
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 <ul style="list-style-type: none"> • 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 Kylo, 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 <ul style="list-style-type: none"> • 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

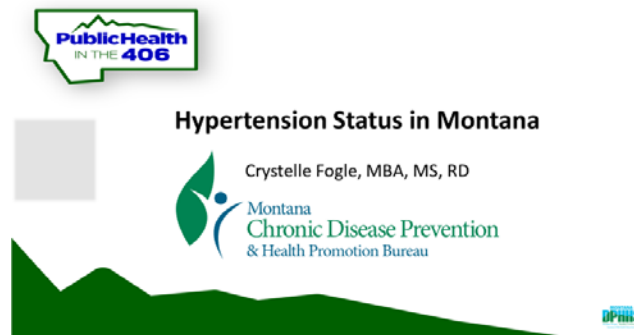
- CDC Foundation Campaign
- Million Hearts 1.0 Addendum
- Hypertension Control Champions
- Cardiac Rehabilitation Think Tank
- AMA/ AHA Scientific Statement SMBP
- [AMA validatebp.org](http://AMA.validatebp.org)

- 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

THE RESULTING EFFORTS

The graphic features logos for TARGET:BP, American Heart Association, and AMA. Below the logos are the slogans "Check, Change, Control. Cholesterol" and "Target: Type 2 Diabetes". To the right, under the heading "All Programs", is a list of three bullet points: "Provide clinical guidelines and protocols", "Offer free resources for both providers and patients", and "Connect clinical partners to others around the country engaged in the same work". A fourth bullet point, "Offer recognition opportunities for any health care provider that demonstrates a commitment to, and/or achieve, clinical excellence.", is partially obscured by a vertical dotted line. At the bottom right, there is a small American Heart Association logo and the text "Use [vevox.app](#) ID: 136-377-847".

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



Mountain-Pacific
Quality Health

**Montana Advancing
Million Hearts®**

Patty Kosednar

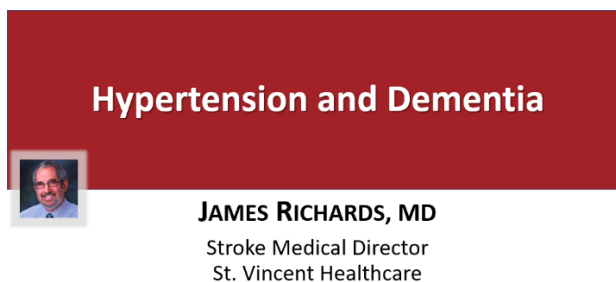
Virtual Workshop
September 17, 2020

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



Hypertension and Dementia

JAMES RICHARDS, MD
Stroke Medical Director
St. Vincent Healthcare



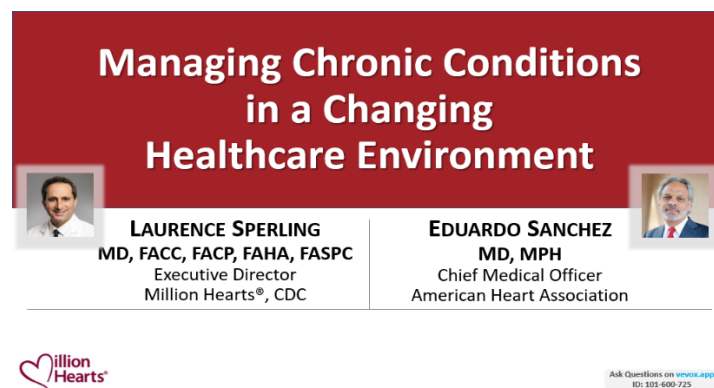
Ask Questions on [wevoLapp](#)
ID: 101-600-725

Dementia Risk Factors

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

Managing Chronic Conditions in a Changing Healthcare Environment

- *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



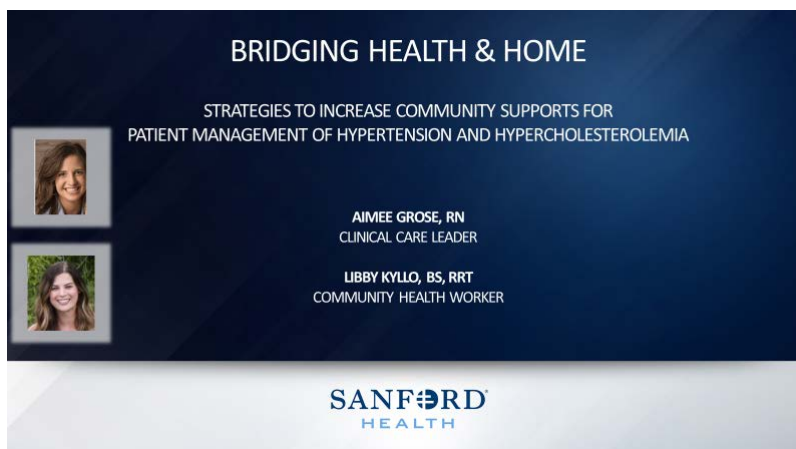
- The RN-Pharmacist Hypertension Clinic started in January 2019
- The team consists of 8 RNs and 8 Clinical Pharmacists
- 38 Practitioners have signed the compact agreement
- Year to date: 240 patients have participated in the program
- 82% of the patients are at goal within 9 weeks
- After graduating, 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 Kylo, Community Health Worker

Sanford Health, Mayville Medical Center



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

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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:

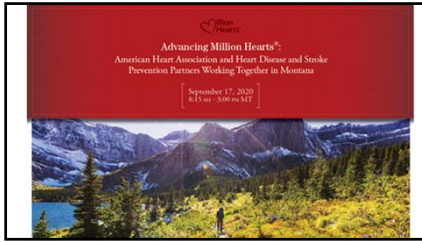
First Name	Last Name	Organization	Job Title	Email
Aimee	Grose	Sanford Health	RN Clinical Care Leader	aimee.grose@sanfordhealth.org
Alona	Jarmin	Mountain-Pacific Quality Health (MPQHF)	Senior Account Manager	ajarmin@mpqhf.org
Amber	Rogers	Mountain-Pacific Quality Health (MPQHF)	Account Manager	arogers@mpqhf.org
Amy	Emmert	St. Peter's Health	Senior Director of Population Health	aemmert@sphealth.org
Angela	Jennings	Bozeman Health	Primary Care Nurse Manager	ajennings@bozemanhealth.org
Chandala	Curtiss	Providence Health and Services	Manager of Population Health	chandala.curtiss@providence.org
Cheryl	Stensrud	St. James Healthcare	Director of Acute Care	cheryl.stensrud@sclhealth.org
Courtney	Buys	Montana Primary Care Association	Health Outcomes Improvement Manager	cbuys@mtpca.org
Crystal	Menick	Southern Peigan Health Center	FNP	cmenick@blackfeetnation.com
Crystelle	Fogle	Montana Department of Public Health and Human Services (MT DPHHS)	Program Manager	cfogle@mt.gov
Cynthia	Armstrong	Northwest Physicians	RN, CHC	cynthianwp@gmail.com
Eduardo	Sanchez	American Heart Association	Chief Medical Officer for Prevention	eduardo.sanchez@heart.org
Erica	Hoversland	Billings Clinic	Clinical Pharmacist	ehoversland@billingsclinic.org
Haley	Stolp	Centers for Disease Control and Prevention (CDC)	Public Health Analyst, IHRC Inc.	hstolp@cdc.gov
Haylie	Wisemiller	St. Peter's Health	Population Health & Community Education Specialist	hwisemiller@sphealth.org
James	Bennett	Transforming Chronic Care	Pharmacist consultant	jbennett@jbaweb.com
James	Richards	St. Vincent Healthcare		james.richards@sclhealth.org
Jeff	Redekopp	Quality Health Associates of North Dakota	Quality Improvement Specialist	jredekopp@qualityhealthnd.org
Jessica	Newmyer	American Heart Association	Community Impact Consultant, Western States	jessica.newmyer@heart.org
Jessie	Fernandes	Montana Department of Public Health and Human Services (MT DPHHS)	Section Supervisor	jfernandes@mt.gov
Jill	Swenson	Sanford Health	Clinical Strategist	jill.r.swenson@sanfordhealth.org

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners
Working Together in Montana – September 17, 2020

First Name	Last Name	Organization	Job Title	Email
Joe	Tabler	Kalispell Regional Medical Center	Clinical Pharmacist	ctabler@krmc.org
John	Bartkus	Pensivia	Principal Program Manager	t-john.bartkus@heart.org
John	Clymer	National Forum for Heart Disease & Stroke Prevention	Executive Director	john.clymer@nationalforum.org
Julia	Schneider	National Association of Chronic Disease Directors (NACDD)	Co-Lead CVH Team	jschneider@chronicdisease.org
Julie	Harvill	American Heart Association	Million Hearts® Operations Manager	julie.harvill@heart.org
Kamesha	Ellis	Centers for Disease Control and Prevention (CDC)	Project Officer	kellis@cdc.gov
Karen	Gray-Leach	SCL Health	Medical Home Coordinator/Educator RN	karen.grayleach@sclhealth.org
Kari	Matthys	Sanford Health		kari.matthys@sanfordhealth.org
Katelin	Conway	Mountain-Pacific Quality Health (MPQHF)	Account Manager	kconway@mpqhf.org
Kim	Pullman	Montana Department of Public Health and Human Services (MT DPHHS)	Wellness Program Manager	kpullman@mt.gov
Kristen	Range	Mountain-Pacific Quality Health (MPQHF)	Senior account manager	kschuster@mpqhf.org
Laura	King	American Heart Association	Director of Public Health	laura.king@heart.org
Lauren	Owens	Centers for Disease Control and Prevention (CDC)	Public Health Analyst, Million Hearts®	lowens@cdc.gov
Laurence	Sperling	Centers for Disease Control and Prevention (CDC)	Executive Director, Million Hearts	lsperling@cdc.gov
Libby	Kyllo	Sanford Health	Community Health Worker	libby.kyllo@sanfordhealth.org
Lisa	Jones Barker	American Heart Association	Senior Vice President, Health Strategies	lisa.jones.barker@heart.org
Marilyn	McLaury	Montana Department of Public Health and Human Services (MT DPHHS)	QI Coordinator	mmclaury@mt.gov
Melissa	House	Montana Department of Public Health and Human Services (MT DPHHS)	Program Manager	melissa.house@mt.gov
Mike	Lionbarger	Centers for Disease Control and Prevention (CDC)	Public Health Analyst	mlionbarger@cdc.gov

Advancing Million Hearts®: AHA and Heart Disease and Stroke Prevention Partners
 Working Together in Montana – September 17, 2020

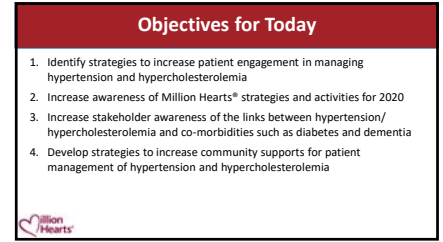
First Name	Last Name	Organization	Job Title	Email
Mike	McNamara	Montana Department of Public Health and Human Services (MT DPHHS)	CV Specialist	mmcnamara@mt.gov
Patricia	Kosednar	Mountain-Pacific Quality Health (MPQHF)	Program Manager	pkosednar@mpqhf.org
Rachael	Zins	University of Montana	Pharmacist	rachael.zins@umontana.edu
Roberta	Wagner	Southern Peigan Health Center	Admin	rwagner@blackfeetnation.com
Sarah	Leake	Mountain-Pacific Quality Health (MPQHF)	Quality Improvement Management	sleake@mpqhf.org
Sharon	Nelson	American Heart Association	Program Initiatives Manager	sharon.nelson@heart.org
Susan	Morgan	Northern Montana Health Care	Director of Clinic Nursing	morgsusk@nmhcare.org
Trina	Filan	Montana Department of Public Health and Human Services (MT DPHHS)	Program Evaluator	trina.filan@mt.gov



1



2



3

Advancing Million Hearts® - Montana Planning Committee

Member	Organization
Crystelle Fogle	
Mike McNamara	
Carrie Oser	MT DPHHS - Cardiovascular Health Program
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

4



5

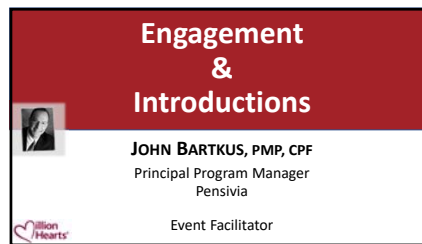


6

Agenda

8:15 am	• Networking
9:00 am	• Welcome & Overview of the Day • Engagement & Introductions • Million Hearts® 2022 Update • MT Hypertension Initiatives and Resources • Hypertension and Dementia • Managing Chronic Conditions in Changing Healthcare Environment • Patient Engagement in Hypertension & Cholesterol Management • Community Supports for Self-Management of Hypertension and Hypercholesterolemia
12:30 pm	• Lunch (and networking through Zoom private chat)
12:50 pm	• Breakout Sessions • Group Report Outs • Common Themes and Strategies • Next Steps
3:00 pm	• Wrap up / Adjourn @ 3:00pm

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8




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Engaging throughout the day



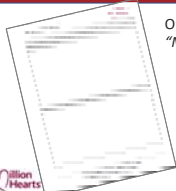
Join at vevox.app
Or search **vevox** in the app store
ID: **101-600-725**



Join: vevox.app ID: 101-600-725

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Alignment and Connections



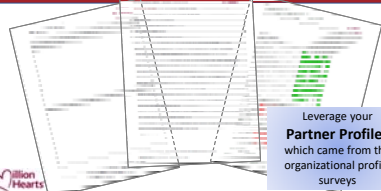
One of the sheets in your packet is "My Alignment Notes"

Opportunities I found to:

- Align with My Organization's work
- Align with Others' work

11

Alignment and Connections



Leverage your **Partner Profiles** which came from the organizational profile surveys

12

Introductions

Introduction Process

- Success requires Change of Approach!
- Let's see all the Organizations & Participants registered/participating!

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Million Hearts® 2022 in Montana Executive Director Update




LAURENCE SPERLING, MD, FACC, FACP, FAHA, FASPC
Executive Director, Million Hearts®
Division for Heart Disease and Stroke Prevention, CDC
Center for Clinical Standards and Quality, CMS
Katz Professor in Preventive Cardiology
Professor of Global Health
Emory University

Ask Questions on vevox.app 101-600-725

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Dr. Sperling has no conflicts to disclose.

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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
- Q & A (post your questions via Vevox)

16

Our world has changed since January 28,2020





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Impact of Pandemic on Cardiovascular Care (4/25/20)

By Dr. Sarah Elmer

Amid the Coronavirus Crisis, Heart and Stroke Patients Go Missing


Emergency physicians are seeing declines in the number of patients arriving with cardiac problems. Some say they were afraid to go to the hospital.



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Million Hearts® Executive Director Update

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ID: 322-489-324

19

Current Challenges / Concerns / Gaps in Care

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



Khera A, et al. Am J Prev Cardiol 2020;1:1-10

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ID: 322-489-324


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Impact of Pandemic (MMWR)

In the 18 weeks following the declaration of the COVID-19 national emergency, visits to emergency departments declined for:

- Heart attack: 23%
- Stroke: 20%
- Disruption of high blood sugar: 10%

Hospitalizations were 6 times higher and deaths 31 times higher for COVID-19 patients with reported underlying conditions*



https://www.cdc.gov/mmwr/index.html

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ID: 322-489-324

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Implications of Delay and Disruption of Care During the Pandemic

Khera A, et al. Am J Prev Cardiol 2020;1:1-10


ASPC

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ID: 322-489-324

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Recommendations for Patient Visits During Pandemic

- Don't defer patient visits
- Use telehealth including telephone – if at all possible
- At each visit:
 - Ask about symptoms
 - Encourage EMS/ER for concerning symptoms
 - Remind them that it is safe
 - Ensure adequate medication refills and access
 - Inquire about physical activity and nutrition habits
 - Use the full care team to enhance patient care



Khera A, et al. Am J Prev Cardiol 2020;1:1-10

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COVID-19 & Cardiovascular Disease PSAs

Emergency Care Focus:


If you experience symptoms of a heart attack or stroke – call 911 immediately

Heart Health Focus:

Reach out to your medical team for questions concerns or continued care

ACTIVATION TOOLKIT:

1. PSA – TV / YouTube / Twitter / LinkedIn
2. PSA – Facebook / Instagram
3. Social Graphics – Facebook / Instagram
4. Social Post Copy – Standard & Abbreviated
5. Digital Communications Burd
6. COVID-19 & CVD Key Messages



CDC FOUNDATION

COVID-19 & CARDIOVASCULAR DISEASE: PARTNER ACTIVATION TOOLKIT

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SMBP – Vital Signs Vital for Telemedicine

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Socioeconomic Status and Cardiovascular Outcomes: Challenges & Interventions

Low SES

Poor access to care and healthy foods
Psychosocial factors
Behavioral factors
Environmental factors

Interventions


- Behavioral counseling
- Physical activity, smoking, alcohol
- Community-based programs
- Health education
- Local and federal health policy

Traditional CVD Risk Factors

Hypertension
Diabetes
Lipids
Smoking
Obesity
Poor diet
Physical inactivity

Interventions

- Disease-based care
- Lifestyle modification
- Task shifting




Schultz WM, Kull NM, Sanderson P, Coughlin AA, Merseth GA, Sperting LS. Circulation. May 2018;137:2160-2178

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ID: 322-489-324

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“In the midst of difficulty lies opportunity ...”

Albert Einstein



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Optimizing Opportunities

- Acceleration of New Care Models
 - Telehealth / telemedicine
- Decreased use of low-value care
- Volume to value transformation
- Healthcare integration / consolidation

Poppea A, et al. JACC 2020; 75(3):2989-2991
Khara A, et al. Am J Prev Cardiol 2020;1:1-10
Ask Questions at www.mh.org
800-488-6876

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Million Hearts® 2022 Aim: Prevent a Million Heart Attacks and Strokes in Five Years

Ask Questions at www.mh.org
800-488-6876

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Relative Event Contributions to "the Million"

Category	Relative Event Contributions (Estimated)
Appoin When Appropriate	~100,000
Blood Pressure Control	~450,000
Cholesterol Management	~350,000
Smoking Cessation	~200,000
Physical Inactivity	~100,000
Sodium Reduction	~150,000

Ask Questions at www.mh.org
800-488-6876

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County-level Heart Disease Mortality Across Age Groups, 2017

Ask Questions at www.mh.org
800-488-6876

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Million Hearts® Executive Director Update

- Our hearts are focused on Millions across the Nation
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- Q & A (post your questions via Vevox)

Ask Questions at www.mh.org
800-488-6876

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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:
 - Keeping People Healthy
 - Optimizing Care
 - Improving Outcomes for Priority Populations
 - 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.org/partners-program/hospitals-health-systems/index.html>

Ask Questions at www.mh.org
800-488-6876

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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

Ask Questions at www.mh.org
800-488-6876

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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

Ask Questions at www.mh.org
800-488-6876

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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/AACC 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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800-488-6876

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Influenza (Flu) Burden and Vaccination

- Only 45% of adult Americans received flu vaccine during the 2018-2019 flu season
- There is a significant association between clinician recommendation and vaccination

CDC estimates* from **October 1, 2018** through **April 4, 2020** (over four years)

18,966,000 - 24,000,000 Flu Hospitalizations
18,066,000 - 26,666,000 Flu Deaths
476,000 - 746,000 Flu Hospitalizations
24,000 - 62,000 Flu Deaths

*All Questions on www.ahrq.gov © 2020 AHRQ

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Summary Million Hearts® 2022- Executive Director Update

- Heart disease and stroke remain leading causes of death in U.S.
- Cardiovascular Health and Prevention Must Remain a Priority
- Never a more important time to focus on Millions across the nation
- Commitment to collaboration, partnership, and perseverance

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Million Hearts® Resources

- Hypertension Control Change Package, Second Edition
<https://millionhearts.hhs.gov/tools-protocols/action-guides/hccp-change-package/index.html>
- Self-Measured Blood Pressure Monitoring
<https://millionhearts.hhs.gov/tools-protocols/monitoring.html>
- Cholesterol Management
<https://millionhearts.hhs.gov/tools-protocols/cholesterol-management.html>
- Medication Adherence
<https://millionhearts.hhs.gov/tools-protocols/medication-adherence.html>
- Cardiac Rehabilitation
<https://millionhearts.hhs.gov/tools-protocols/cholesterol-rehabilitation.html>

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A Million Thanks!

More on Million Hearts at [Millionhearts.hhs.gov](https://millionhearts.hhs.gov)
Reach me at L.Sperling@cdc.gov
Twitter @MillionHeartsUS

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Million Hearts® Hypertension Control Change Package

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst
Million Hearts®
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

September 17, 2020

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Million Hearts® 2022 Priorities

Keeping People Healthy	Optimizing Care
Reduce Sodium Intake	Improve ABCs*
Decrease Tobacco Use	Increase Use of Cardiac Rehab
Increase Physical Activity	Engage Patients in Heart-healthy Behaviors
Improving Outcomes for Priority Populations	
Blacks/African Americans	
25- to 64-year-olds	
People who have had a heart attack or stroke	
People with mental health or substance use disorders who use tobacco	

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The Model for Improvement

- ← Quality improvement goal(s)
- ← SMART objective(s)
- ← ???
- ← Plan-Do-Study-Act (PDSA) cycles
– AKA "rapid tests of change"

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Hypertension Control Change Package (HCCP) 2nd Edition, 2020

Access the Change Package at:
<https://millionhearts.hhs.gov/tools-protocols/action-guides/hccp-change-package/index.html>

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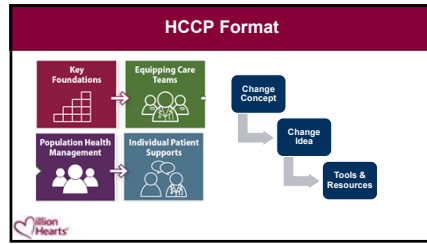
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HCCP 2020

- 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

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Use Practice Data to Drive Improvement

Change Concept

- Determine HTN control and related process metrics for the practice
- Regularly provide a dashboard with BP goals, metrics, and performance

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Appendices – Additional Tools

- A. Additional Quality Improvement Resources
- B. Hypertension Control Case Studies

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What Can Public Health Do?

- Share the HCCP with clinical partners; incorporate into QI collaboratives
- Support optimization of HTN management into health care practice
- Share HTN messages on your social media profiles → #MillionHeartsQI
- Speak with partners about how they can do the same

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Getting to 70% Cardiac Rehabilitation Participation

Haley Stolp, MPH
IHRC, Inc. Public Health Analyst
Million Hearts®
Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention

September 17, 2020

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Million Hearts® Cardiac Rehabilitation Collaborative Road Map

Increasing Cardiac Rehabilitation Participation from 20% to 70%: A Road Map from the Million Hearts Cardiac Rehabilitation Collaborative

Phyllis A. Adlin, PhD, Steven J. Katzman, PhD, Janet S. Singley, PhD, Loretta E. Haines, PhD, Karen Lee, PhD, MEd, Jennifer Thomas, PhD, Donald S. Stroup, PhD, and Faruk J. Thomas, MD, MS

...Increasing CR participation from 20% to 70% would save 25,000 lives and prevent 180,000 hospitalizations annually in the U.S.

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Million Hearts® Cardiac Rehab Collaborative (CRC)

- 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
 - Increase awareness of the value of CR among health systems, clinicians, patients and families, employers, payers
 - Increase use of best practices for referral, enrollment, and participation
 - Build equity in CR referral, participation, and program staffing
 - Increase sustainability, affordability, and accessibility through innovations in program design, delivery, and payment
 - Measure, monitor, and report progress toward the CRC aim

Email MillionHeartsCRC@cdc.gov to join

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CR Communications Toolkit

- Infographics, factsheets, hospital case studies
- Patient testimonials on eCards and in YouTube videos
- Social media posts with #CRSavesLives and #CardioRehabChat
- CR Million Hearts® web content that can be put on your webpage(s)

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Million Hearts® / AACVPR Cardiac Rehabilitation Change Package

<https://millionhearts.hhs.gov/health-systems/learn/understanding-change-package/index.html>

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

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AHRQ's TAKEheart Initiative

Agency for Healthcare Research and Quality's 3-year, \$6M project to increase CR referral, enrollment, and retention.

- Partner Hospitals (n=100) implement automatic referral with care coordination
- Learning Community (n=200) explore strategies from the Change Package and find solutions with other hospitals
- Resource Center for training modules, tools, and resources

<https://www.ahrq.gov/heart/takeheart/>

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

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Capturing and Celebrating CR Successes in the US

- Share your CR quality improvement achievements:
 - Send success stories to MillionHeartsCRC@cdc.gov and/or TAKEheart@ahrq.gov
 - Submit story to the American Hospital Association at: <https://www.ahdjournal.org/submitt-a-story/>
 - Apply to be recognized as a Million Hearts® Hospital: <https://millionhearts.hhs.gov/partners-progress/hospitals-health-systems/index.html>

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

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CR Capacity in the US

If every CR program in the US was filled to capacity, plus 10%, we could only serve ~45% of eligible patients.

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

58

Hybrid or Home-based Cardiac Rehabilitation

Chen, T. Balancing Technology with the Human Touch to Promote Exercise in Medicine. AACVPR 2018

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

59

Proposed Rule by CMS: Hospital Outpatient Prospective Payment

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

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Assessing Performance and Improving Outcomes

- CR Referral:
 - Outpatient CR referrals (NOF 0643 and CMS 243) and Inpatient CR referrals (NOF 0642)
 - Using Cardiac Rehabilitation Referral Performance Measures in a Quality Improvement System
 - Using Clinical Data Registries to Access Cardiac Rehabilitation Referral Data
- CR Participation:
 - Million Hearts® Outpatient Cardiac Rehabilitation Use Surveillance Methodology (claims-based)
 - Outpatient Cardiac Rehabilitation Participation and Enrollment System: Researcher's Guide to the Data
 - HRFQCD Measurement Years 2020 & 2021, Volume 2

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

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Opportunities to Build Equity in the Delivery of CR

- Automatic referral with care coordination (hint: [TAKEheart](https://millionhearts.hhs.gov))
- 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](https://millionhearts.hhs.gov) and/or send us your own
- Employ racially and ethnically diverse CR program staff
- Help eligible hospital employees participate in CR

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

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Thank You!

Haley Stob, MPH
HStob@cdc.gov

Contact the Million Hearts® CR Collaborative at MillionHeartsCRC@cdc.gov for questions, comments, or feedback.

ASK Questions on millionhearts.hhs.gov or 1-800-488-1234

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Q&A


Laurence Sperling, MD, FACC, FACP, FAHA, FASPC
Executive Director | LSperling@cdc.gov

Lauren E. Owens, MPH
IHRC, Inc. Public Health Analyst | LOwens@cdc.gov

Haley Stoip, MPH
IHRC, Inc. Public Health Analyst | HStoip@cdc.gov


Million Hearts®
Division for Heart Disease and Stroke Prevention, CDC

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Hypertension Status in Montana

Crystelle Fogle, MBA, MS, RD

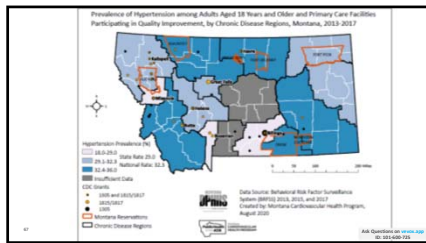


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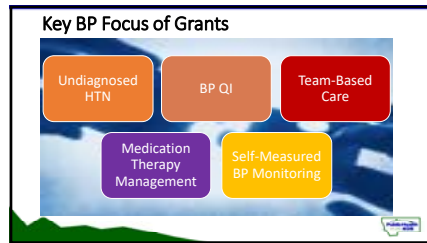
Partners



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Sample Project Outcomes

 5 CareHere health centers: 183 eligible patients - 32% reassessed - 57% diagnosed with HTN	 28 Team Up, Pressure Down pharmacies: - BP med adherence improved from 71% to 86%	 8 BP Cuff Loaner Programs: Year 2 (N=47): - 1% at target* increased from 6% to 34%
--	---	---


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Poll Question


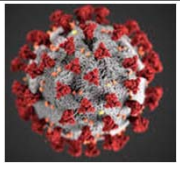
Join: vevox.app ID: 101-600-725 POLL OPEN

Is **blood pressure improvement** currently a high priority in your organization?

- Yes
- No



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Barriers

71






Resources

72

Public Health 406

Crystelle Fagle
Cardiovascular Health Program
ctfagle@mt.gov

73

TARGET: BP

Supporting Clinical System Changes for Hypertension Control

Jessica Newmyer
American Heart Association
Community Impact Consultant
Western States
Jessica.Newmyer@heart.org

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Who we are
The American Heart Association is not just a charity. We are crusaders, innovators, scientists and partners.

Our Mission
To be a relentless force for a world of longer, healthier lives.

75

Building a Culture of Health in Montana

Ask Questions on www.aha.org
© 2019 AHA 100

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Our levels of work

- Quality, Outcomes, Research and Analytics (Get With The Guidelines) - Paula Hudson, Paula.Hudson@heart.org
- Community Impact/Quality Improvement, Ambulatory - Jessica Newmyer, Jessica.Newmyer@heart.org
- CPE - Mike Dietz, Mike.Dietz@heart.org
- Advocacy/Government Relations - Amanda Cahill, Amanda.Cahill@heart.org
- Youth Market - Anne Miller, Anne.W.Miller@heart.org
- Communications - Heather Woodard, Heather.Woodard@heart.org

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Target: BP Can Make A Difference

- The AHA and AMA partnered to launch Target: BP nationally in 2015 to improve blood pressure control and improve heart health by urging medical practices to prioritize blood pressure.
- Target: BP supports physicians and care teams by offering access to the latest research, tools, and resources to reach and sustain blood pressure goal rates within the patient populations they serve.

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How Does The Program Work?

- 1 After the participant registers, local AHA staff will work with the organization to:
- 2 Customize a Plan using the M.A.P. Framework
- 3 Measure Improvement & Report Result
- 4 Strive for Recognition ultimately at 70% or higher

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M.A.P. Framework

- MEASURE** blood pressure accurately, every time.
- ACT** rapidly to address high blood pressure readings.
- PARTNER** with patients, families, and communities to promote self-management and monitor progress.

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Measuring Accurately Clinical System Change Examples

- When first blood pressure measurement taken is elevated or high, take a second confirmation by re-reading.
- Ensure blood pressure measurement protocols are standardized and using AHA/AMA recommendations on proper positioning of patients for accurate blood pressure control.
- Implement into protocol annual refresher training for clinicians on measuring blood pressure accurately.
- Positioning posters are placed in every location where blood pressure measurements are taken to remind clinical team on proper positioning of patients.

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Measuring Accurately Resources


- www.targetbp.org tools and downloads – Measure and Diagnose High BP
- Live virtual trainings and recorded webinars for clinical team on Measuring Blood Pressure Accurately.
- Educational materials on taking accurate blood pressure measurement for clinical teams including checklists, assessments, posters, etc.
- Consultation on resources and strategies from AHA Community Impact Team



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Acting Rapidly Clinical System Change Examples

- Implementing the use of ASCVD Risk Calculator into practice
- Implementation into protocols frequent follow-up with hypertensive patients including a timeline for follow up until hypertension is controlled.
- Implementation of standardized treatment algorithm
- Implementation of team-based care



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Acting Rapidly Resources

- www.targetbp.org tools and downloads
- Live virtual trainings and recorded webinars for clinical team on Acting Rapidly.
 - Trainings include: overcoming therapeutic inertia, team-based care, improving bp control through policy, lifestyle interventions for prevention and treatment of hypertension, etc.
- ASCVD Risk Calculator <http://static.heart.org/tkcalc/app/index.html#/baseline-risk>
- Consultation on resources and strategies from AHA Community Impact Team

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Partnering with Patients and Community Clinical System Change Examples

- Implementation of self-monitoring blood pressure programs
- Implementation of self-monitoring blood pressure stations in clinic lobbies and in community settings
- Implementation of loaner programs for smbp machines
- Implementation of screenings for food/nutrition insecurity and referral to community resources
- Implementation of fruit and veggie prescriptions with referrals to community resources
- Implementation of standardized referral process to local QuitLine for smoking cessation support



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Partnering with Patients and Community Resources

- www.targetbp.org tools and downloads
- Video for patients teaching them how to take their SMBP measurement
- Example protocols for SMBP monitor loaner programs
- New CPT codes to cover SMBP https://targetbp.org/tools_downloads/new-cpt-codes-to-cover-self-measured-blood-pressure-smbp/
- Live virtual trainings and recorded webinars for clinical team on Acting Rapidly.
 - Trainings include: partnering with patients and community, using SMBP to diagnose and manage bp, etc.
- Consultation on resources and strategies from AHA Community Impact Team

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LET'S GET STARTED!

Register for Target BP:
www.heart.org/RequestMuOutpatientOrg

Please Contact Jessica Newmyer, AHA Community Impact Consultant, Western States at Jessica.Newmyer@heart.org

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LET'S GET STARTED!

Please Contact Jessica Newmyer
 Community Impact Consultant
Jessica.Newmyer@heart.org

Register For Target BP:
www.heart.org/REGISTERYOUTRINTENOB



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**American Heart Association
 Advocacy in Montana**

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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



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EMAIL AMANDA CAHILL,
GOVERNMENT RELATIONS
DIRECTOR
Amanda.cahill@heart.org

AND

SIGN UP FOR RELEVANT MONTANA
ACTION ALERTS ON
YOURETHECURE.ORG/

FOR MORE
INFORMATION OR TO
GET INVOLVED:





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Mountain-Pacific
Quality Health

Montana Advancing
Million Hearts®
Patty Kosednar

Virtual Workshop
September 17, 2020



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About Mountain-Pacific



Engage providers
To improve patient care with evidence-based best practices

Encourage collaboration
Among providers and other community stakeholders

Empower patients
To take an active role in managing their health


Since 1973

A nonprofit health care improvement organization

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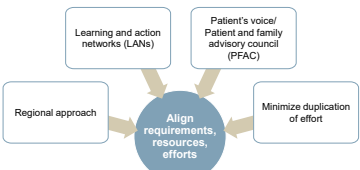
Current Initiatives
Through variety of contracts and funding sources...

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



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Our Approach





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Aligning resources, subject matter experts, outreach and approaches across states and stakeholders



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Learning and Action Networks (LANs)

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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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Activities of LAN

- Group education
- Peer-to-peer sharing
- Data collection/analytcs
- Identify needs and gaps in care and resources
- Connect subject matter experts where needed
- Identify topics, define scope and deliverables and recruit for working groups
- Identify topics, define scope and deliverables and recruit for affinity group

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LAN Events

Chronic Disease/COVID-19

August/September: Hypertension (in progress) *Can still register*

October/November: Diabetes

January/February: Chronic Kidney Disease (CKD)

Ask Questions on [covidapp](#) ID: 101-680-728

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QUESTIONS?

Ask Questions on [covidapp](#) ID: 101-680-728

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Q&A

Crystelle Fogle
Montana Dept of Public Health & Human Services

Jessica Newmyer
American Heart Association

Patty Kosednar
Mountain-Pacific Quality Health

Ask Questions on [covidapp](#) ID: 101-680-728

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Stretch Break

2:00 mins

Million Hearts

Ask Questions on [covidapp](#) ID: 101-680-728

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Hypertension and Dementia

JAMES RICHARDS, MD
Stroke Medical Director
St. Vincent Healthcare

Million Hearts

Ask Questions on [covidapp](#) ID: 101-680-728

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Dementia

- Risk factors**
 - AGE
 - Race: higher in AA
 - APOE status e4 - single copy 2x risk
 - both - 10 x (women) 2-3%
 - TBI, CTE
 - Stroke
- Types**
 - Alzheimer disease dementia (AD)
 - Vascular Dementia
 - Lewy Body Dementia
 - FTL Dementia

SCL Health

Ask Questions on [covidapp](#) ID: 101-680-728

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Vascular Dementia

- Small subcortical vascular disease with increase white matter densities and lacunar strokes
- Compared to AD, shorter life expectancy 5-6 yrs
- Stroke survivors have 2-2.8 x risk of dementia of all types
- 1/3 of AD patients have vascular pathology
- 1/3 of VD have AD pathology

SCL Health

Ask Questions on [covidapp](#) ID: 101-680-728

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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**

SCL Health

Ask Questions on [covidapp](#) ID: 101-680-728

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Control of BP and Dementia Risk?


- Framingham Heart Study**
 - cognitive performance was inversely correlated with BP over 12-14 year period
- Honolulu-Asia Aging Study**
 - BP control decreased risk later life cognitive decline
- EVA study**
 - patients with controlled BP had same risk of cognitive decline as normotensive patients

SCL Health

Ask Questions on [covidapp](#) ID: 101-680-728

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Control of BP and Dementia Risk



- SPRINT-MIND Study**
 - Intensive BP control < 120 vs <140
 - Lower incidence of MCI but not dementia
 - even the control arm had good BP control?
- Both logic and most studies support better BP control with lower risk dementia**

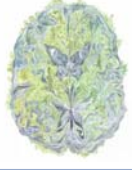
Ask Questions on [Veeva](#) ID: 101-680-720

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Q&A

THANK YOU!


James Richards, MD
Stroke Medical Director
SCL Health
St. Vincent




Ask Questions on [Veeva](#) ID: 101-680-720

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Managing Chronic Conditions in a Changing Healthcare Environment




LAURENCE SPERLING
MD, FACC, FACP, FAHA, FASPC
Executive Director
Million Hearts®, CDC




EDUARDO SANCHEZ
MD, MPH
Chief Medical Officer
American Heart Association

Moderated by
JAMES DEFOE, PHARM D
Clinical Pharmacist, PureView Health Center



Ask Questions on [Veeva](#) ID: 101-680-720

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Managing Chronic Conditions in a Changing Healthcare Environment

Million Hearts/American Heart Association
September 17, 2020

Eduardo Sanchez, MD, MPH, FAAP
Chief Medical Officer for Prevention
American Heart Association


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Causes of Death: USA (2018)

Rank	Cause	Number	Percent
	Total -all causes	2,839,205	100%
1	Heart diseases	655,381	23.1%
2	Cancer	599,274	21.1%
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%

Yu QJ, et al. Mortality in Hypertension. *N Engl J Med*. 2019;381(15):1463-1472. National Center for Health Statistics. 2019. [Ask Questions on Veeva](#) ID: 101-680-720


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AHA Mission Statement

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

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Initial Insights

- Characteristics of and important lessons from the COVID-19 Outbreak in China
- Case Fatality Rates (CFR) by age and underlying conditions
 - Age 80 or older: 14.8%
 - Age 70 - 79: 8.0%
 - Cardiovascular disease: 10.5%
 - Diabetes: 7.3%
 - Hypertension: 6.0%

Wu, McGoogan. JAMA. 2020. [Ask Questions on Veeva](#) ID: 101-680-720

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Hypertension

108 million (45%) of adults in US with hypertension (≥130mm/80mm) or taking blood pressure medications

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

cdc.gov, accessed 7/14/2020. [Ask Questions on Veeva](#) ID: 101-680-720

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Diabetes (2013 - 2016)

26.9 million adults with diagnosed diabetes
7.3 million with undiagnosed diabetes in US (21.4%)

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

cdc.gov, National Diabetes Statistics Report 2020, accessed 7/14/2020. [Ask Questions on Veeva](#) ID: 101-680-720

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Obesity (2017 – 2018)

Race/Ethnicity	Prevalence
Non-Hispanic Whites	42.2%
Non-Hispanic Blacks	49.6%
Non-Hispanic Asians	19.4%
Hispanics	44.8%

cdc.gov; NCHS, NHANES (2017-2018), accessed 7/14/2020

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COVID-19

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

cdc.gov; accessed 7/14/2020

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COVID-19

People with the following conditions might be at increased risk of severe COVID-19

- Asthma
- Cardiovascular disease
- Cystic fibrosis
- Hypertension
- Other immunocompromising conditions (including HIV or use of corticosteroids)
- Neurologic conditions
- Liver disease
- Pregnancy
- Pulmonary fibrosis
- Smoking
- Thalassemia
- Type 1 DM

cdc.gov; accessed 7/14/2020

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COVID-19 and Disproportionality

COVID-19 Mortality

- 1 in 1,450 Black Americans has died (69.7 deaths per 100,000)
- 1 in 1,950 American Indian/Alaska Native Americans has died (51.3 deaths per 100,000)
- 1 in 2,450 Pacific Islander Americans has died (40.5 deaths per 100,000)
- 1 in 3,000 Hispanic/Latino Americans has died (33.8 deaths per 100,000)
- 1 in 3,350 White Americans has died (30.2 deaths per 100,000)
- 1 in 3,400 Asian Americans has died (29.3 deaths per 100,000)

<https://www.cdc.gov/research/compare/covid19/deaths-by-race/>; accessed 7/14/2020

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COVID-19 and Disproportionality

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.

<https://www.cdc.gov/research/compare/covid19/deaths-by-race/>; accessed 7/14/2020

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COVID-19 and Disproportionality

Socioeconomic factors that may contribute to disproportionality

- "Essential" work
- Crowded, substandard housing conditions
- Uninsurance - No insurance
- Underinsurance
- Undocumented residents


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Reckoning: Post-COVID Health and Healthcare System

- Adequately resourced public health system –federal, state, local
- Health insurance for all – expanded Medicaid
- Telehealth/telemedicine for medical care and public health

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PATIENT ENGAGEMENT IN HYPERTENSION AND CHOLESTEROL MANAGEMENT



ANGELA JENNINGS, RN-BC
Primary Care Nurse Manager
Bozeman Health

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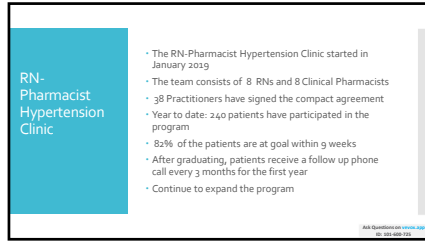
RN-Pharmacist Hypertension Clinic

Angela Jennings, RN-BC
Bozeman Health Primary Care
September 17, 2020

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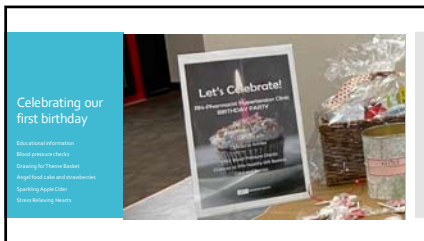
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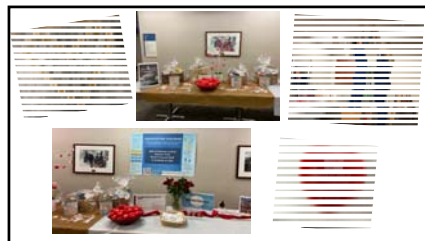
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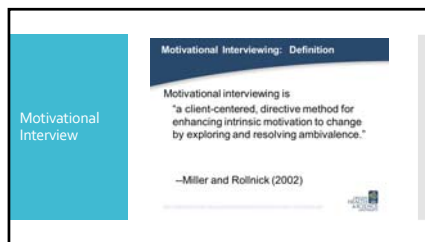
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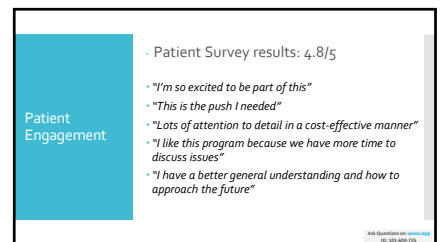
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Community Outreach & Education

- 2020 Public Presentations
- MT Pharmacy Association Winter CE & Ski
- Wisdom and Wine: Hillcrest Senior Living
- Living Well Online Health Series sponsored by Gallatin City-County Health Department and Bozeman Health

Ask Questions on vimeo.com ID: 521-488-774

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In summary:


Tools and Techniques Used to Improve Patient Engagement

- Develop a cohesive, comprehensive team
- Celebrate success in the form of a birthday
- Utilize those tools already created
- Celebrate success with a surprise gift
- Survey for satisfaction
- Reach out and share with the community

Ask Questions on vimeo.com ID: 521-488-774

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Questions




Contact:
ajg@stanford.edu
bozemanhealth.org

Ask Questions on vimeo.com ID: 521-488-774


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BRIDGING HEALTH & HOME

STRATEGIES TO INCREASE COMMUNITY SUPPORTS FOR PATIENT MANAGEMENT OF HYPERTENSION AND HYPERCHOLESTEROLEMIA



AIMEE GROSE, RN
CLINICAL CARE LEADER



LIBBY KYLO, BS, RRT
COMMUNITY HEALTH WORKER

SANFORD HEALTH

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BRIDGING HEALTH & HOME BACKGROUND

- Funding and locations
 - Mayville, ND
 - Webster, SD
- Model of Care
 - The Bridging Health and Home program (BHH) is a community-based nurse-led model of care. BHH intertwines the foundations of:
 - Nurse-led community-based clinic
 - Faith Community nursing principles of intentional care of the spirit
 - Evidence-based self-management workshops, Better Choices Better Health

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DATA

- Hypertension
 - Among participants diagnosed with hypertension (78%)
 - 15% increase in individuals average post-enrollment systolic pressures meeting hypertension goal of 140mmHg or less
 - 0.5% increase in individuals average post-enrollment diastolic blood pressure meeting hypertension goal of 90mmHg or less
- Lipid Panel
 - 47% of participants had a pre and post enrollment lipid panel, which of those individuals 32% had attended 2+ visits with the BHH team
 - 5.1% Reduction in LDL
 - 4.5% Reduction in Triglycerides
 - 4.0% Reduction in Cholesterol
 - No significant change noted in HDL

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INTERVENTIONS

- Weekly Bridging Center clinics
 - Core team
 - RN
 - Assessments
 - POC
 - Lipid panel, HbA1C, Glucose
 - Education (verbal and written)
 - Referrals
 - Community Health Worker (CHW)
 - Social determinants of health
 - Referrals to community programs
 - Pharmacist
 - Pill box fills and education




After identifying the best hypertension and cholesterol care, these community-based health workers and their partners will be the most effective way to improve hypertension and cholesterol care for the community. Through the help of the program and the community-based health workers, the community will be able to improve their health.

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INTERVENTIONS (CONTINUED)

- Community Outreach
 - Referrals from church leaders on members needing services
 - Speaking after services, along with blood pressure screening
 - Monthly newsletters
 - Education on health topics
- Local events/parades
 - Winterfest booth
 - BP and lipid panel screening
 - Floats
 - Handing out promotional items and education



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INTERVENTIONS (CONTINUED)

- Better Choices Better Health
 - Evidence-based program that was developed and researched at Stanford University
 - Self-Management Workshops we facilitate
 - Chronic Disease
 - Pain
 - Diabetes

• Sessions are 2.5 hours, one day a week for 6 consecutive weeks.
• Held in virtual or community setting

*Take control of your health
*Learn self-management skills to live life to fullest
*Set your own goals and make a step-by-step plan to improve your health and life

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INTERVENTIONS (CONTINUED)

Assessing social determinants of health

- employment
- financial resource strain
- food insecurity
- transportation needs
- lifestyle
- stress
- relationships
- ADLs

Linking the gap between communities and health/service systems: Care 2.0/3.0 model

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INTERVENTIONS (CONTINUED)

- Community partnerships and collaboration**
 - Walk for wellness
 - Partnership with the clinic providers
 - Partnership with community facility that provided a free space to exercise
 - Modeling activity for our patients
 - Cardiac ready community
 - Partnership with the board to provide community education
 - Handouts and flyers made during heart month
 - File of life

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TRANSITIONS

- Going from Grant funding to Operationalizing**
 - CPC+ (Mayville)
 - Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ seeks to improve quality, access, and efficiency of primary care. Practices will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Trained Care and Population Health. ND was chosen to participate in the program starting in 2018. It is a 5 year program.
 - CCM Billing (Webster)
 - In 2016, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.
 - Care management for chronic conditions including: systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

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Questions?

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REFERENCES

Roles. (2018). Retrieved August 24, 2020, from <http://mnh.walliance.org/who-are-chwcs/roles/>

Long, Kate. "Help Your Community Take Charge of Its Health." SMRC - SMRC, 2020, www.selfmanagementresource.com/.

149

Lunch & Networking

Use Zoom Private Chat to Connect

Meeting Resumes at 12:50 pm

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Kickstart to Resume

JEN CHILDRESS

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Afternoon Breakouts / Facilitated Discussions

JOHN BARTKUS
Principal Program Manager
Pensavia

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Breakout Workgroups

Breakout Session Topics	Groups
Strategies for Increasing Patient Engagement in managing chronic conditions	PE1, PE2
Strategies for Increasing Community Support for managing chronic conditions	CS1, CS2

2:05pm | 2:15pm MT

Breakout Session ~ 65 mins | Report Outs ~ 5 mins each | Common Themes

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Workgroup Objectives



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

GROUP QUESTIONS - FOR YOUR TOPIC:

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 patient engagement 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)

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

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Workgroup Mechanics

Main Zoom Room

PE1 PE2 CS1 CS2

- You've been pre-assigned to a session based on your topic choice.
- In a few moments - you'll see a popup to join your session.
- At the end of the session, you'll automatically return to the main room. (No need to do anything)


2:05pm

Breakout Session
60 mins

2:15pm MT

Report Outs
3 mins each

Common Themes



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Breakouts In Progress

Main Zoom Room

PE1 CS1

- If you're seeing this slide, it means you're still in the main room.
- Let John Bartkus know if you want to join one of the breakout sessions.


2:05pm

Breakout Session
60 mins

2:15pm MT

Report Outs
3 mins each

Common Themes



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Advancing Million Hearts[®]

AHA and State Heart Disease and Stroke Partners Working Together in Montana
Online Convening - Sep 17, 2020

Order of Upcoming Report Outs

PE1 CS1

Schedule


2:15 pm - Group Reports Begin
2:35 pm - Common Strategies/Themes
2:45 pm - Next Steps
2:55 pm - Final comments / Adjourn

What's Happening Now?

SHORT BREAK - while everyone's returning to the main room from breakouts.

Group Reports start at 2:15pm. In

Action: Group Facilitators/Notetakers - please send john.bartkus@heart.org final notes to be shared on-screen for your group's report out.




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Group Report Outs

Breakout Session Topics	Groups
Strategies for Increasing Patient Engagement in managing chronic conditions	PE1, PE2
Strategies for Increasing Community Support for managing chronic conditions	CS1, CS2


Order of Report outs...

PE1 PE2 CS1 CS2




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Common Strategies and Themes



JULIE HARVILL, MPA, MPH
Operations Manager, Million Hearts[®] Collaboration
American Heart Association



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Next Steps



CRYSTELLE FOGLE, MBA, MS, RD
Program Manager
Montana Department of
Public Health and Human Services



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Adjourn



LAURA KING
Director of Public Health
American Heart Association



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Advancing Million Hearts® - Montana - Partner Profiles

Summary of 15 Responding Organizations



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.



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



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



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



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 existng 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



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



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



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



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



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



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



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



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, starting 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 Kylo



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



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 innovative, we can work on this as a group

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

Slowed down approach to patient engagement, 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



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