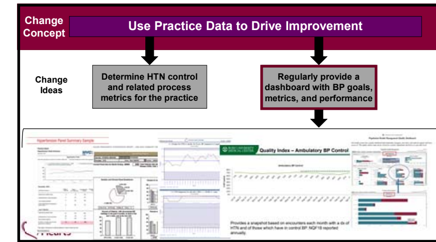

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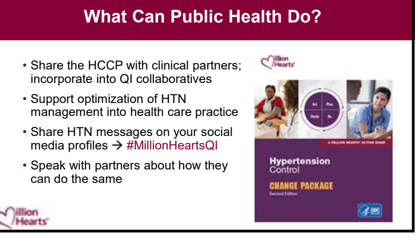

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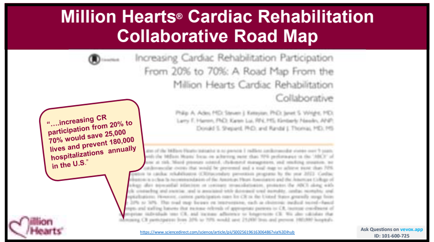

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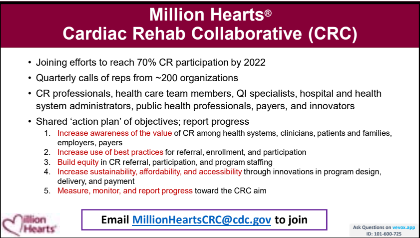

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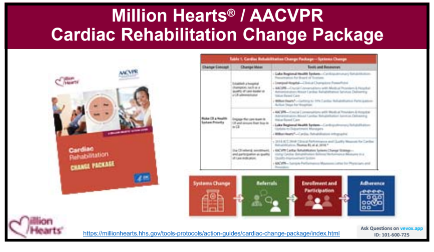

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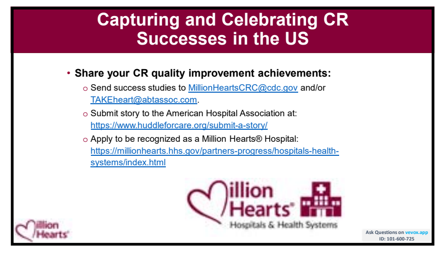

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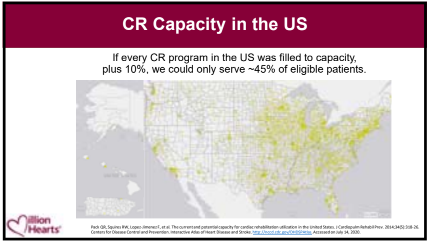

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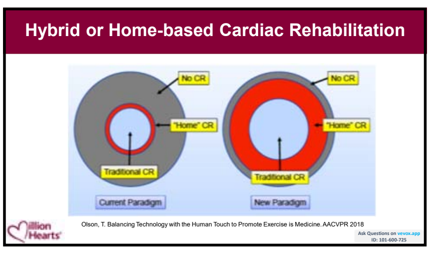

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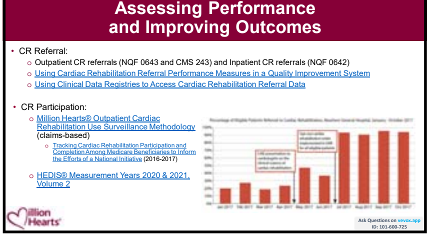

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Opportunities to Build Equity in the Delivery of CR

- Automatic referral with care coordination (hint: TAKEheart)
- Offer culturally appropriate enabling services → leverage patient resources, patient ambassadors, and community assets
- Minimize obstacles for participation and reward participation → see strategies in the CR Change Package and/or send us your own
- Employ racially and ethnically diverse CR program staff
- Help eligible hospital employees participate in CR

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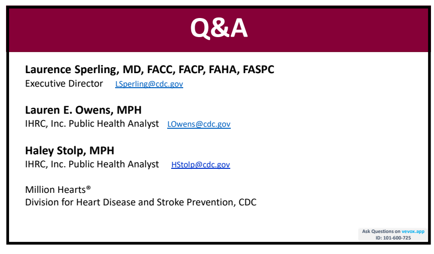

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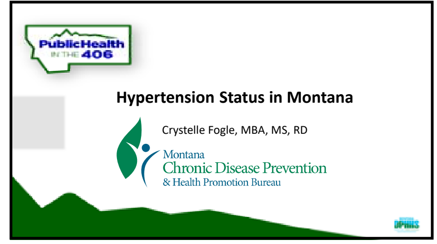

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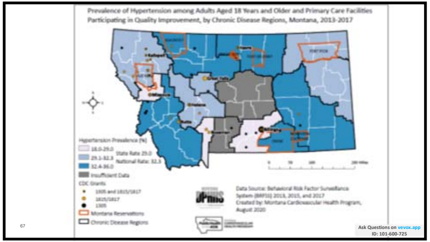

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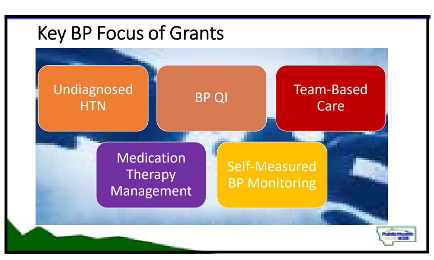

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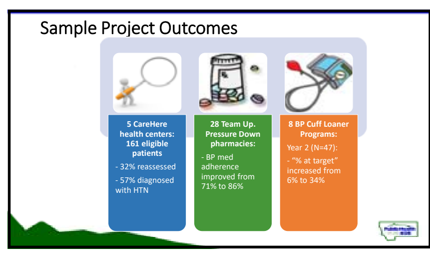

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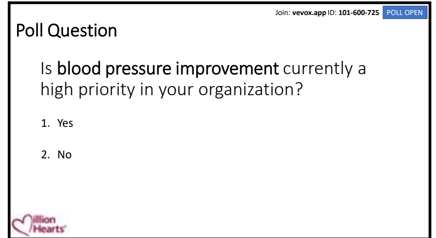

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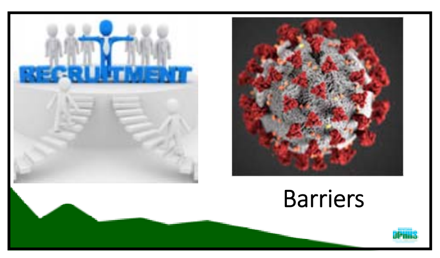

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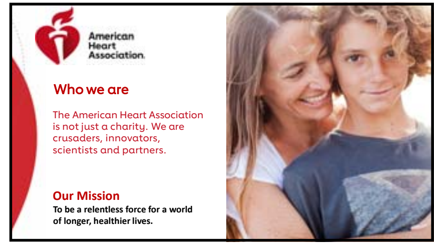

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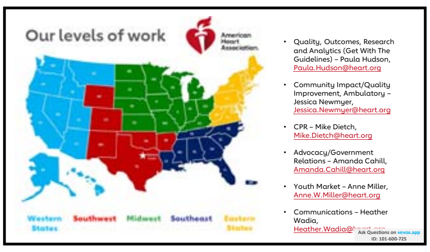

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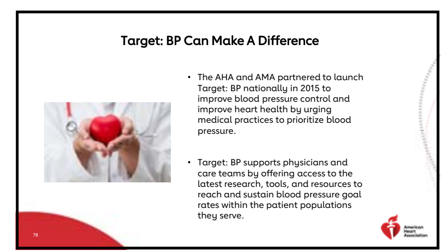

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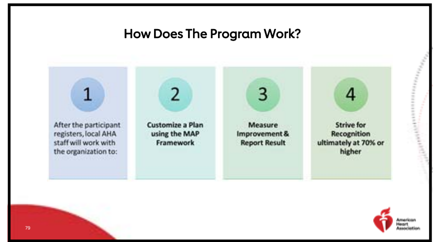

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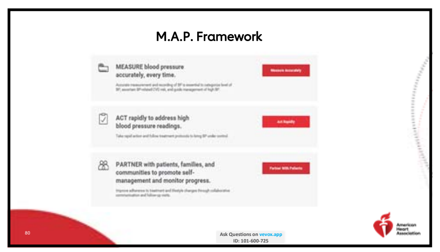

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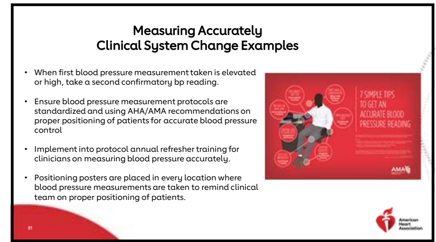

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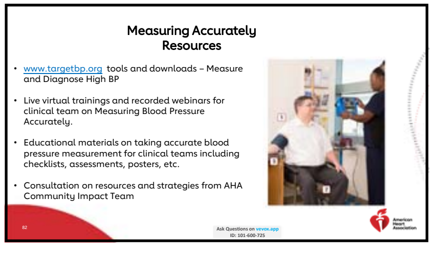

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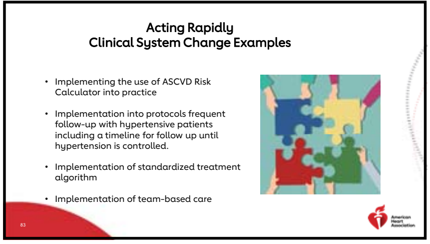

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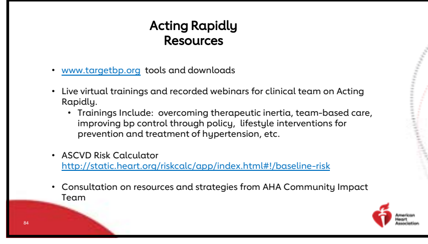

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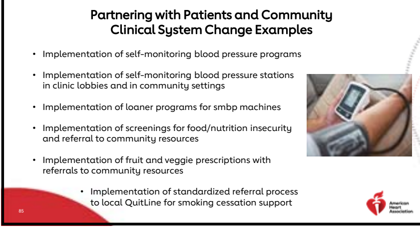

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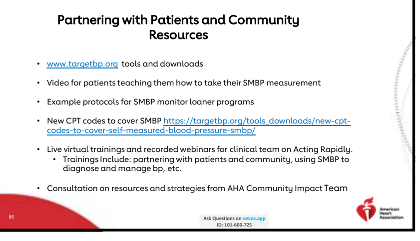

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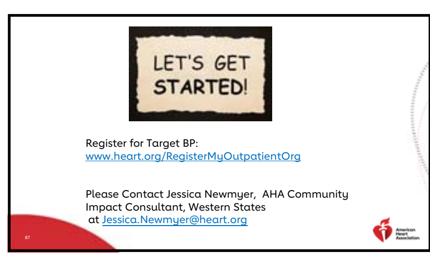

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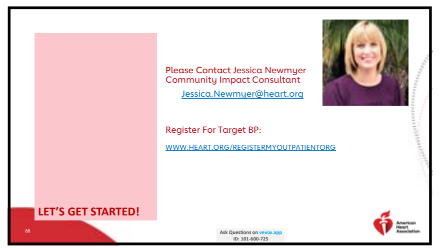

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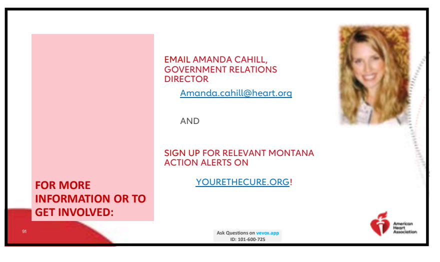
2020 Montana Legislative Agenda

- Restrictions on Sales of Flavored Tobacco and Vape Products- Missoula and other Communities
- Double SNAP Dollars Program Appropriation – State level request
- Stroke Systems of Care legislation (Requiring Data Collection)- State level request
- Fighting Preemption (protecting local governments and Boards of Health)- State level work

90



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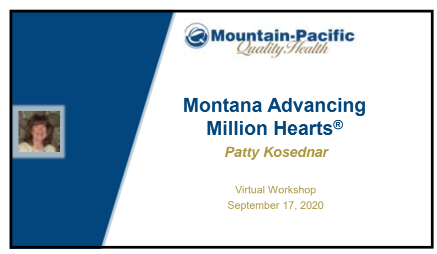

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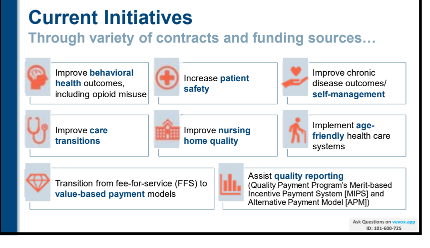

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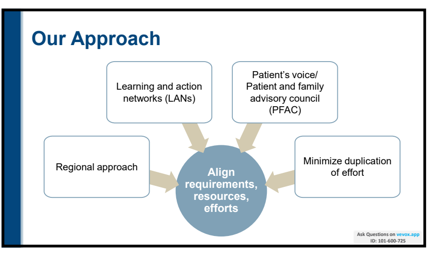

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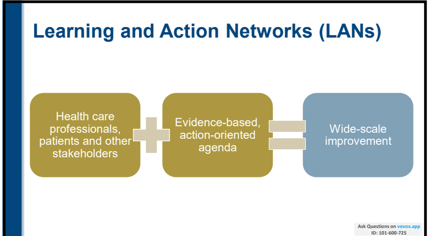

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Our Chronic Disease LAN

Mission

A statewide/regional approach, leveraging the combined resources and expertise of participating members to prevent the development and progression of and improve outcomes for

- cardiovascular disease (CVD),
- diabetes (DM),
- chronic kidney disease (CKD),
- and related conditions.

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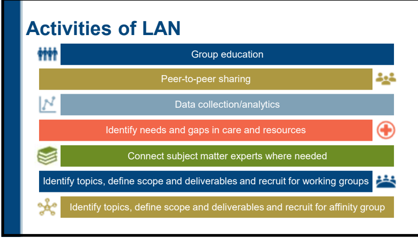

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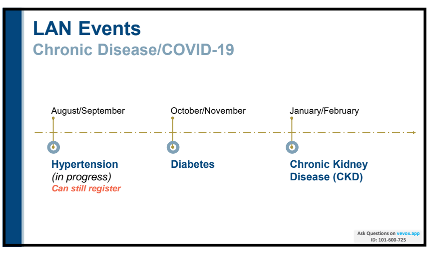

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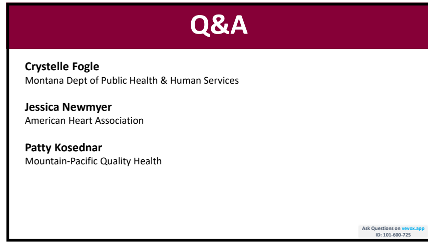

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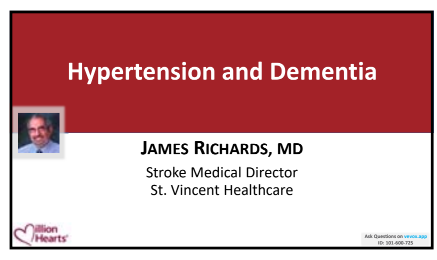

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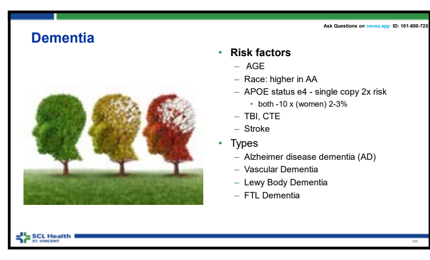

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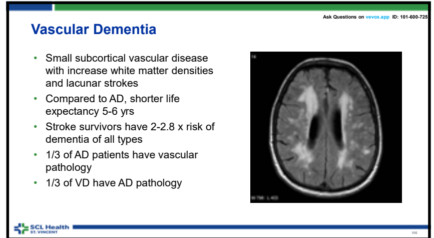

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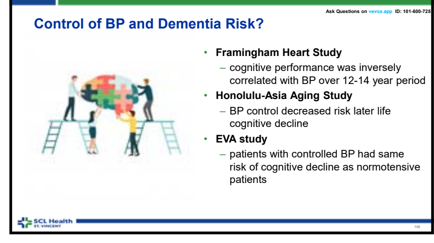
Stroke and Dementia

- Stroke increases risk of dementia
- Only 60% VD
- See increase in AD - ?effect of the stroke unmasking AD
- Autopsy study
  - AD pathology and at least 1 lacunar stroke = 20 times risk of clinical dementia vs AD pathology and no stroke
- Interaction between stroke and dementia risk, **Hypertension – main stroke risk factor**

107



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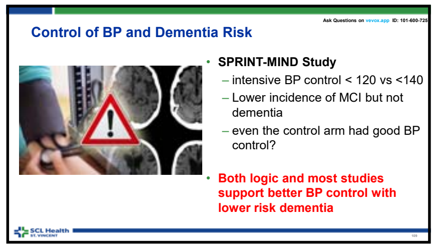

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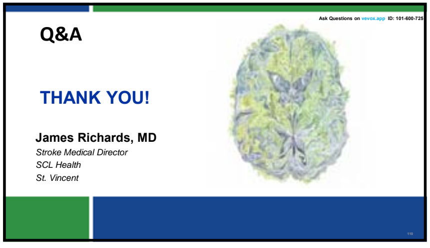

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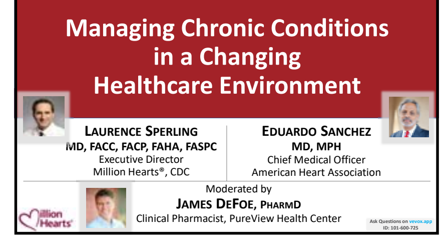

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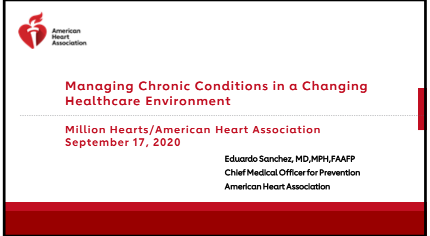

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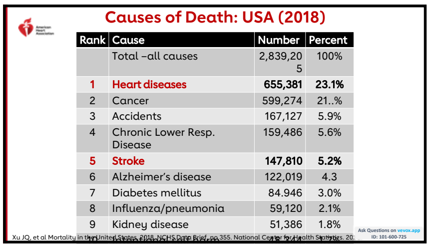

Rank	Cause	Number	Percent
	Total –all causes	2,839,205	100%
1	Heart diseases	655,381	23.1%
2	Cancer	599,274	21..%
3	Accidents	167,127	5.9%
4	Chronic Lower Resp. Disease	159,486	5.6%
5	Stroke	147,810	5.2%
6	Alzheimer's disease	122,019	4.3
7	Diabetes mellitus	84.946	3.0%
8	Influenza/pneumonia	59,120	2.1%
9	Kidney disease	51,386	1.8%

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AHA Mission Statement

… to be a relentless force for a world of longer, healthier lives

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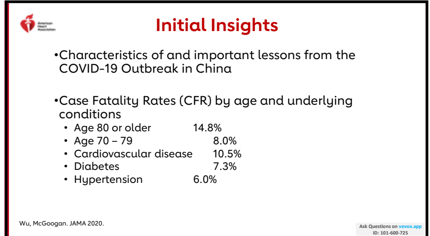

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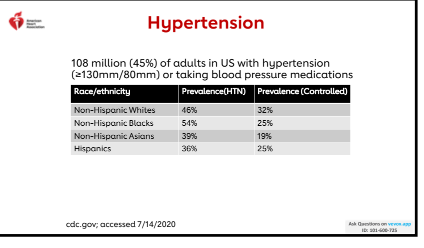
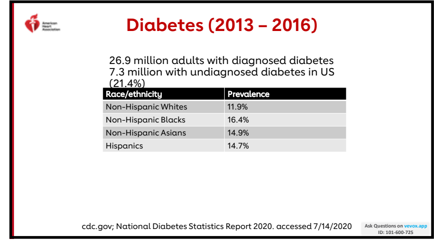


Race/ethnicity	Prevalence(HTN)	Prevalence (Controlled)
Non-Hispanic Whites	46%	32%
Non-Hispanic Blacks	54%	25%
Non-Hispanic Asians	39%	19%
Hispanics	36%	25%

116



Race/ethnicity	Prevalence
Non-Hispanic Whites	11.9%
Non-Hispanic Blacks	16.4%
Non-Hispanic Asians	14.9%
Hispanics	14.7%

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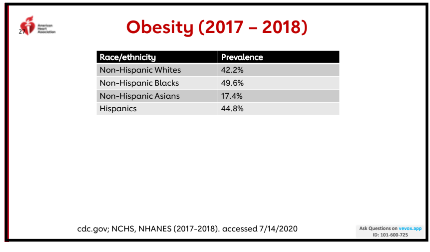

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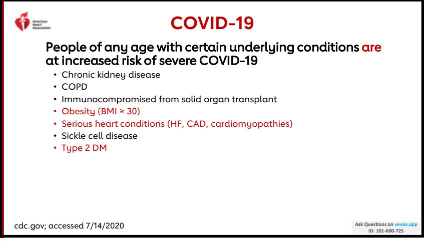

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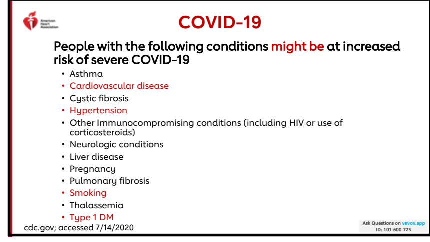

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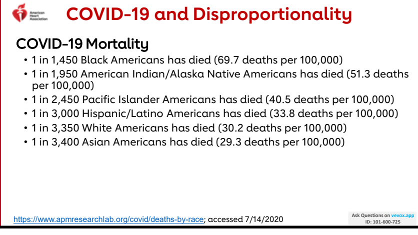

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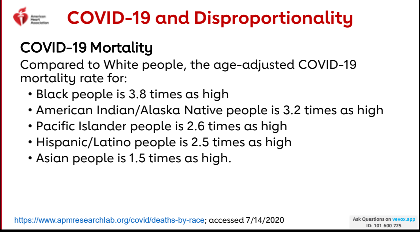

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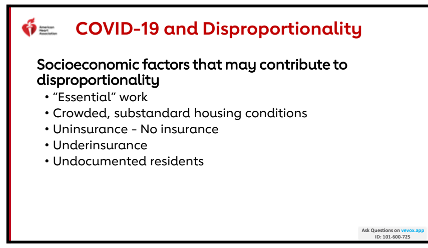

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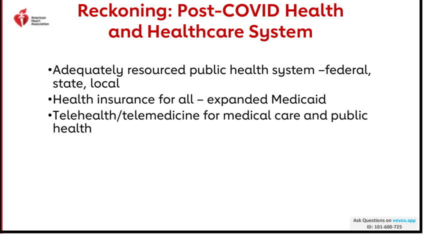

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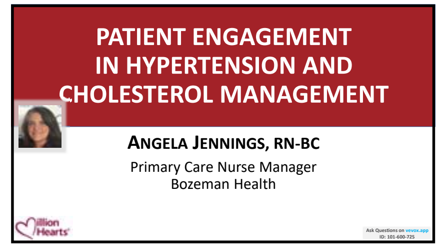

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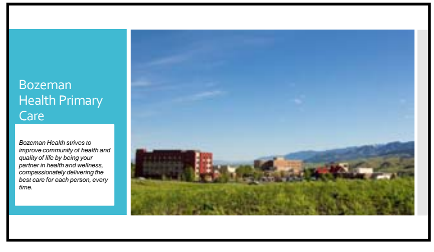

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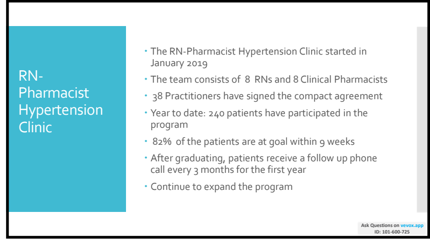

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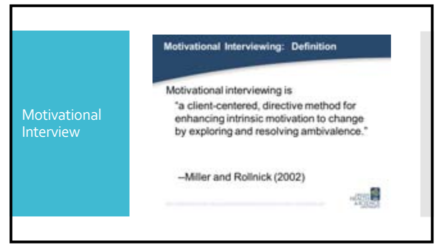

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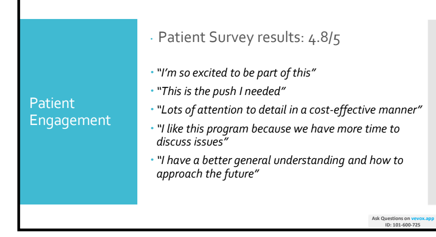

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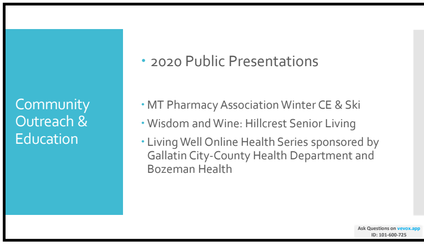

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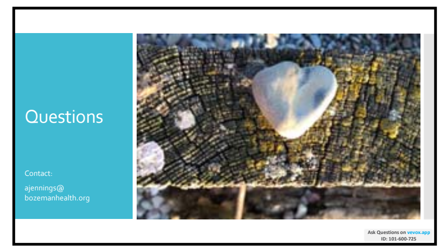

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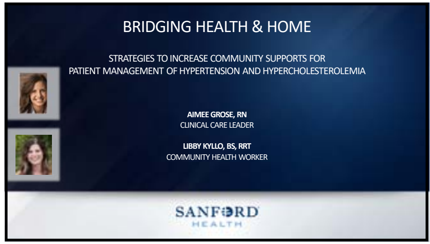

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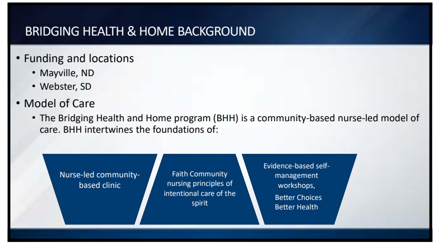

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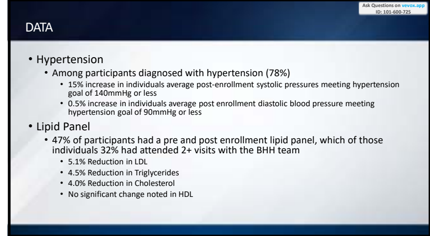

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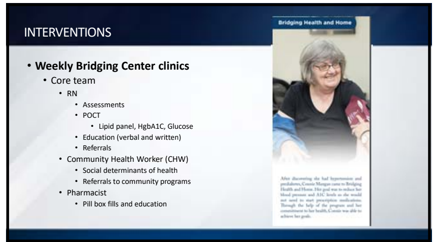

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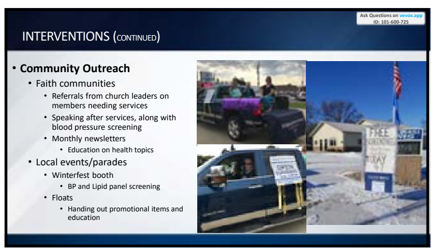

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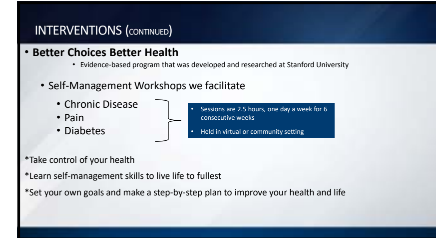

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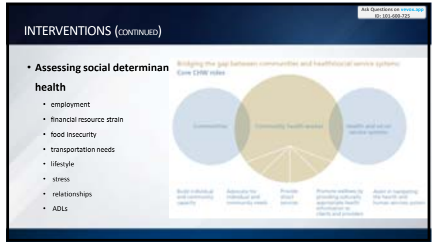

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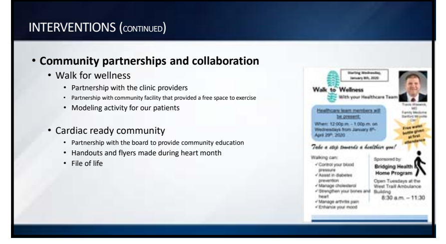

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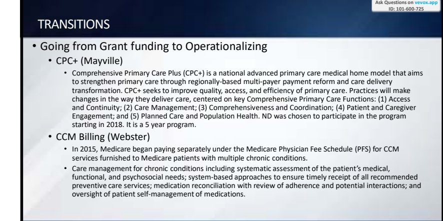

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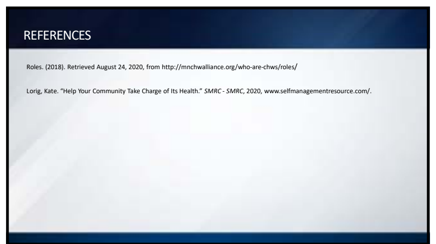

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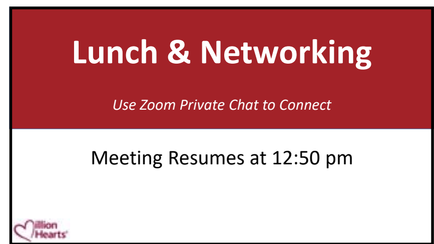

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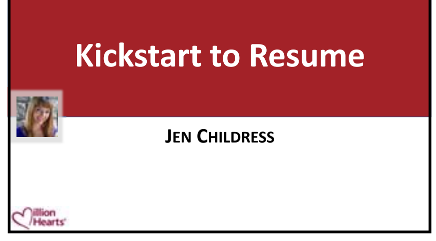

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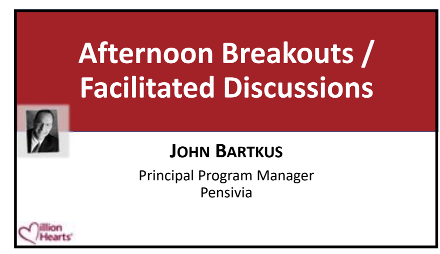

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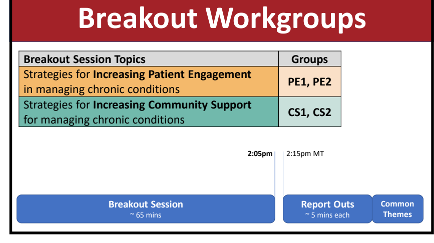

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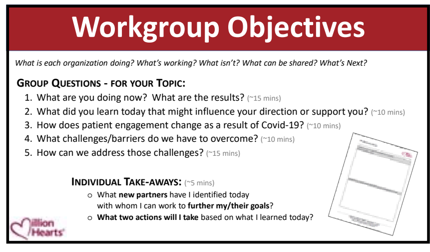

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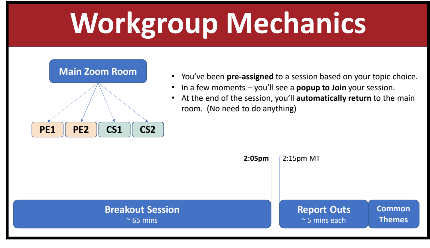

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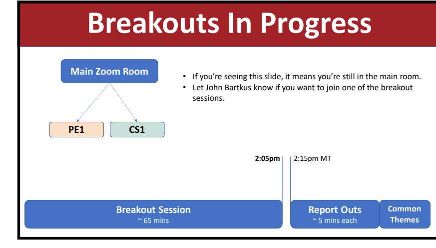

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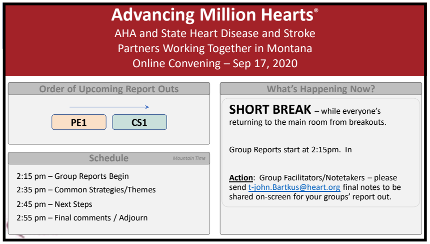

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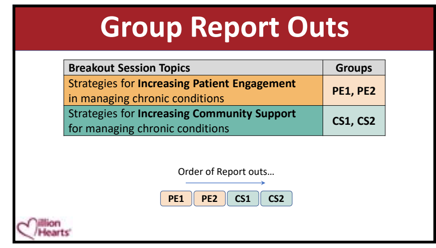

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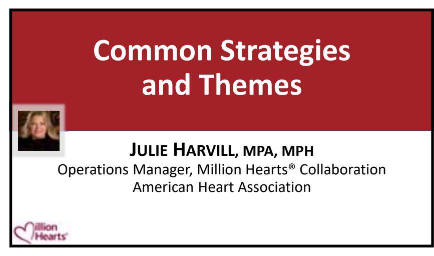

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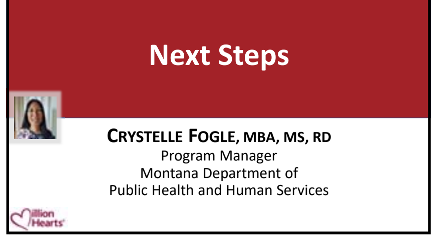

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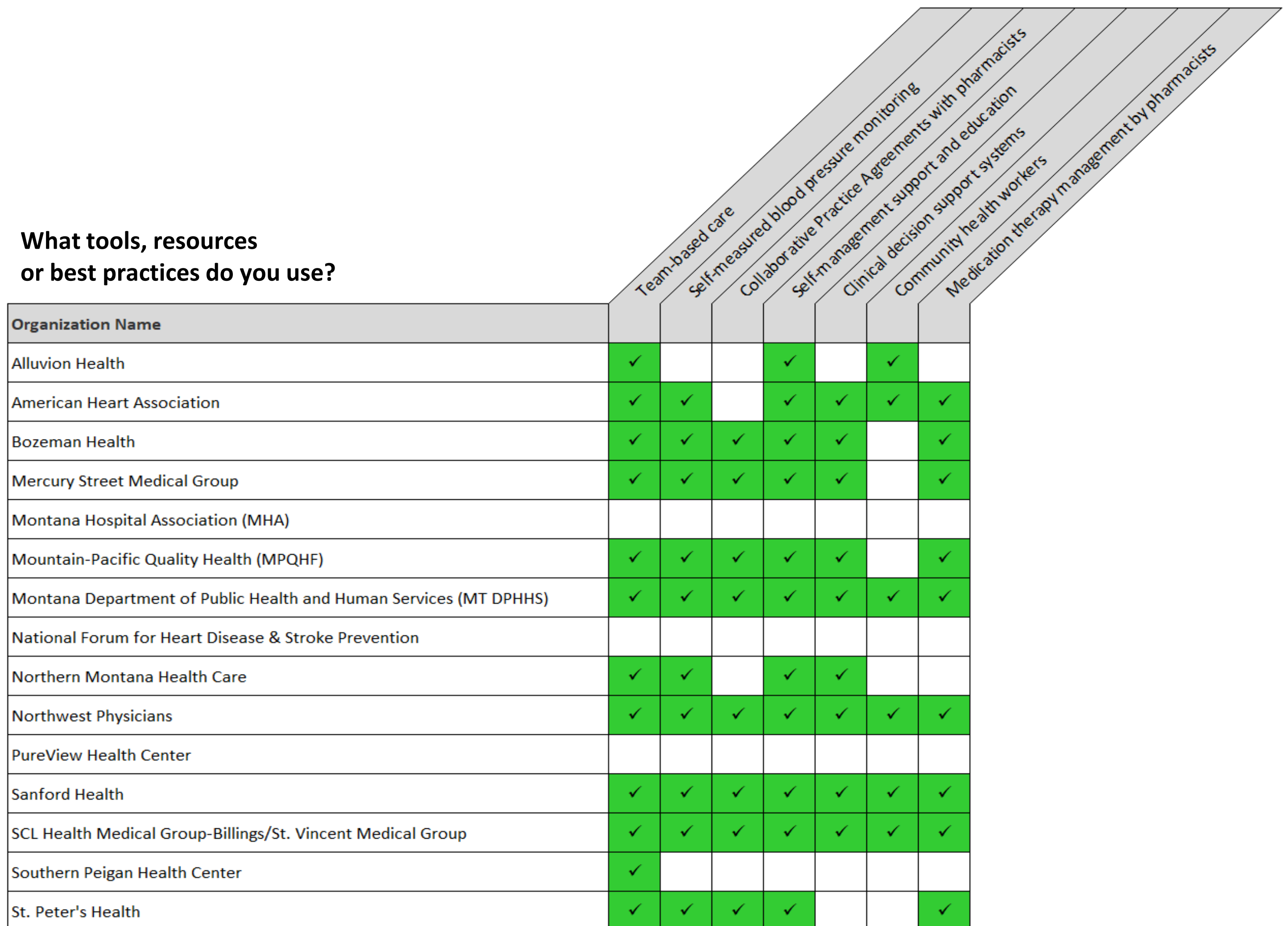

What tools, resources or best practices do you use?

Organization Name	Team-based care	Self-measured blood pressure monitoring	Collaborative Practice Agreements with pharmacists	Self-management support and education	Clinical decision support systems	Community health workers	Medication therapy management by pharmacists
Alluvion Health	✓			✓		✓	
American Heart Association	✓	✓		✓	✓	✓	✓
Bozeman Health	✓	✓	✓	✓	✓		✓
Mercury Street Medical Group	✓	✓	✓	✓	✓		✓
Montana Hospital Association (MHA)							
Mountain-Pacific Quality Health (MPQHF)	✓	✓	✓	✓	✓		✓
Montana Department of Public Health and Human Services (MT DPHHS)	✓	✓	✓	✓	✓	✓	✓
National Forum for Heart Disease & Stroke Prevention							
Northern Montana Health Care	✓	✓		✓	✓		
Northwest Physicians	✓	✓	✓	✓	✓	✓	✓
PureView Health Center							
Sanford Health	✓	✓	✓	✓	✓	✓	✓
SCL Health Medical Group-Billings/St. Vincent Medical Group	✓	✓	✓	✓	✓	✓	✓
Southern Peigan Health Center	✓						
St. Peter's Health	✓	✓	✓	✓			✓

Degree to which you have found the following to be barriers to your work

Barriers to Your Work	Org Survey Responses (x10 anonymous)										Avg
Funding	4	3	2	2	3	3	3	5	4	3	3.2
Patient engagement	5	3	2	3	3	3	3	5	2	2	3.1
Staffing capacity	4	4	1	3	2	3	4	4	1	3	2.9
Physician engagement	3	3	2	4	4	1	2	3	1	2	2.5
Lack of management support	3	2	1	2	4	1	2	5	1	2	2.3

Scale of 1 to 5 - with 1 being 'not a barrier' and 5 being a 'major inhibitor.'

Degree to which you have found the following to be barriers to implementing innovative approaches

Barriers to Implementation	Org Survey Responses (x11 anonymous)											Avg
Funding	4	3	3	4	3	3	3	5	5	2	4	3.5
Staffing capacity	4	3	4	3	3	3	3	2	4	1	3	3.0
Patient engagement	2	3	3	3	3	3	3	2	5	2	1	2.7
Physician engagement	2	3	3	3	4	4	1	1	5	1	1	2.5
Lack of management support	2	3	1	2	3	4	1	1	5	1	1	2.2

Scale of 1 to 5 - with 1 being 'not a barrier' and 5 being a 'major inhibitor.'

Source: Pre-meeting questionnaire.

Alluvion Health

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- Clinical decision support systems
- ✓ **Community health workers**
- Medication therapy management by pharmacists

What type of additional support or resources do you need to execute these strategies and activities?

Resources for education for staff

Source: Pre-meeting questionnaire. Respondent(s): Molly Wendland

American Heart Association

Non-Profit voluntary organization dedicated to fighting heart disease and stroke

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

The American Heart Association supports the use of all of these tools, resources and best practices when supporting quality improvement efforts in clinical systems.

What type of additional support or resources do you need to execute these strategies and activities?

Continued collaboration with clinical systems in order to share the resources and tools that the AHA has to offer

With which community resources/organizations are you currently working to help patients manage chronic

Many healthcare organizations/clinical systems throughout the nation, primary care associations, quality improvement organizations, non-profit community based organizations, faith organizations, etc.

With which community resources/organizations would you like to work to help patients manage chronic

Continue to expand our engagement with healthcare organizations/clinical systems throughout the nation, primary care associations, quality improvement organizations, non-profit community based organizations, faith

Please describe any innovative approaches you use to engage patients in self-management.

The AHA has resources to educate patients on self-management including in written/video format, multiple languages as well as example protocols for clinical systems implementing self-management into workflow.

What are the outcomes of innovative approaches that you have used?

Clinics have been able to improve hypertension outcomes for their patient populations.

How has COVID-19 changed your approach to patient engagement?

The AHA is working with clinical systems in incorporating self-management into telehealth during COVI-19

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Emphasis on self-management integration into telehealth

Source: Pre-meeting questionnaire. Respondent(s): Jessica Newmyer

Bozeman Health

Multi-Specialty Practice; Primary Care Practice; Health Care System

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- Community health workers
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Successful management of hypertension. HTN patients with blood pressure at goal within 9-12 weeks

What type of additional support or resources do you need to execute these strategies and activities?

It would be ideal to have a dedicated compensated leader to maintain and grow the the program

With which community resources/organizations are you currently working to help patients manage chronic

HRDC, Love Inc, Gallatin County Mental Health, GallaVan, Gallatin City-County Public Health, Eagle Mount

With which community resources/organizations would you like to work to help patients manage chronic

Care Connect

Please describe any innovative approaches you use to engage patients in self-management.

Face to face visits with motivational interviewing, patient friendly Cardiosmart informatics, celebrating success with graduation certificate and mug.

What are the outcomes of innovative approaches that you have used?

Patients reaching and maintaining goal within 9-12 weeks; 3-month follow up in the first year after graduation to assure BP goal is maintained.

What other innovative approaches might you try to engage patients in self-management?

At-home 24 hour blood pressure monitoring

How has COVID-19 changed your approach to patient engagement?

We stopped taking new patients during the peak. We continued to follow our established patients by telephone. We are now seeing patients via telemed and face to face.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Adopted the use of telemed for follow up visits.

Source: Pre-meeting questionnaire. Respondent(s): Angela Jennings

Mercury Street Medical Group

Primary Care Practice; Specialty Practice

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- Community health workers
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Small but steady improvement each year

What type of additional support or resources do you need to execute these strategies and activities?

Our exisitng EHR requires a manual process to track HTN.

Please describe any innovative approaches you use to engage patients in self-management.

We have one care management RN that coordinates referrals to Behavioral Health, Comprehensive Medication Management, Diabetic Education, etc. based on needs.

What are the outcomes of innovative approaches that you have used?

We just started this approach and look forward to seeing the results.

How has COVID-19 changed your approach to patient engagement?

We are providing more care via telehealth and telephone so some of our visits lack personal interaction. We are transitioning back to in clinic visits when necessary or desired.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Other than reduced in-clinic appointments and home visits, it really hasn't changed the way we provide self management support.

Source: Pre-meeting questionnaire. Respondent(s): Barb Cook

Montana Hospital Association (MHA)

Hospital Association

Which of the following resources or best practices do you use?

Team-based care
Self-measured blood pressure monitoring
Collaborative practice agreements with pharmacists
Self-management support and education
Clinical decision support systems
Community health workers
Medication therapy management by pharmacists

With which community resources/organizations are you currently working to help patients manage chronic

MHA is partnering with the QIO, DPHHS, and MPCA on projects including antibiotic stewardship and opioid abuse; we are of course also partnering with DPHHS around telestroke interventions!

With which community resources/organizations would you like to work to help patients manage chronic

We are open to any partnerships and strategies that can improve patient health.

Please describe any innovative approaches you use to engage patients in self-management.

We have worked on Community Health Worker projects in the past; the HIIN project includes a patient-family engagement focus.

What are the outcomes of innovative approaches that you have used?

The CHW program showed significant reductions in readmissions and decrease in costs, in addition to improved health. The HIIN work has resulted in better hospital-based outcomes.

Source: Pre-meeting questionnaire. Respondent(s): Victoria Cech

Mountain-Pacific Quality Health (MPQHF)

Contractor

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- Community health workers
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Streamlined and consistent workflows, data and protocols have been implemented, focus on high risk patients have reduced overall costs

Source: Pre-meeting questionnaire. Respondent(s): Patricia Kosednar

Montana Department of Public Health and Human Services

Department of Health

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Increased pharmacist engagement and clinics implementing clinical decision support systems to increase access to screening and care management services. Utilization of these tools has led to better patient management and increased access to programs. The CMS blood pressure measure appears to be improving in clinics and other facilities we have been working with. In the Undiagnosed Hypertension project, we saw more patients with their most recent (at least 2) blood pressure measures being diagnosed with hypertension after clinics reassessed the patients' blood pressure status..

What type of additional support or resources do you need to execute these strategies and activities?

Expanded network of community health workers, more flexibility in electronic health records, and increased provider engagement. Additional information on what others are doing and what is working.

With which community resources/organizations are you currently working to help patients manage chronic conditions?

Mountain-Pacific Quality Health, University of Montana Skaggs School of Pharmacy, local health departments, health systems with DPP and DSMES programs, Community Integrated Health sites, community pharmacies, Community Health Centers, American Indian tobacco prevention specialists

With which community resources/organizations would you like to work to help patients manage chronic conditions?

WIC, local food banks, optometrists, dentists, more tribal governments and community health workers/navigators. In general, we need more community resources for chronic disease management.

Please describe any innovative approaches you use to engage patients in self-management.

CONNECT bi-directional referral system, expanding Community Integrated Health (community paramedicine), cardiovascular/diabetes GIS Hubs, home-based cardiac rehabilitation, digital health/online platforms, patient incentives/support, increased promotion and marketing, providing services in alternative locations, Offering funding to implement innovative approaches, expanding IPHARM, offering Discovery & Action Dialogues that may include patients. Pharmacist-led blood pressure management programs

What are the outcomes of innovative approaches that you have used?

Increased participation, slow movement in getting adaptation/implementation of these strategies. Some of the outcomes from #12 have led to being able to reach patients "where they are" like at community events and in their home.

What other innovative approaches might you try to engage patients in self-management?

We hope to partner with clinics and food pantries on a Food Farmacy project to improve access to healthier foods for patients with hypertension or high cholesterol. Montana also is working on a health information exchange.

How has COVID-19 changed your approach to patient engagement?

Increased the move toward delivering services via telehealth methods to allow for continued program involvement by patients. Participation and some programs have declined or were put on hold, but educators and coaches have increased efforts to touch base with participants to ensure they are still engaged at some level. Partners have shifted many activities to online or telehealth. Looking at more online apps to increase contacts with patients when in-person isn't feasible. DPHHS staff is able to telework. We have more online meetings and are using technology to keep grant projects moving forward.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

DPHHS and health partners are encouraging patients to not avoid or delay care.There has been an accelerated shift toward telehealth services, and the Diabetes Program is looking into additional telehealth/online service platforms.

Source: Pre-meeting questionnaire. Respondent(s): Crystelle Fogle/Marilyn McLaury/Carrie Oser/Melissa House/Jessie Fernandes/Mike McNamara/Kim Pullman

National Forum for Heart Disease & Stroke Prevention

National Non-profit Organization for Heart Disease and Stroke Prevention

Which of the following resources or best practices do you use?

Team-based care
Self-measured blood pressure monitoring
Collaborative practice agreements with pharmacists
Self-management support and education
Clinical decision support systems
Community health workers
Medication therapy management by pharmacists

With which community resources/organizations are you currently working to help patients manage chronic

The National Forum for Heart Disease & Stroke Prevention brings together the most dynamic and diverse organizations in cardiovascular health to: Share successful strategies and practices, and lessons learned Discuss new ideas in a collaborative environment; Develop, pilot and scale innovative approaches to prevent cardiovascular disease;Members value the opportunities created by the National Forum for them to engage in discussions that are uniquely inclusive, transparent and consensus-building. National Forum initiatives enable members to work together, across sectors, to develop and advance strategies to prevent heart disease and stroke in all populations; The National Forum's Annual Meeting convenes 100 thought leaders from over 60 public, private and nonprofit organizations including our members and partners. During this time, our Annual Business Meeting of the organization is held where the National Forum Awards are presented. All Advancing Million Hearts participants are invited to register to attend our virtual annual meeting on October 15, 2020. Visit www.nationalforum.org

Source: Pre-meeting questionnaire. Respondent(s): Julie Harvill

Northern Montana Health Care

Rural Health Clinic; Health Care System

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- Collaborative practice agreements with pharmacists
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

Increased BP control with use of SMBP

What type of additional support or resources do you need to execute these strategies and activities?

More evidence based data to promote buy-in from providers

With which community resources/organizations are you currently working to help patients manage chronic

DPPHS TargetBP

With which community resources/organizations would you like to work to help patients manage chronic

Advancing Million Hearts DPPHS TargetBP

Please describe any innovative approaches you use to engage patients in self-management.

Work in progress

What are the outcomes of innovative approaches that you have used?

Greater interest

What other innovative approaches might you try to engage patients in self-management?

We would like to provide hypertension programs, engage facilities provide physical activity opportunities

How has COVID-19 changed your approach to patient engagement?

More long distance engagement.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Increased use of telehealth

Source: Pre-meeting questionnaire. Respondent(s): Susan Morgan

Northwest Physicians

Primary Care Practice

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Improvements in health & decrease in symptoms

What type of additional support or resources do you need to execute these strategies and activities?

Grant projects, cpc+

With which community resources/organizations are you currently working to help patients manage chronic

Behavioral Health, Pharmacy, Specialty Providers

With which community resources/organizations would you like to work to help patients manage chronic

Any available options

Please describe any innovative approaches you use to engage patients in self-management.

Clinical Health Coaching self-management action plans with patient specific smart goals

What are the outcomes of innovative approaches that you have used?

Improvement in ecqm data over 4 years

What other innovative approaches might you try to engage patients in self-management?

Group visits

How has COVID-19 changed your approach to patient engagement?

Increased our phone and telehealth visits. Decreased access to care. Increased Behavioral Health needs

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Increased use of telehealth, portal messaging communication, and phone interaction

Source: Pre-meeting questionnaire. Respondent(s): Cynthia Armstrong, RN,CHC

PureView Health Center

Federally Qualified Health Center (FQHC)

Which of the following resources or best practices do you use?

Team-based care
Self-measured blood pressure monitoring
Collaborative practice agreements with pharmacists
Self-management support and education
Clinical decision support systems
Community health workers
Medication therapy management by pharmacists

With which community resources/organizations are you currently working to help patients manage chronic

AWARE, PACT, Inch By Inch, Farmers to Families

With which community resources/organizations would you like to work to help patients manage chronic

Helena Food Share, Meals on Wheels, Living Life Well – Arthritis Foundation. Open to suggestions.

Source: Pre-meeting questionnaire. Respondent(s): James DeFoe

Sanford Health

Health Care System

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Increased number of patients meeting BP and Hba1c goals; Increased patient confidence in self-managing chronic conditions; increased completion of Advanced Care Plans

What type of additional support or resources do you need to execute these strategies and activities?

Additional funding for staffing, marketing, etc. Local resources such as transportation, volunteers and increased access to healthy food options

With which community resources/organizations are you currently working to help patients manage chronic

Stanford University Self- Management Resource Center (facilitating self-management workshops) Valley Senior Services (senior center collaboration) Steele & Traill County Public Health Sanford Health Home Health Department

With which community resources/organizations would you like to work to help patients manage chronic

Great Plains Food Bank

Please describe any innovative approaches you use to engage patients in self-management.

Starting to leverage Digital Platforms to meet patients at their level of readiness to change, startingt with their goals. Utilize Lutheran Social Services (volunteer companions) to increase involvement and engagement of older

What are the outcomes of innovative approaches that you have used?

Great feedback from patients, increase attendance to appointments and completion of action plans

How has COVID-19 changed your approach to patient engagement?

Similar to all health care systems, patients are starting to come back to the clinics and engage in their health. Increased screenings, more 1 on 1 appointments, increased education about self-care.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Using digital platforms, virtual workshops and telephone encounters for education

Source: Pre-meeting questionnaire. Respondent(s): Jill Swenson, Libby Kyllo

St. Vincent Medical Group

Multi-Specialty Practice; Primary Care Practice; Health Care System

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- ✓ **Clinical decision support systems**
- ✓ **Community health workers**
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Hypertension with BP control is the most difficult for providers to get a grip on. There is no funding to purchase home BP cuffs to loan to patients.

What type of additional support or resources do you need to execute these strategies and activities?

More health coaching, more Community Health Workers. More peer to peer encouraging by providers. Leadership

With which community resources/organizations are you currently working to help patients manage chronic

YMCA--Diabetes and Heart Disease Prevention Program

With which community resources/organizations would you like to work to help patients manage chronic

I would like to see ALL the healthcare facilities in our community and rural areas to come together to address it.

Please describe any innovative approaches you use to engage patients in self-management.

Patient education posted in the exam rooms. Standard Workflow for elevated BP in the office. Loaner BP Cuff program. Staff education.

What are the outcomes of innovative approaches that you have used?

Not much change. Approaches are not widely utilized.

What other innovative approaches might you try to engage patients in self-management?

Would love to offer virtual classes around self management of BP.

How has COVID-19 changed your approach to patient engagement?

Patients are staying away from the clinics but increasing virtual visits.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Reassignment and cut back hours of the Community Health Workers. Care Coordinators were reassigned to the COVID-19 Triage Line for Feb-April 2020. Overall reduction of resources available to provide patient support.

Source: Pre-meeting questionnaire. Respondent(s): Karen Gray-Leach, RN

Southern Peigan Health Center

Rural Health Clinic

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- Self-measured blood pressure monitoring
- Collaborative practice agreements with pharmacists
- Self-management support and education
- Clinical decision support systems
- Community health workers
- Medication therapy management by pharmacists

What outcomes have you observed from use of the resources or best practices (above)?

We've had positive outcomes

What type of additional support or resources do you need to execute these strategies and activities?

Additional education, case management

With which community resources/organizations are you currently working to help patients manage chronic

Blackfeet Tribal Health

With which community resources/organizations would you like to work to help patients manage chronic

Community health nurses

Please describe any innovative approaches you use to engage patients in self-management.

At-home logs, education for patient and family

What are the outcomes of innovative approaches that you have used?

Improved HTN numbers

What other innovative approaches might you try to engage patients in self-management?

We will try everything and anything to be innovatitive, we can work on this as a group

How has COVID-19 changed your approach to patient engagement?

Slowed down approach to patient engagment, closed clinic, no providers at times.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

Slowed down, patients were not able to come into the clinic

Source: Pre-meeting questionnaire. Respondent(s): Roberta Wagner

St. Peter's Health

Federally Qualified Health Center (FQHC); Health Care System

Which of the following resources or best practices do you use?

- ✓ **Team-based care**
- ✓ **Self-measured blood pressure monitoring**
- ✓ **Collaborative practice agreements with pharmacists**
- ✓ **Self-management support and education**
- Clinical decision support systems
- Community health workers
- ✓ **Medication therapy management by pharmacists**

What outcomes have you observed from use of the resources or best practices (above)?

Increased patient engagement. Increased medication adherence. Increased provider and patient satisfaction.

What type of additional support or resources do you need to execute these strategies and activities?

EHR with clinical decision support-we will be upgrading our EHR over the next couple of years. Examples of successful community health worker programs and resources for implementing such programs within comparable health systems and/or populations

With which community resources/organizations are you currently working to help patients manage chronic

Diabetes Prevention Program (“Inch by Inch”), Living Life Well Program through RMDC, Walking With Ease through Lewis and Clark Public Health, Our Freedom From Smoking Program, Arthritis Exercise

With which community resources/organizations would you like to work to help patients manage chronic

Health Coaches for Hypertension Control (we are working on bringing this to our organization)

Please describe any innovative approaches you use to engage patients in self-management.

Incorporating new team members to increase ability to provide wrap around services and support: Community Paramedics and Registered Dietitians in the Clinic.

What are the outcomes of innovative approaches that you have used?

Both of those previously mentioned are new and lack robust outcome information at this point.

What other innovative approaches might you try to engage patients in self-management?

Community Health Workers further down the road

How has COVID-19 changed your approach to patient engagement?

It has increased the incidence of outreach and support via phone or virtual visit.

How has COVID-19 changed the way your organization and/or partners provide self-management support?

It has provided us with the opportunity to quickly stand up a Community Paramedicine Program to increase patient engagement

Source: Pre-meeting questionnaire. Respondent(s): Haylie Wisemiller